COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE

STATE CAPITOL
ROOM 205, RYAN OFFICE BUILDING

THURSDAY, OCTOBER 20 2011
9:30 A.M.

HEARING ON
HOUSE BILL 1570

BEFORE:
HONORABLE MATTHEW BAKER, MAJORITY CHAIRMAN
HONORABLE JOHN MYERS, MINORITY CHAIRMAN
HONORABLE KERRY BENNINGHOFF
HONORABLE KEVIN BOYLE
HONORABLE MARK COHEN
HONORABLE BRYAN CUTLER
HONORABLE PAMELA DeLISSIO
HONORABLE DAVID MALONEY
HONORABLE JOHN SABATINA
HONORABLE KEN SMITH
HONORABLE TARAH TOOHIL
HONORABLE RONALD WATERS

ALSO PRESENT:

HONORABLE DOUGLAS REICHLEY
PRIME SPONSOR OF HOUSE BILL 1570

JANELLE LYNCH
MAJORITY EXECUTIVE DIRECTOR

ABDOUL BARRY
MINORITY EXECUTIVE DIRECTOR

INDEX

TESTIFIERS

WRITTEN TESTIMONY SUBMITTED:

JOHN S. JORDAN
PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

CHAIRMAN BAKER: Good morning everyone. The hour of 9:30 having arrived the Health Committee will come to order. If we can just introduce ourselves as Committee members. This is not a voting meeting, this is a health meeting in terms of a hearing so there will no voting, but if we can just quickly have the members introduced themselves.

REPRESENTATIVE MALONEY: David Maloney, Legislative District 130th from Berks County.

CHAIRMAN MYERS: John Myers, Democratic Chair.

CHAIRMAN BAKER: Matt Baker, Majority Chair.

REPRESENTATIVE SMITH: Ken Smith, Lackawanna County, 112th District.

REPRESENTATIVE DeLISSIO: Pam DeLissio, the 194th.

REPRESENTATIVE SABATINA: John Sabatina from Philadelphia County.

CHAIRMAN BAKER: Thank the members for arriving. To my right is my Executive Director, Janelle Lynch, of the Health Committee, Majority Health Committee.

CHAIRMAN MYERS: Abdoul, who is my Executive Director.

CHAIRMAN BAKER: Okay. With us today we have the prime sponsor of House Bill 1570, Honorable Doug Reichley, who has a keen interest in this legislation. Before we have Doug just give us a quick overview of the legislation does the Minority Chair have any comments to make?

CHAIRMAN MYERS: Yes, sure.

Mr. Chairman I want to first of all thank you for having this hearing and I think it is a very important issue that needs to be discussed. Of course, there are different points of view and we need to hear all of them so that we can make some intelligent decisions. I am glad that the

folks that are here to testify are going to help us figure out what's right and what's wrong and what our public policy should look like.

So to that end, I want to thank all you for being here and I know that this is going to be a great learning experience for us.

Doug I am not going to mess with the smartest man on the campus today, but certainly that this is a issue that I know is dear to his heart as well as well as many other members. So again, thank you all for being here this morning.

CHAIRMAN BAKER: Thank you. Thank you very much. As most of you know House Bill 1570 is a proposal to update State oversight of hospitals and health care facilities, so we're very anxious to hear the perspectives of the various groups and stakeholders.

And without further adieu, Representative Reichley.

REPRESENTATIVE REICHLEY: Thank you Mr. Chairman and Chairman Myers as well. I always enjoy our conversations I have to decline the title of being the smartest man. I have learned long ago that you are only the smartest person if you say you're not the smartest person in the room, so there are a lot more able and competent people than me on this issue.

I do want to extend my appreciation for the Committee holding the hearing on what I believe is an important issue both in terms of health care but also in terms of patient safety and in reducing overall medical costs for Pennsylvanians.

I will have to begin by offering an apology for leaving early. Unfortunately I have to leave no later than 10:00 as I have a debate in my judicial campaign at 12, noon back in Lehigh Valley, so I am going to have to leave for that. So please don't be insulted if I get up, it's not because of anything anyone is saying in here.

Very briefly, this issue was brought to my attention probably six years or so ago by the Lehigh Valley Hospital and Health Network in our Lehigh County Region, Lehigh Valley Region, which raised to my attention level the dilemma faced by many hospitals and health care networks within the Commonwealth that they are in sort of dual inspection situation where a survey may be conducted by the Joint Commission on Hospital Accreditation coming in and these are not simple one hour surveys where the organization comes in and looks over some records. These can take anywhere from three to five days, it involves interviews with staff and in many cases taking staff away from patient care as the organization does an audit. After a hospital organization has gone through this exhaustive review of their policies, procedures, and records, through no fault of the Department's but without any notice the Department of Health may show up and go through the exact same kind of inspection/audit, duplicating the efforts, taking the staff away from their patient care and really causing disruption in the orderly administration of hospitals.

The intent of this legislation, I should note, is not in any way to try to subvert or to demean ambulatory surgical facilities or outside practices. I have had the benefit of speaking with representatives of both the anesthesiologist community and the urologists and visited with a private practice urology practice out in Lehigh Valley and very impressed with all they are doing. This legislation is geared towards trying to help our hospitals be more efficient in the provision of health care and not to endanger patient's safety or in any way diminish the importance of private physician practices. So, I would hope that if everyone would sort of understand what my intention is.

This would also not invalidate complaint inspections by the Department. This is more or less meant to just streamline the licensing inspections, which are already provided for in at least

44 States which have deemed status for hospital, which is accredited by a national organization.

So with that, having said that, I think it is worth noting that the Joint Commission Surveyors are practicing health care professionals where in some cases the Department's personnel are not and that this kind of legislation would assist in moving forward telemedicine and that as an advancement in health care here in Pennsylvania. So having said that Mr. Chairman, thank you very much I'll sit back and try to listen for as long as I can before I have to depart. Thank you.

CHAIRMAN BAKER: Thank you Representative Reichley, and since you do have a Judicial Debate on-going and we fully expect you to possibly be one of our newer judges, do we need to rise when you leave the room?

REPRESENTATIVE REICHLEY: No

CHAIRMAN BAKER: Okay.

REPRESENTATIVE REICHLEY: Just don't throw anything at me.

CHAIRMAN BAKER: Because Representative Reichley will be leaving shortly – and I know we don't have a whole lot of information really at this point to ask him any questions – does anyone have a question real quickly? Representative DeLissio.

REPRESENTATIVE DeLISSIO: Hi, thank you Mr. Chairman. Representative Reichley, is Jayco (Joint Commission on Accreditation of Health care Organizations; aka JCAHO) the only accrediting organization that DOH (Department of Health) would acknowledge or are there other accrediting organizations out there at this time?

REPRESENTATIVE REICHLEY: I believe the legislation provides for organizations which are recognized by CMS – the federal Centers Medicare and Medicaid Studies. Jayco is obviously the one I think most widely recognized by hospitals and by the Department, but that

this kind of deemed status and the accreditation by Jayco is something that is recognized by CMS, we think this more or less dovetails then with what is already going on from the federal level.

REPRESENTATIVE DeLISSIO: Thank you.

My next question, Jayco accreditation costs acute care facilities, if I remember correctly, thousands of dollars to get that accreditation and DOH survey does not costs any of our health care facilities any dollars. So, by giving them that option – and it is an option, correct? They are not going to be required to be Jayco accredited, but I want to sort of point out that this is, these does cost these facilities a lot of money to go through Jayco accreditation and for what period of time does Jayco accreditation last? What is the current survey from DOH in terms of their cycle, is it annual and Jayco is every other year? I am asking, I am not sure.

REPRESENTATIVE REICHLEY: Right, I believe they are both annually, but I will leave that to Mr. Crafton, who will be here from the Joint Commission, Acting Secretary Wolf here, Deputy Secretary Wolf to be able to advise you on what the Department does.

In terms of the fact that the hospitals pay for accreditation, I think the one reason the hospitals value the accreditation from Jayco is because of the nature of the surveyors that are conducting the inspection and audits. These are the trained health care professionals in this area and I think it is recognized as a national organization that other hospitals see, if a hospital has been accredited by Jayco that has a certain status level to the other institutions. So I think that is one reason which that is so highly valued, not meant to demean the inspection that are done by the Department of Health, but again, we are looking at a streamlining of regulatory process, trying to scale back duplication redundancy and also that can lead to less expensive health care. That can be a savings both from a State budgetary level where you and I are going to be dealing

with very significant budget challenges in the coming year, but also from the private health care side of not having to take staff away, not having to duplicate the production of records, not having to have down time, that will in order will provide a savings to the health care facilities as well.

REPRESENTATIVE DeLISSIO: The Jayco accreditation often is a marketing tool that institutions will use. And it is a valid, a very valid accreditation, it is quite rigorous but it is also used as a marketing tool that institutions have used, because I know in the long term care sector about fifteen years ago we started to focus on Jayco accreditation and it was primarily for that and then deemed to be – right – duplicative and redundant because the Department of Health was there. Do you anticipate that at a point certain Department of Health would not offer surveys at all? In terms of that concept of being cognizant of cost and budgetary requirements since there in fact is a private entity out there that is capable of doing that job?

REPRESENTATIVE REICHLEY: I don't think we are intending that this would completely sub plant the capacity for the Department to do the inspections, but in terms of a hospital that makes the choice to utilize a Jayco inspection in lieu of the Department of Health one. There may be some hospitals who say if we don't want to have to pay the accreditation fee or we don't have the capacity to go through that kind of examination, they would have the Department of Health do it. So I don't think we are trying to eliminate it, but by allowing Jayco status to be utilized instead of a redundant Department of Health inspection, I think you are saving money for the Department of Health, they don't have to do as many inspections which thereby helps you and I find savings to help the taxpayers.

REPRESENTATIVE DeLISSIO: One last question for you. I see that under the Health Care Facilities Act historically long term care facilities have been included in that. It appears

from the analysis that I read that they are being excluded from this definition. Where then are they going to be covered, because would not then skilled nursing facilities have this same opportunity to be accredited by Jayco or another CSM deemed accrediting organization versus DOH? They appear to be carved out by the definition but I am not sure where they get to be put, there is a number of things.

REPRESENTATIVE REICHLEY: Are you talking about the definition under "Outpatient health care facility" or?—

REPRESENTATIVE DeLISSIO: The term, right in the beginning from my analysis that I read that definition of "Health care facility" adds the terms outpatient.

REPRESENTATIVE REICHLEY: Oh I see what you mean, I am sorry, where the brackets starts under health care facility, under definition. Alright

REPRESENTATIVE DeLISSIO: Yeah, so I was kind of, and there may be somebody who is going to testify subsequently who can answer where those categories are going. Home health care, home care, hospice and long term care nursing facilities as well as birth centers appear to be not included in this updated version, and perhaps I've misread.

REPRESENTATIVE REICHLEY: And there may have been a legislative oversight as well. We don't want to leave any particular kind of facility in a void, but again, if we can facilitate a streamlining of the process whether it is for long term health care facilities, assisted living facilities, hospitals overall, that is what our intention was.

REPRESENTATIVE DeLISSIO: So that concept would carry through consistently and nobody if it is left out it may be just a technical event at this point as far as you know?

REPRESENTATIVE REICHLEY: Well I think it is something that I certainly would want to follow-up with you and discuss to see if this is the appropriate place for us to be

including those type of facilities, is there another location for us to be within statutory framework to be doing that, but again, we're not envisioning endangering patient safety or those who are in long term care or assisted living or skilled care facilities.

REPRESENTATIVE DeLISSIO: Okay, thank you Mr. Chairman.

CHAIRMAN BAKER: Thank you Representative DeLissio. I do think we will most likely be making some both technical changes inevitably to this legislation and perhaps even substantive changes. We do acknowledge that some changes will have to be made most likely, to the bill.

Thank you. Thank you very much I know you are pressed for time Judge Reichley and we thank you for answering the questions. Without further adieu, if no other members have a quick question for Representative Reichley, I would like to acknowledge the presence of four more members that have arrived, many of them I believe were attending another committee meeting or hearing and so I appreciate their attending, Representative Waters, Representative Benninghoff, Representative Boyle, and Representative Toohil.

And now we will recognize Michael Wolf from the Pennsylvania Department of Health, Executive Deputy Secretary, Acting Deputy Secretary for Quality Assurance. Welcome.

EXECUTIVE DEPUTY SECRETARY WOLF: Thank you. Good morning Chairman Baker and Chairman Myers and the members of the House Health Committee. As Chairman Baker said my name is Michael Wolf and I am the Executive Deputy Secretary for the Department of Health, as well as the Acting Deputy Secretary for Quality Assurance at the Department. I am joined this morning by Jim Steele. Jim is our Deputy Chief Counsel at the Department of Health. I want to thank you for the opportunity to participate in today's hearing and discuss the Department's role in the licensure of the health care facilities.

The Department takes seriously its mission to protect the health and safety of the citizens of this Commonwealth. Under the Health Care Facilities Act, the Department is given the responsibility to license health care facilities to ensure: That the health care provider is a reasonable person; that the facility is adequately constructed, equipped, maintained and operated to provide these health care services safely; that the services are adequate for care, treatment and comfort of the patients in the facility; and the facility is in compliance with the Department's regulations.

The Department takes pride in the past 30 years of surveying and regulating facilities under the current Act. As such, we look forward to working with this Committee to update the license process. The Department's regulations for hospitals were adopted in the 1980s. Despite minor revisions to these regulations in the late 1990s, there has not been a recent effort to reflect changes in the delivery of health care services in these facilities, including changes in the practice of medicine, changes in technology, amongst other factors.

While the Department is certainly willing to engage in a dialogue with this Committee and members of the regulated community regarding possible changes in the manner of this regulation of health care facilities, I think we would like to first point out some of the concerns we have surrounding House Bill 1570 as it is presently drafted. And we will also spend some time as well as discussing some of the, some of the activities that the Department has been engaged since the change of administration as it relates to this subject as well.

The language used in this bill states that facilities accredited by a national accrediting organization approved by the Centers for Medicare and Medicaid Services shall be deemed to meet licensure requirements and shall be issued a license by the Department. This raises concerns that the General Assembly is delegating a governmental function to a non-

governmental organization. I am sure you are aware of the recent decisions by the Courts that have found such delegation problematic. A review of some other States that have also adopted the deeming process indicates that State legislature has directed the State Department of Health to make a determination of accrediting organizations to the standards would be acceptable as compliant with State licensure standards.

There is also a concern that there is a one-time only adoption of national accreditation organizations that the standards adopted on that date would be those which must be used going forward regardless of any changes that the organizations may make to the standards. A provision that the Department would make this determination on an annual basis could ensure that the accreditation standards applied to health care facilities would remain up to date.

The Department believes that the present legislation could result in conflicting standards being applied to health care facilities in the Commonwealth. Facilities that choose to be accredited would be following the standards adopted by the accreditation organization, while those facilities that choose the traditional licensure path would be required to comply with State licensure requirements. This could result in facilities being held to varying requirements which could prove detrimental to patient care and also confusing for the individuals who wish to compare the quality of care provided at these facilities.

We believe that particular consideration needs to be given to the following areas: First, is the role of the Department performing validation surveys of the deemed facilities to ensure they are complying with applicable standards and providing patient safety care? Second, is the ability of the Department to continue to receive and investigate specific complaints related to quality assurance and patient care at the facilities. Third is the need for the Department to continue to survey to enforce other laws enacted by the General Assembly, such as the MCARE Act. And

finally, an important issue that needs to be addressed involves the changes made to the definition of "Health care facility." The revision made in House Bill 1570 would remove several health care facilities from the definition and thus from any licensure requirements. Those facilities include long-term care facilities, home health agencies and registries, home health care hospices and birth centers.

While the bill amends Section 809 of the Act to provide that all accreditation facilities shall receive a license for the duration of the accreditation cycle and that all non-accredited facilities licenses shall correspond to the time frames for accreditation facilities, this provision conflicts with Section 807 which sets forth specific time frames for licensure of health care facilities, including two years for hospitals, rather than the three year timeframe generally used for accreditation facilities.

I am here to report to the members of the Committee and all affected parties involved that the Corbett Administration is committed to ensuring that our regulations get the proper attention needed and the necessary changes are implemented. The Department will begin this process as soon as possible. Uniformity, consistency and predictability will be our goal.

The Department is also assessing plans to implement an informal dispute resolution or IDR process for all health care facilities. This process is currently available only to long-term care facilities. Under the process, a health care facility is offered an opportunity to dispute deficiencies cited by the Department surveyors.

The purpose of the IDR review is to allow a facility to present information which indicates that one or more deficiencies contained in this statement should not have been cited or contains incorrect or inaccurate information. The Department will not make these deficiencies publicly available or post the statement of deficiencies on the Department’s Web site during an

IDR review. Upon the receipt of an IDR request, the Department can request additional information or clarification from the facility, if necessary, or initiate a telephone conference or in-person meeting with the facility's representatives. If the IDR review results in the elimination or revision of one of the deficiencies, the Department will prepare and the facility will receive a revised statement of deficiencies. The document will be made publicly available only after the acceptable plan of correction has been submitted by the facility. The IDR process will provide facilities and the Department with an opportunity to ensure that the information provided to the public provides an accurate description of the existing conditions at the health care facility.

The Department is also reviewing the entire survey process and the mechanisms by which the results of the licensure surveys and investigations are communicated to the public. We intend to map out the survey process and revise it as appropriate to ensure first, the survey results are written clearly and concisely, and second that those including the statements of deficiencies and plans or correction are provided to the public in a manner that will enable them to understand the specific deficiencies at the facility and the facility's response to those deficiencies.

In summary, the Department is committed to protecting the health and safety of patients and residents at Pennsylvania health care facilities and is actively involved in the review of the licensure and survey process to identify areas for improvement. We would welcome the opportunity to work with this Committee as it proceeds forward on House Bill 1570.

Thank you again for this opportunity. We will be happy to answer any questions that you might have.

CHAIRMAN BAKER: Thank you very much Mr. Wolf for your testimony. I am glad to hear that there will be on-going discussions about updating these regulations. I think one of the

more tangibles reasons this bill was introduced is the need to update a lot of these outdated regulations as they apply to hospitals and health care facilities. I know in terms of the Informal Dispute Resolution I believe Representative Mauree Gingrich has a bill—

EXECUTIVE DEPUTY SECRETARY WOLF: Yes.

CHAIRMAN BAKER: —that would allow that. So, to the degree that the Department can address many of these concerns internally through regulations that would be very, very helpful and I will be encouraging the Department to work very, very closely with all of the stakeholders that will be testifying today because there are a lot of different perspectives, a lot of different opinions, but again, we want to do the right thing and have the best product that we can possibly. Thank you again for your testimony.

Any questions from the members? Representative Myers, Chairman Myers.

CHAIRMAN MYERS: Thank you Chairman Baker.

Secretary Wolf, I was very interested in your testimony because before I got here this morning I had a meeting with my staff and you know we were discussing, you know, what all we committed to on this public policy and where do we think changes needed to happen, where do we think changes don't need to happen? One of the lengthy parts of our discussion today was what is going to happen with the Health Department? You know, if we decide we not going to put a turn to privatize this, and that is how I actually see it, as this forward movement of privatization that is being touted by our Administration. If we do privatize, well first of all, let me ask you this question here. What is the Department's position on privatizing these activities?

EXECUTIVE DEPUTY SECRETARY WOLF: We have, the Department has not adopted an official position as it relates to either this bill or anything around privatization of these kinds of activities. We are committed to working, we recognize that our, the regulations

which we are working under need to be changed and need to be updated to recognize the more modern practice, more modern practices of health care. We are looking, we want to work with the entirety of the group, we are committed to working with all the stakeholders involved in this process.

CHAIRMAN MYERS: In your testimony you had kind of talked about the question that you all were kind of kicking around the room was like you know, is this going to be a good thing for our constituents or is it going be a iffy thing as opposed to a bad thing? And your testimony seemed to suggest that it was more iffy than bad and that you would all like to maintain a more concrete role in these inspections and surveys. I do support that position. You know, I think that you have a history of doing it, I think you all know what you are doing, I think you all are in business to do it, but of course, some of the conflicts with who is being inspected by certified groups as opposed to State-run Health Department, you know. I do share those concerns and as Chairman Baker said you know, as this process moves forward these are some of the questions are, that we would have to answer. I will close my question with this one question and that is, at least in my mind, as I read the bill I don't see the Health Department being a part of this. You know, that this is just going be given out to somebody else, do you all see it the same way or—

EXECUTIVE DEPUTY SECRETARY WOLF: I think one of the things – we've taken the opportunity to come over and testify this morning, as an opportunity to highlight some of the where we believe that there some issues that need to be resolved within this piece of legislation. But also number two, to talk about some of the work that we are already accomplishing or trying to accomplish as it relates to some of the – and I sometimes don't like to use the word – but "legislative intent" was to maybe push the Department along a little bit in that process. We recognize that and we wanted to make sure we had the opportunity to come over here today and

say these are the changes that we're currently engaged in and currently looking at and how do we go about fixing that and make sure that we're both telling our respective oversight committees about the activities that we are engaged in number one; but number two to also take the opportunity to say as it relates to this piece of legislation specifically, there are some concerns that should be raised. And we are taking this opportunity to raise those questions.

CHAIRMAN MYERS: Thank you Mr. Secretary.

CHAIRMAN BAKER: Thank you Mr. Chairman. Any other questions? Representative DeLissio.

REPRESETATIVE DeLISSIO: Thank you Mr. Chairman. Secretary Wolf, does the Department's current efforts include a broad array of stakeholders who are involved in this conversation, or is it internal within the Department?

EXECUTIVE DEPUTY SECRETARY WOLF: At this point in time, it is internal within the Department. We recognized and have been through, I started in the Department in May and started working as the Quality Assurance Acting Deputy in August, so I am playing a little bit of catch-up here as it relates to the past activities, but it has been my understanding there has been a couple of different stakeholders groups through the past two Administrations. So I think we have a pretty good idea who the stakeholders are, we just have not officially reached out at this point in time. We have had informal conversations I guess would be the best way I would describe them.

REPRESENTATIVE DeLISSIO: Would that stakeholder group also include consumers and/or advocates?

EXECUTIVE DEPUTY SECRETARY WOLF: We will make sure that the there are representatives of consumer groups who participate in whatever we move forward on.

REPRESENTATIVE DeLISSIO: I mean, sort of as a voter and a taxpayer I certainly have concern about legislation that doesn't get updated timely, life moves on, things evolve, particularly in the field of health care. So, I guess I could support the premise of this piece of legislation that if things need updating we have the responsibility to ensure that happens as timely as possible, but in the most comprehensive responsible way as possible, and again, not taking forever to do it as well. I am also a rather inclusive person, so any type of initiative or effort should always include all the most appropriate parties so that we're getting the best product at the end of the day. Coming out of long-term care, I guess I have been the recipient of a lot of poorly drafted legislation and regulations over a 30-year career, so this is an opportunity for me to help to ensure that the product, the process is appropriate, and the product is as sound as we can get it.

Just a quick question, in terms of your testimony as it pertains to the IDR. The bill that the Chairman was referring to is an IIDR, Informal Independent Dispute Resolution, you're referring to an IDR.

EXECUTIVE DEPUTY SECRETARY WOLF: That is correct.

REPRESENTATIVE DeLISSIO: So could you please clarify the two for the Committee here today? And I want to be sure that you're saying the IDR is currently only available to long-term care facilities, which has been a process that been around for a long time.

EXECUTIVE DEPUTY SECRETARY WOLF: Correct.

REPRESENTATIVE DeLISSIO: You are now extending that.

EXECUTIVE DEPUTY SECRETARY WOLF: Yeah, so thank you. The Department of Health currently only in long-term care, has what is referred to as an Informal Dispute Resolution process, where we have a group of people who look at, if a long-term care facility

disagrees with the survey results, they have an opportunity to come back and basically file an appeal and that is the IDR process that the Representative was referring to.\

Representative Gingrich's bill, which we had the opportunity to testify on a couple of weeks ago, establishes an Informal Independent Dispute Resolution process, and that process would involve an outside organization at the cost, to the cost of that facility of saying we disagree and there would be an independent investigation of the survey questions.

So there is, and the most significant difference between the two is the informal process has been on-going at the Department and is at no cost to the facility. The process that with Representative Gingrich's legislation is, would be at the cost, would be independent done by a CMS approved organization and also be done at the cost to that facility.

REPRESENTATIVE DeLISSIO: However, only limited at this time to long-term care facility as defined.

EXECUTIVE DEPUTY SECRETARY WOLF: And that is correct. That is correct.

REPRESENTATIVE DeLISSIO: And can you also, while you are here, I would be curious to add this question, is that IDR unit a separate dedicated unit only for this within DOH, or are these folks who wear a variety of hats and also form that function, because it is an appeal process, and I am wondering how independent that group is from the rest of the process, if you will, the process that puts out the deficiencies and does the surveys?

MR. STEELE: The people that review the IDR process are within the Quality Assurance Bureau and within the division of Nursing Care Facilities, but they are unrelated to the investigation, it is on-going. In other words, if a certain office has completed the investigation and files IDR other surveyors or other administrators then review it that have not been involved in that survey. They are within the Department unit, though.

REPRESENTATIVE DeLISSIO: Thank you. Thank you Mr. Chairman.

CHAIRMAN BAKER: Thank you Representative, any other member questions? Seeing none, we thank you Mr. Secretary, Counselor.

EXECUTIVE DEPUTY SECRETARY WOLF: Thank you.

CHAIRMAN BAKER: Next before us we welcome Mark Crafton, The Joint Commission, Executive Director, State and External Relations, Division of Business Development Governmental and External Relations. Welcome, when you are ready you may proceed.

EXECUTIVE DIRECTOR CRAFTON: Thank you, Mr. Chairman, members of the Committee. My name is Mark Crafton and I am the Executive Director of State and External Relations at The Joint Commission. I am pleased to be invited to participate in today's hearing on House Bill 1570 and to share with the Committee information on how the use of accreditation and the licensure oversight process can be beneficial to many stakeholders, including patients and the State regulatory agencies charged with ensuring safe and effective care is delivered to the citizens of the Commonwealth.

Founded in 1951, The Joint Commission is a private non-profit accrediting organization that develops evidence based standards, safety goals and performance measures, and conducts surveys to determine compliance with those standards. Today, The Joint Commission accredits more than 19,000 health care organizations throughout the United States including over 4,400 of the nation's hospitals. In Pennsylvania alone The Joint Commission accredits 188 State licensed hospitals or 76 percent of the hospitals licensed by the Commonwealth. Collectively, these Joint Commission accredited hospitals operate more than 85 percent of the licensed beds. In addition, The Joint Commission accredits 27 Pennsylvania-based ambulatory surgical facilities.

The Joint Commission's hospital and ambulatory accreditation programs have been approved by the Federal Centers for Medicare and Medicaid Services or CMS, which means that hospitals and ambulatory surgery facilities achieving Joint Commission accreditation are meeting or exceeding all federal quality and safety regulations. As a result, the federal government and the State agencies that contract to do work on behalf of CMS do not perform routine federal inspections in accredited facilities. Similarly, 48 of the 50 States recognize and rely upon Joint Commission accreditation in lieu of some or all of its routine licensure inspections. A few of these States conduct licensure inspection less frequently in accredited facilities compared to non-accredited ones, but the vast majority of the 48 States simply no longer conduct routine licensure inspections in accredited hospitals. Currently, only Pennsylvania and Oklahoma continue to conduct all their routine licensure inspections in accredited hospitals. House Bill 1570, if passed, would align the Commonwealth with the 48 other States that include voluntarily accreditation in their licensure oversight process.

Let me begin by talking a little about the standards that we use. The Joint Commission standards are the basis of an objective evaluation process that can help organizations measure, assess, and improve performance. The standards focus on important patient care and organizational functions that are essential to providing safe, high quality health care. The standards address concepts such as effective leadership, safety culture, performance improvement, fire safety, information security, and patient rights, as well as clinical areas such as anesthesia and medication use, restraint use, and preventing infections. Currently, there are 1,776 specific requirements or elements of performance in The Joint Commission Hospital Accreditation Manual. These standards are developed with input from our health care organizations, physicians, consumers, governmental agencies, insurers, and employers. They are

informed by the scientific literature, industry identified best practices, and expect consensus. When emerging quality and safety issues are identified, the Joint Commission convenes work groups to determine the need for new or modified requirements. And, because the Joint Commission is an independent non-governmental entity, it can quickly implement new and revised expectations, ensuring the standards keep pace with the rapidly changing health care environment. Similarly, standards can be quickly removed when they become obsolete due to emerging technology and changes in medical practice.

Let me turn your attention to the survey process that we use. To earn and maintain accreditation organizations must undergo an onsite survey by a Joint Commission Survey Team. The team typically includes 4 or 5 health care professionals, including physicians, nurses, hospital administrators, and life safety code specialists. Joint Commission surveys for all hospitals and ambulatory surgery facilities are unannounced. An organization can have a full routine unannounced survey any time between 18 months and 36 months after its previous full survey. In addition, organizations can receive unannounced for-cause surveys in response to serious patient or family complaints, adverse media coverage, or information shared with The Joint Commission by governmental entities. When non-compliance with a standard is found during a survey, the organization has either 45 or 60 days to implement corrective action resulting in compliance, depending upon the severity of the finding. The decision to award an organization accreditation is only made after successful resolution of all non-compliant standards. In addition, organizations must collect 4 months of data demonstrating ongoing compliance with all previously identified non-compliant standards to prove that corrective actions that they took were both effective and the improvements sustained.

In addition to that on-site evaluation, The Joint Commission requires organizations to complete an annual self-assessment of compliance with all requirements. The organizations must create a plan of action to address each requirement found to be non-compliant and the annual self-assessment and those plans of actions are submitted to and reviewed by The Joint Commission each year. This approach is designed to help hospitals and ambulatory surgical facilities continuously monitor their performance and maintain compliance with accreditation requirements throughout that 3 year cycle.

Finally, let me finish by talking specifically about the benefits that we see of State recognition of accreditation in lieu of doing routine licensure inspections. As mentioned at the beginning of this testimony, the vast majority of State Health Departments rely on accreditation in lieu of their routine licensure inspections of hospitals and ambulatory surgical facilities. However, this does not mean that the State agencies lose the obligation or ability to effectively monitor the organizations to which they issue a license. On the contrary, The Joint Commission's experience has been that the oversight of health care facilities is only strengthened when States rely on accreditation for routine inspections. First of all, the State licensing agencies typically receive the accreditation reports which contain specific information on the level of compliance with the important safety-related processes already discussed. In addition, States that no longer perform routine inspections have found that they have more time to focus their limited resources on high priority issues. For example, States can devote more time and energy to investigating serious complaints and adverse events, and monitoring providers that are not already reviewed regularly by accrediting agencies. It's also important to remember that licensing agencies in all the States that recognize accreditation retain their authority to perform licensure inspections

whenever they have information suggesting that patient safety may be jeopardized in one of their licensed facilities.

The Joint Commission takes seriously its role in the public-private partnership which exists whenever a State relies upon accreditation in the licensure oversight process. For example, The Joint Commission routinely shares its unannounced survey dates with the responsible State agency to keep them apprised of our survey activity involving their licensed facilities. In addition, The Joint Commission proactively shares information on serious complaints it receives in the event the State licensing agency wishes to conduct a coordinated survey and inspection. Whenever The Joint Commission makes an immediate threat to life declaration as a result of a serious condition found in an accredited facility, the State licensing agency is immediately notified of that situation. And finally, The Joint Commission can make facility specific accreditation information available to State authorities 24/7 through a password protected internet based portal.

I trust that this overview of The Joint Commission accreditation process has been informative. As you consider House Bill 1570, please be rest assured that The Joint Commission stands ready to work with the Pennsylvania Department of Health to ensure effective coordinated oversight of our accredited hospitals and ambulatory surgical facilities in the Commonwealth.

Mr. Chairman I would be happy to take any questions that the Committee may have.

CHAIRMAN BAKER: Thank you very much for your testimony Mr. Crafton. Have you had an opportunity to actually read House Bill 1570 and do you or the Commission have recommendations to make improvements to it, does the Commission support the bill?

EXECUTIVE DIRECTOR CRAFTON: We do support the bill and it is really very similar to the legislative process available in most other States. As I mentioned in my testimony,

just because the State relies on accreditation for routine licensure inspections doesn't mean that they can't and shouldn't do complaint surveys and other activity. In all of the States that we worked with there always seems to be a lot of work yet to go around for the Health Department in terms of oversight of our accredited organizations.

CHAIRMAN BAKER: Okay. Just a couple of other things, you had mentioned in your testimony that you accredit about 76 percent of all the hospitals in the Commonwealth and you accredited about 27 of the ambulatory surgical centers, it is my understanding that there are about 212 ambulatory surgical centers, what happens to those others? How are they dealt with?

EXECUTIVE DIRECTOR CRAFTON: In the ambulatory world there is actually other accrediting bodies that generally do more surveys and have more accredited organizations than The Joint Commission. So, I imagine that a good bulk of those non-Joint Commission accredited ambulatory surgery facilities are still accredited, but with groups with other than The Joint Commission, other CMS approved accrediting bodies.

CHAIRMAN BAKER: Okay. And lastly, you had mentioned that only Pennsylvania and Oklahoma continue to conduct their routine licensure inspections in accredited hospitals. That to me, in of itself, makes us wonder if we are kind of behind the eight ball here and again kind of builds perhaps another argument that we need to update and move forward here. Members, any questions? Yes, Representative DeLissio.

REPRESENTATIVE DeLISSIO: Thank you. Mr. Crafton thank you for being here this morning. Can you talk a little bit, I have two questions. Does Jayco accredit currently everything that's listed as a health care facilities organization in 1570 as well as those that look like they have been inadvertently omitted? So I know you do a long term care facility, you do hospitals, do you do birthing centers, do you do home care agencies?

EXECUTIVE DIRECTOR CRAFTON: Yes.

REPRESENTATIVE DeLISSIO: So do you do the ones, I don't want to sit here with that list, is there anything you don't accredit?

EXECUTIVE DIRECTOR CRAFTON: You know, The Joint Commission accredits generally every type of health care facility that you can think of in one of our programs, whether its ambulatory, home health, behavioral health care, office based surgery. Generally we do not accredit a physician's office that are not performing ambulatory surgery centers. We don't accredit most dental offices and we don't accredit retail pharmacies. Other than that, we can accredit them in one of our programs.

REPRESENTATIVE DeLISSIO: You have a full menu.

EXECUTIVE DIRECTOR CRAFTON: Yes.

REPRESENTATIVE DeLISSIO: Can you speak to the cost of Jayco accreditation and the pricing? Obviously this is going to vary by category and vary greatly and also within the category by size of entity et. cetera, et. cetera? So can speak somewhat generally and then somewhat specifically, because I think it would be informative to have a handle on what this pricing looks like you know, it's not hundreds of dollars, it's thousands, and in fact tens of thousands in some instances.

EXECUTIVE DIRECTOR CRAFTON: It is. The price does vary depending on the type of facility, the size, the scope of services of the facility. On the small end of a very small 25 bed critical access hospital, accreditation through The Joint Commission may cost that organization $10,000, which covers all the services that they receive from us including the onsite survey over a three year period, so $10,000 over three years. The average size Joint Commission hospital is 100 beds, 120 beds, their typically fee will range from $30,000 - $40,000, again over a three year

period of time. A thousand bed academic medical center with all their tertiary services, they could have a fee of $80,000, $90,000, again over a three year period. That's generally the range that we are talking about.

REPRESENTATIVE DeLISSIO: I am just curious, do you happen to know if cost reimbursement reporting allows that expense to be included or is that an additional expense outside? Is it, I am trying to figure out costs go for that?

EXECUTIVE DIRECTOR CRAFTON: You know, there is some—

REPRESENTATIVE DeLISSIO: Is that an allowable of cost.

EXECUTIVE DIRECTOR CRAFTON: It is for certain types of providers, for example, the critical access hospitals, the very small ones that are getting paid through a different mechanism than the DRG that most hospitals get paid on. Some of those accreditation costs are allowable on their cost report, but in general most of the hospitals in the Commonwealth the accreditation fee would not be reimbursable.

REPRESENTATIVE DeLISSIO: Okay. And then Jayco is certainly that accreditation folks are very proud of that, it is a rigorous, it is a rigorous process. They are proud of it, they do use that for a marketing tool. Marketing, very competitive health care today, lots of marketing. Under what circumstances can someone not use the Jayco, you know we're Jayco accredited, so if they have some non-compliance issues, do you prohibit them, or as long as there is a plan of correction are they allow to still use your? I am sure you are protecting your brand as rigorously as you can.

EXECUTIVE DIRECTOR CRAFTON: As I mentioned in my testimony, they don't get the gold seal of approval from The Joint Commission until they've demonstrated that they have come into compliance with all the requirements. In 99.9 percent of the surveys that we do, we

find requirements for improvement. We find deficiencies, but organizations have a period of time and correct them and then we grant them the accreditation certificate and then we encourage them to be proud of that achievement.

REPRESENTATIVE DeLISSIO: Now over that three year window, because that is a three year window, so that Jayco accreditation is out there it's possible because any situation can change over time 36 months, it is a rather long period of time, they are still promoting that they're JAYCO accredited but things could have changed. Hopefully not but, I mean that's true with the Department of Health inspection as well.

EXECUTIVE DIRECTOR CRAFTON: Yes.

REPRESENTATIVE DeLISSIO: So I am just, want to you know understand or particularly have consumers understand that you know that it is rigorous, it is there, it deems that it is time and date certain they are in compliance. Correct?

EXECUTIVE DIRECTOR CRAFTON: That's correct, but one of the things I want to stress is that we have a number of mechanisms to monitor those organizations in between times that we physically visit them. As I mentioned in the testimony, they have to do a self assessment and communicate those findings to us on an annual basis. So that is one opportunity for us to monitor them. Also on the complaint side, the Joint Commission receives over 12,000 complaints a year from patients, from family members. We also monitor the media throughout the country and any of those inputs of information could be an opportunity for us to contact the organization and ask them if they are aware of that information, what are they doing? Or go out and conduct one of those for-cause surveys.

REPRESENTATIVE DeLISSIO: Thank you Mr. Chairman.

CHAIRMAN BAKER: The chair thanks the gentle lady. With regard to the 12,000 complaints you mentioned, how many of them are actionable?

EXECUTIVE DIRECTOR CRAFTON: Those twelve thousand are actionable in some fashion and we have a triage system that looks at each complaint and we determine whether it's a relatively minor complaint that we are just going to put into the database and monitor or its one that is a more serious one that we will contact the organization and ask them to give us a written response as to what they are doing to address it, or on the very serious end, those are the ones that we would physically go out and do a for-cause survey. We do about 500 of those a year in terms of going out and doing an unannounced, unexpected Joint Commission survey.

CHAIRMAN BAKER: And, so then there is compliance and if there is not compliance then there's what?

EXECUTIVE DIRECTOR CRAFTON: The ramifications of not being compliance causes an organization's accreditation status to change. You know, they don't automatically lose their accreditation because they are non-compliant with our requirements and weren't able to come into compliance within that 45 or 60 days, but it does drop them down a notch. They go from being fully accredited to what we call contingent accreditation, which means that they are not in compliance with our requirements, but it gives them an additional opportunity to resubmit, try it again, and hopefully move them back into the fully accredited side. Ultimately though, if they are unable or unwilling to make the corrections, they continue down a path and ultimately can become non-accredited.

CHAIRMAN BAKER: Thank you very much, the Chair recognizes the gentleman, Representative Benninghoff.

REPRESENTATIVE BENNINGHOFF: Thank you Mr. Chairman. Mr. Crafton, I just have a quick question. In reference to your testimony, page 3, it talked about the specific requirements and elements of performance under the title Standards. I was somewhat taken back by the number 1776, I guess we get a standard for every year of our country's existence.

EXECUTIVE DIRECTOR CRAFTON: Very patriotic.

REPRESENTATIVE BENNINGHOFF: Yea, well I hope not from the standpoint of regulating people but anyhow. On the last part of that discussion, it also says some of these standards can be quickly removed when they become obsolete due to emerging technology and changing medical practices. My question is, give you time period 20 years, do you have any kind of ballpark figure how many actually ever get repealed, and is there a direct effort to try to reevaluate their necessity?

EXECUTIVE DIRECTOR CRAFTON: We have, we have a mechanism to constantly evaluate the relevancy of all of our requirements. We have opportunities on our Web site for our organizations, for consumers, for anyone to question the on-going utility of any of our requirements and then they are brought before our committees and we make changes as necessary. Just a couple of years ago we had something called the standards improvement process, where we jettisoned probably 100 to 150 elements of performance or requirements that were obsolete, they didn't, they were not necessary any more to effectively cause improvement in our organizations. So it is something we look at closely.

REPRESENTATIVE BENNINGHOFF: Any kind of percentage, if you were able, and I don't mean to put you on the spot as far as a specific number, but would you say in the 20 year time period that we have 10 percent turnover, 15 percent of removals standards? It would be interesting, and if you can't answer that now, if you could provide to the Committee, because I

would tell you and I am only speaking from my own area as a former health care worker, if you talk to people who work in within the medical facilities, I think the majority will tell you, especially some of more senior friends there, some of their reason for getting out is because they spend less time hands-on patient care and feel that they are more paper-pushers in trying to always be bating these standards. And I am all for standards, but it would be interesting for the Committee, I believe, if we had some ideology of what the turnover of those are and how frequently we are modernize them. I thank you for your candor. I thank you Mr. Chairman.

CHAIRMAN BAKER: The chair thanks the gentleman and recognizes Chairman Myers.

CHAIRMAN MYERS: Thank you Mr. Chairman. Mr. Crafton, how are you feeling today?

EXECUTIVE DIRECTOR CRAFTON: Good.

CHAIRMAN MYERS: Good. You know for some reason I am sitting here listening to this and I am thinking about the Harrisburg bankruptcy case. Don't ask me why, but it just, some of the stuff sounds familiar, you know.

Let me ask you this here, the role of the Health Department in other States have they been, have they presented any problem you know, with regards, to what you all are trying to do?

EXECUTIVE DIRECTOR CRAFTON: No, they have not. I think in most States they welcome the alleviation of that obligation to do the routine, you know, every two year, every three year, and in some cases annual licensure inspections that they do in their licensed facilities. Once they understand that another creditable entity is going to be doing those routine inspections, they turn their attention some of the other high priority issues that they need to address. But, we also work extremely closely with Health Departments, as I mentioned in my

testimony you know, in constant contact with them whenever we have information that is pertinent to any one of their licensed facilities.

CHAIRMAN MYERS: Well actually that is a good segway, because I was thinking about the question about enforcement. You know, which I think was being asked earlier about your ability to enforce compliance, and I guess I am trying to figure out at what point does your ability to enforce stop and then it becomes the government's role? Can you, because right now, I am sitting here thinking well the Health Department is going to be more of an advisory to you than an active participant, so if something comes up are we as a legislator giving you all the ability to make final decisions on courses of action and you don't have to talk to anybody, you just do whatever you think needs to be done and it don't have to be discussed with anybody?

EXECUTIVE DIRECTOR CRAFTON: That is a great question. The thing you have to remember about accreditation through the Joint Commission or anyone else, the Joint Commission does not have the ability to shut anyone down and cause them to stop providing patient care. The only entity that has that authority is the agency that issues them a license so if the Joint Commission finds these serious conditions or ultimately make the decision to remove ones accreditation, what that means is the oversight of that facility reverts back to, falls back into the hands of the State Health Department, who then generally goes out, does their own inspection of those facilities and reaches their own conclusions about any actions to take with that provider. If they lose accreditation, it doesn't mean they no longer get paid by Medicare and it doesn't mean they have to shut their doors.

CHAIRMAN MYERS: That certainly isn't a good thing, I would agree with that. Let me ask you a little bit about money, the only reason I laugh because when I say money, people say don't talk to me, we don't have any money. How much does this cost and who pays it? I mean,

you all, I mean because I actually see when Representative DeLissio was talking about marketing, I can actually see the part of this as, you are marketing for a larger share. I mean business is business I understand that but you know, what is the size of the money that we are talking about and who does it come from in order for you to do your job? Who pays for this?

EXECUTIVE DIRECTOR CRAFTON: Again, as I mentioned earlier the organizations that voluntarily pursue accreditation with the Joint Commission pay a fee to the Joint Commission on an annual basis and then in the year that they get an onsite survey they pay an additional fee, but virtually all of the revenue from the Joint Commission is a, it comes from the providers for which we accredit. And we use that money, again as a non-profit organization, to hire and train highly qualified physicians and nurses that all become employees of the Joint Commission. We give them benefits. We ensure that they are doing dozens of these surveys a year so they become and remain very competent at what they do, but the revenue stream for the Joint Commission comes from the organizations that we accredit.

CHAIRMAN MYERS: So, so, so there is no State funding?

EXECUTIVE DIRECTOR CRAFTON: No, no, no funds from State agencies or the federal government.

CHAIRMAN MYERS: Okay. And I think a part of the reason why I was interested in that, as I looked at your testimony on page 5, and you had talked about States can devote more time and energy to investigating serious complaints and adverse events and monitoring providers that are not already reviewed regularly by accrediting agencies, and a thought jumped into my mind, well that is going to cost money for them to become more creative in how they do things. So originally I thought well this is going to be a double-dip, they have to pay more to do more

internally and then pay you to do what they are not doing. But I guess I am glad to hear the state doesn't have to pay.

EXECUTIVE DIRECTOR CRAFTON: That's correct. No, funding from the Health Departments at all for the Joint Commission. All of those fees are paid for by the hospitals and ambulatory surgery facilities that we accredit.

CHAIRMAN MYERS: This is my last question and this may be a naive question, and I certainly have been naive on many of occasions, so don't feel over extended when I say that to you but, it is not going to cost the State any money. The Health Department is going to be reduced in its involvement to almost advisory. What is you all relation to the State government? I mean can you define that?

EXECUTIVE DIRECTOR CRAFTON: Again, we have on-going agreements with most of the States across the country that recognize accreditation in lieu of these routine licensure inspections where we provide them continuous updates on the status of the organizations that we accredit within their State.

CHAIRMAN MYERS: I mean do you submit reports to the State? I guess that would probably be because of State regulations.

EXECUTIVE DIRECTOR CRAFTON: Right.

CHAIRMAN MYERS: Not, because of a formal relationship.

EXECUTIVE DIRECTOR CRAFTON: Well the it is either in the law or the regulation that describes how the accreditation report gets to the Health Department. In some States the regulation and the hospitals authorize the Joint Commission to send that report directly to the State capitol. In other States the Health Departments get it from the hospitals and not directly from us. So again, is varies by State.

CHAIRMAN MYERS: So our relationship with the Joint Commission really is like a vendor. We just hire you all to do some stuff and then you all go do it and, I am still trying to figure out who gets the report, but I guess as we move on we will get a little more deeper into that. So it's kind of like just a contract?

EXECUTIVE DIRECTOR CRAFTON: That is one way to look at it, but one in which no funds change hands.

CHAIRMAN MYERS: Okay. Thank you, Mr. Chairman.

CHAIRMAN BAKER: The Chair thanks the Chair. Recognizes gentlelady Representative Toohil.

REPRESENTATIVE TOOHIL: Thank you, Mr. Chairman. I have a point of clarification. In your conversation with Representative DeLissio, you cited a number and it was over a three year period, it was example, it was eighty thousand or ninety thousand dollars. Can you just clarify that again, that statement?

EXECUTIVE DIRECTOR CRAFTON: Sure, that would be the fee paid by virtually the largest health systems in the United States to the Joint Commission for a three year accreditation period, so Johns Hopkins or the Mayo Clinic or the Cleveland Clinic or any thousand bed academic medical center that you can think of. That would be typical fees paid by those organizations, but those are very, that's the minority of facilities that the Joint Commission accredits. Most of our facilities are a hundred beds, 120 beds which would be in that thirty thousand, forty thousand, spread over three years.

REPRESENTATIVE TOOHIL: Okay. Thank you Mr. Chairman. I did just want to make a comment that I found, I find it compelling that 48 of the 50 States recognize and rely upon the Joint Commission accreditation in lieu of some or all of routine licensure inspections. I think that

seems to be another example where Pennsylvania, we just seem to be behind the eight ball and always having more backlog, more red tape, more beauracy. So I am hoping to, that we can work on that. Thank you Mr. Chairman.

CHAIRMAN BAKER: The Chair thanks the lady and recognizes the gentleman Mr. Waters.

REPRESENTATIVE WATERS: Thank you Mr. Chairman, and I just want to follow-up on Chairman Myers touched on something, a question that I had too and I don't want to be redundant here, but in the cases where the, let's say that the Joint Commission has some findings and since you don't really have any enforcement in your Commission, you would have to rely on the State to do the enforcement part of it. But, has there been a time in other States where you have the Joint Commission functioning where there has been a conflict with the positions that the Joint Commission found and the State Health Department found, is there a conflict?

EXECUTIVE DIRECTOR CRAFTON: Are you asking are there times when the Joint Commission goes out and the State also goes out at the same time or later and has different findings?

REPRESENTATIVE WATERS: Right, I mean your accreditation that you might feel as though it needs to be withdrawn or show corrective action needs to take place and the State had a different position on the same findings.

EXECUTIVE DIRECTOR CRAFTON: That happens occasionally. There are examples of where the Joint Commission removes the accreditation of a hospital for instance, but the State, who is out there continuously with the Joint Commission or on behalf of the federal government makes a determination to continue to keep that facility open and seeing patients because you know, eliminating a hospital from a community is a very serious action that generally State

agencies don't take lightly. So there are examples of where that does happen, where the Joint Commission might remove accreditation and the State licensing agency continues to allow that organization to operate with added oversight.

REPRESENTATIVE WATERS: And since the provider has been paying for a service to the Joint Commission, what recourse do they have if they find out that there is some unjustified decertification as result of the Joint Commission's findings?

EXECUTIVE DIRECTOR CRAFTON: We have an appeals process for organizations that get down that pathway, close to being denied accreditation, where they can appeal to Committees of our Board, ultimately our full board would hear their appeal and render a final decision. So there is lot of procedural steps for them to ensure we haven't been unfair in the way we have evaluated them.

REPRESENTATIVE WATERS: Can you tell me if that has happened? The recourse has occurred as a result of conflicts and/or they feel as though the Joint Commission was overzealous? I am not saying that that is the case, but their position has been there have been overzealous practices?

EXECUTIVE DIRECTOR CRAFTON: There have been times when organizations have been on the cusp of losing their accreditation and the our board committees have reversed that decision and allowed them to continue along with their accreditation. The rationale behind that varies case by case. You know, perhaps the committee takes into consideration, you know, all the corrective action that the organization put into place after the survey that might not have been considered earlier on in the process. I think that is more common reason why they would overturn an organization that was on the pathway to losing accreditation.

REPRESENTATIVE WATERS: And with the training that your inspectors have to undergo for them to go out and conduct these inspections, and I will ask how often are they given professional development training? And on the other side of that, when there is a action of recourse that takes place because maybe their inspections were not done or were not deemed to be fair or overzealous, what happens to these inspectors that brought this recourse action to the Joint Commission?

EXECUTIVE DIRECTOR CRAFTON: First on our training, we bring our surveyors physically to Chicago once a year for a week-long onsite training program. They all receive monthly training through a Web based training program, they all are in constant communication with their supervisors to help them in preparing for their surveys. The thing to remember about Joint Commission surveyors, most of them are actively practicing in health care. They are what we call intermittent surveyors, where they work for 3 weeks in a hospital, in a physician office, in an ambulatory surgery facility and then 1 week a month they take off to devote to working on behalf of the Joint Commission and doing these surveys. So they, they are very qualified and competent and still very clinically active for the most part. But when we find a surveyor who is always making a certain finding in every survey that they do, they have some counseling by their supervisor or if we find surveyors that never ever score in a particular area, again they are counseled and receive some additional education to make sure they are giving us the most effective evaluation that they can.

REPRESENTATIVE WATERS: Please, Mr. Chairman, bear with me because as he talks more questions come to my mind. And I want to ask, as a result of your findings, how is this information revealed to the public as far as, similar to, let's say the Better Business Bureau might have like you know, seal of approval for this business and then they remove the seal of approval

from a business, there might be some adverse impact on that business going forward, because of that. So if, for instance you have some findings that cause the decreditation effort on the hospital and you find out that that was not necessary, there was a conflict. Now how does the Joint Commission, what do they do to help restore the creditability, not just of a stamp of approval, but throughout the community that might have gotten word that this hospital is now – because that has happened before with hospitals that have a bad reputation in the community and it takes them forever to overcome that, so I just wanted to ask you, how do you help in an effort like that?

EXECUTIVE DIRECTOR CRAFTON: Well I think one of the safeguards that we have is that we don't put anything up on our Web site publically available about the findings of the survey until the whole process is complete. So if they want to contest a finding that they think was not appropriate that was given on the onsite survey, we consider that before we put that information out there publically.

REPRESENTATIVE WATERS: Okay, I thank you for that reassurance, we don't want to close, or make a hospital have less patients because, and they really should have been given that kind of report. The reason why you believe that the Joint Commission is necessary because you believe the State facilities are not doing as well of a job that they can do and as result of that you feel as though that there needs to be another layer of surveyors or inspectors to lift up the standards for patient care, is that somewhat of a general perception of the need for the Joint Commission?

EXECUTIVE DIRECTOR CRAFTON: No, I wouldn't testify to the fact that we think that the Commonwealth is not doing a good job of oversight of your licensed facilities. What I am saying is that most of the facilities in Pennsylvania do voluntarily pursue Joint Commission accreditation because they want to be evaluated against a higher bar, against standards that go

beyond the minimum requirements for, say, for an effective operation of a hospital. And that's the opportunity that we provide to organizations that want to voluntarily pursue it.

REPRESENTATIVE WATERS: I thank you Mr. Chairman.

CHAIRMAN BAKER: The Chair thanks the gentleman, notes the presence of Representative Cohen who is with us.

Any other members have any questions? Seeing none, we thank you Mr. Crafton.

EXECUTIVE DIRECTOR CRAFTON: Thank you.

CHAIRMAN BAKER: We appreciate it very much.

The next testifier has been delayed and is in route, so we'll move then to the next testifier, Doctor Joseph Talarico, I hope I pronounced that right, Pennsylvania Society of Anesthesiologists, and Doctor is actually past-President of that organization. Welcome Doctor.

DOCTOR TALARICO: And Bob Hoffman is with me and he is our Association's Legal Counsel.

CHAIRMAN BAKER: Okay, welcome Counselor.

MR. HOFFMAN: Thank you.

CHAIRMAN BAKER: We are used to seeing a lot of lawyers. You may proceed when you are ready.

DOCTOR TALARICO: He is more or less to just here keep me in line.

Good morning Mr. Chairman and distinguished members of the House Health Committee. My name is Doctor Joseph Talarico. Until last week I was President of the Pennsylvania Society of Anesthesiologists. I am a board-certified practicing anesthesiologist at the University of Pittsburgh Medical Center, which is a tertiary care hospital, it is part of a large health care system in Pittsburgh. I teach and train medical students, residents, and fellows in

anesthesiology as well as directly supervise nurse anesthetists, or CRNAs, and instruct student nurse anesthetists. I also provide direct hands-on anesthesia care. Thank you for allowing PSA (Pennsylvania Society of Anesthesiologists) to present its views on HB 1570 and to raise concerns about its impact on medical care and our primary concern, patient safety.

PSA is the professional association for anesthesiologists in Pennsylvania with almost 2,000 members. Anesthesiologists are physicians who, after medical school, have completed a four year residency program in anesthesiology. The residency program includes advanced training in internal medicine, surgery, pediatrics, and a number of other medical specialties necessary to perform their role in surgery; the role being protecting patients. While surgeons are busy performing surgery, anesthesiologists provide the patient with critical care medical management to keep them free from pain and medically stable. I cannot overemphasize the importance of the latter, keeping patients medical stable. Unexpected events that compromise patient safety occur routinely in surgery and addressing them properly is central to a good patient outcome.

Our comments address some issues related directly to the practice of anesthesia and others that affect medical care more generally.

First, we oppose allowing facility licensure based on satisfaction of standards of either a national accrediting organization such as the Joint Commission, or of CMS in lieu of complying with Pennsylvania standards developed by the Department of Health with legislative oversight. Doing so would cede important decisions and legislative authority about health care provided in Pennsylvania hospitals and ASFs to those organizations or, in the case of CMS, to the federal government. By doing so, Pennsylvania would be adopting all of the current standards of these

organizations, regardless of whether or not they comport with Pennsylvania's rules. There are many places, for example, where the Joint Commission's rules differ from the Department's.

Even more importantly, Pennsylvania would be adopting those entities' rules, however they may change for years to come. It is a certainty that the standards will change. How the standards will change, when they change, and what the process is or will be for changing them cannot be known now and will be entirely outside of Pennsylvania's control. There will be no opportunity for the regulated community or health care consumers to submit comments, no involvement of IRRC (Independent Regulatory Review Commission), no publication in the Pennsylvania Bulletin, no review by legislative committees, no certification by the Attorney General as to form and legality. The Joint Commission's changes will be a fait accompli; licensing standards will change without Pennsylvania's legislature or executive ever considering whether the change is desirable.

Because these accrediting agencies are generally private entities, they are quite protective of their work product. What this means is that these standards are not readily available, free and on line, in the same way that DOH and other governmental licensing standards are. That, in turn, impedes the ability of many, including the public at large to access, evaluate and work with and in compliance with the standards.

Finally on this issue, PSA understands that serious State constitutional issues are raised when the legislature incorporates standards to be developed by private entities. We rely on others to press that point. PSA simply notes that doing so is a bad idea as a matter of policy.

Second, we have several comments about the provisions on ambulatory surgical facilities. Section 806 (a.1) references three classes of ASFs, A, B, and C but never establishes any rules as to what those classifications means. For example, what makes something a Class B instead of a

Class C. DOH regulations currently do so, relying primarily on a matrix that includes the procedure, the patient's physical status, and the anesthesia to be used. For example, the regulations discuss the widely used patient "physical status classification" developed by the American Society of Anesthesiologists and relates that system to which patients can be treated at what class ASF. The bill includes none of this information. This may be simply a drafting oversight, but it needs to be fixed.

Section 806 (a.1) also contains certain of the provisions now in the DOH ASF regulations. We do not understand why some of those standards, but not others, have been included in the bill. More generally, PSA thinks that in health care facility licensing, it makes sense to provide the general standards via legislation and leave the details to the Health Department. The bill contains too many details, yet omits others that are of equal or greater importance to patient safety, including as to anesthesia care in ASFs for non-pediatric patients.

This leads directly to PSA's major concern, Section 806 (a.2) (3) on anesthesia for pediatric patients in ASFs. Some pediatric patients raise unique anesthesia concerns arising primarily from their prematurity, low birth weight, co-existing disease, and unique physiology. Prematurely born babies can present with both low birth weight and medical issues associated with their premature birth. The increased risk in pediatric surgery, particularly at ASFs is more directed to the anesthesia than the surgery per se. For example, common surgeries at ASFs are hernia repairs, insertion of ear tubes, et. cetera. Younger pediatric patients almost always need general anesthetic, even in situations in which adults would more likely have regional anesthesia or even just sedation. This in turn requires pediatric surgery take place in a Class C ASF under current rules. While you might expect surgery on these preemies to take place in a hospital rather than an ASF, nothing in the current DOH regulations or 806 (a.2) (3) requires that be done.

All anesthesiologists, as part of their residency, receive training in pediatric anesthesia. Some, but not many, anesthesiologists complete additional fellowship training in pediatric anesthesia. The extent to which anesthesia for pediatric patients should be provided only by pediatric anesthesiologists is difficult to establish for the wide variety of medical situations, including the nature of the procedure and the patient's condition, which may occur across the breadth of Pennsylvania. There are some pediatric surgeries, for example on premature newborns with very low birth weight, or children with complex medical histories, in which the involvement of an anesthesiologist with extra training or experience in pediatric cases would seem warranted. Fellowship-trained pediatric anesthesiologists practice almost exclusively in larger cities and in dedicated children's hospitals. Therefore, individual health care facilities have appropriately addressed this issue in their credentialing and privileging standards and decisions that take into account local needs and resources.

Before any statutory rules are enacted on these issues, PSA suggests that additional research and review be conducted. PSA would be pleased to assist the Committee if it decides to move forward on that issue.

Among the issues to consider are; should CRNAs be permitted to provide an anesthesia to pediatric patients or to a subset of pediatric patients in an ASF unless they are medically supervised by an anesthesiologist? As written, it appears that CRNAs could provide anesthetic services at an ASF to seriously ill pediatric patients as young as 6 months of age without the supervision of an anesthesiologist. PSA certainly respects the ability of CRNAs to provide anesthesia care as part of the anesthesia care team, under the supervision of an anesthesiologist. We have concerns if CRNAs are caring for pediatric patients in ASFs without that supervision.

Should the rules on anesthesia care for pediatric patients vary depending on physical status classification, age, including an adjustment for premature babies, weight, procedure and similar factors so that the cases presenting the most difficulties and risks are handled by anesthesia providers with the greatest amount of education and training i.e. anesthesiologists. For example, current DOH rules allow patients, including pediatric patients with physical status one to three to be treated in ASFs. We would be quite concerned if a physical status three pediatric patient had surgery in ASF without an anesthesiologists close involvement.

Our final area of commentary concerns the introduction of the concept of specialized health care services as a new licensing requirement. The definition, certain diagnostic, treatment or rehabilitative services which involve highly technical medical procedures and require extraordinary expertise and resources to be effective and safe as determined by the Department of Health, leaves PSA entirely in the dark as to what services would be included. We cannot comment on whether it is good or bad idea until we know. Additionally, licensure for this category is, as written, issued to a provider, not a facility, which is quite contrary to DOH's historic role in licensing. We urge the Committee to flesh out the intended application of this provision if it determines to proceed with this comment.

Thank you again for opportunity to present our views. I will be glad to answer any questions.

CHAIRMAN BAKER: Thank you very much for your testimony Doctor. We are running quite behind with respect to the agenda, so if members have continuing questions, I would appreciate it if we could keep them short. Any questions of the Doctor? Mr. Cohen.

REPRESENTATIVE COHEN: Thank you. You expressed opposition of licensure of a provider rather than a facility. Is licensing of a person or a provider mean that the provider can open up a facility anywhere? What is the distinction?

MR. HOFFMAN: Well, Doctor Talarico apparently asked me to answer that question for you and it is typically been the practice in Pennsylvania that licensing of providers of individual people has been by the various boards and commissions in the Department of State, whereas, the Department of Health has licensed facilities, not individuals and as I read the provision here, the language – and it may have been unintended I don't know – but, it appeared to me that the language requiring licensure of specialized services was on a provider, on an individual person, as opposed to a facility. And I think that may be because I don't know what specialized services are but I am not sure that they are a facility. So it is something to flesh out, Representative.

REPRESENTATIVE COHEN: Okay, it doesn't have a specific meaning, it is something that just makes things unclear?

MR. HOFFMAN: I think it is part of understanding what is contemplated by this whole idea of specialized services, which is at the moment as Dr. Talarico said, pretty much undefined in a way that we frankly don't know what it contemplating to capture.

REPRESENTATIVE COHEN: Thank you very much, Mr. Chairman.

CHAIRMAN BAKER: Mr. Cohen we had commented earlier that we had recognized this bill does need some work, does need some changes. A lot of stakeholders need to work together to flesh out and refine this before it moves forward, so thank you, very good question. Any other questions?

Seeing none we thank you for your testimony and your very instructive recommendations. Thank you.

Next on the agenda we will resume the order in which the agenda was established. Doctor Heine is here and we are glad she arrived safely and we appreciate her testimony and if you would like to come forward Doctor, we would welcome you. She is representing the Pennsylvania Medical Society and I am sorry you were delayed in arriving. Welcome.

DOCTOR HEINE: Thank you Mr. Chairman, and it's a delight to be here safely as you have said. The transportation challenges arriving from the southeast were almost akin to John Candy's *Trains, Planes and Automobiles* to allow me to be here but we prevailed and that's a good thing.

So good morning Mr. Chairman, Chairman Baker and members of the House Health Committee. We are really delighted to be able to offer testimony on what we feel is a very important issue. My name is Marilyn Heine, MD, I am the newly elected President of the Pennsylvania Medical Society, having been in this position five days, so I am fairly new to this, but we are really honored to be able to be at this hearing. I practice emergency medicine in Montgomery County, in Norristown and hematology/oncology in Langhorne in Bucks County. So I have a perspective that goes both in hospital and the community-based setting. So that is very helpful I think. And we are grateful for the opportunity for this important legislation to be advanced. We commend Representative Reichley for advancing an important measure, 1570, that will the momentous occasion to be able to comment on the hospital regulations. It is really long overdue, thirty years. And as you have just commented a lot of work still needs to be done on this measure to make it what it needs to be. We have several concerns, some of them actually were likely already addressed earlier, and I am sorry that I wasn't able to be here for that, but we feel that our job as physicians is actually to protect the patient's best interest, that the physician-

patient relationship is paramount, and that we are very much focused on ensuring adequate and as best possible quality and safety for our patients.

So, the regulations guide not only what goes on in the hospital but presently they also comment on things like medical staff membership and clinical privileges, and unfortunately the Joint Commission does not. So, if we went the Joint Commission alone, we would be having a void in those areas without allowing the Department of Health to actually comment and they wouldn't be able to respond if there was a question that might deviate, a complaint that might come up, they would not have that in their ability to oversee what goes on, if they simply had deemed status. It would basically emasculate the Department of Health's opportunity to comment on those important issues.

Several of the issues that we also feel are important to note are that, we are very much, as physicians, very much attuned and adoptable, we understand that clinical practice changes, it can change overnight, and it can even change regarding a particular patient, particular treatment protocol or surgical procedure, things need to be tailored to that particular patient's needs. So we are very much agile and able to rise to that challenge and we do feel again, that change of the regulations is long overdue but we want do it in a very deliberative way, thoughtful way, that has the patients safety as its best interest and prime responsibility.

With regard to the regulations, we find that the hospital does serves as an important location for us to deliver care but the care of the patient is really under the guidance of the particular physician, the attending physician, the consultant physician, those physicians who actually are responsible for that patients safety and quality of care in the facility.

Likewise, in a particular facility such as a hospital, there is a higher acuity of patients than there are in the outpatient or ambulatory centers. So it is important to recognize that there is a difference when we compare those two sets of locations.

With regard to the Department established standards, we recognize that there, if we went with the deeming process that most of the hospitals in the Commonwealth, if not all, would be deemed to be satisfactory, but again, the importance is that it would swing the pendulum too far over and leave bare things like medical staff, membership, and clinical privileges. Likewise, the way its worded, even though there is technically an exclusion for physician offices, that exclusion has a lot of holes in it based on how these the legislation could be misconstrued, so our concern is that it's important to make sure going forward that the things that we do, for example, let me give you an example in our office, in hematology/oncology community based cancer care, we deliver care under guidelines from OSHA, the Oncology Nurses Society, the American Society of Clinical Oncology, so those boards under which we practice as well as those particular professional organizations that have developed guidelines, those are the ones that we really adhere to. And to have another entity such as the Department of Health coming in, it would really hamper our ability to deliver cost effective care because of the additional regulatory burden that would be placed on our practices, which are small businesses and which do provide a significant number of jobs in the community. We want to make sure that we can have access to care for our patients, access to health care jobs for our employees, and not an additional regulatory burden that would hamper that opportunity.

In addition, we feel that there is, in terms of the ambulatory surgery center, like we had talked about, that there is definitely a difference, so in specialized health services as well as outpatient health care facilities, those are two areas which we are very concerned that this

legislation would tread into and be causing new problems then hadn't originally been intended. So the scope of the legislation it much broader than it may be initially be thought of at first blush. So we feel again that we are delighted to work with you and the other stakeholders to make sure that we have the right measures in place and that if we do that in a deliberative fashion we will have the best outcome and we welcome to answer any questions that you have.

CHAIRMAN BAKER: Thank you very much for your testimony and instructive recommendations. I think we all agree there are many regulations that need to be probably eliminated, updated, improved, I believe in the testimony you missed it earlier from the Department of Health, they have pledged to do that and to do their due diligence in making some changes that they have indicated a willingness to meet with all the stakeholders and try to accomplish whatever they can internally within the Department of Health. I think there is a willingness to try to work together here because health care is so important to the Commonwealth of Pennsylvania and its citizenry and its patients. So, we are getting a lot of recommendations for refinement, for improvement, for some changes and we're hoping that we can start the process in making this all happen in a collaborative cooperative way. Any members have questions of the good Doctor? Representative DeLissio.

REPRESENTATIVE DeLISSIO: One quick one Mr. Chairman, thank you. Point of clarification, when you say that the medical staff eligibility and physician supervisory requirements aren't accommodated by HB 1570 as it is currently written, were those, are those covered by the existing Health Care Facilities Act?

DOCTOR HEINE: The current regulations do address that and do provide protection and that would be eliminated if it was only in through the deemed status process.

REPRESENTATIVE DeLISSIO: Thank you.

CHAIRMAN BAKER: That was quite a trip for such a short period of time for you to testify but we thank you.

DOCTOR HEINE: Thank you.

CHAIRMAN BAKER: We will give a lot of good thought to your recommendations and your testimony. Thank you very much Doctor.

DOCTOR HEINE: Thank you very much.

CHAIRMAN BAKER: Lastly, we have with us this morning Paula Bussard, the Hospital and Health System Association of Pennsylvania, Senior Vice President, Policy & Regulatory Services. And a good friend, Ron Butler, from Laurel Health System, President and CEO, who hails from my home county of Tioga County, welcome. When you are ready you may proceed.

SENIOR VICE PRESIDENT BUSSARD: Thank you Chairman Baker and members of the Committee for taking time today to address this important issue. You all have HAPS written testimony before you. Ron and I want to make some brief remarks and then take questions. Everyone who has testified this morning, and I know all of you as you have raised questions are very much committed to quality and patient safety in hospital settings, there is no doubt about it. But hospitals, the reality for us is we have regulations that date back thirty years. Regulations that never contemplated electronic medical records, computer physician order entry, the use of robotics in surgery, telemedicine to improve consultation between physician specialists, use of Pyxis machines in critical care units to prove the accuracy and safe dosage of medicine, the use of PET scans for diagnoses, the existence of trauma centers to assure vital services to critically injured Pennsylvanians.

Thirty years ago hospitals were generally independent entities providing most of their care on an inpatient basis. Now, most hospitals are either a multi-hospital systems or are

intergraded delivery systems such as Laurel Health providing a full continuum of inpatient, outpatient and post-acute care. Thirty years ago most surgery was inpatient, now most surgery is outpatient. Thirty years ago most community hospitals had inpatient pediatric units, now most community hospital do not have that as inpatient pediatric care is largely provided by specialized facilities. Thirty years ago hospital acquired infections were viewed by some to be inevitable, now we all know we can achieve a zero rate of infection for most patients.

I could go on on the differences in health care. What we have seen over thirty years is only one updating of the 5 of the 33 chapters of hospital regs and that update in 1998 took 2 years of stakeholder meetings to get those regulations then through the regulatory process. We have seen numerous other pieces of legislation that impact the oversight of hospitals past, such as Chapter 3 of Act 13 of 2002, which established patient safety requirements, we have no regs for that. We have seen Act 52 of 2007 that strengthened the infection control oversight, we have no regs from that. This Committee has before it numerous pieces of legislation that attempt to address one narrow aspect of hospital care. We have seen hospitals have to file exceptions to regulations that make no sense and so we have also seen legislation passed that addresses the scope of practice for the professionals who may work in hospitals where those bills attempt to regulate health care facilities under a scope of practice. What we see is a patch work of oversight that does not assure Pennsylvanians that they are accessing high quality safe care every day. I don't know as a citizen where I would look to see what standards our hospitals are held to because of the breadth of exceptions, legislation and antiquated regulations. And though the Department of Health has incredible leadership well meaning because of that patch work, the process is going to result in inconsistent practices. What standards are hospitals held to? At what point does an exception really become what should be the standard? And no one can answer that.

What House Bill 1570 would do would bring the standards for hospital oversight up into this decade in this century, consistent across the board. All of the 250 hospitals that we represent support that. They support being moved to a high standard, a consistent standard, regardless of whether they are currently accredited by the Joint Commission or another accrediting agency or not accredited at all.

House Bill 1570 would also help the Department of Health address Governor Corbett's Budget Directive to look at more cost effective delivery of essential State services. Nowhere in House Bill 1570 would the responsibility of the State of Pennsylvania to promote and protect public health and safety be abrogated. It is the State that gives a license. It is the State that can remove a license. In the end, we believe that Pennsylvanians deserve no less to be assured that the hospitals providing care 24 hours a day, 7 days a week, live up to the mission of the blue and white H sign, which is to provide health, healing, and hope to all who enter their doors. I ask Ron now to speak to some specific issues as an integrated world delivery system and then we would be happy to take questions.

CEO BUTLER: Mr. Chairman thank you for the opportunity to submit our recommendation for your approval of House Bill 1570. This legislation will update Pennsylvanian’s regulations for hospitals and other health care facilities with current national standards. I will give you a couple of examples, State regulations require that we use inpatient beds for inpatient care only and this broad approach limits utilizing our staff and facility in a cost effective manner to ensure safe quality care. This is particularly problematic for smaller hospitals. For example, when a patient presents for an elective cardio version as an outpatient procedure, this is still is the safest place in our hospital to complete this procedure in the

Intensive Care Unit. Staff there are trained for this procedure and perform it more often than any other staff in our facility.

However, State regulations do not allow us to provide an outpatient procedure in an inpatient setting, which the Intensive Care Unit is. So we have to move staff and equipment to another location where we have designated outpatient facilities, which increase our cost while providing no quality or financial benefit for our patients. Likewise, if our same day surgery unit has a patient that has to be observed for an extra hour or two at the end of a shift, we are not allowed to move them to the inpatient unit. Instead, we must find staff to stay with one patient in the same day surgery unit until that patient is discharged, because the patient is a outpatient and not an inpatient. Again, this unnecessarily adds cost to our hospital with no quality benefits for the patient.

Another example, if we have 18 beds in our inpatient psychiatric unit, all of which are equipped to meet the standards of an inpatient room, since we are licensed for 16 beds we are not allowed to use the other rooms to accommodate a mix of male and female patients or optimize placement of patients who are confused or who need a single room because of a particular diagnosis. We actually have to turn patients away at times, even if our census is less than 16 if our male/female mix won't fit neatly into those 16 specified beds.

Adopting national standards would provide significant benefits for our citizens, our communities, our hospitals and the State government, including, would reduce the cost associated with the state current hospitals surveillance process, as periodic licensure renewal surveillance for most hospitals would be conducted by national entities. It would enable the State to hold hospitals accountable to far more up to date and rigorous clinical and quality standards. Would improve the surveillance consistency as standards would be clear and there would not be

discrepancies between national and State standards as exist now. And it would enable the State to focus on other health care facilities, such as imaging centers that are not accredited by national organizations.

We welcome being held accountable for providing safe, quality health care services in our hospitals. We also want the regulations to be consistent, relevant and flexible in meeting community needs and to recognize the quality of care being provided in today's environment. In any given year our health system facilities and other providers in our community are surveyed by as many as 28 different agencies. This is the same number as surveyed large organizations but our cost per bed in small hospitals or surveillance is much greater. We appreciate the need to protect the public but the cost of current surveillance is actually reducing access to care. Recognizing national accreditation as a means of compliance with State licensure requirements would apply a higher more effective standard that the State can provide through revision of the current regulations, and it can be accomplished much more quickly and less expensively. It is for these reasons that we support House Bill 1570. Thank you Mr. Chairman.

CHAIRMAN BAKER: Thank you very much for your testimony. When I first saw this bill I was inclined to move it immediately, but upon hearing the various concerns of the health care community, there are some drafting issues, there are a lot of things that I think we need to deal with very, very seriously and cooperatively. The Department of Health has indicated a willingness to have stakeholder meetings and to try to reach a consensus. I will be watching this very closely and if I sense that we're not moving in any particular resolution, I do intend to move this bill. I want it to be something cooperative, collaborative, something that is reasonable that addresses all of the concerns we've heard annunciated here today, but we are way behind the times here on these regulations. I think the Department of Health has made a good faith effort

and pledge to update the regulations and that means hopefully eliminating some old archaic regulations, and I am hoping that every good faith effort is going to made to try to bring us to the new era here. There's a lot of good suggestions from a lot of good people and health care organizations, and so we hope that this will be a high priority for all the groups. I know this bill, particular bill is one of the highest priorities of the hospitals, the 250 hospitals that we have in Pennsylvania, and it just seems to me that we've seen too many years and too much time pass without any resolution in trying to make some substantive changes so I will leave you all with that. At this point in time and open it up to the members, if they have any questions. Representative Cohen.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman. I got the reference to 28 different accrediting standards for hospitals.

SENIOR VICE PRESIDENT BUSSARD: No, it is 28 different types of agencies, State or federal, who might inspect different aspects of hospitals. Not 28 accrediting agencies.

REPRESENTATIVE COHEN: Does the Joint Commission standards, is that going to reduce the number of agencies inspecting hospitals?

SENIOR VICE PRESIDENT BUSSARD: Well, yes, it would reduce the duplicative and redundant surveillance by the Department of Health.

REPRESENTATIVE COHEN: And so it would reduce it to 27?

SENIOR VICE PRESIDENT BUSSARD: Yes.

REPRESENTATIVE COHEN: You would still have 27 other.

SENIOR VICE PRESIDENT BUSSARD: Yes.

REPRESENTATIVE COHEN: Agencies.

PAULA BUSSARD: Yes, everything that small businesses related to OSHA or Labor and Industry, if we have obviously radiology, we have Department of Environmental Protection assuring we have all of those, the same as any other entities.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

CHAIRMAN BAKER: The chair thanks the gentleman and recognizes Representative DeLissio.

REPRESENTATIVE DeLISSIO: Thank you Mr. Chairman. Ms. Bussard, I heard you both testify that you support House Bill 1570, if it's appropriate, a clarification, you support the concept or do you support it as it is currently written?

SENIOR VICE PRESIDENT BUSSARD: We have worked with Representative Reichley to introduce this bill. We are certainly around House Bill 1570 willing to talk to other groups but we support passage of legislation that will ensure that hospitals are held to updated standards. We appreciate everyone's willingness to talk about the regulations, but the regulatory process in Pennsylvania has not enabled up to date regulations for hospitals. So, we support moving legislation that would advance the standards that we are held to.

REPRESENTATIVE DeLISSIO: And is it also a fair statement to say that, and I understand you're representing hospitals, but there are other health care facilities who are equally burdened by—

SENIOR VICE PRESIDENT BUSSARD: You're right, Representative. However, the Ambulatory Surgery Facility Chapter is 1998, the Long Term Care Chapters are 1998. We date back to 1980.

REPRESENTATIVE DeLISSIO: Understood.

SENIOR VICE PRESIDENT BUSSARD: So for us the immediate imperative is to focus on our standards and getting them up to date. We certainly want to see all Pennsylvanians accessing health care through licensed health care facilities, to be accessing care of the highest quality, but our biggest concern right now is how woefully, woefully out of date our standards are.

REPRESENTATIVE DeLISSIO: Now I understand and I don't disagree with that and thank you.

CHAIRMAN BAKER: The chair thanks the gentlelady. Any other questions? Great.

That concludes today's hearing and I want to thank the members and all the testifiers and it looks like we have some work to do ahead of us. Thank you very much.

(Whereupon, the meeting adjourned).

The above is a full and accurate transcript of proceedings produced by the Chief Clerk's Office of the Pennsylvania House of Representatives.

_____

Tamara S. Neidlinger, Chief Clerk's Office