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AHC Media LLC

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JUNE 2007
VOL. 26, NO. 6 • (pages 61-72)

Compliance efforts expanded to address identity theft concerns

Privacy protection begins with 'easy ID,' on-line preregistration

At Gwinnett Hospital System in Lawrenceville, GA, the HIPAA compliance program has been broadened to include "any and all sensitive information," not just protected health information (PHI), says **Nadia Fahim-Koster,** MBA, CHPS, CISSP, information privacy and security director and officer.

In view of the growing problem of identity theft, adds Fahim-Koster, the decision was made to include financial information and employee information in the scope of material protected under the constraints outlined in HIPAA, the Health Insurance Portability and Accountability Act.

Gwinnett's privacy protection program is introduced to the public at the site of registration in a couple of different ways, Fahim-Koster notes.

Patients who preregister over the Internet begin by reading — in English or Spanish — the notice of privacy practices, after which they check a box indicating that they have done so, she says. "On the next page, they start to register and give us their PHI."

For face-to-face registration, employees use a system called "easy ID," Fahim-Koster continues. "It's an information system that prints all the documentation paperwork that a registration associate will need to register the patient."

The process includes a form developed in-house that gives patients the opportunity to tell hospital staff "who they want us to be able to communicate with during their stay," she says. "It is not a blanket release of their records," Fahim-Koster explains, but rather permission to verbally provide certain information to the person or persons designated.

Individuals listed on the form will get more detailed information on the patient's condition than is available from the facility directory, she says. Patients typically put their spouse's name on the form, for example, Fahim-Koster adds, but some choose to designate additional or different "personal representatives," as they are called.

"By law, if you arrive in an emergency situation, you will be included

in the facility directory until you're conscious and tell us not to put you there," she says. "That [directory information] includes your first and last name and your condition, whether good, fair, or critical."

While the facility directory data are given to any individual who calls and asks about the patient by name, those designated as personal representatives are given additional information, Fahim-Koster says. "We can say to your personal representative, for example, 'She just got out of surgery; there are no tumors but there is a cyst, and we need to do this or that and the other."

However, the personal representative is not provided with complete detail, she notes. "We will not give, for example, the discovery that the patient is HIV-positive."

Even so, there is a clause that allows for the clinician's professional judgment, Fahim-Koster says. "If the condition has impacted the patient's health so badly that he or she is no longer able to make decisions, the hospital can share even that more detailed information."

The form was created as a result of initial HIPAA-related concerns on the part of employees, she adds, and "has helped us help staff make decisions without using their own judgment."

"Sometimes, for example, there is a woman who is going through a divorce but still married," Fahim-Koster says. "If the husband, who is not listed [as her personal representative], calls and asks for information, staff say, 'Sir, I'm going to refer you to the patient's personal rep.'" In such a case, she notes, the personal rep might be the woman's mother or another relative.

The personal representative procedure has been in place since January 2003, notes Fahim-Koster, who says she established it because "the anxiety level was palpable" as hospital staff prepared for the advent of HIPAA regulations.

"It was almost like HIPAA took away all of their [knowledge about protecting] confidentiality and they were locked down," worried that if they gave the wrong information, they would lose their jobs, she recalls.

In addition to helping to allay staff fears, the form has been useful in hospital investigations, Fahim-Koster says. "The form goes with the face sheet and becomes part of the patient's chart, and we always have that information. If somebody says, 'You disclosed information to my wife and I didn't want you to,' we can see [from the file] that he did give permission."

Training, auditing in place

New hires at Gwinnett Hospital System are required to complete a segment on HIPAA as part of the training they receive within two weeks of their start date, she says. The HIPAA training — developed in-house — incorporates slides explaining the privacy and security regulations, Fahim-Koster adds. "We use hospital scenarios as examples and fit those into the policies and procedures."

Following the training session, employees answer 25 questions on the material, and must get at least 80% correct to pass, she notes. "The

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

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last question is a confidentiality agreement — 'I agree' or 'I disagree' — that serves as an electronic signature."

Those who don't agree to the terms — not sharing protected information or user IDs, and acknowledging responsibility for anything done under their log-in — cannot work for the hospital system, Fahim-Koster says.

The current HIPAA training, which takes about an hour and is available on-line, took the place of a lengthier session that had been done by an outside company, she says.

The previous training used material written at a Grade 16 level and comprised three phases — an explanation of HIPAA, a description of what Gwinnett Hospital System has done to incorporate HIPAA, and the signing of a confidentiality agreement to go in the employee's file. "It took an average employee upwards of three hours to complete," she says

Gwinnett's program for auditing compliance includes a combination of physical and system audits, she says.

"We do walk-throughs on a rotating schedule and make sure passwords are not taped to computers and patient charts are not in view," Fahim-Koster says. "Every month we audit a few requirements of HIPAA, and once a year we walk through every single floor, every department, and write a detailed status report on what we've done."

Audits of HIPAA security procedures follow the specifications outlined in the rule, she says. "We map those out to all of our policies and then figure out [exactly] what to do. For example, we have a 'minimum necessary' [policy], where users should look only at the records of those they treat. I do an audit to see who has looked at their own records or at relatives' records. Sometimes I see where [staff] have looked at the records of VIPs or of other employees."

If employees are allowed to view their own records, Fahim-Koster explains, "they pretty much think they can look at the records of anyone they know. We want them to go through the proper channels."

To further protect sensitive information, Gwinnett employs "role-based access," she says, whereby the necessary level of access to data is precisely determined for every job code in the hospital.

"Every time [an employee] walks in the door, we know exactly what systems they need to have access to," Fahim-Koster adds.

As for the next step toward safeguarding information, "security is our biggest challenge and our biggest hurdle to true compliance with HIPAA," she says. "True privacy can only be achieved if you have good security.

"All you need is one laptop lost, one employee walking away with a file and losing it in a parking lot" to subvert the effectiveness of the most stringent confidentiality and privacy procedures, Fahim-Koster says, noting that it will take "strong safeguards and technical controls" to do the job right.

"Unfortunately, because [compliance departments] are cost centers and not revenue centers," she adds, "it is difficult to obtain funding."

To have a successful compliance program, Fahim-Koster emphasizes, "it's important to have executive management buy in. It's very important for the program to report high enough up the food chain so that it gets heard. Strong alignment [with management] is definitely needed."

Fahim-Koster reports jointly to the hospital's legal counsel and to the chief information officer, she says.

Use of SS numbers questioned

One of the compliance challenges being reported by access services staff at Gwinnett is the increasing number of patients refusing to provide their Social Security numbers during the registration process, Fahim-Koster points out.

Patients tell registrars that their health plans no longer require Social Security numbers and wonder why the hospital doesn't follow suit, she says. What she instructs the staff to respond, Fahim-Koster says, is that while the health plan may not be using the Social Security number on the patient's insurance card, it very well may be the unique identifier on the back end.

"We still need the unique identifier in our system," she adds. "More and more people are aware of identity theft and trying to protect their identity at all cost. The thing to remember is that [hospitals] always have the right to refuse treatment if it's not an emergency."

So far, staff have been able to make patients understand that if the hospital doesn't have the Social Security number to differentiate between people with the same first and last name, it can impact care, Fahim-Koster says. "It takes a lot of explanation with your front-end people."

[Editor's note: Nadia Fahim-Koster can be reached at (678) 442-4691.] ■

'Survivor' program evolves, inspires broader audience

Focus is on audience participation

A "Survivor" leadership and team-building program developed at Mt. Graham Regional Medical Center is prompting "aha moments" among an increasing circle of access audiences, says **Julie Johnson,** CHAM, director, revenue cycle management at the Safford, AZ, hospital.

"It started out as a way to address a specific problem at our facility," adds Johnson, but has evolved into a vehicle for inspiring self-awareness and interpersonal understanding in the workplace and beyond.

When initially putting the project together, organizers kept coming back to the theme of "surviving the everyday interactions that occur" and decided to use the motif of the "Survivor" television show in their presentation. They play the soundtrack from the film "Pirates of the Caribbean" to add to the island flavor

Participants at the 2006 National Association of Healthcare Access Management (NAHAM) conference and at the 2007 Association of Illinois Patient Access Managers meeting have said they will use the lessons learned from the program to interact "not only with different departments, but with patients and families," she notes.

Mt. Graham's Survivor team is scheduled to present this summer at Tucson (AZ) Medical Center and at the October 2007 conference of the Healthcare Financial Management Association (HFMA). In addition to Johnson, the team includes **Roland Knox,** chief operations officer; Candi Garcia, admissions supervisor; Shayse Cope, coder; and Terry Yoo, customer service concierge.

A Survivor exercise that looks at whether people are socializers, executives, lovers or fact-finders — the first letters of which form the acronym "SELF" — provided a wake-up call about the different ways individuals communicate and how those differences can lead to misunderstandings, Johnson says.

The first instruction in that exercise is for extroverts to move toward the front of the room, and introverts to the back, explains Knox.

Then, the fact-finders are told to move to the right, and the "people people" to the left, he adds. The end result is a group of individuals divided into four quadrants according to personality type.

The dawning realization is, for example, that while access personnel are usually socializers or lovers, those in other areas — particularly the "back end" of the hospital — may be fact-finders, Knox notes.

"The people in accounting may call up and say, 'How did you do this?' or 'Why did you miss that?' and the admitter is waiting for, 'Hi, how are you?'"

Johnson recalled overhearing conversations among attendees in which one person turned to the other and, referring to a colleague with whom she'd had a bad experience, said, 'Oh, that's why she acts like that, because she's a [one of the four personality types]."

Those who feel they don't fit neatly into one of the quadrants may choose to stand on a line between two groups during the exercise, Knox notes. "During the last presentation, we ask them, 'Why are you a liner and don't want to go one way or the other?' One gentleman, who was on the line between executive and socializer, essentially said, 'I'm both and I don't have to make a decision. You're not going to put me in one of those boxes.'"

After addressing self-awareness and communication in a couple of activities, Knox says, the team leaders ask their audience to think about six characteristics of a leader, which of those they have, or whether they have any of them:

1. Committed to self-development and lifelong learning.
2. Self-motivated and build on strengths.
3. Able to communicate regularly — up, down and across.
4. Effective in managing work, people, relations, and situations.
5. Realistic and flexible about expectations of self and others.
6. Able to analyze and organize the performance of self and others objectively.

Leaders then pose the question, "Where are you leading your team?" with the suggestion to look at vision, mission, and values, he adds.

Knox, who left a 19-year career in banking after service on the Mt. Graham board of directors sparked a passion to be part of the hospital's day-to-day operations, says he considers health care his "calling."

During his experience presenting the Survivor material, he says, "the No. 1 thing I've learned is that the concepts we share are ones that each person can relate to in his or her own way. When we

talk to audience members afterward, they all have a [specific] item they grasped."

The team tells stories that illustrate the different ways people communicate and the misunderstandings that can occur when the entire picture isn't apparent, Knox notes.

One story that many people related to, he adds, is about a man who got on a New York subway with three boys who began running up and down the aisle and generally misbehaving. When a fellow passenger comments that he can't believe the man is allowing his children to be so disruptive, the father, who is in a daze, says, "We just came from the hospital, where their mother just passed away. We don't know how to act."

The complaining passenger changes his whole demeanor at that point, of course, and the clear message of understanding people before you judge them always puts a hush over the audience, Knox adds.

'Salmagundi' caps session

As a crowning touch to the Survivor session, participants are asked to make a "salmagundi" — which he says is something that is "hard to describe, but everything you want it to be" — by building something that is reflective of their group and of what they have learned.

Derived from old English, salmagundi is also the word for a pirate stew that is "basically a conglomeration of whatever is on hand," notes Johnson, so it fits the program theme.

Participants sit in groups at round tables, Knox notes, and at the center of each table is an assortment of such items as play dough, shot glasses, shells, pipe cleaners, and dominoes, among other things.

"As a team, they make a salmagundi," Knox says. "It's amazing. It's quite incredible to see what people can make — a huge island, a zoo, a hospital." The components, he adds, "are the treasures — how to guide others, think about other people before we think about ourselves."

One of the most memorable exercises of the program is "the cup stack," notes Johnson, in which participants must work together as a team to stack 10 paper cups to make a pyramid. The caveat, she explains, is that they can't use any body parts to do it.

Instead, they must use a rubber band and strings to encircle the cup and move it, Johnson says. "They have to decide which cups go where, and if a cup falls down they have to figure out how to pick it up without touching.

"Sometimes natural leaders emerge" during the exercise, she adds. "People say things like, 'Charlene, I didn't know you had it in you,' and she says, 'I saw that nobody was taking the lead and so I did.'"

The Survivor presenters cut their original program from two-and-a-half hours to less than an hour to meet the time constraints of the conferences, Johnson notes. "We had to condense a lot of what we have to say."

The format also was changed to allow for more audience participation, she says. "We wanted there to be a lot of interaction and for everyone to have to get up and move." The idea, she adds, was for the program not to be just "oh, another speaker."

"Even with the cup stack and the salmagundi, they have to get out of their seats, be more creative," Johnson adds. "By stimulating this process that way, they can stimulate the access process, think outside the box to accommodate the patient, and not do everything by the book. They realize they can use their creativity on the job."

(Editor's note: Julie Johnson can be reached at juliej@mtgraham.org. Roland Knox can be reached at rolandk@mtgraham.org.) ■

Majority at Level 2 on access career ladder

Annual recertification required

A three-rung access career ladder in place since 2004 at St. Joseph's Hospital Health Center in Syracuse, NY, has drawn a positive response from staff, who move to the next level by demonstrating accuracy and productivity, completing in-services, and scoring well on a mission-based evaluation tool, says **Nicole Doshna,** CHAM, training and quality improvement (TQI) supervisor.

Information on the career ladder is easily accessible on the department's patient access web link **(see related article, p. 66)**, where an initial click takes users to the advancement program's philosophy and reason for being, she adds.

Every patient access employee is automatically at Level 1, once he or she has passed a six-month probationary period, Doshna says, and must meet the following requirements to reach Level 2.

Report cards, on-line classes featured on access web site

'We make it fun for staff'

A patient access site linked to the main web site of St. Joseph's Hospital Health Center in Syracuse, NY, takes users to a wide variety of features, including employee "report cards," online classes, and information on the access career ladder **(see related story, p. 65),** says **Nicole Doshna,** CHAM, training and quality improvement (TQI) supervisor.

Doshna and a part-time TQI customer service representative maintain the patient access site, she says. "We keep it updated, change the colors, make it fun for staff.

"One of the links is for access supervisors," Doshna explains. "On that link we put information for each service area within patient access to allow them to view the report cards we keep on their employees."

The 431-bed hospital's access staff of just less than 80 employees covers central scheduling, preregistration, admitting and hospital registration, primary care clinics, and ED registration, she adds.

"All of the competencies for patient access are listed on the site, so staff can access and pull off the information for their service area beforehand, when they go for their annual review," Doshna says. "Most of the criteria are the same, but each area's requirements are a little different."

An education link includes schedules for all access classes, in-services, and audits, as well as some on-line classes, she says. "We put together Insurance 101 for new hires, and we let them do it at their own pace. They have to go through that before they go to the insurance training class."

Classes on the ADT (admitting/discharge/transfer) system, which is a product of Atlanta-based Eclipsys Corp., are held every other month, Doshna notes. Departmental trainers who she oversees conduct those classes, which include the following.

- A session on registration information, primarily demographics.
- A "visit class," focusing on the specific visit on the date of service.
- A Medicare Secondary Payer (MSP) overview class.
- The insurance class, which covers how to load insurance information into the system and what to look for on certain insurance cards.

The access site, in place since 2004, also contains information for those interested in taking the Certified Healthcare Access Associate (CHAA) examination, she says.

Included on the access site are direct links to the insurance company sites, Doshna adds. "We also have all of our orientation guidelines listed, and all of our policies and procedures, so employees don't have to go fishing through binders."

Doshna is particularly proud, she notes, of the Access Communique, a feature added to the site in June 2006. "It's a weekly communication tool that goes out via e-mail to access and non-access areas. There's a nice quote, and then information about what's going on, including insurance updates, anything that's new with Eclipsys, and any changes that affect the access work flow.

"I used to save that kind of information for the quarterly access newsletter, but it was too cumbersome," Doshna explains. "Now we use the newsletter for personal, fun things, like a new baby or a graduation."

Putting together the access site "was very easy," she says. "I contacted the information services department, got our own link, and now I create everything through Microsoft Front Page. I can do whatever I want. I just save it and it's on the web site." ■

- Attend at least one of several in-house programs that include "conflict resolution," "team building," and "attitude of a champion."
- Demonstrate their productivity level by maintaining 95% accuracy on face sheets and Medicare Secondary Payer (MSP) audits.
- Reach two to three "exceeds" ratings on the seven categories of the evaluation tool based on the hospital's mission statement.

The components of the mission are stewardship, excellence, reverence, vision, integrity, compassion, and enthusiasm, Doshna adds. "All employees are evaluated on these seven criteria during their annual review."

Stewardship, for example, is about "being accountable for responsible use of resources and assets, including time and talents," she explains.

To reach Level 3, Dosha continues, the

employee must have three to four "exceeds" on the mission-based tool, must have worked with another staff member as a preceptor, and must have passed the Certified Healthcare Access Associate (CHAA) examination offered by the National Association of Healthcare Access Management (NAHAM).

The access career ladder "has been a very good opportunity, and a lot of people take advantage of it," she notes. "We have a good majority of staff in all areas that are at least at Level 2. We do tie in a monetary incentive — an additional 75 cents an hour for each level attained."

Participants must recertify each year according to a point system, Doshna says. "For Level 2, you have to achieve 50 points. If you attend different in-services, that counts. If you train people, that counts."

Accruing points has to do with going "above and beyond" the normal job requirements, she adds. That might include volunteering outside the hospital — participating in a "Heart Walk," for example — or taking college courses, Doshna says.

The access department director recently implemented a management career ladder, she notes, which basically consists of receiving an increase in pay for passing NAHAM's Certified Healthcare Access Manager (CHAM) examination.

"That was rolled out [in April 2007] and has received a strong response."

(Editor's note: Nicole Doshna can be reached at Nicole.Doshna@sjhsyr.org.) ■

Education became passion for access professional

Requiring CHAM 'would be ideal'

When **Elizabeth Reason,** MBA, CHAM, agreed a couple of years ago to fill a vacancy on the board of the Michigan Alliance of Healthcare Access Professionals (MAHAP), it was the beginning of a personal crusade for better education and credentialing of access professionals.

"Because I am an educator, I volunteered for [education chair]," says Reason, who is an adjunct faculty member at Davenport University's Lansing campus in addition to being assistant manager for patient access at Ingham Regional Medical Center (IRMC).

In the past, MAHAP's education chair had been responsible primarily for making sure CEUs were done, she notes. But Reason had something more ambitious in mind. "I have always been a very firm believer in personal education for the access field."

She began promoting attainment of the Certified Healthcare Access Manager (CHAM) credential, which she'd like to be a requirement for all patient access managers, Reason says. At MAHAP's fall 2006 conference, she adds, she did a three-hour prep session for 12 members who are now on target to take the CHAM exam in the fall of 2007.

"From a professional standpoint, I think requiring the CHAM for all patient access managers would be ideal," Reason says. "If not required it should at least be encouraged. The CHAM is proof that the manager has met a standard of excellence."

The MAHAP session she conducted focused on "the natural knowledge we have and how to break down a study guide," Reason notes, "but I also talked a lot about study skills and test preparation. Most [access professionals] haven't taken a test in years."

Most of the students in the allied health classes she teaches at Davenport are more than 35, she adds, "and I see a lot of test anxiety in the non-traditional student — those who are not in the 18-24 age range."

Most of the access staff at IRMC are also older and have been with the hospital a long time, Reason notes, so what she's observed from teaching non-traditional students at the university has helped her meet the needs of her own employees.

As well as being "an important distinction for access managers and supervisors," acquiring the CHAM credential sets a good example for staff members," Reason says. "The CHAA [Certified Healthcare Access Associate] is just as important, because the people on the front line are professionals as well. Building the exam into a career ladder requirement is a great way to encourage growth and a standard of excellence."

Her focus in the session at the MAHAP conference, and at a recent presentation to the Association of Illinois Patient Access Management, is on promoting access education and encouraging participants to take the message back to the directors and administration at their individual hospitals, she says. "We have to sell this because education costs money."

At her facility, instituting the CHAA credential as a requirement would have to go through the union to which frontline staff belong, Reason notes. "As a management team, our wish is to have the CHAA exam [required] but I can't guarantee it will get into the [union] negotiations this summer."

In the meantime, the department leadership "will still make a huge push on education" so that employees will be successful if they are in a position to take the exam, she says.

Her assumption, Reason says, is that there will be a pay raise for staff if the CHAA does become a requirement. Access employees at IRMC are already being paid better than in the past, she notes, with a significant increase in the past year.

"They got bumped up a pay grade, and the scale went up," Reason says. "In 2004, the pay range was $10.84 to $13.54, and as of October 2006 it's $12.06 to $15.70."

Comprehensive training implemented

As part of the push toward a better prepared, more professional access department, the scope of Reason's duties was changed in the summer of 2006 so that she could do not only comprehensive education for new hires, but also re-education of existing employees, she says. "We have implemented a retraining program with specific topics."

In addition, Reason notes, she has started a more comprehensive auditing program to provide feedback to existing staff and to the organization's leadership. She also supervises the patient account representatives who do insurance authorization and verification.

After talking about a new access education model for the past several years, and actually putting it together for the past two years, Reason and her boss, the manager of patient access, put the program for new hires into effect on April 2, 2007.

When she joined the patient access department four years ago, there was minimal training on the actual registration and admission process, Reason notes. New employees worked with a trainer for just a few hours before being "pushed out to the front," she says.

Under the newly implemented training program, access employees get 116 hours of classroom and on-the-job training, which is broken down as follows.

- Four hours for human resources orientation.
- Forty-eight hours (12 four-hour sessions) in the classroom, including assessments to monitor comprehension and a final assessment to verify readiness. The staff member must pass the assessment with 90% or better accuracy to progress to on-the-job training.

The classroom sessions include, among other things, comprehensive training on the admission/discharge/transfer (ADT) system, including "all of the accesses and how to register every patient;" Advance Beneficiary Notice (ABN) training; and instruction in compliance, including consent and authorization, HIPAA regulations, patient rights and responsibilities, advance directives and opting out of the facility directory.

- On-the-job training with a mentor for 64 hours (eight, eight-hour days).

When she entered the access field at St. Joseph Mercy Health System in Ann Arbor, Reason says, she was trained on a very similar model. "I don't feel I would be nearly as successful now if I had not had that training.

"Education is a process, and an ongoing process," she adds. "It never ends. That's how we really approach this. What we have now will evolve even more. We really want to invest in our employees."

(Editor's note: Elizabeth Reason can be reached at elizabeth.reason@irmc.org.) ■

Focus on certification helps staff morale, retention

AR days also positively impacted

Looking for a way to retain staff and enhance training, the patient access leadership at Delnor Community Hospital in Geneva, IL, turned their focus to the professional certifications offered by the Washington, DC-based National Association of Healthcare Management (NAHAM), says **Karin Podolski,** RN, MSN, MPH, CHAM, director of patient access.

After Podolski and a registration team leader got the Certified Healthcare Access Manager (CHAM) designation in 2005, they decided to offer front-line staff the opportunity to take the Certified Healthcare Access Associate (CHAA) examination as a way of increasing the profes-

sionalism of the department, she adds.

The results have been extremely positive, says Podolski, who credits participation in the program with a significant decrease in staff turnover and increase in employee morale, as well as a dramatic reduction in accounts receivable (AR) days.

Comparing fiscal year 2005, when the program started, with fiscal year 2006, turnover has decreased from 28% to 11%, and employee morale increased from 63% to 78%, as measured by Sperduto & Associates, an Atlanta-based firm of corporate psychologists and management consultants.

The decrease in AR days — from 74 days to 40 days — during the same period, Podolski suggests, is related to an increase in registration accuracy due to all the reviewing of revenue cycle material.

Because of the amount of certification that goes along with her nursing background, the decision to seek credentialing for her staff was a natural progression for her, she says.

She knew, however, that she would have to sell the idea without the promise of increased compensation because Delnor does not provide a financial incentive for obtaining certification, Podolski adds. "I knew that would be a hurdle."

The kickoff meeting for the program was held in the fall of 2005, and the access department trainer — who passed the CHAM exam that year and also became certified to proctor the examinations — took applications from 32 of Delnor's 110 access employees, Podolski says. Except for a couple of employees who left for various reasons and one who "kept putting it off," all the applicants took the exam, as required, within the following year, she adds.

The employee who let the year deadline go by had to pay back the exam fee — which the hospital pays for all applicants — and the fees for the two employees who left were transferred to others within the department, Podolski says.

The trainer sets up a time each month to offer the exam, which is taken with paper and pencil, she notes, and mails the completed tests to NAHAM. The exam can be completed on-line, Podolski explains, but that practice was discontinued at Delnor, she says, "to reduce the potential anxiety of finding out the results while in a room with peers and to reduce any anxiety staff may have about taking a test on-line."

Four people did not pass the exam the first time, Podolski notes, and the department sent flowers as consolation. They were successful on the second try, she says.

The second year of the program, which is in sync with the hospital's fiscal year, began with a party in October 2006, where 14 more employees applied to take the CHAA exam by the end of August 2007, she says.

That event also was a celebration of the success of the previous year's applicants, Podolski adds. Staff from clinical areas were invited to join their access colleagues in the celebration.

Those who obtained the certification also were recognized with a certificate to hang in their work area, a congratulatory card from the hospital's chief financial officer, and a pen provided by NAHAM, she says. "We also put their names in the employee newsletter, and sent out an e-mail listing the employees and talking about NAHAM and what the certification represents — that it promotes respect for the department and professionalism."

In addition, the CHAA credential is designated on the employees' name badge, Podolski says. Although the certification is not linked to an increase in pay, she notes, it does figure into an employee's annual review.

"There is a 'growth' goal, and the only way to get a [top rating] on it is if the person is certified," Podolski adds.

Even two college students who work in the department — with no long-term access career plans — opted to take the exam, she notes.

Money is not the biggest motivator for this kind of achievement, Podolski says. "It's recognition and support and validation, the fact that [a CHAA] is not just a registrar at Delnor, but a certified access associate. If they move to another area, they have this foundation to hit the ground running and find another position."

(Editor's note: Karin Podolski can be reached at karin.podolski@msn.com.) ■

Professionally attired staff linked to collections boost

'They don't get any resistance'

New, professional-style uniforms for access staff at Florida Hospital Zephyrhills have apparently had a dramatic — and very positive

— effect on the facility's upfront collections, says patient access supervisor **Mike Vanderbilt,** CHAM.

Although he has no scientific data to prove the connection, Vanderbilt adds, he is convinced that the new apparel is behind the new willingness of patients to pay upon request. It replaces much more casual "scrub attire," which consisted of "thin, clingy unisex pullover tops with scrub jackets and anything except denim on the bottom."

The numbers speak for themselves, Vanderbilt notes. "We went from $80,000 in cash collections in December to more than $150,000 in February and March."

While patient access representatives "used to always get resistance" when asking for payment at the time of service, that is no longer the case, he says. "The new clothing has changed their attitudes, the way they interact with people, and their confidence level, especially when it comes to collecting money."

Now that the employees asking for their money are wearing suits, the public's perception of them has changed, Vanderbilt suggests. "The staff feedback is 100% that they don't get any resistance."

The new uniforms were inspired by an extensive renovation that substantially changed the lobby and entryways of the 150-bed facility, he says. "It went from a typical waiting room atmosphere to a nice hotel lobby atmosphere."

As the staff observed all the changes going on around them, Vanderbilt adds, "they started saying, 'Are we going to get fixed up, too?'" After receiving "a lot of group input" from the employees, the department leadership put a plan in motion.

Vanderbilt's vision for the new attire was to create an impression of "total class, total professionalism, so that when visitors and patients come into our facility, they won't have experienced anything like it."

The decision was made to go with black business suits — including several choices of shirts and jackets — appropriately styled for men and women, he says. The shirts and blouses are in a light shade of blue, Vanderbilt adds. "The ladies have a scarf and the men have a tie that ties in with [the colors of] the lobby and our web site. It looks almost like we branded it."

The final touch, he says, is a silver lapel pin in the design of the hospital logo.

Emergency department registrars wear a more casual variation of the same theme, he notes, including a nice quality polo shirt with an embroidered logo. Because of the demands of bedside registration, Vanderbilt says, those employees wear sneakers, while inpatient and outpatient reps wear dress shoes.

Employees who work in central scheduling, because they are not face-to-face with the public, continue to wear their own choice of professional attire, he says

All full-time access reps were given four sets of clothing with an option to purchase a fifth on their own, Vanderbilt notes.

"The first week we rolled out [the new uniforms], people were almost gawking," he says. "Administration, employees from other departments were coming down to look."

Other hospitals in the Adventist Health System, to which Florida Hospital Zephyrhills belongs, have expressed interest in obtaining uniforms for their own access employees, Vanderbilt says.

"It's been extremely positive," he adds. "Based on region and hospital size, [a uniform program] may or may not help, but in our case we needed it badly."

(Editor's note: Mike Vanderbilt may be reached at Mike.Vanderbilt@ahss.org.) ■

NPI contingency plan announced by CMS

'Good faith efforts' acceptable

Health care providers and other covered entities that acted in "good faith" to become compliant with the requirement for a National Provider Identifier can continue to accept legacy numbers through May 23, 2008, one year after the NPI rule takes effect, according to a notice issued recently by the Centers for Medicare & Medicaid Services (CMS).

All entities covered by HIPAA, including providers, health plans, and clearinghouses that process health care transactions using HIPAA format, must implement the 10-digit NPI code.

The CMS contingency plan protects covered entities from enforcement action as long as they continue to pursue "good faith efforts" to meet the NPI requirements, and indicates the Department of Health and Human Services will investi-

gate only when a complaint is filed, as it has for other HIPAA standards.

Answers to frequently asked questions about the contingency plan guidance can be found at http://questions.cms.hhs.gov. The following questions and answers are among recent additions to the FAQs:

Q. I applied for my NPI over the web and haven't received the NPI notification. What should I do?

A. The contact person should first check the computer's SPAM filter to ensure that the NPI notification e-mail has not been routed to SPAM. If the notification is not in the SPAM filter and it has been 15 days since the NPI application was submitted over the web, the health care provider or the contact person should contact the NPI enumerator at (800) 465-3203.

Q. When should a health care provider deactivate its NPI?

A. A health care provider (or the trustee/legal representative of a health care provider) should deactivate its NPI in certain situations, such as retirement or death of an individual, disbandment of an organization, or fraudulent use of the NPI. To deactivate an NPI, a health care provider (or its trustee/legal representative) must complete a CMS-10114 and mail it to the NPI enumerator.

However, the health care provider (or its representative) should be certain that all billing transactions, that is, the settling of all claims with health plans, are completed before submitting the CMS-10114. If all billing transactions are not complete before deactivating an NPI, issues regarding claims payment may arise.

Q. Will I need to change how I submit claims/bill Medicare in order to participate in the Medicare Care Management Performance (MCMP) demonstration?

A. No. Keep in mind that claims must reflect the correct rendering provider, using the appropriate physician identification number (Medicare Provider Identifying Number) or NPI as appropriate) on each line of the claim. Only providers that bill Medicare through a carrier are eligible to participate in the demonstration. ■

NEWS BRIEFS

COPs require almost all to have emergency services

The Hospital Conditions of Participation (COP) require nearly all hospitals, including limited-service providers and others without emergency departments, to provide emergency services, according to guidance recently released by the Centers for Medicare & Medicaid Services (CMS).

The guidance states that almost all hospitals must have the resources to evaluate people with emergencies, provide initial treatment or provide transfer services when necessary. CMS also clarifies that hospitals are not allowed to rely on 9-1-1 services in lieu of providing emergency services.

The guidance does not apply to critical access hospitals, which are covered by a separate set of guidelines.

CMS issued the clarification as one of the elements of its Strategic and Implementing Plan submitted to Congress in 2006 with respect to physician-owned limited-service hospitals.

The agency's fiscal year 2008 hospital inpatient prospective payment system proposed rule also included provisions to improve transparency and public disclosure of hospital emergency services capacity, and also requests public comment on whether Medicare should strengthen its emergency requirements. ▼

Capability, not capacity is preparedness measure

The measures used to assess progress in federal hospital and public health emergency preparedness programs have evolved since 2002

from measuring capacity to assessing capability, according to results of a recent study by the Government Accountability Office.

The Department of Health and Human Services' Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention began developing in 2006 formal data analysis programs to validate performance data reported by preparedness grant recipients and generate standardized reports.

However, at present they cannot provide consistent feedback to recipients or measure progress collectively or across recipient programs, GAO said. The CDC plans to issue a report on recipient programs this year, while the timeline for a similar report from the HRSA program is uncertain due to the program's recent move to the Office of the Assistant Secretary for Preparedness and Response. ▼

Survey: Enrollment up in HDHS/HSA plans

Some 4.5 million Americans are enrolled in a high-deductible health plan (HDHS) associated with a health savings account (HSA), according to a survey released by America's Health Insurance Plans. That's 1.3 million more people than AHIP reported a year ago.

Enrollment in the individual market rose to 1.1 million from 855,000, of which 27% were previously uninsured, AHIP said. Enrollment in the group market rose to nearly 3.4 million from 1.4 million. ■