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## IN THIS ISSUE



# Patients expect self-service — Give options: Register online, at kiosk

## Registration times decreased by nearly 50%

Patients accustomed to using self-service kiosks at airport check-in counters and placing online retail orders likely wonder why they have to stand in line to give demographic and insurance information to a registrar verbally.

"There are many self-service options available in patient access, and more are emerging. It's an exciting time for patient access technology," says **Amber J. Harris**, administrative director of patient-centered access at Integris Health in Oklahoma City, OK.

**Sandra J. Wolfskill**, FHFMA, director of healthcare finance policy at the Healthcare Financial Management Association (HFMA), says self-service options "ease backlogs in the registration area, and in the case of online options, allow patients to interact with the hospital at their convenience." Wolfskill also is director of HFMA's revenue cycle Measure Apply Perform (MAP) initiatives.

Wolfskill says that the options patients expect are "generational in nature. It varies from 20-somethings who expect mobile access and processing, to retirees with time to come in early and chat with the registra-

## EXECUTIVE SUMMARY

A growing number of patient access areas offer "self-service" options with online registration or kiosks. Registration times decreased by almost 50% after kiosks were implemented at five of Integris Health's hospitals. Patient access leaders should do the following:
• Use kiosks for pre-registered patients.
• Have support staff available to help patients.
• Commit to kiosks as the primary arrival mechanism for all scheduled patients.

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tion staff."

She estimates that about 20% of patient access departments offer some type of online pre-registration.

"This is a viable option for many patient access areas, as long as appropriate encryption and security are provided," says Wolfskill. "Some details may require staff intervention, such as electronic insurance verification or billing codes that are captured during registration."

Kiosks are especially useful for patients who have been pre-registered for services, according to Wolfskill. Payments are processed electronically from the kiosk and applied to the account, the patient's armband and arrival paperwork are printed, a staff member bands the patient, and the patient is directed to the service area.

"Since the patient's information has already been validated and updated, the arrival process involves simply checking in, confirming identity, and paying any agreed-upon amount," Wolfskill explains.

## Registration time cut almost 50%

Registration times decreased by almost 50% after kiosks were implemented in the main registration area and surgery centers at five of Integris Health's hospitals.

"We are building a new registration area at Integris Baptist Medical Center, and it fully incorporates kiosk into the registration experience," reports Harris.

"We use them as an express registration option for pre-registered patients," says Harris. Integris Health plans to implement an online patient portal for registration once the hospital converts to a new Epic system, she reports.

Patients adjusted quickly to the kiosks. "They are exposed to increasing self-service technology in other industries," notes Harris. "We asked patients if they wanted to try our kiosks. We didn't force anyone to use them and still don't."

Every patient using the kiosk is presented with a quick survey at the end about their registration experience. "Of patients surveyed, 96% said they liked the kiosks, and 87% said the process was easier than a traditional registration," reports Harris.

Harris says that she would like to see the kiosks used in the emergency room (ER), but that this setting presents some unique challenges.

"The challenge in the ER is integrating fully into your Master Patient Index, just as 'expected' patients for the day are," she explains. "It's a completely different work flow. But other hospitals successfully do it, and I am sure we could, too."

## Do this before implementation

Before implementing kiosks in registration areas, Wolfskill says to take these steps:

• **Define when self-registration is appropriate.**

"Self-service options are not appropriate for the emergency department, walk-ins, or unscheduled outpatients," says Wolfskill.

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**• Have support personnel available to help patients use the kiosks.**

Without appropriate support, some patients will become frustrated or unable to complete the process.

"Even the airlines, who pioneered the extensive use of kiosks, have personnel standing by to help the moment a passenger looks lost or confused," says Wolfskill.

**• Commit to kiosks as the primary arrival mechanism for all scheduled patients.**

Patient access leaders can provide information on kiosks to patients during the pre-registration process, make announcements to the community, post signs about the kiosks, and provide handouts on the kiosks in registration areas.

"Otherwise, the unscheduled arrival area becomes backlogged with people who do not want to use the kiosks," Wolfskill says.

### Moving toward self-service

At Emory University Hospital in Atlanta, the Information Services Department is working on ways to use technology to add self-service options to patient access areas. A related goal is to minimize the need for patient contact with patient access employees at time of service, says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for patient financial services.

"With respect to elective services, it all begins at scheduling," he says.

This process involves the gathering of data needed to pre-register, pre-certify, determine medical necessity, determine whether the patient's status is inpatient or outpatient, and determine financial need and the patient's ability to pay. All these items must be completed as a prerequisite to scheduling, says Kraus.

Kraus recently discussed the feasibility of patients completing the Medicare Secondary Payer Questionnaire using a kiosk or as part of online registration. "Given current complexities, we're not sure it will ever be doable, but we can and do collect the information during preadmission calls," says Kraus.

In coming years, once the patient presents, there could be little left for patient access to do except obtain signatures.

"Perhaps we'll eventually embrace technology to have consent obtained in advance," says Kraus. "Very little of this is current reality. But each step we take is designed to move us in that direction."

**SOURCES**


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# Collections up 25% with this change

## Move cost discussion earlier in process

"Who is in network for my plan?" "How do I sign up for coverage?" "What plans do you participate in?"

Patient access employees at Sutter Health in Roseville, CA, are fielding many such questions from patients, reports **Becky J. Peters**, registration lead, West at Sutter Shared Services.

These changes were made to improve the financial counseling process:

**• The preregistration/financial clearance process was expanded.**

Previously, staff reviewed patients' insurance eligibility and benefit coverage. Now they also give them an estimate of their liability after insurance, which wasn't done consistently before.

They implemented a new patient price estimator: Patient Payment Estimator, manufactured by Franklin, TN-based Passport. "This is now used as our standard across all facilities," says Peters.

The preregistration team provides patients a price estimation based on their scheduled procedure. The estimate calculates the amount of reimbursement expected from the patient's insurance and the patient's specific benefits.

"We also provide the same service for patients that are not scheduled, but come in as a walk-in for outpatient procedures," says Peters. "We saw at least a 25% increase in our upfront collections."

**• Ongoing training programs are offered to update staff on constantly changing payer requirements.**

"We are developing our own training unit. It will focus on all aspects of patient access services: basic registration, customer service, cash collections, technology training, compliance, and insurance," says Peters.

Training will cover identifying participating versus non-participating plans, electronic eligibility and benefit responses, Medicare plans, Medicare Risk plans, and plans available on Covered California, the state's health insurance exchange.

"We will have dedicated trainers, and we will also be doing a lot of 'train the trainer' with our management team," says Peters. "Most of the training will be mandatory."

Many different formats are used for training, including trainer-led sessions, webinars, and online educational tools. "We are developing a new hire training program, as well as ongoing competencies," says Peters.

**• Patient access leaders collaborate with the hospital's third-party liability vendor.**

"They assist patients in applying for federal, state, and county programs," says Peters. "They provide guidance on how to apply for Covered California plans online."

**• A new patient advocate role was added at pre-registration and point of service.**

This individual assists patients in understanding their coverage benefits and identifying whether additional financial assistance is needed.

"The role used to be a financial counselor," says Peters. "We revised it and added responsibilities for real-time financial assistance review."

By identifying the issues earlier in the process, such as that a patient is uninsured or underinsured, staff members have enough time to work with the patient's physician and insurance company to resolve any problems before the date of service. "This eliminates stress and undue financial responsibility for the patient," says Peters.

## Focus is on education

Trinity Rock Island (IL) has cut back on the hospital's financial assistance program as a result of the Affordable Care Act, reports **Linaka Kain**, DE, an Illinois in-person counselor and lead Medicaid specialist.

"When we apply for Medicaid for patients, we ask for retroactive coverage. We use our financial assistance program as a last resort," she says. "All avenues of coverage have to be exhausted first."

Self-pay patients are now required to apply for Medicaid or the Health Insurance Exchange Marketplace before any financial assistance is offered. Written proof of an approval or denial of insurance is required.

"This has worked very well for us," says Kain.

EXECUTIVE SUMMARY

Patient access areas are moving financial discussions earlier in the process to give patients detailed information about their coverage. At Sutter Health, upfront collections rose by 25% as a result of giving price estimates when pre-registering patients. Departments are making these changes:
- implementing training programs for staff, covering all aspects of insurance;
- adding a patient advocate role at pre-registration and point of service;
- requiring patients to apply for Medicaid or other coverage before offering financial assistance.

"Registration staff calls us while they are registering the patients to counsel them." If it's not convenient for the patient at that time, staff members give them business cards with the Medicaid specialist/certified application counselors' general call line number.

"We are really concentrating on educating the patients," says Kain. "We are letting them know that we no longer just write off their bills unless they meet our criteria."

## Focus is on Medicaid signups

Trinity enrolled 1,138 consumers in the last 2014 enrollment period -- 750 in Medicaid and 388 in the Health Insurance Exchange Marketplace. The department's focus is on signing up as many patients for Medicaid as possible.

"This will allow us more time for [the open enrollment period for 2015 coverage] when it starts in November 2014," says Kain.

Kain still encounters many patients who don't know what the terms "copay" or "deductible" mean.

"We have to remember that if someone has never had insurance before, they don't know all the terminology," she says. "Some people don't realize that you have to pay your premium first before the card works."

### SOURCES

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• **Linaka Kain**, DE, Lead Medicaid Specialist, Trinity Rock Island (IL). Phone: (309) 779-2648. Email: Linaka.Kain@unitypoint.org. ■

# Give staff members opportunity to move up

*Advancing gives feeling of forward progression*

Asheville, NC-based Mission Health doesn't use traditional career ladders in its patient access departments, but that doesn't mean there is no opportunity for employees to advance.

"We offer positions within the department that allow staff forward progression in their careers, through promotions to positions of greater responsibility," says **Eliana Owens**, executive director of patient access and coding.

Employees are given the chance to move up to various positions in registration, scheduling, pre-registration, and financial counseling. Vacant positions are published on Mission Health's new career site and are discussed in team huddles.

"Staff can set the system up to notify them when positions in a particular job family become available," says Owens.

Vacancies are also discussed in team huddles.

Traditional career ladders are better-suited for smaller hospitals where patient access employees perform multiple roles, says Owens. "It is not always cost-effective at our smaller hospitals to have individuals who specialize in one aspect of patient access functions," she explains.

Higher volumes at larger hospitals, such as Mission Health, require patient access staff members to perform specific functions such as scheduling, pre-registration, registration, or financial counseling.

"We often accomplish the staffing of these positions through promotional opportunities, versus the traditional career ladder model that may not support a defined number of positions in each role," says Owens.

## Many promotions

Several of Mission Health's patient access employees recently were promoted from entry-level positions to financial counselor or supervisors. Shortly after **Lee Anna Mull** started as an insurance verification representative in 2001, her managers encouraged her to take leadership classes offered by human resources.

"I found that I loved the challenge of always learning something new, whether it be a new daily duty or insurance regulation," says Mull. She was given the opportunity to cross-train throughout patient access, and she moved up to be a patient access coordinator before being promoted to patient access manager.

"Those opportunities made me realize the more I knew, the more I loved my job, and the more I wanted to grow within it," says Mull, who is working to obtain an associate degree in medical office administration.

Many employees who are promoted to a manager role choose to continue their education at the college level.

"They have shown a willingness to learn different aspects of patient access," says Owens. "Some have taken positions that were a lateral move, so that they can learn various roles."

The minimum requirements for the positions are differentiated by years of experience. For example, the patient registration representative role requires one year of prior experience, compared to two years experience for the scheduling coordinator role.

"There are also preferred skills associated with each specific role, such as medical terminology and prior scheduling experience for the scheduling coordinator," says Owens.

The opportunity to move up increases staff morale, reports Owen. "We have a very low turnover rate, which I'm sure can somewhat be attributed to the opportunities for upward career movement," she says.

### SOURCES

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## EXECUTIVE SUMMARY

Patient access leaders at Mission Health offer entry-level employees a variety of options for moving up, including positions in registration, scheduling, pre-registration, and financial counseling.
• Some employees made a lateral move to learn new roles.
• The opportunity to move up internally increases staff morale.
• The department credits its low turnover rate to frequent staff promotions.

# See service skills of staff firsthand

*Rounding is `priceless' opportunity for access*

"Priceless" is the word that **Helen Contreraz**, director of patient access services at Ronald Reagan UCLA Medical Center in Los Angeles, uses to describe the results of rounding.

All patient access employees are trained in the organization's "C-ICARE" (Connect/Introduce/Communicate/Ask/Respond/Exit) principles. These principles are a focus during rounding, which is done by managers three times a month in various areas.

"We ask the staff what can we improve on and also what they think our staff needs to improve on," says Contreraz. Patient access managers ask these questions:

- What do you value most about your role?
- Are any barriers keeping you from achieving your best?
- Is there anything you have personally done that you would consider to be a best practice in your area?
- How do you think you help achieve the "C-ICARE" vision?

Sometimes, Contreraz learns about a problem in another area of the hospital that is affecting patient access. Recently, staff members reported during rounding that some patients were dissatisfied due to problems with parking. "The kiosks weren't opening early enough for the first morning cases, and delays were occurring," says Contreraz. "We coordinated with parking, and we direct patients either to the valets or the adjacent parking structure."

Here are other ways the department improves customer service:

**• Patient access employees are encouraged to help their peers improve the service provided to patients.**

Occasionally, something that happened at home or at work is affecting the customer service provided by a patient access employee. If so, employees remind their colleague to "leave your baggage at the door," says Contreraz. "If someone is caught having one of those 'baggage' days, we give them a gentle reminder of why we're here."

**• Managers observe patient access areas three times each week.**

"We look at how staff are answering the phone and how they are interacting with patients and each other," she says.

Occasionally, Contreraz notices that staff members are busy multitasking and forget to look up from their screen when interacting with a patient. "If someone never takes their eyes from computer, you don't feel acknowledged," she says.

**• Staff greet patients by name and say, "We've been expecting you."**

Patients often arrive agitated, due to getting stuck in traffic, getting lost, or simply trying to figure out how to navigate the hospital building. By telling patients they were expected, says Contreraz, "this reassures patients that 'You're in the right place, and we're going to take care of you.'"

**• If there is a wait, patients are given a pager so they can leave the registration area for a few minutes.**

"Sometimes everybody seems to get here at the same time. With the pager, patients don't have to worry, 'Did they forget about me?' They can go for a walk or go to the cafeteria," says Contreraz.

## Reward staff for compliments

Patient access areas at Mercy Hospital Springfield (MO) use a "Going the Extra Mile" (GEM) Program to acknowledge excellent customer service. *(See program description, p. 91.)* "We have cards that patients or coworkers can fill out to compliment or acknowledge a coworker for outstanding service," says patient access manager **Rebecca Holman**, CHAM. "These are logged and rewarded on a graduating scale."

Employees receive certificates, cafeteria credits, or "Mercy Points," an internal reward system that can be redeemed for merchandise. Based on the level that a registrar achieves, says Holman, a "gem" pin is attached to the name badge. "The

## EXECUTIVE SUMMARY

Rounding in patient access areas gives managers an opportunity to observe the customer service provided by employees firsthand. Some proven patient satisfiers:

- Remind staff to look up from computer screens to make eye contact.
- Tell patients, "We've been expecting you."
- Give patients pagers so they can leave the immediate area.

pins are purchased at a craft supply store," says Holman. *(See related stories on assessing customer service, below right, and setting criteria, p. 92.)*

### SOURCES


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# Reward access for good service

Below is a description of the "Go the Extra Mile" (GEM) program used by the patient access department at Mercy Hospital Springfield (MO):

**Policy:** The policy of the Patient Access Department is to provide exceptional customer service for both internal and external customers. The Patient Access Department has created the G.E.M. Customer Service Program. This program stands for "Go the Extra Mile." All Patient Access employees will adhere to the procedure regarding the program outlined below.

**Purpose:** The purpose is to encourage all employees to provide exceptional customer service and to give to those employees recognition when 'Going the Extra Mile.'

**Procedure:** Comment cards will be available at each registrar's desk or at a designated area in the department for patients and family members to fill out. After comment cards are completed the patient will place cards in a lock box. Managers will retrieve the cards on a weekly basis to determine who may qualify for a G.E.M. award. *(See the reward matrix at the bottom of this page.)* ■

# How was service? Ask patients directly

*Call monitoring and secret shoppers are effective*

At Ronald Reagan UCLA Medical Center in Los Angeles, patient access managers interview 15 patients each month.

"In some cases, patients are approached after they check in and asked if they'd be willing to answer a few questions about the customer service they received," says **Helen Contreraz**, director of patient access services.

Other times, charge nurses recommend a few patients for the patient access manager to interview. "Sometimes they'll recommend a patient who is problematic. Often, we can take away a lot of information from that," says Contreraz.

One patient was upset because his observation of a religious holiday wasn't acknowledged by clinicians. However, the underlying problem was

| Level | Cards Received | Color GEM | Certificate Color | Prize |
|---|---|---|---|---|
| 1 | 1 GEM | Citrine | Yellow | Certificate |
| 2 | 10 GEMS | Amethyst | Purple | cafeteria pass $5.00 |
| 3 | 25 GEMS | Aquamarine | light blue | 10 Mercy Points |
| 4 | 50 GEMS | Emerald | Green | 25 Mercy Points |
| 5 | 75 GEMS | Ruby | Red | 50 Mercy Points |
| 6 | 100 GEMS | Diamond | Diamond Plaque | Special Plaque signed by the VP of Finance and the PA Director. 100 Mercy Points. |

Source: Mercy Hospital Springfield (MO).

traced back to the fact that patient access didn't identify his spiritual affiliation at the point of registration.

Patients are asked these questions about their registration experience:

- Were you greeted with respect?
- Did the registrar introduce themselves?
- Did the registrar explain what was going to happen next?
- Did we provide you with an exit that was courteous?
- Were all your questions answered?

Here are other ways to assess customer service provided in patient access areas:

**• Perform monthly call reviews.**

**Jennifer D. Martin**, patient access manager at UK Healthcare in Lexington, KY, says, "We select random calls for each agent. We utilize a call evaluation survey as an assessment tool."

This system allows managers to measure each employee's strengths and weakness during the phone call interaction. "Patient access managers work with frontline supervisors to provide feedback and recognition to each patient access employee," she says.

The call reviews also allow managers to assess and identify communication breakdowns or barriers to the scheduling process. "This will allow opportunity to collaborate with our clinical teams to update scheduling protocols or streamline the scheduling process," says Martin.

A monthly call review session is held with each employee. The employee and management team listen as a group to the recorded phone call interaction, using a call evaluation form that scores how the caller was greeted, timeliness, customer service, and how the call was ended.

"If managers determine an area in which employee could be struggling, the team provides additional training or ideas to ensure the employee meets the expectations," says Martin.

**• Use secret shoppers.**

**Rebecca Holman**, CHAM, patient access manager at Mercy Hospital Springfield (MO), occasionally uses "secret shoppers" to observe customer service provided by staff. "One of the things they observed was our receptionist not making immediate eye contact with the visitor," says Holman.

The secret shoppers are one of the best ways to assess a department's level of customer service, as long as they are unbiased without pre-conceived opinions, she says. "I have used personal friends who are not patients and gave them brief instructions on what to look for," says Holman. The secret shoppers checked that employees immediately acknowledged visitors approaching the desk, made eye contact, smiled, used a pleasant tone of voice, and spoke clearly.

Holman has also used peers in management positions that patient access employees aren't acquainted with. "The best secret shoppers are our administrative executives that come in for services," she says. "They are sure to tell us if there is something that needs attention." ■

# Set your criteria for customer service

*Have patient access employees sign agreement*

All patient access employees in Mercy Hospital Springfield (MO)'s main admitting area are required to sign a Customer Service Interaction Plan. [*The plan used by the department is incliuded with the online issue. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

"This document becomes a part of their file," says patient access manager **Rebecca Holman**, CHAM. "It states that they will provide the best customer service that they can."

The agreement states that the employee will meet and/or exceed the expectations of the patient or their family; immediately acknowledge the patient by smiling and using the AIDET model (Acknowledge, Introduce, Duration, Explain, Thank); give the patient their full attention; and ask how they can better serve them.

"We keep this in this in the forefront," says Holman. "If a coworker seems to be lacking, we do a coaching session and have them sign a new agreement, reaffirming their commitment."

Patient access leaders at Lexington, KY-based UK Healthcare set clear expectations to let employees know what level of customer service is expected. These four criteria are used:

**• Greeting and identification.**

"We want to ensure the patient access staff properly identify themselves and the appropriate clinic of which they are scheduling," says patient access manager **Jennifer D. Martin**.

• **Quality.**

Patient access staff are expected to speak at an appropriate tempo and volume, use clear and articulate speech, and sound attentive, confident, and knowledgeable. "Lastly, we want to see if the agent gave any unsolicited advice or information," she says.

Patient access works closely with the clinical management teams to ensure both areas are following the scheduling protocols. "Thus, we would not want to schedule or provide advice outside of these scheduling guidelines," Martin explains. "Further, we do not provide medical advice or treatment recommendations."

• **Customer service and wrap-up.**

Managers want to see that patient access staff listened to caller's needs without interrupting, conveyed information clearly, confirmed the patient's needs, and ended the call by saying, "Thank you" or "You're welcome."

• **Timeliness.**

"We want to ensure that during the call interaction, the patient access staff allows the customer to set the pace of the call," says Martin. ■

# Centralized scheduling provides many benefits

Back in 2006, revenue cycle leaders at Pittsburgh-based UPMC noted an increase in patient complaints that calls to physician offices weren't being answered and messages weren't responded to quickly enough.

"We were getting feedback that people were not always getting through to the service/office clinical area. We wanted to make sure we weren't losing customers because they were reaching voicemail versus people," says **Karen Shaffer-Platt**, vice president of patient concierge services/access in UPMC's Corporate Revenue Cycle.

Patients who called the wrong departments weren't always referred to the correct department. "We were hearing that UPMC is so big that it is difficult to know who to call," says Shaffer-Platt. "Not all 60,000 employees have a good decision support tool that can lead them to the right appointment or the right place."

More than 10,000 calls a day are now managed at UPMC's centralized consumer call center, where patient access employees handle primary or secondary scheduling support for more than a dozen hospitals and 23 specialties, in private practice and academic. "We are zealous about it. We are huge proponents of centralized consumer call centers," says Shaffer-Platt. "We had to really grow it up, but it's turned into one of our most valuable assets and customer satisfiers."

## Expanded role of access

Shaffer-Platt says the patient contact center is "taking the real definition of access farther. Access should be the ones who are getting patients to the first service and connecting them to their next service."

Patients can make or cancel appointments 24 hours a day, seven days a week. "We also serve as our doctors' offices answering service. That saved us a lot of money with an outside vendor," Shaffer-Platt says.

Staff members can book an appointment, page a doctor, or use a protocol to direct patients to appropriate care sites. This system sometimes avoids an unnecessary emergency department visit. **Diane Zilko**, senior director of the Patient Contact Center, says, "We have e-visits, and the call center can lead patients to immediate service in the comfort of their home."

Shaffer-Platt says "the real issue is access to services. That's what a contact center is all about."

## Billing concerns are addressed

Here are some of the items handled by the call center's agents:

• **They handle billing concerns, such as adding an additional coverage, reviewing the Explanation of Benefits, and supplying itemized copies of bills.**

If a patient calls stating that a visit should have

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## EXECUTIVE SUMMARY

A patient contact center at Pittsburgh-based UPMC handles scheduling, discharge planning, and collection of unpaid balances for more than a dozen hospitals and 23 specialties.

- Financial discussions occur at the point of scheduling.
- Providers build in decision rules into the system for scheduling.
- Patients can make appointments any time of day or night.

been coded as a wellness visit, the agent refers the problem to the coding department.

"We can't change a CPT code, but we have a coder look at it within eight business hours," Shaffer-Platt says. "Coders are expensive and shouldn't have to call patients, so we may have to do the outbound call, which we have no problem doing."

**• They collect outstanding balances and have financial discussions with patients.**

With higher-out-of pocket responsibilities for patients, the best time to have financial discussions with patients is at the point of scheduling, argues Shaffer-Platt. Agents use a price estimator, built into the system, to give accurate quotes for out-of-pocket expenses.

"Why would I put the patient in a work queue for somebody else to do an outbound call on, or worse, wait until the day of service to try to collect?" she asks.

Instead, staff determine the patient's propensity to pay right at the time of the call. "If I'm a patient, I don't want somebody trying to figure all this out with a calculator," says Shaffer-Platt. "Nobody is smart enough to know all of that, so the system tees it all up right in front of the contact center agent, based on the insurance plan details."

## Find out upfront: Can patient pay?

If the patient is unable to pay for services, "you should know that upfront, not after they have entered into a complex clinical care plan and they are on an OR schedule," says Shaffer-Platt.

In this case, the patient needs a more in-depth discussion of his or her finances, at a convenient time for the patient. "I'd rather talk to mom about her out-of-pocket expense after she puts the kids to sleep, than at the arrival desk the day of surgery," says Shaffer-Platt.

Patients often are relieved to learn they qualify for financial assistance or need-based discounts. Zilko says, "Letting the patient know that will partner with them at the beginning of the care plan eases the mental fatigue from financial worries during an already trying time."

### SOURCES

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# Providers satisfied with call center

*Offices make their own rules for scheduling*

Before a Patient Contact Center was implemented at Pittsburgh-based UPMC, providers accustomed to handling their own scheduling were skeptical, reports **Karen Shaffer-Platt**, vice president of patient concierge services/access in UPMC's Corporate Revenue Cycle department.

"Nobody felt like felt like a centralized call center could know enough about the details and clinical pathways of the specialties to act on their behalf," says Shaffer-Platt. "That was the biggest cultural obstacle we had."

In response, leaders built decision support into the hospital's EPIC system. This decision support allows call center agents to schedule based on the exact same rules as the practice. "If a patient calls and says, `I want to see a doctor for my hip,' by inputting 'hip' as the chief complaint, it leads us to all of the appropriate doctors or a series of questions to garner the information to lead to the right appointment," says Shaffer-Platt. Patients are asked if they prefer a specific physician or if they would like the nearest physician or the first available appointment.

"That response leads you to the next three appointments that you can offer to the patient," says Shaffer-Platt. "The individual scheduler does not have to have expertise or recall for every scheduling scenario."

## Agents follow questionnaires

The decision support questions that lead to an appointment are based on the provider offices' scheduling preferences.

**Diane Zilko**, senior director of the Patient Contact Center, says, "It kind of takes the call center agent out of the decision-making equation. They just follow the questionnaire."

Practices can choose to have all calls handled by the center or only those calls that aren't answered in the first six rings.

Shaffer-Platt says, "If patient calls a cardiology practice in the community, and staff are distracted or busy, it goes to the center. When it gets to our agent, information about the office takes over our

screen."

Staff members can view directions, parking instructions, and local restaurants, which allows them to tell patients the same things anyone in the provider's office would.

Initially, many providers wanted to maintain control over their scheduling. "There was always that attitude of, 'Oh, but you don't know where I can squeeze people in,'" says Shaffer-Platt. "We started with the approach of 'let us take the low-hanging fruit.'"

### Call center handled the simple calls

Using this approach, the call center handled all simple calls and allowed the practice to handle more complicated calls.

"Then we followed what the real patterns were. We could then say, 'Let's be truthful. You do four add-ons that you build into your template every day,'" says Shaffer-Platt.

Providers realized that the call center was able to schedule just as well as their office staff. Here are some things that satisfy providers:

**• The center also handles discharge planning to ensure that recommended care is obtained.**

Zilko says, "We get a set of discharge orders and call the patient on behalf of the doctor's office to be sure tests are scheduled."

Outstanding orders also appear on the screen. Shaffer-Platt says, "We use it to push what I call our 'access agenda. If the goal is to get them back in, why not have access be the ones to follow up with the patient?"

Staff members can say, for example, "Hey, while I have you on the phone, I'm looking at Dr. Smith's order for a mammography. Would you like me to go ahead and schedule that?"

**• When staff get a cancellation, they can go to the wait list to contact patients who are waiting for appointments to open up.**

"This keeps the doctors' schedules full," says Shaffer-Platt.

**• Patients can make appointments after hours, which possibly prevents hospital admissions.**

In some cases, emergency room (ER) physicians are able to comfortably discharge a patient home because they know a follow-up appointment is already in place.

"What a service we offered, if we can say to the patient at 2 a.m. in the ER, 'I can get you an orthopedist appointment or get you in for an MRI at noon tomorrow,'" says Shaffer-Platt. ■

# Humana ranks no. 1 in being easy to work with

For the second year in a row, Humana ranked first in overall performance among 148 payers, according to the 2014 PayerView Report, an annual report from athenahealth in Watertown, MA.

Athenahealth is a provider of cloud-based services for electronic health record (EHR), practice management, and care coordination.

The 2014 PayerView results rank commercial and government health insurers according to specific measures of financial, administrative, and transactional performance. These measures provide an objective, comparative benchmark for assessing how easy or difficult it is for providers to work with payers. Rankings are derived from athenahealth's athenaNet database, which includes more than 52,000 providers. The 2014 PayerView data set analyzes 108 million charge lines and $20 billion in health care services billed in 2013.

The 2014 report reveals these trends:

**• Medicaid's lackluster performance continues.**

For the ninth straight year, Medicaid performed worse than commercial plans and Medicare on key metrics such as days in accounts receivable (DAR), denial rates, and electronic remittance advice (ERA) transparency. While some Medicaids, such as Medicaid Connecticut, performed especially well on select metrics, such as enrollment, as a whole the category continues to underperform.

Even though it is too early to determine the impact of the Medicaid expansion on payer performance, with an expected 85 million enrollees by 2021, all providers who serve Medicaid populations should be aware of their state's expansion status and performance metrics. Understanding strengths and weaknesses related to Medicaid

## COMING IN FUTURE MONTHS

- Dramatically increase ED copay collection
- Get a true measure of employees' productivity
- Boost efficiency by combining scheduling, registration
- Avoid pitfalls with estimates for price-shopping patients

enrollment efficiency and denial rate can help providers prepare for increased Medicaid patient volume and potential associated administrative burden, as well as mitigate risk to their business.

**• Providers' burden to collect on claims varies widely.**

Provider collection burden (PCB), measured as the percent of charges transferred from the primary insurer to the next responsible party after the time of service, is increasing slightly, data indicates. Historically, findings reveal that providers in the West are experiencing higher collection burden than those in other parts of the country. Medicare and many Blue Cross Blue Shield plans require providers to collect large percentages of payments from patients, while Medicaids require minimal collection.

Providers who shift their payer mix to include Medicare and Blue Cross Blue Shield plans might see their collection burden increase. Those providers also might be increasingly asked to explain the meaning of items such as co-insurance, deductibles, and co-pays to patients.

**• Blue Cross Blue Shield plans pay providers the fastest.**

As a category, Blue Cross Blue Shield plans reimburse providers most quickly, with an average of three fewer days in accounts receivable compared to all other payers. On this measure, Blue Cross Blue Shield plans represent 20 of the top 25 performers, and they displace major commercial payers' historical position as the leading category.

As major participants on the health insurance exchanges, Blue Cross Blue Shield plans' performance signals a positive indicator that providers who serve patients covered by these plans can cater to increased patient volume without cash flow disruption.

**• Commercial payers offer the most efficient enrollments.**

While Medicaid enrollment proves particularly burdensome, national commercial payers' enrollment proves simplest. According to PayerView data, no commercial payers require enrollment for electronic data interchange or for enrollment documents to be sent via mail. As providers contemplate potential changes to the mix of payers with which they work, enrollment requirements and associated efficiencies should be considered.

To see the full 2014 PayerView Report, go to www.athenahealth.com/PayerView. An infographic accompanying this mews story is available at http://bit.ly/1rCXkFd. ■

HIPAA Regulatory Alert
Cutting-edge information on privacy regulations

# Physician's tinkering causes data breach, record $4.8 million in HIPAA settlements

Two prominent New York organizations have agreed to pay $4.8 million to settle charges stemming from a data breach, and they take the dubious honor of the largest settlement ever for violating the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The breach has been traced to the actions of a single physician who had access to a computer server.

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) says the providers failed to secure thousands of patients' electronic protected health information (PHI) held on their network. A major lesson from the breach is that partnering with another provider brings substantial risk if you do not thoroughly assess how data will be shared and protected.

OCR initiated its investigation of New York — Presbyterian Hospital (NYP) and Columbia University (CU) following their submission of a joint breach report, dated Sept. 27, 2010, regarding the disclosure of the PHI of 6,800 individuals, including patient status, vital signs, medications, and laboratory results. NYP and CU are separate covered entities that participate in a joint arrangement in which CU faculty members serve as attending physicians at NYP. The entities generally refer to their affiliation as "New York Presbyterian Hospital/Columbia University Medical Center."

NYP and CU operate a shared data network and a shared network firewall that is administered by employees of both entities. The shared network links to NYP patient information systems containing PHI. The breach did not happen in any of the most typical ways, such as a laptop being lost or stolen. Instead, a single physician mistakenly thwarted NYP and CU's security systems.

The OCR investigation revealed that the breach was caused when a physician employed by CU, who developed applications for NYP and CU, attempted to deactivate a personally owned computer server on the network containing NYP patient PHI. Because of a lack of technical safeguards, deactivation of the server resulted in PHI being accessible on internet search engines, the OCR reports. The entities learned of the breach after receiving a complaint by an individual who found the PHI of the individual's deceased partner, a former patient of NYP, on the internet.

In addition to the impermissible disclosure of PHI on the internet, OCR's investigation found that neither NYP nor CU made efforts prior to the breach to ensure that the server was secure and that it contained appropriate software protections.

"Moreover, OCR determined that neither entity had conducted an accurate and thorough risk analysis that identified all systems that access NYP PHI," OCR stated in announcing the settlement. "As a result, neither entity had developed an adequate risk management plan that addressed the potential threats and hazards to the security of PHI. Lastly, NYP failed to implement appropriate policies and procedures for authorizing access to its databases and failed to comply with its own policies on information access management."

## Must assess risk of working with partner

NYP has paid OCR a monetary settlement of $3.3 million, and CU has paid $1.5 million. Both entities agreed to a substantive corrective action plan, which includes undertaking a risk analysis, developing a risk management plan, revising policies and procedures, training staff, and providing

## EXECUTIVE SUMMARY

Two organizations will pay a combined $4.8 million to settle a case sparked by a breach of protected health information (PHI). The settlement is the largest ever for a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The breach involved the PHI of 6,800 people.
- A physician caused the breach by accessing a server.
- Partnering with another provider brings substantial risk if you do not thoroughly assess how data will be shared.

progress reports. (The New York — Presbyterian Hospital Resolution Agreement may be found at http://tinyurl.com/lakqm96. The Columbia University Resolution Agreement may be found at http://tinyurl.com/ofyargl.)

The incident and the large settlement figure illustrate the risk that healthcare providers take on when working on such a data-driven project with another provider, says **Alisa L. Chestler**, JD, shareholder with the law firm of Baker Donelson in Washington, DC. "You have two entities here that were collaborating to do really good work, but even the most minute details of how you create, receive, transmit, or maintain information needs to be understood," Chestler says. "This employee of one essentially compromised them both by trying to terminate access in a way that obviously didn't work. This shows that you have to ask what you know about what your partner is doing and how they're doing it."

A thorough risk analysis is necessary for any partnership involving data sharing, Chestler says. Both of the corrective action agreements in this case call for a risk analysis.

### Risk analysis failure can be your downfall

The risk analysis failure turned out to be as important to this case as the breach itself, which did not involve as many patients as some previous breaches, says **Brad Rostolsky**, JD, an associate with the law firm of Reed Smith in Philadelphia. One sure lesson from the New York case is that you want to stay out of the government's way as much as possible, he says. Once OCR investigated the breach, it found overall deficiencies in HIPAA compliance.

"If they look at you for HIPAA compliance purposes and determine that you have not conducted an appropriate risk assessment under the security problem, there's going to be a problem," Rostolsky says. "Notwithstanding everything you may be doing with HIPAA compliance, if you have not conducted an appropriate risk assessment, you are going to be in trouble if the government finds out."

A key term there is "appropriate." OCR investigators will not look kindly on a risk analysis that seems perfunctory or trying to meet minimum expectations, Chestler says.

"Your risk analysis cannot be a 'check-the-box-and-move-on' exercise," she says. "You may be working with a partner that has a stellar reputation and you have every reason to think their data security plan is top notch, but you still have to go through the due diligence of looking at how data is handled. I'm sure in this case both parties thought they had adequate controls, but there was a fault in the system."

Chestler sees still another message in the New York settlement. OCR is pursuing HIPAA violations with vigor in a wide range of healthcare settings, from small government entities to huge private sector companies such as Wellpoint and these New York entities, she notes. "They are clearly trying to send a message that they are taking a broad approach to enforcement so that no one, large or small, starts to feel that they are under the radar," Chestler says. "There are going to be a lot more settlements like this one. Whether you're a big system or a small provider, nobody is immune."

OCR is becoming more aggressive in enforcing HIPAA and the hopscotching from private to government entities, big to small, is making their actions hard to predict.

Interestingly, the resolution agreements call for more specific training of employees and physicians, Chestler says. She sees that as a warning that OCR is expecting more detailed training tailored to your own organization rather than generic HIPAA education. "I don't think those off-the-shelf HIPAA education programs are going to work anymore," she says.

**SOURCES**


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# Desk audits are coming, but what are they like?

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) will begin conducting desk audits for Health Insurance Portability and Accountability Act (HIPAA) compliance this fall, which has many providers wondering just what they will be like. Most HIPAA experts expect the desk audits to be relatively pain-free, but until someone goes under the microscope, no one can be sure.

OCR is selecting a sample of covered entities, which includes hospitals and other medical service providers, to perform desk audits. OCR has started contacting 500-800 covered entities in preparation to survey these entities this summer. From that 500-800 entity survey group, OCR is going to select 350 covered entities on which to perform desk audits. Some hospitals will be

included. The HIPAA desk audits start in October 2014, and they will run until June 2015.

The hospitals won't receive notice that they are getting a desk audit until late summer or early fall of this year. The desk audits represent phase two of OCR's HIPAA audit program, notes **Melissa Goldman**, JD, an attorney with the Florida Health Law Center in Davie. Phase one, which began in 2012, involved full on-site audits for covered entities conducted by the outside accounting firm KPMG, but the desk audits will be much narrower, more targeted, and conducted by OCR, Goldman says. OCR also will audit some business associates of each provider audited, she says.

So how will the desk audits be conducted? The term "desk audit" is intended to convey that the audit will not be an on-site visit, but rather providers should be able to respond to the audits from their desks by providing policies and documentation of privacy policies and procedures, explains **Patricia Wagner**, JD, an attorney with the law firm of Epstein Becker Green in Washington, DC. For organizations that are well-organized, the response process should be relatively pain-free, she says. Rather than an on-site visit during which the auditors would interview employees about HIPAA compliance, the desk audit is strictly a look at documentation. That difference means that you won't have to tie up a lot of employee's schedules with time to meet personally with auditors.

"Providers should ensure that their privacy policies and procedures reflect the compliant privacy and security practices of the organization," Wagner says. "Providers won't have the opportunity, as they might in an on-site audit, to describe a process that takes place that may not be otherwise documented."

The inability to explain anything lacking or unclear in the documentation will put some organizations at a disadvantage, Goldman says. "The documentation will speak for itself, whether that is good or bad," she says. "If your documentation is such that you're compelled to explain what isn't there on the page, or why you didn't write something exactly in the way the statute requires, you may be in trouble."

For that reason, risks managers and compliance officers should assess their documentation now, before it is requested in an audit, Goldman says. In addition to having all the required policies and procedures, you should ensure that there are no privacy notices that have not been signed and that you have a system for tracking compliance.

Third-party risk management will be a major focus of the desk audits because it is now required in the statute, notes **Michael D. Ebert**, JD, partner with the accounting and consulting firm of KPMG in Philadelphia. Ebert led the work to develop the HIPAA audit program for the government. In this area, auditors will be looking at how the provider or associate is protecting health information and whether it is meeting the protocol requirements of the security rule, he says. *(See the story on p. 4 for more tips on surviving a desk audit.)*

"In the initial audits, two-thirds of the findings were in security, but only one-third of the test procedures performed were in security," Ebert says. "That's why OCR has said they are going to focus more on the security rule than in the privacy rule. This time they're reversing it so that two-thirds of the testing will be about security, and one-third will be about privacy."

To that end, auditors are likely to look at whether providers are training employees on HIPAA compliance and making them aware of the security and privacy rules. This auditing might cover everything from annual training programs to placards in elevator lobbies reminding employees not to talk about PHI in common areas.

Goldman suspects one area of interest will be risk assessments, which were the weak points in many phase one audits. She cautions that conducting a proper assessment is not enough; you must also provide adequate documentation of the assessment, agrees Ebert, noting that in his experience, 90% of risk assessments do not meet OCR's standards. One reason is that most risk assessments are performed internally rather than by an independent evaluator, he says.

If the risk assessment or any other significant component is inadequate, the desk auditors could refer the provider for a live on-site audit, Ebert explains, and that step opens up the possibility of finding many more deficiencies. Fines also can be assessed without an on-site audit.

## Device security might be examined

Goldman also expects OCR to look at device security.

"Are your computers password protected, at a minimum? Are you sending email with encryp-

## EXECUTIVE SUMMARY

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) will begin conducting desk audits for compliance with the Health Insurance Portability and Accountability Act (HIPAA) in October 2014. These audits will be conducted remotely by requesting compliance documentation.

- Adequate and updated risk assessments will be one focus.
- Providers will not have the opportunity to explain any documents.
- Auditors will look closely at compliance with the security rule.

tion?" she says. "I think encryption might be more of an issue with the 2015 and 2016 audits, but it's entirely possible they will inquire about this year. If it is not encrypted, do you have documentation showing that you informed the patient of that and the patient agreed to receive the email anyway?"

Expect follow-up requests and questions after supplying the material requested initially, **Jorge Rey**, CISA, CISM, CGEIT, director of information security and compliance with the accounting firm Kaufman Rossin, based in Miami. Be responsive and transparent, but also think about what you're sending, he says.

A primary goal should be helping the auditor understand what you are sending and how it is responsive to the documentation request. Don't send a batch of documents and let the auditor sort out what they are.

"You can always put your best foot forward," Rey says. "If the auditor requests policy A, send that information with a cover noting that this is policy A, in response to your request on whatever date. Provide that information in the way that makes it as easy as possible for the auditor. No one likes going through an audit, but if you help the auditor, the auditor may be able to help you as you're going through the process."

Ebert, with his extensive experience working with the earlier HIPAA audits, says providers and their business associates should take the desk audits seriously. The fact that they involve only documentation and not on-site visits should not lead to complacency, he says. "I suspect a lot of covered entities will not meet the requirements of a desk audit," he says.

**SOURCES**


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


# Update risk assessments, don't comply on the spot

An initial risk assessment will not enough when you undergo a desk audit, says **Bruce D. Lamb**, JD, a shareholder with the Gunster law firm in Tampa Bay, FL. Risk assessments should be conducted on a periodic basis, with proper documentation, he says. Any breaches of data security must be fully explained, with documentation that details how it was discovered, how affected parties were notified, and any corrective action taken, Lamb says.

"There were some pretty significant changes made in the notification requirements, so obviously if you haven't updated your policies and procedures to keep up with the changes that will be problematic for some entities," Lamb says. "Auditors also will look at how you are classifying classes of employees who have access to data and who doesn't, along with organizational charts."

There also should be documentation that a security official or committee has been designated and when. As with other points of compliance, the date it happened can be crucial.

"In the earlier phase, there were circumstances where the documentation was requested, and then people were rushing to fix the problem before responding," Lamb says. The Department of Health and Human Services Office of Civil Rights "is on to that, and they will be looking not only at whether you complied. Backdating things or complying on the spot is not going to work very effectively." ■

# Google Glass could become HIPAA-compliant

Google Glass, the eyeglass-like device that provides constant computer access, takes photographs, and streams live video, has been used during surgery at some facilities, but there have been questions about whether some uses would violate the Health Insurance Portability and Accountability Act (HIPAA). A new partnership with a software company might help reduce that risk.

CrowdOptic, a company in San Francisco, CA, that makes video streaming software for wearable devices, recently announced a partnership with the University of California, San Francisco (UCSF) to develop ways to use the device in medicine. A key step will be including software that allows the surgeon to stream video to a local server instead of Google's server, as is normally done.

Sending the video stream to a local server will allow the healthcare provider to restrict who has access to protected health information (PHI), the company says. Some of the Glass features will be unavailable in this mode, but the surgeon can switch back to normal mode when compliance is no longer necessary, the company says.

If the device can be made HIPAA-compliant, CrowdOptic and USCF researchers say Glass might be used much more widely in the OR. ■

**PATIENT ACCESS/MAIN ADMITTING**
**INTERACTION PLAN**

Excellent customer service means giving the patient more than they expect; leaving them with a warm feeling that they have been treated as a unique and special individual. Always make eye contact with the patients as soon as they arrive to acknowledge them, even when busy with a task or patient. ***Be aware of facial expressions and nonverbal language***. Introduce yourself, the role you play, and an estimate of how long it will take; "Hello, I'm _____ and I will be completing your registration today. This should only take about 10 minutes." Ask the patients if they are comfortable or if there is anything they need before you start the registration. Explain that we need to complete the registration and make sure all their information is correct for their safety and accurate filing of their insurance. When the registration is completed, ask the patients if they have any questions or if there is anything else you can do for them today. Do what you can to make the patient feel at ease. SMILE!

Consistently monitor your volume and tone of voice whether you are interacting with a patient or co-workers. ***Patients and visitors do not want to hear you socializing or laughing with your coworkers***. It is important to maintain a volume that respects a patient's confidentiality when discussing private information with them. Never talk about the patient with other staff members unless it is necessary to complete their registration.

Take the time at the end of the registration to ask if there is anything else you can do for them. Follow through with any requests they make. If you cannot complete their request, find someone who can.

*I have received a copy of the Patient Access Main Admitting Interaction Plan. I have read the document and understand the content as it relates to our Mercy Values. I agree to follow this plan in my daily interactions with patients, families, co-workers, physicians, nursing staff, and any other internal or external customers. This applies to telephone or electronic communications as well as face to face.*

Employee Name Date

Employee Signature

Source: Mercy Hospital, Springfield, MO.