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## IN THIS ISSUE



AHC Media

# Want dramatic revenue results? Be the 'go-to' place for providers

*Job security comes with increased revenue*

Providers ordering stat CT scans or magnetic resonance imaging scans (MRIs) certainly don't want their patients to wait hours in the emergency department, to show up for a test only to learn the original order was incorrect, or receive a bill due to a failure to obtain a required authorization. Too often, however, those situations occur.

"One of the challenges we faced was that both patients and referring doctors had a perception that it was difficult to navigate the hospital. People don't want to be left on hold and transferred multiple times," says **Mike Horton**, MHA, manager of radiology and the centralized scheduling department at Hackensack (NJ) University Medical Center.

Horton set up a concierge hotline for physicians with "stat" or emergent cases, and asked more than 100 referring physicians in the community to call him directly instead of the hospital's Call Center which schedules the routine cases, so he can get their patients in without delay.

"Providing this service has added a more personal touch and service-oriented approach," says Horton. "It has been a tremendous hit. Physicians are very busy people, and their staff don't have a lot of time to

## EXECUTIVE SUMMARY

Patient access leaders can dramatically increase volume by making scheduling easier, providing education on payer requirements, and obtaining authorizations for providers. Volume of CT scans increased 30% and magnetic resonance imaging (MRI) scans increased 40% at Hackensack (NJ) University Medical Center. To increase volume:

- Set up a concierge hot line for "stat" or emergent tests.
- Give referring physicians your direct line.
- Ensure that orders are valid and complete.
- Ensure that authorizations are for the right facility and ordered exam.

spend on repeated calls."

If Horton is off, another manager carries his phone, and if he goes to a meeting, the call bounces to the front desk so staff can handle it.

"I have empowered my staff to do exactly as I would do," says Horton. "I tell them: 'If a physician calls for a 'stat' exam, do everything possible to accommodate the patient.'" As a result, many patients are seen who previously would have sought care elsewhere.

Horton agrees to get the patient in, on the condition that the provider office does its part to put the authorization in place. If patients call, he makes them aware that their physicians needs to obtain the authorization. This process motivates everyone involved to do their part to be sure the authorization is in place, if and when it is necessary, he explains.

"My philosophy is to make things simple. If a patient has a script and an authorization, why make them wait?" asks Horton. "If I can't help them today, someone else will."

## Volume is priority

Payers are not approving high-dollar diagnostic tests as frequently as they once were, and some patients are reluctant to obtain a CT scan due to high deductibles or concerns about radiation exposure, notes Horton, adding that he has made increasing volume a top priority.

"Our volume has increased at a time when nationally, volumes are shrinking," says Horton. "We are seeing significant growth, year over year." Over the past four years, the number of CT scans performed increased by 30% and the number of MRIs increased by 40%, he reports.

"Doctors and patients often perceive hospitals as big behemoths that are difficult to navigate," says Horton. "I'm reversing these misconceptions by bringing small business customer service to a large organization."

Horton likens the system to a customer calling a "big box" store to find out if they have an item in stock, and having the manager answer the phone and give the answer, versus being transferred to numerous individuals.

"The end result is obviously increased volume, but there are other downstream benefits," he says. "Now that we made it easy for their patient to get a CT scan, offices are more inclined to send patients for other clinical services, such as cardiology or physical therapy."

Horton says job security is another big motivator for staff to help increase volume.

"Right now, we're hearing a lot about layoffs in healthcare. The more CT scans we do, the more job security we have," he says. "Rank-and-file employees often feel they don't have any say over their employment, but here's a way they can have direct control."

## Lighten providers' load

Typically, providers' office staff schedule appointments with the facilities that they like to deal with, according to **Myndall V. Coffman**, MBA, director of patient access at Baptist Health Lexing-

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ton (KY).

"Constant changes in healthcare are very stressful for physicians. If access can lighten up some of the stress and load, not only for physicians, but for their staff as well, loyalty is created," she says. "We do whatever we can to ensure the physician's office is not inconvenienced."

Here are ways patient access can support physicians and increase volume:

**• Patient access can educate providers on payer requirements.**

"Offering education via hospital newsletters and personal meetings can go a long way in not only developing the relationship, but cleaning up practices on both sides," says Coffman. "This directly aids the hospital in making sure a good claim gets out the door."

In "A Survey of America's Physicians: Practice Patterns and Perspectives," a 2012 survey conducted by Merritt Hawkins, physicians reported spending more than 22% of their time on non-clinical paperwork.

"Hospitals are feeling many of these same strains. However, we are typically better equipped to handle the requirements placed by regulators and insurance companies," says Coffman.

**• Registrars can obtain and verify necessary authorizations.**

Recently, patient access leaders at Mercy Medical Center & St. Elizabeth Hospital in Oshkosh, WI, identified obtaining radiology authorizations as a "bottleneck," reports Connie Campbell, director of patient access.

"When the office had to obtain the auth, it caused a delay. There is such a learning curve in trying to figure out what is needed," she explains. They now have a select group of specialists out of their scheduling department who do these, Campbell says. "It helped us, too, as most of the procedures requiring auths are $2,000 to $3,000 in cost," she says.

Members of Baptist Health Lexington's patient access staff have taken on the responsibility of helping physicians obtain pre-certifications for procedures, when possible, by contacting the insurance company directly. Coffman expects to see a 10% drop in claims denials as a result of this change.

Ensuring that the order received is a valid, complete, compliant order is "half of the battle, not to mention that precerts and authorizations are being obtained for the right facility and ordered exam," says Coffman. "Through this partnership, the physician's load is lightened, accuracy increases, and denials decrease."

**• Registrars can fax over an order with all of the patient information needed to schedule a procedure.**

"Patient access staff take care of everything, including calling the patient to work the appointment into their schedule," says Coffman. "In addition, we are working with some physicians to feed back procedure results directly into the patient's electronic medical record." *(See related stories on recording conversations, below, and preventing delays, p. 52.)*

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# Patient disputes appointment time?

*Conversations are recorded*

All conversations that come into central scheduling are recorded and are used for two purposes, says Mike Horton, manager of the central scheduling department at Hackensack (NJ) University Medical Center.

One is to provide a "teachable moment" for staff. "We have staff listen to their own recorded calls as a means of citing specific examples where improvements could have been made or to highlight exemplary performance," says Horton.

The recordings also play a pivotal role in conflict resolution and addressing patient disputes. At times, Horton has had to play a recording for a patient to clear up miscommunications or to prove that the correct information was given at the time of scheduling. "More often than not, these calls tend to vindicate staff more than they implicate them," says Horton.

The goal is not to embarrass the patient, but rather to show that staff are listening intently and care deeply, he emphasizes.

"If you show good faith and are clear that the purpose of recording the call is not to put the

patient down or tell them 'I told you so,' it's been our experience that most patients walk away with a positive perception," Horton says. ■

# Stop needless delays with diagnostic tests

*Catch mistakes early*

If a physician mistakenly orders a CT scan with contrast when it needs to be done without contrast, is this error corrected before the patient arrives?

Previously, these mistakes were discovered only on the day of the exam, causing delayed care and dissatisfied patients, reports **Mike Horton**, MHA, manager of the central scheduling department at Hackensack (NJ) University Medical Center.

To address this, Horton gave his schedulers telephone numbers to reach supervisors of clinical areas directly. This way, the schedulers can clear up potential problems with a patient's prescription right away. "Sometimes medicine may appear black and white, but in real life, it's never that simple," says Horton. "Each patient has their own unique circumstances that have the potential for altering exam protocol."

Horton tells his staff to be on the lookout for specific keywords such as "tumor," "mass," or "infection," as these types of diagnoses have the ability to modify how an exam is performed.

Resolving issues at the point of scheduling improves patient satisfaction, enhances clinical outcomes, and ultimately strengthens the reputation and performance of the medical center, according to Horton

"We empowered the staff to think on their feet. If they think it sounds like a vascular study, they call vascular," says Horton. "It is better to put a little bit of work into a phone call upfront, than a lot of work trying to get a new script on the day of the exam." ■

# Patients benefit from teamwork

*Improve communication with clinical areas*

It was no secret that clinical areas didn't have a good working relationship with registrars at OSF Healthcare in Peoria, IL. In 2013, patient access leaders set out to change this relationship.

"They weren't communicating together in an efficient manner. In some instances when they did communicate, it wasn't always in a positive manner," says **Jacqueline Doerman**, patient access services manager for the health care system's Patient Accounts & Access Center.

Managers in patient access and clinical areas were continually hearing complaints from their staff. "Both patient access and clinical management got together to brainstorm different ideas on how this could be improved," says Doerman. "We did not want to create a culture where it was an 'us-versus-them' mentality."

## Meet with clinical team

Patient access and clinical management held several lunch sessions recently to improve relationships.

"Each manager brought a small group of staff together so they could ask questions and bounce ideas off one another," says Doerman. "We are working on initiatives that bring our staff together."

For example, managers are setting up events during breaks and lunches to get registrars and members of the clinical staff to interact on a more personal level. "The relationships are improving," she reports. "It is a work in progress, but we have seen improvement."

Patient access and ambulatory clinical management also have a standing meeting once a month. "Our management meetings allow us to let each other know what is working or if we are having any issues," says Doerman. "The issues that we have vary each month. We discuss things that are going well, as well as areas that could use improvement."

During a recent meeting, managers discussed the fact that scheduling is no longer going to be


## EXECUTIVE SUMMARY

Patient access leaders can eliminate tension between their staff members and clinical areas by meeting regularly with clinical management, having employees "shadow" one another, and bringing staff together during breaks and lunches.

- Ask members of the clinical staff for input on scheduling problems.
- Educate clinicians on the need for a compliant order and medically necessary procedure.
- Review claims denials with clinical staff.

available as a resource on Saturdays. Because outpatient testing is open only from 8 a.m. to noon, staff were concerned about what to do if they need clarification on orders. There is no current process to page a doctor for clarification if the scheduling department is closed.

"The resolution to this is it will just be a pilot closure for now. We will see the issues that arise and whether it is necessary to keep scheduling open on Saturdays in the future," says Doerman.

### Educate clinicians

Because each patient's encounter starts with a physician's order, it is imperative that good communication between providers and patient access starts at this point, underscores Dee Alugbin, manager of patient access at Longmont (CO) United Hospital. Clinicians work with registration to ensure that missing patient orders are delivered prior to patient arrival, which facilitates an accurate and timely registration, she says.

In addition, patient access educates clinical staff on the need to have a compliant order and a medically necessary procedure. "We explain the benefit of medical necessity to the patient's financial health and direct them to the [Centers for Medicare & Medicaid] website for additional information," says Alugbin. Staff are directed to a booklet that provides information on Medicare requirements for Advance Beneficiary Notice of Noncoverage (ABN) at http://go.cms.gov/10ky5rF.

Alugbin meets regularly with utilization review nurses to identify reasons for claim denials. Recently, they discovered that financial counselors were using payers' notification phone numbers, when a different phone number was available specifically for clinical follow-up in order to obtain approval for admission days.

"Our financial counselors now ask payers for this information and document it where it is easily accessible by our nurses," says Alugbin. "This simple change eliminated the long wait time for our nurses and ensured that clinicals were called in to the right person and location." *(See related stories, on clinicians and registrars working side-by-side, this page, and registrars "shadowing" clinicians, p. 54.)*

#### SOURCES

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# Clinicians and access work side by side

*Claims denials are prevented*

Registrars at Georgia Regents University in Augusta work side by side with utilization review/precertification nurses to prevent claims denials.

"We are located in the same office space. Utilization review nurses are split by services, just like our registrars are," explains **Nikki Taylor**, director of patient access services. "This has greatly opened up communication between departments."

This system allows registrars to convey insurance information for patients with scheduled day surgeries, procedures, and inpatient admissions. At the same time, registrars learn about the specific clinical requirements that are needed.

"Patient access staff have a better understanding of the precertification requirements," says Taylor. For example, registrars explained that workers compensation may take up to 30 days to approve and obtain precertification, while Medicaid and other commercial payers would require a lesser time frame. Also, Medicare does not require precertification for scheduled service but has procedures that are on an inpatient only-list and would not be covered as outpatient," adds Taylor.

More than 80 outpatient clinics schedule procedures or surgeries at the facility, with staff divided out by those services. For example, one registrar handles cardiology, catheterizations, cardiothoracic surgery, chemotherapy and surgery oncology patients.

"Dedicated patient access staff are working with the same physicians, residents, and nurses,"

says Taylor. "They build very strong relationships with the staff in those clinical offices that are referring the patients in for surgeries."

### Clinicians give insight

Clinicians teach registrars about the medical aspect of the case, which gives insight into why it's urgent for their work to happen rapidly for the health and well-being of the patient, says Taylor.

"At times, patient access staff see things more technically, as opposed to the personal aspect of the patient," says Taylor. "They work a lot with insurance companies and scheduling programs. It is important for patient access to remember that the visits are attached to real people."

In turn, registrars educate clinicians on insurance requirements, timing limits set by insurance companies in obtaining authorizations, and insurance benefits such as coinsurance, deductibles, and copays. "It is important that patient access staff understand what the work they are doing does downstream, and how it affects the rest of the hospital," says Taylor. Care of a patient being discharged for additional follow-up care at a skilled nursing facility or nursing home could be held up due to invalid insurance issues on registration, for example.

"The information we are placing on our visits does not just benefit the patient for the current visit. It assists the patient in getting care after their hospital stay, as well," adds Taylor. ■

## Ask registrar to shadow clinicians

*Both sides have a lot to learn*

Registrars at Mercy Medical Center in Oshkosh, WI, have learned a lot by shadowing clinical staff when they are first hired, reports **Linda Swanson**, registration coordinator.

Members of the emergency room (ER) clinical staff shadow a registrar for about one hour, and new registrars shadow a clinical staff person for the same amount of time.

"With ER nurses, we explain our insurances, different rules, Medicare queries that are mandated to be asked, and how denials occur if we list the wrong insurance," says Swanson. "They better understand the financial side and all that registration does."

Clinicians learned the reason why registrars ask patients if they had a kidney transplant or dialysis, for example. "Staff would wonder why a registrar was asking what they felt was a clinical question to the patient," she explains. "They learned why we cared when the accident or injury occurred, and if liability is happening."

Clinicians learned that this information was required for billing. "They didn't realize that our systems needed this, along with the insurance company," says Swanson.

### Encourage teamwork

Mercy's registrars learned to ask nurses whether a urine sample is needed if a patient says they need to go to the bathroom, and to ask nurses whether it's appropriate to give fluids to patients who say they're thirsty.

"These things just seemed like friendly customer service items to them," says Swanson. "We have a grease board that shows the ER rooms and which nurse is responsible for that room so they know who to go to ask." Clinicians also taught registrars that facial and head lacerations bleed more easily, so it appears it's a major bleed when most of the time it is not, which can help calm anxious patients, she adds.

At Longmont (CO) United Hospital, ER registrars work alongside technicians and nurses, so the patient's medical record is available as quickly as possible to allow ER nurses to enter clinical information. "This is a great way to encourage teamwork between departments," says **Dee Alugbin**, manager of patient access. "Patient access gets a glimpse into the clinical world, and vice versa."

Nurses and technicians learned that registration must be completed prior to patient discharge from the ER. "They have been shown the ramifications of incomplete registration," says Alugbin.

At OSF Healthcare in Peoria, IL, registrars participated in a "Walk in My Shoes" initiative. "This was very successful. It helped to bridge the gap between what happens in the front versus what happens on the back end," says Jacqueline Doerman, patient access services manager of the hospital's Patient Accounts & Access Center.

Patient access managers scheduled registrars to work in various clinical areas, and clinical management scheduled their staff to work in the access areas. "The staff shadowed someone for a full day or part of a shift, depending on staffing needs," says Doerman.

Clinical staff asked registrars, "What do you do on your end to make the patient 'arrived' in the system on our end?" "The clinical staff were shown

the process, so they were able to identify what we were doing in the computer system that triggered the patient to show up as 'arrived' on their screens," says Doerman.

Registrars also answered the question "What challenges do you face when transcribing orders?" "This came from the fact that some paper orders are hard to read. The clerical staff doesn't have the clinical knowledge to decipher some of the tests and diagnoses," explains Doerman. "The clinical staff offered to assist in this matter." ■

# POS collections started at 0 and are now $4.5 million

*It was done without incentives*

Just five years ago, patient access employees at University of Washington Medical Center in Seattle weren't collecting anything from patients at all. This year, collections in the emergency department topped $4.5 million.

"We just had to get the right buy-in to be able to do it," says **Donna Aasheim**, CHAM, director of patient access services. "We weren't collecting, and all of a sudden we were. Now, it's second nature."

When point-of-service (POS) collections first started in 2008, motivating staff was a key concern, because cash incentives weren't an option. "As a state hospital, we can't set up any monetary compensation for the staff. So we have to be really creative," Aasheim says. A recent "Knock Your Socks Off" initiative awarded brightly colored socks stuffed with candy and small gift cards to top collectors. Aasheim periodically rewards her staff with breakfast, lunches, and movie tickets.

"Our surgical unit was one of the collection challenges. Now it's just part of their routine, and they are very successful," she says. Next, collection was rolled out in the clinics, which ask patients for copayments as well as a self-pay deposit for patients who don't have insurance and aren't eligible for Medicaid or charity.

"In surgical services, point-of-service collections average over $100,000 per month," reports Aasheim. "The UW clinics average over $200,000 per month, with well over 2,800 transactions." The department took these steps to reach these goals:

**• Supervisors spent a lot of time meeting one-on-one with staff members. They introduced new scripting and did role playing during staff meetings about how to collect.**

**• Supervisors worked shifts alongside staff, so they could observe how staff asked for copays and provide tips to improve collections.**

**• Because the department was switching to a new system, leaders made a point of ensuring collections were going smoothly before going live with it.**

"This way, the new system couldn't be an excuse not to collect," Aasheim says.

**• Aasheim met with the ED director and hospital administrators to show them the potential of what could be collected in copayments at the time of service.**

"I really encouraged them to give their support," Aasheim says. "It's a huge show stopper if too many people have input, so I didn't ask for their permission. I just let them know we were going to do it, and we just went for it."

**• Patient access managers address concerns from clinical staff directly.**

When some clinical staff told registrars that they shouldn't be asking patients for money, Aasheim told her staff members to refer these concerns directly to her.

"I explained that on the contractual side, we are obligated to collect the patient's copay at the time of service," she says. "These are different times now. Sending a bill for a copay costs almost as much as the copay. If we can get that upfront, we don't have those costs."

**• Supervisors post the names of top collectors on a bulletin board, and staff members continually scan it to see where they're falling.**

A few registrars were reluctant to collect at first, but most now continually scan the list to see where they're falling.

"They don't like seeing their name on the bottom of the list," Aasheim says. "If they hear someone is a top collector at the staff meeting, it fires them up to be on the top of the list." *(See related story on price estimation software, p. 56.)*

## EXECUTIVE SUMMARY

Patient access employees collected more than $4.5 million in the emergency department at University of Washington Medical Center. Managers had to be creative to motivate staff, because cash incentives weren't an option.

- Staff are rewarded with breakfasts, lunches, and movie tickets.
- Managers waited until collections were going smoothly before going live with a new system.
- Concerns from clinical staff were addressed directly by managers.

**SOURCE**

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# Ability to estimate equals quadruple revenue

Emergency department (ED) registrars at the University of Washington (UW) Medical Center in Seattle have collected co-pays for five years, but soon they also will collect coinsurance from patients and give cost estimates on the patient's total out-of-pocket responsibility.

"That is a big amount of untapped revenue. Our cash collection will probably quadruple, if not more than that," says **Donna Aasheim**, CHAM, director of patient access services. "We are seeing some anxiety from some staff. But once they get into it, it will become routine for them, just like collecting copays has."

The department invested in a price estimation tool, which staff will use to collect at the time of discharge from the ED and prior to service in other areas, she explains. "We are already developing work instructions, as well as new scripting developed for each phase of the process, and policies around those," she says. "Hundreds of hours have gone in behind the scenes to roll this out."

The project will begin in the emergency department and then will be phased in for all other areas across UW Medicine. The biggest challenge has been the culture shift for the organization, says Aasheim, with the registrars asking patients to pay more of their financial responsibility upfront.

"People are going to be surprised seeing that number ahead of time," she says. "And if there are previous balances, we are going to try and collect those too." ■

# Tell staff the cost of registration errors

*Show the importance of their role*

If the information collected by registrars is not correct the first time around, this problem means less revenue and dissatisfied patients, but patient access employees don't always realize the implications of simple mistake.

Incorrect information sometimes occurs because patients are registered by clinical staff during off-hours or because an emergency department patient doesn't have his or her insurance card, notes **Jennifer White**, director of patient access at Cottage Hospital in Woodsville, NH.

Patient access managers need to "build staff awareness to the tools and resources they have available to get the necessary information to complete an accurate registration," says White. She uses these approaches:

**• Building collaborative relationships with office staff of local providers.**

"We have strengthened the lines of communication with our provider offices," reports White. If the patient states they have a local primary care physician, some provider's offices are willing to share the patient's information with registrars, so the account can be updated and the patient billed accurately.

"The registrar contacts the provider's office after the patient is registered to obtain correct demographics and billing information, so the account is updated prior to the patient being discharged," she explains. "Otherwise, the patient would receive a self-pay notice and would have to call back."

Patient access managers also held practice managers' meetings and provided lunches. "We have a point person sending out communication to the providers' offices on changes, so they are `in the know,'" adds White.

**• Reviewing denied claims with everyone involved.**

"I explain to them what one field of inaccurate information can do to our A/R days," says White. "I review the requirements by all involved staff to correct the issue."

**• Holding a training session on how all the information that is entered at registration affects the bill.**

At a recent staff meeting, White reviewed accounts in which the primary payer on the account was not correct because there was another primary payer. She

## EXECUTIVE SUMMARY

Patient access employees often don't realize the cost of incorrect information obtained at registration. Managers should explain:
• why one field of inaccurate information affects accounts receivable (A/R) days;
• how all the information that is entered at registration affects the bill;
• why poor quality demographic data can result in direct quality-of-care issues.

explained how this mistake delays payment because the claim is rejected, and then the registrar must do additional research on the account. "When this is all finished, billing must submit a corrected claim," says White. "By giving examples of the whole revenue cycle, they begin to realize how their actions at registration affect the whole process."

Staff members didn't realize how important their role is in the revenue cycle process, says White. "After the meeting, staff began asking questions, like 'Did I enter the correct payer?'" she says. *(See related stories, on clinical implications of inaccurate registrations, below, and accuracy with emergency department registrations, below right.)*

**SOURCES**

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# Errors could affect patient's treatment

Patients and family might perceive the information they give registrars as mundane demographic details, says **John Linser**, MPA, director of operations for Registration Services at Cincinnati (OH) Children's Hospital Medical Center.

"We train our employees to always ask for demographic specifics at each encounter," Linser says. "Some parents consider this to be an annoyance, and verbalize that to our staff."

Registrars tell patients, 'We understand this may seem repetitive. But we want be as careful as possible, to have everything right to provide the safest care possible for your child and to be sure the billing process goes smoothly for you."

"We audit 50% of all registrations against multiple criteria, as well as 100% of all registrations requiring a copay," says Linser. Patient access managers provide monthly reports to employees, and this information ultimately becomes a significant portion of the annual performance evaluation.

"Our concerns go beyond billing and patient finance," adds Linser. "An error at registration involving date of birth of a child may create confusion or potential harm for a patient in clinical care."

### Avoid harm to patient

A patient with a date of birth of 02/02/2012 will have significantly different clinical needs than a patient with a date of birth incorrectly entered as 02/02/2002, notes Linser, who adds that registrars use a fully integrated electronic medical record system that includes scheduling, registration, clinical documentation, and billing.

"Obviously, most clinicians will catch an error like this upon the physical presentation of the patient," says Linser. "But the potential does exist for inaccurate demographic information to cause clinical, as well as financial, harm to the patient and family."

Poor quality demographic data can result in more direct quality-of-care issues, he warns. For example, an employee might "select" the wrong patient in the system for another patient presenting for an outpatient lab or X-ray.

"The results of those tests may never make it back to the referring physician of the intended patient," says Linser. "Not only is potentially critical information not communicated, there is also a likely HIPAA [Health Insurance Portability & Accountability Act] issue with the physician and patient who were incorrectly selected upon registration." ■

# ID unique challenges with ED accuracy

*Registrars cope with 'chaotic' environment*

As a new manager in the emergency department (ED) setting, **Shante R. Hill**, manager of the patient access revenue cycle at University of Mississippi Medical Center, Jackson, discovered some unique challenges with registration accuracy.

"Inaccuracy can be as simple as misspelling a patient's name or using an incorrect date of birth," says Hill. "Misidentifying a patient will most likely generate insurance claim denials."

An ED registrar often has limited time to obtain information. "The ED environment can be rapidly chaotic. A registrar can easily create errors simply by moving too fast," says Hill.

Some patients are transported unresponsive and rushed immediately to surgery. Other patients might supply inaccurate information because they're present-

ing in a traumatic state.

"Your family may refer to you as Ann, but your actual name is Angela. A simple mishap can cause chaos for the patient and the facility," says Hill. "This would be a great time to ask for identification cards and insurance information to ensure accuracy."

There are times when the registrar takes on the role of an investigator to obtain patient information, says Hill. "Many resources are utilized, such as the Internet, historical chart information, and contact information for next of kin," she says.

ED registrars also rely on the emergency medical services (EMS) team, who might have communicated with the patient during transport. "Our department also has a follow-up process," says Hill, adding that a new electronic health record system traces the encounter from start to finish. The system acts as an alternate team member, providing warnings and checkpoints for accuracy.

### New approaches

"We are challenged daily with the task of minimizing our errors to decrease claim denials and increase revenue," reports Hill. The ED made these changes to improve accuracy:

**• New staff are required to complete training in the department's electronic medical record system before receiving a system log on.**

**• New staff members continue their education by shadowing a preceptor or supervisor for a two-week period.**

**• Once on-the-job training commences, an assessment is provided.**

"The new team member must master all emergency department functionalities before actively registering a patient," says Hill.

Hill uses registration audit reports to examine revenue collections and insurance claims, to show her registrars the cost of denials. "When errors are created, our leadership team investigates and locates the source," she says. "We then educate the staff on the incorrect and correct actions for performance improvement." ■

# Needless turnover? Put a stop to it

*Pay isn't always the deciding factor*

If one of your best registrars is considering leaving patient access for a higher-paying position in another hospital department that offers better compensation and hours, there might be something you can do to change his or her mind.

"Pay is not always the deciding factor, and that is a good thing," says **Maxine Wilson**, CHAA, CHAM, ambassador for the National Association of Healthcare Access Management (NAHAM) and former director of patient access at Methodist Medical Center in Oak Ridge, TN.

Wilson reports that when she surveyed members of her patient access staff, they often named "appreciation" as the number one reason for their dedication to a position.

After an experienced registrar turned down a position with the business office, she explained that her decision stemmed from the respectful way she was treated by Wilson. "Obviously, some turnover cannot be avoided," says Wilson. "However, minor opportunities for employees to feel appreciated can oftentimes make the difference between a person staying in the area or transferring to another one." Here are Wilson's own strategies for reducing turnover:

**• If an employee is not performing as expected, ask what you can do to help.**

Wilson took aside one poorly performing new hire approaching her six-month evaluation and simply asked, "Is there something I can do to further help you with your performance?" "She stated that other people seemed to avoid her and didn't want to help when she needed it. She felt intimidated by asking," says Wilson.

Wilson then asked a senior patient access employee to take the new hire "under her wing" for a few weeks and make a special effort to answer any questions she might have. "She was enthusiastic after that, and we had a celebration with soda and cookies when her probation period ended," says Wilson.

**• Commemorate birthdays and hire anniversary dates.**

"A small cupcake is very inexpensive, but it shows the employee that you are aware of their spe-


EXECUTIVE SUMMARY

Patient access managers can encourage registrars to stay in the department by expressing appreciation and showing respect.

• Ask poorly performing employees what you can do to help them.

• Commemorate birthdays and hire anniversary dates.

• Post names of top performers on bulletin boards.

cial dates," says Wilson.

**• Pay for the application for certified healthcare access associate (CHAA) examination, with the condition that the employee stays in your department for at least one year.**

Registrars feel a great sense of pride in having "CHAA" on their badge, Wilson explains. "Employees in health care facilities often have many letters after their names on their badges because of the certifications that are required for that position," she says. "This offers the opportunity for the front-end to have credentialing after their name, as well."

**• Post photos of staff with special headlines acknowledging something they are best at.**

"Label your bulletin board any way that you choose — whatever you want them to strive for," says Wilson. Possible headlines are "Best Quality Assurance," "Most Money Collected," "Lowest Call-in Rate," or "Highest Attendance."

"Explain the criteria at a staff meeting, so there is no jealousy or misunderstandings of how this happens," cautions Wilson. "Otherwise, you may cause more harm than good."

**• Arrange for hospital administrators to thank staff members personally.**

Wilson once invited the hospital's chief financial officer (CFO) to present an employee with her CHAA certificate during a staff meeting.

"This was amazing for the employee to have the CFO personally hand them their certificate and pin," she recalls. "I have seen them get tears in their eyes from receiving this, and especially from an administrative leader."

**SOURCE**

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# Cutting Medicaid costs through reduced ED visits

Faced with rising Medicaid costs, most states are trying to come up with ways to save money. About a dozen states have proposed plans that would refuse to pay emergency department (ED) costs for patients whose problems could have been solved with a doctor's office visit, according to the National Association of Healthcare Access Management (NAHAM).

Proponents are basing their proposal on a widely held belief that people without private health insurance use public EDs for minor or routine complaints. The supporters believe that this policy would encourage those individuals to obtain and be treated by a primary care doctor where the care might be better and the price tag is cheaper.

The obvious problem that arises, however, is in figuring out how patients will know what is an emergency, verses what can be treated with an office visit. As an NPR Shots article points out, people come to the ED with symptoms, not diagnoses. Opponents say that enacting a policy such as this one can discourage people from using the ED in cases in which they should be there. Chest pains, for example, can be a heart attack or indigestion, but patients need to be in the ED if it is the former.

Under the Affordable Care Act, Medicare and private insurers are required to pay for ED visits that a "prudent layperson" would consider necessary, such as the chest pains visit that turns out to be indigestion. Medicaid recipients, however, are not afforded the same protection.

One study cited in the article looked at the discharge records for 35,000 people that visited the ED in 2009. When researcher separated out the people who had primary care treatable problems, they were found to only make up 6% of all the records in their study. Additionally, the 6% of primary care treatable patients presented with the same symptoms as 89% of people who went to an ED.

Washington passed a plan to cut ED payments that was overturned by the governor. Without state Medicaid programs paying, the cost for these ED visits would be passed to the hospitals. *(To read the entire NPR article, go to http://n.pr/Y5btk9.)* ■

## COMING IN FUTURE MONTHS

- Make same-day scheduling a reality
- Take credit for revenue cycle successes
- New approaches for emailing patients
- Help employees obtain CHAA certification

# Draft application is long for health exchanges

*Application to take 30-45 minutes*

The Department of Health and Human Services (HHS) came out in March with a draft insurance application that showed what applying for benefits under the Affordable Care Act (ACA) exchanges might look like.

The application runs 15 pages for a family of three, which extinguishes some hopes that signing up for a plan could be as simple as online shopping, according to the National Association of Healthcare Access Management (NAHAM).

According to a CNBC/AP article, the online application outline is not much shorter and runs at least 21 steps. Some of the steps have multiple questions included. The information then will be reviewed by at least three major federal agencies, including the IRS, to verify an applicant's identity, citizenship, and income. The IRS is supposed to process online financial application in real time because the ACA is means-tested, meaning that lower income people get the most generous help to pay premiums. Middle-class applicants will be eligible for tax credits to help pay premiums to private companies, while low income applicants might be eligible for social programs such as Medicaid.

The draft applications in paper and online form were posted by HHS seeking feedback from consumer and industry groups. HHS estimates that the online application will take about 30 minutes to complete, and the paper version will take about 45 minutes. Some groups are concerned that at that length, the form might overwhelm uninsured people and lead them to simply give up. Giving up will be an issue next year when carrying health insurance becomes mandatory.

HHS estimates it will receive more than 4.3 million applications for financial assistance in 2014, with online applications accounting for about 80% of them. Because families can apply together, the government estimates 16 million people will be served. *(To read the entire CNBC/AP article, go to http://www.cnbc.com/id/100548997.)* ■

HIPAA Regulatory Alert

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

# Are you in the cloud? Time to scrutinize agreements

*Omnibus rule clarifies definition of cloud providers as business associates*

Although healthcare organizations have been slower to adopt cloud-computing services than other industries,[1] a recent study shows that 62% are using cloud services for some activities.[2] However, 47% of respondents relying on the cloud are not confident that information is secure, and 23% are only somewhat confident.

The Health Insurance Portability and Accountability Act (HIPAA) omnibus rule addresses security concerns with expanded and clarified definitions of business associates (BAs) to include vendors who may transmit only data, a task performed by cloud service providers.

"Throughout the past two years of review and comment on the rule, cloud vendors insisted they be treated as a conduit of information and not as a business associate with access to data," explains **Cynthia J. Larose**, Esq., an attorney and member of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo in Boston.

The actual conduit exception defined in the final rule is limited to companies such as wireless carriers, telephone companies, or delivery services such as FedEx, she explains. "Even if a cloud services provider is not contracted to work with the data of a client, the point is that the vendor has to have access to provide maintenance, upgrade service, or perform other operations."

Identification of cloud service providers as business associates is not new, points out **Anna L. Spencer**, JD, an attorney with Sidley Austin in Washington, DC. "Even prior to HITECH [Health Information Technology for Economic and Clinical Health], the FAQ guidance on business associates indicated that companies that provided hosting or software services were considered business associates," she explains. This fact was highlighted with the fine levied against Phoenix Cardiac Surgery for using a publicly accessible Internet calendar to schedule appointments and surgeries. One of the findings by the Office of Civil Rights (OCR) was that the practice "failed to obtain business associate agreements with Internet-based email and calendar services where the provision of the service included storage of and access to its ePHI."[3]

The good news for hospitals and health systems is a "crystal clear" definition of cloud providers as business associates. The bad news is a critical need to review existing agreements with cloud providers to ensure they are held to the same standards as all business associates. "Covered entities must revisit all cloud vendor agreements," recommends Larose. "Even if a cloud provider claims to be HITECH-compliant, the covered entity must ask for proof." This proof includes documentation of a third party assessment report certifying existence of privacy and security controls within the organization, a Statement on Standards for Attestation Engagements (SSAE) No. 16, she suggests.

While the SSAE provides proof of an assessment, it is not healthcare-specific, so require other documentation as well, suggests **Andrew Hicks**, MBA, CISA, CCM, CRISC, director and healthcare practice lead at Coalfire, a Louisville, CO-based independent IT governance, risk, and compliance firm. "The best proof is a HITRUST [Health Information Trust Alliance] certification," he suggests. "It is specific to healthcare and covers privacy and security concerns." Third party reports should include documentation of penetration testing as well as vulnerability assessments, and all documentation should be

## EXECUTIVE SUMMARY

While cloud service vendors have argued that they are not business associates (BAs) because they do not "handle" the data as more traditional BAs such as billing services do, the HIPAA omnibus rule clearly defines cloud service providers as BAs.

- Healthcare organizations should revise agreements with cloud service providers to meet BA requirements.
- Ask for documentation of third-party audits to prove compliance with security requirements.
- Understand how and where data is stored and protected.
- Make sure the cloud service provider has BA agreements with all downstream subcontractors.

requested annually, he adds. "The covered entity must hold the cloud service provider responsible for data."

While all of this documentation should be in place at the start of any new contract, a covered entity should specify a timeframe in which existing vendors must prove compliance to continue the business arrangement, he recommends. *(See story on this page for specific questions about security to ask a new vendor.)*

## Know downstream vendors

The omnibus rule also points out the business associate's responsibility for downstream vendors, says Spencer.

"This is critical for healthcare organizations working with cloud providers because many companies presenting themselves as cloud vendors are offering services that run on other cloud platforms such as Google or Microsoft," she says.

While the vendor with whom the hospital contracts has privacy and security controls in place, the actual platform provider might not, she explains. For this reason, make sure the cloud provider is asking for the same proof of compliance from its own vendors.

"Encryption is an interesting wrinkle in this conversation about cloud provider responsibilities," says Spencer. "Theoretically, the cloud service provider's access to data is not an issue if the healthcare organization transmits only encrypted data." At this point, there is no guidance as to whether or not this type of encryption eliminates the business associate responsibility for the cloud provider, she adds.

"Encryption minimizes risk but doesn't eliminate it, so don't select a cloud provider who can't produce the documentation you require, even if you plan to only transmit and store encrypted data," says Spencer. If you are already working with a cloud services vendor who won't produce the documentation you require, be ready to move to a new vendor. "This is not always easy to do," she admits.

Although business associates are required to return or destroy data after termination, a hospital's current contract might not identify the vendor as a business associate, and language in the contract might not address status of the data upon early termination. "Operationally, it may not be easy to switch to another vendor, but even if it is, be sure you know what happens to your data with the previous vendor," she adds.

Ensuring compliance with security requirements might take time and effort, but the risks are great, points out Spencer. "It's not just about OCR penalties. If a cloud service provider can't meet security requirements, and a hospital continues to do business with the vendor, the hospital is financially responsible for all the costs of a breach, which can be sizable when a cloud services provider is involved."

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**SOURCES**

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# Is the cloud safe for healthcare?

*Ask these questions to determine data security*

The benefits of using cloud service providers include improved operating efficiencies as well as reduced costs related to infrastructure, when compared to more traditional, physical environments.

Ensuring data security, however, is more complex than traditional data storage systems, says **David S. Linthicum**, founder and chief technol-

ogy officer of Blue Mountain Labs, information technology advisors in St. Louis, MO. As times go on and more healthcare organizations rely on cloud computing, regulations such as the omnibus rule will provide guidance on how health entities can ensure they are choosing a cloud service provider that is compliant with privacy and security regulations, Linthicum explains. "Until then, it is up to the healthcare organization to be skeptical and ask cloud providers to prove their ability to meet security requirements," he says.

One of the first steps is to understand what service you are purchasing, suggests Linthicum. The cost-savings of cloud computing are related to the multi-tenant structure of the service. The cost benefit of cloud computing are related to multiple customers sharing the costs of transmitting and storing data. The multi-tenancy is something healthcare organizations need to understand. Some of the key questions to ask potential cloud service providers include:

**• How are clients segmented?**

**Andrew Hicks**, MBA, CISA, CCM, CRISC, director and healthcare practice lead at Coalfire, a Louisville, CO-based independent IT governance, risk, and compliance firm, says, "If it is one system with multiple tenants, there are firewalls between data, but healthcare organizations should ask how the cloud service provider ensures data is never mixed."

Another key issue to address is how the cloud service provider can identify what data is involved if a breach occurs. Although the provider is not working directly with the data, it should be able to identify which client's data was breached and the extent of the breach.

**• Where is data stored?**

**Cynthia J. Larose**, Esq., an attorney and member of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo in Boston, says, "Another significant concern that must be addressed in any agreement with a cloud service provider is the location of the data."

Data with a cloud service provider is always moving from server farm to server farm, depending on demand for access and space on servers, Larose explains. "Many providers use server farms outside the U.S., where data security is not as regulated," she says. "For this reason, healthcare organizations should specify that their data is never to be stored anywhere outside the U.S."

**• Do you work with healthcare or financial institutions?**

It is helpful to work with a cloud service provider that understands healthcare privacy and security requirements, but a provider who handles financial transactions, such as credit cards, is accustomed to high levels of security, Hicks points out. "They also have systems in place to track location of data and correctly identify what information was affected by a breach," he says.

Ask specifically about other healthcare clients, suggests Linthicum. "Request permission to contact their largest and most active healthcare clients for a reference," he advises.

**• What are your physical security protections?**

Don't just focus on data security while in storage or transmission, suggests Hicks. "Ask about controls that limit physical access to servers as well as employee access to data," he says. Just as a hospital tries to ensure employees don't carry unencrypted personal health information home on a laptop that can easily be lost, a cloud service provider should have physical safeguards as well as policies to protect your data.

**• What are your disaster recovery procedures?**

When asking about security protections, ask about disaster recovery plans as well, says Hicks.

"Understand what their disaster recovery plans includes such as location of data and how easily accessible it is to you," he says. In addition to making sure your data is secure in the event of a disaster, you also want to make sure continuity of your service is not affected, he adds.

While use of cloud computing can be a safe, cost-effective business solution for many healthcare organizations, it might not be right for everyone, admits Linthicum. "Each organization should evaluate their needs, costs of cloud versus other computing solutions, and their organization's readiness to change," he says.

If an organization enters into an agreement with a cloud services provider, be sure to define specific penalties and responsibilities for the provider, suggests Linthicum. "Healthcare is very wary of cloud computing, but there are benefits," he says. "Each organization needs to weigh the risks and benefits to make the right choice based on individual need." ■

# Free resources help with risk assessments

*If consultant is needed, follow these suggestions*

New provisions and clarifications in the Health Insurance Portability and Accountability Act (HIPAA) omnibus rule might have some hospitals scrambling to determine their compliance level, but it might not be a situation that requires outside help.

"Organizations should always return to a risk assessment when there are questions about compliance or changes in regulations," says **Judi Hofman**, CHP, CHSS, CAP, privacy and security officer at St. Charles Health System in Portland, OR. "A high level assessment can help you quickly identify gaps that you can address in more detail."

Although some organizations might find it beneficial to hire an outside consultant to help with the assessment, there are free resources that might meet your needs, says Hofman. The American Health Information Management Association (AHIMA), is a national health information management professional association that offers free resources, she says. *(Go to http://www.ahima.org and select "resources," and then choose "Privacy, Security and Confidentiality.")* "And state chapters of AHIMA are also producing best practices to share among members," she says. A list of AHIMA state chapters can be found at http://www.ahima.org/about/csa.aspx. Another free source of guidance includes the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC) at http://www.healthit.gov. *(Select "For Providers & Professionals.")*

State hospital associations often have an information technology committee actively working on guidance as well, says Hofman. "There is free guidance if a hospital doesn't have the financial resources for outside help," she says.

If the decision is made to hire an outside consultant, Hofman recommends the following:

**• Decide what services you need before talking with consultants.**

"Do you want a full risk assessment but not a mitigation work plan, or do you want both?" Hofman asks. "It's important to know exactly what you want before interviewing consultants because you want to determine the scope of the project, not ask the consultant to do so."

**• Use a committee to evaluate consultants.**

Invite everyone who will be affected by results of a risk assessment to help evaluate a consultant's skill, experience, and approach, says Hofman. "Obviously, the privacy and security officers should be included, but also include the information technology managers and other key hospital leaders." Their involvement at the start of the project will ensure continuity as gaps are identified and mitigation plans developed, she explains.

**• Remember consultant's perspective.**

"Don't be surprised to receive a list of gaps in your compliance plan," says Hofman. "Consultants are paid to find risks, so they will give you a comprehensive list to justify their fees." The key is to evaluate the risks identified by the consultant carefully, she says. "Ask yourself if the deficiencies are correctable or if they are not a priority at this time."

**• Ask state association and other hospitals for recommendations.**

"It is best to have recommendations for consultants from people you trust," says Hofman. By turning to other healthcare organizations in your area, you can be sure to find someone who knows healthcare and has the skill and experience to handle your risk assessment, she adds.

While the potential cost is prohibitive to some organizations, the benefits of an outside consultant include a subjective, third party assessment, points out Hofman. "Consultants usually arrive with a team of people to focus only on the assessment, which frees you up to do your work," she says. "This is helpful because it is hard to conduct a thorough risk assessment and stay current with day-to-day responsibilities at the same time." ■

# Breaches affect more than 21 million

The importance of encryption is emphasized with most of the most recent major breaches added to the Department of Health and Human Services' (HHS') list of breaches. Seven of the breaches involved laptops, while the other two involved paper records.

Other recent breaches were caused by a hacking incident and unauthorized access. The largest number of individuals affected by a single breach was 109,000. The incident involved Crescent Healthcare, a Walgreens company that provides pharmacy and nursing solutions. Theft of a desktop computer resulted in the breach.

The HHS list includes 556 breaches affecting 21.7 million individuals. More than half of the breaches are related to lost or stolen unencrypted computers or mobile devices. The list contains breaches that affect 500 or more individuals and tracks incidents that have occurred since September 2009 when the breach notification rule came into effect.

For a complete list of breaches, go to http://www.hhs.gov/ocr/office/index.html. Select "Health Information Privacy" on top navigation bar, then select "HIPAA Administrative Simplification Statute and Rules. On the left navigation bar, choose "Breach Notification Rule," and then on the right side of the page, under "View Breaches Affecting 500 or More Individuals," select "View a list of these breaches." ■