Hospital Access Management™

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

AHC Media LLC

IN THIS ISSUE

FEBRUARY 2010
VOL. 29, NO. 2 • (pages 13-24)

Are patients angry at access? Make sure they're happy *before* they leave

Head off all complaints

A young woman is fuming because she just learned about a $5,000 deductible before her insurance coverage kicks in. An elderly man is loudly complaining because he doesn't understand why he can't have anything to eat or drink until he's been seen by a physician. Parents are raising their voices because they don't want to wait to see a doctor before getting their child's test results.

Regardless of the reason, an upset, disgruntled patient is dangerous for your department. To make matters more pressing, customer service has become the new catch phrase for patient access departments. This is for good reason, since it clearly impacts the hospital's bottom line.

If the number of patient complaints involving access increases, your department will have "decreased employee morale, employee turnover, a stressful work environment, and a poor reputation within the hospital," warns **Susan M. Milheim**, senior director of patient financial services at the Cleveland Clinic in Independence, OH.

Access staff at the Cleveland Clinic use the "HEART" acronym to remind them of the things involved in excellent customer service. This stands for:

- Hear the patient.
- Empathize with the patient.
- Apologize for the situation.
- Resolve the situation.
- Thank the patient.

Staff have index cards with these words taped to their computers to remind them of the steps they should follow during difficult situations.

"Too often, we get upset and respond negatively to an unhappy patient or family member," says Milheim. "We need to *listen.* The patient needs to be heard and to feel as if we understand their problem and how they feel. But, that is only half the battle."

The other half is doing something about the patient's complaint, and right away. "We need to resolve the situation for the patient. Resolving

means more than directing the patient to another area," says Milheim. "It means taking the initiative and getting the patient what they need and not passing the patient along."

No more surprises

A small amount of well-timed communication can ward off some explosive complaints. "Patients should be informed upfront about things," says **Amy M. Kirkland**, CHAA, patient access team leader for the emergency department at Palmetto Health Richland in Columbia, SC.

For example, when a patient signs in, that's the time to inform him or her that they are not to eat or drink anything until they have been seen by a doctor. The same is true for test results; patients should be informed prior to their test or procedure that they will get the result when they see the doctor.

"And explain the importance of why the doctor will discuss the results," says Kirkland. Say to the patient, "It is important that your doctor goes over your test results with you in case you have any questions. They will be available to answer any questions you have concerning your tests and/or results."

With insurance coverage becoming increasingly complex, it's sometimes difficult for you — someone who deals with it every day — to comprehend. Thus, it should come as no surprise that patients are coming to you with little to no understanding of their benefits.

"We have seen an increase in confusion for our patients," says Milheim. "So the more information we can provide to the patient, the better."

What the patient will owe should be communicated at the time of scheduling to the best of your ability, to avoid "sticker shock" after the fact. "And if a patient becomes annoyed with a registrar about their copays, we direct the patient to talk with a financial counselor," says Milheim. "This allows for a more comfortable conversation, with an expert who can talk with the patient and fully explain their benefits in a confidential area, instead of at a registration desk."

At MultiCare Health System in Tacoma, WA, scripting is used to create a consistent, customer-service-oriented experience for each patient. "We actively seek ways to minimize surprises to the customer," says **Angie Pike**, the organization's director of customer service. "For example, we will contact patients at pre-admission to make financial arrangements. We have found that patients typically respond positively to these calls."

Pike says that the biggest source of potential patient dissatisfaction with patient access at her organization involves point-of-service collection. As part of this process, staff collect copays, outstanding deductibles, and estimated co-insurance at the bedside or at a centralized registration location. "It can be a challenge to approach a patient who is in a patient bed. Our staff are sensitive to that issue," says Pike.

As unlikely as it may seem, there are some good customer service opportunities in this scenario. For one thing, access staff can help patients

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Hospital Access Management*™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

Call **Jill Robbins** at (404) 262-5557

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Stacey Kusterbeck**, (631) 425-9760.
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).

begin the necessary financial aid paperwork early in the process.

"While point-of-service collection can be a challenge, we have also found that it has given us the ability to reduce patient anxiety, especially if they will be unable to pay for services due to financial limitations," says Pike. "Often, these are patients who are sent to collections unnecessarily. They don't understand the resources available to them from the system and don't communicate with us after they leave our facility."

Ideally, all patients would know their estimated out-of-pocket expenses and be aware of the hospital's collection procedures. "However, because this is a relatively new trend in the industry, it can be surprising to have someone come to the bedside requesting payment," says Pike. "This is why our pre-service center exists."

Staff at the center contact pre-scheduled patients before their surgery or procedure to confirm demographics and insurance benefits. At the same time, they request payment of their copay, outstanding deductible and/or estimated co-insurance. If the pre-service center staff are not successful contacting the patient, this process moves either to a centralized registration area or to the bedside on the day of the surgery or procedure.

"There are many times when people simply don't understand their insurance policies well enough to know what's expected of them," says Pike. "By contacting them up front, we can clearly set expectations at the onset."

For instance, prenatal patients are typically younger, relatively healthy people who have not had a great deal of experience maneuvering through insurance coverage for inpatient stays. "They have no idea what to expect. By notifying them up front, the surprise, and in some cases, anxiety can be reduced," says Pike. "It may not be ideal for every mother-to-be, but overall, we have found that our new moms respond better to the request for payment prior to their arrival."

Re-direct anger

Patient may have a legitimate reason to complain, but in fact, their gripe may have nothing whatsoever to do with your department. Regardless, the situation might generate a complaint letter with misguided anger directed at access. "Patients often confuse patient access staff with other staff," says Kirkland. "It is important that patients understand the role of each individual involved in their care."

For example, they may confuse patient access with a unit secretary or other employee at the front desk of a given area. To prevent this type of confusion, Palmetto Health Richland uses a standard colored dress code for each role in the emergency department. "Also, each patient access employee strives to stress to each patient their role in the beginning of their process as well as the end of the process," says Kirkland.

Pike says that at times, patients do express concerns that are outside of the scope of access staff. For example, there may have been a delay prior to treatment and the patient feels he or she has been ignored.

That doesn't mean that access staff don't get involved in these concerns, however. Staff are instructed to use the "LEARN" acronym: They listen, empathize with the patient's experience, apologize sincerely, respond by either contacting the unit staff or asking if there is anything they can get for the patient, then nurture the relationship with a sincere "thank you" for bringing the concern to their attention. "Unit staff will then follow up to verify that the patient's needs have been met," says Pike.

At times, a patient has lost his or her insurance due to a termination in employment but failed to follow through with COBRA benefits. This is now discovered at the time of registration, when the patient enters via the emergency department or as a direct admit.

"Since the patient now has no insurance, we will investigate the possibility of them gaining coverage through COBRA," says Pike. If the patient has not investigated this at all or previously decided against COBRA coverage, a financial counselor will contact the previous employer to determine if the patient is eligible for COBRA.

If so, the financial counselor contacts the COBRA administrator to determine how much is owed from a premium perspective and how much retroactive coverage will be allowed. The patient or his or her representative is contacted, informed of this, and premium payment is sought.

"If the patient is unable to pay their retro COBRA premiums, MultiCare will more than likely pay for all outstanding premiums in the short term in order for coverage to commence," says Pike. "Patients are very appreciative of this process. It usually allows them to gain coverage for a length of stay that is very expensive and would result in a large out-of-pocket expense by them otherwise."

At MultiCare, any staff member can provide the patient or family with a small gesture of apology. Staff also can sign out up to $50 worth of items at the hospital gift shop without seeking permission.

"This has proved to be helpful in certain circumstances," says Pike. "We trust our staff to use the gifts appropriately, and they have not failed us. We do, however, remind them that the gift cards should only be given after they have sincerely apologized and empathized with the patient's experience. The gesture will be empty without these."

Gift cards can be given for any number of reasons. "In the inpatient setting, we often give gift cards to family members for the cafeteria so that they can take a step back," says Pike. "It's very stressful for families to be with loved ones who are sick. Sometimes, simply giving them a moment for everyone to clear their heads has tremendous benefit for all involved."

When a gift card is given, staff simply write a brief explanation on a log for why the gift card was used. "In order to receive a replenishment of gift cards, the log is simply faxed to customer service, which tracks issues so that trends can be identified and acted upon," says Pike.

[For more information, contact:

***Amy M. Kirkland**, CHAA, Patient Access Team Leader, Emergency Department, Palmetto Health Richland, Columbia, SC. Phone: (803) 434-6652. E-mail: amy.kirkland@palmettohealth.org.*

***Susan M. Milheim**, Senior Director, Patient Financial Services, Cleveland Clinic, 6801 Brecksville Rd., Independence, OH 44131. Phone: (216) 636-7210. Fax: (216) 636-8088. E-mail: milheis@ccf.org.*

***Angie Pike**, Director of Customer Service, MultiCare Health System, 315 Martin Luther King Jr. Way, Tacoma, WA 98415. Phone: (253) 403-6122. Fax: (253) 459-6235. E-mail: Angela.Pike@multicare.org.]* ■

Frustration levels too high? Act now, not later

Pre-empt frustration

To avoid making a bad situation worse, your staff should be prepared to smooth things over before an angry patient walks away. This sounds difficult, but can be surprisingly simple.

"First and most importantly, apologize about the situation and that your facility has failed to meet their expectations," says **Amy M. Kirkland**, CHAA, patient access team leader for the emergency department at Palmetto Health Richland in Columbia, SC. Then she says to follow these steps:

- **Get exact details on what the patient is upset about**.

After learning this information, try to take immediate action to correct whatever is wrong. Recently, a patient told an access staff member at Palmetto Health Richland that he was in a lot of pain, had been waiting for several hours, and had not been seen yet by a doctor. "We contacted the nurse in our waiting room, who contacted a doctor and got the patient's pain under control until they could get them back," says Kirkland.

Another time, a homeless woman came to the emergency department with no socks or shoes. "When I register the patient, at the end of my process I always ask if there is anything I can do or anything I can get them. This patient asked me for socks," says Kirkland. "I went and got the socks, and the patient was so thankful. She explained how she'd been asking for them for several hours. Everyone told her they would bring some back, but they never did. She was so thankful I brought them right away."

- **Determine if you are in a position to resolve the issue personally.**

"If you're not, let the patient know you will notify the appropriate person to handle the issue," says Kirkland. However, if you do hand the problem off to someone else, remain involved. Recently, the wife of a trauma patient who was intubated at Palmetto Health Richland became very upset because the man's valuables were locked up. The hospital's policy states that valuables can be released to someone other than the patient only with verbal consent.

"We printed off our policy and showed it to the spouse, but she was still not satisfied," says Kirkland. "She asked to speak to someone in charge that wasn't in the emergency department. We contacted our administrator on duty to take over with the irate family member." Together, the administrator and the patient access representative consulted with the man's wife to explain the policy. "This did not take access out of the picture. If a formal complaint was filed, this involvement would protect access," says Kirkland.

- **Thank the patient for bringing the issue to**

your attention.

"It's important to make the patient feel you are concerned about them personally and you are there to serve them," says Kirkland. "Ask what you can do for the patient in the meantime. If you can't make your patients happy, someone else will."

Give feedback right away

At Brigham & Women's Hospital in Boston, if a patient issue is identified involving a staff member who did not provide customer service in accordance with the department's policy, immediate feedback is given not only to the individual, but the entire department.

"One patient's perception of the manner in which he or she was treated by a staff member is a reflection on the entire department's customer service," says **Christine F. Collins**, executive director of patient access services. "If even one person says somebody was rude or inattentive, that means there are many more that felt it but didn't take the time to put it down on paper. So we share the negative comment with everyone. And we ask, 'How can we make sure this never happens again?'"

Service recovery can be a powerful tool, if used correctly. "A patient may wait an extended time through no fault of their own, or somebody may be directed to an incorrect location," says Collins. "In that case, we go to wherever they are, apologize, and say, 'Let me give you free parking for the day,' or if they just bought their lunch, we ask them to give us the receipt and we will get them reimbursed."

Recently, access staff mistakenly sent a patient home because a diagnostic test appeared to be cancelled. "We did many things to compensate that particular patient, including calling them at home and apologizing," Collins says.

It's not enough, however, to assuage a patient's frustration after a mistake was made. Collins expects her staff to head off problems before things get to that point. For instance, if a family member is becoming apprehensive while waiting for a loved one to come out of surgery, she wants staff to approach that person, not the other way around. "I tell my staff that if somebody has to ask you a question, then it means you are not staying on top of the situation. You should be one step ahead, because communication is the key," she says. "It is all about the patient and or family, not us."

Remind employees that they may in fact be completely right, but this doesn't mean that the patient shouldn't be apologized to. "You cannot please everybody. And as long as you were courteous, then I am on your side. But that doesn't mean I'm not going to apologize to this patient," says Collins.

Employees at times come forward to tell Collins, "There is just no chemistry here. Can somebody help me?'"

"In that case, the employee can tell the patient, 'Just give me a second, I'll be right back,' and we are able to do a nice handoff," says Collins. "Why would you want to make a bad situation worse?" ■

Tackle even the stickiest cross-departmental issues

Start spreading some goodwill

Often, problems that are a continual thorn in the side for patient access simply cannot be solved without the help of other departments. Likewise, you can spread no small amount of goodwill by helping others with their own troublesome "pain points." Here are some ways to improve cross-departmental relationships:

- **Tell the other department what you need.**

Getting some specific information can, at times, make the lives of access staff much easier. For instance, patient access staff at Seattle Children's Hospital were upset because they weren't getting the information they needed when floor supervisors called with an add-on for an admitted patient.

In order to schedule an admission, access staff needed six key elements: the patient's name, medical record number, date of birth, diagnosis, the name of the attending physician, and the service. A form was developed for admitting, but this was not shared with the floor supervisor group. "Once we did, both teams were on board. The process of add-on admits became almost painless," says **Heidi Dunbar**, manager of admitting/emergency department coordinator. "It was really very simple. As soon as the floor supervisor team knew what we needed to know and why, we started getting everything we needed."

- **Attend meetings of other departments.**

A liaison from Seattle Children's access department routinely attends staff meetings held by

other key areas and vice versa. This keeps the lines of communication open. "I go to the charge nurse and attend staff meetings, and one of their representatives comes to us," says Dunbar. "This way, when issues come up, we already have a liaison we can go through."

• **Find out firsthand what employees in other departments actually do.**

If an access staff person is becoming frustrated with another area, why not have that individual go there to "shadow" the person and see what the job actually entails? "This has been very eye-opening, both for patient access and for other departments," says Dunbar.

In one instance, one member of Seattle Children's access staff spent a day with the insurance processing department. "They learned what takes place on the back end if insurances are coded incorrectly, and ultimately, what happens if the hospital does not get reimbursed in a timely manner," says Dunbar.

Access staff in the hospital's emergency department also shadowed the admitting access team for a day. "They discovered the downstream effects of incorrect patient information and documentation, and that the grass is not always greener on the other side," says Dunbar.

After shadowing another department, a previously frustrated access person typically returns with a new appreciation for the work done by that area. "They may come back saying, 'Do you know what they have to do every day?' That person is then a little more patient because they realize that everybody has a stressful job, not just them," says Dunbar. "They go sit in their chair for a day and see how they live and what they go through. Then, it's amazing how a complaint just goes away."

Connie Campbell, director of patient access of Mercy Medical Center in Oshkosh, WI, also uses the "shadowing" practice to defuse unnecessary tension between departments. "We have found success in sending staff to shadow surgery, radiology, billing, and the cancer center. Each time, we identify new ways we can do things for them," she says. "Staff state it always helps to know the other person's environment. It also puts a face to the registration name."

• **Send out a short survey.**

Campbell recommends sending a survey to other departments about an access service. Attach a letter explaining that your customers are important and you would like to know how well you are doing. "Besides the manager sending them, also have your staff send them. Have them return the surveys to one spot," says Campbell. "A simple e-mail with two or three questions works best."

• **Send a thank-you note.**

"Teach your staff to always talk the other department up, stating how good they are. You'll notice it then comes back," says Campbell. "Our thank-yous are often surrounded with patient examples and the teamwork both units displayed."

[For more information, contact;

***Connie Campbell**, Director of Patient Access, Mercy Medical Center, 500 S. Oakwood Road Oshkosh, WI 54904. Phone: (920) 312-0002. E-mail: ccampbell@affinityhealth.org.*

***Heidi C. Dunbar**, Admitting Manager/Emergency Department Coordinator, Seattle Children's Hospital, 4800 Sandpoint Way NE, Seattle, WA 98106-0371. Phone: (206) 987-3484. E-mail: Heidi.dunbar@seattlechildrens.org.]* ■

Do an immediate consult with staff in these cases

Listen closely to employees

Rushing by a registration area on your way to a meeting with a hospital administrator, you think you hear an edgy tone in an access employee's voice while she's answering a patient's question. Do you stop to investigate further, or do you continue on your way?

It's a mistake to allow problems with staff to fester, as mistakes will recur, and poor service will generate ill will. **John E. Kivimaki**, director of patient accounts at Mary Rutan Hospital in Bellefontaine, OH, says that a negative attitude is one reason to have an immediate consultation with an access staff person.

"If it is not addressed immediately, then the shift that the person is on that has the negative attitude will continue to falter in displaying excellent customer service," says Kivimaki.

Hopefully, staff will take action themselves, by reporting all negative behavior to the registration supervisor. "Otherwise, it can potentially cause poor morale," says Kivimaki. "But with a very active supervisor that is on top of all department activities, the culprit will soon be confronted."

Either way, the key is to take immediate action. "This has to occur as soon as possible," says Kivimaki. "If you do not confront the person with the 'bad' attitude, others in the department will ask each other, 'Why does this person get away with this?' And before you know it, others will start slacking off with their job responsibilities."

Hollis Scott, a patient access supervisor at the Children's Medical Center of Dayton, says that when he first assumed his current role, several employees were clearly disgruntled. "This was supposedly due to issues that had been reported to my predecessor, which were not managed to the satisfaction of the staff," he says.

Scott made a point of meeting with each staff member to discuss his or her individual concerns. "I requested feedback regarding what she did or did not like about the department," says Scott. "I also asked her to share what she perceived to be the biggest impediment to the successful completion of her job duties. The staff appeared to appreciate those conversations. Overall morale has improved."

An individual employee's unhappiness may have less to do with your access department and more to do with other variables outside of the workplace. "We had an employee whose husband was ill. She was struggling to provide for him and their children. After discussing the situation with her, we realized a minor adjustment in her hours could help ease her burden to some degree," says Scott. "I believe the fact that we cared and were willing to assist meant more to her than the actual change in hours."

The simple act of listening closely to the way staff members speak and monitoring their tone of voice "can be immensely helpful," says Scott. "There have been staff who, by the way they said hello in the morning, or did not say hello, we could discern that there was potential for problems that day."

When this happens, take that opportunity to engage them in a short conversation. "Ask them if everything is OK. Gauge his or her awareness of their mood," says Scott. "Perhaps inform the employee that it would be acceptable for them to take a few minutes and collect themselves."

Don't embarrass staff

Christine F. Collins, director of patient access services at Brigham & Women's Hospital in Boston, says that that at no time should you embarrass your employee in front of a patient. "You have to intercede very tactfully," she says. "Without putting the employee in a bad predicament, you need to put the patient in another place. You want them to leave feeling like somebody cares, but without damaging your employee. I don't think any patient or family member really wants you to chastise an employee in front of them."

This calls for a good deal of finesse, and is not always easy to do. One rule of thumb is to give feedback to the employee only after the patient or family member has left the area. When you do so, avoid getting personal.

"You don't want to get into an argument with the employee. It's not about right and wrong. It's all about, 'How does the patient feel?' and 'How can we make the patient feel better?'" Collins says. "You may be having a bad day. Take it to another employees office, but don't take it out on the patient. You may have problems at home, but it has nothing to do with the patient."

Afterward, the incident also can be used as a learning experience for the entire department, but with no blame attached. "You can come out and say that this never should have happened and there really is no excuse," says Collins. "You need to be able to say that to an employee. There is nothing wrong with being honest."

You may overhear an employee giving misinformation at an admitting office. Don't hesitate to correct it, but do so tactfully. "You can say, 'Mary, I don't think you realized that the department moved,'' says Collins. "They know they made an error. And it is corrected immediately, without being disrespectful."

[For more information, contact:
***Christine F. Collins**, Executive Director, Patient Access Services, Brigham & Women's Hospital, 75 Francis Street, Boston, MA 02115. Phone: (617) 732-7453. Fax: (617) 264-6335. E-mail: cfcollins@partners.org.]* ■

Get physician offices to meet the needs of access

Offer options and education

Common obstacles in good communication between patient access departments and physician offices include: duplication of patient

demographic data, communication barriers due to turnover in physician practices, or discrepancies in physician billing requirements vs. hospital requirements.

In many ways, physician offices hold the key to the success of patient access departments, but getting them to meet your needs is often a challenge. The fact is, access requires a great deal of cooperation from physicians, their offices, and their patients.

"We need demographic information, insurance information, and medical information on patients," says **Pam Carlisle**, CHAM, corporate director of patient access services at Ohio Health in Columbus. "We need them to complete a full order with all of the key elements, and we need them to sign the order. We ask them to utilize our systems to make processes efficient for both parties. What a challenge for all." Here are some proven strategies:

• Build a rapport with the staff.

"We really build on the relationship and ask them if there is anything else we can assist them with. They are our customer, and we want to keep them happy," says Carlisle.

Ohio Health's access managers routinely attend practice manager meetings as a way to present updates and process changes. Also, luncheons are occasionally hosted at the large practices to offer support and guidance.

"We try to minimize the impact of regulatory requirements for hospital billing on their practices. We are always asking them how we can make the process easier for them," says Carlisle. "Putting a face with a name has really gained us some momentum for capturing all the data we need."

• Offer more efficient processes to eliminate duplication of work.

This is a surefire satisfier and can be used to build relationships. "Nobody likes to create more work," says Carlisle. "Offer them techniques that help their office and save them time."

• Allow them to choose an option that works for their practice.

Each physician office environment is a bit different — some are more technical than others, some larger, some smaller. Because of this, their needs vary somewhat.

"What may seem like an easy, helpful fix to one practice may be viewed as difficult for another," says Carlisle. "We remind them of all the options available for a particular process, and let them pick the one that best suits their practice operations. Giving them choices is a big pleaser."

OhioHealth's access department offers many different ways to schedule an appointment. The office can call, fax, schedule directly at the office, do so online, or have the patient self-schedule. "They choose an option that best fits their work environment, so it is a win-win for both. We get our information, and they get efficiency," says Carlisle.

• Provide training on payer requirements.

There is a pressing need for education on all of the ever-changing, and often quite complex, requirements and regulations. To help with this, OhioHealth's access department created a concise guide on obtaining precertification for outpatient diagnostic services.

The guide lists which tests require precertification, how to obtain precertification by payer, and a list of web sites and phone numbers for all of the various payers. "Staying up with insurance requirements is very difficult, and it is up to us as providers to help educate the practices. They do not always keep up with those things in their offices," says Carlisle. "We put all the information at their fingertips and give them all the details they may not have known about."

• Partner with the physician relations team at you hospital.

"This can prove to be invaluable," says Carlisle. "Because we have a strong relationship with them, we partner on physician process improvements. So we are sending one clear message to our physicians."

Building relationships, offering options, and making processes as automated and efficient as you can "will boost physician satisfaction with your facility. And in turn, that will bring more satisfied patients through your doors," says Carlisle. ■

Say and do this if patients say they just can't pay

These days, access is seeing many patients who simply cannot pay what they're told they owe. In light of this reality, staff will need to be ready for some uncomfortable moments. "With the current economic situation, the public in general is extremely concerned about expenses," says **Hollis Scott**, a patient access supervisor at the Children's Medical Center of Dayton.

The Dayton area was hit particularly hard due

Continued on pg. 22

Examples of scripting for upfront collections

Below are examples of scripting used for upfront collections by patient access staff at Texas Health Resources in Arlington:

"I have no insurance."	"I understand. We are pleased to offer you an uninsured discount of 30% and that will bring your deposit due to $_____." Which payment option would be best for you?"
"So is this all I am going to owe?"	"What I am providing you is an estimate based on the information that I have today. You will be billed for any outstanding balances after services."
"My ex-spouse is responsible for paying these bills."	"I understand. Unfortunately we cannot become involved in divorce decrees. As the presenting parent you are the responsible party for this account. You, in turn, can seek reimbursement from your ex-spouse. We do have several payment options I'd be glad to talk about today…."
"Send the bill to my attorney."	"Unfortunately, attorneys cannot guarantee the outcome of a case and, therefore, cannot guarantee payment for your claims. We've found that it works best for all parties involved if payment is made at the time of service. Once a settlement is reached, you will be reimbursed from those proceeds. I'd be glad to put this on your Visa or MasterCard today. Which payment option would work best for you?
"Why do I have to pay my outstanding balance?"	"I understand that this may be something new for you. However, health care financial responsibility is a mutual relationship between the hospital and those who utilize its services. We provided those services for you on _____ and your outstanding balance is $_____ . We have several payment options available at this time. Which payment option would be best for you?"
"Is all you care about money?" "Are you afraid I'm not going to pay after I leave?"	"I know that talking about the patient's portion due is sometimes a difficult subject. We have, however, found that it is best to talk about it up front so that there are no surprises for anyone later on. By doing this, I'm able to offer you several payment options today. Would you like to pay by cash, check, credit card, money order?"
"I'm always overcharged and it takes forever to get your money back."	"I understand how frustrating that can be. We've done our very best to make sure we have verified and estimated correctly. If you find that you are due a refund, please call our business office directly on this financial brochure and they will follow up and ensure your credit balance is promptly refunded. Now… how would you like to take care of this today?"
"I'll have to discuss this with my spouse."	"Sure, I understand, I'll be happy to get an outside line and step away so you can have some privacy to call him/her. What is the number where they can be reached?"
"It's not right to pay for a service before you have it done!" "I'll stop back at discharge."	"I understand this may be something new for you. We have, however, found that it is best to talk about it up front so that there are no surprises for anyone later on. Also, once you're finished with your test/ procedure, you'll be ready to go home and won't have to worry about stopping back here. I have some payment options I'd be glad to talk to you about today..."
"Show me the bill."	"Sure! I'd be glad to show you how we arrived at your estimate today…."
"That's why I have insurance."	"Unfortunately insurance rarely covers all costs. As a service to you, we have already verified your coverage benefits and your estimated portion due today is $_____. How would you like to take care of that?"

Continued on pg. 22

"I don't get paid until next week."	"I'd be glad to put this on your Visa/ MC/ Discover / American Express. That way you'll be able to wait until their bill comes to make your payment. As a service to you, I can also contact our scheduling department to reschedule your procedure for next week? Which is best for you?"
"My insurance company said I do not have to pay up front." "My employer told me not to pay because my insurance is contracted with your hospital."	"According to our contractual relationship with the payer, we are permitted to collect deductibles, copays, and the estimated patient cost share at the time of service. How would you like to take care of your estimated portion today?"
"My doctor said I did not have to pay." "I've already paid the doctor." "My doctor just said to come on over…"	"Keep in mind that the payment for hospital-rendered services is separate from physician charges. I know receiving a bill from different providers can become confusing. That's why it's important for us to let you know what your estimated portion due to the hospital will be before you have the service performed. Perhaps you doctor was referring to your account at their office."
"I don't have any money." "I can't afford it right now." "I am not working. How can I pay if I don't work?" "I'm going to file bankruptcy."	"I understand. Why don't I have you talk with our financial counselor? This will help us determine how we can assist you in resolving your account balance.
"Why wasn't I told in advance that I would have to pay today?"	"We do our best to try to inform patients prior to their arrival of their portion due. However, your insurance handbook should detail for you the portion you are responsible for when receiving health care services. I apologize that you were not notified before your date of service. If you are not in a position to pay the total amount in full today, I'd be glad to go over several payment options we have..."

Source: Texas Health Resources.

to the loss of a major GM plant and the city's only remaining Fortune 500 company. "As a pediatric hospital, the tremendous loss of jobs has resulted in an unprecedented shift from commercial insurance to Medicaid coverage for many patients," says Scott. "People are scared and angry."

Many have never had to apply for assistance previously and may feel embarrassed about not being able to provide for their family. "It has become imperative that we communicate the opportunities available for public aid," says Scott.

In addition to offering this concrete type of help, conveying sympathy and understanding has become a critical skill for access. "We need to put ourselves in their shoes and try to understand why they may be dissatisfied," says Scott. "If the parent cannot be placated, staff should politely inform them that they would be happy to connect them with a supervisor."

At Texas Health Resources in Arlington, access staff go through a online upfront collection module that helps explain the purpose of collecting, how to ask the questions appropriately, and the various scenarios that could occur. "It is an online module specific to collections and is mandatory for all patient access staff," says **Patricia Consolver**, CHAM, the organization's corporate director. **(See examples of scripting used by staff, pg. 21.)**

Offer more options

"There are more folks wanting to set up long-term payment plans to meet their high deductibles, but they are not interested in bank loan programs," says Consolver. "We have had to expand our options for patients."

If a patient has no outstanding balances, payment arrangements have been expanded from six months to 18 months, with no interest. "We have had quite a few take advantage of this option," says Consolver.

[For more information, contact:
***Patricia Consolver**, CHAM, Corporate Director, Texas Health Resources, Arlington, TX. Phone: (817) 462-6426. E-mail: patriciaconsolver@texashealth.org.*
***Hollis Scott**, Supervisor, Patient Access, The Children's Medical Center of Dayton, One Childrens Plaza, Dayton, OH 45404. Phone: (937) 641-4323. E-mail: ScottH@childrensdayton.org.]* ■

Your actions can reduce tension over long ED waits

Show patients you care

What's the most common complaint that **Amy M. Kirkland**, CHAA, patient access team leader for the emergency department at Palmetto Health Richland in Columbia, SC, hears from patients? Hands down, it involves frustration over long wait times.

"This is the biggest complaint I see. But patient access has no control over this," says Kirkland. To defuse tension, she relies on honest, direct communication.

"If patients understand why things are taking so long, most of the time they are not as irate," says Kirkland. "Hourly rounding in the emergency department lobby by patient liaisons and assistant nurse managers is one way we connect with our patients and inform them of delays."

Patients are often unhappy to be asked for copayments or deposits. "They feel that we are not concerned about their care but only about the money," says Kirkland. "It is important that patient access perform their job duties in a manner that delivers compassion, just like the patient's nurse is required to do."

Even though patient access is not clinically involved in the patient's care, the way you present yourself matters a great deal. "In no way do you want your patients to get the perception that you are just there for their money," says Kirkland.

Although **Susan Thompson**, director of admission services at Moses Cone Health System in Greensboro, NC, says her department does not see many angry patients, the emergency department is an exception when wait times are long.

"Morale goes down a bit when we have a very high census. Staff cannot spend the time they want to with patients, and I think that bothers my employees more than anything," says Thompson. "Some patients feel they weren't treated appropriately when they come by and clear discharge. Oftentimes, they do not want to pay copays and use the excuse of excessive delays."

Other than requesting that payment is made when the service is rendered, staff do not "push" for any money from the patient. "We do see patients who say, 'If I had known it would cost this much, I never would have come here.' But because of EMTALA, we can't tell them in advance what it will cost," says Thompson.

The biggest collection challenge for the system's two EDs is actually getting patients to come by discharge before leaving. "There are too many egresses where patients can bypass us altogether," says Thompson. "At this point, we simply have a cashier who asks for copays. You can walk out right now and never see us. Our goal is that a clinical person will escort that person to discharge, but sometimes the patient gets impatient and walks out beforehand." To address this, the hospital is considering putting a financial counselor in the ED and plans to redesign the area during a planned renovation.

Another possible solution is to collect copays in the treatment room, once the patient has been assessed by a physician and is stabilized. "The challenge is that you may have to go back into that room three or four times before the patient can actually talk to you. You don't know whether a nurse or phlebotomist is in there or whether the medical screening examination has actually been completed," says Thompson. "The goal is to give them a courtesy discharge, so that everything is taken care of and the patient can save some time. We think it will be a win-win for everybody if we can achieve that."

When asking for a copay, "we basically try to hold to the same script. We say, 'These are the estimated charges for this procedure or visit. How will you be making payment today? Credit card, check or cash?' That kind of negates the possibility of the patient telling you 'I'm not prepared to pay anything,'" says Thompson.

COMING IN FUTURE MONTHS

- Easy ways to educate patients on billing, insurance
- How to get staff to see access as a long-term career
- Proven ways to combat poor ED collections
- How to celebrate when staff collect high-dollar accounts

If patients are upset, however, they aren't asked for a copay. Instead, staff say that they sincerely apologize for the excessive wait. That patient is given the hospital's service excellence phone number so they can report their concerns.

"If the patient is truly irate and think their care wasn't appropriate, we get the director of nursing or the house coverage down to see that patient, if available," says Thompson. "And we will always give service excellence a heads up so they can communicate with the family to defuse it as quickly as possible — if not right then, then within 24 hours."

If the patient cannot pay the full balance, a partial payment is taken instead. "We state that they can follow through with patient accounting when they receive their bill," says Thompson. "At this time, we don't reschedule or postpone procedures if the patient cannot pay, with the exception of a very few elective procedures including cosmetic or bariatric surgery."

When scripting is used, however, it is tailored according to the staff person's own unique personality. "We take each patient as an individual. We try not to sound like we're scripting. I don't want my employees sounding like robots," says Thompson.

For example, if patients are very upset, staff offer to call them back if it's not a good time, or give a phone number so patients can contact them when convenient. "Just being empathetic is the important thing," says Thompson. "If the patient is very worried or upset, my employee may get me or a supervisor involved. In that case, the patient is told, 'I want you to feel comfortable, and here is someone who may be able to shed additional light on this.'"

[For more information, contact:
***Susan Thompson**, Director of Admission Services, Moses Cone Health System. E-mail: Susan.thompson@mosescone.com.]* ■

HIPAA Regulatory Alert
Supplement to *Healthcare Risk Management* and *Hospital Access Management*

HHS increases penalties for HIPAA violations

It's not just the organization at risk, but individual staff members

The U.S. Department of Health and Human Services has published an interim final rule incorporating provisions of the Health Information Technology for Clinical and Economic Health (HITECH) Act related to HIPAA violations that significantly increase the penalties it can levee against employers and health care providers.

Before the HITECH Act, businesses could incur a maximum fine of $100 for a single violation and $25,000 for all identical violations of the same provision. Now, however, there is a series of tiered minimum fines for individual claims and a $1.5 million maximum fine when a group of employees is affected.

HIPAA compliance executives and consultants have been quick to react to the new interim rule. "The new penalties are scary, and I think it really has all of us wanting to go back and review our HIPAA policies and procedures," says **Kathy Westhafer**, RHIA, CHPS, program manager, clinical information at Christiana Care in Wilmington, DE. "Even though we knew they were going to do this anyway, it has created real urgencies."

But **Cassi Birnbaum**, RHIA, CPHQ, director of health information at Rady Children's Hospital of San Diego, was much more sanguine. "Being from California, we have already had to be held to a much higher standard, so we really have a leg up," she explains. "In comparison to ours, it actually looks mild; we're not exactly shaking in our boots." However, she adds, "It can be very frightening if in the past you've just been held to minimal HIPAA penalties."

"I think the biggest issue is that a variety of things have come together," adds **Margret Amatayakul**, MBA, RHIA, CHPS, CPHIT, CPEHR, CPHIE, FHIMSS, who heads a Shaumburg, IL-based consulting firm that bears her name. "First of all, HITECH brings an enforcement rule that increases the size of the penalties; there's more at stake if there is an egregious violation. But there is a tiered approach that still enables a person who just didn't understand, or who tried hard to do what's right and still got in trouble, to be able to have a corrective action plan and perhaps lesser penalties than someone who does things with malicious intent. And this has been made clearer."

The new rule also makes clear, she continues, that it's not just the organization that is at risk, but if an individual member of the workforce does something wrong, they themselves can be held accountable. "You still have to train people, monitor them, and so on, and it's likely that if an individual gets in trouble, the organization will, too; but an individual who does something maliciously will see consequences — where in the past the organization would suffer the consequences directly from the government," Amatayakul says.

Three categories of violations

The interim rule spells out three different classes of violations:

"(A) In the case of a violation of such provision in which it is established that the person did not know (and by exercising reasonable diligence would not have known) that such person violated such provision, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(A) but not to exceed the amount described in paragraph (3)(D);

"(B) in the case of a violation of such provision in which it is established that the violation was

due to reasonable cause and not to willful neglect, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(B) but not to exceed the amount described in paragraph (3)(D);

"(C) in the case of a violation of such provision in which it is established that the violation was due to willful neglect — (i) if the violation is corrected as described in subsection (b)(3)(A),\1\ a penalty in an amount that is at least the amount described in paragraph (3)(C) but not to exceed the amount described in paragraph (3)(D)."

While the minimum penalty varies with each category, the maximum is the same in all cases: $1.5 million. With such significant dollar amounts at stake, it's critical to understand exactly what is meant by each of these types of violations.

For "category A," Amatayakul offers this hypothetical: "Let's say the breach was from a paper-based record — somebody looked at it or overheard something or saw somebody [famous] in the hospital. They did not have malicious intent, but somehow there was a breach."

There is no way to absolutely say you can monitor everybody who works on a paper-based record, she continues. "Obviously, training needs to be done, and the government will be looking at the extent to which you did train people, gave them examples of this type of breach, told them it was wrong, and secured the information in such a manner as to make it more difficult to casually see something you shouldn't," Amatayakul shares. "Even in an electronic environment there could be a person who has legitimate access to the information — maybe a nurse who takes care of the patient — but they happened to tell somebody something they shouldn't have."

A "category B" violation, Amatayakul continues, "might be where a VIP is in-house and a person comes to learn of their alias or snoops. There is no malicious intent, like selling a story to the *National Enquirer;* they are just curious, but they know they shouldn't be doing this, so the penalty would be stiffer."

For the most serious type of violation, "category C," the onus falls much more heavily on the organization.

"This would be more a case of an organization not having very strong access controls," Amatayakul suggests. "They did HIPAA training the first time it was enacted, but never did any more training. Or, they have a policy on sanctions but they don't do anything about it."

The interim rule does provide for a time period in which corrective action can be taken, and such actions can reduce the penalties.

Your corrective action plan, says Westhafer, "is really part of reviewing your policies and procedures and setting things up so you know what the remediation plan is up front. I almost think of it like disaster planning — you think about what things can go wrong, and as you go through your policies and procedures, and what the protocol is going to be for each type of violation, so you're a step ahead."

Hospitals, she continues, should be used to this type of preparation. "We get surveyed all the time from The Joint Commission and others, so we know if a situation arises, we're pretty used to jumping in and we know we have to take care of it quickly," Westhafer notes.

"We have developed a grid," says Birnbaum. "We wanted to make sure to have community-wide standards so we did it in conjunction with other privacy officers in San Diego, and in fact just updated it to clarify the reporting process and responsibilities." Under the policy, for example, for a first-time inadvertent breach, verbal counseling is given; if there is a subsequent trend, it will result in a final written warning.

"The big thing for us is the need to consistently apply the policy to all members of the workforce," says Birnbaum. "You can't be more lenient with 'Suzie Q' just because you like her."

She adds that even though she provides education at the time of new employee orientation, "We now have an additional course that is a new requirement for every workforce member — including medical staff. Also, we've passed around the policy so people will know the repercussions of violations."

"It's more likely than not the OCR [The Office for Civil Rights, which handles HIPAA enforcement] will look a little more carefully at whether the corrective action plan is appropriate, and they may move to a civil monetary penalty if they feel it is not strong enough or it is not the only thing that should have been done," offers Amatayakul. "In the past, they just sort of assumed everybody would do a corrective action plan and gave everybody an opportunity. They were nice, and helped you overcome the issue."

Now, she says, "They're under the gun to be a

little bit tougher. Not only is the OCR under the gun to be more proactive, but there is an incentive for them to give out civil money penalties because they get to keep some of the money; they can also turn some of it over to the individual who is harmed."

In the past, she says, the OCR didn't have the staff to go after violators as aggressively. "They were cranking out these letters, asking facilities to come up with a plan," she recalls. "Now, with a little bit more money, and now with [HIPAA] security under OCR (in addition to privacy) they are likely to be a positive force. They want you to do the right thing, and it makes them feel better if they help the [harmed] individual."

In terms of how they will view corrective action plans, she adds, "They will look for more specific evidence that this was done, and that action was taken." Whether you have acted on your plan, she stresses, has now become more important. "People in that situation [of being found in violation] need to come up not just with a specific plan, but with evidence they put it into action," Amatayakul warns.

[For more information, contact:
***Margret Amatayakul**, MBA, RHIA, CHPS, CPHIT, CPEHR, CPHIE, FHIMSS, Margret\A Consulting,LLC, Phone: (847) 895-3386. E-mail: Margret@Margret-A.com.*
***Cassi Birnbaum,** RHIA, CPHQ, Director of Health Information, Rady Children's Hospital of San Diego, CA. Phone: (858) 966-4095. E-mail: cbirnbaum@rchsd.org;*
***Kathy Westhafer**, RHIA, CHPS, Program Manager, Clinical Information, Christiana Care. Phone: (302) 327-3815, E-mail: kwesthafer@christianacare.org.]* ■

Sharing user names is a HIPAA security violation

What's a shared user name between friends? Quite a bit, when it comes to the HIPAA security rule, warns **Marion Jenkins**, PhD, co-founder of QSE Technologies Inc., an Englewood, CO-based technology consulting firm. Unfortunately, he adds, many organizations have individuals who share user names — some because they are unaware of the seriousness of the violation, and others because they have less honorable intentions.

"Generally, the initiative comes from the health care workers — although sometimes it is initiated by management," says Jenkins. "It could simply be out of convenience; people become frustrated with all the different passwords they have to use so they either decide to use common ones, write them down, or share them."

Let's say there are part-time employees who only come in once a month and are replaced from time to time. "What often happens is that you give everyone access because it's a pain to change user names on and off," Jenkins explains. "So during implementation you may make everybody a super-user. But that's a total violation of HIPAA."

Health care organizations that allow shared user names to avoid additional licensing costs are opening themselves up to a "double-whammy" of HIPAA violation penalties *and* hefty fines for violating licensing agreements. "You may have a software package that charges $1,000 for a login, and that software may be used by a number of part-time people," Jenkins posits. "Many vendors will give you device licenses vs. user licenses, which allow you to have one person on at a time per machine, and that's the way you should do it. Some vendors, however, do not do this, so management seeks to circumvent licensing fees [by sharing user names]."

Microsoft Office, he notes, retails for about $300-$400. "If you are found violating that software agreement, you can be fined $3,000 per instance; so if you have 20 workstations and can't produce 20 licenses, you're looking at a $60,000 fine [in addition to HIPAA violation penalties]," warns Jenkins.

Defeating intent of security rule

The key issue, Jenkins continues, is that such a practice completely defeats the intent of the HIPAA security rule. "HIPAA security requires that with anyone who accesses or changes or looks at [protected health information] you have to be able to tell who did it and when," he explains. "If you have a user logged in at a nurse's station on a given day, and you do not know who it was among the eight rotating nurses, it's a violation. It says very explicitly in the security rule that with anyone who can access, view, edit, or change an entry you have to be able to tell who did it and when. There has to

be an audit trail."

In addition, says Jenkins, "it defeats the most basic security policies that represent industry best practices. It makes it difficult to troubleshoot many IT problems, and it can jeopardize your human resource operations if you forget to change user names if and when an employee leaves the company."

So, what should your policy be with regard to allowing employees to share user names? "If you are tempted to share login names, don't," Jenkins warns. "If you are currently doing it, stop. Get yourself in compliance with the HIPAA security rule by having each employee — whether part-time or full-time — use a unique user login name."

Part of the problem, Jenkins suggests, stems from the fact that there are two distinct HIPAA rules — one governing privacy, the other governing security. "HIPAA security is completely different, and many facilities do not understand it," he asserts. "So many of them had been so 'beaten up' by the privacy rule that when the security rule came along, they went to sleep."

Your organization is required to have a completely separate set of procedures around HIPAA security in addition to those around privacy, Jenkins continues. "For example, you need to have a HIPAA security officer; it may be the same person as your privacy officer, but it *has to be formalized*. You have to physically secure your computer equipment. You must maintain a log of all security incidents — so, for example, in the case of a hard drive or power supply failure, you must record who entered the room and what they did."

Specifically around user names, he adds, you must have different ones for every individual. "In addition, that user name and password should only allow them to access what they need; so, for example, billing people should not be allowed to see clinical notes," he explains. "Furthermore, there must be different levels of security; for example, some employees will be allowed to view certain information but not to change it." The most important thing of all, he concludes, is to make sure you have delineated a clear distinction between HIPAA privacy and HIPAA security. "Satisfying one does not satisfy the other," he cautions.

[For more information, contact:

***Marion K. Jenkins**, PhD, QSE Technologies, 359 Inverness Drive South, Suite K, Englewood, CO 80112. Phone: (303) 283-8400, ext. 115. Fax: (303) 283-8401. E-mail: Marion.Jenkins@qsetech.com.]* ■

HIPAA requirements, penalties increased

According to the Ambulatory Surgery Center Association, the economic stimulus package passed by Congress last year included several changes to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) involving privacy of patient information:

- The penalty for violations increased from $100 per penalty to $1,000 per penalty. The maximum penalty is $100,000. If the violation involves willful neglect, the violation per penalty is $100 to $1,000, and the maximum penalty is $100,000.
- When an unauthorized disclosure occurs, facilities have a greater obligation to alert patients and the government. Unless the information was "secured," facilities will be required to notify those whose protected health information was involved. The Centers for Medicare & Medicaid Services (CMS) issued guidance last spring that said information must be encrypted or destroyed to be considered "secured." In some circumstances, facilities must notify the federal government and the media about the unauthorized disclosure.

Patients can prevent providers from giving information to payers about services for which the patient pays directly. This change will require modification of some contracts, the ASC association points out.

Facilities that use electronic medical records (EMR) will be required to provide patients, upon request, with a list of all disclosures made through the use of an EMR for the prior three years. The implementation date for this provision depends on when the Department of Health and Human Services issues rules, but the earliest implementation date will be Jan. 1, 2011. Most of the other changes go into effect in 2010; however, increased penalties for violations have been in effect since Feb. 17, 2009.

On Feb. 17, 2010, facilities using EMRs will be required to provide individuals a copy of their record electronically, upon request. Facilities can charge for the labor costs. ■