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INSIDE

Editor's Note: This is a special issue on patient identification. Our cover story focuses on patients harmed by registration errors. Inside, we cover educating patients, protecting identities of violence victims, standardizing processes, preventing duplicate medical records, and utilizing biometrics.

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JANUARY 2017 Vol. 36, No. 1; p. 1-12

Report Finds Thousands of Patient ID Errors

Registration errors may have 'disastrous consequences' for patients

A patient had a do-not-resuscitate order on file, which clinicians followed. However, the patient in cardiac arrest was a different patient, who was incorrectly identified — and not resuscitated.

Another patient was discovered dead in his hospital room after undergoing surgery, but clinicians made the decision to proceed with the surgery based on the wrong patient's records.

"If we can improve the patient identification process, it will help prevent many different kinds of medical errors that currently plague healthcare delivery," says **William M. Marella**, MBA, MMI, ECRI Institute executive director of Patient Safety Organization Operations and Analytics.

In its recent "Deep Dive" report on patient identification, the ECRI Institute Patient Safety Organization analyzed 7,613 cases of wrong-patient errors at 181 healthcare organizations from January 2013 to July 2015.

"INCONSISTENT PATIENT IDENTIFICATION LEAVES THE ORGANIZATION VULNERABLE TO PATIENT COMPLAINTS FROM INCORRECT BILLING TO IDENTITY THEFT, NOT TO MENTION HEALTHCARE-RELATED RISKS OF TREATING THE WRONG PATIENTS." — EDWARD DIN, KERN MEDICAL CENTER

"Patient access may not realize that the accuracy of their work can impact decisions made by the healthcare team," Marella says. About 13% of patient identification errors occurred during registration. Some examples:

- A woman was admitted under her son's name, date of birth, age, and Social Security number.
- While reviewing surgical orders, clinicians realized a patient was registered under the wrong medical record number. The other patient had the same first and last name, but a different date of birth.

"A call to admissions confirmed the patient was registered under the incorrect medical record number when

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management™,
ISSN 1079-0365, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
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GST Registration Number: R128870672.

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blood specimens were drawn," Marella says. A new type and screen specimen had to be drawn under the correct medical record number before surgery could proceed, delaying the patient's surgery.

• Clinicians received an email from a doctor's assistant requesting a patient be marked as deceased.

"The patient was identified as expired in the EHR," Marella says. "In reality, the patient had been registered under the wrong medical number."

A week later, the patient arrived for an appointment, and was shocked to learn of the error.

"Seven outstanding appointments had been cancelled," Marella says.

False Information in System

Correctly matching each patient with the care providers intended for them is a very basic requirement of safe healthcare, says Marella, "but we saw thousands of events in which that standard wasn't met."

Errors made in registration or scheduling follow the patient throughout his or her hospital stay. Marella gives these examples:

• If the patient's identity isn't correctly confirmed at the point of care, the patient could receive another person's medications or undergo an invasive procedure intended for someone else.

• If someone places a positive lab test in the wrong patient's chart and then another person acts on that test, a diagnostic error can be made.

• If a duplicate record is created for a patient, his or her medical history and test results aren't available.

"If a patient gets admitted under someone else's record, it can have disastrous consequences if clinicians trust and act on false information," Marella adds.

• If information used to identify the patient is entered incorrectly, this undermines the clinical team's ability to confirm the patient's identity when delivering medications or performing lab or imaging tests.

"Many admission/discharge/transfer systems require exact matches when searching for existing patients," Marella notes. "Many older systems do not bring back close matches in addition to an exact match when searching patient records."

Pitfalls of 'Quick Reg'

Edward Din, director of patient access at Kern Medical Center in Bakersfield, CA, recently pinpointed the cause of many potentially harmful registration errors: Non-patient access personnel had completed a

EXECUTIVE SUMMARY

About 13% of patient identification errors involved registration, according to the ECRI Institute PSO's recent "Deep Dive" report, which analyzed 7,613 cases of wrong-patient errors. Some recommendations for registration:

- Utilize biometric technology;
- Track duplicate and overlaid records;
- Clearly define registration policies and procedures;
- Include staff feedback in quality assurance.

"quick reg."

"Inconsistent patient identification leaves the organization vulnerable to patient complaints from incorrect billing to identity theft, not to mention healthcare-related risks of treating the 'wrong' patients," Din says.

These registrations often require re-work to complete missing data elements. Registrars sometimes call ED patients post-discharge to obtain correct information. "Left unedited, these accounts can show up on the discharged/not final billed report," Din explains.

The department recently discovered that an average of 99 accounts each month in 2016 on the discharged/not final billed report were attributed to bad registrations, totaling $378,000 of potential lost revenue.

"There is a need to minimize registration errors and their impact on our patients and the revenue cycle," Din says.

Kern Medical Center's patient access department made these changes:

• Non-registration personnel are no longer able to access the registration and scheduling applications unless they have been validated as competent. *(Editor's Note: The department's Patient Access Service Representative Unit Specific Orientation Checklist is included with the online edition of this issue. For assistance accessing your online subscription, contact customer service by email at Customer.Service@AHCMedia.com or by phone at (800) 688-2421.)*

• A "quick registration" process is still used, but it's limited to the ED, trauma, and labor & delivery. "Previously, it was also used in correctional medicine and for lab specimen drop-offs," Din notes.

• Registrars compare the patient's government-issued ID to any forms completed by the patient during registration. "This ensures the 'right' patient encounter," Din says.

• Training was provided to medical assistants in clinics, appointment schedulers, unit clerks in labor & delivery, and office assistants in correctional medicine. "This includes competency to use our biometric application to scan the patient's index finger as a method of personal identification," Din says. ■

Four Recommendations to Avoid ID Errors

In its recent "Deep Dive" analysis of patient identification, ECRI Institute's Patient Safety Organization provided these recommendations for registration areas:

- Consider supplementing the registration process with biometric methods to improve patient identification;
- Foster a work environment that supports registration staff and values their contribution to patient safety through accurate patient identification;
- Implement a quality assurance plan, using metrics such as duplicate record and record overlay rates;
- Use clearly defined policies and procedures for registration. ■

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- **Edward Din**, Director, Patient Access, Kern Medical Center, Bakersfield, CA. Phone: (661) 862-4901. Email: Edward.Din@kernmedical.com.
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Watch for Signs Something Just Isn't Right

To prevent identify theft, patient access leaders conduct Red Flags Rule training annually at Kern Medical Center in Bakersfield, CA.

"This is done with an online learning module as part of the staff competency validation process," says **Edward Din**, director of patient access.

If any of these red flags occur, registrars immediately notify a patient access supervisor:

• a patient providing photo identification that doesn't match the patient;

• a patient providing a different Social Security number than one used on a previous visit;

• a patient providing information that conflicts with other information in their record;

• a patient providing information that conflicts with information received from third parties, such as insurance companies;

• a patient providing an address that the department's software

determines is not a valid address;

• **family members or friends calling the patient by a name different than that provided by the patient at registration**.

Recently, registrars encountered a situation that wasn't covered by any of these red flags. Law enforcement arrived at the ED with a patient who sustained an injury during an altercation.

"The patient was in restraints and unable to sign in, nor provide any valid ID, nor scan her finger," Din says.

Registrars had to depend on the information provided by police officers, and entered the patient's supposed name and date of birth.

"The information provided to law enforcement and then passed onto registration was found to be incorrect," Din recalls. "This was a learning opportunity for us."

The mistake was discovered when the hospital was notified by the patient, who was trying to clear her name in court. Din says either of these things would have prevented the error:

• **Finger-scanning the patient once the medical screening exam required by the Emergency Medical Treatment and Labor Act was completed.** This could have been done once the patient was no longer restrained, Din offers, prior to the patient's departure from the ED.

• **Checking the EHR instead of the master patient index before the start of the registration.** "The EHR indicated a patient with the same name, but a different date of birth and visit history," Din explains. ■

Turn Unhappy Patients Into Partners

Explain that identifiers are for their own safety

Patients and family often are exasperated when asked for the same information over and over again. Registrars are usually the ones to bear their wrath.

"An average hospital patient probably has their ID verified anytime from 10 to 30 times a day. We need to do a better job of setting that expectation," says **Kathy J. Eichner**, RN, MSN, CJCP, principal consultant at Joint Commission Resources.

The Joint Commission's National Patient Safety Goal addresses the longstanding problems of misidentifying patients and not matching patients with the correct orders or procedures.

"Patient access has been dealing with this issue for many years, trying to get rid of duplicate and inaccurate medical records," Eichner notes.

However, the problem is more difficult than it appears.

"Hospitals are incredibly busy places, and also very complex places," Eichner says. "It's very common for patients to move around the hospital system interacting with different departments."

Patient access is the first step.

"Registration really has an opportunity to set the stage from the beginning and promote safety anywhere the patient goes," Eichner says.

To put patients at ease, registrars can state, "I want to make sure I have all the information correct."

"Other industries routinely ask for verification. We do it with banks and credit cards," Eichner says. "In healthcare, it's the same principle — to match up the right work with the right people."

Stephanie Uses, PharmD, MD, JD, a patient safety analyst at ECRI Institute, recommends asking patients in an open-ended way, "What is your name and date of birth?"

"During the course of the admission, the patient may just start telling you their name and date of birth without asking," she says.

Registrars often ask patients, "Are you Mr. Jones? And is this your date of birth?" This can elicit inaccurate responses.

"It encourages simple 'yes' or 'no' responses," Uses explains. "This may mislead the clinician into thinking they have confirmation."

Eichner offers this sample scripting: "It's important to us at ABC hospital to make sure we are always

EXECUTIVE SUMMARY

Patients often are upset to be asked for demographic information repeatedly. Patient access counters dissatisfaction by educating patients that it's for their safety.

- Tell patients upfront they'll verify their identity multiple times.
- Encourage patients to ask clinicians to verify their identity.
- Ask patients to confirm the accuracy of information before placing wristbands.

providing you with the specific medications and treatments that your physician orders for you. We do that by always making sure that we match up your identity with the indications on the order. Because of that, whenever someone comes to give you medication or take you for a procedure or does a treatment, you can expect they will always want to validate your name and date of birth."

"Just by setting that expectation, then the first, second, or even 10th time they're asked, they understand you're wanting to keep them safe," Eichner notes.

Eichner says departments that struggle with satisfaction issues related to patient identification "may be the ones who don't proactively set that tone."

Patient access can partner with patients in these two ways:

1. Tell patients, "If somebody forgets to ask you, you should stop them. Ask them to verify your identity first."

"This is the same thing we do with handwashing. We tell patients it's OK to ask healthcare providers to wash their hands," Eichner says. The same is true for asking healthcare providers to verify the patient's identity.

2. Ask patients to read wristbands carefully to be sure the information is accurate and spelled correctly.

"That's the last safety net to make sure we identify the patient correctly," Eichner says.

Fix These Problems

Surveyors from The Joint Commission report these five common issues involving patient identification processes:

• Two identifiers are obtained, but they aren't specific to the patient.

The Joint Commission's National Patient Safety Goal requiring the use of two unique identifiers has been in place for about a decade, but there are still problems with compliance. Most often, this is due to the use of incorrect identifiers.

"The key there is unique," Eichner says. "We are looking for identifiers that are as specific to that patient as possible — and two separate ones."

THE JOINT COMMISSION'S NATIONAL PATIENT SAFETY GOAL REQUIRING THE USE OF TWO UNIQUE IDENTIFIERS HAS BEEN IN PLACE FOR ABOUT A DECADE, BUT THERE ARE STILL PROBLEMS WITH COMPLIANCE.

This is to make sure patients with the same name are distinguished by a piece of information that's unique to them such as date of birth or a medical record number.

"We especially guard against using the room, cubicle, or bay number, because patients do move around in hospitals," Eichner adds.

• An order or test result doesn't seem to go with the rest of the patient's record.

"It could be that someone selected the wrong patient before they started charting. We see that a lot, actually — it's not uncommon," Eichner says.

There might be several Fred Johnsons, all related, even with the same address. It's easy to imagine how a test result could get into the wrong person's chart.

"That is a significant issue for patient access," Eichner says.

• A roomful of people is waiting to register.

When the registrar calls out, "Mr. Johnson," several people stand up.

"Clearly, we need more information about the Mr. Johnson we want to speak to," Eichner says. "We need a process for figuring out how that's going to happen."

• A patient is quick-registered at the bedside, and goes up to a floor unit where a patient with a similar name is receiving treatment.

"If a registration person goes up to collect the rest of the patient's information and there is another Mr. Johnson up there, we can run into confusion," Eichner explains.

• A patient is pre-registered, but only basic demographic information is collected.

"Anytime there is a campaign trying to encourage people to pre-register, we need a good process to gather unique information on the patient," Eichner emphasizes. ■

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Standardize Processes for Patient Identification

Department maintains 98% accuracy rate

Patient access leaders at AtlantiCare Regional Medical Center, which has hospital campuses in Atlantic City and Pomona, NJ, set out to standardize patient identification processes in 2015.

"We needed to assess our process and identify ways to improve it," says Patient Access Director **Jacqueline Lilly**.

She led the hospital's Enterprise Master Patient Index Quality Committee, with representatives from IT, quality and training, and health information management.

"We identified the need for a standardized process for naming conventions and positive patient identification across all points of access," Lilly says.

At that time, patient access was working with the hospital's IT department to consolidate electronic medical records across the organization.

"The committee was critical to helping us create the single best process to standardize creation of, and access to, patient records," Lilly says. These goals were set:

• Create guidelines and implement education to ensure staff can properly access, maintain, and update a patient's electronic medical record;

• Maintain the integrity of patient information;

• Improve operating efficiencies and minimize adverse events stemming from misidentification and duplicate medical records.

All patient access associates now use the same approach for patient identification.

"This helps prevent duplicate medical record creation. It also helps us establish expectations and accountabilities for maintaining the integrity of our databases," Lilly notes.

Since the change, the department has maintained a 98% average accuracy rate.

"We are in the process of enhancing our reports to identify medical record duplicates," Lilly reports. "We are implementing a tool to help automate this process."

All patient access staff attended training, led by the patient financial services quality and training manager.

"Our slogan was #MPISPELLIT," Lilly says, explaining that the "MPI" refers to master patient index, and "SPELLIT" reminds staff of the importance of spelling names accurately.

The training covered:

• how to search the master patient index for an existing patient;

• how to handle duplicate medical records;

• understanding what happens if the wrong person is selected;

• how to enter a name properly for new or existing patients;

• why it's important that the patient, not the registrar, should spell the patient's name.

Lilly explains, "Staff shouldn't be saying, 'Do you spell John the standard way?' Jon might consider his spelling standard."

Financial Outcomes

Lilly has found that good patient identification is linked to better financial outcomes.

"The revenue cycle process starts with capturing the patient's accurate demographic information and insurance information," she explains.

Having correct, up-to-date information makes billing and payment go smoothly.

"When the same patient name and medical record is used on subsequent visits, clinicians have access to information about previous visits and/or medical history," Lilly adds.

If there were two medical records for a patient, different clinicians might order lab tests even though results of a previous test might still be recent and relevant.

"This affects cost of care," Lilly explains. "Also, the second clinician might not see a diagnosis the first clinician entered, which could impact treatment." ■

EXECUTIVE SUMMARY

Patient access leaders at AtlantiCare Regional Medical Center standardized patient identification processes in 2015 and achieved a 98% registration accuracy rate. Training covered:

• how to search for an existing patient;

• how to enter a new patient's name properly;

• the importance of asking patients to spell their names.

Conceal Identities of Patients Who Have Been Victims of Violence

Organization must institute different registration process

Being rushed to an ED takes a physical and emotional toll on anyone.

"Another layer of anxiety is added if patients are also afraid the wrong people may find out where they are," says **Ashley Franklin**, a patient access associate at Northwest Hospital in Randallstown, MD.

If someone arrives with bruises, swollen eyes or broken bones who was not in a car accident or a similar circumstance, a red flag rises immediately.

"Patient access immediately alerts the triage nurse when someone arrives whom they suspect may be coming from a dangerous situation," Franklin says.

The clinical staff then assess the patient. If indicated, a representative from the hospital's domestic violence program is called to provide additional help to keep the person safe.

"If patients express concern about other people knowing where they are, patient access associates tell them about the confidential program," Franklin says. If patients choose this option, organizations take these steps:

1. The patient fills out a disclosure letter, and a patient access associate signs as a witness.

2. The form goes into the patient's medical record, and a patient access staff member changes the name in the hospital system.

3. The patient access associate changes the patient's ID bracelet and prints a face sheet with the new confidential name. The patient signs her or his actual name on that form. "The patient access associate documents the account in a memo, and the patient has a new identity," Franklin notes.

4. When the name change is complete, the patient access manager sends an email notification to all departments that could be involved with the individual's care throughout her or his stay.

If ED patients are unresponsive, a request for anonymity can be made by police officers or the clinical staff.

"A disclosure letter must be filled out by the requestor with a written reason, and witnessed by a patient access associate," Franklin says.

Organizations use a similar process for patients with scheduled procedures who are pre-registered over the phone. The patient access associate fills out the disclosure letter, and the patient signs it when he or she comes in.

"Throughout a patient's stay, the new identity is used," Franklin says. "When the individual is discharged, patient access changes the identity back to the person's real name."

Clear communication between all the departments involved in the patient's care is necessary to avoid confusion.

"Diligence is required to make sure the new name is used, while retaining the real name on X-rays and medications that are needed," Franklin explains.

Patients Can Opt Out

At Saint Francis Hospital & Medical Center in Hartford, CT, registrars flag the account as confidential if patients choose to opt out of the facility directory.

"This can be set at the patient level for all future encounters, or it can be encounter-specific," says **Susan Kole**, director of patient access.

Registrars tell callers and visitors they have no information on the patient. Patients are made aware that they won't receive mail, flowers, visitors, or incoming calls.

"Requests for patient information can be difficult if the patient has been flagged confidential but has given friends and family their location," Kole notes.

Patients can provide a limited list of approved visitors. If the person requesting information is not on the list, no information is provided.

"Oftentimes, they have received a call from the patient," Kole says. "But we are still obligated to respect the patient's or security's decision for confidentiality."

Registration flags accounts as confidential if the patient is a gunshot or assault victim.

"Unidentified traumas are automatically flagged confidential until the name is verified and changed," Kole says.

Security and the clinical staff review the accounts, and either leave the flag or remove it.

"Access to confidential patients is security-driven — and clearly marked — for anyone working in the patient record," Kole says. ■

SOURCE

- **Susan Kole**, Director, Patient Access, Saint Francis Hospital & Medical Center, Hartford, CT. Phone: (860) 714-6300. Email: skole@stfranciscare.org.

Overlaid Medical Records: More Dangerous Than Duplicates

Although duplicate medical record numbers (MRNs) certainly are problematic, registering a patient on another person's MRN is dangerous.

"This is particularly true with the implementation of EMRs as this can lead to medical decisions that are based on a different patient's history," says **Shannon Haager**, director of patient access services at The Ohio State University Wexner Medical Center in Columbus.

For this reason, Haager says, "We are much more uncompromising about the selection of a wrong MRN than with the creation of a duplicate."

If, after using several search techniques, registrars aren't absolutely positive their patient matches an existing MRN, they create a new record.

"The most common reason for this is two people with the same name and other data points are not validated," Haager says.

A registrar assumes he or she has the correct "Tabitha Jorgenson" because only one comes up in the system, for instance.

"But it's a brand new patient, raising doubt," Haager notes.

Researchers found that 98.81% of individuals were uniquely identified using first name, last name, and date of birth while examining a database of more than 85 million individuals.[1] However unlikely, it's still possible to misidentify patients, even with those identifiers.

"We have several sets — at least five that I know of — where two people have the same name and date of birth," Haager says.

Haager finds that talking with staff about what happens when the wrong MRN is used — "specifically, how dangerous it can be — is the most effective tool for reducing misspellings."

Protocols to stop duplicate medical records were put into place recently at the centralized scheduling department at The Ohio State University Wexner Medical Center.

"We work directly with patients to verify multiple pieces of information," explains patient access director **Brooke Bellamy**. This confirms whether it's an existing patient in the system, or if a new account needs to be created.

"We have also standardized our registration process," Bellamy adds. "We are confirming and collecting

Study IDs Root Causes of Duplicate Records

Incorrect middle names, Social Security numbers, misspellings, and first, middle, and last names in the wrong order were the most common causes of duplicate records, according to a study on a database of 398,939 patient records with confirmed duplicates.[1]

"The findings weren't a surprise to me as we had studied this back in 2007 and 2008," says **Beth Haenke Just**, MBA, the study's lead author, noting the only improvement was the accurate capture of the patient's date of birth. "I believe this is due to the large emphasis over recent years on positive patient identification."

Just suggests that patient access departments incorporate these findings into their training programs. "If patient access staff understood more clearly the top data capture challenges and their impact on duplicate record creation, their data capture quality would increase."

Just views capturing the patient's legal name accurately as a top challenge. "Nearly 50% of all duplicate records have a discrepancy in the last or first names, some with both," she says. Nicknames and misspellings are common, as are last name changes for women and children due to marriage or divorce. Just recommends these practices:

- **Query the patient or parent about prior names used**;
- **Obtain a legal document from the patient, such as a driver's license, and use that for entering the patient's name**;
- **Ask the patient "Have you ever been here, or anywhere in the health system, before?"** If the patient says "yes," but the registrar does not find the patient when searching the database, ask, "Have you ever been here under another name?"
- **Ask for the patient's full middle name**. "This ensures there are enough data points captured on each record to uniquely identify the patient," Just says. ■

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accurate data for patients for every appointment we schedule."

Patient access quickly and easily identify any records that could match the patient, so a duplicate record isn't created. The current processes still rely on the information given by patients, though.

"This allows for errors to be made," Bellamy acknowledges.

Patients don't always feel comfortable giving or confirming their Social Security numbers, one of the few pieces of information that does not change, over the phone. Patient names, aliases, addresses, and phone numbers often change.

"It leaves room for errors resulting in duplicate records," Bellamy notes. ■

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Biometrics Soon Will Be 'Essential' for Patient Access

Technology is no longer just 'nice to have'

The use of biometrics will go "from a nice-to-have, to an essential requirement" for patient access departments, predicts **Mollie Drake**, MBA, former senior director of corporate access management for Scripps Health in San Diego.

"Any other means to tie an individual to their medical history will be fraught with the same problems we see today with Social Security numbers and photo identifications," Drake says. "These can be easily compromised."

In a 2014 report, the Office of the National Coordinator for Health IT recommended implementing technological solutions to reduce the number of patient misidentifications.[1]

Drake says patient access is in a unique position to utilize technology to avoid mistakes.

"When that first step in the patient interaction is conducted accurately, the entire cycle flows smoothly," she explains.

Some registration errors stem from a desire to boost productivity and "the need for speed," Drake explains.

Registrars sometimes create new records simply because it's quicker than researching existing multiple records.

These duplicate medical records are fairly easy to detect.

"But they're very tedious and time-consuming to resolve," says Drake, noting that the records must be merged, which could involve multiple systems and even paper records. "Great pain must be taken to ensure the two records are, in fact, on the same patient."

An existing medical record "overlaid" with incorrect information is a much more serious problem than a duplicate record.

"Now one patient record contains information on two separate individuals," Drake says. "Clinicians are viewing an inaccurate medical history."

The problem typically is discovered only after the wrong person receives a bill for medical services.

"Determining which information belongs to which patient is very difficult," says Drake, noting that often, the second person who received the services can't be identified. "Frequently, the solution is to block the corrupt record and create a new one when the patient again presents."

Biometrics "take the guesswork out of assigning a medical record number," Drake says, by taking the registrar directly to the correct patient's record.

"This eliminates interpretation of demographic information and plain old human error," Drake adds.

Biometric identification is going to be necessary, Drake concludes, "if we are ever to achieve the goal of a single medical record for every person." ■

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SOURCE

- **Mollie Drake**, MBA. Email: mdrake@cox.net.

Charity Care Regs: 'Significant Area of Risk for Patient Access'

Make financial assistance information clear and available to all

These are some misconceptions patient access has about 501(r) requirements for financial screening, which became effective with the Affordable Care Act.

"I see this as a pretty significant area of risk for patient access," says **David Figueredo**, business development manager for revenue optimization services at Change Healthcare in Nashville, TN. The regulations have been in place since January 2016, but some departments still are not in compliance. "Hospitals are finding that efforts that they made in 2014 and 2015 aren't as compliant as they thought they were," Figueredo adds.

Figueredo says patient access leaders should ask these questions: "Where might the department go wrong? What might an individual patient access employee be doing to cause issues? How do I mitigate that risk? Will technology help? If we are meeting the need, how are we documenting it?"

At many hospitals, financial assistance traditionally has been a "back end" activity handled by patient accounts. **Sandra J. Wolfskill**, FHFMA, director of healthcare finance policy at the Healthcare Finance Management Association, says, "So patient access staff assume nothing has changed for them. This could not be further from the truth."

If patients complain they weren't told by patient access about financial assistance, "that can trigger a whole sequence of audits," Figueredo says.

Auditors will be interested in whether the patient access department followed its own policies and procedures.

"They will look at whether or not you adhere to what you told the public, and that policies are nondiscriminatory, and uniformly and rigorously applied," Figueredo says.

Auditors want to see financial screening carried out consistently. "Are you screening all patients for financial aid? Or is it more of an on-demand, hit-or-miss process?" Figueredo asks.

Available to All

An analysis of more than 1,800 nonprofit hospitals nationwide found that just 42% reported that they were notifying patients about their potential eligibility for charity

Go Outside Hospital Walls

Patient access leaders already educate employees, patients, and clinicians on financial assistance policies. Why not the community?

"I see a great deal of interest in the question of how hospitals engage with their communities to improve health," says **Sara Rosenbaum**, JD, Harold and Jane Hirsh Professor at George Washington University's Milken Institute School of Public Health in Washington, DC.

In a 2015 paper, Rosenbaum notes that 501(r) regulations call for hospitals to "essentially push their policies out — not only into their facilities but also into the communities they serve."[1]

"Increasingly, hospitals are regarded as community health actors, with the responsibility not only to identify community-wide health needs, but to take measurable steps to address them," Rosenbaum says.

Maybe the hospital's financial assistance policy isn't doing a very good job of meeting the needs of the community. To ascertain this, **Holly Lang**, a New York City-based contractor specializing in healthcare financing, public policy analysis, and non-profit hospital strategy, suggests patient access leaders ask local charity clinics and Federally Qualified Health Centers for feedback. Ask them how the hospital's financial assistance policy is working for their patients.

"Often, their patients are going to be the ones qualifying for financial assistance at your hospital," Lang explains.

This kind of collaboration also could be valuable to the hospital in another way — by reducing preventable ED visits.

"Telling an uninsured patient to follow up with their cardiologist upon discharge is not a feasible directive," Lang says. "These patients likely wouldn't have access to a specialist."

Discharge planning, conducted in partnership with the community-based clinicians most likely to see the patients, is a more realistic strategy.

"You have to create pathways to care that go beyond the hospital's walls and are tailored to the patient's socioeconomic need," Lang says. ■

care before attempting to collect unpaid medical bills.[1] Another problem is that financial aid screening is too narrowly focused.

"Some hospitals have started to align their charity care policies with the Affordable Care Act's income limits by reducing charity to people who can purchase subsidized marketplace coverage," notes **Sayeh S. Nikpay**, PhD, MPH, the study's co-author. However, many of these people still face difficulties paying for care because of high out-of-pocket costs. "Many low-income people with incomes above 133% FPL have signed up for marketplace coverage with very high patient cost-sharing requirements," Nikpay adds.

Jessica Curtis, JD, senior advisor of the Hospital Accountability Project at Boston-based Community Catalyst, says the new rules are "all about making information about financial assistance and billing clear and easily available to all patients." The hospital's board ultimately is responsible for compliance. "But in reality, a lot of the work of getting information into the hands of every patient is going to fall on patient access," Curtis adds. ■

REFERENCE

1. Nikpay SS, Ayanian JZ. Hospital charity care — Effects of new community-benefit requirements. *N Engl J Med* 2015;373:1687-1690.

SOURCES

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Problematic Practices with Charity Regs

Some hospitals failed to train all patient access employees on the new 501(r) requirements for financial screening, reports **Holly Lang**, a New York City-based contractor specializing in healthcare financing, public policy analysis, and nonprofit hospital strategy.

"A fully compliant policy is only as good as its execution," Lang says. "Unfortunately, we've seen a lot of hospitals fall short in this respect."

Here are some practices that can put patient access out of compliance with 501(r) requirements:

• Failing to provide hard copies of the financial assistance policy, and failing to display the application prominently.

"While the decisions about displaying information are probably made by hospital leadership, front line patient access staff still need to know that patients will be looking for this information — and have a right to get it," says **Jessica Curtis**, JD, senior advisor of the Hospital Accountability Project at Boston-based Community Catalyst.

> "A FULLY COMPLIANT POLICY IS ONLY AS GOOD AS ITS EXECUTION," LANG SAYS. "UNFORTUNATELY, WE'VE SEEN A LOT OF HOSPITALS FALL SHORT IN THIS RESPECT."

The law requires hospitals to construct "conspicuous" public displays about financial assistance in the ED and admissions.

"It's the law now that each patient get a 'plain language summary' of the financial assistance policy to take home with them at either intake or discharge," Curtis adds.

• Patient access notes accounts if a patient expresses a need for financial assistance, but it doesn't drive a specific workflow.

David Figueredo, business development manager for revenue optimization services at Change Healthcare in Nashville, TN, says, "Successful organizations will identify that the patient requested financial need, and

there will be a key indicator in the comments to drive that account into a specific work queue."

• Inconsistent processes for how and whether patients receive information about financial assistance.

Patients should be alerted that financial assistance may be available at every date of service. "This sounds like extra work," Curtis acknowledges. "But it's really about making these conversations routine so everyone can avoid problems later."

• Failing to share financial assistance information because patient access "knows" that a particular patient is ineligible.

Curtis suggests viewing financial assistance screening the same way as patient privacy requirements: "something that is just part of the conversation they have with patients at every visit."

• Staff conducts financial assistance screening inconsistently across various entry points.

The ED may feature a strong financial assistance screening program, for instance, but hospital clinics or other entry points don't. Figueredo notes, "Often, it is not a lack of policy that causes this." Staff don't always follow existing policies.

Sandra J. Wolfskill, FHFMA, director of healthcare finance policy at the Westchester, IL-based Healthcare Finance Management Association, agrees: "Too often, patient access makes financial assistance the solution of last resort — or doesn't even mention it at all."

• Patient access staff pressure uninsured or underinsured patients to make a payment or accept a payment plan solution.

Doing so if a patient indicates, even subtly, that financial assistance is needed, says Wolfskill, "creates an opening for noncompliance allegations." ■

REFERENCE

1. Rosenbaum S. Additional requirements for charitable hospitals: Final rules on community health needs assessments and financial assistance. Health Affairs Blog, Jan. 23, 2015. Available at: http://bit.ly/1Ju7UFC.

RESOURCES

- The Healthcare Finance Management Association's Patient Financial Communications Best Practices for pre-service, the ED, and outside the ED, available at: http://bit.ly/1s2u63E.
- Community Catalyst's Hospital Financial Assistance Policies: A Quick Reference Guide, available at: http://bit.ly/2fF9r3A.

COMING IN FUTURE MONTHS

- Address unfair requirements in payer contracts
- Put patient access front and center on hospital committees
- Drive up "clean claim" metric dramatically
- What work-at-home trend means for patient access

HOSPITAL ACCESS MANAGEMENT™

KernMedical

Patient Access Service Representative Unit Specific Orientation Checklist

Name:_____

Date of Hire:_____ **Date of Central Services Orientation:**_____

Job Title:_____ **Department:**_____

Facility: ☐ **Kern Medical** ☐ **Out Patient Clinic** ☐ **Pre-Service**

☐ **New Hire** ☐ **30 Day** ☐ **90 Day** ☐ **Annual**

TASK/SKILL LEVEL
(See back page for additional explanation of skills)
Level 1 – Novice
Level 2 – Advanced Beginner
Level 3 – Competent
Level 4 – Proficient
Level 5 - Expert

METHOD(S) OF EVALUATION:

(O)bservation/(V)erbal
(NA) Not applicable

Departmental / On Unit Orientation Checklist	Task Skill Level & Method of Evaluation	Preceptor Initials	Employee Initials	Date
Departmental Organization -				
Patient registration services at Kern Medical				
Patient registration services at the Out Patient Clinics				
Patient registration services at Pre-Service				
Remote registration service areas				
Revenue Cycle overview (bed control, HIS, PFS & CM)				
Departmental Staff Scheduling -				
Submitting requests for Paid Time Off (PTO) solicited & non-solicited				
Submitting requests to trade out a shift by mutual consent				
Submitting a completed electronic time card vs payroll edit log				
Review HR/Unit Specific Time & Attendance Policy				
Flexing due to low volumes				
Premium Pay (on-call, call back, overtime, etc.)				
Departmental Dress Code -				
Uniform apparel must be worn during working hours				
Employee ID badge includes safety info				
Review of appropriate footwear				
Personal Hygiene (hair styles, finger nails, perfumes, etc.)				
Body Art (piercings and tattoos)				
Departmental Communication -				
Daily & Weekly Huddles				
1:1 individual meetings with supervisors/manager				
Huddle Binder				
Bulletin Boards				
E-mails				
Cell Phone Usage				
Departmental Quality Improvement -				
Customer Service OP patient wait times < 10 minutes				
Customer Service (AIDET) Helpfulness of Registration Person > 95% (Press Gainey)				
Follow up by Health Benefit Advisors > 90% (EZ Cap)				
Registration Accuracy > 95% (AccuReg)				
Upfront Cash Collections 100% of goal (DivDat)				

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Departmental Skills -				
Access to Bed Control information system (OBS vs Admission)				
Overview & processing of Order Notifications for admission				
Process IP Admission (Direct vs. ER/OP/ SDS)				
Assignment of appropriate accommodation & hospital service codes				
Process Maternity admission, including normal newborn, NICU & multiple birth admissions. Process for Home Undelivered				
Process SDS (including IVR & endoscopic procedures)				
Overview of Surgery Scheduling & HPP				
Process CLI registration				
Process registration (ICC, ERQ, ERR, ERS, IPP, IPJ)				
Process Observation status registration				
Process for Psych registration				
Processes payment transactions per internal control guidelines (uses appropriate receipts, credit card terminals & cash drawer balancing)				
Explains hospital payment assistance options & credit policies				
Process manual registration & post incident data entry/recovery				
Documentation/Forms-				
Access to STAR collection notes to edit/enter comments				
Conditions of Admission				
Advanced Directives				
HIPAA Notice of Privacy Practice				
HIPAA related forms				
Medicare Secondary Payer (MSP)				
Advance Beneficiary Notice (ABN)				
Important Message from Medicare				
Lifetime Reserve Days Letter – Case Management				
Forms Fast – Pulling documentation				
E-signature				
Computer -				
STAR/HPP/OPEN VISTA Overview				
DIVDAT				
AccuReg				
FORMS FAST				
SafeChx				
On-line insurance verification (vendor vs. call center routines)				
Kern Medical Intranet				
Groupwise (Email)				
Other-				
Equipment -				
Lucent Tech/Avaya Telephone System				
Ultrex Copier				
IPad/Surface Pros				
HP printers				
JB Dev				
SnapScan/Canon Scanners				
SafeChx finger scanner				
Zebra ID band printer				
Canon Fax machine				
Intercom				
Dymo Label writer				
Tangent workstation on wheels				
Cisco Telephones HCIN (Health Care Interpreter Network)				
Department Competencies				
Department Policies -				
Access to Intranet				
PAC-IM-401 Emergency Room Registration				
PAC-IM-432 Trauma Registration				

PAC-IM-418 Pre-registration/Registration for Surgery				
PAC-IM-419 Pre-registration Obstetric Patients				
PAC-IM-416 Registration for Outpatient Clinics & Diagnostic Testing				
PAC-IM-421 Pre-registration Authorization/Scheduling				
PAC-IM-985 Orders for Outpatient Tests & Services				
PAC-IM-965 Patient Rights				
PAC-IM-970 Important Message from Medicare				
PAC-IM-975 Notice of Privacy Practices				
PAC-IM-980 Medical Necessity Verification (ABN)				
PAC-IM-403 Referral Self Pay for Medi-cal Application				
PAC-IM-404 Insurance Verification				

I accept responsibility to provide care and services according to our policies of patient confidentiality and privacy.

Employee Signature: _____**Date:** _____

Preceptor Signature: _____**Date:** _____

To be completed and returned to Unit Supervisor upon completion of department orientation checklist.

Unit Supervisors –

Employees: Please place original in Employee's Shadow File.

Model of Competency Skills:

- **Stage 1: Novice**

  Beginners have had no experience of the situations in which they are expected to perform. Novices are taught rules to help them perform. The rules are context-free and independent of specific cases; hence the rules tend to be applied universally. The rule-governed behavior typical of the novice is extremely limited and inflexible. As such, novices have no "life experience" in the application of rules.
  "Just tell me what I need to do and I'll do it."

- **Stage 2: Advanced Beginner**

  Advanced beginners are those who can demonstrate marginally acceptable performance, those who have coped with enough real situations to note, or to have pointed out to them by a mentor, the recurring meaningful situational components. These components require prior experience in actual situations for recognition. Principles to guide actions begin to be formulated. The principles are based on experience.

- **Stage 3: Competent**

  Competence, typified by the employee who has been on the job in the same or similar situations two or three years, develops when the employee begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware. For the competent employee, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organization. The competent employee lacks the speed and flexibility of the proficient employee but does have a feeling of mastery and the ability to cope with and manage the many contingencies of patient registration. The competent employee does not yet have enough experience to recognize a situation in terms of an overall picture or in terms of which aspects are most salient, most important.

- **Stage 4: Proficient**

  The proficient performer perceives situations as wholes rather than in terms of chopped up parts or aspects, and performance is guided by maxims. Proficient employees understand a situation as a whole because they perceive its meaning in terms of long-term goals. The proficient employee learns from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The

proficient employee can now recognize when the expected normal picture does not materialize. This holistic understanding improves the proficient employee's decision making; it becomes less labored because the employee now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones. The proficient employee uses maxims as guides which reflect what would appear to the competent or novice performer as unintelligible nuances of the situation; they can mean one thing at one time and quite another thing later. Once one has a deep understanding of the situation overall, however, the maxim provides direction as to what must be taken into account. Maxims reflect nuances of the situation.

- **Stage 5: The Expert**

  The expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert employee, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The expert operates from a deep understanding of the total situation. The chess master, for instance, when asked why he or she made a particularly masterful move, will just say: "Because it felt right; it looked good." The performer is no longer aware of features and rules;' his/her performance becomes fluid and flexible and highly proficient. This is not to say that the expert never uses analytic tools. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience. Analytic tools are also necessary for those times when the expert gets a wrong grasp of the situation and then finds that events and behaviors are not occurring as expected when alternative perspectives are not available to the clinician, the only way out of a wrong grasp of the problem is by using analytic problem solving.

SOURCE: KERN MEDICAL CENTER, BAKERSFIELD, CA