



**CHEROKEE INDIAN
HOSPITAL AUTHORITY**

Patient Access: Resources

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CHEROKEE INDIAN HOSPITAL AUTHORITY

- What do I include?
 - Tips/Tricks
 - Cheat sheets
 - Testing
 - Culture of Service
- Why do we need it?

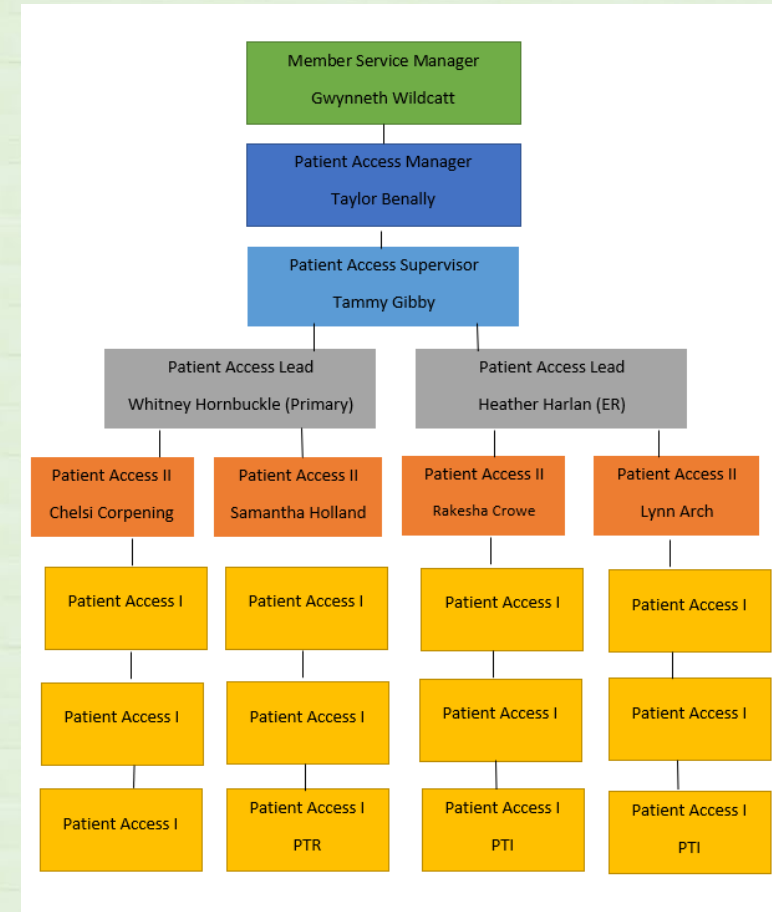
PATIENT ACCESS MANUAL





CHEROKEE INDIAN HOSPITAL AUTHORITY

- Create a checklist
- Review
 - Job Description
 - Policies
 - Cell phone
 - Attendance
 - Dress Code
 - Eligibility
- Create a organization chart





CHEROKEE INDIAN HOSPITAL AUTHORITY

- Review all forms
 - Chart packet
 - Patient Update form
 - Service Agreement
 - HIPPA Agreement
 - Patient Confidential Communications
 - Caregiver Affidavit
 - Affidavits
 - Audit Sheets

Acknowledgement of Receipt of IHS Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your medical information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If you have any questions about this revised notice by logging onto <https://www.ihs.gov/sites/default/files/default-content/2018-05-01-privacy-practices.pdf> or by contacting the IHS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
REQUEST FOR CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS OR ALTERNATE LOCATION

If you have any questions about IHS, call 1-800-453-4613. If you are deaf or hard of hearing, call 1-800-453-4613 (voice) or 1-800-453-4613 (TDD).

1. **Name of Patient** _____ I understand that request for communication by alternative means is subject to change. If you have any questions about this revised notice by logging onto <https://www.ihs.gov/sites/default/files/default-content/2018-05-01-privacy-practices.pdf> or by contacting the IHS.

2. **Signature of Patient** _____ (Note: IHS is only able to send email through the IHS Secure Messaging System. I understand that request for FAX communication if such intercepts occur.)

If patient is unable to sign: _____ Please describe in detail your proposed alternative means of communication: _____

3. **Name of Legal Represer** _____ **Alternate Mailing Address:** _____

4. **Signature of Patient Rep** _____ **Alternate Phone Number:** _____

5. **Signature and Title of Caregiver** _____ **Alternate Means of Contact (Please Specify):** _____

6. **Staff Only:** I hereby certify that the patient understands the IHS Notice of Privacy Practices because: _____

7. **Signature of IHS Staff** _____

8. **IHS Staff Use Only:** Health Record Number: _____

9. **FOR IHS USE:** Request Approved Denied. If denied, reason (check one): Request is not reasonable to accommodate All other (please explain): _____

10. **According to the Paperwork Reduction Act of 1995, no person is required to provide information for this collection of information unless it displays this notice and the instructions on this form.**

OMB STATEMENTS
IHS-963 (4/06)

By signing this form, I understand the contents of the service agreement and have received a copy of the agreement, which was explained to me in English and/or in a common language.

X Patient/Guardian Signature _____ Date _____ Interviewer SI _____

Patient Name _____ HIRN: _____

X PATIENT SIGNATURE _____ OR GUARDIAN OF MINOR _____ DATE: _____

CHEROKEE INDIAN HOSPITAL AUTHORITY
HOSPITAL ROAD, CHEROKEE, NC 28719
MAIL CALLER BOX C-268, CHEROKEE, NC 28719
PHONE: 828-497-9163 FAX: 828-497-5343

Service Agreement

1. **AUTHORIZATION FOR CLINICAL CARE, HOSPITAL CARE AND EMERGENCY ROOM TREATMENT:**
The undersigned voluntarily agrees to treatment and services that his/her physician deems correct.

2. **RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:**
Cherokee Indian Hospital or EBC component units may disclose all or any reasonable part of the pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis, purpose of billing all or part of the hospital's charges to include but not limited to any person, its review, utilization review, modification, financial audit for any other purposes reasonably related to the undersigned. This authorization will remain in effect, until revoked in writing.

3. **ASSIGNMENT OF INSURANCE BENEFITS:**
I hereby authorize payment directly to the Cherokee Indian Hospital or EBC component units of not to exceed the regular charges for this period of services or hospitalization. Should any issue arise it is my responsibility to forward that benefit to the Cherokee Indian Hospital or EBC component health insurance but may include other sources such as Medicare/Medicaid, liability claims and/or other insurance.

4. **STATE REGULATION:**
State regulations require you to present a current identification card every time you are admitted to apply for Medicaid if referred by a Physician, Benefits Coordinator, Contract Health Service or compliance with the Medicaid application process may result in a denial for Contract Health Service if you do not identify yourself as a NC Medicaid recipient, you will be responsible for this bill. Servik Medicaid program will be billed to the patient or Guardian.

5. **MEDICARE:**
This program covers hospital and other services if it is determined that it is medically necessary health care. By signing this agreement I have given this facility a "Statement of Permission for Payment" understanding that the Professional Review Organization and its agents may receive information you are expected to pay the Medicare deductible and co-insurance, if for some reason your insurance, you will be responsible for the entire bill.

6. **NON-BENEFICIARY FINANCIAL AGREEMENT:**
Patient Rights and Responsibilities have been explained to me and I understand my rights and the Advance Directive has been explained to me and if I should have any questions, I must speak with the Director, Privacy Act. I have been given notice and read the Privacy Act Notice and the IHS Directives.

7. **PATIENT RIGHTS AND RESPONSIBILITIES:**
Patient Rights and Responsibilities have been explained to me and I understand my rights and the Advance Directive has been explained to me and if I should have any questions, I must speak with the Director, Privacy Act. I have been given notice and read the Privacy Act Notice and the IHS Directives.

8. **CONTRACT HEALTH SERVICES:**
I have received notice of my Contract Health Service (CHS) eligibility. I fully understand my responsibility to understand the CHS is not an insurance program or an entitlement program. I understand that I am a CHS Part 136 Sub Part C.

Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719

Patient Information Update form

NAME: _____

DOB: _____ **CHART NUMBER:** _____

LEGAL SEX: MALE FEMALE

Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary	<input type="checkbox"/> Transgender <input type="checkbox"/> Other	Preferred Pronouns: <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them	Sexual Orientation: <input type="checkbox"/> Straight, Heterosexual <input type="checkbox"/> Lesbian, Gay, Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer, Questioning/Unsure <input type="checkbox"/> Other
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MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHYSICAL ADDRESS IF DIFFERENT FROM ABOVE: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____

HOME: _____ **CELL:** _____

ARE YOU A VA (Veteran) HEALTHCARE ENROLLEE? YES NO

DO YOU HAVE INSURANCE COVERAGE? YES NO

INSURANCE: _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

ARE YOU CURRENTLY WORKING? YES NO

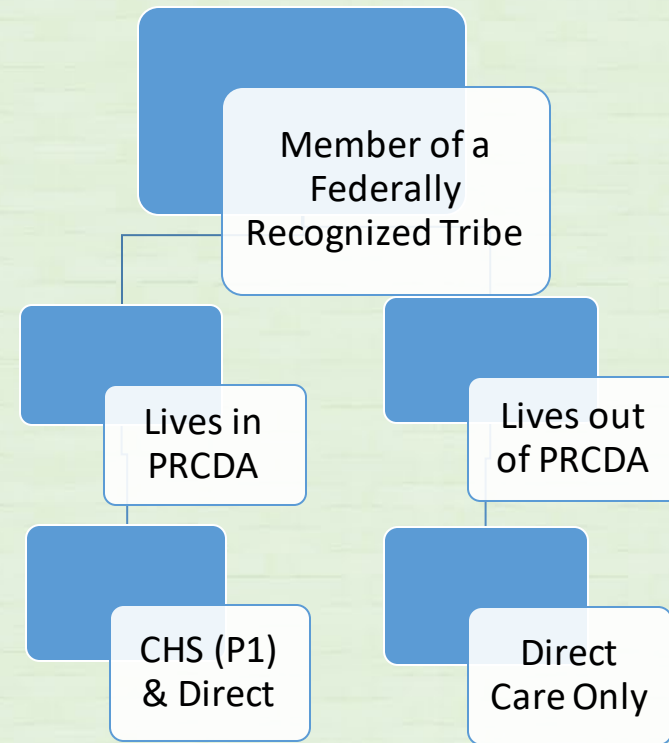
DO YOU WANT TO UPDATE EMERGENCY CONTACT? YES NO

DO YOU WANT TO UPDATE NEXT OF KIN? YES NO



CHEROKEE INDIAN HOSPITAL AUTHORITY

- Create a map highlighting PRCDA
- Create flow charts
- Step Actions
 - RPMS
 - EHR
 - Insurance Portals
 - Workload Reports
 - Notes





CHEROKEE INDIAN HOSPITAL AUTHORITY

- Create a test
 - Eligibility
 - How do you determine eligibility?
 - What qualifies as proof of residence?
 - Create frequent scenarios, how do you remedy situations?
 - Manual
 - How often do you need to update forms?
 - Why do we verify insurances?

Patient Access Specialist Test

Date: _____ Name: _____

1. What policy does the pharmacy eligibility fall under?

PRC Policy	Direct Care Policy
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2. What documents does a newborn chart need to remain CHS and when does eligibility change?

3. When can a Non-Ben r receive services? Name three.

4. What is the difference between a P1 and P3 referral? Who is eligible for P3 referrals?

5. Who are eligible for P3 referrals?

6. How long are EBCI patients able to remain CHS after moving out of the PRCDA?

- A. 60 days
- B. 90 days
- C. 180 days
- D. Eligibility changes automatically

7. How long are Federally recognized patients able to remain CHS after moving out of the PRCDA?

- A. 60 days
- B. 90 days
- C. 180 days
- D. Eligibility changes automatically



CHEROKEE INDIAN HOSPITAL AUTHORITY

- Audits
 - Workload
 - Daily
 - Employee
 - Weekly
 - Referral
 - Daily
 - EOM
 - Aging
 - Monthly





**CHEROKEE INDIAN
HOSPITAL AUTHORITY**

Culture of Service



Learning Objectives

- What excellent customer service looks like
- Dealing with difficult patients
- Our patients are our customers
- Use guiding principles in everyday work
- Key concepts



Key concepts

- 3 Steps to Service
- Eyes and Ears Open
- Ladies and Gentlemen serving Ladies and Gentlemen
- Lateral Service
- Anticipatory Service



CIHA's Guiding Principles

- One who helps from the heart...
- A state of peace and balance...
- It belongs to you...
- Like family to me...



3 STEPS TO SERVICE

1. WARM GREETING (USING PATIENT NAME IF KNOWN)

2. FULFILL PATIENT'S NEEDS

3. FOND FAREWELL (USING PATIENT NAME IF KNOWN)

***EVERY* PATIENT
ENCOUNTER**



Eyes and Ears Open Situational Awareness

“Keep your eyes and ears open” :This not only ensures safety for everyone, it allows you to look for ways that you can go above and beyond for someone. Learning to anticipate the needs of a patient or coworker so that you can deliver and delight is GOLDEN.



Ladies and Gentlemen Serving Ladies and Gentlemen

- We are “**Ladies and Gentlemen serving Ladies and Gentlemen**”: If we, CIHA staff, ever hope to deliver good customer service, we must first treat each other and our patients with the upmost respect. Always greet your coworkers and patients with a friendly “Good Morning” or “Good Afternoon”. Our internal customer service is as important as our external customer service.
- When a patient is approaching your desk, please greet them with “Good Morning, how can I help”. Always think about how you would feel in the patient's shoes and treat them as you would want to be treated.



Lateral Service

- **Lateral Service:** Lateral service means that we view everyone as a member of our team, we anticipate what patients and other departments need from us. If we anticipate a need, we deliver without being asked. This means we go above and beyond for our patients as well as employees from different departments.



Warm Greeting

- Use the patient's name "Good Morning Gwynne, How can I help you today."
- Be pleasant
- Friendly tone
- Smile
- Eye contact
- Be aware of body language



Fulfill Patient Needs

- Remember we are ladies and gentlemen serving ladies and gentlemen.
- When possible don't "send" patients, take them
- Lateral Service
- Manage Up
- Think "Guiding Principles"



Fond Farewell

- Ask if there is anything else you can help them with today, continue to assist until all needs are met.
- Use the patient's name "Thank you Gwynne, it was a pleasure helping you today"
- Be aware of tone, body language and word choice



Difficult Situations

- Soda Effect
- How to move on and shake off difficult situations to provide excellent service in the next encounter.



Contact Information

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