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## **Limiting Exposure/ Patient Care**

**Q: When presenting patients with a phone or tablet to do a virtual registration, who is running this equipment to them and how are the patients being educated to use the equipment and how is it sanitized properly afterwards?**

A: We're actually having patients, for remote registrations, use their own cellular phone or their own devices. If they don't have a cell phone with them, then what we're actually doing is the nurse is handing them the phone that is in the room. Then whenever they leave that room, everything in their room is deep clean before another person goes in there.

A: Same here, we have patients use their own cell phone if that's available. If it's not an available option, then the nurses are helping us by providing the patient with the telephone that's in the room. We are not actually taking copies of patient's photo IDs or insurance cards at this time. Just because again, safety is our first priority and the organization felt like that would be unnecessary risk to expose our caregivers to.

**Q: Are the registrar's working in the tents and are they wearing PPE? And if so, what are they wearing?**

A: We are not actually in the tents, so we do not have to be fully garbed. However, triage nurses are fully garbed before we get them and we have a mask and we have gloves on. We're not passing anything back and forth. But we only have them in a really in a mask outside.

A: Our staff in the tent are wearing goggles and mask. Our volume has come down considerably. But when we first opened, they were in full garb.

**Q: How are you handling collection of valuables?**

A: That came up recently, I had staff who were concerned because we did not have enough sani-wipes. So we are making sure that they're communicating with command center that we have all of the PPE and all of the essential cleaning that we need. Security collects the valuables from the patients and they are wiping everything down before it's being placed into the valuable bag, while wearing gloves. The staff who's receiving it, is also wearing gloves and we're wiping down the outside of the bag and just trying to be as safe as we can with that process. If patients don't need all of their valuables upon discharge we're willing to hold them so they can go home and wait a week. Sometimes that's not the case, patients are allowed one family member with them and if their family member could pick up those valuables.

**Q: How many have started doing telemedicine appointments and how is that going?**

A: We have started telemedicine in our medical groups as well as our community. A lot of the folks that are coming for car side testing have had a telemedicine visit. In addition, we have radiation oncology on site, the physician there is going to do follow up visits with telemedicine. So with the patients do not have to come to the facility.

A: We have seen a huge increase in our Telehealth visits and I've actually partaken in some of them with my PCP and other specialists. The response has been great. I think people are going to want to do this, even when COVID is over.

A: We had no telemedicine. It was on the docket, it was going to be a project. Nothing like a crisis to get things going, and very quickly. We had our telemedicine program up and operational within nine days of our first incident command day. Now it's soaring, we started telephonic and now we're televideo as well. We've had over 10,000 visits. We have a whole call center and our practice sites that are calling patients to bring them in for telemedicine that may have already canceled, who did not want to present.

**Q: So are those who have employees who are positive for COVID 19, are you doing anything to reach out to support those who are at home?**

A: Unfortunately, I've had associates who have tested positive for COVID-19 and we are reaching out to them daily and making sure that they are okay. In one case I was able to run to Publix to get them some supplies and I just dropped them off their door and call them on their cell phone and let them know that I just dropped it off. But we're just keeping in contact because they're home for at least 14 days, and they don't feel well. So we reach out to them every single day. Other associates reach out to them, texting and praying for them. Letting them know we miss them and just constantly asking for the anything we can do for them. So it's been unfortunate and it's sad, but we are taking care of them the best way we can.

A: We've had four positive cases, all out of the emergency department. Our first positive case was admitted nine days later because the symptoms just continued to worsen. We've had a pregnant woman test positive as well. There's a lot of reach out from our team. We send a care package to them, because obviously they can't get to the market. Making sure that they've got those healthy foods and those things to stay hydrated and proteins to keep them healthy or get them healthier.

A: In addition, our employee health nurse is calling every day and doubling checking for anybody who is home on self-monitoring or had an exposure and needs to be watched. It's nice to hear everybody else who's doing those reach outs as well because when someone has COVID they can de-escalate so quickly.

That's what they found with some healthcare workers who have had poor outcomes, it was because they were by themselves and isolated. It can happen so quickly that reach out as a very important.

**Q: What is your protocol when you have an access associate that's tested positive for COVID?**

A: Once they are tested, they are on a 14 day quarantine from the day they were tested. Then they have to call the associate wellness nurse and it gets screened before they can be allowed back to work.

**Q: So do you allow support people for patients for scheduled necessary services in the facilities?**

A: We have a very strict visitor policy right now, we are not allowing visitors in. Unless it's a minor, obviously a parent has to be with a minor or if it is an end of life situation. We also allow one person for a Mother and labor.

A: We became very restrictive early on, before New York State set stronger guidelines. We're working with all the hospitals in the region. Everyone from day one. We went from seven entrances down to two, as well as the ED. We have security guards there 24/7. That's where all temperatures are taken for both visitors with those restricted guidelines that were just mentioned. Ours are exactly the same. It's been challenging, it's very hard to say. But we've also had a publicized it's on our internet site, and as I stated, the most important thing is the same across the entire region of hospitals.

A: What we've been doing for patients who are extended stay as in patients, if they don't have the technology like FaceTime, to be able to use - we have tablets. That we're making sure that we obviously practice safety and clean them. I believe there's these covers over them and then we change those out and we still wipe them all down. So that way they can still hear from their loved ones and see their loved ones and that's been really positive to try to help because it is difficult for patients when they're staying in a hospital for any reason, for any length of time to not have somebody close to them be present.

**Q: If it is determined that I registrar did the registration on a COVID positive patient what steps are taken?**

A: Our employee health has been a part of that process. So once a patient is deemed positive, then they'll do research on the account to see everyone that touched that person. They would have the associate keep a diary and every day they would get a phone call from our employee health. To keep track of how the associate was feeling or if they were presenting any symptoms. As a result, some associates have been tested, thankfully, those did come back negative at that time.

A: You have to sign in and out to every room. So we're keeping track of anybody who's entered, whether it's our environmental services or Nutrition Services staff throughout the organization. So if test results come back that someone was possibly exposed our employee health department is right on top of contacting those individuals and going through the safety protocols screenings and if not testing.

## **Consent/Registration**

**Q: How do you sign consents with verbal consent for documentation into the patient record?**

A: During the COVID crisis we are requiring only 1 witness; generally for verbal requirement is 2 witnesses.

A: We are documenting in Epic "verbal consent" and on the actual document "verbal consent".

A: We are signing, "Verbal consent given, unable to sign due to national emergency."

**Q: Why did you decide to go to all remote registration? Is anyone limiting remote registration to only PUI and positive COVID patients?**

A: We do not limit, because there's potential that somebody can be asymptomatic right now and have the virus right so we wanted to make sure that we were providing safety for all of our associates. In the beginning, we actually started with social distance barriers and making sure that everything was maintained at six feet and then we were able to add Plexiglas into all our registration areas. The patient access staff are still wearing masks, even though they were behind Plexiglas because we've gone to universal masking for all of our associates. So we were being compliant with that. In doing our remote registrations, we wanted to make sure that we maintain the best safety for all of our associates and that's why going to that phone call. That was the go to go for our patients. We've placed registrars on a bank of phone calls, so a call will go to the next one that's available to everybody gets a fair distribution. This has been quite successful with our scheduling. We had a reactive scheduling, which means we always waited for our patients to call us. But this has allowed us to call the patients back, which is something that we were hoping to get to. We were waiting for some more technology to be put into place, but with COVID we had to get those advancements completed. Our schedulers are now working off of a Worklist and the response from our patients has been incredible. We've not really encountered a lot of patients that haven't been understanding.

**Q: How are you handling registration of non-English speaking PUI patients?**

A: We have a language line and an iPad. If it is used, we wipe it down. But we do that in the normal course of business so nothing has changed in that regard.

**Q: What are you doing to assure the collection of a robust set of demographic information? We are having some difficulty providing results because of lack of good phone number.**

A: We too are doing the best we can. We do complete an address look up prior to writing any encounter off.

A: We are working with the Nursing teams to collect information from patients if need be since they are in the room with the patients. We are also contacting emergency contacts noted on patients' accounts if we do not have a good phone number. Obviously, we are not saying anything about the patient being at the hospital due to HIPAA, just that we are trying to contact the person and do not have a good number to reach them. We are doing a mini reg at the time of admission to the ED and therefore are doing follow up calls to patients either in their room if admitted or at home if they were discharged from the ED.

A: We have a mail check system in our software. For phone numbers, we are doing remote registration so they call us from the number. On the rare occurrence that they do not use their phone, we follow our standard practices by taking the number and hoping that they provided us the correct one. Otherwise

we do have the correct address on file and can do certified mail if necessary. If you do not have a software, you can use whitepages.com

**Q: Is there a specific federal or state waiver that can be referenced when deciding to go to verbal consent on your consent and CMS forms?**

A: For any of the verbals that we are doing on our general consent or Hixny form. We went to our risk management and legal. The Medicare financial consent can be signed by any representative. After our last session, I made the recommendation to use the terminology of “national emergency” to risk and legal and it was approved. So we have now moved to verbal consent.

A: We also had legal to weigh in on the verbal consent. So we are documenting everything through the EDS and through inpatient. We're doing remote registration, signing verbal consent given unable to sign due to national emergency.

A: With our legal department and risk's guidance and feedback we were able to do the same. We are able to, if we're doing our Hospital Presumptive Eligibility, do verbal consent. We were given permission. However, the challenge that we're having is with our Medi-Cal full scope applications that has not been granted yet. So we're just making sure that those team members are fully trained on how to utilize the PPE and sometimes we're actually engaging the medical staff to help us depending upon the severity of the patient that that we need to go assess.

A: One of the challenges is keeping that distance or not going into rooms that are deemed COVID, and the medical staff in our organization has been very helpful bridging that gap to allow us to do verbals and additional needs as we have information needs. That has been a nice collaboration.

**Q: So we stated that the majority of your patients, you're speaking to them on the phone to explain forums. How do you deliver the forms, for example, MOONS or IMMS to the patient? If the COVID test comes back negative, are you going back and getting signatures on consent or keeping the verbal consent on file?**

A: Keeping all the verbal consent on file. Additionally, we're providing the patients with a website. So we have actually uploaded every single one of our documents that they could potentially sign while they're in the hospital. Those are available on our website for the patients. So we'll provide an actual link to a document and read the consent with them explain to them what we're getting verbal consent for.

A: Our forms are laminated in most of the rooms. So when the registrar is reading the form to patients over the phone, they're able to follow along if they choose. We are also send copies of the forms that shows that they verbally consented with two witness signatures to their address that they provided us.

**Q: So how do you ensure you're registering 100% of the patient, and you're not having patients leave without being registered?**

A: We have a way of identifying when patients are fully registered our clinical team in the emergency department, so that has not changed with COVID.

A: The one thing we found is we have not had folks without a complete registration. That collaboration with the clinical team, making sure they're watching for the cues on the tracking board and allowing us that opportunity to get the information in a variety of ways has been very helpful.

A: So we have had some issues because we set up tents outside. So we're not allowing patients to enter if they're walking into the ER or they're not scheduled for an essential service without being screened. There has been instances where the information wasn't completely filled out. Luckily, we were fortunate enough to the where the phone numbers were always provided. So we've gone back and called those patients and collected the additional information that we needed to secure a full registration.

A: So we've been doing something similar with the tents. However, I'm rather than giving them a document to actually fill out once they are screened, they're given a piece of paper that has a phone number on it and they're told that they, in order to proceed forward, must call that number. Whenever they call that number, it gets connected with one of our registers and we complete the registration. Then they are told to proceed to a service tent to get the rest of your treatment for your stay.

A: In our tents we have a triage nurse first. If we have a disaster patient, there is a registrar out there with a registration cart and works based on wheels. Like a reduced registration, kind of like a mini-reg with more information.

**Q: How are you registering self-pay patients who test positive for COVID-19? Are you attempting to obtain financial clearance/Medicaid coverage?**

A: We are registering all patients at this time. If they are self-pay, then we follow our standard processes.

A: We are registering self pays as we would normally do and our financial clearance/Medicaid eligibility teams are making follow up calls to qualify/enroll those who meet the criteria.

A: As we are not able to bill the patient for any COVID services - we have a specific health plan - we are assessing for financial aid and reaching out to determine if Medicaid eligible

**Q: Anyone doing remote registration for outpatient visits?**

A: We are, but it's more centralized registration and so we're attempting to call patients who are still scheduled for those essential services. Prior to them entering the facility to complete as much registration as possible. All staff and patients are screened upon entry and we have our entries restricted. They're getting their temperature taken and they're provided a mask. The floor has little signs that show the six feet distance for safe social distancing. So some of it is pre-registration for the outpatients and then the rest of it is completed upon arrival. But again, with all those safety protocols in place.

**Q: Has anyone made any changes to other and patient processes that aren't directly related to COVID-19, for example, are birth certificate clerks working from home or processing remotely? What about other in-patient registrations?**

A: No, all of my staff who were previously on site like financial counselors or registrar who are responsible for the birth certificate paperwork, they're still on site. We just haven't moved them off site yet because we really need all hands on deck. Just because of the volume of patients that we're getting here.

**Q: How does the clinical staff see the patient was registered? This organization has EPIC and on the track board we have a Y or an N for registered, but it seems most don't look at that.**

A: For the ER, when a patient is registered the status changes on our track board. In ASAP, which is the module within EPIC, each organization can build it differently. So for us they'll change a different color in our system so that lets the clinical staff know that that they have been registered. It is the same thing until the MSC is completed, the patient doesn't fall to the ready-to-reg board. So that's how our staff knows not to go in the room and complete the registration yet or not to call and complete the registration.

## **Insurance/Finance**

**Q: Is anyone implemented a different pay code for COVID?**

A: Yes, we have codes for COVID-19.

A: Yes, we are using a different pay code for charging any hours or equipment needed to handle operations or processes due to COVID that we would not normally be doing or using such as having screeners at the front entrances to our facilities or installing additional printers for armbands at the EMS entrances in our EDs to have during a surge.

A: Unsure if this is Healthplan or KRONOS - either way YES for both. New COVID Healthplan and new COVID KRONOS code

**Q: At the start of fiscal year 2020, we set specific financial goals for point of service collections. Staff merit increases for the coming year are dependent upon meeting these financial goals and with visit volumes decreasing drastically the opportunity to collect follow suit. What are other organizations doing in terms of making adjustments to their financial goals during the pandemic? Has best practice been established?**

A: All bets are off. A lot of payers are relaxing their copay and all of that's in play. We are still collecting where we can. In the emergency department, we stopped only because anything related to COVID has been waived. People come in with sprained ankles and then they start coughing, they're tested and now they've tested positive so we just don't know. So we've relaxed on the emergency department on the inpatient side, to make it easier to discern whether it's COVID or not. We are still collecting some on the inpatient side, but we've relaxed all of those financial goals.

A: We're still collecting on outpatient, things that are "essential" and so we will collect on those. But as far as the ED, we are not collecting at all even when we do our follow up calls. Most of it is COVID related and we just don't want to take that risk. Especially with patients in our community too, we want to send a message to our community that we're here to support them during this and it's not all about the money.

**Q: If you're not collecting insurance cards and our patient IDs. How do you verify the patient is who they say they are has this cause an increase in identity theft?**

A: We're having our staff or patients show it. We're viewing it, but we're not we're not taking it from them and scanning it so we're still viewing.

A: We do have patients who show up to the ER that don't have those items. So we're just following what we would normally follow because we're on EPIC have a lot of our patients who have been to our health system before they have their photos from the MyChart feature. So we're utilizing that as well.

A: We are having the patient show their ID. I think this has made our team more diligent in those extra questions to validate Identification and going into EPIC and looking at the scam driver's license from a previous visit to double check.

A: Now we are also looking at the IDs. If there is a PUI patient, the nursing staff is arm banding the patient and registration must keep a visual on the patient at all times. It is our responsibility to make sure that that is the correct patient.

**Q: Has anyone implemented a different pay code for COVID-19?**

A: We are keeping track of all additional equipment. Anything that is out of my normal operation that I wouldn't be doing, but now I'm doing it because a COVID we are using a separate code to track those expenses. So hopefully we can get reimbursed.

**Q: For NY authorization leaders, with the authorization waivers in place, are you still finding authorizations needing to be worked or are all of the payers saying that no authorizations are required?**

A: Even with the relaxed regulations we are still calling for authorization so we have the attempt documented in the same manner (time/date of call, who we spoke with, etc.)

## **Managing Staff**

**Q: Have many of your employees work slowed down or are you redeploying employees to other jobs in the hospital?**

A: So we have redeployed some of our staff. We reached out to our billing department, which was down several positions. So some of our insurance verification team was able to learn how to drop claims and work some additional building reports and that has been excellent intent of solidifying that relationship. We've also redeployed some of our staff as screeners at our entrances because everybody that comes in the building, including position the employees are screened at the door. So they have been working in that capacity as well.

A: We did that too. We have people that are screening and our outpatient facilities we have registrars that are helping with that asking all the questions and handing out a mask.

A: We're Union based environment, so we have to ask for volunteers. With the list of volunteers we've been able to utilize the staff who work in the call center and are now working remote to help cover onsite registration access needs to help a little bit in the billing department reviewing some claims for those who had a stronger background and were able to do so.

**Q: For registration staff that are still having to work on site in the emergency room, are they receiving hazard pay in addition to their normal salary?**

A: No we're not doing hazard pay.

A: We did not employ hazard pay, however, all of our UC hospitals did come up with 128 hours of paid administration leave so we're encouraging staff who need to be at home to take more time for themselves and they're being paid that allotment of hours. An additional 80 hours was actually just rolled out yesterday. So we've been pretty fortunate to be able to, although it's not hazard pay, offer all staff the ability to spend some time at home and take that necessary break

A: Well, my staff is definitely ask the question, but currently we are not doing hazard paid.

**Q: As authorization requirements continue to be way by several payers. How are staff being used, other than getting authorizations?**

A: We are still calling. Even though things have been relaxed, we attempt to call so we've not had to redeploy them.

**Q: What innovative ways have your team's been managing the workload?**

A: For the staff who have now moved remote we have twice a day huddles with leadership to talk through what we're seeing in the work queue and to prepare for questions and challenges that the staff may see when they log in. We want to also make it fun, so we're doing a show and tell to try and keep the team engaged. Whether it's the background or a family photo or if they want to tell a story about doing puzzles with their family while they've been you know in isolation. We're incorporating some of that into the huddles and then we're discussing Individual work queues. So if a staff member doesn't have enough work for the day, we can do a split. We're trying to promote that frequent communication between the team, so we can make sure that we're helping each other out and still staying connected and being able to stay as productive as possible.

A: We implemented WebEx to maintain connected because we can't have staff meetings and the teams loved it. With it being patient access week, we decided to continue with our Patient Access Week celebration. But within their own departments, at their work areas because we can't have more than 10 people in a room. But we've been doing little things like giving them candy and giving out pens and notepads from our business partners. Any little thing at this time to say thank you for what you do.

**Q: What our Surge Planning details for patient access?**

A: We expect our surge to be at the end of April, so we actually had to present our plan today. What we did is we took an average daily census year to date and we had two scenarios: 1) at 26% increase and 2) at 86% increase so we could see the highest surge based on our models for our county. We took our baseline of what we currently staff at and then I increase it to 26%, then I increase it by 86% and then I added those FTEs for our surge planning. Obviously during our surge our other locations will be closed. During the surge only emergency department entrances will be open and our labor and delivery, which we staffed 24/7 with one person on each shift. So with that we will pull from existing outpatient staff as well as our pre arrival services which are usually located at the business office. So we'll pull from those in order to staff the surge.

A: So we do have planning meetings with our entire hospital for both locations and those are have been every day for half hour just to make sure that everybody's on the same page and that we're getting enough resources. People that are in the float pool as well have been redeployed and some of the

people from the float pool have been placed on a on a call list for our registration department. So we've been able to have an additional resource list created as a part of our site meetings.

A: We've been an incident command 24/7 for 31 days. What we have seen is a significant decrease in all volumes right across the board. We had initial significant surge of our alternate care site in the tent the first week and a half that has tapered off when we pulled away from testing because test kits weren't available. So now it's just a surveillance and evaluation tent, but from a surge planning where we're going to have areas closing and we would then reallocate staff accordingly. So what we need to do is make sure that bedside in-patients are being taken care of and we have staff to be able to accommodate that virtually or by phone. But the emergency department surge, we're in Tier-3 critical care, Tier-2 med surge, Tier-1 women and children, that surge has not been comparable from a patient access standpoint, at this point.

**Q: How involved are each of you with your command center?**

A: My life has been taken over by incident command. I have at least five hours a day that it's only incident command, whether that surge updates or the planning for employee health. That's all I'm doing right now. I went to a meeting the other day, for the first time in 30 days that had nothing to do with COVID and I was so happy.

A: Right now being over two hospitals has been interesting. I have three incident command calls for each location. Plus, I also have corporate incident command calls so it's been roughly most of my day. It's great because you get so with such wonderful information to share and be able to bring ease to your associates by having more of that inner circle information. So that's been helpful. I look forward to a day when there is no incident command calls.

**Q: What are you doing to reassure your front line staff (who have no capacity to work from home) that their safety is important and what steps are you taking to demonstrate that?**

A: The front line staff are being given masks to wear full time, gloves should they choose to wear them, and we have gone to verbal consents so no one is touching and passing anything back and forth between patients.

A: Communicating and doing QA. We use key words as well when presenting to the staff just like we would with patients. For your safety, we have implemented social distancing barriers. For your safety, we have provided masks for you to wear every day, etc.

A: Small group and one-on-one conversations; we have placed Plexiglas in the ED, Birthplace and MAIN Registration reception; additionally, starting 4/15 all patient facing positions will be provided surgical masks.

**Q: What is your protocol if an Access is positive for COVID? What is the protocol for staff that come into contact with a COVID positive patient?**

A: Positive HCW remain home for 14 days; Employee Health clears post 14 days; once returned to work, screening daily and wear masks for an additional 14 days. Exposure continue to complete a daily screening of employee twice daily.

A: If someone has been possibly exposed to a COVID positive patient, in the beginning when tests were not available, the person would have to be called off of work and self-quarantine 14 days from the exposure. Now, we have staff get tested and wait at home until the test results come back. If negative, they can return to work immediately if feeling well and if positive, they must self-quarantine for 14 days from the test. The ones called off of work because of possible exposure at work, are still paid while on quarantine.

A: For those that have been in contact...they are to keep a daily diary and receive a call from employee health daily. If they begin to have symptoms they are sent for testing and are required to stay home for 14 days. Positive associates for COVID-19 are required to stay home for 14 days.

**Q: Has anyone added a new sick pay code for employees for the future to encourage employees to stay home when they are sick?**

A: We do not a new sick code.

A: No.

A: Not at this time.

## **Working Remotely**

**Q: For people who have their teams working from home. How are you monitoring the productivity of your teams?**

A: We utilize EPIC, so we already had several EPIC either dashboards or reports set up within that platform. We just continue to be able to utilize those metrics. For example, the authorization team who is at home, we track notes as an example. They continue to follow their normal documenting protocols, and we're able to run those reports and we're communicating that information and tracking it. Obviously our census is lower because we're canceling non-essential services and so we made sure that we communicated to the staff who were really concerned that they weren't meeting their productivity expectations that we understand that this is a unique time and that we would not be penalizing or holding them accountable to our former productivity expectations. So I think that that really eased the stress that they were feeling because they felt like you know working from home, they needed to do more. When leadership was able to just reassure them that we understand volumes are down and we're able to monitor based on their login to EPIC, we can see that they're in the system and that they're working and they can only work the accounts that are available in their queues.

A: Obviously the registration staff is at the hospital, they cannot work from home. But our pre-arrival services for what we have still open are working from home and they work in Worklist, so the managers are able to monitor the productivity. Due to low volumes, in order to try to get everybody hours when they're done with our Wordlist, they're done for the day. Within this past pay period we had over 1,000 hours of PTO. We've done a great job of flexing, so that hopefully our organization will not have to go to furlough or people taking time off with no pay.

**Q: Has productivity increased from your staff now working from home?**

A: Yes, we have seen an increase in productivity.

A: The staff are just as productive at home and that is why we are considering not having some team members come back to the hospital site.