HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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IN THIS ISSUE

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JULY 2006
VOL. 14, NO. 7 • (pages 97-112)

Creativity is the key in discharge planning for undocumented immigrants

Tap into as many community resources as possible

Hospital discharge planners must use their ingenuity to find a discharge destination for undocumented workers who need post-acute care.

"Finding post-acute care for documented workers means starting from scratch every single time and tapping into whatever community resources are available, says **Caroline Keane**, RN, MSN, ANP, CCM, director of case management and social work for New York Hospital-Queens, a private, nonprofit hospital in downtown Flushing.

Hospitals are compelled morally and by law to treat anyone who comes in with an emergency condition under the Emergency Medical Treatment and Active Labor Act (EMTALA), points out **Carla Luggiero** of the American Hospital Association.

"Over the last 10 years, our hospitals have noticed an increase on what we suspect are undocumented immigrants coming into the emergency room," she reports.

In 2000, hospitals in just 24 counties along the Mexican border spent more than $200 million on emergency health care and transportation for undocumented immigrants, according to a study by the Border Counties Coalition.

The undocumented are a subset of the uninsured whose care often strains a hospital's budget, Luggiero notes.

"It gets to be a matter of allocating funds. If a hospital has a large number of uninsured patients coming to their emergency department, they have to allocate funds to that at the expense of other programs," she says.

In 2004, the Centers for Medicare & Medicaid Services (CMS) announced a program to provide $1 billion over a four-year period (2005-2008) "to help hospitals and other providers recoup the costs of providing needed medical care to uninsured patients who cannot pay their hospital bills regardless of their citizenship status," according to a CMS statement. Part of the Medicare

Modernization Act, the program, "proposes to allocate payments based on the costs incurred for the initial emergency services and associated services, including physicians and ambulance services."

But hospitals are likely to get only a few cents on the dollar when they apply for the funds, Luggiero points out.

"This program does not fully cover the cost of providing emergency department care. It's pennies on the dollars," she says.

Funding is allocated to states based on the proportion of illegal immigrants in their state compared to the national proportion, with extra payments going to states with the highest rate of apprehending illegal immigrants, Luggiero says.

"An illegal immigrant who's been in an accident and has head trauma, internal bleeding, and multiple injuries could deplete the entire amount allocated to the state," she says.

It's hard to know exactly how many undocumented immigrants are being treated in U.S. hospitals because citizenship isn't something that usually is included on admissions forms, Luggiero says.

Some illegal aliens tell hospital staff up front that they don't have papers, she says. Among those who don't say if they don't have an address in the United States or a Social Security number, it's a good guess that the person is undocumented, Luggiero adds.

Hospitals are limited by HIPAA regulations when it comes to finding out information about patients from community organizations or government agencies, Keane points out.

Some patients come in confused and may have a green card but are unable to tell the hospital. This means that it is difficult for the hospital able to apply for Medicaid on behalf of the patient.

"At one time, we could call the Social Security Administration to find out if a patient had a social security card. It's not as easy as it used to be. We just have to do the best we can," she says.

Beginning July 1, states must verify that a person applying for Medicaid is a U.S. citizen, a naturalized citizen, or has been living in this country legally for five years, Luggiero says. People who apply for Medicare must have a Social Security number.

When the patient is undocumented and needs post-discharge services, the problem becomes more challenging for discharge planners. Since post-acute facilities are not compelled to take unfunded patients and illegal immigrants can't qualify for Medicaid or other publicly funded assistance programs, they often end up staying in the hospital for long periods of time.

"The first thing we have to do is treat the patients who present at the emergency room. Then we worry about insurance and what will happen later. We do our best to find family members or someone else who can take care of them after discharge," says **Winnie Coburn**, RN, CPHQ, director of care management for Carondelet Health Network in Tucson, AZ.

Hospitals are required to provide a safe

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, 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 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: ahc.customerservice@thomson.com. Web site: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $469. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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This activity is approved by the National Association of Social Workers for 18 contact hours.

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discharge to all patients, unless they sign out against medical advice or just walk out of the hospital, Coburn points out.

Post-discharge services

Undocumented workers tend to fall into two groups — those with supportive families and those who have no relatives and few friends in this country, Keane says.

Patients who have been in the United States a long time and have ties in the community often have friends or family members willing to take over the care.

For instance, New York Hospital-Queens recently treated a hemiplegic patient who had a family in the city who was willing to take care of him after discharge. The case managers were able to reach out for charity care from local home care agencies and to get medication from a program for the indigent. They got a wheelchair and other equipment through a durable medical equipment company's charity program.

"We see how many hours of home health they need and see if we can work it out with nursing services. It's the easiest to find when the family is still involved," she says.

Migrant workers are the hardest to place if they need post-discharge services, Keane says. These workers typically come to the United States alone and send money back to their family in their native country.

"Home care is a big deal for us. We look at individual cases and try to find a discharge destination if we think somebody is going to need services after discharge. We can't discharge them if they aren't going to be safe," she says.

The living situation of undocumented workers often makes it difficult to provide a hospital bed, a walker, a wheelchair, or other equipment they may need after discharge, Keane adds.

"They may be living in an apartment with a lot of other people. Even if we provide them a hospital bed or other equipment, there may be too many people living in a small space to accommodate it, even if it's just on a temporary basis," she says.

If the patient needs help with toileting or other activities of daily living, they don't always have someone who can help.

Some undocumented migrant workers have created their own version of an extended family with friends and roommates who can provide care, Keane says.

For instance, she's been able to find friends who can come in the morning and the evening to take care of the patient while he or she recovers.

"If you're not looking for care to last indefinitely, sometimes it can work. You just have to try to tap into every resource you can and keep looking until you find a solution," Keane says.

Sending patients back to their native country is another solution. New York Hospital-Queens has paid to transport disabled patients back to their homeland if they can find family members who want to take care of them.

In one case, a bilingual nurse explained the care needs to the family, and the hospital paid for the airfare for a family member to come to New York and travel back with the patient.

"The family really did want him/her back home. You can never assume anything. We've had patients who have been in this country illegally for 10 years but when they are sick, their wife or their child may want them back," Keane says.

Keane was able to send one patient from China back to his family with the help of a local church. The patient wasn't able to fly alone so the church helped find someone who was going to travel to China and who agreed to accompany the patient.

"Rather than arranging a medical airlift, with the help of the church, we were able to find someone to accompany him," she says.

The hospital introduced the church member to the patient and paid for his airfare.

On the other hand, sometimes, it doesn't help to find family members. The case manager tracked down an adult son of one injured patient who was an undocumented immigrant, but the son said he had seen his father twice in his life.

"There was no connection there. He wasn't willing to have his father come and live with him and his family," she says.

The social workers at Carondelet Health Network in Tucson work with the Mexican Consulate, which sometimes can help the hospital locate family members who are willing to care for the patients at home.

"We try to find family or friends in the United States and work with the consulate on family connections in Mexico. We try to transition them to another level of care, but if they continue to need care and there is no discharge opportunity, it is our obligation to complete the care," she says.

On occasion, the hospital has been able to transfer the patients to a hospital in Mexico

where they can get care closer to their families.

Recognizing that some Mexican hospitals may not be as well equipped as their counterparts in the United States, some hospitals in Tucson have been helping a hospital just over the Mexican border obtain improved equipment so patients can be safely transferred and receive the care they need, Coburn says.

Case managers and social workers often tap into community resources to find a safe discharge destination for undocumented workers, Keane says.

"Some facilities are very generous, and if they have an empty bed, they will take an unfunded patient," she says.

Some facilities in New York have a program geared toward the Asian population, and if they have an extra bed, they'll take an undocumented Asian patient who needs post-acute care.

If the patients are homeless as well as undocumented, the hospital immediately contacts the city's shelter system to see if the patient meets its criteria.

The case managers work with assisted living facilities and adult care homes for placement when patients don't fit into a skilled nursing bed but need post-acute care.

"It's cheaper than keeping them in an acute care hospital when they don't have acute care needs," she says. ■

Social worker facilitates referrals to shelters

LOS drops from 27 days to 9 days

Having a dedicated social worker who works with local homeless shelters to place patients has significantly reduced the length of stay for homeless patients at New York Presbyterian Hospital/Columbia.

In 2000, before the program was started, the average length of stay for homeless patients was 27 days. In 2005, the figure had dropped to nine days, according to **Paula Roberts**, LCSW, director of social work at the New York City hospital.

The hospital developed the homeless patient referral program in 2001, assigning one social worker as the liaison between the hospital, the shelter system, and the New York Department of Health's department of homeless services.

Before the new system was instituted, individual social workers would fill out the forms for shelter referral and send them to the department of homeless services, a city agency that assesses patients' eligibility for shelter placement.

"They were taking a long time in responding and they were dealing with new social workers at our hospital each time," Roberts says.

If the patient is eligible for a shelter placement in New York City, the hospital must send a patient's medical history, including laboratory results, to the medical review team at the Department of Homeless Services. The information is reviewed and provided to the program referral unit, which determines which shelter will meet the patient's needs.

The system was developed to streamline the complicated system necessary to place patients from the hospital into shelters in New York City.

"Having one social worker track the patients being referred to the Department of Homeless Services has made a tremendous difference. It smoothes the transition of patients from the hospital to the shelter," Roberts says. "The Department of Homeless Services now has one person to call. This has led to a good working relationship between the agency and the hospital," she says.

The agency has agreed to let the hospital know within 72 hours if the patient can be placed in a shelter. The social worker tracks the time and date the application is filed and the length of time it takes to get a response. "We have a dedicated person who has established a great relationship with the department of homeless services, who is relentless about calling them and making sure the paperwork goes through on a timely basis," says Roberts.

When patients who have been in a shelter are readmitted to the hospital, the social worker knows their history and which shelter they have been in. The social worker contacts the Department of Homeless Services and lets them know that the patient has been readmitted.

The hospital provides homeless patients with a two-week supply of medications when they are discharged.

"We pick up the medications for them and hand it to them because we want to make sure they have it in hand," she says. The hospital keeps a supply of clothing for homeless patients and often arranges transportation to the shelter.

Medical needs determine patients' eligibility for placement. "If patients do not want to go to the shelter, it's their right to decline by self-determination," Roberts says.

If a patient is not eligible for shelter or refuses shelter placement, then it is the responsibility of the interdisciplinary team in collaboration with the patient to develop a safe and appropriate discharge plan.

"We've had people who stayed in our hospital for a long time. With this patient population, you have to be creative. We try to find some family or other support system to take care of them," Roberts says.

When patients at Presbyterian Hospital say they are homeless, they are assessed by a social worker who visits them in their room and further assessed by the interdisciplinary treatment team.

"When the social workers do the assessment, they may find that some of the patients are not really homeless. They may have a place to stay but choose not to return for various reasons. In those cases, the social worker works with the patient to either return home or to identify a safe discharge alternative," Roberts says.

In addition to shelter referral, the social workers also may refer patients to a mental health clinic or other community agencies for continuing care needs.

(For more information, contact Paula Roberts, LCSW, by e-mail: roberpa@nyp.org.) ■

Initiative cuts ventilator days by 50%, improves care

Six Sigma initiative focuses on best practices

A Six Sigma initiative to improve care for ventilator patients has decreased ventilators days by more than 50% at St. Anthony's Hospital in St. Petersburg, FL.

"Our goal was to reduce ventilator days but by doing that, we also reduced the total length of stay for patients in the hospital and decreased ventilator-acquired pneumonia and infections," says **Debbie Ulrich**, RN, case manager in the hospital's intensive care unit and cardiovascular intensive care unit.

St. Anthony's is part of BayCare Health System, which includes nine not-for-profit hospitals in the Tampa Bay, FL, area. The health system rolled out a Six Sigma initiative in March 2005 and hired 12 dedicated team members to become Black Belts and assigned each an improvement project, says **Angi Jennings**, Six Sigma Black Belt, who led the clinical team through the project.

"We looked at the cost per case for the ventilator patient population and looked at our outcomes, such as mortality rates, infection rates, and readmission rates. We took a practical problem of patients being on ventilator days too long and made it a statistical problem. We then took the statistical problem and went back to the team to put together practical solutions to improve the problem," Jennings says.

Jennings put together a multidisciplinary team with representatives from every discipline that provides care for ventilator patients. The team included representatives from nursing, respiratory therapy, case management, pharmacy, physical therapy, infection control, pastoral care, and nutrition, along with a representative from senior management at the hospital.

The team conducted a retrospective analysis of ventilator patient data and determined that the hospital exceeded its targeted time for patients to be on a ventilator 30% of the time.

Following Six Sigma methodology, the team determined that five major variables contributed to the problem. They involve: standardization, hospital-driven initiatives, physician-driven initiatives, information system documentation and support, and team member education and training.

Using the data from the analysis and best practices for care of ventilator patients, the team developed a set of weaning criteria and a uniform weaning protocol for all ventilator patients.

They established multidisciplinary rounds each day for every ventilator patient and developed a daily rounding sheet, an accountability tool that is used during rounds every day on every ventilator patient.

The team created a biweekly dashboard that shows how many days patients were on the ventilator and developed a process so that the ventilator team is notified daily which patients in the hospital are on the ventilator instead of having to call each nursing unit to find out.

The team starts each day with ventilator rounds on every patient in the hospital who is on a ventilator, Ulrich says. If the physician who admitted a patient is in the hospital, he or she participates in the daily rounds.

"We discuss how the patient came onto the vent, their situation prior to coming to the hospital, and the clinical aspect of patient care, with each department giving input," Ulrich says.

As the team conducts rounds together, each

team member fills out the daily rounding sheet showing where the patient is on the plan of care and signs it.

The team starts early in the process to look at family support and discharge planning, bringing in social services as necessary.

"We start by looking at how long the patient has been on the ventilator. We determine if the patient is weanable by talking to the pulmonologist and the respiratory therapist. If it's going to be difficult, we start early on to get consent from the family or the patient to do a tracheotomy, which makes weaning easier and helps prevent infections," Ulrich says.

If the patient is going to be on a ventilator long term, the team considers a GI consultation to see if the patient would benefit from a PEG tube for feeding and discusses potential alternative care options, such as an acute rehabilitation hospital.

Team approach

The team's daily protocol includes infection control measures, looking at how long the lines have been in, determining when they need to be changed, and getting bacterial cultures done quickly.

"We look at nutrition, whether the patient can tolerate having tube feeding started. All different departments are involved. The team approach means that patients are getting what they need both nutritionally and clinically in order to be ready for weaning earlier," Ulrich says.

When a patient is weaned, Ulrich consults with the physician to make sure the patient still meets ICU criteria when he or she is off the ventilator. Patients may need to remain in the ICU because they have other conditions or need certain medications, she says.

The case manager's role is as critical to the success of the initiative as nursing and respiratory therapy, particularly in the cases of long-term ventilator patients whose families face a lot of decisions about future care, Jennings points out.

"[Ulrich's] early intervention in discharge planning from the time of intubation has allowed the team to focus on long-term care facility placement and has allowed the family and the clinicians to deal with end-of-life issues sooner," Jennings says.

Ulrich works closely with the hospital's social worker to ensure that the patient can be safely discharged to home or to another level of care.

"The physicians and the family members often don't realize what resources are in the community. We help them determine whether hospice or palliative care is needed and what facilities take tracheotomy patients and which take ventilator patients," Ulrich says.

She refers patients without funding to the social worker, who assists in applying for Medicaid funding.

"The physicians are realizing the value of the team. They are coming to us sooner rather than later asking what is available for the family after discharge and what they need in order to accomplish it," Ulrich says.

The same physicians who work with Ulrich when they have ventilator patients are calling on case managers in other parts of the hospitals for help in coordinating care and discharge planning, she says.

"It has given case management a lot more important role for physicians. They don't just see us as someone to call when a patient needs a nursing home. They know that we are able to help in so many ways to coordinate patient care," she says.

Six Sigma methodology begins with assembling a team, then clearly defining the defect to be corrected, in this case counting the number of ventilator days, Jennings says.

The team gathered 37 clinical and nonclinical variables, including the age of the patient, the principal diagnosis, type of sedation, daily blood gas readings, type of pain medication, and daily chest X-ray results. They also looked at on which day physical therapy and nutrition consults occurred, and which pulmonologist was treating the patient.

The team pulled the variables on 427 ventilator patients who were hospitalized during 2004 by manual chart review and electronic medical records.

"We brainstormed and asked the team members individually and as a group why they thought the patients were on the ventilators too long," Jennings says.

The team found lack of communication among the treatment team was the biggest barrier to getting patients off ventilators in a timely manner, Jennings says.

"Each discipline was doing their job and charting it, but there was no interdisciplinary communication. One department was doing something on the pathway that might interfere or add additional days to what another department was

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CRITICAL PATH NETWORK™

Patient flow initiatives slash average LOS

Rates cut from 7.5 hours to just more than 5

Three years ago, the average length of stay (LOS) for admitted ED patients was about 7.5 hours at the 17th Street campus of New Hanover Regional Medical Center in Wilmington, NC. Today, it is down to just more than five hours.

This improvement was achieved through a combination of initiatives, including the creation of a rapid admit unit and the addition of a computerized bed tracking system, says **Nancy Wooline**, director of emergency and psychiatric services for the New Hanover Regional Medical Center network, which includes the 17th Street campus and Cape Fear Hospital.

"About three years ago, we looked around our network and realized we were super-saturated and that the old tools we had in place for moving patients through the continuum of care were no longer effective," she recalls. 'We felt we had done all that we could do off the back end, so we looked to shorten LOS." At that time, she notes, the network was seeing a combined total of 68,000 ED patients a year. Today, it is up to about 100,000.

By creating the rapid admit unit, the ED was "decompressed," explains **David Doolittle**, MBA, RN, manager of the unit. "We take some patients out of ED, which allows the ED staff to see more patients," he notes. The unit itself resembles a mini-ED, with small stalls, trauma beds, and easy access for the ED staff, who are about 75-100 feet away.

The unit is used, for example, when an ED physician determines a patient should be admitted to the tower (as an inpatient), but a bed isn't ready. "In the old days, that patient would have been locked up in [an ED] bed," Doolittle says. "Now, we can pull them into the nine-bed unit and do all the admission work: paperwork, start IVs, drawing labs, getting the first antibiotics on board, and so forth."

This process takes 48 minutes, he says; meanwhile, the patient's bed is being cleaned and the room is prepared. "The key thing is that we have opened up a bed in the ED to allow an additional patient to come in," notes Doolittle, adding that the unit sees about 75%-80% of all patients not admitted to the intensive care unit.

The unit itself is typically staffed with three nurses; three patient care technicians (PCTs), who are hybrids between unit clerks and nursing assistants; and one unit clerk. They have been cross-trained in phlebotomy, electrocardiograms (EKGs), transport, and other similar functions, Doolittle says.

There were no new full-time equivalents (FTEs) added to the nursing staff at the medical center, says Wooline. "We used parts of the FTEs from inside nursing and moved them to this unit," she says. "For example, we had some floating admission nurses."

A collateral benefit of the rapid admit unit is that it has been "a great morale booster" for the inpatient nursing staff, Wooline says. "When they receive a patient from the rapid admit unit, they receive what for them is really a transfer," she explains. "There are not long hours of extensive assessments, for example."

The bed tracking system is a natural complement to the rapid admit unit, says **David Long**, MHA, business manager for nursing administration. "There is a great deal of collaboration between David [Doolittle] and myself," he notes.

As soon as a bed is requested from the ED, that

individual is entered in the "patient wait queue," so Long knows there is a patient in need of bed. "With that information going into a queue, you know what time the patient arrived," he explains.

The patient placement facilitators examine the system by using Series software from San Francisco-based McKesson Corp., and look to see where available beds are in the tower on the inpatient floors and in rapid the admit unit. All of that information is displayed graphically for them, Long notes. "With a couple of flat-panel monitors, you can have a dual display, look at different icons, and see if a bed is empty, vacant, filled, being cleaned, and so forth," he says.

This process is further facilitated by bedside admission, initiated about a year ago by moving registration staff out of the lobby. All of these factors greatly increase the speed at which a bed assignment can be made, says Long. "With more automation, David and I can look at the system and see, for example, that as soon as a patient presented to the admit area we could just send them to the rapid admit unit," he explains. As the admission orders come together, they are processed at the bedside, Long says. "It's really a collaborative effort to minimize wait time," he adds. ■

In-house 'Access Center' relieves ED bed burden

Unit: 600 calls, 425 unscheduled admits monthly

The creation of an "Access Center" to handle interhospital transfer coordination and unsched-uled admissions at Saint Francis Hospital in Tulsa, OK, has vastly improved the movement of patients into beds.

The center, which is now about 3 years old, has handled more than 20,000 transfer calls — averaging more than 600 a month and has handled about 425 unscheduled admissions a month, according to **Darren Newkirk**, MSN, RN, CCRN, clinical manager of the center.

"That's over 1,000 patients a month we are handling in a coordinated manner," he says. About 54% of transfer patients are direct admits, he says. "Of course, all the unscheduled admissions should be direct," Newkirk says. The remaining patients are ED check-ins or trauma patients at the 682-bed tertiary care facility, he says.

The center is centrally located in the hospital, with the bed assignment desk and nurses in the same room in close proximity — and about a minute's walk from the ED. It has two nurses and bed assignment staff on the day and night shifts. On the third shift, there are three nurses to provide after-hours telephone triage for 140 physicians. Most of the staffing was accomplished without adding personnel, says Newkirk.

"The nurses we brought over were already doing telephone triage," he says. "The bed assignment staff was already in admitting." He did add a single nurse on the day shift to function as bed management coordinator.

Having the center has changed processes significantly. For example, in the past, transfers were coordinated by Life Flight air ambulance dispatchers. "There were always issues that would come up concerning what was and was not a legitimate transfer, and which specialist to call for a consult," says Newkirk. "When we added the nurses, we trained them on EMTALA [Emergency Medical Treatment and Active Labor Act] and all about the transfer process." Complaints went down, coordination went up, and there was much better buy-in from physicians, he reports.

In the past, when physicians would call in unscheduled admissions, the admitting department would send them to one of five entrances, often resulting in delays in terms of getting them to the proper department. "Now all calls from doctors' offices or from homes go through the Access Center, and we coordinate the most appropriate entrance for them to come to," Newkirk explains. "We also notify the ED and tell them they are a direct admit, so they don't check them in."

This process takes a lot of pressure off supervisors, says **Jan Emmons**, MSN, RN, director of emergency services. "Someone else is making those phone calls to physicians, so we are more able focus on patient care," she says. "Plus, instead of filtering everything through our door, the Access Center handles many of the patients."

In addition, because patients go to the appropriate place more quickly, patient satisfaction is getting a boost, Emmons says. "If they need to be in the ED, they should be there, but if they are coming from another facility and the access center can make more appropriate arrangements, that's great."

Initially, the Access Center led to significant improvements in patient flow. In an article in the June 2005 issue of *Journal of Emergency Nursing*, it was reported that patient admission wait times

were cut by 64% and there was a 40-minute decrease in bed assignment times for ED patients.[1]

However, in what has turned out to be a familiar "good news, bad news" scenario, the center also has led to a 9% increase in hospital admissions. As a result, "as we got more and more patients, our wait times started to go back up, and the number of patient denials because of bed availability also started creeping up," reports Newkirk.

In an effort to get on top of the situation again, Saint Francis plans to implement an automated bed board pre-admission system in July. "We are also working to bring in a dedicated admissions unit, so if there is no bed available, the patient can go there to be checked in and pulled out of the ED once we know they are going to be admitted," he says.

Regardless, Emmons is extremely happy with the Access Center. "I wasn't here when it was first opened, but the only thing I would have done differently would have been to make the move earlier," she says. "The burden taken off the ED staff has been unbelievable. I don't know how they did it before."

Reference

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Are you collecting data you don't really need?

Know when to put your resources elsewhere

In the process of collecting restraint data, you learn that certain physicians are not signing daily orders. Other data being collected show that patient education is being documented 97 times out of 100.

These are two examples of scenarios where ongoing data collection is no longer needed, says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC. In the former example, action needs to be taken by profiling noncompliant physicians and speaking to them directly. In the latter, spot checks can be used instead of rigorous data collection.

"A notice can be sent to staff that a good job has been done and letting them know that, since we are still interested, we will spot check from time to time and provide them feedback on this process," she says.

Almost all quality managers are struggling with increasing data collection burdens with limited resources. Yet many organizations are collecting the same data twice, or data that don't give meaningful information.

"Much of the data being collected lacks validity. Even if data is valid, it may not be important," says **Peter J. Pronovost**, MD, PhD, director of the Johns Hopkins Quality & Safety Research Group in Baltimore.

Since data collection requirements are largely driven from outside the health system by insurers, accreditation bodies, and regulators, it would be helpful for these groups to integrate their data collection requirements, he notes.

"There are national efforts by JCAHO, CMS, and others to integrate their measures. However, the measures vary widely among insurers. It would be helpful if insurers could consolidate measures," he says.

To find out if redundant data collection is occurring, say the following to anyone who requests that data be collected, recommends Swain: "If I'm to collect data for you, I need to know: Why am I collecting it? What question will the data answer? And if I'm still collecting, why? What is our goal, have we met our goal, and when will we know we have met it?"

Take an inventory of all the measures you collect, who is collecting the data, and what resources are being devoted to collecting it.

Next, go to the "consumers" of that data — whoever is supposed to take action on it — and ask if they believe it is valid, if they believe it is important, and whether it should continue to be collected, Pronovost advises.

"We did this exercise. It is eye-opening to see how much data being collected that the recipients believe is neither important nor valid," he says.

Two examples of meaningless data collection include auditing operating room practices without clear specifications and collecting data on readmission to the intensive care unit within 30 days. "When we audited this measure, we found that readmissions were due to patients developing a new problem," Pronovost says. "We changed the time from readmission to within 48 hours, and it was much more useful."

All committees routinely evaluate the need to collect data. "There is such a large need to collect

data that we can't support it all. So if we have something that seems to be a nonissue, we stop collecting it," says **Dana Moore**, RN, MS, a coach at the Baltimore-based Center for Innovation in Quality Patient Care, and clinical nurse specialist in the medical ICU at Johns Hopkins Hospital.

For example, the infection control department measured infection rates in intravenous lines used for parental nutrition for years, but the rates were low and below the national norms, so it is no longer collected.

There are many other examples, Pronovost says, adding that it is important to recognize that measurement has costs. "If measures are not valid or not important, then we should not waste resources collecting them," he says. "You are better off not spending your resources collecting invalid data that can misinform."

Choose indicators carefully

A better strategy is to collect data for a smaller number of valid measures, and choose your indicators carefully.

"Data collection, especially for quality control, can go on and on," Swain says. "When it does, there needs to be one indicator that is really important to the whole process. That indicator should also be simple to collect and sensitive enough that when it falls out, some action is taken."

For example, the indicator, "Is patient education documented?" is not a good choice, because it is too vague. A better indicator to use would be, "Is the patient educated at least daily while in the hospital by any provider?"

Data collection that is done to assure a process "took" and that change is being sustained also needs to stop at some point, says Swain. "Most PI projects end if some data are collected to verify that the process change was made and that desired results were achieved," she explains. "When the final report in the project's success is submitted, plan to roll the indicator off."

For example, if it is established that a practice is being done consistently, weekly data collection can stop and be replaced by a monthly quality control with a reduced sample size.

"Also, if findings from data collection are not being acted upon, it may be time to discontinue the study and breathe life back into the project, since it is not performing as it should," says Swain. "Or you may need to evaluate if this is the 'steady state' of the process and accept it, at whatever level it has steadied out." ■

CMS extends coverage for some O^2 patients

The Centers for Medicare & Medicaid Services (CMS) will extend coverage for the home use of oxygen to Medicare beneficiaries enrolled in a CMS-approved clinical trial sponsored by the National Heart, Lung & Blood Institute.

Medicare currently provides coverage for home oxygen for beneficiaries with partial pressure measurements at or below 55 mmHg or oxygen saturation at or below 88%.

If certain other diseases/conditions are present, coverage is provided for patients with an oxygen partial pressure of 56-60 mmHg or an oxygen saturation of 89%.

The trial will include Medicare beneficiaries with arterial oxygen partial measurements from 56 mmHg to 65 mmHg or whose oxygen saturation is at or above 89% who do not meet the current Medicare coverage requirements for home oxygen. ■

No link between higher spending and better care

While the amount of money Medicare spends on chronically ill patients varies greatly from state to state, researchers at Dartmouth Medical School found no correlation between higher spending and better health. In fact, they said patients in states spending the least actually were better off than their counterparts in states spending the most.

The researchers looked at how often Medicare patients went to the hospital in their last six months and the number of times those patients went to the doctor in that time period. They found higher mortality rates in states with the most intense care. Their conclusion: The government could save tens of billions of dollars a year while improving care if it prevented overuse of health care.

"We need to redirect resources away from acute care and invest in infrastructure that can better coordinate and integrate care outside of hospitals — for example, home health and hospice care," the report said. ■

(Continued from page 102)

doing," Jennings says.

The team decided to create standards for each of the seven departments to follow.

For instance, standard weaning criteria varied among the disciplines. The team set out the steps to get patients off the ventilators as quickly as possible, beginning at the moment someone is intubated.

The hospital's pulmonologists took the lead in developing an updated weaning protocol so that all a physician has to do is order weaning and the team understands what should occur. They set out the criteria that needed to be met for the process of weaning the patient to begin and created the daily rounding sheet for each discipline to fill out.

At the same time, the hospital adopted the 100,000 Lives criteria, which provides best practices for avoiding ventilator-acquired pneumonia, giving the team additional improvements that were driven by the hospital.

These include criteria such as elevating the head of the bed by 30% and regular daily vacations from sedation.

"We made these criteria a component of the rounding sheet to hard-wire the process," Jennings explains.

As part of the Six Sigma process, the respiratory therapists had to demonstrate their competency in areas such as emergency intubating and extubating in front of the medical director.

In the past, the physicians wanted to be present before a patient was intubated or extubated.

"It was important that our team gain the confidence of the physicians so that patients could be moved to a lower level of care in a timely fashion," Jennings says.

At the completion of the project, the team conducted nursing inservices on pain management, sedation information, and other clinical best practices, and each of the seven departments involved in the project conducted "lunch-and-learn" sessions with the rest of the clinical staff.

During the last phase, the control phase, the Black Belt relinquishes the process to the clinical staff and charts the results for 12 months to make sure the process is working.

Ten months later, the team has been under its target for ventilator days every month.

"The hospital has made a cultural change, and the gains during the Six Sigma project have been sustained," Jennings says. ■

Model of care improves outcomes, ADLs for elderly

Results: Lower costs, shorter LOS, more discharges

When older, frail patients are hospitalized at Akron City Hospital in Akron, OH, they're likely to be placed on a home-like unit with carpeted floors, a common area with a parlor and a stocked kitchen their families can use, better lighting, and furniture designed so older people can easily get in and out of it.

The 34-bed unit is called an Acute Care for Elders (ACE) unit, and it's designed to provide patient-centered care for older patients in an environment that helps them return more quickly to their homes.

The ACE initiative, which provides care by a team specializing in geriatric issues, has resulted in shorter lengths of stay, lower costs, fewer readmissions, and other positive outcomes for elderly patients at the 550-bed teaching hospital, which is part of Summa Health Systems in Akron, OH.

The ACE model is a multi-component intervention that improves outcomes for older patients hospitalized with an acute medical illness, says **Carolyn Holder**, MSN, RN, geriatrics coordinator of post-acute senior services for Summa Health Systems in Akron, OH.

"Older adults often experience a loss of function and independence during hospitalization for an acute illness. Loss of function is associated with negative outcomes for the patient, including prolonged hospital stay, need for nursing home placement, and death. The ACE model was designed to prevent functional decline and maximize independence," Holder says.

The ACE unit was developed in the 1990s by clinicians and researchers at University Hospitals of Cleveland, and demonstrated a positive impact on patients, who were more functional and less often discharged to long-term care, she says.

"In 1994, Summa Health System conducted a randomized trial of the ACE intervention over a three-year period and concluded that ACE makes a difference in preventing functional decline of hospitalized adults," Holder says.

During the study, the team found that the elder patients improved in mobility and other functions from the time of admission to discharge, no matter what illness caused the hospitalization. There was a decrease in discharges to long-term

care facilities among patients in the ACE program and an increase in patient satisfaction.

There was significantly less use of restraints on the ACE unit. "Because of changes in the process of care, there were fewer patients who were ordered bed rest, fewer on high-risk medication, and significantly less use of restraints," Holder says.

Depression was recognized and treated more often. All of the factors contributed to an overall reduction in expenses for patients in the pilot project. "ACE is designed to prevent older adults from declining physically and functionally. It not only made a difference in their function, it was more cost-effective and decreased length of stay. The results were positive for the hospital as well as the patients and their family members," she adds.

Patient-centered care

The interventions were so successful that in addition to admitting patients at highest risk to the dedicated ACE unit, the hospital has adopted the ACE interventions for elderly patients in the stroke, heart failure, pulmonary, orthopedic, and psychiatric units.

"This model is the way that care should be delivered to elders as well as other chronically ill patients in every hospital unit. When the team sits down and puts their heads together, they can accomplish so much for people who are so complicated and so at risk," Holder says.

At Akron City Hospital, patients ages 70 and older who are at most risk for functional decline are admitted to the ACE unit. "We screen patients who are at high risk for losing function, such as people who had problems with mobility before they came in, those without social support, or who have depression or memory problems. We look for cues that say a patient needs more support," Holder says.

The team meets five days a week for one hour and brainstorms on how to improve the plan of care for patients identified as at high risk for decline. The plan they develop is shared with the primary care physician and the rest of the staff.

The unit provides patient-centered care by an interdisciplinary team led by a clinical nurse specialist. The team includes a geriatrician, physical therapist, occupational therapist, dietitian, social worker, a pharmacist who specializes in geriatric medications, spiritual support, and the patient's nurse. The geriatrician consults with the team informally and is available for a formal consultation if the primary care physician requests it.

All members of the ACE team are trained in geriatrics. "We have the level of expertise so that the most challenging are referred to us," Holder reports.

The team works with the patient's primary care physician to develop treatment plans based on best practices of care for the elderly.

The traditional hospital environment and the process of care are designed for clinical efficiency by the providers and often do not take into account the needs beyond the acute illness, Holder points out.

For instance, Holder describes a scenario, in which an 80-year-old woman who lives alone develops simple pneumonia and comes to the emergency department, where an IV is started. She may be confused because of the illness and not eating for a few days and may try to get up to go to the bathroom. As a result, a catheter is inserted, and the woman is restrained and possibly given medication to control her behavior. She is admitted to the medical unit with an order for bed rest, which is maintained for several days, leading to immobility, weakness, and functional decline.

In this scenario, the patient was living independently when she was admitted. At discharge, she needs assistance with activities of daily living and walking and requires placement in a skilled nursing facility.

"Many older patients never regain preadmission functional status despite hospitalization. In fact, hospital care may contribute to adverse outcomes in older persons," Holder says.

The ACE model includes a multidimensional assessment, which is a holistic evaluation of the patient, looking at the medical assessment and history. It includes a functional assessment, including activities of daily living, such as dressing and toileting, instrumental activities of daily living, including cooking and managing finances, cognitive and depression screening, that patient's support system, and discharge planning information.

By having a geriatrician on the staff, the team can suggest revisions of the plan of care to the primary care physician by pointing out the latest evidence-based care recommended for treating the elderly.

"The physicians love it, and so do the patients and their families. The team provides extra support for the patient. We don't just look at the acute illness. We look at the comorbidities and help the physician and family address other issues, such as end-of-life issues, if it is appropriate," she says.

The team starts working on discharge planning as soon as the patient is admitted. "When we talk

about discharge planning, it's not just the immediate discharge. It's the big picture. If patients need to go to a rehab or skilled facility, we look at what the plan should include beyond the rehab stay," Holder says.

The plan may include referrals to a community agency, such as the area Agency on Aging, to provide long-term assistance with self-care and care management. "We look beyond the episode of illness that brought the patient to the hospital. We look at how we can keep patients healthy and functional after discharge," Holder says.

The team recognizes early on what the patient will need after discharge. If it's home health care, the team arranges for a home evaluation to look at safety issues, medication, and nutrition.

"The holistic assessment often uncovers unrecognized problems, such as cognitive issues, depression, and nutritional issues, which the primary care physician may not be aware exist. In addition, families often are challenged in managing problems such as self-care issues and impaired cognition. The ACE unit provides interventions to support both the family and the physician in maximizing the patient's independence," Holder says.

The team often holds patient and family conferences to develop a comprehensive plan.

The ACE interdisciplinary team process involves each member of the team contributing his or her expertise as well as all disciplines learning from each other. For instance, in the ACE model, it may be the dietitian who recognizes the symptoms of depression as she talks with the patient and brings them to the attention of the team.

The team carefully scrutinizes the medications the patients are taking to make sure the medication and dosages are appropriate for older people and makes recommendations to the primary care physician for changes.

Depression often is overlooked in the elderly, Holder points out. The ACE unit staff and team provide further assessment of patients with symptoms of depressions and make recommendations for follow-up.

Holder supervises the advanced practice nurses working for Summa Health System covering several other units with the ACE model in other hospitals in the Summa system. "We're spreading the model. About 85 other hospital systems across the nation have come to us to learn how to do this," she says.

(For more information, contact Carolyn Holder, MSN, RN, e-mail: holderc@summa-health.org.) ■

CE *questions*

1. According to the Border Counties Coalition, how much did medical care for undocumented workers cost hospitals in 24 border counties on the Mexican border in 2000?
   A. $200 million
   B. $150 million
   C. $75 million
   D. $500 million

2. A program that dedicates a social worker to placing homeless patients in shelters has cut the length of stay for such patients at Presbyterian Hospital/Columbia from an average of 27 days to _____ days.
   A. 10
   B. nine
   C. eight
   D. 12 days

3. Before a Six Sigma project that reduces ventilator days, by what percentage did St. Anthony's Hospital exceed its targeted time for patients to be on a ventilator?
   A. 20%
   B. 30%
   C. 40%
   D. 50%

4. At Akron City Hospital, patients eligible for the ACE (Acute Care for Elders) program are at least 70 years old and at most risk for functional decline during their hospital stay.
   A. True
   B. False

Answer key: 1. A; 2. B; 3. B; 4. A.

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

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Proposed Medicare discharge rule faces criticism

It targets inpatient discharges but has roots in post-acute world

A new rule being proposed by the Centers for Medicare & Medicaid Services (CMS) — and drawing criticism from case managers who have reviewed it — would require hospitals to alert all Medicare patients 24 hours before discharge that their costs probably won't be covered if they stay longer, and that they have until noon the next day to request a review of the discharge decision.

That step would be in addition to the existing "Important Message From Medicare" — advising patients of their rights — that hospitals must give patients upon admission to the hospital.

"I believe this is adding more bureaucracy to an already complicated and confusing discharge process for a population, generally over age 65, who need our assistance and guidance," says **Barbara S. Leach**, RNC, MS, CNA, ACM, director of case management, Sacramento/Yolo, with the Sutter Health Sacramento Sierra Region.

"The average hospital stay is already targeted to be four days or less," she adds, "and to provide [extra] paperwork in advance of the discharge will only add tasks to an already overworked system."

Even in scenarios where there is a plan of care in place, she notes, there are many factors that could disrupt the plan, including changes in the patient's condition and the availability of services at the next level of care.

Proponents of the proposed rule, published April 5 in the *Federal Register*, contend that the "Important Message" is not a timely notice, says **Ellen Pryga**, director of public policy development for the American Hospital Association (AHA), which has several concerns about the proposal. "They're saying [the "Important Message"] isn't close enough to discharge, even though the average length of stay for Medicare patients is six days."

The two-step process being proposed also would replace two existing forms — the hospital inpatient notice of noncoverage (HINN) for regular Medicare patients and the Notice of Discharge and Medicare Appeal Rights (NODMAR) for those with Medicare Advantage plans — with a new form that must be completed if a patient indicates any disagreement with his or her discharge plan.

"The HINN requires all the details about why the patient would no longer be covered and why the patient no longer needs inpatient care," Pryga says. "It also includes more details on the appeal process."

The proposal is not a new idea, she notes, but got its impetus from a final rule (68 *FR* 16,652) published April 4, 2003, in the *Federal Register* that requires post-acute providers to conduct a two-step notice process in connection with the termination of Medicare coverage to an enrollee in a Medicare Advantage (then Medicare Choice) plan.

Among the problems AHA has with the inpatient proposal, she adds, are that in most instances the notice of discharge would add 24 hours to a patient's hospital stay.

"By requiring that it be rendered after the discharge decision is made and yet 24 hours before discharge," Pryga says, "you end up in many cases keeping people another day, and with diagnosis-related groups [DRGs], hospitals don't get paid for that."

Hospital employees would be required to have Medicare beneficiaries sign a copy of the notice of

discharge, a largely generic document that would leave space for the patient's name and date of discharge, and attest that they have received it and understand it, she says. "The entire thing is a recitation of how the person has the right to protest the discharge and stay in the hospital free while [the issue] is adjudicated."

"If the patient isn't able to comprehend the notice," she adds, "then that has to be done with whoever the person's representative is, and whether or not their representative is even available to get the form and acknowledge receipt is problematic."

Pryga says she also is concerned about the way the notice is written. "It will create the impression that it is likely that the patient will be sent home too soon and should automatically be asking the quality improvement organization [QIO] to review the decision."

"It doesn't speak to medical necessity," she adds, "but is all about noncoverage, and 'you will be charged if you stay.' I think patients will be asking for many more requests for review that really aren't founded."

Perhaps the most troubling thing about the proposed rule, Pryga says, is that its proponents "don't really understand who makes the discharge decisions. The hospital doesn't. It's the physician. Trying to pretend that isn't the case isn't helpful."

"The physician doesn't generally make the decision to discharge until all the clinical markers are met," Pryga continues, "which is usually the morning of discharge or late the evening before — but that still wouldn't meet the requirement."

There are situations where the proposed process simply cannot work, she says, such as a one-day admission or an admission in which the patient is scheduled to be discharged on a certain day but then develops a fever overnight.

"We're also trying to figure out how to make it work on off-hours and on weekends," Pryga notes, "because discharge planners are usually on duty Monday through Friday, on a 9-to-5 schedule."

The CMS description indicates that if the patient stay is expected to be only two or three days, the new notice may be given upon admission, Leach points out. "However, the rules clearly say [notice is given] 'where the physician concurs with the discharge decision.'"

"Concurrence with the discharge decision is not defined," she adds. "I don't know if it is a discharge order saying, 'Discharge Mrs. Smith tomorrow after her antibiotic,' or if it is a note in the progress section saying, 'Plan to discharge tomorrow,' or if it is a hallway conversation with the nurse, patient, or family."

"I don't know how the 'physician can concur with the discharge' on admission of the planned two- or three-day stay," Leach says. "There are rules around how the hospital can process this new notice without physician concurrence, but that is with the review of the QIO — not an easy process."

The burden the proposed rule represents for hospital case managers "already overloaded with high caseloads and workloads" is the biggest concern of **Sandra Lowery**, RN, CRRN, CCM, CNLCP, president of CCMI Associates in Francestown, NH.

Like Pryga, she also is concerned about how the extra step would affect lengths of stay, Lowery adds.

CMS cost estimates included in the *Federal Register* article were about $5,200 for issuing the standard discharge notice to all beneficiaries and about $1,875 for issuing a more complex notice of noncoverage, she points out. "I am not sure they

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took into account:

- physician education;
- review and approval of the notice by hospital administrators and others;
- copying the medical record (for appeals);
- mailing or courier expenses (for appeals);
- monitoring, evaluation, and improvement measures to ensure we are following whatever process is established to meet this requirement," Lowery says.

Lowery, Pryga, and Leach all point out the folly in the agency's estimate that the process of delivering the notice will take about five minutes.

Consider the need, says Leach, to explain to older patients — increasing numbers of whom do not speak English — that they are scheduled to go home the next day, but have the right to appeal that decision by contacting a QIO, and that their stay beyond that point may not be covered by their payer.

Then staff must have the person sign a form acknowledging that he or she understands what is being explained, she adds. "Five minutes will not begin to do this justice, and a quality case management department will spend many more than five minutes preparing and executing this process. The cost will be great."

After the form is signed, notes Pryga, hospital staff must copy it, file it, and maintain those files — on some 12 million admissions a year.

At a time when the industry focus is on electronic records, she says, "there is no provision made other than dealing with paper copies."

(Editor's note: Barbara Leach may be reached at LeachB@sutterhealth.org. Sandra Lowery may be reached at ccmi@lowery.mv.com.) ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

PATIENT SAFETY ALERT™

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Massachusetts considering patients-per-nurse limits

Nurses claim staffing levels can affect patient safety

Depending on who you ask, the state of Massachusetts is either: a) on the verge of; or b) seriously considering following California's lead and limiting the number of patients who can be assigned to nurses. Potential legislation has been working its way, in a series of fits and starts, through the state legislature.

The sooner, the better, says **Julie Pinkham**, RN, MS, executive director of the Massachusetts Nurses Association (MNA), a strong proponent of such limits, who says it has been clearly demonstrated that assigning too many patients to nurses can have a direct impact on patient safety.

"Every piece of research we have seen says that the number of patients a nurse has is directly related to morbidity and mortality," she says. "Linda Aiken was the first one to quantify that." (Aiken's article in the October 2002 *Journal of the American Medical Association* found that "in hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction."[1]) "This research validated what nurses have been saying to us."

Pinkham adds that "another paper by Jack Needleman found a direct correlation between patient outcomes and the number of patients per nurse."[2]

Because of these findings, says Pinkham, nurse-patient ratios must be looked at in terms of delivery of care. "Registered nurse assignment of patients is not unlike any other type of care we do — like cancer screenings, for example," she asserts. "Look at it this way: Insurance companies, after doing their research, decide whether or not the money they are investing in a treatment is worthwhile — if it is efficacious. If it is, we expect it to be covered. But in nursing care, even though we have a direct correlation between a nurse having more than four patients and increased risk, one hospital will give you 8-to-1 and another 4-to-1."

She notes that research also shows that improving nurse-to-patient ratios can be cost-effective, as well as safer.[3] "This last one finally puts it in perspective," she says. "Imagine going to a hospital, having a stroke, but the hospital is saying that even though research shows you should be treated with a certain protocol, they are not going to do it?" she poses. "That's why we're saying we need to have a limit in place — and that it needs to be directly linked to patient outcomes. Patients also need to understand what the limit is, and that, for example, their nurse should only have three additional patients."

Easier said than done

While the issues are clear to Pinkham's organization, and the Massachusetts Hospital Association (MHA) is certainly supportive of improving patient safety, incorporating those goals into legislation that both groups can support is not that easy.

"Essentially, everyone agreed there should be a limit on the number of patients assigned to an RN," says Pinkham. "We have been negotiating a waiver for financially strapped hospitals [who say they cannot afford additional staff], and what the 'ideal' number should be."

But, counters **Daniel P. Moen**, president and CEO at Heywood Hospital in Gardner, MA, and board chairman-elect of the MHA, "There has not really been any in-depth discussion on waivers [for financial concerns]. Before we get to that point, we

have major concerns as to whether these guidelines are based on research and evidence."

Pinkham says the state Department of Public Health will have public hearings and set standards and limits, and that there would be an acuity system to adjust those limits up and down. "The final regulations will be developed over a period of 12 months, once the legislation passes," she reports.

"Our biggest concern right now is that this is still a piece of legislation that addresses RNs only," says Moen. "Our board feels strongly that any type of legislative guidelines on staffing need to include the whole direct care team — LPNs, CNAs, and perhaps other types of providers like mental health and rehab units that need to be counted in the staffing pattern."

> "Everybody wants to see mandatory overtime go away, but only if it's done in some way that gives hospitals the flexibility they need to protect patients."

The target issue of the MNA, says Pinkham, is retention, while supply was the key concern of hospitalists. This latter concern is natural in light of the current nursing shortage, but it may not be as big a challenge in Massachusetts, she notes.

"We have the highest ratio of nurses per capita in the nation, and every single [nursing] school is full," Pinkham concedes. "But after three years, these nurses tend to leave the bedside; if we do not set a limit on working conditions, we will continue to lose these people."

She goes on to report that a number of nurses who have left the bedside "have told us they would return if the situation changed."

The numbers game

What exactly are the appropriate standards that should be established? "The limits in our bill for the ICU were no more than two patients per RN, which is also the recommendation of the Institute of Medicine and hard to negotiate around — and that's almost 50% of all beds," says Pinkham. "In med/surg, we say it should be 4-to-1." The bottom line, Pinkham says, is that "we have to have some leap of faith that the Department of Public Health will not abandon all scientific recommendations out of hand."

But Moen is not comfortable with hard-and-fast numbers. "We are very strong on the point that if there are going to be guidelines there needs to be flexibility around them," he shares. "What we're saying is, certainly hospitals and patients differ, and a one-size-fits-all approach ties management's hands as far as using the resources of the organization."

For example, Moen notes, when there is a huge influx of patients and conditions change rapidly, a hospital needs to maintain flexibility. "Or, for example, if you have a patient who is just about to be discharged, they may require only minimal staffing.

"We are not agreeing to something that's a hard-and-fast ratio by another name," he continues. "In reality, you will probably find that most ICUs are staffed that way [with two patients per nurse], but you can have an ICU where there are four patients but two are boarders — they are there for other reasons. In that case, should you have to adhere to that same level?"

Other states following suit?

The legislative moves in Massachusetts may only be the beginning of a developing national trend, says Pinkham. "I believe there are 14 states working on similar legislation," she reports. "And New York's may be even more aggressive than ours."

The states that pushed this type of legislation, she explains, were those that saw the highest penetration of managed care. "They saw big pressure to reduce LOS [length of stay], there were a lot of hospital closures and they really consolidated patients into a small number of beds," Pinkham says. "Since then, we've seen an increase in acuity. Now, we have the sickest of patients and an exodus of nurses from the bedside; it's a perfect storm."

As for whether the legislation becomes reality in Massachusetts, the jury is still out. "Everybody wants to see mandatory overtime go away, but only if it's done in some way that gives hospitals the flexibility they need to protect patients," insists Moen. "We've made a commitment to stay at the table, but we have certain lines we just won't cross; short of that, we are open for discussion."

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