AMERICAN HEALTH CONSULTANTS
HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR JCAHO, CREDENTIALING, AND QUALITY INFORMATION
27

IN THIS ISSUE

OCTOBER 2002

VOL. 27, NO. 10 (pages 133-148)

Joint Commission issues marching orders to combat nursing shortage

There's plenty you can do to retain nurses and improve quality

Hospitals and other health care organizations must take action on a local level to combat the nursing shortage that threatens the quality of the nation's entire health care system, says **Dennis S. O'Leary**, MD, president of the Joint Commission on Accreditation of Healthcare Organizations. Quality and peer review professionals must take the initiative to improve the lot of nurses currently in the workplace and to attract more people to the profession, he says.

O'Leary cautions that health care providers must not rely on the work being done at the national level to solve the problem. Grass-roots efforts must address some of the most fundamental problems that caused the nursing shortage, he says. The Joint Commission's recent call to action on the nursing shortage, in which O'Leary announced that a significant number of sentinel events and other adverse outcomes are a direct result of the nursing shortage, includes a plan for the organization to push for major changes on a federal level, but that is only part of the response. He also stresses that this problem is one for all health care leaders, including quality professionals, to address. It

Are you ready for EMTALA? Audio conference clarifies final regulations

At press time, the final version of the recently proposed changes to the Emergency Treatment and Labor Act (EMTALA) was expected to become effective soon. Issues in the final regulations could include changes to physician on-call requirements, "comes to the emergency department" definitions, later-developed emergencies, nonhospital entities, and prior authorization. With all the confusion surrounding the proposals during the past year, make sure you know what it takes to comply with the final regulations.

(Continued on page 147)

is not simply an issue for nursing directors.

"This is a call to action," O'Leary says. "We in health care are at a crossroads, and the time to act is now."

While the Joint Commission lobbies Congress and takes other large-scale actions, O'Leary encourages health care quality professionals to follow the steps outlined in the Joint Commission's report, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis.*

In that report, the Joint Commission warns the nursing shortage "is putting patient lives in danger and requires immediate attention." To counter that problem, local providers should pursue 16 steps that change the nursing workplace into one that nurses will want to stay in for years, while also creating a clinical foundation for nursing educational preparation and advancement.

The Joint Commission's roundtable of experts came up with 16 recommendations for transforming the workplace and aligning nursing education and clinical experience.

These are the specific steps that the Joint Commission says hospitals should start working on immediately:

1. Create a culture of retention for nursing staff.
2. Adopt the characteristics of "magnet" hospitals to foster a workplace that empowers and respects nursing staff.
3. Provide management training, as well as support, to nurse executives.
4. Delegate authority to nursing executives and other nurse managers, and in turn to staff nurses, for patient care and resource deployment decisions.
5. Positively transform nursing work through the use of information and ergonomic technologies. Adopt information, ergonomic, and other technologies designed to improve work flow and reduce risks of error and injury.
6. Minimize the paperwork and administrative burdens that takes nursing time away from patient care.
7. Measure, analyze, and improve staffing effectiveness.
8. Set staffing levels based on nurse competency and skill mix relative to patient mix and acuity.
9. Limit the use of mandatory overtime to emergency situations.
10. Adopt zero-tolerance policies for abusive behaviors by health care practitioners who work with nurses.
11. Diversify the nursing work force to broaden the base of potential caregivers.
12. Increase funding for nursing education, including endowments, scholarships, and federal appropriations.
13. Establish a standardized, post-graduate nursing residency program.
14. Emphasize team-training in nursing education.
15. Enhance support of nursing orientation inservice and continuing education in hospitals.
16. Adopt fair and competitive compensation and benefit packages for nursing staff. Use nursing career ladders commensurate with educational level and experience.

Make nurses' jobs better to retain them

Many of those steps are aimed at improving the everyday work life of nurses, explains **Marilyn P. Chow**, RN, DNSc, FAAN, vice president of patient care services for the California Division of Kaiser Permanente, and a member of the Joint Commission's roundtable.

"Part of the problem, a big part, is that nurses don't like coming to work every day because of what they face, and that means you can lose that nurse and you can lose every potential future nurse that person talks to," she says. "To have young people and people in other careers be attracted to nursing, we need to have an environment that people will want to be involved in."

O'Leary seconds that point, saying "Young people have lots of opportunities for other careers, and when nurses go home and say bad things about nursing to their friends and family members, they're turning people off from joining that profession."

Many of the 16 tactics address what nurses report is their main complaint on the job: spending their time on everything but actual patient care.

COMING IN FUTURE MONTHS

- Tips for getting a perfect 100 on your next survey
- What kind of data to use in physician profile for recredentialing
- New streamlined survey process for complex organizations
- Biggest mistake hospitals make with Joint Commission surveyors
- PDAs improve quality of care, reduce errors in diabetes unit

Nursing pathways address causes of nurse shortage

Pathways include work force, learning, leadership

Many of the tactics suggested by the Joint Commission on Accreditation of Healthcare Organizations for addressing the nursing shortage already are in place at Kaiser Permanente, the health care giant based in California, says **Marilyn P. Chow**, RN, DNSc, FAAN, vice president of patient care services.

Kaiser Permanente launched a major effort a year and a half ago to address the critical nursing shortage threatening quality of care. A multifaceted, multiyear program called Nursing Pathways already is yielding results, Chow says.

The program involves these six pathways:

- **Work force:** Improving outreach, development, and retention efforts.
- **Learning:** Providing career development opportunities.
- **Leadership:** Providing nurses with more authority and developing executive leadership.
- **Practice working environment:** Improving nursing ratios and workloads.
- **Research:** Improving the clinical pathways used by nurses.
- **Workplace safety and health:** Decreasing injuries and other health risks in the workplace.

The pathways were designed to address individual problems that Kaiser Permanente nurses said were critical to deciding whether they would stay in the nursing profession or recommend it to others, Chow says.

The six pathways may be expanded to include other areas as Chow and other leaders at Kaiser Permanente continue to gather input from nurses. Chow recommends getting the support of hospital leaders, including senior executives, and then requesting input from nursing staff.

"We listened to the staff and agreed to staffing ratios that are richer than what is proposed by the state. We're also developing a zero-tolerance policy for any sort of abuse of the nursing staff," she says.

Documentation burdens were a major issue for the staff nurses, so a Kaiser Permanente team has been working for more than a year to reduce the paperwork requirements. The multidisciplinary team includes nutritionists, therapists, and other staff members whose work overlaps with nursing so they can look for ways to consolidate forms and reduce the overall amount of paperwork.

Another effort that has been embraced by Kaiser Permanente nurses in the northern California region is the "no cancellation" policy for nurse staffing.

Under this policy, a lower than expected census will not result in the facility reducing the number of nurses working that shift, as it did before. Instead, Kaiser Permanente keeps the extra nurses on the clock and uses the opportunity to send them to continuing education classes and other professional development.

"That's proven to be a very positive change for the nurses because it sends the message that we're not focused only on maintaining the absolute bare minimum staffing levels," Chow says.

"We're willing to invest that time in those nurses when the census allows us to." ■

Excessive administrative tasks and paperwork must be eliminated, Chow says, and nurses must be excused from performing "non-nursing" duties such as ordering, coordinating, or performing ancillary tasks. The Joint Commission's report notes the problem of what it calls "scope creep" for the nurses' role, adding supply chain management, housekeeping, food service, and many other tasks that pull nurses away from patient care.

Chow says the way you utilize nursing resources within the organization can have a tremendous effect on how nurses feel about their jobs.

"Often they will report that they are well paid but still don't feel valued because they are required to act as transporters, or they have to run to the pharmacy at midnight," she explains.

One particular problem cited by the Joint Commission is abusive behavior by physicians. The Joint Commission urges hospitals to adopt a zero-tolerance policy on physicians using their authority to berate, belittle, or otherwise abuse nurses.

"I don't think most physicians treat nurses poorly or regard nurses as their handmaidens, though I suppose there is an old guard out there," O'Leary says.

"But it doesn't take a lot of bad-acting physicians to treat nurses poorly. Maybe you're tired; maybe you're busy; but that's not a license to be a jerk. You're not going to get a lot of improvement on this issue until you establish a zero-tolerance policy and call them on it," he says.

Kaiser Permanente is developing a zero-tolerance policy on abuse, and other efforts already have improved job satisfaction for nurses, Chow says. The Joint Commission points to Kaiser Permanente as a leader in implementing many of the recommended steps. **(For more on Kaiser Permanente's programs, see story, above.)**

"It's definitely an issue of leadership," Chow says. "The nursing leadership and hospital leadership must work together to establish a system in which this kind of abuse is just not accepted."

Improvements could have ripple effect

Some of the changes suggested by the Joint Commission will be challenging, but you may be surprised at how much they can improve quality in your organization, says **Keith F. Safian**, FACHE, president and chief executive officer of Phelps Memorial Hospital Center in Sleepy Hollow, NY.

The nursing shortage affects other caregivers in the hospital who may be experiencing shortages of their own, he says. When there aren't enough nurses, some of their tasks may be shifted on to overworked pharmacists, for instance.

"Nursing care is the backbone of the hospital, and when you have a shortage there, it increases the strain on other staff who will have to pick up some of the work load," Safian says.

"And vice versa — when you improve the nursing situation, you can improve the experiences of many other departments and employees within the hospital. The benefits may reach further than you expect," he points out.

Any steps you take to address the nursing shortage should involve substantial input from your nursing staff, Chow says. The Joint Commission's recommendations may provide you a basic plan, but how you implement them should depend on what your own nursing staff tell you needs to be done.

"Listen to the work force, then start systematically putting in programs that address what they say they need. Let the staff tell you what the priorities are. Don't guess what they want and need," she adds.

[For more information, contact:

- ***Dennis O'Leary**, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000. Web: www.jcaho.org.*
- ***Marilyn P. Chow**, RN, DNSc, FAAN, Vice President of Patient Care Services, California Division, Kaiser Permanente, www.kaiserpermanente.org. Telephone: (510) 987-3900.*
- ***Keith F. Safian**, FACHE, President and Chief Executive Officer, Phelps Memorial Hospital Center, 701 N. Broadway, Sleepy Hollow, NY 10591. Telephone: (914) 366-1000.]* ■

Final HIPAA privacy rule still too onerous for some

Much work is needed to comply, some experts say

Although the final version of the Health Information Portability and Accountability Act's (HIPAA) privacy rule included some good news for those who feared it would be an unworkable, burdensome mess, there is good reason to think it will require considerable work for compliance.

When the medical privacy rule was finalized recently, providers noticed right away that they had won some long-fought battles, most notably on the issue of whether explicit consent would be required from patients for the disclosure of medical information during routine health care operations. In the final HIPAA rule, the U.S. Department of Health and Human Services (HHS) said that such explicit consent is not necessary and existing consent procedures might be sufficient.

Covered entities will have to provide patients with a written notice that explains the provider's privacy practices and patients' individual privacy rights, but in a big change from previous versions of HIPAA, HHS now says that providers will only have to make a good-faith effort to obtain a patient's written acknowledgment of that statement. Under much stricter previous versions of the rule, patient care could not proceed without the patient's written consent.

Most covered entities will have until April 14, 2003, to comply with HIPAA. Some small health plans have until April 14, 2004, to comply.

HHS takes a hard line on data for marketing

Marketing, however, is an area in which HHS did not back down much. HIPAA still prohibits providers from selling lists of patient names to pharmaceutical companies or other marketers without first getting the patient's specific authorization. HHS also changed the marketing sections to make clear that covered entities cannot use business associate agreements to get around HIPAA's requirements regarding marketing.

In a change from previous versions, the final rule explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.

The business associate agreements still will require significant attention from providers, says **Barrie K. Handy**, JD, an attorney with the law firm Davis Wright Tremaine in Seattle. HIPAA permits a covered entity to disclose protected health information to a business associate who performs a function or activity on behalf of the covered entity involving the creation, use, or disclosure of protected health information, as long as the covered entity enters into a contract with the business associate containing specific privacy safeguards, Handy explains. There has been widespread concern that the April 2003 compliance date will not provide enough time for large hospitals to reopen and renegotiate their business associate agreements.

"The amendments allow covered entities to continue to operate under existing contracts with business associates for up to one year beyond the April 14, 2003, compliance date," Handy says. "A covered entity's contract with a business associate would be deemed to be in compliance with the privacy rule until either the date the contract is renewed or modified after April 14, 2003, or until April 14, 2004, whichever is sooner."

Requirements for research authorization also have been simplified. For patient information used in medical research, the final HIPAA rule backed down from some of the strictest proposals of recent years.

At one point, the Clinton administration had proposed that 19 patient identifiers be removed from any information used in medical studies, but researchers argued that removing that much data would make the information useless.

The final rule backs off considerably, requiring only that researchers remove "direct identifiers" that could easily identify the patient. Examples are the person's name, Social Security number, street address, and e-mail address.

HHS also removed the worst parts of the so-called "minimum necessary" provision involving communications between medical providers regarding patient care.

The American Hospital Association (AHA) in Chicago and others had argued that the provision would have prevented physicians and other covered entities from freely communicating as part of patient care.

But Handy cautions that the "minimum necessary" rule isn't gone completely. He says the final amendment takes the same approach to the "minimum necessary" concept as proposed in revisions in March 2002. The final rule "emphasizes that 'minimum necessary' is not intended to impede delivery of health care and is intended to offer covered entities flexibility to tailor the rule to the circumstances of their particular operations," Handy says.

For example, Handy says "minimum necessary" does not apply to a covered entity's use or disclosure to another health care provider for treatment purposes. However, it does apply to uses or health disclosures for payment and health care operations.

In addition, HIPAA requires that patients must give specific authorization before entities covered by the rule can use or disclose protected information in nonroutine circumstances, such as releasing information to an employer.

Many health care providers and advocates welcomed the changes in the final rule, particularly the AHA, which had fought hard against earlier proposals. **Dick Davidson,** AHA president, said the final HIPAA rule is good news for patients because it strengthens the privacy of medical information without getting in the way of good patient care. Issuing the AHA's response to the final version, he said it "puts common sense ahead of bureaucracy. Unfortunately, earlier proposals could have created logjams in providing patients with timely care and more paperwork in a system already choked with paper. Hospitals couldn't work with a patient or physician to schedule any tests or surgery until the patient received and read a lengthy privacy notice and returned it to the hospital," he said.

[For more information, contact:

• ***Barrie K. Handy**, JD, Davis Wright Tremaine LLP, 2600 Century Square, 1501 Fourth Ave., Seattle, WA 98101-1688. Telephone: (206) 628-7404.]* ■

Data show hospitalists can improve quality

Standardized care, best practices achieved

Hospitalists are gaining ground in health care, proving that they can improve quality of care while simultaneously reducing costs for the provider. Quality and peer review professionals should consider spearheading the adoption of a hospitalist program as a means of seeking better patient care, some advocates say.

Hospitalists are physicians who specialize in

the care of hospitalized patients. Unlike most other physicians, they can care for a wide range of patients within the hospital and continue with a patient for long periods. By being available around the clock, hospitalists are able to attend to changes in a patient's condition as they occur, proponents say, rather than having care delayed until the primary care physician can arrive from his or her practice. Advocates of a hospitalist system say the critical-care skills of these specialists are important factors in helping more critically ill hospital patients get the level of care they need. By delivering more efficient and timely care, hospitalists can reduce the time a patient spends in the hospital and the associated cost of care.

Providers are adopting the hospitalist model at a rapid pace; quality improvement is the primary motivator, says **Ron Greeno**, MD, chief medical officer and senior vice president of physician services at Cogent Healthcare in Laguna Hills, CA, one of several companies that provides hospitalist services to hospitals across the country. The system of hospitalists is very different from the traditional model of primary care physicians coming to the hospital to care for individual patients.

"Every hospital I've ever worked in has had the goal of trying to standardize care given by physicians within the walls of the hospital," Greeno says. "The first big obstacle is the sheer numbers. With 400 physicians giving care, and most only spending small parts of the day in the hospital, they're much more concerned with their private practice than your hospital goals. The second obstacle is the way physicians are paid."

Physicians are paid under a system that Greeno calls "a reverse incentive" because they receive more money when the patient stays in the hospital longer and more treatment is provided. Hospitals, of course, are paid a flat rate based on diagnosis, so they are motivated to get the patient out as quickly as possible (in addition to the fact that a shorter stay usually means the patient is doing better).

"So the hospital and physician incentives are disparate. That negatively influences a hospital's ability to standardize care to a best practices level," Greeno says. "A hospitalist program, if structured right, can overcome both obstacles. You can have a hospitalist program that handles a very large percentage of hospital admissions with a small group of doctors."

The pay structure for hospitalists can be designed so that they have the same incentives and measure quality the same way as hospitals, he says. A well-designed program can produce a cadre of physicians who are eager to work within the hospital processes.

"That's how you do quality control and improve outcomes," Greeno says. "It's very difficult to measure outcomes sometimes, but you absolutely are capable of measuring adherence to process. You can determine whether your physicians adhered to certain best practices that you know have been shown to result in better quality care."

LOS reduced 31% at one hospital

One recent study found that hospitalists have a significant effect on the quality of patient care. Robert M. Wachter, MD, and Lee Goldman, MD, MPH, originally described the hospitalist model of inpatient care in 1996, and they recently reported on the clinical, financial, educational, and policy implications of the trend (*JAMA* 2002; 287:487-494).

They reviewed data regarding the effect of hospitalists on resource use, quality of care, satisfaction, and teaching; and analyzed the impact of hospitalists on the health care system.

Wachter and Goldman searched medical databases from 1996 to September 2001 for studies comparing hospitalist care with an appropriate control group in terms of resource use, quality, or satisfaction outcomes. They found most studies indicated that implementation of hospitalist programs was associated with significant reductions in resource use, usually measured as hospital costs (average decrease, 13.4%) or average length of stay (average decrease, 16.6%).

"The few studies that failed to demonstrate reductions usually used atypical control groups," they write. "Although several studies found improved outcomes, such as inpatient mortality and readmission rates, these results were inconsistent. Patient satisfaction was generally preserved, while limited data supported positive effects on teaching. Although concerns about inpatient-outpatient information transfer remain, recent physician surveys indicate general acceptance of the model."

Wachter and Goldman conclude that "empirical research supports the premise that hospitalists improve inpatient efficiency without harmful effects on quality or patient satisfaction."

Partly as a result of such data, the clinical use of hospitalists is growing rapidly, and hospitalists also are assuming prominent roles as teachers,

(Continued on page 143)

Discharge Planning Advisor®

— the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

DP staff feel the burden of prospective payment

Forms take more time, patients harder to place

Nursing facilities look at potential patients differently since the advent of Medicare's prospective payment system (PPS), a turn of events that those in the industry say has made discharge planning a more complex and time-consuming process.

More detailed and demanding screening assessments by nursing homes probably have increased the time discharge planners spend completing referral forms by 25% to 50%, says **Kathy Reilly,** RN, MS, A-CCC, CPUM, manager of resource management at MidState Medical Center in Meriden, CT.

Patients with a high cost of care — like those on total parenteral nutrition or expensive medications or who need high-tech durable medical equipment — are becoming more and more difficult to place, she adds.

Because nursing facilities are reimbursed according to the acuity of the patient rather than on a per diem rate, much effort must be spent documenting the factors that give evidence of that acuity, Reilly notes. If, for example, a patient has received intravenous (IV) medication within three to five days of admission to a nursing home, that treatment is reflected on the "minimum data set" (MDS), the patient acuity measurement tool that provides the medical information on which resource utilization groups (RUGs) categories are based. The RUGs category determines the amount of reimbursement.

Under the PPS system, Reilly notes, the number of minutes of therapy received per day gives the patient a different RUGs "score." The exact date a patient is taken off a ventilator after surgery must be noted because that, too, may put the case in a higher reimbursement category, she adds.

But while more acuity translates to more reimbursement, there is a point at which the payment tops out, so that nursing facilities can find themselves absorbing the extra cost of caring for the most acute patients, she says.

"These are the patients we see staying a little bit longer in hospitals, because they need to be more stable, and to receive less high-tech treatment modalities" before they can be placed in post-acute care, she points out.

"We have to know the facilities in our area that can and still do accommodate some of these higher-acuity patients. Some facilities have made the decision not to provide services for patients on ventilators or IV medication," Reilly says.

Nursing homes, meanwhile, are calling on hospitals not only to give them the detailed information they need, but provide it in a more organized fashion, Reilly adds. Formerly the admissions director for a facility with 30 short-term rehabilitation beds and another 300 skilled nursing beds, she has seen the issue from both sides.

Although most hospitals have changed their referral forms to reflect the screening assessment the nursing homes use, a more standardized system is needed, she says. "Having had experience at the nursing home dealing with multiple referral sources, I can tell you that if you look at the referral process at 30 different hospitals, there are probably 15 to 20 ways of doing it," Reilly says. "Some type of standardization might alleviate some of the problems."

It also would help remedy the situation if all nursing facilities would accept a "common nursing home application" from the hospital, she notes. Although most accept the common form, Reilly adds, there still are some cases in which the family has to go to the facility in person to arrange a placement. "It's more time-consuming and complicated, and it's a burden on patients' families."

The National Association of Subacute and Postacute Care (NASPAC) has developed a prescreening assessment tool for skilled nursing facilities (SNFs) that follows the language of the MDS and the PPS, notes **Diane Brown,** a member of the board of the Vienna, VA-based organization and president of JSC Inc., a Boston firm that specializes in education, consulting, and training for post-acute care. Although the form was designed for use by the SNF's nurse assessment coordinator, it would be "a marvelous tool for the discharge planner to use on the hospital side," Brown says. **(See related story, p. 141.)**

Another restriction on the discharge process is that managed care companies often have contracts with organizations that accept risk for some of the home health and nursing home placements, Reilly points out. That means another entity gets to weigh in on where the patient will receive care, she says. "That adds another layer to the complexity of discharge planning."

"[Discharge planning] is a very complex role," she says. "You can't just say, 'Here's the manual, go to it — identify the patients who need the complex planning.' There's not just a clinical perspective. You have to look at the psychosocial, the financial [factors]. They all affect the process rather dramatically."

The complexities of PPS can affect the patient's length of stay, Reilly notes. "That's a negative financial impact, and it can be a negative clinical impact," she says. "We know that patients who stay in the hospital for a long time are at risk for certain infections, and hospitals are not in the business of being rehab facilities."

Working collaboratively with post-acute providers can help discharge planners identify early on some of the barriers to placement, she says. "You can also work with the physicians, suggesting that if it's clinically appropriate, we need to change this treatment modality because we can't provide it in this community."

An assessment of the PPS, conducted by the Office of the Inspector General's (OIG) Office of Evaluation and Inspection not long after the system's 1999 inception, found that nursing homes were changing their admissions practices in response to the new system.

About half of all discharge planners surveyed for the OIG report said that nursing homes were requesting more detailed information about the patient and were more consistently coming to the hospital to directly assess the patient before making admissions decisions.

When asked which types of patients had become more difficult to place, the majority of discharge planners identified patients who required extensive services, specifically mentioning those who need intravenous feeding, intravenous medication, tracheostomy care, or ventilator / respirator care.

That report, *Early Effects of PPS on Access to Skilled Nursing Facilities* (available at www.dhhs.gov), concluded that there was no direct evidence that Medicare patients were not receiving the SNF care they required.

The reason the complexity of the PPS system is coming to the forefront now as a problem for discharge planners, suggests veteran discharge planning and case management consultant **Jackie Birmingham**, RN, MS, CMAC, is that it's part of an overall problem with bed management.

"I think some nursing facilities started doing more scrutiny and calling the nursing units for more and more information, and I think this resulted in delays in discharge planning causing a backup of patients," says Birmingham, who is vice president of professional services for Curaspan Inc., a Newton, MA-based company that produces eDischarge, an on-line discharge system.

"It's probably one small part of the overall problem of bed capacity days," she adds. "Everyone is looking at ways to streamline the process now that there are internal (length of stay, bed capacity) and external (patient admission status and reimbursement case mix) pressures."

Electronic completion of forms can provide some relief for overburdened discharge planners, Birmingham says. "Filling out forms takes so much time. First you have to find the right form, then start it, and if anything changes for the patient, you have to start over. Electronic forms are easier to read, and there is speedier transmission."

Reilly's department has a patient transition coordinator who works with discharge planners, helping to facilitate the movement of communications with nursing homes, she says.

Electronic forms would further smooth the process, Reilly agrees, "putting the professional

doing the professional role."

[Editor's note: Kathy Reilly can be reached at (203) 694-8503 or by e-mail at kreilly@harthosp.org. Jackie Birmingham can be reached at (617) 663-4831 or (860) 668-7575, and by e-mail at jbirmingham@curaspan.com.] ■

Will discharge planners take to NASPAC form?

Collaborative effort would be 'patient benefit'

A prescreening assessment form developed for skilled nursing facilities (SNFs) by the National Association of Subacute and Postacute Care (NASPAC) could be used collaboratively with discharge planners to provide the most appropriate care for patients, says **Diane Brown,** a member of the board of the Vienna, VA-based organization and president of JSC Inc., a Boston firm that specializes in education, consulting, and training for post-acute care.

But getting discharge planners to use the form — which gathers 108 pieces of information and requires two to three hours to complete — is "a hard sell," Brown adds. "[They think], 'Why should [I] use the tool and do all the work?'

The way the process typically works at present, Brown explains, is that a nurse assessment coordinator from the SNF goes to the hospital to physically examine the patient and gather the information before determining if the facility will accept the person.

However, at least one acute care provider — Yale New Haven (CT) Hospital — uses the tool to provide information for the SNFs in its catchment area, she points out. In that case, the SNF would send a person to the hospital to examine the patient only "if there's a very unusual case."

Discharge planners and nursing home staff completing and reviewing the form together would be "a marvelous patient benefit," says Brown, who helps develop the NASPAC curriculum and serves as an instructor for the organization. "We teach certification for nurse assessment coordinators, which is a two-day program, and we designed the tool to teach them how to do the process."

The tool uses the language of the minimum data set (MDS) and the prospective payment system, she notes, and is more extensive than most other forms.

"Once [SNFs] accept a patient, they are legally responsible for that person. They are looking at a per-diem rate, and if the person is on an expensive medication they don't have, they may spend every bit of the [reimbursement] on medication. This is a useful tool to get everyone thinking about the functional needs of patients as they leave one setting and go to the next," Brown adds. "The more you understand functionality, the better you are able to place the person appropriately," she says.

[For more information on the NASPAC prescreening assessment tool, contact the organization at (703) 790-8989 or Diane Brown at (888) 669-8123.] ■

Here's what's behind that thing you do

Discharge planning isn't optional, expert says

Discharge planning is the law. You knew that, right? Or maybe not.

Giving a presentation at a national meeting in Las Vegas recently on the rules and realities of discharge planning, veteran discharge planning and case management consultant **Jackie Birmingham,** RN, MS, CMAC, was shocked to discover that many in her audience did not know there were laws mandating discharge planning.

This was true even of those managing case management or discharge planning departments, notes Birmingham, who is vice president of professional services for Curaspan Inc., in Newton, MA.

What Birmingham came to realize, she says, is that this phenomenon was a function of the widespread hospital re-engineering efforts of the 1990s, during which many organizations decentralized services and laid off middle managers.

When hospital administrators noticed that the changes resulted in less desirable patient outcomes, including longer lengths of stay, they reestablished discharge planning departments, but put people in charge who had no discharge planning legacy, Birmingham explains. "So [the managers] are doing the right thing, but have no idea why they're doing it."

With that in mind, she has taken on the mission of disseminating information on the laws that

support discharge planning. The major impetus for discharge planning and case management, Birmingham notes, can be found in the following laws, which are listed with her interpretation of their provisions:

Social Security Act (SSA)

As stated in the Conditions of Participation for Hospitals (*Fed Reg* Dec. 19, 1997), the SSA makes a number of provisions regarding discharge planning. It directs health care providers to:

- Identify patients who need discharge planning.
- Provide an evaluation for patients.
- Evaluate patients on a timely basis to ensure appropriate plans.
- Include an evaluation of need for post-hospital services, including hospice.
- Include an evaluation in the medical record and discuss results with the patient and/or the patient's representative.
- Develop an initial implementation of the plan.
- Develop the plan under the supervision of a registered nurse, social worker, or other qualified person.

SSA Amendment (Utilization Review)

This amendment came about a few years after the establishment of Medicare sparked an increase in the usage of health care, Birmingham explains. "Utilization review was mandated because this was the first time there had been coverage for medical care and the utilization of services and the cost of the program were beyond what had been expected."

The government decided to start evaluating the quality and outcome of the services it was paying for to be sure there was appropriate care for patients, she adds.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

This act, which applies only to admitted patients, changed the way Medicare reimbursed hospitals, looking at groups of diagnoses and paying according to length of stay and cost per case, Birmingham says.

"That's when discharge planning became critical, because if hospitals began to discharge patients earlier, there needed to be a way to plan for patients who were leaving 'quicker and sicker.'" A process was needed to connect the post-acute providers with patients with more medical care needs, she adds.

Emergency Medical Treatment and Labor Act (EMTALA)

Passed in 1987, this legislation — often referred to as the "anti-patient dumping law" — specifies that a patient cannot be discharged or transferred from an emergency department until he or she is stabilized. "Stabilization," Birmingham points out, means that no significant medical deterioration is likely after the patient is discharged or transferred, and it is judged on professional standards of practice, not on the hospital standard.

A "nonstabilized" patient, she continues, may be transferred only when the medical benefits outweigh the risks, the patient (or family) consents, and there is medical treatment by the transferring hospital to minimize risk during transfer. The receiving hospital must agree to the transfer, all medical records must be sent, and the transfer must be accomplished with qualified personnel and equipment, Birmingham adds.

Preadmission Screening and Annual Resident Review (PASARR)

Another 1987 piece of legislation, the PASARR was passed to ensure that patients who have mental health needs are identified before admission to a nursing home, she says. It addresses the issue of whether patients being admitted to a skilled nursing facility have the medical/nursing needs to warrant the admission.

Medicare as Secondary Payer (MSP)

The MSP rules, passed in 1990, state that Medicare will not be the primary payer when another payer is available, such as when a patient's spouse is employed and has insurance coverage, when the treatment is the result of an automobile accident for which there is insurance coverage, or when workers' compensation applies.

Providers must review the MSP rules for every admission, as well as for outpatient cases and laboratory tests, Birmingham notes. Hospitals are liable for recovery of money for up to 10 years after the admission or service.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This legislation, for which regulations are still being written, burdens discharge planners with needing to know as much about laws as they do about diseases, Birmingham says.

The privacy section of HIPAA will affect how referrals are made and how information about patients is transferred from one level of care to another, as well as what will need to be documented even about referral sources that don't take the patient, she adds.

Discharge planners should be aware of the regulations on privacy as if their license depends on it, Birmingham warns. ■

(Continued from page 138)

researchers, and quality leaders, they say.

Even better results can be realized, says **Craig Miller**, MD, senior vice president of medical affairs at Baptist Health Care in Pensacola, FL. Miller tells *Hospital Peer Review* that the health care network has seen encouraging results from a hospitalist inpatient program put in place recently at its Baptist Hospital in Pensacola. The hospital implemented a hospitalist program in January 2001 and has seen a dramatic decrease in length of stay and associated costs.

"Our encouraging results demonstrate that a hospitalist program can improve quality of care and patient satisfaction levels while reducing the cost of hospital services for patients covered under a variety of reimbursement programs," Miller says. "Since beginning our hospitalist program in January of last year, we have reduced costs and length of stay, but more importantly, readmissions have been lowered and patient satisfaction surveys are at our highest ever."

In addition to saving Baptist Hospital $1.76 million in its first year, the hospitalist program decreased the average length of stay 1.9 days or 31%, and decreased the average cost of a hospital case by $990, a 33% reduction. Satisfaction ratings by both patients and primary care physicians were more than 99%.

Thirty-day readmission rate, another indication of quality care, was 6% for hospitalist-managed patients vs. an overall 11%. Miller notes that the Baptist Hospital results surpassed those found in Wachter and Goldman's study.

Baptist's decision to start its hospitalist program was prompted by a number of factors. Miller and other leaders at the hospital thought that such a program would improve quality of care, and support from local physicians, and they wanted to find better ways to manage care for all patients, especially those who were uninsured or who had no assigned physician.

Once they decided to start a hospitalist program, the next question was how. They could hire the hospitalists themselves and construct a program from scratch, or they could contract with an outside company to provide the hospitalists and manage the program. After looking at the work involved with starting a program on their own, they opted for the latter.

The result has been a dramatic change in how the hospital works with physicians, Miller says. The attitude of hospitalist physicians often is very different from what peer review professionals are used to seeing in a hospital, Miller says. For one thing, they agree upfront that they will work with the hospital's quality and peer review leaders to meet certain goals. There usually is little debate on that general issue; to be a hospitalist is to work with the hospital for mutual goals.

"Right now, hospitals are at the mercy of the medical staff. Hospitals don't pick the medical staff; the medical staff picks the hospital," Greeno says. "With a hospitalist program, you can pick the hospitalists, so you can have a common vision and common set of values, which is standardizing care to a best practices level."

Contracting with an outside hospitalist provider can be a good choice for some hospitals, but of course, it comes with a hefty price tag. But if you decide that an outside company can spare you some of the hassle involved with getting a hospitalist program off the ground and managing it every month, the expense might be worth it.

The hospital or the outside company most likely will contract with an existing physicians group in the community that will be the leader of the hospitalist program in that community. Because the group already is in the community, it understands the politics among local physicians and has relationships that will prove useful. The physicians group probably will have to add more physicians because of the large volume of patients it will be taking on, Greeno says.

The hospital will need to provide an infrastructure for the hospitalists that allows them to provide the expected high level of care. That means nursing support, communications systems, and sometimes additional training.

"You can expect to see decreased readmission rates and an incredibly high patient satisfaction rating. There is a real opportunity for hospitals to see a significant return on investment," Greeno says. "But the program has to be managed. This is much more than just dropping a lot of doctors in the place and telling them to go to work. The way that it's set up from the start and the way it's managed on a daily basis are two major keys to success."

[For more information, contact:

- ***Ron Greeno**, MD, Chief Medical Officer and Senior Vice President of Physician Services, Cogent Healthcare, 23282 Mill Creek Road #300, Laguna Hills, CA 92653. Telephone: (949) 699-6000.*
- ***Craig Miller**, MD, Baptist Health Care, 1000 West Moreno St., P.O. Box 17500, Pensacola, FL 32501-7500. Telephone: (850) 434-4011.]* ■

THE QUALITY - CO$T CONNECTION

Part 2 of 3

Develop a patient safety management system

How to tackle planning and implementation

Protection of patient safety is an important factor in the decision-making process at all levels in a health care organization. A safe environment for patients is not just a legal or moral obligation; it also makes good business sense. Reducing patient incidents means lower costs and improvements in customer satisfaction. Significant adverse events can damage the hospital's reputation and result in loss of confidence among physicians, staff, and community members. Patient safety management (PSM) must be addressed in a proactive but flexible manner. Only a carefully designed and properly implemented management approach can provide the necessary measure of confidence that patient safety goals are met and performance objectives achieved. An effective patient safety program can ensure that risks are well managed through timely identification of clinical, financial, and resource improvement opportunities.

This is the second of a three-part series on the essential PSM elements. Last month, the important components of a patient safety policy were described. This month, the assessment tool covers the next two phases of PSM: planning / commitment, and implementation / operation.

(Continued on page 147)

Patient Safety Policy Self-Assessment Tool

2.0 PLANNING

2.1 Is there a procedure to identify significant patient safety concerns?

Score	Description
0	There is no procedure to identify the specific patient safety concerns associated with clinical operations and activities.
1	There is a procedure to identify patient safety concerns, but it is either (a) driven primarily by accreditation or regulatory requirements, or (b) is limited in scope.
2	There is a procedure to identify significant patient safety concerns.
3	There is a comprehensive, documented procedure to identify all patient safety concerns. The procedure also includes: • An analysis of available and reliable data • An analysis of the impact of process improvements designed to the likelihood of patient harm.

Our Score: _____

2.2 Are significant patient safety issues identified by regulatory or accreditation groups considered in setting organizational improvement objectives?

Score	Description
0	Improvement objectives are not set.
1	Improvement objectives are set, but do not take into consideration patient safety issues identified by external groups.
2	The process of setting improvement objectives takes into consideration some issues identified by external groups. The process for setting improvement objectives is not documented.
3	The process of setting improvement takes into consideration all or most significant issues identified by external groups. This process (or procedure) for setting improvement objectives is documented.

Our Score: _____

2.3 Are patient safety improvement objectives and targets systematically established, reviewed, and documented?

Score	Description
0	Improvement objectives and targets have not been established beyond general regulatory and accreditation standards compliance.

(Continued)

1 Improvement objectives and targets are established and are documented. Objectives and targets primarily address regulatory and accreditation standards compliance. No process exists to ensure that these objectives and targets are reviewed and maintained regularly. Improvement objectives and targets do not cover all appropriate levels and functions of the organization (e.g., objectives are limited to one department or function).
2 Improvement objectives and targets are established and documented, with consideration not only to regulatory and accreditation requirements, but also to significant internal priorities or the concerns of interested parties (e.g., patient and family concerns). Targets and objectives reflect a commitment to prevention of unintended patient harm and continuous improvement. The objectives are specific and the targets are measurable wherever practicable.
3 There also is a documented procedure for establishing, reviewing, and updating improvement objectives and targets. This process is integrated into the overall performance improvement system. Improvement objectives and targets have been developed for each important clinical function and level within the organization.

Our Score: _____

3.0 IMPLEMENTATION AND OPERATION

3.1 Are roles, responsibility, and authorities defined, documented, and communicated?

Score **Description**

0 Top management has not appointed a specific individual or group to oversee patient safety management.
1 An individual or group has been appointed to oversee patient safety management but role, responsibility, and authority have not been defined.
2 The role, responsibility, and authority for the individual or group overseeing patient safety management have been defined, but have neither been documented or clearly communicated through the organization. Roles, responsibilities, and authorities of other individuals and groups that impact patient safety are partially defined and communicated, but are not well documented.
3 All roles, responsibilities, and authorities for patient safety management have been defined and communicated.

Our Score: _____

3.2 Has the organization provided resources essential to implementation and maintenance of patient safety management?

Score **Description**

0 Resources essential to the implementation and effective functioning of the patient safety management system have not been defined.
1 Resources essential to the implementation and effective functioning of the patient safety management system have been defined, but necessary resources haven't been allocated to achieve core performance improvement objectives or commitments.
2 Management has allocated some of the essential resources, but has not provided all resources identified as necessary to meet relevant patient safety performance objectives or commitments.
3 Management has allocated and provided the resources essential to the implementation and effective functioning of the patient safety management system. Resource allocation is reviewed annually.

Our Score: _____

3.3 Have all patient safety training needs been identified?

Score **Description**

0 Patient safety training needs are not defined in a systematic manner. Training to comply with regulatory requirements or accreditation standards may occur, but on an ad hoc basis.
1 A process is established to identify training needs based on regulatory requirements and accreditation standards. A process does not exist to identify training needs of physicians and staff with respect to their specific responsibilities.
2 A process is established to identify training needs for physicians and staff based on regulatory requirements, accreditation standards, and the potential for patient harm. A process has not been established to ensure that outsourced or contracted patient care providers have the requisite training.
3 A procedure is established to identify training needs for physicians and staff and to ensure that outsourced or contracted providers have the requisite training needed to ensure patient safety.

Our Score: _____

(Continued)

3.4 Are appropriate procedures established for internal communications to leadership, physicians, and staff?

Score	Description
0	There is no process defined for the communication of patient safety information to the Board, administrative and medical staff leaders, and physicians and staff.
1	There is a process for the communication of patient safety information to the Board and administrative and medical staff leaders. The information is generally limited to regulatory and standards compliance information. There may be gaps in information dissemination to relevant physicians and staff at various levels and functions within the organization.
2	Patient safety performance results are widely communicated to the Board, administrative and medical staff leaders, and physicians and staff in varied contexts and at all appropriate levels and functions. The information is presented through multiple channels; however, the feedback or response system is inadequate.
3	The internal communication procedure and system also includes a defined process or procedure for responding to questions, comments, and feedback from the Board, administrative and medical staff leaders, and physicians and staff. Communication procedures are regularly reviewed and adapted to changed perceptions and circumstances.

Our Score: _____

3.5 Are appropriate procedures established for external communications regarding the patient safety management system?

Score	Description
0	There is no process for communications to external stakeholders (e.g., regulators, accreditation groups, community) regarding the patient safety management system. Communication occurs on a reactive, ad hoc basis.
1	There is a process for external communications; however, such procedures generally are informal and limited to compliance with external requirements or emergency situations.
2	There is a procedure for receiving, documenting, and responding to relevant external groups or individuals on the organization's patient safety management system.
3	There also is a procedure and commitment for communicating patient safety information, including performance data, to interested external stakeholders on a periodic basis.

Our Score: _____

3.6 Are operations and activities associated with significant patient safety concerns effectively managed?

Score	Description
0	Operations and activities that may cause significant patient safety concerns are not identified.
1	Operations and activities associated with significant patient safety concerns are identified, but situations where the absence of an operational control or documented procedures could lead to a system failure have not been defined (e.g., noncompliance with the patient safety policy, compliance violations, failure to achieve objectives and targets, actual patient harm). Appropriate education, training, or experience requirements have not been identified for physicians and staff that may control or influence patient safety.
2	Situations requiring operational controls and/or documented procedures to ensure patient safety have been identified and described. Appropriate education, training, or experience requirements have been identified for physicians and staff that may control or influence patient safety. Some of the physicians and staff have received training designed to ensure competency.
3	The operations and activities that are related to significant patient safety concerns have been identified and documented. A procedure exists to ensure that physicians and staff who may control or influence patient safety are competent to carry out their responsibilities.

3.7 Are procedures established to identify incidents, adverse events, and hazardous situations?

Score	Description
0	A procedure for identifying incidents, adverse events, and hazardous situations is not established.
1	A procedure for identifying incidents, adverse events, and hazardous situations is established.
2	A procedure for identifying incidents, adverse events, and hazardous situations is established. The procedure includes a mechanism for periodic review and updating.
3	A procedure also exists to utilize the incident, adverse event, and hazardous situation information to develop preventive strategies.

Our Score: _____

(Continued)

3.8 Are procedures established to respond to adverse incidents and hazardous situations?

Score	Description
0	There is no procedure for responding to potential significant incidents and hazardous situations.
1	A procedure exists for responding to potential significant incidents and hazardous situations.
2	A procedure exists for responding to potential significant incidents and hazardous situations. Informal review of significant adverse events or hazardous situations may occur.
3	Procedures have been established related to adverse events and hazardous situations. Procedures also exist to mitigate potential patient harm associated with incidents and hazardous situations. Procedures are reviewed and revised as necessary after an adverse event or near miss.

Our Score: _____

(Continued from page 144)

The planning phase covers the identification of key patient safety impacts associated with patient care activities and operations, compliance with regulatory and accreditation requirements, commitments in the form of objectives (e.g., goals), targets (e.g., timelines, specific reductions), and definition of initiatives to achieve the specified objectives and targets. Implementation and operation includes the definition and communication of roles and responsibilities, including authority and accountability. Everyone is trained in how to identify risk-prone situations and to prevent and respond to adverse events.

(Continued from cover)

To keep you on track, American Health Consultants offers the **EMTALA: Complying with the Final Regulations** audio conference, scheduled for Tuesday, Nov. 12, 2002, 2:30 to 3:30 p.m. ET. The conference will be presented by **Charlotte S. Yeh**, MD, FACEP, and **Nancy J. Brent**, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Co. in Hingham, MA. Brent is a Chicago-based attorney with extensive experience as a speaker on EMTALA and related health care issues. In June of this year, both speakers presented **EMTALA Update 2002**, one of AHC's most successful audio conferences.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $299, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit.

The conference package also includes handouts, additional reading, a 48-hour replay of the live conference, and a CD recording of the program.

For more information, or to register, call customer service at (800) 688-2421 or (404) 262-5476. E-mail: customerservice@ahcpub.com. When ordering, please reference effort code: **63221**. ■

Implementation/operation includes the definition and communication of roles and responsibilities, including authority and accountability.

Everyone is trained in how to identify risk-prone situations and to prevent and respond to

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10 to 20 additional copies, $257 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Editor: **Greg Freeman**, (770) 645-0702.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments, call **Greg Freeman** at (770) 645-0702.

adverse events and hazardous situations.

Two series of questions are found in the self-assessment tool. **(See tool, pp. 144-147.)** The first set can be used to rate your PSM planning and commitment and the second set covers implementation and operation. Rate your organization by considering the examples provided for each score. Score 3 represents the "ideal" endpoint in which the element appears to be completely fulfilled. Add your organization's score to the space provided beneath each element.

In next month's column, the fourth PSM phase — measuring, checking, and corrective action and leadership review — is described. Another self-assessment tool is provided along with suggestions on how to improve all the phases of your organization's PSM system. ■

CE *questions*

13. List the first of 16 recommendations to address the nursing shortage from a roundtable of experts convened by the Joint Commission on Accreditation of Healthcare Organizations.
    A. Measure, analyze, and improve staffing effectiveness.
    B. Provide management training, as well as support, to nurse executives.
    C. Create a culture of retention for nursing staff.
    D. Limit the use of mandatory overtime in emergency situations.
14. Which of the following is not one of the six nursing pathways used at Kaiser Permanente to address the nursing shortage?
    A. Work force
    B. Teaching
    C. Research
    D. Leadership
15. Most covered entities have until what date to comply with the privacy portion of the Health Information Portability and Accountability Act?
    A. Dec. 1, 2002
    B. Jan. 15, 2003
    C. Feb. 23, 2003
    D. April 14, 2003
16. In its first year, the hospitalist program at Baptist Hospital in Pensacola, FL, saved the hospital how much money?
    A. $1.76 million
    B. $1.92 million
    C. $2 million
    D. $4.3 million

Answers: 13. C; 14. B; 15. D; 16. A

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and / or based on independent recommendations from clinicians at individual institutions.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■