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JULY 2008
VOL. 27, NO. 7 • (pages 73-84)

Registration process taking too long? If it's more than a minute — it is

Iowa hospitals tackle ED wait times with team triage, quick registration

"It's a constant struggle." Reducing door to doc times in the emergency department, that is. And though Iowa has traditionally ranked among the top three states for low ED wait times in Press Ganey reports, it still faces the never-ending challenge all EDs face: managing overcrowding, wait times, and patient satisfaction.

"Maybe across the nation we've been successful," says **Jeri Babb**, RN, MSN, CCRN, CEN, director of emergency trauma services for Mercy Medical-Des Moines, "but here in Iowa we still have people waiting so that's not OK for us."

Even so, the facility, which hosts the busiest and highest volume ED in the state, has managed to drop its door to doc time by half. Before the "quick reg" process was implemented in August 2006, the average door to doctor time in the 44-bed ED was 72 minutes. With the new registration policy, that time dropped to 36 minutes.

Using Six Sigma methodology, a multidisciplinary team at Mercy "started to look at throughput," Babb recalls, "because, after all, that is what makes or breaks wait times." The group took the example of a patient presenting with abdominal pain and drilled down to uncover ways to cut the time to "getting patients to treatment, because what the patient cares about is their pain relief, how soon before they see a doctor," Babb says. And since "you can't initiate care until that patient is in the system with an ID number," the quick registration process seemed to answer that need.

When an ambulatory patient walks into Mercy's emergency department, he or she encounters a triage desk, where a team comprising a nurse, a registration clerk, and a tech is stationed. The team works together to check the patient in. As the registrar obtains the four criteria needed for registration — name, date of birth, Social Security number, and the name of a family doctor if appropriate — the nurse can quickly assess the person, asking him or her why they need to be seen. In the meantime, if the patient needs a wheelchair, the tech can grab one and

after the four-part registration is completed, can wheel the patient to a triage room where a brief assessment is done. Only after the nurse and physician treat the patient in the treatment room is the entire registration completed — with address, insurance information, etc. — by another registration clerk.

With the abdominal pain patient, once the registration clerk enters his or her information into the computer, an ID band is printed, and the patient is immediately assigned a patient number. "The [traditional] registration in and of itself can take five minutes or so," Babb says. "Some patients can't wait that long. So we do this quick reg, and it also tells the patient, 'You know what? We're most interested in you and your condition, not in your payment and not in your status that way.' It's been extremely well received by patients. A lot of people at the front desk still say, 'Here's my insurance card.' And we tell them, 'They'll ask for that later. We don't want to see it now.' It gives the right message."

Once the patient goes through quick reg, he is taken to a triage room where he is assessed further and then taken to a treatment room, if one is available, or to the waiting room if all beds are full. That patient in the waiting room has been triaged, had his or her vital signs taken, and has a patient ID. "In our ED and in most EDs, you can't do anything [such as give medicine, order lab work, or complete X-rays] until the patient is registered," Babb emphasizes.

When patients with acute needs — such as those who appear to be in extreme distress, can't breathe, or are experiencing chest pain — or patients arriving in an ambulance come in, they bypass the initial triage desk and are escorted directly to a treatment room, where the quick reg process is completed at the bedside. Once the patient's name, Social Security, date of birth, and family doctor's name is collected, the nurse can immediately begin treatment.

Teamwork integral

Babb credits teamwork for their success. "As long as you have a registration clerk doing their own thing, and the nurse doing their own thing, and the doctor doing their own thing, that meant wait time for the patient. So if we group these people into teams that get to the patient all at the same time, it means things get started sooner."

For each 10 rooms in the ED, also referred to as pods by internal staff, there is one physician, three nurses, a registration clerk, and a tech. As patients come in, the pods are rotated for placement, with the registration clerks taking direction from the nurses and the physicians.

The nurse greeting the patients along with the registration clerk evaluates patients with a five-level classification system. In decreasing order, those are: resuscitation, emergent, urgent, semi-urgent, non-urgent. With levels 1 and 2, patients are taken immediately to a treatment room, where the quick reg is done at the bedside. Since the registrar works alongside a nurse, that information is communicated up front.

Babb works closely with Mercy's director of

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Hospital Access Management***™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

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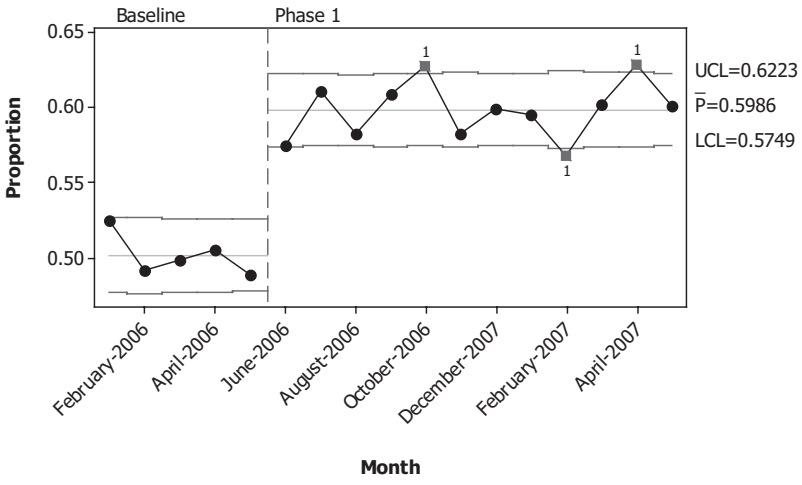
Percent of ED patients seen by a doctor within 30 minutes



Tests performed with unequal sample sizes

Source: Mercy Medical Center-Des Moines.

admitting. "That's key for better patient care," she says — working to eliminate silos; working together "even if you don't report to the same person;" and working to answer the question, "what would be best for the patient?"

Another Iowa hospital's story

St. Luke's Hospital in Cedar Rapids has used the quick registration process for about four years, with positive results, and like Mercy is undergoing new construction of the emergency department. It's added a second triage room and its 24-bed ED will hold 10 more beds when construction is complete in December. Mercy is moving toward universal rooms — "which means everybody can be treated in any room," Babb says — as part of its redesign.

Also like Mercy, St. Luke's emphasizes hastening the traditional registration and triage process, while focusing on providing constant communication between patients and staff. **Sandi McIntosh**, RN, MA, CNA, director of emergency services, says the hospital has hired four guest relations employees and staffs them from 9 a.m. to 1:30 a.m., to capture peak hours, seven days a week.

Their primary goal, McIntosh says, is to meet and greet, "rounding" through the ED to provide patients updates, asking them how they are doing, as well as providing drinks or whatever patients might want and directions to hospital sites including the bathrooms. They check in with patients about every 15 minutes.

The hospital also staffs volunteers or guest relations personnel at another entrance used for general traffic to direct them to the ED. McIntosh says the hospitals holds a "no point" policy, meaning no staff member will point out a location to patients but rather will show them where they are supposed to go. As patients enter the ED, the guest relations staff ask the patient, "Are you here to see a physician?" and then directs them to the appropriate place.

The hospital's registration staff, which report to patient access, "had to go through the learning curve" to adopt the quick registration process. "It works," McIntosh says. Their ultimate goal is to have every patient go directly to a room, bypassing the traditional registration process altogether.

ED bed huddles are held twice a week — on Mondays and Thursdays. Attendants include the patient flow coordinator and representatives from the medical/surgical unit, staffing, critical care, housekeeping, and the ED. There they discuss bed availability, staffing, the patient census, and discharges. The plan is transferred to a spreadsheet after the meeting and circulated to the managers of each department. "Emergency bed huddles" are scheduled when a staff member calls the operator and the message is sent to designated pagers of critical staff members. ■

'Show me the money:' Hiring, retaining coders

Benefit in hiring from outside

"Spoil 'em rotten, pay 'em lots of money, let 'em do what they want, and then cut their throats if they don't give you what you need."

"Really?"

"Yeah, pretty much. Except for the felony part. You can even quote me on that one."

Judy Sturgeon, CCS, hospital coding senior manager at The University of Texas Medical Branch (UTMB) in Galveston, shared some tips with *Hospital Access Management* on recruiting and retaining coding staff, whom she admits are rather "inclined to be job hoppers." She speaks from experience, but relates happily that among her 16-member staff, she has a number of "lifers" — employees who have been in the department for 15-25 years.

Sturgeon's staff are responsible for inpatient hospital DRG, day surgery, and observation coding for the most part, although they work with other departments and pitch in when needed, as well as coding for labor and delivery and the PT/OT department.

The three basic tenets she espouses on hiring and keeping staff are:

- You have to understand where your coding staff are coming from.
- You have to pay them what the market says they're worth.
- You have to provide some pretty good benefits.

In return, Sturgeon says, you'll get a competent, content staff.

Recognizing the challenges inherent in recruiting and keeping coders on staff, she admits that "coders are difficult to retain because everyone pays more and they're inclined to be job hoppers and go to the highest dollar."

Sturgeon, who has been coding herself for 19 years, says UTMB enjoys a geographical advantage that attracts coders. "[We're] not in the middle of a medical center where you can just go across the street, work at a different hospital, get your $5 raise every two years, and then just keep going back and forth depending on who's the highest bidder," she says.

The only hospital of any "comparable" size is in Houston, which is about 50 miles northwest. Though they might pay higher salaries in Houston, she admits, employees have to deal with the environs of a major metropolitan area, which to some may be a boon and to others a benefit. But beyond geography, Sturgeon says the benefits she can offer employees make UTMB an attractive spot for coders.

Lure them in with benefits

Regularly research and benchmark salaries for coding employees, Sturgeon emphasizes. "You have to do market adjustments regularly on high-turnover staff. Some of the biggest issues in high turnover is No. 1 find out why they're leaving," she says.

If it's more money, you need to do some adjusting. "If it's that they can't stand the boss," she adds, "then you have to figure out who's more valuable: the boss or the staff. And one of them has to go or stop what he or she is doing.

"Let's just say I've outlived a lot of bosses at UTMB," she concludes, with a laugh.

Sturgeon uses a software system that tracks her employees' productivity and when they are working. And because she works in a university center, open 24 hours a day, it doesn't necessitate adherence to banking hour work days. "So if [staff] want to come in and work weird hours because it suits their personal schedule or their day care" or if someone needs to take a day off, but has no vacation days, they can do it, she says. Once an employee logs on to his or her computer, the software will show the time he or she has worked.

"Having the right staff, paying them what they deserve, being as flexible with benefits and opportunities and education as you can... A lot of places don't provide for [coders'] continuing education and they don't reimburse you for your CE hours and the costs of your recredentialing every year. Our department does that," she says. And though your hospital might not be able to pay the highest-dollar salaries, Sturgeon says you can make up for that with attractive benefits and additional accommodations such as flex time or education reimbursement.

Buy-in from the big guys

Sturgeon's answer on how to obtain buy-in from administration is a short, blunt, four-word phrase: "Show them the money."

"I can say we do an average of $10,000 a chart, an average of three to four charts an hour, times

seven productive hours a day," she says — that means about a quarter million dollars off the hospital's A/R in one day. "The bottom line is if you can show them the money, they will cough it up."

Hiring managers should "show" administration proof of their need for hiring additional coders, offering higher salaries, or providing for overtime. "If you don't have the coder to get the bills out," Sturgeon asserts, "then they don't go out. And if the bill doesn't get out, the money doesn't come in. [Administrators] don't have the money to pay the bills, and then someone is yelling at them."

Money saved equals money earned and making administrators see it in that light can make the difference in your hiring options.

Speaking the same language

When she began her career, working in an acute care lab in medical technology, she says, "my family started threatening to hose me down with Clorox before I came into the house." At that time, they didn't have a name yet for AIDS ("some strange immunological disorder") and no code for hepatitis C and B. A lot has changed.

Then, Sturgeon entered the world of coding and has been there ever since. She thinks her background gives her a foot up in managing a coding staff.

When hiring staff, she says, the hiring person and the interviewer should understand the complexities of the particular coding job they are looking to fill. Speaking of her own staff, she says, "it helps that the person who's in charge is one of them. I've come up in the ranks. I understand what they deal with. I understand the pressures, I understand the documentation, and I'm willing to turn around and support it to staff who don't understand.

"If you're going to manage a coding staff and don't understand it, you better take their word for it," she recommends, or find someone who does understand and who you can trust. She characterizes coders as usually up front, literal people who'll answer you truthfully. "So, if you're not in the middle of it yourself, you need to understand and respect that they are and they are serious clinical professionals and they have an amazing depth of medical knowledge."

Starter positions

UTMB didn't always have starter positions in the inpatient DRG coding department, but now the center hires coding and reimbursement assistants with no credential required. Assistants might learn the systems to get charts running, basic ICD-9 coding, and how to look over charts to see for instance if all end-state renal disease patients on the transplant list have correct coding. In interviewing applicants for such entry-level positions, Sturgeon looks "for someone who is hungry," wants the job, and is persistent.

If that person doesn't have a credential, that's not as important to Sturgeon as his or her passion is. The person with the credential, she says, might think, "This is boring. I've already done this. And I'm not making $60,000 already like they said I would when I went to school." Sturgeon says if she has six applicants and one is "interested and enthusiastic" that's the one she would hire.

Though UTMB tends to hire from within and promote mobility, Sturgeon says, "I go out of my way to take people in from the outside if I can." Why? Because "we need more coders," she explains. "We won't need to keep moving them around in a circle in the facility. Part of the responsibility to get more coders in the hospital is to stop moving people around your facility and add more coders. Yes, you're going to have people who aren't as trained on the systems but you have to look at the long-term goal vs. the short-term goal."

The problem with sign-on bonuses

Who could find anything bad about sign-on bonuses? Though she doesn't say they don't work, Sturgeon says, "the problem with just offering a lot of money to get someone to move here is you've got someone who is mobile and will move to the highest salary. They're not likely to be the ones who stay." But if you do provide sign-on bonuses, you must provide something equivalent to the staff you already have "or they'll be mad and they're going to go someplace else," Sturgeon says.

As head of her department, Sturgeon says its imperative that she be able to show administration the value of the work her group does and the cost of not doing it. Understanding the real value is imperative, too, in retaining staff. "When the whole department knows that the people who run the place understand their value and their needs, that makes a difference," Sturgeon says. ■

Reimbursement: How care for illegals may change

Fund expires in September

Reimbursement for care of illegal immigrants could take a big hit as of Sept. 30, 2008 — not great news as talk of health care costs, caring for the uninsured, and concern about insurance coverage become more rampant. Lobbyists are taking the issue on now, as hospital administrators, associations, and congressional leaders hit Washington, DC.

At issue is Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, a measure that established funding to reimburse hospitals for the emergency care of undocumented immigrants. That measure is set to expire in September.

What the death of 1011 could mean

"Those funds assist us with a specific population," says **Bridget O'Gara**, vice president, communications for the Arizona Hospital and Healthcare Association. "What would happen [if it isn't extended beyond September] is we would revert back to how life was like before 1011. Many of those patients who would be in our emergency departments we would not receive reimbursement for so it would be [considered] charity care or bad debt."

Kevin Burns, CFO at University Medical Center (UMC) in Tucson, AZ, concurs. "There's still some uncertainty from our viewpoint as to whether they'll be able to move this forward after Sept. 30 and it'll hurt. It'll hurt us." UMC is the city's only Level 1 trauma center.

In April, Burns, along with Sen. John Kyl (R-AZ) — who Burns and O'Gara credit as being instrumental in the introduction and ultimate passage of 1011 — traveled to Washington to push for an extension of the fund, which initially set aside $1 billion ($250 million a year) for fiscal years 2005-2008 to help hospitals cover some of the costs of emergency care of illegal immigrants through "stabilization" (identified by the bill as two calendar days).

Hospitals can apply for reimbursement from Section 1011 only after all other sources of pay have been exhausted; the awarded money covers services mandated by EMTALA and provided by physicians, hospitals, and ambulances. Two-thirds of the fund are divided among the 50 states and the District of Columbia based on their respective percentages of undocumented aliens. The rest is divided among the six states with the largest number of undocumented aliens per fiscal year — Arizona, California, Florida, New Mexico, New York, and Texas. To apply for coverage, providers can enroll with Trailblazer, the contractor for the Section 1011 program.

At UMC, multilingual financial counselors in the admitting department work with patients to see if they have any resources to pay for care. Counselors, who are trained on all financial assistance programs, first determine if the patient can be covered by Medicaid or if the patient was in an auto accident, for example, if there is any insurance monies available. "We pursue everything," says **Denise Fearing**, director of the business office at UMC, "to make sure that we do our due diligence according to the rules of Section 1011." The 365-bed hospital has a program for uninsured self-pay patients to pay at the Medicare rate, the first facility in the state to adopt such a program, says Fearing, who adds that many states have modeled their own after UMC's program.

Because implementation of Section 1011 was delayed by nearly two years, funds will be available until they are exhausted. That might not be long after the original expiration date of September 2008, says **Carla Luggiero**, senior associate director of federal regulations for the American Hospital Association (AHA), which supports Kyl's efforts to continue a governmental fund to help hospitals defray the costs of caring for undocumented immigrants.

According to a CMS spokeswoman, though, the agency does expect funds to be left over after Sept. 30 and welcomes health care facilities and providers to continue submitting claims.

But in a letter from the AHA to the Senate finance committee, the authors, including several senators and other politicians, write: "Since Section 1011's inception, the Centers for Medicare and Medicaid Services reports a steady growth in the volume of submitted claims, provider payments, and enrolled providers. In a letter to Senator Kyl dated June 28, 2007, then Acting Administrator Leslie Norwalk stated that between the first payment period and the fifth payment period, the volume of submitted claims increased by a total of 317%, the value of provider payments increased by 101%, and the

number of enrolled health care providers increased by a total of 107%. Moreover, given the program's growth, Administrator Norwalk wrote that 'CMS anticipates that health care providers will expend all Section 1011 funds.'"

Is it enough?

Are the funds set aside by 1011 sufficient? "I found it is substantive. Is it adequate? Hospital administrators are never going to say it's enough. It's certainly better than a poke in the eye," says Burns. "Could there be more done to help providers — not just hospitals, but physicians, ambulance companies? Certainly," he adds, acknowledging that federal budgets and taxpayer money can only go so far.

In April, a car accident involving about 30 illegal immigrants in Arizona illustrated the challenges border states have been, and are, facing. According to the *Arizona Daily Star*, one of the four hospitals that cared for the crash victims reported the estimated cost of caring for 11 patients at between $44,000 and $55,000. And year to year, treating patients with no insurance coverage costs UMC about $5 million.

"The theory behind [Section 1011]," Burns says, "is somewhat along the lines of it is the responsibility of the federal government to control our borders. So they have to have some responsibility for the cost that is imposed on us by the fact that we have less than stellar border control."

With Section 1011 funds, Burns says, "we probably have been able to offset our expenses to the tune of $1.5 to $2 million to UMC since the initiative was put in place. That's probably about one-fourth to one-third of what our cost will be for caring for that population this year."

Not just a border state issue

If the provision is not extended, it will affect more than the border states, Luggiero says. "Certainly, hospitals, especially those that do have high volumes of undocumented immigrants coming in to their emergency rooms, are very affected. They would have to absorb the cost of the treatment themselves and I have to tell you it's not just along the southern border. We've got other states. North Carolina is a good example. It has a very high population of undocumented immigrants. That is just an example of how this is not strictly something that's along the border. Illinois. Florida, although Florida is not on a border, has a high population of undocumented. New Jersey. New York."

And something is better than nothing. While all hospitals can get some reimbursement with Section 1011, that funding doesn't cover the full cost of emergency care, she says. Ultimately, though, she asserts, Section 1011 funds do help hospitals "maintain at least a little financial wherewithal."

The Washington story

The outlook for Section 1011 is as uncertain as the 2008 presidential election. While some consider a political stalemate on issues to be the trend going into the election, others, including Kyl who sits on the Senate finance committee, are fighting for the provision's extension.

"Obviously there is a need. We know that there are hospitals that but for funding they would have had to curtail their services (cut down on other services in order to accommodate more people coming in to their emergency room). There, of course, is no separate bill," Luggiero says, adding that she hopes the issue will be addressed along with reconsideration of the Medicare physician pay rates slated for this month.

The need is evident.

"Claims have gradually increased over time since the program started and that's an indication that hospitals are becoming more familiar with the funding and how to access it," says O'Gara. "With anything there is a learning curve and that occurred with this as well. Those funds were not tapped as much in the beginning, as people were learning how to do that and how to make sure all the claims were valid, etc. And you can see that the funding source is being tapped more."

For example, in third quarter 2007, Arizona was allotted about $11 million for the quarter and the final payment was about $8 million.

As for the future… "We're in this case the victims of all things politics. There's give and take on Capitol Hill when you have a finite set of funds and you have a number of initiatives under way," says Burns. "We remain hopeful that Sen. Kyl will be able to garner enough support to ask for this program to be continued to help defray these costs."

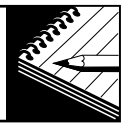
Stephen Frew, JD, a web site publisher (www.medlaw.com) and risk management specialist, expresses doubt about any policy change

heading into the presidential election. "It remains uncertain," he says, "whether the election will lead to effective action from Congress on anything or exacerbate the grid lock that has dominated the scene for much of the past eight years."

We will have to wait and see.

(Editor's note: You can download enrollment forms and other information related to Section 1011 by visiting http://www.trailblazerhealth.com/section1011/. To access the Section 1011 Provider Payment Determination form, see http://www.cms.hhs.gov/CMSforms/downloads/cms10130a.pdf.) ■

GUEST COLUMN



'Not just another smile' Making registration work

Patients want financial planning 'with no surprises'

By Kari Kemper

Several years ago, I visited my local emergency department with my youngest son. His lip made direct contact with his older brother's head, causing quite a gash.

Entering the ED, my main goal was the well-being of my son. However, working in the health care revenue cycle industry, I was curious to see how this particular ED, which is part of a major hospital system in a large metropolitan area, would handle processing my information and asking for payment.

According to EMTALA, when a patient enters the ED, they must be triaged and in stable condition before any insurance or financial information can be requested by the hospital and verified.

And this particular ED followed EMTALA to the letter. My son was triaged, stability confirmed, and we were sent back out into the waiting room to "register."

Sitting in the registration booth, the registrar asked for my son's name and birth date to pull up his patient record. Accessing his record, she recited the address in the file and asked me if this was accurate.

Knowing that insurance eligibility information was coming next, I handed her my insurance card. She glanced at the card, stated she was sure it was all right, and proceeded to have me sign a few consent forms. I told her that per my card, I have a $50 emergency department copay and that I would like to pay by check or credit card.

She responded that they would bill me.

I told her that I wanted to pay now.

She expressed that the billing department handles this and I need not worry about payment at this time.

I pushed further, telling her that it would be better for me to pay now, and in turn, it would benefit her hospital to have money in hand immediately, thus eliminating the overhead costs of billing.

She would not take my money. Nevertheless, she gave me a nice smile.

Now, this was several years ago. Surely hospitals have caught on, right?

Not so fast.

Yes, insurance eligibility verification and demographic validation are becoming more mainstream in hospitals today. Hospitals that are proactive actually verify insurance eligibility and demographic information in real-time while the patient is scheduling or presenting for treatment by using technology vs. taking the patient's word as confirmation or verifying post-service. However, thanks to consumer-directed health plans with high deductibles and funding cuts to both public assistance and employer-sponsored plans, self-pay is the fastest growing segment of hospital revenue. Patients now expect more information. They no longer want to know only copay figures.

Last December, my physician ordered additional testing for me after a routine office visit, which required making an outpatient appointment with imaging.

I was handed the appropriate paperwork and told to pick up the scheduling phone in the hallway to schedule the procedure. Very convenient.

During this scheduling process, the scheduler asked for my insurance information. As I gave her the information, I asked her what my out-of-pocket cost would be for this event. She said she did not have that information. This struck me as odd as I was using insurance that was part of the hospital system, the provider who made the request was part of the system, and the procedure was a standard procedure that all women experience usually after the age of 40. Calculating the cost, if they had the tools in place, would have

been effortless and payment would be in the door earlier. However, the scheduler was quite soothing over the phone. I could hear the smile in her voice.

Checking in at registration a week later, I asked again for my out-of-pocket costs. The registrar said she did not have access to that financial data and wished me well, and all with a smile.

I was ready to pay the copay and out-of-pocket costs immediately, or at a minimum set up a payment plan, and was unable to do so. This hospital missed two opportunities to gather payment from me prior to treatment: at the point of scheduling and at the point of registration.

My experience is not unique. Listening to National Public Radio recently, I heard a story of a woman who suddenly became epileptic after being healthy all of her life. She incurred an enormous amount of bills. However, she is finding that it is almost a full-time job to navigate through the multitude of paperwork sent to her monthly to find out what she needs to pay after insurance, discounts, and write-offs. She still does not understand what she has to pay and has yet to be contacted by the facility that is treating her condition to set up a payment plan or financial counseling. She asked, while at the hospital during her many visits, what her treatments were going to cost her out of pocket and did not receive any financial information. She was told that she needed to contact her insurance company. And when she did talk to her insurance company, they told her that she needed to talk to her provider. Round and round she goes, without any clarification and enormous frustration. The hospital does not receive payment when they need it and worse yet, receives bad PR.

The hospital registration department is the first point of contact for a patient during a very stressful time. Patients have always looked for emotional support during this process, knowing that the registrar will help them register with ease, guiding them to the next level of care. Now, patients are demanding more. Patients want to know how much the procedure will cost them, essentially categorizing health care as a transaction. It is necessary that hospitals change the patient experience on the front end, empowering both the health care industry and the patient, allowing for financial planning with no surprises. The opportunity to educate patients on their financial obligation and collect payment is greatest at the time of service and is increasingly expected.

How does a registration department change to meet these increasing consumer demands?

With process, technology, and people.

Process

Work flow and business processes must drive change. Whether the process evaluation is driven internally or externally from consultants, it is the critical factor for long-term viability and success. Without this key element, any technology you implement or staff you hire are doomed for failure. Every hospital must look at their back-end processes and determine those that can be brought to the front-end. Processes and when they should happen include:

Pre-access

- Comprehensive demographic, insurance, and clinical data gathering;
- Insurance eligibility and benefit verification;
- Managed care screening and processing;
- Patient financial education, counseling, self-pay management;
- Medicaid/charity assessment;
- Risk assessment;
- Pricing estimation.

Time of service

- HIM processing;
- Edit identification and resolution;
- Financial risk assessment;
- POS collection.

Post-service

- Bill transmission/transaction posting;
- Exception monitoring.

Technology

The national average for registration errors is 31%. This translates into almost one out of every three registrations having serious enough errors to delay payment and possibly cause denials or write-offs, with the majority of those errors caused by incomplete or outdated patient information. To know your patients' financial health and assist them in the appropriate resolution of their obligations at the point of service, you need to have an accurate, complete, and single view of the patient.

While there are myriad vendors and products available, the key to technological efficiency is eliminating bolt-on applications by looking for one product that addresses the majority of your revenue cycle issues. A robust platform would integrate with your HIS, allow customization to

adhere to your business rules, and be flexible to change. In addition, it is nearly impossible for your registrars to remember every nuance of your business rules and the registration process. Therefore, an ideal platform would script and guide the registrar through the process, alerting them to issues that need immediate attention, making sure that every patient is registered correctly every time. Using real-time verification as stated above — with pricing estimation that evaluates the combination of contracts, charges, and patient benefits easily, efficiently, and consistently — allows your staff to present the estimated charges with confidence.

People

Registration staff are no longer just greeters and paper-pushers. They now have a critical role in revenue cycle management. Registrars need to be trained on the procedural changes, the importance of accurate information at the point of registration, and empowered to ask for payment with confidence. To create a positive point-of-service education and collections program for your staff you need to:

- collaboratively create a vision and a goal for collections with your staff;
- provide a staff incentive program;
- create awareness in your organization and the community;
- script for consistency and objection handling.

So what do patients, who are scared about their medical procedure and anxious about how much the procedure is going to cost, want at registration? They are looking to you for comfort. They are looking to you for information on their financial obligation. They want to know financial counseling options available to them before they have the procedure. By providing clear, correct, and concise information with high-quality health care and service excellence, you establish trust and confidence, which equates to increased patient satisfaction, patient retention, and an improved revenue cycle.

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Deloitte survey finds key consumer characteristics

A recent survey by Deloitte reveals that U.S. consumers still perceive a technological gap in the health care industry and want more personalized care. Using a web-based questionnaire, 3,031 adults age 18 and older were surveyed.

Among the major findings:

- 60% want online access to medical records and test results, and online appointment scheduling — one in four will pay more for the service;
- three of four consumers want expanded use of in-home monitoring devices, and online tools that would reduce the need for visits and allow individuals to be more active in their care;
- 52% of consumers say they understand their insurance coverage; only 8% understand their policies completely.

Consumers were broken down into six categories: content and compliant (29% of Americans); sick and savvy (24%); online and onboard (8%); shop and cave (2%); out and about (9%); casual and cautious (28%).

- **Content and compliant** consumers, the largest segment, most often prefer traditional care and accept doctors' recommendations. They are less likely to shop for and customize insurance or use value-added services; 26% of this group have a household income of $100,000 or more.
- **Sick and savvy** denotes the group that uses the health care system more than any other and like the latter segment prefers traditional care, though they rely on themselves more than their doctors in making care-related decisions. The group also includes the highest percentage (52%) of consumers reporting one or more chronic conditions. More sensitive to quality differences among providers, they shop around more in an effort to customize insurance and they take advantage of value-added services. The group includes more women and as a whole is satisfied with care received.
- **Online and onboard** includes high users of the system who prefer traditional care but are open to receiving care in nontraditional settings. This group uses online tools and value-added services more than any other group and relies on themselves vs. their doctor's recommendations in care-related decision making. They tend to comply with care instructions and are satisfied with care received. Mean age of this group is 45 years

old.

• **Shop and save** consumers often switch doctors, treatments, and health plans and are more sensitive to the prices of services. This group tends to use traditional care approaches and relies on doctors' recommendations. However, they are open to alternative approaches and nonconventional settings. This group is more likely than others to purchase prescriptions online or through mail-order sources, use retail clinics, and travel outside of their community or the United States for care. They take advantage of value-added services and tend to be less satisfied and less compliant with care. This segment has the lowest average age (38 years).

• **Causal and cautious** consumers are the healthiest and the second youngest (mean age is 40) group. The group is the least insured and uses the system and seeks information less than others. This group feels less financially prepared to deal with future health needs and and fewer report understanding their insurance. They are less compliant and satisfied than others.

(For more details or to see the entire report, go to www.deloitte.com and select "Health care providers" under "Industries." Click on 2008 Survey of Health Care Consumers.*)* ■

HHS launches first national ad campaign

Promoting its Hospital Compare web site, the Department of Health and Human Services launched its first ever national advertising campaign, kicking it off in 58 major newspapers on May 21. The campaign cost $1.9 million.

The ads, placed by the Centers for Medicare and Medicaid Services, provide scores on two of the 26 quality and patient satisfaction measures highlighted on the web site for a sample of hospitals in the newspapers' community.

The tag line for the ads invites consumers to, "compare the quality of your local hospitals" and provides information for the following measures:

• percentage of patients at each hospital who always received help when they requested it, as reported by the patients themselves;

• percentage of patients at each hospital who were given antibiotics one hour prior to surgery, as reported by hospitals;

• the state average for each of these two measures. ▼

Which states get good grades for kids' health?

A report released by the Commonwealth Fund ranked hospitals in 50 U.S. states and Washington, DC, on the value of the health care they provided to children. Iowa and Vermont came in at the top; Oklahoma and Florida fared the worst.

Hospitals were judged on: health care access, quality, cost, equity, and the potential for kids to lead long and healthy lives. Also rated were rates of insurance coverage, vaccinations and preventive visits to doctors, among other things.

States in the top quartile were Iowa, Vermont, Maine, Massachusetts, New Hampshire, Ohio, Hawaii, Rhode Island, Kentucky, Kansas, Wisconsin, Michigan, and Nebraska. ▼

AHA honors four hospitals for volunteer programs

The American Hospital Association (AHA) honored four hospital volunteer programs

COMING IN FUTURE MONTHS

- Putting volunteers to use
- A successful recovery reimbursement program
- Creating a strong patient satisfaction survey
- How to evaluate employees successfully

with the Hospital Awards for Volunteer Excellence (HAVE).

Winners fall into four categories: community service programs, in-service hospital volunteer programs, fund-raising programs, and the positive impact their contributions have had. The winners are: community service programs, VA Puget Sound Health Care System in Tacoma, WA; in-service hospital volunteer programs, Alaska Native Medical Center in Anchorage; fund-raising programs, Mercy Medical in Daphne, AL; and community outreach and/or collaboration, Intermountain Healthcare in Salt Lake City. ▼

$300M RWJ grant to help states tackle health care

The Robert Wood Johnson Foundation (RWJ) has granted $300 million to improve the quality of health care in multiple communities across the United States, as the foundation released a report on the disparities in health care depending on race and where patients live. The grant is also intended to provide models for national health care reform.

In the research performed in conjunction between RWJ and the Dartmouth Institute for Health Policy and Clinical Practice, five measures of care were analyzed. Significant differences, based on where patients lived and their race, were found in whether patients lost a leg to amputation, due to a complication of peripheral vascular disease and diabetes. The report also looked at disparities in relieving basic recommended care.

Communities awarded grant money include: Cincinnati; Cleveland; Detroit; Humboldt County, CA; Kansas City, MO; Maine; Memphis; Minnesota; Seattle; South Central Pennsylvania; Western Michigan; Western New York; Willamette Valley, OR; and Wisconsin. ■