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AHC Media

Patients want self-service, but they aren't finding it in access areas

Online options are 'severely lacking'

Customers can obtain self-service at gas stations, airports, supermarkets, libraries, and retail stores, but not at the vast majority of hospital registration areas.

"Patients are getting used to having access to all sorts of things online in other areas. To date, healthcare facilities are being given a free pass," says **Mitch Mitchell**, president of T.T. Mitchell Consulting, a Liverpool, NY-based consulting firm specializing in revenue cycle and technology.

Self-service registration options "are increasing for sure, but not as much as you might think," says Mitchell. "Hospitals are missing out on another way of promoting great customer service, by not opening up more ways for their consumer base to interact with them."

There is clear demand for alternative options to schedule and pre-register for medical tests, says **Daniel Thiry**, managing principal of Revenue Cycle Solutions in Pittsburgh, PA. This demand is especially seen at facilities where most patients schedule tests themselves instead of going through referring physician offices and where the patient population includes a younger, more computer-savvy group, he says.

While some patient access departments do allow patients to pay account balances online and send feedback by email, "there's still a lot missing," says Mitchell. "Most hospitals have a web presence because they feel the need to be online. But after that, they're severely lacking in so many areas."

EXECUTIVE SUMMARY

Patients increasingly want self-service options, such as online registration and appointment scheduling, but few patient access areas offer these. To meet the needs of patients:

- Allow patients to verify information online instead of over the phone.
- Email patients with a link to confirm appointments.
- Have registrars actively promote kiosk use.

"Online scheduling would be great. Patients could select their own times for certain types of procedures based on what's available, especially since often they can't get to a phone during the day to make appointments," says Mitchell, who adds that this service rarely is offered.

At Ochsner Medical Center in New Orleans, the previous system used by the patient access department allowed patients to do some online scheduling, but the recent implementation of a new electronic medical record gives patients more access to the providers' schedules. "Our first facility went live on Epic in November 2011, and as we bring our other facilities live on the system, we encourage all of our patients to sign up for the online services," says Beler.

When a patient attempts to make an appointment through Ochsner's Patient Portal, he or she is asked to enter demographics and insurance information. "Once this information is entered, insurance verification can be started," says Dale Beler, director of patient access. "Completing authorizations and collection of pre-payments prior to arrival guarantees a quick and efficient registration."

If this information already has been entered, the patient can verify that it is correct and confirm it. Patients appreciate spending less time on hold waiting to speak to a representative, Beler says. "However, not all of our providers have open schedules, so some types of appointments cannot be scheduled through the portal," she adds.

Obstacles are many

Mitchell notes his own frustration with patient access areas using traditional mail instead of giving the option to respond online to requests for demographic and medical information.

"Sometimes the option is there to respond that everything they show me is correct," he says. "Other times, I have to fill everything in, including insurance information and medical history."

Also, Mitchell points to post-service surveys sent through the mail asking patients how the hospital experience went, not only with the department visited by the patient, but also the admissions process. "Truth be told, I don't always respond to those things, but I might be more encouraged if I could do it online and still maintain confidentiality," he says.

Concerns about violating patient privacy regulations are one obstacle for patient access areas asking for information via email, acknowledges Mitchell. "Hospitals need to guarantee protection of information they're given online, while still keeping up with the patients coming into the hospital," he says.

Other obstacles to "self-service" registration are lack of comprehensive staff training and the need to update financial clearance policies, says Thiry. "In our experience, cost is rarely a factor, if the health system has first taken the time to develop a comprehensive and robust patient intake process which meets all of the organization's customer service and reimbursement needs," he says.

If self-service options are offered to patients when current patient access processes are disjointed and lack a defined flow, this offer often exacerbates problems, warns Thiry. It is critical patient access areas first develop their desired intake process, and then

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select the best tools to support it, he says.

"An operational assessment is usually the best place to start," says Thiry. "This is the single best way to document current practices and identify ways to reduce expenses, increase revenue, and give better service."

A safe first step

Patient access departments should start asking for email addresses if they don't already, Mitchell says. The next step might be to send emails to those patients who have to book appointments, with a link they can use to confirm their appointments and verify that all information is correct.

"There's no real medical information that would be revealed, other than the department the person should be going to," he says. "It's a way to see how the community responds. If it turns out to be a big hit, then maybe administration would be convinced to look deeper into new technologies."

With Ochsner Medical Center's new electronic medical record system, email address is a suggested field for registrars. "This reminds all registrars to discuss with our patients the option of receiving information electronically," says Beler.

Kiosks are being considered by the department, but cost is an issue, she explains. "We are still reviewing the feasibility of this equipment," says Beler. "While I think everyone agrees that this will be the future state, we hope to help pave a path [to kiosks] by getting patients to utilize the patient portal."

Thirty says, "A very small percentage of our clients are utilizing the registration kiosks at this time. However, more are inquiring regarding the potential benefits. Use has been limited, but is steadily growing."

Kiosks would give patients a quick way to check in, verify their information, pay any balances due, and sign all necessary forms without intervention from a registrar, but some patients prefer to have human interaction, says Beler.

"There has to be a balance between new technology and good, friendly customer service," she says.
(See related stories on benefits of kiosks, right, promoting use of kiosks, p. 124, and assessing satisfaction with kiosks, p. 124.)

SOURCES

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40% of patients register at kiosks

Location is important

When two kiosks were first placed in a registration area at University of Wisconsin Hospital in Madison in late 2007, hardly anyone used them because patients had to walk by the registrars to get to them.

"It didn't take long to figure out that was not effective," says **Geralyn K. Murphy**, MHA, director of access services. "Patients would stand in line to see a registrar, and they either didn't see the kiosks, or didn't feel comfortable using them because there was nobody assisting them with this new technology."

Initially, only 3 to 5% of patients used the kiosks, but now about 30% of patients do so. Murphy attributes that change to moving the kiosks so that they're the first thing patients encounter and adding a "greeter/promoter" to help patients with the kiosks. "The fact that we have them in multiple locations also helps. Once patients use them in one location, there is a comfort level to use them in our other locations," says Murphy. Currently, 16 kiosks are in hospital registration areas, with an additional 17 budgeted for this fiscal year.

About 40% of patients choose to use kiosks at Vanderbilt University Medical Center in Nashville, TN, calculated by the average percentage of patients who tried to use the kiosk to check in compared to the overall number of patients checked in at the clinic, says **Kathleen Mandato**, MBA, PhD, director of Vanderbilt Medical Group Systems & Service Education Department.

However, clinics with patients having frequent return visits such as cardiology and rehabilitation have much higher utilization rates. "They have the process down pat, so they can just go and do their

thing," says Mandato.

ROI hard to measure

Return on investment (ROI) comes mainly from the additional time staff have to do preregistration and verification functions, which they previously didn't have time to address, says Murphy.

Mandato says that while it's been difficult to determine "hard and fast ROI," the kiosks clearly offset low staffing numbers in some patient access areas. "Many areas have vacant positions that they haven't been able to fill," she explains. "We've been able to weather that by having the kiosks."

Kiosks are especially helpful if registration areas happen to be short-staffed, says Mandato. "It helps keep front desk manpower at a minimum. It is very helpful if you are shorthanded on people," she says. "One clinic has an FTE who leaves early. The kiosk helps carry some of the weight so they haven't had to add an FTE." ■

Survey areas on kiosk satisfaction

85% want to continue

Recently, patient access leaders surveyed all 35 locations with kiosks at Vanderbilt University Medical Center in Nashville, TN, about their satisfaction with kiosks.

"We asked them if they were given the option, would they rather continue to use or eliminate the kiosk, and 85% said they would continue," says **Kathleen Mandato**, MBA, PhD, director of Vanderbilt Medical Group Systems & Service Education Department. Here are the survey items:

1. How satisfied are you to have a kiosk in your clinic? (Very satisfied, somewhat satisfied, neutral, dissatisfied)
2. Would you recommend the kiosk to other clinics that do not have one? (Yes or No)
3. How would you rate the benefits of having a kiosk? (Numerous benefits, few benefits, no benefits)
4. If you were given the option of continuing to use the kiosk(s) or eliminating the kiosk(s), which would you select? (Continue or eliminate)
5. How valuable has it been for the patients to use the kiosk? (Very valuable, somewhat valuable, neutral, not valuable)
6. How valuable has it been for your staff to have a kiosk in the clinic? (Very valuable, somewhat valuable, neutral, not valuable)
7. In your opinion, are the kiosks worth the maintenance and expense of having them? (Yes or No)
8. What are the benefits of having a kiosk?
9. What are the challenges of having a kiosk?
10. Is there a cost benefit to your clinic in having a kiosk? (Yes or No. If yes, please explain.)
11. Please add any additional comments for or against having a kiosk in the clinic. ■

New kiosk users welcome some help

Greeter role helps transition

Patients have an increased comfort level with kiosks compared with five years ago when these were first added to registration areas at University of Wisconsin Hospital in Madison, because more people have encountered kiosks elsewhere, reports **Geralyn K. Murphy**, MHA, director of access services.

Satisfaction hasn't been negatively affected by the kiosks, because patients can see a registrar if they choose, Murphy says. "This is an option for patients who are comfortable using it and patients we are assisting to become comfortable with it," she says.

When the kiosks first were added, a "greeter/promoter" role was created to help patients learn to use them. While the greeter won't recommend the kiosk to patients with an insurance or name change, because they need to see a registrar, he or she actively encourages other patients to give it a try with assistance.

"After several months, we thought patients would have established a comfort level and wouldn't need somebody there," says Murphy. "We took that person away, but the percentage of usage went down the very first week."

If a patient can't complete registration at the kiosk for any reason, the greeter steps in and registers the patient at her workstation. "It's the best of both worlds. During peak volumes. we have a productive staff person assisting patients," says Murphy. "But when it's not busy, she does other work that can be easily put down."'

Be patient-friendly

After kiosks were implemented, University of Wisconsin Hospital made these patient-friendly changes to encourage their use:

- Medicare as Secondary Payer questions were added for patients to view and answer.

"We have received feedback from patients that they like the privacy in answering these questions at the kiosk, instead of having that done by a registrar every time they come," says Murphy.

• Patients can pay copays and outstanding hospital and professional balances at the kiosk.

"Patients have favorably commented on that convenience," says Murphy.

• Patient soon will be able to call up their information more easily.

Patients can bring up their information by swiping their credit cards or entering their names, says Murphy. Soon they will be able to bring up their information even more easily with palm scanner technology that has been used for two years in registration areas.

• Infection control questions were added to pediatric clinic kiosks.

When the parent answers "yes" to any one of those, a medical assistant is autopaged, who immediately takes the patient from registration to an exam room, thereby avoiding contact with other patients in the waiting room, explains Murphy.

Less time waiting

Most patients see the kiosks as a way to avoid waiting in line, says **Kathleen Mandato**, MBA, PhD, director of Vanderbilt Medical Group Systems & Service Education Department. "It keeps the flow moving, especially for high-volume clinics," she adds. "It also alleviates some stress on the front desk staff. If they know the line is building, they can suggest using the kiosk."

Registrars are freed to spend more time with patients who really need face-to face assistance, adds Mandato. "Patients tell us they appreciate having more privacy when verifying demographics, versus saying the information out loud at the desk," she says.

Front desk staff are the ones who "make or break the whole process," says Mandato. "They are the ones looking at the waiting area to see what's happening. If they're not busy checking in a patient, they can come out to act in a concierge role." ■

Don't wait for patient to ask about costs —

Tell them upfront

Point-of-service collections at Advocate Illinois Masonic Medical Center in Chicago have increased by 294% since an electronic payment estimation tool was implemented in 2008, reports **Philip N. Quick**, CHAM, manager of patient access and bed management.

Registrars don't wait for patients to ask about their out-of-pocket expense; instead, they tell them upfront, he says.

"At the point of scheduling for any outpatient service, if the patient does not inquire about estimated price for their service, we'll automatically provide it to them, in addition to the estimated out-of pocket expense they may be responsible for," says Quick.

With this step, there are no surprises, either at the time of service or when the patient receives the statement, says Quick. "Chicago is well known for its competitive healthcare market. We put tools and processes in place early on, prior to healthcare reform," he adds. "We've been proactive in anticipating the shift in healthcare." Here is the department's current process:

• At the point of scheduling, patients are preregistered and given an estimate of what the service will cost.

• This information is supplied to the patient, and payment options are discussed to avoid surprises at the time of service. "For walk-in patients and stat add-on procedures, the process is the same, performed at the time of registration," says Quick.

Estimates expanded

Price estimates previously were given only for outpatient services at Advocate Illinois Masonic Medical Center, but now they are given to emergency department patients and inpatients.

"We wanted to be consistent with our financial advocacy efforts throughout the organization and not limit it to outpatients," Quick explains. "Aside from the upfront revenue opportunity in these areas, we knew that patients in all areas needed to be educated about any financial responsibility as early as possible in their experience."

EXECUTIVE SUMMARY

After an electronic payment estimation tool was implemented, point-of-service collections at Advocate Illinois Masonic Medical Center in Chicago increased by 294%. To be sure patients are given correct information:

• Tell patients their out-of-pocket expense at the point of scheduling.

• Give price estimates to inpatients and emergency department patients.

• Be clear that the quote given is an estimate.

The goal is for the patient to have no surprises, regardless of where he or she is receiving treatment, emphasizes Quick. The emergency department and inpatient services can be difficult to determine, however, because all charges haven't been accounted for at the time the registrar is running an estimate. "In the ED, having set level charges can get to more of a granular level of patient responsibility when running an estimate. But it still won't be 100% accurate," says Quick. It's extremely important to communicate to the patient that he or she is being given an estimate in all scenarios, he underscores. *(See related story, below, on ensuring estimates are accurate.)*

"Without the correct tool or process, you run the risk of not only over- or underpayments from the patient, but also negative patient and staff satisfaction," says Quick.

The more information registrars can communicate to a patient upfront, the better equipped that patient will be to make decisions, adds Quick. "In the changing healthcare environment, where increasing onus is being placed on patients, patient access needs to be equipped to meet their needs," he says.

SOURCE

For more information on informing patients of their out-of-pocket responsibility, contact:

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Payer info accuracy is a challenge

However, patients can be allies

Registrars at Advocate Illinois Masonic Medical Center in Chicago don't typically have any problem giving patients accurate estimates, says **Philip N. Quick**, CHAM, manager of patient access & bed management — that is, unless the benefit information their insurance company provides isn't correct.

"Many insurers don't have the latest updated information at the time we're retrieving benefits, causing a false estimate for the patient," he says. "The most frequent inaccuracy we come across is related to the deductible."

Incorporating scripting to determine if the patient has had other recent services aids the registrar in giving a more accurate estimate, says Quick.

"We know we can't control how often payers update, but we can influence it," he says. "We have very strong working relationships with our provider relations reps to keep the lines of communication open."

However, as out-of-pocket expenses are rise for patients, they are becoming increasingly savvy with their benefit information, reports Quick. Payment estimates show all remaining out-of-pocket expenses so patients can walk away more prepared for future services, he explains.

"It's important that we build and maintain the relationship with the patients," says Quick. "We are the patient's financial advocate. This allows them to concentrate on their clinical care." ■

Remake registrars into financial counselors

Don't be caught unprepared

Healthcare reform will mean registrars will have a much bigger role in financial counseling of "newly eligible" patients, but **Pattie Froehling**, director of the revenue cycle at North Shore Long Island Jewish Health System in New Hyde Park, NY, isn't waiting for 2014.

"There are going to be more eligible patients, and we're going to be there to help those patients get insured," Froehling says. Registration and financial counseling already have evolved into a "one-step process" for patients, she says.

"If they are a financial assistance patient or eligible for a government program, they are not pushed from person to person," she says. "They are speaking with one person." The minute a patient says, "I can't afford to pay that," the registrar reviews all possible options for the patient, says Froehling.

EXECUTIVE SUMMARY

Registrars' roles increasingly include financial counseling, and this role will help patient access departments prepare to help newly eligible patients in 2014. To be sure patients receive the help they need:

- Have registrars review all possible options for a patient.
- Standardize financial counseling processes.
- Verify that a patient is truly self-pay.

Patients might learn they're eligible for a program that allows retroactive reimbursement, such as Medicaid, but even if this isn't the case, the patient might at least be able to obtain coverage for future services.

"If they are not eligible, we take it a step further and let them know what clinics within the health system are available to them," Froehling says. "They may be eligible for a sliding scale."

The department is standardizing the financial counseling processes used at the hospital and provider's offices. "Right now, one practice may refer a patient without insurance to a clinic, and another practice may make a payment arrangement or do something different," explains **MaryAnn Murphy**, the organization's director of revenue cycle management. "We want to have consistent processes across the spectrum."

Underinsured might qualify

If the family members express financial hardship at Cook Children's Medical Center in Fort Worth, TX, they are referred to a financial counselor for assistance, says **Andrea Ayala**, a financial counselor in patient registration. Staff members do a quick pre-screen to determine if the patient is possibly eligible for assistance, and then they transfer the patient to a financial counselor who initiates the process.

"The role of the financial counselor is to confirm the family resides in the hospital service area, determine any extenuating circumstances, and inform the family of other forms of assistance," says Ayala. Counselors tell parents which documents are required to complete applications for assistance.

Many families are underinsured and might qualify for Medicaid secondary, Medicaid Supplemental Security Income, the Medicaid Excess Income program, Emergency Medicaid, or charity care for out-of-pocket costs, says Ayala. "Financial counselors also work all self-pay or non-insured scheduled outpatient and inpatient procedures, and initiate contact with the family," she says.

Froehling makes a point of avoiding scripting when coaching registrars to discuss finances with patients. Instead, she expects staff to, in their own words, convey the message, "We'll work with you."

"Every situation is different. You can't script something to relieve a person's anxiety," says Froehling. "A registrar saying something robotically is the last thing you want."

Registrars often find that patients need extensive education about their benefits. "People get on the defensive when they don't understand something," Froehling says. "It relieves them when they know what they have to pay. Then they can focus on their care." *(See story about handling various types of financial counseling, below.)*

SOURCES

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How complex is patient's situation?

Advocates answer detailed questions

At University of Utah Health Care in Salt Lake City, financial counseling is handled in two ways, depending on the complexity of the patient's question, says **Katie Harwood**, CHAM, admissions manager over financial advocates and ED registration.

"Registration staff in our admitting areas — inpatient and emergency room — can answer basic questions about benefits and payment arrangements, and take payments," Harwood says.

If the patient has more detailed questions, he or she is referred to the hospital's pre-service financial advocate team, who give information on the final bill amount for a specific service, price estimates, and previous balances.

"The admitting registrars for inpatient and outpatient scheduled procedures are located in the same area as financial advocates, so they are readily available," adds Harwood. These steps occur:

- Members of the pre-service financial advocate

team contact patients scheduled for inpatient and outpatient procedures.

"They complete a pre-registration interview, advise them of their patient responsibility, collect deposits, and explain the payment plan options," says Harwood.

• Patients that have been identified as self-pay and those with a patient responsibility after insurance are routed to the financial counselor.

• All self-pay patients are screened for Medicaid or other coverage options.

"In addition to screening for Medicaid, we identify if other payment options are available, such as COBRA, crime victims, or auto insurance," says Harwood. "For pharmacy, we refer them to the pharmacy assistance programs."

• If there is no coverage, counselors create a cost estimate based on the CPT code.

"We require a 50% deposit of estimated charges for scheduled procedures," says Harwood.

• If patients cannot pay for the service, the patient's provider is contacted to determine if the service meets medical necessity to proceed without a deposit.

"If the service is deemed necessary by the provider, a Certificate of Medical Necessity is completed," says Harwood. "This is sent to the medical director, who makes a final decision." *[The form is included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

Self-pays verified

When a self-pay patient presents at UK HealthCare in Lexington, KY, financial counselors go to the patient's room to verify that the patient is truly self-pay.

"Sometimes the patient does not have their card with them. We later find out that the 'self-pay' has third-party coverage," says **Jack Smarr**, MHA, associate director of revenue management.

A true self-pay is patient is asked questions and screened for Medicaid coverage. If the person is eligible, the counselors start the application process immediately. "These people are put into 'Medicaid pending' status," says Smarr. Financial counselors follow up to ensure that the patients complete their application, though a coverage determination might take weeks.

"Those that are not eligible for Medicaid or disability are also screened for financial assistance to be put on a sliding scale of payment," says Smarr. "This process of collecting information for financial assistance takes cooperation with the patients and a lot of follow-up with our financial counselors." ■

200% increase in satisfaction scores

Patient access champions are key

Do you want a department that provides patient-centered registration, achieves excellent outcomes, and works well with colleagues in the clinical services you support?

"It has to start with staff who have the resources they need and who feel recognized and rewarded," says **Steven R. Weiner**, RN, MS, MPA, senior director of patient access at NYU Langone Medical Center in New York City.

Improving the patient experience is one of the patient access department's focus this year, says Weiner. *(See list of behaviors identified as crucial to improve patient satisfaction, p. 129.)*

To ensure that staff members welcome patients and provide a comfortable waiting and reception area, managers identified staff champions in each registration area. "Supervisors met with them every week or two to identify steps we could take to improve. Then, the champions brought the plans back to their colleagues," says Weiner.

In the ambulatory surgery registration area, a registrar in the waiting area now greets patients and gives them the required information and forms. "They can begin looking them over before being called by the registrar," says Weiner. "We now provide standardized apparel — jacket or sweater, shirt or blouse, tie or scarf, slacks, or skirt — for all staff, which staff have very much appreciated."

The department's Press Ganey percentile rank-

EXECUTIVE SUMMARY

Patient satisfaction scores for some patient access areas increased by as much as 200% on the Press Ganey survey at NYU Langone Medical Center, as a result of obtaining feedback from staff. These steps were taken:

• Patient access leaders identified behaviors critical for patient satisfaction.

• Supervisors met with staff champions in each registration area.

• Staff champions shared planned changes with their colleagues.

ings have improved as much as 200% in some cases, reports Weiner. "While we still have a lot of room for improvement, we can see that it's working," he says. "Registrars own the process of improvement and feel respected." In turn, this change creates an environment in which patients are treated with respect, Weiner says. Here are other ways patient access staff members are recognized:

• **A three-step career ladder is available for patient access staff, with steps and requisites clearly defined.**

"This is both to recognize and reward our best performers, but also to help chart career paths," says Weiner. "We also adapt schedules for staff going to school."

• **Supervisors provide extensive training and support.**

"Experienced staff serve as trainers, super users, and mentors," says Weiner.

• **Patient access leaders receive feedback before changes are made.**

"We have instilled in the department the idea that the people who do the work need to be consulted and heard whenever possible about changes in the procedures and tools they use," says Weiner. *(See related story on obtaining feedback during rounding, p. 130.)*

For example, a work station on wheels was set up for completing admissions at bedside, external transfers, labor and delivery admissions, and emergency department admissions, as well as arranging payment for private rooms when requested. "But the registrars assigned to bedside follow-up found it unwieldy going up and down elevators and into patient rooms," says Weiner. They now prepare forms and materials ahead of time and use a special clipboard with attached storage compartment for papers.

"They use their workstation to manage work queues that track patients who still need to sign forms or pay for private rooms, maintain logs, and exchange emails about specific situations," he adds. For example, a registrar might note that "Mr. Smith will be in therapy all afternoon and asked for time to rest after he returns. Please stop by after dinner tonight."

• **Executive leadership give special acknowledgement to patient access staff after emergencies and natural disasters.**

"We have successfully staffed all our registration areas through hurricanes, electrical blackouts, and snowstorms — you name it," says Weiner.

In anticipation of flooding from Hurricane Irene, patient access staff helped the hospital evacuate all patients in an orderly way. "After each situation, we used to order pizza, but now offer a gift card instead so that staff can purchase a meal of their choice," says Weiner. "We have found they appreciate that."

SOURCES

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Top service skills for patient access

Patient access leaders at NYU Langone Medical Center in New York City identified the below behaviors as critical for patient satisfaction, based on its Press Ganey surveys and Press Ganey's support resources, says **Steven R. Weiner**, RN, MS, MPA, senior director of patient access.

• **Physical appearance.** Keep reception/registration spaces welcoming, organized, and comfortable.

• **Greeting.** Greet patients and companions immediately. Make eye contact and smile; introduce yourself.

• **Interviewing.** Manage expectations. Inform the patient what will happen after the interview; give reasons.

• **Privacy.** Maintain privacy.

• **Caring.** Practice simply being present. Show concern for people's comfort. Strive for helpfulness, not simply information provision. Be prepared to address language, hearing, cultural, and communication needs. Anticipate and address common concerns. Leave the desk to speak with patients and companions.

• **Waiting.** Provide frequent updates, and perform quick rounds.

• **Handoffs.** Escort and "hand off" the patient directly to clinicians.

• **Service recovery.** Take their requests and expressions of concern seriously. Listen, empathize, speak calmly, make a blameless apology, and offer options to the visitor. ■

Ask, `What's not working well?'

Taking action can boost morale

Morale of patient access staff has improved noticeably at Indiana University Health in Indianapolis, due to leaders "rounding for outcomes," reports **Cortney Gundlach**, CHAA, CHAM, director of Patient Access Services.

"Our leadership team is working hard on improving the morale in our department," she says. "I would attribute the positive changes to several factors including mutual respect and investing in our team members."

Rounding for outcomes is a successful tool only if two things happen, Gundlach says. The team members must communicate what their needs or ideas are, and the leader must follow up on the topics that are brought to their attention. "This fosters an environment of respect," she says. "A team with high morale creates a more inviting atmosphere. This transfers over to the interactions we have with our patients and their family members."

Formal rounding takes place on Tuesdays from 9 a.m. to 11 a.m., with managers, the director, and the executive director walking through their areas of responsibility asking these questions:

- What is working well?
- What is not working well?
- What tools or equipment do you need to be successful in your position?
- What ideas do you have to improve patient flow?
- What could we do differently to support our internal and external customers?

Here are two process changes that were made as a result of rounding:

- The patient access team at Indiana University Health Methodist Hospital suggested that leadership review the registration process for ambulance patient flow.

"Our evaluation showed redundancy in processes and the need for more equipment," Gundlach reports. The Emergency Department at Indiana University Health Methodist is a Level One Trauma Center and sees more than 320 patients a day on average.

"Patient access works closely with the clinical team as patients arrive. We were completing our process, and then the clinical staff members completed theirs," says Gundlach. Once the patient arrived at the bed, a second patient access team member had to print the appropriate paperwork.

"We decided to place printers in the ambulance triage area and train the clinical staff on completing a 'quick reg,'" says Gundlach. "These changes allowed the patient access team to be removed from the ambulance triage area and be better utilized within the ED."

- Team members communicated to department leaders that more patients are requesting cost estimates and other financial clearance information for their procedures.

The department is considering investing in price estimation software as a result of the feedback, Gundlach says.

"Currently, patient access does not have the technology to provide this information at time of registration," she explains. "We are collaborating with other departments to ensure we choose technology that supports multiple disciplines." ■

Uninsured numbers drop as young adults covered

2011 shows first drop since 2007

Surprising some experts, the number of people without health insurance fell for the first time since 2007, the Census Bureau said.

The closely-watched census report found that 48.6 million Americans were uninsured during all of 2011, compared to 49.9 million in 2010, Kaiser Health News (KHN) reports. The rate of uninsured dropped to 15.7% from 16.3%, the biggest percentage drop since 1999.

The good news on the uninsured comes a day after a report by the Kaiser Family Foundation found that employer health costs rose by a modest 4% this year. KHN is an editorially independent program of the foundation.

Census officials attributed the declining uninsured rate to two major factors: More people were enrolled in government programs such as Medicaid, the state-federal health insurance program for the poor; and the percent of people with private coverage did not decline for the first time in a decade.

The biggest drop in the uninsured was among people aged 19 to 25, for whom the rate fell from 29.8% in 2010 to 27.7% in 2011. It was the second consecutive year that that age group saw at

least a 2% decline in its uninsured rate.

Health experts credit a provision in the federal health law that took effect in September 2010, which allows families to keep adult children on their health plans until age 26. The Obama administration said about three million people have gained coverage from this provision. "I have no other explanation for that decline than the health law because the economy has not been particularly kind to that age group, and it's not likely that they all got great jobs," said **Elise Gould**, PhD, MPAff, director of health policy research at the nonpartisan Economic Policy Institute.

Before the report's release, health policy experts had been predicting the uninsured rate would increase slightly as the sluggish economy caused more people to lose workplace coverage.

About 40% of the decline in the uninsured rate was among young adults, said **David S. Johnson**, PhD, chief of the Census Bureau's Housing and Household Economic Statistics Division. The drop is likely to be due to young adults being able to stay on their parents' health policies, though the census data did not measure this. Lower unemployment also might have played a role.

It appears the federal health law has helped lower the number of people without insurance in two ways, said **John Holahan**, director of the health policy research center at the non-partisan Urban Institute. In addition to letting children stay on parents' health policies longer, the health law's "maintenance of effort provision" has blocked states from making it harder to qualify for Medicaid.

The uninsured figures should give Obama a boost in talking about the impact of his health law, which Republicans have vowed to replace if GOP presidential nominee Mitt Romney is elected, he said. The law is projected to eventually reduce the number of uninsured by as many as 30 million. But its most significant coverage provisions, which are an expansion of Medicaid and the provision of federal subsidies to lower-income people to help them buy insurance, don't begin until 2014.

Romney said on NBC's Meet the Press that he likes some parts of the health law, including the provision allowing parents to keep their children on their health insurance plans up to age 26. But his campaign later clarified that he would not propose a "federal mandate" that insurance plans allow parents to keep children on their plans up to age 26. Instead, he would leave it up to the private market.

The conservative Heritage Foundation said that despite the drop in the uninsured, the number of those without health insurance remains high. In a blog post, the group acknowledged the law had increased the number of young people with insurance. But it warned the provision could "cause employers to stop offering coverage, and will likely increase premiums." *(For more of that blog post, go to http://herit.ag/QKwigc.)*

Republicans have blasted the health law as a "government takeover of healthcare," but census figures show nearly one-third of the population already has government coverage. The percent of people covered by Medicaid rose to 50.8 million or 16.5% of the population, up from 48.5 million or 15.8% in 2010, the new data show. Overall, the percent of people covered by government-sponsored programs rose to nearly 100 million last year, or 32% of the population, compared to 95.5 million, or 31% of the population in 2010.

The uninsured rate fell for whites and blacks and remained stable for Hispanics, the data show. People living in the Northeast saw the biggest declines in the rate of uninsurance, though all regions of the country except for the West, saw some drop.

In other findings, the census report showed a decline in median household income for the second consecutive year. Real median household income was $50,054 in 2011, a 1.5% decline from 2010.

The nation's official poverty rate remained stable with 46.2 million people, or 15% of the population living in poverty. After three consecutive years of increases, neither the poverty rate nor the number of people in poverty was statistically different from 2010. *(The graphs by Kaiser Health News can be found at http://bit.ly/SEdVuJ. The census report is available at http://1.usa.gov/QJlChR. The report from the Kaiser Family Foundation is available at http://ehbs.kff.org.)* ■

COMING IN FUTURE MONTHS

- How to tell patients they aren't eligible for charity care
- Report possible domestic or child abuse to clinical areas
- Avoid misunderstandings that hurt staff retention
- Find out how satisfied your access workers really are

United States Postal Service

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Meaningful use Stage 2 final rule released

Patient portals, behavior changes top list of challenges

An extra year to prepare to meet meaningful use requirements was welcome news with the release of the 2012 final rule for the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record Incentive Program (meaningful use). Eligible hospital participants will report and attest to Stage 2 meaningful use criteria in FY2014, and eligible providers will report in calendar year 2014.

The additional year will give vendors time to develop certified electronic health records (EHRs) and give providers time to implement new software to meet the challenges of Stage 2. However, it's important that providers look beyond just meeting a list of requirements, says **Shane Pilcher**, FHIMSS, vice president of Stoltenberg Consulting, a healthcare information technology consulting firm in Bethel Park, PA.

"The purpose of Stage 2 meaningful use requirements is to stretch our capabilities," Pilcher says.

To effectively meet meaningful use requirements in a sustainable manner, organizations need to go beyond "checking boxes on a to-do list," he adds. "You need to see that you are working toward coordinated care."

The extra year to prepare to report will give organizations that started early an advantage as they have more time to fine-tune their applications and train staff. CMS is requiring participants only to report and attest to 90 days of meaningful use in 2014, which should allow time to upgrade and implement 2014 Certified EHR Technology. However, organizations that have not yet begun to prepare can't look at the extra year as more time to put off implementation of plans, says Pilcher. "If you are waiting, you are already behind schedule," he says.

Some of the changes between Stage 1 and Stage 2 are simple increases in the percentages of records required for compliance. For example, Stage 1 required 50% of patients admitted have demographic information collected as structured data, and Stage 2 requires 80%. *(See resource box at the end of the article for comparison charts and tip sheets from CMS.)* There are, however, some changes that will present challenges, says **Susan H. Patton**, a healthcare attorney at Butzel Long in Ann Arbor, MI.

Patient portals and access to information

"Stage 2 requires hospitals to provide patients with a portal to view online, download, and transmit information about their hospitals admissions within 36 hours of discharge," Patton points out.

"This runs contrary to hospital systems and culture that are accustomed to locking down patient information." Changing the mindset created by the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) regulations will be a huge cultural challenge, she says.

In addition to the technical challenge to create a user-friendly, intuitive system that patients can use, hospitals also have to address the clinician component, says Pilcher. "This is more than an information technology issue," he says. "We have to make sure clinicians complete documentation in a timely

EXECUTIVE SUMMARY

In the 2012 final rule for the Centers for Medicare and Medicaid Services Electronic Health Record Incentive Program (meaningful use), the addition of one year to prepare for reporting and attestation requirements will enable organizations that are just now working on Stage 1 requirements time to implement electronic health records (EHR). Key challenges include:

- Cultural and behavior changes needed to provide patients with online access to medical information within 36 hours of discharge.
- Promotion of patient portals to create use of online service by at least 5% of patients.
- Cost and manpower needed to develop systems to comply with Stage 2.
- Current lack of broadband infrastructure in rural areas.

manner so the information is there for patients to access."

There are also clinical ramifications to providing access to information in a short timeframe, he adds. Clinicians need to pay attention to diagnostic or lab results that should be discussed with the patient to ensure proper interpretation of the results' meaning.

Staff and physician training should include a reminder for clinicians to invite patients to use the portal and to access their information, points out Patton. Stage 2 requires that 5% of patients actually access, view, or transmit information through the portal. This number is a reduction in the 10% that appeared in the proposed rule, but it will be a challenge to change patient behavior, Patton says.

"Hospitals need to take portal development very seriously, make it easy to use, and build in incentives for patients to access information," she says. *(See story at right for tips to make portals attractive to patients.)*

Lack of broadband networks serving some areas

"Some rural and critical access hospitals will not be able to meet Stage 2 requirements," says Patton. "The Federal Communications Commission is in the process of creating broadband access to all areas of the United States, including rural areas. This is happening slowly, and many hospitals, patients, and healthcare professionals cannot make Stage 2 happen for lack of infrastructure."

Even rural or small hospitals in areas with broadband access will have trouble complying with Stage 2, says Patton.

"Compliance will be expensive, time-consuming, and require highly specialized information technology expertise," she says.

Hospitals that lack these resources can "buddy up" with other hospitals that can provide the support, Patton suggests. "This can be done through mergers and acquisitions, or through structural or contractual joint ventures, or vendor service contracts," she says.

If you are using vendors to bring the hospital into compliance with meaningful use requirements, be sure you plan long-term to sustain the program, suggest Pilcher. "Overseeing implementation is a full-time job for a large hospital or health system, and it will last three to four years," he says. Smaller hospitals that are relying upon vendors or consultants for implementation can use a combination of outside sources and staff to be sure employees gain the expertise needed to continue the program throughout the years.

A key to successful implementation of a meaningful use program is the buy-in of all employees, suggests Pilcher. "Don't position meaningful use as an information technology project," he says. Include clinicians as you evaluate tools and develop policies. "This is an organizationwide project that will improve patient care," he says.

Another important thing to keep in mind is that compliance with meaningful use requirements is a long-term strategy, not just a matter of completing specific tasks, says Pilcher.

"Don't stop at the requirements, look at them as a starting point," he suggests. "Meaningful use is not a sprint – it is a marathon."

RESOURCES/SOURCES

The Centers for Medicare and Medicaid Services provides comparison charts and tip sheets on the differences between Stage 1 and Stage 2 of meaningful use. To view and download the free documents, go to www.cms.gov. Select "Regulations and Guidance" from the top navigational bar, then under "Legislation," select "EHR Incentive Programs." On the left side of the page, choose "Stage 2." A list of documents as well as detailed timelines is displayed.

For more information about Stage 2 Meaningful Use, contact:

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• **Shane Pilcher**, FHIMSS, Vice President, Stoltenberg Consulting, 5815 Library Road, Bethel Park, PA 15102. Telephone: (412) 854-5688. Fax: (412) 854-5788. Email: spilcher@stoltenberg.com. ■

Encourage use of patient portals for compliance

Easy-to-use; valuable info will attract patient use

Meeting the Stage 2 meaningful use requirement that 5% of patients access their health information online to view, download, or transmit information requires more planning than just providing a patient portal, points out **Shane Pilcher**, FHIMSS, vice president of Stoltenberg Consulting, a healthcare information technology consulting firm in Bethel Park, PA.

"This goes beyond a technology issue; it requires a change in behavior," he says. "To get people to change their behavior, you have to give them a reason to go online for health information."

The first step is to make sure you provide valuable, timely information, Pilcher suggests. He recommends that, in addition to viewing health information, a patient portal should enable a patient to do the following:

- schedule appointments;

• receive alerts to remind them of follow-up care;
• receive reminders about physicals or preventive screenings that are due;
• use interactive tools to monitor health issues, for example, a tool that tracks weight loss and offers tips on ways to lose weight.

The key to make it easier for patients to contact you or learn about hospitals services through your portal, says Susan H. Patton, a healthcare attorney at Butzel Long in Ann Arbor, MI. "If you offer instant messaging to departments or clinicians, you enable the patient to avoid looking through a telephone directory and calling, just to leave a voice message," Patton points out. "You can also offer links to health education or wellness classes offered by the hospital that can help patients better manage their health."

While training staff members to encourage patients to use the patient portal is important, consider offering a free service as an incentive to use the portal, suggests Patton. "A complimentary blood pressure screening or health seminar can be offered to people using the portal for the first time." If the portal is easy to access and the site is easy to maneuver, patients will be willing to use it in the future.

"I don't think most hospitals can create an effective patient portal internally," admits Patton. "Hospital personnel have to unlearn and uncomplicated the language that is commonly used within a clinical setting and communicate in simple language that can be understood by patients of all educational levels."

Healthcare organizations that serve rural or low income populations also have to consider the lack of computer access for many of their patients, says Patton. "I've heard that hospitals are exploring a variety of ways to provide access for patients," she says. Patton has heard that some hospitals are setting up computers in public locations such as libraries to provide access in the community.

"Hospitals need to approach the development of their portals in the same way banks and online retailers such as Amazon have," says Patton. "More people, of all ages, are using online services but only if they make their lives easier, not more confusing." ■

Report offers guidance on security threats

Analysis of HHS breach data shows gaps

Business associate breaches represent the greatest threat to a healthcare organization's data security, according to a white paper produced by Miami-based accounting firm Kaufman, Rossin & Co.

An analysis of all of the breaches posted on the Health and Human Services website between Jan. 1, 2010, and Dec. 31, 2011, show that in 2010, 42 incidents occurred in which a covered entity's breach was due to a business associate. In 2011, 32 incidents related to business associates were reported. The report shows that one in five breaches occurred at a business associate's location. *(For more information about business associates and HITECH, see "Don't wait: Start reviewing BA agreements now,"* HIPAA Regulatory Alert*, November 2010, p. 1.)*

Some of the key numbers included in the report:
• 19.1 million – The total number of individuals affected by breaches of protected health information since reporting began in August 2009 through the end of 2011.
• 53% — Combined total of instances of theft.
• 9.7 million – Number of records compromised in the "other" category, which includes portables electronic devices, backup tapes, CDs, and X-ray films.
• Four – Florida's ranking, in 2010 and 2011, among states with the highest number of reported incidents. California was number one in 2011, and New York was number one in 2010.
• 71% — The percentage of computer breaches attributed to theft for 2010 and 2011.

Nearly twice as many individuals were affected by healthcare data breaches in 2011 versus 2010; however, fewer breaches were reported. The total number of unique covered entities involved in a breach also dropped in 2011: to 142 from 201 the year prior.

Changes in types of breaches for 2010 and 2011 were:
• theft: 53% of breaches in 2010, and 52% of breaches in 2011;
• unauthorized access: 19% of breaches in 2010, and 22% of breaches in 2011;
• loss: 16% of breaches in 2010, and 11% of breaches in 2011;
• hacking: 6% of breaches in 2010, and 6% of breaches in 2011;
• improper disposal 6% of breaches in 2010, and 5% of breaches in 2011;
• unknown: 1% of breaches in 2010, and 3% of breaches in 2011;

Another part of the analysis looked at the compromised locations where data went missing. Laptops, paper, and "other" top the list. "Other" includes mobile devices such as tablets and smartphones.

Theft was the biggest threat to the safety of patients' health records. For breaches of information on laptops, 95% involved theft; for paper-based breaches, 26% involved theft. And for breaches of "other," which included mobile devices, 44% involved theft, and 42% involved loss.

The growing use of mobile devices by clinicians and staff members increases the risk of breaches due to theft, so report authors recommend strengthening

and enforcing policies requiring encryption as well as controlled access. *(For more information about protecting data on mobile devices, see "Beware of breach sources: Laptops and flash drives"* HIPAA Regulatory Alert, *May 2011, p. 1.)*

Despite the improvements in some categories, healthcare organizations still have a long way to go before patients' information is fully protected. The report identifies areas of vulnerability so healthcare organizations can focus risk assessments within their organization.

To download a copy of the full, free report go to www.kaufmanrossin.com. From the top navigational bar, select "White Papers." Scroll down to "HITECH Act three years later. Are health records safe?" ■

JOURNAL REVIEW

Who should own patient info to protect privacy?

Journal author examines patient ownership

Patient ownership of data included in electronic health records (EHR) offers little improvement over the protections provided by the Health Insurance Portability and Accountability Act (HIPAA), according to an article in the American Medical Association's *Journal of Ethics, Virtual Mentor*.[1]

As more healthcare organizations implement electronic health records and collect and store patient information in formats that can easily be transmitted and shared, the issue of the best way to protect privacy of information has been raised. Author Barbara Evans looks at the perceived benefits of patient ownership of data and the actual protections under HIPPAA. If patients owned their data, the same legal workarounds that infringe upon property rights — public health considerations and eminent domain — would apply to health information. While patients are concerned about the use of their information for research and development of services to improve patient care, patient ownership of information would provide no more protection than already provided by HIPAA.

REFERENCE

1. Evans B, Would patient ownership of health data improve confidentiality? *Virtual Mentor* 2012; 14(9): 724-732. ■

Resource available on health information law

Free service provides federal and state info

The George Washington University Hirsh Health Law and Policy Program in Washington, DC, has launched an online resource on federal and state laws governing access, use, release, and publication of health information.

The website, HealthInfoLaw.org, offers information on laws and regulations such as the Health Insurance Portability and Accountability (HIPAA) Act's Privacy Rule, the Health Information Technology for Economic and Clinical Health Act (HITECH) Act, and the Patient Protection and Affordable Care Act. It will include information on health information aspects of state health insurance exchanges as it becomes available. ■

Entertaining game enhances staff training

New way to present privacy and security info

Tedious and boring are often the kindest adjectives used by healthcare employees to describe privacy and security training required in every organization. However, a new, free training program offered by the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology can make some of the training more enjoyable.

"Cybersecure: Your Medical Practice" simulates a game environment to provide insights into privacy and security issues by having the employee play a game in which they face scenarios they might encounter in their physician practice, a small clinic, or even departments within a hospital. As the game is played, the employee learns about proper procedures as questions are asked and feedback given. Scenarios include game characters asking if they can take their laptop home to work on billing; if records can be loaded onto a personal USB drive; and how to send patient information to a physician at a conference, without sharing passwords.

While the game is not intended to replace comprehensive privacy and security training, it does provide a no-cost solution for periodic refresher courses. To access the training module, go to www.healthit.gov. Select "Providers and Professionals." Under "Privacy and Security" select "Privacy and Security Training Games." ■

Certificate of Medical Necessity (COMN)

(Scheduled/Elective Admission)

Patient Name _____ MRN: _____

Attending Physician _____ Referring Physician: _____

Diagnosis _____ Date of Request _____

Clinic Contact Name/Phone#_____ CPT Code(s) _____

A. CLINICAL NECESSITY (Completed by Physician)

1. Are we providing a unique service not available in the patient's home community? Y N

2. Is the present problem one for which the patient is currently being treated within the University Healthcare system? Y N

3. How long has condition existed? _____

4. Is physician discounting services? Y N
   What percentage? _____

5. Extent of services needed
   - ❑ Medical Management (including Chemotherapy, Radiation Therapy)
   - ❑ Hospitalization
   - ❑ Diagnostic Testing
   - ❑ Surgical services
   - ❑ Other (explain) _____

Admitting Physician Approval _____ Date _____

B. FINANCIAL ASSESSMENT (Completed by Financial Counselor)

1. Has the financial assessment been completed? Y N

2. Is the patient a legal Utah resident? Y N
   If no, where are they from? _____

3. Does patient have outstanding debt with hospital or physician? Y N
   Balance due: _____
   Are repayment arrangements in place? Y N

4. Is patient eligible for any assistance program? Y N
   If yes, what source? _____

5. Estimated cost of services to be provided $ _____

6. Is patient able to make deposit greater than $150.00? Y N
   How much? _____

7. Recommendation: _____

Signature of Financial Counselor _____ Date _____

C. APPROVAL (Completed by Hospital Administrator)

COMN valid for 90 days from date of submission.

Medical Director Approval _____ Date _____

SOURCE: University of Utah Health Care, Salt Lake City.