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INSIDE

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Price Transparency or Price Gouging: Disclosure of Negotiated Rates Called a 'Tipping Point'

How much does a health insurance company actually pay the hospital for an MRI? Nobody really knows — except the hospital and the payer. That is about to change, thanks to a new rule that requires hospitals to disclose secret negotiated rates with payers.[1]

The new CMS rule "is a huge step in the right direction. It will be a tipping point in healthcare pricing, billing, and payment," predicts **George A. Nation III**, a professor of business and law at Lehigh University.

Hospitals have closely guarded this information. "Under the status quo, healthcare prices are about as clear as mud to patients," said CMS Administrator **Seema Verma** in a recent statement.[2]

As of January 2021, hospitals will have to post payer-specific negotiated charges online for 300 "shoppable" medical services (X-rays, outpatient visits, imaging, and other services scheduled in advance). The rule specifies 70 of these services, and allows hospitals to choose which additional 230 services to post. The sheer amount of data posted for each hospital will be "enormous," says **Ross C. D'Emanuele**, JD, a partner at Minneapolis-based Dorsey & Whitney. Revenue cycle departments can expect to field calls from confused patients.

"I have no doubt that hospitals will get more questions and complaints from cash-pay customers and others," D'Emanuele predicts.

For patients to make any sense of the posted prices, they will need to know some specifics — namely, all items and services to be provided during their outpatient visit or hospital stay. As if that were not daunting enough, fees for services provided by any clinicians who are not hospital employees will not be disclosed.

"Services and items that a hospital provides to a patient are far more variable, elastic, and complex than, say, used car pricing," D'Emanuele explains.

The big question is whether hospitals can continue to justify their current pricing arrangements.

"Or, will they be put on the defensive, and ultimately start to rethink current practices and strategy?" D'Emanuele asks. "CMS clearly thinks the latter."

Revenue cycle employees will need to explain why patients are paying more than the posted price. "The published price is an average. Many patients will have a bill

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that is larger than average because they have complications or are sicker than average," says **Gerard Anderson**, PhD, professor at Johns Hopkins Bloomberg School of Public Health.

Nation says it is not too much to ask of hospitals to explain the bill in a way that makes sense to the average person. For example, if the charge for an uncomplicated vaginal delivery is $1,200, but the patient's delivery involved complications, then the hospital can explain why the bill is $1,500.

"The list price of a car may be $35,000, but if I get the leather seats it's going to increase the price. I think consumers are able to understand that," Nation offers.

Hospitals must develop a new mindset and stop trying to hide price information from patients, according to Nation.

"The system that hospitals have been using — that is, stating that 'The charge master price of a delivery is $20,000, but we gave your insurer a $19,000 discount' — is ludicrous," he says.

Under a proposed rule from CMS, health insurance companies would have to publicly disclose their negotiated rates for in-network providers and the amounts paid to out-of-network providers. Health plans also would be required to give their members real-time, personalized information on what they are going to owe.

"This would empower consumers to shop, and enable them to compare costs between specific providers before receiving care," according to CMS.[3]

However, those out-of-pocket costs might exceed the amounts that the hospital has negotiated with private insurers. If so, says Nation, "hospitals should expect blowback and, in my opinion, rightfully so."

If health plans and hospitals really do all this, presumably people would not have to seek financial information from revenue cycle employees. In that kind of situation, says **Ge Bai**, PhD, CPA, "the demand from the public to seek price estimates would be reduced."

Collecting information on what hospitals pay to health plans could be a big advantage for self-pay patients. For instance, if they see a hospital pays health plans $100 for an MRI, self-pay patients could use that information to argue against paying $700 for the same MRI.

"The information provided by the new rule will absolutely be of use to all self-pay patients, whether those who lack insurance, have high deductible plans, or receive care out of network," Nation says.

Hospitals have two choices, according to Nation. They can fight price transparency, or they can fully embrace it and use that to differentiate from competitors. If hospitals choose the latter option, they can market themselves as more efficient, with more reasonable prices.

"Or, they may be able to command higher prices — if they can provide higher-quality outcomes or better service," he adds.

As the public learns even more about secretly negotiated healthcare prices, some hospitals will inevitably come off as more consumer-friendly than others.

"I don't see much challenge for hospitals that are already offering competitive prices," says Bai, an associate professor of health policy and management at Johns Hopkins Bloomberg School of Public Health.

According to Nation, one thing will really determine whether hospitals succeed or fail in the new world of price transparency: whether they are willing to give up the confusing, controversial charge master pricing system.

"Hospitals will no longer be able to try to enforce these prices going forward without suffering serious hits to

their reputation," Nation argues. There is growing awareness that few patients actually pay the exorbitant prices listed in the charge masters.

"After this rule goes into effect, everyone will know it," Nation predicts. "Hospitals will find this ridiculous system impossible to defend."

Nation says hospitals should comply with price transparency in full by taking two steps:

• **Differentiate what they offer to patients.** If a hospital's MRI machine is really that much better than competitors', a higher price tag is justified.

"Hospitals need to offer better quality, better service, or a lower price," Nation says. "As in any other industry, those who can do all three will thrive."

• **Create realistic, all-inclusive prices for procedures that vary no more than 10% or 15% from the average negotiated rates the hospital pays in-network insurers.** If this happens, says Nation, "then things would be much simpler with regard to registration, financial counseling, and giving price estimates."

Some hospitals undoubtedly will try to continue to collect charge master-based prices whenever possible. For these hospitals, says Nation, "life will become more complicated and more difficult."

Patients are finally going to know that the hospital charges the insurance company $100 for a CT scan, but demands $600 from the out-of-network patient. They will not be happy about it.

It makes sense to charge self-pay patients a little more, Nation notes, because an insurance company assures quick payment, and offers the potential of a large volume of members.

"But paying double or more simply makes no sense. It is price gouging," Nation says. ■

REFERENCES

1. U.S. Department of Health and Human Services. Price transparency requirements for hospitals to make standard charges public. *Federal Register*, Nov. 27, 2019. Available at: http://bit.ly/2XRIfGE. Accessed Nov. 27, 2019.
2. U.S. Department of Health and Human Services. Trump administration announces historic price transparency requirements to increase competition and lower healthcare costs for all Americans, Nov. 15, 2019. Available at: http://bit.ly/2qHg0P0. Accessed Nov. 27, 2019.
3. Centers for Medicare & Medicaid Services. Transparency in Coverage Proposed Rule (CMS-9915-P), Nov. 15, 2019. Available at: https://go.cms.gov/2OSN1jj. Accessed Nov. 27, 2019.

Waiting for Outcomes of Legal Challenges Unwise

The new CMS requirement that hospitals disclose secret negotiated rates with payers is facing legal challenges.

Four hospital trade groups (the American Hospital Association, the Association of American Medical Colleges, Children's Hospital Association, and Federation of American Hospitals), said they will join with member hospitals to legally challenge the rule on grounds that it exceeds the administration's authority.

"Instead of helping patients know their out-of-pocket costs, this rule will introduce widespread confusion, accelerate anticompetitive behavior among health insurers, and stymie innovation in value-based care delivery," the groups said in a joint statement.[1]

Hospital Access Management spoke with two healthcare attorneys about what these legal challenges mean for hospitals. Medical facilities should proceed as though the rule will go forward as planned, says **Michael Strazzella**, JD, administrative head in the Washington, DC, office and head of the federal government relations practice group at Buchanan Ingersoll & Rooney.

"They can't wait based on the hopes that it will come out positively in the courts," he offers.

One possibility is that litigation simply will delay the disclosure requirement. Regardless, "hospitals should be moving toward, and preparing for, public disclosure of charges," advises **Emily Cook**, JD, a partner in the Los Angeles office of McDermott Will & Emery.

Many hospitals will struggle to find the resources to fully comply with the new requirements. "It is not a cheap or easy process to undertake the activities that the rule contemplates," says Cook, who specializes in healthcare regulation and reimbursement.

According to Cook, there are three options available to hospitals:

• Prepare to publicly post the charges;

• Prepare for compliance by developing a searchable price estimator tool that is available to patients online;

• Anticipate receiving a civil monetary penalty of $300 a day.

Some hospitals may opt to pay the fine instead of comply. "For a small rural hospital, a penalty of $110,000 a year is significant. For a large academic medical center, it is not as significant," Strazzella notes.

On the other hand, there is no guarantee that the relatively low

penalty will remain that way. "Penalties could change in the future," Cook warns. "There could be other consequences for noncompliance." ■

REFERENCE

1. American Hospital Association. Hospital and health system groups on public disclosure of privately negotiated rates final rule, Nov. 15, 2019. Available at: http://bit.ly/2qOTnlc. Accessed Nov. 27, 2019.

Fewer Than Half of Seriously Ill Medicare Patients Well-Informed on Costs

More than half (53%) of Medicare beneficiaries with serious illnesses struggled to pay medical bills, according to the authors of a recent study.[1]

"Our motivation for doing this study was to better understand the experience of patients with serious illness," says **Michael Anne Kyle**, MS, MPH, the study's lead author and a doctoral student in health policy and management at Harvard Business School.

Efforts to improve the healthcare delivery system usually focus on high-need, high-cost patients. Kyle and colleagues wanted to study the view through the eyes of these patients. "We were interested in these patients' own perspectives on their needs and challenges," Kyle explains.

The paper was part of a larger national study of seriously ill adults.[2] After discovering the extent to which Medicare patients were struggling with medical bills, the researchers decided to write a paper on this group specifically.

The findings contradicted the general perception that this patient population is well-protected through a combination of Medicare and Medigap, Medicare Advantage, or Medicare and Medicaid. "We were surprised at the extent of the financial distress reported by Medicare beneficiaries," Kyle reports.

It was not just that Medicare patients struggled with bills. Part of the issue was that no one had ever talked to them about what they would owe. Fewer than half (46%) of seriously ill patients felt adequately informed by their healthcare providers about what their insurance would cover.

"This has gotten less attention than the financial hardship findings, but it is so important," Kyle stresses. These other findings showed how ill-informed patients felt about what they would owe:

- Only 27% said their main doctor discussed cost of care;
- 27% struggled to understand what insurance covers for a doctor's visit;
- 19% struggled to understand a doctor's office bill;
- 21% struggled to understand what insurance covers for a hospital stay.

"There is a lot of room for improvement in financial counseling," Kyle concludes. Patient access can do its part by discussing the cost of care with all seriously ill patients, regardless of their insurance coverage.

"Medicare beneficiaries may not be an obvious population for counseling," Kyle notes. However, these patients spend about the same out of pocket as the overall patient population. "The top 5% of patients face about half the out-of-pocket costs. This is definitely a key group to do outreach with," Kyle offers.

Even if medical bills are covered adequately, patients might be struggling with informal caregiving.

"Inadequate support at home could be a risk factor for a future admission," Kyle adds. ■

REFERENCES

1. Kyle MA, Blendon RJ, Benson JM, et al. Financial hardships of Medicare beneficiaries with serious illness. *Health Aff (Millwood)* 2019;38: 1801-1806.
2. Schneider EC, Abrams M, Shah A, et al. *Health care in America: The experience of people with serious illness*. Commonwealth Fund, October 2018. Available at: http://bit.ly/33pmq2k. Accessed Nov. 27, 2019.

Promoting From Within Can Lead to Strong Commitment

If patient access staff at Arlington-based Texas Health Resources want some reassurance that they really can move up in their jobs, they can just look around. Every single manager and director currently working in the department was promoted from within.

"Employees know that it can happen for them, too, with hard work," says **Alyssa McDonnold**, CHAM, director of the patient access intake center.

Certain patient access staff are the ones that colleagues always turn to for help. "They are the 'go-tos,' the people everyone relies on. They are leaders, but without the title," McDonnold reports.

The department made a concerted effort to do something for these unsung heroes. "You can take an employee with a natural leadership gift, and mold and mentor them into the leader your department needs," McDonnold explains.

Staff promoted from within are strongly committed to their new role. "In the end, you have less leadership turnover," says McDonnold, adding that her department recognizes the "go-to" employees two ways:

• The most promising patient access employees can attend a leadership training class. This idea stemmed from McDonnold's own experience with a year-long program at Texas Health University. The program is designed for high-producing managers with the goal of becoming a director. McDonnold learned so much from the program that she created something similar for patient access staff: an eight-month program that teaches leadership and teamwork.

All patient access employees received an email that included information about the class and an invitation to apply. Ultimately, six employees were chosen, three each from preaccess and insurance verification. McDonnold taught the first class, then the department's applications trainer took over.

At the end of the program, each participant chooses a topic to present to leaders. "Some focus on relevant problems that they hear about from their peers that leaders may not even be aware of," McDonnold says.

One employee created a presentation called "Dr. SnapChat" about virtual physicians available to patients online. Another presented information on patient satisfaction from the frontline point of view. **Karlei Carrico** was one of the first group of patient access employees chosen for the program.

"After the program, I applied the skills to my position. This professional growth led me to be promoted into a new position," says Carrico, now a revenue cycle electronic health records trainer.

• A career ladder separated patient access roles into level 1 and level 2 positions. The level 2 role already existed informally. "They are the go-getters of the department," McDonnold notes.

The problem was that these standout employees were not recognized in any formal way. The first step was to create a separate job description that spelled out how level 2 employees differ. Mainly, they are held accountable to higher standards for Key Performance Indicators. Also, level 2 staffers are assigned to work with between five and seven new employees.

"We call them 'Promise Pals.' They work alongside the new hire for the first month, and act as their contact person thereafter," McDonnold says.

Most new hires are confused about which CPT code to use or how to give an accurate price estimate. That is where the Promise Pals step in. "The new hire can go to the Pal and get the information," McDonnold says.

Trish Vartan, a recently promoted level 2 rep, says that serving as a Promise Pal "has really taught me that I am a leader within my department and to my peers."

With level 2 employees fielding most questions from new hires, senior leaders can work on other departmental priorities. "The amount of questions we were getting were endless, all the time," McDonnold reports.

Before Promise Pals existed, employees at more than a dozen hospitals in the health system called continually with questions about authorizations, estimates, and more. It was not that the employees were terrible at their jobs; rather, things in the department are changing constantly.

"Even though they know their jobs, new scenarios come up every day," McDonnold explains.

The job description made it clear that level 2 reps work harder and handle more tasks than their level 1 peers. This resulted in HR approving a pay grade increase.

Several years ago, the department had created a similar role without extra pay. Staff expressed little interest in taking on the duties. "There's a fine line between what you can ask somebody to do without a pay increase," McDonnold offers.

Still, it took more than just a new job description to convince HR that level 2 people should be paid more. Leaders also researched compensation of similar roles at other hospitals. "We were able to show that the industry

standard is going in this direction," McDonnold says. It also helped that the hospital's Central Business Office had created a similar role — at a higher pay grade. "We reached out to HR, and said, 'We see the need for this in our department, too," McDonnold recalls.

After defining criteria the level 2 employees have to meet, HR came back with the pay rate difference. "Turnover is very solid in the level 2 position," McDonnold adds. "When people do leave, it's normally an internal transfer within the company." ■

With a Little Patience, IT Expertise Pays Off for Revenue Cycle

An occasional upgrade to the registration system used to be the only reason the paths of IT and revenue cycle leaders ever crossed.

"The old legacy registration and billing systems really didn't touch anything else. IT would just turn it on; there wasn't that much to it," recalls **Jon Neikirk**, executive director of the revenue cycle at Froedtert Health in Milwaukee.

That has changed dramatically. Revenue cycle leaders and IT need one another to thrive. "Today's registration systems are all very integrated, with organizations trying to push the envelope and offer more self-service and a better patient experience," Neikirk notes.

Until recently, an Epic analyst was stationed within the revenue cycle department. "We were very involved from an IT standpoint," Neikirk says. "It allowed us to do a lot of things that we otherwise would not have been able to."

The situation ended recently. With the analyst now stationed in the IT department, "it's made things a bit more challenging," Neikirk says.

But after spending time with IT in close proximity, revenue cycle leaders gained a great deal of expertise. This comes in handy in bridging the gap between the two areas. "Our registration leaders have had to work really hard to get some familiarity amongst the teams," Neikirk says. "You've got to put the time in, and keep regular communication going." Revenue cycle leaders invited IT leaders to come see how employees register patients. "There's good collaboration at this point," Neikirk reports. There were a few recent revenue cycle initiatives that succeeded because of good relationships with IT:

- **Patients who want appointments sooner can go on a wait list.** Previously, it required time-consuming calls with a scheduler. Patients hated it, and schedulers spent a great deal of time on it. Now, if an appointment slot opens, an email or text is sent to the patient with an offer for the spot. If the patient clicks "yes," it is scheduled automatically, and the previous appointment is cancelled.
- **Some patients receive estimates automatically.** "One of our goals is to estimate out-of-pocket costs, for both hospital and physician charges, prior to their visit," Neikirk says.

  For several years, the department offered price estimates, but patients had to request them. Now, estimates are produced automatically for imaging. At the time it is scheduled, staff tell the patient to keep an eye out for the estimate.
- **The process of obtaining authorizations is beginning to become automated.** "We've got a lot of FTEs working in the prior authorization department," Neikirk observes.

  A lot of time is spent on lengthy phone calls with payers. The goal is for some authorization requests to be sent electronically, with a response coming back from the payer. "We are rolling it out one payer at a time," Neikirk explains.

  The department started with United Healthcare, their largest payer. If things go smoothly, the next two largest payers, Anthem and Humana, will be next. For now, at least, only imaging authorizations are automated. Generally, these are less complex than other types of authorization requests, and, usually, no peer-to-peer review is required.
- **The department recently implemented patient self-scheduling.** Patients can book primary care visits online. "That's been a huge win. Our patients love it," Neikirk says.

  Revenue cycle leaders maintain a long list of projects they want to complete right away. Many expect IT to drop everything else to handle it. "We're not always going to be first," Neikirk admits. "Every department is saying the same thing — 'There's a new shiny object out there, turn it on.'"

  Sometimes, the hospital CEO asks IT to focus all its efforts on a single initiative. "There are multiple priorities that IT is juggling that aren't necessarily what the registration department thinks is the right priority," Neikirk laments. "We've got to be OK with that."

  The health system's steering committee, not the revenue cycle, ultimately decides what IT works on.

Still, a "squeaky wheel" strategy pays off. But just making demands without any research to back it up is not going to be effective. "As a revenue cycle leader, you can't just expect that IT will anticipate your needs," Neikirk notes.

Simply saying, "We've got to have this functionality. It's going to make our lives so much easier" is not going to cut it. Tying the IT request to an organizationwide priority is much better. Patient safety, the patient experience, or more revenue all are good bets. "If you come and say, 'I can save 10 FTEs by doing this,' it will go higher on the list," Neikirk says.

IT is not going to go out of its way to educate revenue cycle areas on all the exciting new developments coming soon. Revenue cycle leaders can learn by attending vendor-sponsored user groups. "If you look at the list of presentations, it's not IT directors giving them, it's registration directors," Neikirk observes. Participating in these kinds of events can answer loads of questions: What kind of results can the revenue cycle achieve? What is coming next? This kind of insider knowledge, combined with some patience, goes a long way. "We can then have a better conversation with our IT counterparts," Neikirk says. ■

ED Registration No Longer a Stepping Stone; Staff Feel Valued

Several years ago, turnover of ED registrars was almost 50% at Lakeland (FL) Regional Health. Morale was at an all-time low, both for registration staff and their supervisors.

"Lots of staff were very disgruntled. They didn't understand why some things were being imposed on them," says ED Registration Manager **Nancy Jessee**.

To push back against plummeting retention rates, the department made some simple but important changes. "There are not lots of dollars to bolster the department. It's been small things that don't take any money at all, or very little money," says **Jason Driskell**, associate vice president of revenue cycle.

First, Jessee invited registrars to tell her what they wanted fixed. She held multiple meetings to give all shifts the chance to be heard. Many really wanted to know the "why" behind various tasks. They did not realize some things had to be completed because of federal regulations, or because putting information in a certain format means the claim is paid. "It's not just 'Do this because I said so,'" Jessee says.

More than anything else, registrars wanted accountability for the entire department.

"They wanted the same standards for everyone, regardless of their shift," Jessee says.

It was obvious that the team of about 70 ED registrars felt overworked and undervalued. QA revealed there also were problems with registration accuracy. For the ED, accuracy rates were only at about 83%.

Patient access leaders could not offer more compensation, other than the standard cost of living pay increases given to all hospital employees. They also did not lighten the workload; in fact, they did the opposite. "We asked them to do more," Driskell says.

Jessee set out to make ED registration fun — or at least as enjoyable as humanly possible. Here are some ways she does it:

• Before every shift, staff enjoy some pleasant conversation, jokes, or small talk during staff huddles. "Instead of dreading going on to the floor, they now have started their day off with a smile," Jessee says.

Supervisors always ask team members to thank one of their colleagues. "This builds camaraderie and support," Jessee observes.

The huddles also serve a practical purpose. Jessee may comment, "Collections were awful yesterday. What happened?" This gives staff a chance to explain why. Sometimes, she notices an employee appears ill. If so, she takes the opportunity to assess whether they should go home or report to employee health.

• Team members asked for, and received, a standard uniform of a colored polo shirt and black slacks.

• Small rewards are doled out occasionally. Recently, there was a sudden surge of patients in the ED due to an accident involving a busload of disabled students. "The registration team did a great job getting the patients registered in a timely manner," Jessee recalls.

Many played with the children during the troubling time. All registrars who worked that day earned a gold coin (these are worth $5 toward lunch in the cafeteria or an extra 15 minutes for lunch breaks).

• Scavenger hunts send employees to various hospital areas to pick up clues, with a prize at each station. At the end of a recent hunt, the last prize was a card with personal comments signed by all the supervisors and director. "Staff seemed to appreciate that the most," Jessee says.

• Staff have come to expect birthday cards. If staff are out sick for

more than a day or two, they receive a card. If they tell Jessee about an upcoming hospital stay, she visits that employee.

• **Supervisors ask staff to work in group community service projects.** Some recent initiatives include collecting items for people displaced by Hurricane Dorian in the Bahamas, a vocational training program, and adopting a family for the holidays. "We have team members who are willing to volunteer and take the lead on these initiatives," Jessee notes.

• **Supervisors go around the department and ask each registrar, "How are you today?"** Sometimes, they do not even need to ask; they can clearly see a registrar is overwhelmed. If so, the supervisor grabs a registration cart and goes right to work.

Sometimes, it takes only 15 minutes to catch up. Other times, it takes two hours or longer, but the supervisor stays until things are manageable. "The fact that they are willing to help out when we are slammed has really helped morale," Jessee says.

Today, staff brighten at the sight of supervisors since they view them as people who offer help. "They no longer see leaders as people who are just going around looking for what's wrong," Driskell observes.

With more than 200,000 visits per year, Lakeland Regional is the busiest single-site ED in the country. "The goal is to get people in and out in three hours, from the time they hit the 'Quick Reg,'" Jessee explains.

Collections used to be minimal, about $30,000 a month. Now, collections average $70,000 a month, with a high of $100,000. Staff were reluctant to ask patients for money, so they rarely did. Previously, new registrars felt ill-prepared. Now, a preceptor works alongside them for a few days or even weeks. They are not left alone until they are fully competent. "When the preceptor believes they are ready to fly on their own, the supervisor monitors that the quality is really as we expect it to be," Driskell notes.

ED registrars are held accountable for high-quality work. Some left the department; the ones who did not like the accountability. "If you don't hold people accountable, the hardest workers will still work hard. But they will leave," Jessee cautions.

Flexible schedules are offered whenever possible. Some employees want to change from working eight-hour shifts five days a week to working 12-hour shifts three days a week. Certain college students want to work only weekends. Other staff want to try working in different registration areas or even billing. Jessee not only encourages them, she introduces them to her counterparts in those areas so they can try it.

All team leads and supervisors encourage staff to call them anytime with any questions. If frontline staff ask for a promotion, Jessee hands over the phone for a day to see how they like serving as leaders. Some love the faster pace and the chance to be a leader. One registrar admitted, "This is not for me after all."

"It's a litmus test right there as to whether they can handle it," Jessee notes.

Better morale is mirrored in higher departmental metrics. For almost a year, accuracy rates have been at 99%. "What that means is that what we are saying people have as insurance, we've gotten it right," Driskell explains. Employee engagement scores for ED registration rose from 3.09 (on a 5-point scale) in 2017 to 3.98.

For many years, the ED was seen as just a stepping stone to another job, but that is not true today. "Staff are no longer always seeking to leave the department," Driskell reports. "We have people in other departments who are wanting to come to the ED." ■

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