Acute Care Hospital Fine Matrix Workshop Notes: December 7, 2021

Background

- The Seattle Times expose (2018) focused on psychiatric hospitals and specific issues of concern. DOH has had limited enforcement tools, resulting in an all-or-nothing approach. This has a huge impact on hospitals and communities.
- The psychiatric hospital bill was passed during the 2020 legislative session. It introduced new enforcement tools for this type of hospital and gave the department the ability to issue civil fines for repeat violations. It also included language around enhanced technical assistance for psych hospitals.
- The acute care hospital bill followed, in 2021. It mirrored the psych hospital bill but did not include language around technical assistance. Additionally, it included language that stated that when determining fines, the department must consider the size of the hospital.
- The rulemaking component of this project is a result of section 3 of the bill, which states that the department shall adopt in rules under this chapter specific fine amounts in relation to: 1) The severity of the noncompliance and at an adequate level to be a deterrent to future noncompliance; and 2) The number of licensed beds and the operation size of the hospital.

A few things to keep in mind

- When completing the fiscal analysis for this bill, the department did not assume that we would be fining any hospitals or generating a revenue from the fines.
- It is very resource intensive to issue fines. The benefit must outweigh the cost and always account for patient safety.

Initial thoughts/questions

- We tried to mirror the language of the psych hospital fine matrix, but we understand that these are different facility types, so if this just doesn't work, that is ok.
- The tracked changes that are in the rule language document we are looking at today are the difference between the first draft that was sent out a week or so ago and today's draft.
- The enforcement process looks like this: The department receives a complaint. Staff from the legal team, survey team and the facilities program review the complaint. If the complaint were to be true, would it constitute a violation? Is the complaint substantiated or not? If yes, a statement of deficiency is written up for the hospital. The hospital is asked to address the deficiency. These are logged in a database. The next time a surveyor goes into the hospital, they will see what the hospital was cited for previously. Is there a trend happening? A team looks at it and then it goes to legal review, which is much more intense. The legal review team asks whether there is enough evidence for an enforcement action and whether it constitutes a repeat violation.
- The timeframe for repeat violations is not defined in the statute. Everything is taken into consideration. If the hospital took corrective action and fixed the deficiency and then reverted to the deficiency, is that considered a repeat violation? There has to be a reasonable and defendable argument for why the department is making the decision.

Questions	Answers
Is this both for licensing surveys and complaints?	Yes, it is for any violation.

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When does DOH anticipate implementing the Administrative Penalties (APs) once the comment period is over and the rule is final?	The expectation is that we get these rules in place quickly. There will be a comment period after the hearing and then we file the CR-103. Once that is filed, the rule becomes effective 31 days after. Right now, we're looking at a late spring/early summer timeline.
Is there a possibility that the rule will not become final and not be implemented?	No, the law requires us to write the rule.
Will the rule be suspended during the Public Health Emergency?	It will only be suspended at the Governor's request.
Will the "repeated violations" clock start fresh with the new rule? If not, how far back will DOH look for repeated citations?	Most likely, we will go back so far as the effective date on the bill. However, we will try to verify this and get an official answer soon.
Will the basis for new APs begin with implementation of the new rule or will it be retrospective for a period of time, 3 years for example?	The plan is to only go back as far as the effective date of the bill.
Aside from what is demonstrated on the matrix, will there be additional penalties for *immediate jeopardy* findings?	No, there is no specific monetary penalty for immediate jeopardy.
Will hospital providers' licenses be sanctioned, other than the APs, for the number of citations received?	It is possible that a hospital would receive a fine as well as be subject to another enforcement action. For example, if there was a repeat violation that led to an immediate jeopardy, there could be a stop placement and a fine issued. So there is potential for there to be multiple enforcement tools applied in a situation, but how common would that be?
For hospitals that are a part of a multihospital system, do the citations observed at a specific hospital (CCN) apply to the system or only to the individual hospital?	Only to the individual hospital because they are separately licensed.

Dissecting the draft language

- (6)(a) is directly from the statute, so it will stay as is.
- (6)(b) is the fine table. When designing this for the psych fine matrix, we looked at what other organizations considered, and it was most often the severity and the scope of the violation. The max fine amount of $10,000 is in the bottom right cell. Advice was to have ranges and not specific dollar amounts, and the ranges are based on what would make the most sense in the next cell.
- (6)(c) is the description/definition of the "severity of the violation", categorized as low, moderate or high. When coming up with definitions for this subsection and (6)(e), the department looked at CMS and other accrediting bodies and tried to tie them to Joint Commission definitions.
    - **Suggestion** to associate frequency /time with the terms "rare" and "occasionally."

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- JC has published a decision tree that tells how they determine whether something is low, medium, high, widespread, etc. This might make things less subjective, put more meat on the bones. We can also incorporate the decision tree into our guidance.
- Language about timeframes was added in (6)(f).

Questions	Answers
In regard to low, moderate and high: who will make the final determination of the scale for a violation? It seems very subjective. Will this be the department?	The department will make the initial recommendation. Then it goes to the Attorney Generals office. The AG's office reviews the recommendation and determines whether it is defensible/reasonable.
If the department determines it to be a moderate, but the hospital believes it is a low, does the hospital have to wait for an appeal or can it be negotiated outside of the appeals process?	DOH will look into options other than appeals for negotiating scope and severity.
Will the department be able to create examples or guidelines of what low, moderate or high might mean? Will interpretive guidelines be published for hospitals?	Once the rules go into effect, the department can post an FAQ document or guidelines on our webpage. They can also be sent through GovDelivery. Keep in mind that guidelines are not legally binding.
In terms of individual surveyors, what will the department do to coordinate to ensure consistency?	The surveyor does not decide if it is a low, moderate or high. They collect and write up the data and what the deficiency violates. Then it goes through legal review. It is all based on the evidence and there are multiple levels of review. There was additional concern about variability and interrater reliability of investigators. The department appreciates this feedback, will provide it to the survey program, and will work on ideas for improving consistency.

- (6)(d) – These are factors that the department will consider when determining the severity of the violation.
  - Concern about the language "may include, but are not limited to…" Is there a catch-all?
  - The impact of actual or potential harm on the patient (ii) – There was a suggestion to consider the definitions of harm from ECRI or NQF.
  - Concern about (iii) – Failing to meet the patient's highest practicable well-being – is this a perfect standard?
    - Agreement that (iii) needs clarity.
    - The concern is that patient complaints are about a failure to meet their expectations, which may not be realistic.
    - Language in (iii) is not familiar.
    - (iii) could be more that the hospital failed to meet a comparable standard of care with a like hospital.
    - "Standard of care" may be the most appropriate. "Standard of care" may be different for the type of hospital you are.

  - Will there be a scale to determine the factors in (d)? It is not necessarily a scale. All the factors will be considered.
- (6)(f) – Received feedback that this language is too vague.
  - Suggestion to put a hard limit on the duration of time, for example, three years.
  - What are we trying to accomplish here? Perhaps we need to look at the cadence of annual accreditation surveys. If we want to look at violations survey to survey, we will need to push the timeframe out.
  - We could not even talk about duration, but DOH would consider duration anyway. Interested parties wanted assurance, which is why it is in the language.
  - What would be the most reasonable? Five years would be a more appropriate time so department can look at previous accreditation surveys.
  - Overall concern that what is now a collaborative relationship/interaction with the DOH will change. The fear is that hospitals will no longer look at surveyors as partners and will not disclose things that they need help with.
  - Can we look at data to see frequency/patterns of what was happening in the past? Hospitals usually correct deficiencies very quickly, so the department rarely has to take enforcement action on acute care hospitals and there are not often repeat violations.
  - The term "same or similar" is concerning.
    - This is used throughout the bill, but it doesn't mean that we have to use that term.
- (6)(g) – There are several different options that we reviewed for language that incorporates the number of licensed beds and the operation size of the hospital. Option 1 would be to take language straight from the RCW. Option 2 would be to create a methodology that reduces fine amounts by a certain percentage, depending on number of licensed beds. The department is open to other ideas as well.
  - Conversation around licensed beds and the operation size of the hospital.
    - What are the considerations around licensed beds? There could be a 300 bed hospital that runs a census of 150?
    - What is meant by operation size? Can we include census in that? Average daily census?
    - Hospitals also use the term "staffed beds" as they may not be utilizing all of their licensed beds. Several workshop participants preferred this term.
    - Staffed beds can fluctuate throughout the day. In certain times, a facility that has 30 beds may shut down ½ of a unit to meet changing demands. The denominator is ever changing. Other times the hospitals might be operating over licensed bed capacity.
    - Are staffed beds reported to DOH?
    - Staffed beds would be a nightmare to figure out.
    - Tracking staffed beds could create additional tracking requirements that would be very challenging.
    - There are inpatient beds and observation beds. Do observation beds count?
    - Is it an "and" or "or", for number of licensed beds and the operation size of the hospital? Is there flexibility?

        - We need to further define "licensed hospital beds." How this is defined and how the beds will be counted will be very important for some facilities. A CAH on the call is licensed for 68 beds.
        - Are there exceptions for beds? Such a Medicaid vs. private pay? There are no exceptions. For licensing purposes, the department does not take that into consideration. So it is outside of consideration for the bill but we will research it further.
        - This needs to be more specific and consistent.
        - What terminology is used and recorded on the DOH application? We should use the definition of "licensed beds" that is on the application.
        - Some hospitals have split campuses but you have two facilities that are under the same license. Could we define licensed hospital beds as per location rather than per license? Both campuses are under a single budget and the intent of the bill language regarding bed count was to have a fair fiscal impact on the different sized hospitals.
        - Make sure that we are not fining a smaller facility at a larger facility size.
    - Conversation around option 2, the methodology.
        - Most participants liked 50%, 35%, 25%.
        - For CAH's, 50% is a much better number, although lower is good too!
        - One suggestion was to determine the average number of beds for licensed beds in WA, then apply the percentage of the hospital beds per average. E.g. if the average is 100 beds and a hospital has 25 beds, they would receive a 75% reduction. Where a 75 bed hospital would receive a 25% reduction.

Additional questions

Questions	Answers
What will the hospital know about the scope and severity on the day that surveyors leave the building?	On routine surveys, there are usually exit interviews. We're assuming that that happens during investigations as well, but we are not sure. Perhaps when the exit interviews happen, the surveyor may be able to tell you what they think, but it will not be an official position.
Will the assignment of fines trigger a survey?	No, it is very specific to particular incidents.
Would fines be published or available by FOIA request?	We will research this.
is it possible to share our comments and questions after this workshop, and if so- where should we send them to? Will there be an additional conversation like this one, or just during the official comment period?	Yes, please send questions and comments to Julie.tomaro@doh.wa.gov. It is likely that we will need to have a follow-up meeting to this one. Julie will send an announcement.
Will CMS have knowledge of these deficiencies?	If the department finds a violation, if it is also a violation of CMS regulations, then they do notify CMS. It would have to meet the threshold for notification of CMS, not for something like the hot water temperature being too low. It would be a condition level finding that would be reported.

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Are there any protections for hospitals to avoid getting fined by both the feds and the state? The feds have fines already and it would be painful to be fined by both.	Julie to take it back to the group and see whether this would be taken into consideration. Usually what happens is that if the hospital is found to be out of compliance by the state surveyor, CMS still needs to come onsite with their jurisdiction.
Would it be possible for the department to consider these fiscal penalties be directed to resolving the issue within the hospital with proof of payments rather than sent to the state?	The department is only able to use the proceeds to offset the costs of licensing a hospital. The department only charges fees based on the costs of licensing a hospital.

Next steps

- The DOH team will work on reviewing all of the great questions that workshop participants asked. Some will need legal review.
- We'll send a notification of when the next meeting will take place. There will be at least a two-week notice before the next meeting.
- Thank you for participating in our workshop!