

**MINUTES
HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP**

ADAMS BLDG, ROOM 264

Tuesday, February 19, 2008

ATTENDANCE:

Dr. David Rubinow, Mike Pedneau, Dr. Stephen Oxley, Cliff Hood, Peter Mumma, Iris Rubin, Rickye Collie, Mike Hennike, Laura White, Dr. Jack St. Clair, Deby Dihoff, Dr. John Esse, David Womble, Dr. Donald Baucom, Pamela Graham, Dr. Michael Zarzar, Dr. Patsy Christian, Barbara Whitaker, Kathryn Davis, Walker Wilson, Patti Henke, Representative for Laura Thomas

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
Welcome and Introductions	Mike Pedneau welcomed the group and requested everyone introduce themselves. He asked that any revisions to the minutes from the last meeting be given to him outside the meeting.	N/A
Role of State Hospitals	<p>Mike Hennike led discussion about how NC uses its regional psychiatric hospitals and the volume of acute admissions. NC is one of the few states with huge numbers of acute admissions rather than long term. Lengths of stay are shorter, averaging 7-10 days. Data for 2006 show that NC admissions to the state hospitals comprised approximately 10% of the entire nation.</p> <p>What is the best model for NC? Looking down the road the State Psychiatric hospitals should not be in the business of short-stay, acute admissions. It requires changes in community capacity and help of local hospitals. Jim Osberg indicated that this is consistent with the long term goal and mission projected for NC State Psychiatric hospitals. John Esse asked what would need to change to stop the state hospitals from being the stop gap. Mike Hennike suggested legislative changes and incentives/disincentives to impact change. Dr. Oxley discussed that reducing the size of the hospitals would not accommodate those patients needing more long term and for those needing to be in the hospitals indefinitely.</p> <p>Other states like West Virginia contract for care with local hospitals using the state hospitals as a second or last resort. Peter Mumma shared that Maryland uses a streamlined admission process, using state capitation programs required by Medicaid. Incentives were for the community to provide the majority of the care. Deby Dihoff indicated that NC is 43rd in the US for community funding for mental health. Dr. Oxley talked about the money it takes to handle the more highly acute patients and that facilities are run to be the least costly. There is the issue of indigent care and how that care can be paid for, when Medicaid and Medicare break even usually. The rate required for medically compromised and higher acute patients would require a couple hundred dollars more per person per day than the average right now. Staffing patterns on units do not allow for differential to cover costs. A bill based on service delivery—cost reimbursement—per Peter, would be best and most efficient for the state. Pro-fee per billing would be the easiest way to get at a true cost.</p> <p>There is a need to look at differences in academic and non-academic hospitals and which could offer outpatient services. IRCs have become more stringent on regulations for residency training and some of their work is non-reimbursable, as well as non-licensed professionals. Jim Osberg mentioned the Medicaid rate methodology might be applicable to determining rates for non-</p>	<ol style="list-style-type: none"> 1. A mission statement is to be developed to incorporate the change that NC State Psychiatric Hospitals are to serve the most acute and those needing longer term services, rather than a provider of mostly acute services. 2. A formula is recommended to incentivize local hospitals to care for psychiatric patients. 3. Recommendation to develop a policy so that CON beds do not have to be transferred (via a formal process).

HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
	<p>Medicaid. John Esse said accounting for the population growth in NC should be considered as well. There is wide disparity among counties and how much they pay for services.</p> <p>Not every state has CON requirements. State hospital beds could be transferred without going through a CON process. Debbie mentioned revisiting some of the policies that were put in place during Thomas S. and that some things should not have to be recreated.</p> <p>Special populations are also an issue that needs to be addressed. Contracts and carve out, or whatever model is decided must be in place in order to change the pattern of admissions. It was agreed that the NC State Psychiatric hospitals should not stay in the acute business, but that they must still accommodate needs at this time. Also, must account for sub-populations (particularly extremely violent individuals) that will always need the state hospitals for acute care, per Dr. Oxley, and to build in an accountability system so that it is not abused. Local hospitals will need to be assured that there will be a safety net for those most highly acute patients.</p>	
<p>Standardization</p>	<p>Laura White discussed how SOS has attempted to standardize processes and documents. One example is in corporate policies across all State Psychiatric hospitals being standardized. Mike Pedneau and Carmen Vincent have reviewed policies submitted to the workgroup. SOS is to send out policies to review and to also see Mike and Carmen's comments on what should be common across all hospitals. Patient rights are an exception and it is agreed that it should be the same across all hospitals. Laura said that all hospital directors would need to review and approve these before the policies go out for public comment. Deby suggested a standardized policy on treatment options for smoking cessation. Laura said she and Mike Hennike wanted to ensure the workgroup members are in agreement on the direction and process of standardizing policies.</p> <p>Dr. Oxley indicated that standardization encompasses more than policies, such as quality of care and standards of quality. He mentioned the DOJ reviews and the outcomes of the audits. Widely disparate staffing patterns across hospitals was also mentioned as an area needing attention, such as nursing ratios for standards of care. Dr. Oxley also mentioned that using evidence based practices across all facilities would improve care. There is no formal process, mechanism or structure to work on improving practices and should be a focus now for all state hospitals. Having relationships with academic hospitals could be beneficial. Laura mentioned that the treatment malls are one example of how best practices have been implemented into patient care. It was suggested that staff should also be able to participate in clinical training from outside North Carolina. Dr. Hall suggested the train-the-trainer model as one mechanism to meet training needs of staff.</p> <p>Dr. St. Clair asked how standardization and outcomes would be measured, and that reports are being completed in different ways and these need to be standardized. He suggested using common definitions for monitoring and measuring outcomes. Laura mentioned possibly using the Governing Body reports to be a mechanism to report in a more standardized manner. Iris mentioned the need for both quantitative and qualitative monitoring.</p> <p>Mike Hennike would like the committee to develop a benchmark as a starting point for standardization. Questions about who is accountable and who is</p>	<p>1. SOS to send out corporate policies to the workgroup for review and feedback.</p> <p>2. A separate entity needs to work on developing standardized practices across the hospitals.</p>

HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
	<p>responsible for measuring and monitoring performance were raised. Mike Hennike discussed how the corporate policies would drive operations and practices at each facility. He also said that the hospital practices would be comparable and would follow the corporate policies so that measuring compliance would be easier. Jim Osberg mentioned that assuring compliance depends on certain processes and practices being standardized as much as possible. Dr. Hall brought up inter-rater reliability and how you measure success and that infrastructure would need to be standard, including the language/definitions used. It was brought up that compliance is different than meeting best practices and setting the bar higher than simple citations would be an objective of the committee. Dr. Christian reminded the group that state hospital policies would change based on survey findings by JCAHO, CRIPA, DOJ, etc.</p> <p>Mike Hennike asked about additional resources being targeted for SOS to facilitate compliance. Jim Osberg indicated that an expansion budget has been requested which includes staff to enhance oversight and compliance among the hospitals. Positions within SOS to strengthen capabilities in compliance among hospitals and ADATCs have been requested (nurse positions). DHHS is supporting 2 positions per hospital and 1 for each ADATC. Funding for training and communication as well as additional consultation regarding developing best practices has been requested. SOS will be able to hire a nurse on the Hospital Team due to a vacant administrative position targeted for JUH.</p> <p>Compliance regarding IJ findings for Broughton was discussed. John Esse indicated Broughton has been working on getting ready and the application for re-certification went out today. Documentation requirements, communication and practices have been enhanced. Seclusion and restraint usage has been reduced by almost 50% after training of all staff. DHSR will do the first survey to look at previous deficiencies and subsequently a full survey will be conducted. CMS and DHSR may review deficiencies differently. Every corrective action has a qualitative audit attached to it. Staff oversight is a major focus for the surveys and getting back into compliance.</p> <p>Mike Pedneau asked about other stakeholders being involved in oversight of changes and for helping them understand that the hospitals are providing quality care. Jim Osberg said more proactive scrutiny practices are needed to ensure facilities are in compliance but the details have not been worked out yet. Mike Pedneau suggested having outside stakeholders involved in the compliance process. John Esse indicated that there is a rift between the State Psychiatric hospitals and EDs and that this is the most vulnerable area regarding care. Jim mentioned capacity versus demand and what the statistics look like.</p> <p>Mike Hennike asked about each state hospital's comfort levels with doing the day to day monitoring and compliance efforts. JUH and Cherry are staffed somewhat adequately, but Dix is short-staffed, which makes it more vulnerable given the patient population. Challenges of the merger of JUH and Dix are adding to staffing issues—due to the delay in CRH opening. The DOJ issues have taken staff away from other issues that needed to be addressed. The increase in admissions takes up additional resources that could be focused on proactive and compliance monitoring.</p>	

HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
Staffing	<p>Mike P. discussed the data provided by Dr. Christian's presentation at the last meeting. According to Memphis data all hospitals are short-staffed, especially in the admissions units. There is a shortage of health care techs on acute units. Dr. Oxley and Dr. Christian have reviewed staffing. They are working on creating ratios that would better match the Memphis model and are looking at health care techs and RNs to meet ratios. Rotation of health care techs and training is being taken into consideration for staffing. They should have the plan completed this week. Dr. Oxley reworked the psychiatrists and psychologists to enhance stability. The forensic area is also being focused on due to expectations of increases. This will be used for all hospitals. Filling vacancies will be an issue. Per Laura, the vacancy rate is hard to determine, so the turnover rate is easier to use. Satisfaction surveys are being done and costs related to staffing are forthcoming.</p>	<p>Staffing ratio model to be reviewed by all state hospital directors.</p>
Metrics	<p>Laura handed out folders with most of the data requested from the last meeting. The following was provided:</p> <ul style="list-style-type: none"> • restraint rates, • patient injury rates, • 30 day readmission rates, • temporary employees – number and cost, • vacancy rates, • nursing staffing by hospital x discipline x unit x shift for Oct. 2007, • lost work days, • turnover rates for RN, LPN, HCT, SW, Psychologists, Psychiatrists, • staff and patient satisfaction survey results, • education levels of current nursing staff, • discharge destination data (2002 through 2007), • diversion and delay data • admission/discharge rules (applies to ADATCs as well), • facility/LME contract, • denial rates (JUH still to come), • percent of patients seen within 7 days of discharge, • percent of discharge planning that was done jointly between hospital and LME, • number of CON and operational psychiatric inpatient hospital beds in the community (from fall of 2006). 	<p>Workgroup to review the data for discussion at the next meeting.</p>
Next Meeting	<p>March 4, 2008 at 1:00 p.m. Staffing ratios will be the focus.</p>	

There being no further business, the meeting was adjourned at 3:10 p.m.

Respectfully submitted,

Lena Klumper
State Operated Services