HEART BEAT

FALL - 2011

hfma

healthcare financial management association

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Disaster Recovery Planning

Steven Collins *- MSIA, CISSP*
Facilities Information Security Officer
Carondelet Health

An organization's disaster recovery plan exists as a duality in most organizations. It is one of the most critical documents an organization possesses while simultaneously being the document that everyone hopes will never be needed. But that hope is rarely validated. Rather, the unfortunate reality of life is a near total probability that your organization will sustain a catastrophic disaster, which takes down the electronic health record system, business applications and processes, the data center, or the entire hospital/system's communication and information infrastructure.

Disaster Recovery Plan Essentials

The National Institute for Standards and Technology (NIST) recommends 7 items that an organization needs to complete or adhere to in order to have a successful disaster recovery plan:

- ✔ Develop a contingency planning policy statement
- ✔ Conduct a business impact analysis
- ✔ Identify preventative controls
- ✔ Create contingency strategies for various scenarios
- ✔ Develop an information system contingency plan
- ✔ Ensure disaster recovery plan testing, training, and exercises
- ✔ Ensure review, maintenance, and updating of the disaster recovery plan

The items that NIST recommends are not required, nor are they all inclusive. When creating a disaster recovery plan, it is important to custom tailor the plan for your organization. Do not rely on a generic high level plan. If you do, when the inevitable disaster strikes your organization, it will be completely unprepared and unable to respond in a timely and effective fashion to the disaster. You must create and maintain in-depth plans that cover all of your business processes, assets, people, technologies, etc, so the organization has step-by-step lists to follow to bring the organization back on-line in a timely and efficient manner.

Of all the NIST recommended items, the most important is to conduct a thorough and accurate business impact analysis. The analysis will allow you to determine the potential risks the organization faces as well as the potential costs associated with those risks. This allows an organization to focus its efforts on the risks most likely to occur, as well as risks with the potential for the biggest impact the organization's bottom line. Other parts of the business impact analysis determine the core components most critical to re-establishing the organization's ability to function. For example, for a hospital system a top priority would be to bring their EHR system back online, after the safety of the patients has been assured.

Many organizations treat disaster recovery planning as a "once and done"

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President's Corner

Believe to Achieve

Esteban Ponce

Hola!

Wow! I cannot believe that summer is already gone and we are ready to move into the autumn months. Holiday times are just around the corner!

John Maschger and I will be leaving Kansas City to attend the Fall President's meeting (FPM) the last week of September. We will be sailing the Western Caribbean Seas on the Disney Cruise ship. By the time you read this, we will have returned and will be equipped with additional information as we move forward into the fiscal year. This meeting provides an invaluable opportunity for connection with the other Region 8 HFMA Chapter leaders. Region 8 Chapters include: Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Show-Me, Greater St. Louis, Sunflower, and Heart of America Chapter. Several best practices are shared among the Presidents and President Elects who attend this meeting along with discussion for areas where the Chapters might be struggling.

We have several excellent opportunities for upcoming quality education. I would like to encourage all members to attend our October Program on the 25th of this month. This program will be related to Charity Care and Best Practices for Patient Access. Also, we are working on the November program where we invite several CEO's of the hospitals and medical practices around the Kansas City Metropolitan area to discuss financial trends and issues healthcare is facing these days.

We also had our Joint Workshop Program in conjunction with the Show-Me, Greater St Louis, Sunflower (Kansas) and Heart of America Chapters. This workshop was one of the most attended in the last couple of years! Thank you to all the members from all the Chapters who made this event such a great success!

The Heart of America Chapter is also sponsoring the Region 8 Webinar in the month of October. This month's webinar title will be ***"Optimizing Your Hospital's Portfolio of Service Lines and Businesses".*** Within my organization, these webinars have been great to keep staff connected to the latest and greatest news and updates in Healthcare.

The leadership team continues to work on ensuring that the Chapter is on track related to our Chapter Balance Scorecard and member satisfaction. Up to August 16th, we were 252 members; we are short to meet our goal of 318 members so far. I encourage you to remind our members who have not joined yet to do it! Your participation as a member in our Chapter is vital!

My hope is that your responses as a member to any of the survey questions provided by National will help us to improve in different aspects in our Chapter and get better with every program! If for some reason you have any question or suggestions, please let me know and I will be happy to look at it. We want you to receive the fullest benefits from your HFMA membership.

As always, it is an honor to serve you as your Chapter presidente! ■

Esteban Ponce
HOA Chapter President

You can now follow us on Facebook! Just search for HFMA Heart of America Chapter. The Facebook site also contains photos from recent Chapter events. Become a fan today!

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Teri Reger, FHFMA
Region 8 Regional Executive

Greetings HFMA Region 8 Friends and Colleagues!

I hope you all have had a wonderful summer. It's hard to believe we're already looking toward the fall with its beautiful colors, many football and baseball games to watch and kids back in school! In addition, the fall months bring you as HFMA members so many opportunities to enjoy outstanding programming and networking experiences. Be sure to watch for upcoming events available to you at the local and national level that will help you keep up to date on the latest in healthcare finance as well as to allow you to network with other HFMA members.

The monthly Region 8 webinars are again in full swing. This year they are scheduled for the third Tuesday of each month from 12:00 noon – 1:30 pm through April 2012. Be sure to put a place-holder on your calendar for these great webinars. They are an excellent way for you and your staff to participate in an outstanding educational event with minimal expense. The Region 8 chapter leaders have committed to providing these webinars at a cost of $50 or less per connection.

The fall is also a perfect time for you to begin to work toward achieving certification in HFMA. There are two levels of certification. The first level is the Certified Healthcare Financial Professional, CHFP. This is achieved with three to five years of healthcare financial management experience, a current and active HFMA membership, and through the successful completion of a standard examination. The second level of certification is FHFMA, a Fellow of the Healthcare Financial Management Association. After successful achievement of CHFP status, the FHFMA can be earned with five years of HFMA membership, a bachelor's degree and by

volunteering your time in the healthcare finance field and/or in HFMA. The reasons to believe you can and should achieve certification in HFMA:

1. It will demonstrate that you are a proven leader in your organization.
2. It will demonstrate your commitment to healthcare industry.
3. Employers tend to look for the HFMA certification when evaluating potential employees.
4. Survey results show a strong link between HFMA certification and career advancement.

Please contact your chapter's Certification Chairperson for additional information about becoming certified, as well as whether your chapter offers any form of financial assistance to chapter members for the study materials and/or the exam.

Thank you again for the opportunity to serve Region 8. In the winter edition of the Region 8 Connection, I will provide an update on recent meetings with the chapter Presidents and Presidents Elect. When you see your chapter leaders at meetings and net-working events, please thank them for their tireless efforts leading the chapters on to what is sure to be an exceptional year! I welcome your questions and comments, any time! My telephone number is 314-523-8771 and my email address is Teri_Reger@ssmhc.com. ■

www.hoahfma.org

Visit our website to view updated information on program announcements, board minutes, financial statements, committee participation and job postings. Plus, you can register for Chapter events. ■

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COMING SOON: *The Revision to the Health Care Audit Guide*

By: Kimberly McKay - kmckay@bkd.com

On April 6, 2011, the American Institute of Certified Public Accountants (AICPA) released a draft of the proposed Audit and Accounting Guide, Health Care Entities. The comment period for the guide ended June 6, 2011. The guide has been through all levels of review, and the published copy will be available in fourth quarter 2011.

This is the first comprehensive guide revision since 1996. The proposed guide incorporates certain guidance in the Accounting Standards Codification (ASC) and highlights items prevalent in the health care industry. The guide is considered supplemental guidance and not intended to be a complete set of generally accepted accounting principles. The guide's intent is to provide nonauthoritative guidance, improve clarity and reduce diversity in applying accounting standards to health care organizations.

Enhancements to improve user understanding and reduce diversity in practice include the following new chapters:

- Derivatives
- Municipal Bond Financing
- Contributions Received and Made
- Unique Financial Statement Considerations for Not-for-Profit Health Care Entities
- Unique Considerations of State and Local Governmental Health Care Entities

The additions provide health care organizations and their auditors practical guidance on complex health care industry topics. The ASC is the single source of accounting standards for nongovernmental entities, but the guide is a good resource for health care organizations researching topics prevalent in the industry.

Additional enhancements include expanded discussions on industry specific topics, such as recording of insurance claims and recoveries and charity care, which will have the following effects:

Insurance Claims & Recoveries

Health care organizations are subject to numerous litigation risks, including malpractice, general liability and workers' compensation. Unlike other industries, health care organizations have been allowed to offset anticipated insurance recoveries against potential losses, resulting in no amounts recognized on the balance sheet if insurance coverage was in force.

Effective for fiscal years beginning after December 15, 2010, Accounting Standards Update (ASU) 2010-24 requires health care organizations change to a gross basis for reporting estimated liabilities and related insurance recoveries related to malpractice and other insurance claims. If an entity determines it is responsible for an insurance claim, the full amount of the liability would be recorded on the financial statements and a receivable would be recorded for the insured portion. Because of this change, organizations could see an increase in both assets and liabilities.

Charity Care

Health care organizations currently report services for qualified charity patients in the notes to the financial statements. The disclosures generally report the amount of charity based on charges or the cost of providing the services. Effective for fiscal years beginning after December 15, 2010, ASU 2010-23 requires all disclosures for charity care be based on an organization's cost of providing those services.

Presentation of Patient Service Revenue for Health Care Entities

After the finalization of the guide occurred, the Financial Accounting Standards Board issued ASU 2011-07, Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities. ASU 2011-07 will have a significant effect on how health care organizations report net patient service revenue.

Historically, most health care entities have recognized patient service revenue at the time of service, regardless of the expected collections. This resulted in a gross-up of patient service revenue and the related provisions for bad debts, which was reported in operating expenses for all nongovernmental entities.

ASU 2011-07 is an effort to increase consistency and transparency in how health care entities recognize patient service revenue. This new standard requires certain health care entities to

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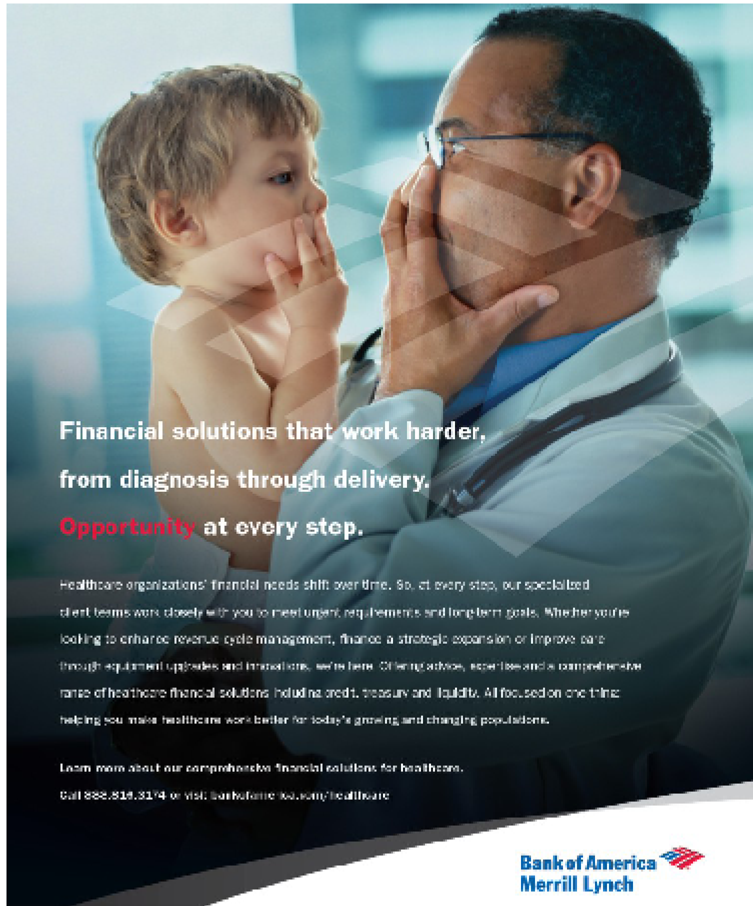

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15th Annual HFMA Joint Conference

was held at the Westin Crown Center in Kansas City on August 24th-26th.

◀ *Kimberly McKay, CPA with BKD*

Stacy Harper, JD, MHSA, CPC with Forbes Law Group ▶

▲ *Chip Madera, MS, CSP- motivation and performance management expert.*

Sandy Praeger, Kansas Insurance Commissioner ▶

▲ *(left to right) Mike Quintero, Director-Patient Financial Services at University of Kansas Hospital, Holly French, CFO-Newman Regional Hospital, Laraine Gengier, CFO-Lindsborn Hospital.*

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Disaster Recovery Planning

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project. Most certainly this should not be the case. The initial development of your disaster recovery plan is very important, but it is also critical that the plan be reviewed and updated on a regular schedule. Larger organizations typically review their disaster recovery plans every six to 12 months. Disaster recovery plan reviews take substantially less time than the initial development unless your organization has undergone drastic operational or process changes, making plan maintenance a less monotonous task.

As part of the annual or biannual recovery plan review, it is critical that the plan be tested. The plan may appear quite good and comprehensive on paper, but unless it works in a real time, real world simulation, the plan is essentially worthless. Table-top exercises are a common method to test the plan by simulating a disaster and allowing appropriate players to react accordingly. Many organizations choose to go beyond simulations to exercise a full shutdown of main services with a cut-over to their off-site disaster recovery area. This is much more expensive and time consuming, but provides a higher level of confidence that your disaster plan will allow your organization to return to full function in a timely and efficient fashion under real world conditions.

Carondelet Health's Disaster Recovery Plan

A disaster recovery plan holds little value unless it has been tested and proven to work properly. Different organizations test their disaster plan in different ways. Carondelet Health uses TRAPS (Technical Recovery Action Plans) a testing procedure developed to ensure their main electronic health record system, Meditech, could survive a catastrophic failure in the hospital data center.

The idea behind TRAPS is a detailed list of items that need to be accomplished and/or checked while working to bring up the warm site. The list includes items such as "checking network connectivity," "checking the backup tape integrity," and "ensuring applications in Meditech are providing appropriate data results." The TRAPS include detailed step-by-step processes to recover specific functions in specific applications. The TRAPS are tested on a yearly basis in order to ensure that they will function appropriately during a disaster.

Carondelet Health, as part of a larger agreement with its parent company Ascension Health, partners with a company called SunGard to have an always ready "warm site." One phone call to SunGard informing them of a disaster activates the process. By providing them with a list of "hardware classification levels," they can have the offsite recovery center setup before the disaster recovery team arrives.This service is used in conjunction with the already defined TRAPS in order to ensure that systems

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Member Highlights

Get to Know...

Ann Klusmeier
Business and Academic Manager,
Cardiac Surgery
Children's Mercy Hospital & Clinics

Why did you join HOA-HFMA? After many years of belonging to MGMA, and the local affiliates in different locales I have lived, I find that my work the last few years has focused more on hospital related Finance concerns so the MGMA meetings offer a bit less in my areas of interest than they did when I was in Practice Management.

How long and why do you work in healthcare? 30+ years, initially fell into healthcare after college, loved running physician practices, and later consulting work with practices, but as healthcare evolved I transformed my interest from private practice concerns to hospital owned and academic practices, and have in the past few years worked at Washington University in St. Louis, University of Missouri Clinics in Columbia and now at Children's Mercy Hospital here in Kansas City in very diverse roles but all of them with a strong financial bent.

What do you like most about your job? I enjoy the contracting and budget work, they are fun puzzles, but I also enjoy some HR functions – in a previous position I spent a lot of time managing teams, building consensus, implementing initiatives and improving service performance……. miss that a bit.

Marital status? Children? Married 36 years, 2 adult children

Do you have a funny/embarrassing event that has happened on the job you can share? I'm sure there are many, but none stands out right now.

What is your personal or professional motto? Do the right thing – that works well both in my personal and professional life.

Please describe some of your favorite accomplishments or biggest challenges met: Meeting and working with JCAHO when they visited some of our 58 clinics at MU (located all across the state). Although I had spent my entire adult life in healthcare, this was the first time I had interacted with Joint Commission, and I was point person for all of our clinics (I ran 11 of them at that time. Later became Director of Service Improvement for all clinics so……… guess I did an okay job). Loved the consulting work I did for a few years – collaborated with Bob Howard, a wonderful healthcare CPA in Chicago. Probably the greatest challenge was being asked to put together operating budgets for 11 clinics @ MU after 1 week of employment, and finding out none of my clinic managers had ever been involved in the process previously…. at a time when the Hospital and clinics were being run by an outside consulting firm trying to prevent them from bleeding red.

What advice would you give to someone entering the healthcare field? Heed the history lessons learned by others, but bravely question all and keep our industry moving forward. ■

The Revision to the Health Care Audit Guide

(continued from page 4)

report the provision for bad debts associated with patient service revenue as a separate line item in the statement of operations, as a deduction from patient service revenue (net of contractual allowances and discounts). The standard applies to health care entities recognizing significant amounts of patient service revenue when services are provided, even if the entities do not assess a patient's ability to pay.

There are two exceptions to the bad debt reporting provision. If a health care entity records patient service revenue only to the extent it expects to collect that amount, the related bad debts would still be reported as an operating expense. Secondly, bad debts related to receivables from nonpatient-service revenue also would continue to be reported as operating expenses.

The reclassification of the provision of bad debts to a revenue item comes with additional disclosure requirements. Example disclosures are shown in ASU 2011-07 and include the following:

- Policies for recognizing revenue and determination of bad debts by major payor source
- Qualitative and quantitative information about significant changes in the allowance for doubtful accounts, which may include the amount of write-offs by payor class, significant changes in underlying assumptions or estimates

For nonpublic entities, the new standard will be effective for the first annual period ending after December 15, 2012; for public entities, the new standard will be effective for fiscal years beginning after December 15, 2011. In both cases, early adoption is permitted. Presentation of the provision for bad debts in the statement of operations will be applied retroactively to prior periods presented, and the financial statement disclosures will be applied in the period of adoption and subsequent reporting periods. ■

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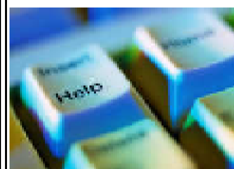

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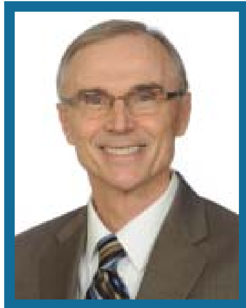
HFMA President & CEO Clarke to Retire in 2012



Richard L. Clarke, DHA, FHFMA, HFMA president and CEO, recently announced that he will retire July 31, 2012, after more than 25 years of service to the Association.

Clarke has been president and CEO of HFMA since 1986. During his tenure, HFMA has experienced membership and operating revenue growth as well as broad influence in improving healthcare efficiency and effectiveness through initiatives such as the ***PATIENT FRIENDLY BILLING®*** project. Clarke has been named one of *Modern Healthcare* magazine's "100 Most Powerful in Health Care" for nine consecutive years, and is one of only 12 healthcare leaders who have made the list every year since its inception.

"HFMA has become the indispensable resource for healthcare finance under Dick's leadership," said Gregory M. Adams, FHFMA, HFMA Board chair and senior vice president and partner at Panacea Healthcare Solutions, LLC. "His vision for value-driven health care, his passion for education and continuous improvement, and his ability to bring together diverse perspectives has benefitted HFMA's members, their organizations, and their communities."

With the announcement, HFMA will soon begin its search for a successor, ensuring a smooth transition for HFMA's 37,000 members across the nation. A search committee has been formed of volunteer leaders with diverse HFMA and industry experience to best represent the association's members in this effort. This committee will work with a search firm to identify and assess potential candidates.

Clarke is a past chair of the Commission on Accreditation of Healthcare Management Education and a former chair of AHA Financial Solutions, Inc. Additionally he has served on the Federal Reserve Bank of Chicago's Advisory Council. He currently serves on several committees and the Board of Directors of CHRISTUS Health in Dallas, Texas, as well as the Finance and Strategy Committee for Catholic Healthcare Partners in Cincinnati, Ohio. Dr. Clarke holds an instructor faculty position in the Department of Health Systems Management at Rush University in Chicago and the MBA in Health program for the University of Miami in Coral Gables, Florida.

Reflecting on his time leading HFMA, Clarke says, "Every day for the past 25 years, I have been impressed by the dedication of HFMA members not only to the association, but to their role in improving our nation's health. It has been an honor to serve with them and to support the mission of HFMA." ■

HFMA Chapter Calendar of Events

Tuesday, October 25th
Patient Access (Charity Care & Self Pay)
12:00 PM – 4:30 PM ❖ Lunch 12:00 pm
Program Fee: $45 per participant
Location: Centerpoint Medical Center

Tuesday, November 29th
CFO/CEO Forum
12:00 PM – 4:30 PM ❖ Lunch 12:00 pm
Program Fee: $65 per participant
Location: Ritz Charles

Thursday, January 26th
AHA Update and Value Based Purchasing
7:30 AM – 11:30 AM ❖ Breakfast 7:30 am
Program Fee: $65 per participant
Location: Ritz Charles

Wednesday, February 22nd
Payor Workshop & Health Insurance Exchange
12:00 PM – 4:30 PM ❖ Lunch 12:00 pm
Program Fee: $45 per participant
Location: St. Joseph Medical Center

Tuesday, March 27th
ICD – 10
7:30 AM – 12:00 PM ❖ Breakfast 7:30 am
Program Fee: $45 per participant
Location: TBD

Thursday, April 26th
Awards Banquet & Leadership Organizational Skills
12:00 PM – 4:00 PM ❖ Lunch 12:00 pm
Program Fee: $65 per participant
Location: Ritz Charles

Believe to Achieve

Framework for Health and Medical Regional Collaboration in the State of Missouri for Emergency Response

Dan Manley is the Health Care System Program Manger at Mid America Regional Council in Kansas City, Missouri, *Dan has a diverse background with over 30 years experience in planning, preparedness and response specific to public safety, hospitals, and emergency medical services.*

Missouri Department of Health and Senior Services have contracted with Mid America Regional Council. The role of Mid America Regional Council (MARC) MARC is to manage the Department of Health and Human Services (DHHS) Assistant Secretary of Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) for Missouri Region A.

The funding from the grant program provides support for hospital planning and resources to assist stakeholders in enhancing medical surge capacity as well as the ability to distribute medical counter measures.

One of the elements of the program was to establish a Region A Hospital Coordinator. The Healthcare System Program Manager from MARC serves in that role. The Healthcare System Program Manager, as well as other MARC staff, collaborate regularly with the Department, Hospital Preparedness Program Manager (HPPM), Missouri Hospital Association (MHA) and East West Gateway Council of Governments' St. Louis Area Regional Response System (STARRS) Hospital coordinators, local public health planners and other entities to improve the current health care system in order to prepare for terrorist or non-terrorist events including rare or biological diseases including pandemic influenza, exposure to chemical toxins, radiological materials, mass casualties due to explosions and earthquakes, or other public health emergencies.

Kansas City Bi-State Regional Support and Planning

Technical assistance to Hospitals, Public Health, Emergency Medical Services, and Emergency Management focusing on the National Strategic Goal of Enhancing Medical Surge and Mass Prophylaxis is provided by MARC Staff. This is accomplished through facilitation of monthly meetings as well as site visits in the Metropolitan area.

MARC Regional Homeland Security Coordinating Committee

Regional Homeland Security Coordinating Committee (RHSCC) Subcommittees

To implement the work supported by the RHSCC, a number of working committees have been convened. These subcommittees have been formed when an existing committee or organization did not have the appropriate membership or mission to respond to the specific issue. The subcommittees include:

- Regional Training and Exercise Subcommittee
- Regional Law Enforcement Subcommittee
- Regional Interoperability Subcommittee

(continued on page 11)

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We could use some help!

If you are interested in joining the Publication Committee or would be interested in writing an article, please contact one of the above committee members.

Deadline for submission of articles for the next newsletter is December 15, 2011. ■

Surviving the Disaster-Key Take Aways

By Shelly Hunter, FHFMA, MBA

On May 22, 2011 St. John's Regional Medical Center in Joplin Missouri, took a direct hit from an F5 tornado. The winds were calculated to be at 212 mph at time of impact. The tornado hit one side, filled the building and blew out all the remaining windows, devastating the entire campus. Even with extensive disaster training, there is no way to be prepared for this type of impact. The coworkers at St. John's were prepared, when Execute Condition Gray was announced, they prepared with flashlights, plans of action and disaster preparedness. This is how they were able to evacuate the 183 patients in 90 minutes.

There is no substitute for drills. The fact that everyone was so well trained speaks to why more people were not hurt and why everyone was able to reach safety so quickly. It is imperative that all staff has been through drills and knows emergency procedures very well so they can react intuitively in the time of disaster.

In preparing for a disaster there are key takeaways from this event that can be shared. One key component is record retention and recovery. In your disaster plan make sure you have a documented list of record storage, legal responsibility of record retention and where the records are located. In Joplin, records were damaged and wet, they had to be recovered, freeze dried, cleaned and stored. It saves a lot of time and money if you know where your records are located, what needs to be recovered and how you would like to have them stored. It is also a good idea to do research now and plan what company you want to use for restoration and retention.

Communication is key in a disaster and in Joplin, all phone lines were down, radios didn't work and the only way to communicate was through texting. Make sure you have all important coworker, city, and area hospital contacts stored in your phone. This was imperative as we navigated a city wide disaster. We were only able to communicate through texting primarily for a full week. The other path to communication for us was through social networking. This was a great source for city update information and emergency response. Make sure someone on your team is connected through social networking.

In a disaster of this magnitude you will need assistance from insurance, FEMA, and asset/debris recovery experts. To ensure you have all of this covered in your disaster plan, do research now and incorporate possible contacts and plans in your planning document and training. Make sure you communicate this to everyone and continue to drill often. Make sure when you drill all coworkers know to respond to the emergency with badge or identification. Make sure each coworker knows where disaster kits are located and how to respond in the event backup power is down, communication is down and where they need to report.

The last thing I would add is to ensure that you and your coworkers take care of themselves. Provide counseling sessions, make sure there is scheduled time off and that people are dealing with the emotional impact of surviving a major disaster. ■

PATIENTS IN THE HOSPITAL:

183 evacuated in 90 minutes

TORNADO VICTIMS NEEDING MEDICAL CARE:

Estimated 1,000

CO-WORKERS:
- 276 working on Sunday, May 22
- 2,097 to account for
- 134 lost their homes completely
- 224 had damage or losses

COMMUNITY: (update as of 7/20/11)
- 159 deaths - greatest number in six decades; overall eighth worst
- 20% of the city destroyed
- 8,000 homes and apartment buildings destroyed
- 18,000 vehicles were damaged
- $2 billion anticipated insurance claims
- 1,000 businesses destroyed; 500 businesses damaged
- 5,000 employees estimated affected; 3,500 have been kept on payrolls
- 18,000 citizens displaced
- 1,500 awaiting housing including those in FEMA

Pictures reprinted with permission by author, Shelly Hunter.

Framework for Health and Medical Regional Collaboration in the State of Missouri for Emergency Response

(continued from page 9)

- Regional Hospital Subcommittee
- Regional Public Health Subcommittee
- Metropolitan Emergency Information System/Personnel Accountability Security System Subcommittee
- GIS Subcommittee
- Regional Disaster Mental Health Subcommittee

Other regional committees operate independently yet support the RHSCC's agenda, including:

- Metropolitan Emergency Managers Committee (MEMC)
  - MEMC Plans Subcommittee
  - MEMC Citizen Readiness Subcommittee
- Mid-America Regional Council Emergency Rescue Committee (MARCER)
- Mid-America Local Emergency Planning Committee (LEPC)
- Heart of America Metro Fire Chiefs (HOAFC)
- Metropolitan Official Health Agencies of the Kansas City Area (MOHAKCA)
- Regional Association of Public Information Officers (RAPIO)
- Kansas City Metro Chapter of Public Works (APWA)
- Public Safety Communications Board
- Kansas City Area Maritime Security Committee

The co-chairs of the RHSCC subcommittees and leadership from the other supporting committees meet every other month to support coordination and information exchange among committees. Major decisions are made in the full RHSCC meetings, unless decisions are required prior to a full meeting. In those circumstances, the co-chairs are asked to make decisions on behalf of the full RHSCC.

During the monthly meetings the committees review and enhance regional plans. The Metro District/KC Urban Area has been meeting regularly to continue development of the Emergency Support Function (ESF) # 8 of the Regional Coordination Guide. ESF #8 is designed to develop the necessary capabilities to achieve the first lines of response to bioterrorism, pandemic influenza, mass fatalities and other public health emergencies requiring a coordinated response from multiple jurisdictions and facilities. The ability to administer mass prophylaxis, triage and provide decontamination when necessary is essential. Emergency ready hospitals and other healthcare entities must be able to work collectively to handle different types of injuries, infectious disease, chemical, or radiation induced injuries and be ready to immediately accommodate an influx of supplemental healthcare assets from mutual-aid partners, States, and the Federal Government.

Ensuring response readiness of the Healthcare System is a crucial part of evaluation. Site visits are conducted at each of the Hospitals in Missouri Region A. During each site visits, staff discuss and review facility specific emergency management plans, and then assess inventory of medical surge supplies provided by MHA and MARC.

An important part of the planning process is to understand risk. Healthcare facilities through the region worked together each year to develop a Regional Hazard Vulnerability Analysis. This tool provides a framework by which we are able to prioritize elements of plans that may need additional focus. Staff provides support to Regional Hospitals to ensure that all facilities completed the MHA Capacity assessments.

Based on the result of the assessments and site visits, we are able to ensure that acquired resources were response ready. Additionally we are able to identify gaps and coordinate additional investments that would reduce gap and enhance or expand the regional medical surge capacity.

Collaboration continues between other health care entities (i.e. community health centers; emergency medical services, home health agencies, long term care facilities, mental health facilities, ambulatory surgical centers) to assure a community wide approach in preparing for an event. To accomplish this we have extended invitations to aforementioned groups and encouraged participation in planning meetings, training and exercise opportunities. We communicate with agencies point of contact in person, by phone, and through electronic mail.

Planning coalition include representatives from Federally Qualified Health Centers, Emergency Medical Services, Public Health Agencies, Emergency Management Departments, and other entities. Rosters are available on request. For additional information on regional hospital planning please contact Dan Manley, Healthcare System Program Manager by e-mail at dmanley@marc.org, or by phone at (816)701-8209. ■

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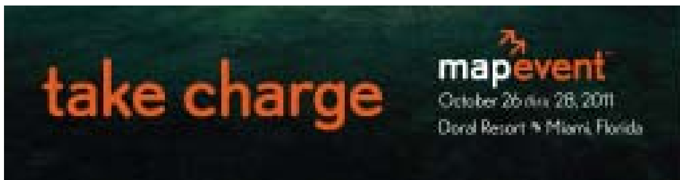

Dear HFMA Chapter Member,

One of the most important HFMA-sponsored education programs for the chapter year –
HFMA's MAP Event – takes place in Miami on October 26-28, 2011.

MAP Event is a peer-to-peer program where you'll take away tools to make real-life performance improvements, instill proven practices, extend accountability, and achieve revenue cycle excellence.

When?	October 26-28, 2011
Why?	You can earn up to 20 CPE Credits
How much?	Members: $895 / Non-Members: $1,019
Where?	Doral Golf Resort and Spa in Miami, Florida
How do I learn more and register?	
	Visit www.hfma.org/mapevent

During hands-on sessions, HFMA's MAP Award winners – hospitals demonstrating outstanding results – will share proven practices to preserve net revenue, improve Cash Collections, reduce DNFB, Aged A/R, and FBNS, and much more. MAP Award winner – Baptist Hospital of Miami – will also conduct a tour of its facility and lead a session hosted by Baptist's VP, Revenue Management.

You will also discover 6 new national key performance indicators (KPIs) – called MAP Keys – part of the industry's 25 most compelling revenue cycle metrics established by healthcare leaders through HFMA's MAP initiative.

What is HFMA's MAP?

HFMA's MAP gives you the revenue cycle tools you need to **Measure** performance, **Apply** evidence-based strategies for improvement, **Perform** to the highest standards across the board, and receive recognition for your success.

Please forward this to interested colleagues and/or staff in your organization today!

If you have questions, HFMA's Member Services Center will be happy to assist you at (800) 252-4362, ext. 2. ■

Yours in financial health,
Esteban Ponce

Disaster Recovery Planning

(continued from page 6)

are recovered in a timely and accurate fashion. Employees are, once per fiscal year, sent to the offsite warm site where a disaster is simulated. The employees practice bringing up the site from disaster through full working and verified system functionality.

Included in the disaster recovery plan is a list of all of our applications, and what level of criticality they represent to the organization. Each level of criticality is associated with a different level of service and recovery time. Information Services interfaced with the application owners and users to determine how critical to the business the application is, and assigned it the appropriate criticality level.

So what do the clinicians do during a disaster? They go extremely low-tech, and utilize pen and paper methods of tracking patients. All of this physical paper is then stored until the disaster is over and the electronic systems are back up and running, at which point it is manually entered into the system.

A well thought out and maintained disaster recovery plan means the difference between 10 minutes of downtime, and 10 days worth of downtime. If an organization currently has no disaster recovery plan then its creation should be one of the top priorities for the organization for the coming months. Even if an organization has a disaster recovery plan, there is no time like the present to dust it off and make sure it is meeting the organization's current needs. ■

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