Medical Facilities Planning

North Carolina State Health Coordinating Council
Quality, Access and Value Work Group Meeting Minutes

Thursday, April 3, 2008

10:00 am - 12:00 Noon
Council Building

MEMBERS PRESENT: Dr. Copeland, Dr. Bradley, Mr. Feezor, Ms. Lovin, Dr. McLaughlin, Dr. Silberman, Dr. Sullivan, Dr. Wallenhaupt, Dr. Bruch, Dr. Lancaster, Mr. Miller
MEMBERS ABSENT:
STAFF PRESENT: Mr. Fitzgerald, Ms. Brown, Ms. Hoffman, Ms. McClanahan, Ms. Fisk

Agenda	Discussion/Recommendations
1. Welcome & Introductory Remarks	Dr. Copeland welcomed Work Group members and guests and thanked everyone who sent in suggestions for restatement of the Basic Principles.
2. Approval of Minutes from March 6, 2008	Minutes approved unanimously.
3. Review and Discussion of Revised Basic Principles Drafts for "Quality" and "Safety"	• Dr. Copeland tasked the group with agreeing on a framework to shape the rewording of the Principles. He noted that it has been harder to apply the quality principle to the CON process due to the lack of specific measures than it has been to apply the other Principles. However, workable healthcare quality and safety measures are now emerging and the work group needs to explore ways to incorporate quality measures into the Planning and CON process. Dr. Copeland reviewed the "Elements to be Considered for Incorporation into Quality and Safety Principle(s)" handout. • Dr. Copeland raised 2 questions: 1. What elements does the group want to capture for the revised "Quality" Basic Principle? 2. Should "Safety" be a separate Principle or included with "Quality"? • Patient satisfaction identified as an element of quality and the difficulties in separating clinical outcomes and patient satisfaction were noted. In some cases, there may be a conflict between patient satisfaction and clinical outcome, e.g., it may be clinically necessary for a patient to wait before a procedure, which may lead to patient dissatisfaction. It may be necessary in some cases to set clinical outcome as a higher priority than patient satisfaction. Suggestion that good communication with patients about clinical processes is an important part of providing care and helps increase patient satisfaction. Consensus that patient satisfaction is an important element of quality care. Monitoring and measuring quality and patient satisfaction raised as an issue. Suggestion that: 1. CON applicants be required to agree to report in the future quality and patient satisfaction data related to the project for which they are applying as a condition of obtaining a CON

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	2. CON applicants providing services at the time they are applying for a CON be required to report past quality and patient satisfaction data related to the services they are currently providing. If a CON applicant is part of a joint venture, all participants with at least a 10% ownership stake in the joint venture would be required to report quality data. 3. Quality/Patient Satisfaction measures reported need to be objective, widely reported, recognized and independently verifiable. The State needs to be able to "look behind the data" and authenticate it. 4. Suggestion that the revised Quality Principle be broad in nature and not specify measures. • Question raised as to utility of a need determination based on deficient quality. Discussed time limited CONs and noted that the Agency encourages converting unused beds to a health service for which there is need. Noted problems with taking CONs away. Question – how should high and low quality providers be differentiated? Suggestion that a "quality need determination" should be generated because a need for better quality has been demonstrated. Suggestion that a provider could petition for a need determination based on a need for better quality – any services approved because of the petition would be in addition to the existing services. Identification of poor quality would be the first step in the "quality need" determination process. Would need to provide the existing poor quality provider an opportunity to improve quality. Concern raised about excess capacity created as a result of "quality need determinations". Suggestion that quality issues alone not sufficient to award another CON – should look at all factors when awarding a CON. Suggestion that if a provider falls below a defined quality threshold, another provider could petition for a need determination and the CON applicants for the need would have to agree to provide access to the same group patients receiving services from the existing provider. This type of petition would only be allowed after specified quality deficiencies had been identified. Group agreed to defer making a recommendation as to "quality need determinations". • CON applicants are currently required to adhere to a minimum standard. The current system does not address excellent providers who exceed minimum standards. Point made that minimum standards are no longer adequate. Point made that CON process should encourage better than minimal standards. • Suggestion that the Agency could request public comments on time limited CONs, quality measures and that quality standards will evolve over time. Group noted the fine line between CON and Licensure as to evaluating providers' quality. • Suggestion that CON holders must be made accountable for promises related to quality made in CON applications. Possible consequences for CON holders who do not adhere to promised made in CON application: fine or removal of time limited CON. • Noted that Licensure is statewide, whereas CONs are specific to an area – consequently need to build into the CON process a way to ensure the level of quality so that we do not lose the CON Section's intent when awarding a CON in a particular area. • Point made that quality data based on billing data is not a good measure of care quality and that currently outcomes quality data is limited. Agreement that good nursing home care quality data is available. Noted that this data did not become available until the late 1980's and that pressure should be applied to develop quality measures for other healthcare areas. Focus should be on putting a quality monitoring process in place, not on specific measures.

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	Action: Dr. Copeland, Dr. Wallenhaupt, Dr. Bradley and Ms. Lovin to draft wording for the revised "Quality" Basic Principle. Work Group will review the draft at the next meeting.
4. Preliminary Discussion of Basic Principles for "Access" and "Value"	The work group discussed the elements of Access and Value and identified the following elements for consideration: • Service to all patients in the service area • Geographic access • Insurance coverage • All feasible services available – how to define feasible • Encourage providers to reduce access disparities – how to encourage outreach • Time – some services may be available only at certain times • Availability of some services dependent on the size of the community • Point made that when there is no hospital in a county it is difficult to demonstrate need for a hospital in that county and with a small hospital it is difficult to generate the numbers necessary to show need for additional services. Agency noted that the petition process is available to remedy the issues cited. Question raised regarding backup when services made unavailable - noted that the Joint Commission has standards for backup and that CMS is getting ready to implement regulations related to disaster response. • Access for mental health services raised – noted that funding is currently the primary impediment to access to these services.
5. Next Meeting	The next meeting will be held May 14 from 1 pm to 3 pm, location to be determined.
6. Adjournment	Dr. Copeland adjourned the meeting.