



Streamline your front-end processes

Opportunities abound for improvement when a hospital looks at building a super-efficient patient access production system.

By Julie Waddell



The healthcare industry has consistently been stable, responding well to changes in the economic climate over the years. But in the last year, the outlook for the healthcare sector has shifted from stable to negative as a result of many different factors: increased bad debt exposure, softening volumes, restricted pricing growth opportunities and increasing charity care.

Several sweeping trends with far-reaching implications for years to come are affecting the industry. Healthcare organizations face identity fraud and theft, resulting in the need for identity verification and validation in the scheduling, pre-registration and registration processes. In addition, hospitals are managing new financial risks such as financial securitization and alternative payment sources. These new concerns, combined with staff shortages, industry-wide escalating costs and increased patient liability, leave hospitals scrambling to stay ahead.

In order to thrive under these conditions, hospitals must look carefully at their front-end processes for areas of possible improvement. By addressing, analyzing and improving front-end issues, hospitals can reduce the cost of collection, avoid denials, expedite payment and eliminate rework.

In late 2007, OhioHealth, a network of non-profit, faith-based hospitals and healthcare organizations serving patients in central Ohio, realized the need to streamline its front-end processes. With 108,000 total admissions, 325,000 emergency visits and more than 1.5 million outpatient visits, OhioHealth had a patient cash goal of \$60 million. Anything that could be done to improve patient access would increase patient satisfaction and ultimately improve the bottom line as well.

To begin, a front-end analysis was performed. Officials gathered data from all areas related to the business office, including failed claims, denials, physician satisfaction surveys and cash amounts. With data in hand, OhioHealth then determined its overall vulnerabilities so that plans could be put in place to address and eliminate them. Finally, officials used clean claims data to identify shortfalls.

An ongoing theme throughout the entire process of gathering data and determining areas for improvement was accountability. Officials adopted an acronym, "GOFAR," which stood for "gotta own functional areas of responsibility." Staff members were encouraged to apply the GOFAR concept to three key ideas: go beyond daily tasks and think about functional processes that could benefit the entire health system; adopt accountability as a personal value; and build accountability as a departmental value.

"We clearly outlined the traits of an accountable employee," says Pam Carlisle, OhioHealth's corporate director of patient access services. "We expected employees to take initiative, proactively make reports, relentlessly pursue results, overcome obstacles and meet deadlines. At the same time, we trained managers to identify issues they could control, while teaching them how to influence or strategize around those issues they could not directly control. Managers also received training in coaching others so we could give everyone the tools they needed for success."

All activities related to patient access were identified and grouped into three key areas: pre-encounter, encounter and post-encounter. The pre-encounter segment included the following actions:

- Customer and referral services,
- Patient assessment,
- Resource scheduling,
- Pre-registration,
- Patient and family education,
- Clinical and financial prerequisites,
- Payor authorizations,
- Benefit verification,
- Pre-encounter communications,
- Proration, and
- Financial clearance.

While OhioHealth already had a high pre-registration rate, officials found other points in the pre-encounter area that could be improved with simple process changes. First, to improve the pre-certification process, employees began faxing scheduling forms to central scheduling with

clinical details included on the forms. Next, the issue of same-day requests was tackled by eliminating calls to ancillary areas and instead employing an automated process that would add the requests to the schedule and send an electronic notification to the appropriate contact.

Finally, the length of telephone calls in the pre-encounter process needed to be addressed. By adopting the use of standardized procedural questionnaires, OhioHealth was able to minimize the amount of demographic information collected at the time of each call. In addition, as a result of the questionnaires, all facilities began gathering more consistent data across the system and the number of questions was reduced.

In another effort to provide easier access for patients, OhioHealth implemented alternatives to the traditional telephone method of scheduling. Patients could use a fax option, or physicians could schedule procedures over the Internet. Other online requests also were accepted.

“Overall, we were pleased with these improvements,” says Carlisle. “For the first half of the fiscal year, our pre-registration rates either remained stable or increased, and the average length of calls into the central scheduling center gradually began to decrease.”

OhioHealth’s next steps in the pre-encounter phase will be to develop deferral policies. In the future, for those patients who have not been pre-certified, their procedures will be rescheduled. In addition, self-pay patients will be required to qualify for charity care or pay a deposit prior to scheduling.

In the second key segment – the encounter – the following actions were addressed:

- Concierge services,
- Transport coordination,
- Way finding,
- Information,
- Family liaison services,
- Order entry,
- Consent education,
- ADT system entry,
- Charge capture,
- Billing,
- Customer service,
- Collections,
- Financial counseling,
- Benefit verification,
- Scheduling, and
- Patient identification.

As expected when evaluating the large number of activities related to each patient encounter, OhioHealth officials found several vulnerabilities that could be translated into areas for improvement. Missing or incorrect insurance information was at the top of the list, followed by the need for more timely distribution of paperwork to the patient care floors.

To improve the quality of insurance information gathered from patients, OhioHealth updated its hospital

information system (HIS) to include mandatory fields that would ensure the proper data was collected initially. Patient identification information was scanned into the system for verification purposes. Self-pay patients were required to sign a waiver so their information could be referred to an outside vendor for screening.

In addition, a daily review of all error reports was implemented to identify pre-billing edits that could easily be made. New reports were developed, and employees received additional education and training.

“We really felt as if we were redefining the customer experience for our patients,” says Carlisle. “We wanted to provide optimal patient experiences, reduce wait times and eliminate redundancies in the often tedious paperwork process.”

The first six months of fiscal year 2009 saw dramatic improvements in customer service scores, along with improvements in both cash levels and clean claim rates. The next steps for OhioHealth regarding the encounter phase will involve developing more efficient procedures for collecting past balances and notifying patients when services will not be covered by their insurance. Identity theft also will be an important area of focus.

In the third key segment, the post-encounter area, OhioHealth officials reviewed the following:

- Patient billing statements,
- Insurance follow up,
- Payment variance,
- Cash posting,
- Medicare regulations and recovery audit contractors (RACs), and
- Collections.

Perhaps the most critical concern within this area was determining how to handle RAC audits. The RAC program was established to identify improper payments made on healthcare claims for services provided to Medicare beneficiaries. According to the American Hospital Association, RACs corrected more than \$1.03 billion in improper Medicare payments from March 2005 to March 2008 in just five states during a demonstration period. Of that number, approximately 96 percent were overpayments collected from providers – and more than 40 percent were linked to patient access issues.

OhioHealth formed a RAC steering committee to address concerns related to RAC requests, as well as conduct front-end training and education on managing the coordination of benefits.

Looking to the future, OhioHealth plans to expand its successful improvements and implement even more technological advances to enhance the patient access process.

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