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Warning! Accreditation surveyors may talk with patient access staff

Get your employees involved with initiatives

Any staff member with patient contact, including those who perform a registration function, might be approached during a survey by The Joint Commission, according to **Cynthia Leslie**, RN, associate director of The Joint Commission's Standards Interpretation Group.

Lauree M. Miller, director of patient access at Catholic Health Initiatives — Nebraska in Lincoln, says, "The perception of patient access was that they just get a name and date of birth. Actually, patient access has a lot of ownership in different Joint Commission standards."

Patient access leaders need to let administration know they want to be involved in Joint Commission initiatives, says Miller. "You don't want to hear it in a memo. You want to be at the table to drive the changes," she advises. "You don't want to be afraid of Joint Commission coming to your facility."

Before the new patient tracer methodology was implemented by The Joint Commission in 2004, Miller recalls, surveyors would ask to see charts from previous months to review them retrospectively. "Now they come in, and they talk to the patient. They say, 'Tell me about the admission process. How were you explained your rights?' We need to be consistent with what the patient is saying," she says.

At Catholic Health Initiatives — Nebraska, patient access staff are "very involved" in ensuring compliance with The Joint Commission's National Patient Safety Goal requirement to use at least two patient identifiers, says Miller.

"We start the process by identifying the patient upfront. The clinical staff

EXECUTIVE SUMMARY

Members of the patient access staff need to comply with many different standards from The Joint Commission, and surveyors might visit registration areas as they trace a patient's path through the organization.
- Offer to lead a chapter on your hospital's Joint Commission committee.
- Collaborate with clinical areas.
- Ask supervisors from other areas to role play as surveyors.

then validates it, but we need to be involved in that piece," she says.

Staff members need to have a clear understanding of the two identifiers, says **John Wallin**, RN, associate director of standards interpretation at The Joint Commission. "Some people think that an armband is considered an identifier, but it is not. An armband is merely a source of information," Wallin says. "People need to be clear on that." *(For more information on this topic, see "Outdated processes for patient ID must stop — Adopt new strategies,"* Hospital Access Management, *May 2011, p. 49.)*

If the patient is not correctly identified during the registration process, this problem potentially can lead to a bad outcome, Miller warns. "If we have the wrong date of birth, that can have some negative impacts down the road, since care is sometimes driven by a patient's age," she says. "We have to hold each area responsible for their part in the process, to make sure the patient is safe."

4 items to review with registrars

Melissa R. Almond, patient access team leader at Palmetto Health Richland in Columbia, SC, says the following information is reviewed with registrars to ensure Joint Commission compliance:

- **completing the patient language field, to ensure that the patient can be cared for appropriately if they are a non-English speaking patient;**
- **asking for information on advanced directives and letting patients know that information on how to obtain living wills and healthcare power of attorneys is available;** *(See related story on increasing involvement of registrars in this process, p. 51.)*
- **obtaining consent for treatment and the assignment of benefits, and making sure that these forms are accessible after they have been signed;**
- **obtaining signatures for the Important Message from Medicare.**

"We send out an email blast once a day when we are expecting that The Joint Commission may be coming soon, just to keep it on everyone's mind," says Almond. Take these steps to improve compliance in registration areas:

- **Ensure patients understand their rights and responsibilities.**

At Catholic Health Initiatives — Nebraska, an educational folder was created with all of the materials staff members are required to give patients.

"We hand out lots of brochures, but does the patient really understand them?" Miller asks. "You can't go through everything. There is just not enough time. But we have a lot of scripting in place for registrars to cover the highlights of the content."

Staff should be able to articulate their process for informing inpatients and outpatients of their rights and responsibilities, says Wallin. "Staff may think that standards are specific to inpatients only, and that is not accurate," he says. "There are actually very few elements of performance that we even differentiate between inpatient and outpatient."

- **Protect the privacy of information by speaking quietly, making sure computer screens are not visible to unauthorized people, and not asking for protected health information (PHI) at a registration desk that is within earshot of anyone else.**

"Some organizations have established a line with a sign that says, 'Please wait here for the next available receptionist' to create distance, so the audible piece of

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this is not problematic," Wallin says.

If registrars copy or scan a patient's driver's license or insurance cards, there must be a process to ensure that the paper copy doesn't end up in a waste basket, he adds.

If sign-in clipboards are used in registration areas, be sure that the information you are asking for is not PHI, adds Wallin.

• Be sure staff can determine when an interpreter might be needed and how to access those resources.

"When interpretive services are needed, the organization needs to ensure that those serving in that role are competent to do so," Wallin says. *(See related stories on getting involved in survey preparation, right, and questions that registrars might be asked, p. 52.)*

SOURCES

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Involve registrars in advanced directives

Follow-up is a 'risk point'

Members of the patient access staff at Catholic Health Initiatives — Nebraska now play a role in complying with The Joint Commission's requirement that patients be offered educational materials on advanced directives when they are admitted, says **Lauree M. Miller**, director of patient access.

"In some hospitals, it falls on the clinical staff to do this," says Miller. "With our new process, patient access starts the ball rolling to find out if the patient has this or not."

While many registration areas are involved in the advanced directives requirement, there must be a process in place to ensure that the clinical side follows through as needed, cautions **John Wallin**, RN, associate director of standards interpretation at the Joint Commission. "That is a risk point," he says. "If the patient says, 'I don't have one, but I'd be interested in finding out more,' or if the patient has one but doesn't have a copy with them, that is one area where we see inconsistencies in the process."

If the patient has the directive with them, registrars at Catholic Health Initiatives — Nebraska scan it into the system so it becomes a permanent part of the patient's medical record, Miller says, and it can be pulled up during future visits. If the patient didn't bring a copy of the advanced directive with them, clinical staff members are informed of this issue and follow up with the patient.

Registrars ask patients to identify a surrogate decision maker at the time of registration by asking patients, "Who would be your decision maker today if you were unable to make decisions for yourself?"

"This carries through to the clinical staff," says Miller. "It helps the patient understand that we are coordinating their care. Patient access can start the process, and clinical staff can validate it." ■

You must be involved in survey preparation

Volunteer to be a leader

When **Lauree M. Miller**, director of patient access at Catholic Health Initiatives — Nebraska in Lincoln, became the organization's coordinator of admissions, patient access didn't have anyone represented on the hospital's committee that oversees accreditation by The Joint Commission.

The hospital was looking for someone to lead the patient rights and responsibilities chapter, so she volunteered. Patient access leaders have to "raise their hand and be involved" in Joint Commission initiatives, advises Miller.

"It's important for us to see the bigger picture, not in just patient access, but throughout the patient's visit," she says. "It's also a growth opportunity to get involved in the organization."

It might be helpful for the Joint Commission committee to have a non-clinical person at the table, adds Miller. "If you don't want to do it alone, you can tag-team with a clinical person to lead the chapter," she says.

Cheryl L. Webster, director of patient registration services at Beaumont Hospital in Royal Oak, MI, participates in her hospital's Joint Commission teams alongside clinical staff. "I can help keep our team supportive of their efforts and standards as well," she says. "Our functions overlap, so it is important to work together."

Here are two ways to help your organization comply with Joint Commission standards:

• **Be involved in mock tracer activities.**

How the tracers are conducted will drive what kind of questions registration staff members might be asked, explains **John Wallin**, RN, associate director of standards interpretation at The Joint Commission.

"It may have nothing to do with privacy of information," he says. "I've been out on a survey and asked staff, 'How do you, as a registration clerk, identify an infectious patient and transport them to a safe area?' Additionally, other infection prevention and control questions may be asked."

• **Perform a risk assessment of the admission process.**

"Conducting a risk assessment is one of several tools an organization may use to review their policies and procedures for the admission process," advises **Cynthia Leslie**, RN, associate director of The Joint Commission's Standards Interpretation Group.

Leslie says this assessment is an opportunity to look closely at these areas: What is our process? What admission questions are we are asking? How do we ensure privacy? Are registrars educated as to policies and procedures? Has their competency been assessed?

Patient access team leaders and supervisors at Palmetto Health Richland in Columbia, SC, visit registration areas to role play as Joint Commission surveyors. "We know that they know the information, but we want to be sure they are comfortable answering the questions," says **Melissa R. Almond**, patient access team leader. "We want to be just as prepared as the clinical staff."

At Beaumont Hospital, Webster asks supervisors from other areas to role play as surveyors, and she reminds registrars that surveyors will ask them questions about things they do every day.

"Some staff know what they are doing, but are a little shy about being put on the spot with a stranger asking questions," she says. "We just want them to shine as they talk about how they perform their tasks." ■

Surveyors may ask this list of questions

Below are examples of questions used to prepare registrars at Catholic Health Initiatives facilities in Nebraska for surveys by The Joint Commission:

• **What performance measures are collected and assessed in your area?** Examples are registration accuracy rates and productivity monitoring.

• **How often are your departmental policies and procedures reviewed?** Patient access policies and procedures are updated every three years, or sooner if a procedure changes.

• **How do patients receive their rights and responsibilities?** The patient rights and responsibilities are posted in all registration areas and are offered in writing to all patients or upon their request.

• **What is your role in identifying if a patient has an advanced directive?** At the time of registration, the patients or personal representatives are asked if they have advanced directives in the form of living wills or a durable powers of attorney for healthcare.

• **How does a patient know where and how to file a complaint?** The information to file a complaint is listed in the Rights and Responsibilities brochure that is provided to a patient upon registration.

• **How does the hospital demonstrate respect for the patient's right to privacy and confidentiality?** For patient access, we register patients in a private registration office. We maintain patient confidentiality by keeping voices low when others can hear, we knock before entering a room, and we also abide by the Health Insurance Portability and Accountability Act regulations. ■

Collections soar: $4.4 to $8.3 million

Payment is obtained consistently

When **Diane C. Settle**, CPA, CHFP, became executive director of revenue cycle at Sarasota (FL) Memorial Health Care System in 2005, no upfront cash collection was done at all.

"The revenue cycle was in really bad shape. The challenge was, 'Can you fix it?'" Settle says.

The patient registration's department's dramatic success in upfront cash collection was a highlight of the last budget presentation given to the hospital board, she says. "We were at $4.4 million annually in 2006, and in 2011 we collected $8.3 million. We have had about a 15% increase each year," Settle reports.

The first step was to convey to staff that they were expected to ask for payment and to convey to patients

EXECUTIVE SUMMARY

Patient access staff at Sarasota (FL) Memorial Health Care System collected $8.3 million in 2011, up from $4.4 million in 2006, with a 15% increase each year. The department made these changes:

- Collections goals were established for each site.
- Registrars worked alongside the best collectors.
- Patient access staff members handle screening for Medicaid eligibility.

that the hospital expected to be paid for services, says Settle. "Physicians offices had been doing it forever. You don't go there thinking you won't have to pay your copay," she says.

First, Settle established goals for each site, based on what she thought was achievable for her staff, and these have been met each year.

Registrars must meet their collection goal in order to receive their quarterly bonus, a program that was started in 2008. Though many registrars initially were reluctant to ask for money, competition has become fierce in outpatient clinics, says Settle.

"We did a lot of training and showcased people who were really good at it," she says. "We had people buddy up and shadow them for the day, to see how their coworker went about collecting."

Staff began to realize that patients really wanted to know their out-of-pocket responsibility, Settle adds. "There is nothing worse than waiting 60 or 90 days and then getting that unexpected bill in the mail," she says.

Everyone collects

Settle discovered that the secret to collecting much more cash is to simply ask for it, which wasn't being done previously.

"If you ask, you usually get it," she says. "The biggest obstacle was to get people to ask."

Though a few registrars never became accustomed to the collections role and left the department over time, most have become very good at it, says Settle. "When we interview people now, we are clear that you are going to be collecting money. Everyone collects, except for insurance verifiers," she says. "If that doesn't fit your personality, this is not the job for you."

Financial counseling role

If patients can't pay their out-of-pocket responsibility, they're put in touch with a financial counselor to determine if they can afford a payment plan, if they're eligible for Medicaid or disability, or whether they meet criteria for the hospital's charity and financial assistance guidelines.

Patient registration staff play a much bigger role in financial counseling now, says Settle. "This past fiscal year, we really took control of that piece. We became the ones that steer what path the patient is going down," she says.

One vendor helps patients with disability applications, and one vendor handles more difficult Medicaid applications, but patient registration does the screening. "We brought most of the Medicaid eligibility program in-house this past year, and it has been pretty successful," Settle says. "We have hired a few people that really enjoy it."

This change means that only one person is entering the patient's room to set up a payment plan or do an application for Medicaid, she explains, and only patients who are likely to be eligible for disability or are having problems getting qualified for Medicaid are referred to the outside vendors.

When self-pay patients are found to be eligible for Medicaid after staff members ask some basic screening questions, this means more cash collections for the hospital, says Settle.

"It also helps the patient with every one of their health care bills, because they will have health care claims outside of our walls," she says. *(See related story on the department's implementation of a price estimation tool, below.)*

SOURCE

For more information on increasing upfront collections, contact:

• **Diane C. Settle**, CPA, CHFP, Executive Director, Revenue Cycle, Sarasota (FL) Memorial Health Care System. Phone: (941) 917-1479. Email: diane-settle@smh.com. ■

New tool may mean 25% more collected

Accuracy will be much greater

Registrars at Sarasota (FL) Memorial Health Care System have gotten very good at calculating estimates manually, but the department is implementing a price estimation tool to make the job much easier, says **Diane C. Settle**, CPA, CHFP, executive director of revenue cycle.

"I expect this will really make our numbers go up. I'm really hoping our next fiscal year is going to be awesome," she says. "We will be able to show the deductible and the coinsurance in a written letter. It's going to be much more formal."

Performance bonuses for registrars will be based on a 15% increase in collections, the same as for the previous five years, but Settle is hopeful that the tool might increase collections by up to 25%.

Staff members now have frequent conversations with the physician's office staff about the actual procedures being done, and they consult with coders to be sure that the right code is used. "Some staff think we've gotten so good with manual processes that there

isn't much more opportunity out there, but I'm optimistic," Settle says. "We're currently collecting close to 2% of net revenue on an annualized basis."

More accuracy

With the new tool, registrars will be able to explain to patients exactly how an estimate was calculated.

"Right now, we can see the deductible through our eligibility system, but staff don't necessarily know what the contracted rate is," says Settle. If a patient with a $5,000 deductible is having major surgery, the entire deductible will be collected, but if it's a minor surgery, staff will estimate a lower amount to be sure they're not overcharging the patient.

"We are estimating on the low side," Settle says. "But if we ask for $1,500 and the patient ends up owing $2,200, we sometimes never get paid the remainder." Estimates now will be closer to what the patient actually will owe, she says.

"Staff right now go to multiple payer websites and, even then, sometimes can't find the answers they need," she says. "We have a lot of patients who travel here from all over the country. If they have a smaller insurance plan, it's a real challenge to determine what's going to be owed." ■

$150M in charges paid due to process

Pre-arrival nurse acts as liaison

A new pre-arrival unit at University of Mississippi Health Care in Clinton has revamped the authorization process for services that are pending authorization, reports **Sylvia Greer**, MBA, associate director of revenue cycle management. The hospital has obtained $150 million in revenue for reimbursable services, she adds, many of which would have otherwise been denied by payers.

The main focus of the pre-arrival unit is to financially clear patients prior to receiving services, says Greer, with staff handling pre-registration, pre-admission, insurance verification, benefit eligibility, and pre-authorization/pre-certification.

In 2011, the pre-arrival unit had a less than 1% denial rate due to no authorization or non-covered benefits, says Greer, with 63% fewer overall denials.

"Previously, authorization work was sparsely performed, resulting in many claims being denied," says Greer. "We have implemented a standardized, quality-driven authorization processes for an ever-changing payer environment."

Tougher criteria

Until recently, the authorization process was fairly simple for imaging services such as CT scans, magnetic resonance imaging (MRI), and positron emission tomography (PET) scans, but this simplicity is no longer the case, according to **Hope Johnson**, RN, the pre-arrival unit nurse.

"Payers are now enforcing more stringent guidelines and criteria for authorizing services, including procedures that may be routine," Johnson says.

More payers are using third-party vendors to authorize services, says Greer, which makes the process even more cumbersome. To reduce claims denials, a pre-arrival unit was created, with specific employees working under Johnson's direction. Each employee is assigned to work specific types of denials, such as authorizations, coordination of benefits, and eligibility, which has reduced non-reimbursement of services, says Greer.

Johnson acts as a liaison between the payer and the clinician, in order to obtain clinical information submitted to the payer promptly. "The information may not be in our system, and the nurse in the doctor's office may not easily give it out," she explains. "Once they realize how important it is, they want to be sure the patient is not responsible for the bill."

If the patient has an MRI of the lumbar spine, for example, the payer will want to know the complete history and physical before approving the test, says Johnson. The payer also will want to know that the patient has exhausted all other options, she says.

"They want to make sure the patient has tried everything else prior to getting the MRI: physical therapy, pain management, and medications," she says.

That information isn't always in the provider's medical charts, which means Johnson must contact other provider offices where the patient has received treatment.

If the payer's physician wants to speak with the patient's physician directly, Johnson facilitates this con-

EXECUTIVE SUMMARY

A pre-arrival unit revamped the authorization process at University of Mississippi Health Care, which resulted in more than $150 million in reimbursable services collected, with a denial rate under 1%. Denials were cut by 63% by making these changes:

- Each employee is assigned to work specific types of denials.
- A pre-arrival nurse acts as a liaison between the payer and the clinician.
- Clinical information is submitted to the payer promptly.

versation.

"All of the notes may be in there, but the doctor who is looking at this from the insurance company wants to know why the doctor ordered a certain test," she says. "Most of the time when they talk, then the case is approved."

SOURCES

For more information on processes to obtain required authorizations, contact:

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• **Hope Johnson**, RN, Appeals Coordinator, University of Mississippi Health Care, Clinton. Phone: (601) 926-3802. Fax: (601) 926-3821. Email: hrjohnson@umc.edu. ■

Alert! Access areas at high risk for fraud

Protect patient information

Could a patient standing in front of you be using another patient's ID and insurance to obtain care? Is someone stealing a patient's information to obtain credit fraudulently? These areas are the primary risk in registration areas, according to **Dan Schulte**, executive vice president of revenue cycle solutions at The Outsource Group in St. Louis, MO.

Schulte recommends that patient access leaders take these steps:

• Store all patient-identifying information under lock and key in a secure office, and not in bins or trays.

"Registration forms with demographic information or insurance information should be signed and then secured," says Schulte.

The best practice is to eliminate the permanent paper record by scanning and then destroying paper forms, he advises, or using digital solutions entirely, including digital signature devices.

• Immediately move any document with protected health information (PHI) away from any area easily accessed by the public.

If a registrar is interviewing a patient at the counter or in a booth, he or she should enter data with the computer screen situated so the public cannot see it, print on a printer away from public access, and immediately obtain any printed forms for immediate signature and proper disposition, says Schulte.

• Manage all financial information in a private office.

Payments, credit card information exchange, receipts, charity care applications, pay arrangements, and promissory notes are not for public domain, warns Schulte.

"These transactions have the highest threat of identity theft," he says. "Complete these tasks in a more private area."

• Ensure that policies and processes are clearly understood regarding Red Flag Rules and other identity-related issues.

"These should be as important to patient access as the Fraudulent Claims Act is to the billing group in the business office," says Schulte.

Each group needs to develop a "visible culture of compliance," in which identifying problems, fixing them, and preventing future problems is an everyday occurrence, he says.

"This will take a commitment from top to bottom in the organization," he says. "It will require resources to educate, monitor, support, and counsel every employee on a regular basis."

• Identify every patient being registered with a legitimate ID card.

"Unless the patient is a clearly defined emergency or urgent care patient, the patient's ID should be clearly established before treatment begins," says Schulte. *(See related stories on penalties of non-compliance, below, and validating a patient's identity, p. 56.)*

SOURCES

For more information on preventing fraud in registration areas, contact:

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• **Dan Schulte**, The Outsource Group, St. Louis, MO. Phone: (314) 692-6500. Email: dschulte@togarm.com. ■

EXECUTIVE SUMMARY

Patient access areas are at risk for unintentional fraud due to patient identity theft, privacy breaches, and stolen protected health information (PHI). To avoid penalties:

- Avoid storing documents with PHI in bins and trays.
- Keep documents with PHI away from any areas accessed by the public.
- Prohibit staff from overriding patient demographic information.

Check security of `up front' areas

Penalties are very high

Unintentional fraud can take many forms in patient access areas, including some involving protected health information (PHI), says **Dan Schulte**, executive vice

president of revenue cycle solutions at The Outsource Group in St. Louis, MO.

"Patient access areas are up front in the organization," he says. "Each entry point multiplies the opportunity for identity theft. Hospitals need to rigorously maintain the same level of security at every site."

The Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) are federal laws that allow the courts to assess civil monetary penalties ranging from $100 to $50,000 per violation, with an annual limit of up to $1.5 million.

These same laws permit a judge to assess up to five years in prison for criminal acts regarding privacy breaches, he warns. In addition, states' attorneys general can levy fines and assign attorney costs to the convicted defendant.

There are hundreds of examples of lost and stolen PHI in the news, including a national drugstore chain penalized $2.25 million for mishandling its PHI, and another group fined $100,000 for losing laptops and data files, says Schulte. "These fines are the direct result of a lack of discipline regarding PHI," says Schulte. "Criminal activity by employees will reflect negatively on hospitals, as well."

The False Claims Act, the Civil Monetary Penalty Laws, HIPAA, and HITECH have significantly increased the need for careful stewardship of data in healthcare, with a growing ability for the government to impose severe sanctions on accidental and intentional violations of patient privacy, says Schulte.

"Healthcare has seen a consistent increase in regulatory policy since the early 1990s, as an outgrowth of audits and fallout from the aerospace and banking industries' failure to establish compliant cultural environments," Schulte says. ■

Validate patient info at registration

Reduce threat of identity theft

Registrars at St. Luke's Episcopal Hospital in Houston, TX, are using a tool to validate a patient's identity using name, date of birth, address, and social security number during the registration process, reports **Na Toshia Joseph**, manager of patient access services/quality and process improvement.

"Utilizing this tool has helped with minimizing the threat of identity theft and the possibility of a HIPAA [Health Insurance Portability and Accountability Act] breach," she says.

Registrars are required to use secured shred bins for all documents containing protected health information (PHI), she adds. "Unfortunately, there are unique situations in which patient access could potentially provide PHI unintentionally," says Joseph. She gives these examples:

• Patients with the same name, or same date of birth, might have the same insurance carrier.

Prohibit the staff from overriding patient demographic information, advises Joseph. "Staff are required to validate all responses received from our validating patient identity tool before making any changes to the registration," she adds.

The hospital's Admit/Discharge/Transfer system warns registrars if there is a patient existing in the system with a social security number they are trying to use for a different patient, she adds.

"This should always prompt the registrar to ask more questions of the patient," she says.

• Patients might receive registration paperwork and face sheets that belong to another patient.

A busy registrar might inadvertently give the wrong paperwork to the patient, says Joseph, who adds that the department has taken several steps to be sure this mistake doesn't happen.

First, registrars are required to review all signed consent forms before giving the patient a copy. Also, registrars are allowed to give the patient only the face sheet during the registration process to confirm the accuracy of the data entered.

"We are prohibited from giving patients face sheets to keep for their records," says Joseph. ■

Win the loyalty of physician offices

Make their patients much happier

Often, physician offices aren't aware of the differences between hospital insurance requirements and provider requirements, which creates tension between the two areas, says **Kellie Hawkins**, director

EXECUTIVE SUMMARY

Patient access can improve relationships with physician offices by making the registration process easy for their patients.

- Teach providers about insurance guidelines and scheduling/registration processes.
- Complete everything that is necessary before the patient's visit.
- Work directly with the patient to save time for the provider.

of patient access for Shady Grove Adventist Hospital in Rockville, MD.

Physicians might be confused about the requirements of health maintenance organizations, medical assistance plans, and managed care organizations, for example, because these can differ from requirements of outpatient surgical centers.

"Participating physicians frequently don't need an authorization or pre-certification to perform procedures at an outpatient surgical center," Hawkins explains. "However, if the physician is scheduling the procedure at a hospital versus a surgical center, the facility may need an authorization number to ensure payment."

Patients more satisfied

"The relationship between providers and the patient access department can be challenging," acknowledges Hawkins. "But various forms of communication, at key moments, can lead to a great experience."

The key to a provider's heart is often through the customer, says Hawkins. "Many times, the registration process is seen as a necessary evil," she says. "Providing an excellent experience for the patient is a sure way to earn a provider's loyalty."

Hawkins recommends taking these steps to improve relationships between patient access and providers:

• Work directly with the patient.

"As the patient access representatives work with specific customers, providers often find themselves in the middle of the conversation," says Hawkins.

Patient access can remove some of that workload for providers by working directly with the patient to do scheduling, verifying insurance, and setting up payment options, she suggests. "This can be a huge time-saver for the provider. It reduces the back and forth needed when a third party is involved," she says.

• Complete everything that is necessary for the patient's visit prior to the date of service.

This step might include phone or online pre-registration, verification of benefits, insurance authorization, administrative consent, and patient financial responsibility, says Hawkins. It allows the patient access team to "fast-track" patients, she says.

"The patient can bypass the facility's registration area entirely and go directly to their destination for care," she says. "Both patients and physicians ask about this feature when planning for an upcoming appointment at the hospital." *(See related story, above right, on giving in-services to provider offices.)*

SOURCE

For more information about improving satisfaction of physician offices, contact:

• **Kellie Hawkins**, Director, Patient Access Department, Shady Grove Adventist Hospital, Rockville, MD. Phone: (240) 826-6299. Fax: (240) 826-5383. Email: khawkin2@adventisthealthcare.com. ■

Teach providers about your role

It's worth the effort

Take the time to provide training to provider offices about insurance guidelines and registration processes, because this training is a good way to encourage collaboration with patient access, recommends **Kellie Hawkins**, director of patient access for Shady Grove Adventist Hospital in Rockville, MD.

"This ensures both the provider and the facility are getting everything needed to care for the patient and to receive payment," Hawkins says.

The in-service also puts a face with the voice at the end of the phone, which encourages better communication and teamwork, she adds. Hawkins recommends you take these steps:

• Schedule in-services early in the morning before office hours or mid-day when many offices close.

"Tying the in-service into a scheduled staff meeting can be very convenient for the office," Hawkins says.

• Provide refreshments.

"This is a nice touch and creates a collaborative atmosphere," she says.

• Use a roundtable discussion format.

"This creates a two-way conversation. Questions surface that may not have been on the original agenda," says Hawkins.

• Invite front-line staff from patient access and the provider office.

"They are important contributors, and should be represented," she says. "They can provide real-life scenarios and focus problem-solving discussions on solutions that fit the workflow." ■

Need a solution? Just ask your staff

Staff can ID necessary changes

Patient access leaders at St. Elizabeth Community Hospital in Red Bluff, CA, are improving satisfaction by using feedback from newly created "transfor-

EXECUTIVE SUMMARY

Patient access employees can provide valuable input on necessary process changes in your department.
- Create teams of employees to collect suggestions.
- Ask staff how interruptions can be avoided.
- Involve employees when analyzing communication problems.

mational care" teams.

"The benefits will be better quality care for our patients," says **Vicki Sanseverino**, admissions manager/patient financial services liaison. "Sometimes the best ideas for change come from employees. When something is employee-driven, it may be better accepted."

The team members, who are all employees and not managers, collect ideas and suggestions from the entire staff for improvements. "There are so many changes that are management-driven or rolled out on a corporate level," she says. "Employees often feel we do not take their opinions into account."

Ask staff for solutions

When a radiologist at St. Joseph's Wayne Hospital/St. Joseph's Regional Medical Center in Paterson, NJ, needs to verify if the insurance is complete before giving a CT scan with contrast, he or she contacts a manager instead of the pre-registration staff person.

This change was suggested by a patient access employee who noticed that staff members were being interrupted by calls from the radiology staff when they were with patients, says **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access. "This allows the manager to be able to identify who is available to review the case and is not with a patient," she says.

Rivera routinely involves her staff when any communication or process issues need to be resolved in the department. "It is important to make them a part of the solution," she says. "At the end of the review, we will have one 'takeaway' that we all agree on."

It is easier to implement changes if staff members are included in the process, adds Rivera. "It allows the staff to have a better understanding of all the moving parts to the system," she says. "Our goals as an organization are not negotiable, but how we get there can be."

SOURCES

For more information on obtaining input from patient access employees, contact:
- **Sandra N. Rivera**, RN, BSN, CHAM, Director, Patient Access, St. Joseph's Wayne Hospital/St. Joseph's Regional Medical Center, Paterson, NJ. Phone: (973) 754-2206. Email: riveras@sjhmc.org.
- **Vicki Sanseverino**, Admissions Manager/Patient Financial Services Liaison, St. Elizabeth Community Hospital, Red Bluff, CA. Phone: (530) 529-8065. Fax: (530) 242-5419. E-mail: Vicki.Sanseverino@chw.edu. ■

Employees differ in training needs

Work with individual learning styles

If you stick to one teaching style for all of your patient access staff, this process can result in poor morale, warns **Tracy Abdalla**, assistant manager of hospital access services at University of California -- Davis Medical Center Hospital.

"They can become very disenchanted with the process, because they aren't understanding what you're teaching," she says. "By working with their learning style, you'll make them feel more comfortable."

Some registrars learn best by jumping in and working hands on, while others would rather see others do the job or read step-by-step instructions, says Abdalla.

Training might entail use of practice systems that allow the user an opportunity to complete the task without fear of making errors with active patient data, she notes. "For those who need to hear or read the information, we utilize PowerPoint presentations and classroom training, and we provide support documentation with training manuals," she says.

Here are some methods Abdalla uses to train her patient access staff:

• She works alongside the employee to determine his or her learning style.

"While working alongside of new employees, I'm able to review the type of notes they may be taking," says Abdalla. "Do they write down information word for word, or do they jot it down with bullet points?"

Those who write it down with bullet points often learn best by completing tasks hands-on, says Abdalla. Thus, she moves to the side and talks them through the process while they complete it.

EXECUTIVE SUMMARY

Use different teaching styles for patient access employees, depending on the way they learn best.
- Provide classroom training to staff members who need to hear or read information.
- If employees use bullet points to record information, allow them to complete tasks while you observe.
- Offer manuals or computerized graphic presentation to detail-oriented employees.

Employees who write information down with the details tend to re-read their notes and often do best by reading the manuals or viewing computerized graphic presentations, says Abdalla.

• She emphasizes the personal connection to patients.

"Show them that the job is not just paper, insurance information, and computers, but people," she advises. "Remind them the people you're dealing with today could be you or your loved one tomorrow."

• She partners new hires with experienced staff.

These staff members will share shortcuts to completing processes and show their own way of performing certain tasks, says Abdalla. For example, registration can be completed by writing patient data on a face sheet, then returning to a work station to type the same data into the registration system, she says. However, it also can also be done by using bedside computers or mobile workstations so the registration is entered into the computer, Abdalla says.

Experienced staff members can demonstrate to new hires that while insurance eligibility can be verified by phone one patient at a time, insurance web sites can be used to verify several patients at one time using a batch eligibility process.

"This will help the new hire to see that it's possible to complete the same task in several ways," Abdalla says. "They will eventually adapt the best practices from each person, to develop their own rhythm in the registration process." *(See related story on using a QA tool for training, below.)*

SOURCES

For more information on training patient access staff, contact:

• **Tracy Abdalla**, Assistant Manager, Hospital Access Services, University of California — Davis Medical Center Hospital. Phone: (916) 734-3282. Fax: (916) 734-0550. Email: tracy.abdalla@ucdmc.ucdavis.edu.

• **Deborah L. Brown**, CHAA, Education Coordinator, Quality Assurance and Staff Development, Medical University of South Carolina, Charleston. Phone: (843) 792-3808. Fax: (843) 792-0108. Email: hutchind@musc.edu. ■

Use QA tool to train staff

Needs of employees vary

A patient access employee working in central admitting has different training needs from someone working in radiology, the emergency department, or same-day surgery.

Deborah L. Brown, CHAA, education coordinator for quality assurance and staff development at Medical University of South Carolina in Charleston, uses an automated quality assurance (QA) tool to see where each individual employee is having difficulty, so she can customize training.

"This has become more important due to so many different areas of patient access," she says. The QA system has dramatically reduced errors, which in turn has reduced claims denials, reports Brown. "Having this system, with rules that we write, has become a wonderful teaching tool," she says. "How are you going to know if you are doing something incorrectly, unless you are shown?"

Staff give input

As part of their annual review, members of the patient access staff are required to participate in quarterly training and testing on topics such as Medicare as secondary payer completion, insurance, and customer service.

"With so many changes taking place in healthcare and the more we are asking our patient access team to do, it can easily become overwhelming," says Brown. "It is easy to become complacent in our everyday jobs. Refreshers help to keep our tasks upfront."

To determine the training topics, Brown reviews actual claims denials and also asks staff members what they would like to review.

"Providing continuing education and training has helped to build staff confidence," she says. "This gives back tenfold to our patients, visitors. and fellow team members." ■

Staff members' roles are made more specific

Two years ago, patient access leaders at Hackensack (NJ) University Medical Center "had everyone doing everything," says **Anne Goodwill Pritchett**,

COMING IN FUTURE MONTHS

■ Simple ways to wow patients with excellent service

■ Prepare staff now for switch to ICD-10 coding

■ Dramatically reduce high-dollar claims denials

■ Offer registrars incentives for cash collections

EXECUTIVE SUMMARY

The patient access department at Hackensack (NJ) University Medical Center was restructured to assign team members to specific functions, with these benefits:
- Staff developed expertise in specific areas.
- Point-of-service collections have increased.
- Training became easier because it is customized.

MPA, FHFMA, vice president of patient financial services. "We found that for us, that was not the best way to do it."

Supervisors previously were responsible for all access roles, but two years ago the department was restructured so that a group of team members is assigned to specific functions, says Goodwill Pritchett. "The people who were performing specific duties the majority of the time were the ones we picked to handle those duties 100% of the time," she says. "Some wanted to do something else, and we were flexible to the extent we could be."

The change allowed staff to develop expertise in specific areas of patient access. "We are not all comfortable performing the same roles. Now everybody can become an expert in the duties they are performing," says Goodwill Pritchett.

While some staff members are responsible solely for informing patients of expenses and collecting; others only verify the patient's benefits and determine out-of-pocket expenses, she explains. This change resulted in increased point-of-service collections, in part because some employees were just not comfortable asking patients for money, she says. "Collections was not something we had done consistently over the years," Goodwill Pritchett says."We selected the people with the right skill sets who were comfortable doing that."

The top five patient-staff interactions were identified, and scripting was created for each scenario, with customized training. For example, collections training is only provided to those individuals responsible for collecting.

"It became much easier to train," Goodwill Pritchett says. "If you have 50 staff, and you only need five of them to handle collections, there's no reason to train everyone in how to collect."

SOURCE

For more information on patient access roles, contact:

• **Anne Goodwill Pritchett**, MPA, FHFMA, Vice President, Patient Financial Services, Hackensack (NJ) University Medical Center. Phone: (201) 996-3364. Email: AGoodwillPritchett@HackensackUMC.org. ■

HAM publisher launches *Hospital Report* blog

For further analysis and discussion of topics important to hospital professionals, check out *Hospital Report*, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com. Hospital Access Management executive editor Joy Daughtery Dickinson contributes. ■

HIPAA Regulatory Alert

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

HIPAA compliance audits begin with a pilot program

You should prepare now — Documents are due 10 days after notice

As promised by the Department of Health and Human Services' Office for Civil Rights (OCR) and mandated by the HITECH Act, HIPAA compliance audits have begun, and 20 organizations were visited during the pilot phase of the program.

"Hospitals selected for the audit have to provide a lot of documentation in a short timeframe," explains **Adam Greene**, partner at the Washington, DC, law firm of Davis Wright Tremaine and a former OCR official. In addition to the expected policies and procedures related to privacy and security, auditors want to see current risk analyses and documentation related to improvement of data protection, he adds. *(See related story on documentation tips, p. 2.)* "Be aware that the audit's scope extends past electronic health records and covers privacy and security of data in clinical, research, and billing departments, as well as employee use of email and text messaging."

From the time of notification of an audit, you have 10 calendar days to provide all of the documents requested, says **Mac McMillan**, chief executive officer of CynergisTek, an information technology security consulting company. McMillan advised a Texas hospital included in the initial audit.

Because initial documents requested also include non-HIPAA specific items such as demographic information about a hospital's market and patient population, and an organizational chart, prepare ahead of time by knowing where these documents are located, he suggests.

The audit is scheduled between 30 and 90 days from the date of the notice, but OCR does give five days' notice before auditors arrive, says McMillan. "Actually, my client got eight days' notice, which helped us make sure everyone who was likely to be interviewed by auditors, or involved in the audit, was onsite during those days." OCR estimates audits to take 3-10 days, depending on the organization being audited. McMillan says his hospital client's audit was one week long. *(Learn what to expect during an audit, p. 3.)*

Because you do not have a lot of time to educate people who may be involved in the onsite audit, set up your audit team now, suggests **Chris Apgar**, CISSP, president of Apgar & Associates, a Portland, OR-based consulting firm. "This will make preparation for the audit easier because everyone will understand their role." *(See how to set up an audit team, p. 3.)*

Results of the 20 audits conducted during the pilot program will be used to evaluate the audit tool as well as the audit process, and to make changes if needed before the remaining 130 audits scheduled for 2012 are conducted after the pilot program's completion in the spring, says Apgar. Although larger organizations such as health plans, claims clearinghouses, and larger hospitals expected to be audited earlier rather than later in the process, the pilot program included a dental office, a long-term care facility, and a pharmacy. "I am sure these smaller organizations were surprised at their inclusion, but it is important to smaller providers that the pilot included them," he says.

EXECUTIVE SUMMARY

At press time, results of the HIPAA compliance audit pilot program and any resulting changes in the process or the audit tool were expected to be finalized in the spring. Lessons learned by organizations in the pilot phase of the program include:

- Identify and locate key HIPAA policies, procedures, and documentation. Develop a system that ensures quick access before you receive the 10-day notice to provide information.
- Have an up-to-date risk analysis related to privacy and security rules.
- Evaluate your business associate program to ensure you have documented your management of those relationships.
- Establish your HIPAA compliance audit team, and assign specific responsibilities before your receive an audit notice.

OCR auditors and staff members will be able to ensure that the audit tool is practical for smaller as well as larger organizations, which will help small hospitals, specialty hospitals, and freestanding surgery centers, he adds.

Prepare now

Although there is no way to know if your organization will be one of the 130 additional audits conducted in 2012 or in upcoming years, you can take steps now to prepare, suggests McMillan.

"Even if you don't know exactly what documents will be requested in your initial notice, there are a number of items that can be expected," he says. "Ten calendar days is not a lot of time to gather documents, so the first step is to know where everything is located."

Apgar says, "You don't have to centralize all policies and documentation related to HIPAA privacy and security issues, but you do need to have a way to quickly access them."

Assigning the responsibility to one or two people and creating an index of all documents that might be requested is a good start, he says. Identify the documents, their location, and contact information for the people who can access them easily.

Be sure you have a current risk analysis, says Apgar. "The rule does not specify how often a provider must conduct a risk analysis, but a good guideline is annually or whenever there is a change that might affect security risk levels," he points out. Adding a new business associate or introduction of a new system such as electronic health records are points at which a risk analysis should be done, he says.

Along with the documentation of the risk analysis, auditors will want to see corrective action plans and data to show progress in remediation of areas that were identified as non-compliant, says Greene. "This is very important if the hospital is aware of a potential weakness in compliance," he says. "Demonstrate to auditors that you are aware of the issue, have identified steps to correct it, and are making progress."

McMillan says, "Pay close attention to how you manage your business associate relationships, and document your efforts to carefully control information released to them. This requires more than showing a copy of an agreement. Document due diligence related to flow of information, procedure for termination, and process to jointly handle breaches." *(For information about business associates and HIPAA, see "Data breaches attributed to business associates increase,"* HIPAA Regulatory Alert, *March 2012, p. 1.)*

Set up an audit team

"OCR has hinted that there will be no hesitance to levy fines on non-compliant organizations identified in the audits," says Apgar. These fines will be used to support the audit program, so although it was originally described as a non-punitive program, it is important to take the process seriously to avoid potential fines, he adds.

Because the HITECH Act has given OCR the ability to assess significant financial fines, this is not the time to play the odds, warns Greene. "Although your chance of being one of the 130 organizations audited this year is small, look at this as a way to get your house in order," he says. "Perform a thorough assessment, make sure your HIPAA training programs are effective, and even if you prepare for an audit that doesn't happen, your hospital and your patients benefit."

SOURCES

For more information about preparation for HIPAA compliance audits, contact:

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- **Mac McMillan**, Chief Executive Officer, CynergisTek, 8303 N. MoPac Expressway, Suite 128B, Austin, TX 78759. Phone: (512) 402-8555. Email: mac.mcmillan@cynergistek.com. ■

Get these documents ready for an audit

Although there is no way to know exactly what documents you will be asked to provide in the initial HIPAA compliance audit notice from the Department of Health and Human Services' Office for Civil Rights (OCR) there are some items you can expect to see on the list, according to experts interviewed by HIPAA Regulatory Alert:

• all policies related to compliance with HITECH privacy and security requirements;

• documentation of risk analysis for the organizations;

• business associate agreements and documentation of provider management;

• HIPAA training program for employees;

• names of compliance officers along with organizational chart for the provider;

• demographic information about the hospital, the patient population, and the medical staff.

Some of the documents you should also be prepared to provide include:

• List of terminated employees as well as new hires.

"This list will be used by the auditors to see how well you disable access for terminated employees and control access to protected health information for new employees," explains **Mac McMillan**, chief executive officer of CynergisTek, an information technology security consulting company, who advised a Texas hospital included in the initial audits. Although you might have a policy that describes the process, this list will give auditors an opportunity to see if your actual practice follows the policy.

• Proof of employee training on privacy and security requirements.

Having a HIPAA training program and proving that employees receive the training are different things, points out **Adam Greene**, partner at the Washington, DC, law firm of Davis Wright Tremaine. Your documentation should describe the content of the training program, who provides the training, and how you ensure that all employees are trained, he adds.

• List of complaints related to privacy.

Be prepared to share a list of complaints you've received from patients, family members, or employees about data privacy or security issues, says Greene. Documentation should include the complaint, who handled it, how it was handled, and how it was resolved.

There are also some documents you should choose to include, suggests Greene.

• Description of your best practices.

"The audit contract calls for identification of best practices, so if you know you have an effective poster campaign or HIPAA hotline, provide documentation of the program's success," suggests Greene.

• Improvement plans related to privacy and security.

Almost all risk analyses result in identification of areas that can be improved, points out Greene. "If you know you have a weakness, don't try to hide it and hope the auditors don't notice," he says. "Provide documentation of a plan to address a non-compliant area, show that you have prioritized the issues, and provide the results of evaluations of your efforts to come into compliance." ■

What can you expect when auditors arrive?

The initial notice of audit from the Department of Health and Human Services' Office for Civil Rights (OCR) asks for a significant amount of documentation and information to be submitted within 10 days of the notice date, but that will not be the end of information for which you'll be asked, says **Mac McMillan**, chief executive officer of CynergisTek, an information technology security consulting company, who advised a Texas hospital included in the initial audits.

"A pre-audit conference call is made a minimum of five days before the visit," explains McMillan. His client's audit occurred six weeks after the initial notice, but it could have been scheduled anytime during a 30-90 day period from the date of the notice, he says. During the conference call, additional documentation and a list of people with whom the auditors want to meet is provided. "The call is helpful because you can make sure your key people are onsite when the auditors arrive and prepared to meet with them," McMillan adds.

His client provided a conference room for the auditors to use during the visit and gave them guest privileges on the hospital's wireless network, he says. "The privacy and security officers cleared their schedules so they were available to the audit team the entire week," he explains. In addition to the privacy and security officers, make sure other administrative and medical staff leaders are aware of the audit and are prepared to meet with auditors, he suggests.

Auditors did walk around the facility, says McMillan. "Let your entire staff know the auditors will be onsite and that they may talk with employees at any time," he says. The walking tour and talks with employees are two ways the auditors can check to see if the hospital policies are communicated and understood by all employees.

Remember that an auditor's job is to uncover weaknesses, points out McMillan. "After you submit your initial documentation, you don't know if the auditors are going to audit your entire program or focus on specific areas," he says. They have the option of conducting the audit either way, he adds.

Immediately following the onsite visit, the hospital received an outline of audit results along with specific areas in the privacy and security rules in which the hospital was deficient, says McMillan. "This outline gives hospital leaders a good idea of what the final report will include," he says. "The hospital had 10 days to respond to the final report and provide any additional documentation that demonstrated compliance." ■

Do now: Set up in-house audit team

A well-prepared team that understands roles and responsibilities when a notice of a HIPAA compliance audit is received is essential for every

organization and should be established long before a notice is received, suggests **Chris Apgar**, CISSP, president of Apgar & Associates, a Portland, OR-based consulting firm. Educate them about the purpose of the audit, and give each person specific responsibilities, he says.

"Define who the caretakers of the auditors will be when they are onsite, and make sure they understand their role in the audit," Apgar says.

One way to test your documentation index and the effects of your audit team's education is to conduct a "fire drill," recommends **Adam Greene**, partner at Davis Wright Tremaine, Washington, DC. Deliver a mock audit notice to the administrative offices. If plans go well, the chief executive officer is immediately notified that the letter has arrived and requests for information are disseminated quickly. "Making sure the letter doesn't sit unopened on someone's desk is important," Greene points out.

Set a deadline of gathering all requested documents in 6-7 days from the date of the notice so you have time to identify missing items.

In addition to testing your ability to respond to the audit notice in 10 days, conduct a mock HIPAA compliance audit throughout your organization, suggests Apgar. Don't focus only on policies and procedures, or the information technology department, he says. "Auditors are likely to walk throughout your facility, in multiple departments, so take your own walk through the hospital," he says. "Look for shared computers that have passwords on notes taped to the monitor or screens that can be easily read by members of the public," he says.

Mac McMillan, chief executive officer of CynergisTek, an information technology security consulting company, says, "Make sure all employees understand your privacy and security policies and the purpose of the audit. The greatest risk in a HIPAA compliance audit is not your information technology staff; it is other employees." ■

Proposed rules published for stage 2 meaningful use

Comment period ends May 7, 2012

The Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS) have issue Notices of Proposed Rulemaking that are open for comment until May 7, 2012.

The CMS proposed rule applies to stage two of the "Meaningful Use" rule and new requirements that participants in the Electronic Health Record (EHR) Incentive Programs will have to meet to demonstrate meaningful use in the program. The companion ONC rule discusses the certification capabilities and standards and tests that Certified EHR Technology (CEHRT) would have to do. Although the two rules overlap some, they are different.

A few of the items included in the proposed rule include:

- Nearly all of the Stage 1 meaningful use core and menu objectives would be retained for Stage 2 meaningful use.
- "Provide patients with an electronic copy of their health information" objective would be removed because it would be replaced by an electronic/online access" core objective.
- For eligible hospitals and CAHs, the set of CQMs beginning in 2014 would align with the Hospital Inpatient Quality Reporting (HIQR) and The Joint Commission's hospital quality measures.

The proposed rule for Stage 2 Meaningful Use also includes a minor delay of the implementation of the onset of Stage 2 criteria from the current 2013 implementation date to 2014.

To access the CMS proposed rule, "Medicare and Medicaid Programs: Electronic Health Record Incentive Program-Stage 2 Meaningful Use," go to federalregister.gov/a/2012-4443.

To access the ONC proposed rule, "Health Information Technology; Implementation Specifications, and Certification Criteria: Electronic Health Record Technology, 2014 Edition," go to federalregister.gov/a/2012-4430. ■

Consumer privacy is subject of FTC report

The Federal Trade Commission (FTC) has issued a final report outlining best practices for businesses to protect the privacy of American consumers and give them greater control over the collection and use of their personal data.

The report proposes a privacy framework that would have no legal effect on HIPAA-covered entities. However, some of the practices proposed in the report, such as automated mechanisms to track access of information and restoration of patient consent to sharing information, might be considered as the Department of Health and Human Services updates the HIPAA privacy rule to incorporate more stringent privacy protections.

To see a copy of the report, go to http://1.usa.gov/H3LgcC. ■

Hospital Access Management

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

2012 Reader Survey

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

Please fill in the appropriate answers or write your answers to the open-ended questions. Return the questionnaire and answer sheet in the enclosed postage-paid envelope by **July 1, 2012.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25. To what other publications or information sources about access management do you subscribe?

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

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

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

28. What is the highest degree that you hold?

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

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

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

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

32. What issues would you like to see addressed in *HAM*? _____

Contact information _____