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Use upfront collections to help hospital and patients

Proactive collections and compassion not mutually exclusive

The main reasons **Susan Baxley**, corporate admitting manager, wanted to work for Adventist Health was because of their mission statement "to share God's love by providing physical, mental, and spiritual healing," and because of their desire to implement best practice registration.

She joined the Sacramento, CA-based health system, which oversees 20 hospitals in California, Washington, Oregon, and Hawaii in November 2001 after a lengthy tenure with a national hospital chain.

Coming from a "pro-collection background," Baxley adds, she was struck by the fact that Adventist was not tracking and trending registration statistics, particularly over-the-counter cash collections, and was not soliciting payment at the time of service.

The mindset was, "We'll just send a bill from the business office — we're a not-for-profit company," she explains.

Experience taught her, however, that compassionate customer service and a proactive collections policy were not mutually exclusive, Baxley notes. "I knew the [positive] effect of communicating with patients about what is owed. Insurance and Medicare are so complicated the average person has difficulty understanding what is covered and what is not covered."

Baxley once read that a national survey revealed that 75% of patients who left their health care providers did so because "they were surprised or upset about the bill," she notes. "Nobody said anything to them up front, they didn't understand their [insurance] coverage, and they were upset about this large bill arriving."

"I believe part of customer service is helping patients work through this," Baxley adds. "Financial expertise and compassionate understanding are needed. Financial counseling is the cornerstone of good customer service."

That philosophy — along with some focused training on the how and why of upfront collections — has helped boost over-the-counter cash

totals for Adventist's 20 hospitals from $2.6 million in 2001 to $10.5 million in 2002 to $16 million in 2003, she says. **(See Over-the-Counter graph, p. 75.)** By mid-May, Baxley adds, the system was on track to collect about $20 million in 2004. "We hit a [monthly] high in April of $1.8 million."

The success, she emphasizes, was very much a team effort. "I'm so proud of every single one of the registration managers. This is their accomplishment. I've simply been the cheerleader."

Hiring Baxley was part of a strategy to bring oversight for patient financial services (PFS) and admitting to Adventist Health's corporate office, according to **Jim Brewster**, the health system's vice president of finance.

"For about 10 years, we didn't have a presence in patient financial services in the corporate offices," Brewster says. "About three years ago, we added staff to assist hospitals in the operation of their PFS offices."

In addition to Baxley, he notes, there now is a PFS director at the corporate level, as well as a regional business office manager.

What began as a focus on best practices in admitting — ranging from obtaining good demographics to providing excellent customer service — extended into "add-on pieces" that included a hard look at over-the-counter cash collections, Brewster explains.

"Our board is extraordinarily pleased with what is happening," he says, noting that, among other improvements, days in accounts receivable have come down steadily over the past 2½ years and there has been a positive impact on bad debt.

Despite tough economic times, "we haven't seen the kind of rise [in bad debt] that others have seen over the past couple of years," Brewster points out. "In a number of our hospitals, there has been a reduction in what had to be put aside for bad debt and as a system, we have leveled off."

Learn what and how to collect

When she first started doing assessments of the different facilities, Baxley says, she realized that cash collections was not a focus, and she knew from working with hospital registration employees all over the country that at least one of the following reasons applied:

1. Registrars don't know what to collect.

"Maybe they don't have the right tools, like eligibility systems, or maybe they just don't understand insurance coverage."

2. Registrars don't know how to collect.

"I've found registration staff that feel very comfortable asking for an emergency contact, a diagnosis, a Social Security number, and other personal information, but when it came to asking for money, they became very nervous."

3. Registrars just don't believe in it.

"Maybe they think [asking for money] is poor customer service or that it isn't their job, it's the business office's job."

With those potential challenges in mind, Baxley says, she "started off with making sure they knew what to collect." She taught classes, and worked with admitting managers on Medicare,

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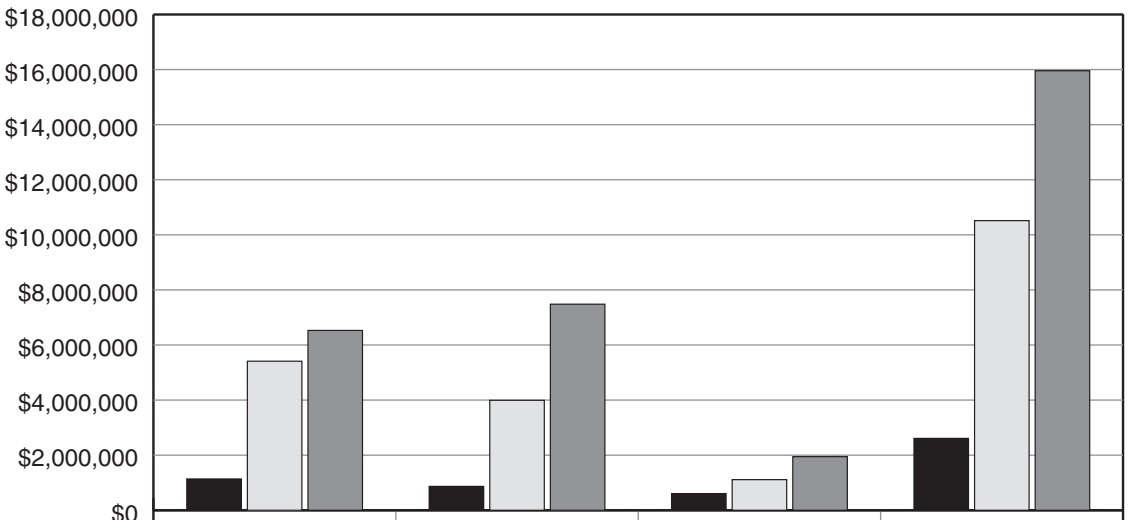
Over-the-Counter Cash Totals



	Region 1	Region 2	Region 3	Total
2001	$1,136,545	$866,775	$605,761	$2,609,081
2002	$5,412,000	$3,991,716	$1,111,330	$10,515,046
2003	$6,529,294	$7,482,393	$1,945,843	$15,957,530

Source: Adventist Health, Sacramento, CA.

MediCal (California's version of Medicaid) and other forms of coverage.

Adventist installed the HDX integrated eligibility system, so registrars can confirm that a patient still has the insurance that is listed and determine the copay or deductible, she adds. "If [the insurer] is MediCal, there is month-to-month eligibility, so maybe the patient needs to be [classified as] private pay.

"I also made sure access personnel knew how to check insurance via the Internet using payer-specific web sites," Baxley says.

The class on collection skills included not only the "what to collect" and "how to collect" parts of the equation, she adds, but also focused on helping registrars realize that proactive cash collection "is a good thing."

Baxley pointed out to her staff that the practice is in line with Adventist's mission statement. "We want to be good financial stewards," she says. "If we can collect from those who can afford to pay, then we can provide charity care for those who can't afford to pay."

"The shift in the paradigm," Baxley adds, "was that in the past, Adventist had just sent a bill, and if the patient complained, or said she or he couldn't afford to pay, [the health system] tried to get them on Medicaid, but it was often too late, so the bill ended up being written off to bad debt."

Work together with the patient

In training registrars, Baxley uses an analogy of taking a car to a mechanic who works on it and then says, "Don't worry about it — I'll just send a bill later." Later, the person gets a bill for $3,000 and "feels really ripped off," she adds. "And we wonder why patients are upset with big bills from the business office."

It will be much better, Baxley suggests, if the mechanic tells the customer up front there are many problems with the car. The cost will be $3,000, but there are several payment options available, including a loan program.

In that case, she says, "The person feels the mechanic is saying, 'Let's work on this together.'"

Registration staff have been "pleasantly surprised" to discover that this scenario applies to patients as well as car owners, Baxley says. At one Adventist hospital, she notes, "customer service scores improved dramatically" after employees began discussing payment options with patients.

Adventist Health System
Over-the-Counter Cash Collections — FY 2001, FY 2002, FY 2003

Facility	Fiscal 2001 Total Over-the-Counter Cash	Fiscal 2002 Total Over-the-Counter Cash	Change in Total OTC — 2001 to 2002	Fiscal 2002 Total Over-the-Counter Cash	Fiscal 2003 Total Over-the-Counter Cash	Change in Total OTC Cash - 2002 to 2003
1	399,627	1,527,684	1,128,057	1,527,684	1,476,189	(51,495)
2	396,305	1,788,222	1,391,917	1,788,222	2,101,863	313,641
3	266,930	1,264,532	997,602	1,264,532	1,957,572	693,040
4	0	295,077	295,077	295,077	431,108	136,031
5	73,683	536,485	462,802	536,485	562,562	26,077
Region One Total	**1,136,545**	**5,412,000**	**4,275,455**	**5,412,000**	**6,529,294**	**1,117,294**
6	90,712	185,051	94,339	185,051	159,285	(25,766)
7	188,773	369,026	180,253	369,026	366,391	(2,635)
8	163,978	588,206	424,228	588,206	2,188,426	1,600,220
9	102,537	255,276	152,739	255,276	264,365	9,089
10	90,961	307,432	216,471	307,432	489,476	182,044
11	38,835	84,528	45,693	84,528	121,125	36,597
12	36,057	174,764	138,707	174,764	234,948	60,184
13	6,992	1,668,277	1,661,285	1,668,277	3,205,756	1,537,479
14	147,930	359,156	211,226	359,156	452,621	93,465
Region Two Total	**866,775**	**3,991,716**	**3,124,941**	**3,991,716**	**7,482,393**	**3,490,677**
15	29,097	309,482	280,385	309,482	856,950	547,468
16	218,565	199,605	(18,960)	199,605	168,673	(30,932)
17	237,660	161,276	(76,384)	161,276	181,235	19,959
18	113,287	385,484	272,197	385,484	578,541	193,057
19	7,152	44,408	37,256	44,408	113,687	69,279
20	-	11,075	11,075	11,075	46,757	35,682
Region Three Total	**605,761**	**1,111,330**	**505,569**	**1,111,330**	**1,945,843**	**834,513**
AHS Total	**2,609,081**	**10,515,046 +303%**	**7,905,965**	**10,515,046**	**15,957,530 +51.8%**	**5,442,484**

Source: Adventist Health, Sacramento, CA.

In the class on collection skills, Baxley adds, she works with staff on how to approach the patient in a customer-friendly manner, and leads employees in some role-playing. "Any time you speak with a patient, it's like an interview. You can't help them unless you get them to communicate."

"I tell [registrars] never to ask a 'yes' or 'no' question," she says. "You don't say, 'Can you pay for that today,' but rather, 'How would you like to take care of that?'

"Then, if the patient says, 'I don't have any money,' you're able to draw the patient out, work with them."

Baxley says she stresses the following concepts when working with registrars:

- **Believe in yourself.**

This has to do with "making sure you have the right attitude when you approach the patient," she explains. "You need to be sure you know what you are talking about. If you don't understand the estimated charges, the patient feels uncomfortable."

- **Communicate in a clear, concise way that leaves no doubt money is owed.**

"[Registrars] need to be able to gauge the patient's reaction to what they are saying — all this terminology that the average patient may not know," Baxley notes.

- **Act as a patient advocate.**

Offer solutions that work for the hospital and the patient, she adds. "We're there to help them work through this process." Offer all the options available, Baxley says, and if they don't work, look for other ways to get reimbursement.

Competitive spirit emerges

Every month, Baxley says, she receives an admitting data quality indicator from the

registration manager at each of Adventist's 20 hospitals. From that report, she extrapolates the following data and trends it on a spreadsheet. **(See Over-the-Counter Cash Collections excerpt, p. 76.)**

1. Pre-registration totals
2. Percentage of scheduled cases that are pre-registered
3. Number and dollar amounts of registration-related denials
4. Over-the-counter cash collections
5. Compliance with regulatory requirements.

The data are sent to all Adventist Health registration managers, patient financial services directors, chief financial officers, chief executive officers, and other regional and corporate financial administrators, Baxley reports.

Although it wasn't her intent, she notes, the report has sparked some competition among the registration staffs at the various facilities

Because the hospitals are so different — running the gamut in number of beds and predominant payer type, among other measures — Baxley sets collection expectations using a standard that levels the playing field, she points out. "It's not fair to compare a DSH [disproportionate share hospital], which won't bring in as much cash, to a hospital with more payers."

"I looked at industry standards and found that it was considered best practice if registration departments (that includes inpatient, outpatient and emergency department) can bring in 2% of what is collected by the business office," Baxley says. "We compare percentage to percentage. Then you know where the true target is."

"All of our facilities have dramatically improved," she adds. "We've had one at 3.59% in March and another hit 5.08%. On average, 2% is what they should bring in."

In addition to the benefit of getting money sooner rather than later, there is another financial plus to upfront collections, Baxley points out.

"There are a lot of costs associated with sending out a bill," she says. "There is postage, computer time, stationery, and the soft costs — people spend hours posting, reposting, telephoning patients, and documenting. The American Collectors Association estimates it costs $6 to $8 to rebill one statement."

That means that for a hospital rebilling 1,000 patients for 90 days in two-week billing cycle, Baxley continues, billing costs alone would equal between $36,000 and $48,000.

Proactive cash collection is "good for the hospital, good for the patient, and good customer service," she adds. "It's about being good stewards of resources."

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Nurses help ED collections and customer service grow

Hospital's Press Ganey rating soars

Cash collections in the emergency department (ED) at Wake Forest University Baptist Medical Center, in Winston-Salem, NC, have almost doubled in the past two years as staff continue to focus on enhancing customer service and gaining buy-in from clinicians.

The hospital's ED operation was highlighted in *Hospital Access Management's* June 2002 issue. **Keith Weatherman**, CHAM, associate director of patient finance, notes that, since that time, monthly collections have increased from about $25,000 to — as of April 2004 — about $42,000. May figures were on track to surpass that, he adds, with an expected total for fiscal year 2004 of more than $350,000.

Before Baptist Medical Center began a formalized discharge process in February 2002, annual ED collections had been about $70,000, Weatherman says.

"We've been [making some] continuous improvement over the past two years," he adds. "One of the things that has made a difference is going to a 'quick registration' function. [Access staff] have miraculously been able to work with nurses to get them to agree to go into the computer system at triage, do a patient index search, and assign an account number."

That step, instituted by ED registration manager **Charlynne Lynch**, has virtually eliminated patient wait time and any registration bottleneck, Weatherman says. "Registration is no longer a factor in delaying patient treatment."

Before, with pertinent patient information placed on a piece of paper and handed off, there often was a delay in placing treatment orders, which require a patient account number, she notes.

"In the past, a bottleneck would occur between patient triage and patient treatment," Lynch explains. "Registration, which took place before a patient was assigned to a treatment

room, could take up to 10 minutes. We've been able to eliminate that by completing a quick registration — done either by the greeter or, if a room is available right away, at bedside."

Early registration means faster treatment

Because order entry can be done at triage, treatment begins immediately in some cases, she points out. "There are some protocols that can start at triage." That might be the case, she adds, if a patient comes in with pain in the left ankle and an X-ray is called for. "They can even do urine [tests] before the patient goes back."

"What the nurses are doing is searching [the computer system] for the patient's name," Lynch says. If the name is there, the nurse does a quick registration using the medical record number and basic identifying information, she explains. If there is no existing account, the nurse creates a medical record for the patient and then does the quick registration.

Emergency Medical Treatment and Labor Act regulations are not a concern, she explains, "because we're just asking for demographics — date of birth, reasons for the visit, attending physician. It's really just a patient identification process."

While many registration managers would "shudder at the thought" of allowing nurses to do that computer search and assign medical record numbers — for fear they would create duplicate accounts — the process has not been a problem at Baptist, Weatherman notes.

"If [nurses] can do lifesaving procedures," he adds wryly, "I think we can trust them to do this. It's not like it can't be fixed if they do make a mistake."

To ensure accuracy, Lynch points out, nurses received special training in the procedure, and get feedback — and additional training — if there are duplications or other errors.

Since the quick registration process was implemented, Weatherman says, the hospital's customer service survey scores from South Bend, IN-based Press Ganey Associates — already in the 99th percentile overall — have gone up another 2.5 percentage points for the ED. For the quarter ending March 31, he adds, Wake Forest University Baptist had the highest overall ranking of any Press Ganey client in the nation.

Another plus, notes Lynch, is that the number of ED patients who leave without being seen also has been reduced significantly. That figure went from a high of 9% at the beginning of the hospital's fiscal year, in July 2003, to 3% for April 2004, she adds.

Much of the improvement has been attributed to the quick registration process and the ability to start treatment at triage, Lynch says.

ED staff focus on gathering information for the full registration during the period after the patient has gone back for treatment and family members have arrived and are in the waiting area, she says.

"We also have an opportunity to bring closure at the back end," Lynch continues. "At discharge, a nurse will escort the patient back to the discharge desk, where we do a final review. We are able to look over the patient account, make sure we have all the information we need, and we schedule return visits to our downtown clinic for those who don't have a primary care physician."

Final review aids patient care and payments

One of the most positive things about that final review, Weatherman points out, is that the first thing the employee asks patients is whether they have any clinical questions. "If they do, we call the nurse to come back and talk to them."

Weatherman had successfully instituted a similar process at another hospital, he adds, in response to patient complaints. "People said things like, 'I was hurting, and all they wanted to know was how I'm going to pay.' We want them to know that we really do care about their treatment."

Registrars follow a script, Lynch explains, that begins, "How was your visit?" After asking if there are questions about treatment, they offer to schedule the follow-up appointment, and then say something like, "How would you like to make your copay today?" or "I see this is personal pay. We do have a requested deposit on your account."

These self-pay patients, she adds, are asked to put $275 toward hospital charges and $140 toward physician charges, which was part of the process that required "working out some logistics with the accounting department."

Collecting for physicians helped the hospital get their buy-in on such things as making sure patients are escorted to the discharge desk, says Weatherman. "They're on our side. The team approach has been one of the big [positives]. It's like one department down there."

The formalized discharge process also ensures

that, for the most part, patients do not leave without checking out, he says, noting that of some 6,100 patients who came through the ED in March, only 30 left without coming to the discharge desk.

Arrange follow-up visits

Scheduling the follow-up visits to the hospital's primary care clinic has paid off in several ways, Weatherman notes. "We used to just give the patients a phone number and leave it to them to call. Most didn't do that — they would just show up in the ED if there was another problem."

With the present system, he says, about 70% do make that follow-up clinic appointment, and perhaps continue to use the clinic for their nonurgent health care needs. This likely has had a direct bearing on the fact that the percentage of self-pay ED patients has gone down, Weatherman adds.

Further enhancing the operation, Lynch says, is the newly remodeled ED registration and discharge area that opened in March 2004. In addition to a separate area for "fast-track" patients, she adds, "we have a better area in which to interview people, with private booths for more confidentiality. [The remodel] has improved both customer service and patient flow."

[Editor's note: Keith Weatherman can be reached at (336) 713-4748 or at kweather@wfubmc.edu, and Charlynne Lynch can be reached at (336) 713-4708.] ■

'Career ladder' increases payments; reduces turnover

Positive feedback from and to managers

A new career ladder for emergency department (ED) registrars at Wake Forest University Baptist Medical Center in Winston-Salem, NC, has helped reduce staff turnover and is providing increased motivation for employees to perform at higher levels in cash collections, among several other categories.

Under the umbrella of the departmental goals of "accuracy, timeliness and friendliness," says **Charlynne Lynch**, ED registration manager, "we want to have an achievement rate (accuracy of patient registration) of 97%. Anything over 97% is above standard."

Employees who achieve that ranking — along with meeting standards relating to teamwork, customer service excellence, high professional standards, and collection rate at discharge — are eligible to be designated "senior registration clerk" and receive a pay increase of between 4.5% and 7%, Lynch adds.

"The quality of work has to reflect that high standard," she says, noting that to qualify, employees also must not have been subject to any disciplinary action, such as tardiness, and must behave and dress professionally.

"We look for those who are exceeding our standards," Lynch says, "for the value-added things. We have some [employees] who have conducted inservices for the staff. That plays into this as well."

An employee who has met the collection and accuracy goals, but was not a team player or did not interact well with patients, would not receive the promotion, she explains.

Standards must be maintained

To qualify, employees must have been in their position for at least six months and have maintained the high scores for more than six months, Lynch adds. After they've received the senior registration clerk designation, she says, if they don't maintain the standards, they move back to the former position.

Since the program was instituted in February of 2003, the cumulative achievement rate for the department has increased from about 93% to between 96% and 97%, Lynch notes. Cash collection rates also have grown dramatically during that period, she says. **(See ED Registration graph on p. 80.)**

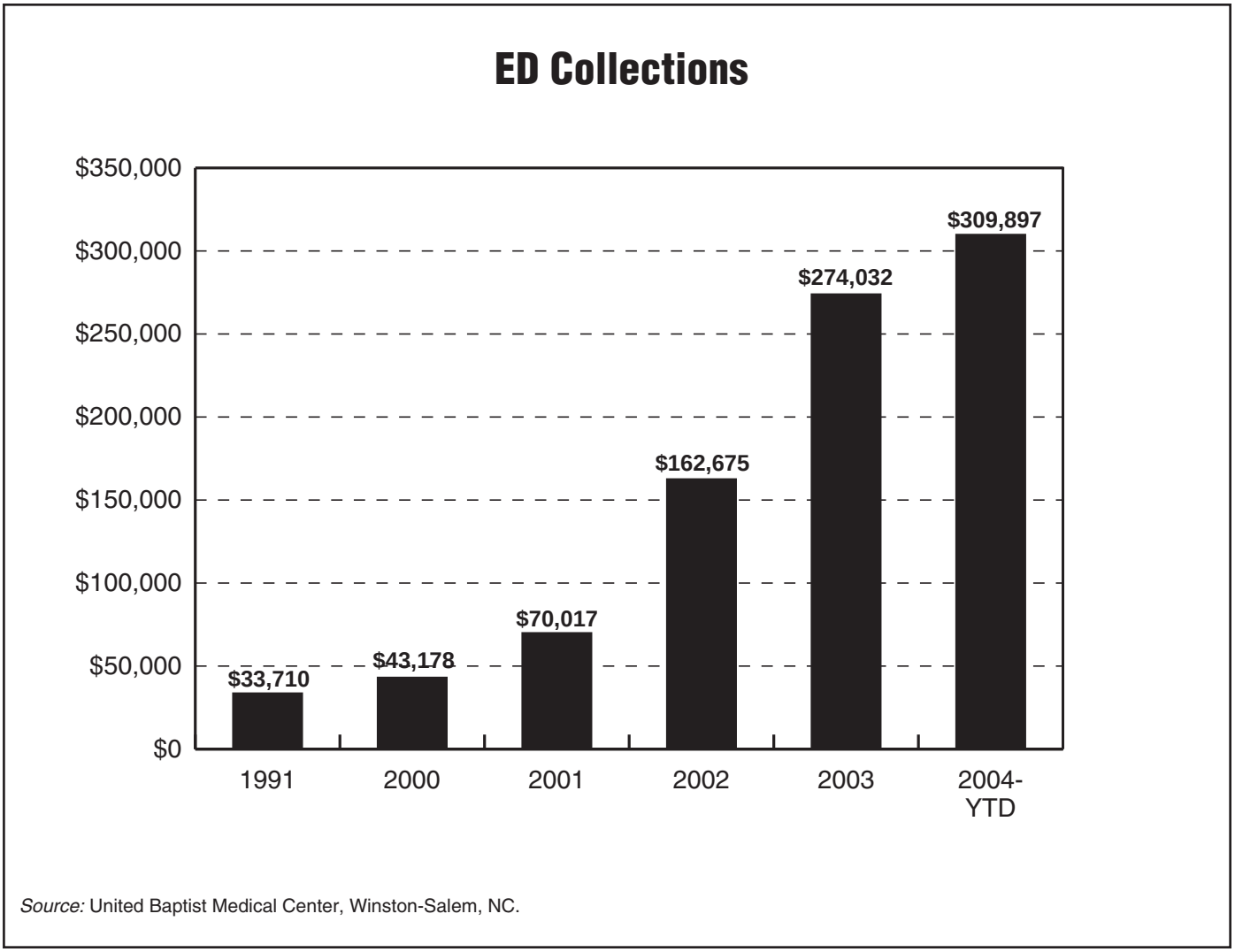
Collection goals "can be a moving target," Lynch adds. "In the past, we shot for $30,000 [a month], then we moved [that figure] up."

Good management reduces turnover

Keith Weatherman, CHAM, associate director of patient finance, points out that when Lynch assumed her position four years ago, there was a 116% turnover rate among ED registration employees. "It's less than 8% now," he adds.

"Just having a good manager" is as important as any salary incentive when it comes to employee morale and motivation, Weatherman suggests.

That means "not micromanaging," he says, "but just being a 'go-to' person and empowering [staff] to make decisions." Employees had a



Source: United Baptist Medical Center, Winston-Salem, NC.

voice, for example, in the recent ED remodeling project, Weatherman points out.

Competition is good for business

The atmosphere of healthy competition that has been created around the cash collections effort, meanwhile, is keeping Lynch, Weatherman and the patient financial services director busy providing positive feedback to the highly motivated registrars, he notes.

"It's a game now," Weatherman says with a laugh. "We get e-mail messages saying things like, 'I collected this much by myself on one shift.' We can't slack off one day on responding. The first message we get that we don't respond to will kill it."

The hospital's chief financial officer visits with the staff on a monthly basis to show her appreciation for their efforts, he notes.

Lynch marvels that she and Weatherman also have been the recipients of some pretty positive feedback — from staff. "We've actually gotten thank-you letters from employees," she adds. "How often does that happen?" ■

Finish 'to-do list' for HIPAA security rule

Check faxing, log-in practices

If planning isn't already under way, the time is now for your hospital to get ready for implementation of the Health Insurance Portability and Accountability Act's (HIPAA) security rule, which takes effect April 21, 2005. And although the rule doesn't apply as specifically to access departments as does the HIPAA privacy standard, there is definitely an access "to-do list," say those leading the preparation effort.

The privacy rule, which became effective April

2003, had more impact on day-to-day access operations because, among other things, access personnel were on the front lines, handing out the notice of privacy to patients, notes **Rita Aikins**, MBA, CHS, system director, privacy and information security, for Providence Health System's West Coast hospitals.

But she adds that if access departments are using systems that don't have unique log-ins and passwords for each individual, "whoever is managing the department will have to figure out what to do about that" as part of the security rule implementation.

Providence began doing away with generic log-ins "years and years ago because we didn't think it was good practice," Aikins says. However, there are many hospitals that have not taken that step.

Prepare now to implement rule

Access managers also need to conduct a departmental analysis, she says, to look at issues such as how they handle the faxing and photocopying of protected health information.

Meanwhile, a report released at the end of April by URAC, a health care accreditation organization, recommended that hospitals begin preparing immediately for security rule implementation, suggesting that most security risk management programs can take up to a year to fully implement.

That report said key challenges encountered by the sample of health care organizations studied included incomplete or inappropriately scoped risk-analysis efforts; incomplete or poorly executed risk management strategies, limited or faulty review of information system activity, and ineffective security incident reporting and response.

Handle risk management first

The American Hospital Association reports that it is working with the consulting firms Ernst & Young and Computer Associates to provide hospitals with additional resources to help jump-start their security efforts.

Providence Health System is "right in the middle of the pack" in terms of its security rule preparation, says Aikins. "What's on everyone's mind is getting the risk assessment done. Once that's done, we can figure out the workload and the cost."

Providence began its risk assessment — "a very complex" process — in September 2003, she notes. "The complexity of it [means that] you have to look at every computer system that stores or uses electronic protected health information [EPHI] and there's not a good inventory to work with. We're trying to create an inventory as we go along, trying to reach compliance."

In addition to the systems that Information Systems support, Aikins points out, there are "departmental systems and access databases that departments have created, and they're all covered under the security standard if they have EPHI in them. That's my opinion as to what makes the security rule more complex — this identifying, fact-finding, analytical phase you have to go through before you do anything."

With the privacy standard, on the other hand, "when you read it, you knew what to do here, here and here," she adds.

Aikins says she has the "gap analysis" — an accounting of issues the risk assessment has indicated need to be addressed — for the health system's Oregon region, but not for the Alaska, Washington, and California facilities.

"The biggest challenge is the audit requirement, because systems will need to set a standard around their auditing," she notes. "The security standard says you have to audit, but doesn't tell you how often or what to look at, and it says you have to have a sanction policy."

One concern is that the policies must be consistent throughout the organization, Aikins points out. "For us, we don't want California to say, 'We're going to audit this way,' and then another state say, 'That's too much work. We won't audit that way.'"

Categorize auditing practice

Aikins says she puts the various systems at Providence into three categories, defining what each category should include, and how stringent the auditing practice should be for each:

- **Category I** includes the main hospital information system, with all registration, admission and transfer functions, the order entry system, and the electronic medical record, if one exists.
- **Category II** includes systems to which only a single department has access, such as a laboratory system, Aikins adds. "It will still require auditing, but not as stringently, because only a small percentage of people have access."
- **Category III** includes systems with "small applications, few users, and smaller data repositories," she says. "This might be a database that someone created that has three users in the

department, or a database that tracks mammograms and sends reminders when a woman needs to come back."

All categories will be audited, Aikins adds, but with Category I, the auditing will be proactive, and with II and III it will be done only for cause.

"Auditing will be labor-intensive," she says, "and we have to be careful that the parameters we put around auditing are realistic. If we set the bar too high, we won't be able to achieve anything."

Much to be done for compliance

"Getting one's arms around the [HIPAA security] regulations is challenging," says **Gillian Cappiello**, CHAM, senior director of access and chief privacy officer at Chicago's Swedish Covenant Hospital. "Most hospitals — and Swedish Covenant is no exception — have so many systems and databases that need to be up to snuff."

"I would have to say that while we are not in panic mode yet," she adds, "there is much to be done."

The hospital's senior information technology director is "leading the charge," and likely will be named the hospital's chief security officer," Cappiello says. "He is in the process of creating a charter to define the purpose, scope, roles and responsibilities, risks and vulnerability assessments, and processes" for complying with the security standard.

Swedish Covenant has engaged a consulting firm to do a facilitated risk-analysis project (FRAP), and also is using information from the gap analysis and road map developed by another firm during preparation for the privacy standard, she notes. "It was done mostly for the privacy regulations but [also addresses] what was known of the security rule before it was final."

Updates can be extensive

The hospital also is using and updating some of the strategies from its Y2K planning, Cappiello says, "particularly as they relate to threats or hazards, the risk to security or integrity of data, disaster recovery, backup systems, continuity plans, and business impact assessments and contingencies."

Such initiatives come with a price tag that is likely to be substantial, she suggests. While implementation of the HIPAA privacy standard was "pretty low cost," adds Cappiello, "security is a whole different story. Some of the requirements are going to be more expensive to implement."

"We had difficulty finding a consultant — for the fee we wanted — that could also do the physical plant assessment," she notes, "so that is not included in the FRAP."

Aikins says that until the Providence assessment is completed, she won't know what the cost of preparing for security rule implementation will be. She points out, however, that she expects much of it to be paid from operating dollars.

"I'm not sure some of this [expense] can come out of capital, with the rules around capital dollars having changed," Aikins adds. "There are certain rules for health care organizations as to what qualifies to have capital spent on it."

"If you don't have an audit trail and have to have one created, can you use capital for that? These are the questions people will have to ask and answer," she notes. "The way one organization wants to handle it, another may not. With the current business environment, some have strengthened and tightened up their accounting practices and may say, 'No, we can't spend capital for this."

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Care of uninsured putting EDs at risk

Increasing numbers of uninsured patients and limited Medicaid reimbursements are placing a third of the nation's emergency departments (EDs) at risk of closing or eliminating emergency services, according to a recent report from the Centers for Disease Control and Prevention.

The report, which can be found at www.cdc.gov, identifies more than one-third (36%) of the EDs in the study as carrying a high safety-net burden, which is defined as serving at least 30% Medicaid-eligible patients, 30% uninsured, or having a total of 40% of patients falling into either category.

The analysis also finds that public funding does not offset this high safety-net burden.

"Inadequate public and private funding for emergency services is threatening the ability of emergency departments to provide care to all regardless of ability to pay and has already contributed to the closure of more than 1,000 emergency departments across the country," said **J. Brian Hancock**, MD, president of the American College of Emergency Physicians (ACEP).

Uninsured patients increasing

In an ACEP report regarding the uninsured, meanwhile, nearly three-quarters of emergency physicians say the number of uninsured patients they treat has increased in the past year, and eight in 10 expect the number to grow higher in the coming year.

Nearly three in five emergency physicians surveyed ranked providing health coverage to all Americans the nation's most important health care goal, the survey found. A summary of the findings can be found at www.coverthe uninsuredweek.org ▼

Uninsured impact hospitals' bad debt

Growth in the number of uninsured and underinsured Americans is contributing to rising bad-debt expense for hospitals, and the situation likely is to continue, according to a recent report by Moody's Investors Service.

"Lack of insurance as well as higher copays are leading more people to avoid hospitals unless absolutely necessary," the rating agency said. "When they eventually do have to be hospitalized, they require more care and incur higher costs than they would have otherwise."

The trend was cited in a new Moody's report on the credit outlook for investor-owned health care companies. The agency said both for-profit and not-for-profit hospitals are experiencing the rise in bad debt expenses, which could lead to lower cash flow from operations and credit ratings.

Many young adults uninsured

An analysis by researchers with the Commonwealth Fund, meanwhile, indicates that adults under 30 comprise 30% of the nonelderly uninsured. Young adults ages 19-29 comprise just 17% of the population, but 30% of the under-65 uninsured, the study found.

That report, which can be found at www.cmwf.org, says that nearly two in five college graduates and one-half of high school graduates who do not attend college will endure a period without health insurance in the first year after graduation.

The researchers say policy-makers could extend coverage to more uninsured young adults by extending eligibility for private family coverage to age 23, and ensuring that colleges and universities require and offer coverage to their students.

The study notes that young adults are a relatively low-cost population to insure, and that keeping them in insurance pools may lower the average costs of group coverage. ▼

Get help on-line for move to EMR

The Foundation for eHealth Initiative has launched an on-line repository of information on health information exchange designed to help health care organizations moving from paper-based record keeping to electronic medical records.

The Community Learning Network, as it is called, includes articles and community profiles addressing the financial, clinical, and legal aspects of on-line health information exchange and the adoption of electronic-based records.

The target audience includes hospitals, clinicians,

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- 'Best Practice in Admitting' success story
- Financial counseling initiative pays off
- Innovative customer service strategies
- Strategies for staff training

payers, and other health care organizations.

The foundation is a council of health care leaders with the stated purpose of improving the quality, safety and efficiency of health care through information and information technology. The learning network can be found at http://ccbh.ehealthinitiative.org/. ▼

Tool helps evaluate disaster drill planning

A tool to help hospitals evaluate their disaster training drills is available free to hospitals from the federal Health and Human Services Department's Agency for Healthcare Research and Quality (AHRQ).

The tool, developed by the Evidence-Based Practice Center at Johns Hopkins University, helps hospitals identify their strengths and weaknesses during a disaster drill and improve their ability to meet required emergency management plans. Areas assessed include pre-drill planning, incident command, decontamination, triage, and treatment.

The tool also includes checklists to help hospitals tailor drills to specific health threats, such as biological or radiation incidents, and a spreadsheet to track and compare drill performance among hospital units or hospitals.

The resource, *Evaluation of Hospital Disaster Drills: A Module-Based Approach*, is available from the agency as a notebook with accompanying CD-ROM. Call (800) 358-9295 and reference AHRQ Publication No. 04-0032. It also can be downloaded on-line at www.ahrq.gov/research/hospdrills/hospdrill.htm ■