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Innovations in Collections

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ScrippsHealth's 2000 goal: Move patient collections to the point of service

Preauthorized payments will be the norm

Paying a hospital bill will become a lot more like buying a new television if all goes as planned at ScrippsHealth in San Diego. The goal at the six-hospital health system is to move the heart of the collection process to the point of service and reduce by 80% the number of patients who require a collection call by September 2000, says **Dan Kehl**, director of collections and customer service.

A key part of the plan, Kehl explains, is getting a commitment from patients upfront for their share of the bill. "We're taking a hard look at treating [payment for health care services] more like a retail installment agreement, getting back into the world of promissory notes and preauthorized payment."

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Scripps will move away, he adds, "from the historic model of two or three letters, then phone calls, then, if there's still a balance, going to collections. If we're successful on the point-of-service [POS] side, we won't have to go down the road of, 'If you don't pay by X date, we'll send it to a collection agency.'"

As in retail, when payment is preauthorized to take place once delivery of goods is made, the patient's credit card would be charged once Scripps has determined from the insurance company exactly what the patient owes, he says. "We'd already be preauthorized to take [for example] $50 per month on the credit card. The goal is not necessarily to collect [upfront] 100% of every patient portion due, but to secure a prearranged payment."

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Planning by key players crucial to scheduling

✔ *Rehiring staff, adding PCs part of challenge*

Creating a planning team with the appropriate people — radiology managers, cardiology services managers, etc. — is essential to the smooth implementation of an enterprise scheduling system. That's the lesson Mercy Health Partners learned with the installation of Atlanta-based HBOC's Pathways Healthcare Scheduling. Dedicated staff with a focus on quality assurance worked to modify scheduling reports and do other fine-tuning after Mercy's first 'go live' week on the new system. . . 30

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"We know we cannot continue to sustain large amounts of accounts receivable," Kehl adds. "It's the same old story — the longer you wait to get the money, the less value it has." To achieve its goal, Scripps has put together a multifaceted effort that centers around improved customer service, he says. "The happier patients are, the more likely they are to pay the bill."

With that in mind, he explains, Scripps is moving away from "the historic model of the confusing hospital bill." The health system has heard from its patients — through extensive focus groups and surveys — that they want "access to more information they don't have and quicker response to inquiries and questions."

The patients let Scripps know, for example, they wanted the access representatives to explain their insurance benefits to them, he notes; they felt that was the health care provider's job. To respond to that request, Scripps will offer patients more complete information and payment options at POS or, better yet, at the time of scheduling, Kehl says. All six Scripps hospitals now have the same policies and procedures for POS collection, he notes. "Historically, each hospital had a customized way of doing things."

Giving price estimates for procedures, for example, is "part and parcel to the POS program, so that patients don't get a different price at different facilities," Kehl says. As of the past fiscal year, which ended Sept. 30, 1999, Scripps created and implemented a systemwide chargemaster to ensure that consistency, he adds.

Employees from the central business office and those at the different hospitals worked together to resolve the customer concerns brought up during the patient focus groups, he notes. One of the benefits of that collaboration, Kehl adds, has been better communication between the two groups. **(See related story, p. 27.)**

Instant eligibility check

Part of the Scripps POS solution will be a system — expected to be in place by the end of February 2000 — that checks insurance eligibility automatically as the patient is being registered, Kehl says. Before patients leave the registration desk or hang up from the scheduling call, they will know whether they're eligible for the service and how much the copayment or deductible will be, he adds. "Historically, that would take a phone call lasting up to 30 minutes. We don't have the labor available to do that."

Scripps is a beta site for Delray, FL-based software vendor Eclipsys Corp., which is designing the insurance eligibility system using a product from Envoy Corp. in Nashville, TN, says Kehl. Some systems for checking insurance eligibility fall short because they aren't comprehensive enough in the third-party payers they handle. Envoy, however, has agreed to pursue aggressively the carriers Scripps needs that the company doesn't currently cover, he notes.

"The end result is going to be an integrated eligibility system that is part of Eclipsys," Kehl says. "It will automatically go out and do the inquiry and then populate the [registration] screen with the information."

Education is the key

To make the POS collections model work, the staff must understand how to make the patient understand the new system, he points out. "Admitters need to have these conversations, share this information, and they have not had to ask for money historically. They now need to be current [for example] on the Fair Debt Collection Practices Act, [a federal law] which mandates what one can and cannot say or ask for in the process of collecting a debt."

The challenge comes from the fact that people understand health care coverage less than any other insurance coverage they have, says Scripps access director **Mollie Drake**, MBA, who oversees staff training and development as well as the scheduling and eligibility projects. **(See related story on staff training, p. 28.)**

"We're finding it's not really a collection matter, that we're actually doing the patient a better service by educating them upfront," Drake says.

"Where collection is tough is when the patient is not aware and gets a bill," she says. "Our surveys tell us they find it very confusing and feel it's the hospital's responsibility to figure it out. They're paying the premium [for insurance], but they didn't make a conscious decision to buy it — the employer decided on that."

Because the patient didn't pick the insurance and, oftentimes, didn't pick the physician, the hospital, or what the physician ordered, the patient feels out of control in the situation, she points out.

Additionally, "the rate they're expected to pay usually is not based on the total hospital bill, but on the contract with their insurance company," Drake says. "They have a contract with the

Point-of-service push promotes collaboration

Central office, site employees on same page

Special Report: Innovations in Collections

When the central business office staff at San Diego-based ScrippsHealth began to collaborate with their access colleagues at the system's individual hospitals to improve customer service, an extra benefit resulted: better rapport between the two groups.

"What has historically existed in all hospital systems is a separation between the centralized business office and the facilities," says **Dan Kehl**, director of collections and customer service. "Any time there was a problem with an account, there was lots of finger pointing. The front end pointed at the back end, and vice versa."

Knowledge levels must be equal

When the two groups sat down together to address issues raised in Scripps' patient focus groups, they came to realize that all access representatives need to have the same level of knowledge no matter where they work in the system, Kehl says.

The emphasis on point-of-service collections and customer service, he notes, led to the establishment of systemwide protocols and performance standards for all access personnel, whether they work in the hospital, in the business office, or in an ancillary department.

All access personnel, for example, will present information to the patient on advance directives and Medicare in the same way. Staff will be taught by a professional educator, not a peer, to ask questions the same manner when getting the various consent forms signed.

"Now [access staff in] the business office and the facility work more closely together to resolve problems," Kehl says. "Now if there's a problem, it's a ScrippsHealth problem, not a problem of one group or the other." ■

insurance company, but we have another contract with the insurance company. There needs to be a go-between to explain how they work together."

The patient may have a copayment of 20%, but if the case is being handled on a per diem rate, he or she has no way of knowing it will be paid differently, she says. Many patients get angry when they receive a $500 hospital bill — because they had a deductible — two months after the service and after the hospital has settled with their insurance company. "Our expectation is that it will be paid in 30 days, and at this point, the patient has no option," she says. "They can't go back to the physician and say they won't have the procedure."

Explaining options upfront

Under the new system, the idea is to eliminate that kind of miscommunication by having an access representative present all the patient's options, including payment expectations, at the time of scheduling, Drake says. With some 1,000 outpatients a day spread out among clinically trained employees doing scheduling in the various service areas, that had not been feasible before, she says. "All that [clinical] person cared about was getting the technician, the treatment room, and the right [medical] instructions. They weren't even accessing the database to get the address or insurance."

By the time access management got involved, 24 to 48 hours before the appointment, "there was rarely enough time to register the patient, call the patient, get the insurance authorization, and maybe get back to the patient," she says. "Even if you did get back, it's after the appointment's been scheduled and now you're calling to say, 'Can you bring $500 with you?' Then the patient may not show up because he can't pay, and you've wasted resources. The time to do it is when [the patient] is calling to schedule."

Having the financial conversation with the patient upfront also allows the hospital to identify charity cases right away rather than months later after the patient has been subjected to the collections routine, Drake points out. "That saves effort on the back end and allows the patient to go in [for the procedure] with more comfort."

Realizing she couldn't find a computer scheduling system that could show a clinical person how to understand financial information, Drake decided to go in the other direction: She would start with a financially trained employee and buy a system that walked that person through the clinical aspects. "With outpatient services, most protocols are standard," she says. "You can build them into the system."

Scripps is in the process of adding the Eclipsys scheduling system to the patient accounting, patient registration, and medical records modules it already uses from that vendor, Drake says. Procedures and protocols are being loaded into the system in phases, with most of radiology on-line by mid-January, physical therapy and speech therapy to follow, and then endoscopy, she adds.

The remainder of the outpatient areas will be brought on-line after that, with the entire system expected to be in place by the end of 2000.

Initially, each of five hospitals will centralize scheduling within its own facility, Drake says. The sixth Scripps hospital is not included in the project, she explains, because it has close ties with one medical clinic that prefers to control its own scheduling.

As soon as Scripps goes to the Eclipsys multi-entity format — an upgrade that allows an access representative to sign on to Scripps as a system rather than to one individual hospital — scheduling will be centralized throughout the system, she adds, and patients will call one number for all facilities. ■

'Boot camp' for access runs the gamut of skills

The comprehensive training for access services staff at ScrippsHealth in San Diego includes a "boot camp" for new employees and a core competency program that builds in motivational achievement. The boot camp, a two-week program first held in January 2000, covers everything from techniques for upfront collections — a focus of Scripps' new point-of-service (POS) program — to insurance information, to a crash course in how the health system works, says **Dan Kehl,** director of collections and customer service.

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Using the POS training techniques, explains **Mollie Drake,** MBA, access director, staff learn how to:

(Continued on page 30)

ScrippsHealth

PATIENT FINANCIAL ASSESSMENT STATEMENT

RESPONSIBLE PARTY NAME LAST	FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY		ACCOUNT # (S):
SPOUSE		NUMBER OF DEPENDENTS
STREET ADDRESS		PHONE
CITY, STATE & ZIP		WORK PHONE
EMERGENCY PHONE	RESPONSIBLE PARTY DATE OF BIRTH	RESPONSIBLE PARTY S.S.#

RESPONSIBLE PARTY		SPOUSE	
OCCUPATION		OCCUPATION	
EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)		EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)	
ADDRESS		ADDRESS	
SUPERVISOR NAME		SUPERVISOR NAME	
PHONE	YEARS AT EMPLOYER	PHONE	YEARS AT EMPLOYER
SALARY ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY		SALARY ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY	
OTHER INCOME	SOURCE	OTHER INCOME	SOURCE

ASSETS		LIABILITIES	
CASH ON HAND	$	REAL-ESTATE PAYMENTS	$
CHECKING ACCOUNT*	$	INSURANCE PREMIUMS (AUTO, MEDICAL, HOME)	$
SAVINGS ACCOUNT*	$	TAXES	$
CREDIT UNION ACCOUNT*	$	UTILITIES	$
REAL ESTATE EQUITY	$	AUTO PAYMENTS	$
MOTOR VEHICLES OWNED	$	FOOD	$
MAKE YEAR		HOUSE PAYMENT IF RENTING	$
MAKE YEAR		OTHER LIABILITIES: DESCRIPTION / PAYMENT / BALANCE	
TRUST ACCOUNTS	$		
OTHER SOURCES (STOCK, BONDS)	$		

*BANK BRANCH (S) & ACCOUNT NUMBERS:

I HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA

Signature _____ Date _____

WHITE - Hospital CANARY - Patient/Responsible Party

Source: Scripps Health, San Diego.

• make the patient aware there is a financial obligation;
• help the patient understand how the amount was determined;
• figure out the easiest way to pay;
• counter any objections to payment.

"If the patient has a fairly high out-of-pocket expense, we want to let them know before and give them the opportunity to set up payments, she says. "The terms we're requesting are less lenient than those for credit cards, but then, we're not charging interest."

If patients request payment terms that are outside the norm, they are asked to complete a patient financial assessment form that allows Scripps to do more sophisticated financial counseling, Drake adds. **(See form, p. 29.)** "If we find out they're sending $300 to the cable company, for example, we might suggest they could cancel HBO for six months," she says.

Class just one in a series

The POS class is one of 24 courses in access level one training, which is required for all access employees, Drake says. Scripps offers a self-study workbook for each course to accommodate employees who aren't able to attend the classes or prefer to work on their own.

An access level two class covers the art of self-pay negotiation. "If access representatives are not confident how an HMO or a PPO works, they won't be comfortable talking to the patient," Drake points out. "If the staff feel confident, it will come across in the conversation. If they start wavering, the patient will lose confidence in how we've come up with [the amount to be paid]."

The courses are part of a "Career Paths" program, introduced in December 1999, that allows access representatives to achieve upward mobility based on their own training and initiative, she explains. After access level one training, with demonstration of each additional competency level, employees can be promoted one salary grade and receive a 5% increase in pay in addition to any merit increase, Drake says.

The curriculum includes different classes for all three levels, plus a few — customer service and Medicare compliance, for example — that continue through all levels, she adds.

(Editor's note: Look for a complete discussion of ScrippsHealth's Career Paths program in the next issue of Hospital Access Management.*)* ■

Planning by key players crucial to scheduling

Rehiring staff, adding PCs part of challenge

The overall lesson learned when Cincinnati-based Mercy Health Partners went live with its new Windows-based scheduling system is that the participation of key players in the planning process is crucial.

That advice comes from **Jane Lach**, RHIA, MBA, regional director of access, who is overseeing the system's implementation of Pathways Healthcare Scheduling (PHS), a product of Atlanta-based HBOC.

"You have to create a team with the appropriate people — radiology managers, cardiology service managers, etc. — and gain the participation of the sites and the people affected," says Lach. Because the Mercy project team lacked initial participation from personnel in the ancillary departments at the system's four hospitals, modifications had to be made after the system went live, she adds. "We got feedback from the departments and had to make changes to the [scheduling] reports."

Before going live on Pathways, staff had to load 4,000 future appointments into the new system.

Each department works off the next day's schedule because of the need to order supplies for specific exams and make other preparations for appointments, Lach notes. The nuclear medicine department, for instance, needed the patient's height and weight, and other areas required other clinical information. Because there also were questions about the way the exams were listed on the reports, the form was changed so the exams were grouped under the various resource groups.

Another issue that arose after Pathways went live on Jan. 10, 2000, was that the departments realized they needed more computer hardware than they initially had requested, Lach says.

"This scheduling system requires a pretty robust PC, and to make life easy, they soon realized they needed PCs in places where they had terminals with no memory and no hard drive."

The system requires a PC with a random access memory of at least 64 megabytes, she explains.

Before going live on Pathways — the crux of a new call center consolidating precertification, preregistration, and scheduling for the four facilities — staff had to load 4,000 future appointments into the new system manually, Lach says. "The entire [call center] scheduling staff, plus others from the sites, worked four days straight until 10 p.m., which was good, because they took ownership for how correct [the information] was."

The staff met the goal of entering all the January and February appointments before the live date, and by the end of that day, they had entered the future appointments for March through June, she says.

Anticipate errors beforehand

Although staff did quality assurance on the work, there were some errors in the 4,000 entries during the first two weeks the system was live, she adds. The individual departments were encouraged to print out scheduling reports from the old DOS-based scheduling system before the "go-live" date so they could verify the new PHS computerized schedule.

"We're running a report from the old system and then looking at what's in the new system," she says, "but it's like a moving target because every day it changes. A patient could call and change a time, [for example], so it's like swimming upstream."

Surgery department eyes system

As of late January, the scheduling system was operational for four hospitals in radiology, cardiology, and pulmonary services, Lach says.

"As far as future applications for PHS, we're looking at creating a schedule for preadmission testing appointments at all four sites. We're working with the surgery department on that," she explains.

Through June or July, Lach will be overseeing efforts to bring up radiology, cardiology, and pulmonary services at two additional hospitals acquired by Mercy Health Partners in April 1999 and then add physical therapy and the system's wellness center at all six facilities, she says. "The project probably will go on for another 12 to 18 months."

Feedback from the call center's own staff during the system's first week in operation also has prompted some retraining, clarification, and rebuilding of schedules to make the system easier to use, Lach notes. "The other thing we monitored during 'go live' was the call center service levels, including abandonment rate [the percent of callers who hang up before staff can answer], length of talk time, and grade of service [calls answered within 50 seconds]."

Those service levels went down during the first week on the new system, with the abandonment rate increasing from 3.6% to 8.8%, the average talk time increasing from three minutes and 15 seconds to three minutes and 45 seconds, and the grade of service falling from 85% to 69%, she says.

The good news is that those levels bounced back by the end of the second week, with the abandonment rate down to 3.3%, the average talk time at three minutes, 19 seconds, and the grade of service back at 85%, Lach says. "We made a fast recovery."

Project hits a snag

The scheduling project suffered a bit of a setback when Mercy announced to the staff at the two new hospitals, located on the city's west side, that they would be moving to a new central location: "One [employee] of 10 or 11 decided to come to us," Lach notes, "so we had to rehire. We're training new people to support the westside hospitals until we can move them to [the call center], which won't happen until next summer."

Those who elected not to move have taken other positions within the admitting department or transferred to other departments at the hospitals, she adds.

After the westside PHS database is built, Lach says, staff will be trained on-site so they already will know PHS when they move in with the rest of the call center employees to take calls for the entire health system. ■

Need More Information?

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Be ready to sound alarm in handling transfer cases

AMs can help prevent liability, expert says

The liability risks for hospitals and physicians under federal EMTALA / COBRA laws are growing in ways even many experts never considered, two recent court decisions illustrate.

Access managers may need to be the ones sounding the alarm in such situations, suggests **Stephen A. Frew**, a Rockford, IL, a health care lawyer who advises hospitals on the 1986 law.

Both cases, which involve transfer patients and on-call physicians, "put a premium on having a set of policies and procedures that define exactly how transfers and specialty cases will be handled," says Frew.

"[Hospitals] need written policies and procedures, including a system to get administrative review in real time within the institution on a stat basis," he adds. "If the on-call [physician] isn't responding or turning down transfers, often the admission folks are aware because they will be the ones stuck in between in the negotiations.

"There needs to be a mechanism to put a real-time solution in place to prevent a violation. Fixing it afterward doesn't help."

Misconceptions could be dangerous

In the most recent case, a Missouri court had dismissed a lawsuit against an on-call physician, saying no physician / patient relationship had been established. The case against Mexico, MO, general surgeon Joseph A. Corrado, MD, isn't settled, but it shows a dangerous misconception about physicians' legal obligations, Frew says.

Corrado has argued he should not be held liable for failing to respond to a call to treat a woman who was badly injured in a November 1995 car crash because he had no physician / patient relationship with her, a requirement of the state's malpractice law.

When the woman was brought to Audrain Medical Center's emergency department, Corrado, who purportedly was on call, was attending a four-hour meeting of the American College of Surgeons in nearby Columbia, MO, and had left an orthopedic surgeon in his place. According to the Corrado's lawyer, the hospital was informed of the change. The patient's lawyer contends the hospital was not informed.

The patient, Marjorie Millard, who needed the services of a general surgeon, was transferred to a trauma center. She survived but lost a kidney, has an ileostomy, and suffered a brain injury. She later sued the hospital, Corrado, and an emergency department (ED) physician, as well as General Motors for a safety defect in the car she was in. All but Corrado, who was dismissed from the case early on, settled for an undisclosed sum.

Case sent back for trial

In December 1999, the Missouri Court of Appeals, Eastern District, overturned the ruling and sent the case back for trial, saying Corrado's on-call status created a duty to provide reasonable notice to appropriate hospital personnel when he would be unavailable to answer calls.

"This case holding represents, in my opinion, just another realization that the old rules that govern on-call and duty to accept transfers no longer apply," says Frew. "Previously, physicians could pick and choose patients, and an on-call physician had no obligation until he or she accepted the patient, with no duty to accept transfers."

That philosophy has been entirely replaced, he adds, "by a formal structure, working its way up through the courts. Basically, the EMTALA and the COBRA law have substituted a legislated standard."

In the other case, a federal administrative law judge (ALJ) entered an order finding that an Oklahoma hospital violated COBRA / EMTALA laws when its on-call surgeon turned down a transfer of a vascular surgery patient from another community. The ALJ assessed a $25,000 civil monetary penalty against the hospital rather than the $50,000 fine provided by the legislation.

The case, which is on appeal, was publicized on NBC television's "Dateline" program after the network investigated allegations that several hospitals turned down transfer of the patient, who ultimately died in surgery many hours after the first request for emergency transfer was made, Frew says. Several hospitals were cited by the federal Health Care Financing Administration, submitted plans of correction, and reportedly settled civil lawsuits arising from the case, he notes.

The ED physician at the hospital at issue in the

case contacted the on-call vascular surgeon, who indicated he was "not interested" in taking the case, according to the ALJ findings, explains Frew. The surgeon recommended transferring the patient to the Norman-based University of Oklahoma hospital, which previously had turned down the transfer. At trial, the hospital disputed whether it had been requested to accept transfer and whether it was obligated to accept a patient medical personnel deemed better off at another facility. The ALJ rejected all of the hospital's arguments and entered the fine.

This case is the first instance of a hospital going to trial over the issue of fines.

"The hospital escaped a maximum fine because the ALJ found that the hospital had proper policies that required the transfer to be accepted but negligently failed to assure that they were complied with by the on-call physician and the ED physician," Frew says.

Hospitals have to accept

Federal law requires hospitals that have greater capabilities than referring hospitals to accept emergency transfers of patients needing those services and to do so without regard to means or ability to pay. This case is the first instance of a hospital going to trial over the issue of fines, Frew points out.

"The message from this case is that hospitals have to accept requested transfers, and their on-call physicians must facilitate those acceptances," he says. "It also appears that if the hospital gets involved in the process and makes a financial denial, rather than just failing to assure that their personnel understand the acceptance rules, the fines are likely to be substantially higher."

The highest administrative fine to date for denial of acceptance of a transfer was a $148,000 fine last fall against the Lawrence-based University of Kansas Medical Center for turning down three patients as a result of financial disputes with the state of Missouri Medicaid program, Frew adds.

(Editor's note: More information on EMTALA standards and court cases is available at Frew's Web site: www.medlaw.com.) ■

Don't reinvent the wheel: Ask your vendor for help

Medicare, 72-hour snags solved at OSU

Struggling with the best way to handle advance beneficiary notices (ABNs)? Need an efficient method for getting the Medicare Secondary Payer (MSP) questions answered? Don't panic and think you have to reinvent the wheel, says **Joseph Denney**, CHAM, lead, patient management system implementation at The Ohio State University (OSU) Medical Center in Columbus.

Instead, go to your software vendor for help, Denney suggests. "When an issue like this comes up, we go back to our vendor, [Malvern, PA-based] SMS, because we know the same issue has got to be on the plate of every SMS client. We ask SMS, 'What are you doing about it?'"

That question, he says, usually leads to a collaborative solution between OSU and the vendor. In the case of the MSP questionnaire, "SMS did not have an electronic solution at the time, but being the size we are, we said, 'We need [a solution] custom-built.' They took our idea and are making it a product."

OSU Medical Center also worked with SMS on processing for the Medicare 72-hour rule, which requires that charges for outpatient services that occur within 72 hours of an inpatient stay be rolled into the same account, Denney notes.

"We did custom programming on that with SMS, and now they're looking at [making it] a product." An added benefit is that when the solution becomes a product, the vendor must compensate the hospital for its part in the design, adds Denney.

The SMS/OSU solution for the Medicare 72-hour rule processing, he explains, works like this: When a Medicare patient is admitted, the software searches the computer system, using a date range, and comes back with the information that there are, for example, two other outpatient accounts that now need to be rolled into the inpatient account.

"What was special about us is we had two rules in effect," he says. "The [OSU Medical Center] is under the 72-hour rule, and the other hospital that is attached to us, James Cancer Hospital and Research Institute, is [diagnosis-related group]-exempt and under a 24-hour rule.

"We had to make [the software] go in two

different directions," Denney adds. "We did custom programming to have an entity indicator. Both hospitals are on one patient management system, but via the indicator — 'U' or 'J' — [the software] points the admission to the correct patient accounting system."

The 72-hour solution took eight or 10 months to complete, he says.

The annual users' conferences sponsored by virtually all major software vendors are another problem-solving source, Denney points out. "In many cases, users run the conference, and there is strength in numbers. The almighty dollar talks."

Similarly, e-mail list servers, whereby users trade questions and answers on the vendor's products, can provide valuable feedback, he says. "I have come up against a few problems over the past four or five months and have put the question out on the SMS [list server].

"I just put one out because we are going to start to collect copays upfront in connection with [providing] ABNs," Denney adds. "We figured if we're going to tell the patient they have to pay for a service, we might as well have them pay for it. We're going to get into the collection game for the first time in patient access services."

Although patient accounts professionals traditionally have been more likely to subscribe to such list servers, he notes, the increased emphasis on upfront billing accuracy is changing that. ■

Look at bigger picture for career advancement

'Grass is greener' whichever direction you look

When it comes to the life and work of an access manager vs. that of a health care consultant, the grass truly is always greener on the other side, says **Beth Ingram**, CHAM, director of patient financial services at Touro Infirmary in New Orleans.

Whatever direction you're going, experience in one job brings valuable skills to the other, adds Ingram, who has come full circle in the access/consulting loop: She spent 25 years in patient access and business office positions, worked as a consultant for two companies between 1994 and 1999, and recently returned to the world of hospital management.

"The experience that you get being a hospital department director or manager in assessing, implementing new systems, and working through problems positions you very well to go into the consulting field," Ingram says. "It puts you at an advantage over people who have more technical experience on systems but don't understand the overall hospital process as well."

Her message for access managers and directors looking to expand their horizons: "Do as many different things as you can; volunteer for as many committees as you can, particularly those that cross multiple departments, so you can learn how things fit together."

In both her consulting positions, Ingram points out, she acted as a project manager, with involvement in a lot of process engineering. One company outsourced and ran medical records and admitting departments, she says. "As the professional services director, I supported the director [at the client site] and even served as interim director if there was a vacancy. We were trying to re-engineer to the savings we had promised the client."

At Detroit-based Superior Consulting Co., she says, she managed a wide range of projects, depending on the client's need. "There were nine or 10 [cases] where I was helping the hospital implement a new system of some kind. Process improvement is part of that — make sure they're maximizing use of the system, automating as much as they could."

One important trait often missing in access managers but invaluable in consultants is objectivity, she says. "It's the ability to separate yourself from your narrow corner of the world, look at the organization from the big-picture standpoint, without just thinking of your piece, and ask, 'What is in the best interest of this organization? How would this process work to support the overall goals of the organization?'"

A frequent pitfall for access managers is becoming fatalistic about what they can accomplish, Ingram says. "They begin to get complacent about

what they can do, what they can affect." It's true that some problems are out of one's control, she adds, "but you can always keep trying to address the issues you do control.

"The real key is to look at facts, not feelings," she says. "When you get buried in details, you get to the feeling level. Step back and collect the data that is required, and do that without it being a seven-month project."

For example, an access manager who gets calls every day from the emergency department saying there aren't enough staff should plot for two weeks what time patients come in and what time employees are there, she suggests. "You will find you're staffing to the needs of the employees and not the patients. Shift one person's hours by three hours and make all the difference in the world."

As a consultant, she worked in dozens of hospitals where that approach was not taken. The barrier to that kind of critical thinking, crucial in the consulting arena, is often that managers think data collection has to be a big, formal process, she says.

"What people frequently don't do well at hospitals, but that is taught very well to consultants, is documentation," she says. "[In consulting], you have to document everything you do all day long every day. That's how the company demonstrates value to the client. You also have to make sure you're documenting decisions and the steps you're taking to go through a process, so when you're gone, [the client] will know how to carry on."

Although her current employer does require such documentation, including monthly reports from each director, that isn't the norm at most hospitals, she says.

Returning home

Coming back into a hospital setting, she has drawn on a "toolbox of information" gathered during her time on the road as a consultant. "I've seen things done a million different ways — how people worked through processes — and it's so much easier to deal with the issues than it was before."

The biggest choice Ingram faced in considering a return to a hospital director position had to do with people management. When she left, "I was ready not to manage people anymore, not to have that responsibility. That part of consulting is very nice."

The tradeoff in returning, she says, was regaining the camaraderie and sense of family that working at a hospital provides. "It's not that the [consulting firms] don't help you feel part of the company, but it's different from being in a facility with people interacting face to face."

Her consulting experience, meanwhile, has strengthened those people-management skills, she says. "When you go back to [hospital management] after having been out of it, you have seen the best and worst of management styles and really are positioned to do things a different way [and] be more objective.

"I remember agonizing over having to tell somebody they're not doing a good job," Ingram says. "Now, while it's not pleasant, it's just a matter of business. We have a job to do. You're doing what you're doing because it's the right thing to do for the organization that pays your salary. It deserves the same level of commitment and drive that someone would give who was there as a consultant being sold as a value-added product." ■

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NEWS BRIEF

If you build the Web site, don't assume they'll come

As hospitals experiment with Internet sites — many aimed at allowing patients to schedule or register for an appointment on-line — it's important that the Web site visitor find them easy to use, says Rockford, IL-based health care consultant **Stephen A. Frew**, JD.

Most hospital sites now on the World Wide Web are a complete waste of time and resources, Frew says. "Most hospital sites don't have any clear idea of what they want to achieve, who will be using the site, or what those users want when they reach the site."

The worst sin for the hospital Web site is a lack of clear purpose, he adds, or what he calls the "Build It and They Will Come" syndrome. This myth, he suggests, causes Web site developers to assume that if they are "on the Internet," it will have some mystical power to draw users to the site.

"Today's Internet users will give you about 15 seconds to show them why they should stay at your site, and then they will click on to other sites," Frew says.

Steps to a successful site

Here are Frew's suggestions to improve sites and make them a valuable hospital asset:

1. Reduce photos and other graphic images. Skip the cute gimmicks.

2. Skip the corporate and statistical material on the home page and save it for elsewhere.

3. Figure out what the site is supposed to *do* before you design it.

4. Design the site for the user, not for a graphic design competition.

A complete article with site make-over suggestions, including examples, is available at Frew's Web site: www.medlaw.com/sitecrit.htm. ■