ACADEMY FOR EXCELLENCE IN HEALTHCARE

IMPACT ASSESSMENT PAPER

Executive Summary

Patient Access Registration Process

Roseland Community Hospital provides comprehensive healthcare services on Chicago's far South Side, a neighborhood challenged by severe social and economic conditions. Established in 1924, the full-service facility has 162 licensed beds, average daily census of 50 to 60 patients, and an emergency room (ER) that receives 26,000 visits annually. Roseland is a "safety net" hospital, obliged to provide healthcare for individuals regardless of their insurance status, and it is the only hospital in an eight-mile wide radius. Sixty percent of Roseland patients are covered by Medicaid or Medicare, and the hospital annually expends more than $20 million to ensure that uninsured and underinsured residents receive appropriate healthcare services.

Capturing revenue is critical for safety net hospitals. Roseland began to document billing-denial problems in 2016, such as improper insurance authorization, not securing admission orders within 24 hours of the patient's admission, insufficient documentation, and patients identified with incorrect status (observation vs. full admit). In 2017, six months of billing denials totaled approximately $1.9 million. Tim Egan, Roseland CEO, became aware of the problem, and eliminating billing denials became a top priority. A cross-functional improvement team from Roseland — led by Dr. Glennell Conaway, Administrative Director of Accreditation & Regulatory Compliance — attended lean training at the Academy for Excellence in Healthcare (AEH) at The Ohio State University in January 2018. Team members from registration, billing, HIMS/medical records, care transition, and revenue cycle departments learned about and improved their understanding of lean techniques at AEH.

The team enlisted other ER staff and incorporated the help of interns when back at Roseland. The team conducted gemba walks that focused on the registration process (the component of the problem they could best control), and staff developed a better understanding of the process and learned how departments impact each other. The walks found no common way to register patients; no checks and balances to ensure proper completion of steps in the process; little standard work (individuals had customized ways of working); and poor patient flow for triaging, processing, and moving patients to treatment bays. In addition, some physicians had not embraced electronic medical records (EMR) and were not completing documentation requirements.

The team mapped the current state of the ER and patient access registration process — patient arrival to patient seen by a doctor and either admitted or discharged — and found rework to address denied registrations (40 percent of staff time) and reprocessing of service-denial claims (50-90 percent of billing staff time). The team used a fishbone diagram to document the specific reasons for unbillable accounts and identified primary causes (e.g., patient status incorrect) and root causes (e.g., patient status not updated).

The expanded improvement team defined a new, standardized process for patient registration and revenue cycle, and set objectives to lower denials; lower the amount of unbillable accounts; incorporate checks and

balances; make all functions involved with patient registration aware of changes underway; and ensure all criteria required to bill an account is completed prior to discharge. The goal was to reduce non-billable charges by 80-100 percent and to improve admission authorizations within 24 hours.

The team used a three-phase approach to improve the patient registration process, decrease denials, and improve patient satisfaction scores (i.e., less waiting). In *Phase 1,* the team implemented the new process: countermeasures included visual alert for waiting patients; method of notifying triage that a patient is waiting; posting alerts on a status board to speed the discharge process; and finding ways to get necessary documents in less time. The team also identified the dollar value denied per physician and communicated this data to physicians and the administration. They sought to get physician buyin for changes and attended medical executive meetings, brought in a physician advisor, and conducted one-on-one training.

The team updated electronic information to clearly show patients who had missing orders, which gave physicians an easy opportunity to resolve a major contributor to denials and dramatically improved the application of admit orders. The hospital also began to withhold patient reports from the most problematic physicians (one physician had omitted 17 orders in one month that resulted in billing denials), which meant the physician could not bill and receive payment. Plans also were set to remove some non-compliant physicians from the on-call rotation. The team also worked with physicians to resolve challenges with the EMR system, such as significantly reducing the number of EMR screens to submit admission orders.

In *Phase 1*, standard work also was developed and documented for ER discharge, registration, and utilization review processes and for social workers. *Phase 2* included revenue-cycle training and internal audits to measure compliance. *Phase 3* included culture change through education, process improvements in remaining areas, and internal audits to measure success. During these phases the team trained 40 staff members on the new standard routines and implemented many changes to patient flow.

The improvement team reduced unbillable accounts from $194,656 in March to $35,461 in April and $41,197 in May, when just three patient accounts lacked an admission order. The team continued to apply standard work in the five departments; track metrics at six-, 12-, and 24-hour intervals; and conduct internal audits weekly to ensure that staff and physicians are adhering to new department standards. As changes are made and new objectives set, the team will communicate them via staff meetings, huddles, emails, and computer-based training. The team also will continue to train and retrain staff and embed standard work in e-learning modules (packages specific to departments). The team expects to share their standard work models and methods to improve *hospitalwide* patient access registration, where similar problems exist within Roseland.

Read the full study of the Roseland Community Hospital project, which illustrates the need for standard work in healthcare— to streamline patient flow, enhance patient care and satisfaction, improve billing procedures, and reduce billing denials. The project highlights the effectiveness of gemba walks, which offered a realistic picture of work and, combined with mapping and unbiased staff interviews, guided the development of standard work. The project also shows how consistent and ongoing documentation of the billing-denial problem helped Roseland leadership prioritize the ER registration process for improvement, and spurred leadership's development and support of a cohesive, engaged, and successful team.

About the Academy for Excellence in Healthcare: AEH blends in-person class time with hands-on project work, interactive simulations, and recurrent coaching, all aimed at helping healthcare teams spark actionable change at their organization. To learn more about AEH, contact Beth Miller, Program Director.