Revamp process for sudden surges in registrations

Cross-training is key

This spring during the H1N1 epidemic, registrations through EDs increased dramatically nationwide. The processes of virtually every patient access department were put to the test.

Cross-training is the key for any unexpected surge in patient volume, according to **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital. "Patient access has spent a great deal of time cross-training for all units within the department," she reports. "As a leadership team, if the need arises, and it does often, the manager is on the front line, the associate director is on the front line, and I am on the front line."

Pallozzi says that as a patient access professional she deals with staffing shortages "on a regular basis."

"When there is an influx of patients due to H1N1 or just another day of high census, we have learned to manage with the staff we have," she says. "Our secret is being able to flex staff by bringing staff from other areas. Also, having managers with the ability to work the front line in not only their unit, but in multiple units."

Due to the cross-training effort and the team approach, Pallozzi's patient access department was able to appeal to other units to assist in the emergency department during a particularly high-volume period. "We were able to pull six to eight staff members," says Pallozzi. "Their willingness, our need, and the cross-training effort resulted in coverage being achieved."

"Volume surges, including flu epidemics, can certainly present challenges to patient flow," says **Bridget D. Puryear**, director of patient access at The George Washington University Hospital in Washington, DC. "Flexibility, including allocating staff to other areas, is critical when facing fluctuations in patient volume."

Staff are cross-trained to complete all types of registration. Training for the registrar position entails an admit, discharge, transfer (ADT) system review, a review of department policies and procedures, and hands-on training, including an actual patient registration in the emergency department. Staff need to obtain proper identification of the patient, complete a full registration, verify insurance, and collect the copayment.

"Having a good, quick registration process is key," says Puryear. "There are many challenges. However, proper patient identification is important. And ensuring that the full registration is completed prior to the patient's departure from the emergency department is critical."

Either prior to triage or during the triage process, staff obtain the patient's name and date of birth, primary care physician, and reason for the visit. This allows them to create an account number for their emergency department visit, while allowing the clinical staff to move forward with the patient's care.

"Facilities want to be sure that their patient access representatives know their quick registration process," says Puryear. "You need a strong process in place to complete the registration process prior to the patient's departure from the emergency department. Having good communication between patient access team and the emergency department is also very important."

If staffing shortages should occur due to H1N1 or seasonal flu, Puryear says that her department's contingency plan is to utilize part-time and per diem employees to meet the increased work load. "The part-time and per diem employees have completed all of the competencies required for the job and have been fully trained in the positions," says Puryear.

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Capture revenue, revamp your screening process

Respond to the recession

Unemployment is at its highest level in decades, which has led to the largest-ever number of uninsured Americans. This has a direct impact on your patient access department.

"Those without coverage are flocking to hospitals as a last resort for emergent and non-emergent care," says **Katherine Murphy**, director of access services at Passport Health Communications, a Franklin, TN-based health care technology provider.

"This will theoretically put more pressure on hospital emergency departments and expanding Medicare and Medicaid rolls," says Murphy. "As long as the economic recession continues, there is no real prospect of these trends turning. However, there are ways for hospital patient access departments to respond, by focusing on eligibility verification and patient collections."

Screening pre-service

Many people who have carried private insurance all their lives, through their employers or by other means, have lost a job. These individuals may now be eligible for Medicare and/or Medicaid for the first time. For this reason, Murphy says that every patient — even those with commercial coverage — should be screened.

"Some don't even know they are eligible or don't know how to go about enrolling. Some may forget, and others may knowingly withhold information or attempt to avoid payment, such as not disclosing the recent loss of a job and related private coverage," says Murphy. "Every age-appropriate patient who walks in as uninsured should also be screened for Medicare eligibility."

Although many state Medicaid budgets are being cut, a smaller government reimbursement is better than no payment at all, says Murphy.

Lourdes Health System, with hospitals in Camden and Willingboro, NJ, checks all patients who present as self-pay against state Medicaid for coverage. This process consistently yields a 10% or better rate of eligible patients for whom Lourdes can bill payers, instead of attempting to collect from the patients themselves or sending the account to third-party collection.

"If we don't do these things, we don't get paid," says **Maria Wence**, corporate director of patient access for Lourdes Health System. "By searching for eligibility on self-pay patients, we capture hundreds of thousands of dollars in revenue each month that would otherwise probably be written off as bad debt."

During scheduling, pre-registration, and/or registration, current address, social security number, and other demographic information should be validated. "Not doing this for all patients — insured or not — opens the door for denials, returned patient invoices, and even fraud, which hospitals will be expected to monitor more closely, in light of the upcoming enforcement deadlines for the Federal Trade Commission Red Flags Rule," says Murphy.

Checking medical credit scores will help hospital access staff to determine patients' ability to pay based on income, and the likelihood of a patient paying based on credit history and other factors. "This information is important in categorizing which self-pay patients qualify for discounted or charity care, or should be set up on a payment plan," says Murphy.

Collect pre-service

Given the increasing numbers of uninsured patients, collecting from self-pay patients at the point of access has become all the more critical. "The likelihood of collecting from patients drops 60% or more between the time an appointment is scheduled and 30 days after services were rendered," says Murphy. "Hospitals should perform all necessary cash collections on the front end. Despite an increase in uninsured patient volumes, there are ways to ask for and receive payment, and still uphold the mission of delivering care."

Insured patients are also bearing more responsibility for payment and should not be overlooked. "Some 8 million Americans are covered by Health Savings Account-eligible insurance plans. This is an increase of more than 31% since 2008," says Murphy. These plans carry hefty out-of-pocket deductibles and copays that should be collected up front, or they may not be collected at all.

Murphy recommends the following:

• **Offer convenient payment options and accept all forms of payment, including cash, checks, and credit cards.**

"This increases the likelihood that patients will pay their portions in full," says Murphy. "Credit card swipe terminals can be integrated with the HIS and revenue cycle management system for fast, secure processing and accurate financial reporting and reconciliation."

• **Use registration kiosks and self-service web portals, which allow patients to pay balances online via credit card.**

Offer a zero-interest medical finance card, available through a third party.

"This is another increasingly popular option to limit the financial liability of the hospital and help patients settle payment prior to or at the point of service," says Murphy.

• **Screen patients for Medicare and Medicaid post-service.**

Self-pay patient accounts should not be prematurely sent to third-party collections or written off, as they may actually be retroactive for Medicaid and/or Medicare eligibility. "On average, 10% of all patients who are treated as uninsured or self-pay actually qualify for public aid," says Murphy.

At Lourdes, the billing office processes a batch file 90 to 120 days after service for those patients who have not been determined to be eligible for any insurance and remain classified as self-pay. The revenue cycle for these accounts is typically exhausted, and this exercise is the final reimbursement effort before the balance is written off to bad debt. In just nine months during 2008, Lourdes identified more than $850,000 in billable fees that it otherwise would have written off, Murphy says.

Similarly, Atlanta's Grady Health System obtained an estimated recovery of nearly $390,000 in a six-month period in 2008 from Medicaid for patient accounts previously categorized as private or self-pay. In the same six months, the hospital collected an additional $200,000 from Medicare.

• **Use technology to expedite processes, ensure accuracy, and allow front-end staff to dedicate more time to patient care.**

For example, real-time electronic insurance eligibility verification takes seconds to process, saving valuable time and effort. Staff would otherwise spend this time calling insurers or looking up information on payer web sites. "Manual processes are more tedious and tend to be delayed until after the patient leaves," says Murphy. "By that time, it may be too late to avoid a rejected or denied claim or collect from the patient."

Murphy says that batch file processing through third-party revenue cycle management partners is especially helpful for back-end or post-service charity care screening.

"All the financial tools needed to collect prior to or at the point of service, such as credit card processing, credit scoring, and automated patient payment estimation are available through third-party business partners," says Murphy. "Depending on the company, a hospital may even identify a 'one-stop shop' partner that can deliver a full line of financial services for patient access."

• **Give front-end staff the tools and training to collect.**

Staff must thoroughly understand the process of when and how to verify critical patient information, including charity care eligibility, and have a clear understanding of how each patient account impacts the hospital's bottom line. They also need to be comfortable in asking patients for money.

"Staff meetings and written scripts are sometimes the best ways to ensure that all collections discussions with patients are consistent and patient-friendly," says Murphy.

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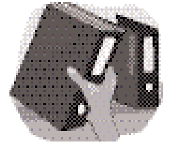

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