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Top revenue cycle position is a realistic goal for access directors

'It doesn't have to be someone on the back end'

Raising the value of patient access professionals throughout the health care industry continues to be a major focus of the National Association for Healthcare Access Management (NAHAM), says new President **Julie Johnson,** CHAM, director of health information management for Mt. Graham Regional Medical Center in Safford, AZ.

Johnson assumed her position at the organization's annual conference in May.

Related priorities are enhancing patient access educational opportunities and promoting access professionals as viable candidates for top revenue cycle positions, Johnson adds. Along that line, she notes, NAHAM is finalizing an improved certification process that includes new examinations for its certified healthcare access manager (CHAM) and certified healthcare access associate (CHAA) designations. **(See related article, pg. 63.)**

Despite much lip service throughout the industry regarding the importance of patient access, Johnson continues, access employees typically are still paid less than their business office counterparts, even though they are expected to perform a wider range of duties.

"They really have to do more upfront, because in addition to being pre-billers and collectors and a huge part of the revenue cycle, they also have to have customer service skills," she adds.

While Johnson is now director of health information management, she previously has held the positions of director of revenue management and vice president of revenue management.

Those career advancements, she says, "came from promoting a can-do attitude" and emphasizing that "it doesn't have to be someone on the back end" overseeing the revenue cycle.

She recently scaled back her work commitment to allow more travel time to be supportive of sons who are professional baseball players.

As NAHAM vice president, Johnson says, she was charged with recruiting vendors to serve as "business partners" with the organiza-

tion. During those conversations, she notes, she took the opportunity to encourage them to consider patient access when developing and marketing revenue cycle products.

In many cases, she notes, vendors are coming forward with software that benefits the front end — such as automated guidance built into the registration process — and marketing it to back-end directors who don't always recognize the need.

"I feel like they need to promote [these innovations] in patient access," Johnson says. "There are a lot of [facilities] where they know that patient access is important, but many processes are still manual. [Vendors] need to be sending information to patient access directors."

Training programs offered by these companies, she adds, are "almost always" designed from the back-end perspective and don't fully encompass patient access processes.

To promote access education in her own arena, Johnson says, she is talking with the president of a local two-year college about developing some sort of access-related curriculum "so we can grow our own" qualified patient access staff members.

The idea is to create an associate's degree in the field, she adds, noting that there is growing interest in the CHAA and CHAM process among such colleges.

Transition to MACs under way

A recent regulatory event that affects patient access is the change from fiscal intermediaries (FI) to Medicare administrative contractors (MACs). Johnson points out.

It is the result of a Medicare contracting reform that was established as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Johnson's hospital happens to be in the first jurisdiction — which includes Arizona, North Dakota, South Dakota, Montana, Utah, and Wyoming — where the FI was taken away and the MAC took over, she says.

"That's been a nightmare for all of us," Johnson says. The transition will be done in phases, she notes, and is to be completed by October 2009.

Keeping in mind the need to embrace technology and strengthen the revenue cycle through improving front-end quality, she says, the agenda for the 2008 NAHAM conference included sessions covering the following topics:

- pre-service or pre-processing departments, with an eye on improving data entry;
- why employees must be part of the technology selection process;
- tablet-based electronic consent and charting;
- keeping a balanced scorecard (evaluating work performance);
- going from mediocre to synergetic;
- automated registration QA: What's next?;
- denial management technology;
- using work lists on the web.

[Editor's note: Julie Johnson may be reached at juliej@mtgraham.org.] ■

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CHAA, CHAM credentials revised, updated

Aim is 'legally defensible' program

The National Association of Healthcare Access Management (NAHAM) credentialing programs for patient access services managers and front-line staff are being completely revised and updated, with new certification examinations to be offered beginning in October 2008, says **Holly Hiryak,** RN, CHAM, chair of the Washington, DC-based organization's Certification Commission.

"We decided about a year ago that we needed to 'up the ante' and improve our certification process," Hiryak adds. "The tests were a little outdated, and we needed to make sure we had products that were [in credentialing terms] 'legally defensible.'"

That means that the examinations have gone through a rigorous development process that ensures their validity as testing tools, she explains.

The Certification Commission, established at the May 2007 NAHAM conference, was charged with creating a "valid, credible, and sustainable certification program," according to a posting on the organization's web site, separate from the mission of the NAHAM Education Committee, which traditionally had overseen certification matters along with other educational responsibilities.

NAHAM contracted with the international testing company Schroeder Measurement Technologies (SMT), which is helping guide the process, Hiryak notes.

To establish a blueprint for the new exams, the commission put out a call for two groups of volunteers — one for the CHAA credential and another for CHAM — and "started from scratch" the process of creating test questions, she says.

"We looked at the old outline of our study guide and used that as the basis for moving forward," Hiryak says. "We eliminated some topics, added some, and then sent a survey to our membership and to anyone who had been certified. We asked them to review the outline and indicate the relevance of the topics we had [proposed] as a blueprint."

After receiving feedback from members and from others who have the CHAA and CHAM certifications, she adds, the group met again to review those responses. "We realized we were on target. We made some adjustments, but not many."

At that point, the actual writing process began, Hiryak notes, with participants spending almost three days "just sitting in rooms and writing questions. People would volunteer for [subject] areas in which they were most comfortable."

Once the questions were written, they were submitted to the facilitator of each group and then put up on a screen to be analyzed for appropriateness, she says, by project participants who represented various regions of the country. Each question was either accepted by the group or thrown out, Hiryak adds, with SMT providing support in determining whether a question was relevant nationally or limited to a particular area.

"That was a long and rigorous process, and once we completed that we had a good start on a databank," she says. A little further tweaking was set for an early session at NAHAM's annual conference in May, Hiryak notes, and an electronic SMT process allowed the on-line submission and review of questions.

SMT is "a full-service test development company, which means that they offer support for all the steps in a standard certification process," adds **Ellen Moore,** vice president of education and program services for SmithBucklin Corp., the management firm that runs NAHAM. Moore serves as the certification expert for the CHAM and CHAA credentialing program.

The process begins with an assessment of the type of program needed, she says, and continues with a job analysis — "outlining the tasks and skills necessary to perform in the job." In this case, Moore notes, an analysis was done for two positions — health care access manager and health care access associate.

"The job analysis gives us an established body of knowledge and helps create a blueprint for the content and requirements for the job we're going to certify," she adds.

Further steps include development of test specifications, test development, test administration, cut score (the pass-fail point), and score reporting (giving candidates information on how they did on the test), Moore says.

Grading is not done on a curve, and the cut score is not at all arbitrary but determined very deliberately, she points out. "Subject matter experts help us set the [cut] score."

The old CHAA and CHAM exams were used at the conference and through the end of May 2008, Hiryak says, and then testing was to be suspended from June 1 to Sept. 30, 2008. Testing will

begin again, with the new exams, on Oct. 1, 2008.

The break is needed, she explains, "to build up a pool of people to test, so we can set the baseline. From there, we are making some changes to the process in terms of prerequisites and frequency of test offerings."

The strength of the new exams, she points out, lies in the "quality and validity of information. These are not just questions off the top of your head, but are research-based." People who served as "item writers" for the tests, she adds, were required to provide a resource for the information they provided.

The intent was not to make the examinations harder, but to accurately test the knowledge base of those in the access field, she says. "Because these are cleaned-up, valid questions with resources, I think we will see an increase in the pass rate — because the information is more relevant to what they're doing."

Continuous revision process planned

"For instance, in the previous tests, there was a heavy focus on coding and medical records," Hiryak notes. "We limited that [in the new versions] because it's not really that relevant. We adjusted [content] based on what the membership told us was relevant in their day-to-day jobs."

When the CHAM and CHAA tests are relaunched in the fall, Moore says, 15 "extra" questions will be added, and there will be "a continuous process in which we are always updating and revising questions."

Each question, she adds, will be looked at from several perspectives: "Is it well written? How do people do on that question? Are their answers well-formulated?"

As with any certification program, Moore says, the intention is that "the person who passes this test meets the minimum industry standards" for the job. "If someone were to question NAHAM, or the candidate, we can go back and show the rigorous process we put in place."

Having such a credential is valuable for many reasons, she contends. "It helps elevate the profession. It helps [those who attain it] to have a certain level of professional achievement."

In addition, Moore says, "more and more facilities are requiring [certifications] for promotions or using them as hiring criteria for certain levels in jobs."

[Editor's note: Holly Hiryak can be reached at hiryakhollym@uams.edu. Ellen Moore can be reached at EMoore@smithbucklin.com.] ■

Ambulatory business center to meld outpatient functions

Clinics affected serve 400,000 per year

Planning is under way for a new ambulatory business center that will consolidate a wide range of outpatient functions at the University of Arkansas for Medical Sciences (UAMS) in Little Rock.

The goal of the new center is to consolidate business functions so that new outpatients will have a single point of contact for scheduling and registration, according to **Philip Baroni,** associate director for outpatient services.

Imperatives in the plan include:

- Reducing patient frustration with telephone tag and difficulty contacting someone when attempting to schedule appointments at UAMS.
- Reducing the number of calls to outpatient clinics — which serve 400,000 patients a year — that cover an entire range of specialties and are located in multiple sites.

Centralizing the business function in the outpatient environment is a concept that has been under consideration for most of the past 10 years, Baroni notes, but for various reasons has not come to fruition.

UAMS now has 130 front-end staff handling registration and appointments at 30 plus outpatient clinics in a half-dozen buildings, he says. Those functions are accomplished in several different ways.

A unit operating under the supervision of **Holly Hiryak**, director of hospital admissions, currently does preregistration and some insurance verification for 10 of the outpatient clinics and an appointment center serves some of those clinics plus some additional ones.

"Our goal is really to expand those services to cover the gamut [of outpatient clinics]," he says. "The preregistration and appointment groups are really a microcosm of what we want to do with the ambulatory business center."

Achieving that single point of contact for outpatients will require a cultural change, Baroni says. "The appointment-making process here is done in a variety of ways — the appointment center, the individual physician's office, the clinic — and one of the imperatives is to streamline that.

"Our purpose," he adds, "is to provide excellent customer service by addressing the needs of

ambulatory patients in a warm, friendly way."

The initial effort will be with patients who are new to the system, with return appointments continuing to be made in the clinics, Baroni says. "Our goal is to preregister 95% of new patients and to complete any consult or referral obligations prior to the clinic visit as well."

One of the goals is to standardize business processes across the ambulatory clinical enterprise, he notes, and ensure that requirements are consistent in all the clinics.

One of the first steps will be to merge the outpatient preregistration unit and the appointment center.

"We are hoping to do this on an FTE-neutral basis," Baroni adds. "We've done some analysis on that."

The intent is to have new patients being served by the ambulatory business center within a year, Baroni says.

Crucial to the process, he notes, is an advisory group of senior physicians that will meet monthly to discuss the project. An operational group made up of "those in the trenches" will meet twice a month.

"We've been presenting the proposal to various physician groups," Baroni says, "and we've had a positive response, but some doubts have been expressed as well."

Once the new ambulatory business center is in place, he explains, the process would work as follows: Someone who needs, for example, an orthopedic appointment — instead of grabbing the phone book and trying to find the right UAMS number — can call the ambulatory business center number for assistance in making an appointment.

Staff will have been trained to make an appointment with a specialist if the patient requires a referral, he says. "If this is a new patient, the employee will do the registration."

Other methods of registration — the Internet or an automated voice response system — that are already being used by the preregistration unit also will be available. **(See related article, this page.)**

In addition to gathering demographic and insurance information, staff will advise patients of any copays that may be due, he notes. "Ideally, there will be very minimal check-in at the clinic, which will free up clinic staff to focus on the customer service needs of our patients."

[Editor's note: Philip Baroni can be reached at baronijohnp@uams.edu.] ■

Internet, 'VoiCentral' registration options

Numbers small, but growing

Some outpatients at the University of Arkansas for Medical Sciences (UAMS) are being preregistered on their own timetable by choosing to provide their information via the Internet or an automated telephone process called VoiCentral, says **Mica Dunn,** CHAM, CHAA, manager of the outpatient registration department.

While the numbers are small at present — 10 or 12 patients a week between the two programs — her hope is that the two methods will increase in popularity with the establishment of an ambulatory business center that is now in the planning stages, Dunn adds. **(See related story, pg. 61.)**

The outpatient Internet registration process went live in August 2007, she says, following her appointment as manager in January, and registration via VoiCentral was made available about the same time.

Because the Internet registration option is available only to outpatients making appointments at one of the 10 clinics served by her staff, Dunn notes, there is some potential for customer confusion.

It must be explained on the web page, she says, that only patients going to those clinics may click on the link to preregister on-line, and that others may do so by calling a telephone number that is provided. There are plans, Dunn says, to include a notice telling patients that they will be informed when other clinics are added to the list.

The site also allows for Internet preregistration by inpatients and labor and delivery patients, she adds, but those functions are handled by staff in the hospital admissions department.

At present, both departments are notified through "a global e-mail for central admissions" when someone preregisters on-line, and staff must go inside the message to see whether it's an inpatient or outpatient account, Dunn says. "Someone is assigned to check anything that comes in.

"I want to have [the process] changed so that we get our e-mails and they get theirs," she adds.

Some other tweaking has been necessary, Dunn adds, including a small change to the way telephone and Social Security numbers are entered on the registration form.

"People were filling in dashes and [the system]

was leaving out the last two numbers," she says, so the form was adjusted to include the dashes.

After the first few on-line registrations, she called those patients to ask for feedback on their experience, Dunn says. "I have not had any negative comments. They all said they liked it and would do it again.

"I recently have created a survey for patients to fill out," she notes. "The link is live, but we're in the process of working out the bugs." Still to be added, Dunn says, is a prompt at the end of the registration that leads people to the survey.

At the beginning of the process, she notes, patients are asked if they want to be notified via e-mail that the registration has been received and, if so, to include their e-mail address. To date, all those preregistering on-line have chosen to get their confirmation the same way, Dunn adds.

A section on the site for frequently asked questions, she notes, addresses such concerns as:

- Is it secure?
- How long does it take?
- What information do they need?
- How do I know I have been preregistered?

With the VoiCentral system, Dunn says, staff do not receive automatic notification of incoming registrations, but must call every morning to see if there is anything there for them to handle.

While Dunn was initially concerned that patients would not like the experience of verbally completing a registration in response to a series of prompts, she says the reaction from those who have tried it has been positive.

Patients reported that the VoiCentral system, which gives one registration option for new patients and another for existing patients, was slow enough to allow comfortable response time, adds Dunn, who notes that it also lets users pause during the process.

A couple of adjustments did need to be made, she says, one of which had to do with questions about the person's "referring physician" and "primary care physician."

"Many times the primary care physician is also the referring physician," Dunn explains, "so patients would say, 'I don't understand why you're asking me that.'"

The language was changed, she says, to clarify the distinction that was being made.

While the VoiCentral process is geared toward new patients, Dunn notes, one of the side benefits has been help in reaching existing ones.

"If we leave a message during the day for [an existing patient] we've been trying to reach who's coming in the next day, we tell them that after hours they can do the registration on-line or through VoiCentral."

If the patient does so, she adds, that makes it possible for staff to pick up the information the next morning and update the account before the person's appointment time.

At present, Dunn says, the Internet registration option is marketed through the distribution and display of flyers and brochures at the clinics for which her department preregisters. The brochure advertises the fact that registering on-line — or through VoiCentral, for which it provides the phone number — saves time on the day of service and that it can be done any time, day or night, she adds. "It also gives the option of faxing or mailing the information two weeks in advance."

Staff weed out calls concerning clinics for which the appointment center does not make appointments, Dunn notes, and forward those to the appropriate place — an individual clinic or physician's secretary.

[Editor's note: Mica Dunn can be reached at dunnmical@uams.edu.] ■

Pay disparity, staffing still hot access topics

Consultant: Rethink 'promotion cycle'

After 12 years on the provider side of the revenue cycle, and another 12 in outsourcing or consulting, **James F. Heinking,** CHFP, FHFMA, finds that the health care professionals he meets and works with "keep talking about the same issues we had 24 years ago."

Chief among those are the large disparity in pay between patient access staff and their counterparts in other health care roles and the related difficulty in hiring and retaining employees with the skills to do an increasingly complex and challenging job, adds Heinking, executive vice president of Healthcare Financial Resources Inc., an accounts receivable outsourcing firm in Schaumberg, IL.

Whatever the setting, he notes, "we all struggle with employee issues: Who do we hire and what kind of training and assistance do we provide?" His personal recommendation, Heinking says, is that billing and collections and other back-end departments should serve as the training ground

for workers who would then be promoted to the position of registrar.

At the very least, he advises, give front-end and back-end employees the same status and compensation.

"Work toward integrating the front end and back end into a centralized unit," Heinking says. "Be creative, rotate management, and re-evaluate the promotion cycle. Either equalize or turn the pyramid upside down."

Additionally, he suggests, for someone (such as a well-trained registrar) who can "operationalize the diagnosis," use critical thinking skills and an acquaintance with medical necessity criteria to manage the patient's care, determine the corresponding financial liabilities and financial benefits that apply and comply with state and federal requirements, the pay should be about $30 an hour.

"[Employees] should be excited about being a registrar," Heinking says. The payoff to the organization for this upgrade, he maintains, would be a dramatic reduction in bad debt and increase in cash collections.

At the same time, organizations should "teach, teach, teach, train, train, train their patient access employees," he notes. "You will never lose money on providing new information to people who don't know what questions to ask."

The health care industry, unfortunately, is "in the Stone Age" where staff education is concerned, Heinking says. While there are independent schools providing structured training in medical terminology, coding, and claim preparation, he adds, they are too costly — typically $4,000 to $7,000 for a 160-hour course of study — and are not doing enough to fill the need that exists.

"How many times have we hired the best of the worst because there was an open position and we needed a warm body?" Heinking says.

Still, there are health care facilities that are making great strides in their operation by the effective use of technology, he notes. "If you can't improve the people, take the decision-making out of the process by getting wired."

Weigh all investment in technology, Heinking suggests, by determining whether it is vital to the operation: Will it decrease bad debt and increase cash collections?

'The good, the bad, and the ugly'

During a presentation in March to the Illinois Patient Access Management Association, Heinking — dressed as Clint Eastwood in the classic film — talked about separating "the good, the bad, and the ugly" in health care.

Most of the "ugly" issues, he points out, have to do with rules imposed by the government that providers have to follow. "EMTALA creates all kinds of desperate decisions and measures in the emergency department," Heinking says, while the Medicare "72-hour rule" — requiring the bundling of outpatient services with the inpatient claim if admission occurs within three days — is an ongoing threat to reimbursement.

Despite all that has been written and discussed about practices regarding the Medicare Secondary Payer (MSP) requirement, providers continue to struggle with its implementation, he notes. "I'm the primary caregiver for an elderly relative who receives services from a certain hospital," Heinking adds, "and not once have we had the MSP questions asked of us."

In one instance, a client approached his firm about taking on Medicare accounts more than 90 days old, he notes. "I asked why [the need existed] because Medicare pays within 14 days."

It turned out, Heinking says, that Medicare had the claims pending because they contained an accident code — a possible secondary payer situation — "and the hospital doesn't have that information collected."

"It should have been collected right away," he says. "MSP information *must* be collected."

His company's business model, Heinking notes, is if Medicare pays in 14 days, you shouldn't have an accounts receivable problem. "If you do, it's operational."

Heinking puts in the "bad" category such issues as staffing and employee training, as well as registration audits and other processes that are still done manually.

"It goes back to breaking down barriers," he says of automated technology solutions. "When you can reliably share information it helps improve staff's and patients' experience of care."

He advises providers to incrementally automate their operation and take action to "unify the members of the revenue cycle team, identify common goals, and work toward simplification of processes and elimination of rework."

The "good" centers around the people involved in health care, who are "some of the most dedicated professionals" in any field, Heinking adds. "Whether you're clinical or clerical, when you're dedicated, it's more than just a job. You've answered a calling."

He also includes on that side of the ledger the

opportunities for networking and support provided by the industry's professional organizations.

[Editor's note: James Heinking can be reached at jheinking@hfri.net.] ■

Is it chess or checkers? Management styles eyed

ID individual strengths, consultant says

As a manager, are you playing chess or checkers? That's the question posed by **Tony Coletta,** MS, PHR, an organizational development consultant for Chicago-based Advocate Health Care.

Much has been written about the need to take cultural and generational differences into consideration when creating and managing a team, Coletta notes, but he contends that what distinguishes a great manager from a good one is the ability to dig into the characteristics that make each employee unique.

In the game of checkers, he points out, all the pieces move in the same way, while with chess, each piece has a different move — and strategy is important. "The same thing applies to management skills," Coletta says. "A great manager knows where [an employee's] strengths are and how to use them."

While generational and cultural attributes "are something to pay attention to as a leader, focusing on a staff member's individuality is where the rubber meets the road."

The chess/checkers analogy and related ideas about the differences between great and average managers are from an article by motivational speaker, trainer, and researcher Marcus Buckingham in the March 2005 issue of the *Harvard Business Review*, he says.

Coletta has a background in human resources and organizational development, with a master's degree in industrial organizational psychology, and is certified in applying various types of personality assessments.

The Buckingham article, however, provided the inspiration for a more accessible way of employing those concepts — one that can be used effectively without certifications or specialized training, Coletta says.

"[Managers] don't even need to give these official [personality assessment] tests," he suggests. "Just take simple steps to identify employee strengths and weaknesses. In particular, focus on strengths."

Someone he considers to be a great manager, for example, "went above and beyond" to under-

Here's a quick look at generational work styles

Many health care organizations have at least three generations of employees at work. According to estimates by Rainmaker Thinking, a Connecticut-based research and management training company, the U.S. workforce looked like this in 2006:

- The generation born before 1946 made up just 7% of the workforce.
- Baby boomers, born between 1946 and 1964, made up 42% of the workforce.
- Generation X, born between 1965 and 1977, made up 29% of the workforce.
- Generation Y, born in 1978 and later, made up 22% of the workforce.

Here is a breakdown, from the Diversity Jobs web site (www.diversityjobs.com), of how those three generations respond to different elements in the workplace.

Competition and the chain of command:

- Baby boomers are typically very competitive at work and often described as the workaholic generation.
- Generation Xers want more work-life balance because they saw how hard their parents worked only to be downsized or reorganized out of a job.
- Members of Generation Y, sometimes called the Millennials, are averse to following the chain of command in the workplace. They are more likely to try and find the person in charge of a project and communicate directly with that individual.

Using technology:

- Members of Generation Y are the most adept at using today's technology. They're likely to text-message or e-mail their colleagues and superiors to communicate information.
- Gen Xers communicate a great deal of information through e-mail, but are not as comfortable sending text messages as their Gen Y counterparts.
- Baby boomers have become accustomed to using e-mail to transmit information, but enjoy communicating in person. ■

stand what drove each individual as she was bringing a team together, Coletta recounts. "She asked things like, 'How do you like to be recognized?' and 'What are your hobbies?'

"If a person said, 'I'm not one for public recognition, but, if in private I'm able to speak about what I did,' that resonates. [The manager] used that information," he says. "Other leaders use one-size-fits-all ways to recognize employees."

This manager was involved in a start-up and so assembled her team all at once, Coletta continues. "She even asked, 'Where are your favorite places to shop?' and then gave certain employees a $15 gift card for Target, as opposed to Wal-Mart."

While for some employees the most powerful trigger is recognition, for others, clear goals and a challenge provide the motivation, he says. "The challenge for me is to learn and develop, to be in situations where I can learn new things."

'Your best day at work'

Coletta suggests that managers ask a few simple questions during the hiring process: "What was the best day you had at work in the past three months, what were you doing, and why did you enjoy it so much?"

Whatever task is mentioned, he notes, it's a good bet the person will be happy doing a job that includes similar duties.

Then, Coletta adds, ask the same questions about the employee's worst day at work in that period.

"Say, for example, you want to hire a customer service representative, and the candidate says her worst day was when she was chewed out over the phone by an angry patient," he says. "Those two questions really show what energizes people and what drains their energy."

Understanding generational characteristics is a valid way to get a group moving forward, Coletta notes, "but you still may not have everyone at their optimal level of performance. While there are group commonalities — the older generation being loyal to the job, for example — if you dig in, you can find uniqueness. It's like the 'nature vs. nurture' debate."

Another issue Buckingham addresses in the *Harvard Business Review* article was the effectiveness of identifying a person's learning style, he says. Three ways of learning, which Coletta describes below, are identified:

- **Analyzing.**

An individual with this style learns by taking apart a system or process, he notes, and should be given ample time in the classroom to understand the model. "You want to give these people the manual and say, 'Come back with questions.'"

- **Doing.**

This kind of learner takes the trial-and-error approach, Coletta says. "They want to see how it works and adjust as they go along. Let them jump into the system in a test environment."

- **Watching.**

Just like it sounds, he adds, these individuals "want to see the behavior modeled — to watch somebody do it."

Almost a century ago, adventurer Ernest Shackleton led a group of 56 men in an attempt to make the first voyage on foot across Antarctica, Coletta says, and much of what he accomplished had to do with great management techniques.

"They got stuck in pack ice — a thousand miles from civilization — for 19 months, and he didn't lose a single crew member," he adds. "What got them through was his unique leadership style. He was able to assess each person's individual strengths and weaknesses and meld them together for the common good.

"Shackleton asked his men questions like, 'What songs can you sing?,' which could be thought of as wacky, but when times got tough, he could pull those out and was able to keep morale high," Coletta says. "He also understood that there were those who were technically competent but a pain in the neck, and he didn't let them mingle with the crew. As a great manager, he knew that the way forward was to understand what each person brought forward to create harmony."

[Editor's note: Tony Coletta can be reached at Antonio.coletta@advocatehealth.com.] ■

Initial claim accuracy crucial for SSA programs

Impact of baby boomers felt

Make sure you get everything right the first time.

That's certainly not new advice for patient access staff, but in this case it specifically refers to applications made for coverage of patients by the federal disability program.

With the first baby boomers having reached

early retirement age in January 2008, the Social Security Administration (SSA), which also administers the federal disability program, is feeling the impact of that "bulge of people," notes **Patti Thrailkill,** director of governmental affairs for MedAssist, an eligibility services vendor.

"Retirement claims have started hitting, and this group is also in their most disability-prone years, so there will be more of those claims coming from baby boomers," she adds. "SSA is absolutely inundated with work."

The agency has been under-funded for 30 years, Thrailkill says, and has 30% fewer employees than 12 years ago.

That's why initial claim accuracy is crucial, she says, and why the hospital's self-pay population must be screened immediately to determine eligibility for the disability program.

Medicaid, which administers the Supplemental Security Income (SSI) part of the federal disability program, pays from the date of application, Thrailkill notes. "Say a self-pay patient meets the eligibility requirements and is allowed under SSI. In order to get the date of service covered, you want the screening process to be such that the patient is screened and the application made on day one."

In addition, she emphasizes, access directors should make sure there is someone at their facility with a basic understanding of the process for filing federal disability claims. That could be a staff member if the claims are handled in-house, Thrailkill adds, or a vendor representative if the job is outsourced.

It is also important that as much information as possible be submitted electronically, she continues. "SSA is rapidly moving to an all-electronic disability claims environment and paper significantly slows down the process."

The Centers for Medicare & Medicaid Services (CMS) "has been beating this drum for many years and some hospitals have picked up on it, but a lot have not," Thrailkill says. Despite the national push for electronic storage of the medical record, she adds, "there are now more providers who have not reached that point than who have."

SSA will send a representative to the hospital to explain the process, Thrailkill notes. "It really is easy once there is an understanding, but there has to be someone at the facility that learns it all."

SSA has employees known as professional relations officers, she says, "who are out there trying to educate [providers] about using [the system] as efficiently as possible."

Her experience, she notes, is that most hospitals are outsourcing the process — whether locally or with one of the national eligibility services vendors — and that there are vendor representatives stationed on-site.

In those cases, Thrailkill says, "there is an electronic download every morning [as to] who's been admitted and where they've been admitted. The determination is made then on eligibility for coverage."

In instances where the process is not being outsourced, she adds, "what's probably going on is that there is some awareness that the application needs to be filed and someone will give the patient an 800 number to call."

"As soon as that patient gets out the door after receiving care," Thrailkill says, "getting [the hospital] paid is not at the top of the list. The process is intimidating and not easy to understand.

"For any [provider], how to get self-pay patients covered is a big deal," she adds. "Access folks have a lot to do with screening and the direction that paperwork will go. They need to jump on this right away."

The more help that is provided to the patient, the better, Thrailkill notes, and the quicker the process will go. She advises access staff to take these steps to facilitate the claim:

- Electronically transfer medical records as often as possible.
- Provide upfront medical records on the most severely medically compromised patients.
- Provide medical records on long-term inpatients.

It's more important than ever before that access staff make the effort to obtain federal disability coverage for their patients, she says. "State Medicaid programs are drying up, and local and state programs don't have the kind of money the feds do to improve the situation."

[Editor's note: Patti Thrailkill can be reached at pthrailkill@medassistgroup.com.] ■

HDHP-related deductibles too costly for many families

Costs could be thousands per year

Many uninsured households can't afford the out-of-pocket costs associated with health savings account-qualified high-deductible health

plans, according to a recent study by the Kaiser Family Foundation.

The study's authors found that fewer than half of households with one uninsured member had sufficient assets to cover an HSA-related deductible of $1,000; fewer than one-third could cover a deductible of $2,364; and fewer than one-quarter could cover an out-of-pocket cost limit of $5,000.

The percentages were even lower for households with two or more uninsured members, the study found.

"Although the premiums for HDHPs are more affordable than those for more comprehensive policies, HDHPs also expose enrollees to thousands of dollars in annual financial risk," the study's authors said. "This raises the question of whether lower-income families can afford to pay the relatively high cost-sharing required by these policies if a serious illness arises."

In another study, the actuarial consulting firm Milliman Inc. found that consumer-directed health plans reduce costs by only 1.5% after adjusting for their higher cost-sharing and healthier members.

The firm analyzed data from six employers with roughly 30,000 employees enrolled in consumer-directed health plans — high-deductible plans with access to a funding account. Few of the enrollees had access to information on the cost or quality of health care providers, the employers indicated.

Without such information, the authors concluded, CDHP savings are likely to remain limited to the reduced utilization expected from high-deductible plans. ■

Many eligible for help don't use public programs

Need for outreach, simplification cited

One in four people who lack health insurance in America are eligible for public insurance programs but do not enroll, including 64% of uninsured children, according to a recent report by the National Institute for Health Care Management Foundation.

Possible solutions include increasing outreach and education activities, simplifying eligibility determination, and facilitating the enrollment and re-enrollment processes, the report states.

Options for insuring those who are not eligible for current public programs include expanding public programs and strengthening private market options, the authors add.

"Key policy decisions around expanding public coverage include which additional categories of people should qualify and what income level should be used to determine eligibility," the report states. "Selecting an appropriate income threshold requires making judgments regarding the affordability of health insurance, and is greatly influenced by political and fiscal realities."

In a related development, a study on Medicaid and the uninsured released by the Kaiser Foundation found that a one percentage point rise in the national unemployment rate would increase Medicaid and State Children's Health Insurance Program enrollment by 1 million and cause the number of uninsured to grow by 1.1 million.

"As a new economic downturn unfolds, many states appear headed for serious budget shortfalls," states the study, prepared by researchers at the Urban Institute. The states' fiscal problems "warrant serious consideration as part of an ongoing national strategy to minimize the duration, severity and consequences of economic downturn," the study adds.

The poor health and shorter lifespan of the uninsured cost the U.S. economy between $102 billion and $204 billion in 2006, according to an earlier report by the New America Foundation.

That's at least as much as the public cost of covering them, and does not include the cost to society when medical bills go unpaid, the authors said.

That report updates estimates reported by the Institute of Medicine in 2000 to reflect growth in the economy and the number of uninsured.

An estimated 43.7 million U.S. residents were uninsured when interviewed during the first nine

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months of 2007, up from 43.6 million in 2006, according to the Centers for Disease Control and Prevention.

Based on the CDC's National Health Interview Survey, the estimate includes 6.8 million children. An estimated 54.5 million residents were uninsured for at least part of the year prior to the interview, and 31.2 million were uninsured for more than a year, up from 30.7 million in 2006.

An estimated 17.5% of privately insured respondents in that survey were enrolled in a high-deductible plan and 4.5% were enrolled in a consumer-directed plan. ■

NEWS BRIEF

OIG makes changes to self-disclosure protocol

The Department of Health and Human Services' Office of the Inspector General (OIG) has announced changes to the provider self-disclosure protocol (SDP), which health care providers use to voluntarily disclose self-discovered evidence of potential fraud, and to its process for resolving those cases.

In an open letter to health care providers, the OIG said the changes "are intended to provide an opportunity for providers to work with the OIG to more efficiently and fairly resolve matters appropriately disclosed under the SDP."

The OIG also clarified that providers should not submit disclosures characterized as mere billing errors or overpayments, as they are not appropriately addressed by the SDP.

Providers can avoid federal investigations of fraud by voluntarily disclosing self-discovered evidence of potential fraud through the SDP. ■

HIPAA Regulatory Alert

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

Computer hackers step up attacks on health care records

Why is health care information attractive to hackers?

An 85% increase in the number of Internet hacker attacks on its health care clients has been reported by SecureWorks, a security-as-a-service provider. The company says attempted attacks have increased from an average of 11,146 per client per day in the first half of 2007 to an average of 20,630 per client per day in the last half of 2007 through January 2008.

SecureWorks Counter Threat Unit security researcher **Don Jackson** tells *HIPAA Regulatory Alert* criminals are looking for additional places from which identifying material can be obtained and have turned to health care companies. "We've seen attacks level out at the normal targets such as banks and financial services companies," he says. "People are asking where else they can find information and are turning to job sites and health care providers. They're turning over another rock."

Jackson says the increase in hacker attacks is likely due to several factors. First, there is an increase in client-side attacks (attacks against employees' PCs). Another factor is that health care organizations have large attack surfaces that hackers can try to break into. Third is the volume of personal, identifiable information and health insurance credentials that are stored by health care organizations; the final reason is the valuable computing resources that are available to health care organizations.

Jackson says hackers often "go after the low-hanging fruit" — health care facilities can be easy targets because they often have open networks able to conduct many different functions such as billing, transfer of patient records, and communication with different physician networks. "Health care facilities have to be able to speak many different protocols," he says, "and so there's a lot more doors to guard to be sure controls are in place. If you don't evaluate properly, you may have the wrong controls in place."

Because health care organizations store a lot of valuable personal identifiable information such as Social Security numbers, names, addresses, age, and banking and credit card information, they are valuable targets, Jackson says. Information scammers can develop complete profiles on victims, making them ripe for identity theft. He says the increase in the number of attacks on health care systems correlates to an increase in the price being paid for data that are fraudulently obtained.

Growing market for fraudulent cards

Health care information is particularly sought after, he says, because the criminals can defraud health care providers if they are able to obtain insurance contract and group numbers. There is a growing market, he says, for counterfeit health insurance cards that is being fueled by the increase in health care costs.

Jackson says some criminals involved in bringing illegal immigrants into the United States supply them with complete identity packages that include health insurance cards.

Health care organizations usually have high-bandwidth networks with lots of PCs connected and operations that run every hour of every day. That level of computing resources makes health care organizations a very attractive hacker target because they not only have lots of PCs that can be harvested for valuable data, but the computers can be turned into spam bots that collect e-mail addresses from the Internet to build mailing lists. Also, the health care networks' high bandwidth and server computing power make them a prime target, giving hackers lots of resources in which

to run large phishing campaigns (attempts to acquire sensitive information), spam operations, etc.

Solid security plans needed

Jackson says implementing a solid information security and risk management program is a good step toward protecting a health care organization from hacker threats. "HIPAA compliance offers a good baseline," he says. "IT governance frameworks... provide broader guidance. These programs' ultimate product is a defense-in-depth system that matches the healthcare organization's business goals, risk profile, and regulatory compliance requirements."

According to Jackson, health care networks are often less protected than others because there are so many things to evaluate and analyze that those responsible for health information technology may not know where to begin.

HIPAA helped bring about a security culture in health care, he says, but that culture is still more mature in banks and the financial services industry.

"We see [health care organization] people doing their due diligence but not dedicating as much resources even though they have a larger attack surface," he says. "Most health care organizations need to have more people working in IT security than are in the same positions in the financial services industry."

[Editor's note: For more information, contact Don Jackson at (877) 905-6661.] ■

Tennessee sets up medical info exchange

The State of Tennessee has expanded an existing contract with AT&T to provide the country's first statewide system to electronically exchange patient medical information. Officials say the system is designed to securely transmit detailed patient information between medical professionals, allowing doctors to access medical histories, prescribe medicines over the Internet, and transfer images such as X-rays and MRI and CT scans.

"As patients, we really want our information to be available to physicians whenever and wherever it's needed," says AT&T director of health care marketing **Diane Turcan**. "And we certainly don't want to be copying paper records." She says the program is likely to be a model for other states and a springboard for interstate information-sharing networks.

To make the system work, AT&T is developing a private portal within the secure network it already provides for Tennessee state agencies. Doctors can use the system to remotely evaluate patients in rural areas who have less access to medical facilities. It also will link to the state health department for access to that agency's immunization and disease registries, death certificate processing, and medical license renewals.

Tennessee eHealth Council Director **Antoine Agassi** says the council and state legislature worked with AT&T to amend the current statewide network agreement so health care providers could tap into the network and purchase services at an attractive price.

"We're allowing doctors to leverage the state's purchasing power," he says, "and offering them a very sophisticated catalog of services. Doctors are not required to participate. But the state is offering them grants of $6,000 to help them get started. They can always choose not to participate, but we think we're offering very attractive pricing."

So far, Agassi says, the plan has been received enthusiastically by physicians and agreements were reached with 165 sites within the first 45 days. "We're very encouraged," he says. "The feedback has been tremendous."

Doctor fee less than local Internet providers

Doctors will pay between $100 and $750 per month, depending on the bandwidth they need. Agassi says that monthly fee is considerably less than they would pay local providers.

Privacy is a major concern for the system, Agassi says. It is running on a private network that has firewalls and will require authentication of the physician users.

Not able to wait for a national data standard to be adopted, Tennessee has published its own minimum data standards that will be applied to the program.

"We believe we have made this attractive enough that it would be difficult for someone in health care not to participate," Agassi says. "The incentives are so great they will really have to do it." ■

NCVHS: Individuals should have control over disclosure

The National Committee on Vital and Health Statistics (NCVHS) says the Department of Health and Human Services (HHS) should adopt a policy for the Nationwide Health Information Network (NHIN) to allow individuals to have limited control, in a uniform manner, over disclosure of certain sensitive health information for purposes of treatment.

A Feb. 20 letter to HHS Secretary **Michael Leavitt** says the NCVHS recommendation is based on several critical considerations, including protecting patients' legitimate concerns about privacy and confidentiality, fostering trust and encouraging participation in the NHIN to promote opportunities to improve patient care, and protecting health care system integrity.

"We have concluded that NHIN policies should permit individuals limited control, in a uniform manner, over access to their sensitive health information disclosed via the NHIN," the letter says. "Public dialogue should be undertaken to develop the specifics of these policies, and pilot projects should be initiated to test their implementation."

NCVHS says its goal in making this recommendation is to improve patient safety and quality of care while developing a network that is practical, affordable, and inclusive and that protects confidentiality of individual health information.

Development of networks of longitudinal, comprehensive, and interoperable electronic health records provides great opportunities for enhancing coordination of care, avoiding duplication of services, and improving health care effectiveness and efficiency, NCVHS says. But the electronic network model of health information exchange is a major shift from the decentralized, disconnected, largely paper-based health record system now in use. And there are significant implications for individual privacy and confidentiality due to this shift. "Unless specific, privacy-enhancing measures are designed into networks," the letter says, "individuals could have significantly less privacy than they currently have and that they may reasonably expect would continue with EHR networks. With proper privacy-enhancing measures, however, we believe individual privacy will be reasonably protected across the NHIN."

NCVHS said it had considered various options and concluded that affording individuals the opportunity to restrict the flow of their personal information by categories is the most promising alternative. It recommends permitting an individual to sequester information based on pre-defined information categories. Under this proposal, every individual would have the option of designating one or more categories for sequestering. If a category is selected, all of the information in that category, as the category is defined, would be sequestered. Individuals would not have the option of selecting only specific items within the category to sequester. For any category that is so designated, health care providers accessing an individual's electronic health record via the NHIN would not see any information in that selected category. Individuals would be given the option to provide consent to a health care provider to access the sequestered information.

NCVHS says it recognizes that individuals differ in their opinions on what categories of health information should be considered sensitive and also recognizes that designating particular categories, and, even more critically, defining information to be included in each category, will be a complex and difficult undertaking.

But NCVHS says it's important to make the effort and says having uniform definitions of sensitive health information across the NHIN will be critical to establishing a solution that works well in a society where people travel frequently and receive care from multiple healthcare providers.

Possible categories, NCVHS says, include domestic violence, genetic information, mental health information, reproductive health, and substance abuse.

Legitimate concerns have been raised about how sequestering categories of health information could affect medical malpractice liability, the letter says. NCVHS believes liability could potentially be affected in at least two ways. First, sequestration of critical information might cause providers to give less than optimal advice or treatment because critical information is not considered. And liability may also be implicated as a result of violations of confidentiality due to imperfect sequestration of data by a provider and the provider's system. NCVHS says the implications for liability deserve additional consideration.

Increase provider trust in records

NCVHS believes that, to the extent permitted by law or regulations, health care providers

should be notified when information is being sequestered to increase providers' trust in the record's contents. It suggests that if providers knew that patients could sequester information but they would not be notified, providers could never really trust that their records were accurate and complete, and would be hesitant to treat patients based oin those records.

"The inclusion of some notation that information is missing alerts a provider that caution and special care are appropriate," the letter says. "Furthermore, a significant advantage of the notation is that it provides an opportunity for providers to discuss with their patients concerns about the sequestration of information and the resulting impact on their health care."

NCVHS recommends procedures be put in place for emergency access to sequestered information such as instances in which an unconscious, delirious, or otherwise incompetent person is treated in an emergency department, physician's office, or other health care setting. If such a "break the glass" emergency access provision is used, NCVHS says, an audit trail should record the specifics of the incident and it should automatically trigger a review by the relevant privacy officer. In addition, the patient or patient's representative should be notified as soon as possible that the emergency access provision was used.

Once sequestered information has been accessed through a patient's authorization or emergency procedures, the information should still be treated as sensitive in future NHIN records exchanges unless otherwise consented to by the patient.

The letter says that if a provider accesses information that had been sequestered by the patient, the provider should be required in the future to ensure that the categories of information identified by the patient for sequestration continue to be sequestered when the patient's record is shared over the NHIN.

New care model

NCVHS says it recognizes that sequestering sensitive health information by category represents a new model of clinical care and various healthcare providers may be concerned about the implications of an incomplete record for patient care quality and this concern must be addressed. "More than technological solutions will be needed to make this new arrangement successful," the letter says. "It will require substantial public and professional education as well as policies and procedures that consider the medical, social, psychological, cultural, and personal factors in patient care."

[Editor's note: You can download the letter at http://www.ncvhs.hhs.gov/080220lt.pdf.] ■

Health IT national strategy still missing

The Government Accountability Office says that even though the Department of Health and Human Services (HHS) is undertaking a number of activities to pursue President Bush's goal for nationwide implementation of health information technology, it still has not developed a national strategy that defines plans, milestones, and performance measures for reaching the goal of interoperable electronic health records by 2014. "Without an integrated national strategy, HHS will be challenged to ensure that the outcomes of its various health IT initiatives support the president's goal for widespread adoption of interoperable electronic health records," GAO said in testimony before Congress.

Among the activities that have been undertaken, according to the GAO testimony:

- the Office of the National Coordinator has taken steps to advance the implementation of both outpatient and inpatient electronic health records;
- HHS' secretary has recognized certain interoperability standards to be implemented in federal healthcare programs;
- the Office of the National Coordinator has begun trial implementation of a nationwide health information network at nine health information exchange organizations across the country;
- the Office of the National Coordinator has released a summary report and toolkit based on the results of its privacy and security solutions contractor's work.

But, GAO says, given the amount of work yet to be done and the complex task of integrating the outcomes of HHS' various initiatives, it is essential that a national strategy for health IT be defined. ■