

# Patient Access ADVISOR

INNOVATIVE SOLUTIONS FOR THE FRONT END

## Case study

### Auditing patient access: How one health system benefits from technology

As a patient access manager, you know that improving your hospital's front-end operation is your primary responsibility and biggest challenge. Errors in registration can ripple throughout the revenue cycle. That's why it's imperative to take a proactive approach toward auditing patient access.

Don't take this job lightly, says **Yvonne Focke, RN, BSN, MBA, CHAM**, director of access and care management at TriHealth, Inc., in Cincinnati. "Little things make a big difference," she says. "The auditing process is very important."

#### The problem

TriHealth, a 901-bed health system consisting of Bethesda and Good Samaritan Hospitals, recognized in 2000 that it

needed to revamp the way it audited the front end. When TriHealth officials first scrubbed their claims, they found an alarming number of mistakes.

They found the small errors (e.g., missing suffixes and prefixes, incorrect spelling of names and addresses, etc.). However, there were also bigger mistakes (e.g., incomplete information on the Medicare secondary payers questionnaire or requirements specific to each insurance plan that were not met).

Training staff how to always get the right information was the first step, but also was a difficult step considering the myriad differences between health

plans, as well as patients not always understanding their coverage.

"We found so many variations between contracts that we'd have memos going out to everybody and Post-it® notes on many computers," says Focke. "Not all registrars have a background in insurance, but they are expected to understand the many different elements from various plans." Therein lays the challenge—the medical record is doubly important considering the patient safety and financial ramifications that come with inaccuracies.

#### The first few steps

TriHealth began its auditing reconstruction with a 20% registration inaccuracy rate. Today, that rate is down to 1%–2%. But it was a long road to arrive at near perfection. First, in 2001, TriHealth positioned an auditor in registration to run reports, review for accuracy, and help build a training module.

**"We found so many variations between contracts that we'd have memos going out to everybody and Post-it® notes on many computers."**

—Yvonne Focke, RN,  
BSN, MBA, CHAM



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## Case study

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The auditor identifies which information is the most problematic for staff to accurately obtain.

“We’re looking for the areas that scream at us the loudest, from compliance concerns to what is most problematic from the back end, where our errors are corrected,” Focke says.

Next, TriHealth built a training module. “There had not been a structured training program, and we really needed one,” says Focke.

For example, the auditor might dedicate one week just to insurance training. But Focke realized that the training wasn’t a one-stop solution.

You need continuous updating for new and difficult decisions to make during a registration, and the oft-changing payer rules further complicate this. “Knowing that increasing variations are only getting more complex with consumer-driven health plans, we know we needed more technological help,” Focke says.

### A little help from our friends

In 2005, TriHealth partnered with Cincom, an international provider of software solutions with domestic offices in Cincinnati, to develop a system that could provide a decision tree to overlay on its platform system (Meditech) to help navigate staff through the formal registration process. The system, which the group calls Intelligent Guided Registrations, went live in 2006.

It walks registrars through the registration process, step-by-step, and prompts them with messages if information is missing or questions and prompts them when there are multiple choices (see p. 3 for sample screenshots from TriHealth).

“It’s like TurboTax,” Focke says. “It helps tremendously.” The software enables registrars to catch about 50% of the mistakes they make before the claims reach their registration auditor.

“It’s prevention versus correction,” says Focke. “That’s what this software provides.”

The software greatly limits the amount of work the auditor must perform. And because of the increased efficiency, TriHealth went from three auditor full-time equivalents to two last year. “We audit each person each month and base their performance [reviews] on their scores,” Focke says. “But the accuracy level has improved dramatically, and most people are now in the ‘good’ to ‘very good’ category.”

Staff are also happier knowing that they are making fewer mistakes. “[The software] slowed them down a little bit initially, but we also don’t have to give out a lot of memos that say something’s changed,” says Focke.

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Senior Managing Editor: **Corey Goodman**,  
cgoodman@hcpro.com,  
781/639-1872, Ext. 3737

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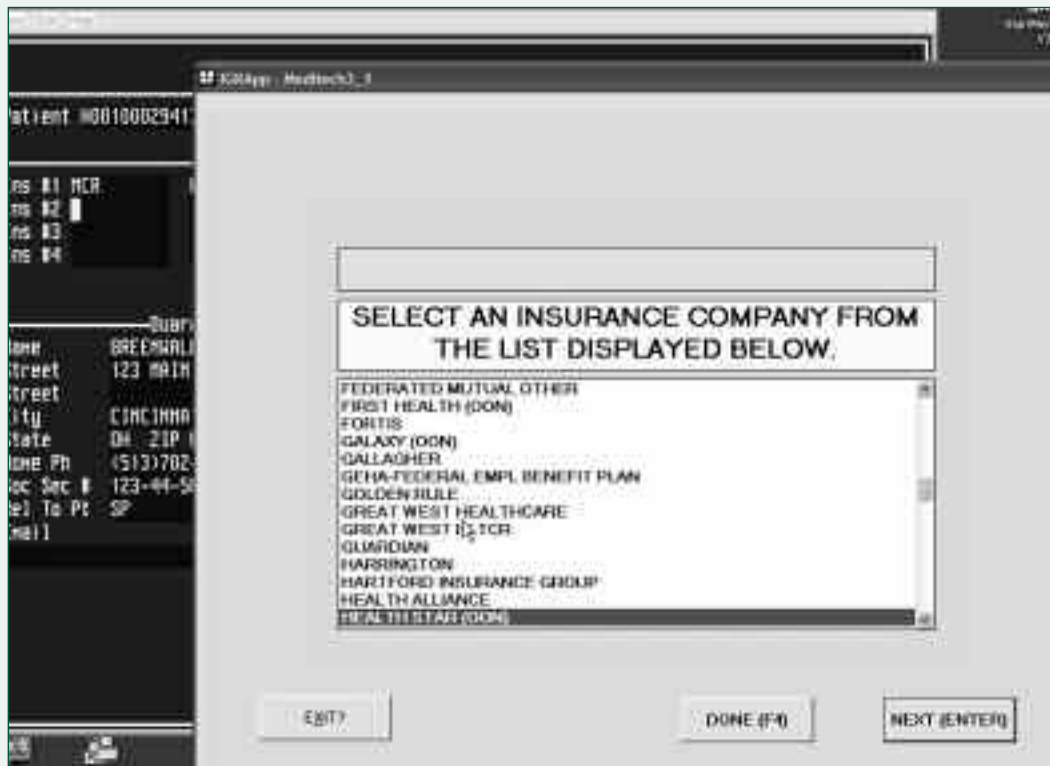


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**Sample screenshots**

Below are sample screenshots that illustrate how TriHealth has tailored Cincom's software to fit its needs.



Source: TriHealth, Inc., Cincinnati. Reprinted with permission.

This Month's

**Form****Sample central registration auditor job description****I. Identification**

**Position title:** Auditor (Central registration)  
**Department:** Central registration  
**Cost center #:** XXXX

**Job code:** XXXX  
**Area director title:** XXXX

**Date completed:** XXXX  
**Position reports to:** Manager of central registration  
**Locations:** XXXX

**II. Principle accountabilities (summary)**

This position is responsible for auditing completed registrations that the central registration performs for quality measures (i.e., to ensure a consistent format for data entry, accuracy of insurance information, and appropriate diagnosis, and to provide meaningful statistical information and a tool that will identify retraining needs).

The auditor must maintain the database to track and trend quality issues and report outcomes to management and staff. The position requires in-depth knowledge of registration software, medical terminology, and insurance. The auditor must communicate quality issues to staff in a positive manner and correct quality errors in a short time frame to ensure that accurate information flows to billing.

**III. Position requirements****Education, credentials, and licenses:**

Associate's degree or high school education with medical terminology and three years of registration experience.

**Specialized knowledge:** Technical training and education/experience in designated systems. Proficiency with Microsoft Office. Thorough understanding of database concepts. Knowledge of healthcare or experience with systems in a clinical environment.

**Type and length of experience:** Excellent technical, communication, and interpersonal skills. Experience with database management and end-user training and support.

**Working conditions/physical demands required:** Must be able to communicate effectively with various personality types. Must coordinate efforts with coworkers to maximize productivity and quality of service. Must maintain competencies appropriate to customers served. Requires variable amounts of sitting, standing, lifting, bending, and walking. Fast-paced office environment requires the ability to work under pressure while performing multiple tasks. Employee is responsible for working in a safe manner.

**IV. Performance measures & standards****Identify the major results/standards your position is expected to achieve.**

1. Audit registrations that the central registration performs for quality measures (i.e., ensure consistent format for data entry, accuracy of insurance information, and appropriate diagnosis, and provide meaningful statistical information and a tool that will identify retraining need).
2. Demonstrate in-depth knowledge of registration software, medical terminology, and insurance.
3. Communicate quality issues to staff in a positive manner.
4. Correct quality errors in a short time frame to ensure that accurate information flows to billing.

This Month's

**Form****Sample central registration auditor job description (cont.)****Human resources use only****Position title: Systems coordinator (registration)****V. Problem solving****Briefly describe two or three typical problems this position must resolve to achieve the standards.**

1. Medical records are merged inappropriately when a patient's identity is changed on a registration. The auditor must have the knowledge to correct the registration and take all steps to ensure that a correct registration is established, as well as reinstate the original medical record. Charges must be moved to the appropriate account and notification of all units must occur.
2. A list of all inactive accounts with charges must be reviewed daily. Charges are sometimes posted to incorrect accounts. The auditor must have the ability to recognize the accounts with inappropriate charges. Charges must be moved to the appropriate account.
3. A duplicate registration for the same date of service is created. Charges are posted to both accounts. Auditor must identify duplicate registrations, consolidate charges to one account, and cancel the registration.
4. Patient is not registered prior to service. Charge is posted to an inappropriate account. Auditor must create a new registration and move charges to appropriate account.

**VI. Position structure****Incumbents report to what position?** Manager registration**What other positions report to the same position?** Supervisor registration, supervisor registration, supervisor bed management**Of what TriHealth teams is incumbents a member?** Registration team, others vary with current projects**What departments/cost centers report directly to this position?** 0**What titles report directly to this position?** 0**How many full-time equivalents report to this position?**  0  Directly  0  Indirectly**Annual operating budget?**  0  Revenues  0  Expenses**Management approval:** \_\_\_\_\_*Source: TriHealth, Inc., Cincinnati. Reprinted with permission.*Download this form in the **Patient Access Advisor** section of [www.patientaccessresourcecenter.com](http://www.patientaccessresourcecenter.com).

## High-deductible health plans: How to sidestep your payer restrictions on up-front collections

Your registration staff have probably noticed an increasing number of patients with high-deductible health plans (HDHP). If they haven't, they soon will.

About 31% of large employers—those with 20,000 or more workers—now offer HDHPs to their employees, according to a 2006 Mercer Health & Benefits survey.

That percentage should rise in 2008 as more employers, big and small, look to divert the often crippling cost of healthcare to their workers.

This trend comes with its share of patient access migraines, none more painful than the challenge it poses to up-front collections. Determining whether a patient has met his or her deductible is difficult enough without technology to speed the process. But when a payer's policy restricts you from attempting to collect monies up front, your team is playing shorthanded.

"Your best chance of collecting money is when the patient is standing right in front of you," says **Robin Fisk, Esq.**, a lawyer in Ashland, NH. "When a payer takes that away from you, particularly in respect to [HDHPs], it causes big problems."

But teaming up with your managed care contractors to combat payer policy restrictions through information gathering will give your organization the tools it needs to build a solution.

### The root of the problem

Some payers have not adjusted entirely with the times, Fisk says. Many of the payers that used to feature low-deductible plans have buried wording in their policies and procedures that prohibit patient access staff from collecting money up-front, before the payer provides an explanation of benefits.

The idea behind these policies is to protect members from paying twice and eliminating the back-end work for both sides. But low-deductible plans pose less of a problem because it is easier to meet the deductible, and, in turn, the bills are a smaller percentage of the total bill.

Many payers, especially the small to medium-sized insurers, have not rewritten their policies to allow providers and practitioners to collect the deductible immediately.

For example, the minimum deductible required for a HDHP enrollee to qualify for a health savings account in 2007 is \$1,100 for single coverage. How-

ever, there are plans with much higher deductibles.

If the patient hasn't met the deductible yet, you may be unable to collect the deductible from him or her or the balance from the insurer. More HDHPs in the marketplace further this problem.

"You can't really expect all these patients to write a check for \$1,100 or more," says Fisk. "So providers need to figure out [a strategy]."

**"Your best chance of collecting money is when the patient is standing right in front of you. When a payer takes that away from you, particularly in respect to [HDHPs], it causes big problems."**

—Robin Fisk, Esq.

### Solutions

Some of the more responsible payers have begun to address this issue by providing hospitals with the technology and lines of communication to determine in minutes whether the patient has met his or her deductible.

These payers' motivation is to smooth the business relationship with providers and to ultimately protect their membership from overbilling or billing by multiple pro-

### Questions? Comments? Ideas?

Contact Senior Managing Editor **Corey Goodman**

Telephone **781/639-1872, Ext. 3737**

E-mail **cgoodman@hcpro.com**

viders for the same deductible. Unfortunately, not all payers have followed suit.

“Some payers are beginning to think this through,” Fisk says. “But right now, it’s a provider-beware situation.”

Fisk suggests that patient access managers take a more proactive approach in the contracting process. Start by meeting with your managed care director to review the dozen or more managed care contracts that you have on file to see which currently allow, or could allow, HDHPs. Jump into the policy details and identify what restrictions each payer has in regards to up-front collections. “You can offer some [patient access] feedback that the managed care staff can use in future negotiations,” she says. “Give your best price to the products that make it easier for you.”

But in the short term, take your list of payer requirements and train registration staff on how to approach the different collection scenarios.

“Registration needs to be resourceful,” Fisk says. “So you need to educate the front desk about how far they can go [in pursuing up-front collections] without violating your agreement with the insurer.”

In the absence of payer technology to immediately determine whether the patient has met his or her deductible, your registrars must be able to identify specific payer restrictions for the patient who is standing in front of the registration desk.

Some payers will offer technology to determine the

deductible, or a 24-7 call center so registration can get an answer over the phone, and some will have restrictions on your ability to collect at the time of service.

“When a patient pays twice, the phone call is going to the insurance company. And payers don’t want to deal with the complaints,” says Fisk. “If the tools aren’t in place for the provider, the calls are going to come in, and there will be problems.”

### Patient education 101

The most basic—yet important—step is patient education, Fisk says. Patients must understand exactly what it means to belong to a HDHP and what that membership requires of them.

“Consider taking credit card information and a credit card number and explain why you’re doing that,” says Fisk. “If the patient hasn’t met the deductible, the payer doesn’t have to pay dollar one.”

Better understanding of the pros and cons of a HDHP will gradually improve the provider collection issues.

And, in the future, as these products evolve along with the vendor services that support them, they will become easier to manage.

“Payers ultimately want to protect their members from inconveniences,” says Fisk. “The [payers] that care about their providers will help fix this, as will the payers that don’t want their plan dragged into a mess.” ■

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## Case study

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### Hands-on technology

The Cincom software only provides the mechanism by which patient access managers can assist their registration staff.

The program requires someone to provide the scripting or questions to assist with decision-making, which ultimately directs registrars to the correct decision.

“The registrar shouldn’t have to remember so many things, especially if they’re new to healthcare,” Focke

says. “There are many fields that could create consternation because there are so many variables. We’ve got a population that doesn’t have all the information, so we need to try and guide them through some of that.”

Focke says the software enables her to make changes whenever she desires, and that ability has dramatically increased the accuracy of the registration work.

“It has been a great help to us,” she says. ■

## Watch out for limited benefits plans, identification plans

### Make sure your organization can answer these questions

by Robin Fisk, Esq.

As healthcare costs continue to rise, employers are feeling the pressure to reevaluate the health plan they offer to their staff.

Limited benefits plans, which are gaining ground as an attractive option for employers, are touted as an affordable alternative to more comprehensive health insurance plans.

Limited benefits plans often feature deductibles and benefit caps.

This is significant because, unlike deductibles—which are predictable (i.e., occurring each anniversary of the patient's enrollment) and finite—these policies have benefit limits that can crop up at any time.

You may not know whether or when your plan may discontinue your payment because you've exhausted a particular benefit or reached a policy limit.

Whereas traditional insurance plans offered lifetime benefit limits in the millions of dollars, limited benefit plans can offer caps on certain services/much lower lifetime benefit limits—sometimes in the tens of thousands of dollars.

Although the healthcare industry is seeing a growth in limited benefits plans, the concept is not new.

What is new is their spread. In the past, employers have offered limited benefits plans mostly to workers who tended to be transient (e.g., temporary agency employees, restaurant workers, and part-timers). Now, more typical employers are offering these plans to their full-time, permanent work force.

Companies offering self-insured health plans have long used the self-insured plan's exemption from state insurance laws to avoid offering state-mandated benefits and to incorporate benefit limits and caps.

The passage of the Americans with Disabilities Act of 1990 limited the ability of self-insured plans to single out specific diseases for exclusion.

However, lifetime benefit maximums and caps for certain services—fixed numbers of physician visits or outpatient therapies/dollar limits for transplants—are not uncommon.

If, for example, a plan limits the number of physician visits, and the patient requires ongoing treatment, the physician's office must prepare for this.

Similarly, a plan that caps all benefits at \$35,000 will not cover the cost of a single open-heart surgery.

Providers treating patients enrolled in limited benefits plans need to be able to identify these products and plan ahead to ensure that they do not get caught between abandoning a patient and treating him or her without compensation.

**In the past, employers have offered limited benefits plans mostly to workers who tended to be transient, (e.g., temporary agency employees, restaurant workers, and part-timers). Now, more typical employers are offering these plans.**

### What should providers do?

Questions to ask include the following:

- ▶ **What do your payer agreements allow?** Look at the terms of your existing payer agreements to see whether they permit individuals enrolled in these types of plans.
- ▶ **Do your payer agreements limit the products you will accept? How is the limit defined?** What notice must a payer give you before launching a new product? Ideally, your contract will require a payer to give you details about the product and 45 or more days advance notice, or a new product design to evaluate.

- ▶ **How do your payer agreements define new products? Does the definition clearly include limited benefit design products?**
- ▶ **If a payer notifies you of a new product, what rights do you have to review the product and negotiate additional terms related to it?**
- ▶ **Do you have the ability to opt out of new products?**
- ▶ **What are your payer policies?** Because there are also limited benefits in standard plans or products, prepare to respond to them among the plans you currently accept. Not only must you know which benefits the plan caps, but you also need to know how to answer each of the questions below. Some of these questions raise very complex issues. To complicate matters, patients often do not realize that they have limited coverage.
- ▶ **Do you know which benefits the products offered by each payer in the region limit or cap?**
- ▶ **Under what circumstances does each payer permit you to discontinue services to a member with capped coverage and no other means to pay for services?**
- ▶ **What procedure, if any, must you follow with each payer with whom you deal most often before discontinuing services to their members with capped benefits and no other means to pay for services?**
- ▶ **Can your front office staff identify limited benefits plan patients by their identification (ID) cards, or as part of the precertification or eligibility verification process?** Identify patients enrolled in health plans with limited benefits and plan for how a patient will make payments when he or she reaches the cap. This is especially true if the patient is undergoing a course of treatment that you cannot interrupt without raising concerns of patient abandonment.
- ▶ **Do you have the ability to determine how much of a limited benefit has been spent?**
- ▶ **Do you have the ability to determine whether a patient enrolled in a limited benefits plan has other resources available to cover medical expenses if the benefits become exhausted?**
- ▶ **Do you have the ability to swipe the patient's ID card or credit card?**
- ▶ **Do you have the ability to run a credit report on a patient?**
- ▶ **Have you trained staff to assist with financial counseling?**
- ▶ **Have you trained staff and authorized them to set up payment plans?**
- ▶ **Do you have a private location within your office to offer financial counseling?** Because members can exhaust limited benefits plans unexpectedly, plan for the services these patients will need.
- ▶ **Do financial counselors and those responsible for collections coordinate with clinical staff to ensure that they counsel patients undergoing a course of treatment about their financial obligations in advance? Do these staff verify the extent of coverage periodically during treatment? ■**

*Editor's note: Fisk is an attorney in Ashland, NH, and advises healthcare providers and practitioners concerning payment issues and managed care contracts. Robin also writes a blog called "Managed Care Contracting & Provider Payment." She may be reached at rf@FiskLawOffice.com.*

## Ease the flow: New position helps Pennsylvania emergency department run more smoothly

A few years ago, **Gregory Smolin, DO**, traveled to Washington, DC, with the American College of Emergency Room Physicians to meet with members of Congress to discuss ED medical issues.

During the trip, Smolin says he experienced an epiphany that would eventually improve the throughput of emergency care provided at the hospital in which he worked.

Ironically, the realization did not come from talking with members of Congress, but rather from watching them.

Rushing from event to event, Smolin noticed how at all times, at least three constituents trailed each member of Congress, waiting to convey some piece of information.

To control the disorder, the politicians had legislative aides who interjected and interfaced with the constituents to organize and streamline their requests.

“I saw how efficient these politicians were in dealing with multiple tasks in a finite amount of time,” says Smolin. “I thought, ‘How come in my environment—where I also have a finite amount of time and where patient safety is an issue—I don’t have a system where I can also extend myself?’ ”

Returning to Memorial Hospital in York, PA, Smolin worked on developing a new role in the ED—that of patient flow coordinator (PFC)—designed to extend the attending physician further to staff and patients while improving patient safety.

### Seeds of change

When Smolin first introduced the PFC concept in January 2006, Memorial Hospital averaged about 85 patients per day in its ED.

The PFCs, who were last-year nursing students with some clinical background, served as physician

extenders who essentially followed the attending physician around to improve his or her physical movement throughout the department.

PFCs carried charts, had a general idea of patients’ conditions, and did light documentation work, says Smolin.

As the months passed and Memorial’s ED volume surged to an average of 110–120 patients per day, the hospital expanded the role of the PFCs.

“I think the best description of them now is that they’re flow managers,” says Smolin. “Instead of following the attending around, they’re now doing parallel tasks with the physician.”

Smolin says the biggest responsibility of the PFCs as they help with flow is to chase down data and assist with discharge planning.

“They’re finding lab results that aren’t on a chart, inquiring about an x-ray that is not back yet, and using the computerized discharge system, which is often a big trap for physicians,” he says of the jobs performed by PFCs. “Now, while the coordinators are doing the discharge instructions, I can go dictate the chart instead of sitting at a computer terminal.”

### Day-to-day responsibilities

PFCs work exclusively with the attending physician, juggling multiple responsibilities and doing parallel tasks.

Memorial Hospital is a teaching hospital, so the PFCs also support the residents who are working with the attending physician.

“The attending serves as the point person for the entire shift, so, after a while, there is really an intuitive rhythm between coordinator and physician,” says Smolin.

“The overall job goal is to do whatever it takes to improve throughput on behalf of the patient and to decrease length of stay,” he says.

Smolin says the PFC position has also helped to increase overall patient satisfaction.

In the PFCs’ expanded role, they interact more with patients and also assist with communication.

The coordinators visit rooms to check in with patients to ask how they’re feeling or reacting to a particular medication.

“Part of my job is to keep the patients updated,” says **Nicole Taromina**, a PFC who has held the position since its inception. “I can help explain or clarify a detail once the doctor has left the room. I can also help explain why the doctor has ordered a certain test and what the intentions are.”

Taromina says the expanded PFC role has reduced patient complaints and increased patient satisfaction. She attributes this largely to the fact that patients have less time to sit alone in the room and wonder what is happening with their care.

### Communication control

Like the aides who help funnel communication to members of Congress, the PFCs help streamline communication to the attending physician.

Taromina says before the hospital introduced PFCs, nurses used to line up and fight for physician’s attention to ask questions about concerns such as increasing a patient’s pain medication.

“Now, the nurses just come to us, and we relay the information to the doctor,” says Taromina. “It’s easier for the doctors and the nurses because there’s less standing around and more focus on patient care.”

On particularly busy days, Smolin says he will stop everything he’s doing and ask the PFC on duty to help him prioritize the needs of the ED.

“They [the PFCs] have a bird’s eye view of throughput and will often say to me, ‘If you can just approve a

discharge for the guy in bed six and look at the labs, and get a disposition from the woman in bed seven, we can focus on the new patient in bed four.’ ”

### Hard numbers, easy sell

When Smolin first introduced the PFC concept to hospital administration, he was prepared to pay for the new positions through his physician group.

However, Smolin says Memorial administrators quickly realized how much time the PFCs saved the physicians and nurses and agreed to pay for 12-hour coverage.

“It’s simply economics,” he says. “If we can see an extra patient every 10 hours, we’ve paid for that position. We’re seeing more patients, and we’re more efficient.”

Over the past year, Smolin also looked at data comparing when PFCs worked in the ED versus when they did not and found that every throughput category suffered substantially when the PFCs were not working. When there was a PFC in the ED, Memorial Hospital’s door-to-discharge time decreased by 10%, its door-to-admission time decreased by 5%, and its door-to-doctor time decreased by 10%, says Smolin.

“You could have the smartest ED physician sitting in the back waiting for a patient, but if you have him or her plugged up in the front because of inefficient registration or triage, or you don’t have beds to put a patient in, it doesn’t matter,” he says. “You could have anybody in the back you want, but if you can’t get patients to take care of them—if you can’t keep track of the data you need to take care of them—it’s all wasted.” ■

**“You could have the smartest ED physician sitting in the back waiting for a patient, but if you have him or her plugged up in the front because of inefficient registration or triage, or you don’t have beds to put a patient in, it doesn’t matter.”**

—Gregory Smolin, DO

This Month's  
**Form**

**Sample patient flow coordinator job description**

**I. Identification**

**Position title:** Patient flow coordinator  
**Department:** Patient access  
**Cost center #:** XXXX

**Job code:** XXXX  
**Area director title:** XXXX  
**Date completed:** XXXX  
**Position reports to:** XXXX  
**Locations:** XXXX

**II. Responsibilities**

The patient flow coordinator is responsible for

- ensuring that patients are going in for x-rays and scans in a timely manner
- informing physicians when all test results are back
- monitoring patient conditions and ensuring that staff record all vital signs
- keeping track of patients during the shift change to ensure a smooth transition
- explaining procedures to patients, such as the admittance process and why it takes so long
- making sure things are neat around the department and that staff clean beds in a timely manner
- entering orders in the computer if a secretary is backed up and pain medicine is ordered
- going into rooms with physicians to get information about treatment and help field questions

**Management approval:** \_\_\_\_\_

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## Registration checklist

New this month from HCPro, Inc., is the *Upfront Collections Toolkit: 50 Essential Tools for a Winning Program*. The following checklist is an example of the tools that the kit offers.

This checklist allows each person who handles an account to see at a glance which required activities staff have completed and which must still be completed. Ideally, staff should complete this type of checklist electronically, allowing the system to track completed activities. However, when that option is not available, using this paper to track work is efficient and effective.

<b>Registration checklist</b>	
Patient name: _____	MR#: _____
Social Security#: _____	
Date of birth: _____	Insurance: _____
Group#: _____ Employer: _____	
1. Requested date of service _____ Service _____ MD _____	
2. Pre-registration completed Date _____	
3. Medical necessity screening completed Passed? YES or NO _____	
4. Pre-service visit completed Yes/date _____ No/pre-registration required _____	
5. Comprehensive data set complete Insurance card _____ Driver's license _____	
6. Signatures completed _____	
7. Regulatory requirements complete: ABN, MSP, and privacy notice _____	
8. Insurance eligibility verified _____	
9. Verified service covered _____	
10. Deductible verified _____	
11. Pre-certification/authorization complete? YES or NO _____	
12. Pre-certification/authorization number _____ Date received: _____	

Source: Adapted from *Upfront Collections Toolkit: 50 Essential Tools for a Winning Program*, published by HCPro, Inc. Visit [www.hcmarketplace.com](http://www.hcmarketplace.com) for more information or to order.