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INSIDE

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For Patients, Self-Registration Options Mean More Control and Speedier Care

If a department had all the available "bells and whistles" vendors are offering for self-service options, patients could completely bypass registration altogether.

"There is a big push to implement tools that allow the patient to be more in control," says **Patti Consolver**, CHAA, CHAM, FHAM, senior director of patient access at Texas Health Resources in Arlington.

It is not just vendors pushing the self-registration concept. Patients also want more self-service options in their registration experience. "Patients are increasingly aware of the gap between their everyday consumer experience and their healthcare experience," says **Howard Bright**, vice president of patient engagement at Livonia, MI-based RevSpring.

People have become accustomed to digital boarding passes for airlines, self-checkout at grocery stores, and one-click shopping. In contrast, the registration process seems hopelessly antiquated. In theory at least, it is now possible for patients to do it all themselves: scheduling appointments, paying balances, signing consent forms, and even setting up payment plans. "Patients could report to the service area on the day of the procedure, completely bypassing registration," Consolver says.

Patients soon could be in complete control of their registration, whether that happens over the phone, online, or through a mobile app. "Patient access needs to stay relevant as we get further into the digital patient experience," Consolver suggests.

However self-registration is introduced, patient access leaders need to keep a close watch on satisfaction. Whether patients will take full advantage of the option is an open question. Registering for surgery is not the same as buying an airline ticket. "Patients tend to want hand-holding during their healthcare journey," Consolver observes.

As patients handle more of the preservice work themselves, the role of front-end registration inevitably is going to change. "Patient access needs to get ahead of this, so they are leading the charge and not being pushed," Consolver notes.

Self-scheduling is convenient and saves time. "But patient access teams still need to cater to patients' preferences," says **Joe Polaris**, senior vice president of product and technology at R1 RCM, a revenue

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cycle management company based in Chicago.

A tech-savvy, overworked parent might want a self-service experience that does not include speaking to a live person. Others prefer a traditional phone or face-to-face encounter. Regardless of self-service gaining traction, patient access remains the "friendly and educational face of the organization, putting patients at ease and helping them navigate the complexities of healthcare," Polaris says.

The obvious question for patients who now have to input demographic and insurance information on their own: What's in it for them?

"Patients should be rewarded for self-registering because it reduces hospital workload," Bright offers.

People pay for the TSA precheck option because it speeds them through airport security lines. The same should be true for patients who go to the trouble of self-registering, says Bright: "They should be rewarded with a 'fast-pass' mentality, and be called back right away." Not everyone has the skills to self-register. Some people may have adult children or caretakers helping them.

"Ensuring that these third parties can participate in the registration process is essential," Bright stresses.

Patient access should "start collecting more patient data and do it as early in the patient journey as possible," says **Steve David**, RevSpring's vice president of patient messaging. Collecting current email addresses and home and cell numbers is necessary; so is learning the patient's communication preferences.

"Also be aware of guarantor, responsible party, and caretakers who may be involved in patient communications," David adds.

These data allow digital registration to become a reality. All these front-end processes must be connected to the back end and billing, David cautions: "Though in reality systems may be separate, it's one experience to the patient." ■

Many Patients Self-Register, But Registrars Still There to Help at One Chicago Facility

Recently, a medical center in Chicago added kiosks to some registration areas. The change went over well with most patients, but registrars remain to offer a friendly face and some help.

"One thing we are committed to is being available for our patients. Removing registrars from the area is not aligned with our core values," says **Kim L. Osinaike**, CRCR, director of patient access services.

About 90% of patients scheduled for radiology and imaging appointments now use self check-in. The patients already are preregistered; that is handled at the time the appointment is scheduled. "When they arrive, all they need to do is check in," Osinaike says. Registrars quickly take care of securing signed consent forms and collecting copays, and the patients are on their way.

Some, although not many, patients offered strong opinions on the kiosks, voiced via the comment section of recent PressGaney surveys.

"A few patients felt that it complicated their registration experience," Osinaike reports. Other complaints were more specific. "We've made some changes based on those

comments," says Osinaike. Specific examples include:

• **Some patients were OK using the kiosk, but just could not see the small font on the screen.** "One patient stated she had to get her glasses out of her purse just to see the lettering," Osinaike says. The department worked with the vendor to switch to a larger font.

• **Patients worried that someone behind them could see their personal information.** This was more about perception than reality. People standing in line were not really able to view anyone's information. Still, to make the experience feel more private, a privacy screen has been strategically placed behind the patient.

• **Patients thought the kiosk was unsanitary.** From the beginning, hand wipes had been placed near the kiosk, but apparently many did not always notice. Leaders put up a sign directing patients' attention to the hand wipes. "It encourages patients to use the wipes, and registrars continually wipe the kiosk down as well," Osinaike says. Kiosk check-in is just the first step for the department. Once Epic is fully implemented, patients can complete the entire registration process at the kiosks. For return patients, it will be a quick validation of demographic information and emergency contacts. They will be asked if their insurance has changed. "If so, the next step is to go to a registrar. If not, they'll go into a queue that expedites their services with the clinician," Osinaike explains. ■

Networking Expertise Elevates Revenue Cycle Employees — and Their Departments

Hospital employees in clinical areas have long recognized the value of networking with others in their field. Now more than ever, the same is true for their revenue cycle colleagues.

"It's important to stay attuned to what is happening in the industry, gain recommendations for technology, and share the great work our teams are doing with others," says **Becky Peters**, executive director of patient access at Banner Health in Mesa, AZ.

Gaining exposure to the wider healthcare industry can jumpstart individual employees' careers, and also their departments overall. "Providing these opportunities has taken our leadership team to a new level," Peters reports.

Over the past year, Banner Health's patient access leadership has strongly encouraged conference attendance. "This is an excellent way to network, learn best practices, and share feedback on new technology," Peters says. Here, she shares specifics on relevant recommended conferences:

• **For patient access leaders**: State and national Association of Healthcare Access Management (NAHAM) conferences (http://bit.ly/2NzhFx8);

• **For billing and financial leaders**: State and national Healthcare Financial Management Association (HFMA) conferences (http://bit.ly/2oGzVMU);

• **For any revenue cycle leader**: Health IT and other vendor conferences such as those offered by Epic (information on the upcoming Epic Users Group Meetings available at: http://bit.ly/2WwGAWm), Experian (information on their upcoming May 2020 Vision Conference available at: http://bit.ly/3378VVN), and Becker's Hospital Review (information on the upcoming 6th Annual Health IT & Revenue Cycle Conference available at: http://bit.ly/36jaqlP);

• **For team members who are on track for promotions**: Webinars hosted by various vendors and healthcare organizations.

At Banner Health, senior directors attend at least one national conference per year. Directors, managers, and supervisors attend local conferences throughout the year. Up-and-coming leaders submit topics for speaking engagements. "This helps them develop their presentation skills and executive presence," Peters says.

Becoming well-known in the field pays off. One senior director recently became vice president of the Arizona Association of Healthcare Access Management (AzHAM). Several directors have spoken at conferences for AzHAM and the Arizona chapter of HFMA.

The department pays conference fees and travel costs, with a big return on investment. Anyone who attends one is expected to share their newfound knowledge. "We require all leaders who attend a conference to present to the patient access service and revenue cycle teams," Peters says.

Leaders are also asked to implement at least one newly learned best practice. "Our senior directors have also been building a professional network of peers," Peters says. The department draws on the expertise of this group when implementing various revenue cycle projects.

Staying highly visible at conferences, whether as an attendee or as a speaker, engenders confidence in patient access leaders. "They are fully engaged in our improvement initiatives," Peters says. "They have seen what is available in the market from a technology perspective as well as business models."

Networking does not have to mean paying high registration fees. There are

plenty of free options to find people in the field. At Banner Health, patient access leaders are encouraged to create LinkedIn profiles. "This allows them to connect with other healthcare professionals across organizations," Peters says.

Carol Plato, vice president of revenue cycle at North Mississippi Health Services in Tupelo, says, "There are many methods of getting in touch with peers." She often attends conferences held by Medicaid and Medicare intermediaries. "These conferences are usually free and a good way to make contacts with peers," Plato offers.

Plato also asks technology vendors for contacts at other organizations who are using the same software or systems. If staff cannot attend a vendor conference, Plato asks for the attendee list. "You can then reach out to peers to ask questions," she explains.

Plato finds membership in research groups (such as Healthcare Business Insights) helpful for obtaining peer contact information. "They can be the intermediary and help you reach peers in the same type of cohort group," Plato says.

Hospitals may belong to some groups already, both for-profit or non-profit, that offer revenue cycle connections. Plato has found Vizient, a not-for-profit healthcare performance improvement company, a particularly good resource for this. "They can provide cohort contacts," she reports. ■

Patient Ambassadors Held to Same Standards as Five-Star Hotels

Charged with developing a registration process for the new NewYork-Presbyterian David H. Koch Center in New York City, **Brenda Sauer**, RN, MA, CHAM, FHAM, kept customer service top of mind.

She created an important and ambitious new role: patient ambassador. These employees, wearing distinctive grey suits and white shirts, are the first people arriving patients see. "No longer is the person going to see a registrar, because we are not checking in at a desk," says Sauer, director of patient access.

Patients still needed someone to assist them, identify them, and apply arm bands, allowing the patient to proceed upstairs to the clinical areas. The ambassadors do all of this with a friendly, welcoming demeanor. Twenty-eight people were hired for this new role. About one-third were employees currently working in the patient access department, one-third were hospital employees from other departments, and one-third came from outside the hospital. The mix was intentional. "When you start something new like this, having some new blood come in provides for a better team," Sauer explains.

For registrars, the ambassador role was a promotion on the same level as senior registrar. The job requires top-notch customer service skills, problem-solving, and standing for long periods. A typical encounter unfolds thusly:

- When patients enter the building, they are greeted by the patient ambassador and directed to the kiosk. "The ambassador is right there if they have a question or get stuck," Sauer says. Patients ask questions about the documents they are signing, want printed copies of the forms, struggle with moving to the next screen, or need a wheelchair.
- Once the patient is checked in, the ambassador verifies the patient's identity, places an arm band, and asks for a cellphone number for text updates.

Some wonder whose number they should give (usually, the cellphone of whoever came with the patient, so that person can go eat without having to wait around for hours).

A second ambassador is stationed upstairs, and offers a greeting and directions to anyone coming off the elevator.

"The expectation is that they know the building inside and out. They also know the hours to restaurants and what's open when," Sauer notes. Most people have become comfortable with the new process. However, at first, some seemed overwhelmed with the spacious building. Some patients wanted to go straight to their service area as they normally did, and asked, "Why do I have to check in here?" The ambassadors cheerfully explained that the process for check-in was centralized. "It doesn't please everybody, but now that we've been open for a year, patients have gotten used to it," Sauer says.

That has happened much more quickly for frequent patients, such as those who come to the radiation oncology department every day. "They have developed relationships with the ambassador. They make a point of greeting these patients by name," Sauer says.

Ambassadors offer casual, friendly remarks such as, "Mrs. Jones, it's good to see you again. Let's get you checked in and on your way as soon as possible."

"The level of customer service is very high," Sauer reports.

The ambassadors are highly satisfied, too. **Alexander La Salle** says, "It brings me joy to see a patient whose health may not be the greatest before treatment, but weeks down the line when all is complete they leave looking and feeling better than when

they walked in." Another ambassador, **Nashira Guerrero Duarte**, says the role's meaning goes deeper than just assisting with check-in: "My day-to-day goal is to be a new friend, and make things easier and pleasant for patients."

This patient-centric mindset is reflected on PressGaney and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. These surveys ask questions such as "Were you greeted when you came in?" "Did you feel welcome?" and "What was the ease of check-in?"

Previously, patients did not always connect all these interactions, which happened during preregistration calls, at registration areas, and on the date of service, with these specific questions. Since the ambassadors handle all the things the surveys ask about, it is easier now for patients to make those connections. "We always score very high on those," Sauer reports.

Family members who want to know the best place to find a latte during off-hours really appreciate the "concierge" feeling. "You take away that cold, 'nobody cares about me' feeling. People see, 'Somebody is watching out for me,'" Sauer offers.

For ambassadors, the challenge is to convey that feeling in a short period. "It's a 30-second connection. They need to instantly connect with the patient," Sauer notes.

When it comes to the ability to make people feel welcomed, ambassadors are held to a high standard: That of a five-star hotel. "In a nice hotel, everybody greets you," Sauer observes. "That's the experience that I want patients to have when they walk into the building."

One of the first concerns when creating the new check-in process was how to avoid gridlock. "We needed to arrive our patients as expeditiously as possible so they wouldn't be milling around in the lobby," Sauer recalls.

A decision was made to set up self-check in, using a kiosk. "But in order to do that, we had to have all of our patients preregistered," Sauer says.

Now, 99% of patients who come through the ambulatory care center are preregistered. "That can be something as simple as putting them on the schedule, and then we just check them in in the lobby," Sauer explains.

Each service area had to ensure their patients all are preregistered prior to the patient coming into the building. Some physicians were in the habit of telling their patients directly to just come in, bypassing the usual process. The doctor does not tell anyone, so the patient is not scheduled.

"They'll show up at the front door, and we can't find them in the system. But we have a process in place where we can just add them on, and get them upstairs," Sauer says.

Most service areas were preregistering most of their patients already. "We just needed to get them to do it all of the time," Sauer adds.

Patient access leaders explained the reasoning behind it. "A little information goes a long way," Sauer says. Administrative staff and clinicians realized that the new process was far more efficient. Since patients are in the system already, there are no delays. "They can go ahead and document. They can do the things they need to do," Sauer says.

Staff in the clinical service areas now have less to do. No longer do they check patients in, secure signed documents, or place arm bands. "My staff took over that process for them," Sauer explains.

When the center first opened, average check-in time was about three or four minutes.

"We are now down to about 90 seconds," Sauer reports. "Not only have our staff learned the process, most of our patients have, too."

Some physician practices in the health system used kiosks, but this was the patient access department's first experience with them. One major concern was the five different registration systems used to check patients in at various hospital areas. "We needed a system that would be able to talk to all of the downstream systems," Sauer says.

The ambulatory care center covers multiple different services, not just ambulatory surgery and endoscopy but also the infusion center, radiation oncology, and the GI physician practices. The kiosks now send information to all these registration systems. Patient access worked closely with IT to achieve this.

"We told them, 'This is the vision. We need to get from here to there,'" Sauer recalls. "And they did it." ■

Patients Will Compare Registration to Hotels, Retailers, and Restaurants

Fair or not, patients compare their registration experience with the check-in process at a nice hotel, making reservations at their favorite Italian restaurant, or the ease of buying a new sweater online. How would your department measure up?

"If you look at other industries, many times front desk clerks at hotels have had more customer service training than registration staff," says **Richard L. Gundling**, FHFMA, CMA, vice president of healthcare financial practices at Healthcare Financial Management Association (HFMA).

Gundling urges cycle leaders to "walk through their registration, admission, and preservice processes through the eyes of a consumer."

One obvious issue is that registrars are not used to trying to live up to the same service standards as employees in other industries. "Yet the registration staff is dealing with consumers with far more complicated needs," Gundling notes.

Until recently, hospitals focused solely on the clinical experience when considering patient satisfaction. "But to the consumer, the financial experience is very important," Gundling says. There are several opportunities for registrars to impress patients with great service:

• When giving a price estimate. The amount owed is going to be the same regardless of how the information is delivered. "When you communicate their financial obligation, do you do it with compassion?" Gundling asks.

It is not a good idea to wait for the patient to bring up the topic of financials; most will not. "Talking about money is uncomfortable for people, so the registrar should open up the conversation," Gundling suggests.

• When explaining healthcare benefits. Many people know next to nothing about how their coverage works. Even savvy healthcare consumers get confused by the terminology.

They are going to look to the first person they encounter (the registrar) for some help.

"It's probably the first time somebody's talked to them about their coverage," Gundling offers.

• When collecting. "A $2,500 deductible sounds abstract on paper until you need to pay it," Gundling notes. Simply asking, "Can you afford this?" is a good start. "That question is often like a relief valve. You are saying, 'How are we, together, going to solve this?'" Gundling explains.

If the patient says no, it opens the door for the registrar to offer some good options. "A lot of times, people don't have $2,500 at their disposal," Gundling observes. The patient may not realize a payment plan or zero-interest loan is possible, or that he or she might even qualify for financial assistance. The registrar could ask, "Would you like to complete the application to see if your income allows you to get a discount?"

Some patients experience sticker shock. They just need time to absorb the information and come up with a plan. It is possible that the patient may decide to borrow money, reschedule an elective surgery, or put it all on a payment plan. Many wrongly fear they will need to come up with the entire amount immediately.

"The idea is to communicate that it's not 'all or nothing,'" Gundling adds.

• When a patient is upset for any reason. The "customers" registrars are dealing with are not buying shoes or making a dinner reservation.

"Some are sick or injured or worried about their health. They are stressed and often scared," Gundling says.

Some really need a family member or friend with them when talking about a hospital bill, just as they do when talking about medical issues. Anxious patients often remember little of what a doctor tells them, Gundling notes: "The same is true of financial discussions."

On the positive side, a good encounter with a friendly registrar produces lasting effects.

"If they remember talking to the nice registrar about their $1,000 deductible, and they get a bill for $1,000, it takes away the feeling of being tricked," Gundling says. ■

Cost and Transparency Top Issues Facing Revenue Cycle

Cost and transparency are the leading challenges in healthcare today, according to a recent survey conducted by the HealthCare Executive Group (HCEG).

More than 100 C-suite and director-level executives ranked their biggest challenges. (http://bit.ly/2JIexhv) "We've talked about costs for decades, and it just keeps growing. But today we can really address costs," says **Ferris W. Taylor**, executive director of HCEG.

The switch from fee-for-service to value-based reimbursement is underway. But like many changes in healthcare, it is happening slowly. "We need to do more," Taylor says. "And if we don't, then outside forces are going to be imposed on the stakeholders in healthcare."

Surprise billing is one obvious example. It is a hot topic, both in the political world and in the regulatory environment. "Do we want the government to dictate what we do? Or, should we come together as an industry to figure out what we should be doing?" Taylor asks.

The question is really whether healthcare is able to change itself quickly enough. "Or, will the system be replaced in a way that may not be advantageous to consumers, providers, or insurers?" Taylor asks.

Registration, scheduling, and billing processes are not always patient-friendly. Revenue cycle professionals sometimes forget they are also healthcare consumers. Waiting 45 minutes for a three-minute doctor's appointment is just one example, Taylor offers. "It doesn't fit into the consumer's life flow at all," he adds.

The United States spends more than any other country on healthcare. "Yet the results we have are really not enviable," Taylor observes. "How much of that is because we haven't put on the consumer's hat?"

Outdated data and analytics are another obstacle. Many hospitals still use legacy systems that are not fully integrated. "We do not have common agreement around what data elements actually mean," Taylor notes.

Not too long ago, all the information that allowed providers to personalize healthcare was contained in a wall of paper folders. "We couldn't even consider how to change healthcare when everything was in those folders," Taylor recalls.

The fact that all this information is now available electronically makes big improvements possible for the revenue cycle — if the data are analyzed correctly. Recently, HCEG executives noticed something was amiss with data on healthcare plans. "It did not logically make sense," Taylor says. The problem involved a field labelled "member enrollment," which referred to the date the member first enrolled in the health plan.

It turned out that every time a member changed from one benefit design to another, the enrollment date changed. This made it look like members had enrolled in the health plan more recently than they actually had. "We lost the data we wanted to use because it had been overridden by something new," Taylor explains.

This kind of frustrating situation carries big implications for the revenue cycle.

"If we don't agree on mutually beneficial outcome measures, we are not going to improve the healthcare system," Taylor warns. ■

Revenue Cycle Needs Feedback From Patients and Family Advisors, Too

Patient and family advisory committees give valuable input at many hospitals. Often, though, the focus is on clinical processes more so than the revenue cycle, even though both matter to patients and families.

"The patient financial experience can make or break the way they feel about their clinical experience," explains **Jennifer Dyrseth**, MSITAM, CHAM, CHAA, CAC, patient financial services supervisor at Olympic Medical Center in Port Angeles, WA.

Previously, Dyrseth worked at an organization with a productive patient and family advisory committee. "I felt that it made me a more patient-centered leader," Dyrseth says.

When she found out Olympic Medical Center did not have a similar committee in place, Dyrseth contacted the patient experience team to see if she could help start one. "I was eager to get the ball rolling," she shares.

Today, revenue cycle leaders regularly consult the hospital's Patient and Family Advisory Council. "Both do important work," Dyrseth observes. "Together, they can make positive changes for patients." Here, Dyrseth offers some practices that can help revenue cycle departments get the most out of the committee's input:

• Ask the committee for feedback on something specific.

This is the only way to ensure attention is paid to a particular revenue cycle issue.

"A lot of these committees have a process where managers can fill out a form to request the committee review a certain topic," Dyrseth explains.

These committees have a chair and possibly co-chairs to facilitate meetings. "Reaching out to them is another, potentially easier way to get their attention," Dyrseth says.

• Ask for a seat on the committee.

Just because there is not a seat immediately available does not mean one cannot attend a meeting or two to show interest.

"Asking to sit in on meetings can help to make you next in line when one becomes available," Dyrseth suggests.

• Listen to feedback with an open mind.

"It's easy to start to put on blinders where you may notice something that's not patient-friendly," Dyrseth says. Her advice is to take the blinders off and "see the patient experience as if it were the first time."

It is not always possible to do exactly what the committee recommends. For example, they may express frustration with someone asking for the same information repeatedly. "Eliminating the process entirely is unrealistic," Dyrseth laments.

However, there can be a middle ground, with staff explaining why it happens. Telling the patient the registration process will only take about two minutes is another way to reduce frustration.

"This is both patient-centered and beneficial to the organization," Dyrseth says.

Recently, the hospital's central access department gave a presentation on the clinic registration process at a committee meeting. Members suggested telling patients that some of the information collected is required by federal guidelines, or because it is needed to make sure they are the right patient.

Revenue cycle leaders may receive feedback that sounds negative and overwhelming, that patients do not like their billing statements, that it takes too long to schedule a visit, or that they do not understand the importance of revenue cycle in the first place. Instead of taking a defensive stance, remember that this is a valid perspective, Dyrseth recommends: "Be appreciative of the time committee members are taking to review the process."

• Use a show-and-tell method.

Revenue cycle leaders will receive the best feedback only if the committee really understands the entire registration process. "In addition to telling them about the process, showing them a mock registration will help them get the feel of it," Dyrseth says.

Likewise, instead of just verbally describing the financial assistance process, handing the committee an actual application is better, according to Dyrseth. "Ask the committee to go through it with you," she advises.

Dyrseth attended a meeting during which the council reviewed the financial assistance application the hospital used. Members suggested using simpler language and shortening it. "They wanted to make it easier to understand and less tedious," Dyrseth says.

It is a mistake to sugarcoat revenue cycle processes. If a form includes confusing terminology, or a question usually is asked multiple times, it is important for the committee to hear about it.

"We don't want to hide anything from our council," Dyrseth stresses. "The more they understand the processes, the better feedback they can provide." ■

HOSPITAL ACCESS MANAGEMENT™

HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Avoid Most Common HIPAA Violations With Best Practices, Education

HIPAA breaches can happen even to the best prepared healthcare organizations, but knowing the most common failings can improve your chances of staying in the good graces of the Office for Civil Rights (OCR).

Organizations sometimes have a false sense of preparedness because they put policies in place and think that is enough, says **Lucie F. Huger**, JD, an officer, attorney, and member of the healthcare practice group at Greensfelder, Hemker & Gale in St. Louis. "I see a lot of technical compliance, but one thing I see organizations overlooking on a routine basis is the human element involved," Huger says. "Through those mistakes, even with the best policies in place, you can still be violating HIPAA. People get curious and click on links in phishing emails, which can be very dangerous to an organization. Or, I see it when people work too quickly and provide information about a patient to the wrong person."

Data management and restricted access can address some of the inevitable human failings that lead to HIPAA breaches, says **Jorge Rey**, CISA, CISM, risk advisory services principal at Kaufman Rossin in Boca Raton, FL, which provides business consulting and compliance services. If employees have limited or no access to protected health information (PHI), they cannot release it even accidentally, he explains. "We've seen a lot of healthcare institutions trying to limit the access that everyone has," he says. "They are becoming better at understanding where that data resides to prevent that unauthorized access. Laptops were a big issue for a couple years because data was not encrypted and data were being lost, but we've seen in the past couple of years that is becoming less common."

When training staff and physicians on HIPAA compliance, healthcare organizations should tailor the content to explain what HIPAA compliance looks like in the day-to-day work environment for that organization, says **Melissa Soliz**, JD, an attorney with Coppersmith Brockelman in Phoenix. Leaders should provide practical guidance on how to protect the privacy and security of health information, she says. "HIPAA trainers and educators often forget to cover some of the most basic HIPAA compliance measures that are most effective in protecting the privacy and security of health information," Soliz says.

She cites these examples of important points often overlooked:

- Reminding workforce members to not take any health information outside the organization unless it is necessary to do so and permitted by the organization's policies and procedures;
- Prohibiting workforce members from accessing health information systems through devices such as cellphones or tablets or storing health information on such devices that do not meet HIPAA standards or are not approved for use by the organization;
- Prohibiting workforce members from posting details about or pictures of patients in the workforce members' social media posts;
- Reminding workforce members that paper records containing health information cannot be disposed of in open garbage or recycling bins;
- Instructing workforce members on how to avoid cyberattacks, such as phishing emails;
- Informing workforce members of who to contact if they want to ask HIPAA-related questions, who to contact if they suspect there has been an unauthorized use or disclosure of health information, and where the organization's HIPAA policies and procedures are located.

It is important that the organization maintains robust privacy and security policies and procedures, Soliz says. Further, the organization should implement those policies and procedures through regular training, auditing, and enforcement. The most common mistakes employees make is individual carelessness, such as leaving paper patient records in an unlocked car, clicking on phishing links in emails, or inadvertently disclosing patient health information in a social media post about their

workday, Soliz says. "Educational efforts often focus on abstract privacy and security concepts without providing workforce members with sufficient context to understand how they can be HIPAA compliant within their work environment," Soliz says. "Providing workforce members with concrete examples of what HIPAA compliance and noncompliance looks like will enable organizations to avoid the most common errors."

Soliz cites a recent example in which a small dental practice paid OCR $10,000 as part of a corrective action plan arising out of the practice's response to a patient's social media review, in which the practice disclosed the patient's last name and details of the patient's health condition. *(Read more about this case at: http://bit.ly/2pPYg30.)* "OCR imposed a $2.15 million civil monetary penalty on a health system that lost paper records on over 1,400 patients, allowed a reporter to share a photograph of an operating room containing patient health information on social media, and had an employee who had been inappropriately accessing and selling patient records since 2011," Soliz says of another case. *(Read more about this case online at: http://bit.ly/2Pii0qI.)*

Training should be aligned with the organization's policies and procedures and it must be practical, says **Erin S. Whaley**, JD, partner with Troutman Sanders in Richmond, VA. Too often, organizations provide generic HIPAA training, she says. "The generic trainings are, at best, not based on the organization's policies and procedures and, at worst, inconsistent with the organization's policies and procedures. Customizing generic trainings will help ensure consistency and alignment with the organization's policies and procedures," she says. "Another pitfall is training on concepts instead of practical application of those concepts. By offering real-life examples and horror stories, organizations can help their staff and physicians recognize and avoid risky or noncompliant behavior."

One of the most frequent system-level oversights is failure to perform a complete annual risk assessment, Whaley says. Considering the number of cloud-based solutions, some organizations believe they can rely on their vendors to perform these assessments. However, these organizations are obligated to conduct a thorough assessment for all their systems, she explains. "These assessments may be informed by information from vendors but should not be delegated to the vendors," Whaley says.

In terms of individuals, the most prevalent mistakes usually are simple human error, such as losing a laptop, sending an email to the wrong person, or discarding PHI in the wrong bin, Whaley says. "There is still a surprising amount of paper PHI in practices. Paper PHI must be properly disposed of to ensure destruction," Whaley says. "Organizations should have a secure bin for discarded paper PHI, but the organization may only have a few of these secured bins throughout the facility. For efficiency, individuals sometimes keep a shred box at their desks so that they don't have to walk to the secure bin each time they need to discard a document, even though this may not be consistent with the organization's policies and procedures."

The individual may empty this "shred box" only occasionally when it is full, Whaley explains. If the cleaning crew inadvertently throws this box away in the trash or recycling instead of the secure bin, this could be a breach. Investigating and reporting this type of incident is difficult and completely avoidable, Whaley adds. When providing HIPAA education, it is important to ensure the workforce appreciates that management has bought in relative to compliance, says **Brad Rostolsky**, JD, an associate with Reed Smith in Philadelphia. Training should not be viewed as "something you just need to do," he says. "Beyond that, it's important to do more than provide a HIPAA 101 training," he advises. "Training should spend some time focusing on the actual policies and procedures of the business."

From a system perspective, one of the more common challenges is logistics, Rostolsky says. The bigger the entity, the more challenging it is to communicate information throughout that entity in a timely and efficient manner, he says. "It's important to ensure that a process is in place for the workforce to understand who in the privacy office needs to know what information and when they need to know it," he says. "A basic example of this would be to prospectively designate a particular individual to receive subpoenas, or even just requests for PHI, so that the requests are processed appropriately."

Individuals, on the other hand, often violate HIPAA merely because they do not fully appreciate that one person's action, or failure to adhere to what may seem like an annoying rule, can significantly affect a large business, Rostolsky says.

"To this end, part of training should include examples of where big dollar enforcement actions were triggered by the noncompliant actions of a single individual," he suggests.

Training also should be provided in different forms, says **Michele P. Madison**, JD, partner with Morris Manning & Martin in Atlanta. For example, there should be training at orientation, staff meeting reminders about HIPAA safeguards, and education about ransomware attacks. Healthcare organizations also can conduct phishing exercises to test employee response, sharing the results on an annual basis during the staff member's performance review, Madison suggests.

"One common mistake is providing an initial education forum at orientation and requiring annual review of an

online training program that fails to address the specific job functions or roles of the individual," she says. "The lack of specific and continuous training may not adequately prepare the staff member for his or her job and lead to a mistake that causes a breach."

Another common mistake is failing to provide continuous security awareness training, she says. Such training is a requirement of HIPAA, Madison notes, and technology is constantly changing. Therefore, the organization's security safeguards should be reviewed on a regular basis. Staff should be trained on the new and upgraded security safeguards as well as the vulnerabilities and risks associated with electronically accessing, storing, or transmitting PHI, she says. "[OCR] fines and penalties have focused upon organizations failing to implement a comprehensive security risk analysis. Failing to fully evaluate all mobile devices and the different access points to the organization's information technology infrastructure is a significant risk to the organization," Madison explains. "In addition, when the technology infrastructure changes, even to troubleshoot an issue, the risk assessment should be performed to identify any safeguards that need to be implemented as part of the change to the system."

Social media continues to pose a significant risk for HIPAA violations, says **Susan Tellem**, RN, BSN, APR, a partner with Tellem Grody Public Relations in Los Angeles, which assists providers with their responses to HIPAA violations. Instagram and Facebook create an easy medium for people to violate HIPAA, Tellem says. But beyond those channels, there are many ways healthcare employee can inadvertently disclose PHI and never even realize it, she adds.

"Faxing of some PHI is allowed, but a fax can wind up easily in the wrong hands," she says. "What if a healthcare professional is taking a break and decides to share a photo of what she is eating with an open patient file in the background? Photo sharing among doctors and patients is becoming more common and may be shared by accident." ■

Enforcement Action Follows Predictable Path, Starts With a Letter

A healthcare organization's involvement with OCR may begin with a simple letter acknowledging a complaint and providing guidance documentation related to it, notes **Elizabeth Litten**, JD, partner and HIPAA privacy and security officer with Fox Rothschild in Princeton, NJ. "Sometimes, [OCR] will send a complaint warning letter, knowing that it may be a one-off, but they want to make the covered entity aware and ensure it is complying with HIPAA," Litten explains. "Sometimes, they'll ask the covered entity to respond in some way, but, frequently, if they think it just involves one incident or individual, they will say they consider it closed but will be concerned if the problem persists."

For a more serious concern, OCR will assign a case number and ask for substantial information, such as policies and staff education records. Typically, OCR gives a 30-day deadline, but often will grant an extension if requested. "They may ask for documentation on what occurred, your policies and procedures, how you addressed the incident. They'll ask for very specific information, even financial information, to get a sense of who your business associates are," she says. "They may ask for specific names and titles of individuals involved."

The letter usually says that if an organization does not respond, that will be considered a violation of HIPAA. The course of OCR's response will be determined largely by the nature of the complaint, says **Emily Quan**, JD, an attorney with Weinberg Wheeler Hudgins Gunn & Dial in Atlanta. Impermissible use and disclosure is the most common type of complaint.

"With that complaint, typically, the covered entity will be asked for some information to review the complaint," Quan says. "[OCR is] looking at when this potential violation occurred, whether the entity is covered by the privacy rule, whether the complaint was filed within the usual six months, and whether the incident actually violates the privacy rule." The outcome can be tough to predict. OCR could determine there was no violation, or the agency could rule there was a violation, and levy various civil penalties. Quan says this is why it is vital to conduct a comprehensive risk analysis early. "This is a process that tends to snowball, particularly if this involves a massive health system or institution. There can be a number of offshoots from the investigation, with each one of them requiring time and resources to investigate."

There are countless HIPAA violations every year that are never detected or reported, says **Eric D. Fader**, JD, an attorney with Rivkin Radler in New York City. A media report may trigger an investigation, as with a recent case in which OCR fined a health system more than $2 million after reporters shared a photograph of an operating room screen that included a patient's medical information *(See previous article in this issue for more information.)*

"Sometimes, the OCR will begin an investigation after receipt of a complaint from a patient or other party," Fader says.

"However, I think most often, the filing of a covered entity's or business associate's own breach report with OCR will trigger the investigation."

OCR uses wide latitude when determining potential penalties. Generally, a breach or other HIPAA violation in and of itself will not result in an expensive fine. If the breach affects few people and was identified and corrected promptly, an investigation is less likely. Still, OCR has made a point of publicizing some tiny breaches, just to show that "size isn't everything," Fader cautions.

OCR usually has much less patience and understanding when the covered entity or business associate has not adopted required HIPAA policies and procedures, has not properly trained and retrained its employees (no less often than once per year), failed to conduct required periodic enterprise-wide risk assessments, or failed to investigate and report a breach timely.

The absence of a business associate agreement between a covered entity and its business associate or between the business associate and its subcontractor can compound the potential penalty. "Breaches happen," Fader says. "An entity that has taken HIPAA seriously and that investigates and takes corrective action promptly, and that doesn't attempt to deceive OCR or minimize the severity of its actions, has a good chance of getting off lightly."

Enforcement is not limited solely to the imposition of monetary fines, notes **Matthew R. Fisher**, JD, partner with Mirick O'Connell in Worcester, MA. Enforcement can include investigations, audits, requirements for corrective actions, and private lawsuits, although litigation will not fall directly under HIPAA.

It is difficult to find any pattern for when a fine will be imposed. If there is a particularly egregious violation or the organization can pay a substantial fine, then infractions may be more likely to result in a monetary penalty. "Additionally, OCR is increasingly focused on denial of access problems, which suggests more fines could be coming on that front," Fisher suggests.

An investigation may not necessarily make headlines, but it does affect an organization and take time and resources. For enforcement, OCR's primary options are monetary penalties and/or corrective actions. "Monetary penalties are imposed in few instances, but there does not seem to be any rhyme or reason as to when a penalty will be imposed. Corrective actions often consist of technical advice to help organizations better comply with HIPAA requirements," Fisher says. "Corrective actions will result quite frequently when an interaction occurs between an organization and OCR because some issue of noncompliance will likely arise. A corrective action is often collaborative and not punitive, as OCR wants to see good practices put into place."

Enforcement will follow a standard course of investigation, audit, discussion, determination of baseline issues, and then outcome. The first few stages will consist of document requests and a written or verbal back and forth. Often, the goal is to establish that efforts are in place for an organization trying its best. "Even with the best of efforts, mistakes or issues can arise. The good faith effort at demonstrating compliance will be a big factor in influencing the outcome of an investigation or potential issue," Fisher says. "If an organization is ignoring or deliberately not implementing a policy or procedure required by HIPAA, then issues will arise."

In an ordinary course, the timeframe for resolution of an issue will be a few months. OCR usually will send a document request within one month of a large breach report or an individual complaint filing. From there, an organization will have about two weeks to submit a response. Some time later, OCR will reveal the resolution to the organization. "That is the ordinary course. However, recent monetary penalties seem to take years from the underlying incident," Fisher observes. "There is no indication as to why so much time passes, though it could be that there is a lot of back and forth going on in the background."

The biggest impact on a potential outcome is transparency and taking good faith steps to comply with HIPAA. OCR recognizes that no organization can be perfect all the time. Still, so long as honest efforts are taken, OCR will be willing to work collaboratively.

Sometimes, the OCR investigation reveals relatively minor violations that can be corrected without significant penalties, says **Kimberly J. Gold**, JD, partner with Reed Smith in New York City. OCR may only seek corrective action in these instances. They may seek changes to an organization's HIPAA policies, procedures, and training. In more serious cases, OCR will pursue penalties in addition to corrective action. Criminal charges are seen less frequently. The course of enforcement typically is determined by how egregious a HIPAA violation is in the mind of OCR. "A data breach involving hundreds of thousands of individuals and underlying HIPAA violations, like the failure to conduct a security risk assessment, could trigger significant penalties," Gold warns. "Even the failure to execute business associate agreements has led to penalties. Less serious violations that can be quickly remedied are often easier to resolve without financial penalty."

In addition to cooperating, maintaining strong records (including documentation of policies, procedures, training, and risk assessments) will go a long way with OCR. "Should OCR investigate a large data breach and find no evidence of a risk assessment having been performed, or of any commitment to a HIPAA compliance program, enforcement will be more likely," she cautions. ■