

# Your Strategies for Improving Patient Registration Processes

**M**any of today's strategies and technologies focus on the back end of the healthcare revenue cycle, such as claims editing management, remittance and denial management, and contract management. Yet significant potential for cleaner claims, enhanced revenue, reduced cost to collect, and an improved patient experience typically falls much sooner—during the hospital's registration activities. In this roundtable, sponsored by Emdeon Business Services, financial executives share their thoughts on key strategies for optimizing patient access and registration activities at their organizations, with particular attention to such functions as capturing accurate patient information, effectively using technology, and optimizing staffing resources.

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## What strategies have been most successful for you in improving accuracy of patient registration?

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**Julie Johnson:** Communication is our number one strategy. Our patient accounting team meets quarterly to identify and communicate the top 10 list of denials. Once we've identified critical bill stoppers, we set up specific edits that are automatically generated. Also, we set accuracy goals by facility and registrar longevity.

In addition, we link our registration accuracy to patient safety, because we believe registration needs to be integrated into our organizational strategic planning to meet our goals for the Joint Commission and other national patient safety initiatives. The vigilance of our registrars can make an important difference in the quality of patient care. For example, they can pull forward a past history of allergies in medical records or identify duplicate or fragmented medical records. I believe that financial managers need to better emphasize to front-end employees how important their work is in ensuring patients receive high-quality care.

**Kathy Banner:** We recently implemented eligibility verification, which is one piece that has aided in the reduction of denials. As a result, our denials dropped from about 8 percent three years ago to less than 5 percent by the end of 2007.

Our biggest concern now is how to identify our mobile patient population—not just those emergency room and urgent care patients who may be trying to evade payment,

but also patients for whom we have the wrong address. We are using a tool that can search U.S. Postal Service records to validate addresses and facilitate a real-time correction. Although there's no guarantee the patient lives at the postal address, such capability prompts us to question a patient at registration when an address is different from what is printed on the identification card.

**Patrick Murphy:** Four years ago, we reduced denials dramatically by moving to a fully automated quality assurance system. It allows us to get accurate information into registrars' hands more quickly for corrections. Every registration runs through 120 or more edits nightly. Directors review a summary report the next morning, which includes accuracy and types of errors made. Area registration team leaders—in the emergency department and surgery center, for example—receive specific reports on their team and individual breakdowns. Such a process builds in layers of responsibility for correcting errors before the bill drops. Also, directors can see who their high performers are and who needs more training.

Volume, accuracy, and success in correcting errors can also be included in manager and staff performance evaluations. We set accuracy benchmarks for employees by reviewing the performance of top performers and adjusting for the environment—for example, an outpatient area that is preregistered versus an evening emergency department shift.

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### What do you see as some of the biggest challenges providers face in patient registration?

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**Philip Hardin:** As an industry, we need to redefine requirements for staffing, information, and work flow across the entire revenue cycle to meet increased retail-oriented demands, particularly in patient access. As deductibles increase, it's no longer adequate to simply know whether or not a patient has commercial insurance. Under a health savings account or consumer-directed health plan, there may be a \$2,500 deductible with an 80 percent coinsurance obligation, leaving a large self-pay balance. I find that providers who are most successful in meeting this challenge are those that have a highly automated eligibility and verification process that is well integrated into workflow.

**Lyman Sornberger:** One challenge is that eligibility information is only as accurate as what the payer provides in terms of timely updates. Our analytics show about half of registration errors are the result of external factors, such as inaccurate eligibility updates. To address this challenge, we copy and scan identification cards so that we have an image document to cross-check. We also use weekly communications to registrars about what we are seeing in the payer industry, so they can more closely scrutinize accounts that may be affected.

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### How do you prioritize your improvement efforts?

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**Johnson:** We work our list of top 10 denials. In staff meetings, we always reference progress being made on the list and celebrate the wins: "Congratulations! You got rid of numbers one and three!"

**Banner:** At our organization, four payers account for about 80 percent of our patients. So we focus on denials and collections from those payers.

**Murphy:** We start with write-offs rather than denials. We know we can get paid through back-end work on denials.

#### PARTICIPANTS IN THIS HFMA ROUNDTABLE:

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**Julie Johnson**, CHAM, president NAHAM, is director HIM at Mt. Graham Regional Medical Center, Safford, Ariz.

**J. Patrick Murphy**, FHFMA, is CFO, Gulf Health Hospitals, Inc. (Thomas Hospital, North Baldwin Infirmary, and Oakwood Center for Living), Baldwin County, Ala.

**Lyman Sornberger** is executive director of patient financial services, Cleveland Clinic, Independence, Ohio.

But how much money did we write-off because of something that occurred on the front-end in registration? Then we look at patterns in denials to determine where we're losing money and what our business office has had to fix to get the claim paid. As an example, two years ago, one major commercial payer moved from social security numbers to random identification numbers. We were able to identify the shift to catch the errors quickly and work proactively to correct them, while also retraining staff on the new format.

**Sornberger:** Our driving philosophy is to contact the patient only as a very last resort, because if we do a second search we usually find an internal error, eligibility timing issue, or payer pattern. First, we look at the most frequent errors to identify patterns with managed care, managed Medicaid, and HMOs. We know patients can change plans every 30 days, so we use software that flags fields in these patient records and prompts registrars with scripts like, "Did you for any reason change your managed Medicaid plan last month?" We also build scripts around payers, particularly because the four or five major industry payers do not give effective dates. So if a patient comes across with three types of coverage, it's difficult to know which is primary, which is secondary, and which is tertiary. Registrars need to look closely at identification cards.

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### What is your process for providing feedback when a registrar makes an error?

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**Banner:** We are just now loading an employee database that will enable us to track denials back to the individuals who touched the encounter. Eventually, we will tie the program into a formal feedback mechanism. For now, we send an informal e-mail within one week of the occurrence letting the employee know, for example, that authorization information or insurance verification was missing. We also use QA [quality assurance] software to give real-time feedback during registration. It runs the encounter through various rules that we created based on feedback we receive from billing and denials. The rules determine when an error has been made. Then the registrar is prompted to ask the patient for such things as a correct policy number or address. This allows for real-time corrections.

**Sornberger:** Our registrars receive a list of their errors daily as well as a monthly report card.

They also receive a daily update on their denials, where anything posted the previous day will show up in their queue with an individual scorecard. Our benchmark is to turn the denials around within 72 hours. In addition, employees receive a weekly e-mail with overall scorecard results and communications about problems we are seeing.

The monthly report card is a valuable feedback tool because it motivates performance improvement. Employees have seven days during which they can respond to issues noted on the report card. Once we receive their response, the report card goes into the employee record. If accuracy rates continue to be below par for two months in a row, we use an escalated system of employee counseling to address the issues, beginning with verbal counsel and followed, if necessary, by a written warning and, eventually, suspension. Such a strategy creates responsiveness. We also work hard to highlight star performers in many ways. For example, senior management votes on which employees should be recognized in our newsletter and extends personal congratulations with balloons and handshakes, among other things.

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**Where do you see the greatest potential for improving patient registration processes? What role do you see technology playing?**

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**Banner:** Our hospital has a “shared excellence” program, where department and hospital goals align. One of the metrics that determines whether our registration staff receives bonuses is a 90 percent accuracy rate. As a result, we are seeing improvement in eligibility verification across the organization as well as cash collection by helping us identify when and how much is due in the forms of copayments.

As for technology, we’re about to phase in an approach where patients can check themselves in using a kiosk. Using this “swipe and go” smart card technology—similar to a VIP grocery card or frequent flyer number—should reduce duplicate medical record numbers while also generating brand loyalty.

**Sornberger:** I think one area of potential is for providers to build in provisions in their contracts with payers that would require real-time eligibility. I feel that it is the obligation of anyone leading registration to understand the reasons behind limitations in eligibility verification and work collaboratively to address them.

Also, using software that shows patient wait and registration times can help us to improve the patient experience and collections. As an example, our financial gatekeeping starts at scheduling. We try to collect enough information to preregister patients 72 hours in advance of a scheduled procedure and then work those exceptions. As a result, we’ve already verified eligibility on 95 percent of these patients by the time they arrive. A quick double check of the identification card streamlines wait time and registration. We also advertise on-line registration on our web site and encourage patients to correct registration or coverage errors either on-line or by phone, which allows for behind-the-scenes verification by registrars. Patients appreciate such time-savers.

**Hardin:** We are actively working with CORE [Committee on Operating Rules for Information Exchange] industry initiatives to improve the level of data that are available from payers for real-time information. Increasingly, payers are recognizing they need to return these improved data because of the growing number of consumer-oriented benefit plans. However, there are still many gaps in available benefit information.

Also, we have been seeing the elimination of manual processes and improvements in the amount of benefit information from the payer community. As consumers increase their use of non-self-pay mechanisms for credit, charity care, and governmental programs, providers will use third-party sources to gain a 360 degree profile of those patients’ sources of funding. So, for example, if a provider enters demographic information at a point of registration, the registrar will send an eligibility request directly to the identified payer for real-time screen updates. This information will help employees direct patients in the most appropriate way. They can send the patient to a financial counselor if they see, for example, that the patient qualifies for charity care or Medicaid, or they can ask how a patient would like to take care of a large deductible.

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**Registration typically is a staffing area fraught with high turnover. What advice would you offer to other providers for recruiting and retaining quality individuals?**

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**Lyman:** With the complexity of the insurance industry, we as an industry can no longer afford to hire a body off the street. I will leave the chair empty before I hire a person without the attitude, enthusiasm, personality, and customer service skills the job requires.

Also, there was a time when individuals who worked on the front end were not paid comparably to those on the back end. I don’t believe in that. One of the first things I did



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when I started in my position was to review and adjust job and salary grades. I also encourage managers to recruit former billers to become registrars as their expertise complements the other skill set well.

**Johnson:** I would recommend working with your community college to create career ladders through a curriculum for certifying registration staff. We have three levels on our career path for patient admission representatives and a specialist position. Those who are certified start at level two or three. Certification also helps us to standardize the diplomacy and customer service skills we need to recruit and retain the right employees.

**Murphy:** It's important to invest in a structured training process that gives registrars the information they need to be successful. In addition, meaningful feedback from the manager to the registration staff is critical to retention. Individuals need to understand the value they bring to the organization in terms of making an important first impression with patients and as financial gatekeepers. Without them, our financial viability and patient satisfaction are at serious risk.

**Banner:** At my organization, we've moved away from front-end/back-end silos to a platform with training that includes the full spectrum of revenue cycle and life cycle of the account, so everyone understands their roles and the patient's perspective from the time the procedure is scheduled at the physician's office until the time that account balance is at zero.

Recently, during recognition of patient access week, we used the theme "Everyone Is an Essential Piece" to foster a sense of being part of a larger whole. A puzzle piece on everyone's badge signifying "We are one piece of the puzzle" was a real conversation starter. The PFS leadership team also visited all areas of patient access and handed out candy bars with wrappers that depicted how much billing, and ultimately payment, is affected by information gathered at registration.

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**What are some key ways you track registration performance? What are your processes for translating this information into actionable improvement?**

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**Murphy:** We keep a weekly report in every registrar's employee file so that we can trend results by individual. Since we only have 40 registrars, this is an easy way to capture information for quarterly and annual reviews. The system also provides trend reports that allow us to offer a quarterly incentive plan for the registration staff.

**Banner:** We use a career ladder in patient access. Everyone comes in as a Level 1, regardless of experience. Once they are functioning independently, they can rotate into four areas and demonstrate their competence by testing up to the next level. We also track and share with the staff their statistics, which are tracked through a variety of software packages. Some of what we share includes patient wait times and registration times. Error/accuracy rates are posted in the department as well as cash collection statistics and insurance eligibility/verification statistics. We post everyone's statistics publicly to encourage a sense of teamwork and accountability.

**Lyman:** We use a combination of scorecards, software, frequency reports, and analysis. We also use a random registrar prompt that forces the registrar to do a real-time patient survey with five questions: "Did I confirm your address? Date of birth? Coverage? Was I courteous? Did I answer everything to your satisfaction?" In this way, it prompts future positive behavior.

**Hardin:** Providers do best when they invest in both staff and automation. Training on eligibility verification, credit scoring, and other functions that classify the patient is just as important as embedding these activities in the workflow with compliance reporting. In this way, we can gain the operational feedback to improve performance and identify future training. Because you can't really observe staff, the reports are helpful. By getting correct information up front, it positively affects third-party and self-pay collections and lowers the cost to improve those processes.



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