

## Chapter 2 – Hospital & Medication Rules

### Subchapter 2 –

#### **Hospital Reporting Rule**

##### **1.0 Authority**

This rule is adopted pursuant to 18 V.S.A. §§ 9405a, 9405b, and 18 V.S.A. § 1919.

##### **2.0 Purpose**

The purpose of this rule is to establish the process and timeline for data submission and reporting for the generation of a statewide hospital quality report and reporting on the community health needs assessments.

##### **3.0 Definitions**

- 3.1 "Annual Reporting Manual" means the document published annually by the Department and the Green Mountain Care Board (GMCB) that describes in detail the necessary data specifications and guidelines for submission and publication for hospitals and the development of Community Health Needs Assessments (CHNA). The reporting manual shall contain, at a minimum, a list of quantitative measures; the methodology for collecting and analyzing data; and parameters for presenting quantitative and qualitative information. It is maintained on the Department website.
- 3.2 "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.
- 3.3 "Charge" means the amount, in U.S. dollars, that a hospital invoices a purchaser or patient 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 is obligated to pay for the performance of such service(s).
- 3.4 "Community Health Needs Assessment" means a written report made widely available to the public by the hospital that, using qualitative and quantitative data:
- 3.4.1 Identifies significant health needs of the community it serves;
  - 3.4.2 Prioritizes those health needs; and
  - 3.4.3 Identifies resources (such as organizations, facilities, and programs in the community, including those of the hospital) potentially available to address those health needs.

- 3.4.4 For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).
- 3.4.4.1 These needs may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.
- 3.5 "Commissioner" means the Commissioner of the Vermont Department of Health.
- 3.6 "Department" means the Vermont Department of Health.
- 3.7 "Hospital" or "Community Hospital" means a place licensed under Chapter 43 of Title 18 devoted primarily to the maintenance and operation of diagnostic and therapeutic facilities for in-patient medical or surgical care of individuals who have an illness, disease, injury, or physical disability, or for obstetrics.
- 3.8 "Hospital Report Card" means a compilation of standardized quality and financial information for statewide comparisons by hospital.
- 3.9 "Implementation Plan" means the specific plan to address the results of the Community Health Needs Assessment developed by a hospital. This plan includes a description of identified health needs, strategic initiatives developed to address the identified needs, annual progress on implementation of the proposed initiatives, and opportunities for public participation.
- 3.10 "Psychiatric Hospital" means a hospital for the diagnosis and treatment of mental illness, as defined in 18 V.S.A. § 1902.
- 3.11 "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.
- 3.12 "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.

#### **4.0 Reporting Requirements to the Department**

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. Measures reported to the Health Department may include:

##### **4.1 Quality, patient safety and infection rate measures**

4.1.1 Hospitals shall submit valid, reliable, and useful information per the Annual Reporting Manual.

##### **4.2 Nurse Staffing Information**

4.2.1 Hospitals shall submit valid, reliable, and useful information on nurse staffing, in accordance with the Annual Reporting Manual.

4.2.2 This information may include system-centered measures such as skill mix, nursing care hours per patient day, and other system-centered measures for which reliable industry benchmarks become available.

##### **4.3 Information on Hospital Pricing**

4.3.1 Community hospitals shall submit information on hospital pricing to the Department using a template, and following a deadline established in the Annual Reporting Manual. Community hospitals shall also respond to the Department's comments and questions after the initial submission, and validate the data the Department produces prior to the publication of the Report, as specified in the Annual Reporting Manual.

4.3.2 This information shall include:

4.3.2.1 A comparison of cost for higher volume health care services; and

4.3.2.2 Any other services to be determined by the Commissioner and to include an array of hospital and/or physician services.

#### **5.0 Requirements for Publication on Community Hospital Websites**

Community hospitals shall post the following on their website:

5.1 **Community Health Needs Assessment** in accordance with the Internal Revenue Service, Annual Reporting Manual, and any other Green Mountain Care Board reporting requirements. This shall include the following:

5.1.1 A description of where and how consumers may obtain detailed information about, or a copy, of the hospital's Community Health Needs Assessment and strategic plan.

5.1.2 Contact information including, but not limited to, the telephone numbers, email addresses, fax numbers and postal addresses of the person in charge of the Community Health Needs Assessment at the hospital.

- 5.2 **Implementation Plan** which shall include a description of initiatives that the hospital is undertaking or plans to undertake to meet community health needs identified through the hospital's Community Health Needs Assessment.
- 5.3 An **Annual Progress Report** of the Implementation Plan, as described in the Annual Reporting Manual, of the proposed initiatives;
- 5.4 A summary description of the **hospital's process for achieving openness, inclusiveness and meaningful public participation** in its Community Health Needs Assessment, strategic planning, decision-making and identification of community health needs. Such description shall include:
- 5.4.1.1 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;
  - 5.4.1.2 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
  - 5.4.1.3 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;
- 5.5 **Hospital governance information including the following:**
- 5.5.1 Means of obtaining a schedule of meetings of the hospital's governing body, including times scheduled for public participation; and
  - 5.5.2 A listing of current governing body members and their qualifications, as required in 18 V.S.A. § 9405b (b) (3), including each member's:
    - 5.5.2.1 Name;
    - 5.5.2.2 Town of residence;
    - 5.5.2.3 Occupation;
    - 5.5.2.4 Employers and job title; and
    - 5.5.2.5 The amount of compensation, if any, for serving on the governing body.
    - 5.5.2.6 Contact information including, but not limited to, the telephone numbers, e-mail addresses, fax numbers and postal addresses of the person responsible for public participation at the hospital.
  - 5.5.3 The hospital's affiliation and membership with other hospital, Accountable Care Organizations (ACOs), and/or other managing entities described in the Annual Reporting Manual.

**5.6 Summary of the hospital’s consumer complaint resolution process, including but not limited to:**

- 5.6.1 A description of the complaint resolution process, including how to register a complaint;
- 5.6.2 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;
- 5.6.3 Contact information, including but not limited to telephone numbers, email addresses, fax numbers and postal addresses for Department of Disability, Aging, and Independent Living, Licensing and Protection Division in order to register a complaint against the hospital; and
- 5.6.4 Contact information for other relevant organizations as described in the Annual Reporting Manual.

**5.7 Financial Assistance Policies** as required by the Internal Revenue Service (IRS).

**6.0 Requirements for Publication on Psychiatric Hospital Websites**

Psychiatric hospitals shall post the following on their website:

- 6.1 Quality of Care measures as described in the Annual Reporting Manual;
- 6.2 Hospital financial and budget information as described in the Annual Reporting Manual;
- 6.3 Hospital pricing information following the template established in the Annual Reporting Manual and described in section 4.3 of this rule;
- 6.4 Information of hospital-acquired infections;
- 6.5 A description of the hospital’s strategic plan, identified areas of need, and strategic initiatives aimed at addressing those needs.
- 6.6 Hospital governance information as described in section 5.4 of this rule;
- 6.7 Summary of the hospital’s consumers complaint resolution process as described in section 5.5 of this rule; and
- 6.8 Financial Assistance Policies as described in the Annual Reporting Manual.

**7.0 Paper copies of reports.**

Should an individual or member of the public need a paper copy of any item listed in sections 4.0 – 7.0 of this rule, the hospital will make a paper copy available.

**8.0 Reporting by Green Mountain Care Board**

The Green Mountain Care Board shall publish reports, based on information provided by hospitals during the budget review process, which shall include:

- 8.1 Finances: Summaries of the hospitals’ 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 two years of actual results and current budget year.

- 8.2 Budgets: Summaries of the hospitals' budgets which represent two years of actual results and current budget year.
- 8.3 Cost Shift: Quantification of cost shifting from public payers to private payers for one year of actual results and current budget year.
- 8.4 Key Performance Indicators: Summaries of the hospitals' capital key performance indicators for two years of actual results and current budget year.
- 8.5 Capital Investments: Summaries of capital expenditures and plans for one to four years.

## **9.0 Process for Adding Reporting Measures**

- 9.1 The Department will consider relevant criteria in evaluation of potential measures for inclusion in the reporting manual, including but not limited to:

- 9.1.1 Reliability;
- 9.1.2 Validity;
- 9.1.3 Basis in scientific evidence;
- 9.1.4 National consensus;
- 9.1.5 Availability of relevant, reliable and valid external benchmarks;
- 9.1.6 Well-developed specifications;
- 9.1.7 Importance to consumers;
- 9.1.8 Adequacy of case numbers;
- 9.1.9 Cost of data collection; and
- 9.1.10 Importance to public health protection.

- 9.2 Measures requiring new data collection by the hospitals:

When the Department wishes to add measures to reporting requirements that require new data collection not currently required by state or federal requirements, the Department will:

- 9.2.1 Solicit input from patient safety experts, hospitals, health care professionals, consumer advocates and members of the public.
  - 9.2.1.1 The Department will convene a meeting with at least one member from each group listed in 9.2.1 of this rule.
  - 9.2.1.2 The Department will send a detailed list of the proposed measures with their specifications and the reason the measure is being proposed to the group no later than 2 weeks prior to the first meeting.
  - 9.2.1.3 If a stakeholder is unable to attend the meeting the Department will accept written comments until the close of business on the scheduled meeting day.
  - 9.2.1.4 After the conclusion of the meeting, the Department will compile the feedback from the group and respond in writing to the feedback and make any changes deemed reasonable prior to notifying hospitals of the new measures per 9.2.2 of this rule.

- 9.2.2 Notify hospitals of the new measures 180 days prior to the inception date for data collection with respect to such measures.
- 9.3 The Department will, whenever possible, use measures that are required by other measure stewards. Measures adopted by the Department from external sources are the same specifications as those of the original measures steward unless specified otherwise.
  - 9.3.1 Hospitals must adhere to reporting and submission requirements and deadlines set by the measure stewards. Specifications will be provided in the Annual Reporting Manual.
  - 9.3.2 Examples of measure stewards are: Centers for Medicare and Medicaid Services (CMS), Vermont Program for Quality in Health Care (VPQHC), National Healthcare Safety Network (NHSN), Green Mountain Care Board (GMCB), Internal Revenue Service (IRS), and Vermont Association of Hospitals and Health Systems (VAHHS).
- 9.4 Measures included in existing federal or state reporting:
  - 9.4.1 When the Department adds measures to the reporting requirements that do not require new data collection processes, the Department will notify hospitals by December 1 of the year prior to the scheduled June 1 publication date.
  - 9.4.2 The timeline for reporting the new measures will be dependent on the type of measure and will be specified in the Annual Reporting Manual.