'Getting Back to Basics'

Investing in Patient Care in Our Hospitals

2009

By Your Side, On Your Side

Health Professionals and Allied Employees

'Getting Back To Basics'

Investing in Patient Care in Our Hospitals

The economic crisis in our state and our nation has made an already turbulent health care environment worse, as hospitals face increasing numbers of uninsured and underinsured patients, declining reimbursements, federal and state budget cuts, tight credit and rising debt. We know too, that in the midst of an economic recession, more people are going without health care, or delaying even emergent care because they simply can't afford it.

Patients, nurses and health professionals throughout the state, including HPAE's 12,000 members, have already suffered the consequences of the mismanagement, misplaced priorities and misguided strategies of hospital executives, compounded by lapses in governance by hospital trustees, and failed oversight by state regulators. As hospitals eliminate service lines, close units or shutdown operations entirely, health care needs go unmet, waiting times in nearby hospital emergency rooms grow longer, ambulances are diverted, and staffing becomes stretched beyond capacity. Each day, nurses and healthcare workers struggle to provide care in hospitals without adequate staffing and supplies, and with emergency rooms overflowing with patients waiting for beds, while facing uncertainty over their own jobs.

In this volatile environment, our hospitals try various strategies to rise above the competition-costly building expansions, excessive spending on niche services, advertising and 'hotel-like' amenities, and failed attempts at profit-making ventures. Too often these strategies lead to huge debt and duplicated or missing services for local communities. The interests of patients and communities would be better served if hospitals got back to basics by focusing on and investing in the frontline staff who provide patient care. Short-sighted hospital policies that cut staff or hours, or eliminate retirement security for staff also fuel the existing nursing and healthcare worker shortages that, even in an economic recession, continue to deepen. Patients deserve experienced dedicated staff at their bedside, and staff turnover and shortages only make the vision of quality health care for all even further out of reach.

Too often, when hospitals face economic crises, their patients, workers, and communities are the last to know of impending cutbacks or closures because the dealings of hospital Boards are largely conducted in private. Until recently, few state laws have required enough oversight, transparency or accountability on the part of top executives and the self-selected, self-appointed Hospital Boards of Trustees.

At HPAE, NJ's largest health care union representing 12,000 nurses and health professionals, we've seen firsthand the downside of hospitals chasing scarce patient care dollars, including the bankruptcy of two of

84% of New Jerseyans want hospitals to 'get back to basics', investing in patient care rather than 'hotel-style' amenities.

But, fewer than half – 42% – thought that their hospitals were making patient care the priority, over building and facility improvements.

Poll of NJ registered voters, conducted for HPAE by Anzalone/Liszt Research, Jan. 09

our hospitals. We've seen that our health care industry can appear to operate like Wall Street, chasing profits without proper oversight, accountability or transparency, and with high CEO salaries and inside dealings among Board members.

HPAE proposes a set of standards, or 'checklists' for how hospitals should be spending scarce patient care dollars, and for how hospitals should focus their efforts at survival in a difficult economy, while meeting the health needs of their surrounding communities. We believe our hospitals' priorities should be assuring safe staffing and patient care provided by experienced, qualified staff, and reducing the rates of medical errors, hospital-acquired infections and healthcare worker injuries. We believe management must commit to fiscal efficiency, financial transparency and accountability to our communities' health needs. We believe that hospital trustees should have the independence needed to hold management accountable.

While we know that our healthcare system needs major reform at the national level, these recommendations can be implemented now, making improvements in the well-being of patients and those providing the bedside care, and ultimately strengthening the financial health of our hospitals.

We challenge our hospitals to 'GET BACK TO BASICS', by:

- Putting patient care and safety first;
- Recruiting, training and retaining qualified staff; and
- Identifying and eliminating waste and mismanagement.

Hospitals must abandon the Wall Street model, and instead focus on:

- Identifying and responding to community needs;
- Coordinating services and resources with area health care providers;
- Strengthening board governance and oversight; and
- Acting responsibly, with transparency and accountability.

How can patients and health care workers identify hospitals that set and meet a high standard for quality care and community responsiveness? HPAE has developed a set of 'check-lists' for evaluating our hospitals, the care they provide, and the transparency with which they operate. These standards, or 'best practices' come from the experiences of dedicated staff working on the frontlines of patient care, model legislation, new IRS disclosure laws, and non-profit and for-profit models of operation.

These are the standards we think hospitals should live up to and be judged by:

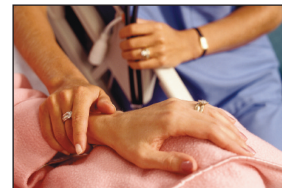
ONE: Get Back to Basics and Put Patient Care and Safety First

TWO: Act Responsibly toward our Communities' Health Care Needs

THREE: Adhere to Good Governance Principles

FOUR: Ensure Financial 'Best Practices' at Our Hospitals

ONE:
Get Back to Basics and Put Patient Care and Safety First



Assure that patients have safe staffing at all times

Every patient deserves the safe and effective care that comes with having sufficient numbers of qualified caregivers at the bedside. The numbers of Registered Nurses and other caregivers available for your care during a hospital stay is probably one of the most important factors in determining whether and how quickly you get well, and whether you and your family members know how to tend to your illness upon your return home. Yet hospitals have tremendous latitude when determining staffing levels, and patients can hardly evaluate the care they will receive before they are lying in the hospital.

The link between staffing levels and patient outcomes has been well documented. The federal Agency for Healthcare Research & Quality (AHRQ) recently commissioned a research team headed by Dr. Robert L. Kane of the University of Minnesota, to conduct a meta-analysis of existing studies on nurse staffing and patient outcomes. Kane et al (2007) found that greater RN staffing was consistently associated with a reduction in inpatient mortality. Specifically, they found that an increase of one RN full-time equivalent (FTE) per patient day was associated with a 9% reduction in the likelihood of death in intensive care units, a 16% reduction in the probability of mortality among surgical inpatients, and a 6% reduction in mortality among medical inpatients. Studies on medical/surgical units have found that higher RN hours per patient day were associated with lower rates of pressure ulcers, pneumonia, postoperative infections, urinary tract infections, gastrointestinal bleeding, and patient falls.[1]

These are some of the very same costly complications that our federal government, through the Centers for Medicare and Medicaid Services (CMS) will now deny hospitals payment for, further threatening hospitals' bottom line.

Understaffing also threatens staff recruitment and retention, in a decades-old vicious -cycle where hospitals cut staff to cut costs, thereby creating intolerable working conditions for those remaining nurses, nurses' aides, radiology technicians, respiratory therapists and other caregivers, who then flee the bedside, creating serious staffing shortages.

Hospitals report that high vacancy rates have a profound impact on hospital services, including:

- Emergency department overcrowding (38%);
- Diverted emergency department patients (25%);
- Closed beds (23%);
- Increased wait times to surgery (19%);
- Delayed discharge and increased length of stay (12%) and cancelled surgeries (10%).[2]

[1] American Nurses Association, 1997; Blegen & Vaughn, 1998; Kovner & Gergen, 1998; Needleman, et al., 2002; Sovie, et al, 2001; Unruh, 2003).
[2] American Hospital Association. The Healthcare Workforce Shortage and Its Implications for America's Hospitals. Fall 2001.)

In a poll commissioned by HPAE, more than half – 55% of NJ residents said that their area hospitals did not have enough nurses and staff.

Only 29% thought their hospital had enough nurses and staff.

72% agreed that nurses took care of too many patients at a time.

Findings of a recent NJ Collaborative Center for Nursing survey of 9,864 direct care Registered Nurses working in hospitals, skilled nursing facilities and home health underline the toll that understaffing takes on the patient safety. Over one third (36.4%) reported that their workload causes them to miss important changes in their patients' condition.[3]

Finally, studies have demonstrated that short-staffing further undermines hospitals' financial health by increasing length of stay, staff turnover and vacancy rates, workers' compensation costs, recruitment costs, and medical malpractice liability. Ultimately, these costs are passed on to consumers and taxpayers in the form of higher premiums and increased costs for Medicare and Medicaid.

Setting nurse-to-patient-ratios, and establishing standards for other direct patient care givers as well, is an essential step in assuring safe patient care as well as hospitals' financial viability.

An ongoing nursing and healthcare worker shortage also demands that hospitals continuously implement ways to recruit, train and retain qualified staff, such as supporting mentoring programs and encouraging ongoing educational and clinical ladders for staff.

SAFE STAFFING CHECKLIST

- ☐ Hospital provides frontline caregivers with a voice in setting staffing ratios/standards.
- ☐ Hospital sets minimum staffing ratios/standards for all job titles, on all units and shifts with systems for quickly responding to increases in census or acuity, or reductions in staff through, for example: staff 'float' pools; flexible work schedules and weekend programs; with designated "admission" nurses.
- ☐ Hospital restricts policies that 'Float' staff from unit to unit without proper training and orientation.
- ☐ Hospital requires appropriate training and orientation for all new and temporary/agency staff.
- ☐ Hospital complies with state public disclosure of staffing levels.
- ☐ Hospital supports mentoring and preceptor programs for new staff, and provides tuition and time off for advanced practice, educational and certification programs.

[3] Flynn, L. (2007). The State of the Nursing Workforce in New Jersey: Findinrom a Statewide Survey of Registered Nurses. Newark, NJ: New Jersey Collaborating Center for Nursing

Provide Safe Conditions for Patients and Staff

When patients enter a hospital, they should be secure in the knowledge that they will be safe during their stay, and not be exposed to further harm due to unsafe practices. However, this is not always the case. Both patients and workers can be exposed to injury or unnecessary illness due to unsafe practices.

The most recent government data for New Jersey reveals that the rate of workplace injuries and illnesses for hospital workers is higher than most other industries.[4]

Patients and caregivers share many of the same exposures, by nature of their shared environment, and hazardous conditions in the workplace affect the care given. In an online survey conducted by the American Nurses Association, 75% of respondents indicated that unsafe working conditions interfere with their ability to deliver quality care.[5]

There are many factors that can lead to unsafe conditions for both patients and workers, among them:

Workplace Violence and Unsafe Patient Lifting

Patients can experience shoulder injuries, hip fractures, bruises, pain and diminished mobility when the lack of appropriate equipment forces caregivers to perform unsafe manual lifts and transfers.[6] Even though equipment and programs exist to minimize or eliminate manual lifting and moving of patients, not every hospital has either purchased appropriate equipment or developed programs to assure the safety of both patients and workers. As a result, these injuries cost our health care system, in medical malpractice and workers compensation claims, medical costs, and lost time of workers.

Workplace violence in healthcare settings also jeopardizes the safety and security of caregivers, patients and visitors; costs our health care system; and undermines the recruitment and retention of staff. Nurses and caregivers have reported being kicked, punched, bitten, choked, hit with objects and threatened while caring for their patients. Many times, this violence spills into our emergency rooms, making them potentially unsafe for patients, visitors, as well as staff.

Legislation passed in NJ in 2007 requires our hospitals to implement programs to prevent unsafe lifting, and workplace violence. Regulations have yet to be developed however, and some hospitals have yet to comply with the laws.

Exposure to Harmful Chemicals

Every day, our hospitals purchase, use, and dispose of products that threaten the health and safety of patients, healthcare workers, and our communities. For example, cleaning products and disinfectants increase the risk of asthma; chemicals like cancer-causing dioxin and the reproductive toxin DEHP, are commonly found in "vinyl" plastic medical devices and building and furnishing materials, and chemical pesticides, another human and environmental health hazard, are regularly used inside and outside of facilities, despite the risk of nausea, headaches, dizziness, cancer, and reproductive and neurological disorders linked to these exposures.

Fortunately, facilities can choose from less toxic alternatives to these and other hazardous substances-alternatives that protect the health of patients, staff, and the environment. Even food purchasing decisions can promote environmental responsibility and sustainability as well as the health of patients, workers and visitors.

[4] http://www.wnjpin.net/OneStopCareerCenter/LaborMarket Information/lmi20/04irnet.pdf [5] www.nursingworld.org/pressrel/2001/pr0907.htm
[6] Nelson,A., Baptiste,A. (9/30/04) "Evidence-Based Practices for Safe Patient Handling and Movement" Online Journal of Issues in Nursing, Vol. #9 No. 3 Manuscript 3. www.nursingworld.org/ojin/topic25/tpc25)3.htm

With the help of organizations such as Health Care Without Harm, Hospitals for a Healthy Environment, and Practice Greenhealth, environmentally responsible hospitals in the U.S. and abroad are conducting environmental health self-assessments and forming multi-disciplinary committees focused on Environmentally Preferable Purchasing to select environmentally sustainable products and building designs that can significantly reduce waste disposal, energy, sick time, and other costs.

Preventable Medical Errors

Under current New Jersey law, the New Jersey Department of Health and Senior Services is required to produce annually a public report listing the total number of preventable medical errors that occur in New Jersey.

However, the Department never publicly discloses hospital- specific information in this report. New Jerseyans are left in the dark, unaware of how safe their local hospital really is. According to the most recent Patient Safety Report, which reflects 2006 data, 450 preventable medical errors occurred in New Jersey hospitals and health facilities. In the same year, it is reported that 42 people died because of preventable medical errors. As cited previously, many of these preventable medical errors are the same complications related to understaffing of nurses.

A survey of NJ residents by the NJ American Association of Retired Persons (AARP) found that 81% supported legislation requiring public reporting of preventable medical errors, sponsored by Senator Joseph Vitale (Weinberg/Sweeney) and Assemblyman Herb Conaway.

S2471/A3633 requires public reporting by hospital of medical errors including wrong-site surgeries, transfusion reactions, and post-operative infections.

PATIENT AND WORKER SAFETY CHECKLIST

- ☐ Hospital fulfills all of its responsibilities under the NJ Safe Patient Handling, Violence Prevention and Needle Safety laws and regulations, including proper training and development of ongoing safety programs.
- ☐ Hospital conducts an environmental health self-assessment, such as the one proposed by Hospitals for a Healthy Environment (H2E), found at: http://www.h2e-online.org/pubs/selfasmt.pdf and, with input from frontline staff, has developed a plan to address any deficiencies
- ☐ Hospital has Environmentally Preferable Purchasing policies to protect patients and workers from hazardous exposures and reduce the facility's environmental impact.
- ☐ Hospital adopts the policies in proposed legislation requiring public disclosure of preventable medical errors. (S2471/A3633)

TWO:
Act Responsibly Toward Our Communities' Health Care Needs

When polled, 54% of New Jerseyans believed that hospital financial troubles were due to mismanagement and waste.

The hospital industry argues that the source of its financial troubles is entirely external and the result of unreasonable demands and inadequate payments by government and private payers. The solution, under that analysis, focuses largely on an increase in reimbursement rates.

This analysis ignores the reality that some NJ hospitals are thriving even while others are in financial disarray, and that some communities are facing a flood of service cutbacks and hospital closings. While there is no question that the lack of adequate funding contributes to the financial vulnerability of many of our hospitals, there are many other factors, among them financial mismanagement, poor internal controls, and inadequate governance, that contribute to the financial disparities among our hospitals – factors that are given little more than lip-service and then allowed to continue unaddressed.

Communities and patients are often the last to know a hospital is facing financial ruin, and have little to say as hospitals downsize, cut staff and reduce or eliminate services. In a number of instances, hospitals have eliminated obstetric and labor and delivery services, outpatient clinics and pediatric units in misguided attempts to stem the loss of money. In NJ, a number of communities have risen up to prevent the closing of their hospital, but efforts were either ignored or came too late. Decisions made by Boards of Trustees, whether correct or not, trump all other efforts at intervention.

Focus on Community and Care

In the midst of an economic recession, cooperation, shared services and a focus on identifying and meeting community health needs are more urgent than ever. We urge our state agencies to assure that all of our hospitals are working with other local and regional providers on a community health care needs assessment for their local areas, to ensure that our communities have access to the care they need and deserve, not just the care that will enable the hospital to pay down the huge debt incurred in building expansions or failed ventures.

COMMUNITY ACCOUNTABILITY CHECKLIST

- ☐ Hospital conducts formal, community needs assessments, on a regular basis, in collaboration with community health, social service and economic development organizations as a basis for setting priorities and allocating resources;
- ☐ Hospital has a formal Community Benefit Plan that provides measurable objectives for their Community Benefit program;
- ☐ Hospital conducts annual community meeting (as required by P.L.1971, c.136 (C.26:2H-1 et seq.) and Title 30 of the Revised Statutes) and actively encourages community members to participate in the annual community meeting;
- ☐ Hospital provides public ready access, through hospital website and local health department, to:
    - Finances: IRS 990s and audited financial statements; compensation of senior management for current fiscal year; charity care policy and sliding scale fee provisions; Community Benefit Plan, billing and collection policies;
    - Governance Issues: list and bios of Board of Trustees; minutes of full Board of Trustee meetings and committee meetings;
    - Quality of Care and Inspection Reports: from state and federal oversight agencies, (Joint Commission on Accreditation of Healthcare Organizations, NJ Department of Health and Senior Services, Occupational Safety and Health Administration); staffing levels, patient satisfaction reports and preventable medical errors.

THREE:
Adhere To Good Governance Principles

New Jersey hospitals are governed by volunteer Boards of Trustees. Board members of not-for-profit hospitals are self-selected, with current board members choosing new board members; the owners of the state's few privately-held for profit hospitals select their board members. Although hospital governing bodies have the ultimate responsibility for quality of care, policies, and management oversight under NJ law, there are few requirements that Trustees possess the experience, training, credentials, independence and information needed to make decisions in the best interests of the communities being served.

For too long, our hospitals have been treated as purely private businesses even though their funding comes from public monies and encompasses a tremendous use of our country's financial resources-an estimated $6,102 per capita in 2004 – and their poor financial decisions can end up denying communities' access to care. Few laws exist to curb inside dealings among hospital board members, or excessive CEO salaries.

At some New Jersey hospitals, trustees have contracts to sell supplies or legal, engineering or other services to the hospital on whose board they sit. Other board members are officers of local banks that loan money to the hospital and still others manage investments for the hospital. In other cases, family members or business associates of board members may provide advertising or consulting services to the hospital. And it is not uncommon for board members to have business dealings with one another. All of these relationships have the potential to compromise the willingness of board members to exercise the independent judgment that lies at the heart of good governance.

At still other hospitals, CEOs are awarded annual pay raises of 10 to 20 percent or even higher at the same time that the hospital they lead is showing a sharp drop in net revenues and frontline staff is being asked to accept benefit and other cuts.

Legislation enacted in 2007 and amended in 2008 requires NJ hospital Trustees to receive a day-long training covering their roles and duties as board members. Pending legislation introduced by Senators Weinberg and Gordon would require hospital Boards of Trustees to adopt written conflict of interest policies.

The January 2008 Final Report issued by the Governor's Commission on Rationalizing Health Care Resources (the Reinhardt Report) includes recommendations to address some of the shortcomings in NJ hospitals' governance practices.

GOOD GOVERNANCE CHECKLIST

- ☐ Hospital bylaws prohibit Board of Trustees, their family members and business associates from doing business with the hospital, and include term limits for board members;
- ☐ Board publicly solicits nominations for new board members from the community;
- ☐ All Board members have satisfied NJDHSS training requirements;
- ☐ Board has independent audit, executive compensation and corporate compliance committees;
- ☐ Board members routinely have access to financial reports; contracts with consultants and vendors; approve annual budget and monitor current financial position with respect to budget; approve IRS 990s and financial statements for completeness and accuracy;
- ☐ Board ensures that quality of care measures are established and monitors hospital performance;
- ☐ Board routinely reviews and follows-up on results of all inspections, compliance reports, and consultant recommendations.

FOUR:

Ensure Financial 'Best Practices' at Our Hospitals

Building expansion and hotel-style amenities must not come at the expense of quality patient care. We have witnessed grandiose expansion plans at hospitals in New Jersey, built with hopes that 'if we build it, they will come', only to fail when patient revenues could not keep up with growing debt payments. That's where the state of New Jersey should be coming into the picture: rationalizing health care resources and helping to ensure that the financial planning and budgeting of our hospitals matches the needs of our communities, without unhealthy competition and duplication of services.

In some instances, hospitals' financial fragility is the result of borrowing millions of dollars in order to finance substantial renovations or new construction. As we all know, borrowing brings with it large debt, in the form of long-term principal and interest payments. These debt service obligations, paid for with patient service revenues, create pressure on hospital executives to develop the most "profitable" service lines, even if nearby hospitals are already offering the service and even if the community has other, less profitable health care needs.

For some hospitals financial fragility is the result of the hospital's failure to put in place policies and practices to maximize reimbursement, resulting in significant revenues losses. And these lapses sometimes include failing to qualify eligible patients for Family Care, Medicaid or charity care, creating financial hardships for patients and their families. In other cases, outsourcing of services or the lack of competitive bidding for goods and services result in waste and inefficiencies.

FINANCIAL BEST PRACTICES CHECKLIST

- ☐ Hospital has implemented effective revenue cycle management policies and procedures, including:
  - Insurance verification and application of medical necessity criteria; qualifying patients for charity care, Family Care and Medicaid;
  - Ongoing internal audits of charge capture and billing processes; contract management system and processes to effectively compare actual to expected reimbursement, and
  - Effective denials prevention and appeal program.
- ☐ Hospital engages in long-term capital and strategic planning.
- ☐ Hospital uses competitive bidding for contracts over a publicly disclosed threshold amount.
- ☐ Hospital sets limits on outsourcing and use of temporary agency staff, with analysis of the total costs of outsourcing

A CHECKLIST FOR SAFE PATIENT CARE, COMMUNITY HEALTH NEEDS, EFFECTIVE OVERSIGHT

We hope patients, patient advocates, elected officials and healthcare workers will use these checklists when judging whether their local hospital is living up to its mission to provide quality care, and its responsibility to put patient care first, and to be accountable to its community, without regard for individual financial advantage of hospital board members.

On Patient Care and Safety

- ☐ Does your hospital post their staffing levels in visible places and provide them to patients and the public?
- ☐ Does your hospital limit its use of outside temporary staff, and provide training to all new staff?
- ☐ Does your hospital provide a safe environment for patients and workers?
- ☐ Do the hospital workers have a voice in establishing patient care safety practices?
- ☐ Does your hospital use safe staffing 'ratios' that can be adjusted quickly to respond to patient needs?

On Community Responsibility and Accountability

- ☐ Does your hospital include community members on its Board of Trustees?
- ☐ Does your hospital hold an open public community meeting at least annually?
- ☐ Does your hospital disclose its finances to the public?
- ☐ Does your hospital conduct a community needs assessment to determine what services are most needed in your community?
- ☐ Does the hospital notify and involve the community before reducing services?
- ☐ Does your hospital make public their preventable medical errors?
- ☐ Does your hospital provide reports on government inspections?

On Good Governance

- ☐ Does your hospital provide training and information to its Board members?
- ☐ Does your hospital have a conflict of interest policy for Board members?
- ☐ Do the hospital's Board members provide proper oversight of finances?

On Financial Best Practices

- ☐ Does your hospital sign-up uninsured patients for the correct and available programs?
- ☐ Does your hospital conduct regular audits of its billing practices?
- ☐ Does your hospital abide by competitive and transparent bidding practices?

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