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Patient Access Staff Working from Home Becomes Winning Strategy

Leaders report improved productivity, higher employee satisfaction

In 2010, patient access consisted of four departments and 100 employees at York, PA-based WellSpan Health.

"We grew to 13 departments and 600 employees — and we are still growing," says **Tracey Shetter**, CHAM, manager of enterprise patient access, which covers education and call centers.

When WellSpan Health added three new hospitals, patient access responsibilities were centralized.

"Our scope of responsibility expanded far beyond just registration to include departments not known traditionally as patient access," Shetter says.

Patient access now includes the medical group contact center, the nurse triage call center, the referral center, the insurance specialty center, on-call services, and switchboard services.

The explosive growth of patient access made a work-from-home program a necessity.

"We literally ran out of office space," Shetter says. "It was more economical to send employees home to work than to obtain more real estate."

Of the department's 600 total patient access employees, about 160 now work from home.

"IT WAS MORE ECONOMICAL TO SEND EMPLOYEES HOME TO WORK, THAN TO OBTAIN MORE REAL ESTATE."—TRACEY SHETTER, WELLSPAN HEALTH

"Basically, any position that does not require face-to-face contact with patients can be considered," Shetter says.

Here are some challenges patient access leaders faced when starting the work-from-home program:

• Putting the right technology in the hands of at-home workers.

The first step was figuring out all the technology that would make it possible for someone to work from home.

"We were relying on other departments to help this be a success," Shetter explains.

The IT department ordered equipment and loaded laptops with the

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necessary software.

"There were times when agents were finished training and were ready to go home, but the equipment wasn't ready — and we didn't have any work stations for them in the office," Shetter recalls.

When this happened, the employees continued training until technology issues were resolved.

• Monitoring productivity of offsite employees.

Most work-from-home staff are at various call centers, so productivity is monitored easily from phone system reports.

"A workforce management team is responsible for all call center schedules and timecards, which need to be completed timely for payroll and staff," Shetter says.

In addition, five employees who obtain authorizations and inpatient insurance verification work at home.

"They gauge their productivity by their monthly stats and verifications completed per hour," Shetter explains.

• Keeping at-home workers in the communication loop.

"We always keep those at home in the forefront of our minds, so 'out of sight, out of mind' never happens," Shetter says.

Skype for Business is one of the main ways they do this. Managers use the instant message tool if they need to communicate quickly or answer an employee's questions.

"We use the Skype meeting tool for staff meetings, and the camera Skype for roundings and quarterly evaluations so we can see each other," Shetter adds.

Many Benefits

Shetter has seen the following benefits from the work-at-home program:

• Employees use less intermittent leave of absence.

• There is phone coverage during office power outages.

• There is continued productivity during bad weather conditions, since at-home agents keep the department running.

• It is easier to cover the 11 p.m. to 7 a.m. shifts for "on-call services," an after-hours answering service for some of the health systems' practices. "It allows the agent to be at home during the night to answer calls, instead of in an office somewhere," Shetter notes.

• Employees are highly satisfied.

Some patient access employees jumped at the chance to work at home because of transportation or medical issues. One employee suffered from continual asthma attacks on the job.

"We sent her home to work, which helped her tremendously," Shetter recalls.

Another employee was exhausted

EXECUTIVE SUMMARY

More patient access employees work at home because of expanded roles, limited space in the hospital setting, and staff demand.

- Staff can retain their jobs despite medical problems or relocation.
- Meetings, evaluations, and observation take place via Skype.
- Offloading calls to at-home workers allows onsite registrars to improve patient satisfaction.

by her commute because of health problems.

"When she didn't have to worry about travel to the office, her productivity improved, as well as her attitude," Shetter says.

Another employee switched to an at-home role after her husband's job required them to move to another state.

"I believe we would have lost these employees if they hadn't been provided this option," Shetter offers.

When the program was first announced, there was no shortage of takers.

"Some employees just love working in their pajamas and not having to go out in the cold weather," Shetter says.

However, not everyone enjoys working at home.

"For some, it's lonely and isolating," Shetter explains. When the department needed more at-home workers, none volunteered, so patient access specifically hired people to work from home.

Occasionally, employees ask to work from home, even though they're in an onsite role.

"Those duties are evaluated to determine if, in fact, it is a role that can be performed at home adequately," Shetter says.

30% Work at Home

Yvonne Chase, MBA, CHAM, manager of the revenue cycle at Mayo Clinic in Phoenix, hired staff who conduct preregistration and precertification from locations all over the United States.

"We also have coders, billing, and account receivable staff, as well as our patient account services areas, that work from home," Chase says.

Currently, 30% of Mayo Clinic's

Meeting Demand for Flex Scheduling

Robin Speaks, MSHSA, CHAM, director of admitting at Ann & Robert H. Lurie Children's Hospital of Chicago, received some surprising feedback from a recent employee engagement survey. Patient access leaders considered the survey results informal "listening sessions" in which employees were encouraged to voice concerns.

"Employees were frustrated and concerned about workload, attendance policy, and staffing schedules, among other things," Speaks notes.

First, Speaks assured them that leaders were taking their concerns seriously. Next, a committee met to address the demand for flexible scheduling.

"In further discussions with team members, we found that 'flexible scheduling' had different meanings for different people," Speaks says.

To some, it meant working from home. Others just wanted to come in an hour or two later, or go home earlier and be allowed to make up the hours so they wouldn't have to use their personal time. Another group wanted to work four 10-hour shifts with three days off.

"Our first hurdle was to define flexible scheduling. We agreed that it could mean all of the above," Speaks says.

Not all flexible scheduling options are practical for all patient access areas. For instance, registrars in the ED or convenient care clinic can't work from home.

"Both areas require face-to-face contact for registration, ID verification, collection, check in, and check out," Speaks notes.

Admitting staff now have the option to leave early or start later as needed. "We currently have varying degrees of work schedules to align with patient volumes — and at times personal preference, to align with their own or children's school schedules," Speaks says.

The business office, which works on insurance verification, eligibility, and precertification, is the best setting for work at home.

"There is excitement among this group," she says.

Patient access currently works 12-hour shifts, but leaders are considering offering eight- or 10-hour shifts instead. Some staff are unhappy having three days off.

"However, we will remind the team that 12-hour days are long and arduous," Speaks says. "At times, productivity decreases, responsibilities are neglected, directions get fuzzy, and there is process drift."

As a result of flex scheduling, the department sees less overtime, better retention, and fewer sick calls.

"When staff work with managers to work out a schedule that meets the needs of the department, the team, and the individual, it is a win-win situation for all," Speaks adds. ■

SOURCE

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patient access staff work from home, including some who've moved but still stayed in their jobs.

"This has allowed us to retain good employees and not to have to rehire and retrain," Chase says. "That's a considerable savings for the organization."

However, patient access managers must stay on top of productivity.

"Our biggest challenge is ensuring everyone is on the phones and working the precertification queues, as well as retaining their efficiencies numbers," Chase says.

Productivity is measured by managing phone queues for volume and accuracy.

"Calls are recorded and used to develop our customer services metrics," Chase says. "Some areas use work queues where we can measure volumes per each staff member."

This shows how many calls were made to patients and insurance companies for preregistration and precertification.

Open space was an important consideration for the department.

"If we can accommodate non-clinical staff at home, it allows more space for key clinical areas," Chase explains.

She's found her staff are more efficient at home.

"We have found that productive time improved by 10% to 20%," Chase adds. "All in all, the benefits far outweigh the challenges."

New Roles, More Telecommuting

Jeff Brossard-Sims, CHAM, says patient access departments offering work-at-home roles is a growing trend, but progress has been slow.

"Patient access has always been the forward-facing staff members. And as with nearly every trend in industry, healthcare tends to be a little behind the curve," says Brossard-Sims, former vice president of patient access at Beverly Hills, CA-based American Health Connection, which conducts preregistration, scheduling, and insurance verification for hospital clients.

"The trend for the last several years is moving as much of the pre-work as possible prior to the date of service," Brossard-Sims says.

> PATIENT ACCESS INCREASINGLY PERFORMS PREREGISTRATION AND PRESCHEDULING IN CALL CENTERS, WHICH ARE DUTIES THAT ARE CONDUCIVE TO WORK-AT-HOME ROLES.

Faced with shorter timeframes, patient access increasingly performs preregistration and prescheduling in call centers, which are duties that are conducive to work-at-home roles.

Another problem solved by work-at-home roles involves patient satisfaction. Increasing volumes of incoming calls to registrars pose potential problems with productivity and patient satisfaction, Brossard-Sims explains.

A registrar might not be able to answer a call because there is a patient standing in front of him or her who takes priority. Conversely, a registrar might be on the phone conducting preregistration, financially clearing a patient's account, or obtaining an authorization from a payer. When a patient walks in to be registered, the registrar has to make a decision.

"Does the registrar place the patient on hold, or ask the patient to wait until the call is finished?" Brossard asks. Either way, patients are likely to become dissatisfied.

If at-home workers field the calls, registrars can give their full attention to face-to-face encounters.

"This allows the front-facing registrar to concentrate on patient satisfaction," Brossard-Sims says. ■

SOURCES

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EDs Dread Questions About Cost of Care

New process connects patients and financial counselors

Patients asking about cost sounds like a simple question, but it's usually impossible for ED clinicians to answer.

"It is one of the most dreaded questions on the front line of an ED," says **Nicholas Gavin**, MD, assistant professor in the department of medicine at NYU Langone Medical Center and chief of service in the ED at NYU Lutheran Medical Center.

Some patients admitted for observation expressed concerns because they'd seen media coverage warning of inappropriate billing practices at other institutions.

"Patients were concerned that observation services would lead to more out-of-pocket expenses," Gavin recalls.

Others worried because of their high-deductible insurance plans.

"As patients' out-of-pocket expenses go up, they are rightly going to be asking more questions about the financial impact of their healthcare choices," Gavin explains.

ED patients ask these questions frequently, reports **Sean McAleer**, senior director of revenue cycle operations in the Ronald O. Perelman Department of Emergency Medicine at NYU Langone:

- How much will the entire ED visit cost?
- How do I know if the ED provider accepts my insurance or is in network?
- Can I choose an ED provider that is in network?
- Does my copay cover every service?
- How much does an X-ray cost?
- If I pay the self-pay amount, is this the entire cost of the ED visit?
- How much will it cost if I get admitted?
- Do I have to pay now?

SOME PATIENTS ADMITTED FOR OBSERVATION EXPRESSED CONCERNS BECAUSE THEY'D SEEN MEDIA COVERAGE WARNING OF INAPPROPRIATE BILLING PRACTICES AT OTHER INSTITUTIONS.

- What happens if I cannot afford to pay?

ED patients are made aware of financial assistance in many ways. The department posts conspicuous signage and offers patients a pamphlet with answers to frequently asked questions. The information also is on ED discharge forms.

In addition, McAleer adds, "registrars are trained to refer patients to a financial counselor if a patient expresses a financial hardship or an inability to pay."

Even so, many patients are still unaware that financial assistance is available. Many ED patients don't read signs or pamphlets or interact with registrars because of severe illness or injury.

When patients confided their anxiety about cost to their ED clinicians, McAleer says, "there was no outlet for the physician to direct those concerns."

Patient access worked with IT to develop a process for ED physicians to refer patients directly to financial counselors. The requests go into a special work list, alerting the counselor that the referral came from the ED.

"They know that a patient confided in their physician with a concern about their bill and to broach the financial aspect of their treatment

EXECUTIVE SUMMARY

Increasingly, ED clinicians field questions from patients regarding the cost of care. At NYU Langone Medical Center, physicians refer patients directly to financial counselors.

- Clinicians were concerned that patients might leave without treatment because of financial concerns.
- Patient access worked with IT to develop a process for ED physicians to refer patients directly to financial counselors.
- Financial counselors contact patients on the next business day.

with utmost sensitivity," McAleer explains.

Patients' increasing worries about cost of ED care was the motivation for this change.

"While our system moves toward more price transparency, we need to facilitate frontline providers' comfort with financial safety nets for patients," says Gavin, lead author of a recent paper that outlined the ED's new process.[1]

If patients ask about cost of care, ED providers respond: "I'm not sure, but I'm going to ask our financial counseling team to reach out to you on the next business day. We are going to do what is best for your health, and work together on financial issues tomorrow."

Referring ED patients to financial counselors, says Gavin, "allows our providers to put these questions in the hands of experts within our system."

Before the new process was in place, ED providers worried that some patients would leave against medical advice, or before their treatment was completed, because of a perception that care was going to be unaffordable.

"With all the burdens on today's frontline ED providers, we hope to alleviate some with this initiative," Gavin says. ■

REFERENCE

1. Gavin N, McAleer S, Asfour L, et al. Bridging the gap: Financial counseling in the ED. *Healthcare Financial Management* 2016;70:66-70.

If There's a Lack of Engagement, Try Creating a Patient Access Council

Staff wanted recognition, communication, and challenges

When patient access employees recently responded to their organization's annual anonymous survey, which seeks feedback on leadership, transparency, and satisfaction, they offered three typical responses:

- "If I contribute to the organization's success, I do not know that I will be recognized."
- "I do not find my job interesting and challenging."
- "When the organization makes changes, I do not understand why."

"Although patient access scores highly in most areas, I decided to focus on our four largest areas for improvement to start," says **Savannah Lacy**, preregistration representative, patient access, Children's Mercy Kansas City (MO). These were:

- staff recognition;
- a desire for challenging work;
- more transparency;
- a greater understanding of the decision-making process.

"Patient access is our second-largest department in the hospital, next to nursing," Lacy notes.

Lacy interviewed a couple of nurses and nurse managers to find out how they created unity within their teams and improved employee satisfaction. She learned of the department's nursing unit council.

"The nursing council is a group you must apply to be in, which is led by more seasoned nurses, much like a student council," Lacy notes.

She really liked the idea of creating a patient access council similar to nursing's. She wanted to include staff members from all five locations.

"We wanted something that would be run by a group of peers within our department," she adds.

Patient access leaders decided to create a council of 15 staff members in non-leadership roles as representatives for the department of 240 employees. Names were drawn at random from the 50 employees who volunteered to participate.

"We designated a small group of working supervisors as their resources and leads for the first year," Lacy says. During its first meeting in fall 2015, the patient access council:

- made introductions. Participants explained at which campus they worked, how long they'd been at the organization, and why they wanted to be on the council.
- decorated small signs with their names, to reflect something interest-

EXECUTIVE SUMMARY

A patient access council was created at Children's Mercy Kansas City in response to staff demand for more challenging work and recognition.

- Representatives from all locations are included.
- Participants have a chance to use expertise such as writing and fine arts.
- Patient access supervisors are available as resources for the group.

ing about themselves. "For instance, mine had a tent and trees because I like to camp," Lacy says. "This helped us remember each other's names."

• played a "get to know you" game. Each person took five candies, and answered a different question based on the color of the candy, such as, "What would you do if you won a million dollars?"

• assigned homework. Employees were asked to create their own personal mission statement. At the next meeting, everyone worked together to create a mission statement for the group: "Our mission is to be an advocate for admissions staff by providing a safe environment to share ideas in order to encourage a culture of transparency and unity while promoting continued growth. We will encourage a culture focused on service excellence, while keeping a lighthearted and creative atmosphere, through positive communication with one another and leadership."

The department is experiencing a variety of benefits — some unexpected — as a result of the council's work.

• Participants have the chance to put skills unrelated to patient access to use.

"Utilizing these skills in creative ways, they feel more fulfilled in their current roles," Lacy says. "This has really improved our employee satisfaction." Employees with fine arts and graphic design skills designed T-shirts and jackets for the council, while others wrote articles for the department's newsletter.

• Participants started a tradition of volunteering at the hospital's Ronald McDonald House.

"We are looking into other philanthropic opportunities in the community," Lacy adds.

• Different teams within patient access have learned a lot from one another.

The department includes financial counselors, insurance analysts, educators, bed control and admissions specialists, and patient access representatives.

"Although these sections of the department work alongside each other, they don't often work directly with one another," Lacy explains.

The council gave them an opportunity to do so, and in the process, they saw how their roles fit into the department overall.

"It gives them an avenue to meet new people and a larger sense of a team atmosphere within our department," Lacy adds.

By understanding how their work affects the overall revenue cycle, staff members are more likely to take their time when entering data. Thus, they are more likely to avoid errors, thereby improving registration accuracy.

"This is cutting down on the number of mistakes staff members are making, such as not gathering the correct insurance information or the Social Security numbers of guarantors," Lacy notes.

The council helped patient access educators develop refresher courses on out-of-network insurance options and interpret legal documents, such as power of attorney or custody documentation.

"These courses have cut down on errors, such as an incorrect family member signing a consent form, or a family not being alerted of their out-of-network insurance coverage," Lacy says. ■

SOURCE

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A Single Productivity Metric for All Patient Access Areas

Registrations require varied amounts of time and effort

How long should it take for patient access to register a patient? First, it's necessary to know the type of registration.

"Each type of registration requires different levels of effort and time," says **Ashwin Kumar**, corporate director of revenue cycle management at Miami-based Jackson Health System.

A full registration of a patient, including eligibility and benefits verification, is very labor intensive. On the other hand, says Kumar, "an ER quick reg, or discharging an encounter, are considered to be low effort."

Therefore, the same metric can't be used to assess productivity for each of these registrations. "As a large, multi-faced health system, Jackson Health System encompasses a variety of different patient access checkpoints in various locations," Kumar explains.

The difficulty of the registration depends on the patient's financial status and the type of service the patient wants.

Myriam Torres, vice president of revenue cycle management, adds: "Different insurances have different ways of checking eligibility."

Some payers require a time-consuming phone call. Others provide the information online or on an inbound electronic format.

"It was necessary to create an integrated productivity model, which takes all of these factors into consideration," Torres adds.

Single Metric Developed

Revenue cycle leaders created Jackson's – Integrated Productivity Model (J-IPM). They divided registrations into these five components:

- event type;
- location;
- patient type;
- financial class;
- productive time.

"Each of the factors was assigned a distinct discriminant factor, which represents the effort," Torres says.

> THE DIFFICULTY OF THE REGISTRATION DEPENDS ON THE PATIENT'S FINANCIAL STATUS AND THE TYPE OF SERVICE THE PATIENT WANTS.

The group created an algorithm. "This takes the raw productivity, distributes it into the component combinations, and applies the appropriate discriminant factor," Torres says. The result: one integrated productivity metric.

Using a single metric has simplified goal-setting for patient access.

"It makes it possible to compare productivity for all service lines of patient access," Torres says.

J-IPM will go through a series of tests with a focus group and the leadership team before moving to full implementation.

Jackson Health System recently implemented a similar productivity model in other areas of the revenue cycle.

Telisa Lyons-Washington, corporate director of patient access services, says, "Productivity gains are just starting to get realized, but the reports clearly show areas and people who are underperforming."

Utilization of overtime also is under close review in relation to productivity.

"As these reports are being shared with the individual team members, we expect to start seeing a spike in productivity," Lyons-Washington adds. ■

Patient Access Leaders Share Best Collections Training Methods

While making rounds in the department, patient access managers at Kadlec Regional Medical Center in Richland, WA, often heard patients claim they already paid a deductible or that they were overcharged for past services.

"There was frequent payment push-back from patients," says **Jackie Jordan**, MBA, CHAM, patient access and scheduling manager for the center. "Observing the conversations helped leadership develop the response we wanted registrars to use."

The department recently implemented a price estimation tool and changed the way it trained employees to collect money from patients.

"We improved upfront collections by 30%," Jordan reports.

Here is how the department handles collections training:

• Employees receive collections training only after learning the basics.

All new patient access hires receive

EXECUTIVE SUMMARY

Patient access departments are fine-tuning the way they train employees to collect money up front from patients. Kadlec Regional Medical Center increased collections by 30% in one year with these methods:

- New hires learn about collections only after they understand the basics of registration.
- One-on-one training allows trainers to observe employees.
- Employees practice scripting during classroom training.

detailed training on copays, deductibles, coinsurance, out-of-pocket costs, and benefits. However, this doesn't happen for at least 30 days.

"The initial orientation process and onboarding is overwhelming for new staff," Jordan explains.

First, new hires work alongside experienced colleagues to gain a general understanding of the registration process.

"Then we move to the next phase of access training — collections," Jordan says.

• Instructors use both classroom and one-on-one training.

In the classroom, trainers reach a larger audience.

"You can answer questions for those staff members comfortable enough to speak up and practice scripting or potential scenarios with team members," Jordan says.

One-on-one training allows employees to ask questions freely.

"It also allows for the trainer or leader to observe the team member in action," Jordan says.

Fostering Credibility

Jill Eichele, CHAA, manager of patient access services at Littleton (CO) Adventist Hospital, says, "Consistency is huge. If we do it one way for one visit, but then do it a different way the next time, we lose credibility and decrease our chances to collect."

The department uses these steps for collections training:

1. Trainers start with "the basics" — defining deductible, coinsurance, copays, and out-of-pocket maximums.

2. Trainers teach staff how to use eligibility tools.

3. Registrars study actual eligibility responses and patient accounts so they can learn how to find the patient portion.

4. Finally, trainers review scripting and different scenarios that might come up.

"We role play and give feedback on what worked and what could be improved," Eichele says.

Registrars don't ask every patient for a set dollar amount.

"Each patient is different, as are their insurance plans," Eichele explains. "If we only ask for a set amount, we lose all credibility."

Instead, registrars show patients how they came up with the dollar amount they're requesting. They fully explain the specifics of the patient's coverage.

"Patients trust that we know what we are talking about. They are much more likely to pay," Eichele says.

Registrars Face Patients' Push-back

With upfront collections a top priority for most patient access departments, it's important that staff ask "every patient, every time," says **Jackie Jordan**, MBA, CHAM. Registrars follow this script:

Patient: "I already paid my deductible." **Registrar**: "Let me review our real-time eligibility (registrar validates the response). The information came back from (states payer name). It shows you did pay some of your deductible, but have a remaining balance of ($), which is how we calculated your estimated cost for your service today."

Patient: "$1,000 is a lot of money, and I can't pay this today." **Registrar**: "I hear your concerns — $1,000 is a lot of money. What amount are you comfortable paying today for your service? We can bill you for the remaining balance or refer you to our financial counselors, who will be able to help discuss options with you?"

Patient: "Do I have to pay this today?" **Registrar**: "We request payment at time of service."

Patient: "I've been coming here for years and you have never asked me for any money at my appointment." **Registrar**: "I am sorry we weren't able to discuss this with you sooner. Yes, our process to request payment at your appointment began in 2014. We want you to be informed, so there is no surprise when you receive your bill."

In the ED, registrars collect copays using this scripting: *"I verified your insurance with (payer), and per your contract with (payer) you have a ($) copayment due for your service today. How would you like to take care of that? We take (list forms of payment)."*

For scheduled services in the outpatient or inpatient setting, registrars use this scripting if the authorization is in place: *"We received insurance verification and authorization from your insurance (payer name) for your procedure today. Per your contract with (payer name), you have a deductible remaining of ($) and (X%) coinsurance, for an estimated out-of-pocket balance of ($). How would you like to take care of that? We take (list forms of payment)."*

Registrars use this scripting if the authorization is not obtained: *"We received insurance verification from your insurance (payer name) for your procedure today. Per your contract with (payer), you have a deductible remaining of ($) and (X%) coinsurance, for an estimated out-of-pocket balance of ($). How would you like to take care of that? We take (list forms of payment)."* ■

The department relies mainly on role playing to get staff comfortable collecting. Still, it's not the same as real life.

"When you have a real patient in front of you who is sick or in pain, it gets much more emotional," Eichele notes.

Patient access managers give staff this simple instruction: Treat the patient as you would want your family member to be treated.

"We let them know there are certain situations where it is not appropriate to collect," Eichele says.

Even if the patient isn't able to pay the full amount requested, patient access educates them about their options so they'll be informed when they receive the bill.

"For the most part, when the conversation is approached with compassion, patients respond well," Eichele says.

Training is tailored to the setting, since collection methods vary depending on the type of service the patient receives. For instance, in the outpatient setting, patients receive calls prior to their visit from health benefit advisors.

In contrast, says Eichele, "In the ER, we weren't expecting the patient, so nothing has been done ahead of time. Those registrars need more training on the eligibility tools."

The department implemented mandatory training for anyone who isn't meeting collection goals.

"There is a direct correlation between the ER meeting their percent of opportunities goal, and whether the facility does as a whole," Eichele says.

Using this approach, says Eichele, "We increased the percentage of patients we collected on in the ER by 10% — and our facility overall increased by 12%." ■

Three Tough Role-playing Scenarios

Here are some role-playing scenarios used to train collectors at Littleton (CO) Adventist Hospital:

- **An ED patient has a $250 copay listed on his or her insurance card.** Registrar scripting: *"I see your insurance card shows a copay of $250 for ER visits. I was able to verify that through our insurance system as well. How would you like to take care of that today?"*
- **A patient is scheduled for surgery and has a total out-of-pocket estimate of $1,500. The health benefit advisor was not able to contact the patient prior to their appointment.** Registrar scripting: *"I see that our health benefit advisor, Jane, was able to verify your insurance and that your procedure is authorized. In addition, I see that she ran a price estimate for your procedure, and your estimated patient portion is $1,500. How would you like to take care of that?"*
- **Patient: "I can't pay that today. That's a lot of money. And I've already paid the surgeon."** Registrar scripting: *"This estimate is for the hospital charges, as the physician billing is separate. And, yes, I understand that is a lot of money. I'm sorry that we weren't able to contact you sooner to let you know. We request that you put down a deposit toward this amount. Then, when you get your bill, you can call and set up a payment plan, or we can even screen you for financial assistance. We understand that healthcare costs may be unexpected and we want to work with you to help with that. We just want to make sure you are aware ahead of time so you know there are options when you do get your bill. How much are you able to put down as a deposit today?"* ■

SOURCES

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Is Candidate a Gem or a Disaster for Patient Access Departments?

Résumé and recommendations only go so far

A young woman spoke with obvious pride about how hard she had worked with her colleagues at a previous job, which paid $8 per hour.

"When I told her this would be a pay bump, she was surprised. She was pleasant from day one, and has been an asset ever since," says **Kimberly**

Horoski, MBA, MHA, department head of patient access at Brookhaven Memorial Hospital Medical Center in Patchogue, NY.

When Horoski interviewed a revenue analyst for an associate position, he arrived on time and was dressed nicely. The man made a great first impression until Horoski asked him why he was making the career change.

"He proceeded to talk endlessly about how he was destined to work with people, and how his wife tells him how special he is," she recalls. "He was interested only in himself."

It quickly became apparent that the applicant wasn't a team player and, therefore, not a good fit for patient access.

Horoski watches for simple qualities when evaluating new hires.

"I tend to look for hard workers with good hearts," she says. "This is something that is innate or learned well before the time I interview people."

Antwan Williams, MHSA, director of operations of the emergency medicine service line at Geisinger Health System in Danville, PA, recalls a recent presentation at the hospital from the CEO of Delivering Happiness, a company that focuses on customer service culture. The presenter gave the example of front-line staff taking on titles such as "Director of First Impressions."

"While we don't use the titles, we believe our registrars are the directors of first impressions," Williams says. "We need to be sure we are choosing the right people for these roles."

One candidate came to Williams highly recommended by a colleague, with an equally impressive résumé.

"To be completely honest, we were ready to hire this individual even before speaking with them," he recalls.

It turned out that the candidate did not agree with the mission and vision of the department.

"We as leaders should pause and take a step back so we can make clear decisions without bias," Williams offers.

Mark Nugent, patient access services manager for the ED at Northwest Community Healthcare, pays more attention to candidates' attitude and interpersonal skills than résumés.

"I want to see how candidates respond to weird questions, or when things don't go their way," he says.

Nugent likes to see candidates who keep their cool during a stressful interview. He often switches gears to ask questions completely unrelated to the job, such as, "What is your favorite TV show?" or "What is the last movie you went to see?"

"If the candidate can stay positive, no matter what is happening around him or her, then the odds are high that he or she can do this in the emergency department," Nugent says. ■

EXECUTIVE SUMMARY

Patient access leaders recommend looking for signs that applicants are kind, work well with others, and provide good customer service. Some approaches:

- Don't assume candidates are a good fit, even if they come highly recommended with good résumés.
- Ask peers if they think they'll get along with the candidate.
- Get input from other departments that work with patient access.

SOURCES

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About to Hire Registrar? Ask Future Colleagues to Weigh In First

Peers notice things managers don't

Does a candidate say all the right things to a patient access manager during an interview, but roll her eyes when a registrar mentions there are sudden volume surges to contend with? Peer interviews can reveal some surprising things, says **Nayesa Walker**, MHA, director of patient access at University of Maryland Medical Center Midtown Campus in Baltimore.

"In the past, I've had candidates

who appeared to be great prospects for the role, but were incompetent," Walker says, noting those candidates' résumés were everything Walker wanted, and they spoke confidently about their abilities and experience. "One candidate even brought in samples of training materials they'd developed. However, when the employee started working, the skills and expertise were nonexistent."

Other new hires were constantly late to work, experienced personal issues that interfered with their work, or were entangled in conflicts with colleagues.

"Unfortunately, there were no red flags that made me think they were less than skilled and capable," Walker laments.

Walker now involves the people the candidate will be working alongside. "Peer-to-peer interviews are great for a number of reasons," she says. "Candidates are much more relaxed and open when talking with their peers."

Peers notice things managers don't, such as a candidate's hesitancy when hearing about the culture of the department in which they'll be working.

"Peers hone in on the candidates' level of commitment and enthusiasm," Walker explains.

Walker also conducts interdisciplinary interviews, since patient access is part of the team in various outpatient clinics.

"We have great cohesive relationships with our ambulatory clinicians, and their input is very valuable to us," Walker notes.

Mark Nugent, patient access services manager for the ED at Northwest Community Healthcare, typically involves several colleagues in the hiring process, especially when he's interviewing multiple candidates for a position.

"This is helpful in making sure the candidates do not run together in my mind. It gives me other viewpoints that I may have missed," Nugent says.

Front-line staff often can tell if candidates will "jell" with the team. Nugent asks them these questions:

- Do you believe the candidate would be a good fit with other team members?
- Is the candidate's personality compatible with the group?

"This is invaluable information when I am making my decision on who to hire," Nugent adds. ■

SOURCE

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COMING IN FUTURE MONTHS

- Proven strategies to get pay increases for patient access
- Avoid EMTALA violations when collecting in the ED
- Actions to take before terminating patient access employees
- Use patient complaints to find root causes of dissatisfaction

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Presence Settlement Shows Need for Timely Notification When Breach Occurs

For the first time ever, the Department of Health and Human Services, Office for Civil Rights (OCR), is settling a HIPAA violation based on failure to report a breach in a timely fashion. The case illustrates how it can be difficult to determine the timeline for a breach, but it could be just the first case of this type.

The breach occurred at a facility owned by Presence Health, one of the largest healthcare networks serving Illinois with 150 locations, including 11 hospitals and 27 long-term care and senior living facilities. Presence agreed to pay $475,000 and implement a corrective action plan, OCR announced recently.

Unlike any other HIPAA breach case, OCR focused on Presence when company officials reported the problem. On Jan. 31, 2014, OCR received a breach notification report from Presence indicating that it had discovered on Oct. 22, 2013, that paper-based OR schedules containing the protected health information (PHI) of 836 individuals were missing from the Presence Surgery Center at the Presence Saint Joseph Medical Center in Joliet, IL. The information consisted of the affected individuals' names, dates of birth, medical record numbers, dates of procedures, types of procedures, surgeon names, and types of anesthesia.

OCR's investigation revealed that Presence Health, without unreasonable delay and within 60 days of discovering the breach, failed to notify OCR and each of the 836 individuals affected by the breach, as well as prominent media outlets. Media notification is required for breaches affecting 500 or more individuals.

The resolution agreement and corrective action plan are available online at: http://bit.ly/2iX7ZjQ.

Assuming good faith from Presence, the delay in notification may have been related to the time administrators confirmed the breach and investigation afterward, suggests **Jeff Drummond**, JD, an attorney with the Dallas office of the law firm Jackson Walker.

> THE CASE ILLUSTRATES HOW IT CAN BE DIFFICULT TO DETERMINE THE TIMELINE FOR A BREACH, BUT IT COULD BE JUST THE FIRST CASE OF THIS TYPE.

"A lot of these breaches are slow-moving train wrecks," he says. "Something happens, it takes time for anybody to realize it happened, and it may take longer for everyone to confirm that yes, it really did happen, even if there's no discernible damage from the breach. So sometimes you can have a breach and it takes a long while for anybody to do anything or make notifications, and that seems odd when you're looking back at that first initial date."

OCR took that into consideration in the past and was not strict about using that initial date as the starting point, Drummond explains. This settlement suggests OCR has changed its position, he says.

"People have not been in any hurry to get their notifications out and they've been getting away with taking long times to investigate," he says. "I think this case is an indication that OCR decided people were taking a little too much for granted that they could get away with that. This case gave OCR an opportunity to make an example of somebody."

Timely notification will join other issues that OCR can bring up if they want to put the screws to a provider

for some reason, Drummond says, along with hard-to-define deficiencies like "insufficient" risk analysis or insufficient policies and procedures, he says.

"Not only were your safeguards insufficient and that's why you had the breach, but you had these other problems as well, and timely notification will be one of those things they can throw in," Drummond says. "It can be one more thing they use to justify imposing a penalty."

Drummond also cautions that the 60 days in the breach notification requirement is not necessarily what OCR will consider acceptable in all cases. It is theoretically possible, though it hasn't happened yet, to notify the appropriate parties within 60 days from the earliest date and still be penalized for a timely notification failure, he says.

"People throw the 60 days around as if that's the time you have to report, and that's not accurate," Drummond says. "You're required to report as soon as is practical. The 60 days is just a drop-dead date you have to report by."

Even if you notify at 60 days or 55 days, OCR could still claim that you should have been ready and able to notify at 35 days, Drummond explains.

Drummond advises marking the 60-day date from the date you first learned of the incident, or the possibility of an incident, rather than using a date further down the line when you determined that a breach definitely occurred, or some other determination is made. Play conservatively with that time frame.

"You could make the argument that it's not until you're certain you have a reportable breach that the 60 days begins to tick, but I wouldn't be comfortable with that," he says. "The only way that might be reasonable is if between the time you discovered a problem and determined it was a reportable breach, you had reason to have a very high level of confidence that it would not be reportable."

Poor Risk Assessment

The breach itself probably occurred because there was inadequate risk assessment, says **Denise Bloch**, JD, an attorney with Sandberg Phoenix & von Gontard in St. Louis.

"While breaches may happen no matter what the preventive measures and policies and procedures are in place, such as workforce members failing to follow policy or procedure, the likelihood of this particular breach might have been reduced if a risk assessment had been conducted and identified the risk the paper operating room records posed," she says. "As a result of risks identified, the covered entity could have implemented stronger policies and procedures requiring that the records be kept in a locked location, with access limited solely to those individuals needing the information and required the individuals to replace the records to the locked location following use."

Even better, the records could have been kept electronically, Bloch says.

Bloch notes that the notification requirements differ according to the amount of information compromised. For all breaches, notification to the affected individuals must occur without unreasonable delay and in no case later than 60 days following the discovery of the breach. In cases with 500 or more affected individuals of a state or jurisdiction, notification must be given to media outlets serving the state or jurisdiction and OCR without unreasonable delay, and no later than 60 days following the discovery of a breach.

In cases affecting fewer than 500 individuals, the notification is due to the OCR secretary no later than 60 days after the end of the calendar year in which the breaches are discovered.

Although there can be some confusion about timing, there is no doubt that notification was not timely in this case, Bloch says. The breach was not reported to OCR until Jan. 31, 2014, 101 days after the discovery of the breach. Affected individuals were not notified until Feb. 3, 2014, 104 days after discovery of the breach. Presence did not notify the media until Feb. 5, 2014, 106 days after discovering the breach.

"The key lesson to learn is to timely investigate possible breaches and timely report any breaches according to the breach notification rule, but another lesson is the importance of training workforce

EXECUTIVE SUMMARY

For the first time, a healthcare provider is settling a HIPAA violation based on failure to quickly report a breach. It can be difficult to determine when to start the clock for the deadline.

- The breach involved paper records of OR schedules.
- Notification is required within 60 days of discovering a breach.
- The provider waited more than 100 days after the breach to notify appropriate parties.

members to not only be aware of their obligations under HIPAA to avoid breaches, but if one occurs, to know who to report any incidents to, and what circumstances require such reporting," Bloch says.

Providers need to specifically train their workforce on how to report breaches and ensure the breach response team understands their responsibilities, says **Kelli Fleming**, JD, partner with the law firm of Burr & Forman in Birmingham, AL. Tabletop exercises are a great tool to identify weak links in breach response process, she says.

Other Deficiencies Found

Each day that notification was not made to the individuals, OCR, or the media constituted three separate violations, notes **Stacey Gulick**, JD, partner with the law firm of Garfunkel Wild in Great Neck, NY, and co-chair of the firm's HIPAA compliance practice group.

"When questioned about the failure to notify in a timely fashion, Presence claimed internal miscommunication," Gulick says. "Also relevant was that when the OCR investigated the breach, it reviewed other Presence breach reports and found other instances of failure to meet the notification time frames. This is the first settlement for failure to notify in a timely fashion, and could very well be the first of many."

The fact that paper records were involved is noteworthy, says **Kristin Jones**, JD, an attorney with the law firm of Stradley Ronon in Malvern, PA. Many providers are so focused on the risks associated with electronic medical records that they forget to protect traditional paper records as well, she says.

"OCR is unquestionably cracking down on HIPAA breaches as a whole, and we see announcements of record settlements regularly. Healthcare providers have had nearly four years to implement their policies, and OCR is no longer tolerating preventable mistakes," Jones says. "Not only should providers expect more enforcement actions related to timely notification, but they should expect other procedural deficits to catch OCR's eye during breach reporting and HIPAA audits."

Fleming agrees that providers should expect greater scrutiny on timely notification.

"The message this enforcement sends is that OCR is taking these breach notification time frames seriously, and that strict compliance with the deadline is mandatory," she says. "While Presence had a history of not reporting breaches in a timely manner, which probably contributed to the level of enforcement taken by OCR, I would not be surprised if we were to see similar action taken against other providers in the future, especially in situations where additional areas of noncompliance are discovered following an OCR investigation."

State Laws Vary

It is important to understand the distinction between federal and state notification requirements, says **Brian Lapidus**, managing director for identity theft and breach notification with the fraud consulting firm Kroll

CAP Requires HIPAA Policy Review

After the Presence Health settlement, healthcare providers are now more likely to see settlements and corrective action plans (CAPs) related to timely notification, says **Denise Bloch**, JD.

"It is likely that the OCR will take more enforcement actions against untimely breach reports in the future," Bloch says. "In the current enforcement action, the OCR has given a clear message that late notification is not acceptable, as a significant fine was imposed as well as requiring the covered entity to enter a [CAP] for a two-year period."

The CAP places many requirements on Presence, including revision of its existing policies and procedures related to complying with the breach notification rule, including proper procedures for handling potential breaches and completing risk assessments, as well as providing timely notification should there be a breach of unsecured personal health information. The CAP also requires revising existing policies and procedures related to appropriate sanctions against workforce members that fail to comply with such policies and procedures.

Presence also is required to forward such policies and procedures within 60 days of the CAP effective date to HHS, within 30 days of HHS' approval of the policies and procedures, and officially adopt and distribute policies to all workforce members and within 30 days of any new workforce member providing services.

The CAP also calls for training workforce members within 60 days of the approval of the policies and procedures, as well as annual certified retraining and written compliance reports confirming the training. ■

in Nashville, TN. The definition of "timely" notification varies from state to state, he says. For example, Connecticut requires notification within 90 days, but Florida sets notification within 30. California states notification must occur "within the most expedient time possible and without unreasonable delay."

"Notification can be a juggling act for organizations, because the process of conducting a thorough investigation to identify all affected individuals is critical and often takes time," Lapidus says. "The timing of notification is a big issue for any organization because releasing incorrect information about a breach can create needless anger, worry, and fear, and in healthcare can be even more critical given the type of information stored."

A plan is not enough. Kroll encourages organizations to regularly review, update, and drill their plans. These exercises help identify security gaps, address employee training needs, strengthen communication structures, and adapt plans to ever-changing nature of cyber threats. By conducting drills, organizations should give themselves a better chance to respond to breaches effectively and meet notification timing requirements.

Aside from the specific violation of the notification rule, the settlement also signals that OCR expects more of healthcare providers. Failure to understand the requirements will be accepted as an excuse less often, he says.

"I think as data breaches continue to occur and evolve, the expectation that an organization is prepared ahead of time and be able to demonstrate movement and notification efficiently and in a reasonable amount of time will be the expected norm," Lapidus says. "That said, every breach is different; it often takes time to understand what happened and to determine next steps."

Lapidus says the lessons in the Presence case include more than just reporting in a timely manner.

"The key lessons are to take proactive incident response planning measures and define the necessary internal roles and responsibilities determined before a breach occurs to help increase the chances of a timely investigation and notification," he says. "And remember, a breach can involve one individual to millions of personal records, so organizations need to plan ahead for a range of scenarios." ■

SOURCES

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USB Drive Containing ePHI Stolen

The OCR recently announced a HIPAA settlement based on the theft of a USB data storage device with unsecured electronic protected health information (ePHI).

MAPFRE Life Insurance Company of Puerto Rico will pay $2.2 million and implement a corrective action plan, OCR reported. MAPFRE underwrites and administers a variety of insurance products and services in Puerto Rico, including personal and group health insurance plans.

MAPFRE filed a breach report with OCR in September 2011 indicating that a portable USB device containing ePHI was stolen when it was left unsecured in the IT department overnight. The device included complete names, dates of birth, and Social Security numbers of 2,209 people.

MAPFRE reported that it was able to identify the breached ePHI by reconstituting the data on the computer on which the device was attached. OCR's investigation determined the company was not in compliance with HIPAA rules, specifically a failure to conduct its risk analysis and implement risk management plans contrary to its prior representations, and a failure to deploy encryption or an equivalent alternative measure on its laptops and removable storage media until Sept. 1, 2014.

MAPFRE also failed to implement, or delayed implementing, other corrective measures it informed OCR it would undertake.

The resolution agreement and corrective action plan may be found online at: http://bit.ly/2jaf5MZ. ■