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Patient Access
ADVISOR
INNOVATIVE SOLUTIONS FOR THE FRONT END

QA: Scoring method helps identify training needs, improve staff competency

Patient access staff often feel like their hospital's punching bag—they're held accountable for much of the organization's financial troubles, but without the respect or salary that should accompany such responsibility.

Michael Friedberg, CHE, CHAM, manager at Besler Consulting in Princeton, NJ, believes that the only way to change the way that access staff are perceived is to improve the quality of registrars.

When Friedberg worked as patient access manager at a multihospital system in New Jersey for more than five years, he tackled this problem using a thorough evaluation and scoring method to better gauge competency levels and uncover job requirements that necessitated retraining.

The strategy improved accuracy rates significantly and brought accountability into patient access. Friedberg could improve the work of his registrars and use the data to illustrate the importance of his staff to other directors and senior managers.

"As patient access managers, we get nothing but beat up. There's a huge focus on the negatives," Friedberg says. "I just wanted to flip it around and accentuate the positives. But I also wanted to get to the root cause of where the errors were coming from."

Shoot, score

Every registrar is asked to collect and input detailed information. But their jobs are difficult and require a balance between accuracy and speed.

Friedberg views this symmetry as a key determinate in identifying excellent registrars from his employees.

"We wanted to come up with a good way to measure the work that staff was doing and be able to use that measurement to focus our training," he says. "It's not enough to say that your error rate is 5%. There's much more that goes into it."

> **"We looked at about 10% of the [registration] work. But even at that level, the areas of deficit and success really jump off of the page for you."**
> *—Michael Friedberg, CHE, CHAM*

Friedberg identified the following 15 categories that he used to gauge staff accuracy:

- Master patient index addition
- Copies of insurance and identification
- Account notes
- Patient demographics
- Guarantor information
- Department location
- Diagnosis
- Insurance selection
- Insurance verification

> *continued on p. 2*

HCPro

IN THIS ISSUE

Quality assurance

< continued from p. 1

- Insurance precertification
- Passport eligibility
- Charity care application
- Medicare secondary payer (MSP) questionnaire
- Physician selection
- Room and board accommodations

These areas of focus vary from state to state and organization to organization, he says. "The area of focus doesn't matter; each organization should decide which areas to focus in on."

Friedberg scored each area on a weighted basis for each registrar, with a total score of 0% to 100% in accuracy. Before the quality assurance (QA) leader reviewed the data and considered strategies for retraining, line supervisors performed the initial reviews.

"It's very touchy feely," he says. "The line supervisor needs to have a feel for what his or her staff is doing. It shouldn't come from someone else initially."

Many providers do not have the staffing model for this type of review to occur. But if you have the structure, the dual review can be very useful, Friedberg says.

Time for some QA

Once the line supervisors reviewed the data, the QA staff review the accounts. The QA staff created spreadsheets hammered down to each specific problem area and registrar. "We looked at about 10% of the [registration] work," Friedberg says. "But even at that level, the areas of deficit and success really jump off of the page for you."

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The next step is identifying why the registrars were making mistakes. Friedberg says registrars slip up because they

- ➤make careless or honest mistakes
- ➤don't care about their jobs
- ➤don't have the proper tools to succeed
- ➤don't have the right skill set to register

The patient access manager can usually tell from the types and frequency of mistakes that the registrars make and which category each falls into whether the registrar is just not a good fit.

Accountability receivable

Inside many organizations, the C-suite views the access staff as the weakest link of an otherwise strong hospital chain. But Friedberg says the scoring tool helped eliminate that stereotype.

"When we'd get a call from the CFO to tell us that a [very important person] came in and was registered incorrectly and that he wanted [someone punished], I had the macro data to refute that," he says. "I could show that maybe the registrar made a mistake, but his or her accuracy rate is 96%."

On the flip side, the tool places the spotlight on the registrars who don't care about the job or the hospital.

"I can't blame [the registrars] when you're in the [emergency room] and physicians are screaming for a chart; the human tendency is to cut some corners and deal with who is in front of you right now," says Friedberg. "But this [pressure] requires registrars to continually strike a balance between the two, which all good registrars do."

Another technique that you can employ is the use of mystery shoppers, says Friedberg.

Sometimes it's useful to ask others to pose as real patients to see how the registrars treat them.

"Customer service standards are harder to quantify, but mystery shoppers and random phone screenings are good ways of keeping everyone on their toes," he says.

Quality vs. quantity?

Some organizations compile accuracy data that can be misleading. For example, one registrar may score 100%

> continued on p. 4

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Quality assurance

< continued from p. 3

accurate, but if he or she only completes two registrations per hour, then he or she is hardly effective.

"We realized this and wanted to have another way to gauge them," Friedberg says.

Friedberg developed a very simple calculation. He took each registrar's registrations by month, and then divided by hours, and subtracted vacation and sick time.

"We got a number. And we used that number to compare against registrars in the same areas on the same shifts," says Friedberg. "It's not perfect, but it gives you some stones to unturn."

The QA leader can use this information in his or her training. For example, if someone's quality score is low, but their quantity score is high, they are likely moving too fast.

Training camp

Training in many organizations consists of the manager instructing the new registrar to sit behind a more experienced registrar and learn the ropes that way.

"That's not an effective way to train," Friedberg says.

Friedberg helped develop a more formalized approach to training new employees and existing ones, oftentimes using classroom settings.

The QA leader chopped up the accuracy data entirely and then used that information to direct the training.

"If [the QA leader] looked at the overall QA scores and saw that Medicare Secondary Payers is an issue with several, he or she would create a class and bring everyone in to tackle that issue," says Friedberg. "This isn't difficult to do. It's pretty blatant where the areas of deficit are."

Friedberg also asked his QA leader to work in the trenches as much as possible.

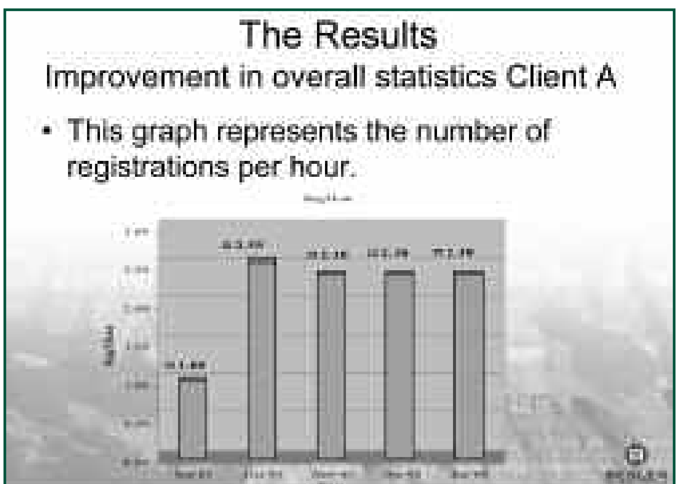
"I wanted the QA staff to keep in touch with what it's like to register. That meant sitting in for an hour or two here and there to get ideas," he says. "I think then they clearly understood what it takes to be successful at [registering]."

Friedberg also emphasized the importance of patience from his QA leader.

The process of improving the quality of your registrars doesn't happen overnight, he says.

"Set a goal. Say that you want to get to 95% accuracy over six months, but be patient," Friedberg says. In the end, the process will work.

"That's the beauty of this—you investigate the problem, hypothesize what the information is really telling you, and then take some appropriate action." ■



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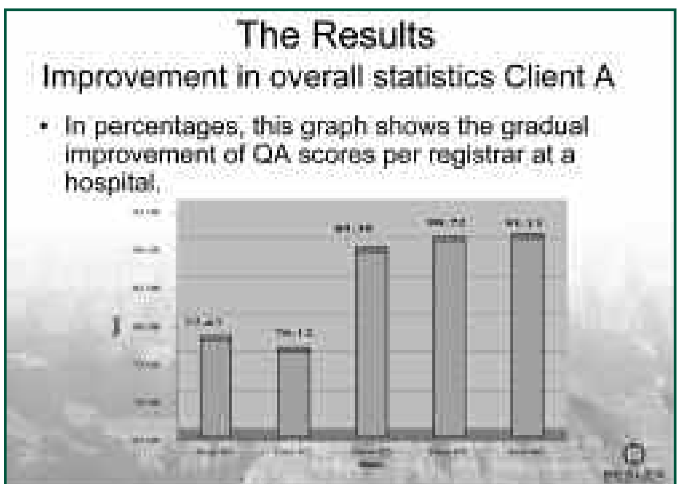

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This Month's

Form

Sample key performance indicators dashboard

KPI dashboard for patient access

Date	POS cash as a % of goal	Complaints to administration	MPI duplicates created	Patients in house >30 Days	% of Eligible patients scheduled
5/1/06					
5/2/06					
5/3/06					
5/4/06					

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Strategies to hire the right quality assurance leader for your patient access staff, competency program

Every good registration training program requires a strong quality assurance (QA) leader. Unfortunately, not all organizations make the right choice when selecting the person to oversee the training of their registration team, says **Michael Friedberg, CHE, CHAM,** manager at Besler Consulting in Princeton, NJ.

The following are some tips to guide you through this important process:

➤ **Try to hire from within.** It's important that the QA leader is someone whom the registration staff respect. "Every hospital is different and every system is different, but there's a cultural aspect to this," says Friedberg. "I think it's nearly impossible to find someone from the outside and have them be successful as a QA leader."

Understand that because registrars typically earn very little money and many view the position as only temporary, you need staff support if you hope to retain the productive members of your team.

➤ **Choose a QA leader that the registrars trust.** Don't be afraid to ask for input from your senior registrars. A mutual trust between both leadership and staff is an important component to the training process.

"If you pick the wrong person, the registrar will react negatively," Friedberg says. "They'll be offended that this person is reviewing their work. If you have the wrong person, it can doom you."

➤ **A good registrar doesn't necessarily make a good QA leader.** A strong QA leader must be a detail-oriented worker. More importantly, he or she must be a creative thinker with analytical skills.

"The person must be able to look at data and understand what it is that the data are telling them," Friedberg says. "That's one of the key qualities that you're looking for."

Registrars typically do not carry the creative gene, so some providers make the mistake of promoting strong registrars who lack the vision necessary to fulfill the responsibilities of a QA leader.

➤ **Sell the process and the role of the QA leader to registration staff.** It's important that staff understand this is not another way for administration to criticize their work.

"They have to see this as a way to emphasize the good work they do and to shield them from the constant attacks they face from others," Friedberg says.

Promote the process to staff and it will run much smoother.

"Every hospital is different and every system is different, but there's a cultural aspect to this. I think it's nearly impossible to find someone from the outside and have them be successful as a QA leader."
—Michael Friedberg, CHE, CHAM

➤ **Make sure that all internal and external candidates know exactly what the job entails.** The QA leader's job responsibilities include:

- ➤ Work review
- ➤ Statistical analysis
- ➤ Training/development of training

Additionally, any QA candidate must communicate well and multitask projects.

Making the wrong decision can mean months of lost time.

"One of my clients picked somebody who was not organized and detail-oriented, and it didn't work well. They wasted six months of their time, and the entire staff got frustrated," says Friedberg. "It took twice as long for the overall program to succeed because of the poor initial choice and the process of rebuilding the staff's trust." ■

How to find the right registrar: Tips to avoid hiring incompetent staff for your organization's front door

Consumer-driven health plans, Medicaid eligibility, and an influx of uninsured patients are just a few of the many factors that make the registrar's shift a series of hurdles. With the potential for long-lasting financial effects on your organization, the registration job is now more complicated and perplexing than ever.

Not to mention that competitive markets dictate that each organization retain as many customers as possible and scoop up every last dollar at the front door.

That's why you shouldn't take the process of finding and hiring suitable registration candidates lightly.

"There are a number of skills you should look for and a number of places to look," says **Michael Friedberg, CHE, CHAM,** manager at Besler Consulting in Princeton, NJ. "But it's very important to be thorough."

Where to look

Think outside of the box and identify industries that hire employees with the same skill set you're looking for, such as hotels, travel agencies, and restaurants.

"I have a colleague who, whenever she has a waitress who is very good, gives her a card and tells her to call if they are interested in a career change," Friedberg says. "It's about people skills, the balance between getting information correctly and with urgency, and multitasking."

Some strong candidates might be scared off by their lack of healthcare experience.

"That's why it's important to emphasize that just because they don't have experience, it doesn't mean they won't make a good registrar," Friedberg says.

Another hidden gem is the college student who is interested in a career in healthcare. Most are willing to work late shifts; some just need pocket money, and others are working their way through school.

"This is a terrific opportunity, but there's good and bad in that you may only get four years out of them. But I have found over time that they are an excellent source [of potential registrars]," says Friedberg. "They don't care that it's an entry-level position; they're just looking to get some experience."

What to look for

A good registrar must have the following qualities:

- ➤ Strong people skills
- ➤ Works fast and accurately
- ➤ Flexibility within a structured set of rules and requirements
- ➤ Comfort with repetition
- ➤ Ability to multitask

Similarly, there are negative qualities to watch out for, says Friedberg.

"I always pay attention to [whether] they're on time for their interviews," he says. "That tells me a lot about whether they will care about their jobs."

An interview with a registrar

Have your access leader conduct your interviews.

"Human resources departments in hospitals don't have the first clue about what it takes to be a registrar," Friedberg says. "So, without question, the access leader should personally interview each candidate."

Also, conduct at least two interviews within the department.

"We'd do an initial screening with the site director or one of the supervisors before they'd come to see me," says Friedberg. "Can they come on time twice? Can they dress appropriate twice? These are some of the small things you're looking for, in addition to the skill set."

It's most important to find candidates who are qualified and show a commitment to the job. The rise of consumerism means that now is the time for providers to actively address their staffing issues and build a strong patient access team. ■

This Month's
Form

Sample quality assurance checklist

The Approach Evaluation tool

REGISTRATION QUALITY ASSURANCE
CHECK LIST

Patient name ____________________

Account number ____________________

STANDARDS	PTS	YES	NO	STANDARDS	PTS	YES	NO
1. MPI addition	5			8. Insurance selection & insurance information	15		
2. ID/ins card copied/proof of address	10			9. Insurance verification/passport eligibility	5		
3. Account notes (proper documentation)	10			10. Insurance precertification/referral/NOA	10		
4. Patient name and demographics	10			11. Charity care application	5		
5. Guarantor information/relative information	10			12. MSP questionnaire	5		
6. Dept loc/adm type & source/arrival mode	5			13. Physician selection	5		
7. Diagnosis/hospital service	5			Total points	100		

Comments:

If not applicable, please assign yes points.

Total yes points scored ____________

Registrar ____________________

Reviewed by ____________________
Facility

Registration QA Check List Rev. 2007

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Using diversions in a different way

How one Miami hospital diverts nonemergency cases to primary care

Providers everywhere are on the hunt for strategies to reduce emergency department (ED) visits for nonemergencies and ED diversions, eliminate hours of wait time from overcrowding, improve the patient experience, and bolster revenue.

But a September 2006 study in the *Annals of Emergency Medicine* found that people who present with serious conditions are so numerous that the existing crisis in emergency care stems from an abundance of genuine emergencies—not a flood of ED overuse by the uninsured, as is often believed.

The American College of Emergency Physicians (ACEP) contends that diverting nonemergencies to urgent-care centers will bring little wait-time relief. "The fantasy is that removing a few sore throats and earaches is going to magically get people a bed in the hospital," says ACEP spokesperson **Richard O'Brien, MD,** a full-time emergency physician in Scranton, PA.

A different kind of relief

Leaders at Miami's Jackson Memorial Hospital are hoping that an initiative to redirect patients to primary care providers brings relief of a different kind. Although the *Annals* study finds that wait times for serious cases are unaffected by a backlog of nonurgent patients, the wait times of the nonurgent patients are longer when they're in line behind a greater number of emergencies.

Leaders at 1,325-bed Jackson Memorial have implemented a plan to tackle the latter issue while educating patients on where to find the right kind of care.

Since November 2005, a nurse practitioner stationed in the 111-bed ED has screened patients who lack clear emergency symptoms in an effort to divert inappropriate presentations to one of the hospital's 12 community-based primary care centers around Miami-Dade County or to an on-campus clinic.

"It's important not just to let patients go, but to link them to another part of the system that is more appropriate for the level of care they need," says **Sandy Sears,** senior vice president for ambulatory services and community health at Jackson Memorial.

The nurse practitioner uses an internally developed checklist to determine who to redirect. Then, at the registration desk, a computerized appointment program assigns them to a time slot reserved for ED referrals at the most convenient clinic—usually on the same day. The facility waives clinic fees for first-time visitors so it can get them into the system and track them via ED-to-clinic referral forms. Throughout the process, nurses and physicians communicate the importance of building a relationship with a primary care provider for treatment of minor ailments and management of chronic illnesses before an ED visit becomes necessary.

> **"It's important not just to let patients go, but to link them to another part of the system that is more appropriate for the level of care they need."**
>
> *—Sandy Sears*

Not a solution for all

Even though the hospital diverted 8,973 individuals from the ED to a clinic between November and August 2006, hospital leaders realize that this method will not reduce ED wait times for most patients. Jackson's ED is still on diversion an average of 30% of the time, but they are seeing fewer repeat visits for nonemergencies, says Sears—an outcome that gives her hope for the long-term goal of helping patients find an appropriate "medical home." ■

Nonemergency surgical prepayments: How a consistent approach lightens the load for patients, providers

Asking your registrars to request money up front from patients is not a new concept. Statistically, it is proven that the more money you collect before the care is delivered, the better chance you have of eventually collecting the balance of the bill.

In some cases, specifically with uninsured patients, the money you collect up front will represent the only dollars you'll ever collect from a specific patient. So, it's important to scoop up what you can, when you can.

Still the concept is one that access departments have yet to master. Hospitals, for the most part, do not hire registrars to ask for money—so the subject may be uncomfortable for your staff to broach. And the absence of technology that can immediately provide the amount of money that the patient is responsible for muddies the collections process.

That's why some organizations are picking a dollar figure and asking all patients to pay it up front.

MeritCare, North Dakota's largest health system, located in Fargo, requests all patients who schedule nonemergency surgery to pay $270 before the service.

They began asking for the up-front payment on November 27, 2006, and officials report a bottom line boost and, surprisingly, positive feedback from patients.

"We have found very few patients who flat out refuse to pay," says **Karen Dufty,** patient access manager at MeritCare. "This is about patient education and letting the patient know about [his or her] financial obligation before they get a bill."

Getting started

MeritCare officials decided in 2006 that the organization needed a proactive strategy to minimize the amount of revenue it was losing to bad debt.

Although bad debt is an issue that providers can address through many different avenues, up-front collection is usually the most straightforward approach.

Dufty focused initially on MeritCare's two surgical day units.

"These are high-dollar procedures and in an area where I have access staff who are involved in asking for payment," she says. "It's an easy area to control and an ideal place to start."

MeritCare hired H*Works, a division of The Advisory Board Company in Washington, DC, to help with the transition.

The key players

Dufty organized a point-of-service collections team made up mostly of care managers from departments such as orthopedics and cardiology.

The team targeted two different types of problem patients:

1. Uninsured patients.

MeritCare's self pay represented 7% of its revenue and 18% of its accounts receivable.

"We wanted to do a better job of talking to [uninsured patients] about their financial responsibilities," Dufty says.

"We hoped that this [approach] would make uninsured patients feel more comfortable to talk to us before they start getting the bills. Some of the dollars we collect now we may never have collected."

—Karen Dufty

Registrars in the different care areas identify uninsured patients up front and then the care areas refer them directly to financial counselors. The counselors can inform the patient of his or her estimated cost, determine the patient's financial situation, and explore either a financial assistance program or MeritCare's charity care program as payment options.

"We hoped that this [approach] would make uninsured patients feel more comfortable to talk to us before they start getting the bills," says Dufty. "Some of the dollars we collect now we may never have collected."

2. Insured patients who would likely have a financial responsibility.

MeritCare also targeted patients with insurance, because many of them were unaware that they had a financial responsibility.

"It's important to ask them for some prepayment because they usually do have deductible/copay financial responsibility," Dufty says.

MeritCare worked with its public relations department to get the word out. Officials even sent letters to physicians who are not part of MeritCare, but use its services. Officials also sent information to social service centers in the area.

"We had a simple patient brochure made up and included it in their surgical packet," explains Dufty. "During the phone registration is when we first talk about it."

Show me the money

MeritCare didn't apply a scientific equation to arrive at the $270 up-front collection amount.

"It's low enough that we wouldn't get into refunds, and patients could manage paying it, yet enough to make a financial statement," Dufty says. "We split that amount between hospital and physician fees."

MeritCare's information technology department is working diligently to get the payment process completely automated. "We had put together an online bill pay by credit card and we encourage patients to pay by credit card when we have them on the phone," says Dufty.

Officials eventually hope to benefit from software that indicates the exact amount of money for which the patient is responsible before the service.

But the customers have still benefited from the collections strategy, Dufty says.

"For the first time, they are thinking about their benefits and thinking about how they're going to make those payments," she says. "We're doing a lot of cost estimates. Much of this is patient education."

Staff can provide the cost estimates immediately if it is part of the current file. However, with new procedures using new equipment, it may take a few days to piece together the different services—usually billed separately—with the surgery.

MeritCare competes directly with another major provider in Fargo and also with several independent practices, so this consumerism and competitive market put a premium on these cost estimates.

"We especially want the patient who might be shopping around to receive an estimate right," Dufty says.

Internal education

Training access staff to ask for the $270 is another challenge to the process, Dufty says.

"We try to explain to them the reasoning behind this project, and if something doesn't flow well we can try a script that's more comfortable," she says.

"These are people who are very good registrars,"she adds. "They know how to ask for the demographic and insurance information, but not for money. And there are varying degrees of comfort level. We keep them aware of everything that's going on, and we update them on total dollars collected weekly."

Patients don't typically object to the registrars' request. "At this time of year, a lot of people have met their deductibles, and that's fine. We just want them to know about the policy," Dufty says.

The access staff also tries to inform the patients about the benefits of paying before the day of the surgery.

MeritCare has learned that only 50% of its patients prefer to pay before the day of the surgery. "We want

> *continued on p. 12*

Questions? Comments? Ideas?

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Consistent approach

< continued from p. 11

that number to be at 75%," says Dufty. "When you are checking in for a surgery, [paying the $270] just adds time."

Plus, patients would likely feel more comfortable without the added worry of a payment on a day when they are probably already feeling apprehensive.

Advice column

Dufty says patient access managers who are interested in a similar approach to MeritCare's shouldn't just assume that the physicians will be against it.

"We made it a point to include our care area managers in the process," she says.

MeritCare is prepared for situations in which the patient has the means to pay for the surgery, but does not want to. In this scenario, the physicians—if they were not on board with the hospital's initiative—could create problems.

"We will contact the manager of the department and see [whether] the physician agrees that the procedure can be postponed," says Dufty. "We've actually postponed some procedures until we received the payment."

Cooperation from physicians facilitates the payment process. MeritCare developed a form for physicians that provides room to indicate whether the physician needs to perform the surgery within 48 hours.

"So we know if there's flexibility," Dufty says. "They're the key people and their surgery schedule needs are important, but they've been very supportive. The physician reaction has not been negative."

The physician cooperation also sends the right message to patients. "The patients know we're quite serious," says Dufty. "But it's surprising how many patients have cooperated."

What's up next?

MeritCare intends to expand its current prepayment process to include high-dollar imaging and endoscopy procedures.

"That's going to be challenging," Dufty says. "The area that performs magnetic resonance imaging would be responsible for collections if the patient didn't prepay during the phone registration. And compared with surgicals, there are many more of those done each day."

Additionally, MeritCare is considering experimenting by positioning a financial counselor at a neurosurgery area. "Even though the numbers aren't great there, we want to see [whether] we can justify the expense of doing that," Dufty says. ■