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AHC Media

Have effective self-pay processes? Facility's fiscal health is at stake

New financial counseling role for registrars

Hospital stays for uninsured patients increased 21% between 2003 and 2008, according to a new report from the Agency for Healthcare Research and Quality (AHRQ).[1] "Increased use of hospitals by uninsured means treating more uninsured patients and probably hospitals absorbing more costs," says **P. Hannah Davis**, MS, the study's co-author and a senior program analyst at AHRQ.

Researchers found that there were 2.1 million uninsured admissions in 2008, compared to 1.8 million in both 2003 and 1998, with the average cost of a 2008 uninsured hospital stay at $7,300.

Increased uninsured hospital stays affect hospital capacity, causing more patients to be held in the emergency department due to lack of available inpatient beds, says Davis. "The increase in uninsured hospital stays may mean that some of the visits could have been prevented, had earlier care been given," she adds.

New era for registrars

Registrars at Advocate Illinois Masonic Medical Center have seen almost a 10% increase in uninsured patients since 2009, for inpatients and outpatients.

"Our department has implemented several changes to accommodate the amount of uninsured patients," reports **Philip N. Quick**, CHAM, the hospital's manager of patient access and bed management, adding that about

EXECUTIVE SUMMARY

You'll need new financial counseling processes, in light of a new report's findings that hospital stays for uninsured patients increased 21% between 2003 and 2008. To address rising numbers of self-pay patients:
Identify possible payer sources.
Accurately and promptly identify the patient's financial responsibility.
Attempt to collect on estimated amounts, or initiate the financial counseling process.

60% of the hospital's admissions come from the emergency department. "We began to brainstorm potential solutions," says Quick. "We realized that we needed to start at the patient's first point of entry to the hospital, and in many cases, prior to service."

The hospital's revenue cycle leaders developed an action plan based on "financial advocacy." Together, they created a standard way to determine the patient's financial responsibilities, discuss payment options, and collect and/or set up a payment plan before or at the time of service, says Quick. "This initiative required us to look at the revenue cycle process for all inpatient, outpatient, and emergency department patients," he says.

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The group's goal was to increase point-of-service (POS) collections, while at the same time reducing the cost of collection to outside vendors, says Quick. Registrars are now required to accurately and promptly identify the patient's financial responsibility and make an effort to collect on that estimated amount or initiate the financial counseling process, he says. As a result, more time is needed to process a registration and educate patients about financial options at the earliest possible point in the revenue cycle, he says.

"The days of only taking demographic information are long gone. We have entered an era of true financial consulting," says Quick. *(See related stories on the hospital's financial advocacy initiative, below, and necessary staffing changes, p. 87.)*

If your registrars are seeing increasing numbers of self-pay patients, "the implications stretch far beyond the realm of just patient access services," says Quick.

More self-pay patients affect the organization's overall growth, as well as the charitable dollars and other resources available throughout the hospital, he says. "To be frank, as this trend continues, it will be difficult for organizations to sustain adequate financial performance without taking the appropriate measures," Quick warns.

REFERENCE

1. Stanges E, Kowlessar N, Davis PH. *Uninsured hospitalizations*, 2008. HCUP Statistical Brief No. 108. April 2011. Agency for Healthcare Research and Quality, Rockville, MD.

SOURCES/RESOURCE

For more information on patient access processes for uninsured patients, contact:

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Action plan maximizes payment, reduces costs

Since beginning a "financial advocacy initiative," Advocate Illinois Masonic Medical Center in Chicago has seen nearly a 160% increase in its

point-of-service (POS) collections.

"Much of that includes self-pay patients," reports **Philip N. Quick**, CHAM, manager of patient access and bed management. "In 2010, our POS revenue was over $1.1 million."

Here are changes that were made:

• **Insurance is verified earlier in the process.**

Although patient access leaders had electronic tools for some processes, there was no way for registrars to perform "real time" verification. "We partnered with our vendors to ensure that we could not only rapidly identify when patients are uninsured, but also do this prior to or at the point of service, rather than post," says Quick.

• **Registrars have financial discussions with the patient prior to or at the point of service.**

"This allows us to take the appropriate actions such as applying for charity rather than seeing these accounts go to bad debt," says Quick.

• **A deposit matrix was established for each service line.**

Once it is determined that a patient is truly self pay, deposits and/or payment plans can be established, says Quick. Self-pay patients generally are asked for a percentage of the estimated cost of the service.

"In the emergency room, it's difficult to predict the estimated cost, so we request a flat rate deposit," says Quick. "We also provide a self-pay discount, as well as a prompt pay discount."

• **Bed management reports to patient access rather than nursing services.**

"Although we partner with clinicians to ensure appropriate patient placement, this reporting structure allows us to ensure the financial viability of the patient entering our facility prior to the bed placement," says Quick.

Registrars now rapidly identify uninsured patients who are being admitted, he says, and they can begin financial counseling prior to bed placement. "No patient is ever turned away from a service for their inability to pay," says Quick. "We provide financial assurance so patients can focus on their clinical care. We are now able to provide more options for all patients prior to service."

• **Training and education was given to registrars and clinicians.**

"This was a major component to the success of this initiative," says Quick. "All of these key players needed to understand the what, who, and why."

Training was broken down into these sections: inpatient, inpatient obstetrics, outpatient diagnostic, outpatient surgery, all other outpatient, and emergency department.

"Clinicians from their area of expertise were brought in from the beginning to gain buy-in and help educate," says Quick. "As we rolled out the initiative throughout the hospital, these individuals became the 'expert' in their area."

In patient access, the training started with a mandatory departmentwide kickoff on a Saturday, followed by individual and group competency-based training, says Quick. "Scripting was a major part of this training," he says. "Our staff needs to feel comfortable to talk to patients about their financial obligations and also understand them." ■

Population shifting to uninsured, underinsured

Staffing needs are changing

You might be seeing a decrease in your "financial buckets" of insured patients, and an increase in underinsured or uninsured patients, without a corresponding increase in the number of services rendered.

"This is a clear sign that the patients have shifted from being insured to limited or uninsured," according to **Le'Kita Brown,** manager of patient financial services and sponsorship at Ohio State University Hospital in Columbus.

Another signal is an increase in volume of emergency department services, which indicates that services that would have been received in a doctor's office setting are being managed at the emergency department level, Brown says. "Due to a patient's lack of coverage, they seek the services from the emergency room for minor complaints instead of utilizing a primary care physician's office," she says. "This is misuse of the emergency department."

Due to the increase in uninsured patients at Ohio State University, some staffing changes were made in the areas of preregistration, scheduling, and financial counseling, says Brown. The hospital also made some process and policy changes at the administration level, she says. "When the economy changed, we as an organization knew we would also have to change to be able to support our community and the overall revenue cycle of the hospital," says Brown.

Patient access leaders formed a committee to work toward changing the healthcare system's culture, which included educating the staff, the patients, and the medical team, she says. "Our

goal was to streamline the throughput process of a patient's care from start to finish," says Brown. "By streamlining the process, our hope was to ensure each patient received financial clearance prior to the service being rendered."

Over the past few years, patients have become more willing to take care of their financial responsibility prior to service, she says. "We expanded the preregistration service and registration department roles, to ensure that the financial communication and screening process is initiated prior to scheduling," Brown says. These steps are taken:

1. If the patient bypasses the preregistration checkpoint, and it is determined that the patient has no coverage at time of registration, then the registrar starts the financial evaluation process.
2. During the evaluation, if the patient doesn't meet the criteria for charity, he or she is referred to a financial counselor prior to their appointment to set up a possible payment plan.
3. If it's determined during the evaluation process that the patient might qualify for other financial assistance programs such as Medicaid or high-risk insurance, a financial counselor starts the application process.

"With every process change, there are pros and cons," says Brown. "The hope is that the end result will outweigh the cons. In our case, we have been very successful."

Registrars more mobile

To ensure that the department was capturing as many patients as possible, management invested in portable work stations so registrars could be more mobile. Also, registrars are now alerted of upcoming uninsured patients or patients with limited coverage.

"That allows us to have a jump start on working with these patients, prior to their scheduled date of service," says Brown.

The staff was reorganized, to have more individuals in high-dollar areas such as the emergency department, radiology, and prenatal areas. "This also helped us to deal with one of the biggest 'cons' of this culture change: increased registration time," says Brown.

Patients are more satisfied with the new process, she reports. "We are able to educate patients that no insurance, or limited insurance benefits, are not always a problem when you have a solution and a healthcare system with the ability and willingness to assist you through the process," Brown says. ■

Don't give patients wrong benefits info

It's a 'patient dissatisfier'

If you tell patients they owe their entire deductible of $2,000 for an inpatient procedure, and they know that $1,700 of the deductible already was met, your credibility and competence are suddenly in question.

"The patient may be reluctant to pay and possibly not be pleased with their services," says **Linda Cousin**, manager of admission/registration at University of Mississippi Health Care in Jackson. The hospital's patient access specialists take these steps to be accurate:

- They refer to notes in the registration system on specific benefits the patient is eligible for and outstanding healthcare balances.
- They use a web-based application that lists a patient's remaining deductible, co-pay, or co-insurance.
- They contact the payer to verify account balances on file, if the patient was not pre-registered or pre-admitted prior to check-in.

"Afterward, staff give full disclosure and education to the patient on any information that was received, with a display of openness for any questions," says Cousin.

If incorrect information is inadvertently given, says Cousin, the registrar apologizes and acknowledges the mistake. "The patient access specialist could also inform the supervisor of this patient encounter," she says. "He or she can also assist in developing procedures to address the patient's direct concerns." To avoid this, these steps are taken:

- The manager meets with the employee to ask pertinent questions related to the matter.
- If necessary, the manager provides clearer

EXECUTIVE SUMMARY

If a registrar gives inaccurate estimates to patients for their out-of-pocket responsibility, his or her competence will be questioned. To avoid giving wrong information to patients:

- Refer to notes in the registration system on outstanding healthcare balances.
- Use web-based applications to identify a remaining deductible, co-pay, or co-insurance.
- Contact the payer to verify account balances on file.

instructions or training.

• The manager follows up with the employee to assess how well the process is going.

• Management offers assistance as needed, to ensure that the processes are working.

Escalate as needed

When you make an incorrect estimate, it *always* has the potential to be a patient dissatisfier, says **Debbie Milke-Wurster**, RHIT, revenue cycle manager at Central DuPage Hospital in Winfield, IL. Their training program includes service recovery.

"These types of cases can be escalated to a management level," Milke-Wurster says. Registrars need the right tools to provide a clear financial picture, she emphasizes. "The word '*estimate*' is a challenge in itself," Milke-Wurster says. "Patients prefer to know the specific amount as opposed to an estimate."

At Central DuPage, a registration educator helps staff to consistently provide accurate financial information to patients. "Information is constantly changing. Hospitals need the right processes to stay on top of the most current information," says Milke-Wurster. "We are working more closely with departments which provide charge information, to stay abreast of this."

Processes that start the financial discussion *pre-encounter* are the most effective, she says. "The more time we can give our patients to review the information to make an informed decision, the better," Milke-Wurster says.

SOURCES

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No bed available? Keep patient satisfied anyway

Explain reasons for delays

If a worried and anxious patient or family member is kept waiting, it might help to convey the underlying reasons for delays in registration, treatment, or room placement, says **Diane Manuel**, director of patient access for admissions and the emergency department at Wake Forest University Baptist Medical Center in Winston Salem, NC.

Lack of available beds is the typical reason for delays in the hospital's inpatient areas, according to Manuel. "What normally keeps a patient waiting is we do not have a bed assigned, or it is not ready for the new patient when they arrive," she says. "We don't do bed assignment in our department. We depend on clinical areas to assign the beds."

The concept of specialty units are hard for patients to grasp, says Manuel, and they might not understand why they can't be given an available bed on a different floor. "We just try to explain as kindly as we can, the real reasons they are having to wait until a bed is empty or ready," she says. "We always apologize and tell them that we understand this is inconvenient."

In the inpatient lobby, management follows up with all waiting patients and family members at 15- to 20-minute intervals. "We support both our inpatient and ED registration staff, by providing management intervention whenever we are notified of the need," Manuel says.

Registrars make an initial attempt to explain the delay to waiting patients and family, says Manuel, but that isn't always enough. "If it gets to a level that a registration person senses that the patient or family is *not* satisfied with their explanation, they let us know right away," she says.

On Memorial Day, for example, four families in the inpatient admitting area were angry because they didn't have bed assignments, so Manuel came to speak with them directly. "They could not understand why they didn't have a room, when a reservation was made a week or two in advance," she says. In this case, Manuel told the families that if 50 of the hospital's 100 beds are filled, and 50 emergencies come in on a given day, the available beds have to be filled with the emergency cases right away. "I explained that I can't hold those beds for the patients who have reservations the next day," she says.

EXECUTIVE SUMMARY

If patients are kept waiting due to lack of available beds in inpatient areas, registrars should apologize and explain the reason for the delay. To keep patients satisfied:

• Follow up at 15- to 20-minute intervals.

• Provide a meal ticket for waits over 30 minutes.

• Tell patients you will check bed availability every five minutes.

Here are other steps taken by the hospital's registrars:

• If a patient waits longer than 30 minutes to be admitted, registrars give the patient a meal ticket for the hospital cafeteria.

"This allows the patient to take a break from waiting," says Manuel.

• Registrars tell patients they will check every five minutes to see if a bed has become available.

• Registrars provide beverages to patients.

A coffee and water cart was added to the inpatient lobby during periods of high census, on a trial basis. "After realizing the positive effect of the refreshment cart, we chose to continue providing this service for our patients and families," says Manuel.

SOURCE

For more information on keeping patients satisfied while waiting, contact:

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ED registrars often ID 'suspicious answers'

Red flags signal possible fraud

Some emergency department (ED) patients are destitute, drug-seeking, or have nowhere else to obtain care, and they might pass themselves off as others to obtain insurance coverage, says **Marsha Kedigh**, RN, MSM, director of admitting, emergency department registration, discharge station, and insurance management at Vanderbilt University Hospital in Nashville.

"We have had a patient present himself as his brother, because he had the brother's insurance card," says Kedigh.

Other patients have provided a date of birth with one digit off, she says, or they have given variations of their name spelled slightly differently to allow the registration system to create a new medical record number. "They personally may not understand our registration system well enough to know that a new medical record number is being created," explains Kedigh. "They just want to provide enough false information to 'trick' the system with a new registration."

Vanderbilt's registrars perform a careful check to validate the patient's date of birth, social security number, name spelling, and address, says Kedigh. They always ask for photo identification. "If there is any question as to the validity of the information, we will set an 'ID' flag in our registration system," says Kedigh.

In some cases, patients are the ones who request that their own accounts be flagged because they are victims of identity theft. "The flag provides information to the registrar of what to do if a person comes in using that name, such as making sure to get a photo ID, or validating a date of birth," Kedigh says.

Registrars also notify a manager about the situation so it can be resolved with the patient present, and they notify security if there is concrete evidence the patient is being fraudulent. "Oftentimes, the staff are the ones who recognize suspicious answers with the registration process," says Kedigh. "With these scenarios, the investigation is low-key. If something is found to be suspicious, the staff get security involved."

For example, a patient's social security number might be off by one digit, and that same patient can't present a valid ID. In a scenario such as this one, "if resolution cannot occur while the patient is present, we take the case to our patient identity subgroup," Kedigh says. "They work the case to resolution and memo the particular account in our registration system as to the findings." *(See related story, p. 91, on one ED's processes for suspected fraud.)*

SOURCES

For more information on emergency department registrations involving possible fraud, contact:

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EXECUTIVE SUMMARY

Give emergency department registrars specific steps to take if they suspect possible fraud, such as when patient provide inaccurate demographic information without a photo ID. Some approaches include:

• Flag the account in the registration system.

• Resolve the situation with the patient present, with involvement of management and security.

• Share suspicions with clinical staff, so they can inquire about past medical history.

Handle red flags differently in the ED

Suspected 'red flags' must be handled differently in the emergency department than other registration sites, according to **Joyce L. Predmore**, associate director of patient access services at Ohio State's University Hospital East in Columbus.

"Staff are trained to safeguard information, look for suspicious activity, and report issues as soon as suspected," she says.

The registration process can be stopped in areas where the health care needs are not urgent, which gives staff members the ability to ask the patient for satisfactory identification information or documentation, Predmore explains. This situation isn't the case in the emergency department, as patients must be provided with a medical screening examination to comply with Emergency Medical Treatment and Labor Act (EMTALA) requirements, says Predmore.

"With that in mind, registration staff use the best identifiers provided to them to access the correct medical record number or to create a new one when the identity is questionable," she says.

These steps are taken:

• If ED registrars believe a patient is falsifying information because of significant changes in demographic information, altered IDs, or a patient photo in the registration system not matching the person who presents, they share their suspicions with the appropriate clinical staff.

• The clinical staff then follow their "Red Flag" procedures for suspicious activity. Based on the patient's condition, they might make inquiries regarding past medical history.

• The clinical team and the registration staff collaborate to research as much information as possible, to determine the next steps.

• A report then is submitted to the hospital's Red Flag Workgroup for further research.

In addition to the hospital's privacy officer, the Red Flag Workgroup includes representatives from patient access services, medical information management, physician offices, the central billing office, legal services, and security. Police are involved when necessary, depending on the nature of the case.

"They determine the next steps for the medical record numbers involved," says Predmore.

• Security is typically *not* involved until a discussion has occurred between the administrative/clinical team and legal services.

"Examples of when we have involved the medical center's security department or the University police department include cases in which a suspect is on site and using the identification of a known identity theft victim," says Predmore.

Other cases have involved individuals known to have presented under multiple names, or those suspected of obtaining services under another individual's name for purposes of insurance coverage or other financial gain, she says.

• Registration staff use system notifications to further validate a patient's identification.

"Depending on the complexity of the situation, relevant comments may include other known aliases used by the patient or instructions to page an on-call supervisor for detailed action steps to take after initial registration," says Predmore.

Photo IDs taken

Registrars routinely validate a patient's name, date of birth, and address, says Predmore, but when suspicions are raised and urgent care is *not* needed, other steps might be taken to ensure a patient's identity.

Registrars might compare signatures, inquire about previous addresses, or review insurance coverage, and they will notify a member of the management team if needed, says Predmore. In addition, registrars now take patient photos at the point of registration and offer an informational handout to explain why this is necessary. *[The Patient and Visitor Information Sheet used by registrars is included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]*

Registrars tell patients that they need to ensure the right care is being provided to the right person and that these are extra measures to protect the patient's medical record and keep an individual's identity safe.

"Our registration sites also display signs informing patients about showing photo IDs at check-in and taking pictures for our records," says Predmore. ■

Did registrar complain? It's an opportunity

Give specifics on status of requests

Do you overhear registrars making remarks such as "We were slammed this morning!" or "We don't have enough staff today?" You'll need to re-evaluate your staffing levels to be sure the department is providing optimal coverage and customer service, says **Kathleen Bowles**, LSW, patient access supervisor at The Ohio State University Medical Center in Columbus.

"Staff concerns often lead to an improvement in a process or a policy," according to Bowles. "Giving feedback on complaints communicates that you value their input. This directly impacts staff retention."

Dana Anthony, manager of patient access in the emergency department at University of Mississippi Health Care in Jackson, gives these recommendations:

Avoid using the term "they" to refer to senior leadership.

Saying "they" gives the impression that a manager does not agree with administration's point of view, says Anthony. "This may have a negative impact on employee retention. It implies there's a division within the department, which does not build trust," she explains.

Consider inviting a registrar to a brief meeting so he or she can hear directly from senior leadership, suggests Anthony. "This reassures the registrar that he or she can trust the information being conveyed by the manager," she says.

Make it known that you have an open door policy.

"The employees shouldn't feel that they are always reporting to the 'principal's office,'" says Anthony.

EXECUTIVE SUMMARY

If a registrar complains to a patient access supervisor, this complaint can result in needed changes in a department's process or policy. Use these practices to demonstrate that you value this input:

- Arrange for registrars to meet briefly with senior leadership.
- Identify less costly alternatives if budget constraints are involved.
- Give specifics as to why a request *can't* be granted.

Be clear that whatever is discussed won't be shared with other employees.

"Also, the employees should not reveal any confidential information that has been shared with them," says Anthony.

Update staff on the status of requests.

"Registrars often complain about not having adequate equipment to do their job," says Anthony, such as better printers or additional space.

Be upfront, if you don't think the request will be possible due to budget constraints. "Make the employees aware of the estimated cost of the items being requested," Anthony advises. "Make a joint effort to come up with a less costly alternative." *(See related stories, below, on important information to learn about complaints, and p. 93, what to say if you can't do what a registrar is asking for.)*

SOURCES

For more information on responding to complaints from registrars, contact:

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If registrar complains, learn this information

Hear from everyone involved

If a registrar complains to **Kathleen Bowles**, LSW, patient access supervisor at The Ohio State University Medical Center in Columbus, she begins by asking these questions: When did the incident take place? What occurred? Who was involved? What was the outcome of the situation?

Next, Bowles takes these steps:

A timeline of events is established.

For example, if a staff member complains about a co-worker's productivity, Bowles wants to know the timeframe in which the co-worker was not being helpful. She researches patient flow and the productivity of all the other staff members in that registration site during that time period, to determine if the workload was unbalanced.

If there were multiple individuals involved in the

situation, Bowles sits down with each one separately to obtain their recollection of the incident.

"By speaking individually with staff members, they may speak more openly regarding the circumstances surrounding the incident," says Bowles.

After speaking with the parties involved, Bowles reviews any additional data to understand more about the situation.

She might need to see reports involving staff schedules, productivity levels, department training, or attendance as part of her investigation.

Bowles informs human resources if the complaint involves possible hospital or department violations or disciplinary actions.

"Situations involving confidentiality concerns are a primary example," says Bowles. "Ensure that all necessary steps are taken to thoroughly investigate the situation."

By involving human resources, staff members realize that you are taking their complaint seriously, says Bowles. "They realize that you are taking all steps possible to be fair and impartial, and that you are investigating the information that you may not have had answers for at the time of your discussion with the employee," she says.

Once Bowles has concluded her investigation, she communicates the results to the involved employees.

To avoid violating staff or patient confidentiality, Bowles stays focused solely on the behavior of the individual with whom she is speaking. "Communicate details on process changes, but not any type of disciplinary action," she advises. ■

Can't do what staff are asking? Explain

Tell them reasons for decisions

The results of a survey of registration staff at University Orthopaedic Center, part of Salt Lake City-based University of Utah Health Care, were a little surprising to managers.

"It wasn't that we didn't do what staff suggested. Staff simply wanted an explanation as to *why* some suggestions might not be implemented," says **James Carey**, CHAA, patient access manager at that facility and Huntsman Cancer Hospital.

While managers obviously can't do everything that registrars suggest, they can certainly communicate the reasons behind the decision, says Carey. "We had some issues with team morale, and communication was one of the biggest things we needed to work on," he reports. "Our message to staff is that *they* are the experts."

Registrars often pick up on problem areas that managers wouldn't necessarily notice, says Carey, and they often come armed with possible solutions. It might be necessary to change processes as a result of a staff complaint, but in many cases an explanation is necessary for why things *can't* be changed, says Carey. Carey's registrars expressed frustration with the new registration system, for example, because it was taking them longer to register patients.

"With our previous system, registrars could skip over certain things, and it would be dealt with on the back end," says Carey. "Now, because this is a front-end system, they can't get past those fields without populating them."

Carey explained to the registrars that it was necessary to enter the information upfront to avoid claims denials. "It will take longer to complete a registration, but we can get a claim out clean the first time," he says.

Share underlying reasons

Staff often complained to Carey about having to ask patients for the same piece of information multiple times. For example, a Medicare patient might be asked "Are you currently residing in a skilled nursing facility?" or "Are you currently employed?" more than once in a single day.

In some cases, it might be possible to change the registration system so that the answer to these particular questions will automatically appear on subsequent screens, says Carey.

"A patient is not likely to be employed at 8 a.m. and unemployed at 1 p.m.," he says. "In some cases, though, you really *do* have to ask certain questions at every visit."

For example, a patient might have an orthopedics visit for a work-related accident earlier in the day and be seen for an unrelated reason later that same day. Thus, patients might have to be asked, "Was this illness/injury due to a work-related accident or condition?" for each visit, says Carey.

In one case, Carey had to explain to registrars that entering authorization and insurance benefits information more than once was necessary because case managers only had access to the comments. If the information wasn't also entered separately on the comment screen, the case managers had no way to view it, he explains. In another case, how-

ever, registrars complained about having to make a separate notation if they collected any payments from a patient, when they had already entered the payment information on a previous screen.

"Staff told us, 'Why are we doing this? It's repetitive.' We literally just told them that we don't need to anymore," Carey explains. "It was needless work." ■

80% of uninsured in ED eligible for coverage

Offer them help on the spot

If an individual receives an array of costly diagnostic tests in your emergency department and ends up being admitted, the patient's uninsured status doesn't necessarily mean the hospital can't receive payment for services provided.

Nearly 80% of the uninsured patients in the emergency departments (EDs) of four San Diego hospitals were eligible for free or low-cost health coverage, yet weren't enrolled, according to a Point-of-Service ER Survey conducted by the San Jose, CA-based Foundation for Health Coverage Education (FHCE)[1].

"As a result, hospitals nationwide lost millions of dollars in revenue for the care provided," says **Phil Lebherz**, the organization's executive director. "U.S. hospitals lost $36.5 billion in 2009, according to the American Hospital Association, much of which they chalk up to charity care."

Researchers surveyed 13,069 uninsured patients who came to the EDs over 11 months. Of this group, 79.7% were eligible for state and federal health coverage programs, 16.9% were eligible for private coverage, and 3.3% were eligible for high risk pool coverage. "There is a clear issue with the distribution channels of these public health coverage programs to the recipients who qualify," says Lebherz.

According to an online survey done by FHCE, 61.7% of 180,250 people seeking to obtain health benefits over 17 months were unaware they were eligible for government coverage.

The biggest challenge for uninsured patients today is not the lack of free or low-cost programs, according to Lebherz, but poor communication about existing programs. "This is becoming an increasingly important new role for patient access departments as the Medicaid ranks grow," he says.

Eliminate coverage barriers

San Diego-based Sharp Healthcare's hospitals saw an 11% increase in the number of self-pay accounts from 2008 to 2010, with a 27% increase in self-pay dollars, reports **Gerilynn Sevenikar**, vice president of patient financial services.

While referrals to the state's Medicaid program have increased because of more uninsured patients coming through the door, the eligibility percentage has dropped by 10% from the previous year, she adds.

In a perfect world, says Sevenikar, if an unfunded patient arrived at any care provider's facility, the ability to determine eligibility and secure a benefit would happen "right then and there."

"Currently, we are only in a position to arm our patients with information," she says. The obstacle, she says, is the registrar's inability to verify the information in an application, including income, assets, family size, expenses, citizenship and residency. There is quite a bit that goes into qualifying for county, state, or federal funding," says Sevenikar.

Sharp HealthCare's registrars ask uninsured patients to complete the FHCE's five-question Eligibility Survey. "Because the quiz is embedded in the registration process of an unfunded patient, our staff are asking the questions and producing the matrix," says Sevenikar. "The patient could also do it, but we are already at the screen performing input related to the registration." *(See resources, p. 95, for how to access the Eligibility Survey.)*

The patient's responses become part of their account, says Sevenikar, and he or she is given a list of possible funding options with information on how to apply and who to contact. "Whether these patients never sought coverage because they never thought they were going to be injured or sick, or whether they did and there were simply too many barriers to securing the coverage, they need the information now," says Sevenikar.

EXECUTIVE SUMMARY

Almost 80% of uninsured patients in the emergency departments (EDs) of four San Diego hospitals were eligible for free or low cost health coverage, yet weren't enrolled, says a survey done by the Foundation for Health Coverage Education. To identify individuals eligible for coverage:

- Give patients a list of possible funding options.
- Assist patients with the application process.
- Determine if liability insurance will cover the visit.

Registrars also perform some additional outreach to patients and assist with the application process, she says.

"We opted to take the process a step further," Sevenikar explains. "Our desire is that those who are eligible for assistance are able to receive it, and do not fall through the cracks because of the burdensome application process." *(See related story, below, on an ED's process to convert self-pay patients.)*

SOURCES/RESOURCE

For more information on providing assistance to uninsured emergency department patients, contact:

- **Nikki Mahieu**, Manager of Registration Services, Trinity Regional Health System, Rock Island, IL. Phone: (309)779-2250. Fax: (309) 779-2209. E-mail: MahieuNA@ihs.org.
- **Gerilynn Sevenikar**, Patient Financial Services, Sharp HealthCare, San Diego. Phone: (858) 499-4215. E-mail: gerilynn.sevenikar@sharp.com.

The Foundation for Health Coverage Education (FHCE) provides public and private health insurance eligibility information, including an uninsured help line and eligibility quiz to simplify the enrollment process. To access the quiz, go to http://coverageForAll.org. Click on "Eligibility Quiz." For more information, contact the FHCE at (800) 234-1317 or FHCEinfo@coverageforall.org. ■

$550,000 of self-pays converted in one month

Offer eligibility assistance to patients

In a single month, registrars at Trinity Regional Health System in Rock Island, IL, were able to obtain disability coverage for five patients with a total of $450,000 in charges, and they were able to obtain Medicaid coverage for 104 patients who had received a total of $100,000 in services.

All of these patients initially came into the hospital's emergency department (ED) as self-pay, says **Nikki Mahieu**, manager of registration services, and their account balances likely would have gone to collection.

In some cases, well-meaning family members might help you to register an ill ED patient, but they offer inaccurate or outdated demographic information. You also might get bad information from patients with language barriers or those under the influence of drugs or alcohol, says Mahieu.

Accurate information gives registrars the ability to offer ED patients coverage options they don't realize are available to them, says Mahieu. "We will screen them for any sort of hidden potential coverage," she says. "Many ED patients are potential Medicaid patients."

If patients are receiving limited assistance from the state, they often qualify for full Medicaid coverage, depending on their diagnosis, says Mahieu. Registrars ask injured patients if they were hurt at home or in a car accident, she says, to determine if liability insurance will cover the ED visit.

If patients are eligible for COBRA coverage but can't afford the back premiums, it might be worthwhile for the hospital to pay these in order for the services to be covered, adds Mahieu. "You have to build a really tight process on screening every self pay patient — not just for Medicaid, but also everything else," says Mahieu. "There are a lot of things we can do upfront to make sure we get the best information possible."

Convert from self-pay

Trinity Regional's ED financial advocates routinely ask self-pay patients key questions and refer them to a Medicaid specialist if there are any "yes" responses, says Mahieu. *[The form used to screen self-pay patients is included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]*

"We've got people going to the floors to get additional information from ED patients who become inpatients," Mahieu says. "If an application is incomplete or contains errors, a lead [financial advocate] goes back to review it with the advocate."

Recently, Mahieu consulted with a self-pay patient who was receiving an EKG about the possibility of obtaining Medicaid coverage. "I explained that she was better off getting some sort of coverage, than going out as self-pay where it may end up going to collection," she says. "She was very positive and forthcoming, and didn't hide any information."

This reaction is typical, in part due to scripting used by registrars that emphasizes patients can only benefit from the process, says Mahieu.

If self-pay patients do obtain coverage, this saves

COMING IN FUTURE MONTHS

- ■ Collect millions in retroactive insurance payments
- ■ Ask your star registrars to educate poor collectors
- ■ Uncover self-pay patients' "hidden" insurance coverage
- ■ Update on technology to fight claims denials

the hospital's charity funds for those who really need them, adds Mahieu. "Charity is there as a last resort," she says. "If we can keep that available for people who are never going to qualify for Medicaid or another form of coverage, that's the best case scenario." ■

ID both crowding and under-utilized capacity

'Smooth out' admissions

"Smoothing" occupancy over the course of a week can protect patients from crowded conditions, according to a study involving 39 children's hospitals during 2007.[1] Researchers compared weekday versus weekend occupancy to determine just how much "smoothing" can reduce inpatient crowding. Their findings:

- After smoothing, 39,607 patients from the 39 hospitals were removed from settings where occupancy levels exceeded 95%.
- To achieve within-week smoothing, a median of only 2.6% of admissions — 7.4 patients per week — would have to be scheduled on a different day of the week.

The fact that this amount of variation existed wasn't surprising, according to **Evan S. Fieldston**, MD, MBA, MSHP, the study's lead author and assistant professor of pediatrics at The Children's Hospital of Philadelphia. "What was surprising, however, was the relatively small number of patients that would have to be scheduled differently to bring down the census for very high levels and make better use of resources over the days of the week," says Fieldston.

Fieldston recommends that patient access leaders meet with clinicians to explore ways to address admission and occupancy patterns. "The first step is for hospitals to analyze their own data," he says.

If you find patterns of scheduled admissions and occupancy clustered on some days but not others, and you are concerned about crowding and/or under-utilized capacity, consider steps to proactively manage scheduled admissions patterns, says Fieldston. "This may not necessarily mean admitting patients, or many patients, on weekends, but it may mean altering the weekdays on which patients enter," he says.

REFERENCE

1. Fieldston, ES, Hall M, Shah, SS, et al. Addressing inpatient crowding by smoothing occupancy at children's hospitals. *J Hosp Med* 2011; 6. Doi: 10.1002/jhm.904. ■

PATIENT AND VISITOR
Information
www.medicalcenter.osu.edu

Keeping Your Identity Safe

Keeping your identity safe is important to us. That is why you will be asked to present photo identification at registration. We want to make sure that the name on your record matches who you are.

Why do I need to present my photo ID?
We want to make sure we are providing the right care to the right person. We will use your photo ID to match your name with your medical record.

Do I need to present my photo ID each time I come to OSU Medical Center?
To ensure that the name in the medical record matches who you are, we will be checking your photo ID each time that you visit any OSU Medical Center facility.

Why are some areas taking my photo when I register?
As an extra measure of safety, some areas of the Medical Center will ask to take a photo of you. This photo will be placed in our system so if you need to come back again we can match your photo with your record. This is just another way we are helping to keep your identity safe.

How can I ensure my identity is safe?
To help protect yourself, and to make sure that your identity is not being used by someone else to receive care, the Federal Trade Commission suggests the following:

-Closely monitor any "Explanation of Benefits" sent by public or private health insurers. If anything appears wrong, raise questions with the insurer or the provider. Do not assume that there are no problems simply because you may not owe any money.
-Once a year (or more often, if you believe there is cause for concern), request a listing of benefits paid in your name by any health insurers that might have made such payments on your behalf.
-Monitor your credit reports with the nationwide credit reporting companies (Equifax, Experian and TransUnion), to identify reports of medical debts.

For other tips on how you can ensure your identity is safe, visit the Federal Trade Commission's site at www.ftc.gov/idtheft. If you feel that your identity has been compromised contact the Ohio Attorney General's Identity Theft Verification Passport Program at 1-888-MY-ID-4-ME (1-888-694-3463) or online at http://www.ohioattorneygeneral.gov/.

If you have questions about your medical record, please contact the OSU Medical Center privacy officer at 614-293-4477.

Ohio State University Medical Center is committed to improving people's lives through personalized health care. That's why all OSU Medical Center locations – inside and outside – are tobacco-free. If you use tobacco and are ready to quit, contact the OSU Medical Center Tobacco Treatment Center at 1-866-504-0561.

The Ohio State University Medical Center

SOURCE: Ohio State's University Hospital East, Columbus.

TRINITY
IOWA HEALTH SYSTEM

A better experience.

SELF PAY FORM

Thin website/IA Audio line (State pt lives): ___ Yes ____ No

Check any of the following if they apply to your current situation:

____ Patient is currently 18 or under and currently lives in Illinois

____ Patient is currently 20 or under and currently lives in Iowa

____ Patient is a pregnant woman

____ Patient is a caretaker of a minor child who lives full time in the household (ex: grandparents raising children in place of parents)

____ Patient is age 65 or over

____ Patient is disabled (per guidelines of social security)

____ Patient is a parent with underage biological or adopted children living in the home full time.

____ Step-parent (person legally married to patient's biological parent)

____ Patient is considered legally blind

Are you currently receiving assistance from any of the following programs:
Proof of assistance and picture ID are required-please make copy and attach

____ Currently Illinois Medicaid Eligible or lock in Attach printout from Thin

____ Currently Iowa Medicaid Eligible or lock in Verified per Audio line? Yes or No

____ Illinois Healthy Women Attach printout from Thin

____ Iowa Family Planning Verified per Audio line? Yes or No

____ Iowa Care Verified by audio line? Yes or No

____ Receive Food Assistance Attach copy of food assistance approval letter

____ Receives funds through the Housing Authority for rent or energy assistance Attach copy of Housing Assistance approval letter

____ WIC program Attach copy of WIC Voucher

Homeless: _____ Yes _____ No complete homeless form

SOURCE: Trinity Regional Health System, Rock Island, NY.

August 2011/ Online Supplement to HOSPITAL ACCESS MANAGEMENT ®

TRINITY
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Trinity Health System
Self Pay Guide for Registration
Purpose: Appropriately identify and document all Self Pay patients using the Self Pay forms. The team leads will be following up on the Self Pay Forms to ensure accuracy of documentation in Carecast and on the Self Pay Form.

Carecast Codes for Self Pay Screening	
Potential Medicaid Category	IPAC
Presumptive Category – With or Without Proof	PRES
No Medicaid or Presumptive Category	NOCA

Medicaid Category:

- Forward to Medicaid Specialist (MaryKay/Linaka)
- Use **IPAC** code in Carecast and scan to HPF

Presumptive Category (no proof):

- Complete the Self Pay Form and give the patient a copy of the Form
- Give patient a self addressed envelope to return proof of presumptive category
- Use **PRES** to document that you completed the Self Pay Form and give a self-addressed return envelope to the patient

Presumptive Category (has proof):

- Forward Self Pay form and proof of presumptive to Financial Advocates to review & process. Scan all documents to the business office document
- Please print clearly on Self Pay form
- Use **PRES** and scan proof of presumptive to business office

No Medicaid/Presumptive Category:

- Give patient financial assistance application
- Use code **NOCA**
- Nothing gets scanned to HPF

Financial Assistance:

- All patients must be screened for Medicaid/Presumptive categories
- Give Financial Application if NO category is found

Homeless:

- Treat as Self Pay patients
- Must still be screened for possible Medicaid or Presumptive categories
- Must sign the homeless/cert of current residence form

SOURCE: Trinity Regional Health System, Rock Island, NY.

TRINITY
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Trinity Medical Center
2701 17th Street
Rock Island, IL 61201

Our records indicate that you were involved in an accident. The information requested below is necessary for us to complete our billing process. Please be aware that all billing will come to you until the information is provided. We ask that you complete and return this form at your earliest convenience.

LIABILITY INSURANCE INFORMATION

Patient Name_____ **Account #**_____

1. On what date did the accident occur?_____
2. Has there been any fault determined yet?_____

Please list **liability insurance** information:

Company Name_____ Phone Number_____

Address_____

Policy Holder Name_____

Claim#_____ Policy #_____ SS#_____

Do you have any **health insurance?**_____ If yes, please list below:

Company Name_____ Phone Number_____

Address_____

Policy Holder Name_____

Policy #_____ SS#_____

Employer Group Name/#_____

SOURCE: Trinity Regional Health System, Rock Island, NY.

August 2011/ Online Supplement to HOSPITAL ACCESS MANAGEMENT ®

TRINITY
IOWA HEALTH SYSTEM

A better experience.

Trinity Medical Center
2701 17th Street
Rock Island, IL 61201

Our records indicate that you were involved in an auto accident. The information requested below is necessary for us to complete our billing process. Please be aware that all billing will come to you until the information is provided. We ask that you complete and return this form at your earliest convenience.

ACCIDENT AND INSURANCE INFORMATION

Patient Name_____ **Account #**_____

1. Was this a one or two car accident?_____
2. Was the patient the driver or passenger in the vehicle?_____
3. Who is the owner of the vehicle?_____
4. On what date did the accident occur?_____
5. Has there been any fault determined yet?_____

Please list the patient's **auto insurance** information:

Company Name_____ Phone Number_____

Address_____

Policy Holder Name_____

Claim#_____ Policy #_____ SS#_____

Please list the owner's **auto insurance** information:

Company Name_____ Phone Number_____

Address_____

Policy Holder Name_____

Claim#_____ Policy #_____ SS#_____

If other party involved, please list their **auto insurance** information:

Company Name_____ Phone Number_____

Address_____

Policy Holder Name_____

Claim#_____ Policy #_____ SS#_____

Do you have any **health insurance?**_____ If yes, please list below:

Company Name_____ Phone Number_____

Address_____

Policy Holder Name_____

Policy #_____ SS#_____

Employer Group Name/#_____

SOURCE: Trinity Regional Health System, Rock Island, NY.

August 2011/ Online Supplement to HOSPITAL ACCESS MANAGEMENT ®

HIPAA Regulatory Alert

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

Proposed rule allows patients to see details of health record access

Begin analysis of your facility's ability to meet requirements now

Compliance and regulatory officers have until Aug. 1 to comment on a proposed rule that includes a new accounting of disclosures provision that gives individuals the right to receive a report on who has electronically accessed their protected health information (PHI).

Although healthcare organizations have been required to maintain an audit trail of access to PHI since the implementation of the HIPAA Privacy Rule, and institutions have always been required to provide a report upon request, the proposed rule will be a challenge for some, according to experts interviewed by *HIPAA Regulatory Alert*.

"Under the existing privacy rule, an individual has a right to an accounting of disclosures of PHI made by a covered entity, and the accounting must be provided to an individual within 60 days of a request," explains **Gina M. Cavalier**, Esq., Partner, Reed Smith in Washington, DC. The proposed rule suggests several changes to the existing rule, including shortening the timeframe for response to a request for an accounting of disclosures from 60 days to 30 days, Cavalier says. "This shortened time-frame may pose challenges, depending on the hospital's current systems for tracking disclosures," she says.

The proposed rule also adds the right to an access report that enables individuals to learn if specific people have accessed their electronic personal health information. "In effect, OCR [The Office of Civil Rights] bifurcated the existing right to an accounting and created two separate rights: accounting and access report," says Cavalier. The right to an access report implements the HITECH Act's mandate that covered entities account for disclosures, including disclosures made for treatment, payment, and healthcare operations, of PHI made though an electronic health record, she says. "The proposed rule has a broader reach and includes uses in addition to disclosures of PHI in a designated record set, not only an electronic health record," she explains. "Moreover, the report must include a description of who has accessed this PHI for treatment, payment, healthcare operations purposes, as well as any other reason."

"Hospitals already have audit trails in place to identify access to a patient's designated record set, but this capability may only apply to the primary system," says **Kate Borten**, CISSP, CISM, president of The Marblehead Group, a privacy and information security consulting firm in Marblehead, MA. "Some feeder systems, such as a lab or registration system, may not be able to provide the audit trails now needed," Borten adds.

Software that identifies users who access patient records is used by many hospitals to produce access audit trails and identify "snoopers," but the proposed rule will require hospitals to produce a

EXECUTIVE SUMMARY

Hospitals have been required to maintain an audit trail of access to protected health information (PHI) since the implementation of the HIPAA Privacy Rule, and organizations have been required to provide a report upon request. However, the new provision of an access report that is included in the Proposed HIPAA Privacy Rule Accounting of Disclosures Under the Health Information Technology for Economic and Clinical Health Act will be a challenge for some providers.

- The access report must give specific information to the patient requesting his or her report, including names of individuals who accessed their electronic PHI.
- The report must aggregate all access, including access by business associates.
- Although most hospitals collect access information, not all systems include feeder or departmental systems.

report for patients that provides specific information. *(For a list of information required, see p. 3.)*

Another issue for many hospitals will be related to business associates, Cavalier says. "With respect to both accounting and access reports, covered entities [CEs] must be able to quickly obtain relevant information from their business associates," she says. "The logistics associated with coordinating numerous business associates may pose challenges."

Prepare now

Even though the rule is not yet final, Borten suggests that hospital compliance officers start now to prepare.

"Go through the proposed rule carefully, and evaluate your organization's ability to meet the proposed requirements," she suggests. "Put a plan together to address the technological adjustments and process changes that you will need to make."

After the plan is put together, wait for the final rule, she suggests. Re-evaluate your plan to make adjustments that reflect changes between the proposed and the final rules, and then begin implementation, she says.

At this time, the proposed rule sets Jan. 1, 2013, as the date on which individuals have the right to request an access report from organizations that acquired electronic designated record sets after Jan.1, 2009. Organizations that had acquired electronic designated record sets as of Jan. 1, 2009, have until Jan. 1, 2014, to implement processes to provide the access reports.

Also, start talking to your business associates now, recommends Borten. Because the proposed rule refers specifically to designated record sets, carefully review your business associate relationships to identify which business associates have all or part of the information covered by the proposed rule. Work with those associates to make sure they are aware of the proposal for changes related to disclosure accounting and access reports, Borten suggests. "Don't necessarily make the technological changes at this time, but make sure everyone involved has inventoried their capabilities and identified how they will make changes to comply once the rule is final," she adds.

While you are analyzing your compliance readiness, be sure to talk with your information technology vendors as well, suggests Borten. Be sure they are ready to implement changes once the final rule is published, she adds. "There will be time to implement updates and changes, but no one should wait until the final rule to make plans," Borten says.

There already is pushback from some healthcare organizations with complaints that meeting the requirements are too difficult or too burdensome, admits Borten. Even though OCR states in the proposed rule that the access report must include "information that a covered entity is already required to collect under the security rule," the requirements will present a challenge for hospitals that might not be in full compliance with the rule at this time, she says. The rule requires covered entities to record and examine activity in information systems and to regularly review the activity related to information access.

"There has been a disconnect between the security rule regulations and the interpretation of the rule," Borten says. "The rule is often interpreted loosely, and the access log technology often doesn't extend to departmental or feeder systems, such as lab systems."

At this time there are no official government resources available to help compliance officers prepare, but there should be once the rule is finalized, says Cavalier. "However, the OCR, which enforces the Privacy and Security Rules, periodically posts training materials, answers to FAQs, and other resources on its web site," which is located at http://www.hhs.gov/ohr, she points out. "In addition, covered entities may submit comments on the proposed rule, which may include questions or requests for clarifications," she adds. *(See resource, below, for information on how to access proposed rule and comment.)*

Borten says that even with the policy updates and potential technology changes some organizations will need to implement, "I think access reports are a good thing." If employees know there is a record of access of PHI and that an individual can request the report, there might be fewer cases of internal snooping, she points out.

"Be sure to remind your employees and anyone who may have access to electronic PHI that there is an audit trail that shows access," Borten says.

SOURCES/RESOURCE

• **Kate Borten**, CISSP, CISM, President, The Marblehead Group, One Martin Terrace, Marblehead, MA 01945. Telephone: (781) 639-0532. E-mail: kborten@marbleheadgroup.com.
• **Gina M. Cavalier**, Esq., Partner, Reed Smith, 1301 K St. NW, Suite 1100, East Tower, Washington, DC 20005. E-mail: gcavalier@reedsmith.com.

To see a copy of the proposed rule and to see information on how to submit comments, go to www.gpo.gov/fdsys. On the

right-side navigational bar under "Featured Collections," select "Federal Register." Select "2011," and choose "May 31." Scroll down to "Health and Human Services" and under "Proposed Rules," select "HIPAA Privacy Rule Accounting of Disclosures Under the Health Information Technology for Economic and Clinical Health Act." Comments about the proposed rule must be submitted by Aug. 1, 2011. ■

Know specifics of proposed rule

Requirements spelled out clearly

Unlike the current privacy rule which identifies purposes that might be omitted from disclosure accounting reports, the proposed rule published on May 31, 2011, identifies those purposes for which disclosures must be tracked and reported.

"Listing what must be included in a disclosure accounting is better because a covered entity doesn't have to make their own decision about what is intended to be included or excluded," says **Kate Borten**, CISSP, CISM, president of The Marblehead Group, a privacy and information security consulting firm in Marblehead, MA.

The current privacy rule states an accounting of disclosures of protected health information must include all disclosures except in the case of disclosures made for treatment, payment, and healthcare operations; to the individual; incident to a permitted use or disclosure; per an authorization; and for various public policy and other enumerated reasons, explains **Gina M. Cavalier**, Esq., Partner, Reed Smith in Washington, DC.

"Covered entities will only be required to account for disclosures made in seven circumstances," Cavalier says. "As a general matter, this is likely a smaller universe of disclosures for which a covered entity must account." The disclosures that must be included in a disclosure accounting are:

- **an impermissible purpose** (unless a breach notice has been provided);
- **public health;**
- **judicial and administrative proceedings;**
- **law enforcement;**
- **to avert a serious threat to health or safety;**
- **military and other government activities;**
- **workers' compensation.**

The proposed rule is also specific about what should be included in the access reports, says Cavalier. An access report must include:

- **the date the electronic designated record set (eDRS) was accessed;**
- **time of access;**
- **name of the person, if available, and if not, the name of the entity accessing the eDRS;**
- **a description of what information what accessed, if available;**
- **a description of the action taken by the user, if available; for example, "create," "modify," "access," or "delete."** ■

Free tool assesses privacy risks

12 steps to survive OCR investigation

Frequent news stories and headlines about the Department of Health and Human Services (HHS) Office for Civil Rights' (OCR) crackdown on covered entities that have reported data breaches or other privacy rule violations increase the importance of continually assessing compliance with privacy and security rules.

A free, interactive toolkit that helps healthcare compliance, privacy, and information security officers assess and mitigate risks within their organizations is available from ID Experts, a Portland, OR-based software company.

The toolkit also offers information to help organizations prepare for OCR investigations. "The biggest challenge is that every OCR investigation is different, and the only way an organization will survive one is if it is completely aware of the potential paths of the investigator and prepared," said **Rick Kam**, CIPP, president and co-founder of ID Experts.

Twelve steps that healthcare organizations can take to prepare for an OCR investigation are:

1. Assign privacy and security responsibility. Ensure accountability for patient privacy with a specifically designated privacy official in your organization.

2. Conduct an annual risk analysis. Carry out an annual risk analysis intended to identify privacy/security risks and vulnerabilities.

3. Address security vulnerabilities. Implement security measures to reduce risks and vulnerabilities identified in most recent risk assessment.

4. Train workforce. Train workforce members including management and volunteers in patient privacy and security requirements, and document evidence of security awareness enforcement.

5. Develop policies and procedures. Develop thorough policies and procedures for safeguarding protected health information (PHI) and for unauthorized disclosure of PHI.

6. Prepare for privacy incidents. Develop procedures and tools for compliant investigation, analysis, and review.

7. Report incidents. Capture and maintain a copy of the incident report that was created/submitted that triggered concern that a potential breach has occurred.

8. Analyze incidents. Develop and document a detailed description of the facts of the incident and the incident risk assessment that you carried out to determine if the incident requires notification to affected individuals and authorities.

9. Document patient notification. Develop and document your notification to individuals affected by the data breach, including all means used to ensure delivery of the notification.

10. Mitigate harm to affected individuals. Describe actions taken to mitigate the harm to individuals/patients affected by the breach.

11. Send notifications to regulators and media. Develop and document your notifications to necessary regulatory authorities including HHS/OCR as well as media.

12. Determine root cause and corrective actions. Determine and document actions to determine the root cause of the incident and to address the root cause with corrective actions.

To access the free toolkit and checklist, go to www2.idexpertscorp.com and select "Breach Tools" from the top navigation bar. At the next page, scroll down to "OCR Survival Tool," then "Download Tool Here." ■

Survey shows security is not improving

$100,000 breaches occur daily

In spite of increased focus on regulatory compliance, a survey of over 100 information technology (IT) administrators, managers and executives of healthcare organizations reports ongoing data breaches.

The survey, conducted by Boston-based Global Sign, an accredited public certificate authority, showed that although 56% of IT security teams are spending between 25% and 100% of their workweeks devoted to compliance, breaches that cost organizations as much as $100,000 per incident are happening every day.

Exacerbating the problem is the sheer number of applications and solutions flooding the market that claim to satisfy security and compliance requirements, according to survey respondents. In fact, results revealed that 79% of respondents find that identifying effective tools that can provide both security and compliance is moderately to extremely challenging.

Other results of the survey included:

• 54% of respondents are devoting the most of their time to HIPAA compliance procedures;

• 37% of respondents spend no more than 25% of their workweeks devoted to improving security and ensuring data privacy;

• 34% of respondents' organizations have experienced a patient-records data breach within the past two years;

• 10% of respondents believe that data breaches that cost organizations $100,000 per incident occur daily. ■

Doctors may not be ready for 5010

Over 45% have not implemented upgrades

As the January 2012 deadline for hospitals to convert to HIPAA Version 5010 quickly approaches, a survey conducted by the Medical Group Management Association (MGMA) has found that medical practices are lagging in the race to meet 5010 deadlines. The results are:

• 45.2% of practices report that they have not yet started implementation or software upgrades.

• While 53.4% of the respondents said that they are fully aware of these HIPAA mandates, the majority said that they have not yet scheduled internal testing. Another 84.8% said that they have not yet prepared an impact analysis detailing how this conversion will affect operations.

• Of the respondents, 42.9% said that their practice management vendor is geared up to replace or upgrade their system to accommodate the newer version, 34.5 percent said they are not.

• Only 9.2% of practices said that they have begun internal software testing and 2% said that they do not plan to start internal testing until after the January 2012 deadline. ■