Questions & Answers from Webinar Launch on Jan 14, 2015

1. **Q: KPI #5 - Accounts with Collections / Accounts Registered - Question: Is this KPI looking at all accounts registered verses all accounts registered having some type of POS fee, co-pay, deductible, etc?**

All Accounts registered. NOTE: The uniqueness and value of this ratio is that it represents the percentage of registration volume (not dollars or time) where ANY payment was collected, regardless of the amount, insurance status, patient type, location, service, or patient's capability or propensity to pay. It can form the basis of a fair incentive program that is designed to motivate staff to ask at every patient opportunity, regardless of the potential revenue differences that exist between departments, service locations and patient types.

2. **Q: Is it recommended to poll quarterly?**

We believe semi-annual surveys are adequate to keep the benchmarks in check with industry changes and norms. The first survey confirmed that the initial benchmarks were on target, with only minor changes to only 3 of the benchmarks after ISC discussions. An updated AccessKeys and Benchmarks report will be available by 4/20/15 and on the NAHAM website, in time for the National Conference in Indianapolis.

3. **Q: KPI #2: POS Collections to Total Patient Payments Collected – Is total patients = scheduled patients only?**

No, the denominator in this ratio, Total Patient Payments Collected, represents patient payments made to the organization regardless of timing (pre-service, point of service or post-service and post-billing). The numerator, POS Collections, is total payments received from patients and posted prior to and including discharge date. This metric produces a percentage of all patient payments received before discharge date versus after discharge date. For example, at the "good" benchmark level, 30% of all patient payments were collected by registration prior to service, meaning 70% of patient payments were collected after service and billing. The purpose is to provide a clear goal for front-end teams to collect more prior to service.

4. **Q: What is recommended as the considered total hospital collections per month to compare with POS?**

The POS collections AccessKeys do not compare Point of Service (POS) Collections to total hospital collections because Patient Access is not tasked with 3rd party insurance collections. For example, KPI #2 compares POS Collections to Total Patient Payments Collected, which does not include insurance or 3rd party reimbursement. The AccessKeys are focused on processes that are the responsibility of Patient Access.

5. **Q: I understand the conversion calculation, but wonder how to gather the data needed?**

The numerator in this equation, "Uninsured Patients Converted", requires a query or report to identify all accounts that were initially registered as self-pay and were subsequently changed to something other than self-pay by a Patient Access employee, prior to BILLING, allowing for lag-time in securing 3rd party sponsorships. Examples include but are not limited to changing from private pay to presumptive charity, discount or payment arrangement plan, loan program, or 3rd party insurance plan code in the case of finding undisclosed coverage.

The denominator, "Total Uninsured Patients", can be calculated by counting the total number of self-pay patients registered over the same period as the numerator above (for example the prior month). We recommend only including accounts on patients that have been discharged for both the numerator and denominator. This metric is focused only on conversions that are accomplished by Patient Access during the registration or pre-registration process and prior to billing.

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6. **Q: KPI # 19 - Are the registration totals done by staff considering that the patients have been fully pre-registered already? The total amount of registrations done in a day I would assume are dependent upon if they are pre-registered or full registrations.**

In this metric, "Average Registrations Per Person Per Day (PPPD)", the Total Registrations numerator is a count of all patients registered, including all patient types, not just pre-registered patients. However, we expect the good/better/best benchmarks for Average Registrations PPPD to correlate with benchmarks for Scheduled Patient Rate, Pre-Registration Rate, and Pre-Registration Completion Rate. For example, at "Better" benchmark levels, a 60% Scheduled Patient Rate and a 90% Pre-Registration Rate is likely to correlate with 60 Average Registrations PPPD. A higher percentage of scheduled and pre-registered patients is a significant driver of higher productivity in registration, reducing labor cost and improving patient satisfaction.

7. **Q: Can this be applied to Inpatient, Emergency, Outpatient and Clinic services?**

Yes, generally the AccessKeys are applicable to all locations. However it is important to note that the benchmarks for each AccessKey may not apply to every patient type, stay type or registration location. While ED registration is likely more involved and clinic registration less intensive, the target benchmarks should apply to most types of registrations. For assistance with variations between stay types and registration locations, see the Registration Time and FTE Calculator which was designed to assist Access Managers in predicting productivity and labor cost based on specific tasks and times unique to a particular patient type, registration type or location.

8. **Q: Is the best Registration wait time of 3 minutes referring to new patients or returning patient?**

All patients. "Best" implies that work has progressed on a new patient prior to arrival to the extent there is little difference between new and returning patients.

9. **Q: What does PTS stand for starting with KPI #9?**

PTS = Prior-to-Service. This definition will be added to the revised AccessKeys document prior to the 2015 National Conference in Indianapolis.

10. **Q: California requires a Medical Screening and clearance before registration can be completed. Calculating the wait time would be difficult. Any suggestions on this?**

KPI #7, Average Wait Time. While this equation is an appropriate measure of wait times for any registration location or patient type, the benchmarks may not apply to emergency locations that are subject to EMTALA or other state-specific regulations. The ISC recommends tracking wait times for each service location, which allows the manager to assess and establish baseline wait times for ED and then set goals for improvement that are reasonable for each location. The Average Wait Time benchmarks listed in the AccessKeys are applicable for most outpatient, inpatient and clinic locations.

11. **Q: How can hospitals get the training they need to meet best practices?**

One way is through NAHAM webinars like this one. NAHAM plans to provide additional webinars to support Patient Access Managers in learning and implementing the AccessKeys, and developing a toolkit to assist Managers in training their staff. We also recommend looking to your technology and education vendor-partners to develop the reports and dashboards needed to track the AccessKeys as well as to provide more in-depth training services. NAHAM has also developed a "How to Start" document as a primer to assist new adopters. The ISC plans to provide further explanation of KPI components, an online forum to discuss KPI-related topics with colleagues, an email help line, etc. We welcome your input and suggestions on how to best support education and adoption of the AccessKeys at your facility by emailing or calling the NAHAM office staff. Suggestions will be routed to the ISC for discussion and consideration within volunteer time limitations. The goal of the ISC in 2015-16 will be to educate and promote the adoption of the AccessKeys in Patient Access and Revenue Cycle Communities.

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12. Q: The Registrations per person per day BEST is 80, is this assuming that every patient is pre-registered and the total registration time is 2 min?

KPI ratings feed on each other. In order to meet this number, other KPI components, such as Scheduled Patient Rate, Pre-Registration Rate and Pre-Registration Completion Rate must also have high numbers. That's why it pays to work on KPIs selectively and logically, a few at a time. If there are reasons you can't meet the best numbers for component KPIs, you are unlikely to be best at others either. That's okay. You learn your strengths, do the best you can with your current resources, try to build resources, and gradually improve the numbers.

13. Q: Pre-Reg Process Tiers; regarding tier one and tier two criteria. How can you determine tier one task 8 without having done tier two task 12 and 13?

Tier One, task 8, "Determining financial responsibility" refers to a general determination of the party most likely responsible for paying the bill, i.e.; the Guarantor and any potential 3rd party sponsorship. Tier Two, task 12 and 13 are secondary tasks where the registrar or a verifier confirms coverage and benefits from the 3rd party insurance, identifies secondary payers and coordination of benefits between payers.

14. Q: Will you have these specific definitions available to us after the webinar for reference?

Yes, definitions and Best Practice recommendations will be made available to members shortly.

15. Q: Regarding #1 POS Collections / Net Revenue... Is the Net Revenue from previous month, 30 or 60 days ago?

POS Collections and Net Patient Revenue are reported monthly. The time lag to obtain the prior month's figures depends on how long it takes Finance to close the prior month's books, which can vary. In some cases this is averaged over a running three month period to even out the highs and lows. We recommend asking your CFO or finance department leader for a history of these figures and to include you in monthly reporting so you can track and report this AccessKey.

16. Q: Why are newborn registrations excluded?

Often rolled together with mother's account. Circumstances vary by facility. You may include them if you feel it's appropriate.

17. Q: What is the amount used as a base for cost per registration?

Due to variations in registration processes between facilities and locations within each facility, we refer NAHAM members to the Registration Time and FTE Calculator to calculate the cost per registration. This online tool allows Access Managers to specify the tasks required for a registration location, the time required to complete each task. After entering expected patient volume and average hourly labor cost, the tool calculates the FTE's required to staff that location as well as the average cost per registration – for that specific location and set of required tasks. Note this tool also supports peer comparison. NAHAM highly recommends using the peer comparison function of this tool as every entry adds to the statistical significance of the comparison data.

18. Q: Does the registration time allow for time between patients, patient travel, calling patient, etc.?

KPI # 18, Average Registration Time, includes only the time from the beginning of the patient interview to closing and does not include patient travel time, wait time between patients, etc.

19. Q: Will you provide the definition of completed vs initiated preregistrations?

Pre-Registrations Completed: NAHAM requires a minimum of TIER 1 pre-reg tasks to be completed in order to be considered a "Completed Pre-Registered Patient". Tier 1 pre-reg includes patient and guarantor demographic data collection and verification, insurance data collection and clinical order data collection (include procedure/diagnosis), and a phone call to the patient or guarantor. For more information on Tier 1 Pre-registration see NAHAM's "Pre-Registration Process Tiers".

Pre-Registrations Initiated: All pre-registrations initiated or started (regardless of the tier or process depth) should be included in this denominator. These are scheduled accounts that are assigned to the Pre-Service Team >48 hours prior to arrival (>2 days out)

20. Q: How did your case studies count or track the number of issues and number of issues resolved for KPIs 9-11?
We have not done a case study yet, that is the next step. However, some hospitals are doing this with the help of automated technologies that identify, track and report both process failures and resolutions. At this early stage the ISC based these benchmarks on anecdotal data from ISC member hospitals and NAHAM member survey results, which will be updated over time as information becomes available.

21. Q: what would you consider total revenue to compare with POS
Net Patient Revenue (NPR) is total revenue received for patient services net of contractual allowances and discounts (also known as "Net Patient Service Revenue"). This figure does not include revenue from other sources such as donations, cafeteria, gift shop, parking fees, rent, interest, investments, etc. NPR is a commonly reported financial metric that you can find on your organization's Income Statement. Because it is tracked and monitored carefully by finance leaders, it is a credible denominator for Access Managers to use in communicating and measuring POS Collections and allows for meaningful peer comparison to hospitals of any size. While there may be variations due to payer mix or patient types, we highly recommend using this metric in addition to at least two other POS collections metrics to get a complete picture of POS collections performance.

22. Q: How is this information being measured? Is it a manual process or automated?
Can be either way or a combination of both. Generally speaking, the better numbers require a higher degree of automation, including measuring.

23. Q: Is the Pre-Authorization process calculated anywhere in the productivity rate?
Yes, please refer to the FTE Calculator which includes Pre-Auth tasks and calculates into productivity and cost per registration. Please note that KPI #9, Service Authorization Rate, is categorized in the "Process Failure & Resolution" domain rather than the "Productivity" domain. This is because it is a process critical to reimbursement, where failure typically results in non-payment.

24. Q: Suggestion: Change wording on KPI #15 to say "less than" 2 days out.
Actually, this should state 2 days out or *greater*. For Scheduled Patient Rate, the numerator should only include accounts that are scheduled 2 days or more prior to arrival. This standard allows adequate time for Tier 4 level pre-registration (See NAHAM's "Pre-Registration Tasks and Tiers").