# Acute Care Hospital Fine Matrix Workshop Notes: January 5, 2022

## Agenda and background

- The agenda for today is to work through a few ideas and determine preferences and recommendations for draft rules.
- The goal is to increase patient safety by giving the department the ability to fine hospitals. We would like to draft rules that are defendable and easy to explain to leadership and legal staff.
- The acute care hospital bill was passed last session. It gave the DOH additional enforcement tools such as fines for repeat violations. The bill requires the DOH to write rules to establish fine amounts and a process to issue fines.
- In the prior session, a similar bill was passed for psychiatric hospitals, due to patient safety challenges in these types of hospitals. The legislature then applied the psych hospital language to a similar bill for acute care hospitals.

## Discussion about levels of harm – subsection (d)

- Last workshop, attendees recommended classifying levels of harm, so we looked at different definitions that could be used.
- AHRQ was referenced in the research and is included in this draft.
- If we incorporate this in the draft language, we can carry it to subsection (e).
- WSHA had some concerns that this takes impact into account, because it will factor in the fragility of the patient and will have a disparate impact on different hospitals. If you fine hospitals a higher amount if the patient dies, the starting point of the patient is important. A possible patient is a better way to evaluate it, vs. actual harm. WSHA would not like for the definition of harm to be included.
    - Agreement on this point from another participant. The condition of the patient at entry should be considered. It creates more risk for taking in high-acuity patients.
- SEIU concerned with WSHA's comment. Actual harm should be considered when looking at repeat fines, and not hypothetical. There are other things in place in regard to acuity. SEIU union members would be concerned. SEIU to send in more comments on this.
- Question from Julie: If we keep the original language in (e)(i), is that language still a concern for WSHA? If that language was left in, would that help with union concerns?
    - WSHA good with the original language.
    - SEIU will circle back.
- Question: If harms are considered as an indicator of the violation, who would determine the level of "harm"? Would a surveyor from the DOH be the determinant of "harm"? What would their qualifications be?
    - It is not up to one individual to determine. A surveyor would collect the data and a case management team would review documentation or data and make a determination. It then goes through an additional legal review if action is recommended.
- Poll question: Should we move forward with defining levels of harm or go back to the original language?
    - 17% Add level of harm language and revise (e)(i)
    - 67% Do not add "level of harm" language and keep as is
    - 17% Other

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- Preference is to go back to the original language. We did look at other sources/definitions instead of AHRQ. If anyone is interested, there was a handout included with that information.

## Discussion about factors the department will consider when determining the severity of the violation – subsection (e)

- Last workshop, participants felt that this was too subjective and liked incorporating standards of care language. Option 1 incorporated the standards of care language and option 2 removes the "highest practicable" language. Thoughts?
- WSHA concern about "resulting in harm" in option 1. Julie asked if it would help if we removed that part.
    - Yes, but WSHA likes option 2 and needs to think more about option 1.
- SEIU thinks that "resulting in harm" is important to keep.
- Poll question:
    - 44% Use the drafted standards of care language – Option 1
    - 56% Remove "highest practicable" language – Option 2
- Participant comment: Whichever is selected, I would like to see crisis standards of care mentioned. They change everything.
- Participant comment: As a patient, I would prefer harm language included.
- Participant comment: Most hospitals are facing crisis staffing before we even get to crisis standards of care. Are we considering that as well? Does this roll into crisis standards of care?
- Julie action item: Get clarification on this. Standards of care and crisis standards of care are terms that people are familiar with so we would need to be clear on where those fit.
- Participant comment: Good point. We are at crisis staffing now. You get more patients/staff member. PPE can also cause a crisis and extended use can occur.
- Participant question: Does crisis standard of care mean that the hospital hasn't prepared? Seems to be a loophole for hospitals to be let off the hook.
- Julie answer: It is very specific when that can be used. It's not always up to the hospital to choose to say that they are operating under crisis standards of care. Any hospitals care to weigh in?
- Participant comment: Planning for surge. Since the public health emergency has been ongoing, most hospitals are planning for further surge. Capacities have been more than 100% since the beginning of the public health emergency. Responding to the failure to plan comment, this is a moot point because we are all dealing with the emergency and seeing patients we may otherwise not see. Planning would be at a different level of leadership and may not go here.
- Participant comment: We are at capacity and it comes down to staffing, which was an issue prior to the emergency. The second issue is that staff are leaving the medical and nursing practice because of burnout. We have planned and continue to do so daily.
- WSHA comment: The whole state enters into it crisis standards of care together. It is the technical term for transitioning to population care. This happens when we can't care for all patients. Must make choices of who gets care and who doesn't. It happens at a state level, it is not a hospital decision. This has happened in other states but not here in WA.

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## Discussion about scope of the violation and the duration of time that has passed– subsection (g)

- The idea is to link this to a certain number of years that would cover surveys. Discussed internally as to what would be an appropriate timeframe. Decided to attach to survey cycles to make it equitable, rather than to attach a specific number of years. Thoughts?
- WSHA likes the idea of making it more equitable. Would want to consider limiting it to one survey cycle, since a lot can change in one cycle.
- Julie: Two survey cycles would be a maximum of six years.
- Participant comment: Would agree with previous survey cycle.
- Participant question: What is a survey cycle?
    - DOH conducts routine surveys during a specified number of years. For example, for hospitals routine surveys are done every 3 years. There are other times that the survey cycle may be shortened depending on the licensing of the hospital.
- Participant comment: If we went to two survey cycles, that would be a poor idea.
- SEIU comment: Changes that occur over long periods of time impact violations. It's important to keep the longer survey cycle.
- Julie: Survey cycle is the routine surveys, but the department also does complaint investigations which are not on any time scale.
- Participant comment: Agree with WSHA because there is more than one opportunity to get into an organization if there is noncompliance. The state would have the opportunity to validate a plan of correction. Extending the lookback period is not necessary. One should be significant. Turnover is at a peak. Less than 40% of staff that were non-compliant will be there. The state has the ability to launch a full survey if needed, in response to a complaint.
- Julie: The bill says that if the hospital doesn't follow through with a plan of correction within a specific time, they would be subject to a fine.
- SEIU: If the current system was perfect than this conversation wouldn't be needed.
- Julie: The legislature drafted this bill b/c of legitimate concerns and to have tools to address the issues.
- Participant comment: The longer lookback is safer for me as a patient. The shorter favors the hospital. We need a legitimate timeframe. The survey cycle should be the same for all hospitals.
- Julie: The idea is the opportunity for DOH to find violations. It puts the smaller hospital at a disadvantage. For a smaller hospital, the DOH will have four opportunities and for a larger hospital, the DOH would have two opportunities to find violations. Looking to achieve the intent of the bill while also being equitable.
- Participant comment: Two survey cycles would be good. It ID's issues and gives time to work on it. The second survey, they can complete it. By the third survey it could be looked at in more depth.
- Participant comment: It is unlikely that DOH would approve a POC due date as far out as a second survey.
- Julie: Plan of corrections has a due date. The hospital responds, then DOH will approve and then check when they come in again. Other times, DOH will verify that they followed through on the plan of correction if it is more serious.

- Participant comment: The level of severity allows the state to be in the hospital until the problem is corrected.
- Julie: Fines are not our only enforcement tool. DOH can stop placement depending on the level of severity.

**Discussion about the fine amount methodology – subsection (h)**

- Must consider the size of the hospital for an equitable impact. The bill provided four categories. When a fine is issued, DOH must adjust as appropriate. What is the best way to do this and ensure that the fine amount is a deterrent and also keeps it equitable?
- Option 1 – interested parties felt that the original %s weren't high enough. The percentages here, interested parties thought that they were more fair.
- The bill stated that DOH has to consider the number of licensed beds and the operation size of the hospital but didn't specify what operation size means. Staffed beds? That varies and would have to be tracked and reported. Hospitals do not currently do this. For that reason, this may not be the way to go. One data point that is reported is the average daily census, on the hospital application. Workshop handouts include an Excel spreadsheet with hospital licensing data to compare. Some hospitals are licensed for 80 beds, but their daily average is only 7 patients. We posed this question to legal staff, but an answer is still pending. In the meantime, can this group come up with a recommendation for a measure of operation size – same as number of licensed beds or average daily census? Or other ideas?
- SEIU question: In the last session, were stakeholders mostly hospitals? Or were there community groups who advocated for reduced fine amounts?
    - Primarily hospitals. No identified community members.
- Poll question:
    - 50% Use bed count and average daily census to categorize
    - 50% Use bed count only to categorize
- Julie: This may depend on legal input regarding average daily census. Any additional thoughts on why folks answered the way they did? If you categorized using the average daily census, some hospitals would fall into the lower categories.
- WSHA: Average daily census. Some hospitals keep a license for higher levels of beds to keep the capacity available. Otherwise, it is difficult to expand capacity quickly. To be fined for a census they aren't operating at doesn't make sense. If they are licensed for 100 beds but are only running 15, they should be fined for 15. Fining based on how many patients they have makes sense.
- Participant comment: Use bed count only. KISS – Keep it Simple & Sustainable.
- Participant comment: Hospitals have allocated more beds than they can use. This is hoarding and keeping them from other hospitals. It decreases the ability for patients to choose. They should be based on the number of beds they have and not claiming more than they can use.
- SEIU: Patients vs beds, thinking about communities that do not feel safe.
- Participant comment: ADC would penalize larger hospitals who consistently have ADCs greater than licensed capacity.

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- Julie: Additional language, so they would be categorized on whichever was the lower number. So in surge situations, larger hospitals wouldn't be penalized during a pandemic situation like the one we're in.

- Option 2 sent in by an interested party. Features reductions in fine amount based on data. These discounts are based on the average number of beds in the category. So hospitals would pay fines based on number of beds. 100%=300 beds. In the smallest category the average number of beds for the category is 12.5 beds so 12.5/300*100=4.2%. The size correction is therefore 95.8%. So on for the other hospitals.
- Julie: When I first saw these numbers, my initial reaction was that there's no way we'll be able to get this to fly, primarily because the law also requires us to fine hospitals at an adequate level to be a deterrent to future noncompliance. So we would need to be able to somehow show that a fine reduced by 95% would still be a deterrent or at least an equivalent deterrent to a small hospital versus a large hospital being fined at 100%. This leads us to option 3.

- Option 3 is similar to option 2, but is based on annual data regarding operating budgets. If the intent is to have an equitable financial impact, then it would be tied to operating budgets. Pulled data and sorted by bed count or ADC, then calculated the average operating budget for each of those categories. Smallest hospital is about 10% of a 300-bed hospital, so the reduction in the fine amount would be 90% to keep it equitable. Thoughts?
- SEIU: What would keep a hospital from creating operating budgets that aren't realistic? Actual budgets and actual spending/income are different.
    - Julie: This data is based on actual, not projected.
- Participant comment: Could this be based on Medicare Cost Reports?
    - Julie: Does DOH get Medicare Cost Reports? Also, this would only be used to justify this rule language one time for this concept and we could revisit it occasionally, but it wouldn't be done every time a hospital is fined.
- Participant comment: In lieu of having two survey cycles, the next time a hospital is found noncompliant and has fines assessed, a third visit where issues still exist, then the discount would erode.
    - Julie: There is language that does allow DOH to consider if the fining worked previously.
- Participant comment: This option because larger hospitals will be concerned as smaller hospitals because it is equitable on both ends. Wouldn't want a bigger hospital to have more noncompliance b/c of a larger budget.
- Julie: Will move w/option 3.
- Poll question:
    - 0% Use % recommendations from the last workshop (option 1) – 50%, 35%, 25%
    - 25% Reduce based on avg # of licensed beds in each category
    - 75% Reduce based on avg operating budget in each category
- WSHA: If we did operating budget, it would be one year and not reconsidered every year?
    - Julie: We have data back to 2013 and can look at how much it fluctuates. If it stays consistent, then we don't have to revisit it often. I'll do some additional research.
- WSHA: Licensed beds?
    - Julie: I can look at that as well. It doesn't change significantly.

- WSHA: Average daily census?
    - Julie: That would be used to put the hospital into different categories – option 3. This would be based on using ADC. Slight difference when done by licensed bed count. If there is a significant change, then we could do rulemaking at that time. It would be updating based on the data.

**Discussion about retaliation language – subsection (j)**

- This was recommended by an interested party.
- Julie: There was a question previously – if the hospital disagrees do they have to go through the entire appeals process or is there room for negotiation? The appeals process if the last straw that happens – DOH would send out notice of the fine and the hospital can respond and enter into the negotiation period. If the negotiation doesn't work, then the hospital can go through the appeals process.
- Julie: The WAC are for specific licensing requirements and this rulemaking is describing a process DOH uses to issue a fine. WACs usually do not contain directives specific to DOH, they are usually in statute. Current statute doesn't mention this. That said, I can take this to DOH leadership as a hospital concern. Thoughts?
- WSHA: Haven't heard any specifics from hospitals but there is anxiety about the implementation of this rule and DOH using this rule as a way to make money. How will this rule affect relationships with hospitals? It's a big change.

**Next steps**

- Written feedback can be sent between now and the end of the public hearing, which hasn't been scheduled yet. The sooner you can send Julie your comments, the better.
- Hearing time and date will go out via GovDelivery.