Washington State Hospital Association

Zosia Stanley, *Policy Director, Access*
(206) 216-2511 • zosias@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Ease burdens for patients

Help People Get the Care They Want at End of Life

Everyone deserves to have their wishes honored regarding what care they do or do not want at the end of their lives.

Advance directives are legal documents that let people express their future wishes for health care. Unfortunately, the current advance directive law creates barriers that make it hard to execute these documents; and only 25% of people have an advance directive. These important documents must be witnessed by two people to whom the patient is "personally known" and notaries are not allowed to fulfill the role of making the documents valid. Adding the option of a notary and allowing witnesses to verify a patient's identity by looking at proof of identity would ease these burdens while maintaining important protections against fraud or abuse.

Advance directives allow patients to thoughtfully and legally express end of life health care wishes

Health providers assume patients want all available medical treatment unless the patient directs otherwise. Advance directives can help direct these decisions. These documents allow loved ones and health care providers to honor the patient's wishes. To be enforceable, two witnesses must sign the document, attesting that they "personally know" the patient executing the advance directive.

Witness requirements for advance directives need to be improved to reduce barriers

Washington law requires an advance directive to be witnessed by two people in order to protect against improper or fraudulent documents. There are several other limitations on the witnesses as well, including a restriction on health care providers serving as witnesses. These limits are important safeguards against abuse. However, the fact that the witness must also "personally know" the patient can burden the patient trying to get the document executed. Also, unlike other legal documents, the advance directive cannot be notarized as an alternative to witnesses.

Adding a notary reduces barriers and aligns with existing law for other health care documents

Unlike the durable power of attorney for health care, a legal method to appoint a health care decision maker, the advance directive cannot be acknowledged by a Washington State notary. A notary is a person authorized under law to perform certain legal duties, including service as a formal witness to legal documents. The advance directive law should be amended to allow a notary as an alternative to the two witnesses.

Patients should be able to use advance directives to express end of life wishes.

Allowing a patient to provide proof of identity reduces burdens, while maintaining legal protections

Each witness must state that the patient executing the advance directive is "personally known" to the witness. Because witnesses must also meet several other standards, it can be challenging for a patient to find witnesses who meet this standard. Allowing witnesses to verify a patient's identity by checking a driver's license or passport allows for an alternative way to verify identity, while maintaining important safeguards.

WSHA position

WSHA strongly supports assisting people in executing advance directives by adding a notary option and allowing witnesses to verify the identity of the patient executing the advance directive.

Washington State Hospital Association

Jacqueline Barton True, *Director, Rural Health Programs*
(206) 216-2541 • jacquelineb@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017
ISSUEBRIEF

Critical Access Hospital (CAH) pilot program

Provide an Alternate Payment Model for Vulnerable CAHs

Allow innovative care delivery in Washington's smallest communities by providing a new payment methodology for hospitals participating in the Washington Rural Health Access Preservation (WRHAP) pilot.

Through Healthier Washington, about a dozen of the smallest Critical Access Hospitals are working with the Department of Health and the Health Care Authority to model and pilot a new payment and delivery system. New legislation is needed to build upon House Bill 2450, enacted in 2016, that encouraged participation in the pilot program. The new legislation would authorize the Health Care Authority to pay hospitals participating in this pilot in innovative ways.

This program will apply a new model for only 10-12 of the smallest, most remote hospitals with a low number of inpatient stays.

Essential care in Washington's smallest communities

Currently, Critical Access Hospitals are paid for primary care services, emergency care, and other health care services through a complex set of payment systems that do not provide adequate support for high-value care in low-volume settings. These payments lack both the flexibility needed for innovative care models and accountability for quality and total cost of care.

Given appropriate flexibility, Critical Access Hospitals can innovate to meet the unique needs of Washington's smallest communities, transforming to a sustainable hub for comprehensive primary care services, emergency and long term care and low acuity inpatient care. For some smaller communities, the low volumes of patients, the shift from inpatient to outpatient services, and a lack of commercial pay patients have strained the local hospital's ability to deliver essential services. For these communities, a new model is needed to ensure access and aid in the management of local community health. The WRHAP pilot will involve Medicaid payments as a first step; true transformation will require the participation of multiple payers, particularly Medicare.

Washington's smallest rural hospitals seek to improve the health of local residents through the delivery of high-quality primary care, care management, emergency, and other health care services.

An alternative payment system

Hospitals participating in the pilot will receive an alternative payment methodology for essential community health services, including primary care and the emergency department. Under the pilot, hospitals will receive: (1) enhanced primary care payments for local residents to deliver integrated and coordinated care; (2) population-based payments to sustain the vital infrastructure needed to deliver emergency care in remote areas; and (3) performance-based payments based upon quality measures to ensure the delivery of high-value care.

To preserve and strengthen primary care and ensure that fragile emergency services are not penalized by successful efforts to keep residents healthy, the pilot requires investment of $2 million per year over the next 3 years. This money will be used to enhance care coordination and care delivery, while supporting the hospitals as they make the changes necessary to better manage the care of their community and operate in a value-based environment.

WSHA position

WSHA urges the legislature to authorize a new payment methodology and to appropriate $2 million per year to support the smallest Critical Access Hospitals as they pilot a new payment system that promotes high-value care in Washington's most rural communities.

Washington State Hospital Association

Ben Lindekugel, *Executive Director, AWPHD*
(206) 216-2528 • benl@awphd.org
Association of Washington Public Hospital Districts
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 **ISSUE**BRIEF

Retirement of EMTs working for public hospital districts

Clarify the Retirement of EMTs Working for Public Hospital Districts

The legislature should clarify that an emergency medical technician (EMT) employed by a public hospital district does not qualify for membership in the Law Enforcement Officers and Fire Fighters (LEOFF) retirement system unless the EMT was a member of the public employees' retirement system (PERS) while providing emergency medical services as a first responder for the public hospital district. The state Department of Retirement Systems interprets current law as requiring hospital district-employed EMTs to be enrolled in LEOFF. This interpretation, if allowed to stand, would impose significant costs for PHDs.

Legislation intended to allow EMTs on state retirement to convert to firefighters' retirement

In 2005, HB 1936 was passed allowing 67 EMTs who were participating in PERS to participate in the more robust LEOFF retirement system. Six years later, in 2011, the state Department of Retirement Systems issued a ruling that interpreted the 2005 law to require that all EMTs employed by hospital districts be allowed to convert their existing retirement to the LEOFF system and, further, that the option be applied retroactively to 2005.

The legislature never intended this law to apply to public hospital districts

There is no evidence that the 2005 legislation was intended to include hospital district EMTs. The bill title clearly defines the intent of the bill as only applying to employees currently enrolled in PERS. Staff bill reports and fiscal notes that accompanied the bill made it clear that it only applied to 67 EMTs who were covered under the PERS retirement system; and hearing testimony assured the legislative committee that this was a very narrow bill, applied only to EMTs covered by PERS and even suggested the number covered might be less than 67.

There is no clear legal way to apply the requirement retroactively

Unlike EMTs who previously participated in PERS, no mechanism exists for these EMTs to transfer credit or to elect to stay in their current system. Currently, hospital district-employed EMTs are covered by various retirement programs such as 401(a), 457 and 403(b) annuities, and others. In some cases, regulation and oversight of these retirement programs is at the federal level, where the state has no jurisdiction. It is not clear whether it would even be possible to disengage district EMTs from their current retirement and, if not, whether hospital districts would be required to "double cover" some employees.

Hospital District EMTs were not intended to be mandatorily included in the firefighters' retirement program.

High costs to hospital districts and state

The cost of covering EMTs in the LEOFF system is distributed as follows: 50% employee, 30% employer, and 20% state. However, the law requires that the employer (hospital district) must pay both the employer and employee portion (e.g. 80%) and then seek to recover the employee amount. If the district employer is unable to recover those costs (either because the EMT/employee has since left and can't be located, is uninterested in participation or has died), the state keeps the money. To illustrate the magnitude of the problem, the cost to the four most impacted districts of paying the employee and employer share of the retroactive costs would be **more than $4.6 million**; the cost to one district alone would be **more than $3.2 million**; and the **cost to the state** to provide it's 20% share would be **more than a million dollars**.

WSHA position

We are seeking legislation that clarifies that an EMT employed by a public hospital district does not qualify for membership in the Law Enforcement Officers and Fire Fighters (LEOFF) retirement system unless the EMT was a member of the public employees' retirement system (PERS) while providing emergency medical services as a first responder for the public hospital district.

Washington State Hospital Association

Andrew Busz, *Policy Director, Finance*
(206) 216-2533 • andrewb@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Hospital clinic payment reductions

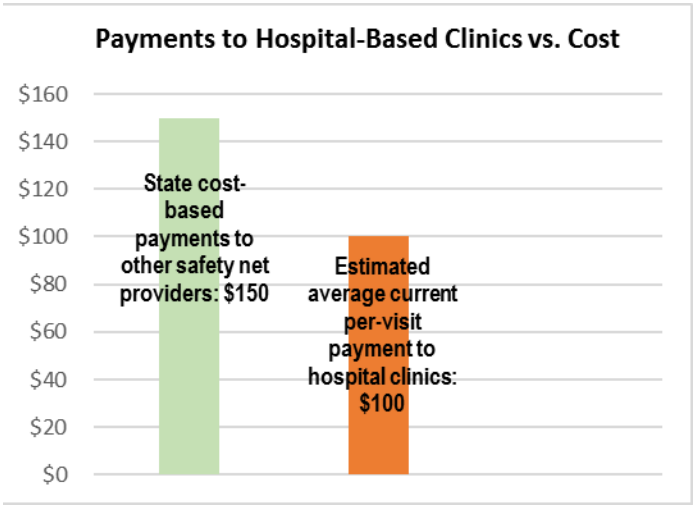
Cuts Threaten Access to Care for Low-Income Patients

In many communities, the hospital and its clinics are the main or only provider of primary and/or specialty care for Medicaid and Medicare patients. This is particularly true in communities with high proportions of underserved patients, or where independent clinics limit or turn away Medicaid and Medicare patients due to low payment rates.

Cutting payment rates for hospital-based primary and specialty care clinics would harm access to care for vulnerable populations, drive patients to unnecessary emergency room visits, and worsen the state's budget problem in the long run.

Hospital clinics are a critical source of access to pediatric and adult primary care, as well as specialty and subspecialty services such as cancer care, wound care, nephrology, autism services, and craniofacial surgery. Without sustainable payment levels, the risk is not only that Medicaid patients will be turned away, but that the clinics themselves may be forced to cut back services or close, reducing access to needed care for the entire community, including seniors and commercially insured patients. **Washington State currently has more than 1.8 million residents on Medicaid. Hospital clinics help meet the demand for increased access to care. Washington should be encouraging clinic capacity for both primary care and specialty services for low-income citizens.**

Hospital-based clinics are already paid far less than their cost of providing care, and less per visit than other safety net providers that serve high proportions of Medicaid patients. Hospital-based clinics are often the only option for Medicaid patients to receive specialty services. These clinics are integrated with the hospital, enabling them to serve more complex patients and provide enhanced care coordination for patients with multiple needs. They are also able to provide access to complex patients and specialized services that otherwise would need to be done in the hospital. Hospital clinics typically do not limit their mix of patients and provide care to all who need their services. The proposed cut would reduce payment to an unsustainable rate for facilities that provide complex services to high proportions of Medicaid patients. The hospital clinic payment helps offset these under-payments and supports clinic costs to ensure patients with Medicare and Medicaid can get needed health services in their community.



The state currently pays hospital clinics about two-thirds of the average $150 it costs to provide a clinic visit. Hospital-based clinic payments help keep clinic services open by paying closer to the actual cost of providing the care.

Overall Medicaid costs may actually increase if access to clinic care is reduced

Hospital clinic payments support the sustainability of primary care and specialty care capacity in a clinic setting. If clinics can no longer take patients with Medicaid, the result may be that patients will delay care and get sicker, or turn to the emergency room instead for needed care. This is a high-cost setting for care, and reduced clinic access may ultimately undermine the progress made to enhance cost-effective care coordination and reduce emergency room usage.

WSHA position

Medicaid already pays significantly less than the cost of providing clinic services. Hospital-based clinics provide access to critical health care services that are often not available through private physician offices. No cuts should be made to hospital-based clinic payments.

Washington State Hospital Association

Beth Zborowski, *Senior Director, WHS*
(206) 577-1807 • bethz@wsha.org
Washington Hospital Services
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Allow public hospital districts to participate in self-insurance risk pools with other hospitals

Level the Playing Field for Liability Insurance Coverage

For years, organizations have used self-insurance to better manage risk and ensure price stability over traditional insurance. One way organizations achieve self-insurance is through liability risk pools. Under current state law, public hospital districts and other government-owned hospitals cannot participate in risk pools with non-governmental hospitals, despite sharing similar risk. The Washington State Hospital Association supports creating a new chapter of law to allow public and non-public hospitals to jointly participate in self-insurance liability pools.

Creating space for hospital risk pools

Recently, hospitals explored the creation of a self-insured risk pool to control costs and stabilize insurance premiums. Self-insurance provides the potential for savings and price stability over traditional insurance with the support of management, implementation of loss controls, training and educational programs, and effective claims management.

Until the 2016 session, both public hospital districts and non-governmental hospitals had the option of jointly participating in the state's risk pool program. This changed in 2016 with the passage of Senate Bill 5119, which prohibits local governments from participating in self-insured risk pools with non-governmental organizations.

SB 5119 addressed concerns that governmental organizations could be held financially responsible for non-governmental organizations' liabilities if the shared risk pool was underfunded or one of the non-governmental members went out of business.

The legislature should maintain the safeguards put in place by SB 5119, while also allowing health care organizations with similar liability risks to gain the economies of scale of self-insurance through risk pool participation. Other industries have followed a similar path successfully.

Health care organizations face similar risks. Allowing them to self-insure through risk pools increases efficiencies and leads to better risk management.

The proposed legislation creates a separate chapter of law and is modeled on the process used in addressing the needs of affordable housing stakeholders in 48.64 RCW. By putting the legislation into a separate chapter, the needs of the hospital risk pool can be specifically addressed, while also ensuring that the State Risk Manager and the Local Government Self-Insurance Program have sufficient tools to ensure hospital risk pools are financially and operationally sound.

WSHA position

Health care organizations should be allowed to participate in risk pools regardless of their ownership. Other industries have successfully formed risk pools that share risk among governmental and non-governmental organizations with appropriate oversite from the State Risk Manager. The legislature should support authorization of a health care pool modeled on the success of affordable housing organizations.

Washington State Hospital Association

Chelene Whiteaker, *Policy Director, Member Advocacy*
(206) 216-2545 • chelenew@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Mental health funding

Investments to Make Behavioral Health Integration a Reality

Our state is well positioned to integrate physical and behavioral health care in ways that help patients identify and treat problems more effectively and efficiently. Without some strategic investments over the next few years, this goal may not be achieved. Some key steps our state can make include: paying for a new integration model in primary care, incentivizing regular screenings for depression, providing adequate reimbursement for hospitals caring for patients in crisis, and building up the work force.

Integrated model in primary care

Integrating behavioral health into primary care helps patients and controls costs, but payment systems have not kept up with changes. Medicaid should follow Medicare's lead in paying for care using a clinical care manager and a psychiatric specialist to deliver services. The integration model, known as the University of Washington's Mental Health Integration Project, has been nationally and internationally recognized as a better way to deliver mental health in primary care. A major barrier to statewide adoption is lack of reimbursement.

Targeted depression screening

Currently, Medicaid does not reimburse for screening for psychiatric conditions. Medicaid should pay for depression screening for adolescents ages 11-18, as well as mothers who are post-partum. Identifying mental health problems earlier will help people get the care they need.

Increasing the work force using psychiatric advanced registered nurse practitioners (ARNPs)

Psychiatric ARNPs have a history of working with safety net populations and continuing to practice in settings where they are trained. WSHA has identified two choke points that are a barrier to educating and training more psychiatric ARNPs. The first is that there are not enough faculty to teach more students. The second difficulty is placing psychiatric ARNPs in preceptorships for the 500 clinical hours needed for licensure. In addition, there is no standard for the clinical training. To address these barriers, a competitive pool should be funded for faculty positions and preceptorship placement, including dollars to appropriately train preceptors. A pool of funds would allow universities to apply for and receive a grant for a two- to three-year cycle to increase the numbers of educated and trained psychiatric ARNPs. This proposal will result in an additional 60 psychiatric ARNPs being educated and clinically trained over the next two to three years.

Funding key mental health strategies will speed up behavioral health integration and improve care.

Appropriately fund hospitals that are opening new psychiatric services and update the rate for the psychiatric inpatient care

Hospitals are increasing capacity to serve patients who have been committed under the Involuntary Treatment Act, but the Medicaid payment rates fail to cover the cost of care. WSHA supports paying new providers of inpatient psychiatric services under the same methodology as existing providers, while also reviewing and updating the psychiatric payment rates for each facility.

WSHA position

WSHA supports Medicaid funding for the integrated mental health model, depression screening for targeted populations, adequate reimbursement for hospitals caring for patients in crisis, and investments to educate and train more psychiatric ARNPs.

Washington State Hospital Association

Chelene Whiteaker, *Policy Director, Member Advocacy*
(206) 216-2545 • chelenew@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017
ISSUEBRIEF

Mental health system capacity

Increase Access to Mental Health Services

Our patients and families need more mental health services closer to home. WSHA has identified two areas where changes in law would create more mental health treatment capacity so that hospitals, health systems and other providers could do more to serve people with mental health needs.

Long-term mental health care in community hospitals

Concentrating all long-term mental health placements at Eastern and Western State Hospitals is not working. Some general-acute care and freestanding psychiatric community hospitals are interested in providing long-term, court-ordered mental health services.

Patients could be better served when closer to their home, communities, and families. Patients can transition out of care when close to home; and with community supports, will be less likely to be readmitted to care. Community hospitals are likely to have shorter lengths of stay for patients, as long as there are resources provided for community living once the patient no longer needs to be committed. Legislation should be enacted directing the Department of Social and Health Services to contract for long-term mental health services with community hospitals.

Certificate of Need for psychiatric beds

While some new inpatient psychiatric services are beginning to open, the state's Certificate of Need (CN) law continues to slow down the expansion of psychiatric services. The boarding of mental health patients in emergency departments is a major problem with the number of single bed certifications reaching all-time highs.

The legislature has twice allowed licensed hospitals to be exempted from CN for new beds, but those provisions have expired. WSHA supports continuing to exempt psychiatric beds from CN in currently licensed hospitals when certain conditions are met. This will allow hospitals that want to expand services to do so more quickly and efficiently.

The legislature can take concrete steps to increase capacity for inpatient mental health care.

WSHA position

WSHA supports directing the state to contract with community hospitals to provide long-term care and treatment for mental health patients in communities around the state.

WSHA also supports exempting licensed hospitals from going through a long CN process for badly needed psychiatric beds. These policies will help create more options for patients in need and are part of a broader solution for long-term mental health care.

Washington State Hospital Association

Zosia Stanley, *Policy Director, Access*
(206) 216-2511 • zosias@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Sharing mental health information

Allow Sharing of Mental Health Information for Care Coordination

Patients are better served when their health care providers have the whole picture, including both physical and mental health information. Currently, Washington State law is confusing and prevents care coordinators from accessing mental health information. State law needs to be updated to clearly allow this important access, while maintaining the privacy and confidentiality of sensitive information.

Integrated whole person care needs robust, informed coordination

Fragmented health care information can lead to care that is disjointed and redundant and can result in increased health care costs. Care coordination that takes into account information about a patient's physical health, substance use disorder, and mental health leads to high-quality, efficient and lower-cost care that is right for the patient.

Current Washington State law causes unnecessary confusion and barriers to care coordination

State and federal law protect patient privacy, but state law creates confusion about what information can be shared with care coordinators. State law allows sharing of mental health information without patient authorization in limited circumstances that are specifically listed, but the statute is conflicting and unclear about just what is allowed. While the statute gives general permission to share mental health information with properly trained people for care coordination, it also specifically states that mental health information can only be shared for care coordination by certain licensed providers who are activity treating the patient. These conflicting provisions create confusion. Under rules of statutory construction, laws on a specific topic control over more general statements. Unfortunately, fear about violating the unclear law is preventing necessary sharing of mental health information.

Care coordinators provide essential services and need access to mental health information

Care coordinators are a vital tool to help identify patient needs for integrated, whole person care. They often have a background in patient services, social work, and counseling and their training includes education on state and federal health information confidentiality laws. Allowing care coordinators access to mental health information can free up licensed providers to provide direct patient care. However, these important work force members cannot access mental health information under current state law that specifically requires that mental health information can only be shared for care coordination if two requirements are met: (1) the information is accessed only by certain licensed providers (such as physicians, psychologists, ARNPs and nurses) and (2) the providers are actively treating the patient. Care coordinators are specially trained in coordination and state and federal privacy laws, but are not always specially licensed and may not provide direct patient care.

The care team, including care coordinators, need access to both physical and mental health information to improve patient care and outcomes.

Mental health information can be used for care coordination while maintaining the privacy and confidentiality of sensitive information

Allowing care coordinators who are specially trained in state and federal health information confidentiality laws to access mental health information maintains patient privacy while improving care.

WSHA position

Increase safe, effective, and efficient care by amending RCW 70.02 to make clear that mental health information can be shared for care coordination purposes with the care team.

Washington State Hospital Association

Zosia Stanley, *Policy Director, Access*
(206) 216-2511 • zosias@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Noncompete clauses

Maintain Flexibility in Physician Contracts

When hiring physicians, many hospitals and medical groups in Washington State use noncompete clauses to protect investments to help relocate and establish physicians.

Noncompete clauses protect investments to establish and support physician practices

Many employers (including hospitals and physician groups) invest significant amounts of money to bring physicians to the community and support them once there. These investments can run into hundreds of thousands of dollars, including recruitment, moving expenses, licensure costs, administrative support, student loan relief, income guarantees, and marketing. Many of these costs are expended before the physician's first day of work.

Both rural and urban hospitals use noncompete clauses

In some remote areas, it can be difficult to recruit physicians. Some rural hospitals offer income guarantees as the practice is getting up and running, and before the physician has a significant patient population. Subsidized recruitment arrangements make it possible for these communities to have general and specialty care. There is also concern that hospitals need to be good stewards of resources and make sure investments are recouped.

State case law already regulates the scope and reasonableness of noncompete clauses

Current law strikes a balance for all professionals in regard to employment contracts and requires noncompete clauses to be reasonable, appropriate and justifiable in scope and duration. Recent court cases have upheld reasonable noncompete clauses in physician employment contracts.

Noncompete clauses are required to meet a three part test: (1) is the clause necessary to protect the employer's business or goodwill; (2) does the clause impose any greater restraint than necessary to protect the employer's business or goodwill; and (3) does injury to the public warrant non-enforcement of the clause.

Noncompete clauses are important tools to protect hospital investments in hiring and supporting physicians.

Physicians freely negotiate terms of employment. They have the power and responsibility to negotiate all portions of their employment contract – salary, retirement, noncompete clauses, and other elements.

Restricting use of noncompete clauses will impact the availability of physicians in our communities

Without noncompete clauses, hospitals and medical groups may feel it is too risky to spend money to put together substantial packages to recruit and support physicians because the hospitals cannot be sure of regaining the investment. This could adversely impact the availability of physicians to care for patients in this state. Hospitals are a chief source of all kinds of care including primary and specialty care for Medicaid and Medicare enrollees.

Banning noncompete clauses could also make it hard for physicians entering the medical field because employers will be less likely to offer benefits such as debt repayment, guaranteed income, and payment of malpractice premiums.

WSHA position

Noncompete clauses in physician employment contracts are reasonable and necessary clauses that are freely negotiated and covered by existing law. Washington hospitals oppose legislation that would prevent them from being used.

Washington State Hospital Association

Ian Corbridge, *Policy Director, Clinical Issues*
(206) 216-2514 • ianc@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017
ISSUEBRIEF

Nurse staffing

Ensure Safe and Responsive Staffing

Washington State should be proud of our state's record on patient safety. We are a national leader when it comes to improving the health of hospital patients with innovative, data-proven best practices that save lives and improve patients' health. Our success in many cases can be attributed to high-quality and driven staff who are constantly looking for new ways to deliver better care.

Hospitals need the flexibility to staff appropriately according to the needs of their patient population. State legislation mandating staffing requirements would treat all hospitals the same – small and large, rural and urban – and would not allow hospitals to be responsive to emerging patient needs. WSHA opposes laws that impose rigid staffing requirements or that undermine existing work force rules.

Staffing ratios do not improve care

Safe staffing is a crucial component of patient safety, but mandating inflexible ratios does not improve patient care or outcomes. Mandated ratios, also called patient assignment limits or minimum staffing standards, are only used in California.

There are a variety of hospital measures where the quality of nursing care is directly linked to patient outcomes. Three important measures include: catheter-associated urinary tract infection rate, central line-associated blood stream infection rate, and post-surgical blood clot rate. In all of these areas, Washington nurses perform better than or as well as those in California. Staffing ratios are not a proven strategy for improving outcomes.

In addition, because ratios must be maintained at all times, nurses cannot leave the work unit, meet with a patient's family members in the waiting room, or transport an unstable patient to another unit without violating the ratio. Instead of guaranteeing patient safety, mandated ratios can actually jeopardize it.

Prescheduled on-call

Hospitals provide care to patients 24/7, 365 days a year. Important, often life-saving, treatment does not occur on a set schedule. Patient needs can change rapidly. Hospitals need the ability to use prescheduled on-call to provide patients critical services such as needed surgeries and delivering babies when more patients than anticipated arrive for care. This is why hospital staff have prescheduled on-call hours. This ensures patients' planned and unplanned needs are met.

The quality of nursing care in Washington State surpasses the national average and California, which is the only state that mandates nurse staffing ratios.

Meal and rest breaks

Washington hospitals support healthy work environments and meaningful breaks for health care providers. However, when a family member arrives or a physician returns a call, many nurses choose to interrupt their break to care for their patients. Mandating uninterrupted meal and rest breaks would remove this much needed flexibility and the nurse's ability to balance patient needs in care delivery.

The Washington State Department of Labor & Industry governs meal and rest breaks for all workers, including nurses. In 2016, the Department undertook an extensive stakeholder process to examine meal and rest break guidance in its administrative policy. After an extensive process, draft guidance from the Department does not mandate uninterrupted breaks for nurses. While the Department has not yet adopted any final guidance, the examination of whether any changes to current rules or guidance documents for breaks for all workers, not just health care workers, has been exhaustively examined during the 2016 interim.

WSHA position

Washington hospitals need the flexibility to staff according patient care needs. WSHA opposes legislation establishing nurse staffing ratios, prohibiting the use of pre-scheduled on-call, and mandating uninterrupted meal and rest breaks.

Washington State Hospital Association

Ian Corbridge, *Policy Director, Clinical Issues*
(206) 216-2514 • ianc@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Addressing the opioid crisis

Create Systems to Stop Prescription Drug Misuse

The U.S. is in the midst of a prescription drug addiction crisis. Approximately two million Americans are addicted to prescription painkillers. In 2014, there were more than 600 opioid overdose-related deaths in Washington State. While Washington health data shows a significant drop in deaths from prescription drugs in recent years, this has been offset by a doubling of the number of heroin deaths. There are several state policies to address this crisis that could be very powerful if enacted.

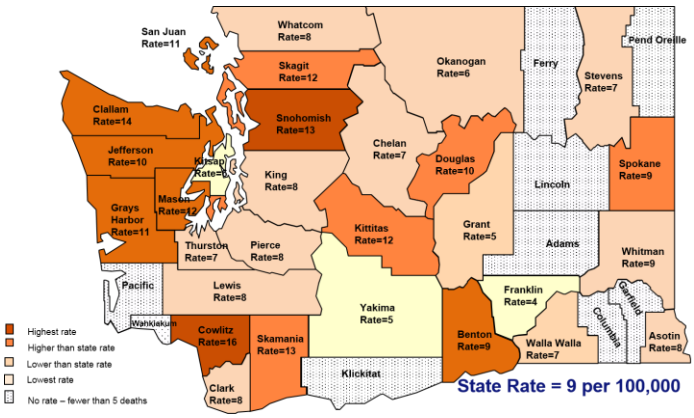
Use data to confront crisis

Washington State's Prescription Monitoring Program (PMP) has proven effective in improving patient care and curtailing prescription drug misuse. In 2016, the Washington State legislature passed House Bill 2730 which expands and streamlines access to the state PMP. This was a big step and will promote wider adoption and use of the PMP. However, continued enhancements are needed.

The Washington State Hospital Association has been working closely with the Washington State Medical Association and the Washington State Department of Health on ways to further strengthen the PMP and leverage data to promote quality improvement and appropriate opioid prescribing practices. The legislature can further address the opioid crisis by passing legislation to:

- Clarify and expand the Department's role in supporting quality improvement efforts around opioid abuse;
- Allow local Public Health Officers access to PMP data to identify persons at risk for abuse and provide appropriate follow up and care coordination services;
- Alert a patient's primary care provider and the opiate prescriber when a patient experiences an overdose event, with the goal of informing future treatment options and decreasing opioid-related deaths; and
- Provide de-identified prescribing and opioid related data to hospitals, clinics and the Washington State Hospital Association for the purpose of internal and community-wide quality improvement around opioid prescribing practices and abuse.

Opiate Overdose Death Rates by County of Residence 2012-2014



The abuse of prescription painkillers is impacting communities all across Washington State. Targeted state policies can help address this crisis.

Together, these changes will provide the health care and public health community greater resources in identifying patients at risk for abuse, stopping overdose deaths before they happen, and promoting high-quality care and evidence based opioid prescribing guidelines

Getting prescription opiates out of communities

Prescription opiates are an effective tool in treating pain, but once a patient is stabilized, we need an effective and statewide system to get unused prescription pain medications out of patients' homes and communities. This is an important step in addressing the opioid crisis given that over 70 percent of people who misuse prescription opiates obtain them from a friend or family member. WSHA supports a robust, appropriately-funded and statewide drug take-back program.

WSHA position

Health care institutions and providers need effective tools and data to address the opioid crisis. WSHA supports enhancements to our state PMP that identify those at risk for abuse and promote the sharing of information to support quality improvement and appropriate opioid prescribing practices. WSHA also supports a statewide drug take back program.

Washington State Hospital Association

Chelene Whiteaker, *Policy Director, Member Advocacy*
(206) 216-2545 • chelenew@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Access to Care

Preserve Access to Care for More Than 700,000 Washingtonians

In Washington State, more than 700,000 low- and moderate-income individuals have gained health insurance through Medicaid expansion or the premium subsidies on the Health Benefits Exchange. As a result, the uninsured rate is at an all-time low. WSHA strongly supports maintaining access to health care and health insurance for these newly covered people. For many people, this is the first time they have had health insurance and the ability to access ongoing health services. Access to comprehensive health services, not just an emergency room, is a critical reason WSHA strongly supports maintaining access to health care and health insurance for these newly covered people.

Serving patients

In order to provide comprehensive care to the newly insured, hospital clinics have added important services, such as primary care, specialty care, and mental health. Having more insured patients helps stabilize health care services so hospitals and health systems can serve their communities into the future.

Hospitals helped pay for coverage

The Affordable Care Act (ACA) coverage expansions are funded in part by cuts to Medicare and Disproportionate Share Hospital payments – a total of about $3.5 billion over ten years in Washington State alone. The deal struck in the ACA acknowledged that reductions in charity care and bad debt would help balance out these cuts.

While charity care and bad debt are decreasing, hospitals have seen significant increases in Medicaid payments that do not pay the cost of providing care in addition to patients unable to cover their portion of the large cost-sharing requirements of many Exchange plans. Despite these complex financing arrangements, hospitals continue to support increased access to coverage and care.

People across the state have gained access to care as a result of Medicaid expansion and the Health Benefit Exchange.

Only when its patients are accessing care in the appropriate setting and with stable reimbursement can hospitals and the health care system create innovations that lead to better outcomes at lower costs. Both the federal government and Washington State will have important decisions to make moving forward; maintaining access to care should be the top goal.

Finally, the expansions have provided important funding to the Washington State budget for health care services across the state, which has allowed the state to spend valuable resources on additional infrastructure and services to support Washington communities. The federal government and the legislature should maintain this funding for health care services into the future.

WSHA position

The legislature should scrutinize any changes at the federal level before making decisions impacting newly covered individuals. At every decision point, Washington State should choose the path that maximizes access to care and funding for health care services. WSHA strongly supports ensuring that our state continues to move forward on access to care and coverage for low- and moderate-income individuals.

Washington State Hospital Association

Claudia Sanders, *Senior Vice President, Policy Development*
(206) 216-2508 • claudias@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017
ISSUEBRIEF

Hospital safety net assessment program

Renew the Hospital Safety Net Assessment Program

WSHA supports a renewal of the hospital safety net assessment program to provide increased payment for hospitals that treat a significant number of Medicaid patients and to provide additional general fund dollars to the state for health care programs.

Background

In 2010, Washington State enacted a hospital-supported safety net assessment program. This program assesses a levy on hospitals in the state to draw down additional federal matching funds. The purpose was to restore hospital rate cuts enacted in 2009. The additional funds help hospitals meet the needs of Medicaid patients, and also provide additional funds for the state.

In 2012, hospitals worked with the legislature to reformulate the program. With this substantial revision, the program now provides approximately $150 million per year to hospitals, and about the same amount to the state. The program is set to expire on July 1, 2019, but needs to be extended for another two years in order to help balance the state's four-year budget.

Proposed program

Washington State hospitals want to renew and extend the safety net assessment program for another four years. Doing so, however, requires technical updates to account for changes in federal rules.

In addition, the program will need to be recalibrated if Congress repeals the Affordable Care Act. If the Act is repealed, the level of federal match for Medicaid drops and therefore, the overall benefit from the program would be severely reduced. The proposed assessment legislation continues to provide an equal share of any new benefit levels to the hospitals and the state.

The hospital safety net assessment program helps support hospitals that see a high proportion of Medicaid patients.

WSHA position

Washington State should renew the hospital safety net assessment program for another four years, as long as the program:

- Provides half the net benefit for additional hospital funds for Medicaid patients;
- Establishes a reasonable assessment rate (lower than $380 per non-Medicare patient day);
- Continues the current protections in the law for hospitals;
- Provides for a proportionate reduction in benefits for both the hospitals and the state if changes in federal law reduce the program's overall return; and
- Sunsets after four years, at which time the Washington State Hospital Association will work with the legislature on the future of the program.

Washington State Hospital Association

Zosia Stanley, *Policy Director, Access*
(206) 216-2511 • zosias@wsha.org
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Increase timely placement for Medicaid patients in skilled nursing homes

Incentivize Appropriate and Timely Patient Transfers from Acute Care to Skilled Nurse Facilities

Hospitals excel at providing acute care for patients in need of immediate, intensive or emergency care. Some patients are not ready to go directly home from the hospital and need to transition to a skilled nursing facility (SNF) to receive specialized care and rehabilitation. Unfortunately, some post-acute patients, especially Medicaid patients, are essentially "stuck" in hospitals when a SNF bed cannot be found. Some of these patients have complex needs and appropriate placement would be at a facility that can accommodate them.

Patients deserve the right care, at the right place and time

Many hospitals have a significant number of patients who stay at the hospital long after their inpatient care is complete. They are ready to go to another care setting, but remain in the hospital. The hospital is no longer the right place for the patient and keeping a patient there uses a valuable community resource in hospitals that are already running at or near capacity.

Medicaid plans are responsible for moving Medicaid patients into skilled nursing

Post-acute care services, including SNFs, are a Medicaid benefit. The plans are responsible for arranging placement of patients in SNFs and facilitating timely and appropriate transitions. The Health Care Authority should closely supervise and enforce this timely placement obligation.

Provider networks should include skilled nursing capacity

Medicaid managed care plans have the responsibility to assemble an adequate and appropriate network of covered post-acute providers, including SNFs that can accommodate complex patients. This obligation should be monitored and enforced by the Health Care Authority.

Medicaid plans must meet their obligation to place patients in the most appropriate care setting, including skilled nursing facilities.

Current rates do not incentivize timely placement of Medicaid patients in skilled nursing

Hospitals are paid a set rate, called the administrative day rate, when a Medicaid patient is clinically ready for discharge but remains in the hospital. This rate, based on the annual statewide average SNF Medicaid rate, is currently $185 per day. The rate is often less than the amount plans pay for the patient to receive care at a SNF. This creates an incentive to leave a patient in the hospital.

To properly align incentives, the plans should pay additional fees to the state when the plan has not found SNF placement within a reasonable time period. The fee should increase incrementally with the length of the unnecessary patient stay in the hospital, topping out after 30 days. While the hospital continues to receive only the standard amount, the additional fees paid to the state would provide an added incentive to move the patient to a more appropriate setting.

WSHA position

WSHA supports creating incentives for Medicaid plans to find placement in a skilled nursing facility within a reasonable time period for a patient who no longer needs care in the hospital.

Washington State Hospital Association

Beth Zborowski, *Senior Director, WHS*
(206) 577-1807 • bethz@wsha.org
Washington Hospital Services
Washington State Hospital Association
(206) 281-7211 • www.wsha.org

2017 ISSUEBRIEF

Hospital Worker's Compensation Insurance Trust

Allow More Health Care Facilities to Participate in the Worker's Compensation Trust Program

For more than 30 years, hospitals in Washington State have managed their worker's compensation claims through the Hospital Worker's Compensation Insurance Trust. Through the Trust, hospitals have implemented risk and claims management strategies leading to safer work places, fewer claims and lower claims cost.

WSHA supports legislation to expand the opportunity to participate in the Hospital Worker's Compensation Insurance Trust to other health care facilities with similar worker's compensation risks.

Increasing efficiency and managing risk

Over the last few years, WSHA has been approached by non-hospital members who are interested in joining the Washington Hospital Worker's Compensation Insurance Trust. These health care facilities, particularly kidney centers and large clinics, share similar worker's compensation risks as hospitals, but are too small to take advantage of self-insurance.

Under current law, they are not able to participate in the Hospital Worker's Compensation Insurance Trust programs because membership is restricted to hospitals as defined in RCW 70.41.020. By changing who is eligible to participate in the Trust to include "health care facilities" as defined in RCW 70.38.025 (6), more WSHA members and other health care facilities can take advantage of the benefits of Trust membership. Another added benefit for current Trust participants is the increased efficiency of shared administrative costs.

Health care facilities are committed to keeping their employees safe on the job. Being able to participate in self-insured worker's compensation trusts allows health care facilities to better manage risk and claims costs.

Preventing injuries and getting people back to work

The hospital trust program partners with the hospital association to provide access to best practices in work place safety to prevent the types of injuries that occur most frequently in the health care setting. The longer an injured worker stays off the job, the more likely they are to never return to work. The trust is committed to getting injured workers the care they need and then getting them back to work. The trust actively manages claims and works to get them closed appropriately. Trust members also benefit from shared best practices in return to work programs for our members. This reduces costs and gives people better long-term outcomes.

WSHA position

Washington's hospitals have benefitted from the Washington Hospital Worker's Compensation Insurance Trust program for more than 30 years. The association supports expanding access to the Trusts to other health care facilities that share similar risk that are also members of the Washington State Hospital Association, especially kidney centers and large clinics.

Chelene Whiteaker
Policy Director, Member Advocacy
(206) 216-2545 • chelenew@wsha.org
Washington State Hospital Association

Katie Kolan
Director, Legislative and Regulatory Affairs
(206) 618-4821 • kak@wsma.org
Washington State Medical Association

2017 Issue Brief

Physician licensure compact

Support the Physician Licensure Compact

The interstate physician compact speeds up the process for physicians who seek to be licensed in multiple states. Its benefit is substantial in a state such as Washington with major border communities. Recruitment of qualified physicians takes place in an increasingly national market. In addition, the continued development of services delivered through telemedicine makes this legislation important. The compact will help providers working to meet increased demand for outpatient services.

Why it's good for Washington State

The compact will allow Washington State to maintain local control and accountability of physicians' licensure and disciplinary actions.

A physician practicing under an interstate compact is bound to comply with the statutes, rules and regulations of each compact state where he/she chooses to practice.

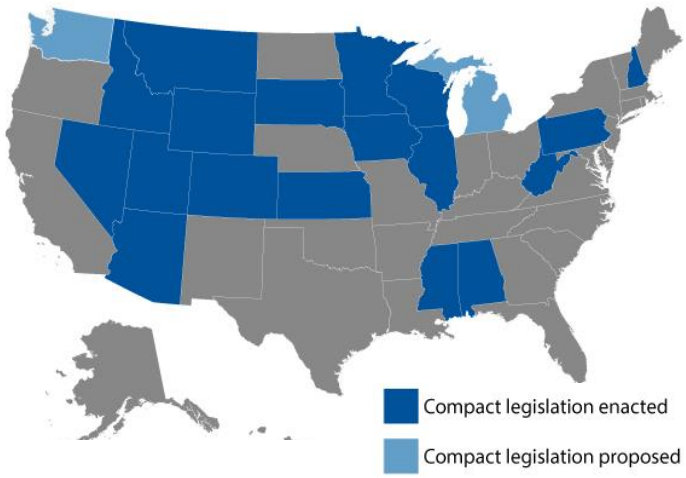
How will the physician compact work?

The physician compact legislation is national model legislation that each state must enact as originally drafted. Eighteen states have agreed to participate.

For participating states, the compact establishes a commission to help administer licensing of physicians in multiple states. The compact facilitates more timely exchange of licensing and disciplinary information among states. The commission will have two representatives from each state medical board participating in the compact.

The compact continues the requirement for physicians to be licensed in the state where the patient receives care. The compact would create another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act.

States with interstate medical licensure compacts



The physician licensure compact legislation protects the state's ability to regulate doctors, while at the same time allowing them to serve cross-border communities.

The compact is self-sustaining and funded entirely by licensing fees paid by physicians.

The expedited compact process will help to ease current and future licensing process duplications. Compared with 20 percent nationally, 30 percent of Washington's physicians have active licenses in two or more states. The need for multi-state licensure will only grow over time with more services provided through telemedicine—providing residents with better access to more highly qualified primary and specialty care physicians.

WSHA and WSMA position

WSHA supports legislation to allow Washington State to participate in a compact to expedite physician licensure in multiple states.

The compact reduces licensing paperwork, but does not otherwise change a state's existing Medical Practice Act.

"Advances in telemedicine have allowed physicians to deliver care safely and securely across state lines, bringing the care to people who need it. By joining the licensure compact, we make it easier for doctors to obtain the proper licenses to deliver more care to more people safely." - Dr. John Scott, Medical Director, UW Telehealth