

Patient Access ADVISOR

INNOVATIVE SOLUTIONS FOR THE FRONT END

Case study

UNC system turns adversity into significant process improvement initiative

Editor's note: The following is the first in a four-part series that will examine the significant patient financial process changes UNC Health Care has undertaken during the past six months. Next month, we'll discuss how UNC has increased patient access and improved financial assistance.

Accepting criticism is an unpleasant responsibility for any organization. But adversity can be an excellent opportunity to initiate change that emphasizes the hospital's commitment to excellence and loyalty to the community it serves.

The University of North Carolina Health Care System (UNCHCS) found itself in such a situation in the summer of 2006 when newspaper articles and community feedback highlighted deficiencies in the system's delivery of care.

Specifically, the reports grilled UNCHCS for what oth-

ers perceived to be unduly collection practices, unreasonable payment plans, and miscommunications with patients regarding financial assistance options.

"Not all the reports were 100% accurate," says **Hunter Wagstaff**, UNCHCS' director of healthcare system accounting. "But people were questioning whether we were following our mission." Because UNCHCS is a state agency, it must follow certain statutes in terms of its collection policies, but at the same time remain a safety net for those who are unable to pay their hospital bills.

"The comments that were made focused attention on specific areas we already wanted to improve."

—Hunter Wagstaff

"The comments that were made focused attention on specific areas we already wanted to improve," Wagstaff says. "The [criticism] just accelerated the process for us."

A team effort

UNCHCS, which is based in Chapel Hill, cares for approximately 400,000 patients per year in a multihospital system with more than a dozen community-based practices spread out over six counties.

Refining processes for so many patients at so many different facilities was a challenge for UNCHCS administrators.

UNCHCS CEO Dr. William L. Roper spearheaded the initiative with input from legislators in the state's general assembly, citizens in the local community, and the president and chancellor of the university system.

The administrators surveyed the patient population for concerns it had with the system. The group compiled the list and used it as a framework to develop six teams of healthcare staff, which the group commissioned to observe processes over several months and report back with



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suggestions for change. Each team had a leader and anywhere from two to six team members. (We'll discuss their specific findings in future issues of **PAA**.)

Team 1

Administration assigned the first team to observe communications with patients. They focused on whether staff knew what the financial policies were and if they helped patients understand them.

"They also looked at the language barrier," Wagstaff says. "We have lots of Spanish-speaking patients in this area, so they wanted to see if we needed more bilingual staff."

Team 2

The second team set out to determine ways that patients could access financial assistance more efficiently. This was an important task as solutions directly affect the uninsured patient.

It also directly affects the reimbursement the health system can reasonably expect.

"They looked at everything from hiring more financial counselors to working closely with the Orange County Department of Social Services," says Wagstaff.

About 25% of UNCHCS' patients are on Medicaid or uninsured. "This meant a lot of work with the state and county [to facilitate change]," he adds.

Team 3

Administration assigned the third team to look at the health system's discharge procedures. It's an important safety and customer service responsibility that administration hoped to revamp.

"We want to make sure we're doing the best job we can with postdischarge care, making sure they received cared here and got home in a safe manner," Wagstaff says. "This was a big job because it crosses various departments in the hospital. But it was important to ensure that we're all working together as one."

Team 4

The fourth team looked at collection policies, specifically innovative ways to streamline the financial assistance, billing, and appointment processes.

"This was one of the bigger groups because [it] tried to incorporate so many different areas to improve the patient experience while they are at the hospital. They also tried to improve throughput so staff can move patients around easier," says Wagstaff.

The team focused attention on ways to schedule appointments faster, while looking at reminder notices.

Additionally, the team identified strategies to review

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Payment arrangements: Develop a policy with structure

The number of uninsured Americans—47 million and counting—is startling enough without considering that hospitals leave \$40 billion on the table each year in unpaid bills.

The problem is only getting worse for organizations, specifically business offices, but there are measures that patient access can take to help ease the pressure on the back end and the bottom line.

James Yarsinsky, CPAM, president of Expeditive in Princeton, NJ, says the most important quality any payment strategy should have is structure.

“You need to have a plan. There has to be policies and guidelines, and you must spell out everything clearly,” Yarsinsky says.

Basic guidelines

Yarsinsky advises organizations to endorse the following guidelines:

- ▶ Monthly payments must be \$50 minimum
- ▶ Payment arrangements should not extend beyond 12 months
- ▶ All patients must sign a payment arrangements form or promissory note
- ▶ Department director must approve any payment agreement longer than six months
- ▶ If a patient misses two consecutive payments, write the bill off to bad debt

Monthly payments

Not only is it not a smart business move to require less than \$50 per installment, Yarsinsky says, there’s no incentive for the patient to comply, particularly with larger balances.

“If you accept less than \$50, it would take forever to pay off most balances,” he says. It’s also time-consuming for office staff to send notices and track each bill for that long.

“There are always extenuating circumstances, but any

deviance from your guidelines should require director approval,” Yarsinsky adds.

Another school of thought is to analyze when a payment typically comes in, says **Steven Orvis**, director of revenue cycle services at Sinaiko Healthcare Consulting in Los Angeles.

“I had a client who was sending statements, past due letters, a final notice, and then calling the patients. When the organization identified when payments were coming in, it was almost exclusively after the first statement and after the final collection letter,” Orvis says. “So the other statements, letters, and calls were not making much of an impact.”

12-month arrangements

Anything longer than a year should be a big no-no for hospitals, Yarsinsky says.

“It’s one thing if there’s a \$50,000 bill, but most people wouldn’t be able to pay that anyway,” he says.

The longer the payment agreement extends, the less chance the hospital will see the bill paid in full, he adds.

“The hospital provides the service and expects to be paid. It’s that simple,” says Yarsinsky.

Suggest that patients borrow money from a bank or through a family loan if they can’t pay the bill within 12 months, he says.

“Hospitals aren’t in the business to finance loans. They don’t charge interest, so financing longer than 12 months is just unrealistic,” says Yarsinsky.

About half of organizations extend their patients’ payment plans to 24 months, he adds.

One thing to consider is the value of the dollar looking ahead. “A dollar collected today isn’t the same as a dollar collected two years from now,” says Yarsinsky. “Plus you must factor in the work that goes into the life of the bill, such as making phone calls and sending out statements.”

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Payment arrangements

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Promissory notes

As soon as the bill drops, you know the exact amount for which the patient is responsible. Be proactive with this information, says Yarsinsky. Financial counselors should call the patient immediately and come up with a payment arrangement.

“But they must sign a promissory note,” he says. “It should state specifically what they have to pay monthly, the balance, and what should happen if the patient misses some payments.”

It’s easy for organizations to lose track of accounts and not set up payment arrangements with every patient who cannot pay their bill within a predetermined window of time, such as 90 days. Orvis had a client with the 90-day rule in effect. “But when we analyzed how many accounts over 90 days did not have payment arrangements, there were over 1,300,” he says. “That meant the process was not as formalized as we thought and the accounts were not being proactively managed, even though the organization felt it was on top of this.”

Diagnosis of the problem

Many providers focus too much on the size of the

outstanding bill. They aggressively pursue the larger balances, and outsource the small ones. The medium-sized bills can get lost in an unstructured system that relies too much on the patient’s willingness to pay, says Yarsinsky.

“Providers just continually send out statements. But just sending out statements doesn’t get the job done,” he says. “It’s a proven fact that hospital bills are on the bottom of the stack of bills that patients pay.”

Some hospitals don’t contact patients at all, he adds. “It’s incredible how many providers just send out statements a month apart. Some never contact the patient to see what [his or her] intentions are.”

This practice also is an example of poor customer service, he adds. “The bill probably ends up going to collection, the patient gets upset, and it’s a real black eye for the hospital.”

Notifying the patient early on about his or her responsibilities and the organization’s policy on payment arrangements is a winning philosophy.

Anyone who comes into contact with patients in the access area—be it financial counselors, registrars, or

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This Month’s

Form

Sample payment arrangements form

The following is a sample payment arrangements form that Sinaiko Healthcare Consulting in Los Angeles recommends for hospitals. It’s important to inform patients about your payment policy as early as possible.

<u>Billed amount</u>	<u>Months allowed to pay</u>
\$0–\$100	3
\$101–\$500	4
\$501–\$1,000	6
\$1,000+	9

Source: Sinaiko Healthcare Consulting, Los Angeles. Reprinted with permission.

Worried about retail clinics taking space on your turf?

Some providers are fighting back with their own convenience centers

Retail healthcare clinics, which promise consumers shorter lines and lower costs, are the newest trend in customer convenience. The bad news for providers is that the momentum behind these clinics isn't waning.

So, with a multitude of entrepreneurial companies opening clinics by the handful, a growing number of traditional healthcare systems are entering the convenient care arena—both to ward off encroachment on their markets and to strengthen ties with the communities they serve. Along the way, many say they may have found the missing link in the continuum of care.

"We were the first to open in New Jersey, so you could say it was a defensive measure to create a competitive barrier," says **Donald Parker**, president of AtlantiCare Health Services, the ambulatory care wing of southeastern New Jersey-based AtlantiCare. "We have about a 65% market share in our region, so that presents a unique challenge for an outside provider who has no reputation in the market."

The Egg Harbor Township-based system is opening a network of convenient care clinics in ShopRite supermarkets across the region. Like many quick-access clinics that have opened in recent years, nurse practitioners staff AtlantiCare's HealthRite centers, which are open evening and weekend hours and are designed to treat a number of relatively low acuity conditions. Fees range from \$55 to \$89 and are listed on a menu of service options that patients receive when they come in for care. The system opened its first center in the fall of 2006 in Somers Point, NJ, and is on track to open four clinics by the end of 2007 and three more in 2008.

"There's a halo effect to being in the stores and communicating with patients all the time," says Parker, noting that the clinics not only serve patients in the stores, but also act as patient-finders for the rest of the system, which includes the two-campus AtlantiCare Regional Medical Center, four urgent care centers, and an affiliated physician network. "These give us immense exposure to

the public, as each of the ShopRites that we're in see an average of 33,000 customers a week who are walking in front of our HealthRite clinics."

Parker says the added exposure will be helpful because the organization will open some of the HealthRite centers near the edge of AtlantiCare's current service area to attract new patients. "We have four urgent care centers, and three are right on the fringe of our market—they're patient-finders, business-developers, and relationship-builders," he says. "These retail clinics become an even more reasonably priced business to get into because the cost of entry is about one-sixth that of an urgent care center."

A pioneer in convenient clinics

However, AtlantiCare is not the only system to jump into the quick-access business. One of the first provider organizations to enter the sector was Wisconsin's 13-hospital Aurora Health Care, which opened its first QuickCare-branded clinic in early 2004.

"When we first looked at the QuickCare concept, we were looking at patient visibility, accessibility, and convenience for the consumers," says **Janet Teske**, manager of Aurora QuickCare. "We started with our pharmacies to trial them because it was our own space, but now we're looking at where else patients want us. We've ended up at some of the shopping malls, grocery stores, and now at Wal-Mart."

By the end of 2006, Aurora's QuickCare network included 17 clinics spread across its southeastern Wisconsin service area. Plans were in the works for opening three to five more clinics during the first quarter of 2007. Staffing the clinics are 54 nurse practitioners, says Teske, an advanced practice nurse herself.

"It's been beneficial for us," she says. "It's almost the missing link between classic primary care physician services and urgent care, and it's saving costs for people overall."

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Case study

Climbing the career ladder in patient access

Organization uses program to create more opportunities for registration employees

Linda Southard, the regional manager of patient registration for Asante Health System (AHS) in Medford, OR, didn't need any more convincing. She had piles of employee satisfaction surveys to suggest that a process change was necessary. She had heard others discuss the problem within their organizations, and her supervisors discussed the issue with her, as did some of her registrars.

When Southard approached her human resources (HR) department last year with an idea to shift more money into patient access through a dedicated career ladder program, she was armed to the teeth with anecdotal feedback.

"Employees were complaining that there wasn't any place to go for them," she says. "Everyone did the same job for the same pay, so we thought this idea would give them the opportunity to move forward and get a pay increase for it."

The idea, in itself, isn't an original one. Providers understand the importance of capturing accurate data in patient access and that plan requires competent, dedicated, and happy staff.

However, developing and implementing a career ladder program is easier said than done. AHS officials approached the idea with vigor two months ago and positive feedback has been overwhelming.

Level 1

AHS has two sites—Rogue Valley Medical Center in Medford, OR, and Three Rivers Community Hospital in Grant Pass, OR.

In total, Southard supervises 110 registrars, so the task of creating a process for each of them was daunting.

Southard and her supervisors sliced the registration department into four levels.

All initial hires fall into the entry level—Level 1—which requires six months of previous customer service experience in an office or medical office environment.

All AHS registrars must advance to Level 2 before they can work alone with patients, so Southard affords everyone six months to achieve the competencies AHS has laid out for Level 1.

They require staff to complete the following:

- ▶ A registration training class so they can understand and demonstrate the registration process
- ▶ A training module for proficiency in insurance verification
- ▶ A training module for proficiency in AHS' Image Now program
- ▶ A training module for proficiency in creating advance beneficiary notices
- ▶ Several teamwork exercises
- ▶ An Asante Learning Management System course, also known as ALN, on effective communication
- ▶ An ALN course on patient confidentiality and HIPAA
- ▶ An ALN course on telephone skills
- ▶ An ALN course on customer service skills
- ▶ An ALN course on medical terminology
- ▶ An ALN course on the revenue cycle
- ▶ A demonstration of proficiency in AHS' insurance verification software

AHS gives staff a six-month commitment, but sometimes it's clear during the two-week initial training class that an individual isn't a good fit.

"Usually that's where we weed them out," Southard says. "They have to pass 90% or better. If they can't pass the first time, we'll mentor them. But if they can't pass after that, that's it."

Level 2

Once registrars have mastered the responsibilities of Level 1, they must tackle additional competencies before AHS promotes them to Level 2.

These competencies require staff to do the following:

- ▶ Understand account update nuances
- ▶ Complete Code Correct software training
- ▶ Become proficient in the preadmitting process
- ▶ Complete Oregon Health Plan training
- ▶ Complete the performance improvement (PI) workbook and gain an understanding of the PI process

AHS doesn't just require Level 2 registrars to achieve a number of competencies; it also asks them to assume additional job duties.

"[Level 2 registrars] must identify copay deductibles, try to collect those copays, and then know to refer to our financial counselors when they can't collect," Southard says. "These [responsibilities] are standard for everyone."

Level 3

AHS doesn't require registrars to ascend to Level 3, but those who wish to advance further than Level 2 must tackle the following set of competencies:

- ▶ Complete an ALN course on the revenue cycle and understand the procedure for completing account changes and corrections
- ▶ Identify areas for process improvement and develop recommendations
- ▶ Demonstrate advanced technological troubleshooting capabilities, and become a go-to person when such problems arise
- ▶ Demonstrate analytical problem-solving skills, such as gathering statistics, analyzing the results, and proposing solutions for process improvement
- ▶ Demonstrate strong conflict-resolution skills and develop a personal conflict-resolution plan of action
- ▶ Retroactively contact patients to assist with Oregon Health Plan and charity care application process
- ▶ Report to the Level 4 staff member the status of the applications
- ▶ Troubleshoot patient issues to resolution and refer to the appropriate authority
- ▶ Mentor new employees
- ▶ Demonstrate strong motivational skills and develop

and implement a personal motivational plan for the year

- ▶ Understand the creation of the midnight census
- ▶ Demonstrate proficiency in several Microsoft applications, such as Word, Excel, and Outlook

Level 4

Level 4 registrars at AHS are considered leads and assistant supervisors; it's the highest level an employee can ascend to through the registration career ladder program.

It's a challenging position that requires staff to do the following:

- ▶ Mentor employees
- ▶ Demonstrate the ability to audit employee registrations in compliance with policies and procedures
- ▶ Assist with the development of policies and procedures
- ▶ Monitor and coordinate daily workflow and staffing levels to accommodate patient volume, while ensuring excellent customer service skills and maintaining the budget
- ▶ Complete Asante's Becoming a Master Manager course
- ▶ Develop strong employee-interviewing skills
- ▶ Manage the time card process
- ▶ Assist with department scheduling
- ▶ Assist with employee performance communication
- ▶ Serve as a role model and resource for coworkers
- ▶ Assist patients in completing Oregon Health Plan and charity care applications

A fresh start

Once Southard developed the career ladder parameters, she determined that every one of AHS's registrars would have to start at the bottom rung.

"We had a couple of people say that they didn't like it because they had been here longer," says Southard. "But the only way to be fair about it was to have everyone do it this way."

As of January 1, all 110 registrars began their climb from Level 1. By June, the experienced and effective

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Career ladder

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registrars will advance to Level 2.

“We prepared everyone for this in advance, so they know what they now need to do,” Southard says.

Administration and HR have also been very supportive, even though the eventual success of the program means they must commit more money into patient access.

Initially, Southard found some resistance from HR.

“It took a while to get HR to agree. First, they just wanted to give us the job description but not the pay increase,” she says. “But they finally came around.”

So did AHS’ vice president of finance.

“We just showed him the employee satisfaction surveys,” she says. “When you have that as your fuel, you’ve got your ammunition. If you have a high rate of turnover, and people are leaving because there are advancement opportunities elsewhere, that’s not good.”

Positive feedback

Southard was unsure of what to expect initially from staff once AHS unveiled the program in January. But she reports that staff have been incredibly supportive of the changes.

“I’ve seen more people enthusiastic about moving beyond Level 2, which surprised me some,” she says.

Understandably, some have expressed an interest in staying at Level 2. “That’s fine,” Southard says. “Levels 3 and 4 have their own requirements and they’re not for everyone.”

Because HR has been so supportive, Southard doesn’t have a limit of staff she can promote to Level 3.

“They’ve been great. They’ve given us the pay scale, so we’re good to go, and anyone who wants to move to Level 3 can pursue that,” she says. ■

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large claims to determine whether the patient was eligible for any type of financial assistance.

Team 5

The fifth team monitored changes and reported results.

“Basically, the team used data to support ongoing self-assessment and improvements,” says Wagstaff.

That includes setting up an audit process for charity care applications, tracking availability of bilingual Medicaid assistance counselors, and tracking the numbers of patients approved for financial assistance.

The team has also started using mystery shoppers to determine whether patients are happy with their experience, says Wagstaff.

Team 6

The final team set out to increase community participation. This task had two major initiatives.

First, the team added a community representative to

the board of representatives to serve as a voice for the patient population.

Second, it considered adding community membership to an internal group called the Financial Assistance Oversight Committee, which will monitor policies and procedures. However, this group discusses technical issues, so the team hasn’t decided whether community membership is necessary.

Report cards

All six teams reported their findings in January. Some of the teams’ recommendations were already in the pipeline, and others are on the way. The adversity that the health system faced last year only forced it to slam on the gas pedal.

“I think everybody here knew we needed to make some changes, but getting there was a struggle,” says Wagstaff. “It took some effort, but I’m happy that we made the effort.” ■

This Month's
Form

Sample registration career ladder spreadsheet

Level 1 (entry level)	Level 2	Level 3	Level 4 (lead)	Complete
Is trained to understand and demonstrate the registration process.	Same as level 1	Same as Level 1 and Level 2	Same as Level 1, Level 2, and Level 3.	Complete
Demonstrates proficiency in the insurance competencies shown by completion of training modules and observation.	Is able to understand account update (patient type changes, clear lock wait, inactive accounts, exit census event history, and pointer revision).	Is able to identify areas for process improvement and develop recommendations for solutions. Participates and may lead implementation of solutions through the PI processes.	Has the ability to audit employee registrations and maintain compliance with policies and procedures.	
Demonstrates proficiency in Image Now, shown by completion of training module and observation.	Is proficient in Code Connect, shown through completion of Code Connect training.	Advanced computer/technological troubleshooting (e.g., printers, copiers, fax machines, phones, headsets, etc.). Must have the ability to perform maintenance/repair through to resolve the issue.	Assists with the development of policy and procedures.	
Demonstrates proficiency in the requirements and tools for the creation of ABNs, shown by completion of training module, observation, and QA.	Is proficient in preadmitting process.	Analytical/Problem Solving skills. Is able to gather statistics, analyze the results, and propose solutions for process improvement.	Monitors and coordinates daily workflow and staffing levels to accommodate patient volume while ensuring excellent customer service and maintaining budget.	
Teamwork. Has read or listened to the 17 indispensable laws of teamwork and completed the corresponding workbook with teamwork group.	Has completed OHP training, and is able to track and report OHP applications to level 3 by the 15th of the month.	Conflict resolution. Has read one of the suggested "managing conflict" books available through the department and then developed a personal conflict resolution plan of action.	Has completed the Becoming a Master Manager course.	
Effective communication. Has taken on the Asante Learning Network titled "Communication".	Has completed public information (PI) workbook to develop an understanding of the PI process.	Retrospectively contacts patient to assist with OHP/charity care application process and/or verify that the application process has been completed.	Develop interviewing skills. Has read one of the behavior-based interview skills book from the department library. Analyze the current interview questions. Work with supervisor to make potential changes and conduct potential employee interviews.	
Patient Confidentiality. Has taken on the Asante Learning Network titled "HIPAA for Patient Registration".	Has successfully completed the Asante Patient Access Training Program. Has demonstrated competency to successfully perform Patient Access Specialist Level I job, which would typically be obtained through six months of direct experience in Level I.	Reports to the Level 4 the results of OHP applications.	Time card management.	
Telephone skills. Has taken on the Asante Learning Network.		Is able to troubleshoot and resolve patient issues and/or refer to appropriate source.	Assists with department scheduling and staffing.	
Customer service. Has taken on the Asante Learning Network.		Mentors new employees.	Assists with employee performance communication.	
Completion of medical terminology course. Has taken on the Asante Learning Network.		Motivational skills: Has read one of the mentoring books available through the department. Develop and implement a personal motivation plan for the year.	Acts as a role model and a resource for coworkers.	
Understanding the revenue cycle. Has taken on the Asante Learning Network.		Understands the creation of the midnight census.	Assists patients in completing OHP and/or charity care applications.	
Is proficient in Insurance Verification Software.		Is proficient in Microsoft applications.		
Has six months of previous customer service experience in an office and medical office environment.		Has successfully completed the Patient Access Training Program. Demonstrated competency to successfully perform Patient Access Specialist Level II job, which would typically be obtained through 12 months of direct experience in Level I.		

Source: Asante Health System, Medford, OR. Reprinted with permission.

Case study

ED overcrowding: Staff at one facility go the extra mile

Emergency department (ED) staff everywhere realize that ED overcrowding is a clinical and financial nightmare with no quick fixes. Additional space, staff, and financial backing can each mask the process problems that most, if not all, providers face.

In the absence of those solutions, providers know that it's important from a long-term perspective to scope under the surface to examine the problem at its roots. However, most just don't have the time or the resources for such an endeavor.

Staff members at the Boston Medical Center (BMC) ED wouldn't settle for anything less than the answers to its overcrowding problem. Several staff members at BMC decided to take matters into their own hands by starting an intervention program to focus on frequent ED users. The results were enlightening.

Examining the problem

The BMC ED, located in downtown Boston, is the largest and busiest 24-hour level one trauma center in New England, serving 132,000 patients per year in only 60 beds spread across four EDs.

Like many other large city hospitals, BMC's ED constantly struggles with an impossible volume-to-space ratio, and routinely experiences overcrowding, diversion, and bottlenecks due to an increasing number of frequent users and nonemergent patients clogging the system.

Lacking resources and the funding to establish a full-time ED program, the group's initial mission was to zone in on the top 10 patients who had the highest frequency of ED visits and to learn more about them. Who were they?

What was their reason for coming? How much time did they actually spend in the ED, and could they reduce that time? In essence, the group's mission was to take a snapshot of a problem—a biopsy of a crisis—and examine it until it produced answers.

Going above and beyond

The group, called the Focus Intervention Program (FIP), consists of an ED nurse manager and physician, a hospital administrator, and two outpatient social workers who devote part of their time each month to gathering details about their hospital's top 10 ED users and meet once a month to report their findings.

"Everybody in this group already has a full-time job," says **Linda Fisher, RN, MSN**, director of ED nursing. "No one really has a specific job of dealing with these patients. We all just contribute when we can piece by piece."

Rita Whelan, the administrator in the group, keeps the team together and drives the process by collecting and searching through data the group collects. She goes through the records and helps determine the most frequent users.

"Going through records, we discovered that nine out of 10 of the most frequent users were alcoholics, and the other person was homeless," says Whelan. "We also learned that a small amount of people were taking up a large amount of minutes, and not just in the ED, but on the acute side, because many of these patients would get admitted and needed to be watched."

After receiving the data and charts from Whelan, Fisher and the social workers interviewed the patients whenever possible in an effort to gain a better understanding of their situation.

They asked the following key questions:

- ▶ Are they homeless?
- ▶ Do they have a family?
- ▶ Do they have a primary care provider?
- ▶ Have we tried to get them any kind of treatment?
- ▶ Do we have a plan of care?
- ▶ Do we need legal advice?

"We conducted interviews to learn more about their family and social history to learn more about the patient's

lifestyle and to see if there was a family member who might be interested in helping,” says Fisher.

Interviewing and investigating

By zoning in on a select number of patients and filling in a lot of the blanks in their backgrounds, Fisher says the group is better able to initiate interventions. “Our goal is to develop a care plan for these patients so they can avoid an admission to the hospital and sometimes even a trip to the ED in the first place.”

For example, the group learned that one of the frequent alcoholic users would leave his homeless shelter and drink all day, but stop at 2 p.m. so he could try to sober up and gain reentrance to the shelter at 4 p.m. It was between these hours that someone would find the man passed out in the street and bring him to the ED.

As an intervention, the social workers worked with the patient to reduce his drinking earlier in the day and arranged a deal with the doughnut shop inside the hospital to allow the patient to have free coffee and doughnuts, and a place to sober up until the shelter reopens.

In the past four months, Fisher says the patient has only ended up in the ED three times—as opposed to his usual three times per week—a huge difference with direct financial implications for the hospital.

Through interviewing and investigating, the group also learned that another frequent user actually did have a place to live, but just came to the ED because she was lonely, depressed, and had serious psychiatric problems.

The team connected her with a community health center that offered nighttime group counseling and psychiatric services until the woman slowly began to feel more comfortable at home.

In another case, the team discovered that a woman who often presented with internal bleeding, cuts, and bruises was working as a prostitute.

The group learned that the woman had a guardian who desperately wanted to help and recruited the guardian’s services to help provide a safer environment for the patient.

Finding success

Not all interventions lead to success stories, but sometimes even grim scenarios are much better than no action or involvement at all, says Whelan.

“Sometimes patients are at such a high risk that we have to admit them for the night and pull together a doctor and a lawyer and begin the process of obtaining a Section 35,” says Whelan. A Section 35 is the involuntary sentencing of a patient to a state hospital or psychiatric facility.

In these cases, Whelan and the team help gather all possible information on the patient and pass it on to the hospital lawyer. The process is time-consuming, expensive, and inconvenient—often the ED physician will have to spend an entire day in court because the patient does not have a primary care physician—but Whelan says the process is oftentimes essential to ensure the safety of the patient.

Most of the ED staff at BMC still vividly recall the well-publicized story last winter when two homeless men died of hypothermia on the frigid Boston streets. “This story really reconfirmed for us the need to work with courts more,” says Whelan. “Sending people away for 30 days may make a patient upset, but it can also save their life.”

During the first year of the FIP, the group reduced the amount of time that the most frequent users spent in the ED by 50%, and in 2006 that number improved to 68%. All of those minutes saved are now available for other patients with true emergent needs and, in turn, the ED is a much more time-friendly destination for consumers.

The group has now widened its scope to intensely focus on the top 20 frequent ED users, and they have a list of 60 to 70 patients on the radar who they keep an eye on. ■

Questions? Comments? Ideas?

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Payment arrangements

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others—should hand out brochures clearly stating the hospital’s policy. Orvis suggests giving all self-pay patients a 20% discount and an additional 15% off if they can pay off the balance within 30 days.

“This is not only good customer service, but it makes business sense, since self-pay issues and how facilities handle these patients are increasingly under scrutiny,” he says.

Consider credit applications for patients who do not qualify for charity care or say they cannot meet the payment arrangement schedule, Orvis says.

“Use financial counselors to identify if patients qualify for governmental programs, such as Medicaid and/or any local or state programs based on income or other specific criteria,” he adds. ■

Quick clinics

< continued from p. 5

A ‘win-win’ for organizations?

Tine Hansen-Turton, executive director of the newly-formed Convenient Care Association in Philadelphia, has heard similar comments from other provider-based organizations. “It’s a good market for hospitals to get into because it’s a more limited scope, but then they have a system behind them that they can refer patients to if necessary,” she says. “It’s a win-win for them.”

Michael O’Neil, senior vice president and chief operating officer of Memorial Health System in South Bend, IN, says the one-hospital system’s three MEDPOINT Express clinics have been an important tool for bringing new patients into the network.

“About 30% of the people coming in are not connected to a provider, and many require subsequent follow-up care,” he says. “We’re seeing a lot of our affiliated primary-care physicians get a number of referrals from these operations.”

With nearly 18 months of experience running the retail clinics, O’Neil says Memorial is now focused on taking the concept to another level—opening clinics in other markets through partnerships with local providers.

The first three clinics to open outside the South Bend market will be in Indianapolis through a partnership with Community Hospitals of Indianapolis, and O’Neil says discussions are under way with additional health systems in other markets.

“We’ve developed a model that we believe in, and that model is based on the connection with a local health system to ensure the quality and continuity of care,” he says. “From a strategic perspective, this is a line extension and it’s the right thing to do.” ■

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Revenue cycle competency quiz

Multiple choice, 10 points, one attempt permitted.

1. Which component of the revenue cycle gets the "revenue ball" rolling?

Correct	Choice
	Scheduling
	Patient registration
	Coding
	Business office

Matching drag and drop, 10 points, one attempt permitted.

2. Put the revenue cycle components in order.

Choice	Match
1	Scheduling
2	Patient registration
3	Charge entry
4	Coding
5	Business office

Matching drag and drop, 10 points, one attempt permitted.

3. Match the term with the description.

Choice	Match
Eligibility	describes whether a patient truly has insurance or not
Copay	is a small fixed amount required by a health insurer to be paid by the patient for each outpatient
Deductible	is the amount for which the patient is responsible before an insurance company will make payment
Coinsurance	applies to an insurance policy provision under which the patient shares costs incurred after the deductible is met

Source: Asante Health System, Medford, OR. Reprinted with permission.

Revenue cycle competency quiz (cont.)

Multiple choice, 10 points, one attempt permitted.

4. If a patient's coinsurance is 15%, how much is the insurance company responsible for?

Correct	Choice
	75%
	85%
	90%
	100%

Multiple choice, 10 points, one attempt permitted.

5. Diagnosis information is gathered by the coding department and put into _____ format.

Correct	Choice
	ICD-9
	CPT-4
	DID-9
	ICA-9

True/false, 10 points, one attempt permitted.

6. Components of the revenue cycle are independent entities that don't work together for a common goal.

Correct	Choice
	True
	False

Quiz settings

Property	Setting
Passing score	100%
Display point value	Yes
Randomize questions	Yes
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Total number of questions to ask	All
Display user score	Yes
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