AccessKeys 3.0 Webinar Questions

1. **Q:** Are there any payers that you don't include in the POS collections numbers? For example, Medicaid accounts.
   A: Currently the POS Collections KPI calculations do not exclude any payers. However, the more sophisticated estimation systems allow the option of excluding payers, dual insurance patients and even specific service codes and patient types so that certain estimates are not automatically generated. Manual estimation systems result in a lower estimation to registration rate (a lower percentage of patients will receive manually-generated estimates compared to automatically-generated estimates).

   For simplicity and peer comparison of POS Collection KPI's, the ISC does not recommend excluding any payers in the POS Collection calculations. However, it may be beneficial to review POS Collections by payer periodically to assess the effectiveness and efficiency of your workflow or to find opportunities; for example, if you rank POS Collections by payer you may identify your top-earning payer populations and provide more resources or training to prioritize and capitalize on the top earning payers.

2. **Q:** Completed order rate - you might have multiple orders per scheduled patient. How do you address this in your calculation?
   A: Currently the Completed Orders Rate does not factor in this situation. It is implicitly assumed that multiple procedures per scheduled patient are sent in one order. Therefore, there should be a 1 to 1 correlation between the number of orders and the number of scheduled patients. We recognize that some variation exists between HIS systems and scheduling workflows. However, we do not believe that variation is material to calculating the percentage of COMPLETE orders to the number of scheduled patients. While we could compare the percentage of complete orders to incomplete orders, we believe it is more meaningful to set an industry benchmark that is based on complete orders to scheduled patients. It would be good to benchmark the rate of complete to incomplete orders, but we believe it is more beneficial to the industry to benchmark the rate of complete orders as a percentage of scheduled patients. Like all AccessKeys, the ISC usually chose simplicity to complexity as a guiding principle, especially given the early stage of adoption. We anticipate exceptions and exclusions will be added in future versions of the AccessKeys, however at this early stage the goal of the ISC is adoption, and simplicity and ease of calculation supports that goal.

3. **Q:** Could you speak in a little more detail about the LWBS rate (PX-6). In our ER, ED Registration staff are not permitted to speak about wait times, they have to refer to the RN at the front. In what way do you see us contributing to an improvement in that rate?
   A: Multiple factors contribute to the LWBS rate, some of which are outside the influence and responsibility of Patient Access staff to control. However, rather than place a burden to subjectively choose and report what is within PAS responsibility versus Clinical team responsibility, the ISC recommends reporting the percentage as described in the user guide, and focusing on improving the factors that are within their control, such as check-in workflow, bedside registration, providing more patient comforts such as coffee or frequent patient updates. PAS can also assess the bottlenecks in workflow that are not within their influence and make recommendations to peers or through supervisors and executives.

4. **Q:** Does POS-6 take into account payer mix? Only 30-35% of all of our accounts necessitate an estimate.
   A: Similar to our answer to question #1 above, currently the POS Collection KPI's do not exclude certain payers from this calculation. Future versions are likely to take payer mix variations into account to support more meaningful peer-to-peer comparisons. We appreciate the questions about payer mix variation and will add them to discussions and research for future versions. The focus in the near-term is for PA managers to begin tracking and reporting an estimate-to-registration rate at all, so that more focus can be given to one of the primary drivers of higher POS Collections. The more estimates, the more collections.

5. **Q:** Does PX-5 include patients who are rescheduled?
   A: Yes. No-show patients who reschedule later are still no-shows for the past scheduled visit. If they are rescheduled and they show, the rate will show improvement. It would be difficult to identify no-shows who rescheduled and exclude them retrospectively from this statistic. Again, simplicity over complexity is the guiding principle when faced with outlier variations in process.

6. **Q:** PX-7 and PX-8 are the denominators the same?
   A: Yes, and thank you for pointing this clerical error out. We will update the denominator in PX-8 to "Total Patient Calls Received" to match PX-7.

7. **Q:** When you are calculating POS Collected Accounts Rate, using Total Registrations...would the Total Registrations exclude accounts with secondary coverage?
   A: Currently this KPI does not exclude dual insured patient accounts. Also see the answers to questions 1 and 4 above, which are similar regarding payer mix variations in the KPI's. Future versions of the AccessKeys may factor in payer mix; keep in mind that few PA departments are currently tracking and reporting this metric. We must walk before we run, and adoption of the metrics in simple form is more likely than complex forms.

8. **Q:** Is there a division of NAHAM that has focus on ambulatory practices?
   A: NAHAM has initiatives focused on ambulatory or clinical practices, however the AccessKeys do not currently measure performance for ambulatory services, only acute care facilities.

9. **Q:** Is there a standard for when hospitals should be allowing providers to schedule without written orders? How to address provider dissatisfaction if require written orders prior to scheduling?
   A: Yes, most hospitals have a "no orders no service" policy. The issue is how well that policy is enforced. Hospitals with large employed physician groups will be able to more easily enforce that policy, and much depends on the market each hospital operates in. Publishing a Completed Orders Rate benchmark of 30% as a minimum standard should support an orders-required policy.

10. **Q:** Relative to POS Payments, I routinely hear that organizations exclude departments from their calculations when they are not actively serving at a front desk for specific areas, particularly in recurring areas such as physical therapy. This may skew benchmarking if created by survey calibration efforts. When new calibration is completed, can the excluded encounters be clarified in the questionnaire?
    A: Great question we will add to discussions for future versions of the AccessKeys as well as benchmark survey questions. We do recommend in the Users Guide to report POS Collections by location (aka department) so that un-owned or decentralized location performance can be compared to centralized PA departments.

11. **Q:** We are doing all four tiers of preregistration; the problem is reaching the patients. How would you rate the preregistration if you only reach 50%?
    A: The Pre-Registration Rate (P-3: Pre-Registrations Started / Scheduled Patients) will include patients reached and not reached – it does not factor what tier or whether the

patient was reached or not. By definition if the patient was not reached, it was not a complete pre-reg at tier four. Note that the Completed Pre-Reg Rate (P-4: Pre-Registrations Completed / Pre-Registrations Started) does NOT include the patients not reached because the pre-registration is not complete. For example, if you only reach 50% of patients and you are doing tier 4 pre-reg on all of them, your pre-reg rate will be 100% but your Completed Pre-Reg Rate will be 50%. These two KPI's were designed to work together to help track situations like what you describe. One tracks volume, the other tracks depth (aka completeness or Tier 4). Another way to think about it is the number of pre-registrations completed will be a percentage of the pre-registrations started. So the short answer to your question is that a pre-registered patient that wasn't reached would be counted as a "pre-reg started" in P-3, but would not be counted as a "pre-reg completed" in P-4. Great question, I hope this isn't too confusing. If so, please call us to discuss further. It will help us fine-tune our explanations!

Thank you for all the great questions and let us know how your implementation efforts go – we love all the feedback you can give us!