

The following presentation was presented during the
Indian Health Service

Patient Registration & Patient Benefits Coordination Training

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If you have questions about this presentation you may contact the presenter(s) or you may send an email to
ihsbusinessoffice@ihs.gov

Please note: The aim of this presentation is to share and facilitate the sharing of helpful information, but please note that it may reflect presenters' opinions and not necessarily those of the Indian Health Service or the U.S. Department of Health and Human Services.



Patient Registration

The First Step To Quality Health Care



“May You Walk In Health and Beauty”

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Agenda

- Learning objectives:
 1. The importance of timely registration
 2. Verifying patient data and impact to health care
 3. Validation & scanning of legal documents
 4. Privacy and General Records requirements

M.V.P.

Patient Registration staff have become the Most Valuable Professionals in the entire health care process over the past decade.





First Step to Health Care

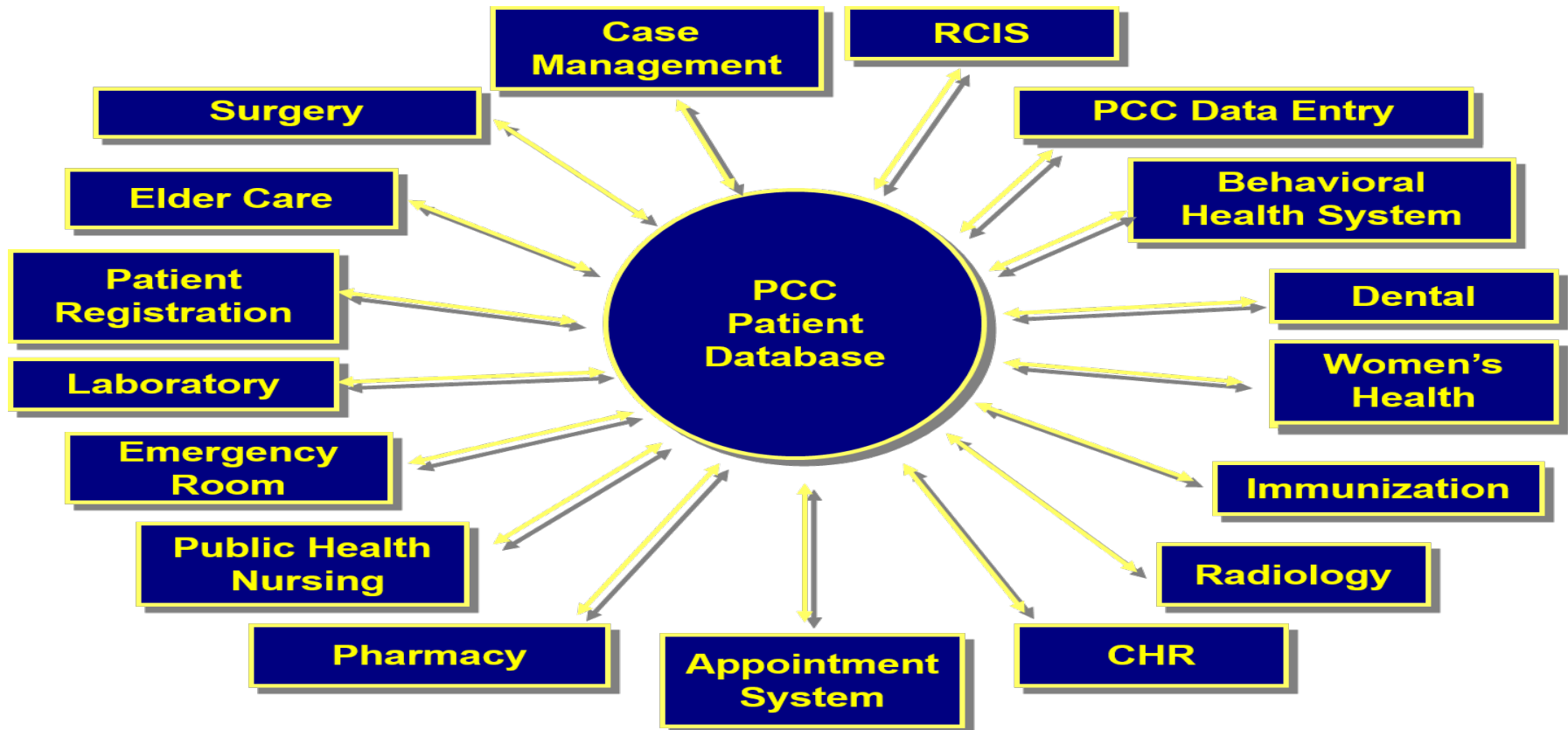
Patient Registration is important to the patient's overall health care process for:

1. Patient Identification
2. Communication between their health care provider/facility
3. Statistical Data
4. Meeting healthcare initiatives (GPRA)
5. Revenue

It is critical to have accurate and complete data for the health care team and health care organization.

Quality Health Care Through Quality Information

RPMS Patient Registration is the hub of all RPMS packages.



Timeliness Is Critical

Real-time data entry is crucial to patient care services in the following settings:

1. All health care services (clinic, ER, hospitalization)
2. Health Center & Health Station services
3. Remote & virtual EHR user
4. Admission to the nursing unit
5. Bar Code Medication Administration (BCMA)
6. Ancillary services (lab and radiology)
7. Purchased Referred Care (referrals & eligibility)



Correctly Identifying the Patient

- It is very important to correctly identify the patient for health care services.
- Regulatory requirements indicate two or more identifiers to properly identify a patient.
- Delay with updating information may impact the health care process, such as: cancellation of surgery, delay of administering medication and even drawing blood.
- Patient record must match patient I.D.
- If different spelling or date of birth difference, add name to AKA or other date of birth to Page 8, until patient can verify.





SCAN ALL is your BFF!

- It is imperative to use “SCAN” every single time you establish and search for a patient record to avoid duplication.

PATIENT REGISTRATION
SCAN the patient files

ALL	SCAN for similar names - entire data base
SCA	SCAN reg. pats (incl. inactive & deceased)
DOB	List patients in DATE-OF-BIRTH order

- Search by all names the patient may use, date of birth, and social security number.



Duplicate Registration

- Using SCAN ALL will avoid the possibility of creating a duplicate registration on the same patient at another Service Unit location.

PATIENT REGISTRATION

SCAN for similar names - entire data base

Select PATIENT NAME: 123456

1	123456	DEMO,JOHN Q	12-25-2001
	KAYENTA-AZ	MOTHER'S (MDN): SAMPLE,JANE	
	123456	NORTHERN NAVAJO MEDICAL CTR	
2	123456	DEMO,JOHN Q	123456789 12-25-2001
	KAYENTA-AZ	MOTHER'S (MDN): SAMPLE,JANE M	
	123456	FOUR CORNERS REGIONAL HLTH CTR	

Impact on Patient Care and PHR

- Duplicate registration impacts ancillary services that the patient may be referred to from another Service Unit or site.
- Patient health information is not consolidated for health care provider and patient.
- Patient is not able to view complete health information under the Personal Health Record (PHR) web portal.
- Creates a possible patient safety issue.





Updates for Continuity of Care

- Mailing addresses – need current address for medical correspondences and appointments
 - Use USPS.com to validate address/zip code
 - Avoid return mail. Is this documented on page 8?
- Telephone number – Fastest way to contact patient. (Cellular and land-line)
- Telephone update - Use 4 or 5 PII to validate patient identification.
- Alternate Registration Authority - Is PRC able to update via phone?
- Create an Area Registration contact list for reference.



Eligibility

- Determining Eligibility is Registration responsibility. Beneficiaries have 30 days to provide CIB.
- Non-Ben – Only for emergency services, then referred out. Non-Ben will be billed for services.
- Non-Ben Employee/CO – Only if facility is designated as an approved “remote facility”. Services will be billed.
- EMTALA – Follow your State requirements.
- Follow-up Services – Do not schedule a follow-up appointment or referral for IHS services for Non-Bens.
- May consider using RPMS Patient Flag “Not Eligible For Care” to be placed on the record.



John Doe and Disaster Chart

- John Doe Chart is to be issued when a person cannot be identified at the time of care. John Doe Chart is temporary until the patient is identified.
- This can be a Temporary or Permanent Chart number assignment, depending on your facility.
- Disaster Chart may be used during a horrific event that will bring many people to the facility or when a mass casualty is called and any and all patients will be treated in various locations, on or off site.



John Doe Registration

- Every attempt should be made to appropriately identify a person.
- Enter the minimum mandatory fields to create the new chart.
- Document on page 8 unable to update.
- Call other surrounding Service Units facilities.
- Registration is responsible for following up with the John Doe patient until identified.



Updates for Continuity of Care

- Emergency Contact – is a person that knows the person's health status and can talk to medical professionals about medical history, allergies, chronic conditions and current medications.
- Next-of-Kin – Someone who is of close blood relation to the person who can be notified for death notification.
 - No authority for disclosure to, or authorization to disclose PHI is delegated.
- Caregiver – Someone who regularly looks after a child, sick, elderly, or disabled person.
- Add Caregivers to the first 3 lines on Page 8 for providers to see on EHR side.



Updates for Continuity of Care

- What to do if patient refuses?

Record refusal on Page 8 of RPMS Patient Registration.

- *“Patient refuses to update demographic information”*
- *“Patient refuses to provide mailing address”*
- *“Patient refuses to provide telephone number”*

- Explain to the patient the need for the information and the purpose it will serve for their healthcare need.

Master Patient Index

- MPI is the heart of Patient Registration.
- MPI should be maintained at each facility site.
- MPI should be cross-referenced with other names used or gender used.
- MPI are permanent records of the facility and should not be destroyed.





Reactivating a HRN in RPMS

For sites that are paperless, it is very important that Registration and HIM communicate when changing the status of the record.

- For patient care - HIM to update Master Control Log
- Chart Review or Audits – To temporary reactivate for the duration of time, then deactivate.

Identifying record activity is important for inactivating records in the future when the patient is no longer active for care, in accordance to the General Records Schedule.



Accuracy Is Important

Wrong data impacts the following:

1. Statistical Data – wrong community, sex, address. Data is used for research, user population, and as the denominator for many RPMS reports, such as GPRA.
2. Patient care services – wrong mailing address
 - a. Example: Farms, AZ ABQ, NM Gallup, AZ
3. Special characters are not acceptable and result in an error.
 - a. Example: Email address
4. Duplication of medical records within a Service Unit impacts access to health information for providers
5. Personal Health Record - patient access to all health information not available due to duplication.

Why is this important ?

- Accurate patient information and managing information is not just used for reimbursement.
- Think about it...Could timeliness and inaccurate data directly impact patient care?
- Bad outcomes: No revenue – Tort Claim – Patient Death





Privacy Concerns

- Notice of Patient Privacy Acknowledgement – Explain correctly to patients
- Knowledge of HIPAA Forms for Restrictions and Corrections
- Minor's rights to privacy under the Privacy Act.
- Patient Interviews – location, open areas
- Phone Interview – Ask for 4 identifiers
- Patient clipboard and worksheets – don't hoard and shred immediately after usage.



Privacy Concerns

- Privacy Act System of Records authorizes IHS to obtain personal information for their medical record.
- What if patient doesn't trust giving IHS personal information in fear that "someone" will get it:
 - *All information is secure in RPMS.*
 - *Employees access based on need-to-know in the performance of their job.*
 - *RPMS Sensitive Patient Tracking monitors all access in RPMS & EHR.*



Privacy Concerns - Continue

- HIPAA Restriction IHS-912-1 – What if a patient asks to restrict their record/information?
 - IHS only approved for one type of restriction for admission.
 - Restrictions may prevent patient care services.
 - Locking up record does not lock up lips.
- Register privacy concern/complaint with Patient Advocate. Need who-what-when-where
- FYI - Personal information is available in cyberspace.



Legal – Time Sensitive

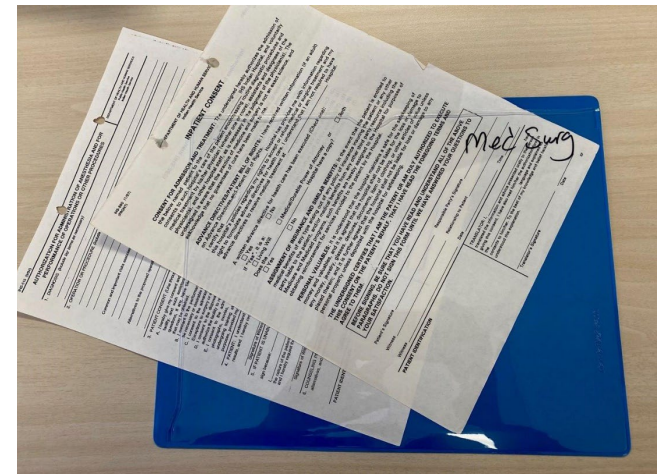
The information needs to be updated for patient care:

- Name changes – Need to be done asap.
- Adoptions – Process asap. Copy to HIM.
- Court Orders – Review to see if pertains to custody or health care decision making.
- Gender change (SOGI) – Process asap. Court order is needed to change name and sex. Copy to HIM.

On Page 8 – Enter Court Order Number, Date issued, Type of document, Issued by Federal/State/Tribe

Legal Documents

- Documents should be only obtained once for the patient medical record within a Service Unit.
- The medical record is a UNIT record, so if a CIB was provided at a satellite clinic, the other facilities within the SU don't have to request it for their facility record.
- Documents should be scanned into VistA for sites in the Service Unit to view.





Legal Documents For Scanning/Filing

These documents below are approved for filing into the permanent medical record:

- Advance Directives: Power Of Attorney & Living Will – for health care decision making.
- Certificate of Indian Blood (CIB) – for eligibility
- Guardianship Court Documents
- Copy of Death Certificate – To officially close out active record.



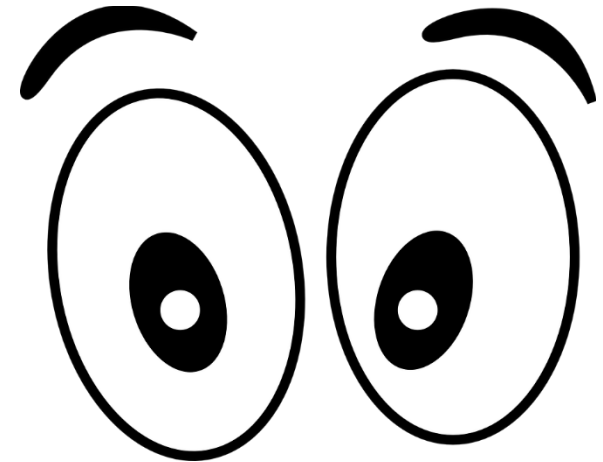
Legal Documents

- Durable Power of Attorney = *Person is incapacitated and unable to handle matters on own until death.*
- Medical Power of Attorney = *Legal document that lets you give someone else legal authority to make decisions about your health care.*
- Power of Attorney = *The authority to act for another person in specific or all legal and financial matters.*
- Temporary Custody = *temporary partition and custody.*
- Executor of Estate = *an individual appointed to administer the last will and testament of a deceased person.*

Documents Not Required

Visual Verification:

- Copies of SSN Card
- Marriage Licenses
- Copy of Birth Certificates
- Health Insurance Cards
- Refer to IHS Memorandum dated August 20, 1999 titled *"IHS Guidelines of Filing Patient Registration Documents into the Medical Records"*
- State, Federal or Tribal re-disclosure laws versus patient's right to entire copy of record.





Editing and Clean-up Page 8

- Page 8 should be used to communicate important information to the health care team.
- Too much old data that needs to be removed.
Example: last updates in clinic and insurance dates.
- Leave important information to first 3 lines, as that is viewable in EHR to the health care team.
- Examples: Caregivers
Refused to update
Record activity



IHS Records Management

- If worksheets or checklists tools are used, destroy immediately after usage.
- Update patient information in real-time. Do not put aside or delay if patient does not have documents.
- Do not include copies of face sheets or other PII documents to shift reports or PMAPs.
- Destroy any RPMS generated reports after usage.
- Safeguard all patient documents at all times when in clinics and in open areas.

Auditing

- Check to make sure MPI's are maintained.
- Are MPIs maintained in a fire/waterproof cabinet.
- Random review of face sheets to see if data is appropriate and timely for name changes & adoptions.
- Establish competencies for Registration staff.





Auditing

- Other areas to check are for compliance:
 - Notice of Privacy Practices (handout & poster)
 - Personal Health Record handout (page 10)
 - Maintenance of Number Control Log



Education & Training

- Management - Invest in training your Registration & Admission Staff
- If outsourced, what are the plans to get your staff trained to perform the work
- If outsourced, does the scope of work include training staff on-site on the work process to eliminate the need of a contractor



Educating the Public

- NNMC Four Directions of Wellness Show (video)
Topic: Patient Registration



Quality Health Care begins with you obtaining Quality Information



Questions



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