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IN THIS ISSUE

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Will your hospital measure up as consumers take health care reins?

Easy scheduling, quick access will make providers more competitive

In much the way 401k investment plans forever changed retirement benefits and led to the realignment of the financial industry in the 1980s, a concept called "consumer-directed health care" (CDH) appears poised to transform the way health care is delivered.

While increasing numbers of employers sponsor consumer-directed insurance plans that emphasize high deductibles with a safety net to cover long hospitalizations, the government offers health savings accounts (401k-type plans for health care) to make the transition easier for employees.

Baby boomers already prone to comparison-shop — reviewing a hospital's quality indicators and the price of routine procedures — are expected to pay even closer attention when a larger percentage of the money being spent is coming directly out of their own pockets.

CDH advocates contend, as employees take a more active role in purchasing their health care, providers will be forced to compete for their business, resulting in dramatically reduced costs for similar quality and significant improvements in service levels.

As hospitals prepare for this new dynamic — with the goal of increasing service levels and giving these new consumers what they want — the attention inevitably turns to access management.

An article titled "The Role of Access Management in the New World of Consumer Directed Healthcare," posted recently on the web site of SCI Solutions, suggests that hospitals and health systems focus on how to better market their services, target their customers, and navigate comparisons regarding trade-offs between cost and quality, and offers eight questions to help providers assess their CDH readiness.

Hospital Access Management asked several leaders in the access field to respond to those questions and discuss their implications:

- **How easy is it for the physician-referral population to do business with my hospital?**

  The University of Arkansas for Medical Sciences (UAMS) Medical

Center in Little Rock offers referring physicians, as well as internal ones, the option of completing an on-line scheduling form to request an appointment, says **Janet Lynn**, director of patient coordination.

"That form gives us the patient and physician demographics, the diagnosis, and the requesting clinic," she notes. "If they provide an e-mail address, the system will automatically e-mail them back with an appointment."

Staff also call back to confirm the information, Lynn adds. At present, "there are very few referring physicians who opt for that service," she says, noting that most use the toll-free number that is provided for appointment scheduling.

One of the things UAMS Medical Center does to make that process easier, Lynn says, is to have enough schedulers so there is very little chance a caller will be placed on hold or have to wait for someone to pick up the call.

"Our average answer delay is consistently 10 seconds or below," she says. "Our goal is 10 seconds, and we pretty much stay within that."

Schedulers get basic information — name, date of birth, telephone number, provider, and reason for the appointment, Lynn notes.

"The difficulty we have is appointment availability. Our physicians serve three hospitals, do research and teach, and their clinic time is limited," she explains. To help alleviate that situation, physicians are asked to increase the number of patients they see in a half-day clinic from six to seven.

At Swedish Covenant Hospital in Chicago, says **Gillian Cappiello**, CHAM, senior director of access services and chief privacy officer, "we make it as simple as possible [for referring physicians] with one advertised number."

Providers who offer a single number, however, should make sure employees answering the calls have the skill level and resources, such as databases, to appropriately respond to or direct callers, Cappiello points out. "If [physicians] schedule surgery, they shouldn't also have to call admitting."

Swedish Covenant recently put together a physician orientation manual that outlines need-to-know information such as hours of admitting, key service lines, and contact people for each department, she adds.

- **How many phone calls does it take to get an appointment?**

"It should take only one — for patients and physicians, but if a patient is calling, [the scheduler] is only as good as the information the physician provided," Cappiello says. If, for example, the physician didn't included the ICD-9 code, she notes, a callback might be required.

"We try to schedule with the patient as best we can, have them assume we're finished, and then follow up with the physician if necessary," adds Cappiello. "On rare occasions we may need to call the patient back — if we discover the person needs a two-hour, rather than one-hour, appointment. Ninety percent of the time it's one call."

At UAMS Medical Center, the appointment staff can schedule on-line in its scheduling system for about half the hospital's clinics, Lynn adds.

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Editorial Questions

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"For some clinics, we gather the demographics and forward the appointment request to the scheduler for that area. Then there are other clinics that we can only transfer the caller," she says.

"We do get complaints that it takes too many calls to get an appointment," Lynn points out, primarily because of the need for some specialties to pre-screen appointment requests.

"We have 14 people who schedule appointments [in a central location], but they are not allowed to schedule for all of our clinics. When someone calls for a neurosurgery appointment, for example, schedulers take the information and forward it to that clinic, Lynn explains. "Physicians are trying to ensure that the patient needs to be referred to their clinic, so they may want to look at the medical records before scheduling."

The process can be frustrating for callers who provide information and still have to wait for another step, she adds.

- **On average, what is the lead time to get a radiology exam done?**

Routine radiology is an on-demand service at the University of Pennsylvania Medical Center-Presbyterian in Philadelphia, says **Raina Harrell**, business administrator for patient access.

Streamlining the process is the practice of allowing certain physician practices to have block time in the radiology area so they can bring patients in more quickly, she adds.

"Orthopedics is one of our high-referring [specialties], so their patients take priority in those rooms," Harrell says.

The practice also allows the hospital to get other patients in more quickly because space has been allocated for the high-demand practices, she notes. "Our schedule moves faster than some of the other hospitals because of the way patients are organized with that block time."

Same-day or next-day appointments should be provided, Cappiello says. Timeliness with this kind of service is particularly important, she adds, because of the recent profusion of freestanding radiology centers. "The physicians want [their patients] in as soon as possible. If we can't fit them in, they're going to go somewhere else."

With a routine procedure, patients might be willing to wait, but if they have a busy schedule and can only come before work, they have choices," she adds. "There are dialysis centers, and cancer centers all over the place. [To be competitive], we really have to make [care] available at their convenience."

Another trend that is providing patients with more choice in providers — at least in her area — is a shift from HMOs back to preferred provider organizations (PPOs), Cappiello notes.

Her personal experience, she says, is that HMO plans are no longer significantly less expensive when one takes into account discounts and the ability to go to a specialist without a referral from a primary care physician.

- **Can our customers interact 24-7 with the hospital over the web to schedule services, complete mandated, seemingly redundant forms, and pay their copays or outstanding balances?**

Swedish Covenant patients can pay copays and outstanding balances on-line, Cappiello says, but at present, scheduling over the web is available primarily for classes offered by the hospital.

While noting that the ability to schedule services — particularly, routine procedures — on-line certainly is coming, she points out that, even with mammograms, on-line scheduling will present challenges.

"People may say they want a routine mammogram, but when you ask them for a diagnosis, it may turn out that they forgot [that something else was needed], or their grandmother had a history that turns it from screening to diagnostic, which is a whole different [procedure]," notes Cappiello.

"A lot of our testing now is so [complicated], and physicians are not very good at indicating exactly what they want," she adds. "The scheduling system would have to be very sophisticated, or there are few kinds of appointments that would qualify."

At UAMS Medical Center, patients and physicians, as described, can request appointments 24-7 by filling out an on-line form, Lynn notes. "We [make] that appointment, and the person receives an e-mail [confirming it]."

- **How well are we positioned to compete with retail health care storefronts in malls and specialty radiology centers?**

One of the major issues that comes into play here is cost, Cappiello points out. "Our charges are typically higher than some of those places, largely because our overhead is more." On the other hand, her hospital offers benefits such as an automatic 50% discount for self-pay patients, she adds.

"Hopefully, that would take care of [cost competition], although it's not why we're driven to do it," she notes. "Part of our mission is to serve the uninsured."

- **Can our patients go directly to the point of service without having to interact with the registration system?**

While patients must have some interaction with registration — certainly demographic information must be obtained at preregistration — those details can be taken care of over the phone, by mail, and perhaps in the near future, via the Internet, Cappiello says.

At Swedish Covenant, she notes, patient interaction with registration is virtually seamless, thanks to a code that prints on departmental schedules and on lists provided to lobby services personnel, indicating the patient's registration status. **(See story on keying ancillary department schedules, below right.)**

Although anyone at UPMC-Presbyterian who is scheduled also is preregistered, that amounts to only about 40% of the patients, Harrell says. "We have a huge population of walk-ins."

At UAMS Medical Center, Lynn says, "some of our customers are being preregistered before they come to the clinic. Others have to be registered on arrival. In some of the clinics, the point-of-service coordinators are the ones who do the registration."

These employees, who report to clinic management, "are almost financial advisors," overseeing copay and billing issues, she adds.

Patient access staff now preregister patients for five UAMS clinics, Lynn notes, and "our goal is to do that for all the clinics."

That goal may be realized with the implementation of a new scheduling system in about 18 months, she says.

- **Do we know if we are going to get paid for the services we are about to render?**

"More than 95% of the time, we do [at Swedish Covenant]," Cappiello explains. "If the patient is scheduled, we pretty much know [if we're going to be paid]. We don't know if [the patient] is urgent or an add-on. We usually have a pretty good idea and start working on it right away, but we're not going to delay services for that small percentage we can't figure out."

The answer is yes at UPMC-Presbyterian, says Harrell. "We verify all patients coming in for services prior to rendering services."

At UAMS Medical Center, that certainty of payment does not exist at present, says Lynn, noting that a large percentage of uninsured patients is the greatest obstacle to reimbursement.

"Because we're a state hospital, we've always been perceived as a free clinic." There are plans to implement a program whereby patients will be made aware at the time of scheduling that a payment will be expected, she adds.

- **Do we offer patient self-service capabilities such as payments and registration through the web and kiosks?**

Swedish Covenant patients can make payments through the web and through a secure phone system, Cappiello says. Patients also may go on-line to print out preregistration forms and then send the completed forms through the mail, she notes — a method that is used primarily by obstetrical patients.

With most other patients, registration staff initiate a preregistration phone call, Cappiello says, "because we have the [notice of their upcoming service or procedure] from the physician before they have a chance to call us."

While UPMC-Presbyterian currently is not offering on-line or kiosk options for payment or registration, Harrell says, she is eager to take steps in that direction. **(See related story on using kiosks for registration, p. 79.)**

"Our patients are looking for the best route to get to health care," she adds. "They're always asking, 'Is there something I can do in advance?' or 'Can I do it myself?' Any hospital that makes that available will definitely have an advantage." ■

Unique ancillary symbols streamline patient flow

85% to 90% bypass registration

A method for keying ancillary department schedules enables patients at Swedish Covenant Hospital in Chicago to go directly to the point of service (POS) and have any missing pieces of the registration process completed there — unless there's something unusual that needs to be taken care of in registration.

Either way, says **Gillian Cappiello**, CHAM, senior director for access services and chief privacy officer, an employee in lobby services directs the arriving patient to the appropriate place, based on a list of scheduled patients, so that there are no unnecessary steps.

To put the process in motion, she explains, the scheduling coordinator who makes the appointment and preregisters the patient enters the

(Continued on page 78)

Patient Flow Identifiers

POS	Point of Service	Patient goes directly to the department for the service (POS). POS registers/attends the appointment.
POSI	Point of Service — Insurance	Patient goes directly to POS. POS copies insurance cards and registers/attends the appointment.
POSR	Point of Service — Referral	Patient goes directly to POS. POS obtains referral and registers/attends the appointment.
POSRI	Point of Service — REF/INS	Patient goes directly to POS. POS copies insurance cards, obtains referral, and registers/attends the appointment.
POSABN	Point of Service — ABN	Patient goes directly to POS. POS issues an ABN for one or more tests and registers/attends the appointment.
POSDX	Point of Service — DX Needed	Patient goes directly to POS. POS contacts the physician for a diagnosis, or issues an ABN and registers/attends the appointment.
REG	Registration	Patient goes to Registration. Registrar updates all information, obtains referrals, copies insurance cards, and registers the account.
REGC	Registration — Cashier	Patient goes to Registration. Registrar updates all information, obtains referral, copies insurance cards, registers the account, and directs patient to Cashier.
REGFC	Registration — FIN Counselor	Patient goes to Registration. Registrar updates all information, obtains referrals, copies of cards, registers the account, and takes patient to Credit Services.
		If there is no Patient Flow Identifier, the patient goes to Registration.
C	Cashier	Patient goes to Cashier.
FC	Financial Counselor	Patient goes to Credit Services.
FCR	FIN Counselor — Referral	Patient goes to Credit Services. POS obtains referral and registers/attends the appointment.
FCI	FIN Counselor — Insurance	Patient goes to Credit Services. POS copies insurance card and registers/attends the appointment.
FCIR	FIN Counselor — INS/ Referral	Patient goes to Credit Services. POS copies insurance card, obtains referral, and registers/attends the appointment.

Source: Swedish Covenant Hospital, Chicago.

appropriate letters — choosing from a list of "Patient Flow Identifiers" created by the access department — in a customer-defined field in the hospital's Meditech system and gives instructions and directions to the patient. **(See "Patient Flow Identifiers," p. 77.)**

The flow identifier and the department location print on information desk schedules and the flow identifier prints on department schedules, Cappiello says. For example, if there are no extra steps needed, and the patient is to go directly to the department where service will be rendered, she continues, "POS" appears after the person's name.

Routinely, the personnel in that department are responsible for getting the consent signed, giving the Joint Notice of Privacy Practice if applicable, and activating the account in the Meditech system by changing "preregistered" to "registered," Cappiello adds.

If "POSI" appears after the name, the patient also goes directly to the point of service, and personnel there know to make a copy of the individual's insurance card, she points out.

In most cases, registrars can verify the person's insurance on-line before the appointment, but with certain insurers that isn't possible, notes Cappiello.

"If they have [an insurer] like Private Healthcare Systems, where the address for billing is different across the country, the patient flow identifier might be 'POSI,'" she adds.

Other abbreviations let staff know that a referral is needed for the appointment, that an Advance Beneficiary Notice (ABN) needs to be issued, and so forth, Cappiello says.

"Information desk and department [personnel] know where to direct a patient, as well as if there is anything needed from the patient," she notes.

If there is a "C" after the name, the person at lobby services says, 'I see that you have an appointment at radiology, but I need you to go first to the cashier,'" Cappiello adds.

For a patient who does need to be seen in registration, the patient flow identifier might be "REG" or "REGC," she points out. In the latter case, a

CDH may offer AMs another chance to shine

'Access' definition broadens

Considering the ramifications of consumer-directed health care offers yet another opportunity to broaden the definition of access services.

With health care organizations scrambling to do a better job of serving patients in an increasingly competitive environment, there may be new roles that ambitious access managers can assume, suggests **Gillian Cappiello,** CHAM, senior director for access services and chief privacy officer at Swedish Covenant Hospital in Chicago.

After all, she notes, that's how "admitting" became "access services" in the first place.

One possibility may lie in the field of customer relations management, which aids organizations in identifying and targeting customers more efficiently, Cappiello says.

Special software, for example, can ensure that hospitals send materials relating to women's health issues only to households with female members between certain ages.

In some cases, however, one might argue that the term has become almost too comprehensive.

"The word 'access' pops up everywhere," notes Cappiello. "Physicians are leaving their practices due to malpractice concerns, and in some parts of the country, there is a shortage of neurologists. So there's the issue of access to physicians."

Another access issue has to do with patients who can't get insurance, she adds. "The term is bandied about in all kinds of circles.

"All these issues are beyond the scope of access services as we've defined it," Cappiello says. "We may not be directly involved, but it gives access managers the chance to say, 'That fits,' and look at what the career opportunities are."

It's about how access managers can rise to the occasion, she adds.

Recently, Cappiello says wryly, her boss turned to her during a discussion of whether hospital departments should be closed on a holiday, and said, "Well, that's an issue of access. What do you think?"

Her response: "It's really not my decision, but if you want me to make it, I will." (The departments closed that day.) Cappiello, meanwhile, went on to write the hospital policy that clearly defined that, if a holiday falls on Saturday, the departments will be closed on Friday, and if it falls on Sunday, they will close on Monday.

She points out, however, that there is room for discussion there. "Everyone [else] is off on those holidays, and they want to come in and have their tests done then. That might not be the best decision for [every hospital]. It depends on the market and demographics."

Sounds like another access issue. ■

registrar needs to update all the information, obtain referrals and copies of cards, register the account — and direct the person to the cashier.

"We try to make sure our description of the department actually matches what it is," says Cappiello.

"The CT scan is not in the same place as the MRI — there is a 'RAD-M' [main] and a 'RAD-G' [referring to the name of the other building where radiology is located]. We need to make sure patients don't get lost," she explains.

The process, in place since August 1998, "saves a lot of people from coming to registration. We probably have 85% to 90% bypassing registration," Cappiello adds. ■

Kiosks win patient kudos and speed registration

$140 million effort enhances patient-centered care

A series of MediKiosks, designed by Maitland, FL-based Galvanon Inc., have cut patient check-in time at the Baylor Sammons Breast Imaging Center in Dallas from seven or eight minutes down to three, while winning broad approval from patients.

The pilot program, which ultimately may spread to the entire Baylor Health Care System, is part of a $140 million clinical transformation effort at Baylor.

"One of our overriding goals is to consolidate several [electronic] systems into one, to allow a single patient record across all of Baylor," explains **Randy Fusco**, corporate director of Internet development services for the Baylor Health Care System.

"Within this initiative is a specific opportunity to create what we call the 'ideal patient experience.' This entails making the entire patient experience faster, better, and safer," he points out. "Self-service technology is one way to achieve this."

The pilot program for the kiosks was launched Oct. 15, 2004, but it had its origins in earlier work Fusco had done with Galvanon.

"We were working with this vendor on another software development project inside Baylor," he recalls, "and it turns out, they had some work going on with this device that, with the swipe of a driver's license or a credit card like at some airports, allows a patient to check in. I was intrigued, and since they use similar technology to us, it made it a nice fit both for technology and the ideal patient experience."

Fusco set up a meeting for product demonstration in the summer of 2004. "We got rockin' and rollin' fast, because when we demonstrated it to executive management, they were blown away by it, and said, 'Let's do a pilot,'" he reports.

Although Galvanon does make freestanding kiosks, this pilot program started off with hand-held versions of the technology.

"The hand-held model is a wireless display device with a touch-screen," explains **Jason Whiteside**, manager, business management, Internet development services, who managed the pilot project and interfaced with the staff.

The devices work like this: When patients come to the desk, staff hand them an e-clipboard, on which they fill out the required forms. (A soft keyboard at the bottom of the device allows patients to spell out words when required.)

"There are a total of 14 in the clinic right now," Whiteside says. "We are in the process of determining where the best fit is to do this; our goal is to include the freestanding floor model as well, so we will have experience with that technology, too. This way, as we continue to move forward, we will be in a position to see which of the two models fits specific problems best."

Getting the project up and running required little if any staff training. "The workflow basically emulates the same forms, the same activities," he explains. "All we really had to cover was what to do if the device freezes, and so on."

In introducing the kiosks, Baylor had three major goals: streamline the patient check-in process, reduce administrative costs, and enhance the total patient experience. All three seem to have been achieved.

"Our No. 1 patient complaint had been the cumbersome paperwork," Whiteside notes. "This process is not only faster, but it allows the patient to do it only once; when they come back, we can present them with the information they gave the last time, and they only have to update it."

There were some fears the technology would meet with patient resistance, as many of the patients are 50 or older, but that resistance never materialized. "When we first launched, we expected a high percentage of the ladies would just decline to use it," Fusco adds. "But to our surprise, they didn't. The response has been tremendous."

As for administrative costs, Whiteside sees

many advantages. "This practice spends $20,000 a year on paper," he says. "We have taken a 12- to 14-page paper process down to one piece of paper, so we've seen maybe an 80% to 90% reduction in costs per year, and those savings will be ongoing."

In addition, Whiteside says, a tremendous amount of staff time has been freed up.

"They spent a vast majority of their day doing forms, shuffling paper," he observes.

"Since the pilot began, they have gotten about 50% of that time back — that's over three hours per day per staff member, so that's a total of 18 hours per day back. We want to focus that [regained time] on day-to-day customer support," Whiteside explains.

Budget constraints should not prevent smaller facilities from using such a system, he continues, because it will pay for itself.

"I would say absolutely [it would work at a smaller facility]," he insists. "With the old registration process, appointments were scheduled a month or so out. What we see is that date getting closer, and we're seeing more patients in a day.

"That means a pretty nice increment of patients we've not seen before. If we can do that, the incremental revenue alone will pay for the project," Whiteside adds.

Baylor is now looking at starting pilot programs at its new Plano Regional Medical Center, as well as other facilities.

"The interesting thing is, everyone gets it — they see the potential, and they're scrambling to see how to best fit the technology into their work flow," Fusco explains.

"But, I'd caution against introducing a new technology with old processes. You've got to make sure your forms and so on are in good shape, too," he adds.

"The main thing I want to emphasize," Fusco continues, "is this is not so much an exercise in trying to find technology, but an effort in looking to improve the patient experience. We have come across a lot of technology, but this is the first time we have had patients come unsolicited to administration and say, 'This is the best.' Those things are golden." ■

Take concierge approach for best customer service

Stop patient handoff, consultant says

Think "hotel," rather than "hospital," when it comes to taking care of your patients.

That's the No. 1 piece of advice offered to access managers by **Patti Daniel**, MS, CCM, LPC, LMSW/AP, director of patient advocacy and entitlement solutions at Healthcare Management Solutions in Dallas.

While many hospitals are moving in that direction, notes Daniel, a former director of admissions and registration at a large, publicly funded Texas hospital, most haven't gone far enough.

"Trends are to make it easier for patients to register themselves, to make appointments or change them, and to know in advance what their time of service payment will be," she explains.

"Those are the kinds of things you see hotels doing. The customers have a reservation, they know what the anticipated charge is going to be, and all they have to do is hand over a credit card and check in," Daniel adds.

At most hospitals, there is still a handoff of the patient from scheduling to insurance verification and check-in, she points out.

"It's easier in some facilities and not so easy in others. The bigger the organization, the more disjointed it becomes for the patient. We need to make it a more seamless process and less difficult for patients by anticipating what would make things easier for them," Daniel explains.

Are your patients still waiting in line?

If you're a patient at a hospital today, what's probably *not* happening, she notes, is the following: You walk up to a kiosk in the lobby area, swipe your credit card, hospital ID card, or driver's license. The magnetic strip picks up who you are, identifies your appointment location, and checks you in without delay.

More likely, Daniel says, you're waiting in line at the registration desk, and there's a problem with the registration of the person in front of you that's slowing things down.

"This happens especially in large teaching hospitals where there are hundreds of people checking in for appointments who wait for hours," she adds, "simply because the check-in process is antiquated, coupled with overbooking of appointments and waiting on physicians.

"Even if you make the appointment, preregister the patient, verify insurance, and precert the visit," Daniel notes, "they still have to contend

with lines that could be streamlined by the use of electronic check-in methods."

Referencing another industry from which hospitals could take a lesson, she points out that before going to the airport to catch a flight, she is able to print a boarding pass at home that allows her to board the airplane in the first segment of passengers.

"If I wait until I get there, I have to stand in line and, chances are, board with the last group," Daniel adds.

Also on that visit to the airport, she has the option of sliding a credit card into the reader at a kiosk where a security document prints out. With that document, Daniel says, she can skip one episode of standing in line.

"There are varying degrees of what can be allowed [during a patient encounter], but we should at least have check-in be a smoother process," she adds.

Give patients more tech tools, save money

Giving more control to patients — some of whom have the technical savvy to check themselves in easily via electronic means — could result in salary savings for hospitals, she notes.

Although there always will need to be patient advocates to assist those who cannot use the Internet or electronic check-in kiosks, Daniel adds, fewer employees would be needed if even some patients can make or change their own appointments.

Continuing her discussion of "the way things should go" at hospitals looking to become more customer-friendly and more competitive, Daniel offers several suggestions:

- **Allow patients to make appointments online, change appointments if necessary, and when they arrive, check themselves in.**

"There will have to be some mechanism for patients to give their consent, but there are now electronic means to perform signatures on computer notepads," she adds.

At least one large Dallas hospital is looking at the use of electronic signatures for patient consent forms, Daniel notes, as well as an easier check-in process through the use of electronic check-in kiosks that also will provide maps to appointment locations.

- **To improve upfront collections, hospitals need to be much better at telling patients what they should be prepared to pay.**

Access personnel should be able to give patients an estimate of what their charges will be that day, while emphasizing that the figure is an estimate, Daniel says, and doesn't include the cost of any additional tests the physician might order.

Providing the amount of charges in advance for scheduled patients, she adds, will avoid the embarrassment of "I don't have that much in my checking account" or "If I had known that, I would have brought my credit card," and result in higher point-of-service collections.

Real-time on-line eligibility systems that allow staff to verify third-party payers are a must, Daniel says, unless patient appointments are scheduled far enough in advance that delayed-response systems will suffice.

Automated telephone systems for checking eligibility, she adds, "are antiquated compared to what is available on the web."

- **Use a concierge approach as your role model for customer service.**

"Communication with patients is key," Daniel emphasizes, and it's not just about informing them of required fees, but about providing instructions and directions so they will be on time and won't get lost when they have an X-ray in another building.

"The more we share with them, the better patients they'll be," she adds.

Improve communication

Good communication skills can also help the bottom line, Daniel points out. "The key to being reimbursed in the quickest manner possible is when patient access employees do a good job of getting information from the patient up front."

When confirming a patient's address, for example, she recommends, "May I please have your current address?" rather than, "Do you still live at 210 Main St.?"

With the latter question, Daniel continues, the person may fail to hear clearly because of all the people around, or say yes without really listening or because he wants to speed up the check-in process.

- **Take advantage of technology improvements.**

"Enhanced technology is abounding for patient access functions," she points out, and offers, most notably, the ability to "report well and do data mining — taking the data and being able to sort them any way possible to know more about your client base — and then to build processes that will enhance the hospital's

revenue based on those data."

Being able to identify all the accounts with a particular third-party source," Daniel adds, "allows the data to be mined and the reports used to forecast estimated revenue, when changes occur in reimbursement, for example."

Knowing such information in advance leads to better management of resources, she notes. "If you can predict that reimbursement will be going down in two months, you may want to reallocate resources — adjust the number of FTEs [full-time equivalents], for example."

- **Work more closely with clinical staff, especially case managers and social workers.**

"We're all here to serve the patients and to do that in the most comprehensive and compassionate way we can," Daniel says.

"The clinical staff need to know what kind of coverage patients have. Sharing that information — what's covered, what's not — is the key to effective discharge planning for those case managers and social workers," she adds.

That conversation doesn't always happen, Daniel points out.

At the hospital where she formerly worked, she developed a process whereby financial counselors notified case managers of existing or potential payers by completing a sheet and placing it on the inpatient chart immediately following the patient's screening, Daniel explains.

"The financial counselor was required to indicate — on that sheet — what the patient was eligible for, what information was pending, and what the potential third-party payer was, so the case manager could make an effective discharge," she says.

Management support is crucial

Ultimately, the suggestions Daniel has made are all about "identifying needs and trying to meet those needs in an effort to better serve the patient," she points out. "One thing that must happen for this to occur, is that senior management has to back up [the initiatives] and provide real support.

"For example, when a patient goes to a hospital administrator and says, 'I want to make a complaint; I've never had to pay [up front] before,' that administrator has to confirm that the copay really is $50, and then offer the person all the payment options that are available," Daniel says.

Patients will be more accepting of making payments up front when they are informed in advance of their financial obligations, rather than being hit with a large bill when they get to the hospital or clinic, she suggests.

"It's all about providing excellent customer service, anticipating the needs of patients, and using technology to help in the process," adds Daniel. ■

Report suggests charity care is underestimated

Classification process called 'burdensome'

Approximately 92% of hospitals surveyed for a recent report by the consulting firm PricewaterhouseCoopers said at least part of their bad debt could be classified as charity care.

Hospitals are absorbing higher levels of charity care and bad debt due to rising numbers of uninsured Americans and may be providing far more free care than the $25 billion they report annually, the report indicated.

The report examined the changing landscape of hospital charity care based on interviews with health care leaders and a survey of 100 financial executives by the company's Health Research Institute.

Billions in uncompensated care

Charity care numbers may be underestimated because of the "burdensome and expensive process that hospitals must go through to classify a patient as charity care," the report concluded. It noted that uncompensated care, of which charity care is a component, increased by 20% from 1999 to 2003 — to $24.9 billion.

In another recent development, representatives of the American Hospital Association (AHA) and the Catholic Health Association (CHA) of the United States spoke in favor of continued tax exemption for hospitals in a statement submitted to the House Ways & Means Committee.

AHA cited the $25 billion a year in uncompensated care that hospitals provide — as well as emergency care, outreach programs, and health screenings — in contending that hospitals meet the current community benefit test for tax exemption.

Four Minnesota hospital systems, meanwhile, are among the latest health care providers to offer discounts to low- and middle-income uninsured patients under a voluntary agreement announced by the Minnesota Hospital Association and the state attorney general.

Allina Health System, North Memorial Health Care, Park Nicollet Health Services, and Health-East Care System agreed they will not charge uninsured patients whose annual household income is less than $125,000 more than the rate negotiated by the health insurer from which the hospital earned the most revenue in the previous year.

The health systems, which include 18 hospitals representing one-third of the state's admissions, also agreed to follow certain debt collection standards, including a zero tolerance policy for abusive and harassing debt collectors.

Health care models proposed

In other news concerning the uninsured, health care economist **Kenneth Thorpe** has projected that four models proposed by the National Coalition on Health Care to expand health care coverage to all Americans would save more money than they would cost to implement.

In a report last year (available at www.nchc.org), the group proposed four models for achieving universal health coverage: requiring employer-based coverage while providing subsidies for low-income Americans, expanding existing public health insurance programs, creating new public programs for the uninsured, and publicly financing universal coverage.

Thorpe projected each model would reduce health care spending by at least $320 billion over 10 years when combined with quality and safety improvement, administrative simplification, and cost-containment measures recommended in the 2004 report.

The number of uninsured Americans is expected to grow to 54 million from 45 million within a decade, Thorpe said.

The report noted that the creation of an integrated national information technology infrastructure for health care — including electronic patient records, prescription ordering, and billing — would not only decrease administrative complexity and costs, but help reduce medical errors, protect the safety of patients, and improve outcomes. It pointed out that only 10% of health care providers use computerized medical records and ordering.

This technology infrastructure, the report continued, also should include standards to protect privacy and a process for updating protocols and standards to reflect experience and technological advances.

Under another proposal for a new national health insurance system, the federal government would negotiate with private insurers, set minimum benefit packages for several levels of care, and give every American an annual sum to contribute to the health plan of their choice.

That plan — outlined in a report by the Century Foundation (www.tcf.org) — would be paid for through a payroll tax, dedicated corporate tax, general revenues, and revenue from eliminating the existing federal tax subsidy for employer-based insurance. ■

ED care sites decrease as patient visits increase

Emergency department (ED) visits in the United States reached a record high of nearly 114 million in 2003, up from 90.3 million visits in 1993, while the number of EDs decreased by 12% during the same period, to 3,910, according to a report released recently by the Centers for

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Disease Control and Prevention.

The report attributed the rise in visits to increased use by adults, especially those 65 and older, and said Medicaid patients were four times more likely to seek treatment in an ED than those with private insurance.

Approximately 58% of all hospital EDs were located in metropolitan statistical areas, but they represented 81.5% of annual ED encounters. ▼

More Americans do Internet health search

The percentage of Americans searching the Internet for information about a particular hospital or physician increased to 28% in 2004, from 21% in 2003, according to a study from the Pew Internet & American Life Project.

The increase was larger among Internet users with a college degree, to 42% from 27%; six or more years experience on-line, to 37% from 26%; and broadband access, to 41% from 31%.

Internet searches for diet, fitness, exercise, and over-the-counter drugs also increased over the two-year period, as did searches related to health insurance.

Overall, eight in 10 Internet users, or about 95 million Americans, have searched the Internet for information on at least one major health topic — about the same portion as in 2002. ▼

Health care survey gets approval from NQF

A survey intended to allow an "apples-to-apples" comparison of patients' perceptions of their hospital stay has been endorsed by the National Quality Forum (NQF), closing years of discussion and debate about the way questions are worded, how many items are included, and other specifications.

Known as HCAPS (pronounced "H-caps"), the 27-question instrument was designed and developed over a three-year period by the federal Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality.

The survey includes 22 questions addressing seven domains of hospital care: communication with physicians, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the environment, and discharge information.

It also includes five demographic questions used for patient-mix adjustment and discharge information.

More information is available at www.qualityforum.org. ■