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`Flex up' staffing while staying budget-neutral with cross-training

Patients, employees, and hospital all benefit

Cross-training has allowed the patient access departments at St. Joseph's Wayne Hospital and St. Joseph's Regional Medical Center, Paterson, NJ, to supplement staffing while staying budget-neutral.

"We are able to 'flex up' our staffing, wherever the need may be," reports **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access.

At Swedish Covenant Hospital in Chicago, essential job functions such as outpatient and emergency department (ED) registration recently were merged with appointment scheduling and referral coordination.

Carlos Collazo, patient access applications trainer, says, "The intention is to provide our patients with options to schedule their outpatient testing either by walk-up or by phone. We anticipate our central scheduling call volumes to decrease from 5 to 10%."

Coverage in ED

At St. Joseph's Regional Medical Center, patient access includes the information desk, the previsit service department, outpatient registration and emergency room registration.

"Our volumes in our emergency department continue to grow," says Rivera.

EXECUTIVE SUMMARY

By cross-training registrars, patient access departments can supplement staffing as needed while staying budget-neutral. Patient access leaders report decreased call volumes, better patient satisfaction, and improved morale.

- Emergency department registrars also can perform financial counseling.
- Outpatient registrars also can schedule.
- Staff members need enough time to become comfortable in new areas.

To support the ED registration staff, outpatient and previsit registration staff were cross-trained so they could work during peak times in the ED. The registrars, who already were experienced with patient registration and the hospital's Admission/Discharge/Transfer (ADT) system, were assigned for observation on the first day. "The second day, the employee was assigned to work with an ED registrar who provided elbow-to-elbow support," says Rivera. Finally, the employee was assigned to go to the ED for a minimum of two hours, until he or she was comfortable and knowledgeable.

"Often, we provide coverage so the ED staff is able to go on scheduled breaks and lunches, in addition to being back-up support during normal hours," says Rivera.

This approach has allowed the staff to be comfortable with the processes used in the ED. "In the beginning, the staff was apprehensive because they were working in a new area. But once training was provided, their fears subsided," says Rivera. She pointed out to registrars that while the ADT screens are a little different, all of the knowledge required on how to register a patient is the same.

"We worked with the staff to explain to them that registration is registration, regardless of location," she says.

Staff members need right mindset

Cross-trained staff members need enough practice to feel comfortable in the area they're covering. To reach this comfort level, says Rivera, "the staff needs to keep up their skills, not just go to the area once in a while."

While it is important to have multi-skilled staff, it is equally important for staff to have the right mindset, says Collazo. The mindset is especially important if staff members are discussing financial liabilities with a patient.

Cross-training helps patient access managers to keep costs under control while supplementing current staffing on an as-needed basis. "If staffing needs change due to an increase in volume, however, this is not the long-term solution," cautions Rivera. Because cross-training increases the skills the employee has, it makes them more valuable and marketable, she says. Collazo has seen these benefits from cross-training:

- reduced denials, due to increased staff ability to identify authorization and referral requirements;
- increased collections because more staff are comfortable asking patients for payment;
- the ability to provide staffing coverage when and where it is needed without incurring overtime;
- improved morale, because staff members like to have more variety in their jobs.

"It is also one of the best ways for leadership to identify hidden skills and who your true team players are," says Collazo.

Collazo uses himself as an example to illustrate the benefits of cross-training. He started his career at Swedish Covenant Hospital as an outpatient registrar. After one year, he was given the opportunity to cross-train in patient appointment scheduling, financial counseling, physician referral, and insurance verification.

"I really enjoyed the training aspect of it and offered to work with leadership on expanding staff

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Editor: **Stacey Kusterbeck**, (631) 425-9760.
Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Director of Continuing Education and Editorial: **Lee Landenberger**

AHC Media

Editorial Questions
For questions or comments, call Joy Dickinson at (404) 262-5410.

training material to include developing competency testing for both on- and off-campus registration users," he says. In 2013, he was offered his current position of patient access applications trainer.

The advantages of cross-training by far outweigh the cost and time it requires to do successfully, Collazo says. "Cross-training provides job security when specific tasks or responsibilities become obsolete because they are replaced by systems or software," he adds.

Eliminate redundant work

Kathleen B. MacGillivray, MHA, director of access management services at Robert Wood Johnson University Hospital in New Brunswick, NJ, recently hired a patient accounts manager to bring "back office" knowledge to her employees on the front end.

"Her first assignment was to develop a training module that enhances the front office staff's skill sets," MacGillivray says.

The training module covers scripting, upfront collections, insurance eligibility, and how to determine the patient's out-of-pocket costs. "For access, our role in the revenue cycle is becoming more and more valuable, as it relates to a clean bill drop," says MacGillivray. This change means that redundant work on the back end must be eliminated, she says, "so a front-end manager with back-end knowledge can immediately focus staff on their shortcomings and opportunities for improvement."

MacGillivray is exploring whether it's feasible for staff to develop payment options for patients. "I will do whatever I can to make the front end stronger," she says. "For me, the pressure is on for access management."

MacGillivray is considering developing a new "hybrid" registrar, to handle the functions of access with a strong financial component.

"There's so much riding on our success," she says. "We need to be able to pre-register patients, check eligibility, identify pre-certification requirements, and most challenging, collect the patient responsibility portions. It's a lot." *(See related stories on training registrars to do scheduling, this page, and being flexible with staffing solutions, p. 16.)*

SOURCES

For more information on cross-training in patient access, contact:

• **Donna J. Aasheim**, CHAM, Director, Patient Access Administration, Eisenhower Medical Center, Rancho Mirage, CA. Phone (760) 773-1508. Email: DAasheim@emc.org.
• **Carlos Collazo**, Patient Access Applications Trainer, Swedish Covenant Hospital, Chicago. Email: CCollazo@schosp.org.
• **Kathleen B. MacGillivray**, MHA, Director of Access Management Services, Robert Wood Johnson University Hospital, New Brunswick, NJ. Phone: (732) 937-8909. Email: Kathleen.MacGillivray@rwjuh.edu.
• **Sandra N. Rivera**, RN, BSN, CHAM, Director, Patient Access, St. Joseph's Wayne Hospital/St. Joseph's Regional Medical Center, Paterson, NJ. Phone: (973) 754-2206. Fax: (973) 754-4662. E-mail: riveras@sjhmc.org. ■

Hospital registrars now do scheduling

In 2013, outpatient registrars at Swedish Covenant Hospital in Chicago were crossed-trained to perform outpatient scheduling activities.

A patient might walk in for lab testing and present another order for a pelvic ultrasound, for example. "The registrar will create an account for the lab test, schedule the ultrasound appointment, and then alert insurance verification team to see whether an authorization or referral is required," says **Carlos Collazo**, patient access applications trainer.

As of July 2013, the hospital's emergency department (ED) registrars were cross-trained to perform a variety of patient financial counseling activities and also to schedule follow-up appointments for the ERIE Family Health Center on the hospital campus. These steps occur:

- All ED patients being discharged are escorted by a nurse or technician to the discharge area.
- The ED registrar collects the co-pay, deductible, or outstanding balances identified. He or she provides the patient with a financial assistance packet and application, if applicable.
- The ED registrar then checks patient discharge follow-up instructions to determine if an appointment with Erie Family Health clinic is needed.

All ED registrars were trained in appointment scheduling with an inservice with each of the departments that does scheduling, side-by-side training using dual headsets, and a review of scheduling department procedures including patient scripting and a final competency test.

"Financial counseling training requires an inservice and review of procedures provided by our credit service department," Collazo says. ■

Access should be flexible with staffing solutions

Don't let your department be shortchanged

Patient access departments can be shortchanged with staffing if they don't monitor volumes, warns **Donna J. Aasheim**, CHAM, director of patient access administration at Eisenhower Medical Center in Rancho Mirage, CA.

"Typically, finance is not looking at the actual workloads; they are looking at the volume numbers," says Aasheim. "Due to fluctuating volumes, it's usually the non-clinical departments that have FTEs [full-time equivalents] cut."

It's difficult for patient access areas to cover shifts with reduced staffing especially with sick calls, vacations and the Family and Medical Leave Act (FMLA), says Aasheim. She made these changes:

• Aasheim established an on-call pool of staff members who work per diem.

• Aasheim asks patient access leaders to monitor volumes by hour.

"I have given my leadership instructions to move staff around and/or flex whenever possible," she says.

Eisenhower Medical Center is a large organization with numerous offsite registration locations, and it services varying seasonal volumes. "We need to make sure we can be flexible in the spring and summer months, in order to be optimal when the season starts in October and our volumes nearly triple," she says.

• Aasheim cross trained outpatient registrars in all 15 registration locations.

"During our lower volume days, we move staff across different registration

locations to cross-train with existing staff," says Aasheim.

• Aasheim introduced "registration standards."

"This standardizes data entry as to what information goes into what field, making it easier for registrars to work in different areas," says Aasheim. ■

Registrars given a goal, collections rise by 79%

Another 10% increase expected for 2014

Giving registrars a copay goal increased collections by 79% in one year at Lake Forest (IL) Hospital.

"It started out slow," reports **Tina Sviland**, CHAA, resource coordinator for registration.

When Sviland took over as the supervisor of registration in the ED, copayment collection was not a strong focus. "I saw the missed opportunity for collections," she says. Sviland took these steps:

• Sviland gave each registrar a copayment goal for each month, based on the number of hours they worked.

• She gave the team an overall goal to reach for the month and the year.

• Sviland educated staff on the importance of collecting upfront.

The first year, the department increased collections by 30%. "With practice and consistency, we were up 60% over last year. At the end of the year, we were up 79% over the previous year," says Sviland. The team exceeded the collection goal set for 2013 by 1%, and has set a goal to increase collections by another 10% for 2014.

"The process for setting goals is simple," says Sviland. "I take our yearly goal and break it down into a 12-month period."

The full-time staff all have the same goal, and the part-time staff have goals set based on the number of hours worked. "The team is very focused and will continue to collect even when their goal is met," says Sviland.

Start with the organization's historical benchmarks for collections, and increase these by 10-20% after training and tools are solidly in place, says **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Passport, a provider of technology for hospitals and healthcare providers. "An industry benchmark has been 1% to 1.5% of net revenue," she says. "However, there are so many variables in setting an amount that it is difficult to know the possibilities until you take the plunge."

To make staff members feel successful, Murphy suggests you keep moving the target month by month or quarter by quarter. "If goals are not met, then listen to the registrar's issues and reasons," she says. "Often,

EXECUTIVE SUMMARY

Patient access leaders at Lake Forest (IL) Hospital increased collections by 79% and have set a goal to increase collections by another 10% in 2014.

• Give registrars a copayment goal based on the number of hours worked.

• Increase the goal by 10-20% once training and tools are in place.

• Ask for partial payments if patients aren't able to pay in full.

there is valuable insight that can shed light for overall improvements."

30% of copays missed

A common obstacle to collections is that patients are unwilling or unable to pay at the time of service.

"They will say to my team, 'Just bill me,'" says Sviland.

There is also difficulty in collecting a patient's copayment when the department is extremely busy. "We run on a tight staff, so that can be a challenge," says Sviland. "My team is diligent in capturing every available copayment. But I do know that when we are busy, a few are missed."

For these reasons, Sviland estimates that 30% of copays aren't collected at the time of service. Before goals were set, however, more than 70% of copays weren't collected.

There are times when a patient will present without any identification or insurance cards, which happens most often when patients are brought in by ambulance. Some patients state that they are not prepared to pay the amount.

"My staff will ask if the patient would like to put anything toward their copayment," says Sviland. "This way, we are able to capture a partial payment. This has been successful for us." *(See related story with tips for departments just starting upfront collections, below.)*

SOURCES

For more information on setting collection goals, contact:
• Katherine H. Murphy, CHAM, Vice President, Revenue Cycle Consulting, Passport, Oakbrook Terrace, IL. Phone: (630) 812-2559. Fax: (630) 620-9328. Email: Katherine.Murphy@passporthealth.com.
• Tina Sviland, CHAA, Resource Coordinator Registration, Lake Forest (IL) Hospital. Phone: (847) 535-6404. Fax: (847) 535-7808. Email: tsviland@lfh.org. ■

Set the stage for collections

Collection is "more than just asking," says **Katherine H. Murphy**, CHAM, vice president of revenue cycle consulting in the Oakbrook Terrace, IL, office of Passport, a provider of technology for hospitals and healthcare providers.

"A full assessment of the staff and of the provider's existing challenges, barriers, strengths, and weaknesses should be done to set the stage and expectations properly," says Murphy. Determine if staff members have access to the information needed to ask for the correct amount, or if they will be uncomfortable asking for money, for example.

Murphy says patient access managers should ask these questions before starting upfront collections:

• Are we new to this process, and does my staff need collection and negotiation training?
• What is the economic climate of the population served?
• How much of the process is or will be automated?
• Are determining insurance eligibility and benefit information automated and integrated?
• Is the eligibility information uniform and rich in the content needed for collection activities?
• Is there easy access to procedure pricing, historical data, and contract terms needed to determine the patient liability?
• How easy is it to calculate discounts?
• Do we have an automated estimator tool?
• Is the cashiering process and payment plan process easy and quick?
• Does the collection goal include dollars collected on existing open accounts?

Managers need to determine the best time to ask for the money is crucial, and this varies on a case-by-case basis. "Point of service is also the 'point of stress' or 'point of crisis' for the patient," says Murphy. "You also have to assess if you should collect."

About 50 million people are uninsured, notes Murphy, but many are eligible for Medicaid or other charity and financial assistance programs. "This makes collection a slippery slope without automated tools focused on determining a patient's ability to pay," says Murphy. "As recently as 2011, nearly two-thirds of Medicaid-eligible children were not enrolled." She recommends these approaches:

• Collect money yourself.

Managers who expect staff to collect from patients should periodically get involved in taking a payment themselves, advises Murphy. She recommends going out to the registration area and collecting money yourself.

"Try doing it by phone in scheduling. Show the staff you really do understand their challenges," she says. "They will love you for it."

• Always celebrate if collection goals are met or exceeded.

"Food is a universal way to celebrate," says Murphy. Other ideas include: Pass a traveling trophy between registration areas, give staff members a recognition pin or flower, or give a handwritten thank-you note to top collectors.

• Give staff incentives.

"A reward and incentive program is really important

to the folks in the hot seat," says Murphy. "It doesn't have to be costly, either."

Pick a day of the week for cookies, bagels, fruit bowl, a potluck lunch or dinner, or coupons for a sundae or frozen yogurt from the cafeteria, Murphy says.

"We once had a 'white elephant' gift exchange in the middle of summer at our pizza lunch. This added levity and helped clean out our closets," she says.

• Be visible in registration areas.

Take a walk through registration areas, suggests Murphy. Ask staff if things are in working order, and ask whether they have had any recent challenges or successes they would like to share. Pass around a basket of candy as you talk to them.

"Sometimes my areas were so busy I could barely say hello, but I know that my staff saw me," says Murphy. "It meant a lot to all of us."

During off shifts, weekends, and holidays, Murphy would occasionally pop in to say hello or at least call staff to let them know she was thinking of them.

"Even during the night shift, call your ED registrar," she says. "Let them know that you have not forgotten them and that they are important members of the team." ■

Get all registrars CHAA-certified

It sends a message: 'It's not just a job'

"More and more hospitals are requiring their staff to become certified in their field, and this includes patient access," says **Brenda Sauer**, RN, CHAM, president of the National Association of Healthcare Access Management (NAHAM) and director of patient access at New York Presbyterian Hospital/Weill Cornell Medical Center in New York City.

Certifications allow organizations to standardize the knowledge of all the staff members who participate and can be used in the development of career ladders, she explains. Sauer strongly encourages her staff to become members of NAHAM.

"NAHAM just received NCCA [National Commission for Certifying Agencies] accreditation on our certification program, so we have met their vigorous requirements to receive their approval," she reports.

CHAM is required

Sauer now requires her management team to obtain certified healthcare access manager (CHAM) certification. Currently, 30% of the management staff is certified. "They must all be certified by the end of 2014. I find the information to be valuable in their professional growth," she says.

Sauer is hoping to see a higher level of professionalism and also an understanding of what is important from a global standpoint in patient access, not just what is going on in their area. "With so many changes occurring in patient access at this time, it is important for them to be knowledgeable in all areas," emphasizes Sauer. "Maintaining their certification will force them to keep up to date."

It also helps leaders from the "C-suite" to recognize the added responsibilities and increase in professionalism of staff in patient access, she adds.

There is another more intangible benefit to getting certified. "There is a certain amount of pride in wearing the CHAM pin and adding those letters after your name, and I want them all to experience it," says Sauer.

In the coming year, Sauer will encourage other staff members to sit for the certified healthcare access associate (CHAA) exam as part of the development of their career paths, especially if they have indicated they would like to move forward in their career in patient access. "Many leaders in the field are requesting this of their employees, and incorporating it into their career ladders for patient access," she says. "We no longer see this role as 'just a job.'"

Pay is 5% higher

Patient access leaders at Lee Memorial Health System in Fort Myers, FL, offered staff the opportunity to obtain certified patient account technician (CPAT) certification for many years, but very few did so.

"It wasn't until recently that we have made a concerted effort to encourage certification," reports Colleen Edwards, CHAM, system director of registration and patient business services.

When Edwards and several colleagues became CHAM-certified in 2012, they made it a priority to encourage staff to become CHAA or CPAT-certified. "We began by highlighting the organizational posi-

EXECUTIVE SUMMARY

A growing number of patient access managers are encouraging registrars to get professional certification to promote professionalism and improve retention. Some approaches are:

- Require management team to obtain certification.
- Incorporate certification into career ladders.
- Reimburse staff for the cost of the exam, and offer a small pay increase.

tives," says Edwards. These include gaining a much better understanding of the employee's role in the organization and the revenue cycle, and well as gain a better understanding of the rules and regulations involved in daily functions.

"We also emphasized the personal gain," says Edwards. "Successful achievement of the certification earns staff a 5% pay increase; and they get reimbursed for the cost of the test upon successful completion."

It is important for the leaders to become certified themselves first, Edwards says. "This demonstrates their commitment and excitement for their own certification and encourages staff to do the same," she says. *(See related stories on how the department dramatically improved retention with career ladders, this page right, and how to help staff to study for the examination, below.)*

SOURCES

For more information on certification in patient access, contact:

• **Colleen Edwards**, CHAM, System Director, Registration and Patient Business Services, Lee Memorial Health System, Fort Myers, FL. Phone: (239) 424-3297. Fax: (239) 424-4049. Email: colleen.edwards@leememorial.org.

• **Brenda Sauer**, RN, CHAM, Director, Patient Access, New York Presbyterian Hospital/Weill Cornell Medical Center, New York, NY. Phone: (212) 746-4630. Fax: (212) 746-2891. Email: bsauer@nyp.org. ■

2014 Certification Update

Help staff members to pass CHAA exam

Colleen Edwards, CHAM, system director of registration and patient business services at Lee Memorial Health System in Fort Myers, FL, offers study sessions for staff who express interest in certified healthcare access associate (CHAA) certification as a show of support of their career development.

"Interested staff can come together for open study time. We have found, however, that staff prefers to study on their own or with a partner," says Edwards.

Staff members have gotten together on their own for their study sessions. "If they needed a room to gather, we would help to find one," says Edwards.

She tells staff studying for the CHAA examination to research and understand the topics they deal with every day such as the Health Insurance Portability and Accountability Act (HIPAA), red flag rules, the Emergency Medical Treatment and Labor Act (EMTALA), patient rights, Medicare, Medicaid, the Medicare as Secondary Payer (MSP), advance beneficiary notices, understanding insurance eligibility and authorization requirements, calculating patient responsibility, and good customer service.

She shares general test-taking tips that include use of flash cards, colleagues quizzing one another, highlighting material, and reading and re-writing sections of text. "Many people haven't had to study for a test in quite a while, so study tips are much appreciated," says Edwards.

The excitement of working toward their CHAA certification has made her staff visibly more confident. "It shows in the pride they display in their work, in themselves, and their professionalism and customer service skills," Edwards says. ■

Turnover is cut by 15% with ladders

Patient access leaders at Lee Memorial Hospital in Fort Myers, FL, have seen a greater than 15% reduction in turnover rates over the past few years. **Colleen Edwards**, CHAM, system director of registration and patient business services, attributes this reduction, in part, to the department's career ladder.

"Our average seniority in our departments is approximately eight years, with 25% employed from 10 to 33 years," says Edwards.

The department offers four levels of staff positions: financial counselor, emergency department (ED) financial counselor, lead financial counselor or patient business representative, and trainer.

A pay program fast tracks advancement. All new hires for the same position start at the same pay rate, but instead of receiving only the annual merit increase, they are re-evaluated every three months. Staff receive a 50 cent per hour pay increase as long as they are performing at the expected level, until they reach the midpoint pay rate of the position.

"Merit raises then kick in at year end," says Edwards. "Prior to this pay plan, it took many years to reach the midpoint pay rate of the position."

The three-month evaluations are focused on checking the quality of the registrations as well as the volume. "We review the documents table to ensure they are scanning the cards and photo IDs and getting all necessary forms signed," says Edwards. Here are other things that managers review:

• Are staff choosing the correct payers and reading the electronic eligibility response?

• Are they creating duplicate medical records because they aren't accurately checking the patient's identity or not using the proper search criteria?

• Are they banding the patients using the two patient identifiers?

• Are they bypassing warnings instead of completing the fields?

• Are they working their edits from the work queue?

• In general, are they having more difficulties acclimating to this role than a typical person with the same length of employment?

The department makes a point of hiring from within when leads and trainer positions become available. "Whenever a higher level position becomes available, we always look inside first," says Edwards. "This encourages career growth."

She has promoted ED financial counselors to lead positions and then onto registration trainers. "They were exceptional in each job they held," she says. "We were thankful a higher level position became available so they didn't have to look elsewhere." ■

Access departments lack collection tools

Up to 5% of net patient revenue is at stake

After implementing a price estimation tool, patient access leaders at Ochsner Medical Center — North Shore, Slidell, LA, were able to increase monthly point-of-service collections by $22,000.

"It could have even been a greater growth, but we were in end-of-year status where deductibles and coinsurances have been met," says Tammy Flair, patient access manager. "We plan to see more opportunity with the new year."

The patient payment estimator tool (ClearQuote, manufactured by Chicago-based TransUnion Healthcare) gives registrars with an accurate estimate based off of the CPT code and level of care for emergency department patients. "We can include diagnosis codes, CPT or descriptions, surgeries, anesthesia charges, and professional charges," says Flair. "This tool allows us to inform the patients days in advance so that they can prepare for this financial obligation."

The department has seen a decrease in inquiries about patient responsibility, fewer billing follow-up calls, and less bad debt. Patients seem to have more peace of mind after they're given an accurate and timely estimation of their responsibility, adds Flair.

"The financial requirements for healthcare are a large stressor for our patients," she says. "To be able to communicate this in advance, and offer front end financing arrangements, has been a large satisfier for our community."

If upfront collections aren't done effectively due to lack of the right technology, 2% to 5% of net patient revenue can be lost, says **Paul Shorrosh**, MSW, MBA, CHAM, founder & CEO of AccuReg Patient Access Solutions, a Mobile, AL-based provider of front-end revenue cycle technology. "The trick is to collect prior to service," he says. "A dollar collected before service is worth more than a dollar collected after service, because after service the cost to collect goes up and the likelihood of collecting goes down."

It is generally accepted that the likelihood of collecting prior to service is about 70%, compared to 30% after service. "This ratio improves or declines with technology that automatically calculates patient liabilities, alerts employees to the collection opportunity, and enforces collection of those liabilities through escalation to supervisors and individual performance visibility," says Shorrosh.

Estimation tool is vital

Because it is impossible for anyone to collect an unknown quantity, having a patient liability estimation technology is vital, says Shorrosh.

It is simply too complex and time-consuming to look up a procedure in a chargemaster, identify the allowable from the payer contract, and then pull the copay, remaining deductible, or co-insurance from patient benefit information. All of this information is found in disparate systems, files, contracts, payer sites, and/or spreadsheets.

Additional vital technologies to improve collections are propensity to pay, payment processing, and financial screening tools, Shorrosh says. Many patient access departments don't have the capability of reporting what dollar amounts they have collected over a time period.

"Reporting is a must-have, to track performance,"

EXECUTIVE SUMMARY

Patient access leaders at Ochsner Medical Center increased monthly collections by $22,000 after implementing a price estimation tool. Departments need to be able to do the following:

• Report what dollar amounts they have collected over a time period.

• Give front-end staff goals, training, and scripting.

• Estimate and collect liabilities before a patient's arrival.

Shorrosh says. "In many facilities, front-end staff do not have goals, training, or scripting for effective collections." Shorrosh says patient access managers should do the following:

- Know what their baseline collections have been.
- Have minimum and "stretch" goals, with incentives in place for reaching them.
- Run estimation tools automatically for every patient, regardless of payer status, during pre-registration and/or registration.

"If the employee has to initiate the estimate, they will miss many collection opportunities," he says.

- Alert employees about a collection opportunity with a message or alert in real-time.
- Report collection performance ratios by employee, department, facility, and/or region. "One important key performance indicator is the collection opportunity rate; dollars collected divided by dollars estimated," says Shorrosh.
- Escalate any failures to collect over a certain threshold amount to supervisors for last-chance intervention prior to service delivery.
- Move the timing of collecting further upstream.

"Estimate and collect liabilities as early as possible, meaning prior to a patient's arrival," says Shorrosh. "Pre-registration is the best possible place to get this done, and you have more time to get it done." *(See related story on how a department doubled its collection goal for 2014, below.)*

SOURCES

For more information about improving upfront collections, contact:

- **Tammy Flair**, Patient Access Manager, Ochsner Medical Center — North Shore, Slidell, LA. Email: tflair@ochsner.org.
- **Christopher Lah**, Senior Director, Patient Access, Cincinnati (OH) Children's Hospital Medical Center. Phone: (513) 636-8904. Email: Chris.Lah@cchmc.org. ■

Collection goal doubled for 2014

The total amount of patients' out-of-pocket responsibility is about $140 million annually at Cincinnati (OH) Children's Hospital Medical Center, but less than half of this amount is collected upfront.

"Unfortunately, we are only collecting about 41% of this in 30 days or less," says **Christopher Lah**, senior director of patient access. He adds that some areas have had more success with collections than others. "The areas with the strongest front-end ownership have the best pre-collect performance," says Lah.

Not surprisingly, the emergency department (ED) remains the most challenging area to collect from. "The ED only makes up about 15% of the parent's out-of-pocket available for pre-collect, but that is on the increase," says Lah.

Improving upfront collections is a key area of focus for fiscal year 2014 for the hospital's patient access leaders. These changes were made:

- **The department purchased price estimation and pre-collection software.**
- **Early in the process, the department piloted a moderate discount of 10% to patients paying their balance in full.**

Increasing the discount to 15% increased the number of patients who choose to pay upfront from 16% to slightly over 30%, reports Lah.

- **A goal of $2.5 million was set for fiscal year 2013.**

"We have not hit the goal yet, but we are well over halfway there after only four months into our fiscal year," reports Lah. For pre-pay patients, the amount includes any elective surgical services, most imaging and imaging-related tests, select consults/office visits, and behavioral medicine visits. For prompt pay patients, the scope includes all services.

"We plan on doubling that our next fiscal year, once we have our new pre-collect and price estimating software completely rolled out," says Lah.

- **Full time equivalents (FTEs) were added to improve collections.**

"Over the past 24 months, we have added an additional three FTEs to the program," Lah says "We now have five people dedicated to the process."

Four of the new FTEs are estimating analysts who work with the ear, nose and throat (ENT) and behavioral health divisions to maximum collections while ensuring accuracy. The other FTE handles existing escalating pricing concerns, questions, and complaints. "To justify the hiring of the FTEs, we did a fairly informal ROI [return on investment]. We mainly compared our upstart program with other hospitals that had purchased the same price estimating software," says Lah. Patient access leaders did this research by contacting several hospitals they were familiar with and also by using some contacts provided to them by the vendor.

Patient access leaders made these changes at Ochsner Medical Center — North Shore, Slidell, LA to increase collections and decrease bad debt:

- **All registrars were trained in insurance verifications.**

"They understand what constitutes a copay, deductible, and coinsurance," says Tammy Flair, patient access manager. "Knowledge of these components is

the most important part of the collections."

If staff members aren't confident in their approach, they won't make the patient feel comfortable discussing their finances, she adds.

• The department partnered with Bank of Nevada, which allows the patient to choose a comfortable monthly payment to suit their needs.

• Patients are pre-registered.

"We have found that at pre-registration, our success at collection before the service is 98%," says Flair. This amount decreases to 70% if staff collect on the day of service, and after discharge, it plummets to about 30% and is likely to end in a collection agency placement.

By pre-registering patients, staff members have some lead time to obtain authorization and make sure they have the proper order from the patient's physician.

"This process cuts down on billing issues for the facility," says Flair. "For the patient, it allows them to make an informed decision about their medical treatment." ■

Revamp processes for computer downtime

Protracted recovery periods can occur

Incorrect data, claims denials, protracted recovery periods, and confusion for the entire organization can occur if patient access "drops the ball" during computer downtime.

"Everything starts with access staff. So if systems are down, the entire process is affected," says **Rodney Adams**, director of preservice and patient access at Maury Regional Medical Center in Columbia, TN.

Patient access staff members must know downtime procedures and how they fit into the process, says Adams. Recovery processes also are important, so that when systems come back up, the backlog of data is entered quickly and accurately.

Patient access employees at Littleton (CO) Adventist Hospital recently had an eight-hour scheduled downtime. To prepare, patient access leaders reviewed all policies and procedures with staff during staff meetings.

The downtime process is documented in a reference book easily located in the registration areas, says **Jill Eichele**, CHAA, manager of patient access services. "So if it is not a scheduled downtime, they can pull the book and follow the process and procedures," Eichele says. "It is easy to get comfortable and not review this, but our experience has taught us to always be prepared."

During downtime, everything has to be done on paper, such as a patient's moving from the emergency department to an inpatient nursing unit. "That has to be tracked manually so that once the computers are back up, we can get the patient to the correct location in the system," Eichele says.

Because all patients have to be put back into the system once the computer is up, the work has to be done twice: once on paper and again in the computer. "So until the computers come back up, the amount of work keeps piling up," says Eichele. "The longer the system is down, the longer the recovery time."

Make recovery go smoothly

Patient access employee are the ones who are responsible for balancing the census once the system is back up.

"If things are not organized, it can make recovery very difficult," Eichele says. "The longer it takes patient access to recover, the longer other departments are down."

Because other departments cannot get into the system until patient access has balanced the census, this issue potentially can impact patient care and safety. "Other problems can include not having complete information," says Eichele. "The computer system requires certain fields to be filled out, and these could be forgotten on a paper process." These approaches are used:

• One person manages the census list at all times.

"Anytime there is a call for a status change, that gets reported to the person managing the census list," says Eichele.

• Calls are made at regular intervals to the nursing units to verify that the census file is up to date.

"This helps in moving the charts from one category to the next, in order to ensure a quick and smooth recovery," says Eichele.

• Patient access leaders work closely with other

EXECUTIVE SUMMARY

Patient access needs good processes for computer downtime to avoid incorrect data, claims denials, and protracted recovery periods.

• Be sure staff know both downtime procedures and recovery processes.

• Have one person manage the census list at all times.

• Make regular calls to nursing units to verify that the census file is up-to-date.

departments to set specific procedures in place for handoffs and who will be communicate certain information.

"When good communication takes place, it makes the recovery process go faster," says Eichele.

SOURCES

For more information about computer downtime and patient access areas, contact:
• **Rodney Adams**, Director of PreService and Patient Access, Maury Regional Medical Center, Columbia, TN. Phone: (931) 490-7103. Fax: (931) 490-3910. Email: radams@mauryregional.com.
• **Jill Eichele**, CHAA, Patient Access Services, Littleton (CO) Adventist Hospital. Phone: (303) 734-2130. Fax: (303) 734-3936. Email: jilleichele@centura.org. ■

Catastrophic plan option OK'd for select group

Individuals who had their insurance plans cancelled because they did not meet the requirements of the Patient Protection and Affordable Care Act will be able to buy catastrophic plans and will not face penalties if they don't purchase insurance in 2014.

"I agree with you that these consumers should qualify for this hardship exemption, and I can assure you that the exemption will be available to them," **Kathleen Sebelius**, secretary of the Department of Health and Human Services (HHS) wrote in a letter to Sen. Mark Warner (D-VA) and five other senators. "As a result, in addition to their existing options these individuals will also be able to buy a catastrophic plan to smooth their transition to coverage through the Marketplace." *(To read the letter, go to http://1.usa.gov/1gKHWUH.)*

The Affordable Care Act provides many new consumer protections, according to HHS. In some instances, health insurance issuers in the individual and small group markets are cancelling policies that don't include the new protections for policy or plan years beginning in 2014. Because some consumers were finding other coverage options to be more expensive than their cancelled plans or policies, President Obama announced a transition period allowing for the renewal of cancelled plans and policies between Jan. 1 and Oct. 1, 2014, under certain circumstances. Some states have adopted the transitional policy, which enables health insurance issuers to renew their existing plans and policies. Some health insurance issuers are not renewing cancelled plans or policies. To ensure that consumers whose policies are being cancelled are able to keep affordable health insurance coverage, HHS has reminded consumers in the individual market of the options already available to them, and the agency is clarifying another option for consumers in the individual market.

Options for patients

If consumers' health insurance policy has been cancelled, several options already are available:

• They have the chance to buy any of their health insurance issuer's individual market policies available to them in 2014.

• They may shop for coverage through the Health Insurance Marketplace. Depending on their income and other factors, they might be eligible to receive a premium tax credit that will help cover the cost of purchasing coverage through the marketplace or cost-sharing reductions for marketplace coverage. They also might be eligible for Medicaid.

• They also can shop for policies outside the marketplace. This option is a good one if they don't qualify for premium tax credits or cost-sharing reductions based on their income. If they do qualify for premium tax credits or cost-sharing reductions, they can get such assistance only if they enroll through the marketplace.

If they have been notified that their policy will not be renewed, they will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage. If they believe that the plan options available in the marketplace in their area are more expensive than their cancelled health insurance policy, they will be eligible for catastrophic coverage if it is available in their area. To purchase this catastrophic coverage, they need to complete a hardship exemption form, which is available at http://marketplace.cms.gov/getofficialresources/publications-and-articles/hardship-exemption.pdf. They need to indicate that their current health insurance policy is being cancelled and they consider other available policies unaffordable. They then will need to submit the following items to an issuer offering catastrophic coverage in their area: (1) the hardship exemption form; and (2) supporting documentation indicating that their previous policy was cancelled. For example, they can submit their cancellation letter or some other proof of

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cancellation. If they are applying for catastrophic coverage from the same issuer that cancelled their previous policy, the issuer might be able to confirm that information based on its internal records. They then may purchase catastrophic coverage from that issuer. Their issuer will send these items to the Centers for Medicare and Medicaid Services (CMS), and CMS will verify that they were eligible for this hardship exemption. If they aren't able to submit supporting documentation at the time they submit the exemption form, CMS will contact them to let them know the application is incomplete and cannot be processed until they submit supporting documentation of their previous policy's cancellation. If patients are interested in pursuing this option, and they need assistance, they can contact the call center at (866) 837-0677. ■

Hospitals concerned about final pay rules

The Centers for Medicare and Medicaid Services (CMS) has announced a final rule for hospital outpatient services, or the Outpatient Prospective Payment System (OPPS). CMS estimates that the rule will increase payments for hospital outpatient departments by 1.7%, according to the National Association of Healthcare Access Management (NAHAM). The new rule was effective Jan. 1, 2014; however, CMS will delay implementation and final configuration of the new 29 comprehensive ambulatory payment classifications (APCs) until 2015, NAHAM says.

The rule will create 29 comprehensive APCs to handle payment for device-dependent services and will require direct supervision for a range of outpatient services in critical access hospitals (CAHs).

This rule combines five payment codes into a single payment code that covers all outpatient clinic visits. The outpatient clinic visits code will include drugs, biologicals, and radiopharmaceuticals used in a diagnostic test or surgical procedure, lab services, and device removal procedures. The American Hospital Association believes that the payments will be well below the cost of treatment for complex patients, according to NAHAM.

The Access to Medical Imaging Coalition is concerned that the rule will dramatically reduce the outpatient payments to hospitals for CT scans and MRI services, NAHAM says. The group is concerned because the rule will establish similar reimbursement rates for a CT scan and X-ray image of the same body part, even though a CT scan requires more expensive equipment and is more expensive to administer. ■

HIPAA Regulatory Alert

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

HIPAA enforcement is increasing, and industry experts expect scrutiny in 2014

Role and obligations of business associates still in question

Healthcare providers are under the gun more than ever when it comes to compliance with the Health Insurance Portability and Accountability Act (HIPAA) because of recent changes that make it easier for the government to learn of breaches and to prosecute them, warns **Stephen Treglia**, JD, legal counsel at Absolute Software, a consulting firm in Austin, TX, that assists healthcare providers with HIPAA compliance.

A primary change spurring the increased enforcement was the Health Information Technology for Economic and Clinical Health (HITECH) Act. Before HITECH, Treglia explains, HHS had to rely solely on submitted complaints to become aware of HIPAA violations. *(See the story on p. 2 for more on what is driving the increased enforcement.)*

Changes to the definition and responsibilities of business associates (BAs) also are leading to conflicts that could complicate data security and make things messy if one occurs, Treglia says. "There's a big battle between providers and business associates," he says. "Business associates are trying to deny they are associates and making it hard for the covered entities that want them to become HIPAA-compliant. That's never good when two parties that both have a lot to lose can't work together to comply with the regulation."

Even if you're not arguing with your BAs, a covered entity might put too much confidence in the BA agreements (BAAs) required by HIPAA. Simply having one in place does not shield the healthcare provider from liability in the event of a breach, Treglia has learned.

Treglia recently attended a meeting with Leon Rodriguez, the Office for Civil Rights (OCR) director who has since been nominated to become the Director of the United States Citizenship and Immigration Services office of the Department of Homeland Security. Rodriguez told attendees at the meeting that the OCR was hiring more staff and planning to conduct more audits of HIPAA compliance. The subject of BAAs came up, and Treglia asked Rodriquez if having one in place was sufficient to protect the covered entity from liability related to a breach caused by the BA. Many covered entities seem to think so, Treglia told Rodriquez.

"Is it more in the form of governance that you're seeking?" Treglia asked the OCR director.

"That's exactly what we're looking for," Treglia recalls Rodriquez replying. "We're not looking for a one-shot relationship between the business associate and the covered entity. It's more of a partnership in which the covered entity should be providing guidance and governance to their business associates as to how to protect their patients' information."

The struggle to define BAs and refine the working relationship regarding HIPAA will likely continue for a couple of years, Treglia says. Rodriguez told the group including Treglia that OCR is taking "a very broad view of the definition of business associates."

"So that is probably where the battleground is coming up next," Treglia says.

More class action lawsuits

In addition, Treglia says the plaintiffs' bar has seen gold in the hills of HIPAA. Banking on support from a more empowered HHS to prosecute data breaches, trial lawyers are eager to file class-action lawsuits against entities that have been identified as

EXECUTIVE SUMMARY

The Department of Health and Human Services (HHS) is enforcing the Health Insurance Portability and Accountability Act (HIPAA) vigorously, and the push is likely to continue. Data breaches are more likely to be discovered now even if the provider doesn't report them.

- Prior to the Health Information Technology for Economic and Clinical Health (HITECH) Act, HHS relied on complaints to become aware of HIPAA violations.
- Business associates and covered entities continue to disagree over their roles and responsibilities.
- Class action lawsuits involving data breaches are on the rise.

having their medical records breached.

"When HHS prints a public listing of the breached entities, that makes them sitting ducks for class action suits," Treglia says. "A lawyer can go down the list and see who has the deepest pockets."

But what about encryption? Isn't that the solution that everyone proposes for HIPAA compliance? If the data is encrypted, even a stolen laptop full of protected health information (PHI) doesn't amount to much of a problem, according to many experts.

Treglia is more skeptical about encryption being the ultimate solution. He points out that encryption only works when the person attempting to access the data doesn't have the decryption keys, and sometimes they do. HIPAA data breaches have involved healthcare provider employees with access to decryption keys, Treglia notes. Huping Zhou, a former UCLA Healthcare System surgeon, was the first person sent to prison for intentionally viewing the PHI of co-workers, supervisors, and celebrities after being told he was fired, and encryption would not have stopped him, Treglia says.

"We're most aware of the loss of data, when someone steals a laptop for instance," Treglia says. "But we're realizing now that hacking is a real threat as well, in which the data never leaves your facility and there is no indication that a breach has occurred. The data has been compromised, and that's a breach just as much as a laptop left at Starbucks."

Treglia's advice is to expect 2014 to be a tough year for HIPAA compliance.

"We've only seen the tip of the iceberg. This trouble with business associates and the other issues, that is only going to increase in the years ahead," he says. "The enforcement push is not going to slow down in the near future."

SOURCE

• **Stephen Treglia**, JD, Legal Counsel, Absolute Software, Austin, TX. Telephone: (512) 600-7455. ■

HITECH led to current enforcement push

The Health Information Technology for Economic and Clinical Health (HITECH) Act and the subsequent Omnibus Final Rule have dramatically increased the likelihood that unauthorized releases of protected health information (PHI) will be discovered, for several reasons, says **Stephen Treglia**, JD, legal counsel at Absolute Software, a consulting firm in Austin, TX.

Treglia outlines the effects:

• The HITECH Act empowered certain federal and state agencies to pursue investigations. On the federal side, the Office for Civil Rights (OCR) was given the authority to investigate complaints and conduct random audits.

• HITECH also granted jurisdiction to all state attorney generals to pursue Health Insurance Portability and Accountability Act (HIPAA) and HITECH investigations.

• HITECH changed who is responsible for identifying PHI breaches, imposing a breach notification requirement to OCR for any unauthorized release of PHI.

• The Omnibus Final Rule increased the likelihood of enforcement actions for HIPAA-HITECH violations by permitting the Department of Health and Human Services (HHS) to develop regulations providing for the distribution of collected monies for successful investigation to complainants, offering the means to reward whistleblowers for information provided to OCR.

• The Omnibus Final Rule made it easier to enforce HIPAA's Privacy Rule and Security Rule by changing the burden of proof when a breach occurs. Previously, once a breach occurred, the violating entity simply could allege no harm resulted from the breach and it would be up to the complainant to prove harm existed. The Omnibus Final Rule has reversed that situation. Now, once a breach occurs, it is up to the violating entity to disprove harm occurred. ■

Compliance program must be strong

Case resulted in $150,000 settlement

What might seem like a rather minor data breach could lead to bigger problems if it opens the door to investigators taking a look at your entire Health Insurance Portability and Accountability Act (HIPAA) compliance program. That situation is what happened with Adult & Pediatric Dermatology (APDerm) of Concord, MA, which recently settled allegations of HIPAA violations for $150,000.

APDerm will be required to implement a corrective action plan (CAP) to correct deficiencies in its HIPAA compliance program. APDerm is a private practice that delivers dermatology services in four locations in Massachusetts and two in New Hampshire. This case marks the first settlement with a covered entity for not having policies and procedures in place to address the breach notification provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, passed as part of American Recovery and Reinvestment Act of 2009 (ARRA), notes **Shannon Hartsfield Salimone**, JD, a partner with the law firm of Holland & Knight

in Tallahassee, FL.

The Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS) opened an investigation of APDerm upon receiving a report that an unencrypted thumb drive containing the electronic protected health information (PHI) of about 2,200 individuals was stolen from a vehicle of one its staff members. The thumb drive was never recovered.

The investigation revealed that APDerm had not conducted an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality of PHI as part of its security management process, according to a statement from the OCR. Further, APDerm did not fully comply with requirements of the Breach Notification Rule to have in place written policies and procedures and train workforce members.

"As we say in healthcare, an ounce of prevention is worth a pound of cure," said OCR Director **Leon Rodriguez** said in announcing the settlement. "That is what a good risk management process is all about: identifying and mitigating the risk before a bad thing happens. Covered entities of all sizes need to give priority to securing electronic protected health information."

HHS found in its investigation that the practice did not conduct an accurate and thorough security risk analysis until more than one year after the breach. Additionally, the covered entity did not implement the requirements of the HIPAA Breach Notification Rule to have written policies and procedures and train its workforce members until Feb. 7, 2012. In the settlement agreement, the practice did not admit liability, but HHS refused to concede that the practice was in compliance.

Among other things, the CAP requires the practice to, within one year, conduct a new risk analysis, and then to develop a risk management plan that must be reviewed and approved by OCR. The practice also must report any HIPAA violations to OCR within 30 days. The full terms of the settlement are available online at http://tinyurl.com/DermSettlement.

Although the $150,000 payment is not extraordinary, Salimone says the case illustrates how healthcare providers can find themselves in quicksand once data is compromised. "From the settlement, it was clear they were not being penalized just for the breach," she says. "Instead, it seems this was the result of what the Office for Civil Rights perceived as a lack of compliance with the basic requirements of the security rule. All covered entities are required to do a documented risk analysis, which presumably would have turned up the fact that this practice wasn't being as careful as it should on training employees."

The case also illustrates how doing the right thing by reporting a data breach can prompt more trouble than the breach itself. "From an enforcement perspective, no good deed goes unpunished. That seems to be the entry point for a lot of these Office for Civil Rights enforcement activities," Salimone says. "To me it seems a little bit unfair to just go after these folks who have done the right thing by reporting, and it would be more fair to have some sort of random auditing. But they don't have the budget for that, and I'm not sure that's on the horizon."

Because any breach could invite investigators in for a close look at your HIPAA compliance program, it is important to evaluate your program for any shortcomings and constantly improve, Salimone says. *(See the story below for the most common failings of a HIPAA compliance program.)*

"If you have a breach and you can show that you had those protections in place ahead of time and you did everything you could reasonably to prevent it, I think you're going to be less subject to penalties," Salimone says.

SOURCE

• **Shannon Hartsfield Salimone**, JD, Partner, Holland & Knight, Tallahassee, FL. Telephone: (850) 425-5642. Email: Shannon.salimone@hklaw.com. ■

EXECUTIVE SUMMARY

A dermatology practice recently settled allegations of privacy law violations for $150,000. The fine and other sanctions appear to be the result of systematic failures in the compliance program rather than the breach itself.

• Even a small breach can open the door to an inspection of your entire program.

• This is the first settlement regarding a failure to have policies and procedures for breach notification.

• The settlement includes a corrective action plan.

7 most common failures in compliance programs

Frequent re-evaluation of your Health Insurance Portability and Accountability Act (HIPAA) compliance plan is a good idea, but what do you look for? Start with the most common shortcomings that the experts see in efforts to comply with HIPAA.

Shannon Hartsfield Salimone, JD, a partner with the law firm of Holland & Knight in Tallahassee, FL, offers this list of the most common problems she encounters with HIPAA compliance plans:

• Writing a notice of privacy practices and stopping there. The notice is not enough. It must be backed up by appropriate policies and procedures.

• Not updating your notice or policies and

procedures. Maybe you wrote a notice of privacy practices in 2003 that was entirely adequate, but have you updated it since then? The Health Information Technology for Economic and Clinical Health (HITECH) Act and the security rule required substantive changes in the notice and the policies and procedures backing it up.

• Failing to adequately train employees. Even the best policies and procedures are worthless if your employees don't understand them and put them into action. "HIPAA is extraordinarily complex and detailed in terms of what it requires of covered entities, and a lot of providers don't have the resources or the desire to devote enough to the training," Salimone says. "Training your people well doesn't guarantee the Office for Civil Rights will go easy on you if you do have a breach, but failing to train will be much likely to lead to a substantial fine."

• Not providing a link on your web site to the notice of privacy practices. This requirement is easily achieved, but it is also easily overlooked. "If that link is not there, it tells me that someone did not go through each of the requirements and make sure they were fulfilled, because that is clearly stated in the rules," Salimone says.

• Failing to do an adequate documented risk analysis. There is no set way to do the analysis, Salimone says, but it often involves the use of outside technicians and consultants to test the firewalls and encryption practices. Many covered entities do no risk analysis or do an inadequate one that is carried out by the same people who designed the protections.

• Skimping on the policies and procedures. If your HIPAA policies and procedures manual is 10 pages long, Salimone says you might not be in compliance. HIPAA requirements are so complex that it is almost impossible to cover everything without your policies and procedures going into great detail.

• Not updating your business associate agreements (BAAs). The BAA you came up with years ago, when associates were first a concern, will not suffice now that HITECH has changed the definitions and relationships with covered entities. ■

OCR not auditing enough providers, OIG says

If you feel like government regulators are breathing down your neck about Health Insurance Portability and Accountability Act (HIPAA) compliance, some of their bosses are thinking just the opposite. A report issued recently by the Department of Health and Human Services Office of Inspector General (OIG) concluded that the Office for Civil Rights (OCR) is not doing enough to enforce the HIPAA Security Rule.

According to the OIG, OCR had not assessed the risks, established priorities, or implemented controls for its Health Information Technology for Economic and Clinical Health (HITECH) Act requirement to provide for periodic audits of covered entities to ensure their compliance with Security Rule requirements. In addition, OCR's Security Rule investigation files didn't contain required documentation supporting key decisions because its staff didn't consistently follow OCR investigation procedures by sufficiently reviewing investigation case documentation.

OIG also found that OCR had not fully complied with federal cybersecurity requirements for its information systems used to process and store investigation data. *(The entire OIG report is available online at http://tinyurl.com/ojzv3xl.)*

The OIG also makes clear in the report that HIPAA compliance audits will continue. The pilot audits OCR ran in 2012 indicated that covered entities generally have more difficulty complying with the Security Rule than other aspects of HIPAA, the report says, and that small covered entities struggle with HIPAA compliance in each of the assessment areas: privacy, security and breach notification.

In a hint of what covered entities might see from OCR this year, the OIG report recommended that OCR take these steps:

• assess the risks, establish priorities, and implement controls for its HITECH auditing requirements;

• provide for periodic audits in accordance with HITECH to ensure Security Rule compliance at covered entities;

• implement sufficient controls, including supervisory review and documentation retention, to ensure policies and procedures for Security Rule investigations are followed; and

• implement the NIST Risk Management Framework for systems used to oversee and enforce the Security Rule.

OCR responded to the OIG report by generally agreeing with the OIG's recommendations and describing how it had already taken action to address them. As for continuing the compliance audits, OCR's response said that future audits "are less likely to be broad assessments generally across the Rules and more likely to focus on key areas of concern for OCR identified by new initiatives, enforcement concerns, and Departmental priorities." ■

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Bigger role, more work for access, but salaries are `getting tighter'

Many opportunities still exist for access in 2014

Patient access professionals are consistently expected to do more and more with the same or fewer resources within their departments. Apparently, this trend often applies to their compensation.

"Like other support areas within healthcare, salaries in patient access seem to be getting tighter," says **Jeff Brossard**, BSHA, CHAM, director of patient access at Mercy Hospital Springfield (MO) and immediate past president of the National Association of Healthcare Access Management (NAHAM). "More responsibility is placed on the front end of the revenue cycle, while salaries have maintained." *(See related story, p. 4, on salary survey results.)*

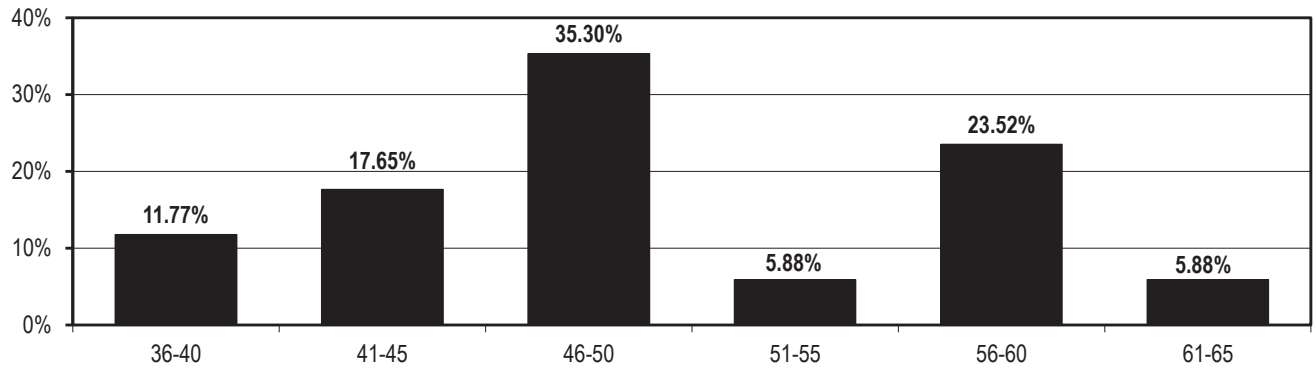
Charlene Cathcart, CHAM, director of admissions and registration at Palmetto Health Richland in Columbia, SC, however, expects current average salaries for patient access positions to increase by 10% due to expanding skill sets involving patient-centered care.

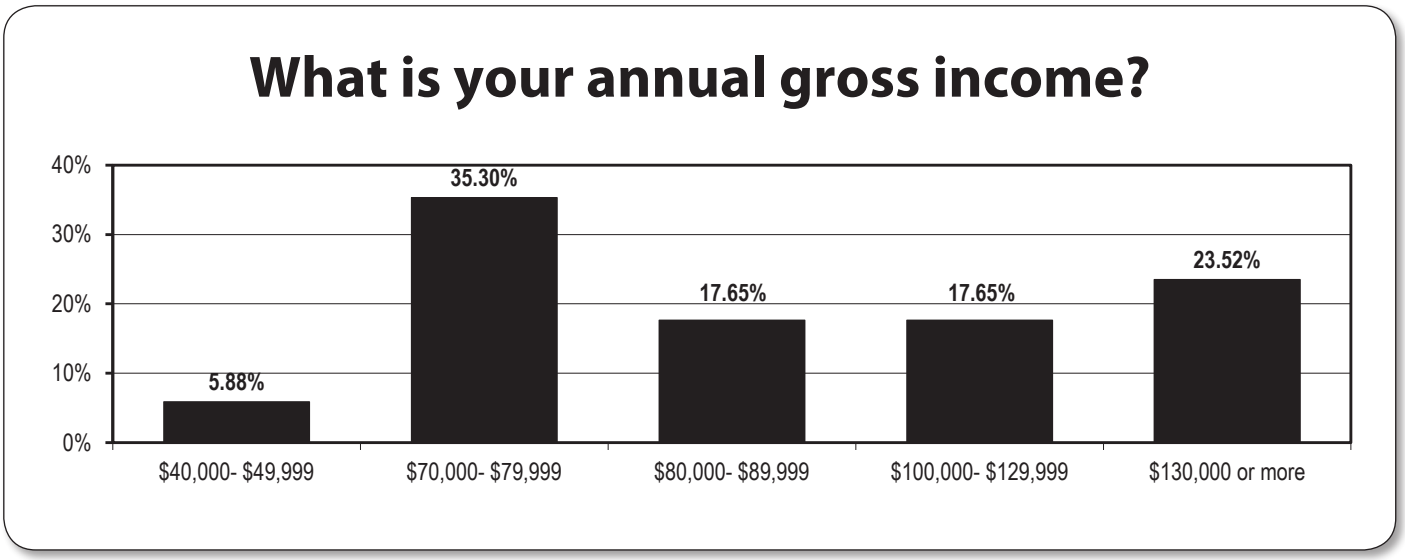
"There are lot of changes and challenges for patient access," Cathcart underscores.

The development of career paths in patient access departments can lead to promotions and higher salaries, as staff becomes more experienced and qualified.

Pete Kraus, CHAM, CPAR, FHAM, business

What is your age?





analyst for revenue cycle management at Emory Hospitals in Atlanta, says, "The expansion of access-related functions also widens opportunities in related fields such as financial counseling, patient finance, scheduling, and even coding and utilization management."

Keys: Creativity and collaboration

Creativity and collaboration with other departments is more important than ever. **Keith Weatherman**, CAM, MHA, associate director of service excellence for the corporate revenue cycle at Wake Forest Baptist Health in Winston-Salem, NC, says, "Technology is giving us the opportunity to share information for compliance, for verification, and signatures. All are opportunities to reduce expensive manual processes."

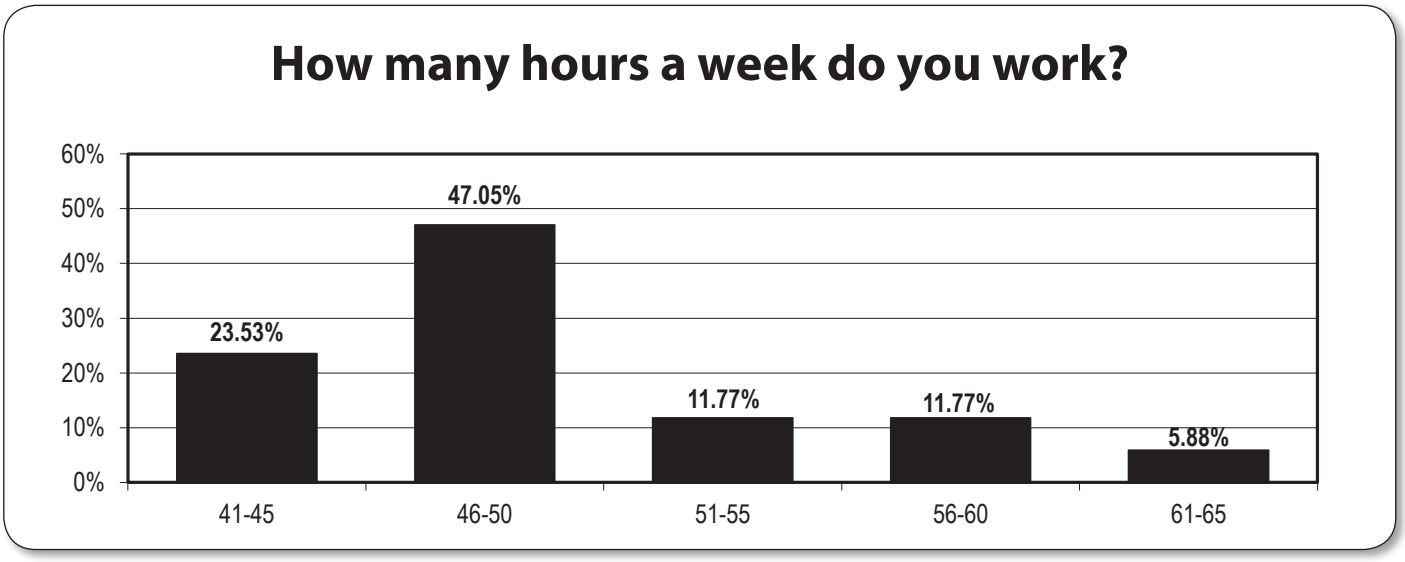
Today's patient access professionals are managing departments with less money and fewer staff members. "Managing with fewer dollars is tough, so doing things the old way will not work," Weatherman says. "Technology and process improvement are more important than ever."

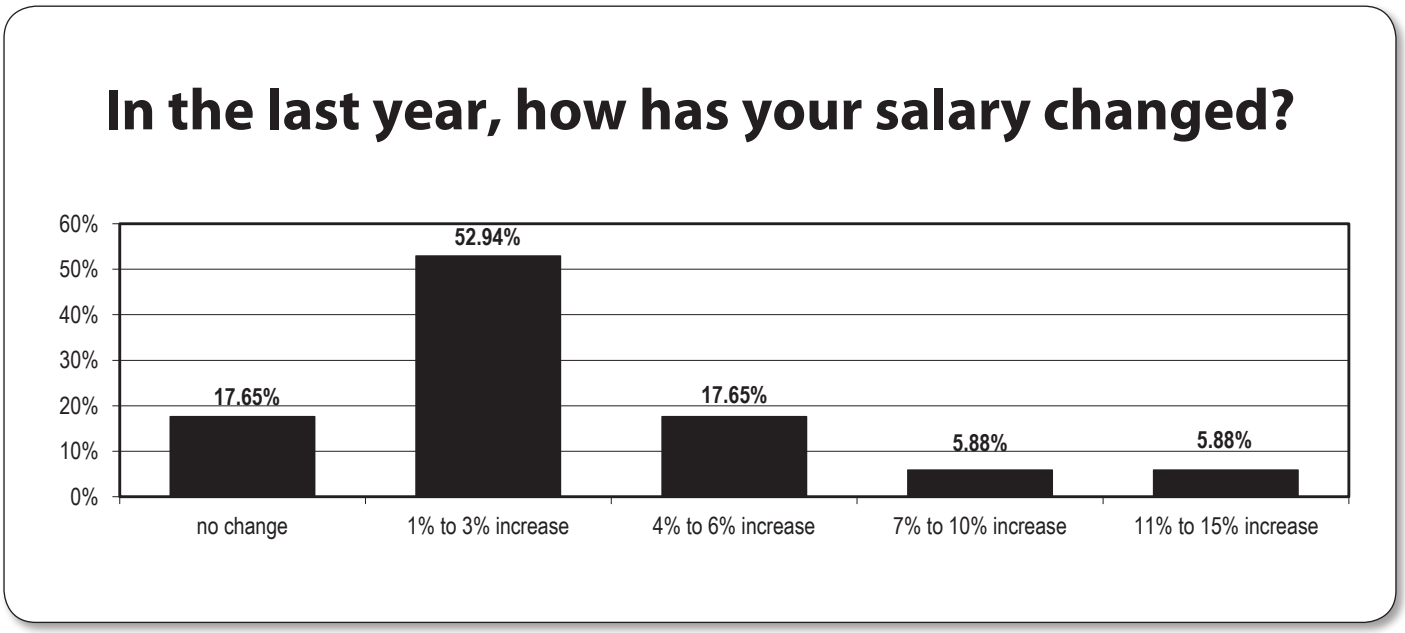
Health reform's impact unclear

The Affordable Care Act has brought challenges and opportunities to the field of patient access.

"Patient access staff will need to be brought up to speed quickly — not just for the benefit of the organization, but also because patients will be asking them to explain it to them," says Weatherman.

Brossard says he doesn't think that healthcare reform has affected salaries within patient access directly, because patient access is on the lower end of the overall payroll budget. "However, where I do see healthcare reform affecting this is in the ability to replace FTEs when a co-worker resigns," he says. "Budgets in many organizations are taking hits, with





all of the changes in reimbursements."

One of the biggest expenses is salary and benefits. "Therefore, the easiest way to adjust the budget is to eliminate positions," says Brossard. "I believe with the increased technology and the move to robust EHRs, [electronic health records], some right-sizing is in order."

The impact of healthcare reform on patient access salaries is still unclear, Kraus says. However, reform seems to be putting even more pressure on patient access to sort out patients' financial status prior to admission. "This is a time for creative responses to fast-moving changes in healthcare," says Kraus, who adds that strong financial skills and ability to keep up with current trends are critical for all patient access managers.

With the financial pressures that healthcare reform is putting on hospitals, doing more with less and understanding how to maximize technological solutions will remain "front and center," says Kraus. "Emphasis on these skills is nothing new — they just need to adapt to the times."

Kraus says that education in broader aspects of healthcare, as well as commanding knowledge of patient access functions, always provides a leg up to promotions and higher salaries. "Uncertain times with dramatic changes to the industry provide excellent opportunities for adaptable access leaders with enthusiasm for taking on more responsibility to advance," he adds.

Leaders can leverage the ever-increasing scope of patient access to take on new challenges in areas that are not typically associated with patient access. "Be aware of the changes, think of the big picture, and be part of it," urges Kraus.

More education required

The most important skills for access leaders are strong communication, flexibility, the ability to not only accept change but to be a change agent, strong mentoring skills, and the ability to multi-task, Brossard says. "I still believe that the opportunities for strong access leaders are almost limitless," he adds.

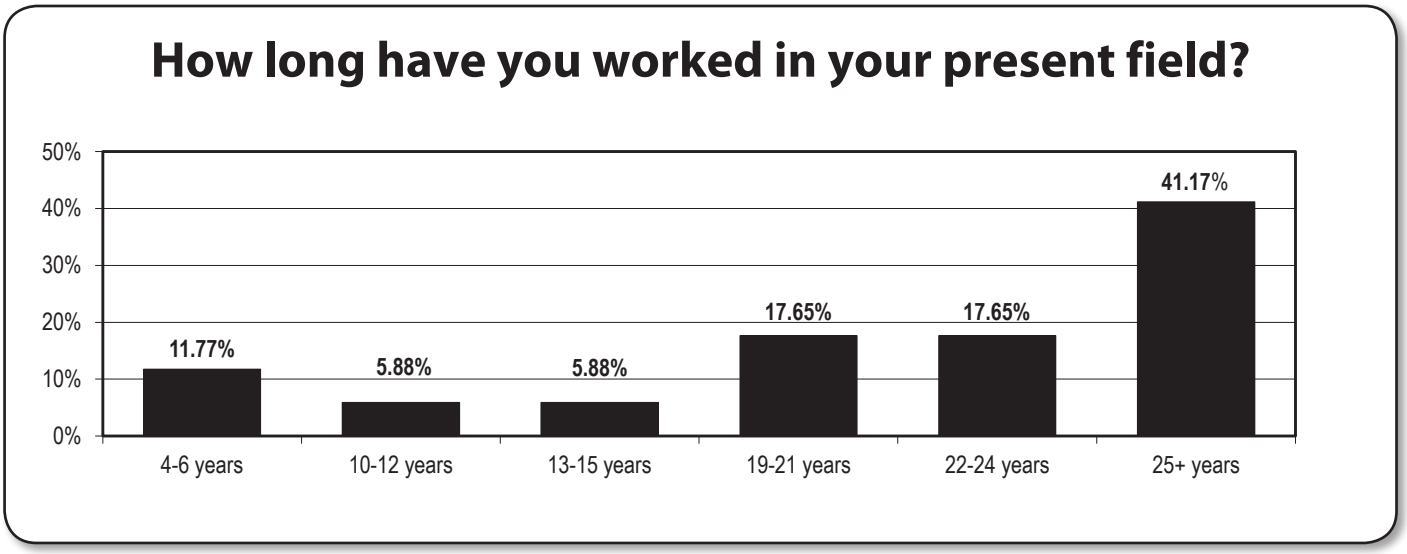
Some patient access leaders are moving into information technology roles, for example. With much more responsibility being placed on the front end of the revenue cycle, Brossard sees much of the same skill requirements for access professionals as for leaders.

"There is an increased emphasis on education requirements for patient access professionals," he says. "In fact, many college-level programs are now being offered to help prepare people moving into the healthcare access field."

One way patient access leaders can acquire new skills sets is by working more closely with their clinical operations team. "See where the points of failure occur," advises Cathcart. "Then, develop the overall patient experience by using access services to help resolve those points of failure where appropriate." For example, if a team member doesn't verify the information regarding the correct patient, patient access can play a role in limiting the number of patient handoffs.

To advance, Cathcart says patient access employees need at least a two-year degree and frontline experience in access services areas or billing.

When **John Woerly**, RHIA, CHAM, FHAM, senior principal at Accenture Health Practice in Indianapolis, entered patient access, he was much more reserved and didn't feel comfortable speaking in front of large audiences. "My boss, at that time, may have sensed



that, and literally volunteered me to present to a sizeable group as well as pushed me to join various local charities," says Woerly.

Shortly afterward, Woerly taught a course on business economics for Junior Achievement and served on a committee for the Red Cross and several committees for the local Chamber of Commerce. "I learned how to feel more comfortable with public speaking, and I found that I could do it," he says.

Woerly says that a bachelor's and/or master's degree is important for promotion and advancement in patient access. He recommends these approaches:

- Have a well-rounded background in finance, human resources, revenue cycle, health information management, patient accounting, and information technology.
- Complete college course work to assist in areas that may require further honing or growth.
- Join and actively participate in professional associations such as NAHAM, the Healthcare Financial Management Association (HFMA), the American Health Information Management Association (AHIMA), and the Healthcare Information and Management Systems Society (HIMSS). "This will give you access to publications, conferences. and individuals that may have information to share," says Woerly.
- Reach out to others within one's organization who have skills that you think you might need to improve.

Woerly says these might be "hard skills" such as information technology methodologies and terms or "soft skills" such as how to effectively conduct meetings.

"I've been fortunate to have had the opportunity to surround myself with those who have been willing to share their 'trade secrets,'" he says. "This is an excellent avenue to gain added knowledge and expertise." ■

Most in access saw 1-3% salary increase

According to the 2013 *Hospital Access Management Salary Survey*, 35% of respondents earn between $70,000 and $80,000, with 6% earning less than that amount; 18% earn between $80,000 and $90,000, and 41% make more than $100,000. Fifty-three percent of respondents reported a 1% to 3% increase in salary in the last year, and 18% received a 4% to 6% increase. About 12% received a larger increase of between 7% and 15%, and 18% reported no change. *(See charts on p. 2 and 3.)*

The survey, which was administered in September 2013 and tallied, analyzed, and reported by AHC Media, publisher of *Hospital Access Management*, identifies some of the factors impacting salaries and benefits in patient access. For the 2013 report, 243 surveys were disseminated. There were 17 responses, for a response rate of 7%. Other key findings of the survey:

- Most respondents (47%) work between 46 and 50 hours a week. Twenty-four percent work between 41 and 45 hours, and 29% put in more than 50 hours. *(See chart on p. 2.)*
- Twelve percent of respondents have worked in patient access for between four and six years; the same percentage has been in the field for between 10 and 16 years. About one-third (35%) has been in patient access for 19 to 25 years, and 41% has worked in patient access for 25 or more years. *(See chart on this page.)*
- Twenty-nine percent of respondents were older than age 50. *(See chart on p. 1.)* ■