

Hospital Licensing Reform Steering Committee  
 May 7, 2007  
 Maine Hospital Association Conference Room

Minutes

*Present:* Stacey Doten, Lynne Gagnon, Jerry Cayer, Judy Street, Bill Zuber, Maureen Parkin, Denise Gay, Lisa Simm, Patty Roy, David Stuchiner, Ali Hilt-Lash, Richard Shaw (Centers for Medicare & Medicaid Services, Region 1), Denise Osgood, Jennifer Hoppe (Joint Commission), Mark Crafton (Joint Commission), Margaret Naas, Anne Flanagan, Carole Kennally, Vicki McFarlane, Linda Abernathy, Annette Adams, Sharon King, Julie Marston, Mary Finnegan, Diane Bubar, Sandra Parker, Susan Schow, Melissa Gallant. By video conference: Ruth Lyons, Beth Dodge, Carney Williams, April Daigle, Sandy Giles, Tammi Snow. Muskie School: Sue Ebersten, Maureen Booth, Eileen Griffin.

*Absent:* Laura Benson, Sally Lewin, Laird Covey Catherine Valcourt, Cindy Leavitt, Sue Boisvert, Kathy Bonney, Sherry Rogers, Missy Marter.

Item	Discussion	Decision/Action	Who's Responsible	Date Due
Welcome and Introductions	Denise Osgood welcomed special guests to the meeting: Mark Crafton and Jennifer Hoppe for the Joint Commission and Richard Shaw from the Centers for Medicare and Medicaid Services. The Joint Commission had been invited to talk about how the Joint Commission uses data to support its survey process and how other states align their licensing requirements with the Joint Commission's accreditation process. CMS had been invited also to talk about the use of data and deeming, and anticipated policy directions for the Conditions of Participation. Denise invited members to introduce themselves.	NA	NA	NA
Review April 2 Meeting Minutes	The minutes for the March 2 meeting were reviewed. Denise explained edits that she had made to the minutes: she clarified that federal complaints are addressed within the CMS required timeframe but that, due to a reduced workforce, the Department is late in responding to complaints that do not require the federal level of review. Denise said the recommendations coming out of the Complaints Work Group should be aimed at reducing the number of low level complaints that require state review. The minutes were approved with these changes.	NA	NA	NA
Joint Commission	Denise introduced the Joint Commission & CMS presentations by noting that there are significant differences between the two regulatory bodies. The Joint Commission is voluntary and the Conditions of Participation are mandatory, at least for any hospital participating in the Medicare program.	NA	NA	NA

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	<p>Denise also reported on a recent conference on patient safety practices, which emphasized transparency of data as a means to performance improvement.</p> <p>Mark Crafton, for the Joint Commission, provided background on the Joint Commission's approach to accreditation. Before 2004, about 70% of the Joint Commission survey involved interviewing department heads &amp; leadership, only 30% of the time was spent with those delivering the care. Now that ratio has reversed, with the focus more on practice, than policy. Also, the Joint Commission provides data to hospitals, wanting hospitals to improve care before the Joint Commission arrives. In the past, the Joint Commission treated every hospital identically. Each survey was predictable. This approach was thought to be inconsistent with the state of "continuous readiness" desired for ongoing quality and safety. Now the Joint Commission uses data to customize the survey to the hospital, so each survey is unique.</p> <p>The Joint Commission will be rolling out a "Strategic Surveillance System" (S3) starting in July. S3 has two components: the Performance Risk Assessment (PRA) and the Performance Measurement Compare (PMC). The PRA uses "intelligent algorithms" to identify "Priority Focus Areas" (PFAs) using data provided by the hospital and from other sources. The PFAs include Communication, Infection Control, Staffing, etc. The algorithms rely on the literature and experts to connect a "problems" with the likely cause. For example, a wrong site surgery would indicate staffing as a PFA. S3 will be available through the web, enabling accredited hospitals to view data for their hospital. The hospital will be able to select from a variety of comparison groups to see how well it's doing.</p> <p>The Joint Commission has now moved to unannounced surveys. Beginning this year, the window for unannounced surveys will widen to 18-39 months. The Joint Commission will use the PFP to adjust the frequency of surveys.</p> <p>Mark showed segments of a training video that demonstrated what the tracer methodology might look like in practice. Data will have been used to identify PFAs. For these PFAs, the tracer methodology involves observing and following patients through their experience in the hospital, and observing and asking questions of their care providers along the way. Observations might trigger targeted questioning to better understand, <i>e.g.</i>, staffing issues.</p>			

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	<p>Mark also discussed the different strategies that different states use to align their licensing requirements with the Joint Commission. The Joint Commissioner will not share accreditation report without the hospital's permission. Some states require the hospital to share the accreditation report in order to avail itself of the deeming option. Mark noted that Pennsylvania has the option but does not accept Joint Commission accreditation in lieu of a licensing survey. This policy is based on concerns about the Life Safety Code. However, the Joint Commission has recently added a Life Safety Code specialist to the survey team and hopes to address this type of concern among states.</p> <p>During Q&amp;A, Mark explained that there is variation in how states interact with the Joint Commission. In Maryland, state surveyors accompany the Joint Commission on any survey. The Joint Commission provides Maryland surveyors with Joint Commission standards. In New York, the state receives the survey schedule but does not usually accompany the Joint Commission on the survey. New York will accompany the Joint Commission on a follow-up survey for conditional accreditation. New York gets the accreditation report directly from the Joint Commission. In Florida, as long as hospital has Joint Commission accreditation, the state will not conduct its own survey. If accreditation is conditional, Florida will go out on the follow-up survey. Florida also conducts its own validation survey 2-3 times/year. Ohio provides the Joint Commission with complaint data but does not accompany the Joint Commission on surveys. When a state shares complaint data, the Joint Commission decides how to respond, <i>e.g.</i>, go on site, call, use to focus next survey. The Joint Commission will only use substantiated complaints in the S3 process. The Joint Commission will disclose medium and high priority complaints to the state if they have a complaint information sharing agreement with that state.</p> <p>Lynne Gagnon asked whether Florida treats critical access hospitals the same. Mark replied yes. Mark explained that the Joint Commission's Performance Improvement standards provide more flexibility for CAHs, giving these hospitals more flexibility in picking measures.</p> <p>Maureen Booth asked whether the Joint Commission conducts a minimum amount of review across all PFAs. Mark explained that the PFAs are the starting point but that over the course of the survey, the surveyor will have touched all of the priority areas.</p> <p>Judy Street asked whether the Joint Commission has views of staffing ratios.</p>			

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	<p>Mark explained that the Joint Commission evaluates the effectiveness of staffing, not numbers; that you never know the right number on any particular day.</p> <p>Denise asked about the Joint Commission's organization of its standards, explaining that they could be difficult to access. Mark explained that the Joint Commission is working on making the standards more accessible.</p> <p>Bill Zuber asked whether PPR data will be shared with states. Mark explained that the Joint Commission wants hospitals to be candid and thorough and thinks turning the information over to the state would inhibit that.</p>			
CMS	<p>Rick Shaw, from Region 1 for the Centers for Medicare and Medicaid Services, began by explaining that many hospitals lack a working knowledge of the COP. He noted that when Maine's licensing division receives a complaint that they think meets federal criteria, they refer the complaint to CMS for authorization to investigate. If CMS agrees, Maine will conduct the complaint investigation. Rick noted that CMS does not have a wide range of enforcement options. It can either do nothing or refuse to allow a hospital to participate in Medicare. As a result, CMS is very slow to take any drastic measure. However hospitals must submit a Plan of Correction (POC) for condition level non-compliance. Standard level deficiencies do not require a mandatory POC. However, most hospital with standard level deficiencies do submit a POC, as the Statement of Deficiencies (SOD) is available for public disclosure.</p> <p>Maine's licensing division periodically conducts a validation survey about 60-90 days after a Joint Commission survey. Because CMS accepts Joint Commission accreditation in lieu of the COP, the validation survey is a check on the Joint Commission survey process.</p> <p>CMS does not use data to target the survey process. In recent years, CMS has put more emphasis on quality assurance and quality improvement: do you know what your problems are and what is you doing about them? If a hospital is already working on its problems, it's in a better position.</p> <p>Rick noted that changing federal regulations requires years and years of discussion at the national level. Attempts to completely overhaul the COP have failed. Instead CMS amends the COP incrementally.</p> <p>Rick sees value-based performance as playing a role but it will not be a</p>	NA	NA	NA

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	<p>major role. The major challenge with value-based purchasing is defining the difference between what's expected and what's "above and beyond."</p> <p>Rick also discussed the relationship between the National Quality Forum's patient safety practices and the need to make sure that the COP are consistent and that surveyors understand best practices.</p> <p>During Q&amp;A, Rick explained the changes to the Restraints and Seclusion standards under COP. The law has been revised so that any death that occurs while a person is in restraints or seclusion must be reported to CMS; CMS will determine whether a survey is required. This removes from the hospital the decision about whether a death meets certain criteria (and thus whether or not to report it).</p> <p>Sandy Parker clarified with Rick whether or not a hospital owning a physician practice can call 911 rather than have emergency capacity. Rick explained that the required emergency capacity affects specialty hospitals not physician practices.</p>			
Next Meeting	<p>The next meeting is <b>June 4, 2007</b>. At this meeting, Complaints, Communications and Data work groups will report out of their progress. In addition, the group will discuss the "added-value" that Maine licensing standards potentially provide over and above Conditions of Participation certification or Joint Commission accreditation.</p> <p>The group also identified the kind of information they would be interested in as they think about how to align Maine standards with the Joint Commission's or with the COP:</p> <ul style="list-style-type: none"> <li>● Has the Joint Commission documented the different ways that states align their licensing requirements with the Joint Commission?</li> <li>● Is it possible to find out what Maryland, New York and Florida think about their alignment with the Joint Commission? From the licensing perspective? Hospitals? Critical access hospitals?</li> <li>● What does Cathy Cobb see as the list of "value-added" requirements that Maine regulations bring to the COP?</li> </ul>			
Process Check	<p>Members found today's presentations helpful. It was discussed that the meetings so far have been focused on getting started and information gathering, appropriate first phases for this process and the group is making</p>			

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	reasonable progress.			