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INSIDE

Editor's Note: Next month, we're offering a special issue on patient identification processes in patient access. We'll report on how registrars' errors harmed patients and report on a new campaign from The Joint Commission that educates patients on the importance of multiple identifiers.

AHC Media

Dig Deeper on Patient's Insurance, or Face a Surge in Claims Denials

At one facility, about 30% of the department's claims denials have a root cause of incomplete or inaccurate registration

Is the patient's insurance active? A simple "yes" or "no" once was all patient access had to know.

"Plans used to be more straightforward. Now, we need to do investigative digging," says **Andrew Ray**, director of the professional revenue cycle at Stanford (CA) Children's Health.

About 30% of the department's claims denials have a root cause of incomplete or inaccurate registration.

"An increasing percentage of those [nearly 40%] are due to not accurately capturing the granular plan details," Ray adds. "This requires significant rework by our follow-up staff to resolve."

Here are four problems patient access faces:

• More complex plans take a toll on productivity.

"A straightforward registration process takes five to seven minutes," Ray says. "But the added plan complexity can easily double that."

This means delays at registration and sometimes in care scheduling.

"The sad result is that it's added another layer to get through," Ray notes. "The process becomes longer when we want to provide a quick process for patients."

Registrars make many more time-consuming calls to payers to discover the details of what's covered.

"We are having a lot more 'one-off' situations, working with payers," Ray says.

It takes up to 30 minutes to get the needed information. Sometimes, registrars learn that there is hardly any coverage at all, since the hospital is out of network.

"PLANS USED TO BE MORE STAIGHTFORWARD. NOW WE NEED TO DO INVESTIGATIVE DIGGING."—ANDREW RAY, DIRECTOR, PROFESSIONAL REVENUE CYCLE, STANFORD CHILDREN'S HEALTH

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AHC Media

"The out-of-network benefits are often close to not having insurance, because the deductibles are so high," Ray says.

Most patients usually have no idea that their plan has changed, or that a certain service or provider isn't covered any longer.

"It's a tough conversation to have with folks, especially when they have existing relationships with our physicians," Ray laments.

The department has had success in getting plans to make an exception for specialty care and patients in midstream care with an ongoing health condition. In some cases, they've been able to prove the hospital employs specialists to handle what the patient needs, while in-network providers don't.

"We have less success at getting considerations around general routine sick care," Ray reports.

• Big balances surprise patients.

"This can result in patient bills of hundreds to tens of thousands of dollars, depending on the clinical complexity of the services," Ray says.

Registrars field some very complex questions about out-of-pocket costs. Frequently, patients express frustration and even anger.

"Quite often, folks are upset with us. I understand where they're coming from," Ray says. "In every other business transaction, the financial pieces are fairly well known."

Patient access is in a difficult spot.

"We are trying to sort out what's going on with a particular patient. Where they are in their deductible and coinsurance cycle is sometimes unclear," Ray notes.

Patient access could overstate the potential liability — it's possible that more of the deductible or coinsurance was met than is apparent — or just wait until everything processes.

"Then we have a potential surprise, which is not good service," Ray explains. "The solutions we're left with are not great, across the board."

Without better education when patients buy insurance, sometimes the best outcome is to "at least limit the surprise a little bit," Ray says.

The more accurate and complete the insurance information is, the more accurate the out-of-pocket estimate is.

"We make patients aware of financial assistance and payment plan options. They can weigh that versus seeking care elsewhere," Ray adds.

• Cards look almost exactly alike, and plan names are almost the same, but offer very different coverage.

"Getting down to the extra granularity of detail with the plans we're dealing with is new over the

EXECUTIVE SUMMARY

Patient access departments are dealing with increasingly numerous and complex insurance plans. About 30% of claims denials at Stanford Children's Health occur because of incomplete or inaccurate registration. To improve insurance verification processes:

- provide staff with training;
- implement technology;
- identify coverage gaps, or non-coverage, early in the process.

last couple years," Ray explains.

Registrars might register the patient as presenting with an in-network plan, failing to realize that it's a slightly different plan — one that's out of network with the hospital.

"None of our [systems] trigger us to alert the patient that they are out of network and will have a high out of pocket [expense]," Ray says.

• The number of insurance plans has surged.

Health plans create a multitude of different networks and products.

"For us, a lot of it is just trying to stay on top of that. It feels like a lot of times we're playing catch up," Ray says.

Stanford Children's patient access department handles about 450 different plans.

"Most of our major payers have added at least one to three new plans," Ray explains. "With many payers, the number of plans has doubled."

Technology Flags Glitches

Patient access is adapting with revamped insurance verification processes, technology, and training.

"We are coming at it from multiple angles," Ray says.

Plans aren't always what they appear to be. The sooner patient access realizes it, the better. One frustrating obstacle is that the electronic eligibility data obtained from health plans often are vague and misleading. Ray explains, "Many times the detail is just too high level."

It's unrealistic to expect registrars to notice every slight discrepancy in hundreds of plans. Instead, the registration system flags potential problems, such as a member ID or group number, indicating the hospital isn't in network.

"Within our systems, we're trying to find ways to flag folks that this is one of the scenarios where we have a different relationship than we used to," Ray says.

It doesn't help that patients rarely carry their insurance cards — they expect those to be on file. **Tinnie C. Garlington**, BSB/PJ, CHAM, manager of financial counseling and quality assurance at Emory Healthcare in Atlanta, says, "Therefore, when their coverage changes, there is a challenge when attempting to identify what type of plan the patient has."

To address this, the hospital created an insurance verification master committee.

"We work together to identify and solve insurance verification challenges," Garlington explains.

Recently, the committee tweaked

Inaccurate Coverage Info Costly to Organization

Much revenue is at stake, if registrars misinterpret the patient's coverage.

"Surgical and inpatient services are often $25,000 and up. Given the specialty nature of our care, it is not uncommon for services to cost six and seven figures," says **Andrew Ray**.

Registrars at Stephens Memorial Hospital in Norway, ME, were entering insurance information incorrectly into the Epic system.

"My staff were not 'billers,' prior to our new computer system," explains **Kelly C. Moore**.

Quality assurance staff discovered the problem during quality assurance audits.

"We review what was manually entered into the patient's chart versus the image of the scanned insurance card, which is kept in the patient's medical record online," Moore says.

According to Moore, there were three problems:

- Registrars chose the incorrect insurance plan.
- Registrars typed in the incorrect insurance number.
- Registrars failed to scan the card into the patient's medical record.

"Re-billing was needed, stalling payment to the hospital," Moore says. "This crossed over to the patient, who wondered why it wasn't done correctly in the first place."

Registrars now consult tools provided by payers, such as examples of insurance cards for different plans.

"These tools are very helpful. We also do rounding with staff as new insurances are uncovered," Moore adds.

Registrars are required to check their email prior to starting their shift to keep updated on plan changes. For instance, registrars used to document an observation patient's status only for Medicare.

"Now we are doing this for all payers, to let the patient know they are an outpatient," Moore notes.

Often, patients don't understand this when they are in a hospital bed.

"If this document isn't signed, we could lose revenue for over-the-counter prescriptions," Moore adds. ■

the hospital's registration system so it notifies users if a plan is non-participating.

"This allows us to have the conversation with the patient regarding how they would like to proceed with their visit," Garlington notes.

Registrars notify someone on the committee about any plan changes once someone becomes aware of such changes.

"Updates to the system are then made to reduce the issues with patients not being financially cleared prior to arrival," Garlington says.

Small differences in plan names have been the cause of many claims denials. For instance, the patient may still have Humana coverage, where previously the patient presented with a Humana National POS plan. And although the two plans sound similar, the new plan actually is an HMO.

"We have to be very cautious, because the plan name may change unknowingly to us," Garlington explains.

At Stephens Memorial Hospital in Norway, ME, if a scheduled procedure isn't covered by the patient's insurance, the registration system alerts registrars, who then discuss the situation so the patient can make an informed decision about what to do.

PLANS AREN'T ALWAYS WHAT THEY APPEAR TO BE. THE SOONER PATIENT ACCESS REALIZES IT, THE BETTER. ONE FRUSTRATING OBSTACLE IS THAT THE ELECTRONIC ELIGIBILITY DATA OBTAINED FROM HEALTH PLANS OFTEN ARE VAGUE AND MISLEADING.

Kelly C. Moore, manager of Stephens' central registration, says, "The patient has a right to get the services and bill their insurance, knowing it might not be covered, have the test and not bill their insurance, or not get the test at all."

Very soon, this will happen earlier in the process.

"In the near future, the provider practices will be dealing with the advanced beneficiary notice during the patient encounter," Moore says. "It will be dealt with at that time either by the provider or by front-end staff." ■

SOURCES

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Patients and Providers Need Training on Plans, Too

Many have no idea of coverage limitations

Patients don't understand their coverage. Providers schedule services without realizing the patient's plan doesn't cover the provider, the service, or the hospital. Patient access staff are the only ones standing between this scenario and a denied claim, lost revenue, and an unexpected bill for the patient.

"We are coming at it from both angles," says Stanford Children's Health **Andrew Ray**. Here is how patient access departments are educating all involved parties.

• Patients

Most patients have no idea of the specifics of what their plan covers. They don't even realize they could be out of network. Emory's **Tinnie C. Garlington**, BSB/PJ, CHAM, says, "Most patients view having coverage as if they are able to see any provider in any situation."

Patients are surprised to learn that certain procedures are not covered, or that procedures were denied due to untimely notification.

"Our goal is to avoid costly denials," Garlington says.

Stanford's registrars are expected to answer questions from patients about what a service will cost them, regardless of the plan.

"We still struggle with this, but we are getting better at it," Ray says, noting that in some cases the patient is the one who has to contact the health plan. "Patients don't necessarily have the expertise to initiate the request. We're doing a lot of education on that piece."

Patient access ask patients to do these two things:

- *Research their insurance before scheduling, especially what the plan covers for that particular service, and whether the hospital is in network.*
- *Provide specific details so it's clear exactly which plan the patient has, instead of just a basic plan name such as "Aetna PPO."*

• Providers

Clinicians are consulted more often to resolve thorny coverage issues.

"We see this quite often," Ray notes. "We've seen a big shift in the last year, with clinicians being much more involved than ever before."

This usually happens after a patient gets a big bill because of a high deductible or going out of network.

"Oftentimes, it is the providers who patients feel most comfortable with in venting this frustration," Ray notes.

Providers have advocated successfully for patients in this scenario by calling or writing the payer.

> PATIENTS ARE SURPRISED TO LEARN CERTAIN PROCEDURES ARE NOT COVERED, OR THAT PROCEDURES WERE DENIED DUE TO UNTIMELY NOTIFICATION.

"In some cases, they have gotten the insurance to cover the services in network," Ray says.

This is true particularly for specialty and sub-specialty services, whereby the patient may not have any other options in the area. Other times, though, there's no wiggle room no matter who calls the payer.

"We are basically informed that we're not considered in network. We are not given a whole lot of choice," Ray says.

Providers aren't experts in insurance — nor do they want to be.

"They just want to treat their patients. To have an administration issue limiting or delaying care is quite frustrating," Ray says.

• Patient access employees

"There are so many changes, and we have relationships with hundreds of payers and health plans," Ray explains. "The industry is evolving so quickly."

Keeping all patient access employees updated is a daunting challenge.

"We have hundreds of registration staff at 65 sites, and another 100 or so at providers' offices. To get all the information out to everyone is a challenge in itself," Ray says.

Emory Healthcare's schedulers as well as its pre-registration and pre-certification teams all receive continuous updates on plan changes.

"Everyone should be knowledgeable on how to communicate the patient's benefits," Garlington advises. ■

MACRA Going to Change Patient Access Processes 'Tremendously'

Much work remains, and patient access departments must be proactive to stay ahead of the curve

Social Security numbers must be removed from all Medicare cards by April 2019, according to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

"Medicare patients will need to be educated on the new identifier to use when accessing care. They need to be informed why the change was made to stop potential identity theft," says **Cindy Ovalle**, patient registration director at PIH Health Hospital – Whittier (CA).

At the point of access, Medicare patients now will be assigned a new Medicare card with a Medicare Beneficiary Identifier (MBI) instead of the current Health Insurance Claim

EXECUTIVE SUMMARY

Patient access processes will change due to the Medicare Access and CHIP Reauthorization Act of 2015, which requires removal of Social Security numbers from all Medicare cards by April 2019. Top challenges include:

- Patient access must obtain a copy of the new insurance card and update the policy number for every patient with a traditional Medicare plan.
- There is no guarantee that insurance companies will update their databases, which could result in inaccurate information.
- If patients need to call the payer directly, patient access can explain what information is needed.

Number, which includes the patient's Social Security number.

Roger Stone, system manager for admission services, patient registration, and central access at CoxHealth in Springfield, MO, predicts MACRA will change his department, and all other patient access departments across the country, "tremendously."

"We are already proactively brainstorming the work that needs to be done to be ready for this change," he says.

Patti Consolver, FHAM, CHAM, senior director of the patient access intake center at Texas Health Resources in Arlington, TX, says having more than a year to plan for MACRA risks delays.

"It will go the way of ICD-10 and sit on a shelf," Consolver warns. "We just need to get ahead of it and provide timely communication."

Many Hours of Extra Work

Stone doesn't blame CMS for making this move.

"They are following what many other health insurance companies have already done to try and help protect patients and their identity," he says.

However, there is no question that it means more work for many areas of the hospital, "not only our patient access teams, but many other departments within the revenue cycle and IT departments," Stone says.

Time-consuming phone calls to payers will be needed, but not by registrars.

"The even bigger challenge with this is that most payers will not talk to our staff, but instead will want to the talk to the patients," Stone explains, noting patient access will take a more indirect role. "One way our staff can be beneficial to the patient is walk them through the phone call, instead of telling them to go home and call their insurance provider."

If patients present their updated Medicare card, patient access staff will have to deactivate the old Medicare insurance in the registration system. They will then re-enter it with the new MBI, instead of simply asking for the Health Insurance Claim Number.

Ovalle explains, "The registration team will need to make sure we are updating with the most current insurance information. Hopefully, the patient has his or her new ID card available."

Patient access will have to ask the patient for their new Medicare card with the MBI. Staff currently ask for the Health Insurance Claim Number.

"If patients do not have their new MBI number or card with them, the process may take longer," Ovalle warns. Patient access will have to run eligibility with the Health Insurance Claim Number.

"As with any process, there is a learning curve for staff," Ovalle explains. "Processing time may slow down as the new protocols are learned and refined." Here are some expected challenges for patient access departments.

• Getting staff to update the information for established patients.

"If people are used to using card copies from previous visits — we have that capacity in some facilities — it may be an issue," Consolver says.

• Dealing with "downstream" issues due to payers not updating the crossover information.

"This will mean claims that previously went to Medicare as secondary may be delayed," Consolver says.

• Preparing for possible coordination of benefits issues.

"The commercial secondary may not recognize the MBI, because they still have the old Health Insurance Claim Number," Consolver explains.

Ovalle hopes this won't happen too often, because Medicare most likely will use a common member identifier that will flag it as a Medicare FFS policy.

"By the time the change is implemented, most, if not all, of the payers should have the capability to match the policy numbers," Ovalle says.

• Making sure that the ID number is updated, and a copy of the new insurance card is obtained, for every patient with a traditional Medicare plan on file.

"If patients have Medicare Replacement/HMO plans, we need to be sure their records get updated as well," Stone says.

Patient access currently requires the Health Insurance Claim Number to be listed, along with the policy number for their replacement/HMO plan.

"This alone will bring many challenges," Stone notes. "We will have to rely on other insurance companies to update their databases so when our teams go to check for eligibility it is accurate."

• Training patient access staff to field questions from patients.

"We will work to get this information out across the system, to all staff involved," Stone says, noting that tip sheets and workflow maps are under development. "I don't believe patients are educated enough about their healthcare insurance coverage from insurance carriers."

This puts the onus on patient access to explain the changes. CMS said it will use the message field on the eligibility transaction responses to inform providers when a new Medicare card has been sent to each beneficiary. Patient access will be instructed to look for this message.

> CMS SAID IT WILL USE THE MESSAGE FIELD ON THE ELIGIBILITY TRANSACTION RESPONSES TO INFORM PROVIDERS WHEN A NEW MEDICARE CARD HAS BEEN SENT TO EACH BENEFECIARY.

"This will help us make sure the patient is aware a new card was sent to them if they have not already received it," Stone says. ■

SOURCES

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Watch for These Encouraging Signs When Identifying Future Leaders

Taking initiative, putting coaching to good use among key traits

If a registrar noticed families were standing too close while waiting to register and could overhear what's being said, would he or she just complain about it? Or would the registrar place signage in an appropriate spot to ensure privacy and confidentiality during the registration process?

The latter reaction is a signal that the registrar is a good candidate for a leadership role, says **Sarah Thomas**, senior director of access systems at Seattle Children's Hospital.

"Some people are just wired that way. When they see that something is less than ideal, they don't just say, 'Ugh, that's annoying.' They take action," says Thomas, who looks for these signs:

• Taking the initiative to come

EXECUTIVE SUMMARY

Identifying front-end employees who are potential management material is important for the future of the department. Some signs of leadership potential:

- Alerting supervisors to problems and possible solutions;
- Developing a reputation as a resource person;
- Putting training to good use on the job.

to leaders with a recommendation to solve a problem.

"It can be as simple as noticing that some areas don't have recycle bins in close proximity — so they step in and ask if it's OK to order them," Thomas says.

• Getting buy-in from others for ideas.

To do this effectively, employees must listen closely and incorporate feedback — not an easy skill to master, according to Thomas.

• Having other staff look to them as a resource person.

"Are they comfortable and effective at sharing information with others and working through problems?" Thomas asks.

• Putting information from coaching to good use.

"I watch to see that they carry the lesson forward and grow from the investment in training," says Thomas. She takes note of these things:

• *What questions employees ask*;

• *If they retain new information and apply it to their work*;

• *If they speak up and offer ideas*;

• *If they point out opportunities for improvement, even if they don't know yet what the solution will be.*

Over time, Thomas gives the employee increasingly complex tasks. She might ask them to cover a particular topic at a staff meeting, or collect data to support a departmental initiative.

"Even if the person isn't cut out for leadership, they still learn something along the way — and I avoid promoting the wrong person," Thomas notes

All of Thomas' department's patient access supervisors have been promoted internally. "Some of them have gone on to become managers and directors over time," she adds.

Sara Polak, director of patient access services at Robert Wood Johnson University Hospital Rahway (NJ), says if an employee presents issues in a negative manner without resolution, "that's definitely not a good sign." Polak looks for employees who handle things on their own without turning to management every time they encounter a difficulty.

Michelle Ross, director of the Patient Access Resource Center at St. Luke's Health System in Boise, ID, considers technical skills such as proficiency with electronic medical records and quality assurance auditing. She wants to know if the employee understands what it takes to create a clean, billable registration, for instance. Ross also looks for these things:

• *Do they build relationships?*

• *Can they think strategically?*

• *How are their written and verbal communications skills?*

"Beyond skill, all of those play a part in successfully serving in a leadership role," Ross says.

In her experience, patient access leaders fall into one of two categories:

• The Informal Leader.

These folks are usually easy to spot. "They are the 'go to' for their area of expertise," Ross explains.

To develop these employees, Ross gives them what she calls a stretch project — an assignment outside their current scope.

"I assign them a task with minimal instruction. Then I evaluate the tactics they use to complete the assignment," she says.

• The Unexpected Leader.

A registrar came to St. Luke's patient access department without

Other Possible Roles for Hard-working Registrars

Some patient access staff are capable of strong, independent work, but just aren't cut out to supervise others.

"Hard workers with people skills are for management. Hard workers that are more reserved are always excellent in the QA role," says **Sara Polak**.

Michelle Ross says hard-working employees usually are proficient in their jobs, "but being a technically strong individual does not, on its own, make you a strong leadership candidate."

She's placed team members who aren't suited for leadership in quality assurance, education, and technical design roles. One extremely skilled registrar always completed her registrations with accuracy and advocated for her patients.

"She understood insurance like no one else on the team," Ross recalls.

The registrar was promoted into a lead role, but it was a bit too challenging.

"She knew all the answers, but some of her soft skills were lacking," Ross explains. "Her interpersonal interactions were rough, and she had a hard time thinking globally."

Still, the registrar continued to demonstrate strong technical skills. Realizing the leadership role wasn't the best fit, her manager encouraged her to apply for a new quality assurance role. The position required her to evaluate technical and operational workflows, audit accounts, and provide liaison support to employees.

"This was the sweet spot for her. She is now the subject matter expert on the team," Ross says. ■

much experience, joining a team of very seasoned employees. She lacked the technical skills of her peers.

"But the way she was able to build trust within the team, her openness to trying new things, and her ability to navigate challenging situations made her stand out among her peers," Ross says.

A year later, a supervisor position opened. The registrar decided that going through the application process would be a good way to practice interviewing for future opportunities.

"What she didn't know was that this was the opportunity," Ross notes.

Competing against some very experienced candidates, the registrar was promoted into the supervisor role.

"She has quickly developed into one of our strongest leaders," Ross adds. ■

SOURCES

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To Find Out If Employee Has Potential, Delegate a Task

Independently managing simple duties could be a sign of future success

When **Sarah Thomas**, senior director of access systems at Seattle Children's Hospital, suspects an employee has leadership qualities, she delegates a job to them.

"I start with smaller tasks that have a lower risk if not well done," she says. Some examples include:

• sending the employee to a training session and asking him or her to teach their peers what he or she learned.

"That gives me insight into how organized they are about taking notes, how well they absorb the big picture, and how well they communicate," Thomas explains.

• asking the employee to make copies of an agenda for a meeting.

"It could be that they have 20 questions just to determine how to put the copies together," Thomas notes. If the employee can't do a simple task without a lot of coaching, he or she isn't ready to manage others. On the other hand, the employee might pleasantly surprise by figuring out how to program the department's copy machine, or come up with an extra article that's relevant to the meeting agenda.

> SENDING AN EMPLOYEE TO A TRAINING SESSION, FOR EXAMPLE, AND ASKING HIM OR HER TO TEACH COLLEAGUES WHAT HE OR SHE LEARNED IS A GOOD INDICATOR OF ORGANIZATIONAL SKILLS.

Even if the employee flounders, it's low risk for the patient access leader.

"At the end of the day, you're still the one leading the meeting," Thomas adds.

Teresa Carballo, a quality and training manager at Seattle Children's Hospital, came to the organization as a scheduler from a small physician practice.

"It was my first experience in a really large organization," she recalls.

Shortly after she started, Thomas asked Carballo to be part of the committee involved in planning implementation of a new system.

Carballo was able to give input from the scheduling perspective to tweak the way the new system was under designed.

"People were looking to me, asking, 'How does that sound?' and 'Does it actually happen that way?'" she recalls. "On the front line, you don't always see how decisions are made."

Carballo enjoyed the experience and began training staff in the new system, and shortly afterward, was promoted to her current position as manager of Epic training and cur-

riculum development. She credits this to receiving a chance to work outside her role.

"It allowed me to think bigger than what I was doing in my day-to-day work, and see how things worked in the organization," Carballo recalls. ■

SOURCE

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Rude, Disrespectful Employees Create Tension Across Departments

Establishing good working relationships is not always easy

Does a colleague question you constantly, undermine departmental goals, or just get on your nerves?

"One of the biggest challenges for today's patient access managers is simply getting along with all of their coworkers," says **Valerie Macelis**, BA, MBA, CHAA, a marketing representative at VITAS Healthcare in Norwalk, CT. Macelis is a former patient access trainer at Western Connecticut Health Network.

"We spend more time with our co-workers per day then we do with our own families," Macelis says. "Values, ideas, and work ethic vary from person to person."

Macelis recently worked with one particularly difficult colleague.

"She refused to listen to me, as a veteran employee, and questioned everything that I did," she recalls. "She created problems with other co-workers."

The employee complained to the department director about Macelis.

"The tension in the department made it very difficult for me to do my work properly and on time," Macelis says. Other patient access employees were uncomfortable with the friction between their two colleagues.

"The advice I would give other patient access leaders who have to face something similar is to find a way to get along," Macelis says. She suggests finding a common interest to make it easier to work together. If you are unable to do so, make management aware of the issue.

"They may be able to work things out, or move people around to make sure work is not uncomfortable for everyone involved," Macelis notes.

Lauren Blanchard, MBA, interim director of patient access for Crozer-Keystone Health System in southeastern Pennsylvania, says patient access managers or supervisors should get involved right away if there's tension between two co-workers. The first step is to have a meeting with both of them.

"Discuss what is and is not appropriate and make consequences clear if the behavior continues," she says.

Blanchard says that simply walking around the department and being visible is an effective way to open communication about conflicts between colleagues. She also encourages employees to call or email with concerns with an open-door policy.

"Let employees know all of the different ways that they can report concerns so that they feel confident that they will be heard," she says.

Blanchard says a confidential employee hotline also can help.

"This can handle concerns that need a mediator, or that cannot be addressed directly with the manager or supervisors in the department," she says.

Here are some common examples of patient access employees who might be perceived as difficult, with strategies for each:

• Employees who constantly question leadership's decisions.

Blanchard welcomes questions if they're asked out of a genuine desire to improve.

"The problems arise when ques-

EXECUTIVE SUMMARY

Tension between patient access employees and colleagues produces negative effects on morale, productivity, and retention. Some strategies include:

- holding a meeting with co-workers to resolve the issue;
- instructing registrars how to speak up if they encounter disrespect;
- responding to concerns within 24 hours.

tions have been fully and clearly answered, but performance standards are still not being met," Blanchard explains.

She recommends these steps:

1. Find out if more education is needed. "Check the process. Is there something that was left out or unclear?" Blanchard says.

2. Interview the employee directly. "Find out if there is something they want, or do not understand," Blanchard recommends.

3. Ensure employees communicate concerns directly to leaders. Blanchard encourages this by always following up promptly. "Do this even if the cause for concern proves to be unfounded," she says. "This shows the patient access employee that management takes time to investigate things that are important to the staff."

• Employees who question the productivity of their co-workers.

"I post productivity statistics on our community board so that all employees can see that they are productive as a team," Blanchard says.

First, she asks the employee who is making the complaint why they believe their co-worker is not productive.

"I then run the reports. If there is no reason for the complaint, I let the employee know I reviewed the numbers again and they are correct," Blanchard says.

• Employees who complain often, undermining departmental initiatives.

EMPLOYEES WHO COMPLAIN OFTEN OR WHO NEED EVERYTHING EXPLAINED MULTIPLE TIMES CAN DRAG DOWN THE ENTIRE DEPARTMENT WITHOUT APPROPRIATE MANAGEMENT.

"This creates a toxic, negative atmosphere. It drives good employees away," Blanchard warns. She recommends these steps:

1. Make time to sit down with these employees and clarify expectations regarding professionalism. "Try to pinpoint what exactly is making them so unhappy," Blanchard advises.

2. Ask the employee what you can do to help them succeed.

3. Create an action plan with a timeline.

4. Document your conversation. "This will assist if the problem continues and corrective action must be taken," Blanchard says. "Gossip and complaining must be dealt with on an individual level."

• Employees who need everything explained multiple times.

Clear expectations — and consistent enforcement of standards — are two keys.

If a particular registrar still struggles after training, Blanchard says, "The employee should be re-assigned to a different area more suited to their abilities." ■

SOURCES

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Are Clinicians Really Rude, or Just Doing Their Jobs?

High-pressure situations may lead to misinterpretations of messages

A nurse rushes by a registrar on her way out of the treatment room without even making eye contact. A physician doesn't even acknowledge the registrar in the room who's obtaining demographic information. Are they being disrespectful, or just doing their jobs?

"Some clinicians viewed as difficult are merely driven and detail-oriented," notes **Lauren Blanchard**, MBA.

ED nurses and physicians working in high-acuity, time-sensitive situations might appear rude when, in fact, they're just doing what's needed for the patient.

"If a trauma physician makes a demand and appears agitated or irate, it is often due to the critical nature of the patient," Blanchard notes.

At times, if the registrar enters the patient's information incorrectly or too slowly, it delays care.

"Harm could come to the patient," Blanchard notes.

However, this doesn't mean clinicians are allowed to be rude or inappropriate to registrars.

"To avoid these situations, create a culture of respect and responsibility between clinical and non-clinical staff," Blanchard urges. She recommends patient access directors address concerns about rudeness by:

• meeting with clinical leaders about the issue at a later point in time.

"It's better to have the discussion about proper behavior at such time when patient safety will not be affected," Blanchard says.

• encouraging registrars to speak up if they feel they're being disrespected.

Blanchard encourages registrars to use this format: "I felt (emotion) when (what happened) because (reason)."

For instance, "I felt disrespected when you demanded I update the patient's information, because you yelled across the room and other patients and staff members could hear everything you said." Or: "I felt confused when you told me to go to lunch right away, because another employee came in earlier than I did and had not gone to lunch yet."

"This allows the employee to calmly convey what they felt, what triggered the reaction, and why, without accusing the other employee of any wrongdoing," Blanchard explains.

• creating a workflow for handling concerns in a private and timely fashion.

Blanchard responds to concerns within 24 hours to show she received the complaint. She provides a date as to when the employee can expect to hear back. "I usually offer follow-up within a week of the initial communication, regardless of whether there has been a resolution," Blanchard says.

• providing follow-up to the employee who brought up the concern, even if the cause for concern proves to be unfounded.

This shows the patient access employee that management takes time to investigate things that are important to the staff.

"By being diligent in providing two-way feedback, behaviors such as gossiping, complaining, and questioning leadership are greatly reduced," Blanchard says. ■

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Cloud Service Providers Still Are Business Associates, According to Office for Civil Rights

Healthcare providers increasingly are turning to cloud-based providers (CSPs) to manage data, but the Office for Civil Rights (OCR) reminds them that this arrangement needs a business associate (BA) agreement, even if the CSP has no access to protected health information (PHI). In addition, OCR has indicated that covered entities are not obligated to audit BAs for HIPAA compliance.

The role of CSPs in relation to HIPAA was somewhat unclear because the rule was not written to include them specifically, and one could argue that they have no access, says **Nathan A. Kottkamp**, JD, a partner with the law firm of McGuireWoods in Richmond, VA. The issue arises because the 2013 Omnibus Final Rule contained a subtle alteration to the definition of a business associate so that it includes an entity that "maintains" PHI, he explains.

But no one was clear on what "maintains" means in this sense, Kottkamp says. The dictionary definition suggests much more hands-on activity and affirmative action than what many would associate with a CSP, he says. CSPs make possible online access to shared computing resources with varying levels of functionality depending on the users' requirements, ranging from simple data storage to electronic medical records. They also may provide on-demand internet access to networks and servers.

"What a cloud provider does is not unlike what a bank does with respect to a safety deposit box," Kottkamp says. "They provide the environment, and though there may be a master key, banks would go out of business if they were found to be using the master key to get into people's boxes. Some of the cloud providers could get into the data if they had to, but others just can't because there is no key to access it."

> THE ROLE OF CLOUD SERVICE PROVIDERS IN RELATION TO HIPAA WAS SOMEWHAT UNCLEAR BECAUSE THE RULE WAS NOT WRITTEN TO INCLUDE THEM SPECIFICALLY.

Cloud Providers Resisted BA

Without clear guidance, many covered entities wondered if CSPs were BAs, particularly since some CSPs would not even know if they had PHI in their customers' stored data. Access also became an issue, with covered entities and CSPs both wondering if having no access to stored data would change their status in the eyes of the OCR. The CSPs argued that they were not BAs partly because the other interpretation would obligate them to compliance and bureaucracy that they would rather avoid.

"We had companies saying they were not a business associate, and so they're not going to sign your papers," Kottkamp says. "They did not want to enter into an agreement with every client that might have PHI in their stored data."

Access to Data Not Necessary

Some CSPs were begrudgingly beginning to accept

that they are BAs, but recent OCR guidance erases all doubt. *(Editor's Note: The guidance is available online at: http://bit.ly/2dA07zu.)*

In a particularly important note, OCR explained that even when a CSP stores only encrypted electronic PHI (ePHI) and does not have a decryption key — what OCR calls a "no-view service" — it is still a HIPAA BA.

"Lacking an encryption key for the encrypted data it receives and maintains does not exempt a CSP from business associate status and associated obligations under the HIPAA rules," the OCR guidance says. "An entity that maintains ePHI on behalf of a covered entity (or another business associate) is a business associate, even if the entity cannot actually view the ePHI."

The encryption does not negate the BA status because it does not maintain the integrity and availability of the ePHI, such as ensuring that the information is not corrupted by malware, or ensuring through contingency planning that the data remain available to authorized persons even during emergency or disaster situations, OCR explains. Encryption also does not address other safeguards that also are important to maintaining confidentiality, such as administrative safeguards to analyze risks to the ePHI or physical safeguards for systems and servers that may house the ePHI, the guidance says.

CSPs also argued that they fell under the "conduit" exception in HIPAA, which says that PHI merely passing through an entity does not make that entity a BA. The conduit exception does not apply to CSPs because they should have at least limited access to the data, OCR explained. Unlike PHI merely passing through with no attention from the conduit, the CSP must create a mechanism to at least identify the owners of the data to let them know a breach has occurred or data have been destroyed, Kottkamp says.

"The guidance confirmed what they meant by maintaining data," he says. "It's not just about the content of the data. 'Maintain' means protecting and providing access to that data, and that's what these [CSPs] do. They have to do that, even if they never have access to the data itself."

Review BA Agreements

OCR recently finalized a resolution agreement and corrective action plan with a healthcare provider that stored ePHI of more than 3,000 people on a cloud-based server without entering a BA agreement with the CSP. (*For more on that case, see the story at left.*)

However, OCR guidance says that if a CSP receives and maintains only information that has been de-identified in accordance with the HIPAA Privacy Rule, is it is not a business associate. De-identified data are not considered protected health information.

Hospitals and health systems

Cloud Service Provider Needed BA Agreement

A HIPAA breach at Oregon Health & Science University (OHSU) illustrates how CSPs fit into compliance efforts. In addition to other violations, the OCR dinged OHSU for not having a BA agreement with a CSP.

OCR concluded that OHSU had "widespread and diverse problems" with HIPAA compliance. OHSU had submitted multiple breach reports affecting thousands of patients, including two reports involving unencrypted laptops and another large breach involving a stolen unencrypted thumb drive. The violations were settled with a comprehensive three-year corrective action plan and a monetary payment of $2.7 million.

The violations included the storage of the ePHI of more than 3,000 individuals on a cloud-based server without a BA agreement. OCR found there was "significant risk of harm" to 1,361 of these individuals due to the sensitive nature of their diagnoses.

OHSU performed risk analyses in 2003, 2005, 2006, 2008, 2010, and 2013, but OCR's investigation found that these analyses did not cover all OHSU ePHI.

"OHSU did not act in a timely manner to implement measures to address these documented risks and vulnerabilities to a reasonable and appropriate level," OCR reported. "OHSU also lacked policies and procedures to prevent, detect, contain, and correct security violations and failed to implement a mechanism to encrypt and decrypt ePHI or an equivalent alternative measure for ePHI maintained on its workstations, despite having identified this lack of encryption as a risk."

Furthermore, OCR said OHSU should have addressed the lack of a BA agreement before allowing a vendor to store ePHI. OCR Director **Jocelyn Samuels** said, "This settlement underscores the importance of leadership engagement and why it is so critical for the C-suite to take HIPAA compliance seriously." ■

should review their use of CSPs and ensure each has a BA tailored to the way it interacts with PHI, Kottkamp recommends.

"Cloud providers have no argument now that they are not business associates, so they should be incorporating this into their operations quickly," he says. "If you had cloud providers who balked at signing your agreement and participating with your HIPAA compliance program, you can go back to them and say there is no reason to resist now, and if they want do business with you, they have to agree they're business associates."

Not Required to Audit

Even without a BA agreement, the CSP becomes a BA by definition once it participates in BA activities. That could leave some CSPs in a difficult position if they are trying to stay out of that territory, Kottkamp says. They may provide all sorts of warnings and declarations that they do not want to store PHI, but once a customer disregards their wishes and posts the private data, OCR could argue that they became a BA, he explains.

"It is unclear how much a cloud host has to do to know whether a client is storing PHI on their system," Kottkamp says. "And if they find PHI, do they have to get rid of the customer, or is it enough to keep telling them you're not a business associate so you're not responsible for protecting this PHI? That question hasn't been answered yet."

The good news in the guidance is that covered entities are not required to monitor or audit their BAs for compliance with HIPAA. OCR most likely made that clear because BAs can be held directly liable for violations now, Kottkamp says.

"If OCR wants to know how a business associate is doing in terms of compliance, it can look into that directly," he says. "It's not going to force the covered entity to engage in its own separate enforcement and oversight activities. That's good news for covered entities, because they have enough on their plate as is, and checking up on every one of your business associates could be more than they're capable of doing." ■

SOURCE

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Surviving Phase 2 Audits Requires Serious Review

Phase 2 audits from the OCR should be taken seriously, and that includes a significant review of HIPAA policies and procedures. Don't assume the compliance program you've had for years is good enough for an audit, warns **Stephanie W. Schreiber**, JD, shareholder in the healthcare section within the law firm of Buchanan Ingersoll & Rooney in Pittsburgh.

"Back in 2003, when HIPAA first came into play, everyone was involved with writing policies and procedures. Then, many entities put those policies on the back shelf," Schreiber says. "As new rules came out, they took them out and looked at them again. The 2013 Omnibus Rule prompted some to update those policies, but simply looking at your policies and updating them is in itself insufficient for an audit."

Schreiber advises consulting HIPAA rules and assessing whether your existing policies and procedures address all the requirements. Entities can narrow that assessment somewhat because unlike a general compliance audit, OCR in Phase 2 focuses primarily on aspects of the privacy, security, and breach notification rules.

> IN PHASE 2, THE OCR FOCUSES ON ASPECTS OF THE PRIVACY, SECURITY, AND BREACH NOTIFICATION RULES.

The privacy rule could be the least challenging for covered entities. Some of the most common problems an audit might uncover involve up to date privacy notices, mechanisms for providing notice, and prominently displaying the privacy notice online.

"I suspect the security rule will be more of a struggle for some covered entities, and I think OCR is going to look there with more intensity," Schreiber says. "This is all about assessing how your organization holds and transmits PHI, how it is protected, and whether you have done risk assessments and updated those assessments in light of all the cyber threats recently."

The Phase 2 audit process begins with OCR sending an email to covered entities and business associates requesting that contact information be provided to OCR in a timely manner. Once it receives that informa-

tion, OCR then transmits a pre-audit questionnaire to gather data about the size, type, and operations of potential auditees. That data will be used with other information to select entities for audits. If an entity completes the pre-audit questionnaire, OCR will use publicly available information, which may still be selected for an audit.

The same applies when OCR sends notice that a facility has been selected for an audit. Pretending the notice never arrived won't help.

"Failing to respond to the audit notification does not mean you won't be audited. Rather, it is likely that even more attention will be paid to you," Schreiber warns. "Depending on what they find in a Phase 2 audit, it could lead to a general compliance audit, which would be much broader." ■

SOURCE

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Office for Civil Rights Settlement Focused on Search Engine Access

A recent settlement with the OCR involved healthcare files that were accessible through search engines. The health system had purchased a server that, unbeknown to it, featured a default setting that allowed anyone to access sensitive medical information online.

St. Joseph Health (SJH) in Irvine, CA, has agreed to settle potential HIPAA violations related to how files containing ePHI were publicly accessible through search engines from 2011 until 2012. SJH agreed to pay a settlement amount of $2,140,500 and adopt a comprehensive corrective action plan. The health system is comprised of 14 acute care hospitals, plus home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations throughout California, as well as in parts of Texas and New Mexico.

SJH self-reported the HIPAA violations on Feb. 14, 2012, alerting OCR that certain files it created for its participation in the meaningful use program, which contained ePHI, had been publicly accessible online from Feb. 1, 2011, until Feb. 13, 2012, via Google and possibly other search engines. The health system traced the breach to a server SJH had purchased to store the meaningful use files, realizing too late that the server contained a file-sharing application with default settings that allowed internet access with no restrictions.

> THE FILE-SHARING APPLICATION ALLOWED UNRESTRICTED ACCESS TO FILES CONTAINING THE PERSONAL HEALTH INFORMATION OF 31,800 PATIENTS, INCLUDING NAMES, HEALTH STATUSES, DIAGNOSES, AND DEMOGRAPHIC INFORMATION.

The file-sharing application allowed unrestricted access to files containing the ePHI of 31,800 patients, including names, health statuses, diagnoses, and demographic information. OCR's investigation determined that the health system was at fault for not inspecting the server and detecting the open door before ePHI was placed on it.

"Although SJH hired a number of contractors to assess the risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held by SJH, evidence indicated that this was conducted in a patchwork fashion and did not result in an enterprise-wide risk analysis, as required by the HIPAA Security Rule," OCR reported when announcing the settlement.

In addition to the monetary settlement, SJH agreed to a corrective action plan that requires it to conduct an enterprise-wide risk analysis, develop and implement a risk management plan, revise its policies and procedures, and train its staff on these policies and procedures. The settlement agreement and corrective action plan are available at: http://bit.ly/2dqIWhe. ■