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INSIDE

AHC Media

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Cyberattack would be a disaster of 'epic proportions' for access

Most downtime protocols don't address long-term events

Your patient access department probably can cope with unscheduled downtime for a few hours due to system updates or weather events. But what if a cyberattack forces registrars to revert to paper processes for days?

"A cyberattack has the potential to be a disaster of monumental proportions — one that will impact healthcare delivery at every level," says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Healthcare in Atlanta.

A February 2016 cyberattack left Hollywood Presbyterian Medical Center in Los Angeles unable to access medical records for 10 days, until the hospital paid a $17,000 ransom in bitcoin to hackers. The FBI is investigating the attack, which forced patient access employees to switch to paper processes for registration.

When contacted by *Hospital Access Management* for this story, a hospital spokesperson declined to comment. In an official statement, the hospital's president and CEO said, "The quickest and most efficient way to restore our systems and administrative functions was to pay the ransom and obtain the decryption key. In the best interest of restoring normal operations, we did this."

"WE SHOULD BE PREPARED FOR UNSCHEDULED DOWNTIME AT ALL TIMES, WHETHER IT IS A CYBERATTACK, WEATHER INCIDENT, NATURAL DISASTER, OR TERRORIST INCIDENT." — STACY CALVARUSO, CHAM, LCMC HEALTH

Ransomware attacks against hospitals are on the rise, says **Mac McMillan**, co-founder and CEO of CynergisTek, an Austin, TX-based information security and privacy consulting firm. "In the last six months, at least half a dozen hospitals we work with have been the victims of a ransomware attack," he reports.

Cyberattacks against doctors and

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hospitals have more than doubled in the past five years, with the average data breach costing a hospital $2.1 million, according to a May 2015 study from the Ponemon Institute, a Traverse City, MI-based security research and consulting firm. *(The Fifth Annual Study on Privacy & Security of Healthcare Data is available at bit.ly/1nzomQG.)*

"The attacks highlight the lack of preparedness of some of our health systems to fight or defend against these more advanced threats," says McMillan.

Switch: Manual processes

Unscheduled downtime is never easy for patient access, regardless of the reason.

Stacy Calvaruso, CHAM, system director of patient access at LCMC Health in New Orleans, says, "We should be prepared for unscheduled downtime at all times, whether it is a cyberattack, weather incident, natural disaster, or terrorist incident."

Patient access employees suddenly find themselves faxing requests to and from payers and spending multiple hours manually processing frontline transactions. "Outside of the manual workflows, the registration process feeds many downstream systems," adds Calvaruso. This connection means slower-than-normal processing times by clinical areas. Internal systems such as bed placement, provider order entry, and medication dispensing are affected, as well as diagnostic services such as laboratory and radiology.

"Most providers and clinicians have spent years working in an EMR environment," notes Calvaruso. "They will find it difficult to transition back to a manual process in some instances."

Short-term events

Most downtime protocols in patient access are geared toward a short-term event of hours, not days.

Kraus says, "Addressing the ongoing impact of a prolonged, successful cyberattack should be an integral part of hospital disaster preparedness and training."

Joseph Ianelli, director of patient financial services at Massachusetts General Hospital in Boston, has never seen unscheduled downtime last longer than about five hours. Like many patient access leaders, he questioned just what the department would do if a ransomware attack left his staff unable to access data for days.

"We have never had to deal with somebody holding the data hostage for money," Ianelli says. "A lot is undefined." It's unclear how patient access would handle having to revert to manual processes for an

EXECUTIVE SUMMARY

Patient access leaders are revamping unscheduled downtime procedures in light of a recent cyberattack that left Hollywood Presbyterian Medical Center unable to access records for 10 days.

- During prolonged downtime, registrars will need an alternate way to access data.
- Most downtime protocols cover only short-term events.
- Duplicate medical records and inability to obtain authorizations electronically are two major concerns.

undetermined period of time.

"We could probably float by for a little bit with paper processes, but to get authorizations, we really do need access to the medical record," Ianelli says. "Anything extended would affect the clinical piece, which would be really problematic."

Ianelli sees the inability to provide requested clinical information to payers to obtain authorizations as one of the biggest roadblocks. "If we were going to be in a major downtime, the first step would be to reach out to the payers," he says. "Usually the payer liaison is able to be flexible in emergent situations."

Unscheduled downtime used to be common in patient access areas, but upgrades in technology have made these events very rare, says **Kim Rice**, director of patient access at Redding, CA-based Shasta Regional Medical Center. "We usually come across downtime during an IT implementation or an actual downtime due to a fiberoptic cable getting cut, for example," says Rice.

The department created pre-made registration paper packets. "My team uses a template that we follow to make our own labels during downtime," says Rice. "This provides pertinent information that the clinical team needs on all the paperwork."

Room for error grows significantly when staff is handwriting information, however. "Remind staff to take that extra moment to make sure they write down the correct information and keep organized with the account/medical record numbers," advises Rice.

Contingency plans

To be ready for a ransomware attack that locks users out of the EMR, patient access leaders should do these two things, recommends McMillan:

• Identify what data employees need to do their jobs.

• Have a plan to access the necessary data without going through the EMR or the Internet.

"If you need today's schedule or next week's, or information about the patient, does that data exist somewhere else, other than the system?" asks McMillan. Patient access should ask the question, "If we had to operate in a worst-case scenario, if we lose access to the EHR and the Internet, will registrars still have access to the information they need?" he says.

McMillan recommends that patient access leaders meet with health information systems to determine exactly what they would do if a ransomware attack occurs. "Too many organizations don't do that level of detailed contingency planning," says McMillan. If crucial data can't be accessed during a prolonged ransomware attack, hospitals will have no choice but to turn patients away, he warns.

Solutions include separate computers that are not connected to the network, are offline, or are connected to a different network, with a certain amount of data backed up at regular intervals. "It's not as current as what they normally have, but the data is no more than a day old," McMillan says. "If you are just missing the last few hours, that's still enough to operate. You can, at least, look at the schedule as it was last night."

Mary Lee DeCoster, vice president of consulting services at Phoenix-based Adreima, sees these as the primary issues for patient access:

• There is a possibility of duplicate medical records being created.

"Lacking access to the database, the registration specialist must rely on the patient's memory as to their history with the hospital," says DeCoster.

• Additional time and resources are required to process each step of the registration manually.

"The registration specialist will need to conduct a thorough interview versus the more efficient 'update' method," says DeCoster.

• All registration documents, including the Condition of Admissions, need to be printed and signed by the patient.

"Where a registration event which is supported by a fully functioning electronic health record system may take five to seven minutes, a full interview — capturing information and printing on paper —may take 10 to 12 minutes," notes DeCoster.

• Employees need to call payers to confirm eligibility and to verify insurance coverage, including effective dates.

"Management may wish to review the potential requirements for additional staff," says DeCoster.

• The face sheet has to be printed to paper, and distributed to the receiving clinical department, to be included in the paper health record.

"Existing downtime procedures should be reviewed to ensure they are complete and robust enough to cover special circumstances such as a cyberattack," emphasizes DeCoster. *(See related story in this issue on how patient access departments handled unscheduled downtime.)*

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Lessons learned from unscheduled downtime — Data inaccessible for up to 10 days

During Hurricane Katrina, all organizations in the area had "tremendous challenges" with registration, says **Stacy Calvaruso**, CHAM, system director of patient access for LCMC Health in New Orleans.

"That incident was treated like a war-zone process, that actually flipped the priorities from patient identification and registration and treatment, to clinical triage and categorization, followed by patient identification and registration," says Calvaruso, who worked for a different organization in the New Orleans area at the time.

The problems lasted for up to 10 days, depending on the location. "We were doing patient care in the parking garage, as we had thousands of patients coming in," says Calvaruso. During other weather events, the department has had outages for six to eight hours.

"We keep a downtime emergency kit for the registration areas available at all times. Everyone knows where it is," says Calvaruso. The kits are used by patient access whenever the system is unexpectedly down, whether due to a natural disaster with large numbers of casualties, a cyberattack, or other issues. These items are stored in a waterproof container:

- 50-75 downtime charts;
- 100 armbands for children and adults;
- waterproof permanent markers, so patients or their clothing can be marked for identification purposes if staff run out of downtime charts, or staff can write on posters that serve as bed boards;
- paper and pen;
- flashlights;
- two-way radios;
- flashlights and extra batteries;
- blank labels, to be used for patient clinical services;
- digital camera with large secure digital card and extra batteries, used to identify individuals who are dead on arrival during weather-related or other disasters;
- tape and scissors, to attach items for identification purposes to individuals who are dead on arrival;
- downtime chart log.

"We keep the log so that we have a centralized list of which downtime chart number was used, and so our centralized dispatcher can confirm or deny that we have that particular patient," says Calvaruso.

Access to backup data

Being able to access necessary data if the EMR is unavailable during unscheduled downtime is a necessity for patient access departments.

Phyllis A. Cleary, CHAM, director of patient access and eligibility services at The MetroHealth System in Cleveland, OH, meets regularly with the hospital's admissions/discharge/transfer information system team to discuss unscheduled downtown strategies.

"We reviewed Epic's downtime backup method and the reporting functionality to be utilized during scheduled and unscheduled downtime," says Cleary. Cleary worked with nursing leadership to ensure that reports, which are updated hourly, contained all pertinent information. This information includes patients identified with an isolation factor, diagnosis, attending provider, patient name, medical record number, gender, and date of admission.

"We have over 50 inpatient and 65 ambulatory PCs designated where the Epic reports can be printed during downtime," says Cleary. "The PCs have generic logons for ease of access."

MetroHealth System maintains generic medical record numbers and contact serial numbers in the emergency department, labor and delivery, and admitting to use during downtime. Recently, MetroHealth System had unscheduled downtime for about six hours.

"Our advisory alert system automatically sent text and email alert notices to key personnel," says Cleary. The patient access department took these steps:

- Staff members used their personal phones to alert their respective managers of the situation.
- Scheduled conference calls were used for regular updates by key clinical and operations personnel.
- When the system was brought

back up, patients were entered into Epic.

"Any duplicate medical record numbers were merged upon patient discharge," says Cleary.

SOURCE

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Did registrar warn patient about long ED wait time? It could violate EMTALA

"You are welcome to wait, but it may take the doctor several hours to get to you. We won't be nearly this busy in the morning!"

Such comments made by a well-meaning emergency department (ED) registrar could be interpreted as encouraging a patient to leave, in violation of the Emergency Medical Treatment and Labor Act (EMTALA).

"It is not uncommon for hospitals to be cited for failure to provide a medical screening examination and stabilizing treatment due to comments made by a registrar," says **Gina Greenwood**, JD, an attorney at Atlanta-based Baker Donelson.

These violations often come to light after a neighboring hospital files a complaint, after receiving a patient who presents due to a long wait time at the previous facility. "I have seen cases in which an individual presents to the hospital ED, then quickly decides to seek care elsewhere because a registration staff member or a security guard mentions the long wait time or otherwise steers a patient away from the hospital," says Greenwood.

She also has seen EMTALA violations alleged because registrars failed to log in patients. "Registration staff need to understand the gravity of the words that they use when communicating with patients," says Greenwood.

There are ways to communicate and inform patients of long wait times without steering patients away from the hospital, she emphasizes. "If the patient asks about the wait, staff can certainly respond, but should not in any way indicate to the patient that the hospital is too busy to care for the patient," says Greenwood.

Don't delay treatment

ED registrars should never collect a copay or deductible when the patient arrives, warns **Sue Dill Calloway**, RN, JD, president of Patient Safety and Healthcare Consulting and Education in Dublin, OH. Dill Calloway is also vice president of risk and patient safety at Auburn, CA-based Emergency Physicians Insurance Exchange Risk Retention Group.

"This can never be done before the medical screening is done and the patient is determined to be stable," advises Dill Calloway. Otherwise, the hospital is at risk for violating EMTALA.

The medical screening exam and/or stabilization treatment should never be delayed to inquire about payment status or the patient's insurance. "This does not mean that hospitals cannot follow reasonable registration processes," says Dill Calloway. She says registrars should follow these practices:

- Once the patient is triaged or brought to a treatment room, ED registrars can obtain basic information such as name, chief complaint, and primary care physician.
- Registrars can ask for an insurance card, demographic information, and who to contact in case of an emergency. "There can be no prior authorization from managed care," says Dill Calloway.
- Registrars can obtain authorization for payment and services only *after* the medical screening exam is done and the patient is stabilized.

EMTALA was intended to be an antidiscrimination statute, notes Greenwood, and it primarily was created to prevent emergency patients

EXECUTIVE SUMMARY

Warning patients about long wait times, or failing to log them in, are common registration practices, and both are potential violations of the Emergency Medical Treatment and Labor Act.

- Never collect a copay or deductible before the medical screening examination.
- Implement bedside registration when possible to avoid treatment delays.
- Do not attempt to collect payment, even if it would not delay treatment, until after the stabilizing treatment has been provided.

presenting to the ED from being refused care because the patients were indigent and/or uninsured. EMTALA has been expanded through the years.

"Of the numerous EMTALA violations that I have defended, ironically, the violations defended rarely have been related to the actual discrimination of patients because of inability to pay," says Greenwood.

However, to avoid even the appearance of doing something wrong related to the uninsured, hospital staff members often wait to obtain basic registration information or consent forms until after the patient has been stabilized. "In reality, EMTALA does not prohibit a hospital from maintaining normal registration and consent processes," says Greenwood. However, EMTALA guidance makes it clear that hospitals may not delay examination and/or treatment in order to ask about the individual's insurance or payment, she says. Greenwood recommends these steps:

• Use bedside registration when possible to avoid treatment delays.

• Don't try to collect payment, even if the collection would not delay treatment, until after the patient is medically screened and stabilized.

"The key is not to delay treatment due to anything related to money or insurance," Greenwood emphasizes. *(See related stories in this issue on EMTALA violations involving ED registration and on EMTALA-compliant registration processes.)*

SOURCES

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- **Gina Greenwood**, JD, Baker Donelson, Atlanta. Phone: (404) 909-0665. Email: ggreenwood@bakerdonelson.com. ■

ED registration practices led to EMTALA problems

Here are some practices in emergency department (ED) registration areas that **Gina Greenwood**, JD, an attorney at Atlanta-based Baker Donelson, has seen come up in alleged violations of the Emergency Medical Treatment and Labor Act (EMTALA):

• Inadequate EMTALA signs.

"There has been a resurgence of surveyor focus on inadequate EMTALA signage," reports Greenwood.

Hospitals are required to post an easy-to-understand sign specifying patients' EMTALA rights in a very visible location at any ED entrance, admitting area, waiting room, and treatment area. "As the years pass and/or as EDs are renovated, hospitals sometimes forget to replace the EMTALA mandatory signage," says Greenwood.

• Technical central log violations.

"These are also fairly common," says Greenwood.

Hospitals are required to maintain a central log on each individual who comes to the ED or presents on hospital property seeking emergency treatment.

"The central log must detail whether the individual refused treatment, was given or was refused treatment, was transferred without stabilization, was admitted and treated, was stabilized and transferred, or was discharged," says Greenwood.

• Registration staff failing to obtain appropriate documentation of patients who leave against medical advice or leave without being seen.

If an individual leaves the ED of his or her own free will, which means there was no coercion or suggestion by staff that the patient leave, and this action is appropriately documented, then the hospital is not in violation of EMTALA, says Greenwood.

"Refusal to consent to treatment generally is a competent, adult patient's right and is also a full defense to EMTALA," says Greenwood, *if* the hospital documents the following items:

• that it offered the person an exam and treatment;

• that it told the person about the risks and benefits of the exam and treatment;

• that it told the person about the risks of leaving;

• that the person voluntarily refused to consent.

"Commonly, patients will get tired of waiting and leave the hospital without telling registration staff," says Greenwood. In this case, staff members should document in the medical record that they attempted to locate the patient.

Monitor waiting rooms

To avoid the situation of not being able to find a patient, registration staff should carefully monitor waiting rooms, and clinical staff should reassess patients every 15 to 30 minutes to avoid patients leaving without being seen, Greenwood says.

"Communicate periodically with patients regarding changes in their condition and where they are in line to be seen, without steering patients away," she recommends. ■

Avoid EMTALA woes: Keep registration in the emergency department 'clear and simple'

To comply with the Emergency Medical Treatment and Labor Act, patient access leaders at Wall Township, NJ-based Meridian Health keep the emergency department (ED) registration process "clear and simple," says access services trainer **Donna J. Roettger**, CHAA.

These steps occur when a patient presents to the ED:

1. Registrars do a quick reg.

"This initial process only takes a few minutes from the time the patient comes in the door until they are triaged," says Roettger. During this encounter with the patient, registrars ask only for identification. Once the patient is entered into the system, an account number is created.

"That allows us to put the patient into the tracking system that we share with clinical," says Roettger. "This assists in the communication between access services and the triage nurse."

2. After the patient has been triaged, registrars collect the patient's demographic data and insurance information.

"During that time, we are able to electronically connect with most of the big insurance companies, whereby we send out a request for insurance information," says Roettger.

If the insurance company responds that the patient's policy is active, registrars find out the patient's co-pay or co-insurance. The insurance company sometimes responds that the patient's insurance is not valid.

"Either way, we do not speak to the patient about their insurance or any money owed," says Roettger. Instead, registrars make a note to return after the patient has been seen by the emergency physician. "No money or financial obligation conversation is to be initiated by the registrar until after the patient has seen the doctor," says Roettger.

3. Registrars return to discuss the patient's insurance coverage.

If the patient's coverage is invalid, registrars ask if he or she has other insurance.

"Sometimes it's just a matter of the patient having given us the wrong card," says Roettger.

If there is no other coverage, registers tell the patient that any services rendered during that visit will not be covered. "We are able to offer a discounted rate if the patient pays in full for their ED service," says Roettger.

If the patient's coverage is valid, registrars discuss co-pays and/or co-insurances that are due. "The registrars also need to keep an eye on patients who are being admitted. We don't want to collect the upfront discounted amount if the patient is being admitted," says Roettger.

Each of Meridian Health's EDs rewards top collectors in some way. One ED gives individual registrars a ticket for each collection, which is put into a monthly raffle drawing for a gift basket. "The more tickets a registrar gets, the more chances they have to win the basket," says Roettger.

Monthly collection totals for each ED are sent to all patient access supervisors, so each of them can see how his or her staff compares to others.

"We have a continuous dialogue with registrars regarding collections," says Roettger. Patient access managers give workshops on use of the electronic insurance communication program and collecting copays and co-insurances.

"We have found that just initiating the conversation with patients at the appropriate time produces results," says Roettger. Registrars find that many patients are willing and able to pay at the time of service. "They appreciate the ability to take care of their obligation on the spot, versus waiting for a bill," says Roettger.

SOURCE

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Registrars call police about patient's suspicious ID

Recently, a patient was arrested after clinic staff at Houston, TX-based Memorial Hermann Hospital called local law enforcement because she allegedly presented with a suspicious driver's license. The incident led to protests by immigration rights groups and triggered an investigation by the Department of Health & Human Services' Office for Civil Rights.

In a statement, the hospital said, "For quality and safety reasons, our staff requests and verifies proper identification to ensure appropriate treatment. The patient was unable to provide another valid form of identification and in an effort to verify the authenticity of the suspicious driver's license, the office then called the licensing bureau of the

EXECUTIVE SUMMARY

A patient who presented with a suspicious driver's license was arrested after Memorial Hermann Hospital's clinic staff called law enforcement, which led to protests by immigration rights groups and an investigation by the Department of Health & Human Services' Office for Civil Rights.

- Do nothing to impede treatment of emergency department patients.
- Inform the compliance department, to ensure that medical records do not get combined.
- Contact the billing department, so claims are put on hold.

Texas Department of Public Safety (DPS). DPS instructed our staff to contact local law enforcement to validate the driver's license number. This inquiry confirmed a false identification. Local law enforcement took this information and made the decision to arrest the patient."

All patient access areas need to be prepared for how to handle suspicious ID, emphasizes **Nancy Farrington**, CHAM, FHAM, Enterprise Master Patient Index administrator at Main Line Health in Wynnewood, PA.

"It is not fair to staff to be confronted with such a troubling situation for which they have not been given guidance," she says. Farrington recommends these approaches:

• If the patient is in the emergency department, staff members should not do anything to impede treatment.

"However, they should alert the care providers of their suspicion," says Farrington. If it's a different patient, then any medical history the hospital has for the patient on the ID might be incorrect for the patient being treated. "Additionally, sometimes based on clinical data, such as anomalies seen on images or implanted devices, care providers can determine if it is the same patient or not," she adds.

• Involve security or police only if patient access staff members are concerned about their physical safety.

"Doing that opens the provider to charges or accusations of HIPAA [Health Insurance Portability and Accountability Act] violations," says Farrington.

However, patients seeking medication, or needing treatment related to drugs and alcohol, sometimes present with false or stolen ID and become belligerent when questioned. "When that happens, involving security is important," says Farrington.

• Involve a social worker if possible.

"Typically, social workers are better trained than registration staff to de-escalate the situation, avoiding the need for police involvement," says Farrington.

Balancing act

Compliance with the Emergency Medical Treatment and Labor Act (EMTALA) is a concern whenever patients present with suspicious ID, says **Aimee Egesdal**, manager of patient access at Genesis Health System in Davenport, IA.

"We have to balance taking care of the patient medically prior to approaching the issue of possible false ID," she explains.

At Genesis Health System, the following steps occur:

1. Patient access staff members report the concern to the ED charge nurse.
2. The ED charge nurse contacts security staff and possibly outside authorities.
3. Patient access staff members inform the hospital's compliance department to ensure that medical records do not get combined.
4. Patient access leaders contact the billing department so claims are put on hold until the patient's identity is verified.

Often, the identification appears valid, but the patient stumbles when answering basic demographic questions.

"It is a fine line on when we can confront the patient," says Egesdal. "It takes registration, ED clinical staff, and security working very closely with each other."

Registrars can't always tell the difference between a patient who is confused due to a medical problem and a patient who is purposely giving incorrect information. "That is the main reason we escalate to the charge nurse," says Egesdal. "They can use their clinical expertise to make the call to security or chalk it up to confusion."

If the patient is seeking non-emergent care, the provider can choose to treat the patient or not, says Farrington.

"There is no national standard on how to respond," she explains.

If the provider is going to treat the patient, he or she should seek additional verifying information, such as recent utility bills or pay stubs with the patient's address. "It is important that the provider have a means of contacting the patient once they have left the facility," Farrington emphasizes. Providers might need to contact the patient about follow-up

care or to share test results.

"If the provider chooses to not treat the patient, they should offer a future appointment when the patient can present documentation to validate their identity and potentially make payment arrangements," says Farrington.

SOURCES

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Registrars connect patients in the ED to primary care physicians

Is your emergency department (ED) waiting room filled with patients who could be better served at a primary care physician's office? In May 2015, registrars at Inova Fairfax Hospital in Falls Church, VA, took on a new role of connecting some ED patients with primary care physicians.

"Our scheduling program is innovative and one of a kind," says **Rupande Malhotra**, CHAM, director of patient registration. "It was a huge undertaking."

Patient access leaders wanted to do their part to meet an organizationwide goal to reduce readmissions. "We noticed patients were coming in using the ED as their primary care," says Malhotra. While all discharge instructions provide recommendations about following up with a primary care physician, about one-third of patients don't have one.

Patient access leadership met with Inova Medical Group leaders to implement direct scheduling for some patients at the point of discharge from the ED. "We actually make the appointment for them," says Malhotra. Registrars tell patients that in the future, they can go directly to that primary care physician for non-acute needs, instead of the ED.

"We want to ensure that our patients are following up with a primary care physician who can review their overall wellness," says Malhotra. "This can reduce non-acute utilization of the ED."

Previously, ED clinicians often recommended that patients schedule an appointment with a primary care physician, but there was no way to tell if the patient followed through. "The patient may or may not do it themselves. By direct scheduling, it's a great service we are providing our patients," says Malhotra. "The impact is the reduction of emergency department utilization for non-urgent needs."

Better flow expected

Currently, ED registrars can schedule patients only if they don't already have a primary care physician and if the Inova Medical Group providers are in-network for their insurance.

"About 16 patients a day fall into this criteria," says Malhotra. Many are recently employed college graduates who have coverage for the first time.

"While it isn't a large population, it was a good starting point," says Malhotra. "Once we do take on other insurances, we can really start to hit the ground running." Malhotra expects to see increased patient satisfaction, improved patient flow in the ED, and decreased readmission rates.

After registration is completed, ED registrars take these steps:

• They provide patients with a referral sheet of primary care physicians and ask them, "Would you like to choose a primary care physician for your future healthcare needs?"

If the patient doesn't know anyone on the list, registrars provide biographies of physicians based on the patient's preferred location. "We are able to show the patients the physician's credentials, languages spoken, and education," says Malhotra.

• They offer to make an appointment for the patient. About 10% will schedule the appointment

EXECUTIVE SUMMARY

Emergency department (ED) registrars at Inova Fairfax Hospital connect patients with primary care physicians and schedule appointments at the point of discharge. Once the program is expanded to all 11 Inova EDs, an additional $6.8 million in revenue is expected.

- Patients often don't realize their copay is higher in the ED setting.
- Registrars use scripting to explain that they are trying to improve the patient's access to care.
- Because scheduling is done within Epic, registrars don't need to switch back and forth between systems.

before they leave the ED.

"The Inova Medical Group schedulers have noticed an increase in calls into their call centers to make an appointment," reports Malhotra, adding that this increase could be because of the education and referral patients received from registrars. "We are working on quantifying the percentages of those patients who do call back to schedule their appointment," says Malhotra.

Mixed reactions

Patients didn't always react positively to the offer of having an appointment scheduled for them in the ED.

"Many of them asked us, 'Is this part of a cutback?'" says Malhotra. Others wanted to know if registrars were getting some type of incentive to make the appointments.

To address this issue, patient access trainers held skill labs to educate staff. "We talked about some objections patients may give and how to address them," says Malhotra. Scripting was changed to explain to patients that registrars were trying to provide them with better access to healthcare. *[The scripting used by the department is included with the online issue. For assistance accessing your online subscription, contact customer service at customer.service@AHCMedia.com or (800) 688-2421.]*

Unexpected lower out-of-pocket costs are a strong incentive for some patients. **Tammy King**, CHAM, senior manager of ED patient registration, says, "We explain to them that they would have a much lower copay at the primary care physician's office than the ED."

Staff buy-in obtained

At first, registrars were reluctant to take on the new role.

"Registrars were saying, 'it's not part of our job description,'" says King.

Staff members learned that since direct scheduling is done using Epic's Cadence application, they didn't have to switch back and forth to a different system. "When they realized it was pretty much just clicking a button, because there was already an account created in Epic for the ED visit, they were more receptive," says King.

Malhotra says, "Staff didn't understand the big picture of why we were doing this." Trainers explained that the registrars' role included getting patients better access to care and helping the growth of the organization.

King says, "We told them how positive a return on investment could occur with this. You are looking at only one or two patients per shift."

Hospital leaders are planning to expand the program to all of Inova's 11 EDs. Malhotra says, "With the assumption of 12% eligibility and a 75% discharge rate, there is a potential to enroll 84 new patients daily. The annual revenue that our Inova Medical Group could yield would be greater than $6.8 million."

Managers give the registrar who enrolls the most patients a certificate incorporating the Inova Medical Group's acronym, titled, "Amaz-ING Scheduler of the Week." *[The certificate is included with the online issue.]*

"The number of appointments scheduled by each registrar is posted in their work area, which is visible to all to see," says Malhotra.

SOURCES

- Tammy King, CHAM, Senior Manager, Emergency Department Patient Registration, Inova Fairfax Hospital, Falls Church, VA. Email: tammy.king@inova.org.
- Rupande Malhotra, CHAM, Director, Patient Registration, Inova Fairfax Hospital Medical Campus/Inova Emergency Care Center of Fairfax and Reston, Falls Church, VA. Email: Rupande.Malhotra@inova.org. ■

Career ladder convinced 35 employees to stay in patient access roles

Emergency department registrars were given new positions handling medical necessity appeals and insurance verification. A surgery center registrar is now an insurance specialist. An ambulatory surgery registrar is now a financial counselor.

All of these employees were actively interviewing for other positions at Macon, GA-based Navicent Health. In some cases, they'd even accepted another position. All decided to stay when given new roles in patient access.

"Over the past year, we have internally placed over 35 employees to different positions," says **Kim Whitley**, RN, CHAM, director of patient access and intake services.

A career ladder stopped the flow of patient access employees to the central business office or other hospital departments, says Whitley. Some wanted to leave because they resented being paid the same amount as peers with lesser skill sets.

"When I first became director,

everyone was equal. We knew that equal pay for varying skill levels was an employee dissatisfier," says Whitley.

At first, the department offered increased pay to employees who passed the Georgia chapter of the Healthcare Financial Management Association's Certified Patient Account Representative certification. *(For more information, you can go to http://bit.ly/1p0804L.)* "This addressed some concerns, but there were varying levels in skill and responsibility, recreating disparity and dissatisfaction," says Whitley. When Whitley did exit interviews with employees leaving the department for other areas, they often said unequal pay was their reason for leaving. Patient access leaders decided to implement a career ladder, and they took these steps:

- They evaluated each component of each patient access position, including knowledge of registration, scheduling in ancillary areas, scheduling in clinical areas, insurance, contracts, authorization requirements, governmental payer requirements, and charity assessment.
- They determined the skill level necessary for each task and they created levels of positions, ranging from patient access services I to IV.
- They created team lead positions in each area, which allowed staff members to begin to grow.

"Team leads keep the team on track," says Whitley. The role includes quality monitoring, management of patient flow, staffing, and scheduling.

- They created an insurance specialist role for complex inpatient and outpatient authorizations.

"Not all staff want to be leaders," notes Whitley. "Having non-leader positions created a growth track for their particular goals."

EXECUTIVE SUMMARY

Turnover in patient access areas decreased from 30% to less than 10% at Texas Health Resources after a career ladder was implemented. At Navicent Health, where a career ladder convinced 35 employees to stay in patient access, the department leaders made these changes:

- They worked with Human Resources to give pay increases to employees with higher skill sets.
- They created team lead positions for each registration area.
- They created an insurance specialist role for complex inpatient and outpatient authorizations.

Here are some challenges when Navicent Health's patient access career ladder was implemented:

- **Some employees thought the new tasks included in the career ladder put them outside their comfort zone.**

"We do not see this often, as many of our staff members are goal-driven and want to learn outside the duties of their roles," adds Whitley.

- **The career ladder needs constant updating.**

"As the industry changes, an IT system may become more sophisticated, creating new skills or reducing the skill level needed for various tasks," says Whitley.

- **It is difficult to obtain appropriate salary increases.**

It's necessary for patient access to work with human resources on salary increases. "There needs to be enough difference in the pay structure from one level to another for the staff to view it as growth and a move up," says Whitley.

Since the career ladder was implemented, fewer staff members are leaving patient access. Many have moved to other positions within the department. "We are able to grow our staff to move up should a position become available," says Whitley.

Turnover less than 10%

Morale was "terrible" when **Alyssa Corallo**, CHAM, started as pre-access director at Arlington-based Texas Health Resources. Employee engagement and satisfaction scores in patient access were just 68% in 2009.

"Turnover was near the 30% range," recalls Corallo.

One reason for widespread dissatisfaction was that the department was newly centralized. "Most of the staff felt like they were forced to centralize, leaving the environments they loved and friends that they had worked with for years behind," says Corallo.

In response, all of the staff members were put into teams, each with different work flows and a different set of goals to obtain.

COMING IN FUTURE MONTHS

- Dramatically reduce duplicate medical records
- Educate clinicians on exactly what registrars do
- Offer patients a single check-in for multiple visits
- Weed out applicants who won't fit in your department

The floor plan also was changed. "Teams could sit by each other, and this created a fusion that worked," Corallo says.

It's challenging to find people who will fit into the call center environment and want to stay for the long run, says Corallo. One reason is that employees must work weeknights and weekends. "It is hard to keep and find staff that are willing to stay long term on this schedule," says Corallo.

Staff members are expected to meet quotas on a weekly basis, such as doing 200 pre-registrations per week. If staff members fall below this amount, they are held accountable by the department's corrective action policy.

"This creates some turnover," she says. "Not everyone can work in a high-intensity atmosphere and handle the pressure that comes with it."

By the end of 2010, employee engagement was up to 85% and turnover was down to 15%. In 2015, a career development program to train and develop patient access staff was created, with the goal of reducing turnover even more. "We accepted six employees into the yearlong program," says Corallo.

One employee was promoted to a team lead position, and two are members of wellness and morale committees. "I am proud to share that we currently have employee engagement scores of 91% and less than 10% turnover," Corallo says.

SOURCE

- **Kim Whitley,** RN, CHAM, Director, Patient Access and Intake Services, Navicent Health in Macon, GA. Email: Whitley.Kim@NavicentHealth.org. ■

Career ladder requires these patient access skill sets

Here are the skill sets required for each level of the career ladder at Navicent Health, based in Macon, GA:

- **PAS I:** Reception desk duties, basic scheduling and ancillary registration, and insurance health plan assignment and eligibility.
- **PAS II:** All of the above and scheduling, multiple modalities and physicians, registration, high-volume reception areas, cash collections, some pre-authorizations, and kiosk self-service registration areas.
- **PAS III:** All of the above and insurance benefit evaluation, authorization, complex procedural registration, case management support, and authorization communication.
- **PAS IV:** High-volume, high-responsibility areas with after-hours coverage such as urgent care and emergency department.
- **Insurance Specialist:** Expert knowledge of insurance health plans, contracts, eligibility and benefits, and price estimation; discussion with patients on patient liability, including payment arrangements. ■

HAM offers 2-question survey

We would like your input. All *Hospital Access Management* readers are invited to take a two-question survey about information you want covered in the newsletter. You can access the survey at svy.mk/1nzsEaI.

We appreciate your feedback. ■

HOSPITAL ACCESS MANAGEMENT™

Operating Unit	Process Name	Process Location	Created	Revised	Author
IFMC	ED Follow-up Appointment Scheduling for an IMG PCP	IFMC	9/4/15	9/10/15	Kayla Cole

Step	Process Step Details	Responsible	Critical Notes on Step
1	Check the patient's demographics in Epic	ED Registrar	
2	If there is no PCP listed in EPIC, ask the patient who their PCP is	ED Registrar	
3	If the patient does not have a PCP, check the patient's insurance	ED Registrar	
4	If it is commercial insurance, then schedule the patient for a follow-up Primary Care appointment: "I wanted to let you know that a follow-up Primary Care appointment is part of the care instructions for our patients. To make this easier on you, I would like to schedule a follow-up PCP appointment on your behalf. The benefit of doing it now is that you will be able to be seen in the next couple of business days rather than waiting until the physician has availability potentially over a week from today. This PCP appointment will have a smaller copay amount than an ED visit and the physician will be able to help you manage your care for preventative measures. Would you prefer a PCP that is closer to your home or work location?" <u>If patient wants further explanation:</u> "It is important that you schedule a primary care follow-up appointment because a physician needs to review your clinical information post-discharge and assess the progress of your medical concerns."	ED Registrar	Each eligible patient needs to be informed of the opportunity to schedule a follow-up today
5	Schedule an appointment based on the patient's date and time preference and physician availability	ED Registrar	
6	Provide an appointment card and tell the patient to call the number provided on the card if, after their discharge, they have additional appointment questions	ED Registrar	
7	List follow-up notes in the patient's record in Epic	ED Registrar	

8	Thank the patient for completing this process	ED Registrar	

Source: Inova Fairfax Medical Campus, Falls Church, VA.

AMAZ-IMG CERTIFICATE OF RECOGNITION

This certificate is awarded to

_____

IN RECOGNITION FOR YOUR ABILITY TO SCHEDULE THE MOST INOVA MEDICAL GROUP APPOINTMENTS
MARCH 2015

_____ _____
Manager Date

_____ _____
Director Date

Source: Inova Fairfax Medical Campus, Falls Church, VA.