

Optimizing Patient Access



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When Richelle Fleischer came to Riverside Health System nearly seven years ago, it wasn't just that the cashier windows weren't used much.

They were boarded up.

"When I started with Riverside, there literally was drywall over the cashier window roll cage. We weren't collecting anything," recalls Fleischer, administrative director of revenue cycle management at the Newport News, Va., health system, which includes three acute care hospitals, a psychiatric hospital, and Virginia's largest physical rehabilitation hospital.

Today, the organization is collecting everything it can. Of all the payments patients make within the first 30 days of service, Riverside's registrars are collecting approximately 79 percent at the time of service. It's just one of the many benefits Riverside and other hospitals and health systems have begun to experience as they've improved revenue cycle efficiencies through enhanced patient access services.

■ Why Patient Access?

As many healthcare providers are discovering, the best chance to improve the revenue cycle is at the beginning of the process—when first capturing data while scheduling and registering patients. Do it wrong, and the problems mount fast. Late payments. No payments. Insurance denials. Copay conflicts. Patients and hospital employees slogging their way through a payment system that seems to conspire against everyone. But do it right today, and you—and your patients—will be happy tomorrow.

"Our business is driven by the volume of patients we see, so it's important that access be provided to our services in a timely and efficient way," says Hal Scott, vice president of information systems and CIO at MCG Health Inc., a not-for-profit corporation in Augusta, Ga., that manages the clinical operations of the MCG Health Medical Center, the MCG Health Children's Medical Center, and associated health system facilities. "If we can collect all the correct information early, then the patient goes through our system much more efficiently and doesn't get bombarded with the same questions over and over again. It also means lower wait times and appropriately prepared staff, so patients' time can be better spent in the care delivery process with the focus on their health needs rather than on providing information to us."

For Fleischer, sound patient access service is particularly critical in today's healthcare world.

"In this economy of declining volumes, it's an increasingly important competitive and strategic advantage," she says. "If you make it easier for the patient to access your facility, then that's a direct advantage you have over other hospital systems."

And it's an advantage not just because it gets patients into the hospital and improves their satisfaction with their experience, but because it pays off when they leave, too.

"The competitive advantage flows through to cost to collect. If I have fewer denials and less administrative burden chasing down payments on the back end, then my cost to collect drops, which gives me a stronger bottom line," Fleischer says.

It's also an imperative in meeting today's many payer requirements.

"The reimbursement system in this country is complex, probably too complex," Scott says. "But if we can collect the necessary information to produce a clean claim, then the system works very efficiently. That's the holy grail. That's what we're shooting for."

How to start? Improved patient access often means taking advantage of effective technology, designing organizational structures for greater efficiencies, focusing on staff training and development needs, and staying nimble enough to address evolving challenges.

■ Technology

Key for patient access effectiveness is securing correct data from the outset. Several applications of technology can aid this effort.

Self-service. In the quest to improve data quality, some progressive organizations are turning to self-service registration kiosks. Patients will find the kiosk experience familiar, similar to what they already are used to seeing at the airport or grocery store: Upon arrival for an appointment, the user swipes a credit card or enters a name directly on the kiosk, along with an additional identifier, such as a birth date, to begin the check-in process.

Kiosks can engage the patient to view and confirm appointment details displayed on the screen, electronically sign consent forms, and enter medical history information. When

patients enter new demographic, insurance, or medical history information, kiosk systems can allow the information to flow directly to the hospital's back-end systems. Such interfaces eliminate the need for registration staff to manually re-enter patient data, which increases overall efficiency and improves data accuracy.

Florida Hospital Fish Memorial in Orange City, Fla., has found the technology improves actual capture of data. Danny DuBosque, the hospital's administrative director of physician practices and former director of patient financial services, says patients are more likely to correct wrong information when using the kiosks than when a registrar is verbally asking them for their information.

"We found that when patients can see the information, they tend to pick up on mistakes much more quickly," he says. "We've really noticed when we have a section in there where patients can validate their information—their name, address, date of birth, insurance information—they catch a lot. When patients simply sit in front of registrars and are asked questions—'Is this right, is that right?'—they tend to just say yes without much consideration. And when they're looking at their information and validating it themselves on the kiosk, not only are they noticing a lot more errors, but also they're able to correct them."

Better data quality also means faster billing. As an example, University of Colorado Hospital (UCH) in Aurora credits an almost two-day decrease in average days to final bill to its use of a kiosk demographic validation process that reduced bad addresses by 12 percent.

Also, the organization's collection process is efficient. Kiosks at the hospital apply coordination of benefits rules to determine copayment amount and then allow users to make the requested payment by credit card. "These credit card payments auto post into our system," notes Melissa Greer, senior director of revenue cycle operations.

Timely edits. Other technologies are aiding patient access as well. Like many organizations, Riverside Health System has its registrars use a billing scrubber that runs edits on claims to confirm that all information—from patient addresses to diagnosis codes—is correct.

"It runs all these checks to make sure you're sending a claim that's as clean as possible," Fleischer says. "We were running it five years ago, and we're still running it today."

Timing Is Everything

How well is your organization timing its efforts toward validation of coverage? At MCG Health Inc., employees who used to verify insurance three to four days out are starting to work 14 days out to meet insurance company precertification requirements.

Such a proactive approach minimizes the likelihood of validation issues holding up clinical services or procedures. "We try to make sure we have everything in order prior to the patient's arrival," says Hal Scott, vice president of information systems and CIO. "We check everything so that when patients arrive, the process is very streamlined and they can get back to see a physician as quickly as possible."

Initially, she says, the biggest billing errors were registration-related, from inaccurate personal and demographic data to insurance information. Administrators realized that the best fix would be a system that lets registrars know when they're making errors in real time so that they could correct them at the front end, eliminating problems for patient accounting at the back end.

"So we instituted a registration scrubber. It gives each registrar a score of how many data elements are wrong as a percentage of their total registrations, which is then translated into a grade," she says.

The results? "We turned on only a few edits, and all of our registrars were failing," Fleischer recalls.

It was then a matter of taking these results one step further, as the system allows registrars to fix their errors.

"What we said was, 'If you fix your error, then it doesn't count against you in your score.' We then went from failing to 96 percent accuracy," she says. "And our billing clean claim rate has gone from about 60 percent clean to 85 percent clean because we've eliminated a lot of the registration errors. All those things that would hang up claims on the back end are now being fixed at the point of registration."

Initially, registrars who fell below 80 percent accuracy were put on corrective action plans. That threshold has since been increased to 90 percent.

"If you aren't at 90 percent accuracy within 30 days of starting with us, then you're put on a corrective action plan," Fleischer says. "You can lose your job if your accuracy is not where it needs to be. We have had turnover, but those who want to be professionals and be good at registration have risen to the challenge. We have a team of 55 registrars across the health system and at the main hospital, and they're averaging 96 percent accuracy."

UCH had been using a claim scrubber in its patient accounting system, but three years ago, administrators started rebuilding the system's edit sets to flag problems in real time at the point of registration.

"Basically, what's happening now is by the time a claim gets to the business services department, any errors are already fixed, and the claim can just go out the door," Greer says. "It doesn't mean registrars are never making mistakes in the registration process—but it means when they do make a mistake, there is an edit at the point of registration catching that mistake. The expectation is that the registrar will correct his or her own mistake."

"Three years ago, our edits were way too downstream in the process. More than 80 percent of the accounts were hitting the edits in patient accounting," she says. "Now, 80 percent of our claims go through without hitting those edits. A lot of the efforts to try and streamline the process and push the ownership upstream have been pretty dramatic for us. We've drastically increased the speed with which we've been able to get claims out the door. Our days in accounts receivable have dropped considerably, our cash flow collections have increased, and we've had a significant decrease in denials."

According to Greer, UCH dropped its net days in A/R by 14 days over a three-year period and now reports days at 40. In addition, cash collections have increased by 15 percent year over year.

Improved monitoring and reporting. Technology also is key for the monitoring and reporting behind many of today's data-driven improvement efforts in access functions. At UCH, Greer uses a sophisticated, high-level dashboard to monitor revenue cycle trends, including cash collections, denials, and clean claim rates. With goals based on HFMA standards, Greer and others will review data weekly to try and not only understand why a particular metric changed, but also what they can do to make an improvement.

"We have the expectation that our standard is going to be between certain ranges for all these things. Every time these ranges flip, we get a team together, dive in to figure out what caused the flip, and correct it," she says.

Fish Memorial measures its registration and point-of-service (POS) performance on key metrics like POS cash collection and the percentage of patients that are preregistered—which is currently targeted at 98 percent. When numbers slip, the digging begins.

For example, says DuBosque: "If we didn't hit our 98 percent, what were some of the contributing factors? Perhaps we weren't able to contact a high number of patients, so we weren't able to fully preregister them. OK, well, why did that happen? We might see that we're not getting good phone numbers from the scheduling side. When patients are scheduled, we might get only one number, we can never reach them at that number, and they don't call us back. So you begin to troubleshoot. How can we avoid that? Maybe we will try getting an e-mail address, daytime phone number, or cell number during the scheduling process."

"Usually you just begin to work backward until you are able to figure out the root-cause problems," DuBosque says.

In addition to monitoring registrars' scores derived from the registration scrubber, Riverside determines POS performance by measuring patient lobby wait times and registration times.

"Interestingly, we found that by reporting the patient lobby wait times back to the registrars, the wait times decreased by about 25 percent," Fleischer says.

Why? "Until registrars saw the numbers, they didn't realize how much time they were spending between patients on things like walking from their work stations to get the next patient or even stopping in the break room for a few words with a coworker," she says.

These days, the hospital has reconfigured its registration area so the break room no longer is as convenient, and registrars know there is a premium on moving patients through. The average lobby wait time has plummeted from more than 20 minutes to eight or nine minutes, while the average registration time has fallen from between 12 to 15 minutes to about 10 minutes.

Effective Organizational Structure

Although kiosks, scrubbers, and measurement tools can help improve patient access services, there still are challenges that technology alone can't solve. Information silos surrounding patient access functions often require shifts in both organizational structure and departmental processes.

Such was the case in 2002, when MCG Health Inc. made patient access a key strategic initiative. "There were a thousand or more ways people could enter the system for health care, and each of those ways in many cases was done differently, so the quality of information we had about each patient was highly suspect," Scott recalls.

What followed was a comprehensive and aggressive program that consolidated a fragmented system into a single ambulatory patient access services department that handles 325,000 physician office visits and more than 100,000 hospital-based ambulatory visits annually.

Over 18 months, administrators reorganized the entire operation into a centralized scheduling and registration organization that handles a wide variety of patient access services through three arms:

- A call center where approximately 30 employees handle more than 9,000 to 10,000 calls per week and schedule all physician office appointments and hospital-based ambulatory services
- A financial quality group responsible for precertifications, authorization, and all insurance validation issues
- Front-desk operations for all of the system's clinics, giving single accountability for capturing accurate data at the front end

Rich Bias, senior vice president of ambulatory and network services, notes the new department allows the system to collect copays and outstanding balances at the point of service (functions that were previously handled at the back end of the revenue cycle) and has ensured that 85 percent to 87 percent of patients are completely cleared for service at the time they present (up from an initial goal of around 75 percent).

"We've had some pretty significant outcomes," Scott says. "First and foremost, we see patients getting into the system a lot faster. Where patients might have had to wait for six or nine months to get an appointment, now they're getting in

Manual Labor No More

Think technology has its limits? Just look at some of the ways Melissa Greer, senior director of revenue cycle operations at University of Colorado Hospital, relies on technology:

- High-level dashboard to monitor revenue cycle trends
- Sophisticated patient accounting system
- Scheduling applications
- Patient registration kiosks
- Electronic insurance eligibility functions
- Business intelligence tool that prepares reports and lets her pull out critical data
- Contract modeling system to help calculate expected payments
- Claim scrubber

"I can't think of anything we're doing manually anymore," she says.

much more quickly. Also, wait times while they're here have been reduced dramatically."

MCG Health Inc. reports that from June 2003 to June 2004, the health system received improved Press Ganey scores for access to care, ease of scheduling appointments, and the ability to see the desired provider. During a six-month period, overall patient satisfaction jumped from 85.3 to a highest-ever 88.2. In addition, scores for patient wait times before going into the exam room improved from 76.0 in 2005 to 80.9 for the fourth quarter of 2008.

"And from a financial perspective," Scott adds, "we're doing much better at being able to collect fees for our services because we have more accurate and more complete information up front."

But it wasn't an easy job getting there. Outside consultants were used to determine how patients were accessing the health system, and then administrators built an organization based on those access routes and developed job roles and descriptions. Current employees who completed training and testing programs were allowed to apply for jobs in the new organization.

“Our approach was to look at the process and eliminate it if it didn’t make sense, and then create a new process based on best practices. We brought some outside help in to tell us what best practices were, and then we implemented information systems following those best practice improvements,” Scott says. “The outcome has been very rewarding.”

At Fish Memorial, preregistration and scheduling responsibilities were combined into a single department about two years ago after administrators began tracking registration and POS performance.

“By doing some root-cause analysis, you realize a lot of it starts in scheduling—that’s where the information is gathered and then communicated back and forth with patients, so that’s where you want to start to drive some of the process,” DuBosque says.

It made sense to put preregistration and scheduling together in one area where they would be able to share resources and better understand each other’s needs.

“The scheduling folks know what their work does and how it impacts processes downstream from them, so they are more sensitive to information their coworkers are going to need as they begin the preregistration process,” DuBosque says.

Believing a cross-trained staff would add efficiency while breaking down perceived walls between the registration and scheduling functions, administrators created job classifications based on length of service and skill set. Employees who are cross-trained are eligible for better pay and higher-grade jobs.

“We were blessed to have most of our individuals excited about the opportunity and willing to participate,” DuBosque says.



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Staff Training and Development

As the duties of the registrar continue to expand in the name of patient access services that provide one-stop-shopping, these front-line employees are playing an ever-increasing role in a very critical function: cash collection.

At Riverside, that meant more than just opening up the cashier windows again. It meant clearing up some basic misunderstandings, too.

“When I talked to the registrars initially, I had someone tell me taking payments from customers was illegal,” Fleischer says. “We had to get past such false impressions and work through this whole culture that was against requesting money up front.”

Key in making this transition has been a strong focus on staff training and development.

“We had to do some role-playing and give registrars some scripting in the beginning. A lot of them were uncomfortable collecting up front. We had to say to them, ‘Would you ever think about leaving your local grocery store without paying?’”

In addition, Fleischer improved the pay equity between registration employees and their higher-paid patient accounting counterparts.

“Registration was three grades lower than patient accounting, yet I was asking them in effect to be a biller and a collector,” Fleischer says, noting that as some functions shifted to the front end, she reduced the number of FTEs in patient accounting to free up money for higher salaries for registration employees.

“Did it cost me more money in registration? Yes it did,” she says. “But it more than paid for itself in the reduction of FTEs in patient accounting.”

At Fish Memorial, cash-collection training is ongoing. The hospital’s collection agency has provided resources and trainers, and employees constantly review the ways to appropriately ask for money. It’s all in the name of improved cash collection.

“The sooner in the process that you are able to communicate balances to the patient, the more likely it is you’ll be able to collect payment,” DuBosque says.

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Improving Patient Access

James. M. Corrigan, vice president and general manager of GE Healthcare, discusses strategies for leveraging technology to support patient access functions.

Q How can hospitals best support efforts of patient access staff toward collection of correct patient information?

A In the more than 40 years that GE Healthcare has been supporting customer success, we have been fortunate enough to observe, learn from, and contribute to the optimal patient access practices of hundreds of healthcare organizations. Our focus is not only about driving business performance, but also supporting our customers' goal to deliver clinical excellence. Through collaboration with our customers, we've seen how critical it is to develop and automate workflow processes that can ensure providers and staff have the information and tools they need to continually improve the patient experience.

We've developed a steadfast belief in these operational assumptions:

- Potential problems should be identified as early in the cycle as possible—even prior to patient arrival.
- Capturing accurate information up front and at the point of care is key to a healthy revenue cycle.
- Automation should be used whenever possible to minimize reliance on manual user intervention to fix problems.

As information technology becomes more and more sophisticated, the benefits of automation are increasingly within reach. These benefits can include:

- Flexible scheduling, making it easier to accommodate patients' and providers' preferences by building in up-front rules
- Online worklists, guiding staff through pre-arrival and admission tasks and helping to increase productivity and improve the check-in process
- Intelligent system alerts, proactively notifying staff of outstanding tasks or missing information prior to the visit while, at the same time, helping ensure complete claims go out the door

Many organizations are already realizing early success in extending this level of service and automation directly to patients, through web-based portals and self-service kiosks.

An exceptional patient experience can set your organization apart. Seamless and swift access to accurate information can improve your staff's ability to provide superior service, and can ultimately have a positive impact on the health of your revenue cycle. The next time you step back to evaluate patient access workflows, consider the optimal practices you could implement with the help of automated tools, and the benefits being realized today by organizations that are taking a proactive approach.

And you have to do more than just ask patients to pay. "You have to be prepared to explain the calculation," he says. "You've got to be able to break it all the way down to let them know how you arrived at the calculation, and that the calculation is accurate. They're going to be much less likely to give you a sum of money if they don't think it's the right number. Do your homework."

At Fish Memorial, that means using a calculator with all the hospital's insurance contracts and charges loaded into it. Reps select the medical procedure and the patient's insurance plan, and the system applies the contract rates for that

particular plan and indicates what the payment will be. From there, reps put in that patient's specifics—including copay levels, unmet deductibles, and coinsurance levels—and the calculator tells them how much to collect from the patient.

"It's a very defensible calculation," DuBosque says. "That's been a huge factor in allowing us to get more accurate information to patients and to collect more at the time of service."

Of course, collection entails a very human element as well. A key focus of training for the centralized insurance verification team at UCH is learning to manage the specific and complex

financial communications that often arise while being sensitive to the patient's needs.

"These are difficult conversations to have, and you have to recognize that it takes a totally different kind of skill to handle all of the possibilities," says Greer. "Patients have lots of questions, and you really need to be an expert in insurance coverage, different aspects of various plans, and all of the other options that are available to help patients without enough coverage to access the care they need.

"What we're working on is making a model where our insurance verifiers are the ones reaching out to our patients," she says. "And we're growing our financial counseling arm so we can have those people more available to jump in when those conversations need to occur."

Success Does Happen

It's no secret that improved patient access services play a key role in efficient and effective revenue cycle management. Healthcare providers that are smart with technology, break down some walls, and get skilled employees on board can realize some very real benefits.



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Although improvements in patient access aren't always easy, experiences like those at Riverside show that success does happen.

"We had longer wait times, we weren't collecting at the time of service, we weren't doing a good job with electronic eligibility, we were tracking registration accuracy manually, and I had a staffing model of about a half hour per registration," Fleischer says.

"Today I'm at .37 hours per man/unit, and yet I've got better accuracy and shorter wait times, and we're collecting over \$250,000 a month at time of service. I'm doing more with a lot fewer people," she says. "And I'm doing a much better job at it than I've ever done before."

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