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AHC Media

Access Copes with Mass Shooting — Fine-tune Processes for Disasters

The patient access team at Orlando (FL) Regional Medical Center was informed a mass shooting had occurred only 10 minutes before patients started arriving, and it ended up registering a total of 44 people.

Ruthy Felipa-Daley, CHAM, CRCR, manager of patient access and revenue management, says "fear of the unknown" was the biggest challenge her team faced that day. "No one knew the severity of the patients until they reached on-site. We were not fully prepared to intake the amount of patients coming in." The hospital, part of Orlando Health system, is Central Florida's only Level One Trauma Center.

"PATIENT ACCESS WILL FACE A NUMBER OF THINGS THAT THEY LIKELY HAVE NOT ENCOUNTERED BEFORE."
— MICHAEL S. D'ANGELO, CPP, CHPA, SOUTH MIAMI HOSPITAL

Registrars' initial reaction was shock. "Once the team determined how serious the incident was, they were able to follow the proper protocol for registering patients" from a mass disaster, says Felipa-Daley.

For years, the patient access department participated in the hospital's annual mass casualty incident (MCI) drills to prepare for a disaster such as this one. "You are never are fully prepared for the

HAM focuses on disaster preparation

This month we have a special issue on challenges faced by access departments during mass casualties, including the mass shooting in Orlando, FL. Our cover story reports on how access employees coped that night. Inside, we offer tips on what access should do to prepare for any disaster, share processes for calling in more registrars, correct common misconceptions about privacy regulations, and share advice on how to protect access employees from harm. ■

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AHC Media

reality of such a tragic event," says Felipa-Daley. Here is how the patient access team coped successfully:

• Registrars were stationed at both entry points: triage and ambulance bay.

"The main goal was to properly identify each patient and prevent poor handoffs, to avoid delaying care," says Felipa-Daley.

The senior patient access representative onsite rounded throughout the ED to make sure registrars were coping and that all patients were captured and documented appropriately.

• The department used its established process for accurate registration of unidentified patients.

"The patient access team utilized our 'Doe' pre-registered accounts, and activated each account as the victims arrived," Felipa-Daley says.

Registrars used pre-printed labels with unique downtime numbers. "Accounts have Doe as the last name, with a unique first name. We use a rotation between categories of states, cities, and fruits," says Felipa-Daley.

Patient access pre-admits the "Doe" charts. **Mary Ellen Daley**, MHA, CHAM, CRCR, a patient access manager at Arnold Palmer Medical Center, also part of Orlando Health, says, "The ER maintains 50-100 pre-admitted charts using a naming convention specific to the facility."

ED registrars make packets in advance that include the "Doe" face sheet, labels, and armband. "We have a very specific protocol for our team during an event," explains Daley. "They work closely with our clinical partners to track the patients from intake to discharge."

One registrar activated the accounts and printed paperwork, while others tagged the patients with armbands. "The main focus was to make sure all patients were accounted for and properly identified," says Felipa-Daley.

An unexpected challenge occurred once patients were admitted. "There was little to no identification with the victims to truly identify their legal name," explains Felipa-Daley. "Our team had to use all internal resources, including nonverbal cues from patients, to properly identify them." Patients nodded or shook their heads when asked to confirm their names or dates of birth.

• An information hotline was established to accommodate the influx of calls regarding the event.

"The Orlando Health Community Relations team was on site and quickly set up a location for questions regarding patients and families," says Felipa-Daley. The hotline was monitored and answered

EXECUTIVE SUMMARY

After mass casualty incidents such as the recent mass shooting in Orlando, FL, patient access needs good processes to register unidentified patients and to call in additional registrars. Patient access leaders can prepare by doing the following:

- designating a separate area for registration;
- holding disaster drills during all shifts;
- reviewing security protocols and providing security training to staff.

by community relations and the hospital's Patient Experience team.

• Immediately after the event, the hospital made employee assistance program counselors available to all team members, including patient access.

"This created a safe environment for team members to express their emotions and feelings," says Felipa-Daley. In addition, patient access leaders held their own "touch base" meetings with staff. "These were informal," says Felipa-Daley. "We discussed anything the team wanted to talk about."

• Patient access counterparts from other hospitals called to offer much-needed encouragement.

Other patient access employees within the health system brought pizza and gift baskets to the team members at Orlando Regional Medical Center. "Currently, team members across patient access are volunteering to cover shifts, to allow our access team involved in the event some time off to process and heal," says Daley.

Michael S. D'Angelo, CPP, CHPA, director of security at South Miami (FL) Hospital, says that in the aftermath of any MCI, "Patient access will face a number of things that they likely have not encountered before."

Working alongside clinicians, ED registrars "will bear witness to the traumatic injuries commonly associated with terrorist events," says D'Angelo.

The biggest challenge he sees for patient access is finding a way to "better synchronize" the processes of registration and triage. "Under normal circumstances in the ED, those two processes flow together rather well," says D'Angelo. However, during a significant surge after an MCI, registration has a difficult time keeping up with the clinical staff.

One solution is to designate a separate area to be used for registration, such as an auditorium or educational room in the hospital. "Clinical teams in the ED drill for setting up alternate care sites or additional triage stations for MCI events," says D'Angelo. "Registration teams need to consider doing the same."

Appropriate identification and routing information on each disaster patient is critical for patients, staff members, and family members. **Thomas A. Smith**, CHPA, CPP, president of Chapel Hill, NC-based Healthcare Security Consultants, says, "Registration can play a key role in ensuring this key information is collected and appropriately entered into the EMR or other patient tracking system."

Here are some ways patient access can prepare for MCIs:

• Hold mass casualty drills during all shifts.

The mass casualty drills at Orlando Regional Medical Center previously were held during traditional business hours. The department now will hold them on different shifts. "Expanding the core hours of the exercise will ensure everyone has the exposure of an emergency intake event," says Felipa-Daley.

• Have an emergency contact list that is readily accessible, to bring in more staff.

Orlando Regional Medical Center's ED patient access supervisor used the department's phone tree list to contact the team, informed them of the situation, and told them they were on standby in the event additional coverage was needed. "Luckily, we were fully staffed the day of the incident and were able to perform our duties without additional staffing," says Felipa-Daley.

• Build a close relationship with the hospital's security department.

Smith suggests providing patient access staff with quarterly security-related training. "Assign a staff member to be the designated liaison with security and emergency management staff to work on and improve routine and emergency plans," he suggests.

• Routinely review security protocols regarding reporting suspicious activity, criminal behavior, and emergency response plans, including bomb threats and active shooters.

"Security is much more challenging if we only look at one aspect," Smith says. "To be effective, it must be layered and include many disciplines."

• Have a greeter direct patients.

During site visits to hospitals, Smith often sees patient access "multitasking in the extreme, with customer service, giving information to visitors, registration, and wayfinding."

Instead, Smith likes to see each visitor entrance have someone greeting and directing people to the appropriate area for service, especially during off-hours. "It is good customer service, not to mention added security," he says. ■

SOURCES

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Prepare Your Patient Access Areas For Challenges that Come after a Disaster

Patient access will face these challenges in the aftermath of mass shootings or other mass casualty incidents (MCIs):

• There will be a surge of people arriving at the hospital.

After an MCI such as a shooting, "we would implement a closely managed vehicle and pedestrian circulation control plan," says **Dan Yaross**, MSM, CPP, CHPA, director of security at Nationwide Children's Hospital in Columbus, OH, and chair of the Healthcare Security Council at the International Association for Healthcare Security & Safety, a Glendale Heights, IL-based organization for healthcare security, safety, and emergency management professionals. The plan includes signs to direct families and visitors to a few doors with security officers, as well as other staff members, present to provide assistance and maintain order.

An outside area can be used to verify the identity of arriving family members. "It's a challenge when you have masses showing up and trying to control that," says Yaross. "It can initially begin as uncontrolled chaos, until the facility implements its circulation control plan and locks down most of the normal entry points."

• Patient access will need to cooperate with law enforcement.

Law enforcement typically takes over the facility during the incident and will interview anyone even remotely involved, says **Richard Sem**, CPP, CSC, president of Burlington, WI-based Sem Security Management. "They definitely will talk with patient access staff, if they were in or near the incident," says Sem. "Also, being frontline staff and gatekeepers, there is a chance that attackers may have earlier passed or interacted with patient access staff."

Michael S. D'Angelo, CPP, CHPA, director of security at South Miami (FL) Hospital, says that when victims are transported from the scene of the event to the hospital, "we create an extension of the crime scene."

Victims' injuries may contain material evidence. "There is no doubt that many of the victims who are alert will have eyewitness recollection of some of the events leading up to the attack," says D'Angelo.

Although investigative agencies recognize medical care is a priority, patient access must understand that law enforcement needs immediate access to victims, says D'Angelo. "We have gone so far as to have detectives 'scrub' into surgery so they can be there when evidence is removed from a patient," says D'Angelo.

• The hospital will become the focus of intense media interest.

During emergency preparedness drills at South Miami Hospital, media sites are set up. "This minimizes their intrusion into regular hospital areas and from maneuvering their way through regular hospital operations," says D'Angelo.

D'Angelo recommends having the hospital spokesperson make hourly visits to the media site. "This aids greatly in gaining their cooperation with staying in this designated area," he explains.

• Processes are needed to identify victims.

"In our jurisdiction, the identification of victims from any mass casualty, terrorism, or criminal incident would be done by the medical examiner's office," says D'Angelo.

A family reunification center would be set up to help people locate their family members, whether hospitalized or deceased, and patient access would assist in directing people to this location.

The location of South Miami Hospital's family reunification center is already identified and is included in its disaster drills. "Patient access, as well as all other staff, should be aware of its location during an actual event," says D'Angelo.

• Patient access employees will need counseling/debriefing.

Sem emphasizes that MCIs are traumatic for all employees, not just clinicians. "As part of the recovery phase, it will be essential to provide counseling and other support to all, including patient access," he says. ■

EXECUTIVE SUMMARY

Patient access needs strategies to cope with a surge of visitors, as well as interest from law enforcement and media in the aftermath of disasters.

- Verify the identity of arriving family members at an outside area.
- Instruct registrars to cooperate with law enforcement.
- Have processes in place for identification of victims.

SOURCE

- Dan Yaross, MSM, CPP, CHPA, Director of Security, Nationwide Children's Hospital, Columbus, OH. Phone: (614) 722-2126. Email: Dan.Yaross@nationwidechildrens.org.

Members of the Patient Access Department Are 'Most Exposed and Most at Risk'

Richard Sem, CPP CSC, president of Burlington, WI-based Sem Security Management, has performed security and violence management assessments at dozens of hospitals and clinics. Thirteen of the assessments were done after "active shooter" incidents occurred.

"While much attention has been given to the high-risk areas such as ED and behavioral health, I usually find the patient access staff to be among the most exposed and most at risk," says Sem.

He has interviewed hundreds of patient access employees. "I hear their concerns and fears," says Sem. "They usually can relate stories of people becoming aggressive and threatening and even coming across the counter at them."

Most importantly, "staff need training on recognizing early warning signs of violence," he says. *(See list of warning signs enclosed in this issue.)* These include patients who: are irritable or agitated; make verbal threats; attack objects, such as hitting walls or banging fists on counters; pace; stare; have intimidating body language, such as clenched fists; argue with others, including family members; or have raised voice levels or change tones. "These early indicators present a higher level of concern if two or more are demonstrated," says Sem.

Sem says the training should cover:

- de-escalation techniques;
- how and when to report concerns;
- safely managing threatening behavior;
- what to do in the face of an active threat.

"The most powerful, least costly, and most neglected of security measures is fostering a strong level of protectiveness, vigilance, awareness, ownership, and engagement by all staff, including patient access," he says.

Sem notes that would-be terrorists tend to "scope out" a facility and test its security long before an attack. "Properly trained and vigilant patient access staff may be able to spot and report such behavior," he says.

Thomas A. Smith, CHPA, CPP, president of Chapel Hill, NC-based Healthcare Security Consultants, has provided security services at a community hospital, an inner city medical center, and an academic medical center.

"In my 36-year career, I have always collaborated with the front-end staff to enhance the security program," he says.

Smith has seen many adverse events averted because patient access staff members reported suspicious or criminal behavior. Some examples:

- individuals with weapons;
- individuals asking to "see the babies" without being able to provide the name of a patient;
- intoxicated persons;
- persons who appear disoriented;
- suspected patient elopement or wandering;
- violations of visiting policies;
- disturbances such as domestic violence or other inappropriate behavior.

"Sometimes, it's just something that does not seem right," says Smith. "Front-end staff need to know what to report and who to report unusual or suspicious circumstances to."

Failing to report suspicions can result in dire consequences. "On a few occasions, concerning behavior went unreported — or was reported, and then was not appropriately investigated by appropriate authorities — and these inactions were contributing factors in tragic incidents," says Smith.

Patient access provides an added level of safety by being alert to unusual behavior, Smith emphasizes. "Know the processes for reporting and gaining assistance from security and/or local police," he says.

When someone comes to visit an admitted patient at Columbus, OH-based Nationwide Children's Hospital, he or she provides a driver's license and is given a photo stick-on ID badge and keycard giving access to the hospital elevators. The visitor's information is run through a federal database of sexual offenders.

Daniel Yaross, MSM, CPP,

EXECUTIVE SUMMARY

As the first people the public encounters, patient access staff need training to recognize early warning signs of violence. Employees should do the following:

- Be alert to unusual behavior.
- Know the processes for reporting and gaining assistance from security or law enforcement.
- Work with security if a visitor is potentially dangerous.

CHPA, the hospital's security director, says, "When the admitting person finds out the person is a match, they discreetly notify us." Yaross is also chair of the International Association for Healthcare Security & Safety's (IAHSS's) Healthcare Security Council. Security staff members then verify the person's identity, and they confirm whether the system's match to the sexual offender database is accurate. "We check the person's demographics with what is listed in the database, as well as the county's criminal records system," says Yaross. If it's valid, security works with nursing, social workers, and the hospital's legal department to determine if the visitor is allowed on the unit, and if so, whether he or she is escorted by a security officer. "It's a pretty restrictive process that many children's hospitals have in place now," says Yaross.

Security planning should address how physically exposed the patient access staff is, Sem says. "These are frontline staff and often the first healthcare staff the public deals with," he says.

Jeffery Young, CHPA, CPP, president of the IAHSS, says the physical environment of registration areas should have security "designed-in," with barriers between patient access staff and the public. "There are many subtle architectural strategies that can be deployed that still look and feel welcoming," says Young.

If registration areas are situated at an entrance, Young says access needs the ability to quickly "lock down" the area. "The organization should have emergency preparedness plans in place that consider both: being the location of the incident and for the receipt of casualties from the incident location," he adds. ■

Look for Early Warning Signs of Violence

A patient, family member, or visitor who may be becoming violent might exhibit physical signs, according to **Michael S. D'Angelo**, CPP, CHPA, director of security at South Miami (FL) Hospital, who developed a program titled "Healthcare Workplace Safety: Recognizing and Responding to Aggressive Behavior."

These physical signs include the following:

- red-faced or white-faced;
- sweating;
- pacing, restless, or repetitive movements;
- trembling or shaking;
- clenched jaws or fists;
- exaggerated or violent gestures;
- change in voice;
- loud talking or chanting;
- shallow, rapid breathing;
- scowling, sneering, or using abusive language;
- glaring or avoiding eye contact;
- violating your personal space. (They get too close.) ■

Patient Access Staff Needed to Register Patients in Aftermath of Mass Shooting

Examine processes to call in additional registrars

Only a handful of registrars were on hand at 1 a.m. when the first victims arrived at University of Colorado Hospital on the night of the July 2012 mass shooting inside a movie theater in Aurora, CO.

Not all patients arrived by ambulance. About 20 came by police car or private vehicle. "The patients arrived in groups or one at a time. There was not a 'known' number to expect," says house supervisor **Paige Patterson**, RN, BSN, who oversees the patient access department.

To address sudden volume surges in the future, some employees were cross-trained to do the registration process at the ED entrance/ambulance bay. "The ED registration is specific, but our general registration staff are able to assist with emergent registrations," says Patterson. "We have only used the non-ED registration staff during disasters and disaster drills."

On the night of the 2012 disaster, however, this process was not yet in place. "We did not have an on-call list for registration," adds Patterson. "Staff just called those whom they thought could come in."

The department was able to get some additional registrars in to register patients and help in the command center. "A call list would have been helpful, because we had some staff say, 'If you had called me, I would have come in,'" says Patterson.

On the day of the 2015 San Bernardino, CA, mass shooting, having a group of employees cross-trained to register ED patients was

greatly helpful to registration manager **Elizabeth Mendoza** at Loma Linda (CA) Medical Center. "We had to get staff to register anywhere from five to 20 people at a time," Mendoza says.

Several years ago, the hospital's financial counselors, insurance verification, and customer service registration representatives were cross-trained to do ED registration. "When we need help, I buddy them up with my staff. That is how we train them," says Mendoza. In addition to shadowing ED registrars, financial counselors come work in the ED during system downtime to keep their skills fresh.

Though greatly helpful during last year's mass casualty incident (MCI), the cross-training wasn't done just for disasters. The same process is used for any other sudden surge of volume that occurs in the ED, with cross-trained staff called in about twice a month. "Once we get the page that we have a possible MCI coming in, we contact our other registration areas to get assistance, or we call in people early," Mendoza says.

Not all registrars are comfortable working in the ED setting. "They are not as comfortable with seeing these types of patients," says Mendoza. "We need people who are able to step in and help us, who can do our job the exact same way we would."

Some employees give it a try, but are simply not suited for the ED setting. "We've had people turn around and say, 'I tried it, and this is not for me,'" says Mendoza. Others found they wanted to work in the ED setting. "I have hired employees from other areas after they've come down to help us and have really liked it," says Mendoza. *(See related story in this issue about how patient access coped after the mass shooting.)* ■

EXECUTIVE SUMMARY

Patient access departments at University of Colorado Hospital and Loma Linda University Medical Center coped with sudden volume surges in the aftermath of mass shootings. Patient access managers say these things would have helped:

- an on-call list for registration staff;
- cross-trained employees to come register ED patients;
- drills to test how well medical record numbers follow patients through the hospital.

Top Challenges for Access after CO Mass Shooting

Here are some of the challenges patient access faced on the night of the 2012 mass shooting inside an Aurora, CO, movie theater:

• Patients arrived who were not part of the shooting but needed emergency treatment.

"Trying to separate the different groups was a challenge," says **Paige Patterson**, RN, BSN, house supervisor at University of Colorado Health.

Some patients from the shooting were ambulatory and arrived through the ambulance bay. "These patients self-triaged and went to the waiting room to wait their turn," says Patterson. "Patient registration was able to register them in the waiting room, alleviating congestion in the ED trauma area."

Because some patients were accompanied by someone or were alert enough to provide names, staff were able register them using their real names instead of coded "disaster names" such as Disaster 123. "This helped track the patients for the tri-county command center," she says. "It is difficult to notify families when the actual name is not used."

Disaster registration packets were available for staff to use that contained quick lab check-off sheets, disaster patient order sets, and registration bands. "Once the patients were registered in the ED, we controlled patient flow through TeleTracking software" manufactured by Pittsburgh, PA-based TeleTracking Technologies, says Patterson. All patients whose names were unknown were labeled as "Disaster." Labeling patients as "Disaster" allowed patient access staff to monitor their status during their entire hospital stay. "It designated them as a victim of the disaster, differentiating these patients from the ones admitted during the same time," explains Patterson. This system allowed media relations staff to give an update to the media as to the number of patients still admitted and their clinical status.

Patient access created a list of all patients, demographics, diagnoses, and assigned physician teams for the hospital and regional command center.

The hospital now is regularly holding virtual mass casualty exercises in addition to full-scale exercises to test how well registrars enter disaster medical record numbers. "How well the medical record numbers follow patients through the hospital is another concern," Patterson says.

• A flood of people called looking for family and friends.

By 5:30 a.m., the hospital established a dedicated phone line for the community to call. "We activated an old number just for this. We pulled staff from registration, operators, and volunteers to man the phone lines," says Paterson. The hospital's media team distributed the phone number to news stations.

Registrars manning the call line were given minimal instructions: to confirm who was calling and why. "They were able to verify if the patient was admitted," says Patterson.

• Registration staff members were in need of counseling and debriefing, just as the staff members in the clinical areas were.

At first, the registration staff members were unaware of the facts of the shooting. "As they were registering patients, they were hearing about the shooting," says Patterson. "They had to keep their own reactions in check."

Registrars are accustomed to having a gunshot victim in the trauma room and receiving information from the ambulance team. "Without an ambulance team, they were gathering information form the patients who were lined up on gurneys in the hallways," says Patterson.

The chaos and traumatic injuries took an emotional toll on the registrars, who later watched news coverage of the shooting. "Staff had to reconcile their role with the whole of the event, how the event was more than they realized at the time. Some questioned what more could they have done," says Patterson.

For several weeks, the hospital's psychiatric department and chaplains conducted grief and debriefing sessions for staff members, including patient access members. "Having attended a counseling session or two, it was incredibly healing to hear the stories of our peers attending to the needs of our patients," says Patterson. *(See related story in this issue about how the hospital handled intense media attention after the shooting.)* ■

'Overwhelming' Media Attention Placed on Hospital after Shooting

After a 2012 mass shooting occurred inside a movie theater in Aurora, CO, University of Colorado Hospital experienced an "overwhelming" amount of media interest from news outlets across the nation and around the world, recalls spokesperson **Dan Weaver.**

"More than 6,000 news stories specifically mentioned University of Colorado Hospital in just the first five days after the shooting," says Weaver. Additionally, President Obama came to meet with hospital staff, patients, and family members. "This brought the White House press corps and additional media interest," says Weaver. "Though we brought in extra media relations help, our team was overwhelmed."

Media staff were flooded with emails and voicemails. "It was impossible to read and listen to all the messages, let alone respond to all of them," says Weaver.

A specific media staging area was designated outside the hospital. When possible, experts used this area to talk with news outlets.

> "MORE THAN 6,000 NEWS STORIES SPECIFICALLY MENTIONED UNIVERSITY OF COLORADO HOSPITAL IN JUST THE FIRST FIVE DAYS ..."

"Media was allowed inside the hospital, but only when escorted by a member of media relations," says Weaver. One journalist was found walking around the inpatient units trying to interview victims and was escorted out of the hospital by security. "Additional security at every entrance helped ensure no media outlets were entering our hospital without an escort," says Weaver.

The media interviewed many patients and family members. "Our media relations staff worked to ensure their wishes were being followed," says Weaver. "All signed HIPAA releases before any interviews or information releases occurred."

One unanticipated outcome was that many people came to the hospital with gifts and cards for victims. "Many of these well-wishers asked to visit the injured patients," says Weaver. University of Colorado Hospital's volunteer services department collected the gifts and thanked people for visiting, but did not allow members of the public to visit any patients.

"Security screened all gifts, and patients or their families were asked before any gifts were delivered to them," says Weaver. ■

Does HIPAA Apply in Disasters? Registrars Can Say More Than They Realize

A frantic woman runs up to an ED registrar after a mass shooting to ask, "Is my son here?" Many registrars believe that if they answer this simple question, it's a violation of the Health Insurance Portability and Accountability Act (HIPAA). This belief isn't correct, says **Kirk J. Nahra**, JD, an attorney specializing in healthcare compliance at Wiley Rein in Washington, DC.

After the Orlando mass shooting, says Nahra, "hospitals seemed to think they couldn't tell anyone anything. That is clearly not true." If the hospitals told people, "Under law, we are not permitted to give out any information," this is false, he emphasizes.

"We can fault hospitals who say 'I'm not permitted to answer any questions,' because that's clearly not the right answer," says Nahra. Stating, "We are not going to give out any information," is more accurate. While hospitals aren't required by HIPAA to give information, says Nahra, "it's just not very empathetic and not very helpful."

In the confusion of a mass casualty disaster, registrars typically refuse to give any information because they're unclear about exactly what they're allowed to say. "In contexts like this, sometimes it's easier to just say 'no,'" Nahra says. "Hospitals may feel it's clearly safer to say nothing. Saying nothing can't violate the privacy rule."

There is no need to take this hard-and-fast position. "There is clearly more room to be responsive to inquiries," Nahra says. "Nobody from HHS [the Department of Health and Human Services] was going to penalize somebody for trying to be helpful in this situation."

Even if a registrar, when trying to answer a frantic family member's questions, inadvertently discloses some protected health information (PHI), such as a patient's HIV status or the fact that a patient was intoxicated, it doesn't necessarily rise to the level of a HIPAA violation.

> STATING "WE ARE NOT GOING TO GIVE OUT ANY INFORMATION" IS MORE ACCURATE.

"If you let it slip in the course of answering questions of a parent, nobody's going to hit you for that," says Nahra. "HHS — and this isn't true of all regulatory agencies — tries really hard to tell when you are trying to do the right thing when you made a mistake. And they are very good at that."

Where Are the Problems?

Problems occur if the same issue occurs repeatedly and no training was given to staff, says Nahra. Also problematic is behavior that's particularly egregious, such as posting a patient's medical records on the Internet in case a parent is looking for them.

If the patient isn't at the hospital, a legitimate answer is, "we don't have a patient registered in that name."

If the patient is at the hospital, "the HIPAA rules are pretty straightforward," says Nahra. If possible, the registrar should obtain permission from the patient to discuss his or her condition. If the patient is unable to give permission, healthcare providers — or patient access staff members, if they're the ones fielding the question — should do what they think is reasonable in the particular situation. "There is lots of room in the rules to exercise appropriate professional judgement," Nahra emphasizes.

What if the person asking about a patient isn't a family member but, instead, a good friend? "If what I say to them is, 'I think she's going to be OK,' is HHS going to have a problem with that? I really doubt it," says Nahra. Problems are more likely to occur if the registrar spoke in detail about the patient's STD or drug overdose, he explains.

EXECUTIVE SUMMARY

In the aftermath of the Orlando shooting, some hospital employees wrongly assumed they couldn't give out any information about patients due to the Health Insurance Portability and Accountability Act. Patient access employees should know the following:

- The law is more flexible than most people realize.
- Providing information about a patient to family members after a disaster doesn't necessarily constitute a violation.
- For an investigation to occur, someone has to complain.

There probably would be no way for a registrar to verify an individual's actual relationship with the patient in the aftermath of a disaster anyway, notes Nahra. It could be that an individual claims to be a patient's spouse and obtains detailed information on the patient's condition. "If it turned out they just got divorced, and it was nasty, I can't guarantee HHS isn't going to look at it. But historically, I *can* demonstrate they have never looked at that," says Nahra.

The patient would have to complain to HHS.

"As long as you made a reasonable judgment, HHS isn't going to nail you for that," says Nahra. If investigators found that patient access staff had no training, and that registrars made the same mistake repeatedly, the hospital could have a problem, he explains.

HHS is sensitive to the likely reaction of other hospitals if one is penalized for giving out information during a disaster. "If there is a penalty issue because one hospital answered some questions, I guarantee you nobody will ever answer those questions again," says Nahra.

Lack of Training

As a result of the Orlando shooting, says **Jay Hodes**, president of Colington Consulting, a Washington, DC-based firm specializing in HIPAA compliance, "hopefully, there is now more awareness of permitted disclosures under HIPAA."

HIPAA was not intended to prevent treatment conversations from occurring and impede the care necessary for a patient, Hodes emphasizes. "When there is confusion, it tells me healthcare staff did *not* receive the proper training to fully understand what is permitted," he says.

Abner Weintraub, an Oregon City, OR-based consultant specializing in HIPAA compliance, points to several guidance documents from the Office for Civil Rights that address this issue. "Medical providers, hospitals, and clinics have *far* more freedom and discretion to lawfully share patient data than most people realize, as these documents make abundantly clear," says Weintraub. (Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care *can be accessed at http://1.usa.gov/28N0H8V. Also see related story in this issue on what patient access can disclose to law enforcement.*) ■

SOURCES

- Jay Hodes, President, Colington Consulting, Washington, DC. Phone: (800) 733-6379. Email: info@colingtonsecurity.com. Web: http://colingtonsecurity.com.

What Can Members of Patient Access Staff Disclose to Law Enforcement?

Jeffery Young, CHPA, CPP, president of the International Association for Healthcare Security & Safety, says a patient's protected health information (PHI) can be disclosed to law enforcement without the individual's signed Health Insurance Portability and Accountability Act (HIPAA) authorization in these situations:

- if it allows the law enforcement official to be reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public;
- if the covered entity in good faith believes the PHI to be evidence of a crime that occurred on the premises of the covered entity;
- to alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct;
- when responding to an off-site medical emergency, as necessary to alert law enforcement to criminal activity;
- when required by law to do so, such as reporting gunshots or stab wounds;
- to comply with a court order or court-ordered warrant, a subpoena, or summons issued by a judicial officer, or an administrative request from a law enforcement official;
- to respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness, or missing person;
- to respond to a request for PHI about an adult victim of a crime when the victim agrees.

In Young's experience, many government and law enforcement officials view HIPAA requirements as a barrier to accessing information needed for their investigations and dislike the need to "jump through hoops," he says. "HIPAA is not meant to be a barrier to bona fide requirements," Young says. "It's an assurance for the protection of personal information." ■

SOURCE

- Jeffery Young, CHPA, CPP, President, International Association for Healthcare Security & Safety, Glendale Heights, IL. Email: Jeffery.Young@fraserhealth.ca.

How to Respond to Clinicians' Complaints About Delays in Registration

"How come you are asking so many questions? I need you to register this person now!" While well-meaning, such statements made by clinicians often are unfounded.

"We have had issues where clinical departments have stated that patients have to wait too long to register," says **Laura King**, access manager at Valley View Hospital in Glenwood Springs, CO.

The patient access department did a time period study to show the times patients arrived and how long it took to register. This study showed that the average wait time was only three minutes. "There was just an assumption that it took too long to register patients," says King.

She says that if a clinical department is complaining about patient access, the best solution is to monitor the situation and come up with some hard data. "Either show that there is not an issue, or improve the problem," advises King.

In outpatient registration areas at Brookhaven Memorial Hospital Medical Center in Patchogue, NY, patient access orders all bloodwork and radiological tests. **Kimberly Horoski**, MBA, MHA, department head of patient access, says, "Clinicians commonly complain about the time it takes to enter orders after registration."

If there is any type of delay, clinicians blame patient access for it. "The best part of electronic charting and records is that there is a timestamp on all orders. Once entered, the time is reflected," says Horoski.

Why settle for offering vague assurances that patient access is working as quickly as possible, when timestamps show exactly when they completed registration? "This helps clinicians see that perhaps the delay is *not* my staff," Horoski says. It's possible that the patient was at a test or getting blood drawn because clinicians wrote orders before full registration was completed.

If the timestamp shows a larger-than-expected delay, patient access staff can be held accountable. The timestamp also might show that, in fact, registrars are working as quickly as they possibly can. "The influx and numbers of patients coming in may be much more than the number of staff we have on that day can handle," says Horoski.

She uses the ED registration system to obtain the average time it takes from the completion of quick registration, when registrars verify only the patient's name, date of birth, and reason for being at the hospital, to the completion of full registration. "Removing the average time it takes to do triage gives you the average registration time," Horoski says.

Next, Horoski runs time studies to validate the numbers. "I ask staff to give me the time the patient was started on full registration until they were finished with all facets of the registration and see how the times line up," she says. This analysis allowed the department to come up with an average turnaround time for registration. "We were able to see what staff were meeting, exceeding, and lacking on the quota," she says. Horoski created an electronic spreadsheet showing the average time it takes each associate to do a registration.

If registration times are too long, Horoski says there are two possibilities:

- **Workflow is the problem.**

In this case, patient access leaders should try to get support

EXECUTIVE SUMMARY

Clinicians' complaints about registration wait times might be unfounded, or they might misunderstand the role of patient access. Some effective responses include the following:

- Determine the average wait time.
- Obtain support from clinicians for needed improvements.
- Inform clinicians that patient access staff members act as financial counselors and ensure that revenue isn't lost.

COMING IN FUTURE MONTHS

- How departments are doubling and tripling collections
- Use flexible scheduling to boost department morale
- Must-have qualities for patient access leadership roles
- Get dramatic cost savings by cross-training registrars

from clinicians to get time-saving resources, such as electronic signatures or portable computers with scanners so that registration can be done at the bedside. "They can support the organization making large operations costs, like gaining new equipment for the patient access staff or more labor to cover the volume," says Horoski.

• Individual registrars are taking too long.

The first step is to track wait times by individual registrar. "Any main outliers need to be removed. Then look at the average," says Horoski.

Patient access managers should speak to registrars who are far over the average in time. "Find out their barriers; then they should be monitored," says Horoski. Inadequate staffing or staff members not working to the best of their ability are two common barriers. "Another barrier could be slow equipment that does not work as fast as staff," she says.

Patient's Best Interest

Keep in mind that clinicians have the patient's best interest at heart when expressing concerns about registration wait times, Horoski says.

"This is certainly understandable, and the core measures dictate this need, since so many medical issues are time-sensitive," she says, referring to standardized best practices to improve the quality of care, reported to The Joint Commission and CMS.

Clinicians don't always realize that the role of patient access is to ensure that their hard work is paid for, however. "Explain to clinicians what patient access brings to the table," urges Horoski. She suggests telling them the following:

• Patient access obtains important demographic and insurance information, and staff members explain important mandatory forms for registration.

• Patient access staff members are the financial counselors of the ED and work with patients who may have difficulty paying their bills.

• The questions that patient access asks are all important for different reasons.

Horoski says clinicians often do not realize that patietn access employees do the following tasks as part of their jobs:

• Ask for emergency contacts.

• Determine insurance eligibility.

• Obtain email addresses so patients can access the patient portal.

• Ask race and ethnicity questions.

"Patients are our number one priority," emphasizes Horoski. "That is for clinicians and patient access alike." ■

SOURCES

- Kimberly Horoski, MBA, MHA, Department Head of Patient Access, Brookhaven Memorial Hospital Medical Center, Patchogue, NY. Phone: (631) 654-7769. Fax: (631) 447-3082. Email: khoroski@bmhmc.org.

Medicaid Expansion Report Issued

The Department of Health and Human Services has issued a report summarizing previous research on how the expansion of Medicaid eligibility under the Affordable Care Act has made healthcare more accessible and affordable for eligible low-income adults. Expansion states have seen a decline in hospital admissions for uninsured patients. *(To access the report, go online to http://bit.ly/28L2tqw.)* ■

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