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Patient readiness system addresses ability to transition in emergencies

Important tool for disaster preparedness, ED overcrowding

A scoring system for assessing which patients are most ready to be discharged from the hospital can be an important emergency preparedness tool, suggests **Pat Orchard**, CCM, CHE, director of health services for Horizon Blue Cross Blue Shield of New Jersey, based in Mount Laurel.

"It's a methodology for tracking acuity," says Orchard, who has worked as a case manager in a variety of settings. "A lot of organizations have acuity systems but use them for determining nursing staffing ratios — [a defined number of] acute patients to a nurse."

The same concept, she points out, can be extremely valuable when used to determine a patient's readiness to be transferred to the next level of care. Hospitals that categorize patients in some format indicating "readiness to transition," Orchard adds, can move quickly and efficiently in the event of disaster or even ED overcrowding.

"When you're talking about capacity, what comes in must go out," she notes. "The balance has to be there. If not, there's a tremendous amount of delay."

Typically, organizations focus on input — getting ED patients into treatment rooms and then to the nursing floor, for example, Orchard says. "But if you don't address output, managing patients to move them out efficiently and effectively, you don't solve the throughput problem," she points out.

Without a system for categorizing patients, she says, hospital staff faced with high-capacity moments may spend hours trying to free up beds.

"Say, for example, you had to move 40 people out of the hospital because there was a disaster in the community," Orchard adds. "Nurses are [examining] every patient in the hospital to determine readiness [to move]. Everyone is running in circles trying to find beds."

If a scoring system is in place, however, the patients who are most ready for discharge already will have been identified, and — after

physician orders are obtained — can be moved quickly and easily, she says.

The first step in implementing such a system is to establish criteria [for acuity levels] and categorize patients based on those criteria, Orchard advises. "You can use numbers, or letters, or any kind of scoring you want, but you are scoring the patient based on readiness."

Whether the scoring grid is based on 1 to 4, 1 to 3, or something else, the information can be put into the computer system and pulled out in a report when needed, she says.

"If you're using a score of 1 to 4, those patients who are leaving in the morning, waiting for nursing home placement, or finishing one more course of treatment may be 4s. "This is a basic acuity system, but it's based, not on clinical findings, but on the transition capability of the patient," Orchard explains.

"How quickly can they transition to the next level of care?" she asks.

These are patients about whom physicians say, "Maybe they can go tomorrow, or maybe they should stay one more day," Orchard adds. "Some physicians don't move patients as fast as they could."

From a managed care perspective, she says, some might question why such patients still are in the hospital if they can be discharged safely. But the fact is, they *are* there, she continues.

"Maybe the physician hasn't been in yet, or the physician was in that morning and test results weren't back then. Multiple inefficiencies are out there," Orchard notes.

Once a scoring system is in place, she adds, "at least you know where to focus your attention."

"Have a set of parameters," Orchard suggests, "so that when you do get in a crunch, you're able to turn quickly to the high-level patients who can be moved out immediately. Make sure physicians have agreed to the process and to the scoring system the hospital has developed."

Whether the physician must be called when the process is put in motion — as the result of a crowded ED or a natural disaster — depends on the policies of the organization, she says. "Most would call to get the discharge order."

Assessing and scoring of patients should be done daily or even twice a day, depending on the hospital census, Orchard recommends.

"If done in conjunction with nursing or case management rounds," she adds, "the time required should be minimal."

System came out of 9/11 response

Virtua Memorial Hospital of Burlington County in Mount Holly, NJ, was one of the facilities that got a call on Sept. 11, 2001, asking staff to find room for a possible deluge of patients seriously injured in the attack on the World Trade Center, says **Dee Page**, RN, director of case management.

"We were one of those hospitals in the Northeast that were in close enough proximity that we thought we would have an influx of patients," she explains.

"On Sept. 11, we got a call about 10 a.m. and were told to be ready. At that time, it was thought

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Editorial Questions

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that we would have a lot of sick and injured patients," Page continues.

By 11:30 a.m., the hospital had emptied 62 beds in preparation for the expected patients, but unfortunately, most of the victims turned out to be casualties, and the beds weren't needed after all, she adds.

The quick and the dirty

That experience, however, led to the development of a quick and dirty way to determine which patients could be moved on a daily basis, she says, not only in the event of an emergency, but to address throughput.

The case management department established a scale of 1 to 4, with 4 being the lowest acuity rating, "the patient closest to the door," for whom there is a discharge plan in place, and 1 indicating an intense level of acute care, Page says. Next are the 2s, who require a significant level of care — patients in a step-down unit or maybe telemetry.

The level 3 patients require acute care but are progressing, she continues. "These may be postoperative patients, or those who are being treated aggressively and showing improvement, but who are not primed enough to go to a skilled nursing facility."

"There could be a fifth tier," Page notes, "a shaded area that would more or less indicate a patient who is being observed. If you wanted to push the envelope, you could add this level."

A departmental flowchart shows each patient and the rating code for the person's status. **(See "Patient Readiness Ratings," at left.)** The patient's readiness level is determined at admission and reassessed daily, she says.

The readiness rating also is entered into a web-based system that includes utilization review and discharge planning information, Page adds. "Pieces of that documentation are printed and placed in the chart, and the rest lives in the system as a lifetime record."

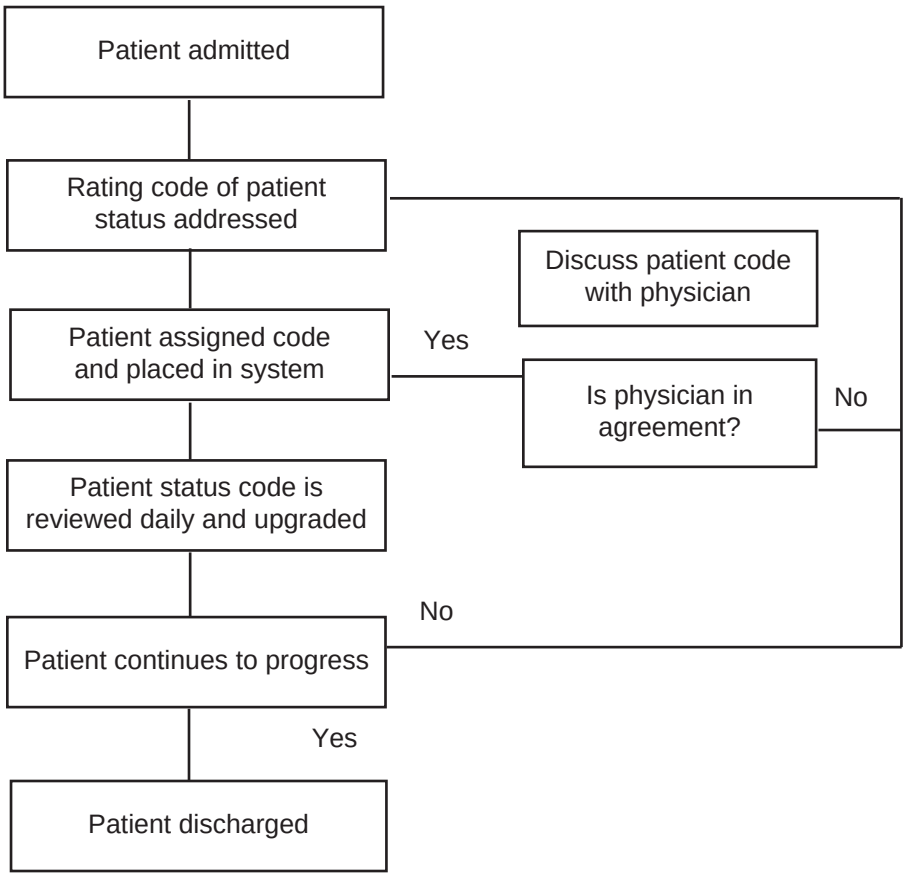
That system is helpful at the time of discharge, she says, because it documents where patients are sent or referred.

"Where we fall short [with the patient readiness rating] is that nursing does not use it with us," Page points out.

"The nursing department has not decided to go along with this," she says.

The nursing department had a readiness project of its own — a color-coded system

Patient Readiness Ratings



Ratings

1. Requires intense level of acute care
2. Requires significant level of care
3. Requires acute care but is progressing
4. Minimal acute care needed; discharge planned

Source: Virtua Health, Mount Holly, NJ.

that was tied to staffing ratios as well as patient acuity," says Page.

"What that meant to them was that, if census and acuity goes below certain levels, the staffing is adjusted. As soon as they see the coding, they know they need extra staffing or that there are empty beds.

"The [nursing project] never got off the ground, but we continue to use our system," Page adds. "We know at any time how many beds are occupied by a particular type of patient."

In addition to its value during times of overcrowding or crisis, she notes, the patient readiness score helps caregivers prioritize the workload, if a case manager is not there, and take a more proactive role in assisting physicians with discharge decisions.

"In our documentation system, we have an RC [review case] due date," Page explains. "For instance, if you have a managed care patient, and have just done a review with the payer, and the payer authorizes a three-day stay, technically, you wouldn't have to look at [that case] for three days."

System helps prioritize

While that system helps in managing caseloads, she points out, "the readiness rating goes beyond the obligation to see the patient again." There might be six patients on the case manager's list who require acute care and are progressing, Page adds, but the readiness check could reveal that one of those patients is now a 4.

The case manager then can suggest to the physician that the patient might be ready for an earlier discharge, she says. "So it helps them further prioritize — it's very valuable in that respect.

"It used to be that if you knew you were being paid for three days, you left it alone, but we really don't feel that way anymore," Page points out.

"It's better to have your beds filled with people who are really sick. It's better for the patient if you can move beds sooner."

With abdominal surgeries, insurance companies often authorize lengthy stays, and patients may be ready for rehab or discharge sooner, she adds. "The theory of 'Fill your beds; fill your beds' doesn't work anymore."

In terms of the readiness scoring system, the focus of the case manager's day is with the 2s and 3s, Page says.

"With 2s, you want to make sure you can move them through the system to a more appropriate bed, or ask, 'Have they finished that course of treatment? Do they need to be transferred to another facility?'"

With 3s, she adds, the idea is to make sure they are not the next patients to be designated as 4s. With 4s, the discharge plan is complete and just needs to be activated, Page notes. "If someone was told yesterday that [he or she] could move to rehab today, that patient would have been a 4 yesterday."

System not labor-intensive

When the time comes to empty some beds quickly, case management — the only department using the patient readiness system — gets the first call from one of Virtua Memorial's bedflow coordinators, she says.

"We often go on divert here — beds are full, and we have to send patients elsewhere — and [the coordinator] comes to us right away, asking, 'What can we do to open some beds?'"

When that call comes, Page says, "We go right to the 4s and make some calls to physicians to let them know there is a crunch. Sometimes, they say they're in the hospital and will be up to discharge the patient. They almost always want to see the patient."

With elderly patients who will be transferred to nursing homes, she notes, the case managers often will have gotten a heads-up that, for example, the patient still is receiving treatment, but this will be the last day. In those cases, Page adds, the discharge might be all sealed up for a particular date.

Although the readiness system is an internal mechanism for the case management department at present, Page says she would like to see it fully implemented at all the Virtua Health campuses.

"It's not labor-intensive at all," she notes.

"It's putting a sticker on the chart. On those days when we're short-staffed, or even when we're full and somebody wants to organize the day, it helps to have [the rating].

"Instead of relying on a whole lot of other people for information, the case managers can look at the scale and see what they have, and know which patient to address first," Page adds.

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ED tracking system is a boon to registration

Communication greatly enhanced

A new emergency department (ED) tracking and documentation system at The Ohio State University (OSU) Medical Center is enhancing communication between registrars and clinicians and streamlining patient throughput, explains **Lisa Siegle**, assistant director of patient access services.

Registration employees are delighted with the new on-line system, which allows staff to move seamlessly from one area to the other — responding to shifts in work volume — without time-consuming telephone calls, Siegle adds.

The overall project, she points out, involves tracking and documenting care throughout the patient's stay, down to details of charge entry and the monitoring of test and X-ray status.

How the process works

From a registration standpoint, the process begins as follows:

- The ED patient fills out a short form that asks for name, date of birth, and chief complaint, with a box to check indicating gender. Not having the patient give the information verbally is a product of the Health Insurance Portability and Accountability Act privacy concerns, Siegle notes.
- A registrar enters the information into the Ibex PulseCheck system.
- The patient goes to primary triage, where a nurse does a quick overview of the patient's condition and checks vital signs.
- Depending on the patient's condition and the wait time, he or she goes back to a treatment room for second-tier, full triage, or to the lobby to wait.
- The results of the triage are entered into the system by the triage nurse.
- When triage is completed, the nurse indicates in the system that the patient is ready for registration. At that point, the name goes to a separate work list of patients who are waiting to be registered.

In the past, Siegle says, the nurse would put the patients' chart on a rack after triage, and registration staff would pull the charts in order and call patients to come to registration.

Now, she adds, registrars take the information off the tracking system and call patients in the order of urgency.

In the back, meanwhile, staff previously would refer to a white board, where a nurse would write the last name of the patient who was in a particular treatment room, indicating a registrar could check with clinical staff.

Clinicians might ask the registrar to wait or might indicate it was OK to register the patient.

Now, Siegle says, "we're not cued until the patient is ready." Rather than place a green "R" on the white board indicating the registration has been completed, registrars now indicate that in the computer.

"So now we don't have to rely on the charts up front, and in the back, all the patients hit our work list [electronically], so we're not looking at the white board anymore," she adds.

Another advantage is the increased legibility of the on-line listing, which helps with patient identification, Siegle notes.

"We still post the tracking board, but we don't rely on it. It's an enhanced re-creation of the old white board on a plasma screen that receives a message from the system and populates it," she explains.

Work list keeps staff on track

The electronic work list also is beneficial because staff who are not occupied in the back can see on the computer screen if there's work to be done in the front, she says.

In the past, Siegle adds, "we might have had some employees hanging out in back, not knowing there were a lot of patients waiting to be registered in the lobby. Now they can come out front and help out."

Although the employees always could be summoned with a phone call, Siegle points out, in many cases, the registrars working in front would be looking for a good time to make that call and, instead of making it, might continue to register patients to try to get ahead.

The on-line system also replaces the need for co-workers to check with each other to determine who will go to what treatment room if there is more than one chart up, she says.

"If you go to register a patient, you click on a box so that as you sign in, your initials are populated on the screen. The system also puts an icon indicating a registration is in progress."

Again, the same information is replicated on the main tracking board, Siegle adds.

"The clinicians can see that we're registering right now, and that shortly they can start their processes — ordering labs, X-rays, etc. Before, we would often get approached by a clinician who would say, 'Is so-and-so in Room 5 being registered?'

"They couldn't tell from the [old] board," she notes, "which only indicated when the registration was complete. So it's a nice function to see who's in progress and who's working on that patient."

When the registration is complete, the registrar clicks on her initials, which drops her off the work list, showing that she is finished. She then takes the next patient, based on urgency, which is indicated in the system by shading.

There are four categories, Siegle explains, with the color black for the most urgent patients, and in decreasing order: red, green, and blue. "If there are two [cases] that are both [category] black, we take them according to length of stay, or the clinician will verbally tell us. For the most part, though, that's not an issue."

Under the old procedure, however, "we couldn't see urgency and would be bombarded by clinicians saying, 'Can you take the patient in Room 5 first?' because they needed care the most quickly," she says.

Thanks to the increased coordination made possible by the new system, Siegle continues, "it's nice to be working in the same direction as the clinicians."

Training time minimal

On-site training was provided by the vendor, and it took no more than two hours for registration staff to get up to speed on the new system, Siegle says.

Although registrars went to two hours of vendor training, she adds, they were grouped in with other staff and probably could have learned what they needed to know in about 30 minutes. Another hour was devoted to operational training.

"It also depends how you'll use [the system]," Siegle notes. "Some facilities have the greet function with the nurse; but our registrars handle the greeting, so there's a little training there." ■

Call center specialist offers tips on hiring

Here's how to cast a wide net

Recruiting and hiring staff for a customer call center is a process rife with challenges, ranging from a shrinking candidate pool to the structured nature of the job, cautions **Katherine Dean**, SPHR, a partner in Banks & Dean, an international professional services firm based in Toronto.

With call centers becoming a common feature of the health care landscape, access managers increasingly are being called upon to take a leadership role in their formation and operation.

With that in mind, Dean, whose company specializes in selection and retention solutions for call centers, offers some advice on how to make the task go more smoothly.

Her firm has found there is a call center talent shortage, she says, fueled both by demographics and by the limited number of individuals who have the skill set and temperament to work in such a prescribed environment.

"We have a built-in challenge with a unique job with unique requirements and a talent pool that is getting smaller," Dean says.

"Between 1998 and 2008," she points out, "there is a shortage of about 25 million workers because baby boomers were the largest demographic and they had fewer children. They're not replacing themselves, and they're getting older; and the education system is not necessarily preparing people for the work force."

Therefore, the most important question when it comes to staffing a call center becomes, "How do you cast a wide net for attracting people into your call center so you can hire the best? You can talk about how to screen better, but if you don't have a pool to start from, it doesn't really matter. You can't successfully choose from a candidate pool of one," Dean adds.

To prepare for a successful search for call center employees, she suggests access managers consider these factors:

1. What do you need as baseline requirements?

Get clear, Dean says, on which skills you are willing to teach and which ones candidates must already have.

"Some candidates have aptitude but haven't been trained on multitasking. Keyboard skills may be adequate but not terrific. The person may

inherently want to serve customers but has never worn a headset."

Not everyone is willing to learn and follow procedures, take scheduled breaks, have calls monitored, and be coached around their performance, she says.

The tougher the minimum qualifications, Dean notes, the more you cut into a talent pool that can be perfect for the job.

2. It's a numbers game.

Because finding the right staff "is a numbers game," she adds, Dean's company has devised some strategies for helping its clients increase the candidate pool. One of those, she explains, involves creating a microsite whereby potential applicants can go on-line to begin an automated screening process.

"We've created a template where we ask call center-specific questions, and the system automatically screens out [inappropriate candidates]," she says. Candidates are asked questions such as, "Are you willing to take very scheduled breaks?" or "Can you meet strict attendance requirements?" or "Are you willing to wear a headset between six and eight hours a day?"

If the person answers "no" to any of those questions, Dean adds, "we don't need to go any further."

Another technique is to screen further by having candidates who survive the on-line questions call a toll-free number and answer automated questions about such issues as job history and experience, she says. "The purpose is not just content, but to hear the [applicant's] voice," Dean points out. "Does the person sound professional? Does he or she have good enunciation, diction, grammar?"

On the back end, the person doing the hiring can see (and hear) the person's answers and decide to move forward in the process, she says. "Now the organization has prequalified candidates."

3. Keep call center needs in mind.

"Another thing we find is that people staffing the call center aren't always aligned with the call center requirements," Dean says. "Is there an alignment between the people you're bringing in and what's expected of them?"

"For instance, some call centers are very productivity related," she adds, "and representatives need to give quick information to customers."

On the other hand, Dean points out, "If it's a more complex call, where there needs to be a true understanding of the situation, you need someone who has very good communication skills, who is warm over the phone. A person with the sense of urgency that is associated with sales calls wouldn't be right at all."

4. Focus in the face-to-face interview.

"What sometimes happens is that people interview a candidate, only to find out 45 minutes later that the person doesn't have a key requirement," she says.

"Make sure the person has been screened on the front end and has the minimum qualifications for the job. Don't waste the interviewer's time," Dean continues.

In other cases, she notes, interviewers may get so excited about a candidate that they go from screening to hiring without having a face-to-face interview.

When conducting that interview, Dean advises, an important issue to keep in mind is whether the applicant has the key competency of being customer-focused.

"Is the candidate exhibiting behaviors demonstrating empathy, building rapport, responding to requests in a professional manner, and going above and beyond expectations?" she asks.

To determine whether the person is customer-focused, Dean suggests asking these questions:

- "Tell me about a situation in which you had to deal with a customer, internal or external, who was emotional or difficult. What made the situation challenging, how did you handle it, and what was the result?"
- "Give me an example of a time when you demonstrated a commitment to following through with a customer's request. What was the situation? What did you do? What was the outcome?"

The purpose of the questions, she says, is to see if the person will follow through with the customer effectively, and if he or she considers interaction with the customer important.

Another key competency is the ability to tolerate and cope with stress, Dean points out. "One of the main reasons people leave a call center is because they have trouble dealing with the stress."

She suggests the following interview question to help identify that competency:

- "Give me an example of a time when, for much of the day, you had customers waiting in line. How did you handle the stress of back-to-back customers, knowing you had to

be on your game, providing good service to each customer?"

Once they're hired . . .

When the right staff have been hired and are in place, Dean says, one of the keys to a successful call center environment is to create a sense of community.

"You need to build a sense of 'you belong here, and we're glad you're here.' That is a motivator for them to stay."

One of the ways to do that, she adds, is to celebrate team success in what often is a solitary activity, perhaps by recognizing the achievement of all the representatives who work under a particular supervisor.

"They really are all in it together," Dean notes. "As the calls queue up, if someone isn't doing their job, there is more pressure on everybody else, so individual efforts contribute to the success of the whole."

Recognize the team and individuals, she suggests, with food, holiday celebrations, or birthday observances. "Make it a fun place to work where people feel important and valued."

[Editor's note: Katherine Dean can be reached at (888) 241-8198 or by e-mail at kdean@banksanddean.com.] ■

Access career ladder promotes staff retention

Three registrar levels available

The access career ladder at Carolinas HealthCare System (CHS) in Charlotte, NC, grew out of two realizations, says **Katie Davis,** CAM, assistant vice president for patient registration:

1. Access employees who don't have the desire or aptitude to be a supervisor or manager need a way to experience career growth.
2. The opportunity for such advancement is a good way to promote employee retention.

"Not everybody wants to be or should be a supervisor or manager, and there are not that many positions that come open," Davis points out.

"We did, for a while, experience a fair amount of turnover, and in looking at what makes it more attractive to stay in registration, [a career ladder] was one of the first things we decided to do," she explains.

The program is open to all full-time staff in corporate registration, which leaves out registration employees who work in the system's clinics, Davis explains. "They come under the Carolinas Physicians Network [CHS]."

Once new hires in corporate registration have completed a 90-day probationary period, they are eligible to participate, she notes.

Level One Registrar

"Everyone comes in as a Level One Registrar," Davis says. "They are expected to demonstrate basic knowledge and skills and behavior consistent with the advanced competent beginner stage. There are important situational elements you can only learn through experience."

Level One employees will have completed the CHS and departmental orientations, as well as a core competencies checklist and training in their primary area, she adds. "As they progress, they will want to master [other registration areas], but at this level, they should show some interest [in those areas] or maybe work there for a couple of days."

These employees also should be sure to participate in continuing education classes, Davis says, such as advanced Medicare Secondary Payer (MSP) training or advanced insurance training.

Level Two Registrar

To move to the second level, she explains, a registrar must meet the following requirements:

- Have been a full-time employee in his or her current department for at least a year
- Received an "exceeds expectations" on the annual performance review, which is based on quality assurance (QA) and productivity
- Received no verbal or written disciplinary counseling in the past 12 months
- Cross-trained in two additional areas in his or her own facility or cross-trained in another Carolinas HealthCare hospital (For example, a registrar who works in the outpatient area at one hospital could cross-train in that facility's emergency department, and in the outpatient area at another facility.)
- Successfully completed at least two continuing education classes in the health system's training program or from an approved outside institution
- Taken and passed a Registrar Level Two exam,

prepared by Davis and other patient access executives ("It consists of 50 questions, randomly selected from a total of 120 questions," she adds. "If 10 people take it, no two tests are the same.")

In addition, Davis says, "Level Two employees are always expected to conduct themselves in a courteous and professional manner. Once they get to that level or to Level Three," she adds, "they have to recertify each year."

A study guide is available for those aspiring to the Level Two designation.

If at any point an employee gets a written reprimand, he or she can lose the Level Two designation, Davis notes.

Level Three Registrar

To attain the Level Three designation, registrars must meet all the requirements for Level Two, including cross-training to additional facilities and working at those facilities, if needed. In addition, they must do the following.

- Work in the department for at least two years, meeting the necessary quality and productivity standards
- Have experience doing charge duty or acting as lead registrar
- Sit for and pass the certified healthcare access associate (CHAA) examination offered by the National Association of Healthcare Access Management (NAHAM)
- Cross-train in three additional areas or facilities.
- Take at least four new continuing education classes within the past year

Salary range doesn't change

A registrar's salary range doesn't change as a result of attaining a Level Two or Level Three designation, Davis points out. Rather, the financial benefit comes through the organization's monthly incentive program, which is geared toward team recognition.

For a registrar to be individually eligible for the program, he or she must be beyond the 90-day probationary employment period, and must have worked at least 120 hours during that month if a full-time employee, and at least 60 hours if part-time, she explains. In addition, the QA score for the facility at which the registrar works must be at a certain level.

If the QA score for the facility is between 95% and 100%, Davis says, Level One registrars who also meet their individual goals receive a bonus of between 2% and 7%; Level Two get between 5% and 10%; and Level Three are given between 7% and 12%.

"The lowest we go is 95% for the facility score," she adds. "If it's less than that, no one is eligible."

Individually, the registrar's monthly QA score must be 97% or better, with a minimum productivity score of 91%, Davis notes. "The registrar can have no more than one MSP error, one duplicate unit number, and one self-pay error for the month."

In addition, she says, the person must meet the established upfront collections guidelines for the department and can't have received any disciplinary action during the month.

"This has been a good incentive for those who want to advance," Davis says. "The [Level Two] exam is given by the training director, and she schedules them quarterly. Those who pass get a nice certificate, and we make a big deal out of it."

For the first time in 2004, the department had a registrar attain the Level Three designation, she notes.

"The first person sat for the CHAA exam, given by NAHAM in May, and found out in June that she had passed."

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Safety net services could replace private insurance

Consequences of policies need to be considered

One unintended consequence of the nation's health care safety net — which includes public hospitals, community health centers, local clinics, and some primary care physicians — is that it is crowding out, or replacing, other insurance options for unmarried childless adults, according to new research by **Anthony Lo Sasso**, research associate professor at the Institute for Policy Research at Northwestern University in Evanston, IL.

According to an issue brief published by Academy Health, national program office for the Princeton, NJ-based Robert Wood Johnson Foundation's initiative — Changes in Health

Care Financing and Organization, Lo Sasso and colleagues examined the effect of uncompensated care provided by clinics and hospitals on insurance coverage for two groups: children younger than 14 and unmarried childless adults between 18 and 64.

They found that adults with good access to safety net services were less likely to have health insurance.

"Our analysis provides a unified framework bringing together privately offered insurance characteristics, Medicaid eligibility, and characteristics of the local safety net to better explain and understand the health insurance decisions of firms and individuals," Lo Sasso says.

"We hope policy-makers will use the information to craft policies and provide incentives to providers to minimize distortions in the private market, while still providing care to those truly in need," he adds.

Unintended consequences of programs

Sometimes, policy-makers are not aware of the unintended consequences on the private sector of decisions made on public programs, and his research is intended to highlight those consequences and urge that they be considered, Lo Sasso continues.

In contrast to the situation with adults, the researchers found only weak evidence that children are being crowded out of private or public insurance.

Children in need of health care services typically have more insurance options than do adults, according to the researchers, particularly public insurance coverage.

In addition, because so many low-income children are eligible for either Medicaid or the State Children's Health Insurance Program (SCHIP), any safety net providers they see usually are able to get them enrolled in the appropriate program.

Lo Sasso says the safety net is a patchwork of providers that is supported by a diverse and haphazard array of funding mechanisms.

Although their funding may be uncertain from year to year, or political administration to administration, safety net providers generally offer a combination of comprehensive medical care and enabling services such as language translation and transportation targeting the needs of those likely to require safety net care.

"The safety net clearly has a purpose and a place in the American health care system," he explains. "But it's not without risks."

Lo Sasso says he sees it as an informal, uncoordinated system of care whose continued existence is not guaranteed.

Many would argue that it is stretched thin already, he adds. Witness the fact, for instance, that between 1990 and 1998, federally qualified health centers experienced a 60% increase in the number of uninsured patients.

Then, in the 1990s, expansions in Medicaid and the creation of SCHIP allowed many individuals who were covered under private insurance to be eligible for public programs.

Premiums for public coverage were more affordable than for private insurance and, in some cases, the health care delivered may have been better, leading many to speculate that public coverage was crowding out private.

Lo Sasso notes that because so many low-income people continue to be uninsured despite the expansions in program eligibility, the researchers wanted to identify alternative reasons for why take-up of private insurance is low for these groups.

Federally qualified health centers provide a substantial amount of uncompensated care. Overall, uncompensated care they provided increased from some $450 million in 1990 to nearly $700 million in 2000.

Hospitals also provide a large amount of uncompensated care annually; hospital uncompensated care increased from just under $19 billion in 1990 to nearly $21 billion in 2000.

Mixed evidence

Results of their study provided the researchers mixed evidence on the extent of crowd-out. Thus, hospital uncompensated care does not appear to crowd out coverage for children or adults, while health center uncompensated care appears to crowd out private coverage for childless adults.

"Less crowd-out for hospital uncompensated care may be plausible," according to Lo Sasso, "given that hospital uncompensated care pays for big-ticket items rather than more routine care that individuals may think of when making coverage decisions."

According to the study, low-income people frequently believe they can avoid the need for health insurance by using free clinics or public hospitals.

Employer-provided health insurance likely is to have greater costs than Medicaid or safety net

care, both in terms of premiums and out-of-pocket costs such as deductibles or copayments. Therefore, a dependable safety net may result in workers accepting employment without health insurance or declining coverage offered by their employers because of the cost.

Also, for many workers in low-wage jobs, employers don't offer private insurance; and when it is offered, premiums and deductibles often make it cost-prohibitive. Buying coverage in the individual insurance market is similarly expensive.

From employers' perspective, the availability of a safety net may affect their decision to offer — or not offer — coverage.

They may come to rely on the safety net as a substitute to provide care for their low-income workers, which saves them money.

Small employers in a particular area may choose not to offer health insurance to workers because of the availability of safety net health care services.

Academy Health said that for many policymakers, one of the most challenging aspects of safety net care is striking the right balance between promoting appropriate take-up of safety net services and preventing crowd-out of other coverage options.

On one hand, the goal and role of safety net institutions is provide health care access to low-income Americans who cannot afford coverage through other vehicles, the report said. On the other hand, a rich safety net may induce people with access to other types of insurance to forgo it for a seemingly free program.

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NEWS BRIEFS

Care costs, demand increased in 2003

Demand for inpatient and outpatient care continued to grow in 2003, as did the costs of providing that care, according to the latest American Hospital Association (AHA) Annual Survey.

Hospital expenses per adjusted admission grew by 6%, driven by the rising costs of new technologies, pharmaceuticals, and payroll, the survey found, but reimbursements failed to keep pace, causing operating margins to decline.

Medicare payment fell to 95 cents for every dollar hospitals spent caring for Medicare patients, and Medicaid reimbursement fell to 92 cents on the dollar.

As a result, hospitals' financial health remained fragile, with roughly one-third operating in the red.

Even as overall demand for care increased, hospitals experienced a 1.1% decline in outpatient surgeries — the first in more than two decades — reflecting the rapid growth of ambulatory surgery centers.

The survey results were released in *AHA Hospital Statistics 2005,* published by the AHA subsidiary Health Forum. ▼

COMING IN FUTURE MONTHS

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AHRQ tool offers help to assess hospital safety

The Agency for Healthcare Research and Quality (AHRQ) has unveiled a new tool to help hospitals evaluate their progress in creating a culture of safety.

The "Hospital Survey on Patient Safety Culture" helps hospitals assess employees' attitudes about patient safety, teamwork within and across units, openness of communication, response to errors, and other key components of a safety culture.

The American Hospital Association (AHA) will encourage members to use the survey to obtain a more complete picture of the quality of care they provide and identify opportunities, according to **Nancy Foster**, AHA senior associate director for public policy development. "Creating an organizational culture in which staff are aware of the critical role they can play in patient safety is fundamental to patient safety improvement."

Paul Schyve, MD, senior vice president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), said conducting the survey would help hospitals meet JCAHO accreditation requirements. For a survey and user's guide, go to www.ahrq.gov/qual/hospculture. ▼

New Jersey hospital gets top quality award

A high ranking in customer loyalty and dramatic reductions in emergency department wait times are among the achievements for which the Robert Wood Johnson (RWJ) University Hospital in Hamilton, NJ, was honored as a recipient of a 2004 Malcolm Baldrige National Quality Award, the nation's top honor for performance excellence.

The hospital, one of four organizations honored in 2004, is only the fourth health care organization ever to receive the prestigious award and the sole health care recipient in 2004. RWJ Hamilton surpassed national averages on a number of key quality indicators and increased retention rates for registered nurses to 99%.

Previous health care winners are Baptist Hospital Inc. of Pensacola, FL; St. Luke's Hospital of Kansas City, MO (2003); and St. Louis-based SSM Health Care (2002). ▼

CMS releases paper on HIPAA security rule

The Centers for Medicare & Medicaid Services (CMS) has released the first in a series of seven papers intended to give guidance on the Health Insurance Portability and Accountability Act's (HIPAA) security rule.

Each paper will focus on a specific topic related to the "Security Standards for the Protection of Electronic Protected Health Information," commonly known as the security rule. Most hospitals and health plans must comply with the rule by April 20, 2005.

The first paper provides background on the rule and its relationship to the HIPAA medical privacy rule. Future papers will address administrative, physical, and technical safeguards; organizational policies and procedures and documentation requirements; the basics of risk analysis and risk management; and implementation for small providers.

The final security rule can be viewed and downloaded from the CMS web site at www.cms.hhs.gov/hipaa/hipaa2. ■