

Hospital Licensing Reform Steering Committee
 June 4, 2007
 Maine Hospital Association Conference Room

Minutes

Committee Members Present: Lynne Gagnon, Jerry Cayer, Bill Zuber, Maureen Parkin, Martie Moore, Lisa Simm, Patty Roy, Ali Hilt-Lash, Anne Flanagan, Linda Abernethy, Annette Adams, Sharon King, Julie Marston, Mary Finnegan, Sandra Parker, Catherine Cobb, Catherine Valcourt, Cindy Leavitt, Sue Boisvert, Sherry Rogers, Diane Bubar

Committee Members joining by video-conference: Ruth Lyons, Missy Marter, Beth Dodge

Interested Parties: Chris McCarthy, MQF

Muskie School: Sue Ebersten, Maureen Booth, Barbara Shaw

Absent: Laura Benson, Sally Lewin, Laird Covey, Denise Gay, Kathy Bonney, Stacey Doten, Melissa Gallant, Judy Street, Denise Osgood

Item	Discussion	Decision/Action	Who's Responsible	Date Due
Welcome and Introductions	In Denise's absence Catherine Cobb and Sue Ebersten facilitated the meeting. Patty Roy and Martie Moore were welcomed sitting in for Laird Covey and Denise Gay.	NA	NA	NA
Review May 7 Meeting Minutes	The minutes for the May 7 meeting were reviewed and approved as written.	NA	NA	NA
Potential Contractual Relationship with Joint Commission	<p>In follow-up to the May meeting, Denise Osgood contacted Mark Crafton, Joint Commission, to further discuss the range of options for state/JC relationships. Of particular interest is a contractual relationship between JC and Maryland, which includes the following terms:</p> <ul style="list-style-type: none"> • No fee • Training 1x per year presented to state survey team • State receives 3 months advance notice of JC's unannounced survey schedule • State surveyors are permitted to attend JC surveys (not required, but permitted) • State receives copies of any statements of deficiency <p>Although the Division has responsibility for making final decisions on the JC relationship, input from the Steering Committee was sought on the</p>	<p>Needs additional research. Suggest a comparison that assesses:</p> <ul style="list-style-type: none"> • Terms of contracts with MD, NY, FL, OH • How/if each state altered state regulations based on JC relationship • How each state 	Will be discussed at DLRS/Muskie meeting	August Meeting

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	<p>benefits of pursuing a contract with JC generally and the sample terms of the Maryland model specifically.</p> <p>After discussion the group concluded that although formalizing a relationship with JC may have benefits for Maine, additional research should be done before adopting one specific model. The committee suggested:</p> <ul style="list-style-type: none"> • Do a comparison of the terms of MD compared to FL, NY, OH (other states highlighted in Mark's presentation at the May meeting). • For any state model that is considered, explore how the state changed its regulations/processes to reflect/incorporate the JC relationship. • Talk to states to see how the process is working. <p>In continuing our conversations with JC, the Data Subcommittee requested that we also ask if our JC relationship could be written to permit use of JC forms, such as Self-Assessment, for all Maine hospitals.</p>	<p>assesses the success and benefits of the JC relationship</p>		
<p>Transparency of Data, Processes and Information</p>	<p>Sue introduced the topic of transparency for group discussion, focusing on how future decisions will be made related to the transparency of data, processes and information. As the three work groups are already discovering, the question of transparency – or what information should and should not be made available to the public – comes up in multiple ways and requires careful consideration.</p> <p>Before we undertake specific decisions on transparency, Denise has suggested that the Committee devote time and resources to explore what is happening nationally and to identify best practice.</p> <p>To this end, a proposal was presented to the Committee that we devote a future meeting to this topic – perhaps in September – and to do so by engaging a national speaker. It was proposed that invitations to the presentation include not only Committee members but also other interested parties, specifically hospital CEO's and Board members.</p> <p>In consideration of this proposal, Committee members were asked to discuss the following questions:</p> <ul style="list-style-type: none"> • Would you be interested in devoting a future meeting to this topic? • Would September be an appropriate timeframe? • Are there any national speakers you would be interested in hearing? 	<p>Arrange a forum for September</p> <p>Invite a broad array of stakeholders</p> <p>Brief potential speakers on topics of interest to the Committee</p>	<p>DLRS</p>	<p>September</p>

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	<p>(Denise has a speaker in mind)</p> <ul style="list-style-type: none"> • What benefits do you see from such a forum? What would you like to hear from a national expert? • What concerns would you have? • Who else (Committee members, CEO's, board members) might be interested? • Do you know of grant or other funds available to support this? <p>Although the Committee expressed interest in the topic they did not see a presentation as a good use of Committee time. Most Committee members already feel well versed in the subject and would like to reserve Committee time to work on our existing objectives.</p> <p>A counter proposal was suggested that DRLS not incorporate the presentation into a Committee meeting but rather host it as a separate forum. Participants could include Committee members, CEO's, Board Members, Legislators and other stakeholders from the updated stakeholder list. It was agreed that September would be an appropriate timeframe.</p> <p>The Committee offered the following suggestions for topics to include in a presentation:</p> <ul style="list-style-type: none"> • Making the business case for increased transparency • Transparency as a method for maintaining public confidence in the face of deeming • Transparency as a method for maintaining public confidence in non-accredited facilities • Dealing with issues of data timeliness • Strategies for making information truly accessible, beyond currently required data reporting: <ul style="list-style-type: none"> ○ How do we make data practical and usable to the average consumer? (This is where most efforts at transparency fail). <ul style="list-style-type: none"> ▪ How can public education help consumers evaluate different rating systems; assess the value of different data sources; understand the limitations of data, etc.? ▪ Who is the "constituency" and how do we engage them? How do public education initiatives reach a varied consumer base (variances by culture, socio-economic status, etc)? ○ What information/processes beyond data and quality indicators 			

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	<p>do other states make accessible? (Complaints, licensing findings, etc)</p> <p>The Committee also recommended that we choose a “thought-provoking” speaker who has innovative ideas to share. Suggested sources for speakers included researchers at foundations such Rand or Kaiser; Lisa Simm suggested Kaveh Safavi, M.D., J.D., Chief Medical Officer at Solucient; Denise has identified other possible speakers.</p> <p>No suggestions were offered for funding.</p>			
Update on LD 1781	<p>Cathy presented an update on the content and status of LD 1781 which has moved out of committee with a recommendation to pass. The legislation exempts hospitals from state inspection if the hospital is certified by CMS and accredited by a CMS-recognized health care accrediting organization. The hospital would not be exempt from state inspection if there is a complaint or suspected violation. The Committee did not accept a proposed amendment related to the “value added” state regulations that had been under discussion in this group.</p> <p>Cathy summarized the impact of the law as follows: If passed, the state retains its authority to promulgate regulations and statutory requirements currently within Chapter 22 remain in place. What changes is when and why the state can go in for inspection, which would now be limited to:</p> <ul style="list-style-type: none"> • Federal inspection • Survey of non-accredited facilities • Validation surveys • Surveys that result from complaints/suspected violations <p>A question was raised about the clarity of the Act regarding investigation of complaints/violations on the state side; Cathy responded that complaints or violations of state rules may still result in an inspection.</p> <p>It was agreed that whether or not LD 1781 passes the work of the Committee remains essential. If the legislation passes, the work on Complaints will be extremely important and, since the Act would be effective July 1, 2008, our timeframes will be shorter. We will revisit this at our next meeting when the fate of LD 1781 should be clear.</p>	N/A	N/A	N/A

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<p>CMS/State/JC Crosswalk</p>	<p>A draft of the crosswalk comparing CMS conditions of participation against additional state and JC requirements was distributed for discussion. Cathy discussed the process for making decisions regarding any changes to state regulations to (a) remove whatever is not in statute and does not align with COP's; and (b) add or retain standards where COP's either do not exist or are inadequate. The proposed process will begin with review and recommendations by the Committee, which will then be shared more broadly with the public (insurers, consumers, other stakeholders), followed by APA steps of rulemaking, public hearing, comment period and finalization.</p> <p>The question to be asked: If we deem for COP's, is there anything not covered that should be?</p> <p>The group agreed to review the draft document before our next meeting and to devote the July meeting to a further discussion. A suggestion was made to add National Patient Safety Goals, which will be considered with other suggestions at the next meeting.</p> <p>To organize the review process, the Committee recommended review by the following categories:</p> <ul style="list-style-type: none"> • Governing Board • Quality • Medical Staff • Clinical Services • Environmental Services • Outpatient Services • Critical Access Hospitals • Outpatient Dental • Psychiatric • Information Management 	<p>Discussion scheduled for next meeting; Committee will review document prior to meeting</p>	<p>All committee members</p>	<p>July 2nd</p>
<p>Data Work Group Report</p>	<p>Maureen reported on the progress of the Data Work Group, which had completed its third meeting just prior to the Committee meeting. (Minutes of the first two meetings are attached). The work group defined its charge as:</p> <ol style="list-style-type: none"> 1. Identify, review and recommend data that should be used to inform and strengthen the hospital survey process. 2. Develop a framework for how data can be used to improve the effectiveness and efficiency of the hospital survey process. 	<p>Work group to continue meeting</p>		

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	<p>3. Determine the applicability of proposed data to hospitals of various sizes and specialties.</p> <p>4. Define regulatory, disclosure, or other barriers to using proposed data in the hospital survey process.</p> <p>5. Propose protocols for using data in the hospital survey process.</p> <p>The first meetings were devoted primarily to reviewing and assessing potential data sets for use in the survey process, using the following criteria:</p> <ul style="list-style-type: none"> • Evidence based and standardized; • Subject to external validation; • Generally applies to hospitals of all sizes; • Recognized benchmarks to assess performance; and • Have been tested and are considered reliable. <p>Data sets discussed included CMS data, Hospital Sentinel Events Reports, nurse sensitive indicators, and hospital internal data. Given the problems of consistency, reliability and legal restrictions with several of the data sets, it was broadly agreed that the CMS quality indicators is best suited at this time to serve as a starter set. Other data sets will be considered as they become available; a process for on-going review of data sets will need to be developed.</p> <p>Conversation is now focused on the following questions: How and when can performance data be used to inform the survey process? How will data modify the breadth, scope and frequency of the survey process?</p> <p>How data will be used is a more complicated conversation and it is just beginning. One concern is the small numbers that are generated each report period for many of the CMS indicators. The group is considering the use of rolling 4-quarter numbers to increase numbers and thereby increase statistical reliability. Also under discussion are the benchmarks and thresholds that will need to be defined if data is to impact “breadth, scope and frequency”. Potential sources for benchmarks are national benchmarks, national averages, state averages, comparisons with hospital’s peer group, and the facility’s own performance over the previous reporting period. Consideration is being given to adopting a consistent Self-Assessment Tool for all hospitals, preferable using the JC tool rather than adding yet another</p>			

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	<p>instrument. Once benchmarks and data sources are defined, the group will make recommendations regarding the survey process and exactly how performance data will be used to target survey.</p> <p>Minutes from the first two meetings are attached. One goal for the work group is to add consumer membership. If LD 1781 passes, the work group with help from the Committee will need to consider the impact of the Act on its plans and recommendations.</p>			
Complaints Work Group	<p>The Complaints Work Group met three times (minutes of first two meetings attached; third meeting occurred just prior to the Committee meeting). The Work Group has expanded its membership to include a consumer representative (Joan Sturmthal, former Long Term Care Ombudsman). The work group has also contacted NAMI to add a mental health consumer representative and/or a MH focus group in recognition of the number of complaints by MH consumers.</p> <p>The work group defined the following charge:</p> <ol style="list-style-type: none"> 1. Analyze complaint data for 2005 and 2006 2. Understand current complaint investigation process – categorization and priorities 3. Consider reforms that will reduce backlog of complaints 4. Develop strategies for greater hospital self-regulation for certain categories of complaints. <p>The goal is to move as much of the complaint process as possible back to hospital self-regulation such that complaints either do not come to the state or if they do, they can be turned back to the hospital for resolution. To do that, public education will become extremely important, as will assuring due process in the hospital response. Preliminary recommendations of the work group relate to:</p> <ol style="list-style-type: none"> 1. Regulatory reform – (a) adopt a one-year limitation in making complaints except under special circumstances and (b) make unannounced visits for complaints discretionary by Licensing 2. Public Education Campaign – to redirect complaints away from the state by explaining (a) the role and limitations of licensing in resolving complaints; (b) why the hospital complaint process is the most effective 	Work group to continue meeting		

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	<p>route for resolution, and (c) the availability of other appropriate destinations for non-licensing complaints.</p> <p>3. Developing new complaint resolution processes for hospitals</p> <p>The group will continue to meet.</p>			
Communications Work Group	Time did not allow a report at this meeting; will be rescheduled for July.	Report scheduled for next meeting	Communications Committee	July 2nd
Next Meeting	Next meeting is scheduled for July 2nd , 1:00 at the Maine Hospital Association.			