

Connecticut Valley Hospital (“CVH”) Public Hearing

November 13, 2017
Legislative Office Building

Presented by:

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Facility Licensing & Investigations Section (“FLIS”)

- Conducts inspections for health care institutions as defined in the General Statutes of Connecticut, section 19a-490
 - Licensure inspections
 - Complaint inspections
 - Life safety code inspections when renovation construction being completed
- Focus:
 - Assess for compliance with state and federal laws and regulation
 - Survey teams are comprised of registered nurses, however, not mental health specialists/practitioners/experts
- License 23 different levels of institutions (2087 total licenses) and frequency established in statute
- Contractor for the Centers for Medicare and Medicaid Services (“CMS”) for certification surveys for Medicare certified entities, including in part, hospitals, psychiatric hospitals, nursing home, and home health agencies

Hospitals: Certification

- Hospitals are defined in the Social Security Act, section 1861(e) (1)
 - An institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services.
- Psychiatric hospital is defined in Social Security Act, section 1861
- The term "psychiatric hospital" means an institution which—
 - (1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;
 - (2) satisfies the requirements of Sec. 1861 paragraphs (3) through (9) of subsection (e);
 - (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and
 - (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.
- Participation in the Medicare program is voluntary
- If participation elected, the entity must comply with the Conditions of Participation ("CoP")
- CMS developed CoP's to ensure that healthcare institutions are meeting the health and safety standards which are the foundation for improving quality and protecting the health and safety of beneficiaries
- 23 CoP's for Hospitals which include in part, Patient's Rights
 - Condition is comprised of standards which further define the condition of participation's expectations
- If certified as a Psychiatric Hospital, 2 additional CoP's, Staffing and Medical Records
- An initial certification survey is conducted prior to CMS certifying

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Accreditation Organizations ("AO")

Accreditation/Deemed Status

Section 1865(a)(1) of the Social Security Act provides that accreditation of a provider entity by a national accreditation body approved by CMS, demonstrates that all of the applicable conditions or requirements of the CoP's are met or exceeded— the entity (hospital) is relieved of certification surveys which assess for compliance with federal regulations and laws. However, this does not exempt an institution from licensure, but, extends the license to 4 years

Deemed status constitutes a determination that the entire certified hospital meets or exceeds the CoP's.

Voluntary process

Validation surveys may be conducted subsequent to a Accrediting Organization ("AO") survey at the request of CMS to assess congruence of State Survey Agency survey with AO's

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Hospitals

- Upon identification of Federal non-compliance, a Plan of Correction (“POC”) may be requested by CMS
 - Condition level non-compliance
 - POC required
 - Standard level non-compliance
 - POC optional

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Elements of a POC

- Six elements
 1. Plan for correcting each specific deficiency
 2. Plan for process improvement
 3. Procedure for implementing the POC
 4. Completion date
 5. Monitoring and tracking to ensure that POC is effective
 6. Title of the person responsible for implementing the POC

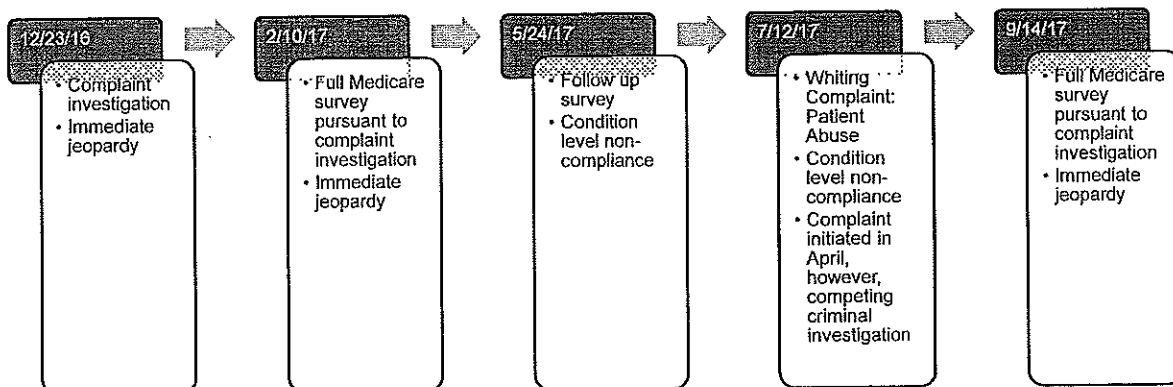
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CVH

- Certified through the Centers for Medicare and Medicaid Services ("CMS") for 615 beds, including the Whiting Forensic Division
 - Pursuant to a request dated August 18, 2017 and effective April 1, 2017, the Whiting Forensic Division beds (total 91) were decertified
- Accredited through Joint Commission ("JC")
 - "Full Event" survey last conducted 3/21/16-3/25/16
 - Typically accreditation reports not shared with state survey agency when completed
 - Posted on JC website, however, broad in conclusions

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Timeline: DPH/CVH Visits



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Timeline: 5/24/17

- Follow up survey to the “B-tag” findings, conducted by federal consultants to the 2/10/17 survey
- Condition level non-compliance identified
 - Medical Records
 - Treatment plans did not reflect individualized interventions
 - Treatment plans did not demonstrate active treatment

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Timeline: 7/12/17

- Whiting Complaint: Abuse complaint, while complaint investigation initiated in March of 2017, competing criminal investigations occurring. At the request of criminal investigators (Department of Emergency Services and Public Protection) FLIS provided “space” for the criminal investigation to move forward.
- Condition level non-compliance
 - Patient Rights; hospital failures
 - The hospital did not ensure that patients were free from all forms of abuse, neglect, or harassment (“abuse”). The abuse included willful infliction of injury, unreasonable confinement and intimidation or punishment
 - Ensure that incidents of “abuse” were reported, investigated and corrective actions taken to mitigate recurrence
 - Report to administration suspected/actual abuse
 - Report suspected/actual abuse to state agencies
 - Follow own policies regarding abuse; suspected/actual
 - Protect patients from abuse during allegations of abuse
 - Staff neglected their duties
 - Ensure that video monitoring of patient areas was reviewed and/or analyzed to mitigate patient risk
 - Ensure that patient rights were protected and honored

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Questions?

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Connecticut Department of Public Health Glossary of Terms

This glossary of terms is for your reference during the Connecticut Valley Hospital Public Hearing at the Legislative Office Building on November 13, 2017.

- **Condition level deficiencies** – Noncompliance with requirements in a single standard or several standards within the condition representing a severe or critical health or safety breach. Health and safety standards that include Patient Rights, Nursing Services, Physical Environment, Infection Control, Governing Body, etc. There is a 90-day termination of the Medicare contract if condition level compliance is not achieved. Condition level findings are measured by the manner and degree of the non-compliance.
- **Conditions of Participation** - CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.
- **De-Certification** - loss of certification
- **Deemed Status** - Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard. Designation that an Medicare + Choice organization has been reviewed and determined "fully accredited" by a Healthcare Financial Management Association (HCFA)-approved accrediting organization for those standards within the deeming categories that the accrediting organization has the authority to deem.
- **Directed Plan of Correction (DPoC)**- means to take action within specified time frames. The purpose of the DPoC is to achieve correction and continued compliance with the Conditions of Participation. A DPoC differs from a traditional Plan of Correction in that the State, not the facility, develops the Plan of Correction. Achieving compliance is the provider's responsibility, whether or not a DPoC was followed. If the facility fails to achieve substantial compliance after complying with the DPoC, the State may impose another alternative sanction (or sanctions) until the facility achieves substantial compliance or it is terminated from the Medicare/Medicaid program. The DPoC includes all elements of a traditional plan of correction as well as when the corrective action must be accomplished, and how substantial compliance will be measured.
- **Immediate Jeopardy** - A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. This can be found in 42 CFR Part 489.3. If immediate jeopardy is not removed there is a 23-day termination of the Medicare contract.
- **Joint Commission (TJC)** - is an independent, not-for-profit group in the United States that administers voluntary accreditation programs for hospitals and other healthcare organizations. TJC is an approved accreditation organization program for hospitals, psychiatric hospitals, critical access hospitals, home health agencies, hospice, and ambulatory surgery centers.
- **Life Safety Code (LSC)** - The LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The Health Care Facilities Code is a set

- **Complaint investigations-** A complaint survey is a more focused survey to investigate compliance with Conditions of Participation related to the nature of the complaint.
- **Violation Letter** – A letter issued to the provider to identify noncompliance with the Regulations of Connecticut State Agencies (Public Health Code) and/or Connecticut General Statutes. The violation letter usually requests a plan of correction.