Summer Training Report

Revenue Cycle Management
in the Healthcare Organisations

By

G Sai Sravan Kumar

MBA (Hospital and Health Management)

2019-21

ACKNOWLEDGEMENT

This opportunity I had at **Indian Institute of Health Management Research** was an amazing opportunity for my professional learning and development. I am grateful for getting a chance to work under the guidance of my mentor **Dr.Sandesh Kumar Sharma**, who guided my way throughout the research report. My extended gratitude for his valuable time, motivation and imparting me with his tremendous knowledge from the beginning.

TABLE OF CONTENTS

INTRODUCTION

Revenue Cycle Management (RCM) includes both logistical and clinical activities involved in the identification, monitoring, and receipt of revenue from health care programs.

Healthcare leaders have also focused on overlapping managerial and therapeutic roles to manage the sales process from start to finish. The vital information has traditionally been gathered and stored in three essential fields – Mid Sales Cycle Strategies, Patient Access Solutions, and Financial Management of Patient – to bill for rendered care.

Conventional wisdom indicates that innovation and productivity improvements generally offer better returns than any of the Chief Financial Officers would want, particularly in today's demanding economic environment.

We assume that emerging market pressures – including the increase of Patient Liability to Consumerism-propel the requirement to move through increasing sales growth to real change on the grounds of patterns defined by industry research and consumer inputs. It 's essential to split open silos and holistically link the patient's income process with payments and consider constraints that may contribute and expensive program breakdowns if ignored.

How do we define Patient-to-Payment?

Clearly stated, consumers are paying quicker and more accurately by simplifying complications and reducing regulatory pressure, both in and between the income cycle functions. It's all about helping organizations in the patient's journey with techniques and resources which contributes to sufficient which prompt reimbursement.

At the macro level, Patient-to-Payment aims to fully maximize the revenue cycle by addressing business challenges holistically throughout the continuum of the sales cycle. To achieve so, it is important to look at activities at any point in the cycle and their effect on outcomes and performance.

Generally, the front line of the RCM process, also known as patient care, includes preparation, enrollment, and financial approval. Throughout the center, like health information management (HIM) and honesty billing, lies fee selection, quality of clinical data, safety recording, case tracking, usage assessment, and other tasks. The RCM is supported by the billing system,

including the handling of requests, contract administration, rejection of payment, A / R follow-up, monitoring, and benchmarking.

Building a foundation

For the whole revenue cycle management process, **Patient Access** is the cornerstone across all functional fields. Front office approaches will reduce rework and denials, improve service points, and increase customer experience at the back end of the RCM cycle. Inaccuracies during the programming and processing will contribute to a serious collection of data and/or issues relating to finances, for the hospital and the patient.

Essential population details would be collected by health care agencies at the entry point for all patients:

- Identity Proof
- Employer
- Social Security number
- Date of birth
- Address

Patient Access is therefore liable for collecting the following important information on policies:

- Policy number and Insurance Company
- Reason for visit

The constructive start of the patient selection cycle is an important part of the obligation of a Patient Access representative. To order to continue to recover the POS expenses of the customer, payments have been increased and inventory minimized later to the business process.

Specific documents, including the issuance of financial clearances:

- Authorization of facilities dependent on knowledge transfer or pre-certification
- Validity and qualifications of dependent policies

Payment also called the collection of POS currency, involves:

- Financial liability collection (i.e. copayments, deductibles)
- Any relevant discounts to apply

- Pre-account balances resolution

In order to satisfy that public accountability and transparency requirements to ensure high-quality treatment at a competitive price, hospitals of many geographical regions of the US are now required to publish their pricing services lists. Today, the incremental process of patient access will enable patients to equate their services with others and provide reliable estimates.

The RCM process often begins with the compilation of forms and details to ensure that all federal and state laws, including:

- Recognition form for financial responsibility.
- Authorization to disclose information on protected health (HIPAA)
- Admission/procedure relationship for work-related injuries or car accidents
- Collection of Advanced beneficiary Notice (ABN)

The "Critical Middle"

In the center of the business process, detailed and accurate reporting, medical coding and paying procedures and graduate activities are recorded. Fully documenting the care of a patient at this stage could improve the results of the income cycle.

Diagnose(s), symptoms observed, therapy planned and implemented, care given, the outcome of treatment, and clinical evaluation of the treatment process are provided in detail in clinical documentation. "Unless it's documented, it didn't happen, as a general rule of thumb."

The accuracy of the data has been checked to maintain the seriousness of the condition and the reliability of care rendered by clinical record transparency. This move guarantees that the coding phase ends in alphanumeric codes that have a fair reimbursement. The quality of the labeling is dependent on reports from the vendor whether diagnostic or procedural.

Such coding forms may be interested:

- ICD-10-PCS (inpatient procedural)
- HCPCS (supplies)
- CPT (outpatient procedural)
- ICD-10-CM (diagnostic)

The simultaneous analysis of the records is critical because they lead to addressing any holes in company and service data in real-time.

The costs are often received in the center of the income period. Charges may be collected by suppliers or after treatment has been completed and reported by ancillary personnel, as a by-product of instructions submitted directly into the electronic medical record system (EMR). They can be inserted explicitly in the EMR in some situations.

One of the big difficulties in the middle of the sales process is to ensure the prompt, reliable, and correct receipt of all charges. When a program is not recorded or ambiguous explanations are used, reimbursement may be less than the right of one company to the services provided.

Typical charges reported include:

- Medications
- Health, medical and mental wellness assessments
- Labs
- Supplies
- Operations (medical, operative)

Although certain resources can be "bundled," they should be listed to guarantee payment.

Case management also exists in two fields that involve high warning facilities: residence period and designation of position.

Case managers preserve the quality of sales by focusing on issues, for example:

- Control of use
- Prep for release.
- Quality of treatment.

Case managers avoid expensive write-offs that hospitals may otherwise feel forced to bear by tracking issues relating to the length of stay and patient care designation.

Case-control proactive may have a beneficial impact on the sales process:

- Denials removal
- Sufficient refund and payment;
- Payment cost waiver
- Reduced stay time
- Lower remittances
- Expense per event upgrades
- Correct case mix index (relative patient diagnostic group (DRG) value)
- Improved medical efficiency for future admission

LITERATURE REVIEW

Hospital revenue cycle management here is referred to a detailed plan a hospital implements in order to increase the patient revenue and also performing the procedures relating to collection of revenue more effectively and efficiently. We must note that due to the unforeseeable changes in the connections among patients, suppliers, payers, and controllers who are portraying the social insurance framework, the manner in which hospitals oversee persistent Incomes and records receivable as it is a quite contrasting concept in firms in most dissimilar Ventures.

To begin with, clinics change from different firms in regards to managing their livelihoods. The cost paid by patients and untouchable payers are not always the cost which is paid by the medical hospital to run its operations.

Rather, emergency hospital bills for administrations dependent on the value data recorded in their charge aces however then award outsider payers generous limits as legally binding stipends. A typical clinic may have a couple hundred assorted lawfully restricting relationship with outcast payers, every one of which decides a substitute course of action of portion rates for explicit administrations. Emergency clinics additionally for the most part give some measure of free consideration to needy patients in the structure of noble cause care, for which they choose to do without income by and large. Therefore, the net patient revenues charges short the aggregate of authoritative remittances furthermore; noble cause care — that hospitals gain are a lot of lower than the charges charged.

Hospitals vary from firms in different industry in their way to deal with overseeing records of sales. Interests in records of deals are along these lines an operational requirement for Hospital and since most outsider payers are volume buyers, hospitals are likewise gone up against with the issue of attempting to remotely control the ideal installment of records.

Also, given the idea of the enthusiasm for emergency clinics, changes in clinical facilities' terms of credit are likely not going to stimulate volume and improve profit and clinics normally bring about all the expenses however determine hardly any, of the advantages related with the

expansion of credit. Along these lines, the substantiality of income cycle the board apparatuses and procedures used in various undertakings to the medicinal services industry is obliged. Or maybe, emergency clinic supervisors have made industry-unequivocal income cycle the board procedures and practices that license them to extend both the whole and the speed of determined salary combination.

OBJECTIVES

- To study the emergency hospital revenue cycle management rehearses.
- Assessing the effectiveness of revenue cycle management depends on identifying ways to measure the amount and speed of revenue collection
- Investigating the money related advantages of powerful revenue cycle management

METHODOLOGY

The scope of the paper is to provide recommendations for the major problems based on an in-depth analysis of these problems rather than to provide an extended analysis of all the issues facing the sector.

The paper analyzes the following sectors presenting for each:

- A historical perspective and the current scenario of Indian Hospital Sector as well overseas
- The major objectives of Revenue Cycle Management
- Interpretation.

Sampling Method : Convenience Sampling

Tools :

1. Ratio Analysis.
2. Trend Analysis.
3. Comparative statement Analysis

The interpretations are also printed graphically using trend line graphs and sub-dividing bar diagram.

Study Design : Descriptive

Data Collection: Secondary Data

- Includes Overseas data references.

DATA ANALYSIS

Payments-

A revenue cycle includes number of means by which a patient makes necessary arrangements to compensate himself. It incorporates front end office like arranging the game plan and checking the protection capability, distinguishing the assignments identified with clinical office, coding and charging catch and back end office like accommodation, recording the installments, taking care of the clarification and organization of dismissed cases. The level of knowledge you are having regarding this will legitimately impact your capacity to get paid with the great pace.

Various variables that influence the income in medical practice incorporate :

- Profitability of supplier

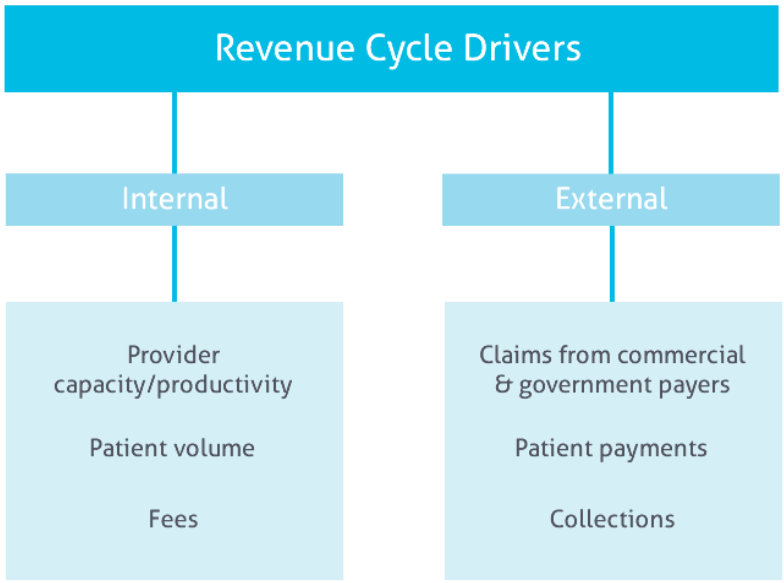
- Patient Volume

- Expenses

- Protection Cases (from both sort of government and private payers)

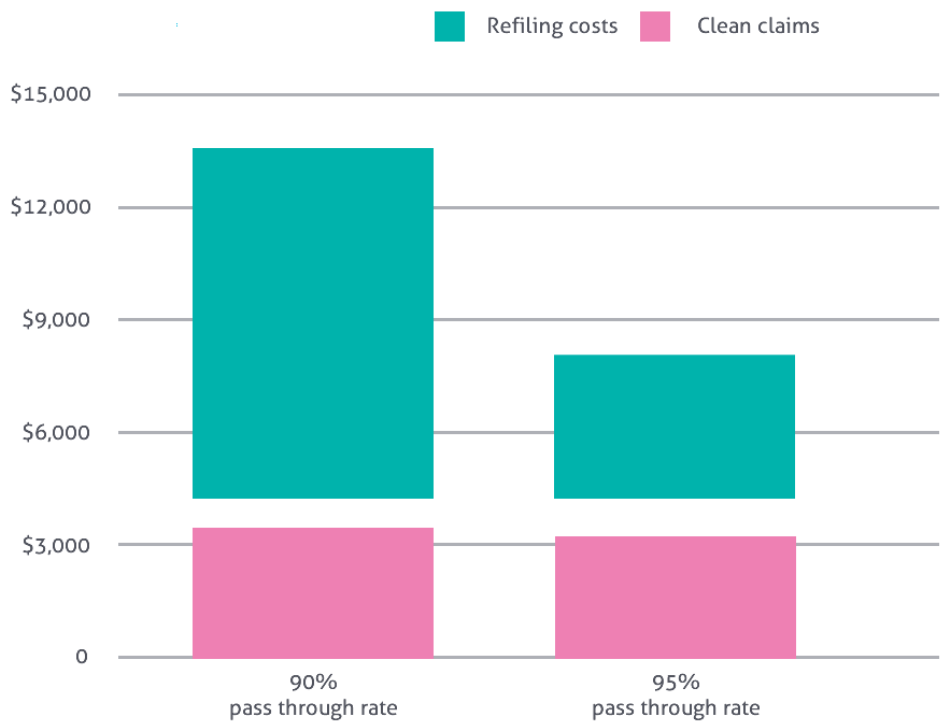
- Installments made by patients the two deductibles and self pay)

- Assortments from patients



On the off chance you think about your payment as a pie, it would incorporate whatever patients pay using cash in hand (counting deductibles and copays), just as repayments from payers for secured administrations. Compelling cases the management not just requires a plan how to ensure efficiency in arranging payers contract, however relies upon commonality with the mind boggling and exclusive standards of every insurance agency, information on right coding ,opportune documenting approaches and experience engaging dismissed cases.

Patients that pay beneath the planned rates or organization that never charge on account of certain viewpoints in the charging method can influence the income as cases which are submitted are not recognized by payers since they did not meet required payer need. Even well-greased practice billing capacity can encounter a cases failure pace of 10% on the first go, with significantly higher dismal rate with an increase in the number of patient visits. With a refilling cost of approximately $25 guarantee, claims arbitration can be a costly measure. Therefore, the better the case accommodation machine will be, the better will be your first pass payment rate and shorter will be the billing cycle.



** Data based on 4,000 encounters. Assumes $1/claim processing fee, and $25/claim refiling fee.*

Collections

There are normally two wellsprings of cash owed to your preparation:

- The receivables after insurance associations have paid their part, and
- Equalizations owed by patients for whom you never recorded security, at any rate who decided to pay using cash close by.

Post-insurance adjustments represent the quickest developing segment of medical practice, bad debt as indicated by an ongoing investigation of the U.S. medicinal services payments framework.

The balances payable by the patients for whom you never recorded the insurance acts as one of the huge piece of records receivable for most practices specially for those who picked to pay using cash in hand. According to a report if it's considered that 23% of total income is generated from self pay and if you gather just 60% of the total billings you might be denying your practice at around 14% of your complete revenue. Considering the pattern more inclined towards

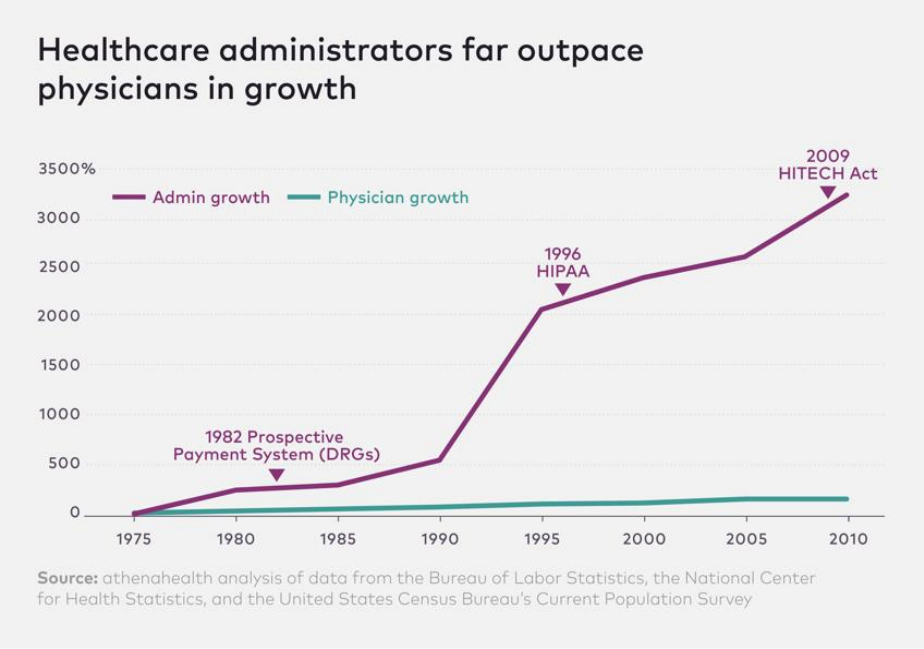
patients self pay this test isn't disappearing at any point in the future. According to the 2009 report by a research firm celent dependent on CMS projections demonstrate that probability of healthcare trouble would add up to $317000 part medical practice by 2014.

If the practice is done using the same way, at the hour of service 30% of the patients will not pay anything by any means. If it is considered that the medical administration is not able to calculate patient's budgetary obligation, past co- installments, until after cases are submitted and processed and chances are acceptable that you are not getting a good impression when the patient first gets through the entryway. There is more responsibility on the billing group to maintain the records for a standard of 42 days to effectively bill and collect revenue from patients. Best practices like insurance qualification check , collecting co-settles in advance, earlier approvals, overseeing referrals, just as having characterized monetary strategies set up and obviously imparting the patients who act as an instrument to get paid in cash payable.

RESULTS AND DISCUSSION

There are many different ways through which you can increase the degree of revenue from both the secondary sources such as patients and suppliers respectively and subsequently lower the parts of income that is payable as expenses. Following are the areas which are required to be the strengths for the organization in order to run effectively and efficiently:

Here clear growth can be seen in the market value. There is a year on 10% growth since 2016 and consecutively expected till 2021.



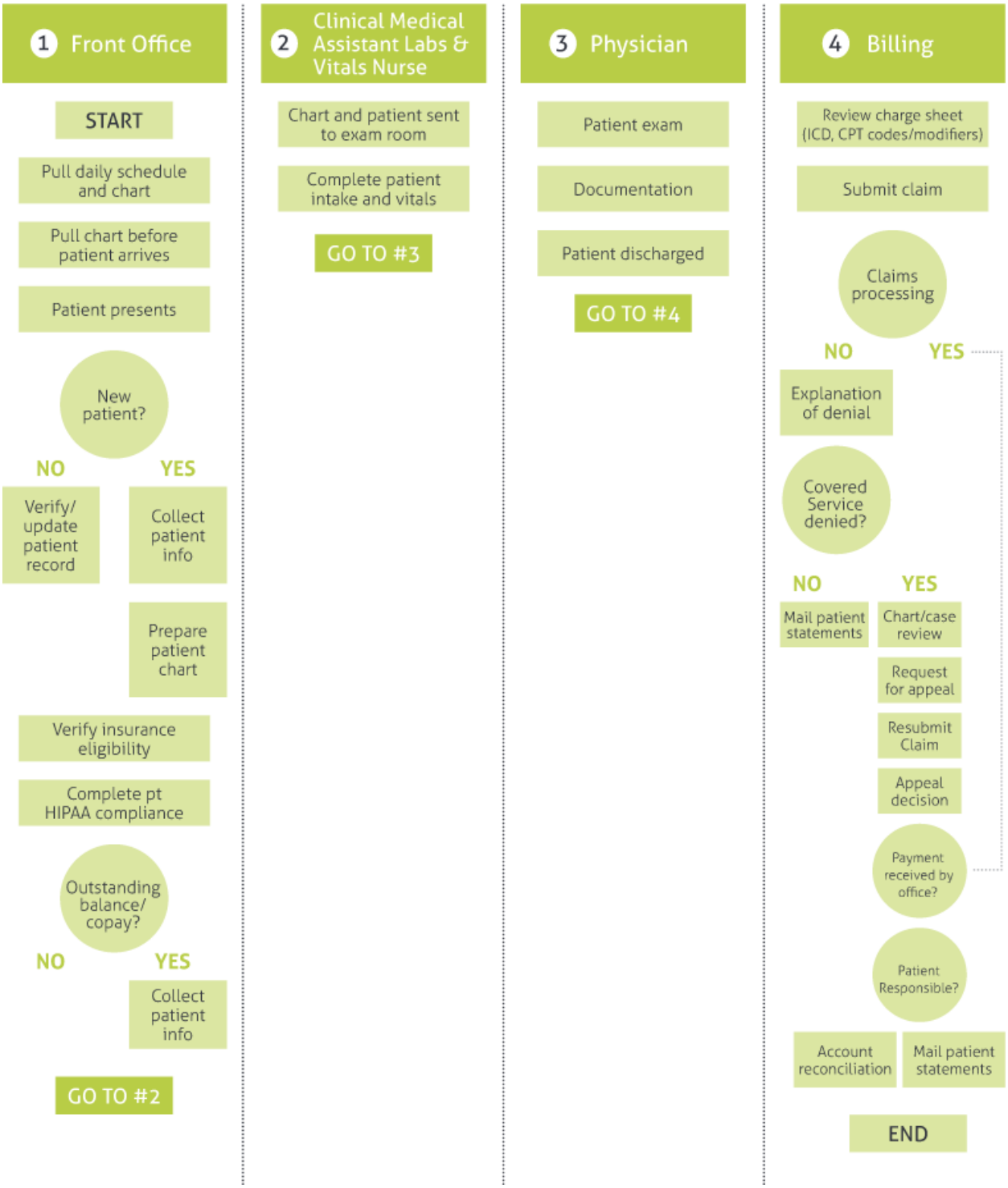
Healthcare administrators have been paid been paid supremely high as compared to physician growth which is flat. Admin growth saw a perpendicular rise in a 15 year time frame which sky rocketed the pay scale and revenue.

Work process

Strong front and back end office charging limit improves income as it makes time efficiencies, helps correspondence and keeps up a fantastic oversight of coding and other charging structures. For example the income cycle of executives work process shows the means for remembering the installment procedure.

Due to the prevalence of high deductible plans in the insurance market, patients act as the primary source for healthcare service providers to support the healthcare service billing. According to a report, it is demonstrated that around 68% of patients with health bills having a value of $5000 or less had not paid the full bills in 2016. The level of candidates has been increasing who failed to pay their full medical bill as there were 53% in 2015 and 49% in 2014 that didn't paid their bills.

Huge lagging in healthcare revenue cycle has been caused by delayed and poor paid patients financial responsibility. The healthcare organizations are exposed to the risk of never getting full payment for the services rendered by them. The responsible staff members utilize extra resources for contacting and collecting the bills from patients. Point-of-service or pre-service payment can be used to avoid such critical situation.


1 Front Office
START
Pull daily schedule and chart
Pull chart before patient arrives
Patient presents
New patient?
NO
YES
Verify/ update patient record
Collect patient info
Prepare patient chart
Verify insurance eligibility
Complete pt HIPAA compliance
Outstanding balance/ copay?
NO
YES
Collect patient info
GO TO #2
2 Clinical Medical Assistant Labs & Vitals Nurse
Chart and patient sent to exam room
Complete patient intake and vitals
GO TO #3
3 Physician
Patient exam
Documentation
Patient discharged
GO TO #4
4 Billing
Review charge sheet (ICD, CPT codes/modifiers)
Submit claim
Claims processing
NO
YES
Explanation of denial
Covered Service denied?
NO
YES
Mail patient statements
Chart/case review
Request for appeal
Resubmit Claim
Appeal decision
Payment received by office?
Patient Responsible?
Account reconciliation
Mail patient statements
END

CONCLUSION

In order to increase the profitability effectively, an organisation is required to focus on increasing revenue and lowering the cost. But in case of hospitals it is not an easy task to lower the cost. Healthcare setups, unorganized inventory and higher maintenance cost are a few challenges in a hospital industry. Also there are incidences of non performing resources in the healthcare organisation.

Technological up gradation like electronic health records that helps to perform medical functions more efficiently without any errors.

Higher patient satisfaction is another criterion which is helpful in generating higher revenue for the hospital. In simple terms if the patients are satisfied with the kind of services served by the healthcare organisation, they are likely to select that particular hospital the next time.

Understanding the revenue cycle management system is also necessary in order to have a sound healthcare setup. Analytical tools help the organisation to perform well which results in increasing the pace of revenue generation.

SUGGESTIONS

Use of Technology

Technology in the healthcare industry acts as an integral part to ensure better medical outcomes but also technology is having vast potential for a medical financial performance. Practice management system or an electronic medical record are some examples of health information technology that helps in optimizing patient's revenue.

Front office-

• Provider productivity has been advanced through automated patient reminders.

• Billing delays and denials can be minimized by verifying insurance eligibility electronically.

Patient visits-

• Electronic medical records helps in recording patient's information and recording other important documents.

• Efficiency in the billing process can ensure accuracy of the data which can be available at the required time without any delay.

Billing functions-

• Transfer of electronic claims to the clearinghouse within a short span of time.

• Checking of claims can be done to ensure that there is no defect before transferring it to the clearinghouse.

A Qualified Team

It's important to have a good team of individuals who can emphasize with patients and the difficult situation that others are facing. Communication is the core of many workplaces but it is even more important in the healthcare industry. Another important trait is a team member's attitude towards work. The way of handling stress should be effective which can be improved by conducting good stress management activities. Since demand for job, stress of teamwork, meeting with patients frequently, it is important to keep a positive outlook.

REFERENCES

1. Centers for Medicare & Medicaid Services. HIPAA Transaction and Code Set Standards; 2005. Washington, DC: US Department of Health and Human Services. Available at: http://www.cms.hhs.gov/TransactionCodeSetsStands/04_CodeSets.asp#TopOfPage. Accessed September 5, 2007.

2. National Committee on Vital and Health Statistics. Letter to the Honorable Tommy G. Thompson. November 5, 2003. Washington, DC: US Department of Health and Human Services. Available at: www.ncvhs.dhhs.gov. Accessed September 5, 2007.

3. Office of the National Coordinator for Health Information Technology. Consolidated Health Informatics Initiative. December 19, 2006. Washington, DC: US Department of Health and Human Services. Available at: http://www.hhs.gov/healthit/chiinitiative.html. Accessed September 5, 2007.

4. Healthcare Information Technology Standards Panel. Chicago, IL: HIMSS. Available at: http://www.ansi.org/standards_activities/standards_boards_panels/hisb/hitsp.aspx?menuid=3. Accessed September 5, 2007.

5. Addison K, Braden JH, Cupp JE, Emmert D, Hall LA, Hall T, Hess B, Kohn D, Kruse MT, McLendon K, McQueary J, Musa D, Olenik KL, Quinsey CA, Reynolds R, Servais C, Watters A, Wiedemann LA, Wilkins M, Wills M, Vogt NE. Update: Guidelines for Defining the Legal Health Record for Disclosure Purposes.

J AHIMA. September 2006;76(8):64A-64G.

6. HL7. EHR-S Functional Model, Release 1. Available at: www.hl7.org/ehr/index.asp. Accessed September 5, 2007.

7. Ibid.

8. Biesboer P, Pace MA. Partnering with Revenue Cycle for Success. Presented at: IFHRO Congress and AHIMA National Convention and Exhibit; October 2004; Washington, DC.

PART – 2

ONLINE COURSE REPORT

COVID-19 CONTACT TRACING

COURSE DESCRIPTION

In this Course we learn about the science of SARS-CoV-2, including the infectious period, the clinical presentation of COVID-19, and the evidence for how SARS-CoV-2 is transmitted from person-to-person and why contact tracing can be such an effective public health intervention. We get knowledge about how contact tracing is done, including how to build rapport with cases, identify their contacts, and support both cases and their contacts to stop transmission in their communities.

The course also covers several important ethical considerations around contact tracing, isolation, and quarantine. Finally, the course helps in identifying some of the most common barriers to contact tracing efforts - along with strategies to overcome them.

OBJECTIVES OF THE COURSE

- Describe the natural history of SARS-CoV-2 , including the infectious period, the presentation of COVID-19, and evidence for how it is transmitted.
- Define an infectious contact and timeline for public health intervention through contact tracing.
- Demonstration on contact tracing, isolation and quarantine considerations.

COURSE CONTENTS

- Basics of COVID-19
- Basics of Contact Tracing in COVID-19
- Steps to Investigate Cases and Trace Their Contacts
- Ethics of Contact Tracing and Technological Tools
- Skills for Effective Communication

LEARNING METHODOLOGY USED IN THE COURSE

- Video Lectures
- Readings

KEY LEARNINGS FROM THE COURSE

MODULE I (Basics of Covid-19)

- Basics of COVID-19, including the virus that causes this disease, some of the signs and symptoms of the disease, and how it's transmitted between people, origins of the virus that causes the disease we call COVID-19.
- The clinical signs and symptoms of COVID-19 and to be able to talk something about the risk factors for severe disease.
- Older adults who are over the age of 65 are much more likely to have severe COVID-19 disease than others. And those risks increase with age. So the older you are, the more likely you are to have severe disease. People who are obese also have an increased risk of severe disease.
- There are two kinds of laboratory tests you might hear about for COVID-19.
- One is a diagnostic test, and that test identifies virus that's in the body. It's called a PCR test, which stands for polymerase chain reaction. That's the chemical reaction that's done in the lab to look for the virus. It's also called a molecular test, and it gives us a sign that the virus is reproducing in your cells.
- Another kind of test is an antibody test. This test can identify antibodies to the virus usually in your blood.
- There are two major ways that SARS-CoV-2 is transmitted between people.
- If someone is infected with SARS-CoV-2, then the droplets that come out of our nose and mouth when we're talking, coughing and sneezing can have the virus in them. And those droplets, if they land on someone else's face, in their mouth, nose, or eyes, can infect someone else.
- The second way the virus is transmitted that you need to know about is through contact with surfaces that have viruses on them.
- People infected with influenza virus, on average, will infect two to three other people, if everyone they have contact with is susceptible. So a reproductive number

of 2 may sound small. But even a reproductive number of 2 can create a large outbreak if each infected person infects just two other people, the size of the outbreak doubles quickly.

- SARS-coronavirus-2 is a new virus infecting people and causing COVID-19 disease. The disease is causing a worldwide pandemic. Although some people never develop any signs or symptoms of disease when they're infected, other people are at very high risk for severe disease and death. People are at higher risk for severity of the disease and death if they are, older adults, or they have some other kind of pre-existing medical condition, such as diabetes or high blood pressure. There are laboratory tests that can be used to identify if someone has an active infection, or if someone has been infected in the past.

MODULE II (Basics of Contact Tracing for COVID-19)

- Every case of COVID-19 that's diagnosed requires action. We have to act, and there are a number of ways that we have to act. First, we need to support the person who is infected. It's important that we act to ensure that they have access to medical care and any social services they may need. They need to be able to access treatment.
- When we diagnose a case, we need to find them, offer them medical support, and also make sure they're changing their behavior to limit their contact with other people to reduce the risk of transmission. Next, we have to also identify all the people that they may have infected. We have to notify them about their exposure and offer them some social services that they may need.
- A case of someone who has COVID-19, someone who could infect others, usually this is defined by a positive laboratory test, a PCR test usually
- Sometimes we may refer to cases that are suspect or probable cases, which means they may not have had a test yet, but we think they probably have the disease.
- Isolation means keeping sick people separate from others, from healthy people, or any other person.

- Quarantine means restricting the movement and contact of healthy people who've been exposed with other people. So we isolate a case, but we quarantine contacts, because they've been exposed, and they could become infectious.
- High Risk Situations:
    - Dense contact environment
    - Difficult to contact trace and identify exposures
    - Difficult to isolate or quarantine
    - Higher Risk of infection and severe disease or death

- We can stop transmission of COVID-19 if we can identify cases and their contacts quickly and get them to a limit, stop their contact with other people while they're infectious. Cases should isolate themselves as long as they're infectious, and at least 10 days after they became ill. Contacts must quarantine for 14 days after their last contact with an infectious patient. And some cases may have close contact with many people because of where they've been or where they live. Some people may not be able to isolate or quarantine themselves, and these situations should be immediately reported to your supervisor because they require extra special attention and effort to stop transmission.

MODULE III (Steps to Investigate Cases and Trace Their Contacts)

- **The Basic Steps:**
    - Introduce yourself, and get their basic information.
    - Figure out the case's likely infectious period
    - Ask the case about contacts during their infectious period
    - Provide isolation instructions to the case, identify challenges, and provide support
    - Call case's contacts to inform about their exposure, ask about symptoms and give quarantine instructions.
    - Check in with the case and their contacts until their isolation or quarantine ends

MODULE IV (Ethics of Contact Tracing and Technological Tools)

- **Contact tracing:** Contact tracing is a common public health tool. It's important for stopping the spread of COVID-19. Contact tracing protects the health of people, because if we can limit contact between infectious people and others, we can limit opportunities for SARS-CoV-2 to be transmitted. Contact tracing is used every day to stop disease transmission. It's used for tuberculosis, syphilis, which is a sexually transmitted disease, HIV, and you may recall a large outbreak of Ebola in West Africa.
- **Privacy** is the right of a person to be free from intrusion or publicity and not released without his/her/their consent. A contact tracer can ask about, learn, and use private information, information from people's private lives, but only for protecting the public, only for contact tracing purposes.
- **Confidentiality:** The legal definition of confidentiality is the right of an individual to have personal, identifiable, medical information kept private, and not to be released without his, or her, or their consent.
- **Autonomy:** Autonomy legally means the right of a person to make their own decisions. It's also known as the right to self or an agency. And what this really means is that each person can make their own decisions.
- **Justice:** So the legal definition of justice is to act or to treat an individual justly or fairly, meaning that everyone should be treated the same way, independent of their race, ethnicity, creed, socioeconomic background, sexual orientation, or gender. Essentially, this means that everyone must receive the same treatment regardless of who they are.
- **Public good:** Contact tracing programs are an example of a public good, because they can reduce the risk to the public of being infected from SARS-coronavirus-2. They can reduce illness and deaths from COVID-19.
- In order for the public health intervention to be able to limit the rights of individuals to privacy or autonomy, as contact tracing can sometimes do, it must meet three tests or criteria. And these are that it must be respectful of individuals and their rights, it must be a benefit to society that is balanced with the limits on individuals, and three, that intervention must benefit all members of society.
- Respect for Privacy and Confidentiality during contact tracing

- Assure cases and contacts that the information provided will be confidential and used only for the public health investigation and will not be shared with anyone else.
- Assure cases and contacts that the information will be kept private- contacts identified will be told that they have been exposed, but they will not be told who the case is

MODULE V (Skills for Effective Communication)

- Rapport is a feeling of mutual understanding, trust, and agreeableness between people. At the end of the day, to be effective as a contact tracer, you will have to have a good rapport with the cases and the contacts that you speak with. If you are able to successfully build rapport with cases and contacts, then you'll be able to ask for and get accurate information. If you build effective rapport, you should be able to persuasively ask for them to follow isolation and quarantine instructions. Isolation and quarantine are difficult to do well. And if you have a good rapport with them, you're going to improve the chances dramatically that they feel like they can effectively isolate and quarantine themselves. So rapport is central to everything that contact tracers do.
- There are five question types, closed, open, probing, checking, and leading. A closed question is used to limit answer choices. Probing questions are an important tool, and they are used as a follow-up question to get more information about a person's response. A checking question is used to confirm that you heard correctly. Leading questions are typically ones that you want to avoid because they're guiding people into believing that they should answer in a certain way.
- **Active listening** is really important, because it tells the case or the contact that you're hearing them. It deepens your rapport with them, and creates space for them to tell you more details. Active listening will also help you develop a relationship that will be important for the future check-ins that you're going to have with them. Active listening means that you are making a conscious effort to hear a person's words and their underlying message without judgment.
- There's this idea that all communication between two people can basically be broken down into four types-- observations, feelings, needs, and requests. So an observation is,

without judgment, noticing what is happening for that person or for you. Feelings are when emotions are being expressed or felt or communicated by you or them. And those emotions could be fear, calm, annoyance, or joy. Needs are requirements for living a good life, like physical well-being, independence, safety, the need to be understood or understand someone else. A request is what you want from some other person or what they want from you.

- So within this communication framework, communication between two people is best when it includes empathic listening, active listening, and honest expression. In your conversations, we encourage you to think about every statement and what it's meant to convey.
- Despite your best efforts, there's no way around this, sometimes you're going to have issues with rapport. Sometimes, people will not want to talk to you. Sometimes people may not have known that their test was positive, and they may be caught off guard or be very scared when you tell them that their test was positive. Some people are impatient and may be tired by the length of the phone call and get annoyed with your questions, and some people with COVID-19 may not want to give you their close contacts phone number. These are common issues that you just need to be prepared for.