

Division of Health Care Administration
**Vermont Department of Banking, Insurance,
Securities and
Health Care Administration**

**Act 53 Hospital and Health Care System
Accountability;
Hospital Community Reports**



June 1, 2010
Hospital Reporting Manual

Updated: March 12, 2010



**JUNE 2010
HOSPITAL REPORTING MANUAL**

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INTRODUCTION

Act 53 of 2003, codified as 18 V.S.A. § 9405b, requires hospitals in Vermont to produce annual hospital community reports, also known as Hospital Report Cards. In response to that legislation, a regulation is being promulgated by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to ensure that each hospital licensed in Vermont publishes for its communities and files with the Commissioner an annual report reflecting the hospital's performance in relation to quality, patient safety, hospital-acquired infections, nurse staffing, pricing and measures of financial health.

The hospitals that are required to produce the report on June 1, 2010 include: Brattleboro Memorial Hospital, Brattleboro Retreat, Central Vermont Medical Center, Copley Hospital, Fletcher Allen Health Care, Gifford Medical Center, Grace Cottage Hospital, Mt. Ascutney Hospital and Health Center, North Country Hospital, Northeastern Vermont Regional Hospital, Northwestern Medical Center, Porter Medical Center, Rutland Regional Medical Center, Southwestern Vermont Medical Center, Springfield Hospital and Vermont State Hospital.

In addition, the following facilities have been invited to voluntarily participate in the hospital community report initiative: VA Medical Center and Dartmouth-Hitchcock Medical Center.

This manual contains the mandatory reporting specifications for the June 2010 Hospital Report Cards, and a description of the approved uniform format for the reports.

The June 2010 Hospital Report Card Timelines, which contain deadlines for key deliverables, are found in **Appendix A**.

REPORTING SPECIFICATIONS

Changes to Act 53 during the 2005 legislative session now require that hospital community reports be published on each hospital's website. By June 1, 2010, each hospital is required to provide an updated menu page on its website with links to required comparative information on BISHCA's Hospital Report Card website, including quantitative measures of quality, patient safety, hospital-acquired infections, nurse staffing, patient satisfaction, financial health and pricing for selected services, as applicable to each hospital. BISHCA's website will present these measures in a format that compares the hospitals with national benchmarks, when available. BISHCA's website will also contain links to previous years' reports. Hospital-specific information, including financial information, summaries of quality improvement and patient safety initiatives, a description of hospital governance, a description of strategic initiatives and the hospital's process for openness and public participation, and a description of the

hospital's complaint process must be included on each hospital's website. The specifications for this information are found in Appendix G.

Each hospital shall conduct "one or more public hearings to permit community members to comment on the report." These public hearings must be held by September 30, 2010 and may be held in conjunction with the hospital's annual meeting. Hospitals are also required to distribute printed copies of the report to members of the public, upon request.

For each required quantitative quality measure for community hospitals in the 2010 reports, the table in **Appendix B** shows the measure, the category of the measure, the source of each measure, links to specifications, and the time period for data collection. These are the measures that will be posted on the Department's website, rather than on each hospital's individual website.

It should be noted that most of the quantitative mental health quality measures for the Brattleboro Retreat and the Vermont State Hospital are hospital-specific measures and are not found on BISHCA's website (an exception is Nurse Staffing). The 2010 measures for **Brattleboro Retreat** are found in **Appendix C-1**. The 2010 measures for the **Vermont State Hospital** report are found in **Appendix C-2**.

Appendix D contains a link to the HCAHPS® experience of care survey.

Appendix J includes the specifications for **hospital financial health and pricing** reports.

COMMON HOSPITAL MENU PAGE FORMAT

- **Common link on hospital website's home page:** Each hospital will establish a link on its website's home page, entitled "Hospital Report Card," which will connect consumers to a separate Hospital Report Card menu page within its website.
- **Common website menu page and style sheet:** The Hospital Report Card menu page will consist of a common menu template; text and layout; section headings; ordering of information; links to BISHCA's comparative reports; and links to financial health data and other hospital-specific information included on each hospital's website. The common hospital menu is specified in the style sheet for the community hospitals and the style sheets for Brattleboro Retreat and the Vermont State Hospital. The content layout for these menu pages (which are representations of the style sheets) can be found in **Appendices E and F**. The ready-to-use electronic versions of the style sheets are found on the Hospital Resource page on BISHCA's website at: <http://www.bishca.state.vt.us/health-care/hospitals-health-care-practitioners/hospital-resource-page>

While hospitals must use the applicable style sheet, each hospital may use its existing website style scheme and may also direct consumers to additional hospital-specific quality and financial information on the hospital's website, if any, that is not required by Act 53.

- **Common report title:** Hospitals must identify the report on their websites as "Hospital Report Card", and use the common logo.

ON-LINE HOSPITAL RESOURCE PAGE

The Department has established an on-line report card resource page to provide hospitals with the 2010 reporting manual, electronic style sheets and other information.

To view this information, go to: <http://www.bishca.state.vt.us/health-care/hospitals-health-care-practitioners/hospital-resource-page>

Information on the Hospital Resource Page includes:

- 2010 Hospital Reporting Manual (PDF and Word versions)
- Electronic style sheet for the common menu template for community hospitals
- Electronic style sheets for Brattleboro Retreat and the Vermont State Hospital
- Link to the Department's 2010 comparative hospital report (under construction until June 1, 2010)
- Contact information for assistance

Any future updates will be communicated to Hospital Public Relations Directors and Quality Improvement Directors via email, and added to the Hospital Resource Page.



APPENDIX A

JUNE 2010 HOSPITAL REPORT CARD TIMELINES

2010 Hospital Quality Measure Data Collection Periods

| ONGOING MEASURES | DATA COLLECTION PERIOD |
|---|--|
| AHRQ volume and mortality data: <ul style="list-style-type: none"> ▪ Esophageal Resection ▪ Pancreatic Resection ▪ Abdominal Aortic Aneurysm Repair ▪ Pediatric Heart Surgery | January 1, 2006 – December 31, 2008 |
| HCAHPS® Patient Satisfaction Survey | Rolling Year, Updated Quarterly |
| Previously Reported CMS measures for: <ul style="list-style-type: none"> ▪ Heart Attack ▪ Heart Failure ▪ Pneumonia ▪ Preventing Complications from Surgery | Rolling Year, Updated Quarterly |
| Central Line Associated Bloodstream Infection Rates | April 1, 2009 – March 31, 2010 |
| Preventing Central Line Associated Bloodstream Infections | 2010 |
| Prevention and Control of Antibiotic-Resistant Infections | 2010 |
| Nurse Staffing Data | April 1, 2009 – March 31, 2010 |
| Surgical site infection rates for: <ul style="list-style-type: none"> ▪ Abdominal Hysterectomy ▪ Hip Replacement ▪ Knee Replacement | April 1, 2009 – March 31, 2010 Oct. 1, 2008 – Sept. 30, 2009 Oct. 1, 2008 – Sept. 30, 2009 |
| NEW MEASURES | DATA COLLECTION PERIOD |
| CMS Readmission Rates for: <ul style="list-style-type: none"> ▪ Heart Attack ▪ Heart Failure ▪ Pneumonia | July 1, 2005 – June 30, 2008 |
| CMS Mortality Rates for: <ul style="list-style-type: none"> ▪ Heart Attack ▪ Heart Failure ▪ Pneumonia | July 1, 2005 – June 30, 2008 |
| AHRQ Mortality Rates for: <ul style="list-style-type: none"> ▪ Heart Attack ▪ Heart Failure ▪ Pneumonia ▪ Acute Stroke ▪ Hip Fracture | January 1, 2006 – December 31, 2008 |

2010 Public Reporting Timetable

| | |
|---------------------------------|--|
| <p>March 15</p> | <ul style="list-style-type: none"> • BISHCA releases 2010 Hospital Reporting Manual and Electronic Style Sheets. • BISHCA sends financial tables to hospitals for review and comment: <ul style="list-style-type: none"> ▪ Blank hospital CPT pricing template for physicians ▪ CPT pricing template for completion • BISHCA sends hospital inpatient and outpatient pricing tables to hospitals for review. |
| <p>April 1</p> | <p>Hospitals send completed Central Line Infection Prevention Form and Multi-drug Resistant Organism Infection Prevention Form to VPQHC.</p> |
| <p>April 17</p> | <ul style="list-style-type: none"> • Hospitals send comments to BISHCA on the following: <ul style="list-style-type: none"> ▪ Financial tables ▪ Hospital inpatient and outpatient pricing review comments ▪ Completed hospital CPT pricing template and physician CPT pricing template • BISHCA sends CMS and AHRQ volume, mortality and readmission data to hospitals for review and comment. • VPQHC sends formatted reports to BISHCA for review and comment regarding: <ul style="list-style-type: none"> ▪ Central Line Infection Prevention ▪ Multi-drug Resistant Organism Prevention & Control. |
| <p>May 1</p> | <ul style="list-style-type: none"> • Vermont State Hospital sends all quality information to BISHCA for review. • Brattleboro Retreat sends all quality information to BISHCA for review. |
| <p>May 4</p> | <ul style="list-style-type: none"> • Hospitals send comments to BISHCA on CMS and AHRQ volume, mortality and readmission data. • BISHCA sends final financial data and pricing tables to hospitals. • VPQHC sends final reports to BISHCA on nurse staffing, central line infection rates and surgical site infection rates. |
| <p>May 15</p> | <ul style="list-style-type: none"> • All final data and text must be sent to BISHCA. • QIO updates quarterly CMS data onto BISHCA website. • BISHCA updates patient satisfaction data to website. |
| <p>June 1</p> | <ul style="list-style-type: none"> • Reports published on all hospital websites. • Comparative report published on BISHCA's website. |
| <p>June 1 – Sept. 30</p> | <p>Hospitals schedule public meetings to discuss Hospital Report Cards within their communities.</p> |

APPENDIX B

2010 QUALITY OF CARE MEASURES

★Denotes new measure for 2010 report

| Measure | Category | Source of Measure | Measurement Specification | Time Period |
|--|-------------------|--|---|------------------------------|
| CMS AMI aspirin at arrival | Quality (Process) | Centers for Medicare & Medicaid Services (CMS) | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI aspirin at discharge | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI ACE inhibitor at discharge | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI Beta Blocker at arrival | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI Beta Blocker at discharge | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI smoking cessation | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI thrombolytic agent within 30 minutes | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI PCI within 120 minutes | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS AMI 30-day mortality | Quality (Outcome) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | July 2005 – June 2008 |
| ★CMS AMI 30-day readmission | Quality (Outcome) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | July 2005 – June 2008 |
| CMS CHF left ventricular function assessment | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS CHF discharge instructions | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS CHF ACE inhibitor | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS CHF smoking cessation | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| ★CMS CHF 30-day mortality | Quality (Outcome) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | July 2005 – June 2008 |

| Measure | Category | Source of Measure | Measurement Specification | Time Period |
|--|-------------------|-------------------|---|------------------------------|
| ★ CMS CHF 30-day readmission | Quality (Outcome) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | July 2005 – June 2008 |
| CMS pneumonia vaccination | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS pneumonia timely antibiotic | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS pneumonia blood culture | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS pneumonia smoking cessation | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS pneumonia initial antibiotic selection within 6 hours of arrival | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS pneumonia influenza vaccination | Quality (Process) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS pneumonia 30-day mortality | Quality (Outcome) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | July 2005 – June 2008 |
| ★ CMS pneumonia 30-day readmission | Quality (Outcome) | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | July 2005 – June 2008 |
| CMS SCIP antibiotic timing | Patient Safety | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS SCIP appropriate antibiotic | Patient Safety | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS SCIP antibiotics discontinued | Patient Safety | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS SCIP venous thromboembolism prevention ordered | Patient Safety | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS SCIP venous thromboembolism prevention provided w/in 24 hours pre/post surgery | Patient Safety | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| CMS SCIP appropriate hair removal for surgery patients | Patient Safety | CMS | www.qualityindicators.ahrq.gov/iqi_overview.htm | January 2009 – December 2009 |

| Measure | Category | Source of Measure | Measurement Specification | Time Period |
|---|---------------------------------|--|---|-------------------------------------|
| CMS SCIP cardiac surgery patients with controlled 6am postoperative serum glucose | Patient Safety | CMS | https://www.qualitynet.org/qmis/browseMeasuresMoreResults.htm?id=810 | January 2009 – December 2009 |
| Central Line Associated Bloodstream Infection (CLABSI) Rates | Health Care Acquired Infections | Centers for Disease Control and Prevention National Healthcare Safety Network | http://www.cdc.gov/nhsn/ | April 2009 – March 2010 |
| Preventing Central Line Associated Bloodstream Infections | Health Care Acquired Infections | Reporting Form developed by Infection Reporting Subcommittee, based on IHI bundle | See Appendix H | Form due April 1, 2010 |
| Surgical Site Infection Rates – abdominal hysterectomy | Health Care Acquired Infections | Centers for Disease Control and Prevention National Healthcare Safety Network | http://www.cdc.gov/nhsn/ | April 2009 – March 2010 |
| Surgical Site Infection Rate – hip replacement | Health Care Acquired Infections | Centers for Disease Control and Prevention National Healthcare Safety Network | http://www.cdc.gov/nhsn/ | October 2008 – September 2009 |
| Surgical Site Infection Rate – knee replacement | Health Care Acquired Infections | Centers for Disease Control and Prevention National Healthcare Safety Network | http://www.cdc.gov/nhsn/ | October 2008 – September 2009 |
| Multidrug-Resistant Organism Prevention and Control | Health Care Acquired Infections | Reporting Form developed by Infection Reporting Subcommittee, based on CDC recommendations | See Appendix I | Form due April 1, 2010 |
| Nursing care hours per patient day | Nurse Staffing | NDNQI and NQF | Nursing care hours per patient days –see Technical Guide on the BISHCA website | April 2009 – March 2010 |
| HCAHPS Inpatient Experience of Care Data | Quality (Outcome) | HCAHPS Survey | See Appendix D | October 1 2008 – September 30, 2009 |
| Volume of esophageal resections | Quality (Process) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| Post-procedural mortality rates for esophageal resections | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| Volume of pancreatic resections | Quality (Process) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |

| Measure | Category | Source of Measure | Measurement Specification | Time Period |
|---|-------------------|-----------------------------------|--|--------------------------|
| Post-procedural mortality rates for pancreatic resections | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| Volume of pediatric heart surgeries | Quality (Process) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| Post-procedural mortality rates for pediatric heart surgeries | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| Volume of abdominal aortic aneurysm repairs | Quality (Process) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| Post-procedural mortality rates for abdominal aortic aneurysm repairs | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| ★ Mortality during inpatient stay for heart attack | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| ★ Mortality during inpatient stay for heart failure | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| ★ Mortality during inpatient stay for pneumonia | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| ★ Mortality during inpatient stay for hip fracture | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |
| ★ Mortality during inpatient stay for acute stroke | Quality (Outcome) | AHRQ Inpatient Quality Indicators | www.qualityindicators.ahrq.gov/iqi_overview.htm | Calendar Years 2006-2008 |

APPENDIX C-1
2010 QUALITY MEASURES FOR BRATTLEBORO RETREAT

| Measure | Source | Measurement period |
|---|--|--|
| Patient Perceptions of Care Measures <ul style="list-style-type: none"> • Would you recommend the hospital? • Overall hospital rating of care • How much were you helped by the care? • Risks/benefits of medications • Information about rights • Involved in decisions about your care • Know treatment plan for after you leave | Brattleboro Retreat Adult patient Perceptions of Care Survey | Calendar Year 2009 |
| Chart Audit Measures <ul style="list-style-type: none"> • Pain assessment • Physical exam complete prior to methadone administration • Initial treatment plan within 24 hours • Lab results in medical record for methadone | Brattleboro Retreat adult chart audits | Calendar Year 2009 |
| Joint Commission Measures <ul style="list-style-type: none"> • Admission screening • Physical restraint • Seclusion • Multiple antipsychotic medications at discharge • Multiple antipsychotic medications without appropriate justification • Post discharge continuing care plan completed • Post discharge continuing care plan transmitted within 7 days to next provider | JCAHO/HBIPS <ul style="list-style-type: none"> • HBIPS – 1a • HBIPS – 2a • HBIPS – 3a • HBIPS – 4a • HBIPS – 5a • HBIPS – 6a • HBIPS – 7a | Calendar Year 2009 |
| Other <ul style="list-style-type: none"> • NDNQI/NQF Nursing Care Hours Per Patient Day • Nosocomial Infection Rates • Adult Inpatient Falls | <ul style="list-style-type: none"> • NDNQI Specifications • Brattleboro Retreat • Brattleboro Retreat | <ul style="list-style-type: none"> • April 1, 2009 – March 31, 2010 • Calendar Year 2009 • Calendar Year 2009 |

APPENDIX C-2
2010 QUALITY MEASURES FOR THE VERMONT STATE HOSPITAL

| Measure | Source | Measurement Period |
|--|----------------------|-------------------------------------|
| Readmission and other inpatient Mental Health Performance Indicators | PIP/DMH | January 1, 2009 - December 31, 2009 |
| Patient Falls | VSH | January 1, 2009 - December 31, 2009 |
| Nosocomial Infection Rates | VSH | January 1, 2009 - December 31, 2009 |
| Treatment Planning | VSH | January 1, 2009 - December 31, 2009 |
| Discharge Planning (4 components) | VSH | January 1, 2009 - December 31, 2009 |
| NDNQI/NQF Nursing Care Hours Per Patient Day | NDNQI specifications | April 1, 2009 - March 31, 2010 |
| Admission Screening | JCAHO/ HBIPS-1a | January 1, 2009 - December 31, 2009 |
| Post-Discharge Continuing Care Plans Created | JCAHO/ HBIPS-6a | January 1, 2009 - December 31, 2009 |
| Post-Discharge Continuing Care Plan Transmitted to Next Provider | JCAHO/ HBIPS-7a | January 1, 2009 - December 31, 2009 |

- Patient feedback will be discussed in narrative description of Patient Advisory Council efforts to increase patient involvement.
- Seclusion and restraint will be discussed in quality improvement project narrative description.

APPENDIX D

HCAHPS HOSPITAL EXPERIENCE OF CARE SURVEY

Hospitals should use the latest version of the HCAHPS hospital survey being fielded by CMS.

For more information about the HCAHPS survey or a copy of the survey, go to:
<http://www.hcahponline.org/surveyinstrument.aspx>

APPENDIX E

2010 WEBSITE STYLE SHEET FOR COMMUNITY HOSPITALS

This year the Department is providing an electronic style sheet for the report card menu template for use on hospital websites.

To download the electronic style sheet files for use on hospital websites, go to BISHCA's Hospital Resource Page: <http://www.bishca.state.vt.us/health-care/hospitals-health-care-practitioners/hospital-resource-page>. Hospitals should create their own links to connect to internal hospital website pages when they see "dummy" links in the style sheet.

Hospitals may change the elements of the style sheet that are necessary for consistency with their own website systems, including font, font size, graphics, color, pixel size, navigation elements, and "skins," but may not change the menu text, format or report logo.

Please note: the style sheet contains three (3) optional links for use by hospitals to provide additional information other than that required by Act 53. **Make sure to remove the optional links from your website menu page if your hospital will not be providing additional information in any of these report categories on its website.**

A representation of the style sheet is shown on the following pages, including links showing connections to either BISHCA's report card website or to web pages within each hospital's website. Where noted, hospitals should connect the link to an internal report card web page in their hospital's website.

COMMON HOSPITAL WEBSITE STYLE SHEET



This report provides comparative data about Vermont hospital quality, patient satisfaction, pricing and financial information. In addition, it provides information about **[INSERT HOSPITAL'S NAME]** quality improvement initiatives, strategic initiatives, governance and process for filing a complaint. To view this information, click on any of the topics below.

INFORMATION ABOUT INFECTIONS AND SURGERIES

See information about the following [Infection Rates and Surgeries](#):

Knee Replacement Infection Rates

Hip Replacement Infection Rates

Abdominal Hysterectomy Infection Rates

Central Line Associated Bloodstream Infections

- Central Line Infection Rates
- Preventing Central Line Infections

Antibiotic-Resistant Infection Prevention and Control

Preventing Complications from Surgery

Volume and Mortality Rates for Certain Surgeries

- Abdominal Aortic Aneurysm Repair
- Esophageal Resection
- Pancreatic Resection
- Pediatric Heart Surgery

INFORMATION ABOUT HEALTH CARE CONDITIONS

See information about [Hospital Treatment, Readmissions and Mortality Rates](#) for the following conditions:

Heart Attack

Heart Failure

Pneumonia

Stroke

Hip Fracture

NURSE STAFFING INFORMATION

See information about [Nursing Care Hours](#) per patient day.

PATIENT SATISFACTION INFORMATION

See [Vermont Hospital Results](#) from a national survey of how hospital patients rated their experiences during recent inpatient stays.

ADDITIONAL QUALITY INFORMATION

See more information about **Patient Satisfaction** at this hospital. **THIS IS AN OPTIONAL LINK TO INTERNAL HOSPITAL WEB PAGES. REMOVE THIS BULLET IF THE HOSPITAL IS NOT PROVIDING ADDITIONAL INFORMATION ON ITS WEBSITE.**

See more information about **Quality of Care** at this hospital. **THIS IS AN OPTIONAL LINK TO INTERNAL HOSPITAL WEB PAGES. REMOVE THIS BULLET IF THE HOSPITAL IS NOT PROVIDING ADDITIONAL INFORMATION ON ITS WEBSITE.**

REMOVE THIS MENU CATEGORY IF THE HOSPITAL IS NOT PROVIDING ADDITIONAL PATIENT SATISFACTION OR QUALITY OF CARE INFORMATION ON ITS WEBSITE.

PRICING AND FINANCIAL INFORMATION

Pricing Information

- 2009 Hospital Charges for High Volume Inpatient Admissions
- 2009 Hospital Charges for High Volume Outpatient Procedures
- 2010 Physician and Hospital Charges for Common Outpatient Diagnostic Procedures and Visits

Financial Information

- Budget Summary
- Financial Information and Benchmarks
- Cost Shift Information
- Capital Expenditure Information
- Additional Hospital-Specific Financial Information **THIS IS AN OPTIONAL LINK TO INTERNAL HOSPITAL WEB PAGES. REMOVE THIS BULLET IF THE HOSPITAL IS NOT PROVIDING ADDITIONAL INFORMATION ON ITS WEBSITE.**

Hospital Discount and Free Care Policy

Additional Information

- Comparative Pricing and Financial Information for All Vermont Community Hospitals
- Discount and Free Care Policies for All Vermont Hospitals

QUALITY IMPROVEMENT AND PATIENT SAFETY INITIATIVES

Read about [Quality Improvement Projects](#) we have undertaken to make patient care safer and more effective.

STRATEGIC INITIATIVES

Read about [Strategic Initiatives](#) to meet health care needs in our community and opportunities for public participation in strategic planning.

HOSPITAL GOVERNANCE

Read about [Hospital Governance](#), including our public meeting schedule and contact information.

FILING A COMPLAINT

Read about the [Hospital Complaint Process](#).

[Prior Years Hospital Report Cards](#)

APPENDIX F

2010 WEBSITE STYLE SHEETS FOR BRATTLEBORO RETREAT AND THE VERMONT STATE HOSPITAL

This year the Department is providing electronic style sheets for the report card menu template for use on hospital websites.

To download the electronic style sheets for use on hospital websites, go to BISHCA's Hospital Resource Page: <http://www.bishca.state.vt.us/health-care/hospitals-health-care-practitioners/hospital-resource-page>. Hospitals should create their own links to connect to internal hospital website pages when they see "dummy" links in the style sheet.

Hospitals may change the elements of the style sheet that are necessary for consistency with their own website systems, including font size, graphics, color, pixel size, navigation elements, and "skins," but may not change the menu text, format or report logo.

Representations of the style sheets for the Brattleboro Retreat and the Vermont State Hospital are shown on the following pages. Where noted, hospitals should connect the link to an internal report card web page in their hospital's website.

APPENDIX F-1

MENU PAGE TEMPLATE FOR BRATTLEBORO RETREAT



This report provides data about Brattleboro Retreat's quality of care, nurse staffing, patient perceptions of care, pricing and financial health. In addition, it provides information about the hospital's quality improvement initiatives, strategic initiatives, governance and process for filing a complaint. To view this information, click on any of the topics below.

QUALITY OF CARE INFORMATION

[Patient Safety](#) - See information about Patient Falls, Physical Restraint, Seclusion, and Multiple Antipsychotic Medications.

[Screening and Assessment](#) - See information about Admission Screening and Pain Assessment.

[Care Planning](#) - See information about Treatment Planning, Discharge Planning, and Post-Discharge Continuing Care Plans.

[Methadone Treatment](#) - See information about Physical Exams and Lab Results for Methadone Treatment.

[Infection Rates](#) - See information about Hospital-Acquired Infections.

NURSE STAFFING INFORMATION

See information about [Nursing Care Hours](#) per patient day.

PATIENT PERCEPTIONS OF CARE

See results from a [Hospital Survey](#) of how patients rated their experiences during recent inpatient stays.

PRICING AND FINANCIAL INFORMATION

[Pricing and Financial Information](#)

- 2009 Hospital Charges for High Volume Inpatient Admissions
- 2009 Hospital Charges for High Volume Outpatient Visits
- Budget Summary
- Financial Information and Benchmarks
- Cost Shift Information
- Capital Expenditure Information

[Hospital Discount and Free Care Policy](#)

[Additional Information](#)

- Comparative Pricing and Financial Information for All Vermont Community Hospitals
- Discount and Free Care Policies for All Vermont Hospitals

QUALITY IMPROVEMENT AND PATIENT SAFETY INITIATIVES

Read about [Quality Improvement Projects](#) we have undertaken to make patient care safer and more effective.

STRATEGIC INITIATIVES

Read about [Strategic Initiatives](#) to meet health care needs in our community and opportunities for public participation in strategic planning.

HOSPITAL GOVERNANCE

Read about [Hospital Governance](#), including our public meeting schedule and contact information.

FILING A COMPLAINT

Read about the [Hospital Complaint Process](#).

[Last Year's Report Card for Brattleboro Retreat](#)

[Current and Prior Year Report Cards for Other Vermont Hospitals](#)

APPENDIX F-2

MENU PAGE TEMPLATE FOR VERMONT STATE HOSPITAL



This report provides data about Vermont State Hospital's quality of care, nurse staffing, pricing and financial health. In addition, it provides information about the hospital's opportunities for patient involvement, quality improvement initiatives, strategic initiatives, governance and process for filing a complaint. To view this information, click on any of the topics below.

QUALITY OF CARE INFORMATION

[Patient Safety](#) - See information about Patient Falls.

[Screening and Assessment](#) - See information about Admission Screening.

[Care Planning](#) - See information about Treatment Planning, Discharge Planning, and Post-Discharge Continuing Care Plans.

[Infection Rates](#) - See information about Hospital-Acquired Infections.

[Readmission and Other Inpatient Mental Health Performance Indicators](#) - See information about Readmission Rates and other characteristics of inpatient care.

NURSE STAFFING INFORMATION

See information about [Nursing Care Hours](#) per Patient Day.

PATIENT INVOLVEMENT

See [Patient Feedback](#) about the Patient Advisory Council's efforts to increase patient involvement.

PRICING AND FINANCIAL INFORMATION

[Pricing and Financial Information](#)

- 2010 Hospital Daily Charge
- Budget Summary
- Financial Information and Benchmarks
- Cost Shift Information
- Capital Expenditure Information

[Hospital Discount and Free Care Policy](#)

[Additional Information](#)

- Comparative Pricing and Financial Information for All Vermont Community Hospitals
- Discount and Free Care Policies for All Vermont Hospitals

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Read about [Hospital Governance](#), including our public meeting schedule and contact information.

FILING A COMPLAINT

Read about the [Hospital Complaint Process](#).

[Last Year's Report Card for the Vermont State Hospital](#)

[Current and Prior Year Report Cards for Other Vermont Hospitals](#)



APPENDIX G

SPECIFICATIONS FOR REQUIRED HOSPITAL-SPECIFIC INFORMATION

Note: Please be sure to write this information so that it is easily understood by consumers.

QUALITY IMPROVEMENT AND PATIENT SAFETY INITIATIVES

The hospital community report shall provide descriptions of new quality improvement and patient safety projects, or quality improvement or patient safety projects that have had significant activity with reportable milestones and/or results within the past 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)
 - 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.

STRATEGIC INITIATIVES AND PROCESS FOR PUBLIC PARTICIPATION

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 call 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) above in previous community reports should be updated annually, as changes occur and as the hospital service area's identified needs change; 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.

DESCRIPTION OF HOSPITAL GOVERNANCE

Each hospital 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. Schedule of governing body meetings including times that the meetings are open for public access and public comment, if available at the time of report publication; and
4. Contact information, including but not limited to the hospital department, telephone numbers, e-mail addresses, fax numbers, and postal addresses for more information, including schedules and agendas of meetings, and how to obtain a copy of the hospital's annual report.

DESCRIPTION OF HOSPITAL COMPLAINT PROCESS

The hospital community report shall describe the hospital's consumer complaint resolution process, including but not limited to:

1. A description of the complaint 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 officer or employee responsible for implementation of the 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 to register complaints against hospitals.



APPENDIX H

CENTRAL LINE INFECTION PREVENTION REPORTING FORM

Report Year: _____ Hospital Name: _____

CENTRAL LINE INFECTION PREVENTION

Please answer the following (if additional space is needed, please use the back of this form or a separate sheet of paper):

1. Does the hospital promote the implementation of the five components of care comprising the Institute for Healthcare Improvement’s (IHI) Central Line Infection prevention bundle?

“This is not intended to be a comprehensive list of all elements of care related to central lines; rather, the bundle approach to a small group of interventions promotes teamwork and collaboration.”

<http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=2>

| | |
|--|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Hand Hygiene |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Maximal barrier precautions |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Chlorhexidine skin antisepsis |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Daily review of line necessity, with prompt removal of unnecessary lines |

2. How do applicable staff train and maintain knowledge of current best practice with Central Line insertion and care? (Please give a brief description of educational programs including educational materials; and how the hospital ensures that the appropriate staff received the training during past year.)

3. How does your hospital ensure compliance with the central line infection prevention bundle? (For example, does your hospital use a central line infection prevention checklist, such as the Institute for Healthcare Improvement’s “Central Line Insertion Bundle Checklist”? Does your hospital have a monitoring plan, policy or procedure? Please give a brief description including supporting materials.)

4. How do applicable staff train and maintain knowledge of current best practice with Central Line insertion and care? (Please give a brief description of educational programs including educational materials; and how the hospital ensures that the appropriate staff received the training during past year.)

-
-
5. **How does your hospital ensure compliance with the central line infection prevention bundle?** *(For example, does your hospital use a central line infection prevention checklist, such as the Institute for Healthcare Improvement's "Central Line Insertion Bundle Checklist"? Does your hospital have a monitoring plan, policy or procedure? Please give a brief description including supporting materials.)*

(Chief of Surgery/Chief Quality Officer)

(Please Print Your Name Here)

(Date) _____

(Infection Control Practitioner)

(Please Print Your Name Here)

(Date) _____

Telephone number: _____ E-mail: _____

Completed form should be sent to the Vermont Program for Quality in Health Care, Inc. 132 Main Street, PO Box 1356, Montpelier, VT 05601, **no later than April 1 of each year.**



APPENDIX I

MULTIDRUG-RESISTANT ORGANISM PREVENTION REPORTING FORM

Prevention and Control of Multidrug-Resistant Organisms (MDROs)

“The prevention and control of MDROs is a national priority – one that requires that all healthcare facilities and agencies assume responsibility. The following recommendations are provided to guide the implementation of strategies and practices to prevent the transmission of MRSA, VRE, and other MDROs.” -- Jane D. Siegel, MD; Emily Rhinehart, RN, MPH, CIC; Marguerite Jackson, PhD; Linda Chiarello, RN, MS; the Healthcare Infection Control Practices Advisory Committee (HICPAC), “Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006,” Centers for Disease Control and Prevention (CDC). For more information about these recommendations click on:

<http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf>

1. Does the hospital comply with the following “Category I (A/B/C) of Tier 1” CDC recommendations for the prevention and control of MDROs? From the menu presented below, please check “yes” or “no” for each recommendation.

ADMINISTRATIVE MEASURES/ADHERENCE MONITORING

| | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital makes MDRO prevention and control an organizational patient safety priority. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital provides administrative support, and both fiscal and human resources, to prevent and control MDRO transmission within the healthcare organization. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital has implemented systems to communicate information about reportable MDROs to administrative personnel and as required by state/local health authorities. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital has implemented a multi-disciplinary process to monitor and improve health care personnel (HCP) adherence to recommended practices for Standard and Contact Precautions. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital has implemented systems to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving healthcare facilities and personnel prior to transfer of such patients within or between facilities. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital supports participation of the facility or healthcare system in local, regional and/or national coalitions to combat emerging or growing MDRO problems. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital provides updated feedback at least annually to healthcare providers and administrators on facility and patient-care-unit trends in MDRO infections, including information on changes in prevalence and incidence of infection, results of assessments for system failures, and action plans to improve adherence to and effectiveness of recommended infection control practices to prevent MDRO transmission. |

MDRO EDUCATION

| | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital provides education and training on risks and prevention of MDRO transmission during orientation and periodic educational updates for health care personnel. This includes information on organizational experience with MDROs and prevention strategies. |
|--|---|

JUDICIOUS ANTIMICROBIAL USE

| | |
|--|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital ensures that a multi-disciplinary process is in place to review antimicrobial utilization, local susceptibility patterns (antibiograms), and antimicrobial agents included in the formulary to foster appropriate antimicrobial use. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital implements systems (e.g. – computerized physician order entry, comment in microbiology susceptibility report, notification from a clinical pharmacist or unit director) to prompt clinicians to use the appropriate antimicrobial agent and regimen for the given clinical situation. |

| | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital provides clinicians with antimicrobial susceptibility reports and analysis of current trends, updated at least annually, to guide antimicrobial prescribing practices. |
|--|---|

SURVEILLANCE

| | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital uses standardized laboratory methods and follows published guidelines for determining antimicrobial susceptibilities of targeted (e.g., MRSA, VRE, MDR-ESBLs) and emerging (e.g., VRSA, MDR- <i>Acinetobacter baumannii</i>) MDROs. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital has established systems to ensure that clinical microbiology laboratories (in-house and outsourced) promptly notify infection control staff or a medical director/designee when a novel resistance pattern for that facility is detected. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital has developed and implemented laboratory protocols for storing isolates of selected MDROs for molecular typing when needed to confirm transmission or delineate epidemiology of the MDRO within the healthcare setting. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital prepares facility-specific antimicrobial susceptibility reports as recommended by the Clinical and Laboratory Standards Institute (CLSI) [www.phppo.cdc.gov/dls/master/default.aspx]; and monitors these reports for evidence of changing resistance patterns that may indicate the emergence or transmission of MDROs. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital with special-care units (e.g. ventilator-dependent units, ICUs, oncology units) develops and monitors unit-specific antimicrobial susceptibility reports. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital establishes a frequency for preparing summary reports based on volume of clinical isolates, with updates at least annually. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital monitors trends in incidence of target MDROs in the facility over time using appropriate statistical methods to determine whether MDRO rates are decreasing and whether additional interventions are needed. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital specifies isolate origin (i.e., location and clinical service) in MDRO monitoring protocols in hospitals and other large multi-unit facilities with high-risk patients. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital has established a baseline (e.g., incidence) for targeted MDRO isolates by reviewing results of clinical cultures; if more timely or localized information is needed, it performs baseline point prevalence studies of colonization in high-risk units. When possible, the hospital distinguishes colonization from infection in analysis of these data. |

INFECTION CONTROL PRECAUTIONS TO PREVENT TRANSMISSION OF MDROs

| | |
|--|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital follows Standard Precautions during all patient encounters in all settings in which healthcare is delivered. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital uses masks according to Standard Precautions when performing splash generating procedures (e.g., wound irrigation, oral suctioning, intubation); when caring for patients with open tracheostomies and the potential for projectile secretions; and in circumstances where there is evidence of transmission from heavily colonized sources (e.g., burn wounds). Masks are not otherwise recommended for prevention of MDRO transmission from patients to healthcare personnel during routine care (e.g., upon room entry). |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital implements Contact Precautions routinely for all patients infected with target MDROs and for patients that have been previously identified as being colonized with target MDROs (e.g., patients transferred from other units or facilities who are known to be colonized). |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | In hemodialysis units, the hospital follows the “Recommendations to Prevent Transmission of Infections in Chronic Hemodialysis Patients” [www.cms.hhs.gov/home/regsguidance.asp]. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | When single-patient rooms are available, the hospital assigns priority for these rooms to patients with known or suspected MDRO colonization or infection. Highest priority is given |

| | |
|--|--|
| | to those patients who have conditions that may facilitate transmission (e.g., uncontained secretions or excretions). |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | When single-patient rooms are not available, the hospital cohorts patients with the same MDRO in the same room or patient-care area. |

ENVIRONMENTAL MEASURES

| | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital cleans and disinfects surfaces and equipment that may be contaminated with pathogens, including those that are in close proximity to the patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in patient care environment (e.g., door knobs, surfaces in and surrounding toilets in patients' rooms) on a more frequent schedule compared to that for minimal touch surfaces (e.g., horizontal surfaces in waiting rooms). |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital dedicates non-critical medical items to use on individual patients known to be infected or colonized with MDROs. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | The hospital prioritizes room cleaning of patients on Contact Precautions, focusing on cleaning and disinfecting frequently touched surfaces (e.g. bedrails, bedside commodes, bathroom fixtures in the patient's room, doorknobs) and equipment in immediate vicinity of patient. |

Please describe other strategies and practices your hospital implements to prevent the transmission of MRSA, VRE, and other MDROs (attach additional page, if needed):

2. Does the hospital have a policy or protocol to implement one or more of CDC's Tier 2 Recommendations for intensified MDRO control efforts when 1) the incidence or prevalence of healthcare associated MDROs are not decreasing despite the use of routine control measures; or 2) the *first* case or outbreak of an epidemiologically important healthcare associated MDRO (e.g., VRE, MRSA, VISA, VRSA, MDR-GNB) is identified within a healthcare facility or unit?

YES NO

Have you had to implement Tier 2 interventions?

YES NO

If Yes, please check the interventions your hospital has used within the past year to reduce transmission of MDROs:

ADMINISTRATIVE MEASURES

| | |
|--------------------------|---|
| <input type="checkbox"/> | The hospital identifies persons with experience in infection control and the epidemiology of MDRO, either in house or through outside consultation, for assessment of the local MDRO problem and for the design, implementation, and evaluation of appropriate control measures. |
| <input type="checkbox"/> | The hospital provides necessary leadership, funding, and day-to-day oversight to implement interventions selected. The hospital involves the governing body and leadership of the healthcare facility or system that have organizational responsibility for this and other infection control efforts. |
| <input type="checkbox"/> | The hospital evaluates healthcare system factors for their role in creating or perpetuating transmission of MDROs, including: staffing levels, education and training, availability of consumable and durable resources, communication processes, policies and procedures, and |

| | |
|--------------------------|--|
| | adherence to recommended infection control measures (e.g., hand hygiene and Standard or Contact Precautions). The hospital develops, implements, and monitors action plans to correct system failures. |
| <input type="checkbox"/> | During the process, the hospital updates healthcare providers and administrators on the progress and effectiveness of the intensified interventions. The hospital includes information on changes in prevalence, rates of infection and colonization; results of assessments and corrective actions for system failures; degrees of adherence to recommended practices; and action plans to improve adherence to recommended infection control practices to prevent MDRO transmission. |

EDUCATIONAL INTERVENTIONS

| | |
|--------------------------|---|
| <input type="checkbox"/> | The hospital intensifies the frequency of MDRO educational programs for healthcare personnel, especially those who work in areas in which MDRO rates are not decreasing. The hospital provides individual or unit-specific feedback when available. |
|--------------------------|---|

JUDICIOUS ANTIMICROBIAL USE

| | |
|--------------------------|--|
| <input type="checkbox"/> | The hospital reviews the role of antimicrobial use in perpetuating the MDRO problem targeted for intensified intervention. The hospital controls and improves antimicrobial use as indicated. Antimicrobial agents that may be targeted include vancomycin, third-generation cephalosporins, and anti-anaerobic agents for VRE; third-generation cephalosporins for ESBLs; and quinolones and carbapenems. |
|--------------------------|--|

SURVEILLANCE

| | |
|--------------------------|---|
| <input type="checkbox"/> | The hospital calculates and analyzes prevalence and incidence rates of targeted MDRO infection and colonization in populations at risk; when possible, distinguishes colonization from infection. |
| <input type="checkbox"/> | The hospital develops and implements protocols to obtain active surveillance cultures (ASC) for targeted MDROs from patients in populations at risk (e.g., patients in intensive care, burn, bone marrow/stem cell transplant, and oncology units; patients transferred from facilities known to have high MDRO prevalence rates; roommates of colonized or infected persons; and patients known to have been previously infected or colonized with an MDRO). |
| <input type="checkbox"/> | The hospital obtains ASC from areas of skin breakdown and draining wounds. In addition, the hospital includes the following sites according to target MDROs: <ul style="list-style-type: none"> • For MRSA, sampling the anterior nares is usually sufficient; throat, endotracheal tube aspirate, percutaneous gastrostomy sites, and perirectal or perineal cultures may be added to increase the yield. Swabs from several sites may be placed in the same selective broth tube prior to transport. • For VRE, stool, rectal, or perirectal samples should be collected. • For MDR-GNB, endotracheal tube aspirates or sputum should be cultured if a respiratory tract reservoir is suspected (e.g., <i>Acinetobacter</i> spp., <i>Burkholderia</i> spp.). |
| <input type="checkbox"/> | The hospital obtains surveillance cultures for the target MDRO from patients at the time of admission to high-risk areas, e.g., ICUs, and at periodic intervals as needed to assess MDRO transmission. |
| <input type="checkbox"/> | The hospital conducts serial (e.g., weekly, until transmission has ceased and then decreasing frequency) unit-specific point prevalence culture surveys of the target MDRO to determine if transmission has decreased or ceased. |
| <input type="checkbox"/> | The hospital repeats point-prevalence culture surveys at routine intervals or at time of patient discharge or transfer until transmission has ceased. |
| <input type="checkbox"/> | If indicated by assessment of the MDRO problem, the hospital collects cultures to assess the colonization status of roommates and other patients with substantial exposure to patients with known MDRO infection or colonization. |

| | |
|--------------------------|---|
| <input type="checkbox"/> | The hospital obtains cultures of healthcare personnel for target MDRO when there is epidemiologic evidence implicating the healthcare staff member as a source of ongoing transmission. |
|--------------------------|---|

ENHANCED INFECTION CONTROL PRECAUTIONS

| | |
|--------------------------|--|
| <input type="checkbox"/> | The hospital implements Contact Precautions routinely for all patients colonized or infected with a target MDRO. |
| <input type="checkbox"/> | The hospital staff dons gowns and gloves before or upon entry to the patient's room or cubicle, because environmental surfaces and medical equipment, especially those in close proximity to the patient, may be contaminated. |
| <input type="checkbox"/> | The hospital implements Contact Precautions until the surveillance culture is reported negative for the target MDRO, when ASC are obtained as part of an intensified MDRO control program. |
| <input type="checkbox"/> | The hospital implements policies for patient admission and placement as needed to prevent transmission of a problem MDRO. |
| <input type="checkbox"/> | The hospital places MDRO patients in single-patient rooms. |
| <input type="checkbox"/> | The hospital cohorts patients with the same MDRO in designated areas (e.g., rooms, bays, patient care areas) |
| <input type="checkbox"/> | The hospital assigns dedicated nursing and ancillary service staff to the care of MDRO patients only, when transmission continues despite adherence to Standard and Contact Precautions and cohorting patients. Some hospitals may consider this option when intensified measures are first implemented. |
| <input type="checkbox"/> | The hospital stops new admissions to the unit or facility if transmission continues despite the implementation of enhanced control measures described above. |

ENHANCED ENVIRONMENTAL MEASURES

| | |
|--------------------------|--|
| <input type="checkbox"/> | The hospital implements patient-dedicated or single-use disposable noncritical equipment (e.g., blood pressure cuff, stethoscope) and instruments and devices. |
| <input type="checkbox"/> | The hospital intensifies and reinforces training of environmental staff who work in areas targeted for intensified MDRO control and monitors adherence to environmental cleaning policies. Some hospitals may choose to assign dedicated staff to targeted patient care areas to enhance consistency of proper environmental cleaning and disinfection services. |
| <input type="checkbox"/> | The hospital monitors (i.e., supervises and inspects) cleaning performance to ensure consistent cleaning and disinfection of surfaces in close proximity to the patient and those likely to be touched by the patient and HCP (e.g., bedrails, carts, bedside commodes, doorknobs, faucet handles). |
| <input type="checkbox"/> | The hospital obtains environmental cultures (e.g., surfaces, shared medical equipment) when there is epidemiologic evidence that an environmental source is associated with ongoing transmission of the targeted MDRO. |

DECOLONIZATION

| | |
|--------------------------|---|
| <input type="checkbox"/> | <p>The hospital performs susceptibility testing for the decolonizing agent against the target organism in the individual being treated or the MDRO strain that is epidemiologically implicated in transmission, when decolonization for MRSA is used. The hospital monitors susceptibility to detect emergence of resistance to the decolonizing agent. The hospital consults with a microbiologist for appropriate testing for mupirocin resistance, since standards have not been established.</p> <ul style="list-style-type: none">• The hospital does not use topical mupirocin <i>routinely</i> for MRSA decolonization of patients as a component of MRSA control programs in any healthcare setting, because mupirocin-resistant strains may emerge and because it is unusual to eradicate MRSA when multiple body sites are colonized.• The hospital limits decolonization of HCP found to be colonized with MRSA to persons who have been epidemiologically linked as a likely source of ongoing transmission to patients. The hospital considers reassignment of HCP if decolonization is not successful and ongoing transmission to patients persists. |
|--------------------------|---|

(Signature, Chief of Infection Control)

(Please Print Your Name Here)

____/____/____
(Date)

(Telephone number)

(E-mail address)

**Completed form should be sent to the Vermont Program for Quality in Health Care, Inc.
132 Main Street, PO Box 1356, Montpelier, VT 05601, no later than April 1 of each year.**



APPENDIX J

SPECIFICATIONS FOR FINANCIAL REPORTS AND PRICING INFORMATION

According to 18 VSA § 9405b, each community report shall include measures indicative of the hospital's financial health and a summary of the hospital's budget, as more fully described below. 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 source 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 financial methodology outlined herein prior to the publication of the community report. Minimum content and presentation requirements for summary hospital budget information is as follows:
 - a. The hospital's financial performance, as reported in the annual hospital budget submission to the Department for the next fiscal year, which shall be presented as follows:
 - i. The income statement shall provide actual results and subsequent budget projections;
 - ii. Revenues and deductions shall be reported separately for Medicaid, Medicare, bad debt, free care and commercial/self-pay;
 - iii. Statistical indicators shall be reported in a manner to describe utilization and employment; and

- iv. Cost shift information shall be reported to describe the amount of shift by Medicaid, Medicare, and uncompensated care.
 - b. One-year and four-year capital spending plans, to be presented as follows:
 - i. Capital spending plans shall be completed for the next fiscal year budget and the three subsequent fiscal years;
 - ii. Capital spending plans shall distinguish facility expenditures and equipment expenditures for each of the four years;
 - iii. Projected Certificate of Need (CON) projects shall be reported separately from the capital expenditures referred to in (b)(i) and (ii) above;
 - iv. Capital indicators shall be provided to evaluate debt structure, cost, age of plant and capital investment; and
 - v. Capital indicators shall include available national and Vermont peer group data.
 - c. Depreciation expenses shall be reported in the income statement provided pursuant to section (2)(a)(i) of this regulation. Each hospital shall make a paper copy of its depreciation schedule available upon request, which shall provide information for existing facilities and existing equipment.
- 3. **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 of the comparison of charges data shall be subject to the following requirements and guidelines:
 - a. Charge data shall be extracted from the Vermont Uniform Discharge Data Set, each hospital chargemaster, or other designated source as appropriate;
 - b. Average actual charges shall be reported for:
 - i. A minimum specified number of inpatient Diagnostic Related Groups (“DRG”) or specified inpatient services; and
 - ii. A minimum number of specified outpatient surgical services;
 - c. The charge listed in each hospital’s chargemaster shall be reported for a minimum number of specified outpatient Current Procedural Terminology

("CPT") codes and/or a minimum number of outpatient surgeries and/or a minimum number of outpatient procedures;

- d. In all instances, data shall be reported from the most recent, reliable data source available;
- e. Average actual charges shall be reported for the latest completed federal fiscal year or the most recent year of available Uniform Discharge Data Set (or other appropriate source) data for those inpatient and/or outpatient services or procedures that require multiple pricing events and/or services; and
- f. Specific charges for distinct inpatient or outpatient services, CPT codes, or otherwise shall be based upon the latest chargemaster.

