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Take patient access to the next level; revamp how you measure competency

Get in front of this 'emerging area'

The role of your patient access staff has undoubtedly changed dramatically and will continue to become more complex. It's likely, though, that the way you evaluate competencies doesn't reflect this evolution.

"The face of patient access is changing dramatically," says **Jennifer Nichols**, director of patient access at Spectrum Health in Grand Rapids, MI. "There was a point in time when access was primarily a welcoming function, with some data entry. The role has grown tremendously in the skill and expertise required."

For this reason, Spectrum Health's access department decided to change the way staff competency is evaluated. In doing that, managers used clinical competencies as a model.

While nurses must demonstrate they are able to perform a given procedure or they aren't allowed to do so, the same is not true for patient access.

"Nursing staff have annual competencies that they have to fulfill, to demonstrate and refresh their skills necessary to perform that job," Nichols says. "Following that analogy, we have expanded that to the patient access role."

The department struggled to find other institutions that had done something similar in their patient access departments. "It's been very difficult for us to find comparative data with comparable institutions doing this. There are some, but there are not many," Nichols says.

"A robust competency department seems to be very well accepted in the clinical world, but has not been extended to the non-clinical world, which is still part of the patient experience," Nichols adds. "This is an emerging area right now."

An Access Professional Competency Program was implemented at Spectrum Health in early 2010. A year prior, a facilitated session was

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held with representatives from all aspects of the revenue cycle.

"We asked them to identify the most important competencies for staff. Some themes started coming together," says Nichols. "One of those was the importance of understanding the linkages with the rest of the revenue cycle, and how the work staff do is intertwined with the entire patient experience."

Staff took online tests with more than 100 questions covering the entire revenue cycle. The test covers nine areas of assessment: compliance, teamwork, computer literacy, patient intake, medical terminology, coordination of benefits, patient balance determination and collection, revenue cycle concepts, and payer identification.

Staff are able to take the test from any work station, and are required to pass each of the nine assessments with a score of 80% or better. The vast majority of staff — more than 90% — passed all the assessments.

"This shows their level of dedication, with what I think could be challenging questions even for long-time hospital professionals," says Nichols. If staff don't pass a particular assessment, one makeup session is offered.

What would be done if staff do not pass the competencies? "We needed to think about disciplinary action," says Nichols. "What should our response be if staff can only address 70% of what we feel is essential regarding, for example, coordination of benefits? What are things that would be risks to successfully performing the job?"

In addition to getting a second chance to take exams that they didn't pass the first time, staff use guided review sessions and online resources to help them prepare. "Our expectation is that each assessment is passed. If you don't, we have competency concerns. We take actions, including corrective action," says Nichols.

Alternatives to tests

Managers intend to give the competencies annually. "But we don't just want to hand out the same exact questions," says Nichols. "With ever-changing payer requirements and the impact of health care reform, with all of these things coming down the pike, we need to keep it fresh and relevant for staff."

Going forward, staff may be offered other options to prove their competency. "We are considering adding more of a demonstrative aspect, another avenue beyond traditional test-taking, that staff can use to demonstrate proficiency," says Nichols.

For instance, staff may be able to present a project or idea that they successfully implemented in their department that demonstrates a specific competency.

The competency testing had "a two-pronged effect" on the department, says Nichols. "It's been a nice success story to share with hospital leadership to show the level of proficiency that our staff exhibit," says Nichols. "Secondly, it is a nice validation for staff."

After the questions were developed, they were

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shared with senior leadership within the revenue cycle.

"They really have a good appreciation for the challenges that can exist for these key, 'front-door' team members," says Nichols. "It was a nice showcase of the level of skill needed for what used to be considered as entry-level staff."

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Use checklists, audits, tests to evaluate staff

Goal is to ensure competence

Patient access staff are the very first contact many patients have with physicians and facilities. Whether staff are registering patients in the emergency department, call center or at the front desk of a physician's office, "this first impression has long-lasting effects," says **Colleen McMahon**, senior manager of the integrated call center/ University of Pittsburgh Medical Center (UPMC) physician service division, registration and scheduling.

"To ensure that you have the correct staff in the correct position, it is important to measure their competency," says McMahon.

Accurate scheduling and registration are important to both patient and provider satisfaction, says McMahon, and are "the key pieces that begin the health care revenue cycle."

McMahon says that the accuracy of registration and scheduling, customer service skills, copay collections, assignment of benefits, privacy notices, and financial assistance notices and counseling are particularly important to measure.

UPMC's patient access department measures these competencies in the following ways:

1. Trainers do quality assurance (QA) audits by monitoring calls.

This is to ensure that staff are following the department guidelines when scheduling and registering patients. "The QA audits give us the opportunity to determine specific areas of education needed on an individual basis," says **Maureen Miller**, training supervisor for UPMC physician service division, registration and scheduling.

A manager might remind staff to ask patients about additional needs before ending a conversation. "Or, we may determine that an individual requires some added training on the protocols and procedures for a particular department," says Miller. "That training may take the form of a one-on-one session or utilize one of our web-based training tutorials."

Managers audit staff on a monthly basis, based on the volumes of calls and registrations they complete. "This QA process is part of our control requirements for Sarbanes-Oxley compliance," Miller notes.

2. Benchmarking tools are utilized.

Copay collections, encounters without charges, and charge lag details are analyzed and trended weekly. When the results of these reports fall in the acceptable range, managers congratulate the staff and encourage them to continue with their good work.

"When goals are not met, staff are engaged in a discussion," says Miller. "Each department collaborates on procedures that will enhance collections, specific to their department."

The training department provides educational materials and Web-based training tutorials to help staff meet these goals.

4. A group of trained staff perform an assessment.

A recent program assessed several different aspects of UPMC's patient access department. This included appropriate signage and whether staff were following established front desk procedure and policy.

"Armed with a checklist, both technical and customer service skills of front desks were observed and reported," says McMahon. If the staff "passed," they were immediately recognized with a congratulatory letter from executive leadership.

"For those departments with deficits, management was notified," says McMahon. "During this process, educational memos were sent to all staff reviewing noted areas of difficulties."

Sites were audited a second time and scores compared. "All of the findings were entered into a database, educational memos were written and distributed, and the training department enhanced discussions of those areas deemed troublesome," says McMahon.

As a result of these audits, tools are being developed for staff to use when discussing UPMC's financial assistance program.

According to **Maribeth Quinn**, director of business process improvement and technology training

at Nationwide Children's Hospital in Columbus, OH, competency is important to measure because access staff "are, in many ways, the biller for the organization."

If all information is provided accurately, the claim often will go out without further work and be paid much faster. "Our hospital has actually not done much competency testing, so this is new for us," says Quinn. "I think that one particular challenge is that hospital billing has many changes. Keeping up with the changes can be difficult."

One area that is particularly important to measure is that the right patient is selected in the system to begin with. This is necessary for billing, but much more significantly, it can affect the clinical care the patient receives. "If someone registers or schedules the wrong 'Billy Smith,' we may not know they have allergies," says Quinn.

Nationwide's access department developed a multiple-choice test to determine competency. In addition, staff complete a new patient registration and a follow-up patient registration involving changing the insurance and guarantor information.

For audits, 10 registrations completed by the same person are picked, to see if all the required information is provided. "Did they run eligibility for the insurance? Did they run the checklist at the end of the registration?" says Quinn. "For our system, that means the system checks for minimum requirements. The system gives you a green check mark if you meet these minimums."

Webinars are used to keep staff updated on new insurance programs and how to read insurance cards. "We also will look at recent errors that we are seeing, and make sure people know how to do the process correctly to stop the error," says Quinn. "The webinars are not mandatory, though we are considering that at least one 'super user' attend from each area."

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Turn good patient access data into a talking point

Make 'extraordinary' results known

You may not think of it this way, but your department has a wealth of data that would impress others. Have patient wait times decreased dramatically, have patient complaints become almost non-existent, or have your accuracy rates doubled? Don't resist the urge to brag.

Catherine M. Pallozzi, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital, says that there are two metrics that she never fails to share with administrators and hospital leaders. These are registration accuracy and copayment collections.

"Patient access' ability to achieve and maintain a 95% registration accuracy rate is an incredible achievement," says Pallozzi. "This has a direct impact on the bottom line and days in accounts receivable."

Access staff are able to collect on 90% to 100% of patients with copayments. "This is extraordinary in these difficult economic times," says Pallozzi. "Any time that a department is meeting or exceeding an industry, department, or facility standard, it is worthy of making it known."

Share any goals that your department is meeting or exceeding. "Certainly with a new product, the senior executives will want to see ROI. More importantly, meeting goals in today's health care environment warrants recognition," says Pallozzi. "Extraordinary effort is put forth to achieve success. Don't miss the opportunity to share your success."

Pallozzi recommends these approaches:

1. Publish data in a monthly newsletter.

"This is a great way to let the staff know how well they are doing. Share your newsletter with executive leadership," she says. The department's newsletter is sent to all staff, the vice president of patient financial services, and the CFO.

2. If you have an internal website, create an access page and post your achievements.

"We, as a society, tend to focus on those things that need improvement or have gone wrong," says Pallozzi. "We all know that positive reinforcement and recognition of the behaviors we want to see continued can yield an incredible result."

3. Share all statistics, even for those areas needing improvement.

"It demonstrates the department's commitment

to quality and the goals and objectives set forth," says Pallozzi. "Any area requiring improvement should always have a noted plan of action. Outline the steps that will be made to make the needed improvement."

Always share this info

Michael Taylor, regional director of patient services at Sutter Health Sacramento (CA) Sierra Region, says that there are many types of data that can impress administrators. He recommends sharing these metrics:

- data quality on correct patient demographics, insurance information, and authorizations secured;
- patient satisfaction, such as courtesy, wait time, and privacy;
- upfront cash collection.

"We report out by e-mail and website our key performance indicators and back-end-identified errors, which are self-inflicted errors identified in the patient accounting flow and reported through our denial management tool," says Taylor.

In addition, monthly A/R is reported at meetings with the facility CFO, case management, medical records, and department managers.

"The key performance indicators are shared with the regional CFO and CEO," says Taylor. "There is a monthly finance meeting with all finance department directors and facility CFOs."

Diane E. Mastalski, CHAA, CHAM, director of patient access at Virtua in Marlton, NJ, says that the data below are particularly exciting to share with senior leadership:

- **Point-of-service cash collection** — especially when there is an increase or better-than-expected report;
- **Administrative denials**.

The department just implemented a Six Sigma project to reduce these. "When we began, we were at about 11% administrative denials," says Mastalski. "After the project, we were down to about 5%. This year — just four years later — we are at less than 2.5%."

- **Patient satisfaction.**

"This is something that gets reported monthly to the whole organization," says Mastalski. "This keeps us on our toes, to always strive to be in that 90th percentile or greater."

- **Emergency department cash collection numbers.**

This information is in a spreadsheet format. It gets e-mailed to the CFO, COOs, and directors and managers of the ED, patient access, and finance.

"Because we are multi-hospital, we break the data down by hospital so each COO and finance director can see what their specific team has collected," says Mastalski.

All of these statistics are reported monthly to hospital leadership via e-mail or one-on-one meetings. With staff, the information is shared at the beginning of staff meetings and also through meeting minutes, bulletin boards, e-mails, and one-on-one or small group discussions.

"To assure our staff are working toward the goals set for our department, they need to know where we are throughout the year," says Mastalski. "This helps in getting the staff to understand where we are and where we need to be."

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Keep patients satisfied, even if waits are long

Information is the key

While you wish that no patient ever had to wait in any registration area, that's not realistic due to patient volumes and other factors beyond the control of your department.

On the positive side, though, there is evidence suggesting that an informed patient is a happy one, even if he or she is kept waiting.

Patients who waited more than four hours in the emergency department, but received "good" or "very good" information about delays were just as satisfied as patients who spent less than one hour waiting, according to Press Ganey's 2010 Emergency Department Pulse Report.

Lisa A Cox, CHAM, admitting manager at

Maine Medical Center in Portland, says she has found this to be true.

"We have found that customers that wait a long time for their bed, but were kept informed and checked on during their wait, were happy even thought they had to wait," says Cox.

Cox says this is the responsibility of both the access rep who admits the patient and the front desk access rep. Updates are given every 10 or 15 minutes.

"Patients like to have a contact person, so they can ask questions and let us know if they need anything," says Cox. "The access rep ensures that the patient has their name and knows where to find them."

The patient and family get meal passes, and a flower is sent to their room with a note saying, "Sorry for the wait." This approach has paid off, according to surveys by hospital volunteers.

"Volunteers go to each unit and survey the patients on their experience and how they were treated by the admitting area," says Cox. "We received positive comments about waiting for a bed if patients got to eat lunch on us, or they had a nice flower in the room when they arrived."

Informed patients are less nervous about their stay compared to those who are not told why they are waiting. "This can be seen in their body language," says Cox.

Sheri Lasater, manager of patient access for Penrose-St. Francis Health Services in Colorado Springs, notes that patients often interact with patient access staff before interacting with members of any other department.

"It is the responsibility of patient access associates to start the visit off on the most positive and professional note that they can," says Lasater.

Even if patients receive the best clinical care and outcomes possible, they will always remember any portion of their visit that they perceived as negative.

"It is crucial that the patient access associates give patients positive things to remember, right from the moment they enter our facility," says Lasater.

Patient access associates often need to act as the liaison between clinical departments and waiting rooms. This is a difficult role for several reasons.

"Patients arriving for scheduled procedures typically have the least amount of wait time, and present fewer challenges," says Lasater. "However, many patients are seen on a walk-in basis and are prioritized by acuity."

This can be very difficult for patients to understand, especially when they see others receiving care outside of a "first-come, first-served" system.

"It is important for patient access staff to be given accurate and appropriate scripting that they can use when explaining patient prioritization based on acuity to patients who are waiting," says Lasater.

Patients may wrongly believe that long wait times for available inpatient beds are the fault of patient access.

"In order to clear up the misconception of these patients, we explain that patients have a discharge time of 11 a.m.," says Cox. "However, that time is not enforced since patients cannot leave until their physician is able to give them the OK to go."

Physicians work to ensure patients are discharged quickly, but sometimes testing may delay the discharge. "As soon as the bed shows as dirty in the bed tracking system, environmental services will be ready to clean the bed, stat," says Cox.

Lasater says that, occasionally, scheduled patients are kept waiting because other patients presented to the emergency department for traumatic injuries. The injured patient might require procedures on the same equipment that was reserved for the scheduled procedure.

"This can be one of the most difficult waits to explain to a patient," says Lasater. "Patients with a scheduled appointment have a hard time understanding that they could be 'bumped' for an emergent patient."

Emergency department patients also are often subject to lengthy wait times, due to high volumes of patients needing to be seen at the same time. "Certain times of the day, week, or year produce extremely high emergency department volumes," says Lasater. "Patients are often required to wait for very long periods of time before resources — rooms, physicians, or nurses — are available."

Be clear about why

Lasater says that the most important thing that patient access staff can do for patients who are waiting is "effectively and positively communicate the expected wait times. When patients know what to expect, it is much easier for them to accept that they will have to wait for their care to be provided."

Keep in close touch with waiting patients and offer to get updates on how much longer they might have to wait. "Patients appreciate proactive staff members who approach them with updates. They prefer not to have to keep asking staff how much longer they might have to wait," says Lasater.

Patients waiting in the ED are listed on an electronic waiting room tracking board. All staff working in the department can access this.

"Patients are sorted based on length of wait, so it is simple for staff to know which patients have been waiting the longest," says Lasater. "This

helps staff to know which patients to approach first with updates."

For other areas, staff have learned to manually keep track of patients in the waiting room. They call clinical departments for updates at regular intervals.

"Patients who are waiting do not have access to speak with the clinical department that the patient will be visiting, but patient access associates typically do have that ability to act as a liaison between the patient and the clinical department," says Lasater.

A clinical staff member may be available to discuss the wait with the patient directly. "This can oftentimes be very helpful," says Lasater. "This is particularly easy to achieve in the emergency department, but can take additional coordination in non-emergent areas."

Patients may want to hear information about the wait directly from clinical staff. "It often makes them feel that they are beginning to move through the flow of patients, because they have now had the opportunity to speak with a clinical professional," says Lasater.

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Cut wait times for scheduled patients

Sheri Lasater, manager of patient access for Penrose-St. Francis Health Services in Colorado Springs, says that wait times have been minimized for scheduled patients through a comprehensive pre-registration program.

All patients who are scheduled for service are contacted via telephone prior to their service so they can be pre-registered. Since all registration information is collected by phone, the patient will not require any meeting time with the patient access department on the day of service.

"Most pre-registered patients are able to go straight to the department where they are receiving services. They are allowed to bypass the patient access department completely," says Lasater.

Some departments are able to accept pre-registered patients directly into their department without any intervention from patient access on the day of service. In this case, pre-calls are made to the patients the day before, to explain the check-in process for the day of service.

"Orienting the patient to where they will be going, prior to service, helps to avoid unnecessary delays," says Lasater.

The percentage of patients who are pre-registered varies from facility to facility within the hospital system. This is because not all procedures require pre-scheduling.

"We often see patients without an appointment for X-rays, lab work, and EKGs," says Lasater. "There are also patients who are sent over to the hospital from their physician's office for stat testing. This has not typically been pre-scheduled."

One facility has particularly high volumes of walk-in outpatients, who require time with a patient access representative immediately before their service. "A paging system was implemented. This is very similar to those you might see in restaurants that have wait times," says Lasater.

When a patient arrives and needs registration services, he or she is advised of the expected wait time and given a paging device. The patient is directed to multiple locations where he or she can wait for the pager to be activated, such as waiting rooms, the coffee bar, and the hospital cafeteria.

"Although wait times are never ideal, the expectations are established for the patient through the communication when they are provided with their pager," says Lasater. "This helps the patient to accept the delay, and view it as less of a negative." ■

Turn positive satisfaction info into morale-boosters

If you want to see how satisfied your customers are, some type of survey is probably the tool you rely on. **Kathleen Bowles,** a hospital admitting supervisor at The Ohio State University Medical Center in Columbus, says that patient satisfaction scores "are a concrete reflection of our efforts, that everyone in the department can understand."

These tell you how you are performing for your own customers, and also how you compare with your competitors nationwide.

"We are always evaluating the needs of our patients, changing cultural priorities, and improvements we can implement to ensure we are providing the services of choice for everyone," says Bowles.

The department's satisfaction survey asks patients to evaluate the speed of the registration process and the courtesy of the registration person

who helped them.

Scores are received on a monthly or quarterly basis, and all are shared with each employee of the department. "We review the scores and set target dates for new processes," says Bowles. "Once we receive a new set of scores over a few months, we then evaluate whether our changes have had a positive impact. If not, we go back to the drawing board."

Individual departments are recognized on a quarterly basis, if they meet or exceed patient satisfaction goals.

"Administration conducts formal congratulatory presentations to the frontline staff in the department," says Bowles. "Also, monies are provided to purchase supplies that will better assist us in serving our customers."

Bowles' department was recognized for meeting or exceeding their patient satisfaction goals for the last three quarters of the last fiscal year, and received $3,000 to further improve scores. "We are currently evaluating options for office hour signage, and some more comfortable furniture, like cushioned chairs and rocking chairs," says Bowles.

Reviewing comments from patients regarding their own experience while at the hospital is a more informal way to keep track of satisfaction. "These may be positive, or not so positive," says Bowles. "Either way, it affords us the opportunity to specify process or customer service changes that may need to occur in order to meet the needs of our customers."

Bowles oversees the registrations for surgery patients as well as overnight admission patients. When patients are scheduled for an admission to the hospital, they arrive, register, and wait for a room assignment.

"This can sometimes take a little while. It depends on how full the hospital is at that time, the admitting needs from the emergency room, and several other factors," says Bowles.

As a result of some patients commenting on their dissatisfaction with waiting for a room, patient access is currently working to examine processes for bed placement.

"A new process will not only decrease patient wait times, but allow patients to remain at home until a room is available," says Bowles.

Occasionally, patients acknowledge a specific registrar by name or position who provided excellent customer service. "Once a supervisor is aware of the staff recognition, the registrar is praised via a congratulatory e-mail from our management team," says Bowles. "This is sent to the entire department."

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Address these concerns before offering incentives

Expect a 'tremendous difference'

Access departments struggling with dwindling cash collections may find that some simple incentives can work wonders. On the other hand, there are some potential pitfalls to consider.

"The downside to using incentives is establishing employee expectations of ongoing rewards," says **Diane Manuel**, director of patient access for admissions and the emergency department at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

The problem is that employee efforts can become overly dependent on incentives, instead of collections being considered just another part of the job.

"Collections monitoring can become labor intensive," says Manuel. "Once a program has been in effect for an extended period of time, employees' satisfaction may diminish."

Manuel says that when she worked as an ED cashier at another hospital, a daily contest was held among cashiers. "The numbers were posted in the cashier area," she says. "After several years, this was discontinued. It was viewed as an unfair display of work performance."

The department experimented with an incentive plan for ED collections in early 2010, which was in effect for three months. The high collector for each month was awarded a $50 gift certificate, and the top collector for the first three months received a $100 gift certificate.

"We had experienced a 12% drop from the first 2010 fiscal year quarter to the second quarter," says Manuel. "The incentive was in place during the third fiscal year quarter. For this quarter, we saw a 22% increase between the second and third quarters, and 7 1/2% above the first quarter." Collections increased $25,952 over the three-month period.

Cook Children's Medical Center in Fort Worth, TX, offers a cash incentive to employees for increased collections. This is based on a monthly

departmental cash collection goal. "We have had an incentive-based collection policy and process for several years now," says **James Nicholson**, manager of patient registration. "It has made a tremendous difference in our point-of-service collections."

All employees are eligible for the incentive, based on particular benchmarks being met or surpassed. These vary according to their job description.

As for the particular type of incentive offered, Nicholson says that a cash-based program has proved to be the most successful. "We have designed our incentive program in a particular way," he explains. "It is not only to enhance point-of-service collections, but to ensure a high degree of accuracy at the same time."

In order to qualify for the incentive, an individual must meet a 95% accuracy standard. This is determined by constant auditing of the employee's work, by the quality assurance (QA) team.

The QA team looks at every field and every screen, to make sure the employee is capturing and updating all the required information at every visit. A full-time employee who meets the accuracy standards receives a $250 incentive every month.

Nicholson says that his major concern with offering a cash-based incentive program is that employees will forget the mission and focus only on collections. "We coach our employees extremely well when it comes to the collections process," says Nicholson. "The staff understand that a point-of-service collection is great, but that we can assist the family in other ways if they are unable to pay at the time of service."

The "Coaching with Compassion" method is used. "Our employees do an outstanding job of not only collecting, but also helping families with payment arrangements, applying for government programs, and assisting them with hospital charity," says Nicholson.

Employees are told to imagine themselves as the customer. "We want our employees to treat our customers just like they would want to be treated when they bring their children here," says Nicholson. "We want our employees to consistently ask each family for their known cost share, but we want them to do it in a way that promotes our compassion for their child, not in a bill-collector style."

Top collectors appreciate the financial incentives, but they're also recognized at staff meetings and in departmental newsletters. "Our employees still like to be personally recognized in front of their peers," says Nicholson. "Everyone likes to be told they are doing a good job. It validates all the hard work the employee is doing."

Patient access managers at Cook Children's are very diligent about sending staff e-mails to give them immediate kudos for their efforts.

"In our system, we have access to all collections made throughout the day," Nicholson explains. "We know it is hard, under the circumstances we deal with daily, for staff to ask families for large amounts of money at the point of service."

The majority of the department's point-of-service collections are driven by scheduled procedures. "We have made great strides in this area by instituting a pre-registration team. We have built a team work module between our insurance staff, financial counselors, and registration staff," says Nicholson. "It takes all three areas working together to create a smooth and seamless registration process for the family."

The pre-registration team calls scheduled patients in advance, and completes the entire registration process over the phone. Since the insurance team has already verified the patient's benefits, the pre-registration team is able to speak to the family about the amount due at the time of service.

This is all taken care of before the family arrives. This way, the registration staff can focus on giving good customer service during the visit, and getting the family in and out of registration as quickly as possible.

"We have the ability to focus on escorting patients to their destination," says Nicholson. "Wait times have diminished greatly in our scheduled procedure registration areas. All but the signing of consents and collecting money has been taken care of before the family arrives." Families now typically wait less than three minutes.

Registration staff also have a better chance of success with collections. The department's point-of-service collections have increased by more than 25% since 2008. "Collections have continued to grow, even with the problems in the economy over the last few years," says Nicholson.

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Get better results with scripting, role-playing

Registrars at Kettering Health Network in Dayton, OH, reported feeling very uncomfortable with certain situations, such as asking patients for money. **Jana R. Mixon**, director of patient access and central scheduling, says that in response, she expanded the use of scripting.

Staff are given "cheat sheets" to refer to for certain challenging situations, but these are not necessarily used verbatim. Instead, employees are encouraged to tweak the wording to reflect their own personal style.

"We have provided them with specific responses that they can use if they are uncomfortable. But staff also have the ability to make up their own," says Mixon. "They can add their own spin to it, as long as they are touching on specific points of the script."

One registrar may stick closely to the script and say, "Mrs. Smith, I'm Jana from registration and I'm going to take care of you today," to every single patient. Another might be more conversational and say, "How are you doing today? It's nice to see you!" before continuing on.

"Basically, we try to script anything and everything," says Mixon. "We use scripting situationally, but it is also used related to processes, especially those that could be sensitive." These include requesting copays, asking about the patient's race, and talking about the patient's income to determine if he or she is eligible for charity discounts.

When Kettering Health's patient access department first started role-playing to improve their customer service, staff were noticeably uncomfortable. "They felt a little silly at first," says Mixon. "But we found a way to make it fun, and they got into it."

Staff worked with real-life examples, after the patient's identity was removed. Also, roles were switched, so staff got more than one perspective by playing both the patient and the employee for each scenario.

The role-playing exercise was used to develop appropriate scripting for employees. Since employees were the ones who came up with the wording, they were truly comfortable talking to patients. "We gave them the scenario and the outcome, and allowed them to fill in the blanks to get to the same outcome," says Mixon.

Monica Rei, director of patient access and patient financial services at St. Joseph Mercy Oakland in Pontiac, MI, says that scripting is most beneficial for a "short, easy type of response." When staff greet a patient, they always say the same exact words: "Hello, Mr./Mrs. XX, my name is XX and I will be doing your registration today. Thank you for choosing St. Joseph Mercy Oakland." All patients are welcomed in a uniform way.

"What we find more challenging with scripting is when it is used for more complex issues," says Rei.

Recently, staff were tasked with asking detailed questions about language and race, as part of a Robert Wood Johnson Foundation initiative. This was very different from asking routine questions about insurance coverage and contact information. Often, patients didn't understand why this additional personal information was necessary.

Once staff themselves understood the value of collecting the information, though, a lot of the awkwardness subsided.

"It was sometimes an uncomfortable conversation," says Rei. "But the reason for asking the question is so we can give them better clinical care. It was really important that staff understood their piece in this, and that we are actually enhancing the clinical care of our patients."

Staff also were informed about research showing inequality of care based on race. "By gathering this data, we could start to identify what the disparity is and work to enhance the care for all races equally," says Rei. "That really was very powerful."

The bottom line is that staff always need to comprehend the questions they are asking, and the reason for asking them. "Before you go into complex issues, the reasoning needs to be understood," says Rei.

Scripting gives a uniform and easy-to-understand explanation of a potentially confusing Medicare regulation that is developed specifically for a Medicare beneficiary.

"We have a uniform way that we talk through it, but access can go off the script if need be," says Rei. "A script is a wonderful thing, but if someone should ask a question about a Medicare regulation, the staff need to be able to answer in an intelligent way."

Otherwise, staff can come off as robotic or canned, which would defeat the purpose of the scripting. "Then, scripting would be more of a dissatisfier for the customer service initiatives that we are trying to put forward," says Rei.

Having a script to work from can put staff at ease during difficult points in the information-gathering process. "It can help you to get past uncomfortable conversations," says Rei. Point-of-service collection — a relatively new role for staff — is one obvious example.

"It used to be that when the patient was coming into the hospital, our role was only to get you well, and they received a bill afterward," says Rei. "Patients may ask staff, 'Why are you asking me for a copay today, when last month I had services and you didn't ask then?'"

Patients may have questions about unexpectedly high copays or deductibles. In this case, scripting is used to tell the patient to forward their questions to their payer about the terms of their contract. This helps to divert misplaced anger about insurance requirements that are not the fault of access staff.

"That simple explanation is something that patients understand very clearly," says Rei.

Scripting won't work, says Rei, if you are just sending staff out with a sheet of paper. "It is really imperative that the staff understand the reason why we are doing down a path we are," says Rei.

Even with something as simple as a scripted greeting, there is an underlying reason why it is important. This, says Rei, is because "we have a customer service initiative here. As part of that, we are standardizing this response." That's the reason why staff in every area of the hospital, including operators, answer the phone or greet the patient in the same exact way.

Role-playing is used to get staff comfortable with new concepts and unfamiliar terminology. Staff are paired off and given a few situations to practice. "First, we have them just get through the dialogue. They get the feeling of just hearing the words and being comfortable," says Rei.

The goal is for staff to know the script so well that they can deviate from it. Soon, they find themselves conversant with the issue and putting the same information in their own words.

"We are still working through some of the issues that are presenting at point-of-service collections," says Rei. "Generally, these are specific questions that patients have about their insurance. The staff direct them to ask these questions to their insurance company, but sometimes there is additional dialogue about this issue."

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Patient access expects fast and accurate QA

The patient access department at Methodist Charlton Medical Center in Dallas recently switched to an automated quality assurance (QA) system. "I had recently come from a very automated facility and was well aware of the benefits a good automated system can provide," says **Jeanette Foulk**, director of patient access.

Patient access leaders looked at several systems, and narrowed it down to a top pick. At that point, they made a site visit to another facility that uses the same registration system as Methodist Charlton and the QA system that was being considered.

This showed the ease of use for the registration staff, along with the speed of QA and verification response time. "With much of the guesswork taken out of the registrar's hands, this should speed up the registration process. When you do not have an automated system, your QA process is only as good as the person doing the QA. It also is very time-intensive."

Staff are immediately notified about errors. "Our current process is staff must maintain a 95% accuracy rating per month," says Foulk. "Failure to do so may decrease staff's performance appraisal, which in turn may decrease the employee's merit raise."

Goals are set for upfront cash collections, QA, and productivity. "We provide monthly incentives for those employees that meet the upfront cash collection goal and meet the 95% accuracy rating in that month," says Foulk. "The incentive amount is increased based on a specific tier level the employee reaches above and beyond that goal." ■

COMING IN FUTURE MONTHS

- Prove a technology investment's ROI
- Keep staff updated with peer-to-peer education
- Raise the bar with inventive role-playing
- Use complaints to make necessary changes

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HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Don't wait: Start reviewing BA agreements now

Business associates a liable for breaches as covered entities

Although business associates are now subject to compliance with the HIPAA Security Rule and the use and disclosure provisions of the HIPAA Privacy Rule, as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act, hospitals should not assume business associates are taking steps to ensure their compliance.

"There is no requirement that covered entities [CEs] police their business associates and make sure they are compliant, but it is in the best interest of both organizations to make sure the business associates have everything in place," says **Robert W. Markette, Jr.**, an attorney with Gilliland & Markette in Indianapolis. "Within the business associate agreement, the CE is asking the business associate to affirm that programs are in place to comply with HIPAA requirements," he says. Most CEs, however, should take the extra step to double-check their key vendors to make sure everything is in place, he suggests. Once the rules are final, there will be a six-month window of time for business associates to finalize their programs to meet requirements; but six months is not a lot of time, he points out.

Business associate agreements should address the role and responsibilities of business associates in a privacy or security breach in more specific language. Address questions such as breach notification requirements and financial responsibility for responding to a breach, says **Phyllis A. Patrick**, MBA, FACHE, CHC, cofounder and managing director of AP Health Care Compliance Group, which has offices in Pittsburgh and Purchase, NY. "All that needs to be spelled out," she says.

In addition to making business associates subject to compliance with HIPAA requirements, a business associate's subcontractors must also be compliant, points out Patrick. "Business associates must also impose compliance requirements on their subcontractors, and a CE must include that requirement in their agreement with the business associate," she adds.

This is the time to start revising your business associate agreements, suggests Markette. "Although the rules are not final, I don't anticipate major changes from the proposed rules," he says. "Develop a new agreement form, but be prepared

EXECUTIVE SUMMARY

Hospitals should not make an assumption that business associates will automatically take all steps necessary to comply with the HIPAA Privacy Rule even though the Health Information Technology for Economic and Clinical Health (HITECH) Act mandates that they are subject to the same requirements as covered entities.

- Review business associate agreements to ensure language clearly specifies the business associate's role and responsibilities in a privacy or security breach.
- Refine your definition of business associate so that you can focus on vendors who do need access to protected health information in order to complete their work.
- Offer hospital resources such as training and forms to help the business associate comply with requirements.

Build a relationship with business associates

Strengthen HITECH compliance

One of the best ways to improve your relationship with business associates that handle protected health information (PHI) is to work with the vendor to ensure that the company has the resources to implement the proper staff training, documentation, investigative, or reporting procedures necessary to comply with HITECH, suggests Phyllis A. Patrick, MBA, FACHE, CHC, cofounder and managing director of AP Health Care Compliance Group, which has offices in Pittsburgh and Purchase, NY.

• Make sure business associates educate their employees about privacy and security requirements related to PHI.

"Hospitals have important resources that can be shared with business associates to educate their employees," says Patrick. Hospital representatives can visit the business associate, or representatives from the vendors or physician office staffs, can attend meetings related to HIPAA or HITECH, she suggests.

• Offer forms and documents related to HIPAA compliance to vendors to make sure they have the latest information.

"I have seen hospitals that set up vendor sections within their hospital website to communicate important information directly to vendors," says Patrick. "This same type of site can be used by vendors to download forms and updates."

• Designate one person as responsible and accountable for all activities related to business associates.

"Depending on the size of the hospital or covered entity, this might be the privacy and security officer or legal counsel," points out Patrick. "The most important factor in choosing someone to oversee business associate agreements is to make sure the person has the time to continuously monitor renewal of agreements as well as ongoing communications with vendors." ■

to modify it if necessary after the final rule is published," he adds.

Although you need to prepare a business associate agreement that complies with current requirements and anticipated requirements, you don't have to redo all vendors' contracts or agreements at once, says Patrick. "If you are at the point where a new contract is due, incorporate the up-to-date agreement," she says.

Another way to prepare for revision of all business associate agreements is to take a close look at who you have designated as a business associate, suggests Patrick. "I have heard people say that their hospital has 2,000 business associates," she says. "That is an unbelievably high number of business associates," she says. One reason for the high number could be an automatic assumption that all vendors must sign a business associate agreement to comply with HIPAA, she says. "If the vendor does not have access to protected health information [PHI] as part of their job with the hospital, there is no need to classify the vendor as a business associate for HIPAA purposes," she says.

Conduct a risk analysis for your vendors to identify which really accesses PHI, suggests Patrick. "The vendor who shreds your documents definitely should sign a business associate agreement, while the company that cleans your offices probably should not sign one," she says. "Even I've been asked to sign business associate agreements by clients for projects where I have not needed access to PHI to complete the work for the hospital," she points out. By evaluating who is a true business associate, you can cut down the number of agreements you need to track and modify, she adds.

Once you've identified your true business associates, develop a relationship with them that will improve communications during a potential breech, suggests Patrick. (See story above for tips on working with vendors.) "You may not be able to meet with all of your vendors during the year, but you should be able to hold periodic conversations with your high-risk vendors," she says. One way to identify key vendors is to involve department managers who work with different vendors, she says. "This helps prioritize vendors who have the most access to PHI, and it helps educate managers about HIPAA and HITECH regulations

and their part in ensuring compliance," she says.

Because CEs have up to 60 days to identify a potential breach, investigate it, and notify affected parties, it is critical that your business associates report their suspicions or discovery of a potential breach as soon as possible, says Markette. "I usually put 'within 24 hours' into the agreements," he says. The business associate may have investigated a potential breach and determined that no information was compromised, but the CE still needs to know, he points out. "If the business associate says there was a breach but the information was encrypted, it is reasonable for the CE to ask for proof that the information involved in the breach was encrypted."

[For more information about business associate agreements and HITECH requirements, contact:

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Access, not use, of PHI results in conviction

Doctor's conviction raises concerns for hospitals

Four months in prison and a $2,000 fine to Huping Zhou, a 47-year-old cardiothoracic surgeon from China and a UCLA health care system employee, for violating the Health Insurance Portability and Accountability Act (HIPAA) should be a cause for concern for hospitals.

"Prosecution and a prison sentence are significant in this case because there is no evidence that Zhou shared any of the protected health information [PHI] he accessed," says **Allyson Labban**, JD, senior associate in the Greensboro, NC, law office of Smith Moore Leatherwood. "The sentence sends a message to all health care employees that merely accessing information without a reason is a crime."

Zhou, a researcher at UCLA, reportedly began accessing and reading medical records of health care system employees, administrators, and celebrity patients following his notice of termination. In a three-week period, Zhou accessed more than 320 medical records for which he had no legitimate reason to access, says Labban.

"I do believe that hospital employees become complacent about following HIPAA requirements when there is no obvious breach of security or when private information is not shared outside the hospital," says Labban. In Zhou's case, UCLA cooperated with the Federal Bureau of Investigation and no charges were filed against the hospital, she points out. "Instead, prosecutors focused on the one individual." Although she does not know for sure, Labban believes that this indicates that the hospital had procedures in place to detect and report the breach.

Because it is obvious that attorneys general are willing to prosecute violators of HIPAA requirements, it is important for hospitals to take steps to limit access of records to employees who need access in order to perform their jobs, says Labban. "With the increasing use of electronic medical records, the ease with which employees can access records will only increase," she says.

Steps that hospitals should take now to prevent a similar situation include:

• Re-educate staff members about who can access records.

"Hospital staff members, especially physicians, are so accustomed to picking up charts and reviewing them that they don't think about whether or not it is appropriate," says Labban. Only physicians or hospital employees who are actively treating the patient or billing for that account, or supervising those activities should be accessing that record, she explains.

• Establish regular audits of medical records access.

"There is no set standard for how often an organization should audit access," says Labban. "Larger organizations may want to audit on a weekly or bi-weekly basis, while a smaller organization with fewer patients and charts might want to conduct an audit every month or two," she says. The key factors in determining how

often to audit are the number of records and the potential risk associated with inappropriate access to information.

• Review policies and procedures related to privacy and security of PHI.

"This is a good time to review policies in light of Zhou's conviction," says Labban. "Make sure policies clearly define who can access information and how to report inappropriate access."

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Health care breach list tops 160

Insurance plans account for most records

Hospitals and provider networks lead the list of health care entities reporting breaches of unsecured protected health information (PHI), according to the Office for Civil Rights (OCR) breach notification website, which lists 166 entities as of Sept. 30.

Breaches that affect more than 500 individuals are included on the list, which includes the name of the entity, number of individuals affected, and date and type of breach as well as location of information that was breached.

According to a recent report by the Health Information Trust Alliance in Frisco, TX, hospitals and provider networks account for the greatest number of breaches, followed by physician practices. Insurance plans experienced the third highest number of breaches. However, due to the number of records at risk for each group, insurance plans' breaches affected the most individuals, with almost 3 million records breached.

To view the OCR breach website, go to www.hhs.gov/ocr, select "Health Information Privacy," then choose "HIPAA Administrative Simplification Statute and Rule" on the left navigation bar, select "Breach Notification Rule" on left bar, then choose "View Breaches Affecting 500 or More Individuals" on the bottom right corner of the page. ■

Looking at HIPAA security risks? Check your copier

Hard drives retain protected information

Time to upgrade some of your copiers? Are you planning to sell the old machines to recoup some money to use for new ones? Think twice before placing your "for sale" sign on the copier because you might be selling more than just the machine.

News reports from two different investigative news teams in different cities in the past year showed how easy it was to retrieve protected health information (PHI) from the hard drives in copy machines.

"A lot of copiers, and even fax machines, contain hard drives that store the information you copy or fax," points out *Jan Gibson*, JD, attorney with Baudino Law Group in Des Moines, IA. "One of the copiers in the news report came from a health insurance group and contained more than 300 medical documents for identifiable patients," she says.

Manufacturers are more aware of the need for privacy and security and have developed software that electronically shreds documents on a copier's hard drive, and there are machines that encrypt information, says Gibson. When a hospital is purchasing new copiers or fax machines that contain hard drives, the purchasing department should make sure they come with encryption and the ability to easily erase the hard drive, she recommends.

What about old machines? "Check with the vendor," suggests Gibson. "There may be a way to delete the data, or you may have to remove and destroy the hard drive," she says. Whichever route you choose, she adds, "don't just put the item up for sale. You might be selling a great deal of PHI without even knowing it."

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