

## ACCESS & COVERAGE

### Rise in Unemployment Means More Uninsured

Hospitals are challenged to prevent bad debt from creeping up

Joyce Farrar, administrator for emergency medicine at Henry Ford Hospital in Detroit, is used to finding beds in nursing homes for uninsured patients who need long-term care. Recently, however, Farrar has found that those beds are in short supply as the employment rate—and the number of uninsured patients—has risen.

Henry Ford has lately gone as far as footing the bill for uninsured patients to stay in nursing homes in order to free up beds at the hospital. "It's cheaper than the cost of keeping them in the hospital bed, and it certainly allows us to put a real patient in there," she says.

As unemployment rates rise, hospitals find they have to be more resourceful in dealing with the uninsured, or risk incurring bad debt, says David Bachman, a health care analyst for Longbow Research, Cleveland. "If you look at unemployment and its relationship to hospital bad debt expense and profit margins, there's definitely a lag, but approximately a year later you start to see an impact," he says.

Bachman says hospitals have been able to control costs by asking patients, particularly those who show up in the emergency department with non-life-threatening conditions, to pay for services up front. Having a financial counselor on-site to see if the patient qualifies for state programs can also make a difference.

"I think there's been much more of an emphasis on up-front things in the past couple of years," says Bachman. "Once the care has been provided and the patient has left the hospital, it's obviously not a good situation—when hospitals collect 5 cents on the dollar for patients unable to pay their bills.

Mary Grealy, president of the Healthcare Leadership Council, says that in the past few years hospitals have been doing a better job of identifying patients eligible for government assistance—including Medicaid and the State Children's Health Insurance Program—then seeing them through the enrollment process.

"A lot of hospitals will work out payment plans, but the key is government-funded cov-

erage if they're eligible for it," Grealy says. "The other really important thing hospitals can do in terms of outreach is working with health clinics to make sure those without insurance are getting appropriate primary care, so they don't wait so long that their condition is critical."

Farrar says she's definitely seeing sicker patients in the ED, including patients afflicted with more than one life-threatening illness, such as heart failure and diabetes or high-blood pres-

sure and kidney failure. "Probably because they don't have the ability to access primary care, they wait longer than they should," she says.

Recently, she had to put more ED staff on the "power shift" from 2 p.m. to 2 a.m. "Patients come in sicker, so they stay in the ICU longer, which means there's fewer ICU beds and we have to care for them in the emergency department," she says. "I'm still taking care of patients I thought I was done with."—LAURA PUTRE ●



## STAFFING WATCH

### SURVEY: DOCTOR ON-CALL PAY INCREASES

A survey of 132 health care organizations nationwide shows that physician on-call pay expenditures have increased substantially. From 2006 to 2008, median expenditures increased in trauma centers by 88 percent and in non-trauma centers by 91 percent. The 2008 Physician On-Call Pay Survey Report, completed by Sullivan, Cotter and Associates, Inc., Detroit, shows 86 percent of the respondents provide on-call pay to non-employed physicians and 54 percent provide on-call pay to employed physicians. The majority, 91 percent, said that physician on-call pay is funded solely by the hospital; 8 percent report that medical groups provide some of the funding.

### NEEDLESTICKS STILL UNDERREPORTED, NURSES SAY

In an American Nurses' Association survey of more than 700 nurses, 64 percent say they've had accidental needlesticks sometime during their career. Of those, 74 percent say they have been stuck with a contaminated needle. While 86 percent say their departments strongly encourage and support reporting of needlestick injuries, 74 percent say these injuries are still underreported. Respondents said the top three reasons for underreporting are: nurses did not feel at risk for infection, the reporting process takes too much time, and nurses fear discipline from the incident.

### REPORT RECOMMENDS FLEXIBILITY TO RETAIN IT STAFF

A report from CSC, Falls Church, Va., encourages hospital CIOs to offer flexible work conditions to both baby boomers and Gen X- and Y-ers in an effort to retain the best staff. Offering sabbaticals to staff approaching retirement can help stem the "brain drain" many departments face, says author Walt Zywiak. Younger workers are attracted to flexible work hours and telecommuting. The report included information from senior IT managers at 10 health care organizations nationwide, including seven integrated delivery networks.

### IN OTHER NEWS...

Medicare policies are fueling the income gap between specialist and generalist physicians, according to a study in the September *Journal of General Internal Medicine*. Among the findings: geriatricians' annual incomes averaged \$165,000 versus \$504,000 for hematologists, even though the two specialties require a similar amount of training... Oct. 2 is the proposal deadline for foundations applying for grants from the Partners Investing in Nursing's Future program, which is aimed at nurse shortage solutions. With 31 projects already under way, the program was reauthorized this summer for another five years. ●

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