Commission to Study Maine's Community Hospitals
Summary of Meetings/Findings to Date, June 7, 2004

At its June 7th meeting, the Commission to Study Maine's Community Hospitals will discuss the steps it wishes to take over the coming months to develop the November 2004 report required by PL 469. To assist the Commission in performing this task, this document summarizes the Commission's meeting and findings to date.

November 20, 2003: Inaugural Meeting. The Commission discussed the approach it would take over the coming months, so there are no "findings" to report.

December 4, 2003: Hospital Financing. Nancy Kane, Professor of Health Policy and Management at the Harvard School of Public Health, was introduced as the Governor's Office consultant conducting an analysis of Maine's hospital system, including performing a financial analysis and assisting in building a baseline against which compliance with voluntary price constraints may be measured. She presented preliminary data findings from her work.

- Most of the 39 acute care facilities in Maine are the sole hospital in the town in which they are located.
- Dr. Kane said that it is difficult to track hospitals' flow of funds and to construct an historical overview of finances for a range of reasons:
  - Many hospitals have a wide range of related entities. For example, MaineGeneral Health System has ten entities, including the hospital. The MaineHealth system appears to have over forty different entities.
  - Some of the related entities are for-profit organizations, removing their financial statements from the realm of public purview.
  - The method of presenting financial data can vary from one hospital to the next and, sometimes, from one year to the next for the same hospital.
- In response to these findings, Commission members discussed the desirability of somehow mandating standardization of hospital financial reporting.
- Dr. Kane presented data showing that Maine's hospital costs per discharge (adjusted for wage and case-mix differences) are higher than the Northeast average, the US average, and a peer group she created, but there was no statistically significant difference between Maine hospitals and the peer group in a number of quality measures.

January 5, 2004: Overview by MHA. The Maine Hospital Association (MHA) presented. Mary Mayhew, Vice President for Government Affairs and Communications, and David Winslow, Vice President for Financial Policy were the presenters. Among the points in the MHA presentation:

- Maine's hospitals consist of 6 teaching hospitals, 3 tertiary care hospitals, 8 critical access hospitals, 9 sole community hospitals, and 2 psychiatric hospitals. Maine's hospitals employ 1,300 physicians, roughly 30% of those in the state and work in a variety of ways to meet the needs of their communities. In many communities, hospitals operate family primary care, dental, and diabetes and asthma management clinics. Hospitals also often provide services that no other entity will offer, such as long term care.
- Health care, in general, plays a significant role in Maine's economy: 10% of all jobs are in the healthcare sector (59,000 jobs); hospitals are the 4th largest employer in state, employing 25,000 people.
- The median operating and total margin among Maine's 39 hospitals are 1.1% and 0.6% respectively.

- Hospitals had $1.9 billion in net patient service revenue in 2001. The 10 highest revenue hospitals accounted for 70% of revenue, 10 lowest accounted for 6.5% of revenue.
- Commercial insurance accounts for 50% of payments, Medicare for 33%, Medicaid for 10%, and self-pay for 7%.
- Medicare and Medicaid do not cover the full cost of providing services to Medicare and Medicaid beneficiaries, which drives up the commercial insurance rates. Maine ranks 46th among the states in terms of Medicare payment to cost ratio: in 1999, on average, Medicare paid Maine hospitals 88% of the actual cost of treating Medicare patients. In 2000, on average, Medicaid paid Maine hospitals 79% of the actual cost of treating Medicaid patients, according to MHA data.
- Wages and benefits account for 52% of all expenses; supplies – including drugs – account for 17%; insurance, utilities, and contracted services account for 20%; and bad debt and charity care accounts for 5%.
- In 2001, Maine ranked 23rd in the nation in terms of licensed hospital beds per capita. Bed-capacity must be sufficient to accommodate spikes in need for inpatient services.

The MHA presented data that seemingly contradicted data presented by Dr. Kane at the previous meeting, in particular showing that Maine's hospital costs are lower than New England averages and only slightly higher than the national average. Dr. Kane and the MHA agreed to discuss methodological differences that account for the differences in reported costs.

The MHA also presented data showing that:

- Maine's administrative costs per discharge had been significantly higher than the nation's and New England's until 1998, but dropped to below the New England average and on par with the US average in 1999 and 2000;
- Maine's average length-of stay is lower than the New England and national averages;
- Maine's staffing per occupied bed is higher than the New England and national averages; and
- Maine's average age of plant is on par with the New England and national averages.

The MHA closed its presentation by reporting that Maine hospitals rank highly in the nation on a range of quality measures and citing challenges faced by Maine's health care system, in particular that: (a) Maine has the 4th highest rate of chronic disease in the US, and 75% of Maine deaths and 33% of all disabilities – which result in high levels of long-term hospitalizations – are due to such chronic diseases; and (b) Maine's population is older than the national average, and it is getting older.

January 20, 2004: Payor Perspectives. Two private payors of hospital care presented.

Cathy Gavin, Executive Director of the Maine Healthcare Purchasing Collaborative, was the first presenter. The Collaborative is a statewide organization formed in September '01 to speak for its membership of approximately 45 large employers to advance value-based purchasing. Ms. Gavin indicated that:

- in order to institute effective value-based purchasing, it is essential to have transparency of data regarding the cost of care, outcomes, and where individuals should go for care;
- the Collaborative is interested in Leapfrog Group standards (the Leapfrog Group is a group of more than 150 public and private organizations that provide health care benefits, for over 34 million health care consumers in all 50 states; the Group's primary goal is to use employer purchasing power to reduce preventable medical errors by initiating improvements

in the safety of health care and by giving consumers information to make informed hospital choices).

- Bureau of Insurance Rule 850 is a cost driver in that it requires healthcare provision close to patients' homes, making it difficult to purchase care from the most cost effective/highest quality providers;
- it is important to have information about costs, not just charges; such information might be obtainable from the State Employee Health Plan; and
- she doubts that quality initiatives can provide significant savings in the short-term, but said that some sort of change is imperative, as the system as it currently exists is not sustainable.

Ms. Gavin also raised several questions for the Commission's deliberation:

- Are 39 hospitals too many given the size of the State?
- What measures should we use to determine how many hospitals we need?
- Why are there variances hospital to hospital?
- It appears that there may be a significant amount of duplication in Maine's hospitals – what is the appropriate ratio of services and where should they be located?

Kevin Gildart, Vice President of Human Resources at Bath Iron Works (BIW), was the next presenter. BIW has 6,700 employees and covers about 16,000 lives in its plan. In 2003, BIW spent about $52 million in health care and $12 million in workers' comp. Of this, about $26 million goes to hospitals. Mr. Gildart:

- described BIW's concerns about hospital costs, noting, for instance, that there was triple digit growth in one emergency room and that some services are cheaper to provide in-patient than out-patient for the same procedure;
- expressed concern about the link between quality and cost, noting that it takes 15 years for best practices to become common practices;
- noted that there was a significantly different hospital cost profile before and after the Maine Health Care Finance Commission, but stated that that he necessarily didn't conclude that MHCFC was the cause;
- indicated that BIW has invited 8 hospitals that serve BIW to meet with them to share data on outcomes, to encourage compliance with national standards, and to support the Maine Healthcare Purchasing Alliance;
- explained that BIW has been focusing on chronic care to bring down costs;
- explained that has contracted with a District of Columbia firm to manage last trimester care for cancer; this effort had shown results; and
- noted that BIW was considering direct contracting, which would represent a significant change in how BIW does business.

Both presenters noted that the Medicare and Medicaid shortfall results in higher rates for private payors, but that the magnitude of both the shortfall and its exact effect on private payors is unknown.

February 2, 2004: Provider Perspectives. Representatives of the Maine Medical Association (MMA), Maine Osteopathic Association (MOA), Maine State Nurses Association (MSNA), the Ambulatory Surgery Centers Coalition (ASCC), and the Organization of Maine Nurse Executives (OMNE) presented.

MMA president Dr. Maroulla Gleaton told the Commission that the MMA: views finances and workforce issues as the primary challenges facing Maine's hospitals today; is particularly

concerned about the on-going financial viability of Maine's rural hospitals; and is concerned that financial issues – and the imposition of an artificial cap on capital investment – might frustrate investment in and dissemination of new technology in Maine. Dr. Gleaton suggested that:

- the association between volume and quality as well as between supply and utilization be re-examined, but that at the same time we should not encourage duplication of services or unhealthy competition between facilities; and
- modifications to anti-trust laws could foster true collaboration between hospitals and between hospitals and physicians.

MOA president, Dr. Bruce Bates told the Commission that the MOA shares the concerns of the MMA and also believes that hospitals play a very needed and important role in training health professionals. Dr. Bates also:

- cautioned that introducing the use of "Centers of Excellence" might have inadvertent consequences that could potentially threaten access;
- suggested that the delivery of primary care was best carried out by local providers rather than tertiary care facilities; and
- stressed the need for a careful review of all rules and regulations, many of which may be found to be redundant.

MSNA Executive Director Pat Philbrook told the Commission that:

- RNs contribute to quality health care and cost savings by reducing complications, infections, readmissions, and death rates;
- the current nursing crisis is not attributable to a shortage of nurses but rather to the fact that nurses are choosing to leave nursing for other pursuits, making retention of quality nursing staff an important issue for hospitals; and
- reducing the use of nurse substitutes and adopting reasonable nurse staffing ratios would be critical to solving this issue.

Ambulatory Surgery Centers Coalition representative John Wipfler:

- explained the role of ASCs in the health care system, noting that all Maine ASCs have been built with private capital and, as for profit entities, all contribute tax revenue to Maine's economy;
- provided the Commission with information developed by the US DHHS Office of the Inspector General indicating that ASCs can present significant cost savings to health care programs while benefiting patients; e.g., ASCs are more efficient than hospitals, and Medicare and Medicaid generally pay ASCs less than they pay hospitals for a given procedure; and
- stated that ASCs contribute to Maine's ability to recruit and retain physicians.

OMNE representative Barbara Whitehead:

- cited studies that have found that Maine hospitals typically rank higher than facilities elsewhere in the US in terms of patient satisfaction, an attribute she correlates with the quality of nursing in this state;
- cited an OMNE study suggesting that, in contrast to Ms. Philbrook's view, there is a nursing shortage in Maine; and
- noted that Maine hospitals' technology needs are critical and should be adequately funded, as should the resources hospitals require to appropriately pay nursing staff.

February 17, 2004: Insurance Perspectives. Representatives of (a) the Maine Association of Health Plans and (b) Employee Benefits Design, Inc. presented.

The Maine Association of Health Plans represents Anthem, Aetna, CIGNA, and Harvard Pilgrim. Among the points made by Director Katherine Pelletreau:

- There are numerous and complex cost drivers in the state, including, but not limited to: (a) an aging population; (b) advances in medical technology and the fact that the growth of outpatient services outpaces that of inpatient services; (c) Maine's high rate of Emergency Room use for primary care, which is an inefficient way to provide primary care; and (d) high administrative costs, which are due in part to differences in procedures among payors (Medicare, Medicaid, and private insurers).
- In rate negotiations, hospitals tend to have greater negotiating power than insurers, due to (a) hospital consolidation, and (b) the fact that in many rural communities hospitals employ most physicians.
- Hospitals cite during negotiations the need for cost shifting to cover Medicare and Medicaid shortfalls. However, during a given negotiation, insurers do not have information about the magnitude of each hospital's shortfall.
- To comply with Rule 850, insurers must pay for services provided outside of their network, which results in increased payments by the insurer which are then passed on to consumer in the form of higher premiums for using an out-of-network provider.
- It is too early to determine the impact that the Dirigo statute's voluntary 3.5% and 3% caps on expenses per case mix adjusted discharge and consolidated operating margins will have on insurance premiums. In addition:
  - the 3.5% cap applies only to one inpatient metric and is not reflective of the of the mix of care a carrier might see at a given facility;
  - because the 3.5% cap applies to aggregate services rendered by the hospital, rather than to individual services, a hospital can increase charges for one service by more than 3.5% and still stay within the cap; and
  - the 3% cap on consolidated operating margins does not adequately address the practice of offsetting losses of some affiliates against the profits of others in hospital systems.

Ms. Pelletreau presented five suggestions for the Commission's consideration:

1. The issue of cost shifting should be directly addressed by ensuring transparency in the quantification of the problem and how individual hospitals were impacted by it.
2. Although payors had not seen a decline in their costs as a result of hospitals' converting to critical access status, such conversions should be encouraged, as they ensure full payment of costs by Medicare which would alleviate cost shifting pressures.
3. The state should fully fund the MaineCare program, allowing a raising of rates paid to Maine hospitals.
4. Standardized hospital accounting procedures should be established. Such standardization will assist payors in comparing one hospital to another and thus facilitate meaningful discussions regarding the cost of care.
5. Further relaxations of Bureau of Insurance Rule 850 would allow insurers to direct patients to cost effective providers.

Mr. Brent Churchill, an expert in benefits-design who consults with Fraser Paper, a company in northern Maine that self-funds its health coverage benefit:

- pointed out that our health care system is “revenue driven rather than health care driven” and that revenues increase through advertising, increased charges, and increased utilization;
- suggested that educating enrollees about differences in costs of care at different facilities can reduce expenditures to some extent;
- stressed the issues of significant variation in cost and utilization across small geographic areas (from one hospital to the next) and supply-induced demand, and the impact they exercise on the cost of coverage;
- expressed some degree of frustration with the inability to move negotiations with providers away from discounted charges to payment based on the actual cost of providing particular services;
- spoke to the issue of regionalization, which he views as reasonable and likely inevitable in Aroostook County; and
- offered his opinion regarding the need for hospital regulation in some form to assist in cost controls, since – especially in rural areas – competition does not work to lower costs.

March 1, 2004: Legal Issues. Assistant Attorneys General (AG) Tina Moylan and Linda Conti presented a review of the laws governing hospital cooperation, anti-trust, and hospital governance.

General Points
- Antirust prohibitions are found in both state and federal law. Maine AG handles state; U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) handle federal.
- Generally, hospitals cannot collaborate to: set fees; refuse to deal with a payor; divide territories; or divide services.
- Mergers are generally opposed unless in the instance where one hospital is failing.
- Hospitals frequently confer with the AG’s office regarding anti-trust provisions.
- The state legislature can enact exceptions to anti-trust laws with adequate state oversight.
- USDOJ is currently reviewing some mergers nationally to determine their impact.

Maine’s Hospital Cooperation Act of 1991
- Allows hospitals to: share, allocate or refer patients or services; coordinate negotiation and contracting with payors; and merge.
- Hospitals appear reluctant to use the Act fearing Federal action despite state protection, and only two applications have been formally submitted through the Act.

An Recent Example Of Anti-Trust Violation
- The Maine Health Alliance, a physician-hospital organization, was formed in 1995 to negotiate joint contracting with third party-payors. It was established to be non-exclusive in practice, but it required hospitals to have exclusive relationships with the Alliance; this ultimately was found by the FTC to be a violation of Federal anti-trust law.
- This case could increase hospitals’ reluctance to coordinate with one another.

At least one Commission-member was particularly interested in whether the AG’s office could recommend changes to anti-trust law to overcome hospitals’ reluctance – or even to incent hospitals – to coordinate with one another.

March 15, 2004: Hospital Variation. Dr. David Wennberg -- who has performed research on national health care efficiency and quality issues and currently works with (1) the Maine Medical Center’s “Center for Outcomes Research and Evaluation” on measuring efficiency and quality on a national scale, and (2) the Health Dialog Data Service, where he consults with large employers and health plans on using efficiency and quality measures to reduce healthcare

expenditures without negatively impacting quality -- presented on measures of hospital quality and efficiency and how some large employers and health plans can use them to reduce healthcare expenditures without negatively impacting quality. Among the points in Dr. Wennberg's presentation:

- It is important to look at the relationship between unit prices and total spending on such units within a market area:
  - 25% of the variation between market areas' health care spending is accounted for by differences in cost-per unit, while 75% is accounted for by the number of units consumed.
  - Market areas with high levels of competition tend to have lower per-unit costs but also higher utilization rates, and savings associated with lower cost-per-unit are often erased by increased utilization; i.e., supply drives demand.
- Higher rates of performing a procedure do not necessarily lead to improved outcomes for that procedure, although sometimes it does.
- When there is not consensus about where services should be provided for a given condition, availability of beds has been shown to correlate with the condition being treated in an inpatient setting. There is little or no increase in quality, effectiveness, or patient satisfaction as you move from areas of country with lower utilization and expenditures to areas of country with higher utilization and expenditures for such services (which Dr. Wennberg refers to as "supply sensitive services").
- Employers and health plans can use comparative information about individual hospitals' practice patterns (e.g., variations between hospitals regarding spending and average length of stay for different conditions) to determine which hospitals are more efficient – i.e., deliver the same quality at a lower cost – and create incentives to steer patients to more efficient providers. This could include "benefits steering," as well as rewarding providers for managing capacity and improving quality for different conditions. "Supply sensitive services" are where the biggest changes in practice – and therefore in cost savings without decrease in quality – can likely be realized.

During discussion, the following points were made:

- Certificate of Need is a tool the state can employ as part of a scientific approach to capacity. In developing a scientific approach, decisions would need to be made on questions such as: what health care services should be provided locally versus regionally; what are acceptable driving times/distances that are accepted for access to different services; etc.
- To steer people to more efficient hospitals, the state could: (1) further relax Rule 850, which regulates the distances individuals can be required to travel to receive different services; and (2) allow a coalition of state health care purchasers to experiment with reimbursement incentives through Medicaid and/or the State Employee Health Plan.
- It would be useful for the state to invest in data system infrastructures that will allow the state to track over time the effects on expenditures and quality of whatever interventions the state employs.

April 5, 2004: Health Status in Maine/Maine's Public Health/State Health Planning. Dora Mills, Director of the Maine Bureau of Health, and Ron Deprez, President of the Public Health Resource Group, presented to a joint meeting of the Commission and the Advisory Council on Health Systems Development.

Dr. Mills presented on the distinctions between Medicine and Public Health and provided an overview of data sources available to assess Public Health in Maine. In particular, Medicine tends to be focused on individuals, illness-driven, and focused on tertiary prevention; Public Health, on the other hand, tends to be focused on populations, prevention-oriented, and focused

on primary and secondary prevention. Health issues can be addressed at multiple levels: public health, medical care, and policy/finance.

Dr. Deprez presented on “Health Planning Framework and Methods.” Dr. Deprez indicated that after determining a Plan’s general focus and specific objectives, health service needs planning can be broken into a four-step process: (1) developing a health status and utilization profile; (2) analyzing prevention, treatment, and outcome indicators to identify priority service needs; (3) assessing local healthcare services; and (4) issuing a health service needs and planning report. He also stressed the importance of incorporating into the Plan goals and measures for (a) prevention, (b) diagnosis and treatment, and (c) management and follow-up; as well as the importance of incorporating into the Plan strategies for informing providers of resources available to them and their patients.

April 20, 2004: Critical Access Hospitals. Andy Coburn, a Professor of Health Policy at USM's Muskie School of Public Service, provided a general overview of Critical Access Hospital (CAH) program. John Welsh, President and CEO of Rumford Hospital, presented about Rumford Hospital's experience since its designation as a Critical Access Hospital in July 2002.

- The CAH program, created by Congress in 1997, allows small hospitals meeting certain criteria to receive cost-based reimbursement under Medicare. State law in Maine requires cost based reimbursement for CAHs as well. Criteria include, but are not limited to: bed-size (15 beds -- changed to 25 by November 2003 changes to Medicare law -- plus 10 swing beds); a maximum length of stay of 96 hours; and transfer agreements with a hospital within 35 miles.
- 30-40% of hospitals in the US -- and 8 hospitals in Maine -- are CAHs.
- Rumford's shift to CAH designation: resulted in decreasing the number of licensed acute beds from 97 to 15; stabilized the hospital's financial situation; and encouraged the hospital to think of itself as part of a community health network (Rumford has a transfer agreement with Central Maine Medical Center and jointly conducts specialty clinics with Lewiston physicians).
- What CMS considers "allowable costs" are often less than the actual costs incurred by hospitals.

May 3, 2004: Hospitals and Maine’s Economy. Dana Evans, State Labor Economist, Department of Labor, and Charlie Colgan, Professor, Muskie School of Public Service, presented about the role of hospitals and health care in general in Maine’s economy.

Among the points made during Mr. Evans’ presentation:

- In March ’04 there were 27,000 jobs in hospitals (1,100 new jobs over the last year).
- The number of private hospital jobs increased by 19% from 1992-2002. This exceeds the U.S. average for hospital jobs at 11%. Most of that growth occurred after 1996.
- Health care jobs comprised 12.7% of all jobs and 14.2% of all wages in the state in 2003.
- Private hospital jobs comprised 35.2% of all health care jobs and 38.7% of all health care wages in the state in 2003.
- Hospital jobs tend to create about 1.3 jobs in the private sector.
- The fastest growth in health care over the last 10 years was in medical and dental labs, and other practitioners and doctors offices, but these are very small segments of the health care industry, especially compared to hospitals.

Among the points made during Mr. Colgan’s presentation:

- It is true that health care is a major contributor to employment and Gross State Product growth; while health care is paid by Maine citizens and businesses, it can also be considered an export industry in that it brings in federal Medicare and Medicaid funds.
- It is also true that "too much" health care spending could be a damper on economic growth.
- In thinking about the costs and benefits of economic activity in the health sector, it is important to:
  - recognize that jobs are not benefits; rather, they are costs of producing goods and services people want;
  - recognize that more activity does not necessarily create more benefits (e.g., health); and
  - be precise in use of the terms, "consumption," "expenditure," "cost," and "price;" these terms are often used as synonyms, despite the fact they are not.
- Other questions the Commission should think about include:
  - How do increases in input affect outcomes?
  - How do distortions in health care markets affect prices (e.g., consumers don't pay directly; there's no clear system of health care delivery)? How can distortions be minimized?
  - Do additional health care expenditures create benefits in excess of costs? How to measure?
  - We know that health care spending in Maine is the10th highest in the U.S.; why? Are we the 10th highest in outcome?

May 17, 2004: Patient Safety. The meeting focused on medical errors. The three presenters were: (1) Rebecca Martins a consumer advocate with "Voices 4 Patients;" (2) Jill Rosenthal of the National Academy for State Health Policy; and (3) Lou Dorogi, Director, Division of Licensing and Certification, Department of Human Services.

Ms. Martins recounted her family's three very different experiences with the same hospital in Maine over a period of 12 years: two were excellent, the third was terrible. Her ongoing frustration in attempting to get information about what led to her father's death in the third experience led to her becoming a patient advocate. In her work as an advocate, she has found that hospitals put up "walls of silence" when families attempt to get information about medical errors and substandard care, and that some families report to litigation as a last resource to get information.

In response to members' inquiries as to whether any states had passed malpractice reform to encourage communication between providers and patients, Ms. Rosenthal sent GOHPF articles indicating that two states, Colorado and Oregon, have passed laws specifically saying an apology can't be used against a doctor in court, and that the Oklahoma legislature is considering a similar provision.

Ms. Rosenthal indicated that much of her presentation was based on the Institute of Medicine's (IOM) 1999 report, "To Err is Human: Building A Safer Health System." Ms. Rosenthal indicated that: as many as 98,000 people die in hospitals each year as a result of medical errors that could have been prevented; medical errors result in between $17 and $29 billion in extra medical spending (over half of which are direct costs); and 2% of hospital admissions are due to medical errors. Errors occur because of systems problems, so shifting focus from blaming individuals to designing safer systems can have a significant impact on reducing error.

A number of states have implemented any of a number of IOM recommendations regarding improved safety. 22 states – including Maine – have implemented mandatory reporting systems, under which hospitals must report to a state agency regarding medical errors. The purpose of such systems is both to hold hospitals accountable for their errors and to ensure that hospitals learn from and correct the source of the errors. Some private purchasers – with the

Leapfrog Group as a prime example – have taken steps to reduce errors for employees covered in their programs, and that state employee programs are beginning to implement similar steps.

Electronic medical record (EMR) systems can reduce medical errors. A member referenced the Maine Health Management Coalition's "Rewards for Excellence" program to incent investment in data systems and suggested asking a MHMC representative to speak before the Commission. That member added that it makes the most sense to implement EMR from a systems point of view, rather than at the level of single institutions. No state has yet succeeded in implementing a statewide EMR system. Privacy concerns can undermine public support for EMR systems.

While nobody at the meeting was aware of studies on ROI from EMR, the Maine Quality Forum (MQF) has made EMR one of its highest priorities, and has indicated to GOHPF that it will forward any studies that the MQF encounters during its work; GOHPF will forward any such studies to the Commission.

Mr. Dorogi spoke about LD1363, a Maine law that became effective Feb 1, 2004 that follows the IOM model. Some fundamental points about the law are as follows:

- Facilities must report on a range of adverse events – including, but not limited to unanticipated death or surgery on the wrong patient or wrong body part -- within one day of its occurrence and then must conduct an investigation and report the findings to the state with 45 days.
- Information obtained through the notification, reporting, and investigative process are deemed by statute to be confidential and privileged. The statute's confidentiality requirements in effect establishes a firewall between the office that administers the LD 1363 process from sharing information with other offices, including the consumer complaints office.
- The facility's report must identify the systems or processes that may have led to the event, as well as changes that could be made or corrective actions planned to reduce the risk of such events in the future. Facilities that knowingly violate any provision of LD1363 are subject to a fine of up to $5000 per event.
- DHS must report on trends in events by February first of each year. Trends will be reported in the aggregate; facilities may not be identified.

Ms. Martins pointed out that the purpose of LD1363 is to enable the system to learn from its mistakes, but that LD1363 does not serve a consumer who has already been harmed.

Mr. Dorogi also indicated that one error would not be considered a licensing and certification violation, but repeated errors at a facility could constitute a violation and could lead to revocation of a license. Historically, 3 to 4 hospitals per year have been given a "conditional license" due to deficiencies of one sort or another. Conditional licenses remain in effect for one year, unless a hospital is unable to demonstrate that it is able to comply with specific conditions and timelines set by DLC, in which case the license may be extended.

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