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AHC Media

Portal doubled online collections, but access still answers questions

Look outside of the healthcare industry to compare web sites

Payments made online have doubled over the past two years at Cincinnati (OH) Children's Hospital Medical Center, reports **Christopher Lah**, senior director of revenue cycle customer service.

"About 15.5% of total dollars collected went through the portal," says Lah. "The portal is starting to have a significant impact on both our copay collections and other out-of-pocket expenses." With 27,919 online payments made in 2014, $5.3 million was collected, with an average of $193 paid per transaction.

Marie-Louise Stanek, a consultant with Atlanta-based Accenture Health Practice, says, "We are definitely seeing healthcare organizations moving toward implementing patient portals for patient collections, both pre-service and post service."

> "HOSPITALS HAVE FINALLY FIGURED OUT THAT CONSUMERS WANT TO BE ABLE TO RESOLVE THEIR ACCOUNTS ELECTRONICALLY."

Patients want more visibility into what they owe. **Don Wright**, senior vice president of operations at The Outsource Group, a St. Louis, MO, consulting firm specializing in the healthcare revenue cycle, says, "Hospitals have finally figured out that consumers want to be able to resolve their accounts electronically."

However, payment portals can't answer complex questions regarding patient out-of-pocket expense. "The billing process in healthcare, right now, is probably the most complicated there is," Wright acknowledges. Most patients know their deductible amount, but they can't determine how much of it has been satisfied to date. Nor do they understand the contract the hospital has with specific providers that can affect the patient's out-of-pocket liability.

Wright recommends these practices:

NEXT MONTH: BE PREPARED FOR EBOLA IN PATIENT ACCESS AREAS

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• offering patients a link to chat with a live person to resolve more complex questions;

• listing frequently asked questions on the portal that tell patients what specific questions to ask their insurer about their out-of-pocket expenses.

"If patients are not asking the right questions, payers won't necessarily willfully withhold information, but they will protect their best interest," explains Wright.

Users want simplicity

Lah says collecting patient balances online "is very much hitting our radar screen. We are constantly figuring out how to address this better."

Several years ago, the hospital's payment portal was getting fewer users each year because it wasn't user-friendly. "Many patients simply want to get in there, make one payment, and be done with it," says Lah. Once the facility implemented a new portal (developed by Franklin, TN-based Passport, a provider of technology for hospitals and healthcare providers), enrollment increased fivefold. "We had dipped all the way down to 3,000 people in the old portal, but it's well over 15,000 now, and climbing," says Lah.

Before the new portal was developed, a customer focus group was held. "We learned that it had to be more than just a payment portal," says Lah. Families wanted these things:

• the ability to set up a payment plan;

• answers to two questions: "How do I pay?" and "How do I get help paying this bill?";

• simple language, such as "Make a Payment Here" or "Getting Help with Your Bill."

"People like the word 'help' better than "financial assistance.' The minute you put 'financial assistance' out there, you start spooking people," says Lah. "Some are reluctant to apply for charity assistance."

Patients still need info

Patients at Oakwood Healthcare in Dearborn, MI, are given the option to pay online, but patient access staff members still spend much time educating patients on their out-of-pocket liabilities, says **Michelle Bidoul**, manager of financial clearance.

"Because the balance of a patient bill includes so many variables, it can be a challenge for a patient to

EXECUTIVE SUMMARY

More patient access departments are offering patients the option of paying out-of-pocket expenses online. Cincinnati (OH) Children's Hospital Medical Center collected $5.3 million in online payments in 2014, comprising 15.5% of total collections. Patient access employees can:

• educate patients on their liability beforehand so they understand the amount due;

• allow patients to set up payment plans or obtain prompt pay discounts online;

• give clear instructions on whom to contact with questions about their online balance.

substantiate what they owe," she explains.

If family members think they owe only a copay and discovers they have a $5,000 deductible, they typically want to know who they can call immediately to discuss it.

"An efficient portal can help provide this information," says Lah. "However, if you are hoping the portal can eliminate phone calls purely by listing assistance options, you are setting yourself up for failure."

While the portal does direct the initial call more effectively, it often does not eliminate the call from occurring. "No matter what you try to answer on the portal, individuals are going to come up with other questions," Lah explains. He recommends these practices:

• Display payment portals prominently on the website's front page.

Paying bills is one of the primary reasons customers log into a hospital website, notes Lah.

"The minute people click on it, it has to become the 'yellow brick road' that shows them how to get to all the different options they want to explore to help resolve their debt," he says.

• Be sure portals don't appear complicated.

Participants in one of the hospital's focus groups requested simple pull-down boxes. "Too often when you go in to make your payment, you end up lost in a vacuum," says Lah. "The navigation needs to be Fisher Price-like."

• Strive to make the hospital's payment portal more like those offered by other industries.

"You can't narrow your scope to healthcare only," says Lah, noting that American Express won J. D. Power's Best in Class award for having an effective and friendly portal. "That's what you should be using as a comparison."

• Consider offering prompt pay discounts via the portal to increase cash collections and reduce bad debt.

Something as simple as 'Click here to inquire about a 10% discount,' will drive interest," says Lah.

SOURCES

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- Christopher Lah, Senior Director, Revenue Cycle Customer Service, Cincinnati (OH) Children's Hospital Medical Center. Phone: (513) 636-8904. Email: Chris.Lah@cchmc.org. ■

Save big on per diem, OT costs by cross-training — Staff can cover almost any registration area

At Wheaton Franciscan Healthcare in Glendale, WI, pre-registration staff members are cross-trained in the main registration area, the emergency department, and front desk walk-in registration, says **Kim Gehl**, manager of patient access in central scheduling and central precertification.

"We can move associates from one job function to another, wherever the volume and need is the greatest," says Gehl. Significant cost savings come from not hiring additional staff to fill shortages due to vacation and sick calls.

At Mercy Hospital — Springfield (MO), the patient access team supports a dozen outpatient locations. "Some of those only have one coworker due to patient volumes," says **Natasha Acra**, manager of outpatient patient access.

Each employee is expected to be trained in at least two outpatient areas; some are trained in all 12. "This gives us more flexibility when a team member calls in sick," says Acra. "Even on short notice, we can find someone that is able to work an open shift much easier than if they weren't cross-trained."

Staff members cover any area that has a sudden surge in volume, which eliminates the need to call in additional staff. "We are able to save costs by needing less FTEs in the outpatient department. We have only one PRN coworker and typically have no overtime," says Acra.

Cross-training also eased the stress of staffing areas with only one registrar, when that person was out. "Previously, few people would be familiar with the location and not able to cover it with short notice," says Acra.

Staff keep their registration skills in each location sharp by rotating shifts. "We give them the chance to work in each location once a month or so," says Acra. *(See related stories on metrics used to ensure adequate staffing, p. 124, and a training program that gives staff knowledge of the entire revenue cycle, p. 125.)*

Expanding access role

Patient access areas at Robert Wood Johnson University Hospital in New Brunswick, NJ, previously relied on part-time and per-diem staff members to support

staffing shortfalls. "However, the expanding role of the access staff makes maintaining competencies of these individuals a challenge," says **Kathleen B. MacGillivray**, MHA, director of access management services.

Staff members are now rotated throughout the department. "We run quality checks on their work to ensure they meet the standard," says MacGillivray.

Managers do this quality check with a report card that includes patient demographic and insurance information, including Medicare as Secondary Payer completion and Medicare Notice compliance. *[The report card is included with the online issue. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]* "Department accuracy is greater than 95%," MacGillivray reports. "Cost savings come by way of efficiencies in patient throughput, as well as reduction in rework."

EXECUTIVE SUMMARY

Patient access leaders are cross-training employees so staff members can cover various registration areas as needed.

- Employees can fill shortages due to vacation and sick calls. Costs are saved because no additional FTEs need to be hired.
- Staff members obtain a working knowledge of the entire revenue cycle.

The pediatric emergency department now has an average registration turnaround time of less than 10 minutes. "This positively impacts overall patient throughput," says MacGillivray. "Overtime is less than 1% of our salary budget."

SOURCES

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Access areas staffed with these criteria in mind

At Wheaton Franciscan Healthcare in Glendale, WI, patient access managers use productivity data, accuracy, and cash collection goals as key metrics to ensure they're staffing patient access areas appropriately.

"Knowing these metrics and our volume, we can know our staffing limits. When new volume hits our department, we try to adjust accordingly," says **Kim Gehl**, manager of patient access in central scheduling and central precertification.

These categories are used: "role model," "exceeds standard," "meets standard," "partially meets standard," and "does not meet standard." "We always want to be at 'meets standard' at a minimum. We strive for 'role model,'" says Gehl. Staff in central scheduling are given these criteria:

• Accuracy.

o Role model: 100%.

o Exceeds standard: 99.7%-99.9%.

o Meets standard: 99.1%-99.6%.

o Partially meets standard: 98.1%-99%.

o Does not meet standard: 98% or less.

• Percentage of worked hours logged in the automated call distributor queue.

o Role model: 100% logged-in time.

o Exceeds standard: 90% to 99.9% logged-in time.

o Meets standard: 80% to 89.9% logged-in time.

o Partially meets standard: 70% to 79.9% logged-in time.

o Does not meet standard: Less than 70% logged-in time.

• Incoming call volume.

o Role model: 8.1 or more calls per logged-in hour.

o Exceeds standard: 7.1-8 calls per logged-in hour.

o Meets standard: 6.1-7 calls per logged-in hour.

o Partially meets standard: 5.1-6 calls per logged-in hour.

o Does not meet standard: Five calls or less per logged-in hour.

• Outgoing call volume.

o Role model: 13 or more outgoing calls per worked hour.

o Exceeds standard: 11.5-12.9 outgoing calls per worked hour.

o Meets standard: 9-11.4 outgoing calls per worked hour.

o Partially meets standard: 6-8.9 outgoing calls per worked hour.

o Does not meet standard: Less than six outgoing calls per worked hour.

Central authorization

Staff members in central authorization are required to meet these criteria:

• Verify insurance eligibility and authorization requirements.

o Role model: Continuously goes above and beyond in follow up and investigation of eligibility, benefits, and authorizations. Independently works to identify and resolve process issues affecting reimbursement. Looks at services outside the design for incorporation to process, thus improving reimbursements and patient satisfaction. Recognized as an expert on processes. Completes 8.1 or more accounts per hour with no authorizations denied due to associate error.

o Exceeds standard: Obtains eligibility and authorization to services inside and outside the department design when appropriate, documenting findings appropriately. Routinely offers improvement suggestions to processes. Completes 6.6-8 accounts per hour, with one account in which authorizations were denied due to associate error.

o Meets standard: Obtains eligibility and all required authorization completing all required documentation in the referral/authorization screen for all appropriate accounts. Completes 4.0-6.5 accounts per hour, with 2-3 accounts in which authorizations were denied due to associate error.

o Partially meets standard: Routinely needs assistance in determining follow up and next steps. Assignments require management follow up. Completes 2-3.9 approval screens per hour, with 4-5 accounts in which authorizations were denied due to associate error.

o Does not meet standard: RA screens not completed where information and/or documentation were not obtained on required accounts. Completes less than two accounts per hour, with greater than five accounts in which authorizations were denied due to associate error.

• Precertification denials.

o Role model: No authorization denials due to associate error.

o Exceeds Standard: One account where authorization denied due to associate error.

o Meets standard: 2-3 accounts where authorizations denied due to associate error.

o Partially meets standard: 4-5 accounts where authorization denied due to associate error.

o Does not meet standard: Greater than five accounts where authorization denied due to associate error.

• Accuracy.

o Role model: 99% or above.

o Exceeds standard: 98%.

o Meets standard: 97%.

o Partially meets standard: 96%.

o Does not meet standard: 95% or less. ■

Give staff members working knowledge of the entire revenue cycle

At Emory Healthcare in Atlanta, patient access leaders developed training programs to allow front-line staff to have knowledge of all patient access areas.

"Having a diverse team allows us to save on overtime and FTEs," says **Miriam Laster,** assistant director of the quality assurance, training, financial counseling, and precertification departments.

Because departments have similar processes for scheduling and registration, any patient access employee has the skills if a position opens up. "There are nuances to each area. But having those basic skills serves as a foundation to succeed in their new roles," says Laster.

The main goal is for frontline staff to have a working knowledge of the entire revenue cycle, says **Tinnie Garlington**, CPAR, CFC, CHAA, CHAM, supervisor of the Quality Assurance and Training team. "We use a homegrown method known as "IDN,'" she adds. This acronymn stands for:

• Identifying individuals who demonstrate a passion for learning and are willing to embrace change.

"We have several ways of identifying these individuals," says Laster. These methods include inviting employees to participate in special projects and using feedback from trainers of new hires. "Individuals that demonstrate a willingness to go the extra mile are the ones who meet the criteria to progress within our department," says Laster.

• **Developing** their skills and providing them with the tools needed to be successful in various areas.

"Using this method enables us to maintain stability when we are challenged with call-outs, special projects, and increased volumes," Garlington says.

• **Nurturing** them through continuous learning and opportunities to expand their horizons.

The department provides in-services on various subjects such as Medicare, customer service, and peer-to-peer communication.

"We are currently using an e-learning system to assist in providing continuous learning," says Garlington. "We also have several focus groups that surround quality and staff accountability." The focus groups include representatives from patient access, billing, Medicare collections, and managed care, as well as the director of the revenue cycle.

"Currently, we are focusing on Medicare patients and reviewing the various types of Medicare rejections," Garlington reports. ■

Make it less likely payer will request peer-to-peer — Closer working relationship with docs is needed

Outpatient Cardiac Imaging service team sees about 40% fewer `peer-to-peer' requests

Even if patient access employees follow all the necessary steps to obtain an authorization for a procedure, the payer might still want to talk to another person before granting the authorization: the patient's physician.

"Our physicians are engaging in more peer-to-peer conversations with payers than they ever have in the past," reports **Pamela D. Scott,** MBA, revenue cycle administrator at Genesis Health System in Davenport, IA. "This means patient access, case management, and physician advisors need to be more closely aligned." *(See related story, p. 127, on other trends resulting in physicians getting more involved in avoiding claims denials.)*

More and more payers are requiring peer-to-peer justification for services, reports **Kasandrah Garnes**, MBA, senior director of patient access at Thomas Jefferson University Hospitals in Philadelphia. However, the Outpatient Cardiac Imaging service team is seeing about 40% fewer "peer-to-peer" requests because of these approaches:

• Physicians, nurses, and patient access representatives review the authorization process at integrated team meetings.

"The team has spent time learning from previous denials," Garnes says. "As the team grows in knowledge, they can better anticipate which types of tests tend to be denied if additional medical documentation is not submitted."

For example, patient access staff learned how payers consider the patient's age and medical history with stress echocardiograms. **Patty Huffnagle**, patient access supervisor, says, "Insurance companies may require a stress EKG before authorizing an echo for our younger patients with no cardiac history and with new symptoms."

For this reason, staff members always submit the current clinical note and EKG when requesting authorization for such patients to have stress echocardiograms. Likewise, patient access staff members learned that certain payers will approve a stress echocardiogram every three years in an asymptomatic patient with a previous echocardiogram showing mild regurgitation. "However, if a patient's regurgitation was moderate to severe, the echo would be approved annually," says Huffnagle.

• Nurses answer questions that members of the patient access team have, when there is a gap in clinical knowledge.

As the patient access team members learn more about diseases

EXECUTIVE SUMMARY

Payers are requiring peer-to-peer discussions between physicians before authorizing procedures, and they are denying claims if a different procedure code is used. Physicians are getting more involved in disputing denials due to the patient's status. To avoid denials, patient access can do the following:

- Call payers to verify benefits at the point of scheduling.
- Obtain additional documentation from providers' offices ahead of time.
- Flag problematic accounts

of the heart, they have a better understanding of the physician notes and the plan of treatment. "This proactive communication has contributed to a decline in peer-to-peer requirements for authorizations," says Garnes.

Technicians and nurses have given in-services to the patient access team, for example, to explain how the heart functions when the patient has a certain diagnosis. "When a clinician has not detailed which specific abnormalities were presented from an EKG, we will ask for that detail," Garnes adds.

The few peer-to-peer requests that are received are electronically submitted to physicians. "The physicians do an excellent job responding to these alerts timely," says Garnes. "They understand the important role that they play in securing these authorizations."

SOURCES

- **Teresa L. Brooks**, Senior Director, Patient Access, Conifer Health Solutions, Detroit. Phone: (313) 578-3675. E-mail tbrooks@dmc.org.
- **Kasandrah Garnes**, MBA, Senior Director, Patient Access, Thomas Jefferson University Hospitals, Philadelphia. Phone: (215) 955-2757. Email: Kasandrah.Garnes@jefferson.edu.
- **Pamela D. Scott**, MBA, Revenue Cycle Administrator, Genesis Health System, Davenport, IA. Phone: (563) 421-1990. Email: ScottP@genesishealth.com. ■

These payer trends call for closer collaboration with physicians — Docs must dispute patient's status

Some payers are changing their care management programs to reflect Medicare's requirements, such as the "two-midnight" rule. This change affects patient access areas, says **Pamela D. Scott**, MBA, revenue cycle administrator at Genesis Health System in Davenport, IA.

"Because this rule predetermines the payment methodology based upon the length of stay in a hospital, it is a simple way payers can identify and contain costs for a case," says Scott.

The two-midnight rule dictates that patients are considered "inpatient status" if they remain hospitalized after two midnights. If the patient stays fewer than two midnights, the patient is considered an outpatient. "This sets the clinical condition of the patient as a secondary element," says Scott. "It makes it more difficult to get approval from the payer."

More often, physicians are getting involved in challenging a payer's decision to deny claims involving the patient's status. "As more payers accept Medicare's requirements, it results in more volume for physicians to take on, where it could become a full-time, defensive role for the organization," says Scott.

Patient access helps avoid denials in these ways:

• Patient access employees obtain accurate insurance verification and authorizations.

"It becomes more important that patient access provide accurate insurance information and get payer approval ahead of time, so the physician has a better advantage," Scott explains.

At the point of scheduling, patient access staff members call the payer to verify benefits and coverage, and they provide the clinical diagnosis. "We also work with the corresponding doctor's office to gain additional documentation ahead of time if we are familiar with the payer's requests," says Scott.

• Patient access leaders collaborate with physician advisors and case managers.

If a payer is challenging the level of care, the physician advisor promptly communicates this information to the case management staff. "This allows patient access the [opportunity] for a financial counselor to work with the patient or family if the coverage results in more financial liability for the patient," says Scott.

• A denial management team with members of clinical operations and revenue cycle staff meets routinely to review pending payer requests and denial adjustments.

"Recently, we have engaged senior leadership more. Their support has helped the areas prioritize," says Scott.

• The department also implemented a workflow management tool that alerts staff of specific payer requirements. (ONTRAC, developed by Chicago-based Huron Healthcare).

"In taking this approach, we have seen a 30% decline in overall denials from Q1 of FY 2013 to Q1 of FY 2014," Scott reports.

Increasingly, payers require requesting or referring providers to have specific procedure codes authorized.

Teresa L. Brooks, senior director of patient access at Conifer Health Solutions in Detroit, says, "They will

deny services if anything other than the specific authorized procedure code is billed on the claim."

To address this new requirement, patient access leaders implemented the "Direct Partner" program. The Financial Clearance Center is now responsible for obtaining authorization for all diagnostic imaging services prior to scheduling the appointment or immediately afterward.

"In the past, we had to rely on the referring provider office staff to obtain the authorization for the services," says Brooks. Patient access staff members often had to call the office repeatedly to confirm that they had done so.

"Then, we would check the various payer sites or call the payers to see if the auth had been issued," says Brooks. Staff members also had to confirm that the authorized service matched the actual service the patient was scheduled to receive. "We would sometimes go down to the wire — the day the patient was scheduled for the service — and still not have the necessary authorization to provide the service," says Brooks.

To maintain good customer relations, the service often was provided without the authorization, which risks a claims denial. With the new process, says Brooks, "we have seen a decrease in the 'no auth' denials, an increase in our volumes, and improved customer service." ■

Find out if goals set for patient access staff need to be changed — Keep criteria patient-focused

Goals in patient access areas at Cincinnati (OH) Children's Hospital Medical Center have three areas of focus: the patient's and family's satisfaction, finances, and compliance, says **Michelle Gray**, MHA, director of registration services.

"For instance, if insurance plan information is put into the system incorrectly, in the long run it is going to impact our patients and families," she says.

One financial goal is the collection of copayments at the time of service. "From a compliance perspective, we have a goal that targets accurate completion of the Document Content field in Epic," says Gray.

This goal ensures that consents and other relevant registration documents are complete and can be easily located in the system by a surveyor from the Centers for Medicare & Medicaid Services or The Joint Commission.

At the end of each fiscal year, Gray meets with the department's project specialist and the vice president of access services to determine what changes need to be made to existing metrics.

"We look at all of our historical data from the current fiscal year and decide which scorecard categories we are going to keep and which scorecard categories we will change out," says Gray.

Sometimes, they decide to keep the scorecard category but make an adjustment to the metric. "Recently, we adjusted our copayment collection metric because we've seen a decline in copay collection rates across the organization," says Gray. "It's all data-driven."

The evaluation scores fall into one of three ratings: exceptional, on target, or needs improvement. "The goal is for the ratings to look like a bell curve," says Gray. Patient access leaders want to see most staff members falling in the "on target" rating and the rest being evenly distributed among the "exceptional" and "needs improvement" ratings.

At Novant Health in Winston-Salem, NC, patient access goals are increased as needed. "We are very clear that if you are exceeding your goals at the end of a quarter, we will increase those goals for the next quarter," says **Craig Pergrem**, senior director of revenue cycle, pre-service, and onsite access.

Need other changes?

Members of the patient access staff at Riverside Regional Medical Center in Newport News, VA, are required to meet goals for registration accuracy,

EXECUTIVE SUMMARY

Goals for patient access employees need to be challenging but still attainable. To achieve these types of goals, patient access leaders should do the following:

- Use the previous year's data to determine if metrics need to be changed for most staff members to meet the criteria.
- Keep goals focused on patient and family satisfaction, finances, and compliance.
- Aim for a certain percentage of fewer registration errors each year.

quality of data, patient wait times, and time-of-service collections.

"Our front-end registration scrubber allows for reporting on individuals and departments with a report card grading score," says **Melanie Stanius**, CHAM, patient access senior manager.

Managers review random accounts on each patient access team member. They use a scoring system to see if individuals are meeting additional quality assurance standards. "We look at our top performers for both departments and team members, and set our goals around their high standards," says Stanius.

At Central DuPage Hospital in Winfield, IL, cash collection goals are set for the emergency department, the financial clearance center, and surgical registration areas, says **Barbara Novak**, revenue cycle manager.

"We have had feedback from a consulting group on what it takes to be in the top 10% of hospitals. That is what we have gone on," she says. Cash collections have increased progressively over the last 12 months.

"The goal for the ED is just shy of $90,000 a month," says Novak. "That breaks down to approximately $300 per day per full-time staff member."

Managers have begun reviewing registration errors from claims denials. "Every year, our goal is to have a certain percentage less, such as 25%," says Novak.

Patient access areas at Novant Health are required to meet goals that are set each quarter and monitored daily, weekly, and monthly for all onsite access facilities as well as pre-service departments.

"We have had changes in our management structure due to a few promotions, so we are currently looking at a 'one-team' approach," says Pergrem.

All onsite patient access teams will share the same goals, such as iris scanning patient identification usage. Some goals will be shared with the entire revenue cycle.

"We have several new systems that have been implemented in the past year, in addition to our rollout of Epic," says Pergrem. "We are measuring now, not only for our own use, but also from an ROI [return on investment] perspective." *(See story, below, on avoiding pitfalls with patient access goals.)* ■

Unrealistic patient access goals? Morale will suffer -- Make expectations very clear

If goals are unrealistic, unclear, or outdated, patient access employees quickly will become unhappy, warns **Craig Pergrem**, senior director of revenue cycle, pre-service, and onsite access at Novant Health in Winston-Salem, NC.

"That is not something you want to have within any department," he says. "We make it very clear to the team what the expectations are and if they are meeting those expectations." Here are some pitfalls to avoid involving goals for patient access:

• Goals need to be realistic.

At Riverside Regional Medical Center in Newport News, VA, patient access leaders strive to keep goals challenging but attainable, says **Melanie Stanius**, CHAM, patient access senior manager. "We want our team to stay engaged and not discouraged," she says. "Goals have to be clear and realistic for team members to clearly understand what they are working toward."

Staff members are required to meet goals for patient wait times, registration data accuracy report card grade, missed time of service, and quality audits. "We look for all registrars to maintain a registration accuracy report card grade of at least 98%," says Stanius. Supervisors monitor this report frequently and meet with team members if they see scores dropping.

You might want to see a 100% quality assurance score, but in reality this score isn't possible to maintain. "Instead, set that goal at an attainable score so the team does not feel defeated by an unattainable goal," says Pergrem. "Goals should be motivational, not detrimental."

Daryl Wells, director of pre-access at Florida Hospital in Orlando, sets criteria for staff based on the number of admissions for the inpatient side and the number of prescheduled evaluations on the rehabilitation side. "Staff can feel lack of accomplishment due to not having a clearly defined, finite goal that they are striving for," says Wells.

On the inpatient side, each team member has an assigned payer split and must meet any 24-hour notification requirement for their payers. "They also initiate the authorization process as needed, for all patients with an inpatient or observation level of care status," says Wells. Staff working weekend shifts focus on the payers that require 24-hour notification.

"When representatives receive concurrent or retrospective denials from payers, they are responsible for notifying the hospital's utilization review team," says Wells. The team either sends clinical documentation

in support of continuation of the stay to the payer or works with the case management team to facilitate the timely discharge of the patient.

The pre-access outpatient rehabilitation team's current goal is to work on accounts at least three days out from the actual date of service. "Representatives verify benefits to match the specific modality of treatment and verify if an authorization is necessary for a specific payer," says Wells.

• Goals should factor in system problems.

During the rollout of the hospital's Epic system, patient access areas had some difficulty with "bolt-on" products such as kiosks and cameras.

"That can cause a shift in the percentage of use for the goal," says Pergrem. "We can then delete the days during the outage, to make it fair for all team members." ■

Patient has high out-of-pocket costs? Find out earlier! Move financial talk to front end

More patients have access to insurance coverage today, but they also have higher out-of-pocket responsibility.

"Our greatest challenge is getting the information we need to verify healthcare benefits and coverage for their stay," says **Susan Kole**, director of patient access at Saint Francis Hospital and Medical Center in Hartford, CT.

The sooner your staff members have this information, the sooner they can reach out to patients and make them aware of their out-of-pocket expenses. "We are working with our schedulers to identify self-pay patients and those with high deductibles," reports Kole.

If staff members know this information at the time of booking, it gives them more time to identify all options for financial assistance and to offer payment plans. "Ideally, this discussion should take place in the physician's office," says Kole. "The more information the patient has, the easier it is for them to make the right decision for their care."

Patient access leaders are working with OR schedulers to add questions to the scheduling questionnaire. At the time of booking, schedulers will do the following ask whether the patient is insured, and if so, whether the plan was bought on the Health Insurance Marketplace. Schedulers then will identify if there are special rates for specific procedures that should be collected at the time of, or prior to, admission.

Previously, scheduling and registration systems were not integrated. "Now that we are on an integrated system, our registrars and auth specialists will be able to start the process as soon as the case is booked," says Kole.

In moving financial counseling to the front end, says **David Kelly**, director of revenue cycle at Mary Rutan Hospital in Bellefontaine, OH, "you need to determine what 'teeth,' if any, your institution wants to have when a patient falls through the cracks."

Managers also need to decide whether to combine scheduling, pre-registration, and financial clearance process into a single call — what Kelly calls "schegistration" — or call the patient back later. "The former might make the patient happier, but yield less reliable information," says Kelly. "The latter is a dissatisfier because of the two calls but allows for very accurate capture of patient information."

Some hospitals route calls to financial counseling if the patient schedules a service, but use the two-call method if the physician's office schedules for the patient. "This seems to work well. But smaller institutions such as ours may have trouble with the systems and personnel to support such a plan," says Kelly. "We're currently investigating how to design this project best for an institution our size."

In preparation for moving things to a "pre-service" model at Mary Rutan, patient access leaders are scrutinizing the entire process.

"We believe there are significant gains for patients, physicians, and referral sources, and the hospital," says Kelly. ■

EXECUTIVE SUMMARY

To inform patients of their out-of-pocket responsibility earlier, patient access departments are moving financial counseling to the front end.

- Have financial discussions at the point of scheduling.
- Integrate scheduling and registration systems.
- Combine scheduling, pre-registration, and financial clearance in a single call.

Customer service isn't just for patients: Reward access staff members at little or no cost

If one of your registrars was offered a little more money or better hours by another area of the hospital, would he or she find your patient access department impossible to leave?

"Patient access leaders often forget that customer service is also for employees," says **Maxine Wilson**, CHAA, CHAM, ambassador for the National Association of Healthcare Access Management. To boost retention, she says, "nothing works better than simple appreciation, and it doesn't cost a dime."

Kym Brown, MHA, CHAM, patient access manager at Conifer Health Solutions at CHI Saint Elizabeth in Lincoln, NE, says, "I feel one of most important roles is to increase morale, decrease turnover, and increase retention." Here are some ways to boost morale:

• Work beside employees.

"My team's morale is increased by simply seeing me actively working and participating at their side," says Brown. "I do not ask any more of them than I would ask of myself."

• Hold small contests.

Brown occasionally gives small prizes to the employee who registers the most patients in one hour or one day, who has the fewest errors that day, or who collects the most during a certain timeframe. "The prizes come from inexpensive $1 bins at craft or department stores. They are just fun little tokens," says Brown. "Staff enjoy the friendly competition."

• Write thank-you notes.

Wilson recommends keeping cards on hand to tell staff members things such as "The department depends on you so much. I'm so glad you're a part of our team," or "Thank you so much for working that extra shift last night. That was so special of you to give up your day off to help us."

Brown mails handwritten thank-you notes to her employees for "anything and everything. It is special when they receive this at home, because their family sees it as well."

She sometimes leaves the notes on the desk with a chocolate candy. "Some staff have a collection of them on the bulletin boards," says Brown. "Others say they keep them on their fridge at home."

• Compliment staff publicly.

Brown chooses a "wall of fame" employee every month. She creates a bulletin board highlighting that employee and anything they want to share with their colleagues.

"Publicly thanking staff at staff meetings is also important," says Brown. "Telling someone that their hard work paid off in front of the entire team is a booster."

Brown posts on the employee webpage recognition program regularly. "All employees can post here freely," she says. "These postings run along our Intranet homepage, similar to a Twitter feed. All staff nationwide can see them."

Recent postings thanked employees for "taking great care of that patient today and being the perfect example of compassion and customer service," and "taking the lead on that special project and ensuring success."

• Give small gifts to reward staff.

At Littleton (CO) Adventist Hospital, leaders distribute $5 gift cards for the hospital's coffee cart, cafeteria, and local coffee shop.

"If an associate receives recognition from a department, doctor's office, or a patient, he or she receives one of these rewards as a thank you for going above and beyond," says **Christen Souza**, scheduling coordinator.

A patient might say that an employee took time to give directions, for example. "A department may recognize someone for staying late to add on a stat patient, making sure the orders are correct so the department does not have to try and track down an order after the offices are closed," says Souza.

• Give employees a survey.

"Some staff may put down that they want a raise. But regardless of what type of feedback you get, they'll appreciate that you are asking," says Wilson.

One registrar wanted the department to use only part-timers to work weekend shifts. Wilson told her, publicly, that it was an excellent idea but would be difficult to achieve. "I told everyone, 'I'm open to suggestions for how we can make it work,'" she says. "You don't want to shut down an idea even when you know the chances are slim that it's going to happen." ■

COMING IN FUTURE MONTHS

- Ask staff for solutions to common patient dissatisfiers
- Revamp processes for getting clinical information to payers
- Avoid pitfalls when offering self-service registration
- Dramatically cut costs with e-training in patient access

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Handwritten notes can be weak link in your compliance with HIPAA

With all the talk about encryption and other high-tech ways to safeguard protected health information (PHI), Health Insurance Portability and Accountability Act (HIPAA) violations still can be traced to the simplest task: jotting down notes about a patient on a piece of paper.

The risk posed by handwritten notes was illustrated recently when AccessHealthCT, the health insurance exchange in Connecticut, announced a HIPAA breach traced to an employee of a contractor. The employee left a backpack containing the PHI of 400 of the state's residents on the street. The PHI was written on a notepad and included various combinations of the customers' names, birthdates, and up to 200 Social Security numbers. AccessHealthCT said the contractor apparently was using the data to work away from the office.

The contractor who employed the owner of the backpack is Maximus, the firm that operates the exchange's call center. On the day of the breach, AccessHealthCT CEO Kevin Counihan said they were working with Maximus to address the situation, including the possibility that the employee left the backpack intentionally as part of a plan to steal the PHI. Maximus leaders put the suspected employee on an administrative leave while it investigated the incident further, and they soon announced their conclusion that the employee unintentionally left the backpack.

Maximus sent 395 letters to those affected offering them options to help protect their identity at the company's expense. *(See the story on p. 3 for advice on contractors and HIPAA security.)*

Even in the age of electronic records, handwritten notes still are common and pose a significant risk, says **Timothy B. Adelman**, JD, an attorney with LeClairRyan in Annapolis, MD. In addition to contractors and others who might jot down notes as part of their work, Adelman points out that nurses and other clinicians routinely make written notes. Nurses often write notes about patients just before a shift change, for example, so they can refer to them when briefing the oncoming staff. Those could contain PHI, but don't always.

Written notes common

Limiting the use of handwritten or printed records should mesh with a hospital's overall privacy policy, particularly the admonition to use the "minimum necessary" PHI, says **Patricia Wagner**, JD, an attorney with Epstein Becker Green in Washington, DC.

That "minimum necessary" phrase will mean that handwritten notes should never include more information than is strictly necessary to achieve the task, and Wagner says it rarely would be necessary for a note to include information such as a patient's full identification and Social Security number.

Jotting down a patient's lab value so it can entered in the electronic record later is a common habit, Adelman notes. That information probably would not rise to the level of PHI unless the note contained enough information for another party to figure out the identity of the patient, Adelman says.

"If it only says `Room 1' and notes about the patient's condition, that might not be PHI, but if the note includes the patient's initials or full name, the room number and date, that might be enough to make it PHI," Adelman says. "Nurses may take these notes home with them at the end of the day, in their bag or the pocket of their scrubs, and that could lead to a breach."

The solution is to require that nurses leave those

notepads at the hospital, in a secure location such as their lockers or a locked cabinet on the unit, Adelman says. Destroying the notes, preferably by shredding, also is an option.

Completely prohibiting such handwritten notes is not practical, Adelman says. It is wise, however, to include education about the risk of handwritten notes in all HIPAA training and to have a policy that restricts how much information can be written down and how the notes are stored or destroyed, he says. "You also should expect any contractor or independent provider to adhere these policies as well," Adelman says. "It's important that you not just give it lip service by saying in the contract that they must adhere to your policies and procedures. There should be a mechanism by which they acknowledge that they receive these policies and procedures and that they agree to abide by them."

Adelman has handled several cases involving shift change notes written by nurses, which can be important in proving what was or wasn't conveyed to the other nurses and physicians. For HIPAA security and risk management concerns, Adelman always has recommended policies that prohibit taking those notes home.

"We've also handled a case in which a physician had his car stolen, along with a lot of paper patient records he had in the trunk. The Office for Civil Rights has made it clear that losing that kind of document, whether in paper or digital form, is a violation," Adelman says. "We strongly encourage people not to take paper records anywhere that makes them vulnerable."

Handwritten notes are not the whole problem, notes **Brad Rostolsky**, JD, an associate with Reed Smith in Philadelphia. Any hard copy record can lead to a HIPAA breach, he says. In one case with which he is familiar, a hospital employee accidentally left a stack of printed records on a subway train.

"The biggest issue with printed out, hard copy records is that you just don't know whose information is at play," he says. "With electronic records, there is a backup somewhere, and you know what is lost or accessed. With handwritten records or printed copies, the tough question is, who do you notify?"

The answer usually will be "everybody" or at least a very liberal estimate of whose information might have been included, Rostolsky says. That broad notification means the impact of the breach could be much larger than if the data were electronic, he explains.

If a healthcare provider needs to use paper records – handwritten or printed – in some instances because going electronic is not feasible for that data, Rostolksy says there should be policies and procedures on how to track that information. Institutional pharmacies create paper records when delivering prescriptions, for example, and it would be nearly impossible to eliminate them. Those records can be protected with policies that require the records to be safeguarded at all times and not treated like just any other piece of paper. *(The loss of paper records accounts for nearly a quarter of HIPAA breaches. See the story on p. 3.)*

"If that kind of policy gets in the way of people taking home a stack of paperwork to work on in the evening, it might be time to move toward a system that allows them to log in to the system from home and work that way," Rostolsky says.

HIPAA education efforts should include pointing out that the notepads and other written materials can lead to a breach. It is easy for people to dismiss a notepad as harmless, with just casual notations that don't really constitute PHI, she says.

"Unfortunately many healthcare organizations will not recognize the danger posed by paper records until they have a breach of that type," Wagner says. "Then they will be alarmed and wonder why they have so much paper floating around."

EXECUTIVE SUMMARY

Writing down protected health information (PHI) on paper poses a significant risk of violating the Health Insurance Portability and Accountability Act (HIPAA). Many healthcare employees and contractors still jot down PHI and bypass all the digital protections.

- HIPAA breaches have been traced to handwritten notes.
- Completely prohibiting the use of handwritten notes might be impractical.
- Some types of information could be banned from handwritten notes.

SOURCES

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Specify quick notification in vendor agreements

Business associate agreements are one of the tricky parts of complying with the Health Insurance Portability and Accountability Act (HIPAA). The reason? You must trust that the vendor will act responsibly with your protected health information (PHI). Requirements for notification of a possible breach should be strict and clear, says **Timothy B. Adelman**, JD, an attorney with the law firm of LeClairRyan in Annapolis, MD.

If a contractor loses information in a way that even suggests a possible HIPAA breach, the hospital's contract should require the contractor to notify the hospital immediately. That contract provision encompasses more situations than a contract requiring notification if there is a breach.

"Some business associate agreements say the contractor will notify the hospital within 30 days of a breach, but we'd rather see a contract that requires the vendor to notify the hospital promptly whenever there is an unauthorized disclosure or access to PHI," Adelman says. "We don't want to leave it up to the vendor to decide whether a loss of PHI is a breach, because they may not have the background and resources to make that decision. We want the hospital to be involved in that decision." ■

Errors by employees are at the root of most data breaches, but not the most costly

The two most common sources of Health Insurance Portability and Accountability Act (HIPAA) breaches are unintended disclosure, such as misdirected emails and faxes (31%) and the physical loss of paper records (24%), which is particularly prevalent among healthcare organizations.

Those findings come from Beazley Breach Response (BBR) Services, an Atlanta company providing breach response insurance. It recently announced findings from an analysis of more than 1,500 data breaches at a meeting of the International Association of Privacy Professionals (IAPP). Breaches handled by the company have affected more than 14 million people.

> " DUE TO HEAVY FORENSICS COSTS ... THESE [MALWARE OR SPYWARE] BREACHES ARE ON AVERAGE 4.5 TIMES MORE COSTLY THAN THE LARGEST LOSS CATEGORY...

These are expensive

Among the data breaches serviced by Beazley in 2013 and 2014, breaches due to malware or spyware represented only 11% by number of breaches in 2013 and 2014. However, they have been increasing, with the total number of breaches in this category growing by 20% between i2013 and 2014. Due to heavy forensics costs (money spent to find out exactly how the breach occurred), these breaches are on average 4.5 times more costly than the largest loss category, unintended disclosure, explains **Katherine Keefe**, JD, head of Beazley Breach Response.

"With more information being stored electronically and in the cloud, the risk of data breaches is growing," Keefe says. "Consumers expect their privacy will be protected, and a data breach can have serious reputational and financial impact."

Most breaches are avoidable with appropriate training and security measures, says Keefe, noting the particular need for encryption services for large-scale computer networks and mobile services. *(See p. 4 for tips on avoiding a data breach.)* ■

EXECUTIVE SUMMARY

Most HIPAA data breaches are tied to misdirected emails and faxes, but the costliest are the result of malware and spyware. The findings come from a company that offers insurance for data breaches.

- The loss of paper records accounted for 24% of the breaches.
- Malware and spyware breaches are costly because of the research necessary to unravel them.
- Breaches from computer hacking are on the rise.

5 ways to avoid a data breach

Most data breaches are fully preventable, and Beazley Breach Response (BBR) Services, an Atlanta company providing breach response insurance, offers these five ways to avoid them:

• Encrypt your devices.

More than 73% of the breaches serviced by Beazley Breach Response in 2013 involving portable devices could have been prevented if the devices were encrypted. Encryption is a safe harbor under virtually every breach notification law.

• Automate patch management.

From 2013 to August 2014, Beazley has seen a 20% increase in breaches due to malware or hacking. Staying on top of the latest available software patches and moving to automated patch management can protect against a breach.

• Enforce password complexity.

Computer systems can systematically cycle through all permutations of potential passwords. Do not allow the use of passwords that are easy to crack. Dictionary words are capable of being deduced with an algorithm.

• Be alert to phishing.

Training is a critical step in breach preparedness. Train employees to spot the indicators of a phishing email. From 2013 to 2014, Beazley Breach Response has seen a 10% increase in breaches attributable to someone inside the company, either an employee or contractor. Most breaches occur because of human error.

• Double-check before hitting send.

Thirty-one percent of the breaches serviced by Beazley in 2013-2014 were due to unintended disclosure. It might be simple, but double-checking the contents of a file, email address, or mailing details can make a difference, especially when sending data to outside contacts. ■

Act expands breach notification requirements

Any healthcare organization with a presence in Florida will be affected by the Florida Information Protection Act of 2014 (FIPA), which expands the requirements on covered entities that acquire, maintain, store, or use personal information of Floridians.

As part of a growing trend in state legislatures, Florida's new data breach and security law expands notification requirements on covered entities that experience a breach of security, according to McGuireWoods.

The new law repealed Florida's prior data breach notification statute and made significant modifications to Florida law that can reach entities far beyond the state's borders, the firm explains. Providers need not be based in Florida for the law to apply; any business presence in the state will trigger the law.

William J. Cook, JD, partner with McGuireWoods in Chicago, offers these explanations of the new Florida law:

• Any commercial or governmental entity that acquires, maintains, stores, or uses personal information of individuals in the state is subject to this law. Although this is a Florida statute, companies in other jurisdictions should assume this statute will apply in the event they experience a breach of security affecting any individuals in Florida,

• Under FIPA, like its predecessor statute, personal information includes an individual's first name or first initial combined with the individual's last name, in combination with social security number, driver's license number, or other similar number of a government-issued ID, or a financial account number or credit or debit card number combined with the required security code. New under FIPA, personal information also will include any information about an individual's medical history, mental or physical condition, or medical treatment or diagnosis by a healthcare professional; or an individual's health insurance policy number or subscriber identification number, plus any unique identifier used by a health insurer to identify the individual.

• FIPA also expands the definition of personal information to include any personal login information that would permit access to a person's online account. Notably, this expansion, which might be the first of its kind in any state data breach notification law, would include login information to social media sites or applications, regardless of whether such sites include more traditional forms of personal information.

• Personal information excludes information already made public or information that is encrypted.

• FIPA reduced the time period for report of breaches to 30 days from the time the breach is discovered, compared to 45 days under the previous Florida statute. FIPA authorizes the Department of Legal Affairs to grant up to 15 additional days to provide notice if good cause is provided in writing to the department within 30 days of the determination of a breach. ■

INDICATORS
Insurance
Insurance card(s) copied front and back
Incorrect insurance plan code
Policy ID number missing/incorrect
Missing phone number and address for misc. insurance (if on card)
Insurance verification not run/documented
Subscriber code incorrect
Patient relationship to guarantor coded incorrectly
Self- pay without documentation
Missing Medicare questionnaire
NOFA/NOSP or WCOM/WCSP without health insurance listed as secondary
Medicare Risk Plan (HMO) / Medicaid HMO properly identified and entered in the insurance field using Emdon to verify
Demographics
Missing patient ID without documentation
Incorrect patient name
Incorrect date of birth
Patient Social Security Number not listed without documentation
No documentation supporting missing or incomplete patient home address
Employer name missing w/out documentation
Forms/Documentation
Proper documentation for missing Assignment of Benefits/Notice of Charity Care
Proper documentation for missing Appeals Consent
Missing prescription without documentation
Missing National Provider Identifier and license # without documentation
Physician listed incorrectly
Diagnosis listed incorrectly
Signatures missing without documentation
TOTAL ERRORS by Indicator
NUMBER OF ACCOUNTS REVIEWED
AVERAGE ERROR PER ACCOUNT
AVERAGE ERROR PER 100 ACCOUNTS
AVERAGE ACCURACY RATE

Source: Robert Wood Johnson University Hospital, New Brunswick, NJ.