SENATE BILL REPORT
SB 6274

As Reported by Senate Committee On:
Behavioral Health Subcommittee to Health & Long Term Care, February 7, 2020

Title: An act relating to protecting patient safety in psychiatric hospitals and other health care facilities regulated by the department of health through improvements to licensing and enforcement.

Brief Description: Protecting patient safety in psychiatric hospitals and other health care facilities.

Sponsors: Senators Keiser, O'Ban, Hasegawa, Conway, Das and Darneille; by request of Department of Health.

Brief History:
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 1/24/20, 2/07/20 [DPS-WM].

Brief Summary of First Substitute Bill

- Establishes additional oversight requirements for certain psychiatric hospitals.
- Establishes penalties for psychiatric hospitals that fail or refuse to comply with state licensing standards.
- Requires psychiatric hospitals to report certain deaths and patient elopements that occur on their grounds.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6274 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Dhingra, Chair; Wagoner, Ranking Member; Darneille, Frockt and O'Ban.

Staff: Greg Attanasio (786-7410)

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Background: Licensing of Private Establishments. The Department of Health (DOH) regulates "establishments" which are defined as places receiving or caring for persons with mental illness or substance use disorder. To become licensed to operate an establishment, a person must receive a certificate of need for the project, obtain approval of facility plans under the construction review process, obtain approval from the state director of fire protection, and successfully complete a DOH survey of the facility. Establishments must operate in compliance with DOH regulations regarding clinical facilities, patient care services, staffing, patient safety, clinical records, and pharmacy and medication services.

DOH may conduct inspections at any time to determine compliance with establishment standards. DOH may issue a statement of deficiencies if it finds the establishment is not in compliance with operating standards. The failure to correct the deficiencies may result in the denial, suspension, modification, or revocation of the establishment license.

Sanctions for Health Care Facilities. DOH licenses several types of health care facilities, including hospitals, establishments, and ambulatory surgical facilities. If an inspection or survey identifies noncompliance with health care facility standards, DOH may require the facility to submit a plan of correction to address each of the deficiencies. DOH may also, for good cause, deny, suspend, revoke, or modify a license or provisional license. In the case of ambulatory surgical facilities, DOH may assess civil monetary penalties up to $1,000 per violation. Operating an establishment without a license may result in imprisonment and a fine of up to $1,000.

Incident Reporting. Certain types of health care facilities, including establishments, must report adverse health events to DOH. Under the reporting system, an initial notification must be filed with DOH within 48 hours of confirmation of the event. Full reports must be submitted within 45 days of confirmation. Adverse health events include the 29 serious reportable events identified by the National Quality Forum in 2011. Reportable adverse events are grouped into seven categories, including surgical or invasive procedure events, product or device events, patient protection events, care management events, environmental events, radiologic events, and potential criminal events.

Summary of Bill (First Substitute): Psychiatric Hospital Licensure. During the first two years of licensure for a new psychiatric hospital, or any existing psychiatric hospital that changes ownership after July 1, 2020, DOH shall provide technical assistance, perform at least three unannounced inspections, and conduct additional inspections of the hospital as necessary to verify the hospital is complying with requirements.

Psychiatric hospitals are defined as a hospital caring for any person with mental illness or substance use disorder. The term does not include acute care hospitals, state psychiatric hospitals, or residential treatment facilities.

Enforcement of Health Care Facility Licensing Standards. If a licensed psychiatric hospital fails or refuses to comply with state licensing standards, DOH may take one or more of several actions. DOH may:

- impose reasonable conditions on a license or impose a civil fine up to $10,000 per violation, with maximum total fines of $1 million, if the psychiatric hospital has been subject to multiple enforcement actions for the same or similar violation, has been

given a previous statement of deficiency for the same or similar violation, or has failed to correct noncompliance by an agreed upon date;
- impose civil fines up to $10,000 for each day that a person operates a psychiatric hospital without a license;
- suspend, revoke, or refuse to renew a license;
- suspend new admissions to the facility by issuing a stop placement order if DOH finds the noncompliance results in immediate jeopardy and is not confined to a specific area of the hospital; or
- suspend the admission of a specific category or categories of patients by imposing a limited stop placement order if DOH finds the noncompliance results in immediate jeopardy.

Civil fines collected by DOH may only be used to provide technical assistance to psychiatric hospitals and to offset the cost of psychiatric hospital licensing activities. DOH may only impose a stop placement or limited stop placement order after it provides notice and allows the hospital 24 hours to develop and implement a corrective action plan. If DOH issues a stop placement order or limited stop placement order, it must conduct a follow-up inspection within five business days to verify the violations that were the basis for the order have been corrected. The stop placement order or limited stop placement order must be terminated if the violations have been corrected and the psychiatric hospital is able to maintain the corrections. A licensee aggrieved by a DOH action may request an adjudicative proceeding pursuant the Administrative Procedure Act.

Beginning with psychiatric hospitals, DOH must make health care facility inspection reports, statements of deficiencies, plans of correction, notice of acceptance of plans of correction, enforcement actions, and notices of resolution available to the public on the Internet, to the extent that resources allow.

DOH is directed to evaluate the appropriate levels of oversight for licensed health care facilities and identify opportunities to consolidate and standardize licensing and enforcement standards across facility types. DOH must work with stakeholders to create recommendations to develop a uniform health care facility enforcement act.

Elopement and Death Reporting by Psychiatric Hospitals. Psychiatric hospitals must report to DOH every patient elopement and any death associated with elopement, medication error, a fall, the use of physical restraints, or resulting from a physical assault or suicide. The report must be made within three days of the elopement or death. An "elopement" is defined as any situation in which a patient admitted to the psychiatric hospital is cognitively, physically, mentally, emotionally, or chemically impaired and leaves the psychiatric hospital unsupervised, unnoticed, and without the staff's knowledge prior to scheduled discharge.

EFFECT OF CHANGES MADE BY BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Specifies that the imposition of license conditions or civil fines for regulatory violations only apply when psychiatric hospitals have been subject to multiple enforcement actions for the same or similar violation, have been given a previous

statement of deficiency for the same or similar violation, or have failed to correct noncompliance by an agreed-upon date.
- Specifies that a DOH approved consultant may only be required when a psychiatric hospital cannot demonstrate it has sufficient internal resources to address deficiencies.
- Changes the civil fines from a minimum of $10,000 to a maximum of $10,000 and requires DOH to adopt rules to specify fine amounts in relation to the severity of the non-compliance.
- Limits the application of stop placements and limited stop placements to only those situations in which the non-compliance results in immediate jeopardy to patient care or safety.
- Defines "immediate jeopardy" as a situation in which the non-compliance has placed the health and safety of patients at risk for death or serious injury, harm, or impairment.
- Removes the provisional licensing structure, but retains technical assistance and additional inspection requirements for newly licensed psychiatric hospitals and hospitals with a change of ownership.
- Specifies that psychiatric hospitals must only report deaths that occur in six circumstances.
- Adds plans of correction, notice of acceptance of plans of correction, enforcement actions, and notices of resolution to the list of documents that must be made public on the DOH website.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony on Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: DOH lacks sufficient oversight and enforcement authority over private behavioral health hospitals. This bill provides needed progressive enforcement tools and mirrors regulations for long-term care facilities. Publishing of investigations will allow the public to know if there have been problems at certain facilities.

OTHER: Fines and other punitive action should be reworked so there is a progressive structure and it is clear when each action would be taken. The use of a provisional license is not necessary and may negatively impact the facilities ability to operate. Enhanced oversight is still possible with full licensure. Publishing of investigations should be accompanied by outcomes and corrective action plans. DOH should have to reevaluate a stop placement order within five days. Any regulation should apply to all care settings.

Persons Testifying: PRO: Senator Karen Keiser, Prime Sponsor; Michael Uradnik, Cascade Behavioral Health; Lindsey Grad, SEIU Healthcare 1199NW; Christie Spice, Department of Health; Jeff Torgesen, citizen; Michael Torgesen, citizen.

OTHER: Chelene Whiteaker, Washington State Hospital Association; Lisa Thatcher, Washington State Hospital Association; Nick Federici, Fairfax Hospital.

Persons Signed In To Testify But Not Testifying: No one.