Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RESCISSION

19 CSR 30-20.021 Organization and Management for Hospitals. This rule established standards for the operations of hospitals. This rule established standards for the administration, medical staff, nursing staff and supporting departments to provide a high level of care.

PURPOSE: This rule is being rescinded as it is being broken in parts and refiled as new rules.

*AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2005. This rule originally filed as 13 CSR 50-20.021 and 19 CSR 10-20.021. Original rule filed June 2, 1982, effective Nov. 11, 1982. For intervening history, please consult the **Code of State Regulations**. Rescinded: Filed June 27, 2007.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with David S. Durbin, Director, Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. Telephone (573) 522-8535. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.080 Governing Body of Hospitals

PURPOSE: This rule defines governing body and establishes standards for the governing body of hospitals.

(1) The governing body is defined as an individual owner(s), partnership, corporate body, association or public agency having legal responsibility for the operation of a hospital subject to provisions of sections 197.020–197.120, RSMo.

(2) The governing body shall be the legal authority in the hospital and shall be responsible for the overall planning, directing, control and management of the activities and functions of the hospital.

(3) The governing body shall establish and adopt bylaws to provide for the appointment of a qualified chief executive officer and members of the medical staff and of the delegation of authority and responsibility to each. A copy of the governing body bylaws and of all amendments or revisions shall be submitted to the Department of Health for its records.

(4) Meetings of the governing body shall be held at regular, stated intervals and at other times necessary for proper operation of the hospital. Minutes of all meetings shall be kept as permanent records, signed and made available to members of the governing body.

(5) Bylaws of the governing body shall provide for the election of officers and for the appointment of standing and special committees necessary to effectively carry out its responsibilities. Written minutes of all committee meetings shall be maintained on a confidential basis.

(6) Bylaws of the governing body shall establish a direct and effective means of liaison among the governing body, the administration and the medical staff.

(7) The governing body shall select and employ a chief executive officer who should be qualified, by education and experience, in the field of hospital or health care administration.

(8) Bylaws of the governing body shall describe and convey authority to the chief executive officer for the administration of the hospital in all its activities. The chief executive officer shall be subject to special policies adopted or specific orders issued by the governing body in accordance with its bylaws.

(9) The Department of Health shall be notified of any change in the appointment of the chief executive officer.

(10) Bylaws of the governing body shall require that the medical staff, hospital personnel and all auxiliary organizations, directly or indirectly, shall be responsible to the governing body through the chief executive officer.

(11) Bylaws of the governing body shall require that a qualified individual be designated by the chief executive officer to act in his/her absence.

(12) Duly appointed representatives of the Department of Health shall be allowed to inspect the hospital as required in section 197.100, RSMo.

(13) Bylaws of the governing body shall provide for the selection and appointment of medical staff members based upon defined criteria and in accordance with an established procedure for processing and evaluating applications for membership. Applications for appointment and reappointment shall be in writing and shall signify agreement of the applicant to conform with bylaws of both the governing body and medical staff and to abide by professional ethical standards. Initial appointments to the medical staff shall not exceed two (2) years. Reappointments, which may be processed and approved at the discretion of the governing body on a monthly or other cyclical pattern, shall not exceed two (2) years.

(14) Bylaws of the governing body shall require that the medical staff develop and adopt medical staff bylaws and rules which shall become effective when approved by the governing body.

(15) The governing body, acting upon recommendations of the medical staff, shall approve or disapprove appointments and on the basis of established requirements shall determine the privileges extended to each member of the staff.

(16) Bylaws of the governing body shall provide that notification of denial of appointment, reappointment, curtailment, suspension, revocation or modification of privileges shall be in writing and shall indicate the reason(s) for this action.

(17) The governing body shall establish mechanisms which assure the hospital's compliance with mandatory federal, state and local laws, rules and standards.

(18) Although independent licensed practitioners are not authorized membership to the medical staff, the governing body may include provisions within its bylaws to grant licensed practitioners clinical privileges, on an outpatient basis, for diagnostic and therapeutic tests and treatment. The privileges shall be within the scope and authority of each practitioner's current Missouri license and practice act.

(A) The provisions shall include a mechanism to assure that independent practitioners who provide services have clinical privileges delineated by the governing body or designee.

(B) The mechanism shall include criteria for a review of an independent practitioner's credentials at least every two (2) years. At a minimum, the criteria shall include documentation of a current license, relevant training and experience, and competency.

(19) The governing body shall establish and implement a mechanism which assures compliance with the reporting requirements in section 383.133, RSMo.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(A). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately $3,723,501 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $11,005,696 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30 – 20.080 Governing Body of Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities, or Hospital Districts	$3,703,840
Department of Health and Senior Services	$19,661
Total	$3,723,501

III. WORKSHEET

Public Hospitals
1995 cost of Governing Body, Administration (CEO), and Medical Staff per hospital = $240,000.

1995 cost of Governing Body = $240,000 ÷ 3 = $80,000 per hospital.

1995 cost of Governing Body for all public hospitals = $80,000 x 35 = $2,800,000 aggregate cost for 35 public hospitals.

2006 cost of Governing Body for all public hospitals = $2,800,000 x 1.3228 inflation factor = $3,703,840 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year.

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of the programs and services required by 19 CSR 30-20.021 (2), Governing Body, Administration, and Medical Staff, through an analysis of six (6) hospitals.
2. In the 1995 fiscal note, the cost of the Governing Body requirements was bundled with the costs of Administration and Medical Staff.
3. The bundled amount for the six (6) hospitals in 1995 was $240,000 per hospital. This has been divided by three (3) to obtain an estimated cost of the Governing Body in the current calculations.
4. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
5. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30 – 20.080 Governing Body
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	Private general/acute care hospitals	$11,005,696

III. WORKSHEET

1995 cost of Governing Body, Administration, and Medical Staff per hospital = $240,000.

1995 cost of Governing Body = $240,000 ÷ 3 = $80,000 per hospital.

1995 cost of Governing Body for all private hospitals = $80,000 x 104 = $8,320,000 aggregate cost for 104 private hospitals.

2006 cost of Governing Body for all private hospitals = $8,320,000 x 1.3228 inflation factor = $11,005,696 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of the programs and services required by 19 CSR 30-20.021 (2), Governing Body, Administration, and Medical Staff, through an analysis of six (6) hospitals.
2. In the 1995 fiscal note, the cost for the Governing Body requirements was bundled with the costs of Administration and Medical Staff.
3. The bundled amount for the six (6) hospitals in 1995 was $240,000 per hospital. This has been divided by three (3) to obtain an estimated cost of Governing Body in the current calculations.

4. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
5. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.082 Chief Executive Officer in Hospitals

PURPOSE: This rule specifies the duties of the chief executive officer of a hospital.

(1) The chief executive officer shall be the direct representative of the governing body and shall be responsible for management of the hospital commensurate with the authority delegated by the governing body in its bylaws.

(2) The chief executive officer shall be responsible for maintaining liaison among the governing body, medical staff and all departments of the hospital.

(3) The chief executive officer shall organize the administrative functions of the hospital through appropriate departmentalization and delegation of duties and shall establish a system of authorization, record procedures and internal controls.

(4) The chief executive officer shall be responsible for the recruitment and employment of qualified personnel to staff the various departments of the hospital and shall insure that written personnel policies and job descriptions are available to all employees.

(5) The chief executive officer shall be responsible for the development and enforcement of written policies and procedures governing visitors to all areas of the hospital.

(6) The chief executive officer shall be responsible for establishing effective security measures to protect patients, employees and visitors.

(7) The chief executive officer shall maintain policies protecting children admitted to or discharged from the hospital. Policies shall provide for at least the following:

(A) A child shall not be released to anyone other than the child's parent(s), legal guardian or custodian;

(B) The social work service personnel shall have knowledge of available social services for unmarried mothers and for the placement of children;

(C) Adoption placements shall comply with section 453.010, RSMo; and

(D) The reporting of suspected incidences of child abuse shall be made to the Division of Family Services as established under section 210.120, RSMo.

(8) The chief executive officer shall be responsible for developing a written emergency preparedness plan. The plan shall include procedures which provide for safe and orderly evacuation of patients, visitors and personnel in the event of fire, explosion or other internal disaster. The plan shall also include procedures for caring for mass casualties resulting from any external disaster in the region.

(9) The emergency plan in section (8) of this rule shall be readily available to all personnel. The chief executive officer is responsible for ensuring all employees shall be instructed regarding their responsibilities during an emergency. Drills for internal disasters, such as fires, shall be held at least quarterly for each shift and shall include the simulated use of fire alarm signals and simulation of emergency fire conditions. Annual drills for external disasters shall be held in coordination with representatives of local emergency preparedness offices. The movement of hospital patients is not required as a part of the drills.

(10) The chief executive officer shall be responsible for carrying out policies of the governing body to ensure that patients are admitted to the hospital only by members of the medical staff and that each patient's general medical condition shall be the primary responsibility of a physician member of the medical staff.

(11) The chief executive officer shall bring to the attention of the chief of the medical staff and governing body failure by members of that staff to conform with established hospital policies regarding administrative matters, professional standards or the timely preparation and completion of each patient's clinical record.

(12) The chief executive officer shall be responsible for developing and maintaining a hospital environment which provides for efficient care and safety of patients, employees and visitors.

(13) The chief executive officer shall be responsible for the development and enforcement of written policies and procedures which prohibit the use of tobacco products throughout the hospital and its facilities. At a minimum, such policies and procedures shall include a description of the area encompassed by the tobacco-free policy; how employees, patients and visitors will be educated and informed about the tobacco-free policy; who is responsible for enforcing the tobacco-free policy and how the tobacco-free policy will be enforced; how the hospital will address an employee's, patient's, or visitor's failure to comply with the tobacco-free policy; and how the hospital, if subject to Medicare Conditions of Participation for Long-Term Care Facilities, will comply with 42 CFR 483.15(b)(3). The chief executive officer shall enforce compliance with the written policies and procedures prohibiting the use of tobacco products throughout the hospital and its facilities beginning one (1) year from the effective date of this amendment.

(14) An annual licensing survey for each fiscal year shall be filed with the department on the survey document provided by the Department of Health and Senior Services. The survey shall be due within two (2) months after the hospital's receipt of the survey.

(15) The chief executive officer shall be responsible for establishing and implementing a mechanism which will assure that patient services provide care or an appropriate referral that is commensurate with the patient's needs. If services are provided by contract, the contractor shall furnish services that permit the hospital to comply with all applicable hospital licensing requirements.

(16) The chief executive officer shall be responsible for establishing and implementing a mechanism to assure that all equipment and physical facilities used by the hospital to provide patient services, including those services provided by a contractor, comply with applicable hospital licensing requirements.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(B). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately $3,723,501 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $11,005,696 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	19 CSR 30 – 20.082 Chief Executive Officer in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities, or Hospital Districts	$3,703,840
Department of Health and Senior Services	$19,661
Total	$3,723,501

III. WORKSHEET

Public Hospitals
1995 cost of Governing Body, Administration, and Medical Staff per hospital = $240,000.

1995 cost of Medical Staff = $240,000 ÷ 3 = $80,000 per hospital.

1995 cost of Medical Staff for all public hospitals = $80,000 x 35 = $2,800,000 aggregate cost for 35 public hospitals.

2006 cost of Medical Staff for all public hospitals = $2,800,000 x 1.3228 inflation factor = $3,703,840 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year.

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of the programs and services required by 19 CSR 30-20.021 (2), Governing Body, Administration, and Medical Staff, through an analysis of six (6) hospitals.
2. In the 1995 fiscal note, the cost for the Medical Staff requirements was bundled with the costs for Administration and Governing Body.
3. The bundled amount for the six (6) hospitals in 1995 was $240,000 per hospital. This has been divided by three (3) to obtain an estimated cost for Medical Staff in the current calculations.
4. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
5. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be <u>no actual new costs</u> for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	19 CSR 30 – 20.082 Chief Executive Officer in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	Private general/acute care hospitals	$11,005,696

III. WORKSHEET

1995 cost of Governing Body, Administration (CEO), and Medical Staff per hospital = $240,000.

1995 cost of Administration (CEO) = $240,000 ÷ 3 = $80,000 per hospital.

1995 cost of Administration (CEO) for all private hospitals = $80,000 x 104 = $8,320,000 aggregate cost for 104 private hospitals.

2006 cost of Administration (CEO) for all private hospitals = $8,320,000 x 1.3228 inflation factor = $11,005,696 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of the programs and services required by 19 CSR 30-20.021 (2), Governing Body, Administration (Chief Executive Officer), and Medical Staff, through an analysis of six (6) hospitals.
2. In the 1995 fiscal note, the cost for Administration (Chief Executive Officer) was bundled with the costs for Governing Body and Medical Staff.
3. The bundled amount for the six (6) hospitals in 1995 was $240,000 per hospital. This has been divided by three (3) to obtain an estimated cost for Administration (CEO) in the current calculations.
4. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
5. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.084 Patients' Rights in Hospitals

PURPOSE: This rule establishes the minimum requirements necessary to assure patients' rights are protected.

(1) The chief executive officer shall be responsible for establishing and implementing a mechanism to assure that patients' rights are protected. At a minimum, the mechanism shall include the following:

(A) The patient has the right to be free from abuse, neglect or harassment;

(B) The patient has the right to be treated with consideration and respect;

(C) The patient has the right to protective oversight while a patient in the hospital;

(D) The patient or his/her designated representative has the right to be informed regarding the hospital's plan of care for the patient;

(E) The patient or his/her designated representative has the right to be informed, upon request, regarding general information pertaining to services received by the patient;

(F) The patient or his/her designated representative has the right to review the patient's medical record and to receive copies of the record at a reasonable photocopy fee;

(G) The patient or his/her designated representative has the right to participate in the patient's discharge planning, including being informed of service options that are available to the patient and a choice of agencies which provide the service;

(H) When a patient has brought personal possessions to the hospital, s/he has the right to have these possessions reasonably protected;

(I) The patient has the right to accept medical care or to refuse it to the extent permitted by law and to be informed of the medical consequences of refusal. The patient has the right to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law;

(J) The patient, responsible party or designee has the right to participate in treatment decisions and the care planning process;

(K) The patient has the right to be informed of the hospital's patient grievance policies and procedures, including who to contact and how; and

(L) The patient has the right to file a formal or informal verbal or written grievance and to expect a prompt resolution of the grievance, including a timely written notice of the resolution. The grievance may be made by a patient or the patient's representative. Any patient service or care issue that cannot be resolved promptly by staff present will be considered a grievance for purposes of this requirement. The written notice of the resolution should include information on the steps taken on behalf of the patient to investigate the grievance, the results of the investigation, and the date the investigation was completed. If the corrective action is still being evaluated, the hospital's response should state that the hospital is still working to resolve the grievance and the hospital will follow-up with another written response when the investigation is complete or within a specified time frame.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000. This rule previously filed as 19 CSR 30-20.021(2)(B)17. Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.086 Medical Staff in Hospitals

PURPOSE: This rule specifies the requirements for the organization of the medical staff in a hospital.

(1) The medical staff shall be organized, shall develop and, with the approval of the governing body, shall adopt bylaws, rules and policies governing their professional activities in the hospital.

(2) Medical staff membership shall be limited to physicians, dentists, psychologists and podiatrists. They shall be currently licensed to practice their respective professions in Missouri. The bylaws of the medical staff shall include the procedure to be used in processing applications for medical staff membership and the criteria for granting initial or continuing medical staff appointments and for granting initial, renewed or revised clinical privileges.

(3) No application for membership on the medical staff shall be denied based solely upon the applicant's professional degree or the school or health care facility in which the practitioner received medical, dental, psychology or podiatry schooling, postgraduate training or certification, if the schooling or postgraduate training for a physician was accredited by the American Medical Association or the American Osteopathic Association, for a dentist was accredited by the American Dental Association's Commission on Dental Accreditation, for a psychologist was accredited with accordance to Chapter 337, RSMo and for a podiatrist was accredited by the American Podiatric Medical Association. Each application for staff membership shall be considered on an individual basis with objective criteria applied equally to each applicant.

(4) Each physician, dentist, psychologist or podiatrist requesting staff membership shall submit a complete written application to the chief executive officer of the hospital or his designee on a form approved by the governing body. Each application shall be accompanied by evidence of education, training, professional qualifications, license and and other information required by the medical staff bylaws or policies.

(5) Written criteria shall be developed for privileges extended to each member of the staff. A formal mechanism shall be established for recommending to the governing body delineation of privileges, curtailment, suspension or revocation of privileges and appointments and reappointments to the medical staff. The mechanism shall include an inquiry of the National Practitioner Data Bank. Bylaws of

the medical staff shall provide for hearing and appeal procedures for the denial of reappointment and for the denial, revocation, curtailment, suspension, revocation, or other modification of clinical privileges of a member of the medical staff.

(6) Any applicant for medical staff membership who is denied membership or whose completed application is not acted upon in ninety (90) calendar days of completion of verification of credentials data or a medical staff member whose membership or privileges are terminated, curtailed or diminished in any way shall be given in writing the reasons for the action or lack of action. The reasons shall relate to, but not be limited to, patient welfare, the objectives of the institution, the inability of the organization to provide the necessary equipment or trained staff, contractual agreements, or the conduct or competency of the applicant or medical staff member.

(7) Initial appointments to the medical staff shall not exceed two (2) years. Reappointments, which may be processed and approved at the discretion of the governing body on a monthly or other cyclical pattern, shall not exceed two (2) years.

(8) The medical staff bylaws shall provide for—an outline of the medical staff organization; designation of officers, their duties and qualifications and methods of selecting the officers; committee functions; and an appeal and hearing process.

(9) The medical staff bylaws shall provide for an active staff and other categories as may be designated in the governing body bylaws. The medical staff bylaws shall describe the voting rights, attendance requirements, eligibility for holding offices or committee appointments, and any limitations or restrictions identified with location of residence or office practice for each category.

(10) The organized medical staff shall meet at intervals necessary to accomplish its required functions. A mechanism shall be established for monthly decision-making by or on behalf of the medical staff.

(11) Written minutes of medical staff meetings shall be recorded. Minutes containing peer review information shall be retained on a confidential basis in the hospital. The medical staff determine retention guidelines and guidelines for release of minutes not containing peer review materials.

(12) The medical staff as a body or through committee shall review and evaluate the quality of clinical practice of the medical staff in the hospital in accordance with the medical staff's peer review function and performance improvement plan and activities.

(13) The medical staff shall establish in its bylaws or rules criteria for the content of patients' records provisions for their timely completion and disciplinary action for noncompliance.

(14) Bylaws of the medical staff shall require that at all times at least one (1) physician member of the medical staff shall be on duty or available within a reasonable period of time for emergency service.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2006. This rule previously filed as 19 CSR 30-20.021(2)(C). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately $3,723,501 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $11,005,696 annually in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30-20.086 Medical Staff in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities or Hospital Districts	**$3,703,840**
Department of Health and Senior Services	**$19,661**
Total	**$3,723,501**

III. WORKSHEET

Public Hospitals
1995 cost of Governing Body, Administration, and Medical Staff per hospital = $240,000.

1995 cost of Medical Staff = $240,000 ÷ 3 = $80,000 per hospital.

1995 cost of Medical Staff for all public hospitals = $80,000 x 35 = $2,800,000 aggregate cost for 35 public hospitals.

2006 cost of Medical Staff for all public hospitals = $2,800,000 x 1.3228 inflation factor = $3,703,840 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year.

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of the programs and services required by 19 CSR 30-20.021 (2), Governing Body, Administration, and Medical Staff, through an analysis of six (6) hospitals.
2. In the 1995 fiscal note, the cost for the Medical Staff requirements was bundled with the costs for Administration and Governing Body.
3. The bundled amount for the six (6) hospitals in 1995 was $240,000 per hospital. This has been divided by three (3) to obtain an estimated cost for Medical Staff in the current calculations.
4. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
5. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Title:	19 CSR 30-20.086 Medical Staff in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	**Private General/Acute care hospitals**	**$11,005,696**

III. WORKSHEET

1995 cost of Governing Body, Administration, and Medical Staff per hospital = $240,000.

1995 cost of Medical Staff = $240,000 ÷ 3 = $80,000 per hospital.

1995 cost of Medical Staff for all private hospitals = $80,000 x 104 = $8,320,000 aggregate cost for 104 private hospitals.

2006 cost of Medical Staff for all private hospitals = $8,320,000 x 1.3228 inflation factor = $11,005,696 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of the programs and services required by 19 CSR 30-20.021 (2), Governing Body, Administration, and Medical Staff, through an analysis of six (6) hospitals.
2. In the 1995 fiscal note, the cost for the Medical Staff requirements was bundled with the costs for Administration and Governing Body.
3. The bundled amount for the six (6) hospitals in 1995 was $240,000 per hospital. This has been divided by three (3) to obtain an estimated cost for Medical Staff in the current calculations.
4. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.

5. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.088 Central Services in Hospitals

PURPOSE: This rule specifies the manner in which central services shall be organized and integrated in a hospital.

(1) Central services shall be organized and integrated with patient care services in the hospital.

(2) The director of central services shall be qualified by education, training and experience in aseptic technique, principles of sterilization and disinfection and distribution of medical/surgical supplies. The director shall be responsible to an administrative officer or a qualified designee.

(3) Sufficient supervisory and support staff shall be assigned as related to the scope of services provided.

(4) Sufficient space and equipment shall be provided for the safe and efficient operation of the services as determined by the scope of hospital services delivered.

(5) Policies and procedures shall define the activities of all services provided. Sterilization and disinfection standards of practice shall be established. The principles of the Association for Practitioners in Infection Control, Association of Operating Room Nurses, Center for Disease Control and Prevention, American Society for Healthcare Central Service Personnel, Association for the Advancement of Medical Instrumentation, and others may be utilized to establish facility standards of practice for central services.

(6) Written procedures shall specify how items stored in central services can be obtained when central services is considered closed.

(7) Reprocessed packaged item(s) shall be identified as to content, show evidence of sterilization and be labeled indicating the sterilizer used and the load/cycle number. A policy on the shelf life of a packaged sterile item shall be established in accordance with acceptable standards of sterilization and dependent on the quality of the packaging material, storage conditions and the amount of handling of the item.

(8) Central services shall maintain documentation from the manufacturer that packaging material utilized for reprocessing is appropriate for this use. Expiration dates shall comply with the packaging material utilized.

(9) Sterile medical-surgical packaged items shall be handled only as necessary and stored in vermin-free areas where controlled ventilation, temperature and humidity are maintained. The integrity of sterile items shall be maintained throughout reprocessing, storage, distribution and transportation.

(10) Preventive maintenance of equipment shall be done as recommended by the manufacturer or as specified by hospital policy. Records shall be maintained as specified by hospital policy. Records shall include documentation that items processed by steam have undergone sufficient time, temperature and pressure and that items processed by ethylene oxide have undergone sufficient time, temperature, gas concentration and humidity to obtain pathogenic microbial kill.

(11) Ethylene oxide sterilized items shall be aerated as specified by hospital policy based on the manufacturer's recommendations to eliminate the hazards of toxic residue for both patient and staff.

(12) Principles of sterilization and disinfection as approved by the hospital's infection control committee shall apply throughout the hospital when central services activities are decentralized.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2006. This rule previously filed as 19 CSR 30-20.021(3)(A). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately $12,020,288 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $35,659,005 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30-20.088 Central Services in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities or Hospital Districts	**$12,000,627**
Department of Health and Senior Services	**$19,661**
Total	**$12,020,288**

III. WORKSHEET

Public Hospitals
1995 cost of Central Services per hospital = $259,204.

1995 cost of Central Services for all public hospitals = $259,204 x 35 = $9,072,140 aggregate cost for 35 public hospitals.

2006 cost of Central Services for all public hospitals = $9,072,140 x 1.3228 inflation factor = $12,000,627 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year.

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Central Services required by 19 CSR 30-20.021 (3)(A) through an analysis of six (6) hospitals.
2. The estimated cost of Central Services for the six (6) hospitals in 1995 was $259,204 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).
5. Since public hospitals constitute about one-quarter of all licensed hospitals, total staff costs incurred in public hospitals will be estimated by multiplying this total by .25.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Title:	19 CSR 30-20.088 Central Services in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	**Private general/acute care hospitals**	**$35,659,005**

III. WORKSHEET

1995 cost of Central Services per hospital = $259,204.

1995 cost of Central Services for all private hospitals = $259,204 x 104 = $26,957,216 aggregate cost for 104 private hospitals.

2006 cost of Central Services for all private hospitals = $26,957,216 x 1.3228 inflation factor = $35,659,005 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Central Services required by 19 CSR 30-20.021 (3)(A) through an analysis of six (6) hospitals.
2. The estimated cost of Central Services for the six (6) hospitals in 1995 was $259,204 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this

fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.090 Dietary Services in Hospitals

PURPOSE: This rule specifies the manner in which dietary services shall be organized and integrated in a hospital.

(1) The hospital shall have a full-time employee designated who—
(A) Serves as director of dietary services;
(B) Is responsible for the daily management of the dietary services;
(C) Is qualified by education, training and experience in food service management and nutrition through an approved course for certification by the Dietary Managers Association or registration by the Commission on Dietetic Registration of the American Dietetic Association, or an associate degree in dietetics or food systems management; and
(D) Has documented evidence of annual continuing education.

(2) When the director is not a qualified dietitian, a qualified dietitian shall be employed on a part-time or consultant basis. The dietitian shall make visits to the facility to assist in meeting the nutritional needs of the patients and the scope of services offered.

(3) The qualified dietitian shall ensure that high quality nutritional care is provided to patients in accordance with recognized dietary practices. When the services of a qualified dietitian are used on a part-time or consultant basis, the following services shall be provided on the premises on a regularly scheduled basis:
(A) Continuing liaison with the administration, medical staff and nursing staff;
(B) Approval of planned, written menus, including modified diets; and
(C) Evaluation of menus for nutritional adequacy.

(4) The consultant or part-time dietitian shall assist the director of dietary services to ensure—
(A) Patient and family counseling and diet instructions;
(B) Nutritional screening within three (3) days of admission to identify patients at nutritional risk. The hospital shall develop criteria to use in conducting the nutritional screening and staff who conduct the screening shall be trained to use the criteria;
(C) Comprehensive nutritional assessments within twenty-four (24) hours after screens on patients at nutritional risk, including height, weight and pertinent laboratory tests;
(D) Documentation of pertinent information in patient's records, as appropriate;
(E) Participation in committee activities concerned with nutritional care; and
(F) Planned, written menus for regular and modified diets.

(5) The director of dietary services or his/her designee shall be responsible for—
(A) Representing the dietary service in interdepartmental meetings;
(B) Recommending the quantity and quality of food purchased;
(C) Participating in the selection, orientation, training, scheduling and supervision of dietary personnel;
(D) Interviewing the patients for food preferences and tolerances and providing appropriate substitutions;
(E) Monitoring adherence to the written planned menu; and
(F) Scheduling dietary services meetings.

(6) When the qualified dietitian serves as a consultant, written reports shall be submitted to and approved by the chief executive officer or designee concerning the services provided.

(7) The director of dietary services shall be responsible for developing and implementing written policies and procedures and for monitoring to assure they are followed. Policies and procedures shall be kept current and approved by the chief executive officer or designee.

(8) Dietary services shall be staffed with a sufficient number of qualified personnel.

(9) Menus shall be planned, written and followed to meet the nutritional needs of the patients as determined by the recommended dietary allowances (RDA) of the Food and Nutrition Board of the National Research Council, National Academy of Sciences or as modified by physician's order.

(10) Diets shall be prescribed in accordance with the diet manual approved by the qualified dietitian and the medical staff. The diet manual shall be available to all medical, nursing and food service personnel.

(11) At least three (3) meals or their equivalent shall be served approximately five (5) hours apart with supplementary feedings as necessary. There shall not be more than fourteen (14) hours between a substantial evening meal and breakfast.

(12) Dietary records shall be maintained which include: food specifications and purchase orders; meal count; standardized recipes; menu plans; nutritional evaluation of menus; and minutes of departmental and in-service education meetings.

(13) The dietary services shall comply with 19 CSR 20-1.010 Sanitation of Food Services Establishments. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance and shall be attractively served at acceptable temperatures. Potentially hazardous foods shall be served at temperatures specified in 19 CSR 20-1.010(4)(I) and (J), (5)(B)1.–3. and (H).

(14) When there is a contract to provide dietary services to a hospital, the hospital is responsible for assuring that contractual services comply with rules concerning dietary services in hospitals.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2006. This rule previously filed as 19 CSR 30-20.021(3)(B). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions $35,043,218 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $104,069,999 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30-20.090 Dietary Services in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities, or Hospital Districts	**$35,023,557**
Department of Health and Senior Services	**$ 19,661**
Total	**$35,043,218**

III. WORKSHEET

Public Hospitals
1995 cost of Dietary Services per hospital = $756,481.

1995 cost of Dietary Services for all public hospitals = $756,481 x 35 = $26,476,835 aggregate cost for 35 public hospitals.

2006 cost of Dietary Services for all public hospitals = $26,476,835 x 1.3228 inflation factor = $35,023,557 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year.

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Dietary Services required by 19 CSR 30-20.021 (3)(B) through an analysis of six (6) hospitals.
2. The estimated cost of Dietary Services for the six (6) hospitals in 1995 was $756,481 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Title:	19 CSR 30-20.090 Dietary Services in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	**Private general/acute care hospitals**	**$104,069,999**

III. WORKSHEET

1995 cost of Dietary Services per hospital = $756,481.

1995 cost of Dietary Services for all private hospitals = $756,481 x 104 = $78,674,024 aggregate cost for 104 private hospitals.

2006 cost of Dietary Services for all private hospitals = $78,674,024 x 1.3228 inflation factor = $104,069,160 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Dietary Services required by 19 CSR 30-20.021 (3)(B) through an analysis of six (6) hospitals.
2. The estimated cost of Dietary Services for the six (6) hospitals in 1995 was $756,481 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this

fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.092 Emergency Services in Hospitals

PURPOSE: This rule establishes the requirements for emergency services in a hospital.

(1) Each hospital providing general services to the community shall provide an easily accessible emergency area which shall be equipped and staffed to ensure that ill or injured persons can be promptly assessed and treated or transferred to a facility capable of providing needed specialized services. In multiple-hospital communities where written agreements have been developed among the hospitals in accordance with an established community-based hospital emergency plan, individual hospitals may not be required by the Department of Health to provide a fully equipped emergency service.

(2) A hospital shall have a written hospital emergency transfer policy and written transfer agreements with one (1) or more hospitals within its service area which provide services not available at the transferring hospital. Transfer agreements shall be established which reflect the usual and customary referral practice of the transferring hospital, but are not intended to cover all contingencies.

(3) Hospital emergency services shall be under the medical direction of a qualified staff physician who is board-certified or board-admissible in emergency medicine and maintains a knowledge of current ACLS and ATLS standards or a physician who is experienced in the care of critically ill and injured patients and maintains current verification in ACLS and ATLS. In pediatric hospitals, PALS shall be substituted for ACLS. With the explicit advanced approval of the Department of Health, a hospital may contract with a qualified consultant physician to meet this requirement.

(A) That physician shall be responsible for implementing rules of the medical staff relating to patient safety and privileges and to the quality and scope of emergency services.

(B) A qualified registered nurse shall supervise and evaluate the nursing and patient care provided in the emergency area by nursing and ancillary personnel. Supervision may be by direct observation of staff or, at a minimum, the nurse shall be immediately available in the institution.

(C) Any person assigned to the emergency services department administering medications shall be a licensed physician, registered nurse, EMT-paramedic or appropriately licensed or certified allied health practitioner and shall administer medications only within his/her scope of practice except for students who are participating in a training program to become physicians, nurses, emergency medical technician-paramedics who may be allowed to administer medication under the supervision of their instructors as a part of their training. Trained individuals from the respiratory therapy department may be allowed to administer aerosol medications when a certified respiratory therapy assistant is not available.

(4) Any hospital which provides emergency services and does not maintain a physician in-house twenty-four (24) hours a day for emergency care shall have a call roster which lists the name of the physician who is on call and available for emergency care and the dates and times of coverage. A physician who is on call and available for emergency care shall respond in a manner which is reasonable and appropriate to the patient's condition after being summoned by the hospital.

(5) Any hospital with surgical services that also provide emergency surgical services shall have a general surgical call roster which lists the name of the general surgeon who is on call for emergency surgical cases, and the dates and times of coverage. The surgeon who is on call for emergency surgical cases shall arrive at the hospital within thirty (30) minutes of being summoned. Patients arriving at a hospital that does not provide emergency surgical services and are found upon examination to require emergency surgery shall be immediately transferred to a hospital with the necessary services.

(6) All patients admitted to the emergency service shall be assessed prior to discharge by a physician or registered professional nurse.

(7) If discharged from the emergency department, other than to the inpatient setting, the patient or responsible person shall be given written instructions for care and an oral explanation of those instructions. Documentation of these instructions shall be entered on the emergency service medical record.

(8) There shall be a quality improvement program for the emergency service which includes, but is not limited to, the collection and analysis of data to assist in identification of health service problems, and a mechanism for implementation and monitoring appropriate actions. The quality improvement program shall include the periodic evaluation of at least the following: length of time each patient is in the emergency room, appropriateness of transfers, physician response time, provision for written instructions, timeliness of diagnostic studies, appropriateness of treatment rendered, and mortality.

(9) Written policies shall be adopted to assure that notification procedures are implemented concerning the significant exposure of prehospital emergency personnel to communicable diseases as required in 19 CSR 30-40.047.

(10) The emergency service medical record shall contain patient identification, time and method of arrival, history, physical findings, treatment and disposition and shall be authenticated by the physician. These records, including an ambulance report when applicable, shall be filed under supervision of the medical records department.

(11) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of emergency services.

(12) A hospital shall have a written plan that details the hospital's criteria and process for diversion. The plan must be reviewed and approved by the Missouri Department of Health prior to being implemented by the hospital. A hospital may continue to operate under a plan in existence prior to the effective date of this section while awaiting approval of its plan by the department.

(A) The diversion plan shall:

1. Identify the individuals by title who are authorized by the hospital to implement the diversion plan;

2. Define the process by which the decision to divert will be made;

3. Specify that the hospital will not implement the diversion plan until the authorized individual has reviewed and documented the hospital's ability to obtain additional staff, open existing beds that may have been closed or take any other actions that might prevent a diversion from occurring;

4. Include that all ambulance services within a defined service area will be notified of the intent to implement the diversion plan upon the actual implementation. Ambulances that have made contact with the hospital before the hospital has declared itself to be on diversion shall not be redirected to other hospitals. In areas served by a real time, electronic reporting system, notification through such system shall meet the requirements of this provision so long as such system is available to all EMS agencies and hospitals in the defined

service area;

5. Include procedures for assessment, stabilization and transportation of patients in the event that services, including but not limited to, ICU beds or surgical suites become unavailable or overburdened. These procedures must also include the evaluation of services and resources of the facility that can still be provided to patients even with the implementation of the diversion plan;

6. Include procedures for implementation of a resource diversion in the event that specialized services are overburdened or temporarily unavailable; and

7. Include that all other acute care hospitals within a defined service area will be notified upon the actual implementation of the diversion plan. For defined service areas with more than two (2) hospitals, if more than one-half (1/2) of the hospitals implement their diversion plans, no hospital will be considered on diversion. For a defined service area with two (2) hospitals, if both hospitals implement their diversion plans, neither will be considered on diversion. Participation in a real time, electronic reporting system shall meet the notification requirements of this section. If a hospital participates in an approved community wide plan, the community wide plan may set the requirement for the number of hospitals to remain open.

(B) Each incident of diversion plan implementation must be reviewed by the hospital's existing quality assurance committee. Minutes of these review meetings must be made available to the Missouri Department of Health and Senior Services upon request.

(C) The hospital shall assure compliance with screening, treatment and transfer requirements as required by the Emergency Medical Treatment and Active Labor Act (EMTALA).

(D) A hospital or its designee shall report to the department, by phone or electronically, upon actual implementation of the diversion plan. This implementation report shall contain the time the plan will be implemented. The hospital or its designee shall report to the department, by phone or electronically, within eight (8) hours of the termination of the diversion. This termination report shall contain the time the diversion plan was implemented, the reason for the diversion, the name of the individual who made the determination to implement the diversion plan, the time the diversion status was terminated, and the name of the individual who made the determination to terminate the diversion. In areas served by real time, electronic reporting system, reporting through such system shall meet the requirements of this provision so long as such system generates reports as required by the department.

(E) Each hospital shall implement a triage system within its emergency department. The triage methodology shall continue to apply during periods when the hospital diversion plan is implemented.

(F) Any hospital that has a written approved policy, which states that the hospital will not go on diversion or resource diversion, except as defined in the hospital's disaster plan in the event of a disaster, is exempt from the requirements of 19 CSR 30-20.021(3)(C)12.

(G) If a hospital chooses to participate in a community wide plan, the requirements of number of hospitals to remain open, defined service areas, as well as community notification may be addressed within the community plan. Community plans must be approved by the department. Community plans must include that each hospital has a policy addressing diversion and the criteria used by each hospital to determine the necessity of implementing a diversion plan. Participation in a community plan does not exempt a hospital of the requirement to notify the department of a diversion plan implementation.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2006. This rule previously filed as 19 CSR 30-20.021(3)(C). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately $23,446,449 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $69,611,027 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30-20.092 Emergency Services in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities or Hospital Districts	**$23,426,788**
Department of Health and Senior Services	**$ 19,661**
Total	**$23,446,449**

III. WORKSHEET

Public Hospitals
1995 cost of Emergency Services per hospital = $506,000.

1995 cost of Emergency Services for all public hospitals = $506,000 x 35 = $17,710,000 aggregate cost for 35 public hospitals.

2006 cost of Emergency Services for all public hospitals = $17,710,000 x 1.3228 inflation factor = $23,426,788 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year.

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Emergency Services required by 19 CSR 30-20.021 (3)(C) through an analysis of six (6) hospitals.
2. The estimated cost of Emergency Services for the six (6) hospitals in 1995 was $506,000 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Title:	19 CSR 30-20.092 Emergency Services in Hospitals
Type of Rulemaking:	Proposed Rulemaking

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	**Private general/acute care hospitals**	**$69,611,027**

III. WORKSHEET

1995 cost of Emergency Services per hospital = $506,000.

1995 cost of Emergency Services for all private hospitals = $506,000 x 104 = $52,624,000 aggregate cost for 104 private hospitals.

2006 cost of Emergency Services for all private hospitals = $52,624,000 x 1.3228 inflation factor = $69,611,027 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Emergency Services required by 19 CSR 30-20.021 (3)(C) through an analysis of six (6) hospitals.
2. The estimated cost of Emergency Services for the six (6) hospitals in 1995 was $506,000 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED RULE

19 CSR 30-20.094 Medical Records in Hospitals

PURPOSE: This rule establishes minimum requirements for medical records kept in hospitals.

(1) The director of the medical record services shall be appointed by the chief executive officer or chief operating officer. This director may be a qualified registered record administrator, an accredited record technician or an individual with demonstrated competence and knowledge of medical record department activities supervised by a qualified consultant who is a registered record administrator or accredited record technician.

(2) Patient care by members of the medical staff, nursing staff and allied health professionals shall be entered in the patient's medical record in a timely manner. Documentation shall be legible, dated, authenticated and recorded in ink, typewritten or recorded electronically.

(3) All orders shall be dated and authenticated by the ordering practitioner and shall be kept in the patient's medical record. Verbal orders shall be authenticated by the prescribing practitioner or attending physician within the time frame that is defined by the medical staff in cooperation with nursing and administration. Authentication shall include written signatures, initials, computer-generated signature codes or rubber stamp signatures by the medical members and authorized persons whose signatures the stamp represents. The use of rubber stamps is discouraged, but where authorized, a signed statement shall be maintained in the administrative offices with a copy in the medical records department stating that the medical staff member whose stamp is involved is the only one who has the stamp and is the only one authorized to use it. The duplication of signature stamps and the delegation of their use by others is prohibited.

(4) Only abbreviations and symbols approved by the medical staff may be used in the medical records. Each abbreviation or symbol shall have only one (1) meaning and an explanatory legend shall be available for use by all concerned. There shall be a list of abbreviations and symbols that shall not be used in handwritten communications.

(5) The medical record of each patient shall be maintained in order to justify admission and continued hospitalization, support the diagnosis, describe the patient's progress and response to medications and services and to facilitate rapid retrieval and utilization by authorized personnel.

(6) Medical records are the property of the hospital and shall not be removed from the hospital premises except by court order, subpoena, for the purposes of microfilming or for off-site storage approval by the governing body.

(7) Written consent of the patient or the patient's legal representative is required for access to or release of information, copies or excerpts from the medical record to persons not otherwise authorized to receive this information.

(8) Patient records shall be considered complete for filing when the required contents are assembled and authenticated. Hospital policy shall define circumstances in which incomplete medical records may be filed permanently by order of the medical record committee.

(9) An inpatient's medical record shall include: a unique identifying record number; pertinent identifying and personal data; history of present illness or complaint; if injury, how the injury occurred; past history; family history; physical examination; admitting diagnosis; medical staff orders; progress notes; nurses' notes; discharge summary; final diagnosis; and evidence of informed consent. Where applicable, medical records shall contain reports such as clinical laboratory, X-ray, consultation, electrocardiogram, surgical procedures, therapy, anesthesia, pathology, autopsy and any other reports pertinent to the patient's care.

(10) Admission forms shall be designed to record pertinent identifying and personal data.

(11) A certificate of live birth shall be prepared for each child born alive and shall be forwarded to the local registrar within seven (7) days after the date of delivery. If the physician or other person in attendance does not certify to the facts of birth within five (5) days after the birth, the person in charge of the institution shall complete and sign the certificate.

(12) When a dead fetus is delivered in an institution, the person in charge of the institution or his/her designated representative shall prepare and, within seven (7) days after delivery, file a report of fetal death with the local registrar.

(13) Medical records of deceased patients shall contain the date and time of death, autopsy permit, if granted, disposition of the body, by whom received and when.

(14) The State Anatomical Board shall be notified of an unclaimed dead body. A record of this notification shall be maintained.

(15) The patient's medical records shall be maintained to safeguard against loss, defacement and tampering and to prevent damage from fire and water. Medical records shall be preserved in a permanent file in the original, on microfilm or other electronic media. Patients' medical records shall be retained for a minimum of ten (10) years, except that a minor shall have his/her record retained until his/her twenty-third birthday, whichever occurs later. Preservation of medical records may be extended by the hospital for clinical, educational, statistical or administrative purposes.

(16) There shall be a mechanism for the review and evaluation on a regular basis of the quality of medical record services.

(17) Should the hospital cease to be licensed, arrangements for disposition of the patient medical records shall be made with nearby hospitals, the patient's physician or a reliable storage company. Notification of the disposition is to be provided to the department.

(18) A history and physical examination shall be completed on each inpatient within twenty-four (24) hours of admission, or a history and physical examination shall have been completed or updated within the seven (7) days prior to admission. A history and physical which is performed up to and no more than thirty (30) days before admission may be utilized provided that the patient is reassessed and an update note is written, signed and dated to reflect the patient's status within seven (7) days prior to, or within twenty-four (24) hours after, admission.

(19) A patient's records shall be completed within thirty (30) days of discharge.

AUTHORITY: sections 192.006 and 197.080, RSMo 2000 and 197.154, RSMo Supp. 2006. This rule previously filed as 19 CSR 30-20.021(3)(D). Original rule filed June 27, 2007.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions approximately $14,580,382 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $43,266,142 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with David S. Durbin, Director of the Division of Regulation and Licensure, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after the publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Name:	19 CSR 30-20.094 Medical Records in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 State Licensed Hospitals Operated by Counties, Cities or Hospital Districts	**$14,560,721**
Department of Health and Senior Services	**$ 19,661**
Total	**$14,580,382**

III. WORKSHEET

Public Hospitals
1995 cost of Medical Records per hospital = $314,500.

1995 cost of Medical Records for all public hospitals = $314,500 x 35 = $11,007,500 aggregate cost for 35 public hospitals.

2006 cost of Medical Records for all public hospitals = $11,007,500 x 1.3228 inflation factor = $14,560,721 aggregate cost.

Department of Health and Senior Services

Staff Involved with Hospital Licensure

Position Title	# of Staff	Annual Salary	Total Salary
Health Care Regulatory Supervisor (RN)	1	$ 61,908.00	$ 61,908.00
Health Care Regulatory Supervisor (non-RN)	1	$ 56,868.00	$ 56,868.00
Health Facility Consultant	7	$ 45,774.00	$ 320,418.00
Health Facility Nursing Consultant	17	$ 54,000.00	$ 918,000.00
Health Program Representative II-III	1	$ 35,148.00	$ 35,148.00
Administrative Office Support Assistant	1	$ 26,532.00	$ 26,532.00
Senior Office Support Assistant	1	$ 23,160.00	$ 23,160.00
Office Support Assistant	2	$ 20,724.00	$ 41,448.00
			$ 1,483,482.00

Total salary for all staff involved with hospital licensure = $1,483,482
28% = percentage of time staff actually devote to licensure activities (based on a time study analysis from August 2006 through January 2007).
42% of salary = value of fringe benefits for staff.

$1,483,482 x .28 = $415,375 salary expenditure for all licensure activities.
$415,375 x 1.42 = $589,832 salaries and fringe benefits for all licensure activities.
$589,832 ÷ 30 = $19,661 total staff salaries and fringe for this rule per year

IV. ASSUMPTIONS

Public Hospitals

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Medical Records required by 19 CSR 30-20.021 (3)(D) through an analysis of six (6) hospitals.
2. The estimated cost of Medical Records for the six (6) hospitals in 1995 was $314,500 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these public hospital costs.

Department of Health and Senior Services

1. Thirty-two (32) proposed rules (19 CSR 30-20.080 through 19 CSR 30-20.142) constituting regulations for hospital licensure are being published.
2. Two of these, 19 CSR 30-20.106 Inpatient Care Units in Hospitals and 19 CSR 30-20.142 Variance Requests by Hospital, will have no DHSS cost.
3. Cost incurred by DHSS for the remaining thirty (30) rules will be approximately the same for each rule.
4. Therefore DHSS staff costs will be estimated by dividing the total staff costs for hospital licensure by the number of rules constituting hospital licensure activities (30).

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to public hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for public hospitals to implement this rule.

FISCAL NOTE
PRIVATE COST

I. Department Title: Department of Health and Senior Services
Division Title: Division of Regulation and Licensure
Chapter Title: Hospitals

Rule Number and Title:	19 CSR 30-20.094 Medical Records in Hospitals
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
104	**Private general/acute care hospitals**	**$43,266,142**

III. WORKSHEET

1995 cost of Medical Records per hospital = $314,500.

1995 cost of Medical Records for all private hospitals = $506,000 x 104 = $32,708,000 aggregate cost for 104 private hospitals.

2006 cost of Medical Records for all private hospitals = $32,708,000 x 1.3228 inflation factor = $43,266,142 aggregate cost.

IV. ASSUMPTIONS

1. This fiscal note is derived from original amounts contained in a fiscal note published in 1995 that determined the cost of Medical Records required by 19 CSR 30-20.021 (3)(D) through an analysis of six (6) hospitals.
2. The estimated cost of Medical Records for the six (6) hospitals in 1995 was $314,500 per hospital.
3. An inflation factor, based on the Consumer Price Index, was determined by utilizing the inflation calculator located on the U.S. Bureau of Labor Statistics web site (www.bls.gov/data/home.htm). On that site, inflation from 1995 through 2006 was given as 1.3228, that is, $100.00 in 1995 had the buying power of $132.28 in 1996.
4. The department has collaborated with the Missouri Hospital Association (MHA) in determining the accuracy of these private costs.

V. TECHNICAL COMMENT

All new regulations are required to have a fiscal note which describes the cost of implementing the regulation as if the regulation did not previously exist. Therefore, this

fiscal note reflects that requirement. However, the requirements for hospitals as described in 19 CSR 30-20.021 are not being changed. The current rule, encompassing many hospital services and programs, is merely being sectioned into smaller rules, so that each rule breaks out a specific hospital service or program. This proposed rule consists of requirements that are currently applicable to private hospitals pursuant to the current rule that will continue to be applicable to these hospitals once this proposed rule goes into effect. Since regulatory requirements have not been changed, there will be no actual new costs for private hospitals to implement this rule.