

# Hospital Access Management™

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### In disaster preparation, try to imagine the unimaginable

*'There were lessons learned . . . things that went well'*

**W**hen hospitals across the country began re-evaluating their disaster response plans in the wake of Sept. 11 and anthrax, Riverside HealthCare in Kankakee, IL, found itself in better shape than most.

Riverside had gone through a mock disaster drill for a hazardous chemical spill the previous May, says **Cindy Hagenow**, director of patient access, and in March 1999 had experienced a true disaster when an Amtrak train crashed in its community.

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"We thought we had a good plan, but after you have a real disaster you have to review your plan," Hagenow says. "There were lessons learned and there were things that went well. There were things that happened that you couldn't have imagined."

After the Amtrak disaster, **Sherry Mayes**, RN, BSN, the hospital's trauma coordinator and disaster chairwoman, attended a workshop on the Hospital Emergency Incident Command System (HEICS). That plan, developed in California and now in effect at more than 800 hospitals, is endorsed by the American Hospital Association, which encourages all hospitals to adopt it.

After attending the workshop, Mayes notes, she was so excited about HEICS that she came back and rewrote the hospital's plan over the course of a year, modeling it on that system. Since Sept. 11, she says, the Illinois Department of Public Health has recommended that all hospitals adopt HEICS, as has the Joint Commission on Accreditation of Healthcare Organizations.

"We've tested it, and it works," Mayes says, "and now I feel like we're ahead of the game."

"It's a system that's based on an organizational chart and a job

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action sheet," she says. "Old disaster plans are basically in paragraph form, and in a disaster, people don't read paragraphs." **(See related story, p. 3.)**

Riverside already had made it a priority to develop a biological exposure plan, and completed it in September as the anthrax cases were beginning to surface, Mayes says. "We had inservices for all of the safety representatives from each department and reviewed the new plan."

Registrars were instructed on what to do if someone came to their desk with a potentially hazardous substance, she adds. "I trained the safety reps and then they were to do an inservice with their staffs. So Cindy trained her employees and then I double-checked their knowledge, asking what they would do if this happened."

That training was put to the test when a man approached the emergency department (ED) registration desk, explaining that he had opened an envelope containing white powder and soon after had developed a rash.

The registrar directed the man back through the door he had just entered, to an outside entrance to the decontamination shower, and then called back to the ED to have someone unlock the door, she says. From a safe distance, ED staff questioned the man and determined that he had opened the envelope two days before, and so had showered since that exposure, Mayes adds.

Meanwhile, the registrar called the operator and had security personnel paged to contain the area, she notes.

"As it turned out, the rash and the envelope had nothing to do with each other, but we called the police and they picked up the envelope and treated it as suspicious," Mayes says.

### *Patient ID system crucial*

With the May 2001 countywide hazardous materials disaster drill, the focus for patient access personnel was on identifying ways to register patients and gather demographic information without exposing themselves to the hazardous material, Hagenow says. That drill, conducted by the

Federal Emergency Management Administration (FEMA) and funded through a FEMA grant to the county in which the hospital is located, was based on the premise that the driver of a chemical truck had lost control and backed into a dock, leaking anhydrous ammonia, she notes.

Patients were triaged under a covered area outside the ED ambulatory entrance, Hagenow explains, and those who were exposed to the chemical and had not been decontaminated in the field were taken to the decontamination shower entrance outside the ED. In the shower, she notes, air is circulated so as not to send any contaminants into the normal air of the hospital. "It's like a filtration system."

An ED "float nurse" who works outside the negative pressure room has radio communication with the staff in the room with the patient, Hagenow says, and passes information on to patient access personnel. "We do any rework that needs to be done."

There is a difference in the way chemical and biological disasters are handled, Mayes points out. "With the chemical, people have immediate reactions, and with the biological, the reaction can be days later." For that reason, she adds, the decontamination process is much more involved with chemical exposure.

"People are very sick and can't do it themselves, and the staff have to wear respirators," Mayes says. "The training is a lot more detailed."

As part of the FEMA grant, Riverside was given a hazardous materials software program, she notes. "We can look up any hazardous chemical in the computer database and get immediate information on antidotes and decontamination."

Before the chemical drill was conducted, Mayes says, the hospital ran a tabletop drill with the hospital leadership to acquaint them with the new HEICS job action sheets and test Riverside's emergency preparedness.

"We had an incident command table," she adds, "and the administrator on call had to pull the files out of the disaster response cabinet and distribute them to the appropriate people."

*(Editor's note: Look for more descriptions of how*

## COMING IN FUTURE MONTHS

■ More on disaster planning

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*hospitals and their access managers are re-evaluating their disaster response plans in the next issue of Hospital Access Management.) ■*

## HEICS: The way to go, but takes time, money

*This plan puts hospitals on same page*

**A**fter Riverside HealthCare in Kankakee, IL, dealt with the crash of an Amtrak train in March of 1999, hospital officials took a hard look at their disaster

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response plan and decided some changes were in order, says **Sherry Mayes**, RN, BSN, trauma coordinator and disaster chairwoman.

Riverside took a year to rewrite its plan, modeling it on the Hospital Emergency Incident Command System (HEICS), a plan first tested by six hospitals in Orange County, CA, and released in 1992 for general use. Copies of the plan have been sent to facilities throughout the United States and Canada, as well as to other countries, according to information on a web site devoted to HEICS. (To download a copy of the third edition of HEICS, go to [www.emsa.cahwnet.gov](http://www.emsa.cahwnet.gov).)

### *A customized approach*

HEICS features a flexible management organizational chart that allows for a customized approach to the crisis at hand, according to the web site. The organizational chart has 49 positions grouped into one of four sections, a structure designed to provide a platform for common terminology to enhance communication and improve documentation.

"We have tested the [HEICS] plan and it works a lot better," says **Cindy Hagenow**, director of patient access. "You have a command center set up, and the incident commander will open that center and assign people on that [organizational] chart.

Under the HEICS plan, Mayes says, "all of the key players have 'job action sheets' and know who to report to immediately and what to do." If the disaster occurs at 3 or 4 a.m., she points out, "I may have to do three or four people's

jobs temporarily, but at least the little details won't be missed because it's all written down in order of priority."

In line with the HEICS plan, she says, people in key positions now have vests to wear that say "incident commander" or "public information officer" in bold letters. "You can go to any area and know who's in charge."

Another change has been the addition of portable radios, which become critical to communication when all the telephone lines are tied up, Mayes adds.

Registration personnel "have a big job" when a disaster occurs, Hagenow notes. "When we've done some of our drills, one of the pitfalls has been that an access person was not initially assigned to one of the other victim care areas [apart from the main triage area] where patients were being treated."

If the drill was being conducted after normal business hours, there would be no registration personnel in, for example, the outpatient center, she says. That resulted, Mayes adds, in some of the "walking wounded" patients being treated and released without any type of registration occurring.

With the revised plan, she says, "we get staff in key areas right off the bat. With the job action sheets, the manpower unit leader assigns a registrar to each area."

As victims arrive under the ED canopy, Mayes explains, the triage physician takes a look at them, even though they may already have been triaged in the field and given color-coded tags indicating the severity of their conditions. "Red is for critical patients, yellow is for serious but not life-threatening conditions, and green is for 'first-aid' patients."

Registration staff, who are under the canopy with the physician, put pre-numbered bracelets on the patients, and record the same number on a patient log sheet, Hagenow says. That number is used to identify blood specimens or any other items associated with that patient, she adds.

Under the plan, Mayes says, patients are taken to various care areas, depending on the color of their tags. "Red" patients go to the ED, "green" patients are assigned an escort who takes them to the hospital's outpatient center, and "yellow" patients are taken the endoscopy procedure lab.

"[Access employees] are assigned to all of the victim care areas," Hagenow notes, "and their job is to make sure that as the patients arrive, the number on the bracelet goes on the log sheet." When they

get to the various care areas, the patients are “mini-admitted,” she says, with admitters entering just their name and basic demographic information into the computer. In some cases, she adds, patients may be listed simply as John Doe, with a number instead of a middle initial to distinguish one from the other.

“In a disaster, the other hospitals, Red Cross, everybody wants to know where this or that person is,” Hagenow says. “Anybody from any area can pull up the list [on the computer] and get an up-to-the-moment list of where these people are.”

Identifying the location of patients was one of the biggest challenges during the Amtrak disaster, Mayes notes. “We had people calling from all over the world. Now we’ve redesigned the system so we can get that list in an expeditious manner.”

If the computers go down, Hagenow says, staff fall back on the disaster log, which has three-ply sheets. “We have runners that come from the command center to pick up the log sheets. That’s our backup system.”

In Mayes’ opinion, HEICS “is the way to go. The advantage of it is that if all hospitals had that plan, we would all be on the same page,” she says. “If I call [another hospital] and want to talk to the incident commander, they know who I’m talking about.”

Having the support of hospital administration is crucial to the successful adoption of the HEICS, Mayes points out. “It costs money and it takes a lot of time to educate people. You have to educate the whole hospital from the top down.” ■

## For access departments, communication is accented

*Key link is between the ED and admitting*

**S**t. Joseph’s Hospital of Atlanta conducts disaster drills three or four times a year, says registration supervisor **Felicia Dafivbiroro**, but it is another world since Sept. 11 for the access department

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and the rest of the hospital.

In the following days, and in the wake of mailed anthrax, the hospital has made some revisions to its response plan.

“We thought it would be a good time [to conduct a drill], and we did see some different things we should be doing,” adds Dafivbiroro, who is a member of the hospital’s emergency preparedness committee.

Previously, for example, the procedure has been to contact the administrator on call when conditions warrant and have that person declare a disaster, she says. “That way, by the time we got the notification, the clearance [to put the disaster plan into effect], took about 20 minutes.”

That meant a delay in deploying extra clinical and administrative staff to the emergency department (ED), Dafivbiroro adds, because those people don’t report until they hear the official declaration. “Now the ED physician present will make that decision.”

A subcommittee of the emergency preparedness committee — charged with critiquing the response plan and suggesting revisions — also has pointed out the need for a method of assigning access staff to do follow-up on disaster victims, she says.

That step takes place after access staff receive an initial list from the triage area, Dafivbiroro notes. Complicating the process is the fact that the main admitting department is in a different area than the ED, she says.

St. Joseph’s disaster procedure is to have medical records personnel on duty with the triage nurse to get victims’ names and as much demographic information as possible, Dafivbiroro explains. Every 15 minutes, the medical records staff brings a list to admitters, who do a more complete registration and assign the patient a “real” medical record number that is then linked to the number they were given upon arrival.

That initial, temporary number is associated with the packet of information that is assigned to each disaster victim, she notes. In addition to a numbered armband, the packet contains clinical data sheets, informed consents, assignment of benefits documents, etc., all with the same number, Dafivbiroro says.

“If the triage nurse sends patients to other areas, we need to have one or two people working each of those areas,” she adds, “and we need a method for deploying them to those areas.”

Meanwhile, other access personnel will be working to obtain telephone consents and to gather additional patient information, Dafivbiroro explains. “Once we get additional information — from family members or as patients are able to give information — we update the list and send

copies to the command center.”

The committee also wants to find the best place to accommodate family members who are concerned that their loved ones may have been involved in the disaster, she adds. “We wanted somewhere that we didn’t have to install new telephone lines,” Dafivbiroro says, noting that an auditorium first considered for the purpose would have required more lines.

Now, she adds, the hospital is looking at using five classrooms on the ground floor beneath the ED as a place where families can come for information.

### *Contamination concerns*

The most recent drill, which dealt with a hypothetical smallpox outbreak, highlighted the fact that because the ED would be contaminated and therefore under quarantine, a runner would not be able to take information back and forth between there and the command center, Dafivbiroro says.

“In the future we will use fax machines, wireless phones, and the Internet to communicate,” she says. “If you only have one or two or three phone lines, you need to come up with alternate ways.”

Because of the possibility of contaminated mail, she notes, St. Joseph’s now provides protective gowns, masks, and gloves in areas that don’t normally have contact with patients.

“Just as a precaution, it is recommended that those who work in the mailroom or open mail wear gloves and masks,” Dafivbiroro says. That includes financial counselors who open mail from customers, she adds. ■

## With possibilities growing, disaster training is needed

### *Keeping your disaster program flexible is key*

Sept. 11th and anthrax bring home one important message to all health care professionals, including access managers: There is no possible way a

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department can prepare for every contingency.

It’s not like

the old days of preparing for natural disasters such as fires, hurricanes, tornadoes, earthquakes,

and floods. These days, a coding department could be shut down for hours or even a day or longer just by the appearance of an envelope coated in a powdery white substance. Likewise after a hospital has been hit with a large influx of casualties after a terrorist attack, access professionals could find their time and phone lines taxed from people trying to locate missing loved ones and insurers trying to identify and quantify covered patients.

The good news is that access departments do not have to prepare for every possible disaster to effectively handle what comes along.

“The value of disaster planning isn’t necessarily that you anticipate the right disaster, but that you talk about it with your staff so that you know what resources are available so these can be applied to a disaster you didn’t think of,” says **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with the American Health Information Management Association (AHIMA).”

Some disasters have internal and often unforeseen causes, adds Hughes, who has written articles and spoken to health care groups about disaster planning.

“Say a sprinkler system goes off and sprays everything,” Hughes offers as an example. “Then the paper can get wet and be ruined, so you might have tarps in the department to throw over them.”

Or if a hospital is flooded from the ground up, as happened last year in Houston, then an access department could save its paper documentation by putting boxes of files on stretchers that are borrowed from the emergency department, Hughes adds.

Access department disasters sometimes are caused by employee sabotage, says **Jill Burrington-Brown**, MS, RHIA, a Snohomish, WA-based professional practice manager with AHIMA. Burrington-Brown also has written about disaster planning and has studied the problems faced by the Oklahoma City hospitals after the bombing of the federal building in 1995.

“I had a mini-disaster at one facility, where over a six-month period, a clerk whose night job was to file records had been putting files above the ceiling tiles in the department,” Burrington-Brown says. “Within four months we knew we were missing a lot of records, but we couldn’t figure out where they were.”

This caused a great deal of documentation problems when records were being requested and none of the hard copies could be found. Then when the department finally found the files during a heating

system check, there was a second mini-disaster because now the staff had to cope with filing an additional 10,000 records and to make them accessible as soon as possible, Burrington-Brown says.

"We made a plan of how to keep up the regular workload while having the records filed as fast as possible," Burrington-Brown adds.

That type of scenario proves that it's impossible to anticipate every type of potential disaster, Hughes says.

"But the value is in going through the process and discussing things with the staff, anyway," Hughes explains. "Sure, if we anticipate employee sabotage, like someone who is angry getting into the payroll system, then as soon as we plan for it the disaster will be something different."

### *Know your limits*

Nonetheless, all departments can take some basic disaster planning precautions and follow strategies that will assist them in remaining flexible should an unforeseen disaster event occur. Here are some suggestions from Hughes and Burrington-Brown and AHIMA:

- **Know your liabilities and limits.**

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health care providers are required to maintain patient privacy. Breaches in a department's electronic records and the unintended release of confidential information could result in major regulatory and legal problems, so it's very important to ensure that records remain private and protected during a disaster.

For example, if a staff member discovers white powder on a paper document and suspects contamination, then the document must immediately be placed in a plastic bag and delivered to a laboratory for testing, Hughes says. "You should do a chain-of-custody on the paper, including making a loan record to the person who will make certain it's not anthrax," she advises.

Then, if the paper turns out to be uncontaminated, it can be returned immediately to the department. If it is contaminated, it can be sterilized and returned when it's deemed safe.

After Oklahoma City, health care providers often mentioned that it would be a good idea for the area to create a centralized computer database that all providers could share. This would have the benefit of giving families one place to go for information, Burrington-Brown says.

"HIPAA does allow for disasters and the release of information to agencies who are legally,

or by charter, dealing with disasters for the purpose of notification of families of a patient's location, general condition, or death," Burrington-Brown says.

"HIPAA does allow for disasters and it does allow for the release of information to agencies who are legally or, by charter, dealing with disasters for the purpose of location of families in the case of a patient's death," Burrington-Brown says.

To prepare for the documentation damage that a disaster could cause, access departments should contact fire or water damage restoration companies to determine what kinds of services they can provide in restoring electronic and paper documentation. (**Read about contracting with restoration companies, p. 7.**)

These companies also might have information that could help a department better prepare for a disaster. Also, access departments need to assess the facility's insurance coverage to see what costs are covered during a recovery period and what strategies can be taken to limit liability and loss, according to a practice brief Hughes wrote.

When records cannot be reconstructed, a department might look into various strategies, including reprinting documents from undamaged data bases in admission, transcription, etc.; transcribing documents from the dictation system, and obtaining copies from copies that were distributed to physician offices and others.

- **Draft a disaster plan.**

First, use what is already available.

"Most plans could work for all sorts of other disasters, but it would be appropriate for people to revisit those annually and tweak them in some way," Hughes says.

For instance, probably nearly all departments created extensive electronic disaster plans as they prepared for Y2K. Those plans could be dusted off and used to prepare for a terrorist technology or electronic attack, such as an Internet virus that destroys files.

"What you do is list your core and electronic processes, starting with a master patient index, for example, so that you can locate patient records," Hughes says.

Then take the function that's electronic and list the various assumptions of what has caused the electronic failure or disaster and describe what might happen, what resulting problems will occur, what is available to the department in the event of the problem, and how to design ways to work around the problem, Hughes adds.

Examples of disasters that should have a similar

flowchart or contingency checklist include fire, flood, bioterrorism event, hurricane, explosion, extended power outage, and earthquake. **(Read about how to generate a contingency plan, right.)**

If there is a terrorism attack or a major natural disaster, it's possible that hospitals will be inundated with more patients than they believe they can handle, and these patients may arrive in unexpected ways, Burrington-Brown says.

"One thing I've seen in the experiences of people who worked through the Oklahoma City bombing or the New York City bombing is that the numbers of people they receive at hospitals is far more than they ever planned for," Burrington-Brown says. "Departments are saying, 'Let's plan for 50 casualties because that's what our hospital can reasonably handle.' But they need to plan for more than they can handle comfortably."

In the event of a major disaster, the people who are injured may not be organized by rescue workers and sent to hospitals in an orderly fashion. It's likely that area hospitals will receive patients through a variety of means, including ambulances, private cars, and walk-ins, and it's likely they'll enter at any door of the hospital, as well as emergency department doors, Burrington-Brown says.

These types of scenarios affect access departments because patients may not always have identification and insurance coverage information on their person. They may be unconscious or disoriented and unable to answer questions by intake workers. Often their family members do not know where they are.

"You may have large numbers of people for whom you have no name, insurance, or other demographic information. So how do you track these people during their stay?" Hughes asks.

Staff may need to work with intake staff in identifying patients and gathering information, Burrington-Brown says. One strategy under these circumstances is to develop a simple system of identification and clean up the documentation later.

For example, after the terrorism attacks in Oklahoma City and New York City, hospital workers identified patients through tags with check boxes that listed physical characteristics, Burrington-Brown says. "On the back of the tag were stickers with the same numbers as the tags, so that as samples were sent to the lab, the stickers and lab samples had the same numbers."

Even this system posed some unexpected consequences. Some patients were so traumatized by the disaster experience that they could not tolerate having anything tied to them, so the tags had

to be put on clips, she adds.

- **Learn from trials, tribulations, and mistakes.**

Access departments can learn from the problems other facilities have had during disasters, as well as from their own disaster drills and actual events. This is why it's important to practice disaster drills twice a year when possible, says Burrington-Brown.

And it's a good idea for an access department to hold its own mini-disaster drill independent of the hospitalwide drill, Hughes suggests.

"It's not just having a plan written down, but having regular discussions with the staff to talk about what might happen and how any of them might need to be the boss and do what needs to be done when it happens," Hughes says.

An example of learning from others' experience might include stocking a department with identification tags and clips that could be used in the event of an emergency in which victims cannot easily be identified, Burrington-Brown says.

"Stock three to five times more than you think you'll need because you don't know what your numbers will be," Burrington-Brown says. "And make sure the people involved know what to do with them, and that includes admitting people and [access] people."

Finally, keep in mind that after a disaster there may be heightened emotions and staff may be personally impacted by deaths and injuries, so it's important to let employees vent, grieve, and heal emotionally.

Once this process is under way, access professionals may begin to evaluate how the department handled the disaster and what can be done to improve the process in the event of future disasters. ■

## Ensure patients' privacy before disaster arrives

*An expert offers up some advice for recovery*

**E**very disaster plan should include a strategy for coping with damaged records. It's a crucial first step in the department's recovery.

If the facility contracts with a fire, flood, or storm damage restoration company, it's a good idea to have a contract ready

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that would address various provisions for ensuring the privacy of the documentation.

According to a disaster planning practice brief written by **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with the American Health Information Management Association in Chicago, here are items that should be included in a damage restoration contract, providing the restoration business will:

- specify the method of recovery;
- not use or further disclose the information other than as permitted or required by the contract;
- use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract;
- include the items required in business associate contracts per the Health Insurance Portability and Accountability Act privacy rule;
- report to the contracting organization any inappropriate use or disclosure of the information of which it becomes aware;
- ensure that any subcontractors or agents with access to the information agree to the same restrictions and conditions;
- indemnify the health care facility from loss due to unauthorized disclosure;
- upon termination of the contract, return or destroy all health information received from the contracting organization and retain no copies;
- specify the time that will elapse between acquisition and return of information and equipment;
- authorize the contracting entity to terminate the contract if the business partner violates any material term of the contract. ■

## Here are the essentials of a contingency plan

*AHIMA offers strategies and samples*

**A**mong the strategies published by the Chicago-based American Health Information Management Association (AHIMA) is the following advice about

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how to create a contingency plan, which is part of a paper written by **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with AHIMA.

Here are some of AHIMA's and Hughes' suggestions for information that should be included in a contingency plan created for each disaster:

1. The facility's name.
2. The department's name.
3. The contingency plan's originator.
4. The date.
5. The major function being addressed, i.e., chart tracking/location, and provision.
6. The disaster being considered, i.e., hurricane.
7. Some assumptions about the disaster, i.e., how will the disaster affect: utilities, staffing, and/or the ability of staff to report to work; security of health information; the facility itself; hardware and software; equipment and supplies; other departments, and patients presenting to the facility for treatment.
8. A description of the existing process used for the particular major function being addressed.
9. An if/then scenario, i.e., if this function is not performed, what will be the result?
10. Interdependencies, i.e., what other processes depend upon the provision of this information or service? On what information or services is this process dependent?
11. Solutions/alternatives, including steps that can be taken to minimize damage or disruption before the disaster, ensure stability, or provide for orderly recovery.
12. The limitations and benefits of each solution or alternative.
13. Activities that will need to be performed before the disaster in order to make this alternative possible; i.e., acquisition of equipment, implementation of backup systems, development of disaster-related forms and materials, procedures, and staff training.
14. The names of the individuals responsible for performing these activities.
15. A list of individuals or departments with phone numbers who should be contacted or notified relative to the disaster and the implementation of this particular contingency plan. ■

## Access staff eagerly line up to strengthen their skills

*Training draws additional takers*

**I**f you offer in-depth, relevant access training, your staff will line up to take part.

That's the lesson at the University Hospital of Arkansas in Little Rock, where the Strengthening Bridges program aimed at adding to and reinforcing the just-learned skills of new access employees has become so popular that existing staff are asking for the training.

"We really weren't addressing this to existing employees," says **Holly Hiryak**, director of hospital admissions. "We were going to let them attend as needed, but they're requesting it. They're passing the word to each other."

### *The whys and why nots*

Strengthening Bridges, the second phase of a comprehensive access training initiative, offers detailed information on the various payers, including the ins and outs of how they work and background on each payer or payer category, Hiryak says. "We're explaining the whys and why nots, as well as how to do it, and the employees really appreciate getting that."

To further enhance the program, the access training advisory committee has expanded it from two days to three, and changed the training style to become more interactive, she notes. "Originally there was a more didactic delivery, with no hands-on training. Employees couldn't practice the how to's, and couldn't sit in front of a computer."

Now, Hiryak explains, employees will get an in-depth description of the various players, including:

- rules or laws that govern how University of Arkansas for Medical Services (UAMS) manages the process;
- checklists and tools for access staff to use to ensure appropriate steps and actions have been taken;
- activities specific to the topic to reinforce training.

"Then we have scenarios — or case studies — that we have developed specific to the various clinics and settings on campus," she says. "The access staff will utilize the information to register a patient in the test system. The test cases will be completed at the end of each session, which is divided by payer categories such as Medicare, Medicaid, commercial payers, managed care payers, etc."

Trainers will attach an insurance card to a patient file and have employees proceed as though there is a patient in front of them, she adds. "They will enter information from this,

[addressing such questions as]: 'Where do you put the referral number? Where do you put the effective dates?' That way, if they hit roadblocks, they can ask questions."

Although Strengthening Bridges is exclusively an access program, the first phase of the training initiative, Building Bridges, has been extended to include all 2,100 of the clinical programs employees of UAMS, Hiryak explains. That includes anyone who works in a department or provides a service that contributes to the clinical activities of the hospital, she says.

Having billers and registrars sitting next to pharmacy and radiology technicians during soft-skills training sessions, Hiryak notes, has gone a long way toward tearing down the traditional silos that exist in a hospital.

Originally these new hospital employees went through the typical human resources orientation together before going their separate ways, she says. Now they spend two more days together, focusing on topics such as teamwork, professionalism, confidentiality, and effective communication, as well as a segment called "Introduction to the Revenue Cycle." (**See more on the UAMS program in the July 2001 *Hospital Access Management*, p. 79.**)

Access managers introduced to the Building Bridges program at a retreat suggested that the revenue cycle segment gave employees too much financial information too early in the process, Hiryak says. Despite that feedback, she made the decision to go forward with the original curriculum and it got extremely positive evaluations from the new hires, she adds.

"We gave them an overview of the revenue cycle, where they fit in it, and what could happen if they were not team players," Hiryak says. "They said, 'We never understood this before. Thanks for taking the time to tell us.'" The new employees also gave positive feedback on the other soft-skills topics, she notes.

### *Strengthening relationships*

Having all the clinical programs employees together for this training also has helped build relationships among the participants, Hiryak adds, and in particular has helped elevate access employees, making them feel a part of the clinical areas.

The off-campus retreat for access managers, aimed at ensuring their buy-in for the training initiative, gave the managers a taste of the soft-skills

curriculum, she says. “There were a lot of interactive activities, to address all of the various learning styles of adult learners. They absolutely loved it.” (See related story, right.)

The training program originally called for employees to work with a preceptor for 60 days after going through the Building Bridges phase, and then to proceed to Strengthening Bridges, but that has changed, she notes. Now employees who are catching on quickly may take that step after 30 days, Hiryak says.

### *At first, preceptor problems*

Establishing the preceptor program — whereby new hires are paired with experienced access employees for the first one or two months — has been somewhat difficult, she notes.

“Those we identified as preceptors didn’t really understand that role,” Hiryak says. “We do have a four- to six-hour training session for the preceptor, explaining their responsibility. The difficulty is that some of the clinics are very small and the preceptor is the only [access] person currently employed there. The perception is that [this task] takes them away from their work station.”

That perception is not altogether incorrect, she notes. In some cases — in clinics where the single access employee is training someone to replace her, for example — arrangements may be made for the training to be done in another clinic, Hiryak adds.

Generally speaking, she says, the preceptors are beginning to embrace the concept. “It probably is a little more time-consuming, but there is no more putting [a new employee] in front of a computer and telling that person to check with you if there are any problems. They’re now committed to be with that employee, not just walk away.” ■

## Managers learn firsthand about employee training

### *Learning to work like a team is highlight*

When the access training advisory committee at the University Hospital of Arkansas in Little Rock established a comprehensive new training program, they knew that management buy-in would be crucial to its success, says **Becky Glover**, RN, MSNc, BC, clinical services manager for the clinical programs education department.

With that in mind, the committee hosted an off-campus management retreat, where not only access managers, but also administrators, directors and managers in the other clinical programs areas got a taste of what their employees were experiencing and an opportunity to add their feedback to the process, she explains.

Glover, whose department assesses, plans, implements, and evaluates training programs for all clinical programs employees, oversees a staff of seven educators as well as the coordinator and five trainers of the computer training center.

Glover says she worked with Holly Hiryak, director of admissions, and the access training advisory committee to plan the retreat.

“We took pieces of the Building Bridges orientation and presented to them what their employees were going to be doing and hearing,” she says. “They received a full outline of each training module, and then we gave an overview and an example of each. After that, there was an action review, so they could react.”

The managers were asked what they thought worked and what needed improvement, Glover notes. “Then we could take their input and revise the modules. With managers, you want to give

them that power, you want them to buy in, to feel they have helped with the development. They liked giving their opinion, saying, 'Why don't you add this?'"

Mindful of the different adult learning styles, the training advisory committee and the staff education department designed the orientation — and the retreat — to include a variety of training techniques, she says. "Some [adult learners] are visual, some are auditory, and a lot are hands-on learners. We use those different strategies in all of the information we present."

To illustrate the importance of teamwork, Glover adds, the managers were divided into two groups, given a jigsaw puzzle to put together, and told that the team that did it the fastest would win a prize. At some point in the process, the team members realize they don't have all the pieces, she says. "People get frustrated, and they finally figure it out, or if not, the facilitator says, 'You might want to check with the other group.'"

An interesting side note, Glover says, is that the managers were much more competitive than were the frontline employees who did the exercise at their orientation.

Another exercise with a similar theme, she adds, had the managers write their job functions on ping pong balls, put them in a punch bowl of water, and then try to keep all the balls underwater with one hand behind their backs.

To get across some of the tedious material associated with regulatory agencies, trainers put up a large crossword puzzle, and attached letters with Velcro, Glover says. "One down,' for example, is 'the agency that oversees Medicare.'"

Some of the activities, she notes, "are kind of silly, but people remember [the information]."

To underscore the theme of professional behavior, Glover says, the participants did a role play in which someone comes in dressed inappropriately, sits down at a telephone, and begins talking, ignoring a patient who comes up for help. Later, she adds, the managers are assigned scenarios involving difficult patients and asked to act out the right way and the wrong way to handle the situation.

To further enhance the managers' understanding of the program, she notes, the retreat planners put together three huge notebooks that were available for participants to review. "One had all of the "Strengthening Bridges" curriculum, another was on the computer training piece, and another had to do with the preceptor program," Glover says. There is a special course for the preceptors, she adds, that teaches them about adult learning styles. ■



## Safest course on copays: Wait until screening done

*If you do ask, exercise caution*

*[Editor's note: **Kathy Pajor**, director of patient*

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access services for St. Vincent's Medical Center in Bridgeport, CN, asked Hospital Access Management for clarification on the federal Emergency Medical and Treatment and Active Labor Act (EMTALA) requirements. Here is her question, with some guidance provided by **Loren Ratner**, an attorney specializing in health care matters with Nixon Peabody LLP in Garden City, NY.]

**“I’ve read many articles about point of service collections in the emergency department. Some hospitals collect payment after discharge, some after the physician completes the initial medical screening. Others ask for copays during the registration process. Would a hospital emergency department (ED) be in violation of EMTALA if the registrar asks for copayments at the time of registration, before the physician completes the initial medical screening?”**

Although hospital emergency departments are not specifically prohibited from requesting copayments from patients during registration prior to medical screening and treatment, caution must be exercised to ensure that the provision of care is not delayed and that patients are not discouraged from obtaining such care due to the request. Hospitals may not condition the provision of the medical screening examination or necessary stabilizing treatment upon payment by the patient.

A hospital ED clearly would be in violation of EMTALA if provision of a medical screening examination and stabilizing treatment were conditioned upon receipt of a copayment from a patient. In their jointly issued *Special Advisory Bulletin on the Patient Anti-Dumping Statute*, the Office of the Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) addressed the issue of the registration process employed in EDs in light of EMTALA’s mandates. (64 Fed Reg 61,353, from 1999). The *Special Advisory Bulletin* provides that while it is acceptable to ask for general registration information prior to the medical screening exam, conditioning the screening and treatment upon payment of the copay “could unduly deter the individual from remaining at the hospital to receive care to which he or she is entitled and which the hospital is obligated to provide regardless of ability to pay, and could cause unnecessary delay.”

While hospitals may not condition screening and treatment upon receipt of copayments, they

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are permitted to request financial information from patients, as long as care is not delayed due to the inquiry about the patient’s insurance status or method of payment. Hospitals should ensure that their ED registration processes do not discourage individuals from remaining for screening and treatment. A reasonable registration process may include asking whether an individual is insured, and if so what that insurance is, along with other relevant information, such as demographic information, and emergency contact information. The OIG and CMS have suggested that hospitals defer discussion of a patient’s financial responsibility or obtaining a patient’s agreement to pay for services until after beginning stabilizing treatment.

So while hospitals are not specifically prohibited from requesting copayments from patients prior to the provision of screening and stabilization, each hospital must carefully evaluate its registration procedures, to ensure that such requests do not discourage patients from remaining for care. The most prudent course would be to defer requests of copayments until the medical screening examination has been completed and until necessary stabilizing treatment is under way. ■