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INSIDE

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AHC Media

Are clinicians rude to registrars? Morale, patient satisfaction at stake

Real-time interventions are needed to address issues

A registrar is finishing up entering an emergency department (ED) patient's demographic information. Suddenly, a clinician enters the room, closes out the registration screen without saying a word to the registrar, and begins talking to the patient as though the registrar isn't present.

When patient access staff members encounter situations such as this one at their hospital, they "have to find a way to exit the room professionally," says **Patty A. Johnson**, CHAM, manager of ED patient registration at Portland-based Maine Medical Center.

Most patients become uncomfortable if they sense tension between clinicians and registrars. Patient access leaders can point out this impact on patient satisfaction to hospital leaders. "Providing the patient's take on this is the best motivating factor," says Johnson.

"OFTEN, THE INTERRACTION IS RUDE, IN THAT THE PHYSICIAN TALKS OVER THE REGISTRATION COORDINATOR OR TELLS THEM TO LEAVE .... "
— MICHELLE H. CRUMBLEY, CHAM, CHILDREN'S HEALTHCARE OF ATLANTA AT EGLESTON

At Children's Healthcare of Atlanta at Egleston, a satisfaction survey completed by a patient included a comment about the disrespect shown to a registration coordinator by a doctor. Patient access manager **Michelle H. Crumbley**, CHAM, says, "She didn't feel our staff respected each other or worked well together, and it gave a poor first impression. This comment was shared with clinical leadership."

Quick resolution

Johnson makes a point of addressing incidents right away by phone or in person with the chief medical officer. "That seems to have a better outcome than waiting until the end of the day or sending an email that may not get addressed until two weeks later," she says.

For Maine Medical Center's

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ED registrars, disrespect is not commonplace. Johnson credits this atmosphere to resolving problems right when they occur. "We have a new plan of attack on this, and it is working!" she says. When an ED registrar reports an incident, these steps occur:

- Registration leadership immediately contacts the department head or his counterpart.
- The department head addresses the situation with the provider.
- The department head then follows up with Johnson or the registrar.

"We have seen a big decrease in this type of interaction," reports Johnson. "I have not had a reported incident for several months."

After one incident, Johnson had the registrar page the chief of the department to explain what happened. The registrar also reported that the patient had commented that the provider was rude. "He thanked her, came within 30 minutes to see me, and followed up with the provider," says Johnson. "The rep's shift had ended, so I sent her an email updating her." In another similar case, the provider apologized to the registrar personally.

When the registrar goes back to complete the registration, he or she doesn't complain about the provider's rudeness. Instead, he or she says something to alleviate the patient's concern, such as, "Our providers are very good at what they do, and their focus point is always on the patient. At times, that is all they see."

"They try to keep it light," says Johnson. "It all goes back to the patient experience — how the patient views our whole team here."

Friction between clinicians and registrars most often occurs in the two locations where bedside registration is done at Children's Healthcare of Atlanta: the ED and Day Surgery. Crumbley says, "Often, the interaction is rude, in that the physician talks over the registration coordinator or tells them to leave in the middle of a registration."

Registrars notify a team lead or supervisor immediately of these unpleasant incidents. Crumbley immediately speaks to everyone involved. "If the family registers a complaint, the physician is written up for a peer review," she says.

Better communication

There are always two sides to every story.

"Sometimes abnormal test results or clinical deterioration of an ED patient results in the physician quickly going into the room to resolve it, not intending to be rude," says Crumbley.

In some cases, a department head is the one who is involved. In one such instance, Crumbley met with a hospital leader to thoroughly explain the role of patient access. "After I shared with him how much money

EXECUTIVE SUMMARY

Clinicians are occasionally rude to registrars, in part because they don't understand the importance of their role. This behavior negatively affects morale and patient satisfaction, according to patient access leaders.

- Speak to involved clinicians immediately.
- Share negative patient feedback with clinical leadership.
- Explain the role of patient access to the entire clinical team.

we collected onsite and how what we do impacts how everyone is paid, he was more respectful," says Crumbley.

The department head asked Crumbley to speak about the role of patient access to a team of nurse managers and physician leaders. In turn, they conveyed the information to staff-level nurses and attending physicians. Crumbley explained patient access processes and what was expected of registrars, including point-of-service collection goals.

"Since then, things have gotten much better," says Crumbley. "There is a lot more respect for patient access." Registrars now take these steps at the start of each shift:

• They introduce themselves to the doctors and nurses assigned to their unit within the ED.

• They provide their phone numbers so the registrar can be contacted immediately if any issues come up.

• They ask the clinical team, "How can we best work together today?"

Competing priorities

It's often difficult for registrars just to get in the room with the patient. **Jamie Bruner**, manager of registration services at Cape Coral (FL) Hospital, says, "They are competing with healthcare providers for the patient's attention." When a registrar is abruptly interrupted, it's usually because a clinician is trying to examine or treat the patient.

"There will be times when a registrar can respond to these interruptions in a way that allows them to continue. It lets the clinician know that they can take over as soon as the registration is done," says Bruner. Other times, the registrar sees the urgency of the situation and quickly steps aside.

"In our high-stress environment, it is best for the registrar to be kind but assertive when asking for more time to complete their function," says Bruner.

First, registrars acknowledge that the clinical team has important things to do with the patient. A registrar might say, for example, "I know you really need to get in here. But if you could just give me a few more minutes, I won't have to come back. Thank you."

"This lets the clinician know that you know what they need to do is important, and once you're done, there will be no more interruptions from you," says Bruner. Here are other ways she's educated clinicians about patient access:

• She looks for "teachable moments."

Recently, an ED technician interrupted a registrar who was in the middle of completing financial assistance forms with a patient.

"The technician later expressed the uncomfortableness they felt overhearing the discussion with the patient about their household income," says Bruner. A patient access leader asked to give a presentation at an upcoming clinical staff meeting. "We were able to educate the entire clinical team on our process and why the questions we ask are so important," says Bruner.

• She displays a bulletin board in the clinical break room, with patient access collection goals posted.

"Our health system's financial outlook is always at the forefront of the system's leadership meetings," Bruner notes. "This helps the clinical teams understand how important our efforts are."

• She calculates the amount of revenue lost if patients are discharged before registration is completed.

"When we present the missed opportunities with a dollar figure attached to our clinical team, they better understand the significance of their actions," says Bruner.

SOURCES

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- Michelle H. Crumbley, CHAM, Manager, Patient Access, Children's Healthcare of Atlanta at Egleston. Phone: (404) 785-7742. Email: Michelle.Crumbley@choa.org.
- Patty A. Johnson, CHAM, Manager, Emergency Department Patient Registration, Maine Medical Center, Portland. Phone: (207) 662-2102. Email: johnsp@mmc.org. ■

ED registration time cut from 30 minutes to 15

To get process completed quickly, timing is everything

Emergency department (ED) registrars cut average registration times from 30 minutes to 15 minutes at Irvine, CA-based St. Joseph Health. In addition, the admission financial clearance process is completed, on average, in just 15 minutes. Assuming an inpatient bed is available, "this advances the patient's transfer to the floor," says **Stefani Moore**, regional manager of patient access.

The most difficult part of bedside registration was not having a "registration-friendly patient tracker," says Moore.

ED registrars had no way of knowing whether the medical screening evaluation had been completed so they could go in to complete registration.

"A delay in completing the financial process in a timely manner increases the length of a patient's visit by delaying the discharge and/or admission process," says Moore. It also results in patient and physician dissatisfaction. "Insurance information is needed by the provider to facilitate the patient's care plan," she explains.

Moore worked with the hospital's IT department to develop a new ED patient tracking system. "We created 'status event' indicators to notify the registrar when the medical screening exam was complete, when the patient is up for an admission, and when the patient is marked for discharge," says Moore.

This system allows registrars to work closely with clinical staff to complete the registration process more quickly. "The registrar has an indicator on the tracker as well, for all staff to view," says Moore. "This shows that the registration has been completed."

Here are other changes made by St. Joseph Health's patient access department to improve bedside registration:

• Registrars use mobile computer carts with a mounted scanner and signature tablet, for a completely paperless process.

• The department implemented several applications to assist in registration quality assurance, point-of-service collections, and insurance verification.

"We've been able to reduce the length of patient time in the emergency department significantly, whether the patient is discharged home or admitted into the facility," reports Moore.

This system helps to decrease the number of patients who leave the ED without being seen, before they're asked to provide financial information. "This improved revenue and claims reimbursements," says Moore. ED point-of-service collections increased 67% over the previous year, she adds.

• Registrars are assigned specific zones or areas of responsibility, but they also work as a team.

If patient volume suddenly spikes, registrars in other areas assist their colleagues.

> "WE'VE BEEN ABLE TO REDUCE THE LENGTH OF PATIENT TIME IN THE EMERGENCY DEPARTMENT SIGNIFICANTLY ..."

"If patients need to be quickly registered for discharge, or registrars are falling behind due to high volume, an 'all-hands-on-deck' process expedites the registrations," says Moore.

Help clinicians

St. Joseph's ED registrars use portable phones for easy communication with each other and all clinical staff. Clinicians contact the registrar for these reasons:

— if they need a patient quickly registered and admitted;

— if they need a patient transfer facilitated to another facility because the patient's insurance coverage is out-of-network;

— if a patient needs a quick registration in emergent situations.

ED registrars at Glenwood Springs, CO-based Valley View Hospital have a very good relationship with clinicians, which helps them to complete bedside registration. "However, it was not always this way," says patient access manager **Laura King**.

To improve rapport with the clinical team, ED registrars found ways to help them, such as assisting with moving patients upstairs or taking care of family members during critical events.

"We sometimes babysit children when necessary," says King. "We have taken care of dogs that have been left in the car that patients worry about." Patient access also orders food, calls for transportation, and makes hotel reservations for family members, if necessary.

"These are things that ED staff appreciate because we are contributing to the patient experience," says King. To help registrars to do their jobs, ED physicians now wear locators. "Registration staff knows when a physician is in the room with a patient, so they do not interrupt," says King.

The department continuously evaluates process improvement to achieve better patient flow in the ED. "We want to eliminate as much rework as possible for the registrar and reduce turnaround time for the patient," King emphasizes.

SOURCES

- Laura King, Access Manager, Valley View Hospital, Glenwood Springs, CO. Phone: (970) 384-6854. Email: Laura.King@vvh.org.
- Stefani Moore, Regional Manager, Patient Access, St. Joseph Health, Irvine, CA. Phone: (949) 381-4685. Email: Stefani.Moore@stjoe.org. ■

Is applicant a good fit for the department? Ask his or her future colleagues

Peers get more honest responses from those applying for employment

An employee satisfaction survey revealed that some patient access employees at Orlando-based Arnold Palmer Medical Center thought that their skills were not a good match for their position.

"That made us question and review our on-boarding process," says patient access manager **Mary Ellen Daley**, MHA, CHAM, CRCR. Daley met with her leadership team and decided to involve front-line team members in the interviewing process. "The next step was to involve HR. They provided a class on how to interview," she says.

Several patient access employees volunteered to serve on the newly created Peer Panel. This participation met the department's Career Ladder requirement for team members to serve on a committee. "But most just liked the idea of participating and having the chance to help select their teammates," says Daley. Team members all have worked at least six months in the department, are currently meeting departmental goals, and have no formal counseling on file. Here is how the process works:

1. Human Resources (HR) sends patient access a list of applicants.
2. Patient access supervisors review the list and forward selected applicants to the Peer Panel.
3. The Peer Panel contacts the applicants and schedules appointments for interviews.
4. The Peer Panel conducts the first round of interviews. "The panel uses an interview template with behavioral-based questions that they created with the help of HR," says Daley. *[The template used by the department is included with the online issue. For assistance with your online subscription, contact customer service at customer.service@AHCMedia.com or (800) 688-2421.]*
5. The Peer Panel sends up to three finalists to a patient access supervisor or manager for the final interview and selection.

If applicants lack flexibility in work scheduling, peer interviewers quickly pick up on this fact. "They also pay attention to an applicant's comfort level with seeing patients in ED rooms and collecting financial responsibility," says Daley.

Applicants get to know the people that they'll be working with. "Those hired through the process have said it gave them a very clear picture of what to expect on the job," says Daley.

Less guarded answers

Some patient access employees at Wilmington, DE-based Nemours Alfred I. DuPont Hospital for Children have the opportunity to provide some honest feedback about applicants. **Pamela Perakis**, CRCR, CHAM, director of revenue cycle quality and development, says, "Including the team in the hiring process has proven to be very successful."

During formal interviews with patient access management, applicants typically offer well-rehearsed responses. These responses are not the case when they're speaking with peers. "On some occasions, the answers are opposite to what was shared during the interview with the manager," says Perakis. *(See related story in this issue on how to identify promising patient access applicants.)*

The employees conducting the interview care about who's hired, because they'll be working alongside that person. "So they generally base their questions on topics that have the greatest impact on the cohesiveness of the team," says Perakis.

The team meets to prepare a list of questions, which are reviewed and approved by a patient access manager. Here are some questions they usually ask applicants:

- What does "going above and beyond" mean to you?
- What does teamwork look like to you?
- Tell me about the relationships

EXECUTIVE SUMMARY

Some patient access managers involve employees in the interviewing process, in order to have a better sense of whether an applicant will be a good fit for the department.

- Arnold Palmer Medical Center's Peer Panel conducts the first round of interviews.
- Human Resources helped the Peer Panel create a template of behavioral-based questions.
- Patient access applicants at Nemours Alfred I. DuPont Hospital for Children work alongside emergency department registrars.

you've had with coworkers. How would you describe the best ones? The worst?

• Based on what you know about this position, why do you feel you would be a good candidate? How would you contribute to our success?

• What would be your ideal work environment?

• Give an example of a difficult situation that you've encountered with a coworker and how you handled it.

"Once the interview is completed, each member of the team completes an interview evaluation form and submits that to the manager," says Perakis. *(To access more information on this topic, see "Identify problems with role before hiring,"* Hospital Access Management, *December 2012, at bit.ly/1ZZnrr4.)*

Applicants shadow staff

Applicants for patient access positions in the emergency department (ED) at Nemours Alfred I. DuPont Hospital for Children are asked to "shadow" employees in the department, after the selection is narrowed down to two or three candidates.

Lead patient access specialist **Jessica Brinn**, CHAA, finds that this is the time when applicants let their guard down. "They get to see what the position is really like, and we get to see a different side of them on a more personal level," she says. Employees get to see how the applicant reacts "in the moment" to different situations that come up in the often-chaotic ED setting.

Jessica Broomell, CHAA, a revenue cycle analyst in the hospital's quality department, participated in peer interviews when she worked as a lead patient access specialist in the ED. "Peer interviewing gave us the opportunity to see if the candidate was truly a good fit for our team," she says.

One candidate mentioned that she really enjoyed her current job because it allowed her to work independently and that she preferred to work alone. "This was a red flag for me, being that collaboration is such an important part of our department's success," recalls Broomell.

Perakis says that peer interviewing and shadowing "are beneficial to both the candidate and the employer. It gives them the opportunity to make informed decisions."

In some cases, applicants decide on their own that the ED registrar role isn't right for them. "The reason is usually due to the constant sense of urgency and long shifts," says Perakis.

SOURCES

- Mary Ellen Daley, MHA, CHAM, CRCR, Manager, Patient Access, Arnold Palmer Medical Center, Orlando. Email: Maryellen.daley@orlandohealth.com.
- Pamela Perakis, CRCR, CHAM, Director, Revenue Cycle Quality and Development, Nemours Alfred I. DuPont Hospital for Children, Wilmington, DE. Phone: (302) 651-5364. Email: Pamela.Perakis@nemours.org. ■

Look for these qualities in access applicants

Two recent patient access hires at Wilmington, DE-based Nemours Alfred I. DuPont Hospital for Children quickly advanced in the department, and both obtained certified healthcare access manager (CHAM) certification. At first glance, though, the applicants didn't appear to have the desired skill set.

"They had very little knowledge about patient access and were lacking healthcare experience in general," recalls **Pamela Perakis**, CRCR, CHAM, director of revenue cycle quality and development.

The applicants did have strong computer skills, however. Most of their background was related to face-to-face customer service experience in the demanding environments of retail and banking. "I have hired several people that I felt I was taking a chance on, because they didn't have the skill set I normally look for in a candidate," Perakis says.

Perakis is more likely to take a chance on candidates who lack a patient access background if they demonstrate honesty about the skills they're lacking, compassion for others, willingness to learn, and a desire to join the organization. "In many cases, this type of hire has resulted in some of my highest performers who are most recognized by patients and peers," says Perakis.

Perakis always asks applicants, "Can you tell me about a time that you made a mistake? How did you handle it?" The response gives a sense of an applicant's honesty, willingness to take ownership for mistakes, and ability to resolve issues. "Access responsibilities have significantly increased over the years," notes Perakis. "As more demands are placed on these employees, there is greater risk for error."

Some applicants are quick to supply an example of an error and how they went about reporting it, resolving it, and learning from it. "They would be considered for the role over a person that makes a

statement that they can't think of a time or they don't make mistakes," says Perakis.

One applicant recounted a time that she scheduled a patient for the wrong type of testing. The test that should have been scheduled required an authorization from the insurance company. "It was brought to her attention an hour before her shift ended, and the appointment was for the next day," says Perakis. The applicant called the patient and asked if he could come in later in the day, instead of in the morning when the original appointment was made.

This approach gave her time to contact the insurance company to obtain the authorization. She also explained the situation to the staff members at the primary care physician's office, and they agreed to help her expedite the request. "Once everything was resolved, she went and told her supervisor about the mistake and what she had done to correct it," says Perakis. ■

Want new hires to have a valuable resource? Give them an 'associate friend'

About 70% of patient access training at Jacksonville, FL-based Baptist Health now takes place on the job, instead of in a classroom.

"We have started a coaching network," says revenue cycle educator **Chad Voiselle**, CHAM. "This places some of our best and brightest team members with new employees, to teach them job skills."

This coaching network gives patient access employees a resource for any questions that come up as they do their jobs. "It gives them a work relationship that will most likely develop into a business friendship," says Voiselle.

By pairing new hires with coaches, says Voiselle, "We are better equipped to keep our employees and our organization current with best practices."

Coaches receive a small pay increase for taking on the role. "This small investment has already begun to pay off in the pride that team members take in their jobs," reports Voiselle. "It has led to higher collections and more 'clean' bills, generating fewer denials."

Better morale is another benefit. "The return on investment exceeds dollars alone. We have seen lower turnover in the team," Voiselle says. Using this system at Baptist Medical Center Nassau, in Fernandina Beach, FL, the patient access department reduced its turnover from 21% to 7%.

Voiselle says having an "associate friend" at work is very important to employees. "Employees who have this kind of connection tend to stay, since they feel work is a friendly environment," he explains.

More comfort with peers

At Children's of Alabama, two patient access educators are responsible for the initial and ongoing training needs of staff, but other employees also assist. *(See related story in this issue on how the department trains patient access employees.)*

Tara Tinsley Smith, CHAM, MBA, director of patient access systems, says, "New hires tend to be more comfortable with peers, and peers can provide 'real-life' training scenarios."

After all the required training is complete, new employees are paired with preceptors. All team leaders and supervisors serve as preceptors, but some experienced employees also have this role. "Just being an experienced employee does not qualify you as a good fit as a preceptor," notes Smith. "Managers were asked to identify staff members in their areas who demonstrate a desire and patience to train."

Once employees are approved by the patient access director, preceptor training is provided. "Preceptors assist in completing the Competency-Based Orientation Checklist and give input into the progress of the new hire," says Smith. [*The checklist used by the department is included with the online issue. For assistance with your online subscription, contact customer service at customer.service@AHCMedia.com or (800) 688-2421.]*

The department's 25 preceptors,

EXECUTIVE SUMMARY

Some patient access departments pair new hires with experienced colleagues to reduce turnover and improve morale. Baptist Health saw these results after implementing a "coaching network" program:

- Patient access staff members take more pride in their jobs.
- About 70% of training now occurs on the job.
- Turnover decreased from 21% to 7% at one hospital.

who cover about 200 employees, don't receive additional compensation for this role. "Informally, we provide 'kudos' to the preceptors and give recognition during evaluations," says Smith.

"Partner" is resource

After new patient access hires at Albany (NY) Medical Center complete system training, they're paired with a "learning partner" for their operational training.

"The learning partner uses a training manual to guide the new hire through all of the day-to-day functions of their position," says **Brenda Pascarella**, CHAM, associate director of patient access.

Learning partners usually are senior staff members, staff leads, or supervisors who are very familiar with day-to-day operations and department policies and procedures. "In addition, the learning partner is available as a resource for any questions the new hire may have once they've completed their training," says Pascarella.

New hires often need assistance remembering where to find policies, procedures, and training updates on the hospital's Intranet. "The learning partner is very instrumental in helping them locate resources when they have questions," says Pascarella.

The employee's role as a learning partner is acknowledged at their annual performance review.

"Those with applicable skill sets are often considered for department promotional opportunities," says Pascarella.

SOURCES

- **Brenda Pascarella**, CHAM, Associate Director, Patient Access, Albany (NY) Medical Center. Phone: (518) 262-4559. Email: PascarB@mail.amc.edu.
- **Tara Tinsley Smith**, CHAM, MBA, Director, Patient Access Systems, Children's of Alabama, Birmingham. Phone: (205) 638-7045. Email: Tara.Tinsley@childrensal.org. ■

Educators correct 'bad habits' during evaluations

New patient access hires are trained at Birmingham-based Children's of Alabama in the following ways:

• Patient access educators, along with IT educators, teach registration and scheduling classes.

"Every user must attend workflow training, taught by Patient Access Education, before getting access to the system," says **Tara Tinsley Smith**, CHAM, MBA, director of patient access systems.

This process includes training in the department's "COA [Children's of Alabama] Way."

"These are workflows that teach staff how to function within our systems in order to prevent downstream issues with other systems and ensure clean claims," says Smith.

• Six weeks after they're hired, employees are brought back for a re-evaluation with patient access educators.

"This is done to check their progress and to correct any bad habits that are developing," says Smith. Preceptors look for these bad habits:

— Employees fail to use the "4/2 rule" when performing patient look-up. "Registrars are trained to search for patients and guarantors using the first four letters of the last name and the first two letters of the first name," explains Smith.

— Employees put in too much information when searching for a patient. "In our system, less is better," Smith explains.

— Employees fail to enter or properly search for a guarantor.

— Employees fail to review the Financial Clearance prompts on Worklists, which tells employees the amount of the patient's copay. "They should use these prompts in conjunction with the encounter prep notes provided by our pre-registration team," says Smith.

• Patient access educators provide managers with an evaluation of the employee.

"Managers use this to target additional training and work toward correcting deficiencies," Smith points out. ■

Momentum is critical with point-of-service collections

In 2015, patient access leaders at Peoria, IL-based OSF Healthcare determined that $3 million in cash was going uncollected each year. At the time, patient access collected only copays and didn't ask for outstanding balances.

"We never audited or looked at numbers or trends. If somebody didn't collect anything for years, they weren't questioned," says patient access service manager **Jacqueline Doerman**. Even copays were collected inconsistently.

The department set out to revamp its point-of-service collection program by informing patients of their total out-of-pocket costs, including

previous balances, and setting patients up with a payment plan if needed. "We believed the opportunity was rather large and that it would be more efficient to collect on the front end versus going through the billing process," says Doerman.

Patient access staff began giving patients accurate estimates. "We had a lot of quick wins," recalls Doerman. "Our cash collections soared in the beginning."

However, collection totals soon leveled off. "We were getting feedback from some staff that they couldn't increase collections because there wasn't that much opportunity," says Doerman.

In response, managers audited the previous month's collections and compared what potentially could have been collected to actual collection totals. "We found that we were only collecting 2% to 5% of what the opportunity was," says Doerman. "That was eye-opening for staff! They saw how much opportunity was really out there."

Collections for Doerman's department, which consists of six outpatient registration sites, rose from $86,000 in 2014 to $283,000 in 2015. For the first five months of Fiscal Year 2016, $205,000 was collected. "We are keeping a watchful eye," says Doerman. "Every day, we tell staff how much they collected the day before."

Most patient access employees were closely following the scripting they'd been given. However, the way in which they were communicating the information needed improvement. "The delivery is what sets the tone and, ultimately, influences the patient's decision to pay or not," says Doerman.

If staff members seemed hesitant or gave patients the option to defer payment, patients often declined to pay. "Patients usually pay if asked directly, 'How would you like to take care of that today?'" says Doerman.

If employees aren't meeting collection goals, they're required to write an action plan for how they plan to improve. "That gives us an opportunity to sit down and coach them to help them be successful in the future," Doerman says.

Some action plans written by employees focused on the need to improve the way in which they used scripting for collections. Other employees admitted that they didn't really make collections a priority. "When they get busy, it goes by the wayside," says Doerman. "But that's when you have your biggest opportunity to collect."

Collection challenges

Point-of-service collection totals usually get a boost in the first part of the year. This increase is due to high-deductible plans that have a large amount of initial patient responsibility.

"But this will taper off as the year progresses, moving future amounts over to insurance payments," says **Jamon Rivera**, senior director of revenue operations at Yakima Valley Memorial Hospital in Yakima, WA.

Yakima Valley's patient access staff members manually calculate estimates for patient responsibility. "We are looking to move toward using software that assists with providing a more accurate, less labor-intensive estimate," says Rivera. This estimate is particularly important for specialty procedures that require a high out-of-pocket cost for patients.

"We have conducted system-wide training with staff on how to collect and provided specific scripting on how to ask for payment," adds Rivera.

Here are other changes Yakima Valley's patient access department made to sustain collection gains:

- Patient access managers created a reference tool for staff to use, which identifies patient responsibility for various payers. *(See story in this issue on meeting needs of patients and staff with point-of-service collections.)*
- Patient access systems were updated to automate insurance eligibility processing.
- Patient access employees are held accountable for meeting copay collection goals.
- Outpatient registration areas implemented registration pads with the ability to accept payments. "Collections are higher for the entities that use the pads," reports Rivera.
- Patient access managers review point-of-service collection totals at staff meetings.
- Patient access managers post point-of-service collection goals and current totals on large bulletin boards, so staff can track the department's progress.

EXECUTIVE SUMMARY

After a patient access department starts a point-of-service collections program, continued focus is needed to achieve sustained increases over time. Here is how departments keep up the momentum:

- Leaders inform employees if they're collecting only a small percentage of their opportunity.
- Employees complete action plans if they don't meet collection goals.
- Managers work with employees on how they deliver scripting.

• Patient access employees discuss patient responsibility when they pre-register patients. "This sets an expectation on the front end regarding payment," says Rivera.

SOURCES

- **Jacqueline Doerman**, Patient Access Services Manager, OSF Healthcare, Peoria, IL. Phone: (309) 683-6765. Email: Jacqueline.D.Doerman@osfhealthcare.org.
- **Jamon Rivera**, Senior Director of Revenue Operations, Yakima Valley Memorial Hospital, Yakima, WA. Email: jamonrivera@yvmh.org. ■

Patients, staff face challenges with POS collections

Step in to offer patients options if they can't afford out-of-pocket costs

Before patient access leaders at Peoria, IL-based OSF Healthcare implemented a new point-of-service collection initiative, patients were asked for their opinion.

"We went to our Patient Advisory Board to further understand what patients wanted," says patient access service manager **Jacqueline Doerman**.

Patient access leaders expected that the patients would be resistant to efforts to collect money upfront, but they received an unexpected response. "They wanted to be informed consumers. They didn't want to get surprised by a huge bill and all the frustration that comes along with it," says Doerman.

Most patients indicated that they wanted to know at the point of scheduling what they would owe. "Once that was confirmed for us, we set about coming up with additional options for patients, such as payment plans or other avenues," says Doerman.

Still, the change wasn't easy for patients or employees — or patient access managers. "It was challenging to manage the culture change the patients were facing, as well as the changes our employees were facing," says Doerman.

Many staff members simply were uncomfortable asking patients for money. "Most of it was just getting used to asking for it and finding their comfort zone. It's not an easy topic to discuss," Doerman says.

Patient access managers held training sessions for employees to give them the scripting and background of the project. Instead of just giving an amount to the patient, staff members are able to provide details about what the service was, the amount covered by insurance, and the patient's responsibility. "Some staff needed help reading the account correctly, and explaining *why* the patients owed the money," says Doerman.

Some employees worried that it would take too much time to set up payment plans during registration, which could cause the patients to be late to their scheduled appointments. Revenue cycle trainer **Mickey Stewart** says, "Some staff expressed to me that they just are not comfortable enough with the computer and the different programs to obtain the information to set up the payment plans for the patient."

During refresher training, Stewart reviews all components of cash collecting, including posting a copay, posting an estimate, posting a previous balance, and setting up a payment plan.

"This helps them understand where they need to go to look for the information to provide the patient with a payment plan," says Stewart.

Patient access can assist

In 2015, patient access leaders at Chesapeake Regional Healthcare in North Chesapeake, VA, updated the hospital's financial aid policy.

"The policy was revised to be more consistent and understood by the registration and billing teams," says **Melissa Viohl,** CRCR, director of patient access.

Patient access employees were trained in these three areas:

• Employees were trained to follow the new process for all patients, regardless of insurance status.

"This includes providing copies of the financial aid applications to any patient expressing concern," says Viohl.

• They were trained to understand the federal poverty guidelines.

• They were trained to use scripting for financial discussions.

When a patient is pre-registered, registered, or being provided with financial counseling, the goal is the same: financial clearance of the account. "This means there is a financial pathway determined for the patient, either through payment plans, charity, or review for Medicaid or Health Insurance Exchange eligibility," says Viohl.

Even after the new financial aid policy was implemented, there was still an unmet need for financial counseling in decentralized registration areas. "A project was initiated that moved financial aid processing from the back end to the front end, for *all* areas of the

organization," says Viohl.

Three financial counselors were added to the front end. "It was projected that the addition of these counselors will result in an after-salary ROI of approximately $200,000, in proper classification of bad debt versus charity for indigent populations," says Viohl.

The department also expects to see reduction in authorization denials and increased point-of-service collections for self-pay populations. "This project was implemented in the first quarter of 2016, with a high expectation for patient satisfaction," reports Viohl.

In 2016, Chesapeake Regional Healthcare will work toward becoming a certified application counselor organization, to assist patients in obtaining coverage through the Health Insurance Marketplace. "Many of our access staff will be certified to be application counselors," says Viohl.

SOURCES

- **Mickey Stewart**, Patient Access and Accounts Center, OSF Healthcare, Peoria, IL. Email: Mickey.J.Stewart@osfhealthcare.org.
- **Melissa Viohl**, CRCR, Director, Patient Access, Chesapeake Regional Healthcare, North Chesapeake, VA. Email: Melissa.Viohl@chesapeakeregional.com. ■

$6,000 saved by cross-training patient access staff

Patient access coordinator **Erica Escobar** recently justified the need for two new insurance verification positions at Chicago-based Norwegian American Hospital. She pointed to a recent change: The shift from Medicare and/or Medicaid insurance, to Medicare and/or Medicaid managed care organization (MCO) plans.

"Nearly all of the MCOs require some form of notification of a patient admission," Escobar says. Currently, 61% of the hospital's inpatient discharges are Medicare and/or Medicaid MCO plans, which is an 18% increase over the previous year.

The insurance verification positions require a minimum of six weeks of training. "This averages over $3,000 in labor per employee, not including the trainer," says Escobar.

Most newly hired insurance verifiers have never used the hospital's information system before and need extensive training on it. "They also need to learn our processes for every area within our department," says Escobar.

Instead of new hires, Escobar placed two cross-trained individuals in the positions. These employees already had extensive knowledge of all patient access areas. "This saved us over $6,000 in training hours," says Escobar.

SOURCE

- **Erica Escobar**, Patient Access Coordinator, Norwegian American Hospital, Chicago. Email: eescobar@nahospital.org. ■

Petition supports a renewed dialogue on voluntary patient safety identifier

The National Association for Healthcare Access Management (NAHAM) has called for support for the following petition, which, at press time, was pending with the White House.

The petition says: "Accurate patient identification is critical to providing safe care. We support a voluntary patient safety identifier and petition for the removal of the federal legislative ban that currently prohibits the U.S. Department of Health and Human Services from participating in efforts to find a patient identification solution. Sharing of electronic health information is being compromised because of patient identification issues. Let's start the conversation and find a solution."

NAHAM believes that congressional language that prevents the Department of Health and Human Services (HHS) from engaging in any work toward the use of a unique patient identifier is harmful to national efforts to improve patient identification and matching.

COMING IN FUTURE MONTHS

- Cutting-edge tools for patient ID in registration areas
- How access can get involved with patient safety initiatives
- Prepare access employees for switch to new EMR
- QA tools identify and fix registration errors in real time

The congressional opposition to a universal patient identification scheme should not prevent a public discourse, including research and analysis of the challenges that only will increase with the move toward electronic healthcare records and the expectations of interoperability among healthcare systems, NAHAM said in a released statement.

The petition is not calling on the adoption of a universal patient identification, nor does support of this petition equate to support for such a scheme, it said. In fact, the petition seeks to spur interest and dialogue in a voluntary scheme, but importantly a scheme that will include a unique patient identification, NAHAM said.

Reinterpreting the congressional language that bans HHS from implementing a universal patient identification so that a robust public policy discussion can take place is long overdue, NAHAM said. "Certainly our nation's lead federal healthcare agency should be an active participant in the inquiry into the possibility that such an identifier could reduce patient safety risks associated with identity integrity," the statement said.

NAHAM's support of the petition is consistent with its *Public Policy Statement: Patient Identity Integrity (October 2015)*, in which it says "Patient Identity Integrity requires additional standardized data attributes in the absence of the universally adopted unique patient identifier." NAHAM also said its support is consistent with its current work on developing standards for best practices in the collection of patient "data attributes" as identified by the Office of the National Coordinator's 2014 report, *Patient Identification and Matching Final Report*. NAHAM said that all of these resources must be in play to prepare for increasing challenges in patient identification.

The petition was launched by the American Health Information Management Association (AHIMA).

"As a patient, you know there's only one you. But sometimes a name or some personal information is so similar to someone else's that doctors' offices or hospitals can have a hard time identifying records correctly," said AHIMA CEO **Lynne Thomas Gordon**, MBA, RHIA, CAE, FACHE, FAHIMA. "It's a dangerous and costly problem that can lead to missed diagnoses, inappropriate treatments or unnecessary tests, as well as making it difficult for providers to exchange health information."

AHIMA says that a possible solution is a voluntary patient safety identifier that could allow patients to create a way for medical systems to recognize them quickly and accurately. An identifier will help ensure all of each patient's health information is kept together and is complete, while remaining under the patient's control.

The petition was posted on the Obama Administration's We the People website. At press time, it was scheduled to be open through April 19, and it would require 100,000 online signatures before it will be considered. To access the petition online, go to 1.usa.gov/1XEXmvu. ■

Reader Survey has 2 options

This year, we are offering you the option of taking the *2016 Reader Survey* in print, enclosed in this issue, or online, at the following link: http://svy.mk/1S0eSJi.

Your responses will guide future issues of *Hospital Access Management.* We look forward to receiving your feedback on how to make *HAM* as useful as possible. ■

HOSPITAL ACCESS MANAGEMENT™

FOR MORE THAN 30 YEARS

HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Don't forget that small HIPAA violations can cause big problems for hospitals

The large data breaches that compromise the protected health information (PHI) of thousands of people are the ones that receive all the attention, but the smaller violations of the Health Insurance Portability and Accountability Act (HIPAA) can be just as harmful, if not more so, to those involved. Healthcare leaders too often devote most of their attention to the large breaches and not enough to the more common, smaller violations, experts say.

A breach involving 500 to 10,000 patients generally is considered small in the healthcare community. The ramifications of a large data breach are well known, notes **Deborah Gersh**, JD, an attorney with the Chicago law firm of Ropes & Gray, but a breach involving only 500 patients still can be serious for the hospital or health system. The Health and Human Services (HHS) Office for Civil Rights (OCR) uses 500 affected individuals as the cutoff for reporting HIPAA breaches; a breach of 500 or more must be reported immediately, but smaller breaches can be reported annually. Once a breach of 500 or more is reported and posted on the OCR web site, the information is available to anyone.

"There are people who troll the site looking for breaches that have the potential for class action on the state level," Gersh warns. "And the report of 500 or more triggers an automatic inquiry by OCR. That can be a fairly robust response that will be a significant event for the healthcare provider."

In addition, OCR will want to see the healthcare entity's HIPAA risk analysis. Even if the analysis was conducted under privilege, OCR takes the position that it can access the document because the analysis is a required document for HIPAA compliance, Gersh says. OCR will retain a copy of the analysis in its records, which are subject to Freedom of Information Act requests and other public access.

"Sometimes that analysis is very honest in describing the things that could be improved, particularly when the company gets a third party to conduct the analysis and make it as objective as possible," Gersh says. "That can place the company in a very vulnerable position if that information is disclosed and someone wants to use it against the hospital in litigation."

> "IT'S DEATH BY A THOUSAND CUTS. IF YOU DON'T HAVE A CULTURE THAT TAKES THESE SMALLER VIOLATIONS SERIOUSLY, THEY ADD UP ..."

Action plan can be costly

A small breach can lead to a corrective action plan, just as with larger breaches, and that plan can create significant costs for the healthcare entity, Gersh says.

The plan may call for updating security and data management systems, improvements that can be a financial challenge for smaller hospitals or systems, she says. They already are squeezed by the cost of system updates that used to come every few years but now are sometimes needed on a monthly basis, and adding improvements from a corrective action plan can make their data management costs rise even more. *(A noteworthy civil monetary penalty from OCR involved fewer than 500 records. See the story in this issue.)*

"I see a lot of smaller hospitals and doctors' offices

struggle with that," Gersh says. "A corrective action plan commonly calls for more training for staff, and that carries a price both in terms of paying someone for the training and also in terms of staff time away from their jobs. These costs add up, and a corrective action plan can force you to make improvements and updates that you had not budgeted for yet."

The smaller violations involving 500 or fewer patients are less likely to be the result of a deliberate intrusion by hackers, who typically can access many thousands of records once they gain access. They are more likely to occur from carelessness by employees who leave a laptop in a public place, for example, Gersh says. That likelihood of occurrence means that hospital administrators must not lose focus on educating employees about physical data security while focusing on the complexities of digital security, she says.

Administrators should seek opportunities to reinforce the need for physical security of documents and hardware, Gersh suggests. Some facilities have a HIPAA security huddle with staff at regular intervals, in which employees and administrators can discuss any questions and note possible security risks, she notes. Others send casual "Did you know…" reminders by email to reinforce good security practices. In either format, the administrator might point out that patient charts were left unattended at a nurses' station, for example, or that a jump drive was left at a computer station.

"The anecdotal reports have a big impact on staff," Gersh says. "The employees can see how all the talk about HIPAA security manifests itself in their daily routines."

Instilling the right culture may require educating the top brass, in addition to the front-line employees who handle PHI. The culture of a healthcare institution must emphasize that smaller HIPAA violations are as important as the larger ones, and the culture emanates from the C-suite, says **Susan Tellem**, RN, BSN, APR, a partner with Tellem Grody Public Relations, in Los Angeles, which assists providers with the response to HIPAA violations.

"It's death by a thousand cuts. If you don't have a culture that takes these smaller violations seriously, they add up, and it becomes a bigger problem," Tellem says. "This is a top down issue, and the board of directors often doesn't even understand HIPAA. The CEO and the board of directors need to understand that it's not just the big fish that they should worry about, that the culture has to instill a respect for HIPAA security on an individual level."

Personal impact

The impact on the individual whose data is compromised can be significant whether that one person comprises the entire breach or whether the person is one of thousands, Tellem notes. When private information is released, there is the possibility that someone will use that data in a way that harms the person financially or in a personal way, and the healthcare entity that failed to protect it will be held responsible.

A large breach immediately brings the likelihood of fines from OCR, the associated costs of a corrective action plan, and bad publicity for the institution. But with a smaller breach, there is still the potential for major liability, Tellem notes.

"If someone loses a job or a patient is revealed to have HIV or mental health problems, something not always looked kindly upon by the general population, that becomes a liability for the institution, which can face huge lawsuits," Tellem says. "Those lawsuits will generate publicity, which also harms the hospital's reputation. All of that can come from failing to protect just one patient's protected health information."

One area of particular risk is when a healthcare entity wants to tell a patient's story or use before-and-after photos, Tellem notes. Although highly desired for marketing purposes, the healthcare provider must be certain that the patient has provided written permission for the use of the story or photos in all intended formats. Don't overlook getting permission for the material to be used in social media, she advises.

Tellem agrees with Gersh that ongoing staff education is key to preventing smaller HIPAA breaches, with anecdotes about how privacy can be compromised inadvertently.

"Use breaches at other institutions as an example so that it doesn't happen at yours. If you just say 'be careful with patient data,' that doesn't mean much," Tellem says. "But if you talk about how a nurse somewhere else took a selfie that happened to show patient data in the background, they can relate to that. Front-line employees might not think they have much to do with preventing a loss of 50,000 records, but you can remind them that they have a lot of control over the security of each individual record they handle."

SOURCES

- **Deborah Gersh,** JD, Ropes & Gray, Chicago. Email: Deborah.gersh@ropesgray.com.
- **Susan Tellem**, RN, BSN, APR, Partner, Tellem Grody, Los Angeles. Telephone: (310) 313-3444. Email: susan@tellemgrodypr.com. ■

Decision on Lincare civil penalties should be a reminder of liability potential

The latest development in a Health Insurance Portability and Accountability Act (HIPAA) breach investigation should serve as a reminder that fines are not the only way the government can punish a healthcare institution for failing to protect patient information. Civil penalties are possible, and the courts are upholding their legality.

In addition, the case is demonstrating that inquiries by the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) should be taken seriously from the outset.

An HHS administrative law judge (ALJ) recently ruled that Lincare, a provider of respiratory care, infusion therapy, and medical equipment to in-home patients, with more than 850 branch locations in 48 states, violated HIPAA and granted summary judgment to the OCR on all issues. The ruling requires Lincare to pay $239,800 in civil monetary penalties imposed by OCR. This is only the second time in its history that OCR has sought civil monetary penalties for HIPAA violations, and each time the penalties have been upheld by the ALJ.

OCR's investigation of Lincare began after an individual complained that a Lincare employee left behind documents containing the protected health information (PHI) of 278 patients after moving residences. Evidence established that this employee removed patients' information from the company's office, left the information exposed in places where an unauthorized person had access, and then abandoned the information altogether, according to OCR.

During the investigation, OCR found that Lincare had inadequate policies and procedures to safeguard patient information that was taken offsite, although employees, who provide healthcare services in patients' homes, regularly removed material from the business premises. Further evidence indicated that the organization had an unwritten policy requiring certain employees to store PHI in their own vehicles for extended periods of time, according to the OCR report. Although aware of the complaint and OCR's investigation, Lincare subsequently took only minimal action to correct its policies and strengthen safeguards to ensure compliance with the HIPAA rules, OCR told the court.

"While OCR prefers to resolve issues through voluntary compliance, this case shows that we will take the steps necessary, including litigation, to obtain adequate remedies for violations of the HIPAA Rules," OCR Director **Jocelyn Samuels** said in a statement released after the ALJ decision. "The decision in this case validates the findings of our investigation. Under the ALJ's ruling, all covered entities, including home health providers, must ensure that, if their workforce members take protected health information offsite, they have adequate policies and procedures that provide for the reasonable and appropriate safeguarding of that PHI, whether in paper or electronic form."

Lincare claimed that it had not violated HIPAA because the PHI was "stolen" by the individual who discovered it on the premises previously shared with the Lincare employee. The ALJ rejected this argument and said Lincare was obligated to take reasonable steps to protect its PHI from theft. *(The Notice of Proposed Determination and the ALJ's opinion may be found on the HHS website at http://1.usa.gov/1P6APVD.)* The company could appeal to one more level but has not indicated it will do so.

Off-site employees

The case holds important lessons for any company that needs employees to work remotely with PHI, notes **Christine G. Savage**, JD, an attorney with the law firm of Choate Hall and Stewart in Boston. The employers should conduct or update a risk analysis to determine the biggest risks for HIPAA violations with these off-site employees, and they should instill appropriate policies and procedures, she says.

"Lincare did not have any policies and procedures in 2008, and at least the first half of 2009, that addressed how people were to safeguard information when they took it off site," Savage explains. "There were no policies about how to check data in and out, or to record how long you had possession of the information. There was no policy on the appropriate storage of that material if you couldn't get it back to the office at the end of the day."

The Lincare case also indicates that OCR is concerned not only with the number of people affected by a breach, but also the nature of the breach, Savage notes. OCR determined that 278 patients' PHI was compromised.

Most of the civil monetary penalty relates to the lack of policies and OCR's claim that Lincare did

nothing to enact policies even after the deficit was brought to company's attention. Savage says this penalty is a reminder to take seriously any concerns of this type coming from the government. If OCR says your policies are inadequate or you haven't conducted a risk analysis, and you don't do anything in response, regulators are likely to look on the violations as more serious and look to civil monetary penalties to get your attention, she says. A slow or less-than-enthusiastic response may end with the same result.

Evidence cited in the ALJ decision suggests that the Lincare chief compliance officer was flippant in responding to OCR. The compliance officer replied to OCR by saying something to the effect of "we thought about putting in place a policy that you shouldn't let anybody steal your stuff," but found it unnecessary. OCR offered to settle the case, but Lincare refused a voluntary resolution, which typically involves a corrective action plan including a period of monitoring.

"Some of it may have been an attitudinal issue with regard to this particular company, which obviously isn't helpful," Savage says. "They may have made a calculated decision that OCR wouldn't pursue it to this level."

Lincare's position was that it was the victim in this case because the patient records were stolen, notes **Roy Wyman**, JD, partner with the law firm of Nelson Mullins in Nashville, TN. That position may explain some of the company's response, or lack of response, to the OCR inquiry, Wyman says.

One lesson from the case is that in addition to protecting PHI and having proper policies and procedures, you also must be prepared to demonstrate that you care about privacy if OCR ever comes calling, he says. Whether you think the breach was your fault or not, start out by conveying that you take seriously any suggestion that your HIPAA compliance program may be inadequate.

You still can make the argument later that OCR is misinterpreting the circumstances or try to prove that your policies and procedures were sufficient, but Wyman says the Lincare experience demonstrates that you must start off on the right foot with OCR. Wyman notes that OCR's arguments before the ALJ suggest that it was not going to come down too hard on the fact that employees were driving around with physical records, and that it was willing to acknowledge that securing those documents was difficult.

"In the end, the message is that you can't be combative and respond with a litigious attitude right from the start," Wyman says. "They could have settled and probably should have. Sometimes you need to take your lumps and accept it. That seems to be where Lincare had a problem, saying they weren't at fault and willing to take it to the limit."

Savage points out that the person who found the PHI was the Lincare employee's husband. The couple was splitting up, and after the employee left the home, her husband found the patient information and reported it. One explanation for Lincare's apparently inadequate response could be that the company leaders thought they were being drawn into an employee's divorce and personal life, with the husband reporting the find to cause trouble for his wife and the company.

"They may have thought this was much ado about nothing and found several years later that OCR took it seriously," Savage says. "I would never advise that if OCR expresses concern about your policy, that you leave that policy alone. You should be asking what you need to do to tweak it, or have a discussion with OCR about why you think you don't need to." ■

OCR: Facilities need organization-wide risk analysis

The University of Washington Medicine (UWM) in Seattle has agreed to settle charges that it potentially violated the Health Insurance Portability and Accountability Act (HIPAA) by failing to implement policies and procedures to prevent, detect, contain, and correct security violations. The Department of Health and Human Services Office for Civil Rights (OCR) reports that the settlement should underscore the necessity of conducting organization-wide risk analysis.

The settlement includes a monetary payment of $750,000, a corrective action plan, and annual reports on the organization's compliance efforts.

OCR initiated its investigation of UWM following receipt of a breach report on Nov. 27, 2013, which indicated that the electronic protected health information (PHI) of approximately 90,000 individuals was accessed after an employee downloaded an email attachment that contained malware. OCR's investigation indicated UWM's security policies required its affiliated entities to have up-to-date, documented system-level risk assessments and to implement safeguards in compliance with the Security Rule. ■

Hospital Access Management

Admitting * Reimbursement * Regulations * Patient Financial Services * Communications
Guest Relations * Billing & Collections * Bed Control * Discharge Planning

2016 Reader Survey

In an effort to learn more about the professionals who read *Hospital Access Management*, we are conducting this reader survey. The results will be used to enhance the content and format of the publication. Please fill in the appropriate answers, and write your answers to the open-ended questions. The deadline is July 1, 2016. Please fax the completed questionnaire to 678-974-5419, return it in the enclosed postage-paid envelope, or complete it online at https://www.surveymonkey.com/r/HAMAnnualReaderSurvey.

1. Are the articles in *Hospital Access Management* written about issues of importance and concern to you?

O A. always O B. most of the time O C. some of the time O D. rarely O E. never

Here is a list of hospital access issues. For each item, please fill in the circle for your answer accordingly:

	A. should cover it more	B. about right	C. should cover it less	D. don't know/no answer
2. Admissions/registration	O A	O B	O C	O D
3. Billing/reimbursement	O A	O B	O C	O D
4. EMTALA	O A	O B	O C	O D
5. Confidentiality/HIPAA	O A	O B	O C	O D
6. Customer service	O A	O B	O C	O D
7. Discharge planning	O A	O B	O C	O D
8. Scheduling	O A	O B	O C	O D
9. Staffing/recruitment needs	O A	O B	O C	O D
10. Technology	O A	O B	O C	O D
11. Training/education	O A	O B	O C	O D

12. How would you rate your overall satisfaction with your job?

O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

13. How would you describe your satisfaction with your subscription to *Hospital Access Management*?

O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

How would you rate each of the following? For each item below, please fill in your answers accordingly:

	A. excellent	B. good	C. fair	D. poor
14. Quality of newsletter	O A	O B	O C	O D
15. Article selections	O A	O B	O C	O D
16. Timeliness	O A	O B	O C	O D
17. Quality of supplements	O A	O B	O C	O D
18. Length of newsletter	O A	O B	O C	O D
19. Overall value	O A	O B	O C	O D
20. Customer service	O A	O B	O C	O D

21. On average, how much time do you spend reading each issue of *Hospital Access Management*?

O A. less than 10 minutes O B. 10-20 minutes O C. 21-30 minutes O D. 31-60 minutes O E.

22. On average, how many people read your copy of *Hospital Access Management*?

O A. 1-3 O B. 4-6 O C. 7-9 O D. 10-15 O E. 16 or more

23. On average, how many articles do you find useful in *Hospital Access Management* each month?

O A. none O B. 1-2 O C. 3-4 O D. 5-6 O E.

24. Do you plan to renew your subscription to *HAM*? O yes O no
If no, why not? _____

25. To what other publications or information sources about access management do you subscribe?

26. Including this publication, which publication or information source do you find most useful, and what do you like most about the publication or source?

27. What is your title? (please fill in the circle for the title that most closely reflects your position and responsibilities):

O A. Director of access management O B. Manager of patient accounts O C. Supervisor
O D. Patient account representative O E. Other (please specify) _____

28. What is the highest degree that you hold?

O A. High school O B. Associate's degree O C. Bachelor's degree
O D. Master's degree O E. Other (please specify) _____

29. Please list the top three challenges you face in your job today. _____

30. What do you like most about *HAM*? _____

31. What do you like least about *HAM*? _____

32. What issues would you like to see addressed in *HAM*? _____

Contact information _____

AO PATIENT REGISTRATION COMPETENCY BASED ORIENTATION (CBO) SKILLS CHECKLIST

Patient Registration-Clinics

Name: _____ **Employee ID: _____**

Clinic: _____ **Date of Orientation: _____**

The Following are Requirements for Orientation:

Topic/Activity	Completion Date	Topic/Activity	Completion Date	Certification	Expiration Date
General Hospital Orientation		CHEX New Hire Curriculum			
AO Patient Registration Office Orientation					
Other Computer Classes:					

Competency I: Safety Standards-Demonstrates knowledge of safety standards guided by COA by answering the following:

1. **What is the emergency phone number? _____**
2. **Where are the fire alarms? _____**
3. **Where is the fire extinguisher? _____**
4. **Where is the evacuation plan located? _____**
5. **Where are the disaster plans located? _____**
6. **What are the different codes that can be called in the organization?**

_____

7. **How do you STAT page? _____**
8. **What is and How do you activate Resident Physician? _____**
9. **Where is the Code Button? _____**
10. **Where is the Crash Cart/Defibrillator/Oxygen Tank located? _____**
11. **What is and How do you activate CHAT? _____**
12. **Where is the closest CHAT box located? _____**
13. **What is and How do you activate the Visitor Illness team? _____**
14. **What does PSR stand for? _____**
15. **What are PSRs used for, and where are they found? _____**
16. **What is Lucidoc? _____**
17. **How to access Lucidoc? _____**

II. To Do within Orientation and to be Validated by Preceptor

Assessment: P=Proficient N= Needs Improvement NA=Not Applicable NO=No Opportunity

CORRECTLY DEMONSTRATES:	Date:	Assess:	Preceptor Initials:	Comments:
REGISTRATION				
Demonstrate how to register patients using the Appointments and Encounters Worklist Filters worklist appropriately				
Demonstrate how to handle guarantors including adding a new one and swapping between ones already attached to the patient				
Demonstrates use/knowledge of the Financial Clearance flags				
Demonstrates use/knowledge of the Encounter Prep features				
Demonstrates use of ChartMaxx during registration				
Demonstrate how to enter a new insurance				
Demonstrates use of Easy Web during registration Knows how to rank documents				
DISCHARGE				
Demonstrates how to Discharge patient using the Appointments and Encounters WL				
Demonstrates how to enter ICD 10 codes				
Demonstrates how to discharge patient is Soarian Financials Knows what to do if discharge is entered outside the registration date				
Demonstrates how to enter clinic charges during the discharge process				
Demonstrates how to make requested follow-up appointments as part of the discharge process				
COPAY COLLECTIONS				
Knows where to find the copay amount				
Demonstrate how to enter a patient's copay including how to enter it into Soarian				
Demonstrates how to reconcile cash collections at the end of the shift/day				
Demonstrate how to credit a copay that has been paid upon the parent's request				
Demonstrate how to print a ledger the next day if Reports and Cubes is down.				
DOWNTIME				

Verbalize the different downtimes that affect registration				
Demonstrates how to register patients when Soarian is down				
Knows what and where downtime numbers are				
Verbalize the backloading process				
HDX/INSURANCE				
Demonstrate how to initiate a HDX request				
Demonstrate how to view a HDX response to include reading the response and locating copay information Was the hyperlink used?				
Demonstrate how to initiate a HDX request for potential policies				
Demonstrate how to add an insurance, allocate, verify, and order policies				
Verbalize auto plan assignment, what it does, what to look for				
What is self-pay? What steps to complete if a patient is self-pay.				
ADDITIONALS FOR REGISTRATION				
Verbalize what a MSPQ is to include how to complete one				
Verbalize the Interpreter process and how to note this in Soarian				
Verbalize the walk-in/work-in process for patients in specialty clinics				
Demonstrates how to enter orders in Allscripts (iConnect)				
Demonstrate how to cancel orders in iConnect				
Demonstrate how to view who entered the order in iConnect				
Vocalize what to do if receive a call from a person asking for information regarding a patient's appointment (what information should be asking to verify it is the parent)				
Demonstrate the process to follow when the patient has unknown doctor				

III. Competency to be Demonstrated/Discussed with Preceptor

Regulatory Compliance:

	Date:	Assess:	Preceptor Initials:	Comments:
Knowledgeable of and applies Joint Commission standards and National Patient Safety Goals				
Knowledgeable of and applies OSHA Guidelines				
Verbalizes/demonstrates Emergency Preparedness Role				
Knowledgeable of and applies Infection Control standards according to P&P to include proper Hand Hygiene				

IV. Orients to Clinic Environment (Clinic Specific)

Patient Registration Job Objectives	Date:	Assess:	Preceptor Initials:	Comments:
The importance of building relationships with clinical staff.				
How to open/send emails. Emails should be checked daily.				
How to look patients up in system using the 4/2 rule				
What to do if you locate a duplicate medical record?				
A patient has been to Children's before but you cannot access them in the system; what key points should you reference?				
What to do if the parent or legal guardian does not present with patient to an appointment.				
Purpose for Armbands.				
What is a referring doctor? Why is that information so important?				
What is a primary care doctor? Why is that information so important?				
Changing the spelling of patient's name. What are our parameters?				
What forms to use if the patient has changed their name. Can we physically change the patient's name at the time of visit?				

How to ensure that all charges are captured through reconciliation.				
How to complete end-of-day activities in your clinic, batching out credit card machine, closing out the money, printing a ledger from reports and cubes, etc.				
How many days you have to enter clinic charges before having to fill out a late charge form.				
What worklists in Soarian are to be worked				
Advance Directive for all patients 18 or older.				
How to print schedules.				
What is a PMP number and when should one be obtained?				
What is the major focal point of the Patient Registration Department?				
What is the proper way to answer the telephone?				

V. Professional Performance

	Date:	Assess:	Preceptor Initials:	Comments:
Acts as a patient advocate				
Does quality work				
Completes tasks in timely manner				
Takes initiative				
Seeks out performance feedback from peers/preceptor/superior in efforts to foster professional growth				
Verbalize with preceptor channels for problem solving, conflict resolution, and chain of command				

VI. Service Standards

	Date:	Assess:	Preceptor Initials:	Comments:
Presents a professional and caring image				
Greets people in a warm manner				
Conveys interest and concern				
Accept responsibility for providing timely customer service in a courteous manner				

Learn and apply customer service skills in a positive manner				
Graceful and tactful under pressure				
Takes extra measures to increase customer's comfort				
Communicates important info and/or problems to the appropriate parties for resolution				
Positive and upbeat personality				
Brings appropriate issues to manager's or preceptor's attention				
Recognized by coworkers as being able to handle difficult situations				
Offers assistance to other staff members when available				
Understand that the success of the organization depends on the level of service provided				

IV. Orients to Clinic Environment (Clinic Specific)

Where in Clinic:

	Date:	Assess:	Preceptor Initials:	Comments:

Skills Needed in Clinic:

	Date:	Assess:	Preceptor Initials:	Comments:

Critical Thinking to Go Over:

	Date:	Assess:	Preceptor Initials:	Comments:

Other:

	Date:	Assess:	Preceptor Initials:	Comments:

Source: Children's of Alabama, Birmingham.

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NOTICE OF COMPLETION OF ORIENTATION

I _____ have completed the attached CBO to the best of my ability on my orientation. I am clear on all items that I have dated and initialed and if I have had a question or concern it has been addressed. I am aware of whom my resource people are in my area for future questions/concerns.

_____ I have reviewed those Policies and Procedures given to me in my Orientation Packet, and I verbalize understanding and compliance.

_____ I agree to abide by the hospital Policies and Procedures and have been shown how to locate them in my clinic.

_____ I will do my best to abide by the Children's of Alabama Mission and Vision at all times.

Signature: _____ Date: _____Time: _____

The above mentioned employee has satisfactorily completed the orientation process required in the Ambulatory Operations Division, Patient Registration.

Signature of Supervisor overseeing employee orientation:_____

Orientation Verification Initials/Signatures:

Initials:	**Signatures:**
_____	_____
_____	_____

Source: Children's of Alabama, Birmingham. .

Interviewer: **Preferred Site/Shift:**

Candidate Name:

Category	Ask the candidate to give specific examples when answering questions.	1-Bad 2-Fair 3-Good	Interviewer Comments
Opener	Please tell us why you are interested in working for Orlando Health (APMC) and specifically with the Patient Access Department.		
Building/ Trusting Relationships	Describe a difficult co-worker you have worked with; how did you deal with the situation?		
Quality Care and Service	Describe a customer complaint that you have resolved. What specific action did you take to resolve the situation long term?		
	When things are hectic, have you identified or come up with shortcuts to get you through the day? Please explain.		
	Tell me about a time when you were complimented on your display of empathy.		
Ownership and Accountability	Describe a time when you demonstrated flexibility with your work schedule to meet the needs of your department.		
	Tell me about a time when a co-worker was not pulling his/her share of the workload. What did you do?		
	Tell me about a time you took ownership of a situation at your workplace.		

Process Improvement	Being in a healthcare setting there are a significant number of process improvement changes. Tell me about a time where you had to adapt to a new process.		
Financial Encounters	Scenario: I'm a patient and I have a financial responsibility of $500. How would you ask for that collection?		
	Would you recommend?	Yes	No

Addition Comments:

Source: Arnold Palmer Medical Center, Orlando.