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Report from the Minnesota Department of Health

Regulatory barriers to rural health care

Report of the Rural Health Advisory Committee to the Commissioner of Health

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1995

December, 1995
Minnesota Department of Health
Community Health Services Division
Office of Rural Health and Primary Care

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SANDRA BUTZ - Regional Coordinating Board 1, Health Plan Representative
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JEFF RINGLIEN - Minnesota Ambulance Association Representative
ANNE ROBERTON - Rural Health Advisory Committee, Volunteer Ambulance Service Representative
JOHN STINDT - Minnesota Hospital Association, Hospital Administrator Representative

The Rural Health Advisory Committee and the Rural Hospital Study Work Group thank staff members of the Minnesota Department of Health and the Minnesota Department of Human Services who contributed their technical expertise to the Work Group: Raymond Christensen, M.D., M. Leeann Habte, Carol Hirschfeld, Stella Koutroumanes, Sharon Mitchell, Mary Stadick, Linda Sutherland, Richard Tester, and Gary Wingrove.

Regulatory barriers to rural health care

December, 1995

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PREFACE

The Rural Health Advisory Committee (RHAC) formed the Rural Hospital Study Work Group in response to a legislative directive to study two issues which impact rural health care:
1) federal and state regulatory barriers that limit rural access to care or limit the ability of rural health care providers to provide care efficiently, without improving the quality of care; and
2) rural health care access needs and the need for an alternative licensing model for rural hospitals. The RHAC was further directed to make recommendations to the Commissioner of Health regarding legislative barriers in 1995, and to make recommendations on rural health care access and alternative licensing models to the Legislature in 1996. The first area of study is addressed in this report.

In its directive, the Legislature required the RHAC to identify regulatory barriers to rural health care access in five specific areas: 1) requirements for emergency room staffing that increase hospital costs and limit access to care, 2) limits on the ability of nurses to prescribe and administer prescription drugs under a physician's supervision in emergency situations, 3) state and federal inspection and regulatory requirements that are duplicative and increase administrative costs, 4) physician supervision requirements that limit the use of physician assistants, and 5) the requirement that a hospital and its attached nursing home have separate directors of nursing.

The RHAC approved the report and recommendations of the Work Group, and forwarded them to the Commissioner of Health in December, 1995. The Commissioner subsequently reviewed the recommendations and responded to the RHAC in January, 1996. This response and the accompanying report represents her recommendations to the Legislature. The transmittal letter to Anne Barry, Commissioner of the Minnesota Department of Health, from RHAC Chairman William Flaig, and the response of the Commissioner follow on the next four pages. In compliance with the legislative directive, the Commissioner has drafted and submitted legislation on needed changes in regulatory requirements identified in the report.

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Office of Rural Health and Primary Care

Minnesota Department of Health

January 2, 1996

Anne M. Barry
Commissioner of Health
Minnesota Department of Health
717 Delaware Street
Minneapolis, Minnesota

Dear Commissioner Barry:

On behalf of the Rural Health Advisory Committee, I am pleased to send you this report on regulatory barriers to rural health care. The barriers studied herein are in response to Laws of Minnesota 1995, Chapter 234, Article 8, Section 55. We commend the members of the Rural Hospital Study Work Group, who assisted us in conducting this study. We thank the Legislature for giving us this opportunity and the Department of Health for making staff available to assist us in carrying out this charge.

As a result of our study, we have identified several areas where legislative changes would be particularly valuable. In the area of duplicative regulatory requirements, the work group acknowledged that this issue is highly complex. Duplicative regulations and the consequent unnecessary paperwork are a burden to health care facility administrators. However, these regulatory burdens can be attributed as much to the nature of the system of regulation as to any specific regulation or standard. We believe that the current regulatory system is problematic in that it fails to recognize the increasing integration of health care facilities, is geared toward enforcing highly specific standards rather than using a more process-oriented quality improvement approach, and holds small rural hospitals to the same standards as their urban counterparts. We further believe that our recommendation to develop a consolidated licensing system for health care facilities represents a constructive, proactive alternative that promises to address these issues in a coordinated, systematic fashion.

In terms of the requirement that hospitals with attached nursing homes have separate directors of nursing, we've also suggested legislative amendments that would enable small, rural hospitals to share directors of nursing. This recommendation is consistent with our belief that small, rural hospitals must be given the flexibility to make decisions about how best to use their increasingly limited resources to meet the health care needs of their community while maintaining quality of care.

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In addition to identifying areas where legislative change is needed, this report is intended to reflect the federal constraints on the state's regulatory authority and to educate providers on the options available to them in the current regulatory environment.

We plan to continue to study ways to preserve access to emergency medical care in conjunction with next year's study on alternative licensing for rural hospitals. We need more time to consider ways that barriers to emergency room staffing can be addressed in order to continue to deliver quality emergency medical care in rural Minnesota.

We encourage the Department of Health to draft legislation in response to our recommendations and submit them to the Legislature in time to have the Legislature act on these items in the coming session. We also recommend that this report be distributed to professional associations, Regional Coordinating Boards, and other interested parties, to inform and to encourage discussion about issues that affect rural health care delivery.

Sincerely,

William Flaig

William Flaig, Chairman
Rural Health Advisory Committee

Enclosure

Minnesota Department of Health
717 Delaware Street Southeast
P.O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5000

January 17, 1996

Mr. William Flaig, Chairman
Rural Health Advisory Committee
Douglas County Hospital
111 17th Avenue East
Alexandria, Minnesota 56308

Dear Chairman Flaig:

Thank you for forwarding the report and recommendations of the Rural Hospital Study Work Group of the Rural Health Advisory Committee (RHAC). I congratulate the Committee on its thoughtful analysis of state and federal regulatory barriers.

I concur with the RHAC's decision to continue to study ways to preserve access to emergency medical care in rural Minnesota in conjunction with the legislatively mandated study on Alternative Licensing for Rural Hospitals. The Minnesota Department of Health (MDH) looks forward to the Committee's recommendations on ways to continue to improve access to health care for the citizens of rural Minnesota.

To help educate hospital administrators and community pharmacists about the ability of registered nurses to dispense drugs in emergency situations, I have asked my staff to contact the Board of Pharmacy and request that the Board distribute the Guidelines for After-Hour Emergency Room Dispensing by Registered Nurses, as the RHAC has recommended. The guidelines will also be published in the Office of Rural Health & Primary Care newsletter. I have also asked my staff to contact the Board of Pharmacy and make preliminary arrangements for appointment of an RHAC representative to the upcoming pharmacy rules work groups.

State and federal agencies at all levels continue to seek to identify duplicative regulations that burden health care providers without adding value to regulatory efforts to ensure the access to and quality of health care. I accept your recommendations in this area and believe that the draft legislative language submitted with your report is appropriate. At the same time, I realize that the alternative licensing study the RHAC will be working on this year might result in recommendations for a special rural hospital license. Those recommendations would need to be integrated into the proposed consolidated licensing system. Therefore, in the interest of efficiency, the Department of Health would prefer to delay developing the consolidated license until the alternative licensing study is completed. This approach will allow us to draft a coordinated bill reflecting the full scope of the RHAC's recommended changes to the hospital licensing system.

In terms of the RHAC's request that the Department of Health monitor federal legislation related to health care, we have a staff person, Andrew Davis, who analyzes on a daily basis federal legislative issues and their impact on the state. We appreciate your suggestions for restructuring the surveying process, if given the opportunity, and will certainly give our full consideration to these issues and options. We thank the RHAC for providing us with a rural perspective on these issues.

Regarding the department's study efforts to aggregate hospital data collection and minimize duplication between state and federal agencies, we appreciate the RHAC's support of our endeavor. However, in terms of the department's study of, and report on, utilization review, I would appreciate it if individual Rural Hospital Study Work Group members would present their comments and perspectives on the report directly to MDH staff for consideration. On behalf of the Health Department, I also thank the RHAC for its affirmation of our efforts in carrying out the directives of the administrative uniformity act. Finally, I will ask my staff to pass on the concerns of the Rural Health Advisory Committee to the Department of Human Services (DHS) and encourage the DHS to implement a standard billing practice that is more consistent with the billing practices of the federal Health Care Financing Administration and private payers.

In the fourth area of study, the RHAC has recommended that legislation be enacted requiring that third party payers not deny reimbursement of physician assistants based on stricter supervision standards than those in the state practice act. My staff has communicated with the DHS and discussed your concerns. DHS staff members have indicated that the DHS has recently adopted the standards of the new practice act as requirements for PA supervision and plans to disseminate information on that policy change. On the other hand, I must respectfully reject the recommendation to require that all managed care contracts or policies include physician assistant services. Although the Department of Health encourages the use of physician assistants and other mid-level providers and appreciates their role in improving access to health care, we have consistently taken the stance that health plans should not be required by law to base their benefits on health professions licensure. We are hopeful that the changes in supervision requirements recently made to the physician assistant practice act, together with the example set by Medicaid reimbursement policy will encourage like policy changes in the private sector.

I agree with the RHAC's recommendation to give small, rural hospitals with attached nursing homes the flexibility to share directors of nursing between these facilities, when appropriate. This recommendation is consistent with our goal of containing health care costs while continuing to provide high quality care to all Minnesotans. I have asked my staff to include this legislation in the department's technical housekeeping bill.

Finally, we will distribute this report with my response to interested parties and to the federal congressional delegation. I congratulate you and your committee on your hard work and look forward to your future efforts to improve access to quality health care for Minnesota citizens.

Sincerely,

Anne M. Barry
Commissioner

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EXECUTIVE SUMMARY

SECTION ONE: INTRODUCTION

The 1995 Minnesota Legislature directed the Rural Health Advisory Committee (RHAC) to study two areas which impact rural health care: 1) federal and state regulatory barriers that limit rural access to care or limit the ability of rural health care providers to provide care efficiently, without improving the quality of care; and 2) rural health care access needs and the need for an alternative licensing model for rural hospitals. The RHAC was further directed to make recommendations to the Commissioner of Health regarding legislative barriers, and to make recommendations on rural health care access and alternative licensing models to the Legislature.

The first charge required the RHAC to identify regulatory barriers to rural health care access in five specific areas: 1) requirements for emergency room staffing that increase hospital costs and limit access to care, 2) limits on the ability of nurses to prescribe and administer prescription drugs under a physician's supervision in emergency situations, 3) state and federal inspection and regulatory requirements that are duplicative and increase administrative costs, 4) physician supervision requirements that limit the use of physician assistants, and 5) the requirement that a hospital and its attached nursing home have separate directors of nursing. The Rural Health Advisory Committee, in turn, created the Rural Hospital Study Work Group to examine and formulate recommendations on each of these issues. Staff for the Work Group is provided by the Minnesota Department of Health Office of Rural Health and Primary Care.

Work Group membership consists of representatives appointed by the RHAC, the non-metropolitan Regional Coordinating Boards (RCBs), and professional associations, and includes physicians, nurses, mid-level providers, and pharmacists, as well as hospital and nursing home administrators, an ambulance association representative, a volunteer ambulance service representative, a county board member, health and insurance plan representatives, and three consumer representatives.

William Flaig, RHAC Chairman, appointed Terry Hill to chair the Work Group, which met in three sessions of five hours each in September, October, and November, 1995. Due to the short time frame for completion of the first part of the study, the Work Group decided to limit its work to the five issues stated in the statutory charge, and in keeping with the intent of the legislation, limit its discussion to hospital-related issues only. This report addresses the first phase of the study. The examination of alternative licensing models will be completed in 1996.

To assist the Work Group in identifying regulatory barriers to access, staff of the Minnesota Department of Health Office of Rural Health and Primary Care and the Minnesota Hospital and Health Care Partnership conducted structured interviews with rural hospital administrators. The administrators were selected from each of the five Regional Coordinating Board areas in greater Minnesota, with equal representation of attached and non-attached nursing homes. Hospitals with an average daily census of 1-58 patients were proportionately represented in the survey.

SECTION TWO: REQUIREMENTS FOR EMERGENCY ROOM STAFFING THAT INCREASE HOSPITAL COSTS AND LIMIT ACCESS TO CARE

Preserving access to emergency care was identified by the Work Group and hospital administrators surveyed as the core issue of rural health care delivery. Effective emergency care was characterized as a network of services including geographic and transportation components as well as availability of physicians and mid-level practitioners, nurses, emergency medical technicians (EMTs), ancillary services, and access to tertiary and specialty care.

National data shows that hospitals experienced a dramatic increase in the number of patient visits to emergency rooms (ERs) in the 1980s, while inpatient days declined. Physician coverage of the ER was identified by Work Group members as the key to providing high quality emergency care. However, in the face of a shortage of physicians and decreasing inpatient revenues, providers in Minnesota and other parts of the country are using a number of strategies to maximize existing resources and maintain adequate staffing of emergency departments while preserving access to care. Five strategies identified by the Work Group are:

- greater use of mid-level practitioners, paramedics, and EMTs;
- utilizing 24-hour nurse triage services to assess and refer patients;
- opening urgent care centers to redirect primary health care problems away from the emergency room;
- exploring the possible uses of telemedicine in patient care; and
- implementing alternative licensing for limited service hospitals.

Due to the key role and complex nature of emergency services in rural health care delivery, and the degree to which alternative hospital licensing relates to these emergency medical care issues, the Work Group decided to study this issue in more detail in 1996, in conjunction with its examination of alternative licensing models.

Recommendation

A. The Rural Hospital Study Work Group emphasizes that emergency medical care is an essential component of rural health care and that emergency room staffing issues and other issues related to preserving access to emergency medical care in rural areas are very complex. Therefore, the Rural Hospital Study Work Group recommends further study of the issues related to and options for providing rural emergency medical care in conjunction with the legislatively mandated study of alternative licensing for rural hospitals.

SECTION THREE: LIMITS ON THE ABILITY OF NURSES TO PRESCRIBE AND ADMINISTER PRESCRIPTION DRUGS UNDER A PHYSICIAN'S SUPERVISION IN EMERGENCY SITUATIONS

Work Group members viewed the prescriptive and administration privileges of nurses to be appropriate under current regulations. However, a number of the rural hospital administrators responding to the structured interview as well as Work Group members identified restrictions on the dispensing of prescription drugs by registered nurses (RNs) in emergency situations to be problematic. Current hospital pharmacy rules allow a designated RN to dispense up to a 72-hour supply of medications when the hospital pharmacy is closed. In October, 1995, the Board of Pharmacy developed guidelines for implementation of the 72-hour rule, which may address some of the circumstances in which difficulties are currently being experienced. It was noted, however, that few rural hospital pharmacists or administrators are aware of the guidelines.

Recommendation

The Rural Hospital Study Work Group recognizes that there is a need for registered nurses working in rural hospital emergency rooms to dispense medications when the pharmacy is closed and the physician is not present. Accordingly:

A. The Rural Hospital Study Work Group urges the Minnesota Board of Pharmacy to disseminate information on the rules governing dispensing privileges of registered nurses in the emergency room and the Board's Guidelines for Emergency Room After-Hours Dispensing by Registered Nurses to rural hospital pharmacists and administrators.

B. The Rural Hospital Study Work Group acknowledges that the Board of Pharmacy, Board of Medical Practice, and Board of Nursing have been conducting meetings on delegation of prescribing privileges under protocol and other related issues. The Work Group further acknowledges that the Board of Pharmacy Rules will be reopened in early 1996. The Rural Hospital Study Work Group recommends that the Rural Health Advisory Committee appoint a representative to serve on the Board of Pharmacy Rules Work Group to provide them with information on the needs and perspectives of rural hospitals.

SECTION FOUR: STATE AND FEDERAL INSPECTION AND REGULATORY REQUIREMENTS THAT ARE DUPLICATIVE AND INCREASE ADMINISTRATIVE COSTS

Administrators who responded to the structured interviews identified four areas in which state inspection and regulatory requirements are duplicative and increase administrative costs:

- licensing and certification,
- data reporting,
- utilization review, and
- billing uniformity.

Each of these areas was reviewed and discussed by Work Group members. Staff of the Minnesota Department of Health Division of Facility and Provider Compliance as well as the Health Policy and Systems Compliance Division's Data Analysis and Health Economics Programs provided information to the Work Group regarding these issues.

Licensing and Certification

Duplication among licensing and certification regulations becomes evident when a single agency delivers a continuum of care through hospitals, nursing homes, and other health care services. In such cases, the organization may be required to undergo separate surveys for the different facilities it owns and operates. The Minnesota Department of Health Division of Facility and Provider Compliance is exploring the feasibility of consolidated licensing for institutions which provide a continuum of care.

Data Reporting

The chief concern regarding data reporting expressed by Work Group members and the hospital administrators responding to the survey is that, while state and federal requirements are similar, they are not identical. Because state and federal reporting schedules and forms are often not coordinated, additional staff and administrative resources are required. This can be costly and burdensome in small hospitals. Currently a work group is reviewing Minnesota Rules, chapter 4650 which implemented the Minnesota Health Care Cost Information System to determine areas in which Medicare data may be used for state purposes, and to develop a system whereby information required by the Department of Health may be reported on a single form.

Utilization Review

Utilization Review was characterized by several Work Group members and administrators as a complex and costly process. In addition, separate organizations use varying standards to meet utilization review criteria. The complexity of utilization review has been a concern of public and private organizations for a number of years as well. In response to this concern,

the Minnesota Utilization Review Act was passed in 1992. In 1994, MinnesotaCare legislation required the Commissioner of Health to study the feasibility of developing standard utilization review criteria. The study has been completed, and the Rural Hospital Study Work Group plans to review the report after it is released for public comment in January 1996.

Uniform Billing

Lack of uniform billing forms and processes is a concern addressed by the hospital administrators in the structured interviews as well as the Work Group. In response to these concerns, the 1994 Legislature passed the administrative simplification act (ASA), which requires uniform billing formats to be used by all Minnesota health care providers effective January 1, 1996. In addition, the ASA requires standard provider and patient identifiers to be implemented on or after January 1, 1998, and seeks to implement Electronic Data Interchange (EDI) which will provide nationally accepted standards for electronic data templates for hospital and provider claim forms, payment forms, enrollment, and eligibility forms.

Recommendations

Licensing and Certification

A. To reflect the changes in the health care marketplace and the increasing integration of health care facilities, the Rural Hospital Study Work Group recommends that the Minnesota Department of Health adopt a systems-level approach toward licensing, certifying, and surveying health care facilities. In addition, the Work Group recommends that the Minnesota Department of Health develop corresponding data reporting requirements which coordinate the data reporting requirements for all components within the single license. Proposed statutory language for this recommendation is attached in Appendix A.

B. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health monitor opportunities available through federal legislative changes in the Medicare or Medicaid programs for streamlining the licensing, surveying, and certifying of health care facilities. The Rural Hospital Study Work Group further encourages the Minnesota Department of Health to use any flexibility available to vary the survey process, including but not limited to the frequency of surveys, as appropriate based on past performance.

C. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health, in crafting any new regulatory system, consider providing technical assistance to health care facilities, instead of operating strictly in an enforcement role. The Minnesota Department of Health is also encouraged to consider providing a mechanism for hospitals and nursing homes to self-regulate their activities, using a continuous quality improvement approach.

Data Reporting

A. The Rural Hospital Study Work Group recognizes the need for, encourages, and affirms the efforts of the Minnesota Department of Health Hospital Rules Work Group to streamline the collection of aggregate data from hospitals and other health care providers.

Utilization Review

A. The Rural Hospital Study Work Group will review the Minnesota Department of Health utilization review report when it is released for public comment, and will make comments and further recommendations to the Rural Health Advisory Committee and the Minnesota Department of Health at that time.

Billing Uniformity

A. The Rural Hospital Study Work Group strongly supports the need for, encourages, and affirms the efforts of the Minnesota Department of Health in carrying out the directives of the Administrative Simplification Act (Minnesota Statutes, chapter 62J, sections 50-61).

B. The Rural Hospital Study Work Group urges the Minnesota Department of Human Services to implement a standard billing practice which is more consistent with the billing practices of the federal Health Care Financing Administration and private payers.

SECTION FIVE: PHYSICIAN SUPERVISION REQUIREMENTS THAT LIMIT THE USE OF PHYSICIAN ASSISTANTS

A cornerstone of the practice of physician assistants (PAs) is the supervision of the PA by the physician with whom he/she practices. Minnesota Law governing registration of PAs requires a written practice agreement, agreed upon by the physician and the PA, which delineates the protocols and parameters of the PAs work. Prior to 1995, PAs in Minnesota were required to be supervised in a clinic setting by a physician on-site, at least twice a week and for eight hours a week. In addition, the physician was required to be available either in person or by telephone within 15 minutes for consultation with the PA. These requirements were seen as restrictive and were changed in Laws of Minnesota 1995, chapter 205 (Minnesota Statutes, chapter 147A), which re-defined the supervision requirement. Under the new law, the physical presence of the supervising physician is no longer necessary, provided the physician may be easily contacted by the PA for consultation and the nature and scope of supervision is clearly outlined in the written practice agreement.

Although the statute removed many practical obstacles to the use of a PA in rural settings, several third party payers continue to require stricter supervision in certain settings in order for services to be reimbursed. Current Medicaid rules require 50 percent on-site physician supervision in hospital and clinic settings to qualify PA services for reimbursement. In addition, the plan of care must be reviewed, approved and signed by the physician before care is begun.

Supervision requirements for Medicare reimbursement vary according to setting. Requirements are less stringent in federally certified Rural Health Clinics (RHCs), and in offices or clinics in Health Professional Shortage Areas (HPSAs). However, substantial supervision is required for PAs practicing in hospitals, in clinics which are not RHCs, or which are not located in a HPSA.

Recommendation

The Rural Hospital Study Work Group recommends that the Minnesota Departments of Health and Human Services require that Medicaid, private insurers, health plans, and other accident or sickness insurance may not deny reimbursement for the services of a physician assistant based on stricter supervision standards than those set forth in the state practice act.

A. The Rural Hospital Study Work Group recommends that the Department of Human Services revise its policy on supervision of physician assistants as stated in Minnesota Rule, part 9505.0175, subpart 46, to reflect the changes in supervision requirements set out in Minnesota Statutes, section 147A.20, and referenced in Laws of Minnesota 1995, chapter 205.

B. The Rural Hospital Study Work Group recommends that the Legislature amend Minnesota Statutes, section 62A.15 to mandate that a carrier may not deny benefits for services of a PA if performed within the scope of practice set out in Minnesota Statutes section 147A.09 and under the supervision requirements set forth by Minnesota Statutes section 147A.01 subdivision 24, and section 147A.20, and referenced in Laws of Minnesota 1995, chapter 205. Proposed statutory language for this recommendation is attached in Appendix A.

C. The Rural Hospital Study Work Group recommends that the Minnesota Departments of Health and Human Services monitor federal legislative actions, and if states are given more latitude in the conditions and levels related to Medicare reimbursement, provide flexibility in the physician assistant supervision requirements for Medicare reimbursement, using the language in Minnesota Statutes section 147A.01, and referenced in Laws of Minnesota 1995, chapter 205, as the guiding principle.

SECTION SIX: THE REQUIREMENT THAT A HOSPITAL AND ITS ATTACHED NURSING HOME HAVE SEPARATE DIRECTORS OF NURSING

The requirement that a hospital and its attached nursing home have separate directors of nursing was identified as a concern of Work Group members as well as a number of the hospital administrators who participated in the structured interviews. This requirement is a burden primarily on small rural hospitals with a low average daily census, which have an attached nursing home of less than 100 beds.

The regulations which prevent hospitals and nursing homes from sharing directors of nursing are nursing home rather than hospital regulations. Federal nursing home regulations require facilities to have 1) 24-hour nursing capability, including the services of a registered nurse at least eight consecutive hours per day seven days per week, and 2) an RN who is designated as a full-time director of nursing. In order for hospitals and nursing homes to sharing directors of nursing, the facilities must obtain waivers of both state and federal regulations.

Administrators and Work Group members identified this complex and often confusing process of obtaining the necessary waivers to accomplish the sharing of a director of nursing as the major obstacle in this issue. An indication of the difficulties associated with this situation are evidenced by the fact that no hospital with an attached nursing home currently has the waivers in place to share a director of nursing although, as noted earlier, this is a desire in a number of facilities.

A primary concern of state and federal regulators as well as Work Group members is that while sharing a director of nursing may make administrative sense, it is important that quality patient care not be compromised in the process. As a result, the Work Group carefully framed the language of the recommendation to set limits on both average daily census in the hospital as well as nursing home beds so that quality of care will be provided in both facilities.

Recommendation

A. The Rural Hospital Study Work Group recommends that the Legislature amend Minnesota Statutes, section 144A.04, subdivision 7, to supersede Minnesota Rules, part 4658.0500, subpart 2 to allow a director of nursing in a nursing home to also serve as the director of nursing of a physically attached hospital under the following conditions: 1) the hospital has an average daily census of less than or equal to ten patients in the most recent reporting year for which data is available; 2) the combined beds of the hospital and nursing home are less than or equal to 100; and 3) the management of the two facilities is under the control and direction of the same governing body. Proposed statutory language for this recommendation is attached in Appendix A.

B. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health disseminate to all eligible hospitals in rural Minnesota information about the Health Care Financing Administration waiver process that enables hospitals with attached nursing homes to share directors of nursing.

C. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health monitor federal legislative action, and if states are given more latitude in the regulation and surveying of hospitals or if an alternative licensing model is developed, consider flexible staffing guidelines that would allow hospitals and nursing homes to share directors of nursing when appropriate.

SECTION SEVEN: CONCLUSION

Throughout the review of the five regulatory issues, the changing landscape of federal health care legislation was a topic of concern. Currently, Congress is considering a number of measures, including an overhaul of Medicare and a re-structuring of Medicaid payment mechanisms to states. There is a possibility that through this legislation, states will be granted a greater latitude in determining the mechanisms for regulating health care facilities and programs and the type and level of reimbursement.

Recommendation

A. The Rural Hospital Study Work Group recommends the Minnesota Department of Health bring to the attention of the state's federal congressional delegation the multitude of concerns addressed in this report about regulatory barriers to rural health care delivery.

On December 5, 1995, a draft of the report and recommendations of the Rural Hospital Studies Work Group was reviewed by the Rural Health Advisory Committee. The RHAC unanimously endorsed the recommendations of the Work Group.

Recommendation

A. The Rural Health Advisory Committee recommends that the report and recommendations of the Rural Hospital Study Work Group be submitted to the Commissioner of Health, with draft legislative language incorporating the appropriate recommendations, and that the Commissioner draft a bill containing the recommendations for legislation herein by January 16, 1996.

B. The Rural Health Advisory Committee recommends that copies of this report, Regulatory Barriers to Rural Health Care be distributed to all interested professional associations, including those represented on the Rural Hospital Studies Work Group and the Rural Health Advisory Committee, and to the Regional Coordinating Boards. In distributing this report, the RHAC encourages continued discussion on barriers in rural health care access, and recommends that regulatory issues not addressed in this report be forwarded to the RHAC for further consideration and/or action.

Introduction

Background and Purpose

Health care access in rural Minnesota has been affected by numerous changes in the structure of rural communities as well as changes in health care delivery. Since the early 1980's, many rural communities have experienced economic declines which have led to increased poverty, loss of businesses, out migration of young people, and a declining tax base. In addition, rural health care has undergone changes including cutbacks in third-party reimbursement, a shift away from in-patient hospital care toward out-patient services, increased competition among both urban and rural hospitals for a declining rural patient base, and a growing shortage of physicians in rural areas.

As a result of these pressures, many small rural hospitals are struggling to recruit staff and obtain the financial resources necessary to provide quality health care services to their communities. Nineteen rural hospitals in Minnesota closed between January 1, 1985 and December 31, 1995. Eleven of these closures have taken place in the 1990s. There is evidence that these closures have created barriers to access for residents in several parts of the state. A 1989 report by the Minnesota Department of Health, Access to Hospitals in Rural Minnesota, found that residents in parts of nine rural Minnesota counties lived more than 30 minutes from a hospital. Each of these nine counties are located in the northern part of the state. Recent hospital closures have severely limited access in other northern Minnesota counties as well. A map of hospitals in Minnesota that closed between 1984 and 1995 is located in Appendix B.

Statutory Charge

In response to access concerns created by the closure of rural hospitals, the Rural Health Advisory Committee formed the Rural Hospital Issues Work Group to identify key issues that impact access to care and to propose how the state Legislature can address those issues in order to alleviate barriers to accessible, quality health care in rural Minnesota. The Work Group issued a report in February 1995, which included a recommendation that the Legislature "direct policy analysis of regulatory barriers and options for reconfiguring traditional hospital-based health care services, to be conducted under the auspices of the Rural Health Advisory Committee and the Regional Coordinating Boards".

During the 1995 legislative session, the Minnesota Legislature directed the Rural Health Advisory Committee to examine two specific areas of health care delivery 1) federal and state regulatory barriers that limit rural access to care or limit the ability of rural health care providers to provide care efficiently, without improving the quality of care; and 2) rural health care access needs and the need for an alternative licensing model for rural hospitals. The Legislature

mandated that the Rural Health Advisory Committee complete the first phase of the study and present recommendations to the Commissioner of Health by December 1, 1995. The Commissioner is then required to consider the recommendations and present recommendations and draft legislation to the Legislature by February 1, 1996.

The first portion of the statutory charge identified five regulatory barriers which must be included in the study. These barriers include:

(1) requirements for emergency room staffing that increase hospital costs and limit access to care;
(2) limits on the ability of nurses to prescribe and administer prescription drugs under a physician's supervision in emergency situations;
(3) state and federal inspection and regulatory requirements that are duplicative and increase administrative costs;
(4) physician supervision requirements that limit the use of physician assistants; and
(5) the requirement that a hospital and its attached nursing home have separate directors of nursing.

The Legislature directed the Rural Health Advisory Committee to examine rural health care access needs and the need for an alternative licensing models for rural hospitals, and present recommendations to the Legislature by December 15, 1996 (See Appendix C for statutory charge).

Rural Hospital Study Work Group Formation

In response to the statutory charge, a work group was formed to develop recommendations regarding the five regulatory barriers and alternative licensing models for the Rural Health Advisory Committee. Membership of the Rural Hospital Study Work Group consists of the following representation (See Appendix D for a list of Work Group members):

2 rural physicians, one appointed by the Minnesota Medical Association and one by the Minnesota Academy of Family Physicians
2 nurses, one a director of nursing in a rural hospital appointed by the Minnesota Organization of Nurse Executives, and one a rural public health nurse appointed by the Minnesota Public Health Association
1 rural pharmacist, appointed by the Minnesota Pharmacy Association
1 mid-level provider, appointed by the Rural Health Advisory Committee
2 rural hospital administrators, one an administrator of a hospital with an attached nursing home, appointed by the Minnesota Hospital and Health Care Partnership
1 long-term care administrator, appointed by Rural Health Advisory Committee
3 consumers, one appointed by the Regional Coordinating Boards, and two appointed by the Rural Health Advisory Committee
3 HMO, Health Plan, or Blue Cross representatives, appointed by the RCBs
1 volunteer ambulance service representative, appointed by the Rural Health Advisory Committee

1 ambulance association representative, appointed by the Minnesota Ambulance Association
1 County Board of Commissioners representative, appointed by the RCBs

The Office of Rural Health and Primary Care (ORHPC) provided staffing for the Rural Hospital Study Work Group. Technical assistance was provided to the Work Group by the Minnesota Department of Health Division of Facility and Provider Compliance, the Division of Health Policy and Systems Compliance Emergency Medical Services Section, as well as the Division's Health Economics and Data Analysis programs, and the Minnesota Department of Human Services.

Preliminary Research

A structured interview with hospital administrators was designed to assist the Rural Hospital Study Work Group to further clarify and expand upon the five regulatory barriers identified in the statutory charge. Twenty rural hospital administrators were selected to participate in the interviews. Four administrators from each of the five non-metro Regional Coordinating Board areas were selected, with equal representation of attached and non-attached nursing homes, and proportionate representation of hospitals with an average daily census ranging from 1-58 patients.

Administrators were asked to review the interview guide with their hospital staff and were then interviewed by telephone by a staff member of the Office of Rural Health and Primary Care or the Minnesota Hospital and Health Care Partnership. The administrators were asked for comments and suggestions regarding regulatory requirements that are duplicative and increase administrative costs in ten areas: governance, quality assurance and utilization review, medical and nursing staff requirements, required clinical and supporting services, physical environment, infection control, optional clinical services, licensing and certification processes and procedures, state and federal data reporting requirements, and Medicare and Medicaid reimbursement policies. A total of 18 administrators agreed to participate in the interview. A summary of their comments is located in Appendix E.

Many of the issues repeatedly voiced by administrators mirrored those identified by the legislative charge:

- lack of flexibility in emergency room staffing requirements;
- requirements limiting the ability of registered nurses to dispense medication when a physician or pharmacist is not on duty in a hospital;
- non-standardized data reporting requirements and lack of coordination among state and federal licensing and reimbursement agencies that create cost and time burdens on administrators; and
- the requirement that a hospital and an attached nursing home must have separate directors of nursing is costly and duplicative for small hospitals.

Study Design

The Work Group addressed regulatory barriers that limit rural access to care in three meetings held in September, October, and November, 1995. The group was chaired by Terry Hill, Executive Director of the Minnesota Center for Rural Health, who was appointed by William Flaig, Rural Health Advisory Committee Chairman. During the first meeting, Work Group members reviewed preliminary results of the structured interviews and defined the nature of the problem in each of the regulatory areas identified in the statutory charge, the key issues to be considered, and the information needed for decision-making. Work Group members agreed that due to the short time period allowed for recommendations to be completed, they would limit their study to the five legislatively mandated issues, and in keeping with the intent of the legislation, limit their discussion to hospital-related issues. Any additional areas would be addressed in the second year of the study.

The second meeting was devoted to a discussion of four of the legislatively identified issues: 1) the barriers surrounding the ability of nurses to prescribe and administer prescription drugs under a physician's supervision in emergency situations; 2) state and federal inspection and regulatory requirements that are duplicative and increase administrative costs; 3) physician supervision requirements that limit the use of physician assistants; and 4) the requirement that a hospital and its attached nursing home have separate directors of nursing. The Work Group discussed each issue and drafted recommendations.

In the third meeting, Work Group members refined recommendations for the first four areas and addressed requirements for emergency room staffing that increase hospital costs and limit access to care. Based on the meeting discussions, the staff drafted a report summarizing each issue and the recommendations of the Work Group. Members reviewed and commented on each section of the report and associated recommendations. Following are summaries of each of the five issues identified by the legislative charge, along with the recommendations of the Rural Hospital Study Work Group.

The information presented in this report is intended as background information only. The reader is advised that due to the evolving nature of this information, they may want to contact the respective state or federal regulatory agency if they feel the information might be out of date.

Requirements for Emergency Room Staffing that Increase Hospital Costs and Limit Access To Care

Problem Statement

How to deliver adequate emergency medical care to rural residents has become a growing problem as hospitals throughout the country have closed their doors. The question of how to provide access to care in isolated areas, where the population base is unable to support a full-service hospital, is of particular concern. Emergency medical care has been characterized as the most vital of services in rural communities (Haskins and Kallail, 1994). In a 1989 special report on rural emergency services, the Office of Technology Assessment stated that injuries in rural areas result in higher mortality than those in urban areas. The possible explanations for this increased mortality were cited as the delay in detection and response to trauma in rural areas, as well as longer times required to transport patients to appropriate hospital care (Conrad, 1991). Even as the availability of hospital beds in rural areas declined, the number of patient visits to rural emergency rooms rose. Between 1984 and 1988, the number of non-metro hospital beds declined 8.6 percent, while emergency visits increased 12.8 percent (Office of Technology Assessment, 1990). A 1992 study by the American Hospital Association found that rural emergency departments experienced a 21 percent rise in patient visits between 1980 and 1990, compared to a 16.2 percent rise in visits to urban emergency departments (Hospitals, 1992).

Work Group members as well as many hospital administrators surveyed in the structured interviews echoed the view that providing high quality emergency medical care is a core issue in rural health care delivery. Comments from administrators as well as the literature indicate that effective emergency care is dependent on a network of services. Work Group members agreed that emergency medical care must be dealt with as an integrated system of services, including adequate levels of emergency room staffing. Members identified the necessary components of such a system as including, but not limited to:

- availability of adequate medical transportation in all geographic areas;
- availability of physicians to provide the necessary level of service to a community or region;
- availability of medical personnel, including registered nurses, emergency medical technicians (EMTs), and midlevel practitioners, for accurate diagnosis, stabilization, and/or treatment as well as rapid transport of emergency patients;
- availability of ancillary services and personnel; and
- access to and availability of tertiary and specialty care.

Emergency Room Staffing

Sufficient staffing of emergency rooms is identified in a number of studies as a critical component of rural emergency care. Wakefield, Tracy, Myer, and Wallace (1994) cited studies which found the 24-hour availability of physicians to emergency rooms crucial to quality care due to the high rates of acute injury, higher concentrations of elderly people, and the use of volunteer emergency medical services (EMS) staff who often receive less training than non-volunteer staff, in rural areas. Wakefield et.al. also indicated that adequate physician staffing of emergency rooms is difficult for many rural communities due to a shortage of physicians in rural areas. The authors cited several factors which compromise a community's ability to recruit and retain physicians including physician demands for more time off and more predictable work schedules, and changes in Medicare reimbursement which reduce overall physician payment for services in both the emergency room and in the inpatient setting.

In an effort to continue to staff emergency rooms in the face of physician shortages, many rural hospitals have utilized the services of locum tenens or contract physicians. A study of 37 rural Washington state hospitals with fewer than 100 beds found that only 14 percent covered their emergency departments with local practitioners on a fee-for-service basis, while 86 percent covered their emergency rooms with some type of contracted physician staffing (Williamson, Rosenblatt and Hart, 1992). Many rural hospitals throughout the country have incurred additional costs of operation by contracting with physicians for emergency room coverage. In the Washington study, hospitals spent an average of $59,419.00 to $390,433.00 annually on locum tenens for emergency staffing depending on the level of services contracted.

Alternative Methods of Meeting Staffing Requirements

Rural hospitals have adopted a variety of strategies in an effort to minimize the cost of maintaining adequate emergency room staffing, and preserving access to care. The Work Group identified the following six strategies: 1) increasing the use of mid-level practitioners' services, 2) telemedicine, 3) expanding the scope of practice for paramedics, 4) establishing 24-hour nurse triage services via telephone, 5) establishing urgent care centers to redirect primary health care problems away from the emergency room, and 6) implementing alternative licensing mechanisms for rural acute care hospitals.

Use of Midlevel Practitioners

A 1991 study of emergency room staffing in rural Kansas hospitals found that 27 of the 84 hospital administrators surveyed utilized midlevel practitioners to augment physician coverage in the emergency room. (Haskins and Kallail, 1994). A 1994 survey conducted by the Minnesota Nurses Association found that 23 percent of the 196 nurse practitioners who responded served on-call in an emergency room, hospital, or clinic. The implications for rural hospitals are unclear, however, as only 19 percent of those responding were from rural practices and survey results did not indicate whether those who took call served in rural hospitals (Minnesota Department of Health, July 1995).

Work Group members concurred that the availability of physicians to provide medical coverage to hospital emergency rooms is a key factor in continued high quality of care. It was generally agreed that using the services of midlevel practitioners is one option for communities seeking to continue to provide emergency care while easing the cost of physician staffing. The Work Group acknowledged that there may be areas in which the roles of midlevel practitioners in emergency care can be expanded. It was noted, however, that at some significant level, a physician must be involved in the care of emergency patients, and that it is the physician who is ultimately responsible for the outcome of the patient.

Expanded Scope of Practice for Emergency Medical Technicians and Paramedics

The 1989 OTA report cited earlier identified availability and adequate training of emergency medical services (EMS) personnel as specific concerns in rural emergency care delivery (Conrad, 1991). To fill gaps in medical services, and to enhance the training and recruiting of EMS personnel, several states have expanded the scope of practice for EMTs and paramedics. In New Mexico, for example, a pilot program was begun in 1993 with funding from a federal Rural Health Demonstration Grant to train paramedics to perform routine physical exams and basic laboratory tests, draw blood samples, and immunize patients as well as assess and triage patients to physicians for care. Indiana and Michigan have also begun programs in which EMTs are used to extend the services of physicians and other medical personnel in the emergency room as well as in primary care settings (Garza, 1993).

Nurse Triage and Urgent Care Centers

Another strategy for providing care in the face of limited emergency room staffing is the establishment of a 24-hour nurse triage service. Through this service registered nurses are available by telephone to answer patients' questions and determine if a presenting condition requires immediate attention or a subsequent clinic visit. Urgent care centers have also been cited as a means of providing access to primary health care after hours, thereby lessening the non-emergency care burden on emergency room staff and decreasing the cost of care.

Telemedicine Applications

Work Group members discussed possible applications of telemedicine which would allow a physician in an off-site location to provide consultation to nurses and mid-level practitioners via telecommunications in the emergency room. It was noted that several programs in other states are using telemedicine to assist in evaluating and diagnosing patients in emergency rooms, thereby making more efficient use of physicians with limited availability. Several Work Group members cautioned that firm data about telemedicine's effectiveness and accuracy is not yet available. In addition, members commented that a key to accurate diagnosis of a condition lies in nonverbal communication, particularly in emergency situations. A concern is that patient care might be compromised by the use of telecommunications, particularly in emergency room settings.

Alternative Licensing for Rural Hospitals

Alternative licensing of acute-care hospitals has been discussed as a possible way for communities to provide access to emergency services in the absence of a full-service acute care hospital. The federal government established the Essential Access Community Hospital (EACH) program in 1989 to address the needs of small rural hospitals seeking to provide limited inpatient services. Through this program, Rural Primary Care Hospitals (RPCHs) with limited inpatient, clinic, and emergency services, link with larger facilities that have greater service capacities. As a limited-service hospital, the RPCH agrees to provide 24-hour emergency care (although staff may be on-call if inpatient beds are unoccupied) and staff no more than six inpatient beds for acute services. The RPCH is required to stabilize, discharge or transfer patients to another hospital within 72-hours of admission. The larger EACH facility must accept patients transferred from RPCHs and agree to receive data from and transmit data to the RPCHs. In addition, it must agree to provide emergency medical backup to the RPCH's in its network (Campion, Lipson and Elliot, 1993). Seven states participated in the initial demonstration project.

Licensing provisions for rural hospitals in federal legislation currently include:

- a House and Senate proposal to establish a Rural Emergency Access Hospital program that creates a category of rural hospitals which would treat patients for up to 24 hours in order to stabilize and transfer them, and
- a Senate proposal to expand the Essential Access Community Hospital/Rural Primary Care Hospital program nationwide.

Rural Hospital Study Work Group members heard from a Minnesota hospital administrator, Lynn Clayton, of Rush City Hospital, which has experienced many of the staffing and financial pressures faced by rural hospitals throughout the country, and is in the process of adopting some of the strategies outlined above. Rush City Hospital is a 29-bed facility in a community of 1500, with a total service area population of eight to ten thousand. Between 1990 and 1994, the hospital's average daily census fell from 3.26 to 2.1 patients. At the same time, its outpatient sources of revenue expanded until in 1994, 80 percent of hospital revenue came from outpatient sources. In addition, the hospital was experiencing difficulties in recruiting adequate numbers of physicians to meet the health care needs of the service area.

In order to continue to provide care in view of the declining inpatient census and difficulties in recruiting physicians, the Hospital Board began a planning process which led eventually to partnership with a large regional provider, Fairview Health System, headquartered in Minneapolis. Along with two other hospitals in nearby communities, Rush City Hospital will become part of a regional health services network. Although the hospital plans to close its acute care and 24-hour emergency room services in approximately two years, it will be part of a larger EMS system. This system will likely include a community-based urgent care center, first responder units and enhanced EMS, 24-hour nurse-triage by telephone, access to a trauma center via helicopter, and community education programs.

Participation in a regional network will preserve most of the vital services to the community. There is reason to believe that some services, such as laboratory and physical therapy, will be enhanced. However several issues are yet to be resolved including the level of coverage and roles of RNs and midlevel practitioners in emergency and urgent care staffing, the ability to stabilize and transfer patients in the absence of a 24-hour emergency room, and the level of ambulance services necessary and available to the community.

Regulatory Concerns

It was noted that many emergency room staffing requirements are federal Medicare Conditions of Participation, and as such, the state of Minnesota may have limited authority to make changes unless Congress grants states greater latitude in health care regulation. Another example of federal regulation of concern to the Work Group is Medicare regulations governing the treatment and transfer of emergency room patients. The regulations were established to prevent the practice of "dumping" a patient. Dumping refers to a hospital's refusal to provide care due to the inability of the patient to pay for services, or for other reasons not related to medical necessity. The rationale for the regulation is that a facility receiving Medicare dollars has an obligation to serve the medical needs of anyone who presents themselves for care. Concerns were raised that hospitals with limited emergency services or physician availability could become vulnerable to dumping allegations.

Issues for Future Study

The Work Group identified several areas crucial to providing high quality emergency services in rural Minnesota. These included:

1. Determining what levels of services and staffing define quality emergency care. It was suggested that the guidelines established by the American College of Surgeons be reviewed regarding standards for emergency care.
2. Viewing emergency services from a network perspective, taking into account the need for an integrated system of services that provides high quality care within a critical time frame. Necessary components include medical transportation, ambulance personnel and emergency room staff, ancillary services, and the ability to refer and transport patients to tertiary and specialty care.
3. Educating providers and the public on what reasonably constitutes quality emergency medical care and the distinctions between emergency room care as a means of receiving primary care, and as a means of treating traumatic injury and illness.
4. Reviewing the State Trauma Guidelines and determining how they can be effectively implemented. The guidelines were developed by a task force of the EMS section of the Minnesota Department of Health under a federal grant. The guidelines were issued in November, 1995.

Recommendation

A. The Rural Hospital Study Work Group emphasizes that emergency medical care is an essential component of rural health care and that emergency room staffing issues and other issues related to preserving access to emergency medical care in rural areas are very complex. Therefore, the Rural Hospital Study Work Group recommends further study of the issues related to and options for providing rural emergency medical care in conjunction with the legislatively mandated study of alternative licensing for rural hospitals.

Limits on the Ability of Nurses to Prescribe and Administer Prescription Drugs Under a Physician's Supervision in Emergency Situations

Problem Statement

Other than physicians, nurse practitioners (NPs), physician assistants (PAs) and registered nurses (RNs) are the primary health care professionals that staff a rural hospital emergency room. The Rural Hospital Study Work Group first addressed the issue of the barriers related to limitations on prescription/administration privileges by identifying the prescriptive, dispensing, and administering authority of NPs, PAs, and RNs. The Work Group members perceived the prescriptive and administration privileges to be appropriate under current regulations; however, a number of the rural hospital administrators responding to the structured interview and Work Group members identified restrictions on dispensing of prescription drugs by RNs in emergency situations as a barrier to health care access.

One of the Work Group members cited as an example of unnecessary restrictions on RN dispensing the case of a patient traveling to an emergency room because they have forgotten their blood pressure medication at home. Under current practice, the physician typically comes into the hospital, conducts an examination, and fills out the appropriate paperwork in order to dispense the supply of blood pressure pills. Work group members thought that restrictive dispensing privileges contribute to increasing the cost of health care and, especially in frontier areas, put additional burdens on the on-call staff. If the physician transmitted a prescription to the registered nurse, and the patient did not request to see the physician, RNs can dispense up to a 72-hour supply of the medication or medications, given that the hospital pharmacist has a written dispensing protocol in place.

Drug "administration" means to deliver by or pursuant to the lawful order of a licensed practitioner a single dose of a drug to a patient by injection, inhalation, ingestion, or any other immediate means (Minnesota Rules, part 6800.7100, subpart 2). "Dispense or dispensing" means the preparation or delivery of a drug pursuant to a lawful order of a practitioner in a suitable container appropriately labeled for subsequent administration for use by a patient or other individual entitled to receive the drug (Minnesota Statutes, section 151.01, subdivision 30).

Prescriptive and Administrative Privileges of Midlevel Practitioners and Nurses

Nurse Practitioners Privileges

A registered nurse who 1) has graduated from a program of study designed to prepare registered nurses for advanced practice as nurses practitioners, 2) is certified through a national professional nursing organization which certifies nurse practitioners and is included in the list of professional nursing organizations adopted by the board, and (3) has written agreement with a physician based on standards established by the Minnesota Nurses Association and the Minnesota Medical Association that defines the delegated responsibilities related to the prescription of drugs and therapeutic devices, may prescribe and administer drugs and therapeutic devices within the scope of the written agreement and within practice as a nurse practitioner (Minnesota Statutes, section 148.235). The Board of Nursing must notify the Board of Pharmacy and all pharmacists in the state on a monthly basis about the nurse practitioners with prescribing authority.

In addition, an advanced practice nurse who is authorized to prescribe drugs is authorized to dispense drugs subject to the same requirements established for the prescribing of drugs. This authority to dispense extends only to those drugs described in the written agreement with the physician.

Physician Assistant Privileges

Physician assistants who are registered with the board, certified by the National Commission on Certification of Physician Assistants or successor agency approved by the board, and who are under the supervising physician's supervision have delegated authority to prescribe, dispense, and administer legend drugs, medical devices, and controlled substances under Laws of Minnesota 1995, chapter 205, article 1, section 17. The written delegation agreement between the supervising physician and physician assistant and any alternate supervising physicians must include a protocol indicating categories of drugs for which the supervising physician delegates prescriptive and dispensing authority. Physicians must review the prescribing, dispensing, and administering by PAs under their supervision on a daily basis. The Board of Medical Practice must provide a list of those PAs who are authorized to prescribe, administer, and dispense legend drugs and medical devices or controlled substances to the Board of Pharmacy and registered pharmacies in the state.

Registered Nurses Privileges

Registered nurses have the authority to administer medications under state practice law, but not to prescribe or dispense drugs. A 1995 amendment to the Minnesota pharmacy law, Minnesota Statutes, section 151.37, subdivision 2, expanded the authority of registered nurses to implement a pre-authorized guideline or protocol which results in a prescription. The new law allows a person authorized to prescribe drugs to do so by directing a registered nurse to follow a

particular practice guideline or protocol when caring for a patient whose condition is covered by the guideline or protocol. The guideline or protocol must specify the circumstances under which the drug is to be prescribed or administered. The nurse is the agent, but does not have prescriptive privileges. The law took effect August 1, 1995.

Minnesota Board of Pharmacy Rules provide for a designated registered nurse to make an emergency withdrawal of a dose of medication required by an inpatient in emergency situations. Only a designated registered nurse in any given shift may have emergency access (Minnesota Rules, part 6800.7530, subpart 3). The pharmacist-in-charge is responsible for developing an emergency access procedure and may make provision for prepackaged drugs for emergency withdrawal. (Minnesota Rules, part 6800.7530, subpart 4).

Prescriptive Dispensing and Administering Privileges Registered Nurses and Mid-Level Practitioners

Professional Category	Privileges
Registered Nurses	No prescriptive privileges May administer drugs prescribed by practitioner and dispense in specific situations
Certified Nurse Midwives	May prescribe, administer and dispense drugs and therapeutic devices within scope of practice
Nurse Practitioners	May prescribe, administer and dispense drugs and therapeutic devices including controlled substances. Written agreement required in each setting in which NP practices
Physician Assistants	May prescribe, administer and dispense drugs and therapeutic devices including controlled substances. Written agreement with supervising physician is required

The 72-Hour Rule

Minnesota Board of Pharmacy Rule (Minnesota Rules, part 6800.7520, subpart 1, item G) states that the hospital pharmacist-in-charge is responsible for developing a system to assure that outpatient drug dispensing through the emergency room after regular pharmacy hours complies with all laws and board rules related to prepackaging, labeling, dispensing, and record keeping. The system must limit dispensing done in the absence of the pharmacist and physician to an amount not exceeding a 72-hour supply. The pharmacist is also responsible for supplying prepackaged legend drugs which are accessible for use without entering either the pharmacy or drug room maintained for use when a pharmacist is not available.

In October, 1995, the Minnesota Board of Pharmacy adopted guidelines which address the issue of emergency room after-hours dispensing by registered nurses. The guidelines call for the pharmacist-in-charge to develop written policies and procedures to be followed for after-hours dispensing by a registered nurse. A copy of the guidelines can be found in Appendix F.

It was noted by the Work Group that the Board of Pharmacy guidelines could address some of the circumstances noted by the Work Group and administrators in which limits on dispensing create difficulties. However, few hospital pharmacists or administrators are aware of the guidelines at this time.

It was reported to the Work Group that the Boards of Pharmacy, Medical Practice and Nursing are currently meeting to review current pharmacy rules, and to explore the feasibility of a joint rule making process when the Board of Pharmacy Rules are reopened in 1996. The intent of this collaboration is to provide continuity between the regulations promulgated by the Boards regarding the prescriptive, administration, and dispensing privileges of health professionals.

Recommendation

The Rural Hospital Study Work Group recognizes that there is a need for registered nurses working in rural hospital emergency rooms to dispense medications when the pharmacy is closed and the physician is not present. Accordingly:

A. The Rural Hospital Study Work Group urges the Minnesota Board of Pharmacy to disseminate information on the rules governing dispensing privileges of registered nurses in the emergency room and the Board's Guidelines for Emergency Room After-Hours Dispensing by Registered Nurses to rural hospital pharmacists and administrators.

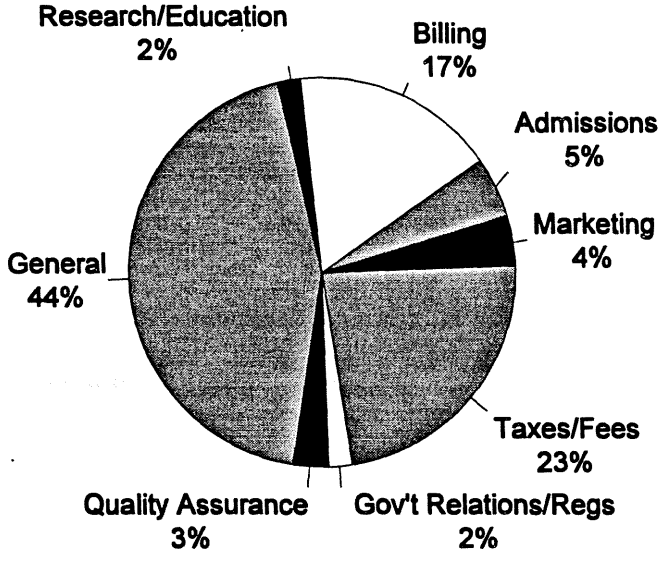
B. The Rural Hospital Study Work Group acknowledges that the Board of Pharmacy, Board of Medical Practice, and Board of Nursing have been conducting meetings on delegation of prescribing privileges under protocol and other related issues. The Work Group further acknowledges that the Board of Pharmacy Rules will be reopened in early 1996. The Rural Hospital Study Work Group recommends that the Rural Health Advisory Committee appoint a representative to serve on the Board of Pharmacy Rules Work Group to provide them with information on the needs and perspectives of rural hospitals.

State and Federal Inspection and Regulatory Requirements that are Duplicative and Increase Administrative Costs

Problem Statement

Operating expenses of Minnesota community hospitals were $4.1 billion in 1993, and almost 13 percent of total hospital operating expenses went to administrative expenses. Administrative costs include a number of components, including admissions, research and education, quality assurance, marketing, billing, taxes and fees, government relations and regulation, and general.

Figure 1
Components of Hospital Administrative Cost, 1993



Source: Minnesota Department of Health, Health Care Cost Information System, Revenue and Expense Report, 1993

Results of the structured interviews with selected hospital administrators revealed that regulatory requirements that are duplicative and increase administrative costs occur in four primary categories: licensing and certification, state and federal data reporting, quality assurance and utilization review, and billing. Therefore, the Rural Hospital Study Work Group focused on exploring the problems and potential solutions in the four above-mentioned areas. Each area identified in the survey is individually outlined below.

1. Licensing and Certification

Issues

For hospitals in the state of Minnesota, the federal Medicare Conditions of Participation have been adopted in state statutes governing the licensing of hospitals. Therefore, state and federal regulations are the same, and licensing and surveying are both conducted by the state as a single process.

What then are the issues regarding duplicative regulations for licensing and surveying? According to Linda Sutherland, Director of the Division of Facility and Provider Compliance, Minnesota Department of Health, true duplication, where regulations are a mirror image of each other is not the real problem. It is when two regulations or two sets of regulations differ slightly that administrative time and consequently cost increases. This is the case with other types of health care facilities, such as nursing homes and home health care agencies, where state and federal regulations and requirements differ.

Hospital Surveying and Licensing

Duplication among regulations becomes evident when a single agency delivers a continuum of care through hospitals, nursing homes, and other health care organizations. In such cases, the organization may be required to apply for licensing and undergo surveys for each of the different facilities that it owns and operates. Some of the problems with licensing are related to the circumstances under which the body of regulations were established. Medicare Conditions of Participation, for example, were developed in the mid-1960s, a time when most health care was delivered through stand-alone facilities on a fee-for-service basis. The creation of the body of regulations predated the expansion of health plans and the growth of health care systems in Minnesota and nationally. As of yet, the resources have not been directed toward updating these regulations in a comprehensive manner.

Hospitals in Minnesota have the option of being accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in lieu of being surveyed by the state. Hospitals which receive JCAHO accreditation are subject to validation surveys by the federal Health Care Financing Administration (HCFA). Only about 5 percent of all accredited hospitals nationally are sampled for validation surveys. One of the problems encountered by JCAHO accredited hospitals is that HCFA and JCAHO standards differ considerably in some instances, with JCAHO being much more process oriented than HCFA. As a result, a JCAHO accredited hospital may not meet the HCFA requirements if it receives a validation survey. Further, in complaint resolution even those hospitals with JCAHO accreditation are subject to Medicare Conditions of Participation.

Alternative Approaches

A number of alternative philosophies for measuring quality of hospital services have been explored. One approach which has shown promise according to a number of studies is the Total Quality Management (TQM) or Continuous Quality Improvement (CQI) approach. The TQM/CQI movement, which is credited with transforming Japan into an industrial giant, has begun to take hold in the United States health care industry within the past five years (Truhe, 1993). TQM focuses on identifying organizational processes that hinder people from contributing to success. The TQM/CQI method uses various tools to examine performance, identify root causes for poor results, and devise strategies for improvement. Fundamental features of CQI methods involve cyclical progression comprising observation or measurement analysis, implementation of interventions, remeasurement, and reassessment. The tools for CQI include: benchmarks (measures of best observed performance used for comparison, goal setting, and relative improvement trending); indicators (rates for certain outcomes statistically charted to make comparisons and monitor results from process charts): protocols (sets of clinical criteria expected for a given treatment or diagnosis used as screens to identify potential quality concerns); and fishbone diagrams, flow charts, etc. (to examine process and identify the cause of problems).

JCAHO released its "Agenda for Change" in 1985, replacing the "bad apple" approach to quality assurance with the methods and philosophy of CQI. Beginning with the 1992 Accreditation Manual for Hospitals, JCAHO began the multi-year process of incorporating TQM methods and processes in the requirements for accreditation. The approach de-emphasizes the existence of structures and discreet functions, substituting a focus on broad processes of care with an interdisciplinary task force responsible for assessing quality and identifying opportunities for improvement. The HCFA is shifting from the review of individual cases to the use of outcomes and practice pattern data to identify areas of concern and opportunities for improvement (Truhe, 1993).

Sutherland stated that the Minnesota Department of Health Division of Facility and Provider Compliance has been exploring the concept of a consolidated license which would integrate some of the requirements for health care organizations, taking into account the size of the organization, the number of staff, and the range of services provided.

Work Group members expressed an interest in the development of consolidated licensing for health care facilities that are jointly owned and operated and advocated the move toward a systems-level approach toward licensing, certifying, and surveying health care facilities. They noted that this approach would better reflect the changes taking place in the health care marketplace. *Furthermore, the Work Group indicated that such an approach would alleviate a current source of difficulty for many small rural hospitals in that regulations require that they meet the same standards as urban facilities, although they operate with considerably fewer resources and serve a much smaller number of patients.*

Members also strongly encouraged the exploration of a regulatory approach based on minimum standards and continuous quality improvement for health care organizations. Work Group members suggested that health care regulators should put greater emphasis on using outcomes as indicators of performance, rather than on enforcing very specific standards for all health care facilities. Undertaking such changes would necessitate identifying ways in which surveyors and regulators may more appropriately provide technical assistance to hospitals and move away from the strictly policing role that they have been required to play.

Federal Action

Proposed federal budget cuts have the potential for greatly affecting the system of regulation for health care organizations. Federal funds for surveys have been decreasing over the past few years and may be cut even more drastically in this year's legislative session. These cuts might be accompanied by a return of some regulatory authority to the states. If regulatory authority is returned to the states, it is expected there will be a need for resources to make the transition possible.

Recommendation

A. To reflect the changes in the health care marketplace and the increasing integration of health care facilities, the Rural Hospital Study Work Group recommends that the Minnesota Department of Health adopt a systems-level approach toward licensing, certifying, and surveying health care facilities. In addition, the Work Group recommends that the Minnesota Department of Health develop corresponding data reporting requirements which coordinate the data reporting requirements for all components within the single license. Proposed statutory language for this recommendation is attached in Appendix A.

B. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health monitor opportunities available through federal legislative changes in the Medicare or Medicaid programs for streamlining the licensing, surveying, and certifying of health care facilities. The Rural Hospital Study Work Group further encourages the Minnesota Department of Health to use any flexibility available to vary the survey process, including but not limited to the frequency of surveys, as appropriate based on past performance.

C. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health, in crafting any new regulatory system, consider providing technical assistance to health care facilities, instead of operating strictly in an enforcement role. The Minnesota Department of Health is also encouraged to consider providing a mechanism for hospitals and nursing homes to self-regulate their activities, using a continuous quality improvement approach.

2. Data Reporting

Issues

The Minnesota Health Care Cost Information Act of 1984 (Minnesota Statutes, sections 144.695 to144.703) and Minnesota Rules, chapter 4650, which implemented the Minnesota Health Care Cost Information System, established reporting requirements for the financial information which must be submitted by hospitals to the Department of Health. In 1993, concern about potential duplication in the collection and maintenance of data by the health department led to the inventorying of data collected by state and federal government agencies from health care providers. The inventory documented the types of data collected and submission dates for reports to the Commissioner of Health, Legislature, and federal agencies. This inventory identified considerable overlap between the Health Care Cost Information Systems and the Division of Facility and Provider Compliance in terms of collection and maintenance of aggregate data on hospitals. In order to consolidate data reporting and eliminate data that is no longer necessary, a Hospital Rules Work Group was formed, and Minnesota Rules, chapter 4650 was reopened.

The Hospitals Rules Work Group is addressing the following issues: developing a system whereby information will be reported to the Department of Health on a single report form; and exploring the feasibility of using data on the Medicare Cost Report for state uses, rather than having the hospital report the same data directly to the state.

One of the difficulties encountered in using federal reports for state reporting is that the Medicare Cost Report was designed as part of a reimbursement mechanism and, as such, excludes non-allowable expenses. In addition, the Medicare Cost Report provides data for a hospital complex whereas the Minnesota Revenue and Expense Report is facility-based. The Hospital Rules Work Group is considering whether data should be reported for the facility or the system, and is seeking to determine the importance and usefulness of hospital-specific data.

It was noted that changes in the licensing process or development of a consolidated licensure system relates closely to the data collection process. Such changes might serve as an impetus for a move from a facility-level to a systems level approach in data collection and maintenance.

Recommendation

A. The Rural Hospital Study Work Group recognizes the need for, encourages, and affirms the efforts of the Minnesota Department of Health Hospital Rules Work Group to streamline the collection of aggregate data from hospitals and other health care providers.

3. Utilization Review

Background

Utilization review is defined by Minnesota Statutes, section 62M.02, subdivision 20 as the "evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending physician, for the purpose of determining the medical necessity of the service or admission".

Utilization review activities began in the 1950's and were greatly influenced by the establishment of the Medicare program in 1965, which required hospitals to operate a utilization review program as a condition of participation. In 1972, professional standard review organizations (PSROs) were established as a Medicare cost containment measure. PSROs were replaced in 1982, by PROs which were required to conduct pre-admission or pre-procedure review for necessity and appropriateness of setting for ten different procedures. Two were set, with the remaining eight chosen from a list of eleven procedures (Minnesota Department of Health, October, 1995).

The complexity and prevalence of utilization review activities has increased steadily since the 1980s. In addition to the early requirements of utilization review, activities now include refining inpatient review services and expanding review activity to outpatient procedures as well as ancillary health care services (Woolsey, 1990 cited by Minnesota Department of Health, October 1995). In addition, the number and types of organizations conducting utilization review activities has increased. According to a 1989 report by the American Hospital Association, hospitals may deal with 50 to 250 organizations during prior and retrospective review (Field, 1989, cited by Minnesota Department of Health, October 1995).

Members of the Rural Hospital Study Work Group commented that the complexity of the utilization review requirement is exacerbated by the practice of providing criteria only after payment for a service is denied by either a public or private payer. This tends to create adversarial rather than cooperative relations between providers and payers. The utilization review act was amended in 1995 to require a utilization review organization to provide the criteria used for a specific procedure to any enrollee, attending physician, or provider who requests it.

Standardization of utilization review activities has been a concern of public and private organizations. In 1992, the Minnesota Utilization Review Act (Minnesota Statutes, chapter 62M) set minimum standards for all organizations that provide UR services for Minnesota residents effective January 1, 1993. *In 1994, MinnesotaCare legislation required the Commissioner of Health to study the feasibility of developing standard utilization review criteria for health care services.* As a result of this requirement, the Department of Health designed a study to review activities in Minnesota, including interviews with more than thirty individuals who represent organizations involved in utilization review activities. The study was designed to

report on the current status of the utilization review industry, to describe current activities in Minnesota, and to answer the following questions:

1) What are the trends, issues, and problems identified by those involved in utilization review?
2) Is there a need for further regulation and reform of utilization review activities?
3) What are the feasibility and utility of adopting standard utilization review criteria?

The final results of the study will be released in January 1996. Initial findings indicate that development of statewide standard review criteria is not feasible at this time. This is due to several factors including: 1) wide variations in utilization review activities and services which are subject to review; 2) the expense and time involved in developing criteria; and 3) the unavailability of detailed information on the costs and benefits of utilization review needed to arrive at an accurate estimate of the cost reductions which may be realized by standardized criteria.

Several Work Group members expressed concern that the utilization review concept itself is outdated in that it is built around a narrowly defined case-by-case approach to medical necessity rather than an outcome-based, process approach. Those members suggested that an alternative system to utilization review be explored.

Recommendation

A. The Rural Hospital Study Work Group will review the Minnesota Department of Health utilization review report when it is released for public comment, and will make comments and further recommendations to the Rural Health Advisory Committee and Minnesota Department of Health at that time.

4. Billing Uniformity

Background

In 1994, as part of MinnesotaCare legislation, the health care administrative simplification act (Minnesota Statutes, sections 62J.50, to 62J.61), was enacted. The primary purpose of the act is to reduce health care costs by "implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange". The impetus for this legislation was efforts of both public and private associations and groups in Minnesota and throughout the nation who had begun to design strategies to simplify administrative and reporting procedures in health care.

The administrative simplification act (ASA) addresses four areas: 1) establishment of uniform billing formats; 2) development of standard identifiers; 3) development of standard patient identification cards; and 4) implementation of electronic data interchange (EDI). In addition, the statute creates the Minnesota Center for Health Care Data Interchange (MCHE) to coordinate and make available information on EDI.

A. Uniform Billing Formats

The ASA requires that effective January 1, 1996, all Minnesota health care providers will be required to use uniform billing formats for medical, hospital, and dental bills using the forms HCFA 1500, HCFA 1450 (UB92) and the American Dental Association (ADA) Dental Claim Form. In September, the Commissioner of Health sent letters to providers outlining the requirements of the ASA.

A concern of the Work Group centers on Minnesota's Medicaid billing forms which are not yet fully consistent with the uniform billing process. Members suggested that the Minnesota Department of Human Services take the necessary steps to incorporate the Medicaid forms into the process as quickly and efficiently as possible.

B. Standard Identifiers and Standard Identification Cards

On and after January 1, 1998, all group purchasers and health providers in Minnesota will be required to use a unique identification number to identify health care provider organizations, individual providers, group purchasers, and patients. The ASA also requires development of a standard enrollee identification card. Minnesota Statutes, section 62J.60 of the ASA sets forth guidelines and requirements for the enrollee card.

The Department of Health has begun to convene work groups through the public notification process to develop the standard identifiers and consider which identifier systems would best fit Minnesota's needs.

The provider identifier, which will cover both hospitals and individual providers, will likely be the HCFA National Provider Identifier which will be implemented Medicare in 1996. The payer identifier currently written into law is a modification of the National Association of Insurance Commissioners identifier. However, HCFA has developed plans for a payer identifier as well. It will be a task of the work group to determine which of these, or other options, offers the best method of identification.

The Minnesota Department of Health expects that resolving personal privacy and other issues associated with development of standard identification numbers are likely to result in a longer implementation process. A work group to develop standard identifiers is slated to begin work in spring of 1996. Work Group members also expressed concern regarding privacy of patients and providers as EDI and identifiers are implemented. Kathleen Kuha, Principal Planner with the Department of Health, urged Work Group members to express their concerns during the public comment period or to become involved in the work groups reviewing each of the issues addressed in the ASA.

C. Electronic Data Interchange (EDI)

EDI is the translation of the information contained on a claim form into a string of numbers which describe each element of the data. The goal of EDI is to make medical business processes more uniform and efficient, which reduce costs to providers and payers, and ultimately to consumers. The ASA seeks to implement EDI standards that are nationally accepted, widely recognized, and available for immediate use. Standardized EDI data templates include:

- individual provider and hospital claims forms;
- payment forms (remittance advice);
- enrollment and eligibility forms;
- reduction in minor variations between formats.

Electronic billing is preferred by Medicare. According to a spokesperson for a Medicare intermediary, approximately 81 percent of all Part B (outpatient services) claims were filed electronically in October, 1995. A spokesperson for the intermediary in charge of processing Part A (inpatient hospital) claims, stated that in October, over 96 percent of all claims processed in Minnesota are electronically processed.

The Minnesota Center for Health Care Data Interchange has coordinated the process of developing EDI templates and implementation guides. An EDI advisory group consisting of payers, providers, public agencies, and vendors has met and developed a draft for the first implementation guide.

Rural Hospital Study Work Group members expressed agreement with the intent of the ASA, and commended the efforts of the work groups currently developing guidelines and protocols for implementation of the statutes' requirements.

Recommendation

A. The Rural Hospital Study Work Group strongly supports the need for, encourages, and affirms the efforts of the Minnesota Department of Health in carrying out the directives of the Administrative Simplification Act (Minnesota Statutes, chapter 62J, sections 50-61).

B. The Rural Hospital Study Work Group urges the Minnesota Department of Human Services to implement a standard billing practice which is more consistent with the billing practices of the federal Health Care Financing Administration and private payers.

Physician Supervision Requirements that Limit the Use of Physician Assistants

Problem Statement

Since the mid-1970s, health care cost and access have become increasing concerns, particularly in rural areas. One response to these concerns has been the development of non-physician providers commonly referred to as mid-level practitioners or physician extenders. This group of providers includes nurse practitioners, physician assistants (PAs), clinical nurse specialists, and certified nurse midwives.

Two cornerstones of the PAs practice is the physician-physician assistant agreement, and the principle that the PA practice under the supervision of a physician. Other mid-level practitioners-- nurse practitioners, for example, can practice independently (Colon, 1995). Under the original registration requirements for PAs, established in 1987, physician assistants were allowed to take patient histories, perform physical exams, interpret patient data, initiate diagnostic procedures, perform therapeutic procedures and instruct patients regarding medical care under the written authorization and delegation of a physician.

The amount and forms of physician supervision for PAs has been a concern since the beginning of PA registration. Requirements for frequent on-site physician supervision, particularly in remote areas of the state, were seen as barriers to access to care. *Due in part to these concerns the 1995 Legislature (Laws of Minnesota 1995, chapter 205) expanded the definition of physician supervision to allow off-site or remote supervision provided the terms of the physician-physician assistant agreement are being met.*

While the Laws of Minnesota 1995, chapter 205, removed many obstacles to the provision of care by a PA, criteria for reimbursement of PA services by third-party payers have not kept pace. Medicare and Medicaid, for example, still require substantial on-site supervision in many settings for reimbursement of services delivered by the PA. The Work Group determined this disparity between the supervision standards in the state practice act, and that which is necessary for reimbursement of services to be an obstacle to use of PAs in rural Minnesota.

Background

In 1986, the Office of Technology Assessment noted that because many mid-level practitioners, including PAs, are willing to locate in underserved areas, geographic access to care has been expanded. This finding is supported by the Minnesota Academy of Physician Assistants (MAPA), which estimates that of the 295 registered PAs in Minnesota, nearly one-third work in

communities of less than 20,000. Approximately 16 percent work in communities of less than 5,000 (Colon, 1995).

Mid-level practitioners are popular among both physicians and consumers. Physicians have increasingly looked to mid-level practitioners to provide health care services. Health care consultants estimate that mid-level practitioners can address 80-90 percent of the problems which result in office visits. The American Academy of Family Physicians (AAFP) estimates that approximately 30 percent of its members employ mid-level practitioners. A 1993 Gallup poll found that 86 percent of consumers are willing to see an advanced practice nurse for basic health care. (Glazer, 1994).

Physician Supervision

The official policy statements of the American Academy of Physician Assistants (AAPA), as well as the American Medical Association and the AAFP stress the importance of maintaining physician oversite and responsibility for the care delivered by the PA.

A focus of Minnesota Rules, parts 5600.2600 to 5600.2670, governing PA registration was the physician-PA practice agreement. Minnesota Rules, part 5600.2620, governing supervision, required that the PA and the supervising physician comply with the following criteria:

A. A supervising physician must be able to be contacted within 15 minutes either in person or by telecommunication for consultation with the assistant.
B. A supervising physician shall review and evaluate patient services provided by the physician assistant on a daily basis from information in patient charts or records. Review may either be in person or by telecommunication.
C. A supervising physician shall be on site at facilities staffed by a physician assistant if they are separate from the usual practice site of the supervising physician at least twice a week for at least eight hours a week during patient contact time.
D. A supervising physician may not supervise more than two physician assistants.
E. The prescribing, administering, and dispensing of legend drugs shall only be done in accordance with Minnesota Statutes, chapters 151 to 152.
F. The physician assistant and supervising physician shall ensure that an alternate physician is available to supervise if the supervising physician is absent.

The rules created concerns among PAs as well as physicians that the scope of practice and supervision requirements were too restrictive and created barriers to access in greater Minnesota. The 15-minute time requirement to contact the supervising physician for consultation, and the need for the supervising physician to provide on-site supervision at a satellite clinic at least twice a week for eight hours a week were seen as particularly restrictive in medically underserved areas (Minnesota Department of Health, 1990).

Over the course of several years, a number of changes in rules and statute expanded the scope of the PAs practice. Laws of Minnesota 1995, chapter 205, put the scope of practice and registration requirements into statutory language. While broadening the definition of supervision, the session law retains physician oversite and responsibility for the care provided. The physician-PA agreement remains the cornerstone of care delivery by the PA. *"Supervision" is defined in Minnesota Statutes, section 147A.01 subdivision 24, and referenced in Laws of Minnesota 1995, chapter 205, as "overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of supervision shall be defined by the individual physician-physician assistant agreement".*

Work Group members agreed that PA and physician practice roles are a dynamic relationship, and that changes made in regarding physician supervision of PAs are appropriate. Work group members also agreed that physician oversite and responsibility for the care provided by the PA should remain in place. Work Group concerns focused on the contrasts between supervision requirements of Minnesota Statues Chapter 147A, referenced in Laws of Minnesota 1995, chapter 205,, and those of current Medicaid and Medicare regulations.

Medicaid Definitions of Supervision

Although Minnesota Statutes, chapter 147A referenced in Laws of Minnesota 1995, chapter 205, allows for greater latitude in physician supervision of physician assistants, Minnesota Department of Human Services Rule, part 9505.0175, subpart 46 governing Medicaid payments of physician extenders requires the following conditions of supervision to be met:

A. The provider must be present and available on the premises more than 50 percent of the time when the supervisee is providing health services.
B. The diagnosis must be made by or reviewed, approved, and signed by the provider.
C. The plan of care for a condition other than an emergency may be developed by the supervisee, but must be reviewed, approved and signed by the provider before care is begun.
D. The supervisee may carry out the treatment but the provider must review and countersign the record of treatment within five working days after the treatment.

Medicare Definitions of Physician Supervision

Medicare allows reimbursement of care provided by physician assistants under several different levels of supervision. Services provided in an office or clinic other than a Federal Rural Health Clinic or a rural Health Personnel Shortage Area (HPSA) must be **"incident to"** physician services. "Incident to" is defined as: services furnished as an integral part of the physician's personal professional service and must meet the following criteria:

- The physician performs an initial service and subsequent services of frequency which reflects his/her active participation in management of a course of treatment;
- The physician must be on the premises and available to render medical care at all times when services are provided;
- There must be a valid employment agreement between the physician and the employee;
- The service performed must be with in the scope of practice of the PA.

Clinic services provided in a Federal Rural Health Clinic or rural HPSA may be provided under **"general supervision"** which defines the physician as primarily responsible for the overall direction and management of the PA's activities however he/she does not need to be on site. The physician supervisor must be available immediately by phone for consultation. Skilled nursing facility services also allow general supervision by the physician. The following table summarizes Medicare and Medicaid supervision requirements in various practice settings

Medicaid and Medicare Definitions of Supervision

COMPARISON OF MEDICAID AND MEDICARE SUPERVISION REQUIREMENTS FOR PHYSICIAN EXTENDERS		
SETTING	**MEDICAID**	**MEDICARE**
Long Term Care Facilities	Service must be provided under the direction of a physician who is a provider	General Supervision unless otherwise mandated by state law
Hospital	Physician must be present and available on the premises more than 50% of the time	Same as above
Office/Clinic	Same as Above	Services provided incident to physician services unless otherwise mandated by state law
Federally Certified Rural Health Clinic	Same as Above	On-site physician supervision not required unless mandated by state law
Office/Clinic if in Health Professional Shortage Area	Same as Above	Same as above

Concerns of Work Group members focused primarily on the contrasts between supervision requirements of the Laws of Minnesota 1995, chapter 205, and those of current Medicaid and Medicare regulations and the policy of private payers. *State Medicaid rules require supervision by the physician 50 percent of the time while care is being delivered by the PA in a clinic or hospital setting. The Medicaid requirement restricts the use of PAs and their ability to practice in accordance with Minnesota Statutes, Chapter 147A. State Medicaid regulations also require that the plan of care to be provided by the PA must be approved by the supervising physician prior to commencement of treatment.* It was noted by the Work Group that in many clinical settings, particularly in rural Minnesota, this is difficult to achieve, and adds time and cost to patient care. Furthermore, group members indicated this pre-approval is often unnecessary in primary health care, such as

treating routine ailments or conducting scheduled physical examinations. It was also noted that the primary purpose of mid-level practice is to provide routine primary care to free up physician resources. This requirement works counter to that goal.

Concerns about Medicare reimbursement regulations were voiced by Work Group members as well. It was noted that a large proportion of rural Minnesota residents are Medicare recipients, and as such rural hospitals and clinics rely heavily on Medicare reimbursement. *Although Medicare regulations are federal, Work Group members noted that with the current debate in Congress over Medicare restructuring, states may be given more latitude in defining conditions and levels of reimbursement in the future.*

No extensive data is available regarding the levels of supervision required by private health plans. However, initial data gathered from several major health plans shows some variance in the supervision levels required for reimbursement of PA or other mid-level practitioner services in hospital settings. Health plan policies range from those with no specific time requirements for physician supervision to requirements of 50 percent or more on-site supervision.

Rates of reimbursement for primary care mid-level practitioners was a related concern of the Work Group. Generally the services of PAs, nurse practitioners, clinical nurse specialists, and nurse midwives are reimbursed at lower rates than physicians services by both Medicare and Medicaid. In addition, the rates vary depending on the setting in which the service is performed. There was discussion in the group that such public policies may influence private insurers to discount the services of mid-level practitioners, which in turn could create additional financial barriers to their use in offices, clinics, hospitals, nursing facilities, and skilled nursing facilities. Further discussion of reimbursement rate issues was deferred to the 1996 Work Group meetings.

Recommendation

The Rural Hospital Study Work Group recommends that the Minnesota Departments of Health and Human Services require that Medicaid, private insurers, health plans, and other accident or sickness insurance may not deny reimbursement for the services of a physician assistant based on stricter supervision standards than those set forth in the state practice act.

A. The Rural Hospital Study Work Group recommends that the Department of Human Services revise its policy on supervision of physician assistants as stated in Minnesota Rule, part 9505.0175, subpart 46, to reflect the changes in supervision requirements set out in Minnesota Statutes, section 147A.20, and referenced in Laws of Minnesota 1995, chapter 205.

B. The Rural Hospital Study Work Group recommends that the Legislature amend Minnesota Statutes, section 62A.15 to mandate that a carrier may not deny benefits for services of a PA if performed within the scope of practice set out in Minnesota Statutes, section 147A.09 and under the supervision requirements set forth by Minnesota Statutes, section 147A.01, subdivision 24, and section 147A.20, and referenced in Laws of Minnesota 1995, chapter 205. Proposed statutory language for this recommendation is attached in Appendix A.

C. The Rural Hospital Study Work Group recommends that the Minnesota Departments of Health and Human Services monitor federal legislative actions, and if states are given more latitude in the conditions and levels related to Medicare reimbursement, provide flexibility in the physician assistant supervision requirements for Medicare reimbursement, using the language in Minnesota Statutes, section 147A.01, and referenced in Laws of Minnesota 1995, chapter 205, as the guiding principle.

The Requirement That a Hospital and its Attached Nursing Home Have Separate Directors of Nursing

Problem Statement

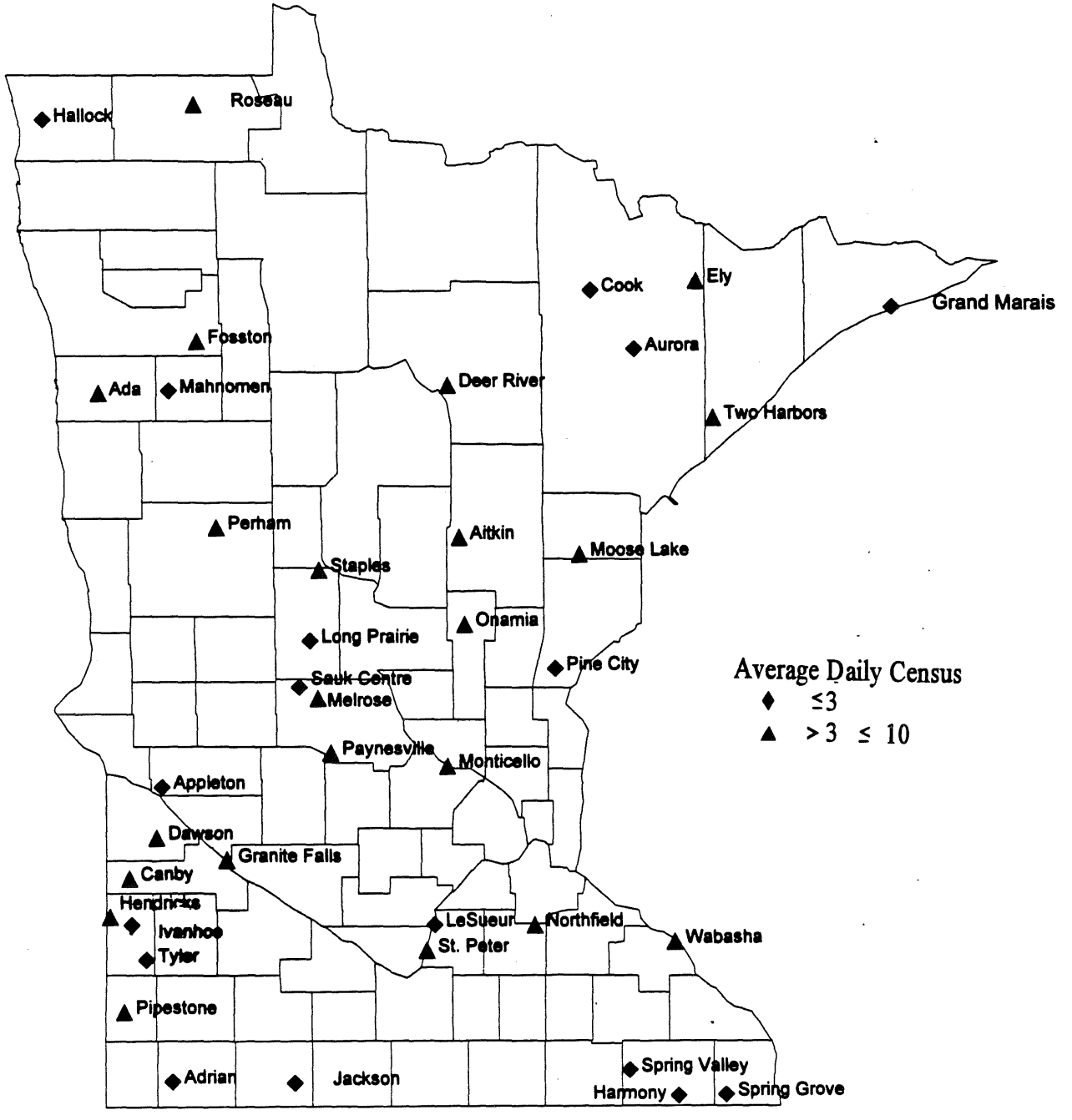
Health care administrators and providers have indicated that the requirement that a hospital and its attached nursing home have separate directors of nursing increases administrative costs. A number of the administrators who responded to the structured interviews, for example, indicated that if a hospital and its attached nursing home could share a director of nursing, personnel costs could be lowered while improving the flow of information between the two facilities. Administrators as well as Work Group members indicated that shared directors of nursing make sense from both financial and quality of care aspects particularly in cases when a hospital with attached nursing home has an average daily census of less than three patients.

It is possible now for hospitals with attached nursing homes to share a director of nursing by obtaining a series of waivers from the state and federal government. Administrators have indicated, however, that the process of obtaining waivers of this requirement are complex and create additional administrative burdens. In addition, the waiver process is not well known among administrators. The Work Group took a two-pronged approach to this issue. The first was an exploration of the current state and federal waiver process. The second was to develop alternative statutory language to provide facilities with greater latitude in determining whether conditions were appropriate to share directors of nursing between a hospital and attached nursing home.

Background

Currently, 52 (47%) of the 111 hospitals in Greater Minnesota, and outside the cities of Duluth and Rochester, have attached nursing homes. A nursing home is considered attached for licensure purposes if the nursing home is operated in conjunction with the hospital and there is a direct physical connection which permits the movement of patients and provision of services between the hospital and nursing home without going outside the building or buildings involved. Over three-quarters of the of hospitals with attached nursing homes have an average daily census of ten or fewer patients, according to 1993 Minnesota Department of Health statistics. Twenty-two (42%) have an average daily census of more than three, but less than or equal to ten patients, and 17 hospitals (33%) have an average daily census three or fewer patients. A map of rural Minnesota hospitals with attached nursing homes, which have an average daily census of ten or less follows.

Minnesota Rural Hospitals with Attached Nursing Homes and Average Daily Census of < = 10



Office of Rural Health & Primary Care
Minnesota Department of Health, 1995

Hospital and Nursing Home Staffing Requirements

Licensure of nursing homes in Minnesota began in the 1940s. With the establishment of the federal Medicare program in 1965, nursing homes became subject to conditions of participation and federal standards as well. Reforms in Medicare requirements for nursing homes were initiated by the Federal Omnibus Budget Reconciliation Act (OBRA) of 1987 and added technical amendments in the 1990 OBRA. Regulatory changes brought about by the two acts centered on ensuring patient rights and quality of care. (CCH-CD ROM Med-Guide 14,751 Nursing Facility and Skilled Nursing Facility Participation Requirements, 1995)

Requirements for nursing staff coverage and competencies were among the OBRA provisions which addressed quality of care. These requirements included:

- *Facilities must have 24-hour nursing capability, including a registered nurse at least eight consecutive hours per day seven days per week unless a waiver is obtained.*
- *The facility must designate a registered nurse to serve as a director of nursing on a full time basis unless a waiver is obtained.*

State rules governing nursing homes also require that a nursing home must have a director of nursing services who is a registered nurse, and that the director must be employed full time which is defined in rule as no less than 35 hours per week (Minnesota Rules, part 4658.0500). Minnesota nursing home rules also provide a waiver process, which is detailed on the following page.

State hospital licensing surveys follow the guidelines set by the Health Care Financing Administration (HCFA) regarding nursing staff. Those guidelines state that the hospital must have an organized nursing service, and provide 24-hour nursing care. The nursing services must be furnished or supervised by a registered nurse (482.23). Although a full-time director of nursing is not required, the hospital must be staffed with adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care to all patients as needed. In addition, there must be supervisory and staff personnel for each department to ensure the immediate availability of a registered nurse for the bedside care of any patient (482.23b).

In addition to applying for and receiving a state waiver, the facility must obtain a waiver from HCFA, which administers the Medicare program. A waiver of the full-time director of nursing in a nursing home is granted through a waiver of either the requirement to provide licensed nurses on a 24-hour basis or a waiver of the requirement to provide the services of a registered nurse for more than 40 hours a week.

Comparison of Medicare Hospital and Nursing Home Staffing Requirements		
	HOSPITAL	**SKILLED NURSING FACILITY**
COMPETENCIES	The director of nursing services must be a licensed registered nurse	The director of nursing services must be a licensed registered nurse trained and/or experienced in nursing administration, or psychiatric or geriatric nursing
REQUIRED HOURS PER WEEK	The hospital must provide 24-hour nursing services furnished or supervised by a RN, and have a licensed practical nurse or an RN on duty at all times except for rural hospitals which have in effect a 24- hour nursing waiver.	The director of nursing must be available a minimum of 40 hours per week and devote full time to the nursing service of the facility. Two nurses may share the director of nursing duties but the total hours per week must equal 40. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
OTHER RELATED STAFFING CRITERIA	There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of an RN for bedside care of any patient. A RN must supervise and evaluate nursing care for each patient.	Must provide 24-hour staffing to provide nursing care to all residents Facility must use services of an RN for at least 8 consecutive hours a day, 7 days a week

The Waiver Process

As was indicated earlier, both state rules and federal Medicare regulations allow for waiver of the full-time director of nursing requirement in the nursing home. All state nursing home rules may be waived. The waiver process is initiated by the institution applying for a waiver with the Minnesota Department of Health under Minnesota Rules part 4658.0040, subpart 1. The waiver request must contain:

A. the specific part or parts for which the variance or waiver is requested;
B. the reasons for the request;
C. the alternative measures that will be taken if a variance or waiver is granted;
D. the length of time for which the variance or waiver is requested; and
E. other relevant information necessary to properly evaluate the request for the variance or waiver.

In reviewing the application, the state evaluates the following criteria:

A. whether the variance or waiver adversely affects the health, treatment, comfort, safety, or well-being of a resident;

B. whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in this chapter; and

C. whether compliance with the part or parts would impose an undue burden upon the applicant.

Waivers granted by the State of Minnesota have an indefinite term, whereas waivers granted by Medicare must be renewed annually.

The duplicative process of obtaining separate waivers for a full-time director of nursing at both the state and the federal level was another prime concern of the Work Group. Although a shared director of nursing between a hospital and an attached nursing home is possible, state and federal waiver processes require a number of steps which are confusing. There is not a single mechanism by which a facility can apply for a waiver, but rather a matrix of state and federal waiver requirements. In addition, several members indicated that hospital and nursing home administrators are often not aware that a waiver is even possible, and that efforts should be made to provide information regarding the waiver process to administrators.

Language outlining the conditions of each waiver is often unclear or conflicting. An example raised by group members is that the need for a facility to demonstrate that it is experiencing difficulties in recruiting nurses is unclear. For example, a small hospital, with an average daily census of less than three that is experiencing excess costs and difficulties staffing both the hospital and nursing home could benefit from a waiver of the full-time director of nursing requirement. However, under waiver regulations, it may be less likely that such a hospital will qualify for a waiver for precisely the reasons why it would benefit from a shared director of nursing--that it is unable to provide 40-hours per week of RN staffing in the nursing home or that it is unable to recruit appropriate nursing staff.

FEDERAL NURSING HOME WAIVER REQUIREMENTS		
Waiver	**24-hour Licensed Nursing Requirement**	**RN Providing Services 8 hours/day 7 days/wk**
Terms	If Medicaid certified only, the state has granting authority . If dually - participating, HCFA has delegated granting authority. Subject to annual review by the state.	HCFA granted waiver authority to nursing homes. Reviewed annually.
Criteria	- facility demonstrates to the satisfaction of the state that it has been unable to recruit appropriate personnel - State determines that a waiver will not endanger the health or safety of individuals staying in the facility; - RN or physician is available and obligated to respond immediately by telephone to calls from the facility .	- facility is located in a rural area and supply of nursing home services in the area is not sufficient to meet the needs of individuals residing in the area. - facility has 40-hours/wk of RN staffing either by one nurse or by two or more RN s working part time. RN may or may not be the director of nursing - facility has EITHER only patients whose physician has indicated, in writing, that they do not require the services of an RN or physician for a 40 hour period or - an RN or physician will provide necessary clinical services to residents when a regular full-time RN is not on duty

Current waiver requirements do not address size of either the hospital or nursing home. Work Group members expressed the importance of size in influencing the kinds and numbers of responsibilities required of directors of nursing. Several members indicated the belief that shared directors of nursing are particularly appropriate in cases where a hospital has an average daily census of three or less, and the attached nursing home has sixty or fewer beds.

A representative of the Department of Health's Division of Facility and Provider Compliance reported that currently no nursing home in Minnesota has a waiver in place for the full time director of nursing. There is one waiver in place for the 24-hour nursing care requirement. She emphasized that quality of care is the overriding criteria by which surveyors review waiver applications. For example, one waiver request was recently denied due to a large number of deficiencies in the nursing home. Group members agreed that the emphasis on providing quality care to patients should continue to receive the emphasis that state and federal regulators place on waiver applications. However, it was pointed out that a shared director of nursing may improve care by making the flow of information between facilities more efficient, and allowing administrators in a hospital or nursing home with a high level of quality to share their strategies more easily with an attached facility.

Several Work Group members indicated that current rules should be relaxed to allow rural facilities to weigh the resources available and the demands on those resources to determine the course which works best for their particular situation.

Statutes Regarding Shared Nursing Home/Hospital Administrators

Minnesota statute currently allows a nursing home to employ as its administrator the administrator of a licensed hospital if the total combined beds of the nursing home and hospital is 150 or less and are located within a mile of each other. A nursing home which is located in a facility licensed as a hospital may employ the administrator of the hospital as its administrator if the individual meets minimum education and long term care experience criteria set by rule of the commissioner of health.

Work group members suggested that rather than revise the waiver process at the state level, rules should be revised to allow shared directors of nursing in the same manner shared administrators are now allowed. It was also suggested by Work Group members that the feasibility of an alternative licensing mechanism to address shared services between hospitals and attached nursing homes be explored in future meetings.

Recommendation

A. The Rural Hospital Study Work Group recommends that the Legislature amend Minnesota Statutes, section 144A.04, subdivision 7, to supersede Minnesota Rules, part 4658.0500, subpart 2, to allow a director of nursing in a nursing home to also serve as the director of nursing of a physically attached hospital under the following conditions: 1) the hospital has an average daily census of less than or equal to ten patients in the most recent reporting year for which data is available; 2) the combined beds of the hospital and nursing home are less than or equal to 100; and 3) the management of the two facilities is under the control and direction of the same governing body. Proposed statutory language for this recommendation is attached in Appendix A.

B. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health disseminate to all eligible hospitals in rural Minnesota information about the Health Care Financing Administration waiver process that enables hospitals with attached nursing homes to share directors of nursing.

C. The Rural Hospital Study Work Group recommends that the Minnesota Department of Health monitor federal legislative action, and if states are given more latitude in the regulation and surveying of hospitals or if an alternative licensing model is developed, consider flexible staffing guidelines that would allow hospitals and nursing homes to share directors of nursing when appropriate.

Conclusion

Throughout the review of these five regulatory issues, the changing landscape of federal health care legislation was a topic of concern. Currently, Congress is considering a number of measures, including an overhaul of Medicare and a re-structuring of Medicaid payment mechanisms to states. There is a possibility that through this legislation, states will be granted a greater latitude in determining the mechanisms for regulating health care facilities and programs and the type and level of reimbursement. As a result of the Work Group's concern for timely action by the state regarding federal policy changes, an additional recommendation was adopted.

Recommendation

A. The Rural Hospital Study Work Group recommends the Minnesota Department of Health bring to the attention of the state's federal congressional delegation the multitude of concerns addressed in this report about regulatory barriers to rural health care delivery.

On December 5, 1995, a draft of the report and recommendations of the Rural Hospital Studies Work Group was reviewed by the Rural Health Advisory Committee (RHAC). The RHAC unanimously endorsed the recommendations of the Work Group.

A primary concern of the RHAC is that prompt action be taken by the appropriate state agencies in drafting legislation on the recommendations of the Work Group. As a result, the committee recommended that this report be submitted to the Commissioner of Health as early as possible, so that legislation may be submitted in time to have the Legislature act on it in the 1996 session.

In addition, the RHAC recommended that this report be distributed as a means to continue to identify and gain input on barriers to rural health care access in Minnesota. The Committee added that it welcomes discussion about the issues presented in this report, as well as other issues which have an impact on rural health care delivery.

Recommendation

A. The Rural Health Advisory Committee recommends that the report and recommendations of the Rural Hospital Study Work Group be submitted to the Commissioner of Health, with draft legislative language incorporating the appropriate recommendations, and that the Commissioner draft a bill containing the recommendations for legislation herein by January 16, 1996.

B. The Rural Health Advisory Committee recommends that copies of this report, Regulatory Barriers to Rural Health Care be distributed to all interested professional associations, including those represented on the Rural Hospital Studies Work Group and the Rural Health Advisory Committee, and to the Regional Coordinating Boards. In distributing this report, the RHAC encourages continued discussion on barriers in rural health care access, and recommends that regulatory issues not addressed in this report be forwarded to the RHAC for further consideration and/or action.

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APPENDIX A

Proposed Statutory Language Addressing Recommendations of the Rural Hospital Study Work Group

Proposed Statutory Language Addressing the Recommendations of the Rural Hospital Study Work Group

Section Four: State and Federal Inspection and Regulatory Requirements That Are Duplicative and Increase Administrative Costs

Licensing and Certification

A. To reflect the changes in the health care marketplace and the increasing integration of health care facilities, the Rural Hospital Study Work Group recommends that the Minnesota Department of Health adopt a systems-level approach toward licensing, certifying, and surveying health care facilities.

The Rural Hospital Study Work Group recommends that the legislature enact the following proposed statutory language:

The Minnesota Department of Health shall develop a single licensure system for a health care system incorporating multiple components, including but not limited to a hospital, ambulance, nursing home, hospice, or home health care services, under common ownership. Such a licensure system shall recognize the ability to pool administrative resources such as record keeping, assessment, and administrative staff, and may consider the size and services of the facility in making a determination. In coordination with the development of a single licensure system, the Minnesota Department of Health will develop corresponding data reporting requirements which coordinate the data reporting requirements for all components within the single license.

The Commissioner of Health and the Emergency Medical Services Regulatory Board will coordinate the licensure of a health care system's ambulance service issued by the Board with the health care system's license issued by the Commissioner. The Board shall promulgate a rule change to allow a health system based ambulance service license to be coordinated biannually with the health system license issued by the Commissioner by July 1, 1997.

Section Five: Physician Supervision Requirements That Limit the Use of Physician Assistants

General Recommendation

The Rural Hospital Study Work Group recommends that the Minnesota Departments of Health and Human Services require that Medicaid, private insurers, health plans, and other accident or sickness insurance may not deny reimbursement for the services of a physician assistant based on stricter supervision standards than those set forth in the state practice act.

Related Statutes:

Minnesota Statutes section 147A.01, subdivision 24. Supervision. "Supervision" means overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the supervising physician and physician assistant are or can be easily in contact with one another by radio, telephone, or other telecommunication device. The scope and nature of the supervision shall be defined by the individual physician-physician assistant agreement.

Minnesota Statutes section 147A.20. Physician and physician assistant agreement.

(a) A physician assistant and supervising physician must sign an agreement which specifies scope of practice and amount and manner of supervision as required by the board. The agreement must contain:

(1) a description of the practice setting;
(2) a statement of practice type/specialty;
(3) a listing of categories of delegated duties; and
(4) a description of supervision type, amount, and frequency.

(b) The agreement must be maintained by the supervising physician and physician assistant and made available to the board upon request. If there is a delegation of prescribing, administering, and dispensing of legend drugs, controlled substances, and medical devices, the agreement shall include an internal protocol and delegation form. Physician assistants shall have a separate agreement for each place of employment. Agreements must be reviewed and updated on an annual basis. The supervising physician and physician assistant must maintain the agreement, delegation form, and internal protocol at the address of record. Copies shall be provided to the board upon request.

(c) Physician assistants must provide written notification to the board within 30 days of the following:

(1) name change;
(2) address of record change;

(3) telephone number of record change; and
(4) addition or deletion of alternate supervising physician provided that the information submitted includes, for an additional alternate physician, an affidavit of consent to act as an alternate supervising physician signed by the alternate supervising physician.

(d) Modifications requiring submission prior to the effective date are changes to the practice setting description which include:
(1) supervising physician change, excluding alternate supervising physicians; or
(2) delegation of prescribing, administering, or dispensing of legend drugs, controlled substances, or medical devices.
HISTORY: 1995 c 205 art 1 s 19

Recommendation Part B:

The Rural Hospital Study Work Group recommends that the Minnesota Department of Health amend Minnesota Statutes Section 62A.15 as follows.

62A.15 Licensed health professional services in accident and health and nonprofit health service policies.

Subdivision 1. Applicability. The provisions of this section apply to all group policies or subscriber contracts providing payment for care in this state, which are issued by accident and health insurance companies regulated under this chapter and nonprofit health service plan corporations regulated under chapter 62C.

Subdivision 2. Chiropractic services. All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure.

This subdivision is intended to provide equal access to benefits for insureds and subscribers who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in these policies or contracts.

Subdivision 3. Optometric services. All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include optometric treatment and services of an optometrist to the extent that the optometric services and treatment are within the scope of optometric licensure.

This subdivision is intended to provide equal payment of benefits for optometric treatment and services and is not intended to change or add to the benefits provided for in those policies or contracts.

Subdivision 3a. Nursing services. All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a duly licensed physician must include services provided by a registered nurse who is licensed pursuant to section 148.171 and who is certified by the profession to engage in advanced nursing practice. "Advanced nursing practice" means the performance of health services by professional nurses who have gained additional knowledge and skills through an organized program of study and clinical experience preparing nurses for advanced practice roles as nurse anesthetists, nurse midwives, nurse practitioners, or clinical specialists in psychiatric or mental health nursing. The program of study must be beyond the education required for registered nurse licensure and must meet criteria established by the professional nursing organization having authority to certify the registered nurse in advanced nursing practice. For the purposes of this subdivision, the board of nursing shall, by rule, adopt a list of professional nursing organizations which have the authority to certify nurses in advanced nursing practice.

This subdivision is intended to provide payment of benefits for treatment and services by a licensed registered nurse certified in advanced nursing practice as defined in this subdivision and is not intended to add to the benefits provided for in these policies or contracts.

Subdivision 3b All benefits provided by a policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a duly licensed physician must include services provided by a physician assistant who is registered pursuant to Minnesota Statutes section 147A as referenced in Laws of Minnesota, 1995, Chapter 205. and who is certified by the profession to engage in physician assistant practice and who is practicing within the scope of practice and supervision requirements defined in Minnesota Statutes section 147A.01 subdivision 24, Minnesota Statutes section 147A.20, and Minnesota Statutes section 147A.09.

This subdivision is intended to provide payment of benefits for treatment and services by a physician assistant as defined in this subdivision and is not intended to add to the benefits provided for in these policies or contracts.

Subdivision. 4. Denial of benefits. (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, licensed optometrist, or a registered nurse meeting the requirements of subdivision 3a, or a registered physician assistant.

HISTORY: 1973 c 252 s 1; 1976 c 192 s 1,2; 1976 c 242 s 1; 1983 c 221 s 2; 1988 c 441 s 1; 1988 c 642 s 2-4; 1989 c 330 s 13,14

Related Statute:

Minnesota Statutes section 147A.09 Scope of practice, delegation.
Subdivision 1. Scope of practice. Physician assistants shall practice medicine only with physician supervision. Physician assistants may perform those duties and responsibilities as delegated in the physician-physician assistant agreement and delegation forms maintained at the address of record by the supervising physician and physician assistant, including the prescribing, administering, and dispensing of medical devices and drugs, excluding anesthetics, other than local anesthetics, injected in connection with an operating room procedure, inhaled anesthesia and spinal anesthesia.
Patient service must be limited to:

(1) services within the training and experience of the physician assistant;
(2) services customary to the practice of the supervising physician;
(3) services delegated by the supervising physician; and
(4) services within the parameters of the laws, rules, and standards of the facilities in which the physician assistant practices.

Nothing in this chapter authorizes physician assistants to perform duties regulated by the boards listed in section 214.01, subdivision 2, other than the board of medical practice, and except as provided in this section.

Subdivision. 2. Delegation. Patient services may include, but are not limited to, the following, as delegated by the supervising physician and authorized in the agreement:

(1) taking patient histories and developing medical status reports;
(2) performing physical examinations;
(3) interpreting and evaluating patient data;
(4) ordering or performing diagnostic procedures;
(5) ordering or performing therapeutic procedures;
(6) providing instructions regarding patient care, disease prevention, and health promotion;
(7) assisting the supervising physician in patient care in the home and in health care facilities;
(8) creating and maintaining appropriate patient records;
(9) transmitting or executing specific orders at the direction of the supervising physician;

(10) prescribing, administering, and dispensing legend drugs and medical devices if this function has been delegated by the supervising physician pursuant to and subject to the limitations of section 147.34 and chapter 151. Physician assistants who have been delegated the authority to prescribe controlled substances shall maintain a separate addendum to the delegation form which lists all schedules and categories of controlled substances which the physician assistant has the authority to prescribe. This addendum shall be maintained with the physician-physician assistant agreement, and the delegation form at the address of record;
(11) for physician assistants not delegated prescribing authority, administering legend drugs and medical devices following prospective review for each patient by and upon direction of the supervising physician; (12) functioning as an emergency medical technician with permission of the ambulance service and in compliance with section 144.804, subdivision 2, paragraph (c), and ambulance service rules adopted by the commissioner of health; and
(13) initiating evaluation and treatment procedures essential to providing an appropriate response to emergency situations.
Orders of physician assistants shall be considered the orders of their supervising physicians in all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services.
HISTORY: 1995 c 205 art 1 s 9

Section Six: The Requirement That a Hospital and Its Attached Nursing Home Have Separate Directors of Nursing

A. The Rural Hospital Study Work Group recommends that the Legislature amend Minnesota Statutes 144A.04 subdivision 7, to provide for a nursing home to share directors of nursing with an attached hospital under certain conditions.

Subdivision. 7. Minimum nursing staff requirement. Notwithstanding the provisions of Minnesota Rules, part 4655.5600, the minimum staffing standard for nursing personnel in certified nursing homes is as follows:
(a) The minimum number of hours of nursing personnel to be provided in a nursing home is the greater of two hours per resident per 24 hours or 0.95 hours per standardized resident day.
(b) For purposes of this subdivision, "hours of nursing personnel" means the paid, on-duty, productive nursing hours of all nurses and nursing assistants, calculated on the basis of any given 24-hour period. "Productive nursing hours" means all on-duty hours during which nurses and nursing assistants are engaged in nursing duties. Examples of nursing duties may be found in Minnesota Rules, parts 4655.5900, 4655.6100, and 4655.6400. Not included are vacations, holidays, sick leave, in-service classroom training, or lunches. Also not included are the nonproductive nursing hours of the in-service training director. In homes with more than 60 licensed beds, the hours of the director of nursing are excluded. "Standardized

resident day" means the sum of the number of residents in each case mix class multiplied by the case mix weight for that resident class, as found in Minnesota Rules, part 9549.0059, subpart 2, calculated on the basis of a facility's census for any given day. For the purpose of determining a facility's census, the commissioner of health shall exclude the resident days claimed by the facility for resident therapeutic leave or bed hold days.

(c) Calculation of nursing hours per standardized resident day is performed by dividing total hours of nursing personnel for a given period by the total of standardized resident days for that same period.

(d) A nursing home that is issued a notice of noncompliance under section 144A.10, subdivision 5, for a violation of this subdivision, shall be assessed a civil fine of $300 for each day of noncompliance, subject to section 144A.10, subdivisions 7 and 8.

Subdivision 7a. Director of nursing. Except as otherwise provided by this subdivision, a nursing home must have a director of nursing services employed full time, no less than 35 hours per week, and assigned full time to the nursing services of the home. The director of nursing of a nursing home may also serve as the director of nursing of a physically attached hospital under the following conditions: (1) the hospital has an average daily census of less than or equal to ten patients in the most recent reporting year for which data is available; (2) the total combined beds of the hospital and nursing home are less than or equal to 100; and (3) the management of the two facilities is under the control and direction of the same governing body.

Related Rule

Rules Relating to Licensing, Administration, and Health Services in Licensed Nursing Homes
Minnesota Rules 4658.0500 DIRECTOR OF NURSING SERVICES.

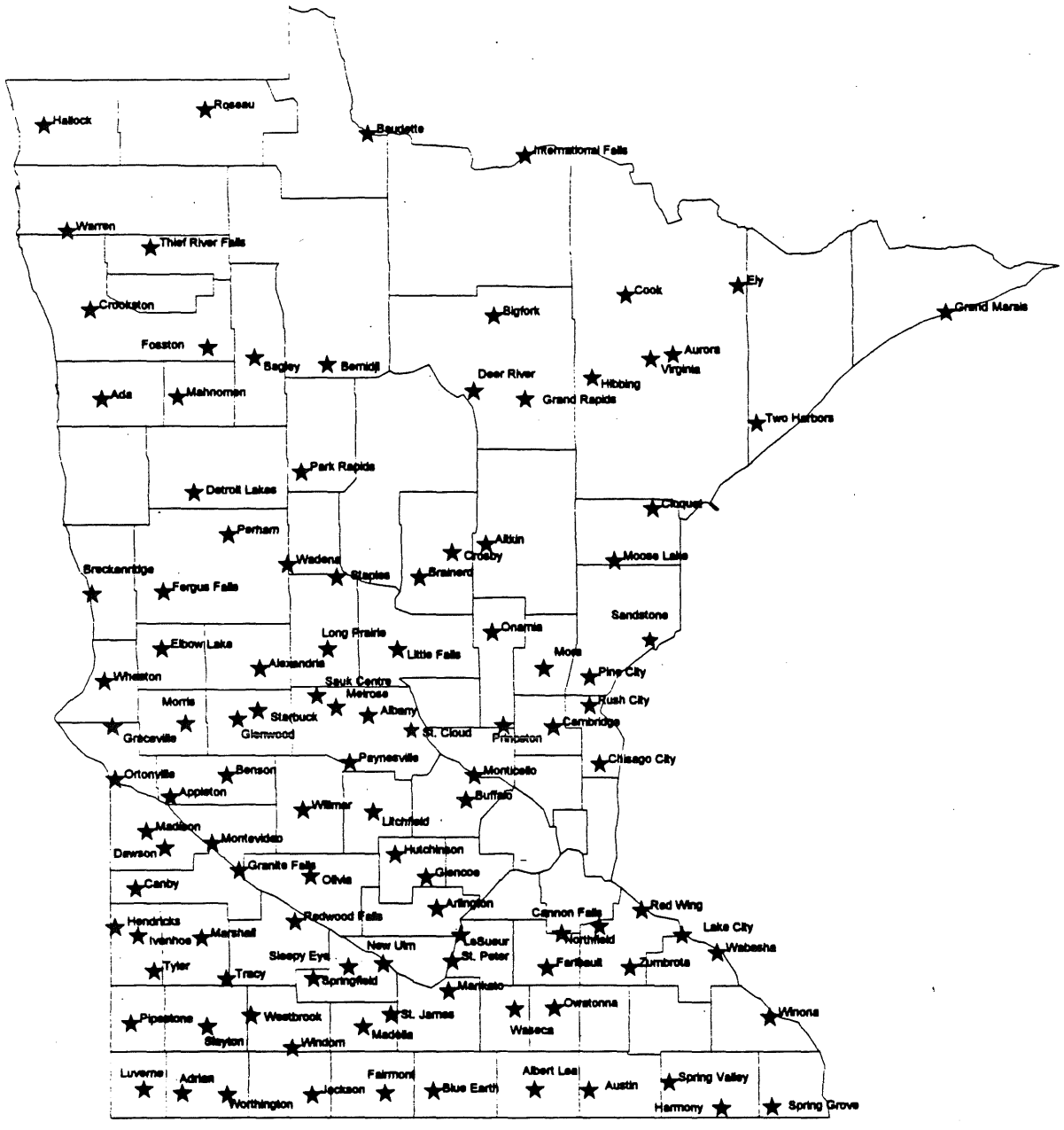
Subpart 2. **Requirement of full-time employment.** A director of nursing services must be employed full time, no less than 35 hours per week, and be assigned full time to the nursing services of the nursing home.

APPENDIX B

Rural Minnesota Hospital Maps

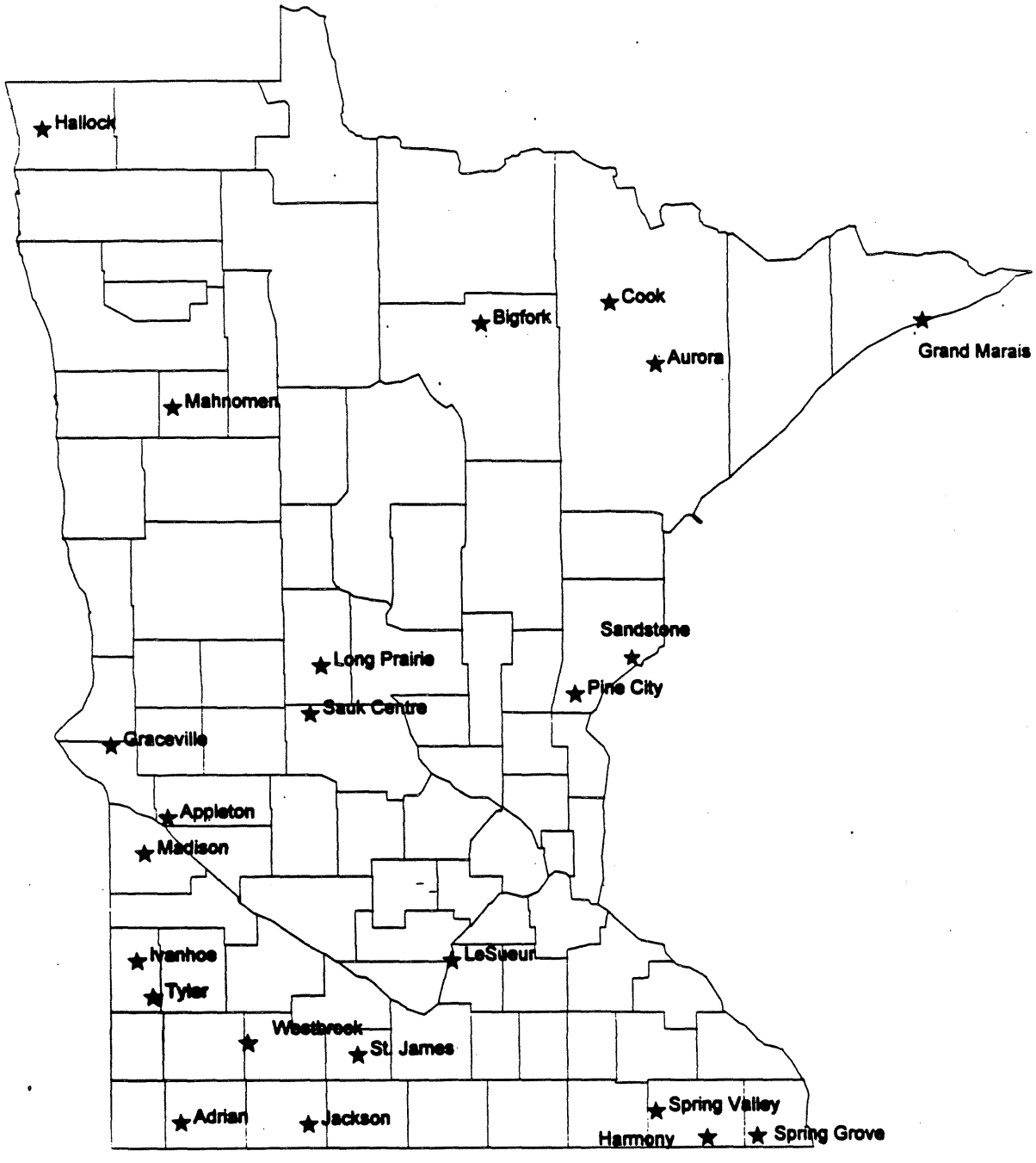
1. Rural Minnesota Hospitals
2. Rural Minnesota Hospitals with Average Daily Census of <= 3
3. Rural Minnesota Hospital Closures 1984-1985

Rural Minnesota Hospitals



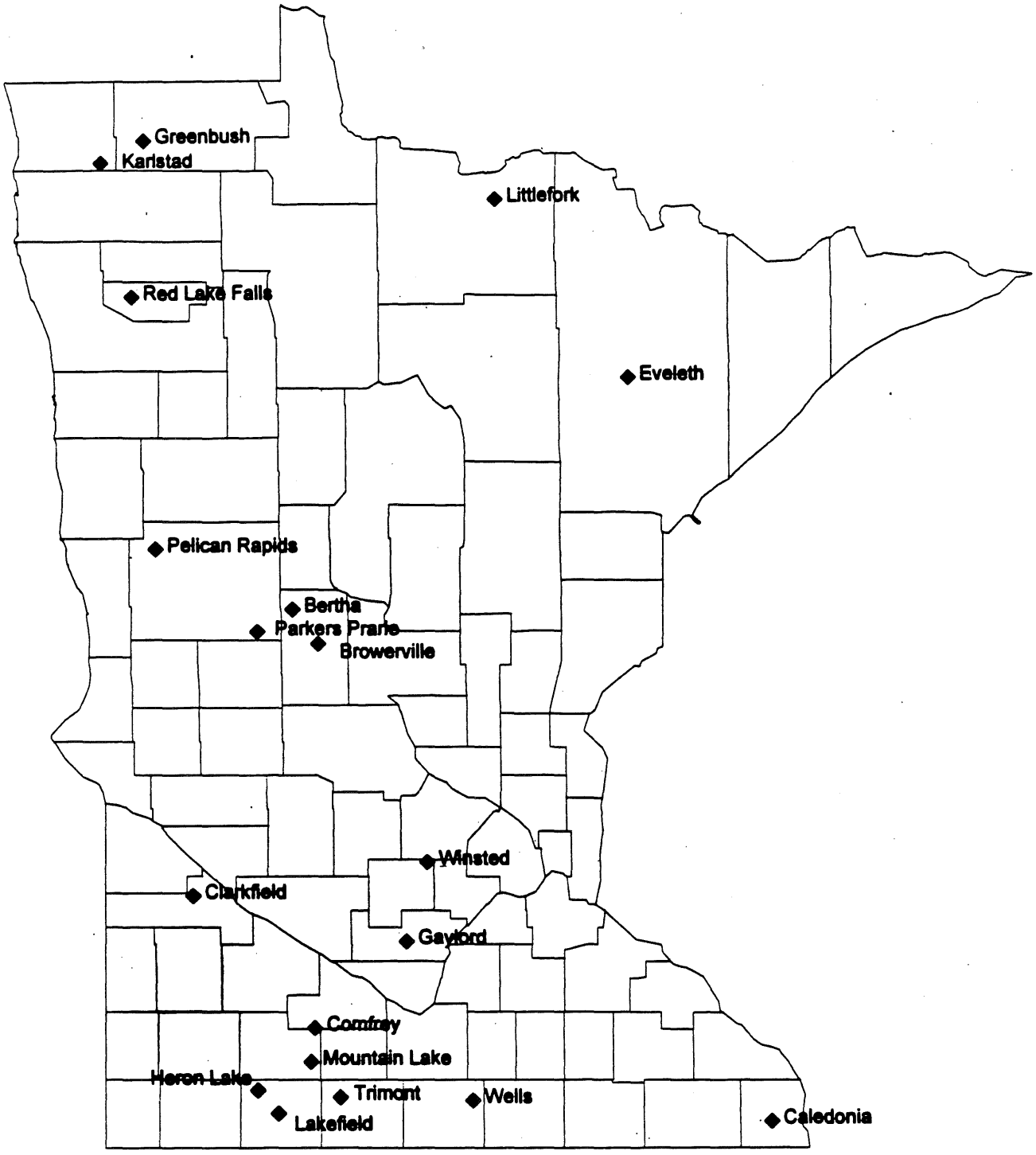
Office of Rural Health & Primary Care
Minnesota Department of Health, 1995

Rural Minnesota Hospitals with Average Daily Census of <= 3



Office of Rural Health & Primary Care
Minnesota Department of Health, 1995

Rural Minnesota Hospital Closures 1984-1995



Office of Rural Health & Primary Care
Minnesota Department of Health, 1995

APPENDIX C

Statutory Charge

MinnesotaCare 1995, Session Law Chapter 234, Article 8

Section 54. [ALTERNATIVE LICENSING MODEL FOR RURAL HOSPITALS.]

The Rural Health Advisory Committee shall examine rural health care access needs and present recommendations on the need for an alternative licensing model for rural hospitals. The committee must first examine:

(1) the projected demographics of rural populations;

(2) access to emergency care, obstetrics, and other traditional hospital-based services;

(3) access issues related to transportation;

(4) health care needs of different regions of the state, including those areas where access to care may be threatened by the financial instability of local hospitals; and

(5) other factors related to access to rural health care and hospital-based services.

Based upon this examination of access to health care in rural areas, the committee shall evaluate the need for and the feasibility of implementing an alternative licensing model for rural hospitals. This evaluation must consider:

(1) the goals of an alternative licensing model;

(2) federal and state regulatory barriers and options for reconfiguring traditional hospital-based health care services; and

(3) the feasibility of implementing an alternative licensing model, including the potential for integration with integrated networks and likelihood of obtaining a Medicare waiver and other necessary federal law changes.

If the committee determines that a need for an alternative licensing model exists and implementation is feasible, the committee shall identify changes needed in federal and state law, and develop draft legislation for a Minnesota-specific alternative licensing model.

The committee shall present a report to the legislature by December 15, 1996. This report must summarize rural access needs and present initial recommendations on the need for an alternative licensing model for rural hospitals.

Section 55. [STUDY OF REGULATORY BARRIERS.]

The Rural Health Advisory Committee, in consultation with the Regional Coordinating Boards, shall examine federal and state regulatory barriers that limit rural access to care or limit the ability of rural health care providers to provide care efficiently, without improving the quality of care. The Commissioner of Health shall provide staff and technical assistance to the Advisory Committee and the Regional Coordinating Boards. The commissioner shall apply for federal and private-sector grants and seek other nonstate sources of funding to supplement state funds appropriated for this study. The barriers to be studied must include, but are not limited to:

(1) requirements for emergency room staffing that increase hospital costs and limit access to care;
(2) limits on the ability of nurses to prescribe and administer prescription drugs under a physician's supervision in emergency situations;
(3) state and federal inspection and regulatory requirements that are duplicative and increase administrative costs;
(4) physician supervision requirements that limit the use of physician assistants; and
(5) the requirement that a hospital and its attached nursing home have separate directors of nursing.

The Advisory Committee shall present recommendations for eliminating these and other regulatory barriers to the Commissioner of Health by December 1, 1995. The Commissioner of Health shall consider these recommendations and shall present recommendations and draft legislation to the Legislature on any needed changes in state and federal regulatory requirements, by February 1, 1996.

APPENDIX D

Rural Hospital Study Work Group
Membership List

Rural Hospital Study Work Group Members

Chairman: TERRY HILL - Rural Health Advisory Committee, Consumer Representative

NICHOLAS BERNIER, M.D. - Minnesota Medical Association, Physician Representative

DEBORAH BOARDMAN - Minnesota Hospital Association, Hospital Administrator Representative

SANDRA BUTZ - Regional Coordinating Board 1, Health Plan Representative

TERRENCE CAHILL, M.D. - Minnesota Academy of Family Physicians, Physician Representative

LYNN DONEK - Minnesota Organization of Nurse Executives, Nurse Representative

MARK HELGESON - Rural Health Advisory Committee, Mid-level Provider Representative

JOHN HOEFS - Regional Coordinating Board 3, Health Plan Representative

PAUL IVERSON, R.Ph. - Minnesota Pharmacists Association, Pharmacist Representative

RONALD JENSEN - Regional Coordinating Board 5, Health Plan Representative

RANDY JORGENSON - Rural Health Advisory Committee, Consumer Representative

ROSEMARY LAMSON - Minnesota Public Health Association, Nurse Representative

AMY LOKEN - Regional Coordinating Board 2, Consumer Representative

MICHAEL MAHER - Rural Health Advisory Committee, Long-Term Care Representative

MIKE PODULKE - Regional Coordinating Board 6, County Commissioner Representative

JEFF RINGLIEN - Minnesota Ambulance Association Representative

ANNE ROBERTON - Rural Health Advisory Committee, Volunteer Ambulance Service Representative

JOHN STINDT - Minnesota Hospital Association, Hospital Administrator Representative

APPENDIX E

Rural Hospital Study Work Group
Structured Interviews
Summary

Rural Hospital Study Work Group
Structured Interviews
Summary

INTRODUCTION

A structured interview with hospital administrators was designed to assist the Rural Hospital Study Work Group in identifying state and federal regulatory barriers to the efficient provision of hospital-based care. Twenty rural hospital administrators were selected to participate in the interviews. Four administrators from each of the five non-metro Regional Coordinating Board areas were selected, with equal representation of attached and non-attached nursing homes, and proportionate representation of hospitals with an average daily census ranging from 1-58 patients.

Administrators were asked to review the interview guide with their hospital staff and were then interviewed by telephone by a staff member of the Office of Rural Health and Primary Care or the Minnesota Hospital and Health Care Partnership. The administrators were asked for comments and suggestions regarding regulatory requirements that are duplicative and increase administrative costs in 10 areas: governance; quality assurance and utilization review; medical and nursing staff requirements; required clinical and supporting services; physical environment; infection control; optional clinical services; licensing and certification processes and procedures; state and federal data reporting requirements; and Medicare and Medicaid reimbursement policies. In total, 18 administrators were interviewed. Following is a summary of the major topics they addressed.

> One purpose of this survey was to determine the perceptions of administrators regarding regulatory barriers. The accuracy of their comments has not been researched. As a result, some of the comments may not represent the current status of regulations, but rather the perceptions of administrators.

1. GOVERNANCE

GENERAL COMMENTS

Four of the 18 individuals interviewed indicated that current regulations regarding governance regulations are appropriate. Nine had comments or suggestions indicated below.

DUPLICATIVE REGULATIONS

OTHER CONCERNS

- The regulation requiring 24-hour physician coverage
- Some hospital board members do not have the expertise necessary to make decisions regarding medical staffing and other issues, yet they can be held legally liable for their decisions. Boards need to be given some protection from liability in their decision-making, perhaps under the Good Samaritan Law.

SUGGESTIONS

- Relax the regulation requiring a physician to be on call 24 hours a day.
- Increase the numbers and authority of mid-level practitioners in rural areas.

2. QUALITY ASSURANCE, UTILIZATION REVIEW

GENERAL COMMENTS

Regulations governing Quality Assurance (QA) and Utilization Review (UR) were identified as duplicative or burdensome by 13 of the 18 administrators. In addition, information required by third-party payers was viewed as adding another level of requirements which increase staff-time and tax the record keeping capabilities of hospitals.

DUPLICATIVE REGULATIONS

- QA and UR guidelines are redundant, however the reporting forms are not coordinated so that information from one can be easily entered on another.
- Each payer has different standards, creating different sets of rules by which hospitals must operate. The rules may change retroactively.
- UR plans are redundant with the growth of managed care, and pre-certification or admissions required by payers.

OTHER CONCERNS

- Committees are a problem for smaller hospitals.
- Patient volume is too low in small rural hospitals to draw valid outcomes from patient statistics. Objectivity is difficult to maintain if physicians are reviewing their own admissions.
- Allocating staff time and resources to provide all the data required by government agencies as well as managed care and insurance companies for UR and QA is costly and administratively burdensome.

- Peer Review Organization (PRO) requirements are time consuming and do not need to be as comprehensive.

SUGGESTIONS

- Modify committee requirements.
- Combine the UR and QA functions in hospitals.
- Cases among hospitals which are similar in size and scope of business should be pooled to make QA and UR more statistically valid.
- Patient chart information could be used for UR purposes.
- Regulators should look more closely at overall outcomes rather than individual cases.
- Use spot checking rather than the current method.
- Looking at overall outcome of services would achieve the same end as UR and is more useful for staff.

3. MEDICAL AND NURSING STAFF REQUIREMENTS

GENERAL COMMENTS

Five of the 18 administrators interviewed indicated they perceive no problems associated with current medical and nursing staff requirements. Two of those 5 stated that larger facilities (both hospitals have more than 50 beds) have economies of scale which result in fewer staffing issues. Nine of the administrators favored the elimination of the requirement for separate directors of nursing (DON) in the hospital and attached nursing home, while 2 indicated that separate directors of nursing are necessary due to the regulatory expertise and different set of skills required for nurses in each setting. Seven did not address the shared director of nursing issue.

DUPLICATIVE REGULATIONS

- The requirement that one RN must be on duty in the nursing home and one RN must be on duty in the hospital is costly and duplicative, particularly on weekends.
- The requirement for separate DONs in a hospital and nursing home is costly. In addition, it limits creativity and discourages coordination of care between the two facilities at a time when we are attempting to make health care services more integrated and cross-functional.

OTHER CONCERNS

- Waiver applications are difficult to have approved, and do not allow facilities to make their own decisions regarding staffing which would work best for them.

SUGGESTIONS

- Waive the requirement to have one RN on duty in the hospital and another on duty in the nursing home during times of low census.
- Regulators should make allowances which recognize that staff in a small hospital must be just as qualified as staff in a larger hospital, and that even if hospital census is low, a basic complement of staff is necessary.

4. REQUIRED CLINICAL AND SUPPORTING SERVICES

A. MEDICAL RECORDS

GENERAL COMMENTS

Medical records departments were seen by each of the administrators interviewed as being a critical department not only for documenting patient care but also for obtaining accurate and timely reimbursement from government and private payers. Several of the administrators indicated they have hired additional staff or contracted with medical records consultants to improve their hospital's efficiency in record keeping and billing.

DUPLICATIVE REGULATIONS

- Hospital staff time is wasted in meeting the requirement that the physician sign every entry in the medical record.

OTHER CONCERNS

- The required time period medical records must be kept is too long.

SUGGESTIONS

- Regulations should provide for less stringent signing of medical records by practitioners, for example, there should be provisions made for a global signature of the chart.
- Assist hospitals in combining medical records duties and functions between hospitals and outpatient clinics or in collaborating between separate hospitals where feasible.
- State and Federal government should provide training to health care facilities in medical records coding and billing procedures.

B. RADIOLOGIC AND LABORATORY

GENERAL COMMENTS

Many small rural hospitals cross-train laboratory and radiology personnel. Proposed requirements calling for increased training and certification of radiology and laboratory personnel are a concern. Six of the administrators interviewed oppose stronger certification and licensing regulations due to increased cost of the service. In addition, they felt that the volume and types of procedures performed in a small hospital do not warrant stricter requirements.

DUPLICATIVE REGULATIONS

OTHER CONCERNS

- Requirements for laboratory quality control runs are too stringent for hospital laboratories that perform low volumes of tests. Unnecessary staff time and equipment costs are generated as a result.
- Some standards for specific radiology tests-such as mammography- are too stringent and not workable for small hospitals.
- Health care workers have the right to know the HIV and Hepatitis B status of patients they are treating, particularly if they have a needle stick.

C. PHARMACEUTICAL

GENERAL COMMENTS

The continued availability of pharmacy services for small rural hospitals is a concern voiced by four of the administrators interviewed. Six indicated that registered nurses should be allowed dispensing privileges under some circumstances.

DUPLICATIVE REGULATIONS

OTHER CONCERNS

- RN's are limited to dispensing one dose of medication at a time under the supervision of a physician.
- Hospital pharmacies can only dispense a 3-day supply of medicine.

SUGGESTIONS

- Expand the 3-day/72 hour supply and dispense rule
- Expand the ability of RNs to dispense medication when a physician or pharmacist is not on duty.

D. DIETARY

DUPLICATIVE REGULATIONS

OTHER CONCERNS

SUGGESTIONS

- A free-standing hospital not attached to a nursing home, with few patients should have the flexibility to contract out for dietary services with the local nursing home, a local restaurant, or catering firm.

5. PHYSICAL ENVIRONMENT

GENERAL COMMENTS

Four of the administrators interviewed indicated that regulations related to the physical plant are problematic. Federal regulations including those of the Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), and the Americans with Disabilities Act (ADA) were noted as most burdensome. Two administrators stated that portions of their hospital facilities are in need of upgrading or remodeling, however they lack the funds to begin the projects.

DUPLICATIVE REGULATIONS

OTHER CONCERNS

- Safety standards and requirements are often unreasonably stringent in non-patient care areas.

SUGGESTIONS

6. INFECTION CONTROL

GENERAL COMMENTS

Infection control regulations received few negative comments. The administrators believed that some level of regulation is necessary.

DUPLICATIVE REGULATIONS

- The State of Minnesota can inspect the infection control program of hospital even if it the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has already approved the program.

OTHER CONCERNS

- Health care workers should have the right to know the HIV and Hepatitis B status of patients
- Infection control regulations are burdensome in a small facility where the responsibility falls on the director of nursing, who already must meet many obligations.

SUGGESTIONS

7. OPTIONAL CLINICAL SERVICES

A. EMERGENCY SERVICES

GENERAL COMMENTS

Three of the administrators interviewed indicated they have no concerns regarding regulation of emergency services. The concerns of the remaining administrators revolved around three issues--staffing, reimbursement, and possible alternative models of providing emergency care. Staffing and reimbursement will be discussed in this section. Alternate licensing concerns are addressed in the following section dealing with licensing requirements.

STAFFING CONCERNS

- The cost of staffing the emergency room with locum tenens physicians or other professional staff, especially on weekends.
- The regulation that physicians who supervise a mid-level practitioner must be within 30 minutes of the ER puts pressure on rural areas where there may be only one or two physicians.
- Ambulance staff cannot provide care for patients in the emergency room.

SUGGESTIONS

- Increase distance and travel time a physician is allowed to be away from an emergency room, if a midlevel practitioner is covering, to one hour.
- Allow and encourage greater use of non-physician providers and telemedicine.
- Emergency Medical Technicians should be used for ER coverage under the training and supervision of an RN.

REIMBURSEMENT OF EMERGENCY SERVICES

- Medicare disallows payment of fees for physicians who are not in-house to cover emergency services.
- The services of Advanced Life Support (ALS) certified RN s who provide care in transferring patients on a Basic Life Support (BLS) licensed ambulance are not eligible for reimbursement by Medicare and Medicaid.

B. SURGICAL, ANESTHESIA, NUCLEAR MEDICINE, REHABILITATION AND RESPIRATORY CARE SERVICES, OR OUTPATIENT SERVICES

PHYSICAL THERAPY

DUPLICATIVE REGULATIONS

OTHER CONCERNS

- The requirement that a patient receiving physical therapy must be seen by a physician

after thirty days is unnecessary.

- Regulations governing swing beds make the purchase of services like physical therapy difficult in that swing bed regulations stipulate that these services must be available five days per week. This level of coverage is not necessary in a small facility.

SUGGESTIONS

SURGICAL AND ANESTHESIA SERVICES

GENERAL COMMENTS

Administrators expressed no concerns regarding current surgical and anesthesia regulations. However 2 of those interviewed indicated that pressure from medical anesthesiologists to tighten the rules on the use of Certified Registered Nurse Anesthetist (CRNA) would add great cost to hospitals. Concern was also expressed that the services of a medical anesthesiologist would not be available at all in many small or remote communities.

8. LICENSING AND CERTIFICATION PROCESSES AND PROCEDURES

GENERAL COMMENTS

The most prominent areas of concern for administrators interviewed for this survey are duplication of certification for JCAHO accredited health care facilities and alternative licensing of facilities. Several administrators pointed to the need for alternative means of licensing small rural hospitals with limited staffs, and regulations that recognize the differences between small and large, urban and rural facilities.

DUPLICATIVE REGULATIONS

- State Department of Health surveyors grant deemed status to hospitals which are JCAHO accredited, however nursing homes, home care, and hospice programs are surveyed separately by the state.

SUGGESTION

- Deemed status should apply to all services and areas, including an attached nursing home, hospice and home care if the hospital is JCAHO certified.

OTHER CONCERNS

- Costs and volume of paperwork associated with maintaining institutional certification and licensure.

SUGGESTIONS

COMMENTS REGARDING ALTERNATIVE LICENSING

- Alternative licensing should be available so that communities which cannot support an acute care hospital can be provided with local emergency or urgent care/clinic services.
- In the absence of a local emergency room, there needs to be a facility and services available by which ill or injured patients can be stabilized and transferred to a secondary or tertiary care facility.
- The feasibility of providing emergency or ambulatory care services less than 24 hours per day should be explored.
- Legislation needs to specify the role of hospital districts and their taxing authority for ambulance services.
- Alternative licensing which allows a facility the flexibility to provide a variety of services, but not necessarily acute care services, under one license should be explored.
- Before alternative licensing is adopted, there needs to be a close look at how these services will be reimbursed on both the federal and state levels.

9. STATE AND FEDERAL REPORTING REQUIREMENTS

GENERAL COMMENTS

Concerns about state and federal reporting requirements centered primarily on lack of coordination between government agencies resulting in the need to report similar but not identical data to state and federal regulators. Several administrators also indicated that regulatory requirements should, where possible, recognize the differences between small rural hospitals and urban medical centers.

DUPLICATIVE REGULATIONS

- Many state reports are nearly duplicates of federal forms, but have enough differences that they are not easily interchangeable.
- There are differences in reporting time lines between some state and federal reports which causes confusion and uses costly staff time.

OTHER CONCERNS

- Some of the data requested by the state has no apparent usefulness.
- Staff time required to complete reports results in increased cost to the hospital.

SUGGESTIONS

- The State should identify areas where information can be shared between state and federal agencies, or between state agencies.
- The State should try to use the same form for the same type of data. For example, use a form for state purposes that follows the format and time frame of the corresponding federal form.
- The state should find reporting requirements that duplicate federal reports or that ask for data that is not be useful.

10. MEDICARE AND MEDICAID REIMBURSEMENT POLICIES

DUPLICATIVE REGULATIONS

- Medicare has a set of billing codes which is different from those of other payers.

OTHER CONCERNS

- Medicare and Medicaid reimbursement rates are too low.
- Under the Diagnostic Related Group (DRG) system, rural hospitals do not receive adequate reimbursement.
- Hospitals probably do not get maximum reimbursement because staff are not as well trained in coding procedures as they could be.
- Medicaid takes too long to pay the hospital.
- Reimbursement procedures create accounts receivable problems.
- Medicare and/or Medicaid often will not explain why a service has been denied, making resubmission difficult, and the amount of time it takes to get a response creates lengthy delays in processing bills
- In order for the services of physician assistants to be reimbursed by Medicare, a physician must be in the building. Medicaid requires that the physician must be on the premises 50% of the time the PA provides care.
- Exclusions to payment are stringent and create problems in rural hospitals. Examples include:

  Oral medications which are not dispensed by a pharmacy are not covered in many instances.

  Patients must be admitted to the hospital for a certain period of time before nursing home charges are eligible for reimbursement.

  Optional services which are beneficial to small hospitals, such as the swing bed program, are reimbursed at much lower rates than regular acute care services.

  Many services of non-physician personnel are excluded or discounted.

SUGGESTIONS

- Use a cost-based reimbursement schedule.
- Implement a more effective data processing system so that the status of Medicaid claims can be more closely tracked, and can be processed more quickly.
- Government agencies responsible for paying claims should provide more help and training to hospitals on proper coding both with ICD-9 and HCPCS as well as revenue codes.
- After processing a claim, Medicare intermediaries should have the authority and ability to submit the claim directly to the State rather than send it back to the hospital to be submitted to Medicaid.

APPENDIX F

Minnesota Board of Pharmacy Guidelines for Emergency Room After Hours Dispensing by Registered Nurses

GUIDELINES
FOR
EMERGENCY ROOM AFTER-HOURS DISPENSING
BY REGISTERED NURSES

1. The pharmacist-in-charge must develop written policies and procedures, describing the steps to be followed by the hospital for after-hours dispensing by a registered nurse (RN). These written policies and procedures must be submitted to the Board for approval before implementation.

   The procedures should indicate, in detail, the drugs that will be available for after-hours dispensing; the accountability of these units; how the pharmacist will double-check the accuracy of dispensing of each medication the next time the pharmacist is on duty; the names of the RN's designated and authorized to dispense during after-hours; and how the pharmacy department will monitor this process, as well as carry out quality assurance plans, to verify the accuracy of dispensing, for reducing the risk of errors and potential harm to patients. No controlled substances may be dispensed with this after-hours system. This policy must be reviewed and updated, as needed, and be resubmitted annually to the Board.

2. A maximum of a 72-hour supply may be dispensed from the emergency room (ER) for any one patient, except for antibiotics where a full course of therapy may be provided. The balance must be dispensed by a licensed pharmacy, wherein the patient has an opportunity to receive proper drug therapy management and counseling.

3. Emergency room after-hours dispensing must be limited to true emergency situations, and only when all pharmacies in the vicinity of the hospital are closed and a pharmacist or the prescriber is not available to dispense the medication.

4. All drugs dispensed from the ER must be prepackaged (pre-dispensed) by a pharmacy in such a way that ensures proper labeling, proper means of patient instruction for use, and that a signed prescription is provided to the pharmacy for each prepack unit.

5. The responsible pharmacist must conduct a monthly inspection of all products made available for ER dispensing, to assure proper expiration dating, accountability, and compliance with all approved dispensing procedures by designated nurses in the ER.

6. The responsible pharmacist must conduct in-service programs for all designated ER nurses on a regular basis, to assure that the nurses, carrying out this dispensing function, have a full and adequate understanding of the procedures approved for RN dispensing in that hospital.

   These in-service programs must be documented.

7. The responsible pharmacist should advise all designated nurses, involved in this dispensing function, as to their inherent liability in the event of a dispensing error, and recommend that they notify their insurance carrier and the Risk Management Department in their hospital.

8. The responsible pharmacist must attempt to contact the patient the next time a pharmacist is on duty, to answer any questions the patient might have and to assure availability of continued drug therapy past the 72-hour amount dispensed in the ER This procedure must be documented by the pharmacist.