

## **Increasing Customer Satisfaction through a Registration Redesign**

*By Kathy Berger*

It is common practice throughout the healthcare industry to blame technology or computer systems when days in accounts receivable and/or patient complaints increase. It is **not** a common practice for a Chief Information Officer (CIO) of an eight-hospital system, recognizing that information systems are not the root cause of the issues, to spearhead an initiative to redesign work processes of the departments utilizing these systems.

This uncommon practice occurred at Advocate Health Care (AHC) located in Chicago, Illinois and its surrounding areas. Bruce Smith, CIO for AHC, heard the issues of Alan Iftiniuk, Chief Executive of Good Shepherd Hospital in Barrington, Illinois, and engaged the services of The Tintari Group (TTG), a consulting firm specializing in process redesign of integrated healthcare financial systems. Laurie Gift from Advocate Information Systems, was assigned Project Team Leader, her goal was to work with TTG to assess the front-end (registration) processes and make recommendations for improvements based on the findings.

The Good Shepherd Hospital (GSH) project began with a kick-off meeting with selected department heads. This eventually became the project steering committee. Karen Lambert, Vice President for GSH, presented a crisis situation in the central scheduling department that was created in large part by employee turnover and leaves of absence. Patient calls were not being answered, physicians were instructing their patients to arrive at the hospital without appointments because they couldn't get through on the phones, and, of course, patient and physician complaints were increasing exponentially.

Entering the hospital the very next day, illustrated the crisis situation Karen painted. The main lobby was full with patients waiting to be registered that potentially could have been pre-registered. Central scheduling (or what was left of it) had only 2 staff on the phones with no relief between calls. An outside agency eventually had to be retained to take calls and leave messages for the existing scheduling personnel. Existing personnel, no longer receiving incoming calls, would return the messages and schedule patients in this manner.

It was easily recognizable that the assessment had to begin in central scheduling. The pre-registration of accounts, also performed by the scheduling staff, was no longer being done. This contributed to the increased volumes of patients waiting to be registered in the main outpatient registration center and increasing the registration wait times.

The first step in the assessment process was to collect the statistics: wait times in outpatient registration, percent of pre-registered patients to scheduled patients, scheduling phone calls answered, the number of abandoned incoming calls, abandoned calls as a percent of the total, etc. These benchmarks statistics established a snapshot of where they were so the affect of change could be measured moving forward.

A by-product of the first steering committee meeting was the development of several subcommittees. One of these was the pre-registration committee, whose charge was to enable the hospital to reach a goal of 100% pre-registration of centrally scheduled patients and, eventually, 100% of all scheduled patients, including those not scheduled in the scheduling system. Other committees formed concerned communications and future technology.

The goal of the pre-registration committee was to resolve the crisis situation and design a process that worked for Good Shepherd. This was done through a number of work sessions with key managers and staff. The communication committee was charged with designing vehicles of communication to physicians, patients and staff regarding the progress of improvements. The future technology committee looked at the effectiveness of the scheduling system. In addition, the CEO was holding meetings twice a week to address progress in getting central scheduling staffed again.

A perception existed that Central Scheduling was a difficult area to move existing staff into and train from other hospital departments because the scheduling system was too difficult to teach to just anyone, and that the learning curve for new staff was incredibly difficult. After asking probing questions, it was determined that the scheduling system had not been maintained over the past several years because of turnover. Staff was checking as many as 12 detailed sheets of exceptions to consider before scheduling a particular test in the system. The scheduling criteria, such as staff and physician availability, room availability, and equipment needs had to be built into the system to transform the system from a glorified calendar to a true scheduling system. An IS employee with previous in-depth system knowledge was immediately dedicated to rebuilding the system. Departments were required to document the criteria needed to schedule a test so staff could immediately “see” when the next available test could be scheduled. Another subcommittee was formed to develop procedures for ongoing maintenance and support for the scheduling system as well.

Over the next several weeks, Central Scheduling was again fully staffed, training was completed, and the system was well on its way to serving as the tool it was intended to be. Central Scheduling personnel were handling all the calls themselves, the services of the outside agency was discontinued, and the percentage of incoming calls that patients abandoned (hung up) before a scheduler could answer dropped from 46% to 22% within six (6) weeks.

Establishing a pre-registration area, while scheduling was being “fixed” was an equally important priority because patients were waiting 13 minutes on average to be registered in the Outpatient Center, which created a lot of congestion in the main waiting area. Good Shepherd Hospital committed to hiring 3 staff to perform this function. The paper flow between Central Scheduling, pre-registration and the front desk was designed, and staff was trained. Removing the pre-registration function from the scheduling staff, allowed both areas to become more proficient in their respective jobs. Registration errors decreased from 35% to 26% and the percent of pre-registrations to scheduled patients increased from 54% to over 80% in two (2) months.

Having resolved this crisis, the management at Good Shepherd Hospital began to look at the entire front-end process for each classification of outpatients entering the hospital. Through flowcharting, it was discovered the registration process had become very fragmented. Different mechanisms were in place for scheduling and registering patients based on the services they received. Many ancillary areas did their own registrations because they did their own scheduling. Some patients went directly to the servicing area, and some went through the Outpatient Center where they waited for a registrar even if they were pre-registered. This fragmentation caused a lot of patient confusion and frustration. Hospital personnel had difficulty-directing patients to their first point of entry. The inpatient admitting process had also become very fragmented, resulting in the Emergency Department or the Admitting office being the place an urgent admission was directed to. If the Admitting Department was not staffed, then the ER was the back up.

The entire front-end process has been completely redesigned with centralization of registration as the primary focus. All patients are currently directed to the central registration area. If they are pre-registered, Guest Services personnel obtain signatures and a copy of the insurance card at the front desk, and patients are directed to their servicing area. If the patient is not scheduled, and therefore not pre-registered, the registration process is completed in the central registration or Patient Intake area. Pre-registration and registration are a combined function of all the staff in the central registration area as well as the Emergency Department and report to the same supervisor. This central reporting structure allows for flexibility in moving staff or reallocating staff to an area that needs assistance during peak times. Implementation is scheduled for late November, and many processes have already been established. Reporting structure changes will be the last step of the re-design process.

Good Shepherd Hospital will serve as an example of improvements that can be made to help increase patient and physician satisfaction for all of Advocate Health Care. Through work sessions, processes were redesigned to accommodate the patients and staff was allocated to the areas in support of their patients rather than patients being directed to the different areas in support of the staff. Paper flows were streamlined and redundancy eliminated. Benchmarking statistics are serving, as the report card to measure what is working and identify what isn't. Utilization of an outside perspective (TTG) provided an objective viewpoint and assisted the hospital staff and management in looking at the whole picture and also provided the opportunity to see that picture through the eyes of their patients. The hospital will continue to monitor the success of the redesign through the benchmarking, making adjustments to the processes as needed. This experience will also provide Good Shepherd Hospital with the tools to enhance this process when their new outpatient facility opens next summer. This experience also illustrated that any information system is only as good as the work processes that support it.

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