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Catch fraud upfront: Medical identify theft is on the rise

It's time to revamp your processes

If a patient gives a different Social Security number from the last time he or she presented, this could mean that that patient is confusing the number with his or her spouse or child's. However, it could also mean the patient is assuming a false identity.

Nationwide, hospitals are reporting increasing numbers of patients registering under false identities because they lack coverage. This presents many problems for patient access — legal, medical, and financial.

"We have seen a significant increase in the amount of identity theft in our organization," says **Amy Schroeder**, a registration supervisor at BryanLGH Medical Center in Lincoln, NE.

"On average, we have about one case per month that surfaces. Almost all of these cases have presented through the emergency department," she says.

Unfortunately, the financial ramifications can be significant for patient access departments. "We work very closely with local law enforcement to try and identify the perpetrators," says Schroeder. "However, we are often left writing their account balances off."

For some time now, BryanLGH's registrars have scanned patients' driver's licenses into the medical record. "Unfortunately, most patients that perpetrate this crime don't bring their identification," says Schroeder. "We are currently exploring the option of obtaining cameras for the registration areas."

It may be a gut feeling

A red-flag rules screen was created within the registration pathway at BryanLGH. This must be completed on every patient. Allowable values include "V" for victim of identity theft, "P" for perpetrator of identity theft, and "S" for suspicious activity.

If registrars suspect a person may be attempting to assume someone

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else's identity, they enter an "S" in the computer system and notify their supervisor. For example, a patient may give a different date of birth from a previous visit.

When this occurs, staff are instructed to do their best to obtain a photo identification from the patient to validate identity. If someone is identified as a "V" or "P" on the registration pathway, the registrar always asks for photo identification.

In addition, staff add a comment to the account as to what was suspicious. For instance, the patient may have presented previously but used a different name.

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"One of the main things that triggers the registrar that there may be potential fraud is a change in Social Security number or date of birth," says Schroeder. "I would say over 90% of the time it's a gut feeling that they have. They may recognize this person from a visit within the last week and they know they came in as John Smith, but today they are presenting as Joe Johnson."

A notice is sent to a supervisor's printer for follow-up. Once the supervisor receives that notice, he or she starts looking into the electronic medical record to see if there are any photo IDs present from past visits. If the supervisor discovers that a patient has been the victim of identity theft at the medical center, the account is flagged with a "V."

"Once the registrar sees this, they are to do their best to obtain a photo ID," says Schroeder. "If it is discovered that a patient has been the perpetrator of identity theft at the medical center, their account is flagged with a 'P.' The supervisors are the only people that can enter a 'V' or a 'P.'"

Registrars were given training on the new red-flag rule procedure at a recent staff meeting. Each signed a competency log stating that he or she understood the rules, and this was placed in the employee's file.

"Unfortunately, we find that the majority of the time, we are uncovering the identity theft at the time the bill is sent out, rather than catching it upfront," says Schroeder.

Typically, an individual calls the hospital's patient accounts department after receiving a bill and indicates that he or she has never been a patient before. At that point, Schroeder gets involved and contacts the individual to obtain additional information.

"We involve local law enforcement once it's been determined that fraud has occurred," says Schroeder. "The process for untangling these situations is very time-consuming, not only for hospital staff, but for the victims that have to attempt to correct their credit report."

Technology can help

According to **Beth Keith**, a consultant with Affiliated Computer Services in Dearborn, MI, there are a number of very good systems on the market that allow you to validate information being provided by a patient. These include address verification, electronic verification, electronic credit-checking software, photo ID cards issued by the facility after receipt of verification of identifi-

cation, and biometric ID systems.

"Any of these efforts will assist in ensuring that you are taking precautions to prevent identity fraud," says Keith.

Since there is growing interest in how to prevent medical fraud, many access departments are establishing policies and procedures to address the red-flag rule requirements. "There is also concern about maintaining positive patient ID for many compliance and liability reasons," says Keith.

However, when it comes to investing in technology, hospitals' "purse strings are still pretty tight," says Keith. "And if the dollars are limited, they are going to the clinical areas to make sure all patient care items have priority." Still, says Keith, "the more you automate the verification process, the more you prevent yourself from being duped into allowing someone to commit identity theft."

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Educate staff on talking to confused patients

Good communication is key

A patient comes in with a mass of misinformation about coverage and benefits, completely unaware of hospital procedures and federal requirements. In situations like this, information is the patient access employee's best friend.

To be truly comfortable responding to a patient's misperceptions, though, the staff person has to fully comprehend them.

"We openly discuss patient concerns in staff meetings to better understand what the issue is and how to resolve it," says **Aaron McDaniel**, director of patient access at Palomar Pomerado Health in San Diego. "Sometimes it's as simple as looking up information on the web, doing a short inservice, or providing scripting that will help them calmly resolve a difficult situation."

All of these strategies involve communication. "The leadership team needs to be coaching their staff regularly," says McDaniel. "The staff need to feel safe to bring up concerns one-on-one or in group meetings. And lastly, they need the knowledge to be able to communicate back with patients in a customer-focused way." The department uses these six approaches:

1. Scenario-based education is used.

This is a similar approach to role-playing, but it involves a facilitator. "All of our scenarios are developed from the personal experience of leaders down to frontline staff," says McDaniel. "We talk in real-world scenarios because they are easy to relate to. These can often be applied in the future exactly as we discussed in our meetings."

McDaniel says that he has had better success with the scenario-based approach than with the role-playing that previously was done.

"In my mind, role-playing is part acting and part training," he explains. "Many people are uncomfortable playing the acting role. I have gotten both resistance and reluctance when trying to role-play, because it calls on a skill set many people do not have or have not developed."

Scenario-based education, on the other hand, puts people in a mock work environment where they are already comfortable. They are dealing with scenarios they have probably seen and experienced many times.

The facilitator of the training is the one who creates the scenario. Then, the staff are invited to participate in reviewing the learning elements. "The scenarios normally come from the staff and sometimes the supervisors," says McDaniel. "These are hands-on incidents with a customer that warrants an education session."

2. Wrong assumptions are corrected.

McDaniel says the most difficult customer service situations are usually the ones in which patients assume something incorrectly, based on their limited knowledge of health care or hospital procedures.

For instance, with the rise in health care savings and reimbursement accounts, many patients claim they do not have to pay their copays because they have a spending account.

"But much like any other spending account they often have from their employer, like one that covers day care for children or prescriptions, these plans require the patient to pay the

copay and seek reimbursement from their spending account," says McDaniel. "These scenarios require us to explain to the patient their own benefits."

Other patients make assumptions about what their insurance covers. "Rarely do they read the benefits information they receive from their employer," says McDaniel. "When my staff have to explain why their coinsurance or deductible amounts are so high or why a service is not covered, it puts the staff in a delicate situation again of having to explain the patient their own coverage."

Emergency department patients sometimes assume they will be evaluated and treated immediately simply because they are in the ED. "They do not understand that, for most hospitals, the emergency room is the largest source of inpatient admissions for the hospital," says McDaniel. "Long wait times can result in long waits to get them in a bed in the hospital."

For all of these situations, patient access staff are put in a position of correcting the patient's misinformation. "It's difficult to have a conversation when one party has all the knowledge and the other has limited or no knowledge," says McDaniel. "We need to build that trust with the patient that will help us to empathize, and then explain the issue."

3. Clarifying questions are asked.

This helps patient access staff understand the underlying issue. When a patient in the emergency department refused to give his real name, an experienced patient service representative went in to complete the registration. She advised the patient that she was concerned that the name he was using was not accurate and asked him if that was his legal name.

The man told her that he didn't want to give his real name, saying that the hospital had to treat him anyway. The representative asked him why he did not want to give his name. Was he concerned about his privacy? Did he not want someone to know he was in the hospital? Did he not want to involve his insurance, or was he unable to pay for services? Was he aware that the hospital offered financial assistance?

By asking these questions, the representative discovered that the man was worried about being able to pay for his visit. She was able to get to the underlying cause of the patient's concern and work with him on a resolution.

"The patient was uninsured on a limited income. By gently probing and clarifying, she was able to convince the patient to give his real name and fill out an application for financial assistance," says McDaniel. "This skill can be applied in just about every customer service scenario to help get you to the root cause."

4. Staff restate the issue to be sure the patient understands.

This assures the patient that his or her problem is understood and will be resolved. Recently, an uninsured patient became irate about the cost of care during a conversation with the financial counselor.

"The uninsured patient was upset when a summary of charges incurred part of the way through their stay was discussed," says McDaniel. "The patient went on to complain about the cost of care, how were they going to pay for it, and the government's failure to help the uninsured."

The financial counselor was able to "reel in" the patient by restating what she understood the issue to be. She stated, "I understand that health care is expensive. You are clearly very concerned and would like to take care of this. Did I understand you correctly? I would like to make you aware of your options. You may be eligible for one of many government programs, such as County Medical Services or Medicaid, or even our own financial assistance program that can reduce the cost of your care substantially. I would like to first start you off with assisting you on completing the applications for the government programs I mentioned. The forms should take you less than 30 minutes to complete and require some documentation on your part to complete the approval process. Once you complete the application, I can get it to the county worker and expect a pending approval within days. This is the best option for someone who may need follow-up care, so you are not worried about how you are going to pay for your care every time you need to see a doctor or come to the hospital."

In this particular case, the financial counselor was able to calm the patient by reiterating to him what she understood his concerns to be. "She got confirmation on her statement. Then, she helped to set expectations by going through the steps and detailing timelines for him," says McDaniel. "She ended by giving him the ideal outcome, which gives him his "what's in it for me?"

What the patient really wanted was to get his health issues resolved. "By getting coverage through a government program, he can do that. He's able to focus on getting better rather than on

figuring out how to pay for it," says McDaniel.

5. The role of financial counselors is explained.

When an inpatient receives a visit from the hospital's financial counselor, this sometimes results in a misunderstanding. The patient may become upset and ask to speak to a supervisor or manager.

"The first reaction to someone asking questions about their finances is often met with resistance," says McDaniel. "Health care has not always done a good job in explaining the costs to the patients, so our financial counselors help to fill that need. The resistance will need to be overcome."

On one occasion, an uninsured patient flatly refused to speak with a financial counselor. The onsite manager made a visit to the patient to explain that the financial counselor is an advocate.

The patient began to understand that the counselor really was on his side and would try to help the patient find funding, get eligibility from one of many government programs, or get him a payment plan or discount.

"The manager then met with the financial counselor, reviewed the issue, and then successfully met with the patient," says McDaniel. "The financial counselor was then able to resolve an identical situation the following week on her own without the manager."

6. Scripting is used.

"This is an important part of our department and is often documented in department procedures," says McDaniel. "Just recently, we began a new program to improve courtesy issues with patients and the multiple staff who enter their rooms."

Staff were given a sample script of what to say to the patient, in order to determine whether this was an appropriate time to complete the registration, and to have a financial discussion. "After presenting the staff with a model script, I asked them what they currently say. Several people offered their own personal scripts, which were not too different from what I had drafted," says McDaniel.

This brought home the point that the message, not the exact words used, is the important thing. "I encouraged the staff to try and say the same thing my script said, but using different words," says McDaniel. "If the staff are allowed to say it in their own way, they are more likely to really 'own' it and make their words effective."

Once staff get comfortable, they are then able to "flex" their conversations with patients and families. Since this sounds more natural, it's more effective than repeating words of a script verbatim. "At our staff meetings I ask for volunteers to offer their own version of the scripts," says McDaniel. "Sometimes they are far better than what I came up with." ■

Turn a rude caller into a gracious customer

Your actions can turn things around

An irate customer called the access center at Virtua in Marlton, NJ, complaining that she could not take her child on a maternity tour because of the new visitor restrictions enforced due to the H1N1 outbreak. "She was so upset when she first called that she threatened not to have her new baby at Virtua," says **Ninfa Saunders**, RN, MSN, MBA, PhD, executive vice president for health services.

First, the staff person listened to the caller's frustrations without interrupting. Next, she proceeded to use a system called H.E.A.T., which stands for:

H: Hear the customer.

E: Empathize with the situation.

A: Apologize for what the customer has experienced.

T: Take action and turn the situation around.

The access employee empathized, apologized, and explained the reason for the new policy to the customer. Then, she was able to provide three suggestions for the caller:

- First, the caller could do the tour online in the comfort of her own home. The navigator explained that by using this option, her son could enjoy the same experience with her.
- Second, the navigator referred the caller to Virtuababy.org, an online resource for pregnant parents, to see information about the hospital and what to expect. Finally, the navigator then gave a third option of attending maternity classes, and made sure the customer was pre-registered at the hospital.

"Because of the H.E.A.T. system, the navigator's tone, and the navigator's ability to provide alternative options, the customer was very satisfied and even apologized for her rudeness," says Saunders.

The H.E.A.T. training is part of Virtua's

"Access Navigation" program created to help its patients access health care services. "This program makes it easy to schedule procedures and services, find a physician, and answer health and wellness questions by calling one telephone number," says Saunders. "Our access 'navigators' are true connectors and facilitators of care."

Meaningful dialogue

A key part of the Navigation program's training covers crucial conversations. "At the core of this concept is the intent to create a meaningful dialogue," says Saunders. Here are the key points:

- Make a commitment to reach an acceptable outcome and reasonable result.
- Teach the navigators to hold their own personal emotions in check in deference to the need of the patient.
- Understand that the intent is always to deliver an outstanding patient experience.

In one instance, a navigator had a patient who needed to see a cardiologist because of a family history of heart problems. "The patient was frightened and didn't want to make this appointment, nor did she want to even talk about it," says Saunders.

The navigator assured the patient that this was just a routine appointment. She shared a story from her own experience with the patient.

"The navigator took a persuasive approach toward the patient and convinced her that this was the right thing to do for her health," says Saunders. "Finally, the patient agreed and even stayed on the line while the navigator made the appointment."

Focus on the patient

Many of the scenarios used in training come from actual situations that patients and staff have experienced. "While many of the situations are positive ones, we do experience challenging ones as well," says Saunders. "Some of the most difficult ones involve patients who are afraid, distraught, and frustrated, to whom a sense of urgency and panic are palpable."

Equally difficult are situations when patients' expectations far exceed what is realistic. In one case, a patient wanted a navigator to schedule all of his appointments to coordinate with the public transportation bus schedule.

"Although it was an unusual request, the navigator did accomplish this task for the patient," says Saunders. "The navigator scheduled him for podiatry and gastroenterology appointments near his bus route. This call took longer to accomplish, but it resulted in a very happy patient."

To prevent a situation from escalating, access staff are asked to always remember that their focus is meeting the needs of the patient. They are trained to do these things:

1. Anticipate all ranges of conversations and emotions.

2. Give the patient "small wins" by immediately delivering on what is doable.

For example, staff have the ability to talk to a patient and schedule his or her appointments while the patient is still in the office. Also, staff can help patients make other appointments for labs or radiology, even if patients are capitated to another provider. "This results in a higher probability that the patient will use our services again in the future," says Saunders.

3. Ask to get back to the patient on all other needs that cannot be delivered at first conversation.

If a call looks like it is going to take a long time, navigators always offer to complete all of the transactions and call back the patient when these are completed. "Our navigators also follow up with patients to ensure they are aware of what is required for their specialists, such as test results and past history, prior to their scheduled visit," says Saunders. "Second conversations with patients are common, depending upon the patient's needs."

Navigators also are encouraged to consider asking for the help of other staff who may have more experience with the matter at hand. 'Excellent service is top of mind. Should we disappoint, service recovery is paramount," says Saunders.

Recently, a man called the access center very upset because he could not find an orthopedic physician that accepted his insurance. "He felt no one could help him," says Saunders.

After listening to the customer's problem, the employee apologized. She explained how the access center and physician referral services work and what she could do for him. The navigator was able to find the caller two options for physicians who accepted his insurance. She then offered to make the appointment for the physician that the caller chose.

The man gave her his information and asked for the navigator to call him back when the appointment was made. After scheduling the appointment, she called the man back with his appointment

date, time, and directions to the office. "At the end of the call, this frustrated caller turned into a very gracious one," says Saunders.

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Make the most of service recovery

Simple things can help

One mother came into the emergency department at Greater Baltimore Medical Center frantic and upset because her small child was very ill. She was visibly frustrated with the registration process, until the patient access representative performing the registration expressed concern.

"She offered comforting words and asked if there was anything the patient's mother needed or anything she could do to put her mind at ease," says **Jeanne Day**, RHIA, CHAM, director of medical records and patient access.

This made such an impression that the mother of the patient sent in a thank-you card recognizing this employee for her concern. "In many situations, a simple expression of compassion and sympathy are all that are required to ease the patient's mind," says Day.

Five steps followed

Patient access staff at Greater Baltimore Medical Center follow the L.E.A.R.N method for service recovery. Here are the five steps in this process:

Step 1: Listen. Staff give the patient or visitor undivided attention, including maintaining good eye contact. This includes keeping an "open" body position without crossing arms, nodding head to acknowledge what the person is saying, and taking care not to appear rushed when listening.

Step 2: Empathize. This entails showing that staff understand how the patient or visitor feels, thanking him or her for communicating the problem. Staff are instructed to repeat their understanding of the problem to ensure that the issue has been properly identified, and acknowledge the emotions of the other person.

Step 3: Apologize. Staff are told to provide a "blameless" apology by making statements such as "I am sorry that you experienced this problem. Please know we are doing all that we can to correct the situation." Staff also are cautioned to avoid providing unnecessary information that may escalate the situation.

Step 4: Respond. This involves thanking the person for sharing his or her problem or concern. Staff fix what they can and forward what they can't fix to the appropriate department or person.

Step 5: Notify. Staff inform others who need to know about the problem. They follow up about what is being done to correct the situation and prevent it from happening again.

All patient access representatives are given additional training in service recovery, in addition to the customer service training they receive during orientation. "I think the most difficult customer service situations are the ones that we have no control over," says Day.

For example, an emergency department patient may be upset about waiting to be seen, but patient access representatives do not control wait times. This doesn't mean that there is nothing that patient access staff can do, however. "We alert the nurse if the patient starts feeling worse. We do everything possible to make the patient's wait more comfortable," says Day. This might mean getting the patient a blanket or pillow, but at times, something extra is needed.

"All of our patient access representatives are given tools, such as parking and meal vouchers, to assist with diffusing situations," says Day. "Any situation where something has gone wrong and/or the patient is unhappy is an opportunity for service recovery. We hope to 'recover' situations before the patient makes a complaint."

If patient access representatives feel they need additional support to resolve a situation, however, they contact their team lead or supervisor for assistance. They also can call the appropriate charge nurse or administrative coordinator for assistance, or refer patients to the hospital's patient relations representative.

"Any situation where the patient access representative feels they need additional support to assist with service recovery warrants involving a member of the management team," says Day. "While we empower our patient access representatives to resolve issues, sometimes patients demand

to speak with a member of the management team."

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Coworkers often are the best teachers

A patient access supervisor, however supportive, probably isn't the first person an employee would ask for help if struggling to remember a certain payer requirement. That employee is more likely to turn to a colleague.

"I think sometimes the manager makes the employees nervous. They may think the manager expects them to know the answer. They may feel more comfortable with someone on their own level helping them," says **Vicki Lyons**, a patient access manager at Baptist Hospital East in Louisville, KY. "I have sat with employees to just oversee the registration process and have had the employee say that I make them nervous watching them."

For this reason, seasoned employees at Baptist Hospital East are expected to routinely help their fellow employees learn more about the patient access process. "It helps the employee to sit with someone who does an excellent job at customer service and knows the patient registration process inside out," says Lyons.

More experienced employees may offer their own "shortcuts" in performing a process, so their co-worker can improve his or her own speed while maintaining accuracy.

Although a patient access trainer works with all of Baptist's new hires, once they are out in the "real world," other coworkers are the ones they turn to. This gives the newer staffers added confidence. "It helps for the other long-term employees to offer suggestions to the new folks," says Lyons. "The older employees started out as they are and know what the employee is going through. The saying 'put yourself in that person's shoes' is so true. They know what they are going through. They, too, have been there before."

Occasional help from coworkers does more than improve speed, though. It's a way to prevent morale from deteriorating.

"It seems that there is a lot of negativity in patient access due to so much information that is gathered in a sometimes tough situation," says Lyons. "Patients or families may not feel like answering questions, and possibly give incorrect information because of being upset."

Shadowing new hires

At Baptist Hospital East, access staff with low error rates and excellent customer service skills are sometimes asked to shadow a new employee. "The trainer has to train many other employees in other areas for their registration needs, so she is not available at all times," says Lyons.

If the new employee seems to be asking a lot of questions about a certain area, the person shadowing can alert the trainer to this. The trainer will then set up a time for the newer employee to come to her office, so she can go over the issue in more detail.

A common question involves completion of the Medicare Secondary Payer form, which is filled out at registration on all Medicare patients. "A lot of the new employees have trouble with the computerized information because it is confusing," says Lyons.

In this case, an employee with a very low error rate on the Medicare Secondary Payer form offers some pointers. The employee may tell them to copy their work and go back and view the Medicare Secondary Payer or other information. This ensures that they have filled in the necessary fields. "They may also tell them the areas that seem to cause the most errors," says Lyons. "Sometimes it is more helpful coming from a fellow employee than the trainer or the manager. It really seems to work."

'Trapeze buddies' are used

Aaron McDaniel, director of patient access at Palomar Pomerado Health in San Diego, says that his key strategy is to provide staff with the education they need to understand the concerns that patients may have. However, the employee won't necessarily know the answer every time.

For this reason, McDaniel makes sure they always have a point of contact in the hospital who will. Those contacts are called "trapeze buddies."

"Their role is to support the people they work with toward their common goal of patient satisfaction," says McDaniel. "The trapeze buddy doesn't just

give the answer. They explain and coach for better results."

The trapeze buddy concept is informal, yet it is an integral part of the patient access department. For example, a financial counseling team has subject matter experts on government aid programs. These staff can be called by anyone to come and help staff, physicians, patients, or family members discuss how to apply for aid and determine their eligibility. "They will make the request a priority. They are the true experts and the best people to help," says McDaniel.

Patient access staff have become very enthusiastic about the "trapeze buddy" concept. "We have even started a 'trapeze buddy of the month' program to highlight how our many subject matter experts are there to help and support each other," says McDaniel. "They catch you and keep you from falling, like a good trapeze buddy should. We have subject matter experts all over the department."

Insurance verifiers are experts on benefits and eligibility rules. These employees can be called upon to help explain why a patient's out-of-pocket payment is a certain amount. They're also the best people to explain to a new mother how the coordination of benefits rules work, to determine whether it is her benefits or her husband's that are primary for their newborn.

An authorization coordinator works with government programs to obtain authorization for inpatients. This person attends case manager/utilization review meetings with nursing to act as an expert on authorization and coverage.

"She can work with physicians, patients, and our own staff as her customers," says McDaniel. "She has even gone to physician offices to train them on getting authorizations, which forms to submit, and how to use the online tools."

Although "subject matter expert" is really an unofficial title, the staff certainly know if they have it. "Many different positions in the department actually have 'subject matter expert' duties written into their job descriptions," says McDaniel. "These duties would include the requirement to draft official department procedures, train other staff, or present topics at staff or other department meetings."

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Be sure QA data are accurate, impressive

Improve processes for monitoring outcomes

It is more important than ever for patient access/registration departments to monitor outcomes, as this can "make or break" the success of the department. However, data can be missing, misleading, or just plain bad. Any of these scenarios means trouble for patient access.

What kind of trouble? You may have problems with timely billing, denied insurance claims, duplicate medical record numbers, duplicate encounters that require clinical staff to move charges and documentation, patient safety, increased bad debt, and poor patient satisfaction.

In 2009, NorthBay Healthcare System in Fairfield, CA, implemented a training and quality assurance (QA) program."After looking at three or four automated QA programs, we chose a manual process," says **Terese R. Davis,** MBA, director of patient access and communications. "We found that all the programs were rules-based, which is the same as our registration system. So, we identified many error types and built rules into our registration system to prevent the errors. This is also an ongoing process, and the cost savings was huge." Here are the steps they took:

• Each access employee received two days of intensive training.

The training covered registration, including selecting the correct patient, the financial identifier number and encounter, capturing patient information, entering encounter information, completing forms, entering notes and documentation, updating accounts, scanning, and downtime procedures. The training also covered the financial aspect of the patient's visit, including compliance with the Emergency Medical Treatment and Labor Act, insurance verification, and financial counseling.

Other key topics are point-of-service collections, good communication, providing high-quality customer service, and ensuring patient confidentiality.

• Program goals were identified.

These goals are identifying and correcting errors prior to the final bill being sent out, providing timely feedback to staff, identifying productivity concerns, making staff accountable, identifying training needs, managing the department from a proactive and not a reactive point of view, develop-

ing data to present the positive work in the department, giving auditors a thorough understanding of the registration process, increasing the accuracy of audits that are performed, and increasing the registration accuracy rate.

"We have seen a decrease in errors and denied claims since we started the QA program in November 2009," reports Davis. "In addition, our point-of-service collections have increased by 46% over last year."

• Key data elements that needed to be audited were identified.

Previously, patient financial services notified the department of any denied claims. A plan was made to audit 100% of patient access registrations, then to decrease the percentage and do random audits.

QA leaders were asked to assist in the new auditing process. "We developed a process for completing the audits and provided training on how to audit to ensure that everyone was auditing the same way," says Davis.

The audit process generates printed reports, which identify accounts to be audited, and reviews accounts in the system for errors. "Errors are corrected in the system," says Davis. "All auditors attended training sessions on how to audit. In addition, the auditors meet quarterly to discuss processes, issues, and concerns."

All errors, defined as missing or inaccurate information in a critical field, are updated by the QA leader. These are then entered into an access database. From the database, weekly error reports are run, which are given back to the staff as feedback.

Then, on a quarterly basis, supervisors meet with staff one-on-one to review database reports for individual quality and productivity. Also, the employee accuracy rate is identified, so a group discussion can take place on what the errors are, why the errors are occurring, and what the resolution should be.

"Educational needs are identified," says Davis. For example, it was noted that admit time didn't match the arrival time, Medicaid as Secondary Payor forms were not being completed, and notes and documentation weren't being entered. These were all addressed by giving one-on-one training, providing department inservices, and developing more user-friendly work guides.

Key metrics

NorthBay's patient access department monitors these key performance indicators:

- pre-registration/registration, including demographics, physicians, visit information, and consents;
- insurance verification, including coordination of benefits, eligibility, and guarantor information;
- insurance plan selection, including billing address, subscriber ID, and other subscriber information;
- authorization, including authorization numbers, admission notification, and requirements for certification;
- point-of-service collection, including copays, deductibles, and attempts to collect.

Clinical errors are also important to measure, as these impact access' ability to ensure "clean" claims. "In our organization, the clinical staff do the bed transfers, which includes accommodation codes," says Davis. "If the accommodation code is incorrect, then the room charge is wrong. We are working with the clinical staff to provide training on how to correctly transfer patients in the system."

Getting long-term employees to adjust to the change was one challenge, as was getting staff to be proactive in staying on top of information provided. Having decentralized registration areas with different reporting structures was another challenge.

After the top registration errors were identified, rule-based registration software was used to help prevent these from recurring. "This ensures errors are identified and corrected prior to accounts being final-billed," says Davis.

QA leaders were trained to assist with auditing accounts and giving timely feedback to staff. "They also develop trending reports for metrics," says Davis. "These are presented to senior management during their monthly meetings."

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Enlist everyone's help for 'cleaner' claims

At Wuesthoff Health Systems in Rockledge, FL, outcomes of the patient access department are measured by various reports and spreadsheets. Of

these, two particularly important metrics rise to the top of the list.

"First and foremost is delivering a five-star customer service experience to our patients and visitors," says **Jacob Lopez**, manager of patient registration. "Second on the list is meeting our financial goals in today's economy."

This is achieved, in large part, by creating cleaner claims so payments are returned quickly and reimbursement is maximized. "This is not always as obvious to the front end as it is to the back end," says Lopez.

To achieve this goal, the department has enlisted the help of its staff, technology, other departments, and administration.

First, it was important to ensure that processes were measured the same way throughout access services. "Our auditing process is unique," says Lopez. "We trained several staff members to become auditors. This way, the audit process is non-biased."

A new eligibility system was just purchased, which is used in access' audit process. "We use this to measure several things, but one in particular is getting correct policy numbers," says Lopez. "We identified that placing a hyphen or asterisk in there can prevent some claims from going out cleanly. By taking this information to the registrars and re-educating them, it helps us get the bills out cleaner."

A recent training effort involved medical necessity, which covered how to screen patients, what to do when the process fails, and completing an Advance Beneficiary Notification. "All of these processes intertwine with each other," says Lopez. "Re-educating registration is a constant thing."

Information also needs to be trended correctly in order for it to be of any use. With the medical necessity screening process, for example, reports were created to do this more timely and efficiently. "But we noticed that with the spreadsheets, certain accounts resurfaced week after week," says Lopez. "The process flow of the work leaving registration to coding to billing was not occurring, and the same accounts would reappear on the list."

The solution was to document notes in a specific location. "These would flow over to coding, allowing them to see exactly what we corrected," says Lopez. "That way, they could code it and have billing send it out timely."

Another goal involved reducing wait times in the outpatient area, which was up to 45 minutes at times. The wait time is measured by the patient's arrival time to the time of completion of registration. "We implemented an acceptable target of 30 minutes or less. We are now averaging less than the targeted time," says Lopez.

First, the process was examined from beginning to end. "We evaluated how we measured this, and realized that the times being noted by the staff were not done consistently," says Lopez. "We then targeted the pre-registration of the early cases and expanded on those numbers."

Not surprisingly, the biggest difficulty was getting staff to buy in to a new process. "The daunting words by the staff to a manager of, 'This can't be done' is something I love turning around in a clandestine manner," says Lopez. "In registration, we know that if we have a nice start at the beginning of the day, everything else flows smoothly."

Reward staff

"For our collection success, we make it fun," says Lopez. Access staff are continually provided with departmental acknowledgements, along with additional recognition items provided by human resources.

For some extra motivation, monthly themes are used, such as "March Madness." During the month of March, if staff members hit a specific amount for the day, they received a prize. In December, several prizes were given for each of "the twelve days of Christmas."

Last year, a selected associate got to show off a "floating trophy" at her desk for the entire month. "We treated it like it was the Stanley Cup. I had it filled with their favorite candies, and a small token of appreciation prize," says Lopez.

Staff members who do especially well in customer service are recognized at staff meetings. "One way to reveal particularly impressive results to higher-ups can be during monthly meetings,"

COMING IN FUTURE MONTHS

- Dramatically cut delays for call center wait times
- Eliminate costly gaps in authorization process
- Make registrars accountable for specific goals
- Career ladder mistakes that will cost you dearly

says Lopez. "We have a hands-on administration group here. When our goals are met, we are given accolades."

During a recent revenue cycle meeting, upfront collections in the emergency department was the topic of discussion. Targeted goals were created for two of the system's hospitals.

A decision was made to monitor the number of patients who left the ED without checking in with anyone. In conjunction with the clinical staff and security, all staff members were educated to make sure that all patients stop and see a staff person before leaving the ED. "With this simple process, we started to see quick results. We are midway into our fiscal year, and I am proud to say we have hit our targets four out of five months in both facilities," says Lopez.

Lopez feels strongly that accolades from administrators have a "trickle-down effect." "Hospital leaders in my organization have noticed my staff in many ways. They understand we are the frontline of the organization and start the encountering process," says Lopez.

On an organizational recognition day called "Thank You Thursday," administration recognizes an individual or department. When this first started, one of the first people to be recognized came from registration.

"This tells me the significance of how much my department is valued in this organization," says Lopez. "To have your COO and your CFO give you kudos in the board room goes a long way for me. I, in turn, channel that energy to the staff."

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

Survey: Hospitals not up to speed on 'meaningful use'

Only about 52% of surveyed hospitals use encryption technologies

According to a survey released in January by Falls Church, VA-based CSC, only two-thirds of hospitals have identified gaps in their current systems to meet the requirements for meaningful use, as set forth by the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services (HHS). While it is true that the "interim final rule" was not published until Jan. 13, 2010, in the *Federal Register*[1], experts have had a good idea of what "meaningful use" would consist of, at least as early as last spring as HHS issued guidance on the Health Information Technology for Economic and Clinical Health (HITECH) Act passed as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

Additional findings include the following:

- Most hospitals (98%) have a policy in place to limit the disclosure of protected health information, but only 52% employ encryption technologies to render data unreadable or unusable in the case of unauthorized access.
- Smaller hospitals have lower readiness scores, especially for use of required applications and quality reporting.
- 54% are using the latest software version of their electronic health record (EHR) product, which indicates upgrading might be required to meet the criteria for meaningful use.
- Although 89% report on core quality measures, only half capture the majority of the required data from their EHR system.
- Only 40% report that there is clear and broad awareness of the new civil and criminal penalties under the ARRA.

The HITECH standards revealed last spring on privacy and security (especially breach notification) and the attendant penalties for violators garnered the greatest attention among compliance officers and risk managers, and according to CSC hospitals have the highest readiness scores for privacy and security protection. But this is not a time to relax; with the publication of the meaningful use standards required for EHRs, "the other shoe" has now dropped.

Although the privacy and meaningful use standards were not formalized at the same time, they are inextricably linked. Consider this language in the *Federal Register:*

"The health outcome policy priorities identified in the Medicare and Medicaid EHR Incentive Programs proposed rule are: improving quality, safety, efficiency, and reducing health disparities; engage patients and families in their health care; improve care coordination; improve population and public health; and ensure adequate privacy and security protections for personal health information."[1]

Or these comments in the "Privacy and Security Standards" section concerning "certified" EHR technology ("certified" technology is technology that meets the meaningful use standards):

"We believe it is necessary for Certified EHR Technology to provide certain privacy and security capabilities. In that regard, we have aligned adopted certification criteria to applicable HIPAA Security Rule requirements and believe that in doing so, such capabilities may assist eligible professionals and eligible hospitals to improve their overall approach to privacy and security. In addition, some may find that the capabilities provided by Certified EHR Technology may facilitate and streamline compliance with federal and state privacy and security laws. We believe that the HIPAA Security Rule serves as an appropriate starting point for establishing the capabilities for Certified EHR Technology."[1]

In fact, the document goes on to say that the adopted certification criteria "assure that Certified EHR Technology is capable of supporting eligible professionals and eligible hospitals comply with HIPAA requirements to protect electronic health

information residing within Certified EHR Technology and, where appropriate, when such information is exchanged."[1]

What's more, this linkage is a two-way street: The HIT Policy Committee has recommended that CMS and Medicaid withhold meaningful-use payment (the HITECH Act offers incentives for compliance) until any confirmed HIPAA privacy or security violation has been resolved.

In other words, if your facility's EHR is not certified, it may not adequately address the privacy and security aspects of HITECH; on the other hand, if there are HIPAA violations in your facility, you could not only face HIPAA-related penalties, but you also could prevent your hospital from reaping the benefits of meeting meaningful use standards.

Know where you stand

Perhaps the first step towards meaningful use compliance, says **Carlos Nunez**, MD, chief physician executive at Picis, is to develop a realistic approach. This is already happening, he blogged after attending the HIMSS conference. "This year's sessions have revealed that a lot of attendees are more comfortable admitting the reality of the situation; that they are just now . . . understanding the challenges that this will bring," he wrote. "I overheard an IT executive from one of the most prestigious and well-regarded health centers in the world claim, 'If we're not sure that we are going to be ready by 2011 (the Phase I date), I can only imagine what others are facing.'"

Vendors such as Picis "need to approach each hospital partner with an understanding that each one will be in a different state of readiness," Nunez continues. There will never be a one-size-fits-all solution for each step along the way to 2015 (the Phase III date)."

"I'm not at all surprised by the fact that many hospitals find themselves at least partially unprepared," Nunez tells *HRA*. "Up until the latter part of last year, nobody knew what [the government] would do. In December, many of the things they had been expecting had changed, and underneath this, most CIOs were starting to realize there's a lot here, and they're just not sure they can get all the pieces in place."

Allison Viola, MBA, RHIA, director, federal relations for the American Health Information Management Association (AHIMA), agrees that the challenge is significant. "We at AHIMA will be submitting our comments officially, but basically we feel the criteria to achieve full use is extremely aggressive given the nature of what's being required," she says. "There's a lot of manual data collection to report — particularly HIT functionality measures, and we envision that a lot of that work will fall on HIM professionals." AHIMA, she says, "will try to get [the government] to look at alternative options or consider ways to ratchet this down a little bit."

"There is definitely time to identify gaps and become compliant so you can receive the incentives," counters **Erica Drazen**, managing partner, emerging practices healthcare group, for CSC in Waltham, MA. "The question is, how quickly they can they get there? One of the things that are going to happen for sure is there will be a shortage of people to do this — vendor employees, consultants, as well as people in the hospital; that will be a major challenge."

In addition, "They've upped the ante on privacy and security, with requirements like audit trails of all disclosures," says Drazen. "To share information with patients and other providers will be challenging for most organizations, as these reports have not been designed to be read by patients."

How to move forward

Viola says facilities that are not yet in compliance need to get going. "We would encourage hospitals to start getting teams in place, pay attention to what is going on with the whole certification process, and start the dialogue with their vendors — reviewing their contracts and potentially looking at new vendors if the current vendor is not certified," she says. "If you have a hybrid environment and are predominantly paper-based, you probably want to get moving on this, because by 2015 you will start to see a reduction in payments if you do not meet the requirements." As a first step, she recommends "getting a task force or committee together of multi-stakeholders within the hospital or provider organization, and start nailing down what each of these measures mean."

Drazen recommends you review the list of standards and pick out those that have the highest priority. "Also, start negotiating with your vendor; if they are not going to be certified on the same time frame, you're out of luck. You and they have to be certified on a schedule as aggressive as meaningful use. So, for example, you have to be certified for stage II requirements for 2013, so look at your vendor and see if they meet all the requirements for stage I, which would mean they're on course for stage II."

Nunez, on the other hand, questions whether it's better to do the wrong things quickly or the right things slowly. "A CIO told me that one of

the big consulting firms said to him they advised some of their clients not to rush into this, but to do it slowly and deliberately so that you're ready by the time the penalties kick in; you might not get incentives, but at least no penalties," he shares. "I read a study recently that said the average hospital would get between $6 million and $8 million if they met all the requirements — but you could be spending tens or even hundreds of millions in IT projects to get to meaningful use."

A lot depends on the progress you have made to date, he continues. "If as a hospital or a health care system you've been part of a process to implement meaningful use and you've been thoughtful and taken a long-term look at things, then you're probably really close to getting toward meaningful use," says Nunez. "If you're a Mayo Clinic, or a Mass General, if you have integrated systems and an efficient automated work flow, you'll probably get there soon. However, if for whatever reason you've not undertaken it, or have not been successful, or have chosen the wrong vendors, and you're just now really looking at a ramp-up effort, you may not be ready by 2011 or 2013. If that's the case, you may need to take a step back and say, 'Are we rushing for a couple of million dollars, or should we take time and start on a path that makes sense for us and our patients, so at the very least we do not get penalized?'"

If you decide to take what Nunez calls the "baby steps" approach, "at the very least you should look at the roadmap of the Office of the National Coordinator," he recommends. "We know what the requirements are for 2011; and we have some idea of what will be required for 2013 and 2015, although right now the descriptions are at a very high level. To the credit of the Office of the National Coordinator, what they've done really well is spelled out a vision; they say they want to get there in three phases, and they initially set the bar low with incentives to move up to better performance."

In other words, he continues, if you are not in good shape at present, "that first baby step to take is an honest assessment of where you are and where you can be in five years." He recognizes that it is a difficult process. "I've seen so many different hospitals and health systems that have tried to implement systems — some of which were the biggest companies — and they failed miserably, while the very same EHR systems have done very well in other hospitals and health systems. If your hospital is ready, the HITECH provisions of ARRA are laid out, as well as what the measures will be. If not, be honest with yourself about where you are and where you want to be in five years."

REFERENCES

1. Department of Health and Human Services Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Interim Final Rule. *Federal Register*: January 13, 2010 (Volume 75, Number 8) [Rules and Regulations] [Page 2013-2047]. ■

Will Medicaid take full advantage of HITECH?

Will funding from the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA), propel state Medicaid programs forward with the use of electronic health records (EHRs)? Or will state fiscal crises or other unforeseen problems prevent the hoped-for progress?

The answer probably is a little of both, but efforts are redoubling now that the Centers for Medicare & Medicaid Services (CMS) actually is releasing funds to Medicaid programs.

The HITECH funding "provides momentous opportunities, significant funding, immense expectations, tight time frames, and huge financial and human resource demands on state Medicaid programs, CMS, and Medicaid providers," says **Patricia MacTaggart**, a lead research scientist/lecturer at George Washington University's Department of Health Policy in Washington, DC. "The potential is great for real transformation in health care, health care delivery, and health care administration."

There is 90% federal funding for administrative activities, including oversight and promotion of health information exchange, and 100% federal funding for provider incentives. However, for providers to get incentive payments in 2010 for adopting, implementing, and upgrading certified EHR technology, states must have a process and infrastructure for administering and disbursing the incentive payments to Medicaid providers. At the same time, duplication of payments made through Medicare must be avoided.

States are now sorting through the Office of the National Coordinator's Interim Final Regulation relating to HIT standards, implementation specifications, and certification criteria, and CMS' proposed rule on the Electronic Health Record Incentive Program for Medicare and Medicaid programs, often referred to as the "meaningful

use" Notice of Proposed Rulemaking.

"They are identifying and clarifying numerous governance, legal, policy, technical, and business process complexities, while educating their stakeholders, including governors, state legislators and their own staff, on what must be done, by when, and how many state dollars will be needed," says MacTaggart. "They are balancing doing it quickly with doing it well, and they are doing it with limited staff in an economic environment that is stretched."

As for the proposed meaningful use regulation, MacTaggart says CMS "did a great job of clarifying many things and requesting comments on areas where there is more than one option being considered."

It will be important for states and providers to review the proposed language, understand the terminology, and comment on feasibility related to operational issues, time lines, and interdependencies with other regulations and activities. These include certification and standards of EHRs, and the commonalities and differences between Medicare and Medicaid. ■

HITECH Act timeline

Pay attention to deadlines to ensure compliance

On Feb. 17, 2009, the Health Information Technology and Economic and Clinical Health Act of 2009 (HITECH) was enacted. On that date, tiered civil monetary penalties were put into place for violations following the enactment, and state attorneys general were given the authority to enforce the act.

On Feb, 18, 2010, all business associates were to be compliant with new regulations.

Future deadlines for compliance include:

• **Jan. 2, 2011:** Initial deadline for complying with new accounting for disclosure rules for entities implementing electronic health systems after January 1, 2009.

• **Feb. 18, 2011:** Department of Health and Human Services required to impose civil monetary penalties in cases of "willful neglect."

• **2013:** Extended deadline for older systems to comply with the new accounting for disclosure rules.

Although these are the deadlines published in the initial act, it is important to stay on top of changes and new deadlines, points out **Heather P. Wilson**, PhD, principal, Weatherbee Resources, a Hyannis, MA-based compliance and hospice consulting firm. "Throughout this process, HHS has missed deadlines, and health care providers have found themselves with little time to implement changes." ■

Breach notification process spelled out

HITECH is very specific about actions to take

Although prior privacy requirements called for home health agencies to notify patients when a breach of privacy was discovered, the Health Information Technology and Economic and Clinical Health Act of 2009 (HITECH) specifically identifies time frames and content of notifications.

Once a home health agency discovers a breach of unsecured protected health information, each individual whose PHI has been or is reasonably believed to have been accessed, acquired, used, or disclosed, must be notified no later than 60 days after discovery.

Notifications must include:

• a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

• a description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

• any steps individuals should take to protect themselves from potential harm resulting from the breach;

• a brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches;

• contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

All of the notifications must be made in writing, and they must be written in plain language.

The notifications can be mailed or, if the individual has approved electronic communications, sent by e-mail.

Special circumstances, such as death of the individual, incorrect mailing address, or urgent need to contact individual also are addressed in the requirements. ■

Hospital Access Management

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

2010 Reader Survey

In an effort to learn more about the professionals who read *Hospital Access Management*, we are conducting this reader survey. The results will be used to enhance the content and format of the publication.

Please fill in the appropriate answers or write your answers to the open-ended questions. Return the questionnaire and answer sheet in the enclosed postage-paid envelope by **July 1, 2010.**

1. Are the articles in *Hospital Access Management* written about issues of importance and concern to you?

O A. always O B. most of the time O C. some of the time O D. rarely O E. never

Here is a list of hospital access issues. For each item, please circle your answers accordingly:

	A. should cover it more	B. about right	C. should cover it less	D. don't know/no answer
2. Admissions/registration	O A	O B	O C	O D
3. Billing/reimbursement	O A	O B	O C	O D
4. EMTALA	O A	O B	O C	O D
5. Confidentiality/HIPAA	O A	O B	O C	O D
6. Customer service	O A	O B	O C	O D
7. Discharge planning	O A	O B	O C	O D
8. Scheduling	O A	O B	O C	O D
9. Staffing/recruitment needs	O A	O B	O C	O D
10. Technology	O A	O B	O C	O D
11. Training/education	O A	O B	O C	O D

12. How would you rate your overall satisfaction with your job?

O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

13. How would you describe your satisfaction with your subscription to *Hospital Access Management*?

O A. very satisfied O B. somewhat satisfied O C. somewhat dissatisfied O D. very dissatisfied

For each item below, please fill in your answers accordingly:

	A. excellent	B. good	C. fair	D. poor
14. Quality of newsletter	O A	O B	O C	O D
15. Article selections	O A	O B	O C	O D
16. Timeliness	O A	O B	O C	O D
17. Quality of supplements	O A	O B	O C	O D
18. Length of newsletter	O A	O B	O C	O D
19. Overall value	O A	O B	O C	O D
20. Customer service	O A	O B	O C	O D

21. On average, how much time do you spend reading each issue of *Hospital Access Management*?

O A. less than 10 minutes O B. 10-20 minutes O C. 21-30 minutes O D. 31-60 minutes O E. more than an hour

22. On average, how many people read your copy of *Hospital Access Management*?

O A. 1-3 O B. 4-6 O C. 7-9 O D. 10-15 O E. 16 or more

23. On average, how many articles do you find useful in *Hospital Access Management* each month?

O A. none O B. 1-2 O C. 3-4 O D. 5-6 O E. 7 or more

24. Do you plan to renew your subscription to *HAM*? O yes O no
If no, why not? _____

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26. Which publication or information source do you find most useful and what do you like most about the publication?

27. What is your title? (please circle the title that most closely reflects your position and responsibilities):

O A. Director of access management O B. Manager of patient accounts O C. Supervisor
O D. Patient account representative O E. Other (please specify) _____

28. What is the highest degree that you hold?

O A. High school O B. Associate's degree O C. Bachelor's degree
O D. Master's degree O E. Other (please specify) _____

29. Please list the top three challenges you face in your job today. _____

30. What do you like most about *HAM*? _____

31. What do you like least about *HAM*? _____

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