

**STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES
AND HEALTH CARE ADMINISTRATION**

Regulation H-2009-05

HOSPITAL COMMUNITY REPORTS.

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Section 1. General Provisions.

Authority. This regulation is promulgated by the Department of Banking, Insurance, Securities and Health Care Administration under the authority of 18 V.S.A. § 9405b, 18 V.S.A. § 1919 and 8 V.S.A. § 15.

Purpose. Section 9405b of Title 18 requires each hospital licensed pursuant to Chapter 43 of Title 18 to publish and provide to the Commissioner and the Public Oversight Commission annual hospital community reports in standard format. The purpose of this regulation is to establish the standard format for such reports, as well as the contents, which must include: (1) measures of quality, including process and outcome measures; (2) measures of patient safety; (3) measures of hospital-acquired infections; (4) measures of the hospital's financial health; (5) a summary of the hospital's budget; (6) measures that provide information for comparison of charges for higher volume services; (7) a description of the hospital's process for achieving openness, inclusiveness and meaningful public participation in strategic planning and decision-making; (8) the hospital's consumer complaint resolution process; (9) information concerning recent or current quality improvement and patient safety projects; (10) a description of identified health care needs strategic initiatives, capital expenditure plans and a depreciation schedule for existing facilities; (11) information on membership and governing body qualifications; and (12) information on nurse staffing.

Definitions.

As used in this regulation:

- (A) "Annual Reporting Manual" means the manual issued by the Department under Section 3(C) of this regulation.

- (B) “Benchmark” means an attribute or achievement that serves as a standard for other providers or institutions to emulate. Benchmarks differ from other standard of care goals in that they derive from empiric data – specifically, performance or outcomes data.
- (C) “Charge” means the amount, in U.S. dollars, that a hospital invoices a purchaser or patient, as the case may be, for a particular service or combination of services performed by the hospital prior to the application of any discounts, reductions or mark-downs that may ultimately affect the amount the purchaser or patient, as the case may be, is obligated to pay for the performance of such service(s).
- (D) “Commissioner” means the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration.
- (E) “Department” means the Department of Banking, Insurance, Securities and Health Care Administration.
- (F) “Hospital” means each hospital licensed under Chapter 43 of Title 18.
- (G) “Public Oversight Commission” means the commission established pursuant to 18 V.S.A. § 9407(a).
- (H) “Reliability” means the consistency of a measure. A reliable measure of quality should produce consistent results when repeated in the same population and setting, even when assessed by different people at different times. Any variation in a quality measure should reflect a true change in quality and not errors produced by the measurement itself. Such inconsistencies and errors occur when trying to measure quality in rare events (e.g., mortality), a small number of events (e.g., small hospitals may conduct very few of a specific procedure), or restricted samples of events (e.g., counting occurrence of an event over a relatively short period of time). Quality measures should be repeated periodically, and any changes in the measures should reflect a true change in quality.
- (I) “Validity” means the accuracy of a measure, so that a specific quality indicator measures what it is intended to measure. Reliability is a prerequisite to validity, but does not guarantee a valid measure. The validity of a quality measure is assessed by whether it makes sense logically and clinically, correlates well with other measures of the same aspects of quality, and captures the meaningful aspects of quality. Quality measures should be linked to significant processes or outcomes of care as demonstrated by established scientific studies.

Section 2. Responsibilities of Hospitals

- (A) Each hospital is responsible for publishing a community report by June 1 of each year. Such report shall contain the contents outlined in Section 4 of this regulation and in the Department’s hospital community reports reporting manual,

to be issued annually under Section 3 of this regulation. Each hospital shall publish its community report on its website, making paper copies available on request, and shall provide to the Commissioner and all members of the Public Oversight Commission the URL website address of its report. All community reports shall be available in electronic format or such other format as the Commissioner may reasonably require from time to time.

- (B) Each hospital shall hold at least one public hearing annually to permit community members to comment on its report, and shall provide notice of the hearing(s) in a newspaper of general circulation in the service area or areas of the hospital. The Department will provide guidance, in writing, to the hospitals regarding any specific hearing notice requirements, either through the annual reporting manual or otherwise.

Section 3. Responsibilities of Department

- (A) The Department may convene one or more advisory committees from time to time to make recommendations to the Commissioner regarding quality, patient safety, nurse staffing, infection and financial measures; parameters for presenting qualitative information; and report format.
- (B) Measures for each annual community report will be selected and communicated to the hospitals in a manner that allows reasonable time for hospitals to prepare for data collection and address budgeting and data systems needs. In any event, measures that do not require new data collection processes shall be selected and communicated to hospitals at least six (6) months prior to the scheduled publication date of the applicable community report and measures for which hospitals do not otherwise collect data according to the specifications adopted by the Commissioner shall be communicated to the hospitals by the Department at least four (4) months prior to the inception date for data collection with respect to such measures.
- (C) The Commissioner's final decision on community report content and format shall be communicated to hospitals in an annual reporting manual for hospital community reports to be distributed by the Department to hospitals on or before March 15 for the community report to be published by June 1 of that same year. The reporting manual shall contain, at a minimum, a list of quantitative measures; the methodology for collecting and analyzing data for each measure; specifications for the uniform format referenced in Section 5 of this regulation; parameters for presenting quantitative and qualitative information; and common explanatory language to be used in each community report.
- (D) Annually, the Department shall establish on its public website a link to each individual hospital's website where the hospital's community report is published, and shall develop and publish on its public website a report that allows consumers to compare hospitals for quality and financial indicators.

- (E) Periodically, the Department shall evaluate the hospital community reports. Such evaluation may include website traffic reports, consumer feedback, hospital and Department efforts to publicize and provide access to the reports to consumers, and hospital and Department resources required to produce the hospital community reports.

Section 4. Community Report Contents

- (A) Quality, patient safety, nurse staffing and infection rate measures. In order to identify quality, patient safety, nurse staffing and infection rate measures for hospitals to include in their annual community reports, the Department may consult with national and state organizations, including but not limited to:
1. The Centers for Medicare and Medicaid Services (CMS);
 2. The Joint Commission, formerly The Joint Commission on Accreditation of Healthcare Organizations;
 3. The Agency for Healthcare Research and Quality (AHRQ);
 4. The Vermont Program for Quality in Health Care (VPQHC);
 5. The National Quality Forum (NQF);
 6. The Institute for Healthcare Improvement (IHI);
 7. The Northeast Health Care Quality Foundation;
 8. The Institute of Medicine (IOM);
 9. The Healthcare Infection Control Practices Advisory Committee (HICPAC);
 10. The Centers for Disease Control and Prevention (CDC);
 11. The National Association of Health Data Organizations (NAHDO);
 12. The American Nurses Association's National Database of Nursing Quality Indicators (NDNQI); and
 13. The Leapfrog Group.

The Department may require hospitals to include patient experience of care survey data for inpatient and/or outpatient hospital services in their community reports as a measure of hospital quality.

The Department, after receiving recommendations from the Commissioner of Health pursuant to 18 V.S.A. § 1919, shall evaluate measures of reportable adverse events for inclusion in the hospital community reports.

The Department shall consider relevant criteria in evaluating potential measures for inclusion in the community reports, including but not limited to:

1. Reliability;
2. Validity;
3. Basis in scientific evidence;
4. National consensus;
5. Availability of relevant, reliable and valid external benchmarks;
6. Well-developed specifications;
7. Importance to consumers;
8. Adequacy of case numbers; and
9. Cost of data collection.

The Department may require hospitals to report measures by payer, race, gender, socioeconomic status, or other variables indicative of equity in treatment or access. In addition, the Department may require hospitals to report only on measures for which there are enough cases to make reporting reliable. The Department, in consultation with experts in quality measurement, will determine what constitutes adequate case numbers for public reporting.

(B) Description of hospital's strategic planning and decision-making processes and the hospital's identified health care needs strategic initiatives. Each community report shall describe the hospital's processes for strategic planning and decision-making and the hospital's strategic initiatives, including but not limited to:

1. A summary description of the hospital's process for achieving openness, inclusiveness and meaningful public participation in its strategic planning, decision-making and identification of health care needs. Such description shall include:

- a. the manner in which the hospital has incorporated meaningful public participation into its strategic planning, decision-making and identification of health care needs in its service area;
 - b. a listing of the activities that are available for public participation (e.g., volunteer opportunities, regional or community partnerships, public meetings, community events, interviews with key community leaders, surveys, and/or focus groups); and
 - c. contact information, including but not limited to the department(s), telephone numbers, e-mail addresses, fax numbers and postal addresses at the hospital for consumers to use if interested in learning about public participation events; website references may also be included;
2. A description of at least three initiatives that the hospital is undertaking or plans to undertake to meet hospital service area needs identified through the hospital's strategic planning process, including key quantitative or qualitative indicators, if available;
 3. The summary and description of the items covered in 1 and 2 in previous community reports should be updated annually, if changes have occurred and if the hospital's service area's identified needs have changed; and
 4. A description of where and how consumers may obtain detailed information about, or a copy of, the hospital's strategic plan, its one- and four-year capital expenditure plan and a depreciation schedule for existing facilities.
- (C) Summary of the hospital's consumer complaint resolution process. Each community report shall describe the hospital's consumer complaint resolution process, including but not limited to:
1. A description of the complaint resolution process, including how to register a complaint;
 2. Contact information, including but not limited to telephone numbers, e-mail addresses, fax numbers and postal addresses for the hospital employee(s) responsible for the implementation of the complaint resolution process; and
 3. Contact information, including but not limited to telephone numbers, e-mail addresses, fax numbers and postal addresses for the Vermont Department of Health in order to register a complaint against a hospital.

- (D) Information concerning recently completed or ongoing quality improvement and patient safety projects. Each community report shall provide descriptions of new quality improvement and patient safety projects, or projects that have had significant activity with reportable milestones and/or results within the previous two years, including but not limited to:
1. A summary of at least three significant projects, including at least one clinical quality improvement and one patient safety project. The summary shall include:
 - a. Project name, time frame and description;
 - b. A description of the problem the project sought to solve or address, including how the problem was identified, and supporting data;
 - c. Project goals, with appropriate measures;
 - d. A description of the intervention(s); and
 - e. A discussion of the evaluation process, and results if available;
 2. Contact information, including but not limited to telephone numbers, e-mail addresses, fax numbers and postal addresses for the hospital quality improvement department through which consumers may obtain more information; and
 3. Contact information for the Vermont Program for Quality in Health Care, if relevant.
- (E) Information on hospital governance, schedule of hospital's governing body meetings and opportunity for public participation. Each community report shall provide a description of the hospital's governance, including but not limited to:
1. Membership and governing body qualifications;
 2. List of current governing body members;
 3. Information on how to obtain a schedule of governing body meetings, and how to obtain information on when the meetings are open for public access and public comment; and
 4. Contact information, including but not limited to telephone numbers, e-mail addresses, fax numbers and postal addresses for the hospital department that can provide more information on hospital governance, including schedules and agendas of meetings, and information on obtaining a copy of the hospital's annual report.

- (F) Measures of the hospital's financial health and budget information. Each community report shall include measures indicative of the hospital's financial health and a summary of the hospital's budget. Measures relating to the hospital's financial health shall include comparisons to appropriate national and/or other benchmarks for efficient operation and fiscal health and shall be derived from the hospital budget and budget-to-actual information submitted annually to the Department pursuant to Rule 7.000 (Unified Health Care Budget).
1. Hospital Finances. Each community report shall provide a description of the hospital's finances, including but not limited to ratios, statistics and indicators relating to liquidity, cash flow, productivity, surplus, charges and payer mix. Such ratios, statistics and indicators shall represent both actual results and projections for subsequent budget years and shall be presented against at least one national peer, regional peer or Vermont peer group data, or against one bond rating agency's comparable rating.
 2. Hospital Budget. Each community report shall provide a summary of the hospital's budget, including revenue by payer and quantification of cost shifting to private payers, and shall use formats, graphic data displays, data sources and common explanatory language approved by the Department. The Department reserves the right to review and approve the data from each hospital to ensure accuracy and consistency with the requirements outlined in the annual reporting manual prior to the publication of the community report. Minimum content and presentation requirements for summary hospital budget information, including one-year and four-year capital expenditure plans and depreciation expenses, shall be detailed in the annual reporting manual.
- (G) Information on hospital pricing. Each community report shall include a comparison of charges for higher volume health care services, such services to be determined by the Commissioner and to include an array of hospital and/or physician services. Presentation requirements for the comparison of charges data shall be detailed in the annual reporting manual.

Section 5. Community Report Format

Each community report shall be provided in a uniform format to allow for comparison among hospitals. The uniform format will be outlined in the applicable annual reporting manual for hospital community reports. The reporting manual shall specify, at a minimum, a common website design; a common menu page; and the required hospital-specific information.

Section 6. Severability

If any provision of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of this regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Section 7. Effective Date

This regulation shall take effect on August 30, 2010.