Cost Burden

Evaluating the Financial Impact of Oregon State Regulatory Compliance on Oregon Hospitals and Health Systems

2019

A collaboration of the Compliance Advisory Committee (CAC)/Oregon Association of Hospitals and Health Systems (OAHHS) and the Master of Healthcare Administration (MHA) Program, Pacific University

CONTENTS

Executive Summary	3
I. Introduction	5
II. Project Scope	6
III. Key Findings	7
IV. Other Related Research	16
V. Recommendations	16
VI. Data Limitations & Explanations	18
VII. References	19

Executive Summary

In October 2017, the American Hospital Association (AHA) issued a report entitled "*Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals, and Post-Acute Care Providers*." The AHA report outlined the administrative costs of federal healthcare compliance requirements on health systems, hospitals, and post-acute care providers. In September 2018, less than a year after the AHA report was published, the Oregon Association of Hospitals and Health Systems (OAHHS) initiated this project to evaluate the cost burden of state statutory and regulatory compliance on hospitals and hospital systems in Oregon. The Compliance Advisory Committee (CAC) under OAHHS formed the project team, working with faculty members and students of the Master of Healthcare Administration (MHA) program at Pacific University.

The goals of this project are to:

1. Identify key statutory and regulatory requirements the State of Oregon has mandated to hospitals;
2. Understand the costs associated with complying with these requirements; and
3. Quantify the costs of compliance in terms of staff hours/salary dollars, technology, contract services, etc.

The project was kicked off in early September 2018; in late November, a survey was distributed to 60 inpatient acute care hospitals in Oregon, which were categorized as DRG (Diagnostic Related Group), Type A, and Type B facilities. The research team received 37 responses from 44 hospitals in mid-January 2019. In addition, during this time, the team conducted follow-up interviews with OAHHS officials and healthcare executives to add additional depth to the data.

Key findings:

- Oregon hospitals spent $126M a year solely on labor to comply with state regulations (based on the latest 12 months). According to October 2017 AHA's report, the staff salaries represented 85% of total compliance costs. The additional costs can be found in IT infrastructure and vendor related expenses. On average each Oregon DRG hospital spent approximately $3.9M annually, and each Type A and B hospital spent close to $0.5M annually on labor alone to comply with state regulations (based on the latest 12 months).
- Acute care inpatient hospitals in Oregon must comply with over 2,000 rules created by the state.
- Type A and Type B hospitals differ from DRG hospitals in their capacity to allocate resources to manage compliance work, with 87% of DRG hospitals, 31% of Type A hospitals, and 25% of Type B hospitals affording a dedicated corporate compliance department.

- Time constraints were the #1 barrier to achieving compliance with state laws and regulations, followed by funding/budget constraints, and staff resource constraints.
- Oregon's nurse staffing law stood out as the most significant burden on hospitals, as providers and staff felt that the law focused more on record keeping than on quality of staff hiring and patient care.

Recommendations to state lawmakers:

(1) Be mindful about the cost burden on healthcare providers and the healthcare system when initiating or publishing new regulations and laws. Legislators and other state officials should review and eliminate rules, especially related to documentation and reporting requirements, that do not directly improve or influence patient care or hospital efficiency. This should include soliciting feedback from healthcare providers, hospitals, and health systems regarding the design and implementation of new laws and regulations during multiple stages of the legislative process.

(2) Before publishing new laws and regulations, ensure that they are written clearly and easily understandable in a consistent format to minimize administrative staff time and costs spent on interpretation.

(3) Ensure that new and existing laws and regulations do not conflict with federal laws and regulations, and ensure that the reporting requirements, timelines, forms, etc. are consistent with between state and federal requirements.

(4) The state must set achievable expectations that are not increasingly burdensome, particularly for the smaller hospitals, and eliminate the process of designating healthcare compliance regulation as passing on "signature." When passing a law and setting an effective date, consider what is required realistically to implement a law, particularly how much time is needed from passage to full and effective implementation. It sometimes takes six months to one year, or even longer, to fully establish the processes needed for hospitals to be in compliance.

(5) Thoroughly review Oregon's existing nurse staffing laws, listen to the feedback from hospitals on the laws, and ensure that the laws focus not on paperwork and documentation but on hiring effective nurses and improving patient care. Instead of focusing the nurse staffing survey on record keeping, we recommend the state focus the survey on the effect of the requirements on patient care and health outcomes.

I. Introduction

The Oregon Association of Hospitals and Health Systems' (OAHHS) 2017 Legislative Report listed 114 healthcare provider-related Senate and House bills proposed by the State of Oregon. Of those 114 bills, 45 were passed and became effective laws in 2017 or 2018. When new laws are passed, healthcare entities often need to adjust workflows to meet new requirements. This adjustment process means increased staff time required for providers to understand the new rules, document and analyze data, and determine increased costs associated with hiring additional personnel and implementing new requirements. How much will it cost hospitals and hospital systems to comply with the new laws and regulations passed in a year?

In October 2017, the American Hospital Association (AHA) issued a report entitled "*Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals, and Post-Acute Care Providers*." The AHA report outlined the administrative cost of federal healthcare compliance requirements on health systems, hospitals, and post-acute care providers. In September 2018, less than a year after the AHA report was published, the Oregon Association of Hospitals and Health Systems (OAHHS) initiated this project to evaluate the cost burden of state statutory and regulatory compliance on hospitals and hospital systems in Oregon. The Compliance Advisory Committee (CAC) under OAHHS formed the project team, working with faculty members and students of the Master of Healthcare Administration (MHA) program at Pacific University.

The primary goals of the project are to: 1) understand and distinguish the healthcare regulatory cost overlay from the Oregon state perspective; 2) identify the specific regulations that are most burdensome; and 3) find a quantifiable way to estimate the potential costs of complying with a new state regulation.

II. Project Scope and Methodology

The project team focused on **fact-based development** to highlight and quantify the financial impacts of state regulatory requirements on hospitals and hospital systems throughout Oregon through a three-step process:

1. The team first conducted a detailed review of key state regulations and statutes impacting providers in Oregon. Oregon has a vast amount of laws and regulations governing healthcare providers. The two primary governing bodies associated with regulating these laws are: the Oregon Revised Statutes (ORS) published by the Office of Legislative Counsel, and the Oregon Administrative Rules (OAR) created by Oregon Health Authority to implement and interpret statutory authority. This project focuses on ORS chapter 441 (Health Care Facilities), ORS chapter 442 (Health Planning), and OAR Chapter 333 (Oregon Health Authority Public Division). Many other state laws that are related to ancillary services provided by hospitals, such as pharmacy, lab or food, are not covered by this project.

2. Based on the statutory review and discussions with OAHHS CAC members, the team then developed and administered a survey of 38 questions to executives responsible for regulatory compliance at each hospital; the survey questions were designed to identify and prioritize key pain points, expense areas, hours and the labor required by different types of staff and departments to develop programs to comply with state laws and regulations. In addition, a separate survey of 17 questions was sent to hospital nurse executives to obtain feedback specifically on Oregon's nurse staffing laws enacted in 2015.

Survey Responses

The survey was sent to 60 inpatient acute care hospitals across Oregon. Per Oregon Health Authority, hospitals are grouped into three categories: DRG, Type A, and Type B. DRG hospitals are typically large, urban hospitals that receive payments based on the prospective Diagnostic Related Group (DRG) system; Type A hospitals are small (fewer than 50 beds) and are located more than 30 miles from another hospital. Type B hospitals are small (fewer than 50 beds) and are located within 30 miles of another hospital. Long-term care and rehabilitation facilities were not included in the project scope; 37 responses representing 44 hospitals were received.

Hospital Type	# of Responses	# of Hospitals represented
DRG	16	21
Type A	14	13
Type B	7	10
Total	**37**	**44**

3. Finally, the team conducted multiple interviews in person or via teleconference with OAHHS officials and healthcare executives representing a cross section of the state's hospitals and health systems, encompassing different types of organizations across different geographies. These interviews were used to further define the key "pain points" and associated costs faced by providers across the state.

III. Key Findings

- Oregon hospitals and health systems must comply with a significant number of laws and regulations governing patient safety, nurse staffing, hospital operations, and management.

Below is the summary of ORS/OAR laws directly related to inpatient hospitals:

Chapter	Description	Total Sections / Divisions	Sections / Divisions related to inpatient hospitals	Specific laws or Regulations related to inpatient hospitals
ORS Chapter 441	Health Care Facilities	171	121	430
ORS Chapter 442	Health Planning	81	68	260
OAR Chapter 333	Public Health Division	117	76	1454

This means acute care inpatient hospitals in Oregon must comply with over 2,000 rules created by the state. State rules from both statutes and regulations cover virtually all aspects of hospital operations and business in Oregon.

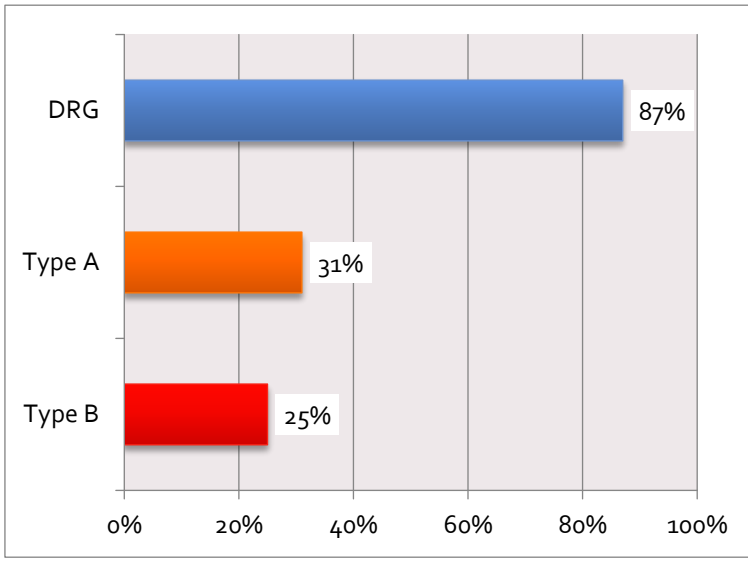
Examples of categories in ORS/OAR laws and regulations related to inpatient hospitals:

Category	Sections	Rules
Hospital Licensing/monitoring/management	34	204
Patient care and nursing services	24	108
Physician Credentialing	9	24
Financing Health care facilities construction	16	45
Certification of Need	7	152
Civil Penalties	13	36
Suicide Attempts by Minors	2	5
Patient Safety Commission	13	44
Rural Health	20	56

- Type A & Type B hospitals differ from DRG hospitals in their capacity to allocate resources to manage compliance work.

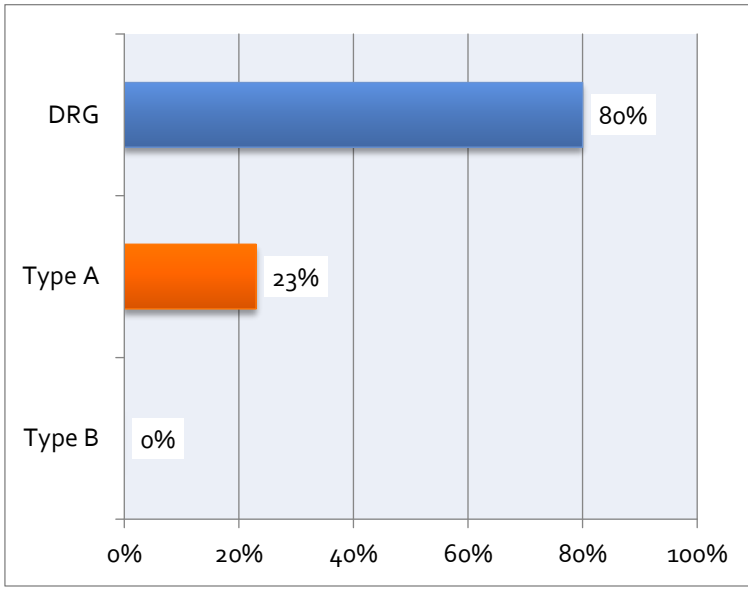
"Does Your Organization Have a Dedicated Corporate Compliance Department?"

87% of DRG hospitals said they have a dedicated corporate compliance department with a dedicated full-time chief officer; however, only 31% of Type A hospitals and 25% of Type B hospitals responded affirmatively. DRG hospitals, reported an average number of 6.10 FTEs (Full Time Equivalent Employees) in the corporate compliance department, while Type A hospitals reported an average of 1.1. DRG hospitals also reported as many as 20 FTEs in the department, while the most reported by Type A hospitals was 1.5 FTEs.



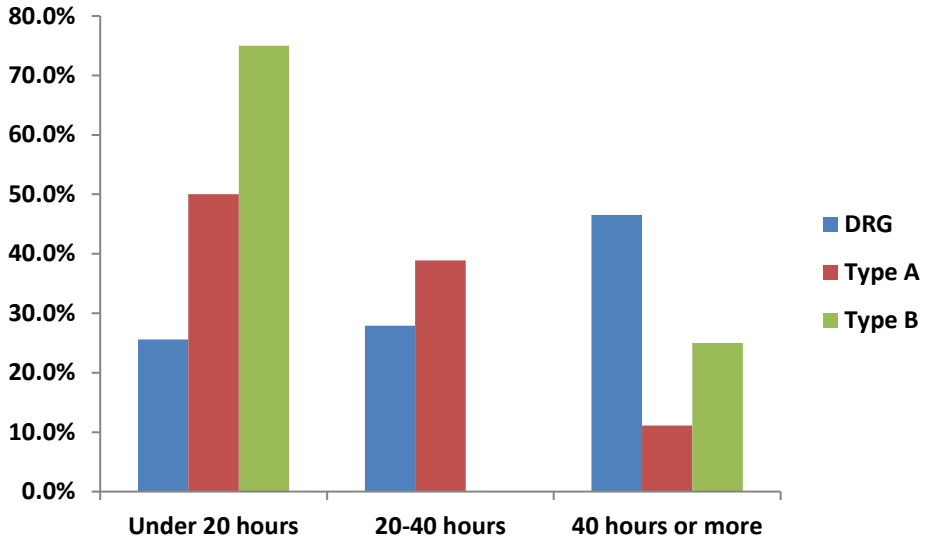
"Does Your Organization Have a Separate Accreditation & Clinical Compliance (ACC) Team?"

80% of DRG hospitals said they have a separate ACC team; however, only 23% of Type A hospitals and none of the Type B hospitals answered "yes" to this question. DRG hospitals reported an average number of 4.2 FTEs on the ACC team, while Type A hospitals reported an average of 1.1. None of Type B hospitals indicated they have a dedicated ACC team. DRG hospitals reported as many as 8 FTEs on an ACC team, while the most reported by Type A hospitals was 2 FTEs.



- For healthcare providers, separating out time and hospital resources spent between federal and state level regulatory compliance work is currently not common practice. Some hospitals responded that they do not know how to allot or assign hours between the two at all. Some responders said they just work on compliance issues when there is a need, either at the federal or state level. Others said their primary compliance focus is on Federal and CMS (Centers for Medicare & Medicaid Services) rules.

"What are the estimated weekly hours your compliance department staff is allotted for overseeing state regulations?"



About 50% of the DRG hospital compliance departments reported spending fewer than 40 hours a week overseeing state regulations, and the other 50% reported spending 40 hours or more a week. The majority (89%) of Type A hospitals reported spending fewer than 40 hours a week overseeing state regulations, and the majority (75%) of Type B hospitals reported spending fewer than 20 hours a week. Additionally, OAHHS hospital compliance committee members approximated, during interviews, that they thought they spent, on average, 10-20% of their time each week on state-only regulatory compliance work.

What is listed above does not include time spent on state regulatory compliance work by departments outside of designated compliance teams. Many hospitals have also established committees to ensure compliance with state regulations. These committees often include physicians, nurses, nurse aides, surgical technologists, and other hospital providers and staff who are pulled away from their patient-care responsibilities to work on compliance administrative tasks. The most common committees are Audit and Compliance Committees, Patient Safety Committees, Nurse Staffing Committees, Clinical Quality Committees, and Medical Staff Committees. One catheterization lab manager commented during an interview: "My staff are pulled to committee after committee."

"My staff are pulled to committee after committee"

"How many committees/boards does your hospital have to be compliant with state regulations?"

# of Committees	DRG	Type A	Type B
0-5	5	5	3
>10	12	4	1
Highest	29	33	11
Lowest	1	1	1
No response	4	4	6

- The study uncovered that the top three primary barriers to achieve compliance with state regulations are:

    a. Time constraints
    b. Funding/budget constraints
    c. Staff resource constraints

Hospitals are given no time to implement the new laws/regulations, especially because many state bills are passed on "signature." This means that once the governor signs the law, the law takes immediate effect. Hospitals are not given time to understand the new law, train their staff, collect data, or otherwise establish infrastructure to comply with the law. Essentially, once the law is passed, the hospitals become non-compliant. Some new requirements involve implementation of changes across many departments in the hospital, which creates even more confusion during the rush to adhere to the changes. Some hospitals feel that, given how tight the constraints on time and resources are, the state is setting unachievable, and sometimes unnecessarily burdensome, expectations. For example, the state might require duplicative regulator bodies investigating the same issue, or require extra time to deal with state investigations on staff complaints.

Oregon's laws on nurse staffing were discussed most during this project. During an interview with the nurse executive at a large local hospital, she said that the state staffing laws are helpful in practice, because the law requires the written hospital-wide staffing plan for nursing services that has been developed and approved by the hospital nurse staffing committee. When nurse managers presented their staffing plans to the nurse staffing committee, everyone was able to learn from each other in a transparent way.

However, she felt that the state surveyor during the site audit focused more on record keeping and how the records are provided, than on the staff and quality of patient care. The law requires that nurse staffing committees consist of an equal number of direct-care staff and hospital nurse managers. For example, her hospital has 32 nursing departments, therefore 64 participants are required to sit on the nurse staffing committee in order to ensure voting pairs between management

and direct-care staff are in place, as required by the law. The committee meets quarterly and it takes at least 8 hours to go over the staffing plans. Sometimes the committee needs to meet twice in a month to respond to the survey result. This is time taken away from patient care and other job responsibilities. The minutes of each meeting end up being over 30 pages long to show the details on who attended, who voted, what was discussed, etc. This is time and resources taken away from directly improving and focusing on patient care, health outcomes, and hospital operations.

Another example is that by law, the hospital is required to prove the meals and break time for staff. However, most hospitals' time systems track an employee's meals by their clocking out and in but not the break time. This means the unit charge nurse needs to manually monitor who takes breaks at what time all day long, which is not a valuable use of their time. There is a general feeling that parts of the nurse staffing law are not realistic to implement, given the workflow in a hospital setting.

For this study, the hospital survey results were consistent with the interview responses. The hospitals surveyed felt strongly that Oregon's laws on nurse staffing diverted their time and resources away from patient care without adding value to patient and employee safety and quality of care provided. The nurse staffing law focused on nurse staffing committee charters, meeting minutes, and voting rights, which have little to do with improving patient care or improving actual staffing of nurses. "It is a waste of time. It is bureaucratic. It is intense," commented one hospital nurse manager. "Nurse staffing regulations are a huge issue for a critical access hospital. There was so much focus on how our meetings are conducted and minutes taken. I thought that was a waste of time since it had nothing to do with ensuring a safe environment for staff and patients," commented a Chief Nurse Executive from a 25-bed Type A hospital. "The regulations are onerous and the documentation requirements are horrendous. The documentation requirements take away from patient care time," commented a finance leader from another 25-bed Type A hospital. Overall, hospital nursing leaders seem to believe that the laws on nurse staffing do not help staffing efficiency or patient safety, and that Oregon Health Authority needs a better understanding of how hospital staffing works in practice.

> *"The documentation requirements take away from patient care time"*

Many hospitals also commented that state regulations often duplicate CMS and other federal regulations. For example, one hospital representative pointed out, "much of Division 505 (Hospital Organization and Management) borrows from CMS." Another commented, "duplicate regulations are not seen as a problem as long as the reporting is the same for both. It is when the various agencies want the reports on their own form or different forms where it becomes burdensome."

On the other hand, when asked, "What are the three primary state regulations you feel strongly support your hospital to improve patient safety/quality care?" the responses are so varied that no single regulation or law can be pinpointed. Some hospitals simply responded, "None identified" or "none come to mind."

- Oregon hospitals spent $126M a year solely on labor to comply with state regulations (based on the latest 12 months). According to October 2017 AHA's report, the staff salaries represented 85% of total compliance costs. The additional costs can be found in IT

infrastructure and vendor related expenses. On average each Oregon DRG hospital spent approximately $3.9M annually, and each Type A and B hospital spent close to $0.5M annually on labor to comply with state regulations (based on the latest 12 months).

It can be difficult to identify costs for state-only compliance when the same staff and resources are often used for federal compliance. As one hospital representative stated, "it is impossible to estimate retroactively as we do not split the costs between state and federal regulations." Therefore, this survey only focused on the labor costs hospitals spent on:

a. Compliance with selected state regulation laws, including mental health, nurse staffing, adolescent suicide prevention, and interpretive services;

"Estimated costs spent on maintaining your state compliance program last fiscal year"

	Mental Health	Nursing Staffing	Adolescent Suicide Prevention	Interpretive Services	Other*	Total
DRG	$ 285,636	$ 437,211	$ 20,200	$ 491,667	$ 708,000	$ 1,942,714
Type A	$ 73,319	$ 24,369	$ 70,000	$ 23,533	$ 35,068	$ 226,289
Type B	$ 50,000	$ 50,000	$ -		$ 100,000	$ 200,000

** Other - genetic research, accreditation costs, information system, etc.*

b. Maintaining state legislatively mandated disease-specific registries, including those for Cancer, Trauma, Burn, Immunization, Physician Orders for Life-Sustaining Treatment (POLST), and Newborn Hearing Screening Tests;

Oregon maintains several health-related or disease-specific registries or databases, including the Oregon Trauma Registry, Oregon POLST Registry, and Oregon Cancer Registry, etc. The data collection and reporting burdens sometimes fall on hospitals. For example, Oregon trauma system hospitals are mandated by the Oregon Health Authority to monitor and provide specific data to the Oregon Trauma Registry (OTR) within 90 days of death or discharge of a trauma system patient. Making entries to the Trauma Registry is very time intensive and requires a lot of manual entries and editing to keep the data clean and meet state data input definitions and restrictions. Based on the survey results, 37% of the hospitals maintain or report to 1 to 5 registries; 43% of them maintain or report to 5-10 registries; and the remaining 20% maintain or report to over 10 registries. Hospitals and health systems are not provided with any resources from the state to maintain these important registries and databases, which are essential to public health. This can add to increasing healthcare costs across the system.

"Percentage of hospitals with disease-specific registries"

	Cancer	Trauma	Burn	Immunization Registry	Physician Orders for Life-Sustaining Treatment (POLST)	Newborn hearing screening test registry
DRG	80.0%	43.3%	13.3%	70.0%	76.7%	76.7%
Type A	38.5%	61.5%	7.7%	46.2%	23.1%	30.8%
Type B	50.0%	50.0%	0.0%	75.0%	75.0%	25.0%

"Estimated costs spent on state disease-specific registries"

	Cancer	Trauma	Immunization Registry	Physician Orders for Life-Sustaining Treatment (POLST)	Newborn hearing screening test registry	**Total**
DRG	$177,840	$ 74,880	$ 93,600	$ 271,440	$ 56,160	**$ 673,920**
Type A	5,616	46,800	9,360	9,360	6,552	**$ 77,688**
Type B	$ -	$ 30,888	$ 30,888	$ 61,776	$ 30,888	**$ 154,440**

***Note**: estimated costs by registry are calculated based on the average FTEs reported by the hospital. Average wage rate is $45/hour. No employee benefit cost is included.*

c. Ancillary data collection and reporting to meet state regulation requirements in imaging, lab, and pharmacy;

Weekly hours of staff time spent				
	Under 20 hours	20-40 Hours	Total	**Estimated Annual Costs**
DRG	20.8%	20.8%	100.0%	$ 66,056
Type A	66.7%	16.7%	100.0%	$ 34,125
Type B	100.0%	0.0%	100.0%	$ 19,500

***Note**: estimated annual costs are extrapolated using the median weekly hours reported in each category; Average wage rate is $45/hour. No employee benefit cost is included.*

d. State mandated quality measurement and reporting; and

"Estimated costs spent on state-mandated quality measurement and reporting in hospitals (excluding patient specific reports)"

	Weekly hours of staff time spent				
	Under 20 hours	20-40 Hours	40 hours or more	Total	**Estimated Annual Costs**
DRG	33.3%	0.0%	66.7%	100.0%	$ 52,406
Type A	100.0%	0.0%	0.0%	100.0%	$ 12,675
Type B	66.7%	33.3%	0.0%	100.0%	$ 25,350

Note: *estimated annual costs are extrapolated using the median weekly hours reported in each category; Average wage rate is $45/hour. No employee benefit cost is included.*

e. Health information technology/system maintenance and upgrades to meet state regulation requirements.

The costs in this area are difficult to quantify for a particular fiscal year. For example, if the hospital implemented its Electronic Medical Records (EMRs) system for the year, the costs could be over thousands of hours and multi-millions of dollars. In addition, there are many outside contractors involved and many caregivers who are not directly IT employees who also contribute hours.

"Capital Investment last 36 months to meet state regulations"

	Capital Investment last 36 months to meet state regulations				
	0-$1 M	**$2 - 3 M**	**Over $6 M**	**Total**	**Annual Labor Costs**
DRG	30.0%	5.0%	60.0%	100.0%	$ 1,037,550
Type A	87.5%	12.5%	0.0%	100.0%	$ 149,400
Type B	66.7%	0.0%	0.0%	100.0%	$ 68,400

Note: *Estimated annual labor costs are derived using the estimated hours spent in the last 36 months for the hospitals reported in the survey"*

f. Salary expenses for dedicated Corporate Compliance Team and Accreditation & Clinical Compliance team.

	Average FTEs			
	Accrditation & Clinical Compliance	Coroprate Compliance	% of State Compliance Work	Annual Salaries
DRG	4.2	6.1	15%	**$ 144,612**
Type A	1.1	1.1	15%	**$ 30,888**
Type B	1.0	1.0	15%	**$ 28,080**

Note: *estimated costs are calculated based on the average FTEs reported by the hospital. Average wage rate is $45/hour. No employee benefit cost is included.*

- In summary, given the limited scope and conservative estimation in this study, on average each Oregon DRG hospital spent approximately $3.9M annually, and each Type A and B hospitals spent close to $0.5M annually on labor to comply with state regulations. In total, all Oregon hospitals spent $126M a year solely on labor to comply with state regulations (based on the latest 12 months). According to October 2017 AHA's report, the staff salaries represented 85% of total compliance costs. The additional costs can be found in IT infrastructure and vendor related expenses.

"Estimated annual labor costs spent on compliance with state regulations"

	Selected State Regulation Laws	Selected State Specific Disease Registries	Ancillary Data Reporting State Reguired	State Manadated Quality Measurement and Reporting	Maintaing Technology System to meet State Reguirements	Dedicated Compliance Teams (15%)	Total
Per Hospital							
DRG	$ 1,942,714	$ 673,920	$ 66,056	$ 52,406	$ 1,037,550	$ 144,612	$ 3,917,258
Type A	226,289	77,680	34,125	12,675	149,400	$ 30,888	$ 531,057
Type B	200,000	154,440	19,500	25,350	68,400	$ 28,080	$ 495,770

All Hospital

	# of Hospitals	Total Labor Costs
DRG	28	$ 109,683,224
Type A	12	$ 6,372,684
Type B	20	$ 9,915,400
Total		**$ 125,971,308**

Note: *Some grants are available through Oregon Office of Rural Health for type B hospitals; Oregon State does not provide financial support for hospitals to implement and maintain the compliance programs as listed above.*

IV. Other Related Research

When researching state compliance findings in other states, the research team concludes that there is a minimal amount of research on this topic. The team found only one existing report on the topic – in 2014, PricewaterhouseCoopers (PwC), a consulting firm, conducted a "State of Compliance" survey, presenting the trends in healthcare compliance at the time, specifically in the non-value-added tasks delegated to compliance departments due to growing regulations combined with the same or decreased budgets. *Note: PwC is an outside consulting firm, with no affiliation with government entities.*

The State of Compliance survey recognized that as states add more regulations, the cost of compliance grows, as well as the duties of the compliance department and chief compliance officer (CCO). Traditionally, this has mostly affected larger hospitals. However, more Type A and B hospitals are discovering the same issues. Based on data from the State of Compliance Survey, hospitals were already spending additional resources to address new state rules and regulations (PwC, 2014). Compliance departments do not generate revenue, and around 33% of hospital executives stated that their compliance department budget was upward of one million dollars or more (PwC, 2014). At the same time, hospital budgets were decreasing or remaining the same *(PWC, 2014, page 3).*

> *"Staffing levels increased 40% during the past 12 months, but either budgets have stayed the same or one in 10 reported a decrease in budget" (PWC, 2014, page 3).*

This has created pressure in compliance departments, and they are scrambling to find ways to comply with new state laws and regulations, and training staff on the changes. Many hospitals that did not have a compliance department were forced to allocate compliance duties to clinical staff, which can negatively impact patient care. The trend appears to be the same in Oregon in regard to increasing costs for hospitals and health systems to address compliance regulations.

V. Recommendations

The results of this project identify key barriers that hospitals and health systems face when tasked with complying with new state rules and regulations. These barriers are non-value added burdens that both prevent compliance teams from meeting strict state regulations and add cost to the healthcare system. The interviews, survey results, and subsequent data analysis bring to light key themes: the number of state rules negatively affecting hospitals and healthcare providers; effect of time constraints, and complaints about Oregon's nurse staffing laws.

Primary recommendations to state legislators and other state rule-making officials are:

(1) Be mindful about the cost burden on healthcare providers and the healthcare system when initiating or publishing new regulations and laws. Legislators and other state officials should review and eliminate rules, especially related to documentation and reporting requirements, that do not directly improve or influence patient care or hospital efficiency. This should include soliciting feedback from providers, hospitals, and health systems regarding the design and implementation of new laws and regulations during multiple stages of the legislative process.

(2) Before publishing new laws and regulations, ensure that they are written clearly and easily understandable in a consistent format to minimize administrative staff time and costs spent on interpretation.

(3) Ensure that new and existing laws and regulations do not conflict with federal laws and regulations, and ensure that the reporting requirements, timelines, forms, etc. are consistent with between state and federal requirements.

(4) The state must set achievable expectations that are not increasingly burdensome, particularly for the smaller hospitals, and eliminate the process of designating healthcare compliance regulation as passing on "signature." When passing a law and setting an effective date, consider what is required realistically to implement a law, particularly how much time is needed from passage to full and effective implementation. It sometimes takes six months to one year, or even longer, to fully establish the processes needed for hospitals to be in compliance.

(5) Thoroughly review Oregon's existing nurse staffing laws, listen to the feedback from hospitals on the laws, and ensure that the laws focus not on paperwork and documentation but on hiring effective nurses and improving patient care. Instead of focusing the nurse staffing survey on record keeping, we recommend the state focus the survey on the effect of the requirements on patient care and health outcomes. In addition, we suggest that the state allow hospitals to monitor their own staffing and create their own staffing plans that fit their specific patient care needs, rather than be strictly limited to the state's format.

When asked, "What are the estimated total costs associated with developing and implementing the new Oregon house rules passed in 2017?", most hospitals could not come up with a dollar figure or "unknown." For the hospitals that actually responded and provided dollar figures, the survey results indicate that large hospitals or health systems spent at least 1 full time FTE or over $100,000 in 2017 just to keep up with the new state laws that took effect in the same year. Smaller hospitals often did not have resources, or were overwhelmed by the new changes and did not know how to implement them. As state officials continue to issue even more requirements each year, they should keep this feedback from Oregon's hospitals in mind.

VI. Data Limitations and Explanations

As survey results are human creation, the data we received from our surveys had certain limits when we first obtained it. Here is an overview of some limitations we encountered and how we tried to resolve them:

- There is some duplicated data – for example, where the same person responded to the survey questions twice at different times with different answers. We eliminated the ones with incomplete answers and kept the ones with more complete answers.

- There is some bundled data – for example, where a response represented 8 hospitals, but 5 were DRG hospitals, 2 were Type A, and 1 was Type B, then in this case we grouped the answers under DRG hospitals because the majority of the hospitals responding were DRG hospitals.

- All data were normalized to weekly or annual data even where the original survey answers may have reflected different time periods.

- The data provided may have included inaccurate information and the answers may not have always truthfully reflected what was requested in the survey. We also received responses in different formats and answers from one respondent that were inconsistent across questions. We spent substantial time cleaning this kind of data and used our best judgment to evaluate its reliability and decide whether to include it in the analysis.

VII. References

Regulatory Overload: Assessing the Regulatory Burden on Healthy Systems, Hospitals and Post-acute Care Providers; American Hospital Association October 2017

https://www.aha.org/sites/default/files/regulatory-overload-report.pdf

https://www.aha.org/guidesreports/2017-11-03-regulatory-overload-report

Oregon Revised Statutes (ORS) published by the Office of Legislative Counsel and Oregon Administrative Rules (OAR) created by Oregon Health Authority

2017 ORS Chapter 441 — Health Care Facilities https://www.oregonlaws.org/ors/chapter/441

2017 ORS Chapter 442 — Health Planning https://www.oregonlaws.org/ors/chapter/442

Oregon Health Authority Public Division – Chapter 333
https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=89

PwC State of Compliance 2014- https://www.pwc.com/us/en/risk-management/state-of-compliance-survey/assets/pwc-soc-provider.pdf

Your Guide to Oregon's Hospital Nurse Staffing Law – Oregon Nurse Association

Appendix A: OAHHS CAC – grit /matrix or Oregon State reporting requirements

Appendix B: OAHHS 2017 Legislative Report 08-23-17 Final

Appendix C: Survey questions