1989

A Specialty Orthopedic Skilled Unit

Vivian K. Landes

A SPECIALTY ORTHOPEDIC SKILLED UNIT

Presented by:

Vivian K. Landes, R.N., B.S.N.

An Abstract Presented to the Faculty of the
Graduate School of Lindenwood College
in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts in Gerontology

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ABSTRACT

Several requests have been made by an orthopedic specialist to our facility for the establishment of a specialty skilled orthopedic unit. The orthopedic practice brought to our hospital does support the grouping of these patients in a dedicated area.

To accomplish this project, four areas needed to be researched; managing change, managed care, medicare regulations, and skilled nursing facilities. A marketing plan was then developed identifying the needed product, price, promotion and placement of the proposed unit. The marketing plan also identified current charges for part of the orthopedic patient, acute bed utilization, service usage in the proposed area, and discharge disposition. After acceptance of the plan, the project was then developed into a budget, implication for facility, and staff and further areas for evaluation.

Currently, all skilled patients, irregardless of diagnosis are in the same location. Orthopedic patients in our facility have usually had elective surgery for joint replacement. They expect and demand the same physical environment and psychosocial encounters as in acute care. A typical nursing home environment is counterproductive to recovery.

To have hospital commitment to establish this dedicated skilled orthopedic skilled unit principles of managing change are needed. Managed care will move the patient through the system efficiently while providing a mechanism of quality care.

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1989

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Acknowledgements

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A special word of gratitude is expressed to the author's husband, Robert, whose patience and love made completion of this masters program and culminating project possible.

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I. BACKGROUND

Introduction

This culminating project was conducted over two study clusters of the Lindenwood LCIE graduate program. The first period was the marketing cluster during which I developed the entire marketing plan to justify this project. The second period was my last cluster used to do further research for implementation and the actual writing of the project.

Over a period of several years there has been voiced a request by orthopedic surgeons for a specialty skilled orthopedic unit. This presents several areas of consideration. Implementation of this project involves many changes and the mechanisms of instituting this change to evoke a positive response. Success of the project is dependant on this exploration. The concept of managed care is established and needs refinement to meet our individualized needs. Requirements of the Federal Government and the Department of Health needs to be explored and met before the unit can be established.

Literature Review

The literature review has been divided into the following components: managing change, managed care, medicare regulations, and skilled care. These are the four areas covered in this project. Managing change, thoughts on change, and several strategies for managing change have been identified and defined. (Marriner's, 1984).

Empirical-rational strategies are based on the assumption that people are rational and behave according to rational self-interest. It follows then that people should be willing to adopt a change if it is justified and if the person is shown how she can benefit from the change.

Normative reeducative strategies are based on the assumption that people act according to their commitment to socio-cultural norms. The intelligence and rationality of people are not denied, but attitudes and values are also considered. The manager pays attention to changes in values, attitudes, skills, and relationships in addition to providing information.

Believing that individuals comprise the basic unit of the social organization, the manager fosters development of people through means such as personal counseling, training groups, small groups, and experiential learning because the person needs to

participate in her own re-education. Organizational development programs are fostered. It is typical to collect data about the organization, give data feedback and analysis to appropriate people, plan ways to improve the system, and train managers and internal change agents. Internal change agents' relationships with other personnel can be a major tool in re-educating others.

Power-coercive strategies involve compliance of the less powerful to the leadership, plans, and directions of the more powerful. These strategies do not deny the intelligence and rationality of people or the importance of their values and attitudes, but rather they acknowledge the need to use sources of power to bring about change.

Unfreezing, moving, and refreezing are the three phases of change. Unfreezing is the development through problem awareness of a need to change. Even if a problem has been identified, a person must believe there can be an improvement before she is willing to change. Coercion and the induction of guilt and anxiety have been used for unfreezing. Removal of a person from the source of her old attitudes to a new environment, punishment and humiliation for undesirable attitudes, and rewards for desirable attitudes effect change.

Stress may cause dissatisfaction with the status quo and become a motivating factor for change. Points of stress and strain should be assessed. Change may begin at a point of stress but ordinarily should not be started at the point of greatest stress. It is most appropriate for it to start with a policy-making body that considers both the formal and informal structures. The effectiveness of the change may be dependent on the amount of involvement in fact finding and problem solving of all personnel.

Moving is working toward change by identifying the problem or the need to change, exploring the alternatives, defining goals and objectives, planning how to accomplish the goals, and implementing the plan for change.

Refreezing is the integration of the change into one's personality and the consequent stabilization of change. Frequently personnel return to old behaviors after change efforts cease. Related changes in neighboring systems, momentum to perpetuate the change, and structural alterations that support the procedural changes are stabilizing factors.

Seven phases of planned change have been identified. First, the client must feel a need for change. The manager, as the change agent, can stimulate an awareness of the need to change, help the client become

aware of the problems, and indicate that a more desirable state of affairs is possible. Thus unfreezing occurs.

Next, the helping relationship must be established and the moving process begun. The manager as a change agent must identify herself with the client's problems while remaining neutral so that she can take an objective view. The change agent needs to be viewed as an understandable and approachable expert. The success or failure of most planned action will be largely dependent on the quality and workability of the relationship between the change agent and the client.

Third, the problem must be identified and clarified. Collecting and analyzing data can facilitate this process. Fourth, alternative possibilities for change should be examined. Goals and objectives are planned. The client's emotional and material resources are examined. Strategies for change are determined. The success of planned change is evaluated by the implementation of the plans. The fifth phase is the active work of modification, which completes the moving process.

The refreezing process occurs during the sixth phase-generalization and stabilization. All too often the client slips back to her old ways after change efforts cease. The spread of change to neighboring

systems and to subparts of the same system aids the stabilization process. Change momentum, positive evaluation of the change, rewards for the change, and related procedural and structural changes increase the stabilization.

The helping relationship ends, or a different type of continuing relationship is established in the last phase. Dependency is the major factor determining when the relationship will end.

As a change agent the manager identifies the problem, assesses the client's motivations and capacities for change, determines alternatives, explores ramifications of those alternatives, assesses resources, determines appropriate helping roles, establishes and maintains a helping relationship, recognizes the phases of the change process and guides the client through them, and chooses and implements techniques for planned change.

Kurt Lewin's force-field analysis provides a framework for problem solving and planned change. Status quo is maintained when driving forces equal the restraining forces, and change will occur when the relative strength of opposing forces change. Consequently, when planning change, the manager should identify the restraining and driving forces and assess their strengths. (Bassett 1986)

In this situation, I am the manager and the client is the hospital utilizing these principles. The needed change can be made to receive commitment for and establishment of the skilled speciality unit.

Managed Care

Any large group or association - a clinic, hospital, or university - has a culture that is developed and defined by "the way we do things around here." We must appreciate the importance of this culture. If we try to make changes in our organization without paying attention to its cultural characteristics, those changes will not be successful. There is a belief in the emergence of regional growth of departments centered around multidisciplinary planned care. In the future, health care and its delivery must be on an organized basis. The environment is too hostile for a health care system to exist, grow, and develop in any other way. (Wenzel 1988)

Hospitals are political institutions. Their interests, and the interests of their many constituents, patients, employees, and in many cases, their sponsoring religious orders, are woven into the fabric of the communities in which they are located. Hospitals are a viable part of the community. They employ thousands of people. When they close, merge, or downsize, lives are affected. Practice patterns

also change. And beneath the predictable chaos of change, hospital policies change as well. People are moved through the health system at such alarming speed that care may be affected. The industry is no longer going to pay for excess charges and waste. We can provide decreased hospital cost by providing an alternative level of care in the hospital based skilled unit. (Engoron, 1988)

What reason do we have for believing that the health-care consuming public would choose less expensive modes of treatment? If the decision were made solely on the basis of cost, the answer is clear; none. For want of better information, the health care consumer tends to equate cost with quality. More complete data, especially data tending to indicate which mode of treatment is likely to make him or her feel better, will change that. Why? Given a choice - in terms he or she can understand - the health care consumer is inherently conservative. (Larkin, 1988)

As has already been pointed out, most people would prefer to avoid hospitalization. They prefer to avoid discomfort. In the future, before they submit to more procedures, they must be convinced the proposed treatment will make them "feel better." (Maurer, 1988)

Life expectancy will be an important, but by no

means a conclusive factor. Peace of mind and relief from pain and other discomfort will remain significant. In the brave new world of medicine now opening before us, they will have to be convinced the proposed treatment is worth the discomfort - that, in the end, they will not only experience symptomatic relief, but also actually be better. (Maurer 1988)

A dimension of managed care is feedback or the set of methods used to evaluate care concurrently and in aggregates and trends retrospectively. Because the most important evaluation is that which can be done while the patient is still undergoing care, concurrent tools and systems are crucial. In nursing case management and managed care, these are:

- Accurate assessments of problem and goal identification which include the patient's and family's perception and concerns.
- Use of the Care Plan and Critical Path every day and/or shift or visit (see example)
- Regular case consultations by both the multidisciplinary team and the immediate care givers,
- Collaborative monitoring by physicians, nurses, and other team members,
- The use of planned telephone appointments for initial assessments, follow-up calls, etc., and
- Patient education in groups or individually.

A Critical Path is an abbreviated, one-page version of the multidisciplinary care plan which shows the critical, or key incidents that must occur in a predictable and timely order to achieve an appropriate length of stay. Critical Paths are tools that, once individualized by the nurse within the first twenty-four hours of admission, are used on every shift on each consecutive unit to plan and monitor the flow of care. (Zander 1988)

The care of the patient is well orchestrated, environment pleasant and needs of patient, physician and hospital met.

Managed care is the gateway to case management. Managed care is "Unit-based" care that is organized to achieve specific patient outcomes within fiscally responsible timeframes (length of stay) utilizing resources that are appropriate in amount and sequence to the specific case type and to the individual patient. Care is structured by case management plans and critical paths that are based on knowledge by case type regarding usual length of stay, critical events and their timing, anticipated outcomes, and resource utilization. (Zander 1988)

Managed care must be more than a philosophy and protocol - it must include professionals skilled as both clinicians and managers who are committed to the

welfare of both patients and the institution. The nurse is responsible for revising the Multidisciplinary Care Plan (see example) in accordance with an assessment of the individual patient's needs combined with the knowledge of attainable outcomes gleaned from experience and research. The nurse, working in a group practice, is accountable for meeting outcomes within an appropriate length of stay, the effective use of resources, and established standards (clinical processes and outcomes).

In the course of the literature search I found nothing specific to specialty skilled units and feel it is logical to deduce there has been nothing written. It is also logical to this author that it is a viable product since skilled units have been in existence for many years.

Medicare Regulations

It is necessary to have a brief knowledge base of the Medicare program and a skilled nursing facility.

The Medicare program is a Federal health insurance program for people sixty-five or older and certain disabled people. It is run by the Health Care Financing Administration of the United States Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information

about the program.

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under the PPS, hospitals are paid fixed amounts based on the principal Diagnosis Related Group (DRG), for each Medicare hospital stay. In some cases, the Medicare payment will be more than the hospital's cost; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high, or the length of stay is unusually long, the hospital receives additional payment.

It is important to remember that this system does not change Medicare hospital insurance protection. It does not determine the length of stay in the hospital or the extent of care received. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible amounts, plus any amounts due for non-covered items or services, such as television, private duty nurses, or cosmetic surgery.

Medicare hospital insurance can help pay for inpatient care in a Medicare-certified skilled nursing facility (SNF), if conditions required daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing

facility.

Skilled Nursing Facility

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not certified by Medicare. DePaul Health Center has a hospital based skilled nursing facility.

Hospital insurance can help pay for care in a skilled nursing facility if both of the following conditions are met: (1) a doctor certifies the need, skilled nursing or skilled rehabilitation services is received on a daily basis, and (2) the Medicare intermediary or the facility's Utilization Review Committee does not disapprove the stay.

Both conditions must be met. But it's especially important to remember the requirement that skilled nursing care or skilled rehabilitation services is needed and received on a daily basis.

Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

The skilled nursing care and skilled rehabilitation services received must be based on a doctor's orders.

Hospital insurance cannot pay if skilled nursing or rehabilitation services is needed only occasionally, such as once or twice a week, or if skilled services can be received elsewhere such as home. Also, hospital insurance cannot pay if custodial care is all that's needed.

When the stay in a skilled nursing facility is covered by Medicare, hospital insurance can help pay for up to one hundred, fifty days a calendar year, but only if daily skilled nursing care or rehabilitation services is needed for that long.

If admitted to a skilled nursing facility in 1989, you will have to pay $25.50 in co-insurance each day for the first eight days of care during the year. (The co-insurance amount will increase in future years.) Medicare pays for all other allowable charges for up to one hundred, fifty days even if discharged and re-admitted to a skilled nursing facility more than once during the year.

Medicare hospital insurance can pay for these services in a skilled nursing facility:

- A semi-private room (two to four beds in a room)
- All meals, including special diets
- Regular nursing services

- Rehabilitation services, such as physical, occupational, and speech therapy
- Drugs furnished by the facility
- Blood transfusions
- Medical supplies such as splints and casts
- Use of appliances such as a wheelchair

(Catastrophic Health Care Bill 1989)

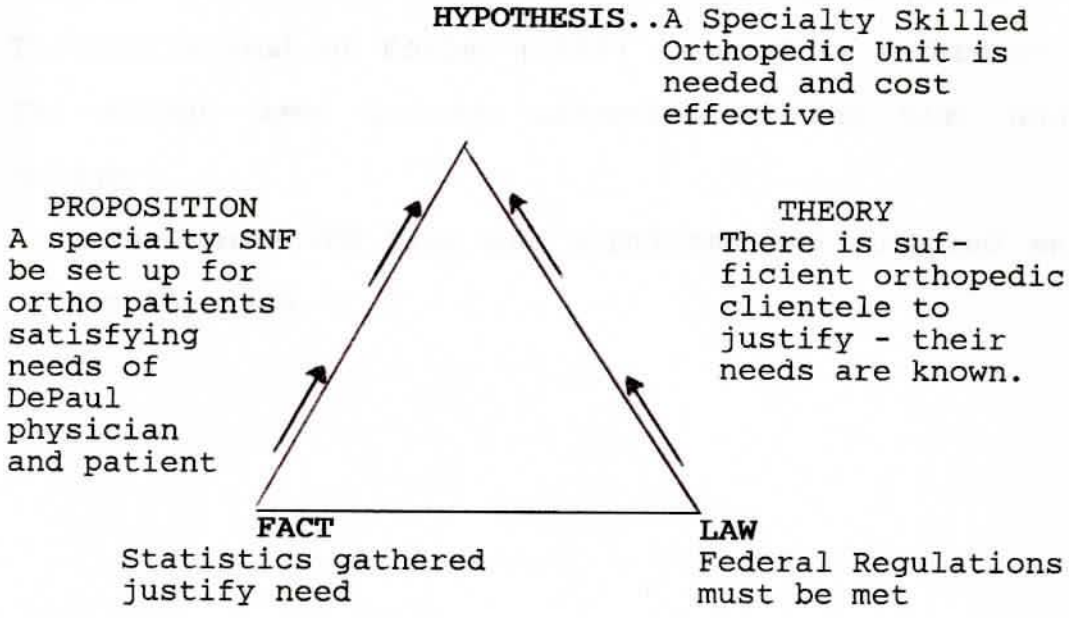
A skilled nursing unit must meet certain federal requirements to qualify as a skilled nursing facility, including total separation and independence in physical and functional structure. It must be a distinct part of the facility and provide its own recreational dining area, nurses station, clean and dirty utility rooms, budget and staff. (Department of Health 1989)

Statement of Need

One of the hospitals largest admitting specialists at the health center has requested the establishment of a designated area for skilled orthopedic patients. Research needs to be done to see if this project would be cost effective and meet the needs of the hospital, physician and patient while also meeting all regulatory requirements. The requesting specialist states this is needed to provide the care required for the patient. The managed care in this environment would control the balance of cost and quality, fast becoming the health care industry's power shift caused by prospective

payment.

Hypothesis



Development of scientific knowledge. (Treece 1982 p 65)

If there is a sufficient patient population to justify a special unit for orthopedic patients, acute hospital costs would be reduced, physician requests would be satisfied and the patient's physical and psychosocial needs would be met in a cost effective expeditious managed manner by the institution of a specialty skilled unit.

Research Design

Survey approach

Because this is an exploratory or descriptive study, and because new facts need to be gained in the actual setting, the survey approach was the likely possibility. Using the survey, I decided to use interview as the approach.

My design was the interview with Dr. Whiteside to determine wants and needs. I also used computer data collected via data processing to justify the use of set beds for the unit in a specific area.

Questions to be answered are:

Is this economically feasible?

Is there space to do this?

Will physician needs be met?

Will patient needs be met?

My role in this project is to have the marketing plan accepted and assist in the implementation of the project.

II. MARKETING PLAN METHODOLOGY

Jim McHugh, faculty LCIE, advised me in the writing of the marketing plan. He is considered an expert in his field as faculty, author and consultant. The entire text of Kotler (1989) is used as reference. The format used is one advocated by the text and McHugh.

The marketing plan was submitted and accepted as of May 13, 1989.

INTRODUCTION

To understand my proposed service/product, it is necessary to have a brief knowledge base of the Medicare program and a skilled-nursing facility.

The Medicare program is a Federal health insurance program for people sixty-five or older and certain disabled people. It is run by the Health Care Financing Administration of the United States Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

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Dr. Whiteside, Chairman of the Department of Orthopedics, has made several requests to DePaul Health Center Administration for a skilled nursing unit dedicated to orthopedic patients. He wants bed availability at all times for these patients so they can be moved out of the acute care setting rapidly. Medicare requirements have loosened considerably in the last year enabling more recipients to benefit from skilled care for longer periods of time once qualified. Because of this, there is less control and predictability of bed availability. At present, all patients

qualifying for skilled care are randomly grouped in the same unit.

A skilled nursing unit must meet certain federal requirements to qualify as a Skilled Nursing Facility, including total separation and independence in physical and functional structure. It must be a distinct part of the facility and provide its own recreational dining area, nurses station, clean and dirty utility rooms, budget and staff.

Dr. Whiteside, only one of the orthopedic surgeons using the unit, projects his practice will increase 20% in the next year. The length of stay in an acute care setting will decrease to five days. Information discussed later will explain the impact this will have on hospital revenue.

THE PRODUCT

The orthopedic skilled unit is a service dedicated to the care of orthopedic patients. As an intangible, the identifying hallmarks are accessibility to service, availability of beds when needed, managed care, trained staff, and part of a total service. The focus is on abilities and rehabilitative capabilities of the patients returning them to home at the highest functioning level possible.

The quality of the service is ascertained and maintained by internal monitors, quality indicators, and a previous outstanding record with licensing surveys. The current Skilled Nursing Facility unit has all of these in place. It is assumed the orthopedic unit will do no less since management will remain the same.

The current fifty bed skilled unit will isolate out ten beds to accommodate the orthopedic patients. The beds will be used only for this purpose. The target market is the physician. Without satisfied physicians on staff, there are no patients. The physician sees his target market as the patient. Without patients, he has no practice. Natural deduction then, is the physician as primary or direct market, and patient as secondary or indirect market. Once the patient is in the facility he becomes the primary market. (See interview and questionnaire).

Currently, there is data to substantiate a ten bed unit. In the month of April, 1989, there were 8.7 orthopedic patients as an average daily census in the Skilled Nursing Facility. If averages are maintained and an upward trend identified, the number of dedicated beds could be shifted upward. A patient room will also be taken out of use and converted to a multi-purpose room to meet the psychosocialization needs. A wellness, not illness, model of care is promoted: encouraging patients to dress in street clothes, engage in communal dining, and share in group activities.

The location in the St. Anne Division is satisfactory but not ideal, for several reasons. At present, according to Mark Stiffler, Supervisor of Social Service in DePaul, 21% of the patients in DePaul have their discharge delayed by one or more days because of bed availability at St. Anne's. Carving out ten dedicated beds and deleting one patient room will compound the problem. The ideal unit will be relocated in the Health Center July, 1990. Demand will be properly documented and trends established for bed utilization. Federal regulations only allows for change of bed allocation July 1 of each year.

All rooms are tastefully decorated; phones, TV's, assistive devices such as grab bars, walkers and wheelchairs are readily available. The Physical Therapy Department is conveniently located to the nursing unit.

Parking is accessible and available for visitors. The multidisciplinary team consists of physician, nurse, Physical Medicine therapists, social worker, activity therapist, pastoral care, pharmacist and utilization review coordinator. Team meetings are held weekly to discuss care plans, goals and progress, and the critical path.

Managed care must be more than a philosophy and protocol - it must include professionals skilled as both clinicians and managers who are committed to the welfare of both patients and the institution. The nurse is responsible for revising the Multidisciplinary Care Plan (see example) in accordance with an assessment of the individual patient's needs combined with the knowledge of attainable outcomes gleaned from experience and research. The nurse, working in a group practice, is accountable for meeting outcomes within an appropriate length of stay, the effective use of resources, and established standards (clinical processes and outcomes).

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The care of the patient is well orchestrated, the environment pleasant and the needs of patients, physician and hospital met.

FIGURE I

SERVICE IMAGE

PRIVATE/SEMI ROOMS

ALL NEEDED ASSISTIVE DEVICES

MANAGED CARE

MULTIDISCIPLINARY TEAM

ORTHOPEDIC SKILLED UNIT

OUTSTANDING RECORD WITH ALL LICENSING SURVEYS

REHABILITATIVE WELLNESS MODEL

ST. ANNE'S
PATIENT /RESIDENT'S PLAN OF CARE

Current Diagnosis _____

_____

Discharge Plan (Long Range Goal): _____

DATE	PROB. #	PATIENT PROBLEMS/NEEDS	EXPECTED OUTCOMES	TARGET DATE	RESOLUTION	INTERVENTIONS (indicate discipline responsible)	DATE	REVIEWED &/OR REVISED SIGNATURE, DEPARTMENT

CODE FOR RESPONSIBLE DISCIPLINE: S.S. - Social Service S.P. - Speech Therapy O.T. - Occupational Therapy
N.S. - Nursing Service A.T. - Activity Therapy R.Ph.- Pharmacy
P.C. - Pastoral Care P.T. - Physical Therapy R.D. - Dietary

Form #2-043-3
Approved by the Medical Exec. Committee 4-2-81.

TABLE I

STATISTICS

ADMISSIONS BY ORTHOPEDIC PHYSICIANS TO ST. ANNE'S SNF BEDS FOR MONTH OF APRIL 1989

Physician	Total Patients	Total Days	ALOS
Physician #1	1	33	33.
Physician #2	2	40	20.
Physician #3	2	58	29.
Physician #4	4	59	14.75
Physician #5	6	72	12.
TOTAL:	15	262	17.47

Average Patient Per Day: 8.7

ORTHOPEDIC MAJOR JOINT CRITICAL PATH

Patient _____

Admitting Physician _____

Consulting Physician _____

Primary Diagnosis _____

Secondary Diagnosis _____

Secondary Diagnosis _____

Code Status _____

Day	Day	Day	Day	Day	Day	Day	Day	Day
Team Consults								
Tests								
Activity								
Treatments								
Diet								
Discharge Planning								
Teaching								

DATE	VARIATION	CAUSE	ACTION TAKEN

Admission Date _____ Surgery Date _____

Sutures _____ Drainage _____

Foley Cath: ____ Yes ____ No Date Removed _____

PRICING

The issue is not the price to charge for the orthopedic skilled unit. The issue is it profitable enough not to lose money? Once again research proved to be most interesting.

Conclusions cannot be drawn regarding charges alone. The issues are cost and reimbursement. With the DRG's, charge is a moot issue. The hospital is paid a flat rate no matter what the cost or charge. The patient cannot be billed for any overage.

Data was requested for Medicare reimbursement vs charges for 5 South orthopedic cases. DRG 209 includes total hips and knees. In this DRG, charges from a profit/loss report were $1,560,818; reimbursement was $923,561 and cost of $1,035,354. The estimated loss is $111,793. If length of stay can be reduced one and a half times to two days, the loss will dramatically decrease.

Skilled care does not fall under a DRG. Medicare pays a per diem room and board and for other covered services. Looking at a profit and loss report for skilled care, diagnosis rehabilitative services that total knees and hips fall in, and the same time period of October 1988 through March of 1989, the following was found:

Charges	$411,483
Reimbursement	$373,840
Cost	$284,647
Estimated Profit	$89,193

It is profitable if skilled care and losses can be reduced in acute care in this DRG and diagnosis. A dedicated skilled orthopedic unit is not only profitable, but a necessity. Current charges for skilled nursing can remain status quo.

PROMOTION

DePaul Health Center has already made a serious commitment to the orthopedic service in several ways. Investment has been made in the acquisition and renovation of the Kroger building at I-70 and I-270. The new facility, the Missouri Bone and Joint Building, has the offices of Drs. Whiteside, Martin and Kasselt, an orthopedic research laboratory and an outpatient rehabilitation medicine department. Dr. Whiteside is world-renowned for his ortho lock joint prothesis.

State-of-the-art surgical suites provide the equipment and technology for the surgeons to utilize their skills. In DePaul Health Center the acute orthopedic unit provides care for the patient and the acute inpatient stay.

The inpatient and outpatient rehabilitation department provides all services to promote mobility, including strengthening exercises and equipment needed for the recovery. The proposed orthopedic skilled nursing area will provide the transition placement from acute care to home. This unit is the final component needed to have a total orthopedic service. I equate the service to a puzzle; all pieces present, fitting together making a picture. If a piece is missing, the picture is not complete.

Health Live is a TV call-in show sponsored by DePaul in one hour segments. The April 1989 segment

was dedicated to the orthopedic service. From this, over two thousand calls were fielded. This is not only a community service, but also a very good marketing strategy.

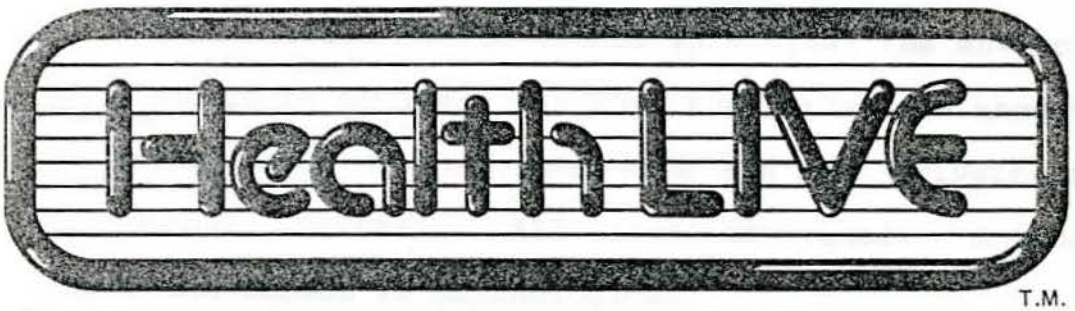
Dr. Whiteside is the largest orthopedic physician admittor and the largest revenue-producing physician for DePaul He has requested a specialty orthopedic skilled unit for nine years. I now feel justified the product has been adequately defined and I should proceed with the implementation. Once sold, the targeted physician and patient, are captured and the service is a closed loop. As long as patient satisfaction is maintained, the physician will be satisfied, his practice will continue to expand, and the ultimate test of success, a full census, will be present.

At present the only expense on the current 300 Unit needs to be a $2,000 expenditure for the room conversion. This is a great promotion and marketing tool. The operating budget is not a liability or cost as we will have proven the need for further Skilled Nursing Facility expansion. Ultimately ideal is the relocation. No specific advertising is needed. The service and census speaks for itself.

Communication is open between Administration and this researcher. I will present this service to DePaul Administration. If approved for Phase I and II,

in-depth budgets will be prepared for the expansion. Conferences with architects for renovation will be held and applications for assistance to the State to meet requirements will be made. Target date for final implementation is July 1, 1990.

The patient will have the opportunity for the optimum recovery before discharge home, cared for by a trained multidisciplinary team providing quality care, in a pleasant environment.



T.M.

A one-hour live call-in show, featuring DePaul Health Center physicians, answering your questions about sports injuries, joint replacements, arthritis, back injuries, strains, sprains and other problems related to the muscles and joints.

7 p.m., Saturday, April 15 4 ***KMOV-TV***

Sponsored by: **DePaul Health Center**

PLACEMENT

As previously stated, the unit should move from the St. Anne Division to the DePaul Division July 1990. The reason for this is psychological impact and physician convenience.

Dr. Whitside stated in his interview, the environment should be no less than what the patient is used to in acute care. Rooms in St. Anne are semi-private and in DePaul, private. All else is equal. Another important impact is psychological.

The majority of the total knee and total hip replacement patients are generally well physically. The joint has just worn out. The surgery is elective. The patient is alert and oriented. St. Anne is not only a skilled facility, but also a nursing home and placement there, even for a short time, can have a negative effect. The patient may feel they have been placed in a nursing home and will never get to their own home. Also, encountering some of the patients in the facility can be depressing since the orthopedic patient identifies with the other person, causing psychological trauma. Although this is a realism, alert, oriented people having elective surgery usually do not like living in the same environment with a confused disoriented person who has little hope of recovery. They have expressed feelings of "will this be me in a few years" which has a detrimental effect on

rehabilitation.

Segregating out ten dedicated beds has solved a lot of the problem, but there is still some contact since St. Anne is thought of as a nursing home by many.

Five North, adjacent to 5 South, is a "neurological" unit. After reviewing utilization of beds by service and total occupancy, I feel this is the perfect location for the orthopedic skilled unit. The non-neuro patients can be placed elsewhere in the hospital where occupancy has only been 68% during the review period. Note architectural drawings for current and proposed plans.

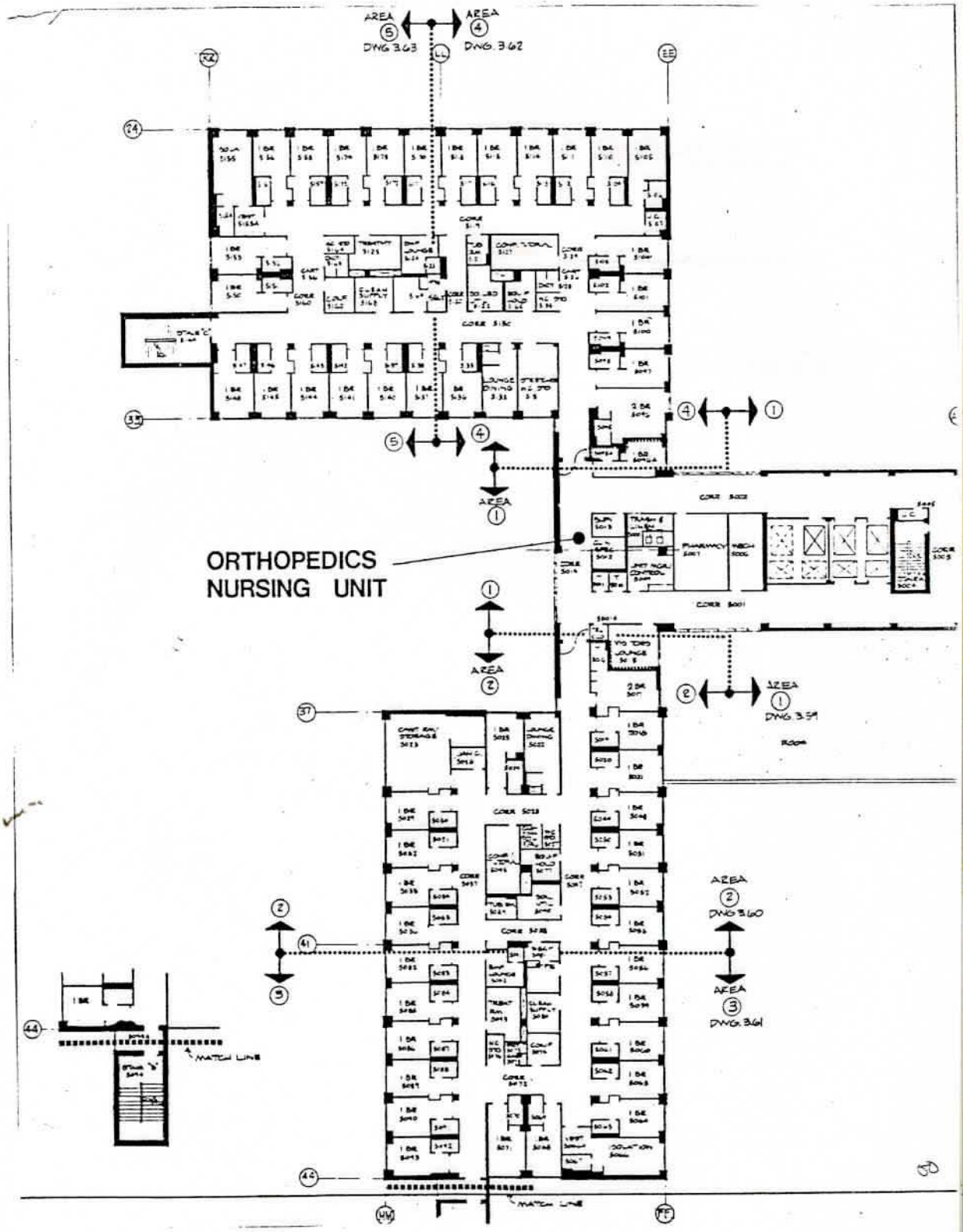
Once the skilled unit is moved from St. Anne, there will be more beds available for medical-surgical needs. The need for skilled beds is ever increasing and this gives DePaul an opportunity to have a viable plan to meet those needs.

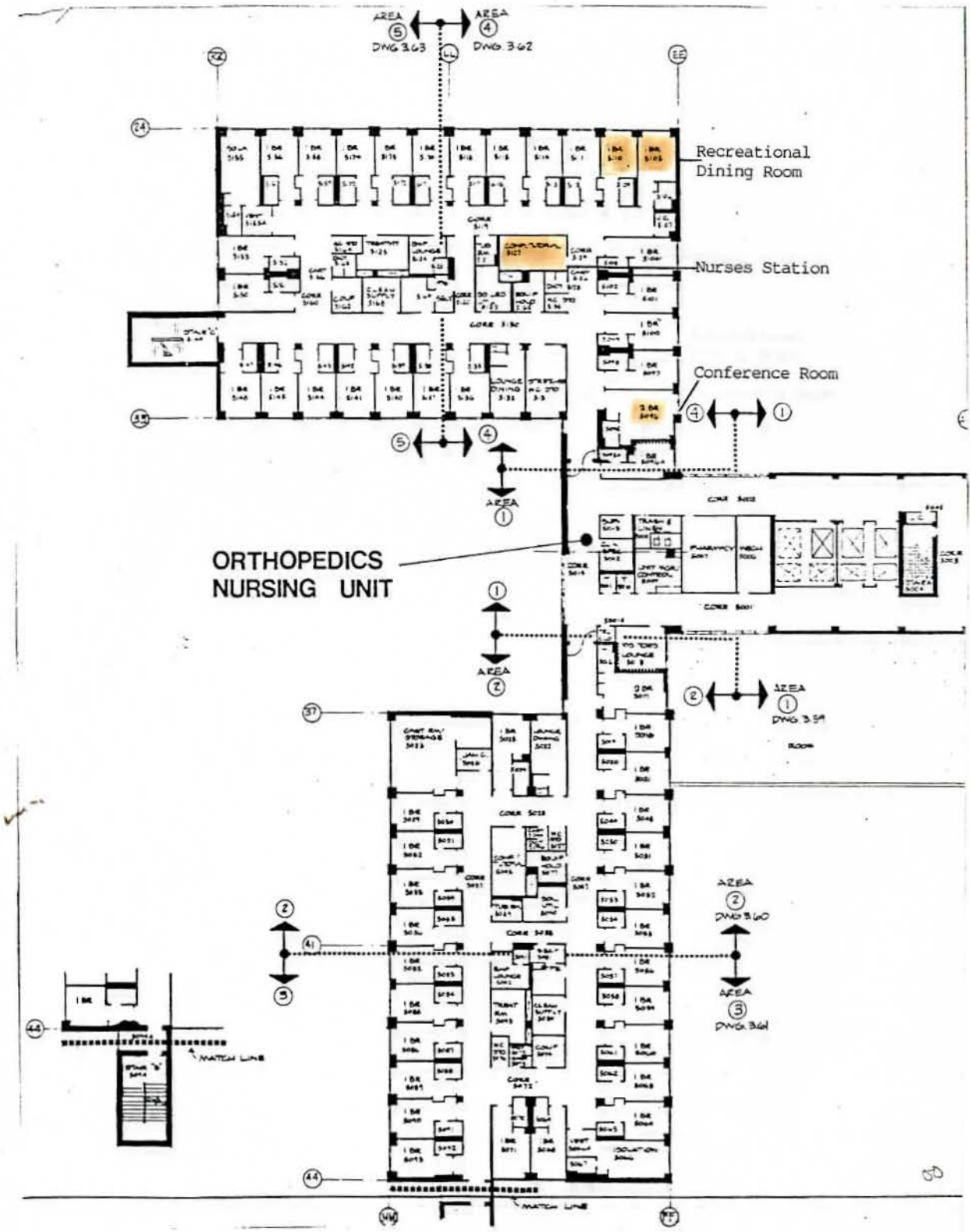
TABLE 2

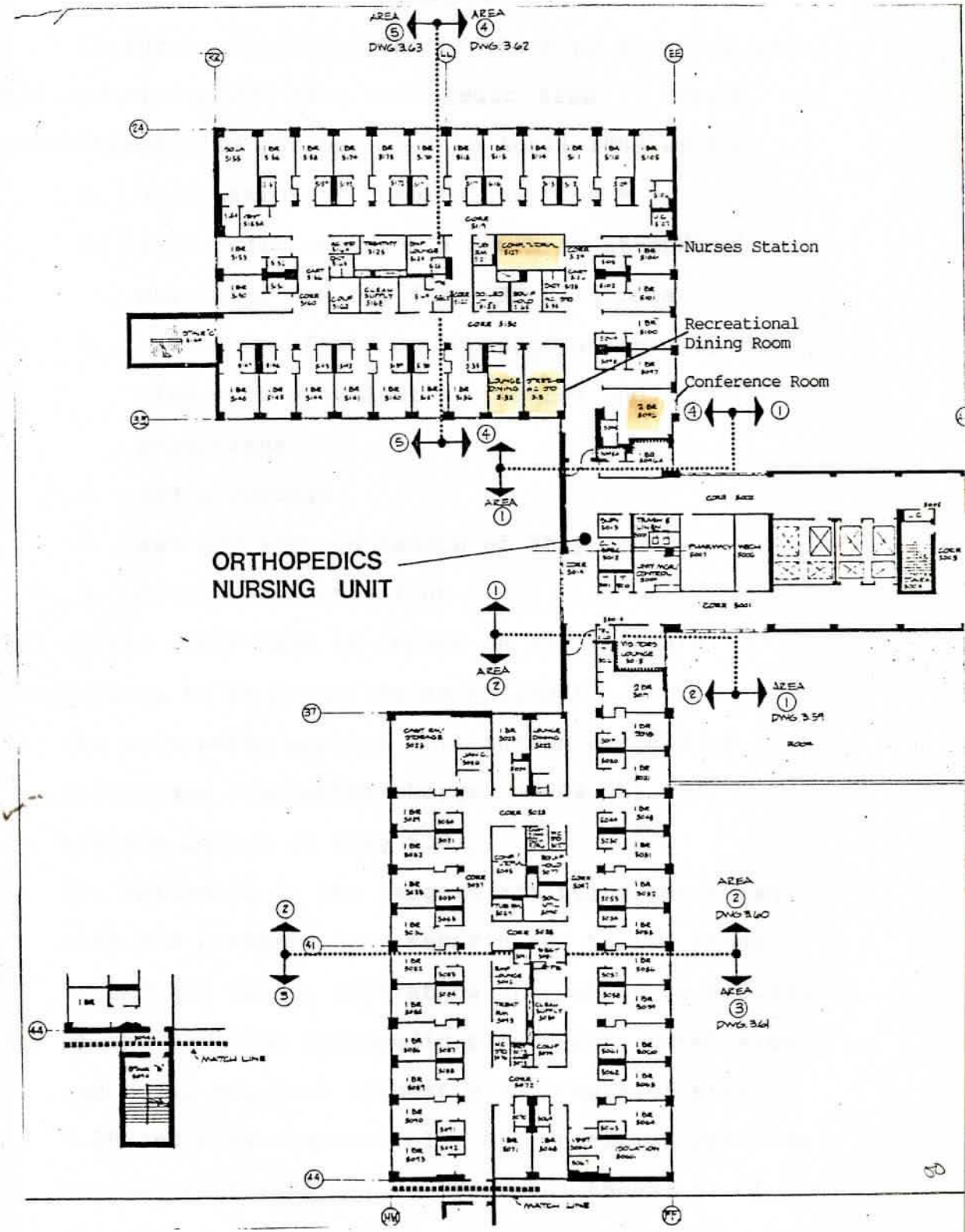
UTILIZATION OF 5 NORTH BY ATTENDING PHYSICIAN SPECIALTY

MEDICINE	244-#	OTHER SURGICAL SUBSPECIALTIES	10
	35.9-%		1.5%
	1594645.38-$		33751.68
	6.75-*		2.70
NEUROSURGERY	216	UROLOGY	7
	31.8%		1.0%
	1561886.56		31319.87
	5.60		4.14
GENERAL SURGERY	61	NOT IN ANY OF ABOVE	4
	9.0%		0.6%
	450034.96		130652.09
	6.52		13.00
PULMONARY MEDICINE	45	MISCELLANEOUS	3
	6.6%		0.4%
	427826.01		12224.33
	9.04		3.00
FAMILY PRACTICE	35	TOTALS	680
	5.1%		100.0%
	165209.89		4619772.92
	5.31		
			6.10
ORTHOPEDICS	31		
	4.6%		
	137758.17		
	4.10		
ENT	12		
	1.8%		
	42354.76		
	2.17		
NEUROLOGY MEDICINE	12		
	1.8%		
	32109.22		
	2.83		

= number patients
% = % of discharge from 5 North
$ = total charge
* = average length of stay


AREA 5 DWG 3.63
AREA 4 DWG 3.62
ORTHOPEDICS NURSING UNIT
AREA 1
AREA 2
AREA 1 DWG 3.59
AREA 2 DWG 3.60
AREA 3 DWG 3.61
MATCH LINE
MATCH LINE


Recreational Dining Room
Nurses Station
Conference Room
ORTHOPEDICS NURSING UNIT
AREA 5 DWG 3.63
AREA 4 DWG 3.62
AREA 1
AREA 2
AREA 1 DWG 3.59
AREA 2 DWG 3.60
AREA 3 DWG 3.61
MATCH LINE
MATCH LINE


AREA 5 DWG 3.63
AREA 4 DWG. 3.62
Nurses Station
Recreational Dining Room
Conference Room
ORTHOPEDICS NURSING UNIT
AREA 1 DWG 3.59
AREA 2 DWG 3.60
AREA 3 DWG 3.61
MATCH LINE
MATCH LINE

THE RESEARCH

To substantiate the Skilled Nursing Facility unit, the current acute care orthopedic area, 5 South, was scrutinized from October 1988 to April 1989 as to:

1. utilization by hospital service -
2. orthopedic cases on 5 South by attending physician and top five DRG diagnoses
3. breakdown of the orthopedic patients by the five most prevalent procedures and physicians
4. age groupings
5. sex and average length of stay
6. discharge disposition

All of the above have an impact on skilled care. Conclusions to be drawn are as follows:

1. The orthopedic service utilization was 84% of discharges generating charges of $4,943,383, average length of stay 6.07.
2. Dr. Whiteside is the largest admitting physician with his partners Drs. Kasselt and Martin being second and third, generating charges of $2,626.225.
3. Of the top five orthopedic procedures, total knee and total hip rank highest with length of stay of 7.29 and 6.84 respectively; Dr. Whiteside performs the majority, 108 out of 126 total knees; 52 of the 68 total hips. From these two, charges are $2,578.478.

4. Ages were grouped in five year increasing increments and the median age of 65 - 74 being the most prevalent.
5. Females outnumber men 166 to 108, and their length of stay 8.17 to 6.54.
   Total hips were about equal, but total knees are 78 female, to 48 male.
6. The majority of the patients were discharged to their homes, but several of the total hips and knees required home health care and skilled care.

Hypothesis is: if Dr. Whiteside, et al, increases their practice by 20% and if he decreased the length of stay to five days if his practice is total knees and hips, the number of patients requiring skilled care will increase because they will be unable to go home or home with home health.

TABLE 3

UTILIZATION ON 5 - SOUTH BY HOSPITAL SERVICE

ORT	560	# of patients
	86.4%	% of discharges
	4943383.13	total charges
	6.07	average length of stay
MED	63	#
	9.7%	%
	322413.36	$
	5.78	LOS
SUR	12	#
	1.9%	%
	120114.75	$
	7.43	LOS
ONS	4	#
	0.6%	%
	15618.12	$
	3.25	LOS
PTS	3	#
	0.5%	%
	15147.49	$
	8.33	LOS
URO	1	$
	0.2%	%
	4506.09	$
	8.00	LOS
ENT	1	#
	0.2%	%
	1136.43	$
	1.00	LOS
TOTALS	648	# of patients
	100.0%	% of discharges
	5491622.99	total charges
	6.12	average length of stay

TABLE 4 A

ORTHO CASES ON 5 SOUTH BY ATTENDING PHYSICIAN

(# = NUMBER PATIENTS, $ = TOTAL CHARGE, * = AVERAGE LENGTH OF STAY)

	ORIF	T.KNEE	T.HIP	FEMUR	SHOULDER
Physician #1	5-#	2	3	2	1
	38101.54-$	22721.30	34794.40	22806.57	6343.45
	7.60-*	7.50	7.00	8.00	2.00
Physician #2	4	0	0	0	0
	53332.67	0	0	0	0
	10.25	0	0	0	0
Physician #3	0	0	1	0	0
	0	0	16122.35	0	0
	0	0	14.00	0	0
Physician #4	14	4	4	1	2
	89696.22	62706.27	74307.09	9926.24	26884.46
	6.50	10.25	11.50	9.00	15.00
Physician #5	1	0	0	0	0
	4188.25	0	0	0	0
	5.00	0	0	0	0
Physician #6	3	0	0	0	0
	24668.05	0	0	0	0
	10.00	0	0	0	0
Physician #7	9	5	6	1	1
	73955.41	61894.01	70326.40	13987.50	32581.65
	8.44	7.00	6.50	8.00	17.00

	ORIF	T.KNEE	T.HIP	FEMUR	SHOULDER
Physician #8	4	2	0	2	0
	42153.94	46496.15	0	12726.38	0
	12.00	19.50	0	11.00	0
Physician #9	3	0	0	0	0
	25797.20	0	0	0	0
	10.33	0	0	0	0
Physician #10	2	3	0	2	0
	12355.05	47617.07	0	36406.99	0
	6.00	11.33	0	17.50	0
Physician #11	4	0	0	0	0
	33712.91	0	0	0	0
	11.00	0	0	0	0
Physician #12	14	2	2	0	0
	110140.44	34633.18	25912.12	0	0
	6.93	10.00	9.50	0	0
Physician #13	0	108	52	1	2
	0	1462436.99	618511.81	14211.05	14790.43
	0	6.81	6.27	7.00	3.50
TOTALS	63	126	68	8	6
	508101.68	1738504.97	839974.17	110075.73	80599.99
	8.14	7.29	6.84	10.75	9.33

TABLE 4 B

ORTHO CASES ON 5 SOUTH BY ATTENDING PHYSICIAN

Physician #1	13	- Total patients
	124767.26	- Total charges
	7.08	- Average length of stay
Physician #2	4	#
	53332.67	$
	10.25	LOS
Physician #3	1	#
	16122.35	$
	14.00	LOS
Physician #4	25	#
	263520.28	$
	8.68	LOS
Physician #5	1	#
	4188.25	$
	5.00	LOS
Physician #6	3	#
	24668.05	$
	10.00	LOS
Physician #7	22	#
	252744.97	$
	7.95	LOS
Physician #8	7	#
	101376.47	$
	14.00	LOS
Physician #9	3	#
	25797.20	$
	10.33	LOS
Physician #10	7	#
	96380.11	$
	11.57	LOS
Physician #11	4	#
	33712.91	$
	11.00	LOS

ORTHO CASES ON 5 SOUTH BY ATTENDING PHYSICIAN

Physician #12	18	#
	170685.74	$
	7.56	LOS
Physician #13	163	#
	2109960.28	$
	6.60	LOS
TOTALS	271	Total Patients
	3277256.54	Total Charges
	7.52	Average Length of Stay

TABLE 5

AGE GROUPINGS FOR ORTHO CASES ON 5 SOUTH

	60-64	65-69	70-74	75-79	80-84	85-89	90-99	TOTALS
OP RED-INT FIX TIB/FIBUL	2	4	2	1	0	0	0	9
OPEN REDUC-INT FIX FEMUR	2	4	2	4	7	8	3	30
OTHER TOTAL HIP REPLACE NON-CEMENTED	7	8	10	8	2	0	0	35
REPLACE FEMORAL HEAD NEC	0	4	0	0	1	2	0	7
SHOULDER ARTHROPL-PROSTH	1	0	3	1	0	0	0	5
TOTAL KNEE REPLACEMENT	14	29	28	14	8	3	2	97
TOTALS	**27**	**54**	**46**	**31**	**20**	**13**	**4**	**195**

TABLE 6

SEX AND AVERAGE LENGTH OF STAY FOR 5S ORTHO CASES

	FEMALE	MALE	TOTALS
OP RED-INT FIX TIB/FIBUL	17 #	15 #	32 #
	5.00 *	4.53 *	4.78 *
OPEN REDUC-INT FIX FEMUR	26 #	8 #	34 #
	11.38 *	11.00 *	11.29 *
OTHER TOTAL HIP REPLACE NON-CEMENTED	29 #	27 #	56 #
	7.31 *	6.22 *	6.79 *
REPLACE FEMORAL HEAD NEC	7 #	1 #	8 #
	10.29 *	14.00 *	10.75 *
SHOULDER ARTHROPL-PROSTH	4 #	2 #	6 #
	13.00 *	2.00 *	9.33 *
TOT HIP REPLACE-METHACRY	5 #	7 #	12 #
	7.00 *	7.14 *	7.08 *
TOTAL KNEE REPLACEMENT	78 #	48 #	126 #
	7.76 *	6.54 *	7.29 *
TOTALS	166 #	108 #	274 #
	8.17 *	6.54 *	7.53 *

= NUMBER OF PATIENTS
* = AVERAGE LENGTH OF STAY

TABLE 7

DISCHARGE DISPOSITION - ORTHO CASES ON 5 SOUTH

	AHR	ARS	ATE	ATO	ATR	TOTALS
OP RED-INT FIX TIB/FIBUL	26	2	2	0	2	32
OPEN REDUC-INT FIX FEMUR	14	2	13	4	1	34
OTHER TOP HIP REPLACE NON-CEMENTED	43	6	6	0	1	56
REPLACE FEMORAL HEAD NEC	6	1	1	0	0	8
SHOULDER ARTHROPL-PROSTH	5	0	0	1	0	6
TOT HIP REPLACE-METHACRY	7	3	2	0	0	12
TOTAL KNEE REPLACEMENT	97	16	9	1	3	126
TOTALS	198	30	33	6	7	274

AHR = Routine discharge (to home or self care)
ARS = Referred to organized home care service, i.e., visiting nurse
ATE = Discharged to extended skill care facility including St. Anne
ATI = Discharged to intermedicate care facility including St. Anne
ATR = Discharged to rehabilitation center including Rehab Unit

III. RESULTS

Evaluation and implementation will be done in two phases. The marketing plan needs acceptance before the actual implementation of the unit can be initiated. The author assumes this phase has been successful. Instructions have been given to pursue with phase two and gather the information needed from the state as to their requirements.

Decisions need to be made in conjunction with all affected parties as to: architectural needs and wants, requirements of a distinct part unit, decertification of acute care beds and addition of SNF beds, time requirements and approvals needed.

A contact was made in Jefferson City, Missouri at the Department of Health for assistance. The following verbal responses were given to my questions. The hospital needs to follow all the state licensing rules and regulations. An in-house evaluation for compliance is requested from the hospital to the Department. Approval for the project is requested via letter. Submission of floor prints - current and proposed - is submitted for approval, then request a visit for the final survey. The Department of Health requests two to three months lead time. Certification and decertification of beds for proper license can now be done at any time during the fiscal year. Keep in mind, there is an

existing SNF licensed and functioning. This project is the establishment of a specialized unit of the SNF beds.

The State Requirements

The state requirements for licensure of additional SNF beds the author needs to be concerned about are the ten listed. If an existing SNF was not already in place, the entire Department of Health building requirements and regulatory manual would need to be adhered to before the unit would be licensed. The SNF unit must be a "distinct part" of the hospital: separate unit, nurses' station, utility and medicine rooms and staffs.

1. Planning and Construction Procedures.

(A) Plans and specifications shall be prepared for the construction of all new long-term care units in hospitals and additions to and major remodeling of existing long-term care units. The plans and specifications shall be prepared by an architect or a professional engineer licensed to practice in Missouri.

(B) Construction shall be in conformance with plans and specifications approved by the Department of Health. The Department of Health shall be notified within five (5) days after construction begins. If construction of the project is

not started within one (1) year after the date of approval of the plans and specifications, the plans and specifications shall be resubmitted to the Department of Health for its approval and shall be amended, if necessary, to comply with the then current rules before construction commences.

2. Grab bars or handrails shall be proved to all bathtubs, within all showers, on at least one (1) side of all waterclosets and located in proper positions to facilitate the bodily movements of residents.

3. Lavatories shall be positioned to be accessible to wheelchair residents and shall not have cabinets underneath or any other unnecessary obstruction to the maneuverability of wheelchairs.

4. Mirrors shall be provided in each resident room or adjoining toilet room. Mirrors shall be at least three feet (3) high and located with the bottom edge no more than three fee four inches (3'4") above the floor or framed tilting mirrors may be used.

5. A separate public area for a long-term care unit shall be provided and shall include a waiting room, public toilets for each sex and a public television.

6. An office shall be provided for the licensed nurse supervisor of the unit.
7. Recreation, occupational therapy, activity and residents' dining space shall be provided at a ratio of at least thirty (30) square feet for each resident.
8. A personal care room with barber and beauty shop facilities shall be provided.
9. General storage rooms shall be provided as follows: ten (10) square feet per bed for the first fifty (50) beds; plus eight (8) square feet per bed for the next twenty-five (25) beds; plus five (5) square feet per bed for any additional beds. No storage room shall have less than one hundred (100) square feet of floor space. Storage space for residents' clothes and for outdoor equipment is required but may be undivided in the minimum area required for general storage.
10. Handrails shall be provided on both sides of all corridors, aisles and stairways. Corridor handrails shall have ends returned to the wall.

A budget for the ten bed SNF orthopedic unit is very generic and divided into three parts. Staff requirements may vary from year to year and only nursing staff is calculated. Staffing ratio is based

on a standards outcome process. Acuity of the patient may need to increase the ratio. There are no written guidelines by the state for numbers to achieve the positive outcomes of care required. Operating expense is estimated from the acute care orthopedic unit 1989 budget. Equipment needed for start up should be a one time initial expense with replacement as needed.

Staffing on a daily basis should be as follows and based on a census of ten (10) patients.

7-3 shift (2 RN's) 1 RN 7-3:30

1 RN 9-5:30 and 2 CNA's

Four hours of Unit Secretary coverage.

3-11 shift 1 RN and 2 CNA's

11-7 shift 1 RN and 1 CNA

Supervisor hours and charges are dependant on location of the unit.

Supplies are divided into specific sub-accounts and would be dependant on specific institution as to format. Things to be considered are medical/surgical supplies, office supplies, repairs, general non-chargeable central service supplies, nutritional and pharmacy transfer of charges to the unit.

Example:	3400 Med/Surg-Supply	$150
	4600 Stationary/Office	$400
	4614 Printing	$1100
	4620 Office Supplies	$100

5000	Gloves	$1080
9216	Tr Out Dietary	$105
9218	Tr Out Nutritional Support	$332
9400	Transfers Central Supply	$2175
	TOTAL EXPENSES	**$7292**

Equipment needed for start up may be already existing in the facility and allocated to the unit or purchased as new.

Ten (10) wheelchairs with interchangeable parts	$7000
Tables and chairs to accommodate patients and visitors in recreational dining area	$3000
TV & VCR for recreational areas	$1000
Raised toilet seats for all bathrooms	$1000
Medicine cart - ability to double lock	
SNF chartbacks and dividers	$ 400
Code 4 Cart	
Clocks and calendars in all rooms	$250
Smooth mover and stretcher	$550
TV's and phones for all rooms	
Two (2) deluxe shower chairs	$2000
Ten (10) transfer belts	$ 100

Refrigerators - patient and employee	$ 900
Microwave	$ 400

Dollar figures are approximate. Exact numbers are dependant on facility and purchasing contracts.

Construction costs are estimated to be approximate to another unit with similar requirements, this estimate is $130,000. Exact numbers would be known at the time plans receive final approval and bids are received.

Implementation of phase two is ideal at the time nurse station innovation is set for the proposed location. I propose the existing unit relocated to the current closed unit. The now vacated unit can be reconstructed to the needed specifications without disruption in patient care. All plans need to have expansion capabilities already in place so no further construction is needed, i.e., ten patients to fifteen patients to twenty patients as the census increases.

Timelines for completion of the plans and approval need to be set in conjunction with the various Directors, Vice Presidents, and Presidents involved. Appropriate staff involvement is a necessity as they are the ones working in and with the unit.

Implication is one of financial and resource allocation. Statistically, there is proof the unit is

cost effective but the initial investment is substantial. The facility needs to decide if the money is available in this fiscal year.

Implications also involve establishment of the multidisciplinary team and time allocations for function. Departments involved are dietary, rehabilitation medicine, social services, recreational therapy, pharmacy, and pastoral care. No new policy and procedures need to be developed as the unit would be under the existing umbrella of the St. Anne Division which is eighty-two (82) beds of skilled care. The facility also needs to make the initial decision as to how many acute care beds will be allocated to the project. The immediate need is ten beds. Is it better to certify an end need and plan space now or make application for expansion each year as the bed usage is proven? I suggest: plan for the maximum now.

Implications for staff require a willingness to be flexible when census varies. Naturally as the census drops, staff will be floated elsewhere to work in the hospital. There is also a need to be fully knowledgeable of all the SNF rules and regulations and to remain current in compliance. Regulations are on a constant continuum of change. Initial inservices will need to be conducted to share this information before the unit opens.

Recommendations for further study are to track utilization of this unit for quality and costs. It will be most interesting to prove the hypothesis. Financial services may want to use this as a tracking method for charges and actual costs. Utilization Management may want to track DRG days and the impact on the facility. The existing SNF may want to group similar diagnosis and institute the same type of managed care by speciality. This project has been thoroughly researched and planned for the implementation. The success should be easily tracked and documented.

APPENDIX A

DePAUL HEALTH CENTER
April 19, 1989

TO: Ruth E. Williams, RN, MS
Vice President

FROM: Vicky Engel, RN
Patient Care Manager

RE: MARKETING AND CULMINATING PROJECT

As you know, this is the final twelve weeks of my masters program and completion requires a marketing and culminating project.

I plan to combine these projects with a perceived need at St. Anne's. My proposal is an additional skilled unit at the St. Anne's facility. The direction of that unit to be the orthopedic skilled market.

Dr. Whiteside has verbally told me his practice is projected to increase to twenty surgeries per week. I plan to investigate the orthopedic:

1. wants vs needs
2. cost
3. target population, i.e. patients and orthopods
4. promotion of the new service to hospital, patient and physician
5. environmental impact

I need to initiate research by April 21, 1989. Research is limited to the compilation of statistical data only. No research on human subjects. Please advise as soon as possible and thank you for your consideration for this important project.

VE/lls

APPENDIX B

RESEARCH QUESTIONNAIRE

As Chief of Orthopedics in the area of Skilled Nursing Facility care:

1. What are your wants/needs?
2. Do you have specific ideas as to patients' wants/needs?
3. What kind of bed capacity can you support?
4. What socio-economic population are we servicing?
5. What is your projected practice pattern procedure?
6. What happens when beds are not in use?
7. Would increase in procedure/practice support a unit?
8. Do you have a general idea how many or what percentage have utilized a Skilled Nursing Facility?

APPENDIX C

DR. WHITESIDE INTERVIEW

Engel: Who is primary customer?

Whiteside: The patient is primary customer. If the patient is not happy, the doctor does not send them there. The doctor is not there all the time; the patient is.

Engel: What does a doctor want/need on stepdown orthopedic unit?

Whiteside: Besides necessary orthopedic equipment to make a patient comfortable and provide them with good, safe care, I want a facility that will make them comfortable in almost every way and will make them recommend it to others.

Engel: Would you say a patient's wants/need is a private room?

Whiteside: Yes, that would be a necessity for most people.

Engel: What kind of bed capacity do you think orthopedics can support?

Whiteside: I would say right now we need ten; next year fifteen, and the year after that, twenty. An expandable unit.

Engel: What socio-economic population are we servicing?

APPENDIX C

DR. WHITESIDE INTERVIEW (continued)

Whiteside: I serve the entire spectrum; however, in general, it is the average working class people from Southern Illinois and North St. Louis. We serve approximately 25% of upper middle-class, executive-type people.

Engel: What do you see for the future patient in length of stay?

Whiteside: I am looking and educating all my patients for a five day stay on total joint replacement.

Engel: What would we do with the beds when they are not filled?

Whiteside: I would fill them with mobile people that can be moved out of the unit.

Engel: Do you now what percentage have utilized a Skilled Nursing Facility?

Whiteside: I don't know. I haven't keep any records of percentages.

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