

GME Central

NEW YORK'S DIRECT LINE TO GRADUATE MEDICAL EDUCATION NEWS

Family Health Plus Implementation Begins

In late spring, Governor George Pataki announced that the Federal government had approved New York State's request to expand its Medicaid program to cover many lower-income, uninsured adults not otherwise eligible for Medicaid by implementing the new Family Health Plus (FHP) program. The Governor made the announcement at a press conference in Manhattan. The Secretary of the Department of Health and Human Services, Tommy Thompson, and several other health care leaders, including Kenneth E. Raske, President of Greater New York Hospital Association (GNYHA) and Dennis Rivera, President of 1199/SEIU–New York's Health and Human Service Union, joined the Governor, who noted, "Family Health Plus will provide people across the State with the comprehensive health care they need to raise a family, work, and reap the rewards of New York's economic prosperity."

Eligibility

The State estimates that over 600,000 uninsured adults aged 19 through 64 will be eligible for FHP when the program is fully implemented, with a little more than half of these eligible individuals residing in the New York City area.

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DOH Raises Continuing Concerns About Hospital Underreporting Under NYPORTS

The New York State Department of Health (DOH) continues to express serious concerns about what it believes is significant underreporting by hospitals of adverse incidents under the State's incident reporting system, known as the New York Patient Occurrence Reporting and Tracking System (NYPORTS). As a result, DOH Commissioner Antonia C. Novello, M.D., M.P.H., has announced that any reportable incidents that come to DOH's attention through complaints or sur-

veys that have not been reported previously to DOH may form the basis for an enforcement action and related fines. It is DOH's practice to issue press releases in connection with all enforcement actions and fines.

Wide Variations in Reporting

The issue of underreporting has been of concern to DOH for some time, in part as a result of several serious

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SUMMER 2001

U.S. Supreme Court Rejects NLRB Test for Supervisory Status of Nurses

On May 29, 2001, the U.S. Supreme Court ruled in *National Labor Relations Board v. Kentucky River Community Care, Inc.* that the National Labor Relations Board (NLRB) test for determining whether registered nurses are “supervisors” and therefore prohibited from participating in collective bargaining agreements was improper and must be reformulated. The ruling may effectively broaden the scope of employees who may be excluded from joining unions.

Background

The case involves 110 employees at a residential mental health facility in Kentucky who joined a labor union in 1997. Kentucky River Community Care, the company that operates the residential facility, objected to the inclusion of registered nurses in the bargaining unit on the grounds that they were supervisors. Since the National Labor Relations Act (NLRA) excludes supervisors from its definition of protected employees, Kentucky River argued that the nurses were ineligible to join the union. The National Labor Relations Board (NLRB) rejected this argument and, in support of the nurses, filed an unfair labor practice complaint when Kentucky River continued to refuse to bargain with the union. After years of appeals, the case reached the Supreme Court in February 2001.

The NLRA defines a supervisor as “*any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.*” 29 U.S.C. §152 (11)

At issue is the definition of “routine or clerical” work and “the use of independent judgment” as criteria for determining supervisory status. The registered nurses at Kentucky River do not have the authority to hire, fire, or discipline other employees, but they typically direct less skilled employees (such as nurse’s aides and licensed practical nurses) in the provision of patient care (for example, dispensing medicine, bathing patients, taking temperatures, and so forth). The registered nurses may ask other employees to stay on duty or come to work early, shift staff between units as necessary, and act as building supervisors during evening hours. However, they do not receive extra compensation for these responsibilities or hold keys to the building, nor can they enforce work requests under the threat of discipline. The staffing levels they maintain are predetermined by the management.

The Supreme Court Ruling

The NLRB argued before the Supreme Court that the registered nurses’ responsibilities are routine in nature; that is,

they rely on professional or technical training and experience, rather than independent judgment, when directing the work of others. However, the Supreme Court, in a 5–4 decision, rejected the NLRB’s test and ruled that the direction of patient care is rooted in independent judgment, even if it is also based in professional expertise, and registered nurses are therefore supervisors. In delivering the majority opinion, Justice Antonin Scalia asked, “What supervisory judgment worth exercising, one must wonder, does not rest on ‘professional or technical skill or experience’? If the [NLRB] applied this aspect of its test to every exercise of a supervisory function, it would virtually eliminate ‘supervisors’ from the [NLRA].”

The minority opinion argued that the intent of Congress in passing the NLRA was that supervisory status would be reserved only for employees with “genuine management prerogatives.” Thus, employees with only minor supervisory responsibilities should be eligible for collective bargaining activities. Indeed, concern has been expressed that this ruling will make it easier for health care employers to assert the supervisory status of nurses and other professionals. Several organizations, including the American Nurses Association, filed amicus briefs supporting the nurses’ right to bargain collectively. Critics of the ruling argue that it is unfair to nurses and to patients, and that it will only exacerbate the existing nursing shortage.

Other Implications

The direct implications for interns, residents, and fellows—who were defined as employees by the NLRB in November 1999 and therefore eligible for collective bargaining activities—are less clear, but the ruling seems to have had a negative effect on the movement to unionize fully trained doctors. Physicians for Responsible Negotiation (PRN), a physicians’ labor union sponsored by the American Medical Association, cited the recent Supreme Court decision as “a major setback” and has suspended organizing activities for an indefinite period of time. The Committee for Interns and Residents will continue to bargain on behalf of doctors in training. In late July 2001, the NLRB heard a case between PRN and Concentra, Inc., an operator of occupational health centers that is contesting its doctors’ right to unionize.

The Supreme Court decision affects only employees in the private sector. The NLRA does not have jurisdiction over employees who work in the public sector (for example, state university teaching hospitals) or who are self-employed. Future cases are expected to further explore the definition of “independent judgment,” which remains ambiguous. The burden of proving supervisory status still rests with the party seeking to assert that an employee is in fact a supervisor. ■

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incidents that had come to its attention but had not been reported under NYPORTS. DOH therefore undertook an analysis of hospitals' compliance with NYPORTS during 1999 by focusing on what it believed was a noncontroversial category of reportable incidents—patient deaths within 48 hours of an operating room procedure, regardless of reason. In a report released in February 2001, DOH concluded that hospitals in general are underreporting adverse incidents, citing only a 16.2% reporting rate for the occurrence category studied. In addition, DOH concluded that there are wide regional variations in reporting under NYPORTS, with hospitals located in New York City having the lowest reporting rates and hospitals in the Finger Lakes region having the highest (see table below). Hospitals on Long Island and in the Hudson Valley had higher reporting rates than those in New York City, but still fell well below the high reporting rates of the upstate hospitals.

Given the low reporting rates identified, DOH asked hospitals to conduct an internal review of records for the years 1999 and 2000, and to notify DOH on or before April 22, 2001, of any reportable incidents they might have missed. The requested notification date of April 22 was later extended to June 1, 2001. While hospitals reported additional incidents through this process, DOH remains concerned that many reportable incidents are not being reported under NYPORTS and continues to see wide variations in hospital and regional reporting patterns. Although some of this variation might be due to differences in procedures performed and types of admission, DOH does not attribute these variations entirely to such factors. DOH therefore continues to warn hospitals that they will be subject to an enforcement action and fines if it discovers any unreported incidents in the future.

DOH's Approach to Its Study: The 605 Exercise

DOH undertook its measurement of underreporting by comparing NYPORTS-reported data regarding deaths that occurred in 1999 within 48 hours of an operating room procedure with those data taken from the acute care discharge database contained in the Statewide Planning and Research Cooperative System (SPARCS). DOH chose this reportable occurrence to review because there is a reasonable match between the two systems with respect to this category, even though the two databases do not capture precisely the same data. Under NYPORTS, hospitals are required to report all deaths that occur within 48 hours of an operating room procedure, regardless of cause or whether the

death was expected. This category of reporting is referred to as occurrence "code 605." The SPARCS database, on the other hand, captures deaths in terms of days but not hours. In addition, the SPARCS database does not identify whether a death followed an operating room procedure or a procedure performed in another setting in the hospital.

To control for these two differences in the NYPORTS and SPARCS databases, DOH compared only the SPARCS cases in which the patient died within one day (the same day or the day after) of what is designated as a "valid operating room procedure" in the 1999 ICD-9-CM coding book. Hospitals were then given the opportunity to explain why they did not report a case that had been identified through the analysis of SPARCS data. DOH then reviewed the reasons given and allowed exclusions that had merit, with the most common reason being that the procedure had not been performed in the operating room.

Outcome: Significant Underreporting Under Code 605

After recognizing the meritorious exclusion requests, DOH identified 1,030 reportable cases based on the SPARCS data. Of these cases, a total of 167 (16.2%) were actually reported by hospitals to NYPORTS

Total NYPORTS Cases Submitted per 100,000 Discharges by Region, 1999

| REGION | 1999 ACUTE CARE DISCHARGES | ALL 1999 NYPORTS REPORTED CASES | NYPORTS CASES REPORTED PER 100,000 DISCHARGES |
|-----------------|----------------------------|---------------------------------|---|
| Western NY | 190,671 | 1,390 | 729 |
| Finger Lakes | 139,455 | 1,536 | 1,101 |
| Central NY | 201,851 | 2,153 | 1,067 |
| Northeastern NY | 163,877 | 1,616 | 986 |
| Hudson Valley | 254,657 | 1,744 | 685 |
| Long Island | 339,916 | 2,417 | 711 |
| New York City | 1,131,582 | 4,271 | 377 |
| Total | 2,422,009 | 15,127 | 625 |

Source: NYS Department of Health.

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Eligible individuals include:

- adults (single or married) without dependent children, whose incomes are less than or equal to 100% of the Federal poverty level (in 2001, \$8,590 for an individual and \$11,610 for a couple); and
- until October 2002, parents whose incomes are less than or equal to 133% of the Federal poverty level (in 2001, \$23,475 for a family of four) and beginning October 2002, parents whose incomes are less than or equal to 150% of the Federal poverty level.

Unlike the rest of the Medicaid program,

FHP does not consider an applicant's resources when determining eligibility. Individuals who are determined eligible for FHP will not pay any plan premiums, and ineligible individuals will not be able to "buy in" to the program.

Enrollment

Program enrollment is scheduled to begin October 1, 2001, with applications available on September 1. Individuals seeking coverage will be able to apply at convenient local sites that will include hospitals, community-based groups, and health care plans. The organizations will conduct

enrollment interviews and provide assistance in filling out applications. At the time they apply for FHP, individuals will choose among managed care plans participating in the program.

New Yorkers who wish to receive information about FHP or receive an application when it becomes available should call the New York State Department of Health hotline at 1-877-9FHPLUS.

Benefits

FHP beneficiaries will receive all program benefits through the participating FHP health plans. Most of these plans also par-

as of September 15, 2000. Although some hospitals indicated that there were misunderstandings regarding the reporting category, DOH has emphasized that the 605 category requires reporting regardless of the cause of death or whether it was expected. DOH believes that the more likely reason for not reporting such occurrences is that some hospitals may not have instituted an effective process for identification and reporting occurrences. In its February 2001 report, DOH published a list of hospitals with the lowest NYPORTS reporting rates.

GNYHA Initiatives to Improve Reporting

Over the last six months, Greater New York Hospital Association (GNYHA) has been providing to its members institution-specific training in undertaking root cause analyses of adverse events, a process that is designed to identify systemic reasons for adverse events and mechanisms to prevent their occurrence. The program includes training on reporting obligations under NYPORTS and mechanisms for improving the identification of events. Both DOH and the Joint Commission on Accreditation of Healthcare Organizations require hospitals to undertake root cause analyses of specified adverse events. GNYHA has also been hosting a number of meetings, attended by DOH and representatives of the statewide workgroup on NYPORTS, on improved case-finding, root cause analysis, and NYPORTS reporting obligations, and is planning a number of initiatives to identify barriers to reporting and best practices in improving internal identification of adverse events.

New York State's Incident Reporting System

New York State has required hospitals to report adverse events to DOH dating back to 1985. The system has undergone a number of revisions over time, with the latest version, the NYPORTS system, being one that permits reports to be made by e-mail, which is intended to simplify reporting, streamline coding, and allow hospitals to obtain feedback on their reporting patterns compared with other facilities in the State. Hospitals have consistently requested that DOH make use of the data for more than investigation purposes and to analyze the data for the purpose of providing feedback in terms of effective interventions to avoid adverse events. It is anticipated that the efforts being undertaken through DOH's Patient Safety Center and other DOH initiatives may yield such tools and information. ■

IN THE SPOTLIGHT

ECIN

GNYHA Ventures, Inc. and Extended Care Information Network, Inc. (ECIN) recently announced an agree-

ment that will bring ECIN's *ExtendedCare Professional™* and *ExtendedCare Provider Access™* to Greater New York Hospital Association's (GNYHA's) member institutions. GNYHA Ventures is a wholly owned, for-profit subsidiary of GNYHA. The alliance between GNYHA Ventures and ECIN, a leading provider of Internet-based discharge-planning solutions and resources to the health care industry and consumers, represents the culmination of an extensive process on GNYHA's part to select a discharge-planning solution for its members.

ECIN's products link the key elements of discharge planning—hospitals, continuing care facilities, payers, ambulette services, durable medical equipment providers, home health agencies, and others—through a comprehensive, secure, Web-based technology that streamlines the hospital discharge planning process.

The *ExtendedCare Professional™* product allows discharge planners to search a database of more than 80,000 extended-care providers, including those specifically designated by participating hospitals, and conduct on-line, real-time searches for providers based on the patient's specific criteria (for example, type of insurance, level of care needed, location, and so forth). The *ExtendedCare Provider Access™* product allows extended-care providers to receive electronic referrals from hospitals. ECIN has also automated New York's Patient Review Instrument (PRI), a feature that will be of significant interest to many GNYHA members.

For more information or to request an on-site demonstration, contact Melissa Sorken at (212) 258-5314.

ticipate in the Medicaid managed care and Child Health Plus (CHP) programs. The FHP benefit package is comprehensive, and closely follows the benefit package for the CHP program, the primary difference being that CHP covers nonprescription drugs and FHP does not. FHP program benefits include physician and nurse practitioner services, inpatient and outpatient hospital services, prescription drugs, laboratory tests, diagnostic x-rays, emergency services, radiation and chemotherapy, and durable medical equipment. More information can be found at the Healthcare Education Project's Web site

(www.healtheducationproject.org)—a joint initiative of GNYHA and 1199/SEIU that conducts outreach campaigns to educate the public and legislators about the uninsured and other health-related issues.

Physician Services

Physicians will be able to serve FHP beneficiaries only as participating providers in FHP plans. The rules for physician participation in FHP plans, including medical residents, are the same as for Medicaid managed care and CHP plans. As in those programs, individual physicians or independent practice associations will negotiate pay-

ment arrangements directly with FHP plans.

Hospital Services

Except in emergencies, FHP plans may require their members to use only hospitals that participate with the plan to receive inpatient and outpatient services. In general, the special payment rules of the Medicaid managed care program for hospitals also apply to the FHP program—namely, the payment of a “triage fee” for non-emergency services, the payment of the alternate payment rate to non-contracted hospitals, and the direct payment for GME to hospitals from the regular Medicaid program. ■

ACGME Executive Director Provides Overview of Outcome Project Requirements

In July 2001, medical directors, GME administrators, and residency program directors attended a briefing at Greater New York Hospital Association (GNYHA) to discuss the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project with David C. Leach, M.D., Executive Director of the ACGME, and Susan A. Swing, Ph.D., Director of Research at the ACGME. The Outcome Project is a long-term initiative designed to enhance residency education through the assessment of outcomes in six core competencies—patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

At the briefing, Dr. Leach emphasized the importance of maintaining communication with the ACGME and with other GME programs as the Outcome Project moves through Phase I, from July 2001 to June 2002. During this initial response period, GME programs must plan ways to integrate the new competencies into existing procedures. In addition, each Residency Review Committee is expected to define the competencies and adopt an evaluation approach that will fit an individual specialty. Programs will not be held responsible for the new ACGME requirements related to the competencies until Phase II begins in July 2002. Phase II (July 2002–June 2006) will focus on refining the six competencies, and Phase III

(July 2006–June 2011) will focus on integrating them with learning and clinical care. Finally, Phase IV (July 2011–June 2016) will identify models of excellence and “build knowledge about good GME.”

Dr. Leach advised GME program directors to “begin where you are” and start Phase I with an in-depth study of each program’s strengths and weaknesses. Small steps were encouraged, since integration of the six competencies will require a change in the overall mindset and culture of residency programs. For example, Dr. Leach recommended the use of more “robust” language in descriptions of educational objectives. Dr. Leach also highlighted the work of several teaching institutions, including the University of Rochester, which is conducting a comprehensive, six-month review of current Outcome Project activities across the country, and the University of Southern Illinois, which is developing a surgery program evaluation system.

GNYHA plans to convene workgroup meetings to address each of the six competency areas and provide feedback to the ACGME about the Outcome Project over the next year. Any GNYHA member institution that would like to receive materials from the recent briefing, or participate in future workgroup meetings, should contact Tim Johnson, Director, Health Finance and Physician Policy, GNYHA, at tjohnson@gnyha.org. ■

Examples of Assessment Methods from ACGME/American Board of Medical Specialties Toolbox of Assessment Methods

| METHOD | DESCRIPTION |
|--|---|
| 360-Degree Evaluation | Superiors, peers, subordinates, and others who interact with the resident complete surveys or questionnaires on diverse topics (e.g., communication, decision-making). |
| Chart-Stimulated Recall Examination | Physician examiner questions the resident regarding the care provided to his patients, probing for the reasons for the particular diagnosis, interpretation of findings, treatment plan, etc. |
| Checklist Evaluation | Resident is assessed on the basis of having achieved or performed a set of behaviors, activities, or steps. |
| Objective Structured Clinical Examination (OSCE) | Assessment tools are administered at separate standardized patient encounter stations. |

Reimbursement Essentials

The Health Care Reform Act (HCRA) of 1996 deregulated New York's hospital inpatient payment system, but maintained partial private payer support for GME training. Not-for-profit and commercial indemnity plans, HMOs, and self-insured plans contribute to GME reimbursement by paying an assessment on behalf of every insured individual and family into a professional education pool. The pool is paid to teaching hospitals on a regional basis, and the hospital-specific amounts from the main portion of the pool reflect the number of residents in training at the hospital as of a certain base date. That is, the pool distribution amounts generally do not change from year to year to reflect changes in the number of residents in training or volume of private payer patients at a particular hospital.

Both HCRA 1996 and its successor legislation, HCRA 2000, carved out a portion of the professional education pool for a program referred to as the professional education supplemental pool, and more commonly referred to as the GME incentive pool. The incentive pool is intended to reward individual hospitals and GME consortia for progress toward, and achievement of, State policy goals in the area of GME.

GME INCENTIVE POOL FUNDING AMOUNT

The original GME incentive pool program included in the HCRA 1996 legislation carved out 10% of the overall GME pool funds for the dedicated incentive pool program. This carved-out amount totaled \$54 million. HCRA 2000 lowered the incentive pool to \$31 million while modifying several of the program requirements. In June 2001, the New York State Department of Health (DOH) began the process of collecting data that will be used for distributing the funding collected in the GME incentive pool in 2000, which is being referred to as "Year 4" of the program.

LEGISLATIVE GOALS

HCRA 1996 directed DOH to distribute the incentive pool funds on the basis of seven identified GME policy goals. HCRA 2000 eliminat-

ed two of those goals, and the following five goals remain:

- reducing the number of residency training programs and/or the number of residents in those programs;
- increasing the number of residents training in underserved areas;
- increasing the number of residents training in ambulatory care facilities;
- improving the quality of training programs; and
- increasing the training of underrepresented minorities.

CURRENT PROGRAM REQUIREMENTS

In order to be eligible for funding from the GME incentive pool, an institution must have at least 95% of its total residents training in accredited programs. DOH developed a system whereby weights were assigned to specific objectives associated with the legislative goals, and each teaching hospital and GME consortia is given an institutional score based on its achievement of, or progress toward, each of the objectives. The objectives and associated weights for Year 4 are:

- reducing the number of non-designated priority program (DPP) residents and training programs (0.40);
- increasing the proportion of residents training in a) ambulatory care sites (0.10), and b) underserved areas (0.20); and
- increasing a) the proportion of underrepresented minorities (0.15), b) the proportion of minority faculty (0.075), and c) linkages with minority pipeline programs (0.075).

FUTURE PROGRAM REQUIREMENTS

DOH is planning to add additional objectives to the GME incentive pool program in Year 5. These objectives involve cultural competency training for residents and increased biomedical research training in residency programs. The State Council on GME will be considering recommendations regarding these additional objectives from one of its subcommittees within the next several months.



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GME Central is a quarterly publication of Greater New York Hospital Association (GNYHA). *GME Central* is free for GNYHA member institutions. The publication can be purchased by nonmembers for \$100 per year. If you would like to subscribe to *GME Central*, please contact Kathy Corbett at GNYHA, 555 West 57th Street, 15th Floor, New York, NY 10019; phone, (212) 506-5473; fax, (212) 262-6350.

ABOUT GNYHA

Greater New York Hospital Association is a trade association that represents 175 not-for-profit hospitals and continuing care facilities, both voluntary and public, in the New York metropolitan area.