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## Don't take 'no' for an answer: Revamp your denial management process

*Avoid getting stuck in a 'losing pattern'*

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The number of claims denials was always an important metric for patient access, but now it's front and center, in more ways than one.

From a business management perspective, if you don't do this well, "you will not be able to establish internal patterns of error, external payer processing problems, or root causes," says **Joseph Ianelli**, manager of Boston-based Massachusetts General Hospital's financial access unit. "You are always going to be that hamster on the wheel."

And from a revenue perspective? "You're going to lose money," says Ianelli. "With a trauma case, that is tens, if not hundreds of thousands, of dollars you can lose. In this day and age, it's a real important thing to capture your revenue appropriately."

Increases in the number of unemployed and uninsured make timely and accurate reimbursement for the patients who *are* insured "more important than ever," says **Jodie Martin**, director of admitting and registration for the department of revenue management at University of Kentucky Healthcare. "Hiring freezes and potential lay-offs within the industry also make it imperative that the front-end work is done right," says Martin.

"The duplication of effort by people on the back end to appeal denials and capture data necessary for re-billing of claims is much too expensive for hospitals to bear in the best of times," says Martin. "It is simply unacceptable in this current economic environment."

If you don't have good denial management processes in place, says Ianelli, "there is money already on the table that you are going to be losing. And in the future, if you don't prevent it, you will always continue to be in that losing pattern."

### ***Prioritize your efforts***

Martin says that to effectively address denial management, the "entire spectrum of the revenue cycle" must be represented. This

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includes leaders of billing, patient access, coding, information systems, utilization management, and medical staff.

"Our enterprise denial management committee is co-chaired by a physician and two other key organizational leaders," says Martin.

The department's approach has been to organize the denials into 12 well-defined categories and focus on the high-dollar, high-volume denials for the codes within each category. Sub-groups for each selected denial code then are charged with determining causal factors and recommending solutions.

"The solutions have ranged from the develop-

ment of a computer-based training module to mandatory twice-yearly refresher training for patient access staff," says Martin. "Technical solutions are being considered as well. Our initial prioritization efforts targeted denials related to authorization and eligibility. We continue to add others as the work of each sub-group is completed."

Although implementations of many of the solutions are relatively recent, Martin says that the "preliminary evaluation data on this focused approach have indicated positive results, both from a professional and a hospital billing perspective."

Mass General uses a computerized system to track denials, which come in two forms: a clinical denial typically involving level of care, which is handled by case managers, or a technical denial involving payer rules and regulations, handled by financial access staff.

A full analysis is done for each of the technical denials. If the information isn't specific enough in the denial letter sent by the payer, then the payer is contacted to get more specific information.

The next step is to characterize each denial as legitimate (meaning patient access made the mistake) or not legitimate (meaning the payer has denied the claims in error).

The department's legitimate denial rate every month is less than half a percent of total volume. "We don't know what our reimbursement would be on the access side, although that might be a goal for the future," says Ianelli. "So we just report that in charges. We do a full analysis every month, which tells us if staff are having problems and which ones are having legitimate denials."

Ianelli says a small number of legitimate denials are bound to happen from time to time with the high volume of the facility, such as a missed deadline due to human error. "Depending on if it's an established pattern with a staff member, there might be different levels of intervention," he adds.

An example of a legitimate denial would be a failure to notify the payer within a business day about an emergency admission. "If we don't, they deny the case. Luckily, we have very few of those now because we identified it as a problem a long time ago," says Ianelli. "It's really an avoidable denial, because we have reports for who is admitted and staff are well aware of the requirements."

Sometimes, though, staff aren't able to gather

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the correct insurance information when a patient comes into the ED because the patient is unable to communicate. If there is a delay in getting that information, that could cause a denial.

“But we would consider that non-legitimate. If we can prove that the patient wasn’t able to speak at the time of registration, we can usually win the appeal,” says **Jessica Rodin**, financial access unit supervisor. Rodin writes all of the appeals for the hospital’s financial access unit.

Another example of a legitimate denial would be a patient’s admission being scheduled for a given date, with authorization obtained for that date, but then the physician’s office calls and changes the date.

“We have a way to catch those as well. But if we don’t notify the payer, they will deny it even though it was technically authorized because the dates don’t match,” says Rodin.

### ***Without documentation, ‘the appeal is lost’***

Ianelli says that “for us, it’s all about documentation. If we don’t have all the documentation, we’re going to lose the appeal,” says Ianelli. “My team is getting very good at making up a bullet point list of what we did and sending an appeal letter. We have very good luck overturning denials.”

For example, if a patient comes in as a self-pay, the hospital’s group of financial counselors starts the process of trying to figure out whether the patient is going to end up being eligible for a state or federal program, or whether there is any insurance coverage.

If the information isn’t available, the financial counselors can’t just say so. They are required to document every attempt they make to see the patient — such as whether the patient was taking tests and couldn’t speak with them or the patient was unconscious. Similarly, if the patient’s identity is initially unknown but a family member comes forward with an insurance card at a later date, all of this also is documented.

Payers examine this documentation very closely. “Our notes are dated by the computer, and they will look to see if somebody went up to see the patient,” says Rodin. “I’ve had appeals that I couldn’t win because there wasn’t enough documentation. They told us, ‘From your notes, it looks like nobody saw the patient for five days.’ And they may have, but if we didn’t document it,

then the appeal is lost.”

Authorizations or proof of notification are another important piece of documentation for appeals. With some payers, this is now done electronically either through the payer’s web site or another portal.

For elective procedures, however, denials typically don’t happen because the approval is obtained before — not after — the patient’s visit. “If there’s somebody saying we can’t approve this, the patient doesn’t get into the hospital until the approval is there,” says Ianelli. “We try to work using more of a prevention model.”

### ***Staff resolve their own errors***

Each denial is a learning tool for patient access staff, who don’t want to make the same mistake again. At Mass General, this is especially true because the staff member will be the one calling the payer if the claim is denied.

“We really get the staff involved in denials. It is part of their job to call the payer and try to get the denial overturned,” says Ianelli. “They learn from the mistake, and also, they are the ones who can best advise us of any shenanigans going on at the payer. We join them arm in arm, and they are pretty involved in helping us figure out what’s going on.”

Rodin sends “each and every” denial to the person who handled it to begin with. The staff member is told the claim was denied and the reason given by the payer and asked to call to check it out. Many times, the payer agrees to pay the claim over the phone.

Ianelli says he implemented this practice when he arrived about seven years ago. Although one or two staff members transitioned out of the department, the ones who stayed became involved in the process in a new way.

“Until we did this piece and helped people become part of the solution, they didn’t understand the implications of a denial,” says Ianelli. “Now they know that if they don’t do it right, they will see it again. The other good piece is if they call the payer, they can ask what they could have done differently and start a dialogue.”

Sometimes, something useful is learned from the payer about the denied claim. In this case, the information is shared with the staff in the group handling that payer. “This may be done at a monthly staff meeting or by alerting each group in an informal meeting if it’s something that can’t

wait," says Ianelli.

At times, payers may make sudden changes in their requirements. For example, most surgery doesn't require an authorization, so those staff only have to check the patient's eligibility, but there is always an exceptions list. A payer may suddenly post a new addition to that list on its web site.

"And if you haven't gone on the web site, you won't know about it," says Ianelli. "They expect us to go to the web site and check for updates constantly. Nobody in hospital operations has the time to do that. They tell us, 'It's part of the contract,' but that is not particularly helpful to an access group."

Payers also have been known to suddenly start denying a large number of cases for an unknown reason. In one case, authorizations were getting deleted from the system. "We couldn't figure out what was happening, but it seemed to be on their end," says Rodin. "As soon as we catch something like that happening, we go after them and they usually knock it off."

If a payer suddenly breaks an established pattern by denying claims that should be approved, the "back end" gets involved, as the hospital's patient account representatives have good relationships with the payers.

"We try not to write appeals for those, because why waste our time if the payer's system is messing up? Instead, we give the whole block of them back to the payer, and we say, 'Take a look at these, because we already have and we don't think we should be writing appeals for your errors,'" says Ianelli.

Although the financial access unit hasn't seen the number of overall denied claims increase outright, other more subtle changes have been noted, which are resulting in less revenue for the hospital.

"I think what is happening is that the plans are shifting things around and trying new things that are making us a little bit beside ourselves," says Ianelli. "They are trying these creative pieces, in order for them, I believe, to save money."

For instance, one payer just decided that if a patient is admitted through the emergency department and goes in to surgery on the second day of his or her stay, it will deny the first day for inpatient services and pay at the observation rate only.

"In a way, that is an underpayment. We consider that kind of a denial as well," says Ianelli. The payer pays for days two and three, but if more information isn't given after day three, the

claim isn't paid.

"Upon entering the information, they give you a length of stay. If that varies and you don't call and get authorization after that, they will deny anything from there on," says Ianelli. "That is a clinical denial and is handled by case management, but it's a denial nonetheless."

Last year, a payer instituted a new requirement that staff had to notify it of a patient's arrival within 24 hours. "This is different from every other payer," says Ianelli. "This means that on Christmas day, you have to let them know that someone came in on Christmas Eve. So we now have to staff every single day."

Another payer now requires "smart sheets" to be faxed to it, which doctors' offices must complete in order for a decision to be made about whether a surgical service will be authorized. Formerly, authorization was not required for surgery.

"They use these as a decision-making tree, but since we are not clinicians, the doctors' offices have to get them to us, and we get them to the payer. That is a big burden, which delays things," says Ianelli. "And we're not sure how that might fall out, appeal-wise."

These and other new requirements are making the job of financial access staff harder. "It is making the administrative burden more difficult for us," says Ianelli. "And it's unclear what it's going to mean for appeals. The rules seem to be changing."

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## Automation is key to pinpoint denial trends

*Savings can offset cost, expert says*

"With layoffs now hitting hospitals and legislation and government bodies reducing payments, health care facilities cannot afford not to automate," says Katherine Murphy,

CHAM, director of access services for Nebo Systems, a subsidiary of Passport Health Communications in Oakbrook Terrace, IL. Murphy also is a delegate to the National Associate of Healthcare Access Management and the president of the Illinois Access Association.

"The savings of denials clearly cover the price" of implementing denial management software, says Murphy.

In fact, Murphy says that the initial outlay for automated contract management, registration quality assurance, and ongoing subscription fees is probably much less than the cost of one denial or registration error that results in a reduction of payment or is a stale claim for which no payment is received.

"The multiple complexities that create troublesome denials are extremely difficult to track, monitor, and to understand root causes for non-payment," says Murphy. "We live in an automated world, and those who embrace the tools available play a better game. They have winning results. I don't buy into the fact that it is not affordable. You really cannot afford to go without it."

Customized automated workflows and work lists can zero in on problem areas before the claim goes to the payer and they have an opportunity to deny payment. "Believe me, the payers are highly automated," says Murphy. "Why give them an unfair advantage?"

Massachusetts General Hospital's financial services department has been using its current denial management system for six years. The previous system lacked the ability to track denials and was only able to give canned reports. With the new system, information on denials can be analyzed a variety of ways.

"You are able to extract the information and put it into Excel and do whatever you want with the data," says **Jessica Rodin**, financial access unit supervisor. "We extract all the denials that came in for the last month and sort it all different ways to identify trends."

For instance, it may be that staff are forgetting that some of the secondary payers to Medicare require an authorization. "When we have new people come in, they tend to be on the Medicare and Medicaid team, which have requirements that are a little more simple," says Rodin. "One pitfall for them is that they don't look at the Medicare supplemental. That is a common mistake."

At Sutter Health Sacramento Sierra Region in

Sacramento, CA, denial management software was implemented in early 2008. This allows the department to communicate insurance denial trends to the patient access workgroups at the health system's various facilities.

"Our definition for denials are any issues that result in an account not being paid the correct payment the first time the claim is billed," says **Michael Taylor**, regional director for patient services. Denials are broken down in to two groups: "self-inflicted" or caused by the insurance company. "The self-inflicted denials are the errors we can control through process improvement," says Taylor.

In 2008, the self-inflicted error percentage improved from 15% to 10% of total registrations. "Our goal is to move from a 90% to 95% registration accuracy rate in 2009," says Taylor.

The software helps the department pinpoint trends in denials. For example, it revealed that the most common error made by registration is failure to collect the correct insurance carrier code. "This is critical for electronic claim submission and accurately matching payments to expected reimbursement," says Taylor. "Being a high managed care region, accuracy is critical."

The software identified errors resulting from an incomplete concurrent review, resulting in denied days, and underpayment by insurers due to outdated contract information in the payer's system.

The department has made these other changes to improve denial management:

- **In April 2009, the insurance verification, notification, and authorization validation process was centralized for nine acute care facilities.** "Immediately, we identified variations in process," says Taylor. "By bringing this function into a centralized workgroup, we have standardized processes and reduced cost."

A new process for post-discharge validation of inpatient days was implemented. "Our case management process related to concurrent review communication has also been centralized," says Taylor.

- **A plan is in place to pilot online tools for insurance companies that recently developed web-enabled notification and authorization tracking software.** Taylor says he expects to see a time savings with staff keying in the authorization data instead of calling the insurance utilization management department. Other benefits will include electronic documentation of authorizations

and the ability to track inpatient authorized days.

• **Education liaisons were designated.** These individuals conduct training sessions at the facilities for trended back-end identified errors, including denials. Recent sessions covered pre-admit and point-of-service copay collection and compliance training. "To augment our on-line classes and testing, they give classroom training, one on one, and web-based training — basically whatever style is most effective for the curriculum and learner needs," says Taylor.

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## Brace yourself for dramatic rise in self-pay accounts

*Patients can't afford their copays*

The number of self-pay accounts is increasing significantly in many patient access departments due to rising unemployment and other factors. "We have seen an increase in self-pay patients in the past couple of years," reports **Craig Pergrem**, MBA, CHAM, corporate director of patient business at Orlando Health. "We work very closely with these patients to see if they have any funding source or qualify for Medicaid and/or charity."

In addition, any patient without insurance scheduled for a procedure goes through financial clearance before being placed on the schedule. "That's not to say some don't get through. But we feel it is better customer service to let the patients know what they are looking at from a charges perspective *before* they come in," says Pergrem.

### **Decrease in copay payments**

**Michael Taylor**, regional director for patient services for Sutter Health's Sacramento Sierra

Regions, says he is seeing a small percentage increase in uninsured patients, but a bigger change has been the decrease in copay payments post-service.

"This results in increased assignment of patient liability to bad debt," says Taylor.

The problem is likely to get worse, in light of California having one of the highest unemployment rates in the United States. "In anticipation of increased uninsured and California state budget cuts in health care programs, we have implemented patient financial advocate positions," says Taylor.

These employees are facility-based and assist patients with understanding the cost of service, government program conversion to Medi-Cal (the state's Medicaid program), county programs, or COBRA, and if needed, charity program eligibility.

"We have brought the traditionally outsourced service of assisting patients with obtaining Medi-Cal and county program eligibility in-house to be performed by the hospital employees," says Taylor. "We feel these positions will be critical to assist patients to obtain eligibility for state and federal resources and offset the reduction in health care program workers."

Financial counselors now focus specifically on patient needs. Any insurance verification and authorization processes that do not require direct patient contact are now part of a separate workgroup. The patient financial advocates are responsible for assisting uninsured patients through final payment or adjudication of the patients accounts.

In the previous model, patients were contacted by financial counselors for payment, referred to a vendor intake worker for government programs, and received post-discharge collection and charity assistance calls from a private pay account rep.

"Now we have one advocate to assist them," says Taylor. "The patient financial advocates also assist patients with service cost estimates and questions about their bill. This new model was implemented with no increase in full-time employees and a projected reduced vendor cost of \$1.4 million annually."

Patients with high deductibles, says Pergrem, "have probably been the highest increase we have seen in the hospital. Many of the insurance companies are offering plans that have \$5,000 or \$10,000 deductibles, and the members just don't realize it. Of course, this impedes our ability to collect."

However, Pergrem says that with an organized pre-registration area, you can contact many of these patients and let them know that they have a responsibility and give them an estimate of what the dollar amount is going to be.

"This also allows us the opportunity to screen them for any programs they might qualify for and/or set them up on a payment arrangement if they cannot pay in full," says Pergrem. "Some patients are opting to hold off on procedures that aren't urgent until they can fund the full amount."

About five years ago, the department created a policy for patients with high-deductible plans. "We did not have to use it until about two years ago, but we do have it in place, and it is being followed," says Pergrem.

Patients with high deductibles appreciate knowing in advance how much they'll owe so they aren't surprised when they receive a bill.

"We also stress that paying in advance allows them to recover at home and not be concerned with a hospital bill," says Pergrem. "It may sound simplistic, but most of our patients are very appreciative of the fact they are being told what they will owe prior to arrival." Patients are informed verbally and in writing that the quote is only an estimate.

Speaking to patients about financial matters, says Pergrem, "all comes down to treating every patient the same. Though a self-pay patient's bill will be larger, they need to be treated just like the patient who has a copay on their insurance."

### **Automation is key**

The number of self-pay patients is "most definitely increasing" for several reasons, says **Beth Keith**, manager of ACS Healthcare Solutions in Dearborn, MI. These are rising unemployment, an increase in personally managed health savings accounts, an increase in self-employment due to job loss, and high-deductible medical catastrophic coverage for the self-employed.

"The need for proactive front-end collection processes has never been more acute," says Keith. "It is essential that intake staff have the ability to accurately estimate the self-pay portion, and/or anticipate the entire expected balance, for the purely self-pay."

You also need a transparent, clearly stated policy for dealing with the self-pay patient. This needs to be explained, and provided in writing if possible, in advance of the scheduled procedure,

says Keith.

Keith says your organization should consider these questions:

- What is the discount for self-pay patients, if any?
- Are you going to allow discounts to insurance carriers but not to an individual?
- Are you going to offer a charity or reduced-fee program for patients with limited ability to pay? "If so, you need a clearly defined policy and procedure that is easily activated at the point of service," says Keith.

Given all the complexity involved, Keith says that software systems are key. These systems should be able to do two things: identify potential candidates for a reduced-fee program and accurately estimate services to be rendered.

"This may also involve having financial counselors available on the front end but would increase your collections over time to a point that the investment would be worthwhile," says Keith. "I believe that the environment is such that you cannot afford to be without some of these basic services."

### **Patients need information**

**Pam Carlisle**, CHAM, corporate director of patient access services and revenue cycle administration at Columbus-based Ohio Health, says her department is seeing that the "self-pay population is increasing but arising in a different fashion. Not only do we encounter uninsured patients, we are now faced with patients who are *underinsured* and cannot meet their out-of-pocket costs.

"Today's world is a new world of high deductibles," says Carlisle. "New plans like HealthCare Savings accounts make it very difficult for patients to manage their financial obligations related to health care."

This change, along with economic challenges, requires hospitals to think "out of the box" to help these patients cover their health care costs. "In the world of patient access, pre-service education is the key," says Carlisle. "This not only takes planning and a new skill set, it takes shifts in FTEs to make this happen. You don't want your pre-registration, precertification, and inpatient notification processes to suffer."

At Ohio Health, pre-service areas focus on educating all elective scheduled patients on their out-of-pocket costs and then helping them with

financial assistance as needed.

"Patients are now turning into consumers looking for the best deal, and the most help related to their elective scheduling needs," says Carlisle. "Consumers want accurate price information *before* they purchase a product. Health care is no different at this time."

Pre-service teams work hand in hand with the hospital's financial counseling teams to be sure if patients cannot pay their out-of-pocket expenses, they are screened for other options such as charity or Medicaid.

"Training for the pre-service team is something that organizations cannot fall short on," says Carlisle. "We do not want to portray any image of 'no pay no service.' That is not what health care is about. Everyone is entitled the same quality care, and we need to find a way to help our patients meet their needs."

Talking to patients over the phone about finances can be difficult. "Staff should be well versed on options in their hospital, and scripting is essential," says Carlisle. "To ensure they are following scripting, we listen to their phone calls to ensure customer service is the best it can be. These calls can be pulled at any time for review."

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## Motivate your staff: Get involved in goal-setting

*Set department-specific goals*

**A**нна Dapelo-Garcia, director of patient admitting services at Stanford (CA) Hospital & Clinics, says that since staff have become involved in setting specific goals, she has noticed "an increase in their engagement. They are excited and proud to be part of their unit, department, and organization."

Although senior leadership of Stanford Hospital and Clinics identify hospital-wide goals, patient admitting services managers work with

their staff directly to set departmental goals.

The goal-setting is done at an annual offsite retreat. The previous year's goals are reviewed, and goals for the coming year are discussed.

During the all-day meeting, a facilitator, admitting managers, and a hospital vice president speak about current and future hospital initiatives. "The offsite retreat is also a celebration of the work done in the prior fiscal year," says Dapelo-Garcia. "To ensure progress is made on our goals, they are reviewed each quarter during the year."

### **Staff, in their own words**

Stanford's patient admitting services department goes the extra mile to be sure that staff are involved in setting goals. To create a presentation, "The Voice of Patient Admitting Services," staff were videotaped and asked to speak about what improvements could be made regarding employee engagement, patient experience, and operations.

"The videotape was then shown at the annual offsite [meeting] to inspire and inform goals for the upcoming year," says Dapelo-Garcia. "It was quite poignant, and everyone enjoyed watching it."

Below are some of the goals that were set for fiscal year 2009 at the annual offsite retreat. All of these were achieved.

- Improve the organization of the admission process and the courtesy of the emergency department registration staff.
- Improve the patient experience by installing language line phones to help non-English-speaking patients during the registration process.
- Create a call-in program, where patients can call a dedicated phone number to renew the labels that are used when undergoing tests and procedures. "This was popular with patients who then did not have to wait in line to renew their registration labels," says Dapelo-Garcia.
- Reduce the average check-in time in the emergency department to four minutes.
- Reduce patient wait time to register in main admitting from fifteen minutes to 10 minutes.
- Implement department-wide staff meetings, which include representatives from each of the six units that comprise patient admitting services.
- Establish a staff advancement program with curriculum so that staff are aware of what steps they need to take to be promoted within the department.

- Revise and improve the financial clearance policy.

Staff also contributed to achieving many “unplanned goals,” says Dapelo-Garcia. For example, a professional image program was conceived. Navy blue blazers with the Stanford Hospital & Clinics logo were selected for main admitting and ancillary registration staff, and navy blue polo shirts with the logo were selected for ED registration staff.

“This created a cohesiveness among the staff and management who radiated this professional image,” says Dapelo-Garcia.

Staff also were involved in creating a revised patient admitting services intranet web site. New and improved sections were added, which included a suggestion box, resources for end-users, and convenient features.

“It is very inspiring to see individuals bloom and become leaders. This positive energy is contagious,” says Dapelo-Garcia. “Their co-workers get excited and eager to become involved as well.”

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## To get results, emphasize positive things staff do

*You need the ‘personal touch’*

To really motivate your staff, you’ll need to do more than simply check a “meets expectation” box on their annual reviews.

You need to find ways to “emphasize the positive work done in patient access,” says **Michael S. Friedberg**, FACHE, CHAM, associate vice president of patient access services at Apollo Health Street and author of *Staff Competency in*

*Patient Access.*

“Patient access leaders and registrars get beat up all day about all the stuff they did wrong,” says Friedberg. “Patient access leaders need to establish the good work that is done in patient access.”

Friedberg recommends using quality assurance, data-driven analysis, and audits to demonstrate this.

At Baptist Hospital East in Louisville, KY, patient access staff themselves select an employee of the month. “They can vote on someone and give information as to why they feel that employee should be selected,” says **Vicki Lyons**, patient access manager. “We read the comments and announce who the employee is at the staff meetings each month.”

A picture of that employee is posted on a bulletin board in the waiting room and decorated with the comments that were said about the person. For example, some recent comments describe co-workers as “helpful,” “caring,” “works extra to help out,” “always willing to help when someone has questions,” “always friendly,” “always starts work on time,” “helps train new employees,” “pleasant to work with,” and “always kind and caring to the patients.”

“I feel having the employees involved and being able to select who they feel does a good job is important,” says Lyons. “They work alongside the other employees and know if they do a good job. Also, it makes them feel a part of the decision instead of the person in charge making the decision.”

### *Treat everyone equally*

It’s important to compliment staff for a job well done, says Friedberg, but the converse also is true: to reprimand your “good” staff when it’s warranted.

“The hardest thing to do as a manager is to create the impression of fairness within the department — and that is particularly true for patient access,” he says. “If you make sure that you treat everyone equally, that is one of the real keys.”

For instance, if your policy is that there is a

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five-minute grace period after the start of a shift to be written up as late, you need to apply this evenly to all employees. "If your best registrar is six minutes late, there is a tendency to say, 'They did an extra shift for me so I will look the other way.' But that employee better get a write-up just the same as your worst," says Friedberg. "The rules must apply the same to everybody. Otherwise, middle-of-the-road staff will not take the rules seriously."

Here are some of the ways that **Carlton Smalls**, director of patient access at Presbyterian Hospital in Charlotte, NC, rewards his staff:

- **Staff are asked to recognize their peers.**

Smalls says that his department operates with a strong belief that excellent service to patients begins with excellence in service to staff.

"We strive for continuous staff engagement and expressions of appreciation," he says. "Our staff serve terms on our IDEAS [I Deliver Excellence Access Services] team, which assists leaders with developing staff reward and recognition plans throughout the year."

One way of doing this involves weekly rounding, when leaders ask staff for peers whom they would like to recognize.

"Each leader used to round in their own area," says Smalls. "Feedback from staff was that it was very redundant, and I did not feel that it was capturing enough."

Now, each leader is assigned to a specific week of the month and does the rounding for all areas. Plans also are in the works to get the staff themselves involved with the rounding process.

"We typically ask if they want to recognize someone in their department and another department," says Smalls. "We get warm responses for both. Staff are always happy to recognize people they have come into contact with from other disciplines, such as nursing or other ancillary areas."

Each person mentioned receives a note card mailed to his or her home address. "I always tell them in the personal note that they were recognized by their peers and note the specific action," says Smalls. "Staff rave about getting something so personal at home when they are away from work."

- **A homemade lunch is served to staff.**

All patient access staff have lunch with Smalls at least once a year. In addition, any staff person who is recognized by a peer gets invited to a "Lunch with Carlton," which is held once a month.

"I love cooking and always prepare the meals myself. This adds to the personal touch — everyone looks forward to the pound cake," says

Smalls. "These gatherings are just for them and me. They are an additional way for me to get to know them personally."

At the lunches, attendees typically have a round-table discussion about life in each department. "They are asked to share what they learned from the group once they return to their department, at their next staff meeting," says Smalls.

- **The "bucket book" concept is used.**

Each new patient access department hire is given the book *How Full is Your Bucket?* as a part of their six-week "boot camp." The concept shows how every interaction is either positive (a drop in your bucket) or negative (dipping from your bucket). Throughout the year, a team of staff members presents one chapter from the book at staff meetings.

A point system is in place, which records the number of "drops" / compliments given to staff.

The "drops" convert to "patient access cash," which can be redeemed in the hospital's "Team Store" for items such as snacks, pens, or badge holders. The store visits each department weekly, and staff are able to order items via interoffice mail.

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## Save on training costs with low-cost online education

*Method is more convenient for staff*

**T**raining and education costs often are the first items on the chopping block when it's time for budget cuts. By offering education online, costs can be cut while quality is maintained.

**Pam Carlisle**, CHAM, corporate director of

patient access services and revenue cycle administration at Columbus-based Ohio Health, says that “staff education and training has not been the target of any of our re-alignment plans. Our training and education department is critical to the overall success of our clean claim rate, and in turn, the bottom line.”

Carlisle adds that her department is, however, “doing more with less. We are working smarter, not harder, as the saying goes.”

One way the patient access department is doing this is by switching to online education, to replace some of its in-person classroom instruction. “We have really tried to put a lot of our education online for our staff to take at their convenience,” says Carlisle. “This is more convenient for staff and gives management a way to track results and monitor competency scores.”

Staff are offered online training for systems as well as processes. “Many people were skeptical of online system training in the beginning,” Carlisle acknowledges. “But the more they use it, the more they are becoming believers.”

The system training walks users through each step of the new system. Next, it requires them to do test patients in the system for practice, and take a competency exam. Staff can do this as many times as they like, to refresh their memory.

“We have posted critical pieces of the registration process online for them to test on annually,” says Carlisle. These include education on how to complete a consent, what is an Advance Beneficiary Notice of Noncoverage, and how privacy laws affect registration. The department is working on a new posting for Medicare Secondary Payer education.

However, Carlisle says that the classroom setting has not disappeared entirely. All new hires and staff with low-quality scores receive classroom training, and classroom training is done on hot topics as they arise.

“There is so much to keep the frontline sharp on; there is not enough staff or hours to cover your team while they are out to train,” says

Carlisle. “By offering these refreshers online, they can complete them anytime. The end results will be a better-educated staff updated on the latest changes, efficient tracking of courses, and competency tests to ensure the material is digested. This is a winning combination for the mountain of knowledge to absorb.”

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## ED collections doubled with these changes

*Change the ‘bill me later’ approach*

What’s the toughest challenge if you want to get serious about emergency department point-of-service (POS) collections? “Changing behavior with the staff as well as the patients,” says **Denise Helm**, director of patient access at St. Rose Dominican Hospital in Las Vegas. “Both prefer the ‘bill me later’ approach.”

Once a patient leaves, the likelihood of collecting decreases. Another challenge is that due to the emergent nature, sometimes patients do not come prepared to pay.

To improve ED collections, all patient access staff at St. Rose Dominican were trained on POS collections. This includes scripting for a variety of different responses.

In addition, a POS collection grid was created for self-pay patients, as well as a copay cheat sheet. For those patients not prepared to pay, the registrar will present them with a letter and a self-addressed stamped envelope and ask that they remit their payment as soon as possible.

“We also utilize friendly competition between employees and the three St. Rose facilities to

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encourage increased collections," says Helm. "Our ED POS collections for March and April 2009 have increased an average of 200% across all three facilities, when compared to the same time period in 2008."

"In 2007, we restructured our front-end model in the emergency department," says **Jodie Martin**, director of admitting and registration for the department of revenue management at University of Kentucky Healthcare. "The registration staff who were currently reporting to ED nursing were moved to revenue management and began reporting to me. Our goal was to emphasize the business requirements of the position."

To that end, clerical tasks were pulled out of the list of registration staff duties, and clerical-level positions were developed to assume the non-registration tasks.

"At the same time, we also developed scripting and provided enhanced training programs for registration employees. Copay and self-pay collections were emphasized," says Martin.

Collection requirements were added to performance appraisals standards, and regular meetings regarding the topic were held. Periodic reports were developed and sent to staff

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by the ED registration manager, and monthly reports of the results of collection efforts were presented at high-level revenue cycle meetings.

"The results were impressive," says Martin. "Almost immediately, we saw a monthly doubling of collections. Some months, collections actually tripled, yielding a cumulative total for 2007 that was double that for 2006."

Since 2007, collection rates have remained fairly stable. "With the recent challenges of this new economy, we are beginning to struggle with maintaining that stability, much less surpass it," says Martin. "However, our plan is to dust off the strategies that worked so well in 2007 and reintroduce them." ■

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