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Boston University
Entire care-giving system of teaching hospitals threatened by health-care cost crisis

It is no secret that the fiscal condition of health-care institutions has increasingly worsened over the past few years. The situation, however, has become even more critical in recent months. Consider this alarming national statistic: Due to a variety of cost-containment pressures, the average net operating margin of hospitals—the difference between what it costs hospitals to provide services and the amount of money they are actually paid—is now 0 percent.

Hospitals cannot afford to simply break even from operations," says Maura Mitchell, R.N., M.A., M.Ed., director for nursing projects and external affairs. "This situation is devastating for hospitals because of the capital-intensive nature of the services we provide. Some surplus revenue is needed in order to pay for the acquisition of new equipment to keep up with the latest medical technology, and to make improvements in the physical environment of the hospital. Because of proposed reimbursement reductions at both the federal and state levels, the entire system of providing quality patient care is now threatened."

In Massachusetts, for the first time in 12 years, more than two-thirds of hospitals are experiencing deficits. In 1988, the average hospital in Massachusetts suffered a 1.4-percent loss in revenue for services rendered. As a result, all Boston-area teaching hospitals, including UH, are grappling with major financial concerns. "For those of us who work as health-care providers, this issue is particularly relevant since the treatment of patients is directly linked to the financial resources at hand," says Mitchell. "Therefore, it is important for the nursing staff to understand how hospitals are paid for their services so that we may take an active role in bringing about changes for a more equitable state and federal health-care reimbursement system."

To illustrate how the University Hospital is paid for its services, it is possible to divide each dollar that the Hospital is paid into two halves. Slightly less than half of every dollar of the Hospital's revenue comes from Medicare, the federal program that covers the elderly patient population over the age of 65 through Social Security. The other 55 cents of each hospital revenue dollar is generated from other sources—Medicaid, which is welfare from either the federal or state government, or reimbursement from other third-party payors, including commercial continued on page 2
Editorial: Confronting the challenge

We in nursing have before us a formidable challenge: Both the state and federal governments are removing huge sums of money from our health-care system. Our patients are older, plus sicker, and we find ourselves struggling to recruit more people to enter the nursing profession. These factors do not stand as separate problems, but rather are tightly interwoven, a seemingly impossible set of opposing circumstances.

We are being asked, it seems, to do more with less. Although working harder may seem to be the answer, it definitely is not. Instead, we must find ways to work smarter. Today's constraints are too great to continue trying to do things exactly as we did them in the past. We must find new ways to meet the needs of both our patients and our fellow health-care providers.

One program that we at UH have introduced to meet the challenge of working smarter is our Nurse Extender Model, involving patient care technicians. Some people are concerned about this change, and ask if we are replacing our nurses. The answer is no, we are not replacing individual nurses, but we are replacing our traditional primary nursing system with a new primary nursing model. In this model of care, instead of having the professional nurses provide all the patient care, our nurses and technicians work together to care for our patients.

This Nurse Extender approach does mean fewer nurses within our department today, but it does not mean we have fewer caregivers. Care is provided at less cost—but that does not mean that the care is of a lesser quality. This nursing model also should provide us with more nurses in the future, if we properly support and encourage our technicians to pursue nursing careers.

We should all feel good about this new model of nursing care, because it is aimed at helping nurses today as well as tomorrow. At the same time, we are developing a smarter way to care for our present—and future—patients. It all makes sense: Today's nurses need helpers, our helpers will be tomorrow's nurses, and our patients will benefit from both.

Although our Nurse Extender Model will help us to deal with the new realities of nursing posed by today's challenges, it will not be enough. We are also going to need to examine how nursing is practiced and make still more changes. We are going to have to look at what we do and ask ourselves, is this really necessary? Will the patient outcome be any different if this is done or not done? Will I feel any less satisfied as a professional if I change this practice? These are hard questions. They are the kind of questions we need to ask as a group.

We are going to need collective thinking and lots of mutual support if we are to change and remain content with—-and challenged by—this special profession called Nursing. I believe that we will be able to do it. The challenge is before us, and I am confident that, together, we will meet it.

Karen K. Kirby, R.N., M.S.N., Senior Vice President for Nursing

Health crisis continued from front page

insurance companies, Blue Cross and health maintenance organizations (HMOs).

Spurred by the spiraling cost of Medicare and mindful of the expanding federal deficit, the federal government devised a plan intended to manage the growing costs of caring for the sick. In 1983, the federal government began to implement this system, called diagnostic-related groups [DRGs], in hospitals around the country. Since Massachusetts was one of four states that received a waiver, hospitals in this state did not go on the DRG system at the same time as the rest of the country, and DRGs were not used in Massachusetts hospitals until 1985.

DRGs work this way: In order for hospitals to be paid for their services, there are over 470 possible diagnoses or medical problems grouped together. Each DRG is assigned a relative weight for the purpose of determining a flat fee to reimburse hospitals for services rendered in providing treatment for a given patient. The relative weight is based on an average or mean amount for all hospitals nationwide. Each year, these guidelines are reviewed and updated by the federal government.

"The problem with DRGs is that, although the system does make adjustments for urban hospitals and for teaching hospitals, it does not take severity of patient illness into account," explains Mitchell. "By definition, teaching hospitals are referral hospitals. Therefore our patient populations tend to have illnesses with complications, and they are generally the sickest patients within any given category of illness. Since reimbursement under the DRG system is based on an average, and there is no adjustment made for the severity of illness, it often costs teaching hospitals more to care for these sicker patients than they receive as payment. The hospitals must absorb the difference between the Medicare reimbursement and what the actual cost is to maintain and provide the highest standards of care for the patients."

These factors alone have placed a strain on an already overburdened health-care system, but events at the federal and state level in the past year have made matters even worse. The federal government has proposed further Medicare cuts in an attempt to balance the federal budget. An additional $5 billion in cuts are proposed for the upcoming fiscal year. This means that there will be even less money for hospital reimbursement at the federal level.

Despite the fact that Medicare expenditures comprise only 9 percent of the federal budget, this program absorbed 36 percent of all federal budget cuts last year. This year Massachusetts hospitals spent $150 million more to provide care for Medicare patients than they were paid by the government. Compounding this problem, Massachusetts is one of the few states that does not allow any cost-shifting, that is, having any other third-party payors absorb any of this cost.

The other 55 cents of hospital reimbursement is governed by Chapter 23 of the General Laws of the Commonwealth. The state's system of reimbursement works this way: Hospitals are paid based on the total amount of case-mix adjusted discharges. This figure is calculated by taking into account two different factors. The first is the total

'Hospitals cannot continue to provide the same level of quality care under such fiscal constraints.'
amount of resources it costs hospitals to provide services to the patient. This figure is then multiplied by the case-mix index, which measures the intensity of the services provided, or the level of the patient’s illness.

The Dukakis administration, like its federal counterpart, has also proposed substantial cuts in its health-care budget. For the current fiscal year, that means that $37 million previously appropriated will not be paid to hospitals, and for the upcoming fiscal year, $50 million will not be paid to hospitals. In addition, there had been money set aside by the state to cover costs for patients who are not covered by any type of insurance. This uncompensated-care fund amounts to an additional $77 million in hospital reimbursements to be cut. Such dramatically reduced state funding will result in over $100 million dollars less in hospital reimbursement during the coming year.

"Hospitals cannot continue to provide the same level of quality patient care with the same access to care under these kinds of fiscal constraints," concludes Mitchell.

"This burden ultimately will be borne by the patient. The result will be that much-needed health-care services will not be readily available, nor will there be enough qualified health-care professionals to provide these services. We as nurses must get involved in the process of educating the public about these issues. It is vital that we make an impact on policymakers to help ensure that hospitals are enabled to continue to provide quality patient care. If not, the real-life consequences will be frightening."

For more information, contact Maura Mitchell, R.N., M.A., M.Ed., director for nursing projects and external affairs, at x8960 (638-8960).

Two-day Boston conference focuses on clinical nurse specialist's role

Last November, more than 250 nursing professionals from New England and around the country convened in Boston for a two-day conference, "Perspectives on Power: Tools for the Clinical Nurse Specialist." Clinical nurse specialists from Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Medical Center, who originated the annual conferences in 1979, were joined in sponsorship of the program by their counterparts at UH, which was the first Boston hospital to employ clinical nurse specialists.

"The purpose of this conference was for the speakers to address the different types of power that we as clinical nurse specialists need to amass and utilize in terms of our job," says Noreen Leahy, R.N., M.S., clinical nurse specialist. With that objective in mind, the panelists focused their presentations on several key topics. These included identifying specific sources of personal and professional power for the clinical nurse specialists, helping determine mechanisms that translate and integrate power in the clinical nurse specialist practice, and developing strategies that predict and direct clinical nurse specialist power as the role exists now and may change in the future. The program offered speaker lectures, informal discussion groups and poster presentations.

Clinical nurse specialists have masters degrees, with a specialty focus in a particular clinical area. "The clinical nurse specialist's role here at the University Hospital constitutes a number of components," explains Leahy. "Although one is teaching and education, the largest component is direct clinical practice, where we're on the units with the staff, caring for the patients, meeting with families. We spend our time trouble-shooting, problem-solving and anticipating a lot of the more complicated problems that enter into treatment, and then proposing intervening measures to help prevent further complications."

Leahy continues, "Another important aspect of our job is consultation, where we may be called upon to evaluate a patient's condition in our particular area of expertise anywhere in the hospital.

Research is yet another part of the clinical nurse specialist's role, and this includes conducting research projects as well as interpreting the most recent findings in journals and conveying them to staff so that they may be incorporated into treatment.

"The nursing administrators here at UH strongly support the important role that clinical nurse specialists play in the institution," says Nancy McCaw, R.N., M.M.H.S., senior nursing director. "We recognize the value of educational programs such as the clinical nurse specialist conference and will continue to assist in marketing and planning such programs in the future."

For further information, contact Noreen Leahy, R.N., M.S., clinical nurse specialist, at x7616 (638-7616).
Profile:
Grey Graham, R.N., clinical nurse leader

keen awareness of professional issues has always mixed with an intelligent and caring approach to competent clinical nursing practice for Grey Graham, R.N., B.S.N. She has been a staff nurse at UH in psychiatry since 1985 and recently was promoted to clinical nurse leader.

As part of her professional growth and development, Graham has fostered a firm political sensibility. "We as nurses face some unique questions as we continue to define and shape our profession," says Graham. "One area of concern is to consider the implication of such issues as status versus image for nurses. In order for us to promote our status as professionals, we must shape our image as professionals.

"This may happen in obvious, and often more subtle, ways—the way we speak with our peers as well as with other colleagues in the medical arena, how we write and document our professional literature, the way we interact and form networks through our professional associations, the way we dress, and even how we are addressed or referred to."

Graham began her health-care career as a medical assistant and laboratory technician for a private physician. As she continued to gain experience in the medical field, she realized that she wanted to go in another direction. "A close friend of mine was a nurse and suggested I pursue nursing as a new career direction," says Graham. "Since this seemed like a good way to combine my clinical interests with direct patient care, I decided to go back to school to study nursing." She got her B.S.N. from Boston State College in 1981, and then worked as a staff nurse at Beth Israel Hospital.

Graham says she came away from Beth Israel with a good sense of the important connection between quality patient care and a strong nursing presence in the hospital setting. "I realized that a professional approach and recognition of the nursing staff enhances all aspects of the clinical care of patients and I wanted to continue to develop my professional goals within this type of environment."

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She became increasingly interested in the specialty areas of psychiatry and geriatrics, which eventually led her to UH. Graham explains, "I chose to come to the University Hospital because of the reputation of superior care in the area of psychiatry. I was impressed with the professional quality of the nursing leadership here, and realized it was a good setting to offer ongoing support for professional growth rather than stagnation."

After nearly four years as a staff nurse in the psychiatry unit at UH, Graham continues to be challenged by the medical aspects of the job. She has also become an informal leader among her peers, someone who takes time to offer to answer questions and provide professional assistance when needed.

When the position of clinical nurse leader was created, Graham was immediately attracted to the possibility of maintaining some clinical practice while becoming more formally involved in the organizational aspects of the unit. Graham puts her job as clinical nurse leader in perspective. "This position presents new challenges and has many diverse aspects," she says.

"My function as liaison between the staff nurses and nurse manager is to troubleshoot, follow-up and work with my peers in order to help the unit work more smoothly. This kind of approach facilitates professional development and cohesiveness for the unit and staff."

Graham enjoys her work and continues to be actively involved in professional development. "I personally do what I can to advance the professional image of nurses, to be a positive role model. Taking professional responsibility has a direct positive effect on the image of nurses in general."
Psychiatry

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nary approach to patient evaluation and treatment, and work closely with psychiatrists, social workers, occupational therapists and psychologists. The unique challenge of caring for these patients is that in addition to requiring inpatient psychiatric care, many of them often have serious medical conditions that require hospitalization as well. According to Shapiro, "Up to 50 percent of our patients require medical as well as psychiatric treatment."

The combination of physical and emotional needs may take a few different forms. Shapiro explains, "One type of patient we have is someone who has a pre-existing medical illness, whether it is a chronic or debilitating illness, or someone who receives a distressing diagnosis of some kind and, as a result, has a psychological reaction, most often depression. Another kind of patient is someone who has a pre-existing psychiatric problem and develops a medical problem that requires hospitalization." There is also a category of patients who are experiencing psychosomatic symptoms and therefore require both medical and psychiatric treatment.

Because of the nature of the unit's work, some unusual design elements were needed to help facilitate the day-to-day routine of the unit and support its goals for patient care. There are two large community areas that afford patients the opportunity to work with patients around two different types of activities at the same time," explains Judith Dillon, R.N., M.S.N., nurse manager, medical psychiatric unit. "We consciously foster a sort of family atmosphere, so there are many activities that revolve around food preparation and meals. The patients' daily routines follow a highly structured schedule of community and group events, along with attention and treatment spent on individual patient needs. These kinds of activities meet several goals—socialization, self-organization in order to carry out specific tasks, interaction with other patients in a cooperative way, and decision-making."

"Most of the time, patients are not in their rooms, but rather are out on the unit together in various activities and social situations," says Shapiro. "The way the physical environment is structured purposefully discourages patients from isolating themselves. There are no phones or televisions in the rooms. Our goal is to use every social situation we can to increase the patients' ability to problem-solve. Instead of avoiding a potential problem, it is discussed openly and we try to figure out a solution."

"The nurses equally value and treat the emotional and medical needs of the patients in the unit," says Dillon. "They have the particular skills, experience, and educational background that are needed to handle the challenge of providing this specialized and demanding care. We work together and assist each other. The multidisciplinary team focus is very important in supporting staff, particularly in working with difficult patients who have a variety of issues to address."
Staff Notes

Department of Nursing members maintain high visibility in the professional community through teaching, publishing, consulting and participating in professional organizations. The following is a partial list of recent achievements.

Appointments and awards
The following were appointed Clinical Nurse Leader:

Nurse. Cathy Tracey, R.N., M.S., C.C.R.N., was certified as a Rehabilitation Registered Nurse. Warna Gillis, R.N., was recently certified as a Nurse in the Operating Room (C.N.O.R.).

Lectures and Publications

Certifications
Recent certifications in Advanced Cardiac Life Support (A.C.L.S.) include: Mary Duggan, R.N., B.S.N.; Louise Slattery, R.N., and Lynne Weinstein, R.N. Those who were recently certified as Psychiatric and Mental Health Nurse include: Grey Graham, R.N., B.S.N.; Alisa Horn Petersen, R.N.; Richard Ridge, R.N., B.S.N., Lorraine Stephens, R.N., B.S.N. Christine Kenny, R.N., B.S.N., was certified in Cardiac Pulmonary Resuscitation (C.P.R.). Carol MacKay, R.N., B.S.N., was certified as an American Nurses Association (A.N.A.) Medical/Surgical Practitioner.

Review of the Literature

The second edition of the American Association of Critical Care Nurses Clinical Reference contains an excellent section on the patient with cardiovascular problems, edited by Joan Vitello-Cicciu, R.N., M.S.N. She also wrote several of the chapters with Janet S. Eagan, R.N., M.S., evening clinical instructor, and two former UH nurses, Mary Michael Brown and Eileen Griffin. The cardiovascular section contains chapters on artery disease, hypertension, cardiomyopathy, valvular disease and vascular disease.

The chapter on anatomy and physiology, authored by Vitello-Cicciu, is a comprehensive review of the heart, containing valuable sections on the control of cardiac output and myocardial contractility not usually included in other books. These clearly written sections enhance the readers' understanding of basic cardiovascular physiology.

Eagan and Vitello-Cicciu co-authored the chapter on data acquisition, which contains information on physical assessment as well as such diagnostic procedures as cardiac catheterization, echocardiography and magnetic resonance imaging (MRI). This text provides an overview of the technique as well as interpretation of the results. It can readily be utilized as a quick reference for the staff nurse.

For a thorough discussion of all aspects of coronary artery disease, one need look no further than the chapter.
UH's Health Channel

Watching television usually means an entertaining way to relax, to unwind or catch a program we enjoy. But increasingly, television is being used as a tool for educating patients about current medical topics and preparing them for procedures they may undergo.

At the University Hospital, the Health Channel is a state-of-the-art, in-house television resource available for both staff and patients. While some of the programs shown on the station are produced in-house, many are produced by outside organizations, such as the American Heart Association (AHA).

"The programming covers a variety of specific, health-care topics, and reflects a collaborative effort between UH and the Department of Educational Media of Boston University School of Medicine," says Catherine M. Geary, R.N., M.S.N., C.S., medical clinical nurse specialist. "The programs are one part of a learning strategy for patients and their families, and they work to reinforce specific information given to patients by the primary nurses. Thus, patients may make informed choices about altering their lifestyles and what actions they may take to have an impact on their health and medical conditions."

As a component of patient education at the Hospital, the programs shown on the Health Channel are reviewed and approved by the Clinical Practice Committee, which is made up of staff nurses and administrators. "Our philosophy is that the patient should be as well-informed as possible in order to take an active role in making health-care decisions," says Geary. "Television has become a very useful component in an overall learning strategy for patients. It is a good medium to provide patients with either reinforcement or additional knowledge on medical subjects, used adjunctively with the information provided by the primary nurses."

Programs are repeated throughout most of the day, making it available for family members to view at a variety of times as well. Programs currently on the air include "Before and After Your Surgery," which teaches patients about the routine preparation for surgery and what to expect after an operation; "Your Heart Attack and Your Future," which covers how the heart heals after a heart attack and what to expect during the recovery period; "Prescription for Health," which includes helpful tips about taking medications at home following release from the Hospital; and "Quit for Life," which discusses how nicotine affects the heart and pointers on how to quit smoking. Some important topics to be covered in soon-to-be-aired programs include "Living With a Pacemaker," "Using COUMADIN® Safely and Effectively," and "A Patient's Guide to Percutaneous Transluminal Coronary Angioplasty (PTCA)."

The Health Channel is a free service available to all patients, with programs airing seven days a week. Programs are aired on Channels 16, 18, 21 and 22, with a Program Guide shown on Channel 8. The channel number appears on-screen one minute in advance of scheduled programs. In the event of technical problems, call x4370 Monday through Friday, 9 a.m. to 5 p.m.

For further information, contact Catherine M. Geary, R.N., M.S.N., C.S., medical clinical nurse specialist, at x8000 (638-8000).

written by Vitello-Cicciu and Griffen. The section on atherosclerosis contains the current theories of plaque formation. There is also a useful section on cardiac rehabilitation from the perspective of the critical care nurse. The chapters on cardiomyopathy and valvular heart disease were also co-authored by Vitello-Cicciu in addition to her editing duties. This entire section represents an important contribution to the body of nursing literature. The Nursing Department at the University Hospital is proud of these members who have contributed to it.
Annual MMHNAAN Homecoming Held

Eleanor Tenney (left), a graduate of the Massachusetts Memorial Hospitals School of Nursing, Class of 1923, chats with Joan Kerr, R.N., of the Surgical Intensive Care Unit, at the Homecoming of the Massachusetts Memorial Hospitals Nurses Alumnae Association held in November. As part of its active support of UH's nursing staff through continuing education programs, the Association's annual event includes the presentation of the William and Anna Ross Fund of MMHNAAN staff nurse scholarship/education awards. This past year's recipients were Kerr, along with Mary Ann Silva, R.N., and Kimberly Gary, R.N., also of the SICU. Ms. Tenney, a 65-year Association member, was honored by UH Senior Vice President for Nursing Karen Kirby. (Photo by Lucy Milne)

In memorium

Catalina Friedman, R.N., who was employed at UH for 33 years, died this past winter. Ms. Friedman was an E.R. nurse for 20 years and worked permanent evenings. She was a kind and giving person who presented a positive image of UH with her enthusiasm and caring nature, and she counted staff, hospital employees and patients among her many friends.

A memorial fund established in her name will be used to send an E.R. nurse to the annual National Emergency Nurse Association conference.

Catalina Friedman, R.N. (Photo by Lucy Milne)

Donations may be made to:

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