Minnesota Hospital Association

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June 17, 2019

Karen Tritz, Acting Director
Center for Clinical Standards and Quality/Quality, Safety & Oversight Group
Department of Health & Human Services
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Submitted electronically via email to HospitalSCG@cms.hhs.gov

RE: Clarification of Ligature Risk Interpretive Guidelines
Ref: DRAFT-QSO-19-12-Hospitals

Dear Acting Director Tritz,

On behalf of the Minnesota Hospital Association (MHA) and our 141 hospital and health system members, we appreciate the opportunity to offer the following comments regarding the proposed changes to ligature risk mitigation requirements as set forth in your April 19, 2019 memorandum to state survey agency directors (hereinafter, "the proposal" or "the proposed standard").

MHA and our members take pride in our long commitment to and earned reputation for not only prioritizing patient safety but also making the investments and taking the responsibility to improve the quality and safety of care for our patients. MHA was the first state hospital association to hire a staff member dedicated to patient safety improvement work, we championed the country's first adverse health events public reporting law, and we have developed a high-performing Hospital Innovation and Improvement Network (HIIN) with our members through the Centers for Medicare and Medicaid Services (CMS) Partnership for Patients. Our members and the dedicated caregivers who are driven to provide the best possible care are committed to suicide prevention for all of our patients.

Over the past few years, however, our members have reported unusual and unrealistic expectations of surveyors with respect to ligature risk mitigation. The steps surveyors have required Minnesota hospitals to take have been significantly burdensome, costly and disruptive to patient care. Just as no inpatient care environment or staffing can be designed to prevent all infections or falls, it is impractical and unrealistic for surveyors to expect a physical environment and staffing to be designed to eliminate any and every circumstance that could constitute a ligature risk.

We are pleased that CMS has heard and is responding to these concerns. It is evident that the proposed changes are intended to clarify that setting and trying to enforce unrealistic standards actually results in further restricting access to mental and behavioral health care at a time when our country is failing to meet our residents' and communities' growing demand for these

services. For example, your memorandum notes that a toilet seat could be a potential ligature risk, yet while the risk technically exists, the risk is minimal. According to a recent study by the National Association for Behavioral Healthcare (NABH), psychiatric hospitals have spent an average of $15,600 per inpatient bed on facility renovations and equipment. These additional costs, especially when they are incurred to address technical but minimal risk issues, compound the challenge of providing a service line that already suffers from unsustainably low reimbursement rates, workforce shortages, and rising employee safety and security concerns.

Every hospital that decides to close an inpatient psychiatric care unit or decrease the number of patients it will care for because it cannot afford to meet a surveyor's expectations for infrastructure renovations or construction or for staffing and security decreases access to care. Even more difficult to measure is the number of inpatient psychiatric beds that have not been constructed in the first place as hospitals around the country reevaluate their plans in light of the recent ligature risk mitigation demands of surveyors.

Just as CMS has recognized that requiring entirely ligature-free environments and staffing is counterproductive, MHA acknowledges and supports the need to make sure significant ligature risks are mitigated.

MHA supports the proposed distinctions in standards for locked rooms or units, on one hand, and unlocked rooms or areas within a hospital on the other hand. By making this distinction, hospitals with locked units or rooms can better understand and anticipate where ligature-resistant environments are expected, and then focus their attention and resources on making any needed changes.

At the same time, the proposed standard offers new guidance for hospitals with respect to steps and plans that they can take to ensure safe patient care environments in unlocked units or areas without incurring the expense and patient care interruptions in an attempt to make all areas meet the ligature-resistant standard.

We also appreciate the memorandum's instruction to surveyors to consider the patient care environment in its entirety and to avoid citing hospitals as noncompliant based on a technical-but-minimal ligature risk, such as a toilet seat, when there are not other risks present.

MHA also appreciates the proposed process for requesting additional time for hospitals to make needed changes. CMS recognized that competitive bidding processes, acquiring the necessary supplies or equipment, obtaining required permits, etc. can pose significant obstacles for hospitals making a good faith effort to come into compliance.

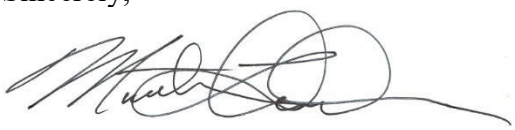
In final guidance, MHA suggests including more definition and description of "ligature-resistant" so hospitals and surveyors have a better shared understanding of what is necessary to meet a "ligature-resistant" standard as compared to a "ligature-free" standard. The example of a toilet seat is helpful, as are the examples of ligature risks such as handrails. More examples or clarity might be helpful to ensure consistent interpretation and enforcement.

To avoid the hardship of repeated renovations to facilities and equipment changes, MHA respectfully requests that the final guidance include a period of time after a hospital makes these kinds of structural changes when surveyors cannot require additional structural changes or retrofitting. A hospital that disrupts patient care, incurs significant expenses, and changes its facilities in a manner approved by one surveyor should not be subject to the next surveyor demanding additional changes to a design and environment recently approved by a surveyor.

Finally, MHA asks that the final guidance clarifies that areas in locked units that have constant supervision, such as cafeterias, common areas or nursing stations, do not have to meet the ligature-resistant standard. MHA believes the ligature-resistant standard is intended to apply to those areas in a locked unit where a patient will spend time without immediate supervision, and that it is not CMS's intention to require hospitals to make every aspect of a locked unit ligature-resistant if there are areas or rooms where patients do not have any access or where they are under supervision.

Again, MHA appreciates the agency's efforts to respond to hospitals' recent concerns with the standards surveyors have been imposing. Thank you for the opportunity to provide feedback and suggestions on behalf of our members. Please feel free to contact me if you have questions or concerns.

Sincerely,



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