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`Significant dollars at stake' with surge in high-deductible plans

Members of the patient access staff need updated tools to collect

The number of patients with high-deductible plans — and therefore, the amount of uncollected revenue — is increasing sharply, according to patient access leaders.

"Significant dollars are at stake if we do not collect the unmet deducible from these patients," says **Lauren Delpino,** manager of the patient service center at Crozer-Keystone Health System in Upland, PA.

The average deductible for a "bronze" plan on the Health Insurance Marketplace is $5,081 a year, according to a 2014 HealthPocket report on insurance offerings in 34 of the 36 states that rely on the federally run online marketplace.[1]

Kevin Coleman, head of research and data for HealthPocket, a Sunnyvale, CA-based technology company that compares and ranks available health plans, says, "My instincts tell me that the reaction to the deductibles will be affected by whether the person had been insured previously."

Individuals who couldn't obtain insurance due to medical underwriting issues might be less concerned about deductible amounts than the previously insured who find themselves with a new high-deductible plan. "Given that current reports suggest that the Affordable Care Act is enrolling much more of the previously insured than the uninsured, that enrollee profile may translate into more frustration with deductibles, particularly for those without out-of-pocket subsidies," says Coleman.

Deductibles have doubled

Deductibles for employer-sponsored plans nearly doubled over the past seven years, to $1,135 in 2013, according to a 2014 Deloitte study.[2] "It appears that this problem is only going to increase, as patients face a tax penalty for being uninsured and are forced to purchase plans with a low premium and a high deductible," Delpino says.

Crozer-Keystone's patient access employees are seeing many more patients

with high-deductible plans who are unable to pay the full unmet patient responsibility portion.

"The challenge we face is that many of our patients cannot afford to pay their entire out-of-pocket pay prior to services being rendered," Delpino explains.

Unless the services are elective, procedures are not cancelled due to lack of payment. However, the department is seeing more unpaid patient balances after insurance payment. "This results in a higher cost to collect," Delpino says.

Crozer-Keystone's patient access areas recently implemented price estimator software (CarePricer, manufactured by Atlanta-based MedAssets). This software allows front-end staff to determine the amount of a patient's unmet deductible and/or out-of-pocket cost.

"We will be using this tool to identify and request unmet deductibles during the pre-registration process," says Delpino.

Technology is needed

At Boston-based Massachusetts General Hospital, patient access staff members are building the infrastructure to be able to collect deductibles, reports **Joseph Ianelli**, associate director of admitting.

Currently, says Ianelli, "if a person registers with a certain payer and is scheduled for a procedure, we can certainly conduct an analysis and subsequently estimate the cost share," he says. "But plans have to be able to give us that information in an easy-to-access electronic way."

Currently, staff calculate unmet deductibles manually. They perform a benefits check, identify all the CPTs, and determine the contracted rate based on the patient's coverage. "So it's a three-step process," Ianelli explains. "It takes a lot of time, with potential for a big margin of error."

Unmet deductibles probably represent a significant amount of uncollected revenue, Ianelli says. "We are looking to be able to capture that revenue, but are working on the systems and technology to implement it," he says. "The intention is for us to move in that direction as an end goal, and I don't see that too far away."

Paradigm shift underway

Collecting deductibles "needs to be a parallel strategy with our e-commerce strategy," says Ianelli.

"When we get an EDI [electronic data interchange] in our system, part of that information needs to be what the remaining deductible is," he explains. "We shouldn't have to go to another system or through a manual process to find that information."

EXECUTIVE SUMMARY

Patient access areas are increasing seeing patients with high-deductible health plans. Significant revenue is at stake if the unmet deductible is not collected.

- Departments are seeing more unpaid patient balances after insurance payment, which result in higher cost to collect.
- Price estimator software allows front-end staff to identify and request unmet deductibles.
- Staff can encourage patients with health savings accounts (HSAs) to pay within 30 days.

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In June 2014, the department will go live with its new Epic system. "As technology changes and we can start to understand where patients are with their deductible, that's going to make life a lot a lot easier," says Ianelli. "We are going through a real paradigm shift."

High deductibles underscore the difficulty of balancing a patient-centered culture with the need to collect revenue. "A lot of patients don't fully realize what their cost share will be when they purchase insurance," says Ianelli. "More and more, patient access will need to work with people to help them understand their situation."

Ianelli expects to be collecting deductibles routinely once six months of data is collected in the Epic system. "A lot of great things are coming down the pike that we can leverage. It's just a waiting game," he says.

HSA changes financial discussion

Members of the patient access staff at Intermountain Healthcare in Salt Lake City, UT, are seeing a significant increase in high deductible plans, says **Teri Mark**, director of patient access.

"We have a process in place to estimate our patient's liability, using the scheduled service in conjunction with the patient's insurance benefits," Mark says. "This process is completed on all of our scheduled services."

The department recently started asking patients if they are going to use a health savings account (HSA) to pay their responsibility. HSAs were created in 2003 so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses. "We then let them know it's important to pay their balance within 30 days after their insurance pays," says Mark. The account then is flagged, so that the hospital's self-pay unit is aware the patient has the HSA.

"The process we developed notifies our billing department that the patient has this fund available to them," says Mark. "It changes the financial discussion they have with the patient." *(For more information, see related stories on high-deductible plans and bad debt, this page, and how to help patients obtain coverage, p. 52.)*

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High deductibles are adding to bad debt

Many patients will be unable to pay

The type of health insurance tier level a patient chooses from the Qualified Health Plans offered through the Affordable Care Act's (ACA's) Health Insurance Marketplace could end up increasing a hospital's bad debt, says **Gwynne Mesimer**, vice president of operations for Union, NJ-based Chamberlin Edmonds, an Emdeon company. Emdeon is a provider of revenue and payment cycle management and clinical information exchange solutions.

"Many hospitals are quite concerned about the patient's choice of high deductible plans," she adds. While they look quite appealing initially to the consumer due to lower premiums, says Mesimer, the cost of healthcare might be quite high just when a patient needs it most, such as an inpatient stay or extensive emergency department visit.

"The question is whether patients will really pay that high deductible or their share of the hospital bill," says Mesimer. It's unlikely, for example, that a person living on the edge of poverty with a "bronze" plan with a $4,000 deductible and 40% co-insurance will be able to afford his or her out-of-pocket responsibility.

"If a patient perceives they are unable to pay those costs, will this expense be considered charity care, or will it just add to the hospital's bad debt?" Mesimer asks.

Burden is on hospitals

While hospitals expect to see fewer self-pay patients, especially in states that have opted in to Medicaid expansion, Mesimer notes that many eligible patients are noncompliant with the steps required to obtain Medicaid today.

"It remains to be seen whether the publicity surrounding the ACA will change this behavior in a substantial

manner that will have hospitals seeing fewer uninsured or underinsured," she says.

Bad debt could be increased due to the mix of plans being selected by new enrollees, says **Joel Gardiner**, principal of New York City-based Deloitte Consulting. "High out-of-pocket responsibilities will burden hospitals in collecting for amounts owed," he says.

In addition, some patients no longer have employer-sponsored coverage and are now eligible to purchase through the exchanges, but often with higher out-of-pocket expenses. Gardiner says hospitals are using these approaches to address the trend toward high-deductible plans:

- prioritizing upfront collections for estimated liabilities owed prior to service;
- establishing policies to defer non-urgent services;
- implementing technologies that predict a patient's propensity-to-pay.

"Providers are also utilizing deep analytics to better understand self-pay patients and utilization patterns," says Gardiner. ■

Helping obtain Medicaid is 'more complex'

Helping patients obtain financial assistance in the form of Medicaid has "clearly gotten more complex" for patient access areas, as a result of the Affordable Care Act (ACA), says **Gwynne Mesimer**, vice president of operations for Union, NJ-based Chamberlin Edmonds, an Emdeon company. Emdeon is a provider of revenue and payment cycle management and clinical information exchange solutions.

Patient access is seeing the following changes:

- **In states that have opted in to Medicaid expansion:** "The most significant change for hospitals is the new regulation related to presumptive eligibility [PE] for patients in a hospital setting," Mesimer says.

All patients for whom eligibility can be determined through the use of modified adjusted gross income (MAGI) will be eligible for Medicaid presumptively.

"Obviously, more patients will qualify for Medicaid in an opt-in state, and this process is likely to be simpler and faster," Mesimer says. She adds that the combination of real-time data matching and the elimination of a medical disability requirement "will usher in a significant increase in the Medicaid-eligible population."

The question that remains is how many of these individuals will seek Medicaid proactively. "If patients continue to wait until they are admitted to either an emergency department or inpatient hospital stay for an episode of care, the hospitals will still be required to screen, apply, and see that enrollment is complete for these patients," Mesimer explains.

- **In Medicaid "opt-out" states:** "There could be an increase in interest to apply for Medicaid — the 'woodwork' effect — if patients see publicity about health insurance and consider this as a personal opportunity for them," says Mesimer.

PE for Medicaid is available in opt-out states. "However, the scope of patients that can be considered for PE remains fairly narrow with the audience generally being limited to pregnant women and children," she says.

Hospitals will need to be able to determine which patients get what type of application and screening criteria in opt-in and opt-out states. "One of the most common forms of Medicaid, related to the long-term care patient who is being discharged with services that they cannot afford, such as skilled nursing facility care, still requires a complex application," adds Mesimer.

Proactive approach needed

Many hospitals have traditionally used for-profit enrollment vendors to help patients obtain Medicaid coverage, notes **David A. Roos**, PhD, executive director of Covering Kids & Families of Indiana, an Indianapolis-based outreach program that assists families with completing paperwork required for the Hoosier Healthwise and Healthy Indiana Plan.

"The biggest problem with that sort of approach is that it's reactive rather than proactive," Roos says. "That is, the hospital has already incurred costs for services they've provided to individuals."

As most states have Medicaid available on a retroactive basis, notes Mesimer, "even if a person waits until they have a healthcare encounter, it is still likely to cover that expense with Medicaid for those persons who meet the income requirements."

Although the ACA does allow hospitals to offer presumptive eligibility for Medicaid programs, Roos says that this strategy is also reactive.

Patients still will be going to the hospital without coverage. "At some point, the hospital will discover they are uninsured and then will react and exercise presumptive eligibility to get them into a Medicaid or CHIP [Children's Health Insurance Program] program," he explains.

Some hospitals have adopted a different approach, by working with community-based agencies to reach patients before they present for services. "By working with community partners, hospitals can come up with creative ways where they can get much 'further up the stream' and increase the total number of people with coverage," says Roos. ■

Access applicants: Are they patient-friendly?

Anecdotes can reveal much

Look for customer service "first and foremost" in patient access applicants. That advice comes from **Elizabeth Reason,** CHAM, director of patient access for Cleveland County HealthCare System in Shelby, NC.

Here are items she looks for as an indication that an employee will give excellent service to patients:

• Certified healthcare access associate (CHAA) or certified healthcare access manager (CHAM) certification.

"If you've gone that extra step to demonstrate competence, you're probably the type of person that will give patients your best each day," says Reason.

• Responses that indicate they work well with people.

Reason asks, "When something has not worked well, how did you recover? How did you adjust your style with the patient?" She also says to applicants: "Tell me about the best customer service you've ever given."

"Patient access applicants have given me some wonderful stories on how they have gotten a smile out of a patient who was initially very frustrated," she says.

• Previous customer service experience, even if it's not in patient access.

"Quite often, we are seeing people who have lost jobs in manufacturing, who have now done some coursework and are looking to transition to the field of patient access," reports Reason.

Similarly, experience with "people contact" in the food service industry or retail stores can be a good fit for patient access, she adds.

• The ability to multitask.

Reason gives applicants a scenario and asks them how they would prioritize it. "There is no one exact perfect answer, but it gets me a sense of how the applicant views the environment," she says.

Use behavioral interviews

Melissa Milligan, CHAA, a patient access supervisor at Porter Adventist Hospital in Denver, looks for three key skills in patient access candidates. These are customer service, eagerness to learn, and good time management.

"To assess an applicant's skill set, we utilize behavioral interviews," Milligan says.

These interviews consist of questions that require the applicant to describe a situation or task, an action, and a result. Here are two examples:

• "Describe a time when you took action to provide quick and thorough service in response to a customer's request or problem."

• "New processes and procedures can be disruptive. What actions have you taken when you've been asked to significantly change a work process or procedure? What were the results?"

A recent applicant described a situation in which a change occurred in system used by her department, but her group received no communication regarding the change.

At the start of their work day, the applicant and her team were faced with a delay in their work because they were trying to find instructions. "She started playing around with the functions within the desktop and found that the only thing changed was the layout," says Milligan. It functioned just as it had before.

"She was then able to help her team get back on track and show them where to find the items they needed to perform their job," Milligan says. "This limited the delay they saw in productivity.

Ability to connect

"I've learned to look beyond the obvious when I meet a prospective new hire," says **Mary Swanson,** MA, CHAM, director of patient access at Advocate Christ Medical Center in Oak Lawn, IL. In addition to a well-groomed appearance and knowledge about patient access functions, applicants should have "people skills," Swanson says

"I am looking for a candidate who can connect to a patient or another person — like me — within the first few minutes of the registration encounter," she says.

In the 10 minutes it takes to complete a hospital registration, a registrar needs to connect with a patient on several important levels, Swanson says. "In those brief minutes, the impression the registrar makes on a patient is setting the stage for the rest of the patient visit, as well as for the responses which will be completed later on during a post-visit patient survey," she says.

Swanson starts most questions by saying, "Give me an example" or "Tell me about a time." "While listen-

EXECUTIVE SUMMARY

Customer service is the number one skill for patient access applicants, according to patient access leaders.

- Ask candidates to give examples of good service they've given.
- Look for previous customer service experience.
- Observe body language of applicants.

ing to the answers to my questions, I try to determine if the candidate has the right communication style which I look for on my registration team," she says.

Regardless of the responses, Swanson trusts her instincts. "If there is any comment during the interview which makes me feel that the candidate does not meet my standards or which makes me uneasy, I do not proceed with the hire," she says. *(See related story, below, on observing body language.)*

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Observe body language of your applicants

It shows how they really feel about the job

Melissa Milligan, CHAA, a patient access supervisor at Porter Adventist Hospital in Denver, always asks applicants if they have any questions about the job, but most reply "no."

"Many applicants don't ask about the daily responsibilities of the position," Milligan says. "I will then give them a high level overview of what they can expect to do on a daily basis."

The applicant's response gives her a sense of their comfort level with the daily routine. "By asking specific questions that relate to daily responsibilities, we are able to identify a good job fit from the start," says Milligan.

Some applicants give signals through their body language, however, as to what they really feel about the job responsibilities. "I have noticed in the applicants who have had prior experience similar to those in the role, their body language remains the same after the question is asked," she says. In contrast, applicants who have little to no experience tend to tense up, shift around in their chair, or clasp their hands a little tighter.

"Noticing these physical clues allows me to dig deeper with follow-up questions to see if the applicant is coachable in the job role or if they oppose it," says Milligan.

At times, applicants will relate the interview questions to a personal story. "That gives me more insight into their personality. I find this really helpful in my decision making," she says.

Milligan steers away from applicants who are unable to give specific examples or detailed responses. "It is a red flag to me when an applicant gives a vague answer to a follow-up question or is unable to ask for clarification," she says. ■

Preceptors ease new hires' anxiety

At Palmetto Health Richland in Columbia, SC, patient access managers chose one or two employees on each shift to serve as preceptors for new hires.

"The preceptor program has been our most successful training method. It helps to ease the anxiety and fear of beginning a new position," reports **Ebony Seymour**, CHAM, patient access manager for admissions and registration.

The selected employees complete classes in adult learning, customer service, the revenue cycle, and financial counseling. The classes are offered at no cost as part of Palmetto Health's continuing education offered to all employees, but they are mandatory for preceptors.

The revenue cycle class is taught by the hospital's patient access director, and the financial counseling class is taught by the team leader of financial counseling. "We allow each member of management to teach the class in which they have the most expertise," says Seymour. "The classes are usually one or two hours in the classroom. We are in the process of converting some classes to online sessions."

Once the new employees complete their formal training with the education and training specialist, they are assigned to work with their preceptor for up to five weeks, depending on the area and level of complexity. "The preceptor is there to immediately answer any questions," says Seymour. "It helps new employees feel welcome in the department. It creates an instant bond between the two individuals."

Monek Lincoln, one of the department's preceptors, says that new hires typically ask these questions:

• **"How long will it take for me to understand all of the steps to the process and be efficient with the system?"**

Lincoln answers, "It seems overwhelming, but ask questions immediately if you don't understand. With diligence and patience, you will persevere. I'll make sure of it by being readily available to assist you."

• **"Are certain days busier than others?"**

Lincoln informs them, "Palmetto Health Richland is a Level 1 Trauma Center. There isn't a specific day in which we are busiest, but we can expect Mondays to be busy. Every day is a busy day. Seasonal illnesses such as flu can account for an increase in patient flow."

Lincoln greatly enjoys watching each trainee grow into the role. "I have trained new hires who didn't think they would make it past the first day," she says. "To see them successfully become a part of the registration team is rewarding." *(See related stories on how one patient access department uses "training buddies," below, and what new hires need help with the most, p. 56.)*

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`Training buddies' can improve morale

After new patient access hires at Nationwide Children's Hospital in Columbus, OH, learn the basics of the registration system, they're given a short period of hands-on training by a supervisor. Next, he or she is introduced to a "training buddy."

"The training buddy shadows the new hire for two to four weeks, depending on how quickly they catch on. During that time, they are pretty much attached at the hip," says **Michael Hester**, vice president of revenue cycle in the finance department.

EXECUTIVE SUMMARY

Using preceptors to train patient access employees results in improved morale, more teamwork, and increased success of new hires.
• New employees appreciate having someone to turn to with questions.
• Preceptors can step in if patients respond poorly to collection attempts.
• Managers look for high-performing and patient employees.

In some ways, team members know more about what the new hire's job will entail than the department's trainers do. "They do it day and day out and know all the idiosyncrasies," says Hester. "This is literally on-the-job training. It's what the job actually looks like."

Next, new hires are given an exit test, which involves a supervisor observing the employee register patients for a day. "In 90 days, we do a follow-up to be sure they are still adhering to the policies," says Hester. If the employee isn't performing well, he or she is again paired with the training buddy for another three weeks.

Only about 5% of employees fail to pass the exit test. "Unfortunately, we had to let a couple of them go, because they didn't catch on even after repeat training," says Hester. "It's not an environment for everybody."

Training buddies report asking patients for money is, by far, the hardest challenge for the new hires. "There are always questions that come up that nobody really expects. Every situation has something new to it," says Hester.

New hires might be completely comfortable asking a "patient" for a copay in the training room, but falter when asking the parent of a sick child. "No matter how much practice you have in the training environment, it's different out in the real world," says Hester.

The training buddy will step in and demonstrate how to respond, if the patient reacts poorly to being asked for payment.

The new role has made the "training buddies" feel more professional. "One person recently asked if this was a path to leadership, and it is," says Hester. "Helping new hires is people management."

Teamwork is unexpected benefit

The training buddy program came about after the department learned that the number of patient access trainers would be cut.

"Compared to previous methods, this is actually more expensive," says Hester. "Prior to the buddy program, costs were limited to a trainer: a person whose only role was training staff. Our current cost is the buddy spending entire shifts for two to six weeks of constant, one-on-one training on the actual floor."

However, the new program gets better results because there is much more hands-on training when compared to the previous system. "Unfortunately, with a limited number of trainers, and the trainers not dedicated to just patient access, very little time was actually spent in a hands-on environment," he explains. "Instead, it was done in a classroom environment with several other people for two days."

Improved morale was an unexpected side benefit. "The new employee has a much better handle on what

they are doing," Hester reports. "People are more invested because they feel more like a team."

The patient access department at Cincinnati (OH) Children's Hospital Medical Center has had a preceptor program in place since 2009, based on the hospital's clinical preceptor program. "We use the same process and methods, minus the clinical piece," says **Sherri E. Kissinger**, CHAM, manager of patient access.

Previously, new hires received some general classroom and computer training, "but when they arrived at their actual site or clinic, they would be on their own," says Kissinger.

As part of the preceptor program, new hires take an online survey that tells them what kind of learning style they have: visual, aural, read/write, kinesthetic or multimodal. *(To access the survey, go to: http://www.vark-learn.com/english/index.asp.)* "The preceptor can then adapt their way of teaching to the employee's learning style," she says. The preceptor can allow for hands-on-learning for kinesthetic learners, or allow for note taking, if they are a read/write learner.

Employees must be high-performing to be chosen as preceptors, but patience and good communication skills are other important qualities. "We try to have a preceptor on every shift," says Kissinger. "We might have two or three on the first shift, but we also try to have at least one on the second shift as well." Preceptors give her feedback on how new hires are doing.

One challenge is to keep new hires with the same preceptor, which isn't always possible depending on the shift.

"There are multiple ways to do the same task and get the same results," Kissinger explains. "One person might show a different method from someone else, which may add some confusion." ■

Preceptors help with these roles

Here are some aspects of the patient access role that preceptors Cincinnati (OH) Children's Hospital Medical Center help new hires to master:

• Determining which payer is primary.

"New hires typically struggle with entering insurances properly, especially if they come in with no past medical background," says **Sherri E. Kissinger**, CHAM, manager of patient access.

• Entering clinical information for radiology patients.

A module used with the registration system requires X-rays to be ordered during the registration process, so patient access now has to enter some clinical data. "Some of our facilities have to enter specifics about what exam has been ordered and how many views," Kissinger explains. "It can be overwhelming for new hires, and takes some practice."

• Explaining research practices to patients.

The hospital's research department is now using remaining lab specimens that were previously discarded. The patient access role includes explaining this change to parents and obtaining their consent.

"So our staff, who are not clinical, are having this conversation with the families," says Kissinger. "We have had a very positive response, but at times, parents will ask a clinical question that we do not know the answer to. We then refer them to the research team that is handling the project." ■

Is patient eligible for discount? Say so!

Access must be knowledgeable and empathetic

"We will work with you." This is the message that **Junko I. Fowles**, CHAA, patient access supervisor at Huntsman Cancer Hospital, Salt Lake City, UT, tries to convey whenever patients ask about their out-of-pocket responsibility.

"I stress that if the patient is willing to pay a deposit toward their visit, we can work out payment arrangements for the rest of the balance," Fowles says. "In other words, I try not to make it seem like they have to pay exorbitant fees upfront before receiving care."

Fowles informs self-pay patients right away that the price being quoted has a 30% discount applied to it. "I tell them there could be more charges added to the price estimate," she says. "However, any charges billed to the patient would have the 30% self-pay discount applied."

In addition, self-pay and insured patients receive an additional 10% prompt pay discount when the balance is paid in full. "We are willing to work with them when it comes to payment, as long as we get a deposit or copayment for services being rendered," adds Fowles.

At Hackensack (NJ) University Medical Center, self-pay patients are offered a compassionate care rate based on Medicare ambulatory payment classification (APC) rates, says **George Brindisi**, director of ambulatory registration. "For all others, we determine rates based on our managed care contracts," Brindisi says.

He tells patients: "We have a compassionate rate if you do not have insurance, as well as financial counselors available who can help you determine if you meet any financial assistance programs."

Brindisi says the key is for access staff to come across

as knowledgeable and empathetic. "Patients want someone who understands and is, in effect, an expert and does not talk in generalities," he says.

Fowles tells patients, "I understand your concerns in getting an idea of how much this will cost. I can give you a general idea. However, the billed amount may be different due to other procedures, medications, or tests that may be required."

Fowles asks if the caller or the person they are calling for is a current patient in the hospital system. "By asking this question, we can find the correct patient and medical record number in the system to link any estimates to," she explains.

Fowles is clear that it is the patient's insurance plan, not the hospital, that determines what cost-sharing will be done for the service being rendered.

"If the patient has questions regarding what they will owe or do owe, I would refer them to their insurance for further clarification," she says.

CPT codes needed

Fowles tries his best to give patients as much information as possible on the call. "However, if their procedure or service is complex, I ask if I can call the patient back at a later time to go over the estimate fully," she says. *(See related story, this page, on price estimates.)*

If the patient is new to the organization, Fowles checks the insurance information and demographics quickly to give the patient a general idea of their situation. "If the caller has the CPT code, we are able to give an on-the-spot answer nine times out of ten," says Fowles. If no CPT code is given, Fowles uses these approaches to obtain it:

- She asks for a detailed description of the procedure and insurance benefits information, and enters this information into the department's price estimate tool (Epic PriceEstimate, manufactured by Verona, WI-based Epic).
- If the codes aren't found in the price estimate tool, she looks up the codes in the department's "dual estimate" spreadsheet, which lists the most commonly used CPT codes.
- She often contacts coders to obtain correct codes and escalates to her supervisor if codes cannot be located, especially for inpatient services based on ICD-9 and DRG codes.

Partnership needed

Fowles emphasizes that if the patient is willing to work with the hospital, various forms of financial help are available. This help includes payment plans, assistance applications, and drug assistance programs.

"I emphasize that our organization is far more interested in giving extraordinary care than haranguing people about paying bills first before being seen," she says.

However, Fowles also emphasizes that a partnership with the patient and his organization is a necessity. "We can only deliver excellent care if the patient is willing to do their part in ensuring that we are reimbursed for our services," he says.

SOURCES

- **George Brindisi**, Director of Ambulatory Registration, Hackensack (NJ) University Medical Center. Email: GBrindisi@HackensackUMC.org.
- **Junko I. Fowles**, CHAA, Patient Access Supervisor, Huntsman Cancer Hospital, Salt Lake City, UT. Phone: (801) 587-4036. Fax: (801) 587-8269. Email: Junko.fowles@hsc.utah.edu. ■

EXECUTIVE SUMMARY

Patient access employees need to convey to patients that the hospital is willing to work with them on payment for services, but that a partnership is expected. Patient access areas are:

- informing patients of discounts upfront;
- being clear that cost-sharing is determined by the insurance plan;
- obtaining a detailed description of what services are going to be done and where.

Ask these questions before estimate given

Patients might want an immediate answer about what a service will cost them, but a quick answer isn't always in their best interest.

"We don't want to give a quick, possibly inaccurate estimate which could result in an unexpected bill for the patient," says **Junko I. Fowles**, CHAA, patient access supervisor at Huntsman Cancer Hospital, Salt Lake City, UT. She says patient access employees should ask themselves these questions when giving estimates:

- Could I this turn into a collection opportunity?
- Have I been proactive in seeking ways to obtain a CPT code or detailed description of what is going to be done and where?

For example, a procedure might be done in the doctor's office versus the operating room, or the patient's status might be inpatient, outpatient, or observation.

- Do the amounts look off?

If so, Fowles says, "Ask your supervisor or coders to review it before giving it out." ■

Access can prevent 30-day readmissions

Collaborate with clinical leaders

Most readmission efforts are focused on patient education and engagement during and after discharge, acknowledges **Paul Shorrosh**, founder and CEO of AccuReg Patient Access Solutions in Mobile, AL.

"But to effectively avoid readmission penalties requires intervention at the front door, in addition to education at the back door," he emphasizes. Shorrosh recommends these approaches:

• The patient access team should be empowered to detect and alert clinicians prior to an admission.

"But how will registrars know when a patient has been in the hospital within the past 30 days? The answer is automation and exception-based workflow technology," says Shorrosh.

In real-time, after a Medicare patient is registered, systems can automatically check against the hospital's historical accounts to determine if the patient has had an inpatient stay in the past 30 days. "If diagnosis codes are captured in scheduling or registration from physician orders, the results can be narrowed down to the 'big four' conditions CMS [Centers for Medicare and Medicaid Services] is targeting in 2014," says Shorrosh. These are heart attack, heart failure, pneumonia, and chronic obstructive pulmonary disease (CPD).

"Even without diagnosis codes, an automated process can effectively flag patients who have been inpatients in the past 30 days in a work queue, with priority alert pop-ups," says Shorrosh.

Scripting can be provided on what to do next, such as to inform the physician, nurse, or case manager. "The appropriate person can confirm and manage the situation, with the option to change the admission plan to observation, a treat-and-release plan, or a home health plan," says Shorrosh.

EXECUTIVE SUMMARY

Patient access can collaborate with clinical leaders to avoid readmission penalties.

- Empower front-end staff to alert clinicians prior to an admission.
- Use an automated process to flag patients who have been inpatients in the past 30 days.
- Assess adherence to scheduling protocols to ensure that a patient's post-discharge care is scheduled timely.

Establish protocols

Patient access leaders need to work with clinical leadership to understand the transition of care from the inpatient setting to the ambulatory setting, says **Larry E. Stuckey II**, managing director of the Huron Consulting Group.

"Through this understanding, these two areas can work together to establish the appropriate scheduling protocols to ensure that a patient's post-discharge care is scheduled timely," he says.

In organizations with highly efficient patient access areas, he says, patients can access post-acute care follow-up visits with primary care and specialty physicians within 48 to 72 hours. "Quick follow-up post hospital stay is key to ensuring a patient's understanding of medications and coordination of ongoing testing and outpatient care," adds Stuckey.

Adherence to the scheduling protocols should be one of the metrics that is measured as a strategic initiative is developed and implemented to decrease readmissions, he advises.

"Patient access can impact the availability of care post-discharge to determine if this adherence is yielding fewer readmissions," Stuckey says. ■

Transition to ICD-10 may cause financial losses

Health providers might experience information and financial loss during the mandated conversion from the current International Classification of Diseases to its new and improved version, report researchers at the University of Illinois at Chicago.

The study, appearing in the March issue of the *Journal of Oncology Practice*, looked at coding ambiguity for hematology-oncology diagnoses to anticipate challenges all providers might face during the transition from ICD-9-CM to ICD-10-CM. The researchers chose to look at hematology-oncology because prior research suggested that, compared to other subspecialties, it would have a simpler transition, due to fewer ICD-10 codes and less convoluted mappings.

As of press time, the nation's healthcare system is scheduled to fully implement ICD-10 on Oct. 1, and many doctors and hospitals still are preparing for the transition. The system is used to classify and code all diagnoses, symptoms and procedures for reference in managing all aspects of healthcare, from insurance reimbursement to staffing decisions to supply procurement.

The ICD-10-CM includes more than 68,000 diagnostic codes, compared to 14,000 in ICD-9-CM. The Cen-

ters for Medicare and Medicaid Services (CMS) provides a general equivalent mapping (GEM) code translation system, but it's complex and often difficult even for billers and coders to interpret, according to the researchers.

Codes often do not map one-to-one or one-to-many, says **Andrew Boyd**, UIC assistant professor in biomedical and health information sciences and one of the study's co-authors. A cluster of codes might map to several ICD-10 codes, which might then map back to different ICD-9 codes, he said.

120 codes identified from Medicaid data

In the study, the researchers used 2010 Illinois Medicaid data to identify ICD-9-CM outpatient codes and the associated reimbursements used by hematology-oncology physicians. The researchers identified 120 codes with the highest reimbursement for analysis. They also looked at ICD-9-CM outpatient diagnosis codes and associated billing charges used by University of Illinois Cancer Center physicians from 2010 to 2012 and selected the 100 most-used codes.

Using a web-based tool developed at the university, the researchers input the ICD-9 codes and translated them into ICD-10 codes. They looked at whether the translation made sense, whether a loss of clinical information occurred, and whether a loss of information had financial implications.

Neeta Venepalli, MD, assistant professor of hematology/oncology at the university and first author of the study, said, "What we found was the transition from ICD-9 to ICD-10 led to significant information loss, affecting about 8% of the Medicaid codes and 1% of the codes in our cancer clinic."

In looking at the financial implications, the researchers found that 39 ICD-9-CM codes with information loss accounted for 2.9% of total Medicaid reimbursements and 5.3% of University of Illinois Cancer Center billing charges. Boys says the report highlights the 39 codes "to help identify that there might be trouble with reimbursement for these codes." ■

ONC releases `Patient ID and Matching Report'

The Office of the National Coordinator for Health Information Technology (ONC) has released the final version of the "Patient Identification and Matching Report."

The report evaluated best practices and current trends in using electronic health record (EHR) systems to accurately identify patients and exchange information between providers, patients, and caregivers.

Mistakes in properly identifying patient health records put patient safety at risk and has resulted in too many patient deaths, according to the National Association of Healthcare Access Management (NAHAM).

The drafting process for the report included an industry environmental scan with input from stakeholders at meetings, on calls, and requests for submitted comments and recommendations. NAHAM was an active participant throughout the drafting process and provided recommendations focused on improving patient safety that are featured in the report. NAHAM's recommendations can be found on page 76 of the report.

The report resulted in findings that ONC will use as they move forward with the process of improving electronic health record systems and patient matching to improve patient safety.

The findings include the following:

- Standardized patient identifying attributes should be required in the relevant exchange transactions.
- Any changes to patient data attributes in exchange transactions should be coordinated with organizations working on parallel efforts to standardize healthcare transactions.
- Certification criteria should be introduced that require certified EHR technology (CEHRT) to capture the data attributes that would be required in the standardized patient identifying attributes.
- The ability of additional, non-traditional data attributes to improve patient matching should be studied.
- Certification criteria should not be created for patient matching algorithms or require organizations to utilize a specific type of algorithm.
- Certification criteria that requires CEHRT that performs patient matching to demonstrate the ability to generate and provide to end users reports that detail potential duplicate patient records should be considered.
- Build on the initial best practices that emerged during the environmental scan by convening industry stakeholders to consider a more formal structure for establishing best practices for the matching process and data governance.
- Work with the industry to develop best practices and policies to encourage consumers to keep their information current and accurate.
- Work with healthcare professional associations and the Safety Assurance Factors for EHR Resilience (SAFER) Guide initiative to develop and disseminate education and training materials that detail best practices for accurately capturing and consistently verifying patient data attributes.
- Continue collaborating with federal agencies and the industry on improving patient identification and matching processes. *(To access the report, go to http://bit.ly/P9cNyK.)* ■

Number of uninsured is lowest since 2009

Number of uninsured adults drops to 15.9%

As the deadline to enroll on the new insurance exchanges approached, the deadline seemed to spur a dramatic increase in the number of adults enrolling in health insurance plans, according to the National Association of Healthcare Access Management (NAHAM).

According to the Gallup-Healthways Well-Being Index released March 10, the number of Americans with no health insurance dropped to the lowest levels since President Obama was sworn in. *(To access the index go to http://bit.ly/1h6I9y2.)* The index found that the percent of uninsured adults dropped from 17.1% in the last quarter of 2013 to 15.9% in 2014. Experts attribute the increasing number of insured adults to the insurance plans made available by the Affordable Care Act.

The increase in enrollment was found across all demographic groups examined by the index. However, enrollment throughout the Latino demographic lagged behind other demographic groups. This is notable because the Obama Administration is actively reaching out to the relatively young Hispanic community to encourage enrollment.

In other findings:

- A significant drop in the rate of uninsured adults occurred among African-Americans, with a 2.6 percentage point decline.
- The rate declined 1 percentage point among white adults, but only eight-tenths of a percentage point for Latinos.
- The largest drop in the uninsured rate was a 2.8 percentage point difference for households with an annual income of less than $36,000. ■

COMING IN FUTURE MONTHS

- ■ Proven ways to justify need for additional FTEs
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HIPAA Regulatory Alert
Cutting-edge information on privacy regulations

Going too far with HIPAA compliance threatens care provided to patients

Overzealous individuals can become the 'HIPAA police'

Healthcare providers have spent years grappling with how to comply with the Health Insurance Portability and Accountability Act (HIPAA), with most of the focus on training clinicians and staff about the dangers of too freely providing protected health information (PHI). Now a new worry is emerging as some providers take HIPAA compliance too far and threaten patient care.

A recent report from the Bipartisan Policy Center, a think tank in Washington, DC, raised the alarm that HIPAA is too far-reaching and "often misunderstood, misapplied and over-applied in ways that may inhibit information sharing unnecessarily." *(See the story on p. 3 for more on that report.)*

The problem can occur in many healthcare settings, but the IT department is a common source. Some hospital IT departments see themselves as "the HIPAA police" and clamp down in ways that HIPAA doesn't require, says **Abraham Gutman**, CEO of AG Mednet, a Boston-based company that assists providers with communication of clinical trial data. Gutman specializes in the de-identification of patient information specific to clinical trials, and he says that with everyone acting as a judge of what HIPAA requires, clinical research and patient care are impeded.

IT departments should publish guidelines on proper HIPAA interpretation to encourage collaboration instead limiting it out of fear, he suggests. The guidelines should explain what is possible in moving data, rather than only focusing on what is prohibited. Explain clearly what safeguards, such as encryption or de-identification, are necessary so that IT managers are willing to try to say "yes" instead of automatically saying "no."

"In my experience the IT departments are among the least knowledgeable about how to comply with HIPAA, but what they do understand is that a breach traced back to them would have very severe consequences," Gutman explains. "Consequently they take the most conservative approach. Nothing can get out, and nothing can get in."

The IT department, however, is sometimes seen by others as authoritative on HIPAA because it is in charge of data transfer. In that case, the IT department's overreaction is passed on to other departments and individuals, eventually creating a culture in the organization that is not based on an accurate HIPAA interpretation but nonetheless hinders data sharing, Gutman explains. *(See the story on p. 3 for an explanation of how the IT department might capitalize on confusion over HIPAA compliance.)*

"It hinders through fear. There is so much fear among the doctor and nurse population that people don't even ask if they can move some data," Gutman says. "They assume from past experience that the exchange will never be approved, so they might as well not ask."

Educate rather than scaring employees

Risk managers, compliance officers, and other administrators should consider whether they are merely scaring employees about HIPAA violations or educating them about the true spirit of the law, suggests **Stephen Cobb**, senior security researcher with ESET, a company based in San Diego that provides IT security for healthcare providers. HIPAA was never intended to prohibit valid data exchanges, but years of scare tactics have made employees fearful, he says.

"What we have ended up with, unfortunately, is a system of compliance that is diametrically opposed to the idea of providing healthcare," Cobb says. "There are some threats to healthcare data, but most of the information threats are for general information rather than people seeking out healthcare data in particular," he says.

Cobb says he is sympathetic with healthcare IT professionals who may be too strict, because they tend to be on the leading edge of understanding what threats exist and how to resist them. Limiting access to data is always key, so he advises working closely with IT staff to develop reasonable policies. "You have to find a way to rein them in if they are going too far, but without diminishing their enthusiasm for security," Cobb says.

Institutions can be guilty of writing HIPAA policies that are overly strict, but more often the problem lies with individuals who do not know the policies or are overzealous in their interpretation, Gutman says. In particular, employees should be reminded that the patient

EXECUTIVE SUMMARY

Healthcare providers can go overboard with efforts to comply with HIPAA, hindering the necessary transfer of patient information. Refusing to provide needed information can threaten patient safety.

- Excessive caution with HIPAA can happen institution-wide or just with individuals.
- The IT department often can be overly cautious with compliance.
- Providers should ensure that staff understand that erring too much on the side of caution can have negative effects.

owns the PHI, not the hospital, he says. Clinical trial participants, for example, explicitly allow the sharing of their information for the purposes of the research, yet some healthcare staff still worry that HIPAA might trump that permission, Gutman says. It doesn't.

"It is important to explain what kinds of data exchanges can be made, with no worries about HIPAA, in all cases as long as these certain criteria are met," Gutman says. "And they must be empowered to act affirmatively in those situations instead of asking someone else's opinion. Once you ask someone else, you're likely to have people say 'no' just to cover themselves."

Individuals fear criminal, civil penalties

Over interpretation of HIPAA became more common in 2013, when HIPAA was amended in an Omnibus Rule that was intended, in large part, to increase certain protections to individuals and for individuals to have greater access to their information, explains **Lani M. Dornfeld**, JD, an attorney with the law firm of Brach Eichler in Roseland, NJ.

The changes also included stiffer penalties for HIPAA violations, including increased money penalties, which triggered covered healthcare providers to amend their HIPAA policies and procedures and re-train staff, she says.

"Although this re-enforced the healthcare industry's obligation to protect patient privacy, it also engendered fear in individual healthcare providers and their staff," Dornfeld says. "They fear both the monetary penalty provisions as well as the criminal penalty provisions of the law. The result is that providers sometimes overshoot. They err on the side of what they believe to be greater protection to the individual who is the subject of the protected health information."

That response sometimes leads to blocking information from others who have a legal right to access such information and whose access would be beneficial to the individual/patient, such as clinicians and administrators.

Staff often misinterpret HIPAA's provisions regarding the amount of information that may be provided to family members and friends involved in a patient's care or in payment for care, as well as what information may be provided to family and friends after a patient's death, Dornfeld says. *(See the story below for more information on difficult situations.)*

Publicity about HIPAA violations encourage fear and overreaction, says **Patricia Wagner**, JD, an attorney with the law firm of Epstein Becker Green in Washington, DC. That reaction is especially prevalent if well-meaning hospital administrators make a point of bringing the incident to staff's attention and reminding them about the need to comply with HIPAA.

"Every incident in the news about HIPAA ratchets up the angst a little more, and people become more cautious," she says.

SOURCES

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- **Lani M. Dornfeld**, JD, Brach Eichler, Roseland, NJ. Telephone: (973) 403-3136. Email: ldornfeld@bracheichler.com.

Abraham Gutman, CEO, AG Mednet, Boston. Telephone: (855) 246-3363.

- **Patricia Wagner**, JD, Epstein Becker Green, Washington, DC. Telephone: (202) 861-4182. Email: pwagner@ebglaw.com. ■

Policies should address difficult HIPAA scenarios

There can be murky situations in which the right interpretation of HIPAA is not obvious, says **Patricia Wagner**, JD, an attorney with the law firm of Epstein Becker Green in Washington, DC.

Many of them occur in provider-to-provider transfers, but others can involve family members. For example, a parent or guardian is allowed access to a child's protected health information (PHI) except in certain circumstances. An adult child might seek information about a parent, and interpreting HIPAA might require some investigation into the legal status of the patient or asking the parent to provide permission. "Families can be very complex, and it's not always OK to provide information to everyone in the family," Wagner says.

In addition, there can be confusion among staff regarding state privacy laws that might be more restrictive than HIPAA, Wagner notes. Some organizations also have longstanding habits on data sharing, such as requiring patients to sign consent for sharing information with another doctor, that might not be HIPAA-related, yet HIPAA is cited as the reason for refusal.

Clear policies and procedures can help alleviate some of those problems, Wagner suggests. Without an explicit instruction stating what is and is not required for the data exchange, staff are likely to default to the safest choice of not allowing the transfer, she says.

"The policy shouldn't just reiterate the provisions of the HIPAA rule. It should delineate the exact steps that must be taken to approve the information release,"

Wagner says. "If you get a subpoena, here are the four steps you need to take. Or if you get a request from a parent of a minor, here are the three steps to take and the criteria to check off." ■

Tactical approach takes advantage of confusion

With providers increasingly skittish about violating HIPAA but uncertain about exactly what is required, some IT professionals see an opportunity to improve data security, says **Mick Coady**, principal and co-leader of the Health Information Privacy and Security Practice at PricewaterhouseCoopers, the financial services and consulting company in St. Louis.

This "tactical approach" means IT staff, when asked for help on data exchanges, might overstate what HIPAA requires in order to improve overall data security, Coady explains. They might say that encryption or a certain level of encryption is required for the data, when HIPAA does not require that precaution, for instance.

"Some of the security guys see this as an opportunity to get the tools or policies that they think are necessary in the institution," Coady says. "What they are seeking may be a completely valid need for the provider, but intertwining HIPAA requirements with other security needs in this manner only exacerbates the confusion and encourages more data restriction than HIPAA requires."

SOURCE

• **Mick Coady**, Principal and Co-leader, Health Information Privacy and Security Practice, PricewaterhouseCoopers, St. Louis, MO. Telephone: (314) 565-1949. Email: mick.coady@us.pwc.com. ■

Report finds HIPAA hindering data usage

Overly strict compliance with HIPAA threatens patient safety and quality of care, according to a report from the Bipartisan Policy Center in Washington, DC.

When the think tank released the report, **Esther Dyson**, chairwoman of the group's Health Initiative Coordinating Council, endorsed the findings. "The problem with HIPAA is [that] it was applied much too broadly, and to be candid, it was often used as an excuse not to move data around," Dyson said.

Concerns about privacy and security are sometimes cited as barriers to further progress on the use and exchange of data, the report notes. While HIPAA is designed to safeguard patient privacy, it is often misunderstood, misapplied, and over-applied in ways that might inhibit information sharing unnecessarily, it says. "Additionally, a great deal of data about individuals falls outside the purview of HIPAA, such as consumer-generated data that might be posted on social networks, stored in apps, or shared through other online sources," the authors wrote. "HIPAA specifies how data should be de-identified, but there is considerable variability in the practice of anonymization and no existing standards to govern it. Additionally, some data, such as genomic data, is difficult to adequately anonymize."

Seeking consent from patients to use their data for clinical trials or observational research can help mitigate concerns about privacy, but there is evidence that using "opt-in" or "opt-out" patient data results in bias, the report says. "Robust security also plays a role in building trust," the report adds. "The use of multilayered approaches, combined with other safeguards — such as encryption, tokenization, and access controls — can play a critical role in addressing privacy and security risks, enabling sharing of data, and supporting research that requires more than fully de-identified data."

The full report is available online at http://tinyurl.com/ld54qmp. ■

HHS considering change for background checks

A proposed change to HIPAA might help healthcare providers alert law enforcement agencies that a person's mental illness should be considered when allowing a gun purchase, an action that is made difficult and sometimes impossible by the convergence of HIPAA and state laws.

The Department of Health and Human Services (HHS) recently issued a notice of proposed rulemaking to modify HIPAA. The proposal is to expressly permit certain HIPAA-covered entities to disclose to the National Instant Criminal Background Check System (NICS) the identities of individuals who are subject to a federal "mental health prohibitor" that disqualifies them from shipping, transporting, possessing, or receiving a firearm. *(The proposal is available online at http://tinyurl.com/kg3ad8m.)* The NICS is a national system maintained by the FBI to conduct background checks on persons who might be disqualified from receiving firearms based on federally prohibited categories or state law.

Among the persons subject to the federal mental health prohibitor are individuals who:

• have been involuntarily committed to a mental institution;

• have been found incompetent to stand trial or not guilty by reason of insanity;

• or otherwise have been determined by a court, board, commission, or other lawful authority to be a danger to themselves or others or to lack the mental

capacity to contract or manage their own affairs, as a result of marked subnormal intelligence or mental illness, incompetency, condition, or disease.

Under this proposal, only covered entities with lawful authority to make adjudication or commitment decisions that make individuals subject to the federal mental health prohibitor, or that serve as repositories of information for NICS reporting purposes, would be permitted to disclose the information needed for these purposes.

HIPAA does not specifically prohibit releasing mental health information to the NICS, but it defaults to state laws that might be more restrictive, explains **Lee Lasris**, JD, a healthcare law attorney with the Florida Health Law Center in Davie. The amendment is intended to make clear that HIPAA affirmatively permits — rather than simply not prohibiting — disclosure to the NICS, but Lasris says that might not be enough.

More restrictive state law that prohibits the disclosure still will trump HIPAA unless Congress passes a law saying otherwise, Lasris says.

"The amendment will have an impact only in states that do not have more restrictive laws. They will have a clear statement from HHS that HIPAA does not prevent this reporting, and that may be helpful," Lasris says. "In states with more restrictive laws, their solution will be to work with the state legislatures to effect those changes."

SOURCE

• **Lee Lasris**, JD, Florida Health Law Center, Davie Telephone: (954) 358-0155. Email: llasris@flhealthlaw.com. ■

Health system uncovers inside data breach

Riverside Health System in Newport News, VA, has fired an employee and is offering free credit monitoring to several hundred patients affected by a privacy breach that involved records covering four years.

The breach was discovered during a random company audit, according to a statement by company spokesperson **Peter Glagola**. After an investigation, Riverside's Compliance Department determined that an employee had inappropriately accessed 919 medical records spanning September 2009 through October 2013. The information accessed included patients' social security numbers, a summary of the patient history, and other information that appears in Riverside's electronic medical record.

The employee was fired, and Riverside is contacting the patients affected by the breach. All will be offered complementary three-bureau credit monitoring. The company has attempted to send notification letters to all patients and next of kin to those known to be deceased, but it has been unable to locate current contact information for all affected patients. ■

HHS to survey 1,200 — Audits might follow

The Department of Health and Human Services' (HHS') Office for Civil Rights (OCR) announced that it will survey up to 1,200 covered entities and business associates to find those in need of a full HIPAA compliance audit.

The survey will collect information such as the "number of patient visits or insured lives, use of electronic information, revenue, and business locations." The Health Information Technology for Economic and Clinical Health (HITECH) Act requires OCR to conduct periodic audits to ensure that covered entities and business associates are complying with the HITECH Act and its implementing regulations.

An audit of 115 covered entities in 2012 found that compliance issues with the HIPAA Security Rule. About two-thirds of audited entities did not have a complete and accurate risk assessment, and many entities were unaware of specific HIPAA Privacy Rule requirements, such as the obligation to provide a notice of privacy practices to individuals. ■

First ever settlement with local government

In the first settlement with a local government, the Department of Health and Human Services (HHS) reached an agreement with Skagit County, WA, about HIPAA violations.

The dearartment previously reached a settlement with the state Medicaid agency in Alaska, but it has never reached a settlement with a local breanch of government.

The county's troubles began on Dec. 9, 2011, when Skagit County reported to HHS that it had inadvertently provided public access to the protected information of seven individuals. HHS then discovered that the breach was larger. Skagit County had inadvertently uploaded files containing the protected health information (PHI) of 1,581 individuals onto a public web server.

The HHS Office for Civil Rights (OCR) investigated the county's privacy and security practices and found what it calls "widespread non-compliance" with the HIPAA privacy, security, and breach notification rules. The investigation ended recently with a resolution agreement that requires Skagit County to pay $215,000 and adhere to a stringent remediation and reporting program. ■

Hospital Access Management

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

2014 Reader Survey

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

Please fill in the appropriate answers or write your answers to the open-ended questions. Either fax the completed questionnaire to 404-492-5933, or return it in the enclosed postage-paid envelope. The deadline is **July 1, 2014**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28. What is the highest degree that you hold?

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

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

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

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

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

Contact information _____