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INSIDE

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Boost Collections by 120% or 634%? These Departments Have Done It

Managers credit training, tools, and incentives for phenomenal success

ED registrars at The Cooper Health System in Camden, NJ, recently began giving patients who are hospital employees a new option: to use one, two, or three payroll deductions to take care of their copays. This seemingly minor change gave revenue a major boost.

"Copay collections in the ED increased by 42%, in part because of this change," reports **Pamela Konowall**, CHAM, assistant director of healthcare access. Point-of-service collections rose 81% at the health system's diagnostic centers and by a whopping 634% at the surgical center.

In 2015, Chesapeake Regional Healthcare in North Chesapeake, VA, got serious about its point-of-service collections program. In fiscal year 2016, total collections increased 58% overall, and they increased 66% in centralized registration departments.

Patient access director **Melissa A. Salyer**, CRCR, says that from fiscal year 2014 to 2015, "[i]n the ED, we saw a phenomenal 120% increase in collections."

" ... IN THE ED, WE SAW A PHENOMENAL 120% INCREASE IN COLLECTIONS."
— MELISSA A. SALYER, CRCR, CHESAPEAKE REGIONAL HEALTHCARE

While ED registrars used to collect only copays, they now give estimates for total out-of-pocket costs based on level of care. "They began collecting on co-insurance and deductibles, as allowed by the patient's insurance plan," says Salyer.

Chesapeake Regional's patient access department increased collections with these other changes:

• Managers added clear definitions of self-pay and prompt-pay discounts to the financial aid policy.

"Pathways for patient assistance were implemented," says Salyer. Registrars are required to review the patient's eligibility for Medicaid and the Health Insurance Marketplace, for example.

"Staff were trained on how to recognize patients who need assistance," says Salyer. "We refer them down the

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right financial clearance pathway."

• Each registrar attended specialized training on how to use automated tools for insurance verification and price estimates.

"There had been software purchased, but there had been no formal training," Salyer explains. "Not all staff were using the tools in the same way."

• Pre-registration staff attempt to secure payment over the phone.

If the patient is reluctant, a promise to pay is noted in the account.

"It's difficult to run estimates and have financial conversations during busy patient check-in times or when it is a complex surgery," explains Salyer.

• Patients are offered a 10% prompt pay discount from their total out-of-pocket costs.

"Many patients have taken advantage of this program and return for services simply because of this discount," says Salyer.

• Managers work hard to keep collections on the minds of registrars.

Here are some ways collections are kept "top of mind":

1. The director sends emails throughout the work week to registration and scheduling staff, and the director lists the amounts everyone collected.

2. At the end of the month, the director sends an email with monthly collections by unit and registrar.

3. If collection goals are met, registrars and schedulers receive an email informing them of their incentive payout. *(See story on the department's incentive program in this issue.)* "Leaders need to stay involved at the front-line level," emphasizes Salyer.

"We round on high-performing staff and encourage underperforming staff to meet goals," says Salyer.

Set Clear Goals

Edward Din, director of patient access at Bakersfield, CA-based Kern Medical Center, is very clear with registrars about what's expected of them in terms of point-of-service collections. In fiscal year 2015, collections increased by 56%.

"The expectation is that each health benefits advisor will exhaust *all* payment options, in order to secure the account for an uninsured or underinsured patient," says Din. These options include short-term loans, interest-free payment plans, or government programs such as Medicaid. "For the six months ending June 2016, our patient access team converted 1,028 self-pay accounts to Medicaid, representing $12.1 million in gross charges," reports Din.

EXECUTIVE SUMMARY

Point-of-service collections at The Cooper Health System increased by 42% in the ED, 81% at diagnostic centers, and 634% at the surgical center, due to training and process changes. Chesapeake Regional Healthcare saw an overall increase of 58%, with a 120% increase in the ED. Patient access departments credit these changes:

- Employees ask consistently for payment.
- Registrars allow employees who are patients to use payroll deductions for copays.
- ED registrars collect co-insurance and deductibles.

The main goal of training is to get staff to be more confident in their "ask." "Registrars are more successful collecting if they have scripting on how to successfully request and collect patient monies," says Din.

Recently, one registrar successfully collected on 42 of 290 "asks," for a 15% success rate, and a health benefits advisor collected on 24 of 288 "asks," for an 8% success rate. These employees were praised for their efforts. "While these numbers may appear low, the fact is that staff are *consistently* asking for patient payments of those who have a demonstrated ability to pay," says Kern.

An estimator tool (Patient Charge from Atlanta-based Craneware) recently was implemented and makes it much easier for registrars to have a conversation about what's owed. "The letter is provided to the patient at the bedside, to initiate the conversation about payment options," says Din. Registrars ask for a deposit, set up short-term payment arrangements, or refer the patient to be screened for government assistance programs.

Previously, registrars called the business office or other local hospitals to "guesstimate" charges, or referred to other patient accounts for similar services to figure out what the patient owed. "Providing one-on-one observation, combined with role-playing in explaining the estimate letter contents to the patient, were the keys to success," says Din.

Chesapeake Regional Healthcare set cash goals for centralized and decentralized registration. "These are based on historical net revenue and cash collections," says Salyer. "The goals were set at 1% of adjusted net revenue and 30% of total patient cash."

At first, averages were 0.5% or less of net revenue and less than 20% of total patient cash. "As the program matured and staff became more comfortable, numbers climbed to 0.8% of adjusted net revenue and 28% of total patient cash," says Salyer.

Percentages continue to climb. In the last quarter of 2015, organizational levels exceeded the goal of 30% of total patient cash and met the goal of 1% of adjusted net revenue. The cost to collect has remained at just 2% for the department.

"As of first quarter 2016, the success has continued, with both goals continuing to be met at the organizational level," reports Salyer. Currently, the percent of adjusted net revenue is over 1%, and percentage of total patient cash is over 40%. *(See related story in this issue on collections training.)*

Staff are well-aware of departmental cash goals, which are part of a scorecard of key performance indicators (KPIs) used for incentives and annual performance reviews. "Meeting the KPIs should *not* be optional," underscores Salyer. ■

SOURCES

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Access Has College Faculty Train Collectors

A local community college was an unexpected source of help in improving cash collections at The Cooper Health System in Camden, NJ. Many hospital employees attend classes at the school.

"The revenue cycle team was mindful that there have been numerous times the college actually comes on site to conduct classes for hospital staff," says **Pamela Konowall**, CHAM, assistant director of healthcare access.

Patient access leaders did some research and discovered that the college had a grant available. Faculty members were willing to provide point-of-service training sessions for registrars.

"The college's Office of Customized Training developed the training to meet the needs of collectors per the specifications of the revenue cycle team," says Konowall. The instructor had a healthcare and sales background. The requirement for these no-charge sessions was that a minimum of 15 people be enrolled.

"The idea was to give front-end collectors the *whole* picture," says Konowall. "Topics from the evolution of the payment system to the evolvement of scripting were reviewed."

In February 2016, the college's faculty held eight training sessions for front-end staff at the hospital's Central Business Office.

"Immediately following this training, front-end collectors were so excited, they were calling the access management team to report their successes," says Konowall.

Registrars learned to build relationships with patients, use

helpful phrases, and address common objections. One registrar excitedly reported making three successful collections. "She stated collecting was much easier than she first thought," says Konowall. ■

Registrars Receive Incentives of Up to $400 A Month — Others Receive Gift Cards, Movie Tickets

Collections have soared at North Chesapeake, VA-based Chesapeake Regional Healthcare since a monthly incentive program was added.

"Incentives have been a driving force for the success of the program," reports patient access director **Melissa A. Salyer**, CRCR. Staff can obtain monthly incentives of up to $400 a month. These are based on departmental, unit, and individual cash goals.

"Incentives are also extended to the scheduling staff," adds Salyer. These are based on how many patients are scheduled per hour.

Staff members earn the payout monthly, and the payout is distributed quarterly.

"The payout last quarter was $14,800," says Salyer.

Registrars receive these payouts:

- $75 if they collect between $3,000 and $7,999 per month;
- $150 if they collect between $8,000 and $12,999 per month;
- $200 if they collect between $13,000 and $17,999 per month;
- $300 if they collect between $18,000 and $22,999 per month;
- $400 if they collect $23,000 and above per month.

Schedulers meet these requirements to receive payouts:

- $75 for 6-6.9 scheduled visits per hour;
- $150 for 7-9.9 scheduled visits per hour;
- $200 for 10-12.9 scheduled visits per hour;
- $300 for 13-15.9 scheduled visits per hour;
- $400 for 16 or more scheduled visits per hour.

More efficient scheduling of accounts improves the hospital's bottom line.

"It results in a cleaner, earlier pre-registration," says Salyer. Even if staff don't obtain incentive levels, they are recognized at their reviews for meeting or exceeding departmental goals.

Patient access managers at The Cooper Health System in Camden, NJ, recognize top collectors every week with gift cards or movie tickets.

"An email spotlighting the employee is sent to all of their co-workers," adds **Pamela Konowall**, CHAM, assistant director of healthcare access. ■

Collections Totals Barely Slowed During EMR Switch

It's proof that new processes work, even during system implementation

Melissa A. Salyer, CRCR, director of patient access at Chesapeake Regional Healthcare in North Chesapeake, VA, created a graphic to track results after the department's point-of-service collections program was revamped.

"I learned that the processes work," Salyer says.

The graphic shows the access leaders how having a new director in the department, and implementation of training, tools, and incentives, affected point-of-service collections.

In March 2015, patient access went live with a new EPIC system and saw only a slight decrease in collections over the next few months. For Salyer, this consistency confirmed that training makes a difference.

"Technology is simply a tool," she says. "If staff have training, they are able to carry out the processes regardless of the tools." ■

Skills Needed to 'De-escalate' Angry Patients

"I didn't see it written anywhere before I was serviced that I would have a copay."

"I refuse to talk about money being owed while I'm receiving treatment."

These are some patient responses reported by registrars to **Victor O. Odoh**, pre-access manager of surgical and pre-registration operations at Florida Hospital in Orlando.

While collecting at the bedside isn't new for the department, the approach has changed somewhat. In the past, a single registrar had

the patient sign consents, reviewed insurance benefits and financial obligations, then collected any payment owed.

"The process has now changed to two separate individuals," explains Odoh. The first registrar collects insurance information and obtains consents. A second registrar reviews financial obligations and collects.

Some inpatients are just not willing to discuss money during their hospital stay, however, and aren't shy about saying so. "Patients express frustration due to lack of price transparency or because payment is the furthest thing from their mind," says Odoh.

The person who gets the brunt of their dissatisfaction isn't a payer representative or hospital administrator, of course — it's the registrar.

Some patients learn their insurance coverage still leaves them with high out-of-pocket costs. Most have no idea of their financial responsibility for a hospital stay. "So when a registrar approaches a patient about their financial obligation, they are blindsided," says Odoh. Scripting helps registrars to respond.

The scripting is based on the AIDET (Acknowledge, Introduce, Duration, Explain, and Thank) model. Here is a typical conversation:

"Good morning/afternoon/ evening/ sir or ma'am. My name is Victor. How is your visit thus far?" (Acknowledge patient's response).

"I will be here with you for five or 10 minutes talking over your visit's financial responsibilities. I am here to answer all of your financial questions or concerns." (Have conversation about financial responsibility.)

"Thank you for your time. Can I assist you in anything else?"

Odoh also developed "patient experience" training, which instructs registrars to do these three things:

1. Hear the patient's complaint fully without interrupting.
2. Apologize, and assure the patient that the registrar will do all that he or she can to assist.
3. Address the issue, and update the patient on the response.

EXECUTIVE SUMMARY

Registrars need "de-escalation" techniques to respond to patients who are unhappy or upset due to financial obligations, scheduling problems, or other issues.

- Give scripting for top complaints.
- Role play, with the instructor playing an agitated patient.
- Check in with patients continually during waits.

ID Common Complaints

As the hospital's patient experience coordinator, Odoh does "patient-centered rounding" on 150 ED patients each month. "I take note of their complaints, then set up a skills lab that specifically addresses the top reasons for complaints," he says. Staff are graded based on how they respond to these three scenarios:

- The doctor was not empathetic.
- The nurse was mean and not informative.
- I wasn't updated on my status timely. *(See related story on dissatisfaction and wait times in this issue.)*

Odoh asks patients these four questions:

1. How is your visit so far?
2. Have you been informed of any delays?
3. How is your experience with your nurse?
4. How is your experience with your physician?

"I keep track of these responses, along with the names of nurses and physicians associated with the patient," says Odoh.

Rebecca Steve, training manager for revenue enhancement at Hennepin County Medical Center in Minneapolis, says registrars usually "get caught in the crosshairs" in these three scenarios:

- when a patient is upset about paying money;
- when a patient's appointment was scheduled incorrectly;
- when a patient can't get access to a physician right away.

Steve created a "de-escalation" course to teach registrars these techniques: actively listening to the patient, allowing a patient to vent, calming the patient, validating what the patient is saying, problem-solving, and giving the patient space.

Registrars are given these techniques to keep patients, and themselves, calm:

- Talk slowly and softly.
- Don't match the patient's tone or volume.
- Avoid saying the phrase "please calm down."
- Redirect the patient to a different topic.

The class members do some role-playing, with the instructor playing the part of an agitated patient. They are given these phrases to use:

- "Excuse me, may I talk to you?"
- "… for your safety and mine …"
- "Could I ask you … ?"
- "Would you assist me with … ?"
- "Can you work with me on ... ?"
- "What can I do to help you with … ?"
- "I'm sorry you feel that way."

Registrars also participate in "non-verbal" role-playing exercises. "This helps them understand the effect that non-verbal behavior has on any situation," says Steve. ■

SOURCES

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- **Rebecca Steve**, Training Manager, Revenue Enhancement, Hennepin County Medical Center, Minneapolis. Phone: (612) 873-2761.

New Electronic Medical Record? Avoid 'Traffic Jams' in Registration Areas

Were the needs of patient access carefully considered in the planning process for a new electronic medical record (EMR)? This step will determine if the registration process is "seamless or a traffic jam," says **Nancy A. Crehan**, CHAM, director of patient access at Cambridge, MA-based Mount Auburn Hospital.

Yaroslav Voloshin, vice president of revenue cycle advisory solutions at MedAssets in Alpharetta, GA, says, "every time an organization switches its EMR platform, patient access is the first area to be impacted." He offers these five ways to avoid problems:

1. Get involved early on.

"Be part of the planning and design meetings to participate in the initial development," says Voloshin.

2. Practice before the new EMR goes live.

This step will keep the amount of time to register new payments to an acceptable industry standard of 7-10 minutes for the average registration. "Many organizations just overstaff to compensate. However, this isn't the most efficient solution," says Voloshin.

3. Do a gap analysis to identify weak areas in the system.

4. Create a hotline so members of the registration staff can reach out for help if they need to.

5. Have a backup plan.

"Have a paper process to register patients if the system is down or there is an issue bringing up the new EMR system," says Voloshin.

Avoid Planning Woes

Most EMR implementation issues involving patient access can be avoided with good planning.

Crehan says, "For example, use a conversion calculator to determine the number of scheduling and registration staff necessary." She recommends these other strategies:

• Inform hospital leaders of resources needed early in the project planning phase.

Patient access needs adequate staffing coverage during the testing, training, and go-live phases. "Abdicating this analysis to consultants could leave your operation short-handed while you're attempting to meet critical project deadlines," warns Crehan.

• Bear in mind that too many required fields can slow down check-in, admission, or registration.

"We include very few required fields, but we have added alerts — warnings, but not 'hard stops' — to assist users as they complete screens," says Crehan. If an alert field is missing information, it goes to a registration work queue for resolution.

• Expect registrars to be pulled away for training for hours or days.

"Someone has to keep registering patients in the department," says Crehan, noting that some vendors suggest a 50% reduction in appointment volume the first week after go live. This volume ensures new users, including patient access, aren't overloaded. "It's a balancing act, as you do not want to impact revenue," cautions Crehan.

• Build a strong relationship with project leaders who work in information systems (IS), admission/discharge/transfer (ADT), and other areas.

"Have monthly meetings with your ADT and IS support team, and take them to lunch," suggests Crehan.

• Inventory all third-party

EXECUTIVE SUMMARY

Patient access leadership must communicate the department's needs to information services during the switch to a new electronic medical record, to avoid ending up short-staffed.

- Plan for staffing to cover for registrars who are attending training.
- Be sure all third-party software used by patient access "talks to" the new system.
- Keep in mind that required registration fields can cause delays at check-in.

software used in patient access areas, and make sure these "talk to" the new system.

For the department's patient estimator tool to work properly, for example, it must integrate with the hospital's registration system to receive appointment types, CPT/DRG codes, and provider information.

"In a large EMR implementation, patient access is usually the only stakeholder thinking about these types of front-end tools," says Crehan.

If glitches are discovered only *after* go live, revenue cycle metrics and patient satisfaction scores could plummet. "Do *not* leave real-time eligibility or patient estimate software functionality at risk," Crehan emphasizes. ■

SOURCE

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Surgical Patients Wait One Hour Less With Revamped Registration

All first cases contacted prior to service, which reduces wait times significantly

Due to a revamped registration process, surgical patients at Lakeland (FL) Regional Health Medical Center now arrive two hours prior to surgery, instead of three.

"We were challenged by organizational leadership and our patients, via patient survey results, to decrease the hours that our patients waited to be processed when presenting for surgery," reports **Jane A. Dyer**, CHAM, CRCE-I, manager for patient access services.

Patient access leaders attended all meetings of the Surgical Services Redesign Committee, which also included nurses, technicians, information technology analysts, industrial engineers, and physicians. "We provided input regarding all of the current processes, not just those related to patient access," says Dyer. Using Lean Six Sigma principles, patient access studied these processes:

- Patient access reviewed every step involved when a patient presented to the admissions department, from the door to the perioperative unit.
- The pre-processing team reviewed the available surgical scheduling reports. They analyzed how the first and second case patients could be identified and then contacted, to verify information and secure authorization for service and collection prior to service.

"We looked at things from a patient's perspective, as though we were the ones actually going through the process, from check-in to arrival in the OR," says Dyer.

First Cases Contacted

Deborah L. Newbern, CHAM, CRCE-I, assistant director of patient access services, explains, "The goal was to improve the patient experience by improving admission and wait times for our surgical first cases."

Previously, patient contact wasn't always prioritized before the time of the patient's surgical case. "Patient contact for insurance and other preprocessing information often took place on the scheduled date of service," says Newbern. This process caused delays on the date of admission for first and second surgical cases.

Now, the preprocessing team makes a focused effort to contact patients scheduled for the first or second surgical case. Dyer says, "Since the inception of the new process, 100% of surgical first case patients are contacted prior to service. For all other cases, the team has reached an 85% contact success rate."

When roadblocks such as lack of authorization or other insurance issues occur, physicians' offices are quick to assist. "For example, if a physician's office cannot secure insurance authorization due to extenuating circumstances by 9 a.m. the day prior to the patient's procedure, some flexibility has been built into the process," says Dyer.

This process gives the physician's

EXECUTIVE SUMMARY

Patients arrive an hour closer to surgery due to a revamped registration process at Lakeland (FL) Regional Health Medical Center.

- One hundred percent of surgical first case patients are contacted prior to service.
- Physicians' offices quickly assist with insurance issues.
- The family can track the patient's location via an electronic bed board.

office staff a little more time to get the insurance company anything that's holding up the authorization. "If everything has been submitted and authorization has not been secured by 4 p.m., the patient's case will be rescheduled," says Dyer.

Two-Hour Arrival Times

The new process achieved immediate results.

Newbern says, "Patient arrival times were shortened from three hours to two hours. The registration process now takes just a few minutes to complete."

These steps occur when the patient arrives two hours before surgery:

- Patients have a quick check-in at the surgical waiting desk.
- The family is provided with a number to track their loved one from check-in to the postanesthesia care unit, via electronic bed board. "The number is displayed, so the family can see where their loved one is at any given time during the surgical visit," says Newbern.
- The patient is taken directly to his or her preoperative room.
- Patient access does bedside registration and secures electronic signatures.

"Our patient access representatives are thrilled to be using cutting-edge equipment to complete patient registration," says Newbern.

To shorten registration times, some registrars had to work different hours. Rather than having most come in at 4 a.m., only a few team members come in at 4 a.m. to have the perioperative area readied to receive patients. Patient access managers then use staggered shifts to cover the rest of the department.

"By using staggered shifts, we are better able to accommodate the needs of our patients," says Newbern. "The change in hours has also improved satisfaction among our team members."

Registrars were not accustomed to working at the patient's bedside, but they were enthusiastic about the new process. "Once the process started, the team was excited to see that, with the registration completed, the patient was in their bed and ready for the next step in the process," says Newbern. ■

SOURCES

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Use Cross-Training to Cope With Sudden Surges in Patient Volume

Expose registrars to other areas — Some decide to stay in patient access

Carlos Diaz says that even after 18 years in the field, he still sees employees viewing patient access as a "transient stepping stone to a career path."

This view is especially true of younger staff.

"Most of those come in to pursue careers in nursing or other allied health fields, such as radiology or respiratory therapists," says Diaz, director of patient access management at Jackson Memorial Hospital in Miami.

Unfortunately, these staff members often are Diaz's star registrars. "They are energetic and career-minded. They are typically my top collectors," he says. "It's difficult when they come in and give notice."

When Diaz started in his current position in 2013, there was no shortage of grumbling in patient access. Many registrars felt that there was no way to get ahead.

"Individuals felt stuck in a particular position or area. There was

EXECUTIVE SUMMARY

Cross-training exposes registrars to many areas of patient access, which opens up the possibility of promotions and offers a better understanding of the revenue cycle. Jackson Memorial Hospital uses these processes:

- Registrars work on their own after being placed with a team lead for two days.
- Registrars are rotated to different areas on a regular basis.
- Shifts are adjusted to allow registrars to work in the new area for a few hours.

really no movement," says Diaz. To move up, registrars had to wait until someone left the organization or retired.

For Diaz, cross-training is one way to encourage registrars to make a career in patient access.

"I try to cross-train every single registrar, so they are exposed to different patient access areas," he says. Though it isn't mandatory, the vast majority of the department's 136 registrars volunteer to be cross-trained.

"This helps keep our staff within the organization," says Diaz. "If there are openings within other areas, registrars that are cross-trained have an advantage."

Skills Kept Sharp

Cross-training helps with sudden volume surges, whether due to disasters or due to it being a busy day.

"We have a group that's fully trained to move into different areas," says Diaz. "We make sure that whatever skill set they learn, they fully master it."

The registrar is placed with a team lead in the new area for the first two days and then is allowed to work on his or her own.

"If they don't feel comfortable, they can come back with any questions or concerns," says Diaz. For example, ED registrars aren't familiar with Advance Beneficiary Notices, so they often need some help explaining it to the patient. Similarly, an outpatient registrar might need extra assistance in working with trauma patients.

To keep skills sharp, registrars are rotated to different areas on a regular basis. Sometimes schedules are adjusted so an outpatient registrar can work a few additional hours in the ED, or vice versa.

If staff members need more time in the new area, Diaz gets creative with scheduling.

"Rather than have them work 11 p.m. to 7 a.m., we cut the shift in half and ask them to come in at 3 a.m. or even 4 a.m.," he says. With this system, the registrar will be in the area when volume spikes between 8 a.m. and 10 a.m.

Staff "Save the Day"

All newly hired patient access employees at CHI St. Luke's Health – Lakeside and Springwoods Village Hospitals, Houston, spend time in three areas: scheduling, registration, and the welcome center. They do so regardless of the role for which they were hired.

"Learning multiple areas of the department better equips the employee to understand how their role impacts the other areas," says **Mike Potter**, director of patient access services.

It also gives Potter a ready pool of trained registrars to fill in anytime it's needed. "I truly feel blessed to have so many cross-trained employees in my departments," he says. "They 'save the day' almost every day."

No patient access manager wants to get a 5 a.m. phone call from a registrar who will be out due to illness. When Potter receives such a call, he tells him or her not to worry, but to get well, and "we will take care of it."

"I say this because it is true," says Potter. "Our team pulls together and can switch areas with ease."

Moving a registrar to scheduling, or a scheduler to the welcome center, is done fairly often. "This is so the hospital and our patients do not feel the impact of a shortage in our department," explains Potter.

Potter sometimes finds himself covering for staff as well. "There is no meeting on my calendar that can't be rescheduled, so I can get in the trenches and do what is best for our team and patients," says Potter.

Registration process times, call handling metrics, and collection rates continue to stay strong, regardless of volume surges or unexpected call-ins. "I believe the national average, or benchmark, is around 2% of net patient revenue collected at the time of service," says Potter. "Historically, we perform closer to 6%."

Registration time — from the patients' greeting at the Welcome Center, to the time they are cleared by registration and ready for their appointment — averages about 15 minutes total. "But the results we see are not easily measured on paper or by standard metrics," says Potter.

The biggest benefit he sees is with the department's morale.

"Historically, we celebrate employee engagement scores in the high 90th percentile. For retention, I have had zero turnover this year," says Potter.

Registrars, when unable to come to work due to illness, appreciate getting calls from coworkers assuring that all is going well in their absence. "Normally, when an employee leaves my team, it's to grow within the organization, which I am always thrilled to support," says Potter. *(See related story in this issue on how the department handles unscheduled "walk-in" patients.)* ■

SOURCES

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- Mike Potter, Director, Patient Access Services, CHI St. Luke's Health — Lakeside and Springwoods Village Hospitals, Houston. Phone: (936) 446-9511. Email: mpotter@stlukeshealth.org.

Revamp Processes to Satisfy 'Walk-Ins'

At CHI St. Luke's Health – Lakeside and Springwoods Village Hospitals in Houston, the medical campus includes several office buildings with many physician practices. This campus layout means a large number of patients are unscheduled "walk-ins."

"We never know if the day will bring in 25 or 75 unscheduled patients," says **Mike Potter**, director of patient access services. "As you can imagine, it's very difficult to plan for the unexpected."

The patient access "time-of-service" team, which consists of three registrars and two Welcome Center staff members, handles all walk-in patients.

"We have to adjust in an instant to exceed the expectations of our patients," says Potter. "To achieve this goal, our team wears many hats."

The hospital's electronic medical record (EMR) requires that all patients are "scheduled," with orders transcribed and linked to the appointment, for the patient to be seen. Patient access employees at the Welcome Center take care of the scheduling and order transcription for walk-in patients. "This dramatically decreases the amount of time the patients spend in registration," says Potter.

Typically, staff at welcome centers do just that: greet and welcome patients, and possibly perform some minor functions within the EMR. "Not here," says Potter. "They do it all, just as any other member of the team would do."

Registrars verify benefits and calculate patients' out-of-pocket costs. These tasks free the insurance verification team to contact upcoming scheduled patients as far in advance as possible. "They do not need to constantly stop to manage the unscheduled walk-in volumes," says Potter. ■

Choose Future Leaders with Care: For Some, It's 'Just Wrong'

Give the right people a way to move up, so frontline staff have strong mentors

It's a mistake that **Joseph Ianelli**, MSW, MBA, has seen many times: Rewarding a loyal, long-term access employee with a promotion, despite the fact that the individual has no leadership skills.

"It's a pattern I've noticed throughout my career," says Ianelli, director of patient financial services at Boston-based Massachusetts General Hospital.

The employee typically gets along with everyone very well and has been in the department for many years. "He or she may be a subject matter expert and amazing in a hundred ways, but a leadership opportunity is just wrong for them," says Ianelli.

This type of promotion is detrimental to morale, as peers quickly realize the leader isn't someone they can learn from. "It's not a matter of taking turns," Ianelli says. "If it isn't someone who staff are able to look at as a model or mentor, don't put that person in a leadership role."

There are other, better ways to reward your long-term employees. "The employee's expertise could be very helpful with orientation, for instance," says Ianelli.

Massachusetts General's employees first become team leads, then managers, before they can be considered for a director role. Ianelli always promotes people with leadership qualities. "Ideally, you want a team lead who can someday be a supervisor," he explains.

If a poor leader stays in the role for many years, it hurts the department in more ways than one. Morale suffers, and qualified team leads have no way to move up. "If positions are locked up because a manager is 'stuck' in a role, you keep new and emerging talent in a place where they can't really grow," says Ianelli.

When a talented employee has no opportunity for advancement, Ianelli doesn't try to convince him or her to stay at all costs. "Sometimes people might be at the end of what they can do here," he says. Ianelli enthusiastically writes glowing recommendations for medical, law, and nursing school, as well as MBA programs, for registrars who decide to leave patient access for those programs. He maintains good relationships with many who have left the department and even the hospital.

"Staff who have gone on to different jobs always stay in touch with me," he says. "I've also had people who weren't successful in moving on and were very happy to come back."

Here are some considerations when choosing patient access employees for leadership roles:

- **Be clear about what it takes for**

employees to advance.

Bob Stearnes, CHFP, CHAM, a Dallas-based patient access leader, says to collaborate with revenue cycle leaders and human resources (HR) to create pathways for advancement. This collaboration allows patient access managers to tell prospective hires exactly how they'll be able to grow in the department.

"If you are unable to do that at an organizational level, how will you ever convince somebody they'll be able to move up?" he asks.

• Work with HR to identify key attributes that are needed in patient access.

Stearns suggests starting with these qualities: open to new ideas, agreeable, extroverted, and even-keeled.

Patient access leaders must take the initiative to tell HR what to look for, though. "It is rare for HR to spend time in the department and evaluate what we do," Stearnes says. "It is also rare for a patient access leader to reach out to HR on this."

HR professionals have the skill set needed to design career paths and necessary training, Stearnes says, "but they need the subject matter experts — patient access — to tell them what to look for."

• Set targets not just for directors, but also for employees.

Days in accounts receivable (A/R) were being reviewed at a previous organization where Stearnes worked, but only directors were being held accountable with a metric.

"I realized that the targets stopped at the director's desk. There was no target for the staff," he says. Stearnes met with supervisors to address this issue. "We knew a certain number of A/R accounts went to dispute. We developed aging goals based on inventory," he says.

Managers gave staff targets to get their A/R timeframes down at the individual level. These were part of performance evaluations. "We talked about tactics and ways they could deal with situations," Stearnes says. Managers created scripted responses to talk with insurance reps, and gave staff a weekly report on their percentage of aged accounts beyond 90 days. "We saw them being more conscientious," Stearnes says. "We showed them what was important to the organization and made it important to them." *(See related story on customer service skills in this issue.)* ■

Does Applicant Claim, 'I'm a People Person?' Rely on Real-Life Experiences Instead

Two of the best hiring decisions he ever made in patient access "had absolutely zero healthcare experience," says **Bob Stearnes**, CHFP, CHAM, a patient access leader who is based in Dallas.

One applicant worked at a customer service call center for a rental car company. Stearnes asked this question: "Can you tell me about a time when something was going bad and you made it right?" The applicant told a story about an irate customer whose promised vehicle was unavailable. She went to her manager with an "out-of-the-box" idea: to rent the vehicle two doors down from a competitor, so that the customer would get what he was entitled to.

Another applicant's previous job was at a fast food restaurant. She recounted a time when a regular customer ordered a side item that wasn't on the menu. She knew the restaurant next door had it, so she bought it to go and put it on his plate. "That's the kind of people we need in patient access," says Stearns.

He weighs real-life customer service encounters far more heavily than sugar-coated claims applicants make about themselves. "When applicants say, 'I'm a people person,' it sounds like a canned response," says Stearnes. "It really does not tell hiring managers a lot." ■

Health IT Certification Criteria Capture Sexual Orientation and Gender Identity

The 2015 Health IT certification criteria include the capture of sexual orientation and gender identity in the demographics certification criteria, according to the National Association of Healthcare Access Management (NAHAM).

"As part of an important patient matching initiative by the Office the National Coordinator for Health IT (ONC), patient sex is one of five key attributes that are now part of the certification criteria," NAHAM said in a released statement. NAHAM is developing Recommended Best Practices on the Collection of Key Patient Attributes.

Patient sex was proposed to be

captured by using the following values: male (M), female (F), and unknown (UNK), as part of the development of the 2015 criteria. The decision to use the coding for "sex" to present birth sex was of significance in the final rule for health IT certification, NAHAM said.

"The ONC did not adopt recommendations made by commenters from the general public to capture a patient's sexual orientation or gender identity as part of this criterion," NAHAM said. "Instead, the ONC proposed the capture of sexual orientation and gender identity (SO/GI) data as part of the proposed 'social, psychological, and behavioral data' certification criterion." ONC's narrative is in the final rule, *Sexual Orientation and Gender Identity (SO/GI)*.

NAHAM reports on the following comment and response from ONC:

Comment. One commenter recommended we consider including structured and coded questions for soliciting SO/GI information as part of certification.

Response. While we [the ONC] thank the commenter for providing this recommendation, we do not believe that the suggested questions have yet been scientifically validated for use in healthcare settings and, thus, have not adopted them. We do, however, believe that these questions are being used today in health care settings as "best practices," and would suggest that health care providers and institutions decide whether to include these questions in the collection of SO/GI information. These "best practice" questions and the answers we have adopted are:

- *Do you think of yourself as:*
  - *o Straight or heterosexual;*
  - *o Lesbian, gay, or homosexual;*
  - *o Bisexual;*
  - *o Something else, please describe.*
  - *o Don't know.*
- *What is your current gender identity? (Check all that apply.)*
  - *o Male;*
  - *o Female;*
  - *o Transgender male/Trans man/Female-to-male;*
  - *o Transgender female/Trans woman/Male-to-female;*
  - *o Genderqueer, neither exclusively male nor female;*
  - *o Additional gender category (or other), please specify.*
  - *o Decline to answer.*

NAHAM advises that patient access departments ask the following questions:

- Does your access department have protocols in place to capture birth sex only, or gender as noted on an official government-issued identification, or do you record only what the patient reports?
- Does your information technology have fields, or do you attempt to capture sexual orientation or gender identity if different from what is reported on a government-issued identification?
- Is patient access ready to capture these attributes? ■

COMING IN FUTURE MONTHS

- Reduce sick calls by allowing registrars to self-schedule
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HIPAA REGULATORY ALERT

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HIPAA Risk Analysis Should Be Thorough And Helpful for Hospital's Compliance

A risk analysis is fundamental to any HIPAA compliance program, but conducting one effectively can be a challenge. Too often, the risk analysis is a perfunctory task that lets you check off a requirement, when it should be a valuable tool that drives the rest of your compliance efforts.

The Office for Civil Rights (OCR) studies the HIPAA risk analysis closely when investigating potential HIPAA violations, says **Kathleen D. Kenney**, JD, with the Polsinelli law firm in Chicago. She previously worked for the OCR, where she was the subject matter expert for breach notification, assisted in the administrative rulemaking process, drafted preamble language for the Omnibus Rule amending HIPAA, and actively participated on OCR's audit team. The risk analysis requirement is defined in Section 164.308(a)(1)(ii)(A) of the HIPAA standards.

"We're seeing risk analysis come up again and again in enforcement cases," Kenney says. "The big challenge for covered entities is identifying the scope of your responsibility, exactly where all your PHI [protected health information] is. It sounds like that shouldn't be so difficult, but a lot of entities struggle with it, especially when they are trying to do the analysis in the aftermath of a breach."

> "THE BIG CHALLENGE FOR COVERED ENTITIES IS IDENTIFYING THE SCOPE OF YOUR RESPONSIBILITY, EXACTLY WHERE ALL YOUR [PROTECTED HEALTH INFORMATION] IS."

The task can be challenging, because of all the many ways PHI can be stored and transmitted, Kenney says. She points to the example in which a covered entity violated HIPAA by failing to delete PHI from a photocopier before selling it. No one had realized that photocopiers can store data, so that risk wasn't included in the analysis, and, therefore, no safeguard was established.

The rapid adoption of new technology worsens the problem, Kenney says. Physicians and employees constantly are finding new devices, services, and apps that make their work more efficient, so they want to use them with PHI. The key for compliance is that you must know about the new technology and approve its use beforehand, Kenney says.

"You want to think about the risks to the data and how you are going to protect it before you allow the use of the device," she says. "Your risk analysis should help you assess the new technology and impose the appropriate limits and safeguards. OCR wants you working on the front end of this, not reacting when you find out Dr. Smith has been using a new device for six months."

Emphasizing the Scope

Providers often underestimate how broad the analysis should be, says **Leah A. Voigt**, JD, MPH, chief privacy and research integrity officer for Spectrum Health, a not-for-profit managed care healthcare organization based in Grand Rapids, MI.

"It's become clear from the Office for Civil Rights in the past couple of years that what they're looking for is far more detailed and far more comprehensive than the industry initially anticipated," Voigt says.

Voigt notes that OCR cited the failure to complete a

comprehensive risk analysis as a key problem leading to the recent $2.7 million settlement with Oregon Health & Science University (OHSU) in Portland.

"What sticks out to me as a privacy officer for a healthcare organization is that the OCR has emphasized that the risk assessment must cover all electronic PHI created or maintained by a covered entity or business associate," Voigt says. "It's that three letter word, 'all,' that I think is really important."

That expectation goes far beyond the electronic medical record, Voigt says. She advises visiting facilities to see how PHI is used in various settings and what must be included in the analysis.

"If you walk around and talk to people, you'll see that you didn't realize someone had PHI in a folder in a part of the system you didn't include," Voigt says. "This analysis is not something you can do just sitting at your desk."

Evaluate Risk and Severity

Once you have data mapped the relevant risk universe, the next step is to evaluate each risk factor and determine the likelihood and impact of these events occurring, says **Eric Dieterich**, a partner with the data privacy practice of Sunera, a cyber risk management company in Sunrise, FL.

The final phase of the risk analysis activities includes an evaluation of your current safeguards to determine the effectiveness of these activities in reducing your inherent risk rankings.

"This evaluation of safeguards is one area that organizations often fall short, increasing the risk of non-compliance with the relevant HIPAA safeguards," Dieterich says. "The HIPAA standards often require specific language to be present in internal policies and procedures, they have defined operational practices, and there is the implementation of technical safeguards, all of which can be easily overlooked."

To evaluate the effectiveness of these safeguards and identify areas of non-compliance, Dieterich says organizations should perform detailed discovery and an in-depth analysis of existing documentation, review operational practices, and evaluate relevant technologies.

"This deeper dive into the effectiveness of an organization's safeguards provides the foundation for the assigned risk mitigation of your risk analysis program, leading to a stronger compliance program and one that can stand the test of the increasing regulatory scrutiny," he says.

Give Yourself Credit

Kenney notes, however, that covered entities often do not give themselves enough credit for the safeguards they do have in place. Even if the safeguard is not ideal, perhaps because you cannot afford the best solution, you should document clearly how you are addressing the risk, she says. Otherwise, OCR could come away with a worse impression of your compliance than is warranted.

"If you can't afford encryption, note that the smartphones are password-protected and you have the ability to wipe them remotely — things like that," she says. "You want to give yourself credit where credit is due, even if there are still shortcomings from what you would do ideally."

A related problem with risk analyses is that covered entities don't act sufficiently on the information they gather, Kenney says. When risks and safeguards are identified as addressable, they must be addressed.

"OCR has said over and over in public engagements that addressable does not mean optional, but we still see entities that don't understand that," Kenney says. "You need to go through the risk analysis and determine whether the potential impact from this addressable risk is high, and, if so, what you are doing to address it. You may have to address it over a longer scope of time than you'd prefer, but you must identify the mitigation steps."

Don't Promise Too Much

Kenney also cautions against overpromising. When you identify a risk and a solution, such as encrypting phones, be careful about saying when that will be completed. If you say you're going to have the phones encrypted in six months, you may have a breach eight months later, and OCR's investigation will find that you didn't follow through on your promise.

"That puts you in a worse position than if you had been more realistic about what you could do with your resources," Kenney says. ■

SOURCES

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First Settlement with Business Associate Shows Focus of Office for Civil Rights

For the first time, the Office for Civil Rights (OCR) has settled potential HIPAA violations with a business associate, and that settlement sheds light on how the government is assessing compliance.

Catholic Health Care Services of the Archdiocese of Philadelphia (CHCS) agreed to a monetary payment of $650,000 and a corrective action plan to settle potential HIPAA violations after the theft of a CHCS mobile device compromised the protected health information (PHI) of 412 nursing home residents. CHCS provided management and information technology services as a business associate to six skilled nursing facilities.

Although direct enforcement against business associates was authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, and detailed in The Omnibus Final Rule in 2013, this settlement is the first action under these amended laws, says **Nathan A. Kottkamp**, JD, a partner with the law firm of McGuireWoods in Richmond, VA.

The CHCS settlement indicates that relationships, in general, and business associate operations, specifically, are a growing focus of action by the OCR, Kottkamp says. In earlier action this year, two covered entities entered into settlements with OCR for failure to have business associate agreements in place. OCR also began Phase 2 audits, including business associates, in March 2016. *(For more information, see "Round 2 of Audits for HIPAA Are Focusing on Business Associates,"* Healthcare Risk Management, *June 2016, which can be accessed at http://bit.ly/1Wm2g3K.)*

The settlement amount is fairly low, which suggests that OCR is focused more on helping organizations comply than on punishing them, Kottkamp says.

"This settlement tells us that the enforcement world has changed dramatically now," Kottkamp says. "It used to be that you could say they're not going to go after business associates because there are other cases to pursue with covered entities, but no one is safe anymore. We've seen ramped up enforcement on covered entities, and now I think this signals a dramatic change in the risk for business associates."

CHCS is the first business associate to enter into a settlement, but it won't be the last. Kottkamp says it is almost certain that there will be more enforcement actions against business associates in the future.

OCR initiated its investigation on April 17, 2014, after receiving notification that CHCS had experienced a breach of PHI involving the theft of a CHCS-issued employee smartphone. The smartphone was unencrypted and was not password-protected. The information on the phone was extensive and included social security numbers, information regarding diagnosis and treatment, medical procedures, names of family members and legal guardians, and medication information.

The CHCS case underscores the risk of allowing PHI on employee smartphones, Kottkamp says. The phone in question had no security features for locking it, which allowed anyone to access the patient records. OCR's announcement stated that the egregiousness of the breach was mitigated by the fact that CHCS provides charity services to a large population of underserved patients.

"If that had been a hospital, I think we would have seen a much stiffer penalty," Kottkamp says. "This is a confirmation of what OCR has said publicly, that, at least for the moment, it is very much focused on compliance and not punishment. They're not looking to shut down somebody's business, but they want a settlement amount that gets your attention and hurts a little bit."

Tips from Corrective Plan

At the time of the incident, CHCS had no policies addressing the removal of mobile devices containing PHI from its facility or what to do in the event of a security incident. OCR also determined that CHCS had no risk analysis or risk management plan.

OCR will monitor CHCS for two years as part of this settlement agreement, which helps ensure that CHCS will remain compliant with its HIPAA obligations while it continues to act as a business associate. Kottkamp notes that, as is often the case, the specific terms of the corrective action plan illustrate OCR's priorities. In the CHCS corrective action plan, OCR emphasizes policies, procedures, and workforce education. *(Readers can accss the corrective action plan by going online to http://bit.ly/29McWXU.)*

The CHCS case and corrective action plan can be used by covered entities to help educate their business associates about the importance of HIPAA compliance, Kottkamp says. Although the hospital is not obligated under HIPAA to ensure business associates' compliance, it is

in the covered entity's best interests to have them comply, he says. When a business associate causes a breach, it is most likely the hospital's name that will be in the headlines.

"The corrective action plan reads like OCR saying what they really care about and how to satisfy them," Kottkamp says. "You can almost go through the plan and use it as a checklist to assess your own compliance." ■

OCR: Ransomware Attack Is Usually a Data Breach

With ransomware attacks a continuing threat to hospitals and health systems, the Office for Civil Rights is warning that, in addition to all the other headaches, such incidents could be considered a data breach under HIPAA.

Ransomware attacks have been recognized by the FBI as a serious threat, and some experts predict there will be more after the February incident in which Hollywood Presbyterian Medical Center in Los Angeles paid $17,000 to hackers who took over its systems. Since then, four hospitals in California, Kentucky, and Maryland have been hit.

Responding to the threat, the Office for Civil Rights at the Department of Health and Human Services (HHS) has released new HIPAA guidance on ransomware. The new guidance points out that a ransomware attack probably means there has been a protected health information (PHI) data breach under HIPAA and says, "The presence of ransomware (or any malware) on a covered entity's or business associate's computer systems is a security incident under the HIPAA Security Rule. A security incident is defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

That type of incident would trigger the notification requirements. Entities experiencing a breach of unsecure PHI must notify individuals whose information is involved in the breach, HHS says, and, in some cases, the media, unless the entity can demonstrate and document that there is a "low probability" that the information was compromised.

The guidance suggests conducting a risk analysis to identify threats and vulnerabilities to PHI and establishing a plan to mitigate or remediate those identified risks. In addition, the guidance advises taking these steps:

- Implement procedures to safeguard against malicious software.
- Train authorized users on detecting malicious software, and report such detections.
- Limit access to PHI to only those persons or software programs requiring access.
- Maintain an overall contingency plan that includes disaster recovery, emergency operations, frequent data backups, and test restorations.

The guidance is available online at http://bit.ly/29zm57B. ■

Worker Fired in NFL Player Incident Sues Hospital

A secretary fired from Jackson Health System in Miami for accessing the medical record of New York Giants' football player Jason Pierre-Paul is suing Miami-Dade County's public hospital network. She claims she did not access the patient record and that the health system defamed and libeled her.

Pierre-Paul had sought treatment at Jackson Memorial after a fireworks accident over the Fourth of July weekend in 2015. A few days later, ESPN posted a photo of part of Pierre-Paul's medical record on Twitter showing that the player had had a finger amputated.

Brenda Jackson had worked for 14 years at Jackson Memorial Hospital and says in her lawsuit that hospital administrators incorrectly blamed her for the HIPAA violation and made false accusations to the media. The experience triggered nightmares, migraine headaches, and other sudden illness, according to the lawsuit, which seeks damages in excess of $15,000.

In addition to Jackson, the hospital fired a clinical staff nurse.

Jackson Health asserts that on July 21, 2015, the secretary accessed the patient's chart four times "without any necessary reason and authorization to do so."

That date is almost two weeks after the July 4 weekend when Pierre-Paul's records were leaked to ESPN, which suggests that the secretary may not have been involved with the initial leak to the media. The statement announcing the dismissal of two employees in February did not say that either was responsible for the leak to ESPN.

Pierre-Paul sued for civil damages, and the hospital announced a settlement. He is now suing ESPN. ■