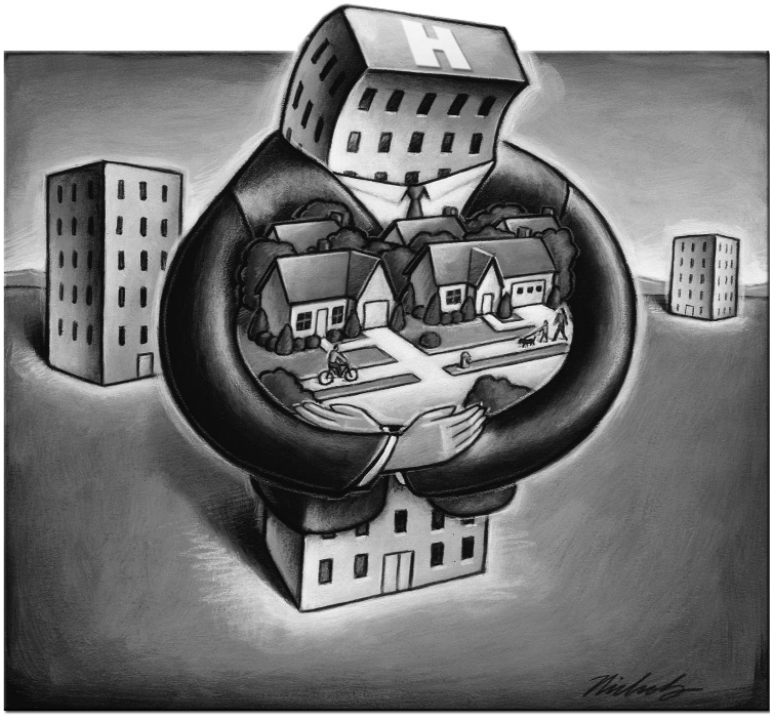
Hospital Closure Guidelines

Best Practices from the Field

First Edition

NJHA
NEW JERSEY HOSPITAL ASSOCIATION
Health Planning Department



HOSPITAL CLOSURE GUIDELINES:

Best Practices from the Field

Developed by
the New Jersey Hospital Association
Health Planning Department

HOSPITAL CLOSURE GUIDELINES:

Best Practices from the Field

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ACKNOWLEDGEMENTS

The Health Planning department consulted and met with several representatives from hospitals that have navigated the closure process. NJHA extends its sincere appreciation to the following individuals for their assistance in developing this resource for hospitals:

Richard P. Miller
President & CEO
Virtua Health

Terence French
Executive Vice President, Communications
Cathedral Health System

Donna Getcliffe
Planning & Market Assessment Coordinator
Meridian Health

Alex Hatala
President & CEO
Lourdes Health System

Paul Mertz
(Former) Executive Director
Newark Beth Israel Medical Center

Rebecca B. Wolfe
Director, Corporate Planning
Meridian Health

INTRODUCTION

In today's environment, hospitals face a number of pressures that affect their financial stability, the spiraling effect of which may lead ultimately to the hospital's management team and Board of Trustees making the difficult decision to close. However, once hospitals realize they must close, they face additional pressures because the regulatory processes involved in closing a hospital are lengthy and administratively burdensome, hence the need for fundamental change in the process.

The current process, which requires a Certificate of Need (CN), places hospitals in the position of *asking* for permission from the Department of Health and Senior Services (DHSS) to close. Instead, the process should allow a hospital to *inform* the state that it needs to close based on financial indicators, and seek DHSS's assistance in protecting patients' safety and access to care during the closure process.

NJHA's Policy Development Committee charged the association in 2006 with examining practices used by hospitals that have previously closed, so that NJHA may develop guidelines to assist hospitals that undergo closure in the future. In addition, political and administrative obstacles hospitals face in the closure process were to be identified and recommendations to resolve these issues presented for consideration. Moreover, the establishment of the Commission on Rationalizing Healthcare Resources, appointed by Gov. Jon Corzine, provided the industry with a unique opportunity to review and examine the closure process.

As part of its effort to develop guidelines to assist hospitals with closing, NJHA staff met with representatives from several hospitals and/or systems that had been involved in previous hospital closings. Representatives provided a comprehensive overview of their experiences, and made suggestions for activities that hospitals could pursue or avoid during the closure process based on what worked and what didn't. A checklist has been developed to assist hospitals in addressing all aspects of a closure (Appendix A).

Executives also recommended specific changes to the CN process for hospital closures, which will guide NJHA in advocating for improvements to the process. The valuable contributions from hospital representatives are reflected in the discussion points that follow, which address how a hospital that elects to close may do so efficiently. NJHA will work with DHSS on developing guidelines for hospitals that must close due to bankruptcy.

Once hospitals realize they must close, they face additional pressures because of the regulatory processes.

ISSUES FOR A HOSPITAL TO CONSIDER WHEN IT CLOSES INCLUDE:

- Assessing the future healthcare needs of the community and preparing to play a role;
- Communicating with the various constituencies throughout the community, including patients, physicians, regulatory agencies, other healthcare providers, community leaders, clergy, and local politicians, among others;
- Ensuring access to care, including maintaining staff until closure, verifying available capacity at other area hospitals;
- Understanding financial liabilities such as bonds, pensions, severance pay and vendor debt; and
- Transitioning the workforce to other employment and the hospital's role in assisting staff in obtaining unemployment benefits.

A HISTORICAL PERSPECTIVE

In 1999, DHSS convened the Advisory Commission on Hospitals and charged it with assessing the overall health of the state's hospitals, identifying warning signs that might indicate a facility is in financial jeopardy and recommending options for hospitals that want to merge or convert to other uses. The Advisory Commission noted in its report that there are a number of external challenges facing hospitals, including the growth in managed care enrollment, the reduction in Medicare and Medicaid payments, inadequate charity care reimbursement and the difficulties in receiving appropriate reimbursement for services rendered to those populations. The commission also examined the role that deregulation of CNs and the movement of more services – including profitable surgeries – to ambulatory settings had on a hospital's ability to maintain a healthy financial bottom line.

The commission made a number of substantial recommendations, including changes to the state's regulatory and leadership practices, the provision of assistance to hospitals that want or need to close and actions to ensure a climate of fair business practices (Appendix B). However, many of the programs and resources that were recommended were not implemented as intended, or were implemented and phased out. For example, one recommendation was to reduce the Medicare length of stay, in part by aligning incentives between hospitals and physicians for continuing an inpatient course of treatment. However, obstacles to implementing what is referred to as the Gainsharing program significantly delayed its implementation until recently. Pursuant to another recommendation, DHSS established a financial monitoring system to identify potential problems with a hospital's finances before they become unmanageable. However, the program was dissolved.

Finally, the state Medicaid program introduced a Periodic Interim Payment (PIP) system for hospitals that meet specific financial and utilization criteria. The system was intended to advance reimbursement to facilities with low cash reserves to ensure that delays in payment did not jeopardize operations in these hospitals. However, allowing Medicaid HMOs to determine the PIP payment based on previously paid claims results in perpetual underpayments, as denials and downgrades by HMOs in an earlier quarter means the appropriate level of reimbursement is kept artificially low.

Not surprisingly, a report issued in 2006 by the management consulting firm Accenture[1] noted that New Jersey hospitals today face many of the same financial pressures discussed in the 1999 Advisory Commission report, such as inadequate payer reimbursement and the underfunding of charity care, as well as structural elements like physicians' practice of medicine and the regulatory environment.

A TRANSITION TO CLOSURE

When the myriad financial pressures result in hospitals' dwindling ability to recover their costs for providing services, the ensuing bleak financial reality could mean a hospital can no longer sustain operations or cover its payroll budget. There is no doubt that hospitals prefer to begin a transition to closure long before its finances reach such a critical point. Too often, a hospital that is struggling financially will be forced to spend-down the remainder of its assets as it awaits approval from DHSS to close.

Once a hospital has identified the need to close, it is essential that DHSS work in an effective and efficient manner to assist the hospital in the process, rather than hamper it. An article in *The Star-Ledger* [2] regarding the closure of Irvington General Hospital states that planned closures could be less traumatic if the state, hospital boards and the host communities would work together before a hospital goes on life support.

As important, a hospital can take steps to ensure that it is moving toward a smooth transition of staff and services, while meeting its obligations to vendors, pensioners and the community.

THE CERTIFICATE OF NEED PROCESS

The Certificate of Need (CN) program is designed to allow the state to have a role in ensuring access to necessary healthcare services and maintaining the quality of the available services. By way of regulatory oversight by DHSS, a CN must be approved before establishing certain services. While many services were removed from CN oversight in 1998, the opening and closing of a hospital remains regulated under the CN program.

Regulations at N.J.A.C. 8:33 require providers seeking approval to establish a service must submit a CN application to DHSS, which is reviewed by department staff. Some services, such as relocating hospital beds, follow an expedited review process. Other services, such as the establishment or closure of a hospital, require a *full* review by DHSS. Under both expedited and full review procedures, DHSS staff reviews the application to determine whether it is complete and advises the applicant if additional information is required.

The processes differ in what happens once the application is deemed complete. The ***expedited*** review process requires the commissioner to render a decision on the application within 90 days of its being deemed complete. However, under the ***full*** review process, once the application is deemed complete it is forwarded to the State Health Planning Board (SHPB) for review. The SHPB is required by statute at N.J.S.A. 26:2H-5.8 to hold a public hearing in the service area within 30 days of the application being deemed complete by the department and issue a written decision to the DHSS commissioner within 90 days of when the application was deemed complete. The SHPB traditionally holds more than one hearing, one in the service area and another held at DHSS offices. Only after review by the SHPB does the application go to the commissioner for final review and

approval. As reflected in Table 1, the timeframe for a full review of a CN application can range from nine months to more than a year.

Although the review process includes deadlines for action by the SHPB, there are no deadlines by which DHSS staff must complete its review of the application. The lack of DHSS review deadlines, combined with the need for at least one public hearing, makes the process for closing a hospital lengthy and administratively burdensome and drains the financial resources of a facility that already is struggling financially.

TABLE 1

DHSS Completeness Review of Application	No Defined Timeframe
Hospital Response to Completeness Questions	No Defined Timeframe
SHPB Public Hearing	Within 30 days of application being deemed complete
SHPB Review and Recommendation	Within 90 days of application being deemed complete
Commissioner Review	Within 120 or 180 days of receiving recommendations from the SHPB

Because the existing CN process can take many months to complete, hospitals will be best positioned to close within their desired (and necessary) time frame if much of the work is done prior to submitting an application to DHSS.

NOTIFICATIONS SHOULD BE SENT TO THE FOLLOWING:

- Local emergency medical services
- Nursing home directors and other licensed facilities
- Local home health agencies
- Federally Qualified Health Centers and local clinics
- Physicians
- Local government and state officials (mayors, county executives)
- Federal Medicare/Medicaid programs
- State Medicaid program

STEPS IN CLOSING A HOSPITAL

■ ASSESSING THE COMMUNITY'S HEALTHCARE NEEDS

Hospital representatives recommend conducting an access analysis so that when it finally announces publicly that it will be seeking to close, the hospital is prepared to respond to community concerns about where residents may access services. An examination of the population and a review of how services are accessed throughout the community will assist the hospital in determining whether the hospital needs to maintain access to certain services at the current location or if patients will be able to obtain services at other facilities. These could include primary care services at Federally Qualified Health Centers (FQHCs), physician's offices and outpatient and emergency services at the remaining area hospitals.

Equally important is that the hospital works to ensure continued access to services that the *community* believes are necessary. Understanding the community will assist the hospital in communicating its closure plan and will allow a hospital to convey that it is not abandoning the community, but is in fact partnering with it to find alternative sites for care.

Hospitals that are part of a system may have fewer obstacles to transition patients smoothly to other care settings. For example, system hospitals can communicate with their partners to determine if the system hospitals will have the bed capacity and diagnostic space necessary to treat the expanded population of patients or whether expansion must be undertaken to accommodate an increased patient population.

Hospitals that are not part of a system should encourage other hospitals in the area to collaborate with them on identifying the community's needs and determining whether those needs can be met at the area hospitals or at other facilities along the care continuum. The closure of a hospital can have a significant impact on hospitals in the surrounding communities, for example, a dramatic increase in the Medicaid or charity care population, physicians seeking privileges, increasing the census of hospitals that are already operating at capacity, among other issues. Therefore, it is critical that the hospital establish regular com-

munication with hospitals that will be affected to ensure they are kept apprised of how the closure is progressing, the steps that are being taken to address issues related to access and possible issues regarding physicians, etc. This routine communication will help facilitate a smoother closure and minimize the negative impact on remaining hospitals.

Equally important is that the closing hospital engages the area's remaining facilities in the development of plans to ensure timely transportation of patients to outpatient services at remaining hospitals and FQHCs. Transportation plans will be requested by DHSS during the CN closure process.

Not every stakeholder or constituency is going to understand the financial realities driving a hospital's need to close

■ Establishing a Community Advisory Committee

What is true for every closure experience NJHA examined is that there is little support in the community for the loss of its hospital. Because the hospital usually has served for decades not only as a source of primary and emergency care, but also has provided employment in the community, residents generally oppose the closure of what is perceived as a landmark.

Regardless of how well-developed the hospital's communication plan is, not every stakeholder or constituency is going to understand the financial realities driving a hospital's need to close. In fact, some hospitals have experienced a high level of vitriol in the press and at public hearings once they announce the plan to close. But bringing important policymakers to the table early in the process may result in hospitals being able to deliver the message that the plan to close received input from a varied perspective throughout the community.

Some hospitals established a community advisory committee that not only assisted with the needs assessment, but also served to help obtain support for the closure within the community. A community advisory committee may be comprised of a variety of stakeholders, including the mayor of the host town, other local politicians, clergy, union representatives, patients. consumers and medical staff.

To some, the idea of engaging in a dialogue with the community before a CN application is submitted appears to be a move that will only invite harsh criticism early in the process, thereby requiring many more months of public accountability for the decision to close – an understandable position considering the public outcry evidenced at SHPB hearings. However, the establishment of a committee could, among other functions, serve as a focus group, allowing the hospital to articulate in a small forum its reasons for closing, giving both the community and the hospital an opportunity to hear each other's perspectives before announcing to the public that a closure is imminent. Members of a committee, having had an opportunity to fully understand the position of the hospital, can serve as the hospital's advocate, explaining to members of the community the challenges the hospital faces and the reality that the hospital has no alternative but to close.

The factors considered by the community advisory committee in reaching a consensus about closing the hospital and the discussion of what the future needs of the community may be and how they will be met by other providers should be included in a comprehensive report, which may be shared with DHSS as part of the hospital's CN application. The report would demonstrate that the closure was reviewed by representatives of the community and that issues related to access to services, as well as operational and financial concerns, were addressed fully by the hospital.

■ Devising a Communication Plan

Hospitals have at their disposal a variety of methods to communicate the fact that they will be closing and what the community's options will be for access to services following closure. Statements can be delivered through press releases, letters to the editor, direct mail campaigns and town hall meetings. Posting letters and statements on the hospital's Web site will provide easy access to reporters and community. Hospitals also may participate in editorial board meetings and maintain open lines of communication with the local media by responding daily to inquiries about the changes occurring.

Regardless of the type of communication used, hospitals agree that consistency of the message is perhaps the most important piece of the plan. A hospital should designate a specific group of staff (or a single individual) to serve as spokespeople to respond to formal inquiries. Hospitals may consider making the communication staff available by pager so the media can easily reach the hospital for questions about the closure, or to ask for a response to a comment or rumor circulating in the community. In addition, hospital staff and trustees must also be knowledgeable about the message so they may respond to questions from neighbors, patrons in the grocery store, etc. Staff and volunteers should be given talking points to help prepare them for delivering the hospital's consistent message about the closure.

Despite holding town meetings and assertively disseminating the reasons why the hospital can no longer stay open, a hospital might find itself subject to ongoing attacks by a small but vocal citizen's action group. Such groups have the potential to generate considerable media attention by dispersing misinformation, accusations and false claims against the hospital. Rather than ignoring the attacks in the hope that they die down, hospitals may choose to respond immediately to set the record straight and mitigate the damage that rumors and innuendo can cause.

A hospital also may want to use early feedback to identify what a community's "hot points" are going to be, and develop a response specific to those triggers. For example, will it be transportation to the remaining area hospitals, or where residents should go in the case of an emergency? Hospitals may want to develop a mailing, newsletter or media statement related to these specific issues to dispel early misinformation campaigns.

Other direct mail campaigns have encouraged attendance at town meetings, educated area residents about the reasons for closure, provided instruction on using 911 in an emergency and the appropriate use of a satellite emergency department (if one is called for), urgent care center or full service emergency department.

Additional educational and promotional activities can offer opportunities to involve the community in projects related to the transition. One hospital conducted a poster contest with area schools to educate students about 911. Following the contest, the hospital printed calendars about safety that featured the

winning posters, which were distributed to students. Sponsors of the calendar provided financial support that allowed the hospital to fund the addition of automatic external defibrillators to police squads, and provide free training to area police departments.

In addition to announcing and providing education about the closure to the general community, hospitals may want send specific notices to targeted audiences.

Hospitals remain responsible for protecting patients' health information after closure

■ Ensuring Safe Access to Care During a Closure

One of the greatest challenges hospitals face during the closure process is maintaining quality care for certain patient populations while safely transitioning others to different sites for care. Hospitals likely will develop different plans to address the specific needs of inpatient and outpatients.

As part of its access analysis, a hospital will determine whether some outpatient services will continue to be provided at the existing site once the closure is complete. Outpatients that are in the middle of a course of treatment or receiving services that will no longer be provided on site will be transitioned to another provider. Patients that have received treatment previously may receive a letter from the hospital notifying them of what options exist for accessing future services.

Hospitals contacted by NJHA for their insight about the closure process universally oppose the creation of a satellite emergency department. Their experience is that no amount of community outreach and education can prevent situations where a person drives his/herself to the SED for emergency treatment that can only appropriately be provided at a full service emergency department.

For inpatient services, hospitals generally stop admitting patients *at least* a week before the scheduled closure date to ensure a small number of patients to transfer to other facilities as well as maintain quality of care. Patients that remain in the hospital up to the day of closure will be transported to an alternate facility at the closing hospital's expense. DHSS, as part of its review of a closure application, will want to review the hospital's plans for ceasing admissions and transferring patients.

Equally important as safely transferring patients to other sites is ensuring facility security for the patients and staff that remain on site. Hospitals report that as the patient census is reduced and staff are directed elsewhere, there may be dark, unpopulated hallways. Maintaining the facility's policies and procedures related to security, such as checking IDs upon entrance to the facility or before allowing individuals to move through protected units, is essential.

Lastly, hospitals remain responsible for protecting patients' health information after closure and must properly plan for the disposition of patient records. NJHA's information services department has prepared a table of the regulatory and statutory requirements hospitals must follow regarding medical record retention and access (Appendix C). The American Health Information Management Association has developed guidelines for protecting patient records after a facility closure (Appendix D). Generally, if a facility is sold to another

healthcare provider, patient records may be considered assets and included in the sale of property. If a facility closes without a sale, records should be transferred to another provider that agrees to accept responsibility or, if not feasible, records may be archived with a reputable commercial storage firm. Some states, such as Indiana, Mississippi and Tennessee, require that medical records be given to a local public health department or public hospital in same geographic area, or if none is available, the state licensing agency.

Prior to transferring records to an archive or another provider, the closing facility should attempt to notify patients and give them an opportunity to obtain a copy of their record. Notification may be achieved through publishing notice in local newspapers and through hospital press releases. In New Jersey, hospitals must submit a plan for record storage and service to DHSS.

■ TRANSITIONING THE WORKFORCE

The federal Worker Adjustment and Retraining Notification Act (WARN) became effective on Feb. 4, 1989. The statute offers protection to workers, their families and communities by requiring employers to provide written notice 60 days in advance of covered plant closings and covered mass layoffs. This notice must be provided to either affected workers or their representatives (e.g., a labor union); to the state dislocated worker unit; and to the appropriate unit of local government. For more details, see the fact sheet at Appendix E**.**

Although the federal statute requires only 60 days notice, hospitals likely will begin the notification process earlier to allow more time to assist its workforce in transitioning to other employers.

The New Jersey Department of Labor and Workforce Development has a number of programs available to support hospitals with their efforts to assist staff in finding other employment. DOL's Rapid Response Team (Appendix F) can assist employers and their workers during a closing or permanent mass layoff with filing for unemployment benefits, referrals to job openings, resume development and retraining programs, among other services. Hospitals also may want to consider hiring a firm specializing in human resources to help with resume development and assist employees with a focused job search.

Hospitals report that it is easier to find placement for nurses and medical technicians than for housekeeping and other services. For non-clinical staff, the hospital may want to host a job fair and invite other licensed healthcare facilities into the hospital to provide a forum for potential employers and employees to meet and interview.

Physicians and other licensed professionals may need little assistance from the hospital in finding another location in which to practice. However, the closing hospital's medical staff office handles credentialing and may be able to assist physicians in obtaining credentials at other area facilities. To mitigate the chance that physicians and other clinical staff leave the hospital prematurely, the closing hospital is encouraged to allow physicians and nurses to rotate among hospitals within the system or between area hospitals to ensure continued staff competency when the number of cases being admitted is reduced.

A hospital's human resources department must evaluate future health insurance needs for employees who don't find other placement and determine to what level the hospital will commit to continuing benefits.

Employees hired by area hospitals will be able to show a Certificate of Creditable Coverage and be eligible for health insurance through the new employer without delay. If the hospital is financially unable to extend benefits for a period of time, the employee may be eligible for benefits under the Consolidated Omnibus Budget Reconciliation Act, a federal law that allows workers who lose their health benefits the option to choose to continue their group health benefits for a limited period of time, covering some or all of their premium.

■ Financial Considerations During a Hospital Closure

In addition to its operational concerns, hospitals have a number of financial issues that must be considered when closing a facility. The following overview will help guide hospitals in reviewing these issues:

PENSIONS - Hospitals will need to evaluate the financial stability of their employee pension program in preparation for questions from the community as well as DHSS. A defined contribution plan, such as a 401(K) or 403(b) plans, provide an individual account for each participant. The benefits are based on the amount contributed and also are affected by income, expenses, gains and loses. Conversely, a defined benefit plan promises the participant a specific monthly benefit at retirement based on a formula that considers a participants salary and service. Defined benefit pensions plans generally are insured by the Pension Benefit Guaranty Corporation, a federal corporation created by the Employee Retirement Income Security Act of 1974.

Regulatory agencies may want to know about a hospital's 401(k) or 403(b) retirement account, since these are not insured at the federal level. A hospital should evaluate whether the plan is funded sufficiently to meet federal standards.

EMPLOYEE SEVERANCE - Certain employees may have a contract with the hospital that includes a severance agreement. Hospitals may want to consider including language in their contract that the hospital is afforded some protection from fulfilling a severance agreement in the event of insolvency or limited cash reserves.

Unions also may have engaged in collective bargaining that resulted in an agreement to provide a level of severance to certain categories of employees.

VENDOR DEBT - Hospitals may have a number of contracts that need to be serviced until they finally close their doors. For example, a hospital may contract with a company to service its emergency department or catheterization lab, or the medical staff president could hold a contract with the hospital. Accordingly, hospitals should include a provision in their contracts that allow a 30- to 180-day cancellation notice without cause in the event the hospital discontinues a service or closes altogether.

Another consideration is how to continue the receipt of goods and services from vendors in the event the hospital's cash flow is struggling. For example, a vendor that supplies a hospital with blood products may refuse to deliver if the vendor has not been paid.

However, if a hospital files for a certain type of bankruptcy, then it may be able to ensure continuation of the delivery of goods and services. Chapter 11 bankruptcy is debt restructuring that provides a legal structure to pay down legacy debt (this is distinct from bankruptcy liquidation).

ACCOUNTS RECEIVABLES FROM CARRIERS **-** Hospital must maintain staff and systems that will allow it to continue to receive reimbursement for services, including payments from HMOs and other insurance carrier. As payments continue, revenue received will go either to the healthcare system, if the closing hospital was part of a system, or to the individual hospital if a mechanism was established to collect revenue after closure. For example, even if a hospital closes, its corporate structure may still be in place and able to accept incoming revenue. There will be a committee of the board that will decide how revenues that continue to come in will be distributed, such as to pensions or to vendor contracts.

BONDS **-** The New Jersey Health Care Facilities Financing Authority (HCFFA) is the primary issuer of municipal bonds for New Jersey's healthcare organizations. Created in 1972 by an act of the Legislature to provide not-for-profit healthcare providers with access to low-cost capital, the authority's statutory powers were expanded in 1998 to include financing for all healthcare organizations or components thereof. Authority staff is available to answer questions regarding covenants and funding requirements as well as to facilitate corporate reorganizations, collateral substitutions and asset transfers.

In the event of a closure, a hospital should seek bond counsel (a lawyer specializing in bonds) to help facilitate discussions with the HCFFA.

In 2000, in response to a recommendation from the Advisory Commission on Hospitals, the legislature approved the development of a hospital asset transformation program under HCFFA. The program, detailed in Public Law 2000, chapter 93, is intended to allow the state to provide financial assistance (through the issuance of new bonds or refinancing the hospital's incurred debt) to non-profit hospitals that are closing.

However, while the program received $8 million in funding its first year, no appropriation was made in subsequent fiscal years. A representative from the asset transformation program explained that the program has been used only recently in the acquisition of PBI Regional Medical Center by St. Mary's, a transaction that was structured to be revenue neutral for the state.

Recommendations

The culture of the CN process for hospital closures must be changed, turning it from a mindset that requires hospitals to seek permission to one that allows hospitals to inform the state of a pending closure.

DHSS should be encouraged to work in partnership with a closing hospital to make the closure process less administratively burdensome. Working together, both the hospital and the state can ensure that access to quality care remains available during a closure.

- **Develop a CN application specifically for hospital closures.** The general CN project application requires hospitals to complete questions related to the initiation of a new service and therefore is not relevant to a hospital that is closing. Streamlining the form for closures will speed up both the application process and the DHSS' review.
- **Establish statutory deadlines by which DHSS must respond.** There must be a sense of urgency in DHSS' approach to reviewing hospital closure applications, especially considering that many hospitals seeking to close are doing so as a result of dire financial straights. To be responsive to such market changes while maintaining a full review for hospital closures, DHSS must fast-track its deliberation under the full review process. Though there are deadlines by which the SHPB must hold a hearing on an application, there are *no* deadlines by which DHSS staff must complete its review of the application. Accordingly, NJHA recommends that DHSS' completeness review for closure applications should not exceed 60 days, which would allow time for the department's initial review, submission of questions to the hospital if additional information is needed and consideration of the hospital's response. Final approval by the commissioner should occur within 30 days of receiving recommendations from the SHPB. Furthermore, a timeline for completeness review of all CN applications would be appropriate to add accountability to the process. The lack of review deadlines affects *all* CN projects proposed by hospitals. If DHSS does not respond to the CN application within the required timeframe, the request for closure is deemed approved.
- **Consolidate SHPB hearings.** The SHPB is required by N.J.S.A. 26:2H-5.8 to hold a public hearing in the service area within 30 days of the application being deemed complete by the department. However, the SHPB typically holds more than one hearing, one in the service area and another held at DHSS offices. NJHA recommends that only one hearing be held – in the service area – followed by, in no more than 30 days, a meeting at which the board votes on the DHSS recommendations and submits its own recommendations to the Commissioner of Health for final approval. Or,
- **Replace the public hearing through the SHPB with the Community Advisory Committee** (CAC) *for those hospitals that established a CAC* (some hospitals may choose not to do this). The CAC is charged with identifying and addressing access issues, among others, related to hospital closures. A report of the CAC's findings and recommendations should be submitted to the hospital board, which will respond to those recommendations in its CN filing.
- **Consider the impact on operations for remaining facilities in the event of a closure**, and require the state to play a role in assisting the remaining hospitals where appropriate. For example:

- If the state closes hospitals pursuant to recommendations from the Governor's commission, how will this affect surge capacity in the event of an emergency?
- DHSS and/or DOBI must research what the payer mix will be on the remaining area hospitals; if it is more Medicaid and charity care patients, the state must provide financial assistance to ensure they remain solvent.

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[1] Accenture. (2006). *New Jersey Acute Care Hospitals Financial Status, October 3, 2006*. Accenture.

[2] When a hospital passes on [Editorial]. (2007, February 22). *The Star Ledger*, p. 014. Retrieved February 22, 2007, from *http://www.nj.com*

APPENDIX

A

Steps to Closing a Hospital

A Worksheet

Step 1	Select Internal Closure Team	A hospital CEO will begin the closure process by bringing together – confidentially – the hospital's senior leadership to ensure all operational areas of the hospital will be considered during the closure process. Closure teams include, but are not limited to, the chief financial officer, chief operations officer, chief medical officer, chief information officer, legal counsel, head of human resources and head of public relations.			
Planning	**Notes**	**Yes (Date)** ***or*** **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Team will plan and implement all steps in the closure process, including: - Holding an initial meeting with the Commissioner and staff from DHSS - Identifying all stakeholders - Identifying community leaders - Assessing the community's healthcare needs - Devising a communications plan - Considering the financial impact - Establishing a plan for medical record storage and access - Establishing a community advisory committee - Holding follow-up meeting with DHSS - Rolling out the communications plan - Transitioning the workforce - Communicating the hospital's closing date following hearings				

Step 2	Hold Initial Meeting with DHSS	Hospital closure team will want to begin communicating with DHSS in advance of submission of the written CN application so that DHSS staff can begin planning for the application's review and hearing. First meeting should be confidential – hospital not prepared for public discussion at this point. Begin preparing CN application.			
Planning	**Notes**	**Yes (Date)** *or* **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Review existing CN regulations at N.J.A.C. 8:33-3.2 regarding the closure process Alert DHSS commissioner and senior department staff that hospital is considering closing Inform DHSS that hospital is putting together a closure plan and will return within 30 days to review plan and submit closure application				

Step 3	Identify All Stakeholders	A hospital closure can significantly impact hospitals in the surrounding communities. Therefore it is critical to establish regular communication with the affected hospitals to ensure they are kept apprised of how the closure is progressing, the steps that are being taken to address issues related to access and possible issues regarding physicians, etc.			
Planning	**Notes**	**Yes (Date) *or* No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Board of Trustees Supporter / Detractor _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ Medical Staff President _____ ☐ ☐ Union Reps _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ Employees Others				

Step 4	Identify All Civic and Community Leaders	Members of a community that are in a leadership role can serve as the hospital's advocate once they understand the need to close. Such leaders can explain to members of the community the challenges the hospital faces and the reality that the hospital has no alternative but to close. Local community leaders such as clergy may have more influence than a city's mayor.			
Planning	**Notes**	**Yes (Date) *or* No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Supporter / Detractor Mayor _____ ☐ ☐ Freeholders _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ Assembly and Senate _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ Clergy _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ _____ ☐ ☐ Other Community Leaders				

Step 5	Assess the Community's Healthcare Needs	Examine the population and review how services are accessed throughout the community. Determine whether the hospital needs to maintain access to certain services at the current location or if patients will be able to obtain services at other facilities, such as primary care services at Federally Qualified Health Centers and outpatient and emergency services at the remaining area hospitals.			
Planning	**Notes**	**Yes (Date)** ***or*** **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Review services available at nearby hospitals Examine whether full emergency departments are nearby, or satellite emergency departments Review transportation resources, bus routes. Consider arrangements that must be implemented for inpatients that will be available at the hospital up until it closes Determine if specific disease management specialists are available for communities with unique healthcare needs (e.g. oncologists or endocrinologists) Consider arrangements that must be made to transfer outpatients to other providers just prior to closure				

Step 6	Devise a Communications Plan	Statements can be delivered through press releases, letters to the editor, direct mail campaigns and town hall meetings. Posting letters and statements on the hospital's Web site will provide easy access to reporters and community. Hospitals also may participate in editorial board meetings and maintain open lines of communication with the local media by responding daily to inquiries about the changes occurring.			
Planning	**Notes**	**Yes (Date) *or* No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Identify what the community's most significant concerns will be and develop communications to target those specific issues Schedule print communications: newsletter distribution, meetings with local editors, press releases Schedule meetings with community leaders that will be held the week that communications are rolled out. Determine what the hospital's message to community leaders will be Schedule meetings with stakeholders that will be held the week that the communications plan is rolled out. Determine what the hospital's message to stakeholders will be For employee stakeholders, establish a contact person for every group of employees to meet with if they have questions or concerns Determine which staff will present testimony during the two SHPB hearings, the first of which is held locally and the second in Trenton, at which time SHPB members will vote on the hospital's application. Anticipate questions related to the availability of transportation to other remaining healthcare providers in the area. Questions may address how long it takes to travel during weekends and rush hour and whether public transportation is available				

Step 7	Consider Financial Impact	Hospitals must address a number of financial considerations in preparation for closing the facility.			
Planning	**Notes**	**Yes (Date) *or* No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Evaluate the financial stability of the employee pension fund and ensure it meets federal standards Consider the availability of continuing health insurance coverage for employees either through COBRA or another mechanism Review personnel contracts for severance clauses and determine how to meet the contractual obligations Review cancellation notice timeframes in vendor contracts Determine which account incoming receivables will be distributed to, e.g. payroll, vendor contracts, etc. Evaluate the hospital's bond obligations Seek counsel to provide input on bond debt				

Step 8	Establish Plan for Medical Record Storage and Access	New Jersey regulations require hospitals to address medical record storage and access in their policies and procedures. Hospitals that are closing must establish a mechanism to continue storing and providing access to patients.			
Planning	**Notes**	**Yes (Date)** *or* **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Hospitals must establish a process to ensure that medical records are completed and signed by physicians during the transition to closure. Until the records are completed, the hospitals cannot transfer or store the records Hospitals that are part of a system may choose to transfer patient records to remaining system facilities Stand-alone hospitals will need to make arrangement to archive records with a company providing the service, for example, Iron Mountain As part of the CN process DHSS will require the hospital to notify patients of the closure and provide them an opportunity to obtain a copy of the record A contract with a record storage/archive company must include a provision stating that patient and others shall have access to records				

Step 9	Establish a Community Advisory Committee	Some hospitals establish a community advisory committee, which can assist with a needs assessment and serve to help obtain support for the closure within the community. A community advisory committee may be comprised of a variety of stakeholders, including the mayor of the host town, other local politicians, clergy, union representatives, patients and consumers and medical staff.			
Implementation	**Notes**	**Yes (Date)** ***or*** **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Participants: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ Summarize the issues raised and conclusions reached during the CAC meeting Develop recommendations related to continuing services in the community and other issues related to closure that will be included in the materials sent to DHSS				

Step 10	Hold Follow Up Meeting with DHSS	Once the hospital has its communication plan and CN application ready, a follow-up meeting with DHSS is appropriate to begin the formal closure process.			
Implementation	**Notes**	**Yes (Date)** *or* **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Include chair of the board and hospital senior leadership in meeting Bring completed CN application that addresses the following: - Participation in a community transportation plan to assist patients in accessing primary care and other outpatient services - Length of travel time to the remaining hospital's emergency department during weekends and rush hour - Patients' access to their medical records and how the hospital will communicate its plan to the community (newspaper ads, direct mail, etc.)				

Step 11	Roll Out the Communications Plan	Word of the hospital's pending closure will spread quickly once the hospital begins its meetings with stakeholders. Consequently, the hospital CEO and senior leadership must plan on participating in a lengthy series of meetings over a very short period of time.			
Implementation	**Notes**	**Yes (Date)** ***or*** **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Day One - Stakeholders – Employees, physicians with privileges at hospital/referring physicians - Community leaders – Clergy - Press – Newspapers, local TV **Day Two** - Civic leaders – Mayor, freeholders, state legislators **Ongoing** Designate specific staff to respond to all media or other formal inquiries. Instruct all employees to direct inquiries to designated response staff Distribute talking points so employees can respond to concerns raised by friends, family and neighbors Develop web page devoted to disseminating status of closure – Go live during roll-out phase Send targeted communications to specific audiences including: - Local emergency medical services - Nursing home directors and other licensed facilities, home health agencies, FQHCs - Officials from state and local government - Federal and state Medicare/Medicaid programs				

Step 12	Transition the Workforce	Hospitals may find it easier to facilitate placement for nurses and medical technicians than for housekeeping and other services. For non-clinical staff, the hospital may want to host a job fair and invite other licensed healthcare facilities			
Implementation	**Notes**	**Yes (Date)** *or* **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	Provide notice to employees at least 60 days in advance of the planned closure in compliance with the federal WARN Act Contact the state DOL to schedule a meeting with its Rapid Response Team Host a job fair for non-clinical staff Rotate clinical staff among neighboring hospitals to assist them in maintaining their competency requirements as hospital admissions are reduced				

Step 13	Communicate the Hospital Closing Date	Following the SHPB hearing, the DHSS commissioner has up to 120 days to provide final approval of the SHPB's recommendations for closure. The hospital will have a better idea of its final closing date after the SHPB meets.			
Implementation	**Notes**	**Yes (Date)** *or* **No (Reason)**	**Feedback Received from Meetings**	**Next Steps**	**Staff Leader**
	DHSS often recommends as part of its closure approval that a hospital fully communicates with the community about the expected date of closure • Hospitals should plan to include in the notification: - A list of alternate service providers in the area - Transportation options for accessing services - Instructions on how patients can obtain a copy of their medical records				

APPENDIX

B

Report of the Advisory Commission on Hospitals - 1999

Executive Summary

On any given day, one out of every three staffed acute care hospital beds in New Jersey is empty. The health care system's success in creating alternative preventive and ambulatory care services is a major reason for empty beds. If current trends continue through 2002, that figure could rise to one out of every two beds. The cost of this excess capacity, which could be as much as $1 billion annually, puts New Jersey hospitals at a staggering competitive disadvantage in today's healthcare marketplace. High length of stay and staffing levels, among other factors, have contributed to the inability of New Jersey hospitals to cover costs with available revenues.

In addition to having eliminated the need for many acute care beds as well as changing hospital missions, a number of external factors are also reducing revenues available to New Jersey hospitals for remaining capacity. Reductions in Medicare reimbursement, some already in effect, others yet to be implemented, will reduce annual revenues by an estimated $515 million by 2002 to this $10.5 billion industry. Managed care, which is an increasingly popular insurance option for New Jersey employers, is also exerting downward pressure on revenues by seeking to eliminate unnecessary hospital days and services through utilization review. The insolvencies of two managed care organizations further reduced revenues to hospitals during 1998. The state's Medicaid program has turned to managed care as well, in an attempt to provide quality care at reasonable prices.

Further exacerbating the situation is the increasing number of New Jersey residents without health care insurance. As a result, the amount of charity care provided by New Jersey hospitals and physicians has also increased. Although state subsidies have helped offset these rising costs, the growth of care for the indigent has put more financial pressure on the state's hospitals.

The cumulative effect of these trends is a hospital industry with rapidly deteriorating financial performance. By 1998, the median profit margin in the state fell to .55% and 42 out of 84 hospitals had negative profit margins. Other financial indicators, notably cash reserves, had declined as well.

After studying the issues since April 1999, the Advisory Commission on Hospitals has concluded that significant structural changes to the hospital industry in New Jersey are necessary to put the state's hospitals on a sound financial footing. The recommended changes are organized into three areas:

- assistance to hospitals and communities in the transition of hospitals to more efficient organizations providing services in the appropriate physical setting;
- modifications to the state's financial, regulatory, and leadership responsibilities to ensure access to and the quality of health care services in the state; and
- actions to ensure a climate of fair business practices between payers and hospitals.

Report of the Advisory Commission on Hospitals, 1999. New Jersey Department of Health and Senior Services, Division of Health Facilities Evaluation and Licensing, 1999. Online: http://www.state.nj.us/health/healthfacilities/acoh/index.shtml

Those responsible for implementing these changes will include hospital management, boards of trustee, physicians and other health care professionals, the state, payers, managed care companies and the general public.

Assistance to hospitals and communities to appropriately configure the state's health care system should include:

- creation of a Hospital Asset Transformation Program to assist facilities that that are no longer needed nor financially viable as acute care hospitals in transitioning to other uses that the market can support;
- creation of a Hospital Transition Group within the Department of Health and Senior Services (DHSS) that will coordinate state actions to facilitate hospital changes;
- establishment by the DHSS of a quarterly financial monitoring system to identify fiscal problems before they become unmanageable;
- creation of a Post-acute Care Study Group to assess how availability of services and financial incentives hinder efforts to reduce acute care length of stay; and
- education of boards of trustees, health care professionals, and the public of the changing realities of the health care marketplace.

The state's financial, regulatory, and leadership practices should include:

- establishment of a supplemental charity care fund to ensure that all hospitals receive some funding for charity care services provided in excess of a minimum standard;
- more flexible charity care documentation requirements to ensure that eligible patients are appropriately identified;
- establishment of affordable health insurance programs that will reduce the burden of charity care;
- consideration of changes to Medicaid reimbursement, including rebasing to a more current year, establishing a new peer group to recognize facilities serving a disproportionate share of low-income patients, and implementing a periodic interim payment system for Medicaid managed care plans;
- uniting with industry groups to: advocate for changes to Medicare reimbursement cuts where they are excessive (the Balanced Budget Act); maximize revenues to New Jersey hospitals from the federal government (e.g., disproportionate share payments); and align payment incentives between physicians and hospitals;
- adoption of measures to reduce the likelihood of insolvencies by managed care companies and adoption of a plan to pay hospitals money due to them as a result of insolvencies by managed care organizations in 1998; and
- attaining favorable rulings from the Health Care Financing Administration (the federal agency that administers Medicare) regarding the close to $400 million in disproportionate share payments for which New Jersey hospitals may be eligible.

Actions to ensure a climate of fair business practices between hospitals and payers should include:

- completing a study of claims processing and billing processes to accurately assess where problems exist;
- enforcement of existing prompt payment regulations; and
- strengthening of regulations where needed.

APPENDIX

C

Medical Record Retention and Access
New Jersey Requirements for Hospitals

Standard	Recommendation
N.J.A.C. 8:43G-15.1 Medical records structural organization: • (c) If the hospital ceases to operate, at least 14 days before cessation of operation the State Department of Health shall be notified in writing about how and where medical records will be stored. • (e) There shall be a system of access to the medical records of all patients, including outpatients.	This plan should be developed as part of a hospital closure transition committee at least 6 months prior to closure if possible. As noted in the AHIMA document, if the facility is part of a sale, the records should be considered as an asset with access being provided to the seller as needed. If sold to a non-healthcare entity, arrangements must be made to archive with a commercial company or to another healthcare provider. A contract would be needed for either option.
N.J.A.C. 8:43G-15.2 Medical records policies and procedures (a) The medical record department shall have written policies and procedures that are reviewed… 1. Procedures for record completion, including chart analysis;	As required by New Jersey, the Joint Commission and Medicare Conditions of Participation, medical records must be completed (signed, dictated, etc). During closure, the facility will be winding down clinical services, but as they do, charts reflecting treatment are still created. A chart completion process must be retained until all records are properly completed. Only then can consideration be given to either transferring records to another healthcare provider or storing them in a record archive facility.
N.J.A.C. 8:43G-15.3 Medical record patient services (d) If a patient or the patient's legally authorized representative requests, in writing, a copy of his or her medical record, a legible, written copy of the record shall be furnished at a fee based on actual costs. One copy of the medical record from an individual admission shall be provided to the patient or the patient's legally authorized representative within 30 days of request, in accordance with the following: 1. The fee for copying records shall not exceed $1.00 per page or $100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than $0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of $200.00 for the entire record; 2. In addition to per page costs, the following charges are permitted: i. A search fee of no more than $10.00 per patient per request. (Although the patient may have had more than one admission, and thus more than one record is provided, only one search fee shall be permitted for that request. The search fee is permitted even though no medical record is found as a	Prior to facility closure, patients should be notified (community notification) that they may obtain copies of their medical record. Fees noted within this standard (or if the facility has a policy with a HIPAA fee) would apply. If a facility contracts with an archive storage company, the contract must include access to authorized users so that patients will have access. The AHIMA guideline covers all other aspects related to the contract with an archive company.

Standard	Recommendation
result of the search.); and ii. A postage charge of actual costs for mailing. No charges shall be assessed other than those permitted in (d)1 and 2 above; 3. The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and 4. The hospital shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her representative, however, has a right to receive a full or certified copy of the medical record.	
N.J.S.A. 26 §26:8-5 Hospitals must preserve medical records for a period of not less than 10 years following the most recent discharge of the patient or until the discharged patient reaches age 23, whichever is the longer period. In addition, a discharge summary sheet shall be retained for a period of 20 years following the most recent discharge of the patient. X-ray films shall be retained for a period of five years.	If the closing facility is transferring its patient records to a surviving facility (within a corporation) it is recommended that the closing facility records be kept on site for at least 2 years to facilitate lower cost retrieval. If space does not permit, or if the closing facility has no other corporate entity to which it can send patient records, records should be prepared with the following in mind: • They must be organized in an accurate manner (by terminal digit or however the facility organized in the past) • The contents of each box should be indexed with a master list being retained by the corporation and a copy being provided to the storage facility • Retention (assuming pediatric and adult patient population) – recommend retaining records and marking archive slips for 24 year retention. • Contract must include provision for destruction after 24 years storage. • Since the discharge summary has to be retained for 20 years for all patients – I recommend just defaulting to storing records for 24 years. Otherwise, someone would have to pull each chart, copy the summary, place summaries into a separate box, etc.

Prepared by the New Jersey Hospital Association Information Services department.

APPENDIX

D

Practice Brief: Protecting Patient Information after a Facility Closure (Updated)

Editor's note: This update supplants information contained in the March 1999 and September 1996 practice briefs "Protecting Patient Information after a Facility Closure."

Patients trust their healthcare providers to respect their privacy, maintain the confidentiality of their health information, and assure its availability for their continuing care. Providers must be concerned with the protection of health information when healthcare facilities close or medical practices dissolve.

Procedures for disposition of patient records[1] must take several factors into consideration, including:

- state laws regarding record retention and disposal, as well as statutes of limitation
- state licensing standards
- Medicare and Medicaid requirements
- federal laws governing treatment for alcohol and drug abuse (if applicable)
- guidelines issued by professional organizations
- the needs and wishes of patients

In some states, a state archive or health department will store health records from closed facilities. Generally, state regulations recommend records be transferred to another healthcare provider. If a healthcare facility or medical practice is sold to another healthcare provider, patient records may be considered assets and included in the sale of the property. If a facility closes or a practice dissolves without a sale, records should be transferred to another healthcare provider that agrees to accept the responsibility. If this is not feasible, records may be archived with a reputable commercial storage firm. Before records are transferred to an archive or another provider, patients should be notified, if possible, and given an opportunity to obtain copies of their health information. Patients may be notified of the opportunity to obtain copies by publishing a series of notices in the local newspaper. Only copies of the health records should be given to patients unless the required retention period has expired.

Background

During the course of treatment, patients share private details of their lives with physicians and other healthcare providers. Patients trust their healthcare providers to respect their privacy, maintain the confidentiality of their health information, protect the integrity of the information, and assure its availability for their continuing care. Because of this trust, healthcare providers must be concerned with the protection of health information when facilities close or medical practices dissolve.

Liability Issues

Generally, a healthcare provider remains liable for accidental or incidental disclosure of health information during or after a closure. Therefore, the provider must make appropriate plans to protect the integrity of the records and the confidentiality of the information they contain, while assuring access for continued patient care. State laws and regulations addressing facility or practice closure should be followed. These are usually available from the state department of health. If state laws and regulations are silent on how to proceed, the provider should consider several other factors, as outlined below.

Retention Issues

State Laws/Licensure Requirements

A provider is bound by applicable federal and state laws and regulations after closure, as well as during its operation. Many state health departments and licensing authorities govern healthcare facility closures and may outline to whom records should be transferred. In some states, a state archive or health department will store health records from closed facilities. More commonly, state regulations recommend records be transferred to another healthcare provider.

If records cannot be transferred to a state archive or state health department, the state's requirements for record retention for both adult and minor patients should be reviewed before a policy is formulated. *(Note: Many states require approval from the state department of health or licensing authority before any plan is implemented.)*

To minimize storage and/or transfer costs, the provider may wish to destroy records that are past the period of required retention. For example, if state law requires that records be retained for 10 years after the patient's last encounter, records that are more than 10 years old could be destroyed. If state law does not specify the length of time records must be kept, the provider must consider the state's malpractice statute of limitations for both adults and minors and assure that records are maintained for at least the period of time specified by the state's statutes of limitations. A longer retention period is prudent, since the statute may not begin to run until the potential plaintiff learns of the causal relation between an injury and the care received. If the patient was a minor, the provider should retain health information until the patient reaches the age of majority (as defined by state law) plus the period of the statute of limitations, unless otherwise provided by state law.

The provider should also contact its malpractice insurance carrier. Both the provider and the carrier must have access to patient records after the closure in the event a malpractice claim is filed.

Medicare Requirements

If the provider participates in the Medicare program, records must be kept in their original or legally reproduced form for at least five years from the date of the settlement of the claim to comply with the Medicare Conditions of Participation. Skilled Nursing Facilities and Home Care

Agencies must retain their records for 5 years after the month the cost report was filed. (For example: Cost report for 1998 was submitted on 01/15/99 the records must be retained until 02/01/04.)

Federal Regulations re: Alcohol and Drug Abuse Treatment

If the provider has offered services pertaining to alcohol and/or drug abuse education, training, treatment, rehabilitation, or research, disposition of these records must meet requirements outlined by federal law.[2] When a program discontinues operations or is acquired by another program, this law requires the patient's written authorization for records to be transferred to the acquiring program or any other program named in the patient's authorization. If records are required by law to be kept for a specified period which does not expire until after the discontinuation or acquisition of the program and the patient has not authorized transfer of the records, these records must be sealed in envelopes or other containers and labeled as follows:

"Records of [insert name of program] required to be maintained pursuant to [insert citation to law or regulation requiring that records be kept] until a date not later than December 31, [insert appropriate year]."

Records marked and sealed as prescribed may be held by any lawful custodian, but the custodian must follow the procedures outlined by law for disclosure. If the patient does not authorize transfer of his records to another program, they may be destroyed after the required retention period.

Recommendations from Professional Organizations

Professional organizations should be contacted for guidelines or recommendations. Such professional organizations may include local or state:

- health information management associations
- hospital associations
- medical societies

Physicians who are closing their practices may wish to contact the American Medical Association and their state licensure board for guidance.

Legal Advice

Advice from legal counsel should be sought to determine the appropriate retention period, assure compliance with state laws and regulatory agencies, and help plan for an orderly closure or transfer.

Budgeting for a Closure

Regardless of which plan of action your facility institutes to deal with the patient records, resources will need to be allocated to carry out the plan. Some of the resources that need to be budgeted for include:

- labor
- copy equipment and supplies
- postage
- telephone
- utilities
- storage boxes and supplies
- transportation costs (to storage unit)
- storage and retrieval costs for required retention period

Recommendations

As soon as a healthcare provider anticipates a facility closure or dissolution of a medical practice, the provider should begin planning for proper disposition of patient health records. The primary objective is to assure future access by patients, future healthcare providers, and other legitimate users.

The second objective should be to protect the confidentiality of the information contained in the records.

To ensure accurate information for continuing care, all health information documentation must be completed before the records are archived. This includes transcription of all dictated reports and interpretation of any diagnostic tests.

Before records are transferred to an archive or another provider, patients should be notified, if possible, and given an opportunity to obtain copies of their records. Letters and or e-mail messages may be sent to former patients, or announcements may be repeated in local newspapers and professional journals to notify patients and their physicians about the upcoming closure/practice dissolution and let them know how to access their information.

Patients should be given a reasonable amount of time (at least one month, unless a longer time period is required by state law) to request copies of their records.

Elements to consider including in the letter and/or e-mail to the patient are as follows:

- the date the facility will close
- notification of where the records will be stored and how to access them
- a release of information authorization form to be completed to receive a copy of their medical record
- notification that only written requests for copies of health information will be honored

- notification of any time limitations (submission deadlines) on the period of time during which requests will be accepted
- instructions on how to seek a new healthcare provider

The custodian of the retained records should retain a copy of the actual letter and/or e-mail sent to patients, along with the mailing list, broadcast e-mail list, post office receipt, all returned (undeliverable) envelopes, and a list of returned or undeliverable e-mails.

If the records pertain to treatment for alcohol and/or drug abuse, specific federal regulations[3] must be followed.

Closure/Dissolution with a Sale

If a healthcare facility or medical practice is sold to another healthcare provider, patient records may be considered assets and included in the sale of the property. As part of the agreement, the original provider who created the records should retain the right to access the records and obtain copies, if needed, from the new owners. In addition, if the new owner considers a sale to a third party, the original provider should retain the right to reclaim the patient records.

If the facility or medical practice is sold to a non-healthcare entity, patient records should not be included in the assets available for purchase. The provider should make arrangements to either transfer the records to an archive or another provider who agrees to accept responsibility for maintaining them.

Closure/Dissolution without a Sale

If a facility closes or a practice dissolves without a sale, arrangements should be made with another healthcare provider where patients may seek future care, unless otherwise required by state law. That provider should agree to maintain the records, permit access by authorized persons, and destroy the records when applicable time periods have expired.

Health information management professionals at the receiving facility should be familiar with record retention and destruction requirements and confidentiality concerns and have systems in place to allow patients and other legitimate users access to the information. Prior to transferring the records, a written agreement outlining terms and obligations should be executed. The original provider is responsible for assuring that records are stored safely for an appropriate length of time.

If transfer to another provider is not feasible, records may be archived with a reputable commercial storage firm. Such a firm should be considered only if it:

- has experience in handling confidential patient information
- guarantees the security and confidentiality of the records
- assures that patients and other legitimate requestors will have access to the information

If a storage firm is used, specific provisions should be negotiated and included in the written agreement. Such provisions include but are not limited to:

- agreement to keep all information confidential, disclosing only to authorized representatives of the provider or upon written authorization from the patient/legal representative
- prompt return of all embodiments of confidential information without retaining copies thereof upon the provider's request
- prohibition against selling, sharing, discussing, assigning, transferring, or otherwise disclosing confidential information with any other individuals or business entities
- prohibition against use of confidential information for any purpose other than providing mutually agreed upon services
- agreement to protect information against theft, loss, unauthorized destruction, or other unauthorized access
- return or destruction of information at the end of the mutually agreed upon retention period
- assurance that providers, patients, and other legitimate users will have access to the information

Providers may consider giving original records directly to patients, but only copies should be given to patients unless the required retention period has expired. During the required retention period, the provider may need access to the original records for the provider's own business reasons.

Regardless of the archival method used, the provider must assure that the integrity and confidentiality of the patient health records will be maintained and that the records are accessible to the patient and other legitimate users.

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Updated by:

Harry Rhodes, MBA, RHIA, CHP

Originally prepared by:

Mary D. Brandt, MBA, RHIA, CHE, CHP
Harry Rhodes, MBA, RHIA, CHP

Notes

1. Patient records may include paper, microfilm, optical storage, or computer-based health information, diagnostic images (such as radiology films, nuclear medicine scans, and cineangiography films), fetal monitor recordings, videotaped operative procedures, and information stored on other media.
2. *Code of Federal Regulations* 42 CFR Ch. 1 (10-1-85). [42 CFR Part 2 Subpart B, Paragraph 2.19]
3. *Ibid.*

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APPENDIX

E

U.S. Department of Labor
Employment and Training Administration
Fact Sheet

The Worker Adjustment and Retraining Notification Act

A Guide to Advance Notice of Closings and Layoffs

The Worker Adjustment and Retraining Notification Act (**WARN**) was enacted on August 4, 1988 and became effective on February 4, 1989.

General Provisions

WARN offers protection to workers, their families and communities by requiring employers to provide notice 60 days in advance of covered plant closings and covered mass layoffs. This notice must be provided to either affected workers or their representatives (e.g., a labor union); to the State dislocated worker unit; and to the appropriate unit of local government.

Employer Coverage

In general, employers are covered by **WARN** if they have 100 or more employees, not counting employees who have worked less than 6 months in the last 12 months and not counting employees who work an average of less than 20 hours a week. Private, for-profit employers and private, nonprofit employers are covered, as are public and quasi-public entities which operate in a commercial context and are separately organized from the regular government. Regular Federal, State, and local government entities which provide public services are not covered.

Employee Coverage

Employees entitled to notice under **WARN** include hourly and salaried workers, as well as managerial and supervisory employees. Business partners are not entitled to notice.

What Triggers Notice

Plant Closing: A covered employer must give notice if an employment site (or one or more facilities or operating units within an employment site) will be shut down, and the shutdown will result in an employment loss (as defined later) for 50 or more employees during any 30-day period. This does not count employees who have worked less than 6 months in the last 12 months or employees who work an average of less than 20 hours a week for that employer. These latter groups, however, are entitled to notice (discussed later).

Mass Layoff: A covered employer must give notice if there is to be a mass layoff which does not result from a plant closing, but which will result in an employment loss at the employment site during any 30-day period for 500 or more employees, or for 50-499 employees if they make up at least 33% of the employer's active workforce. Again, this does not count employees who have worked less than 6 months in the last 12 months or employees who work an average of less than 20 hours a week for that employer. These latter groups, however, are entitled to notice (discussed later).

An employer also must give notice if the number of employment losses which occur during a 30-day period fails to meet the threshold requirements of a plant closing or mass layoff, but the number of employment losses for 2 or more groups of workers, each of which is less than the minimum number needed to trigger notice, reaches the threshold level, during any 90-day period, of either a plant closing or mass layoff. Job losses within any 90-day period will count together toward **WARN** threshold levels, unless the employer demonstrates that the employment losses during the 90-day period are the result of separate and distinct actions and causes.

Sale of Businesses

In a situation involving the sale of part or all of a business, the following requirements apply. (1) In each situation, there is always an employer responsible for giving notice. (2) If the sale by a covered employer results in a covered plant closing or

mass layoff, the required parties (discussed later) must receive at least 60 days notice. (3) The seller is responsible for providing notice of any covered plant closing or mass layoff which occurs up to and including the date/time of the sale. (4) The buyer is responsible for providing notice of any covered plant closing or mass layoff which occurs after the date/time of the sale. (5) No notice is required if the sale does not result in a covered plant closing or mass layoff. (6) Employees of the seller (other than employees who have worked less than 6 months in the last 12 months or employees who work an average of less than 20 hours a week) on the date/time of the sale become, for purposes of **WARN**, employees of the buyer immediately following the sale. This provision preserves the notice rights of the employees of a business that has been sold.

Employment Loss

The term "employment loss" means:

(1) An employment termination, other than a discharge for cause, voluntary departure, or retirement;

(2) a layoff exceeding 6 months; or

(3) a reduction in an employee's hours of work of more than 50% in each month of any 6-month period.

Exceptions: An employee who refuses a transfer to a different employment site within reasonable commuting distance does not experience an employment loss. An employee who accepts a transfer outside this distance within 30 days after it is offered or within 30 days after the plant closing or mass layoff, whichever is later, does not experience an employment loss. In both cases, the transfer offer must be made before the closing or layoff, there must be no more than a 6 month break in employment, and the new job must not be deemed a constructive discharge. These transfer exceptions from the "employment loss" definition apply only if the closing or layoff results from the relocation or consolidation of part or all of the employer's business.

Exemptions

An employer does not need to give notice if a plant closing is the closing of a temporary facility, or if the closing or mass layoff is the result of the completion of a particular project or undertaking. This exemption applies only if the workers were hired with the understanding that their employment was limited to the duration of the facility, project or undertaking. An employer cannot label an ongoing project "temporary" in order to evade its obligations under **WARN**.

An employer does not need to provide notice to strikers or to workers who are part of the bargaining unit(s) which are involved in the labor negotiations that led to a lockout when the strike or lockout is equivalent to a plant closing or mass layoff. Non-striking employees who experience an employment loss as a direct or indirect result of a strike and workers who are not part of the bargaining unit(s) which are involved in the labor negotiations that led to a lockout are still entitled to notice.

An employer does not need to give notice when permanently replacing a person who is an "economic striker" as defined under the National Labor Relations Act.

Who Must Receive Notice

The employer must give written notice to the chief elected officer of the exclusive representative(s) or bargaining agency(s) of affected employees and to unrepresented individual workers who may reasonably be expected to experience an employment loss. This includes employees who may lose their employment due to "bumping," or displacement by other workers, to the extent that the employer can identify those employees when notice is given. If an employer cannot identify employees who may lose their jobs through bumping procedures, the employer must provide notice to the incumbents in the jobs which are being eliminated. Employees who have worked less than 6 months in the last 12 months and employees who work an average of less than 20 hours a week are due notice, even though they are not counted when determining the trigger levels.

The employer must also provide notice to the State dislocated worker unit and to the chief elected official of the unit of local government in which the employment site is located.

Notification Period

With three exceptions, notice must be timed to reach the required parties at least 60 days before a closing or layoff. When the individual employment separations for a closing or layoff occur on more than one day, the notices are due to the representative (s), State dislocated worker unit and local government at least 60 days before each separation. If the workers are not represented, each worker's notice is due at least 60 days before that worker's separation.

The exceptions to 60-day notice are:

(1) Faltering company. This exception, to be narrowly construed, covers situations where a company has sought new capital or business in order to stay open and where giving notice would ruin the opportunity to get the new capital or business, and applies only to plant closings;

(2) unforeseeable business circumstances. This exception applies to closings and layoffs that are caused by business circumstances that were not reasonably foreseeable at the time notice would otherwise have been required; and

(3) Natural disaster. This applies where a closing or layoff is the direct result of a natural disaster, such as a flood, earthquake, drought or storm.

If an employer provides less than 60 days advance notice of a closing or layoff and relies on one of these three exceptions, the employer bears the burden of proof that the conditions for the exception have been met. The employer also must give as much notice as is practicable. When the notices are given, they must include a brief statement of the reason for reducing the notice period in addition to the items required in notices.

Form and Content of Notice

No particular form of notice is required. However, all notices must be in writing. Any reasonable method of delivery designed to ensure receipt 60 days before a closing or layoff is acceptable.

Notice must be specific. Notice may be given conditionally upon the occurrence or non-occurrence of an event only when the event is definite and its occurrence or nonoccurrence will result in a covered employment action less than 60 days after the event.

The content of the notices to the required parties is listed in section 639.7 of the **WARN** final regulations. Additional notice is required when the date(s) or 14-day period(s) for a planned plant closing or mass layoff are extended beyond the date(s) or 14-day period(s) announced in the original notice.

Record

No particular form of record is required. The information employers will use to determine whether, to whom, and when they must give notice is information that employers usually keep in ordinary business practices and in complying with other laws and regulations.

Penalties

An employer who violates the **WARN** provisions by ordering a plant closing or mass layoff without providing appropriate notice is liable to each aggrieved employee for an amount including back pay and benefits for the period of violation, up to 60 days. The employer's liability may be reduced by such items as wages paid by the employer to the employee during the period of the violation and voluntary and unconditional payments made by the employer to the employee.

An employer who fails to provide notice as required to a unit of local government is subject to a civil penalty not to exceed $500 for each day of violation. This penalty may be avoided if the employer satisfies the liability to each aggrieved employee within 3 weeks after the closing or layoff is ordered by the employer.

Enforcement

Enforcement of **WARN** requirements is through the United States district courts. Workers, representatives of employees and units of local government may bring individual or class action suits. In any suit, the court, in its discretion, may allow the prevailing party a reasonable attorney's fee as part of the costs.

Information

Specific requirements of the Worker Adjustment and Retraining Notification Act may be found in the Act itself, Public Law 100-379 (29 U.S.C. 210l, et seq.) The Department of Labor published final regulations on April 20, 1989 in the Federal Register (Vol. 54, No. 75). The regulations appear at 20 CFR Part 639.

General questions on the regulations may be addressed to:

U.S. Department of Labor
Employment and Training Administration
Office of Work-Based Learning
Room N-5426
200 Constitution Avenue, N.W.
Washington, D.C. 20210
(202) 219-5577

The Department of Labor, since it has no administrative or enforcement responsibility under **WARN**, cannot provide specific advice or guidance with respect to individual situations.

This is one of a series of fact sheets highlighting U.S. Department of Labor programs. It is intended as a general description only and does not carry the force of legal opinion.

APPENDIX

F

Customized Training

Rapid Response Team

Employer HR Support Services

Workforce Initiatives

Business Outreach

Contact Information

Customer Satisfaction Survey

Alien Labor Certification

Work Opportunity Tax Credit (WOTC)

Feedback

Rapid Response Team

Toll Free 1-800-343-3919

Rapid Response assists both employers and workers involved in a closing or permanent mass layoff. The Rapid Response Team provides information about and assistance obtaining:

Unemployment Insurance

- Explanation of benefits and eligibility requirements
- Procedures for filing claims

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Reemployment Service

- One-Stop Career Center services
- Referrals to job openings
- Labor Market Information
- Resume development
- Self-service options:
  - America's Job Bank
  - America's Career InfoNet
  - America's Service Locator
  - CareerOneStop.org
  - O*NET
  - WNJPIN.net

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Training Assistance

- Introduction to state and federal retraining programs

Initial Meeting

A Rapid Response Specialist will meet with management and union personnel (if applicable) to develop a service plan for your company's workforce.

Meeting with Workers

A group meeting with the workers is held according to the employer's schedule. Employees have the opportunity to ask questions and complete required forms.

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Response Team Services

- Job search workshops
- Resume workshops
- Job solicitation campaigns
- On-site career center staffing assistance
- Help in forming workforce transition committees
- Job fair assistance
- Career counseling and assessment
- Introduction to computerized job searches
- Services in languages other than English

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Other Information

- Dislocated Workers
- Worker Adjustment and Retraining Notification Act (WARN)

If your company is anticipating a closing or permanent mass layoff call the Rapid Response Team at 1-800-343-3919.

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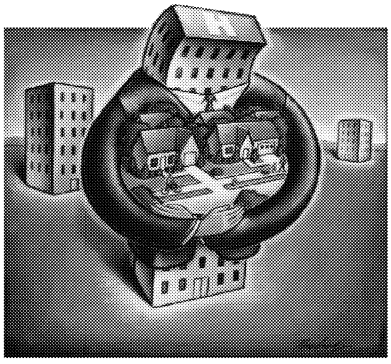

NJHA
NEW JERSEY HOSPITAL ASSOCIATION
760 Alexander Road, PO Box 1
Princeton, NJ 08543
www.njha.com