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Hospital Association of Southern California

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CHCQ Overview

- **Center for Health Care Quality:** Coordinates all statewide efforts for mandated regulatory oversight of health care facilities and providers.
- **Licensing & Certification (L&C):** Evaluate facilities, agencies, and professionals for compliance with state and federal licensing/certification regulations in order to operate in California.
- **Healthcare Associated Infection Program:** Conduct surveillance, prevention and public reporting of infection rates.
- **Professional Certification Branch:** Responsible for the certification and the investigation of allegations involving licensed or certified health care professionals and the enforcement of disciplinary actions.

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CHCQ Major Activities

- Provides regulatory oversight to over 8,000 facilities in 30 different facility and agency types.
- Certify facility compliance with federal requirements.
- Annually provide updates for facility adverse events, administrative penalties, and breaches.
- Annually conduct over 11,000 investigations of general acute care hospitals:
 - Annually review approximately 8,000 entity reported incidents (ERIs);
 - Annually review 3,000 complaint reports.
- Train, inspect, drill, and educate facilities in emergency preparedness response and recovery efforts.
- Effective enforcement = Uniform enforcement

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Center For Health Care Quality

**Fosters delivery of safe, effective,
and quality health care.**


Patient safety protection through:
*Evaluation of facilities for standards of
safe and quality care*

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**LICENSING & CERTIFICATION
PROGRAM**

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**Surveys
Federal & State Processes**

- L&C is the state agency working with CMS to complete Medicare certification for all facilities in California in accordance with federal regulations.
- **Initial State Licensing Survey:**
 - Onsite initial facility survey following an approved application evaluating Health and Safety Codes and Title 22 regulations an.
- **Patient Safety Licensing Survey:**
 - GACH Survey to determine compliance with Statutes enacted since 2006
- **Medication Error Reduction Plan (MERP) Survey:**
 - Survey review of facility formal plan to eliminate or substantially reduce medication related errors.

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Patient Safety Licensing Survey Background

- Tool used only during general acute care hospital survey for compliance with licensing requirements.
- Covers eleven (11) patient-safety statutes chaptered since 2006 – 2010.
- Other facility types identified in Health and Safety Code section 1250 are not included at this time.

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Patient Safety Licensing Survey Information

- Goal is to provide a focused survey process for GACH providers and L&C surveyors to follow.
- *PSLS Process Tool for Providers* timeframes are starting point to provide sufficient documents for compliance review.
- Surveyor may request additional documentation as needed.

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Patient Safety Licensing Survey Documentation


- Survey documents consist of:
 - Administration Entrance List
 - Field Notes
 - Provider Evaluation form
- Reference documents include:
 - CDC recommendations,
 - Health & Safety Code, Title 22 statutes
 - PSLs All Facility Letters released since 2007.
 - Other PSLS related documents (Provider Instructional PowerPoint, Process Tool for Providers, and FAQs).
- Documents posted on the L&C website:
 - www.cdph.ca.gov/programs/LnC/Pages/PSLS.aspx

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Patient Safety Licensing Survey Statutes Addressed

- AB 774 (Chan) Effective 1/1/2007 [Fair Pricing Policies]
- SB 739 (Speier) Effective 1/1/2007 [Patient Safety and Infection Control]
- AB 106 (Berg) Effective 1/1/2008 [Immunizations]
- SB 633 (Alquist) Effective 1/1/2008 [Discharge Plans]
- AB 2128 (Emmerson) Effective 1/1/2009 [Dietician Educational Requirements]
- AB 2400 (Price) Effective 1/1/2009 Notice to Reduce or Eliminate Services]


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Patient Safety Licensing Survey Statutes Addressed, Cont.

- AB 2565 (Eng) Effective 1/1/2009 [Policy on Brain Death]
- AB 2747 (Berg) Effective 1/1/2009 [End of Life Care]
- SB 158 (Florez) Effective 1/1/2009 [Patient Safety and Infection Control]
- SB 1058 (Alquist) Effective 1/1/2009 [Patient Safety and Infection Control]
- AB 818 (Hernandez) Effective 1/1/2010 [Connection Ports Epidural, Enteral, IV]

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MEDICATION ERROR REDUCTION PLAN
(MERP)

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MERP Top Survey Deficiencies

- Failure to include a multidisciplinary process to regularly analyze all errors – 30% (HSC§1339.63(e)(6))
- Failure to identify weakness or deficiencies that could contribute to errors – 28% (HSC§1339.63(e)(1))
- Failure to develop and/or implement policies and procedures for safe use of medications – 21% (Title 22 §70263(c)(1))
- Failure to conduct an annual review to assess effectiveness of the implementation of MERP – 19% (HSC§1339.63(e)(2))
- Failure to modify the facilities plan as warranted when weaknesses or deficiencies are noted to achieve the reduction of medication errors – 13% (HSC 1339.63(e)(3))


Based on exited surveys to date 2013



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MERP Survey Summary


| January 2009 to December 2011 | January 2012 to December 2012 | January 2013 to March 2013 |
|--|--|---|
| Hospitals planned for survey: 374 | Hospitals planned for survey: 121 | Hospitals planned for survey: 45 (first quarter 2013) |
| Surveys completed: 368 (98%) | Surveys completed: 121 (100%) | Surveys completed through January 14th: 10 (22%) |
| Hospitals with deficiencies: 345 (94%) | Hospitals with deficiencies: 120 (99%) | Hospitals with deficiencies: 10 (100%) |
| Average deficiencies per hospital: 5 | Average deficiencies per hospital: 5 | Average deficiencies per hospital: 5 |
| Hospitals in full compliance: 23 (6%) | Hospitals in full compliance: 1 (1%) | Hospitals in full compliance: 0 |



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MERP Medication Safety System Vulnerabilities

- Management of High Risk Medications
 - Fentanyl Transdermal Patch
- Provision of Emergency Medications
 - Adequate supplies – Malignant hyperthermia
 - Competency
- Safe Storage of Medications
 - Refrigeration
 - Concentrated solutions

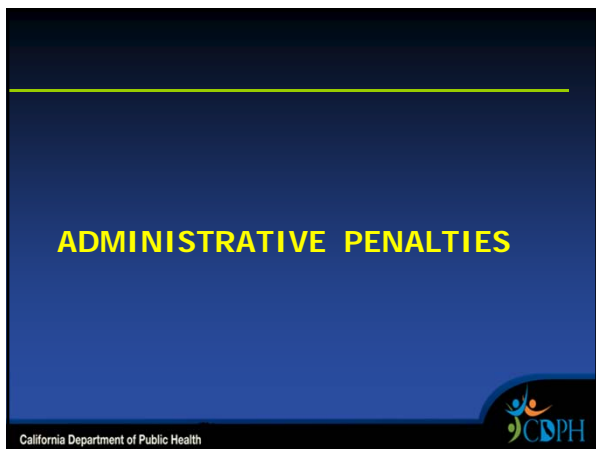


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Adverse Events Report Category by Type


| Adverse Event Categories and Types (HSC 1279.1, data as of 1/2/12) | 2009/10 | 2010/11 | 2011/12 | All |
|---|--------------|--------------|--------------|--------------|
| Abduction of a patient of any age | 0 | 0 | 1 | 1 |
| Adverse event/series of adverse events | 50 | 54 | 106 | 210 |
| Care provided by someone impersonating a licensed health provider | 0 | 5 | 1 | 6 |
| Death associated with a fall | 32 | 23 | 30 | 85 |
| Death during or up to 24 hours after surgery | 28 | 27 | 33 | 88 |
| Death or serious disability associated with a burn | 6 | 2 | 2 | 10 |
| Death or serious disability associated with a medication error | 29 | 29 | 23 | 81 |
| Death or serious disability associated with electric shock | 0 | 0 | 0 | 0 |
| Death or serious disability associated with hyperbilirubinemia in neonates | 0 | 0 | 1 | 1 |
| Death or serious disability associated with incompatible blood | 1 | 0 | 1 | 2 |
| Death or serious disability associated with use of a device other than as intended | 10 | 5 | 9 | 24 |
| Death or serious disability associated with use of contaminated drug, device/biologic | 5 | 2 | 5 | 12 |
| Death or serious disability associated with use of restraints/bedrails | 24 | 50 | 51 | 125 |
| Death or serious disability directly related to hypoglycemia | 2 | 5 | 3 | 10 |
| Death or serious disability due to disappearance | 3 | 6 | 1 | 10 |
| Death or serious disability due to intravascular air embolism | 2 | 4 | 6 | 12 |
| Death or serious disability due to spinal manipulation therapy | 0 | 0 | 0 | 0 |
| Death or significant injury from a physical assault | 5 | 4 | 5 | 14 |
| Infant discharged to the wrong person | 1 | 0 | 0 | 1 |
| Maternal death or serious disability associated with labor or delivery | 6 | 8 | 7 | 21 |
| Oxygen line contains wrong gas or toxic substance | 1 | 0 | 1 | 2 |
| Retention of a foreign object in a patient after surgery or other procedure | 260 | 221 | 241 | 722 |
| Sexual assault on a patient | 17 | 20 | 37 | 74 |
| Stage 3 or 4 decubitus ulcer acquired after admission | 926 | 990 | 916 | 2,832 |
| Suicide or attempted suicide | 12 | 16 | 12 | 40 |
| Surgery performed on a wrong body part | 32 | 21 | 44 | 97 |
| Surgery performed on the wrong patient | 3 | 3 | 3 | 9 |
| Wrong surgical procedure performed on a patient | 13 | 20 | 19 | 52 |
| Total Adverse Events | 1,468 | 1,515 | 1,558 | 4,541 |



Administrative Penalties

- Since 2007,
 - Total Administrative Penalties issued: 254
 - Administrative Penalties generated from Adverse Events: 208

- Total assessed amount: \$10,435,000.00
- Amount collected: \$7,513,878.00




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Administrative Penalties Report Category by Type

The following includes information on general types of conditions for all 235 APs issued since January 2007- December 2012.

| Type of event | Previous Totals | New Totals | Percentage of Total |
|------------------------------------|-----------------|------------|---------------------|
| Retention of foreign object | 62 | 66 | 25.89% |
| Medication errors | 53 | 55 | 21.65% |
| Patient care issues | 47 | 50 | 19.69% |
| Patient safety | 46 | 46 | 18.11% |
| Surgical error | 12 | 15 | 5.91% |
| Staffing/ Training | 5 | 5 | 1.97% |
| Equipment failure | 5 | 5 | 1.97% |
| Diagnostic/ Laboratory test errors | 5 | 5 | 1.97% |
| Patient Abuse | 4 | 4 | 1.57% |
| Improper food handling | 3 | 3 | 1.18% |
| Total | 242 | 254 | 100.00% |



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Administrative Penalties Quality Improvement Opportunities

- Retained Foreign Objects
- Medication Safety
- Underreporting of Adverse Events



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MEDICAL RECORD BREACHES




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Breach Penalties

- January 2009 – December 31, 2012:
 - 12,846 Breaches reported to CDPH:
 - Of the 8,213 completed investigations:
 - 8,177 substantiated medical Breaches.
 - 35 cases resulted in Administrative Penalties.

| Penalty Category | Assessed | Collected |
|-------------------------------------|----------------|----------------|
| PMI Breach Administrative Penalty | \$3,627,100.00 | \$1,872,625.00 |
| Failure to Report to the Department | \$743,300.00 | \$382,050.00 |
| Failure to Report to the Resident | \$278,200.00 | \$170,800.00 |



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Breach Penalties


January 1, 2009 – November 1, 2012

Substantiated Cases= **8,177** (12,846 intakes)
 Non-intentional Breaches: **7,191 (94.05%)**

- Non-intentional breach to person outside facility/HC system: **6,779**
- Non-intentional breach of IT/theft/lost records: **412**

Intentional/Deliberate Breaches: **273 (3.57%)**

- Intentional breach by health care worker: **250**
- Intentional breach by person other than health care worker: **20**
- Intentional breach of IT/theft/lost records: **3**



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Breach Recommendations

- Hospitals must continuously train staff to maintain patient's confidentiality, and ensure that their electronic systems have appropriate security measures to monitor and document unlawful access and implement measures once an unlawful access is detected.
- Facilities and agencies need to improve practices and policies in monitoring and limiting access, as well as, implement better safeguards to make patient medical information secure. Encourage the provider community to work with one another and share best practices.
- As more and more hospitals and facilities implement electronic medical records, facilities must be cognizant to craft their software and policies and procedures to prevent unauthorized employees from accessing and disclosing patient medical information.

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ANTIPSYCHOTIC COLLABORATIVE

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Antipsychotic Collaborative

CDPH – DHCS Executive Report issued the findings of the collaborative and recommendations to address identified quality of care issues, with the intent to reduce inappropriate antipsychotic medication use in California nursing homes.

- Background:
 - 27.6% of Medicare beneficiaries receive antipsychotics
 - ✓ 58.2% of these are inappropriate use
 - OSCAR data over the last three years shows the use has remained relatively unchanged
 - ✓ 24.2% recipients on average both appropriate and inappropriate use

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Antipsychotic Collaborative

California Partnership to Improve Dementia Care and Antipsychotic Medication Reduction in Nursing Homes Collaborative

- Executive Report issued May 2012.
- Development/implementation of a survey tool.
- Alignment w/ CMS National Initiative
- Multi-stakeholder workgroups to identify strategies to improve care
 - Workgroups include:
 - ✓ Informed consent
 - ✓ Enhanced enforcement
 - ✓ Improved dementia care

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Antipsychotic Collaborative Survey Tool

CDPH L&C SNF Antipsychotic Use Survey Tool

Facility: _____ Date of Record Review: ____/____/____

Resident Name: _____ Unit/Room/Bed: _____

Resident Identifier: ____ DOB: ____/____/____ Age: ____ DOA: ____/____/____ Readmit

Event ID: _____

| Antipsychotic Name | Daily Dosage | Order Date | Behavioral Modification |
|--------------------|--------------|------------|-------------------------|
| | | | |
| | | | |
| | | | |

| 1. Which of the following represents the primary indication for use of the antipsychotic? (complete for each antipsychotic) | Y | N |
|---|---|---|
| 1. Schizophrenia | | |
| 2. Schizo-affective disorder | | |
| 3. Delusional disorder | | |
| 4. Mood disorders (e.g. bipolar disorder, depression w/ psychotic features) | | |
| 5. Schizophreniform disorders | | |
| 6. Psychosis | | |
| 7. Atypical psychosis | | |
| 8. Brief psychotic disorder | | |
| 9. Dementing illnesses with associated behavioral symptoms | | |
| 10. Medical illnesses with psychotic symptoms (e.g. neoplastic disease) and/or treatment related psychosis or mania (e.g. high-dose steroids) | | |
| 11. Tourette's Disorder or Huntington disease | | |
| 12. Hiccups or nausea and vomiting associated with cancer or chemotherapy | | |
| 13. None of the above | | |

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Antipsychotic Collaborative May 2012 and Beyond

- Stakeholder engagement to identify strategies, timelines, and commitment
 - CMS, HSAG, CHPH and others
 - Alignment with CMS National Initiative
 - August, October, December and in-between
- Workgroups on:
 - Informed Consent
 - Enhanced Enforcement
 - Consumer Awareness
 - Dementia Care

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QUALITY AND ACCOUNTABILITY PROGRAM

For SKILLED NURSING FACILITIES

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Quality & Accountability Program

- Collaborative effort between Departments of Public Health and Health Care Services.
- Provide incentive payments to skilled nursing facilities achieving minimum scores on Quality Measures.
- Identification of Quality Measures for Staffing, Physical Restraints, Facility-acquired Pressure Ulcers, Immunizations (Influenza and Pneumococcal), Olmstead compliance and, Patient/Family Satisfaction Survey.
- Developing a model to provide incentives for high performing SNFs.

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REGULATIONS

Current updates

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**Regulations
In Process**

- **Administrative Penalties** – Will set guidelines for determining administrative penalties for immediate jeopardy and non-immediate jeopardy violations in General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals.
- **Tuberculosis Testing** – Will allow for the use of a broader choice of TB screening test.
- **Adverse Events** – It will clarify statutory language related to what the hospitals must report regarding the 28 adverse events listed in statute.
- **General Acute Care & Special Hospitals** – Will review and revise Title 22 Division 5 Chapter 1-General Acute Care Hospital regulations in order to modernize an increasingly obsolete regulation set.


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**Regulations
In Process**

- **Medical Information Breach** – Will clarify and specify statutory language related breach violations in all affected facility types.
- **Cardiac Catheterization Labs (CCLs)** – In coordination with OSHPD, will develop emergency and formal regulations amending Title 22 Sections 70438-70438.1 to define requirements for housing CCLs outside of main hospital buildings.
- **General Acute Care Infection Control Revision/Surgical Site Infection Reporting** – Will revise Title 22 Section 70739 Infection Control Program to reflect changes in the current infection control statutes; will clarify and specify statutory language related to what the hospitals must report regarding surgical site infections.


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**HEALTHCARE ASSOCIATED INFECTIONS
PROGRAM**

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HAI Public Reporting


- To improve quality, reduce costs
 - Hospitals = identify areas for improvement
 - Purchasers = determine value of care
 - Patients = informed choices
- January 2012 HAI Reports
 - 4/1/10-3/1/11: Methicillin Resistant *Staphylococcus aureus* BSI, Vancomycin Resistant *Enterococci* BSI, Central Line Associated BSI, *Clostridium difficile* Infections
 - One quarter of data: Surgical Site Infections (SSI)
- August 2012 HAI Reports
 - Conversion to Calendar Year reporting
 - Overlap of one quarter of data
 - 12 months of data
 - Exception SSI: 7-9 months of data



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HAI Reporting Data

| HAI | % of Hospitals Participating | | |
|----------|------------------------------|-------------------------|-------------------------|
| | Data period | | |
| | Prior to April 2010 | April 2010 - March 2011 | January - December 2011 |
| CLABSI | 79 | 97 | 99 |
| MRSA/VRE | 87.7 | 94 | 95.1 |
| SSI | n/a | n/a | 99 |
| CDI | 87.2 | 91.4 | 93.8 |




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HAI Validation Results*

| HAI | CDI | MRSA BSI | VRE BSI | CLABSI |
|---------------------------|-----------|-----------|----------|----------|
| # Reported | 2172 | 442 | 112 | 135 |
| Reported in error | 55 (3%) | 15 (3%) | 4 (4%) | 23 (18%) |
| Should have been reported | 221 (10%) | 150 (26%) | 41 (27%) | 68 (38%) |


*2011 Validation project had 100 volunteer facilities.



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HAI
MRSA/VRE BSI Key Findings

- Second report using NHSN , still first state to report MRSA or VRE BSI rates
- Risk stratified – expanded from 4 to 7 categories
 - LTAC, Pediatric, Major Teaching and Community
 - Rehabilitation, Critical Access, and Prison
- Major Teaching and LTAC hospitals higher rates for both MRSA/VRE compared to other categories
- MRSA rates decreased in Major Teaching while MRSA and VRE rates increased in LTACs

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HAI
CLABSI Key Findings

- Second CDPH CLABSI report using NHSN data
- CLABSI rates continue to be
 - Grouped by locations where patients with similar medical conditions receive similar medical care
 - ✓ Critical Care
 - ✓ Ward
 - ✓ Special Care
 - Compared using California standards – average rate for California hospitals for those locations

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HAI
CLABSI Key Findings

- CLABSI number 10% lower in 2011 than 2010
- CLABSI average rates in majority (74%) of patient care locations lower in 2011 than 2010
 - Reductions in CLABSIs in California appear to be on pace with the US, as a whole
- Hospital locations with statistically higher rates may be priorities for prevention efforts

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HAI
SSI Key Findings

- First report using NHSN data
 - Reporting period: April 1 - December 31, 2011
- Uses Standardized Infection Ratio (SIR)
 - Adjusted for individual patient risks for infection
 - Compares procedure-specific rate to national average
 - Calculated when sufficient volume of procedures
 - No risk adjustment for 5 surgical procedure categories so no SIRs presented

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HAI
SSI Key Findings

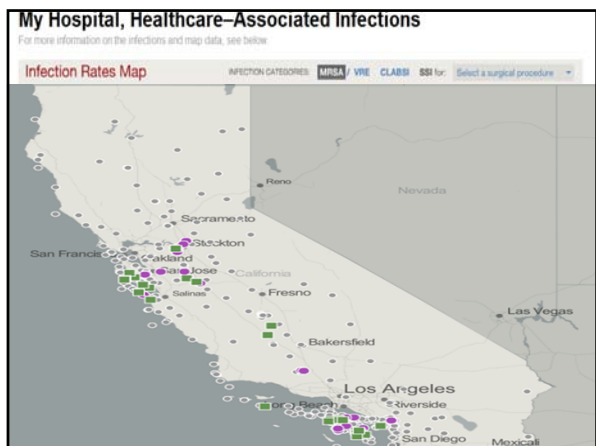
- 99% of hospitals subject to requirements reported data on one or more of 29 surgical procedure categories (SPC)
- 193 of 342 reporting hospitals at least one SIR
 - 47 with significant SIRs
 - ✓ 33 fewer SSIs than predicted for ≥ 1 SPC
 - ✓ 11 more SSIs than predicted for ≥ 1 SPC
 - ✓ 3 both
- Most only modestly higher or lower

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HAI
Interactive Map

- Allows risk adjustment through Standardized Infection Ratio (SIR)
 - Based on individual patient risks adjusted for patient health and surgery
 - Compares procedure-specific rate to national average
 - Calculated when there is sufficient volume of surgical procedures to generate an SIR
- Top four surgical procedures with an SIR:
 - Coronary artery bypass graft (5)
 - Hip replacement (18)
 - Colon surgery (29)
 - Knee replacement (5)

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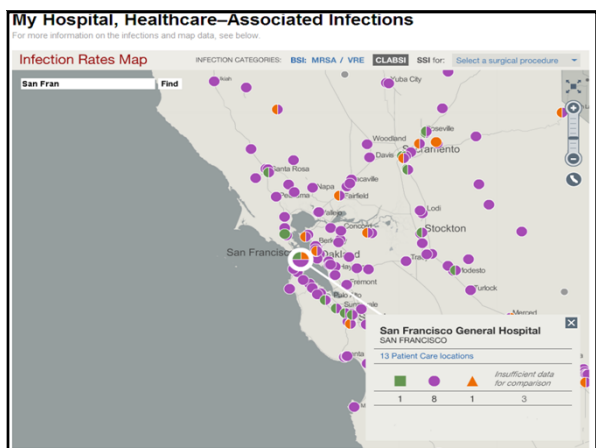
About This Map
Publicly presenting information on individual hospitals' infection rates is a crucial part of the California Department of Public Health strategy to reduce healthcare associated infections (HAI).

We have provided this in two formats: detailed information on each of the 3 HAIs separately (see below) and the interactive map providing summary information on the 3 HAIs.

About The Data
The comparisons on this map take into account how hospital patient populations differ in their risk of infection. Hospital data were used when there was sufficient volume to perform statistical comparisons. Each hospital's infection frequency or rate is compared to a standard. Please use caution when making comparisons between hospitals. The frequency of infections for hospitals may differ due to differences in patients' infection risks not accounted for, or differences in clinical, infection control, or surveillance practices.

LEGEND
 ● NO COMPARISON LOWER SAME HIGHER
 Rates of infection per hospital are compared with the US national average for SSI, and the California average for MRSA, VRE & CLABSI.
 Lower & better.
 In contrast to the other maps, the CLABSI map icon colors indicate hospitals with at least one patient care location (PCL). Lower, the same and/or higher than state averages (i.e., icons may be multicolored). For additional information on specific PCLs in hospitals, see CLABSI.

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CDPH Strategic Plan

- Leverage Key Opportunities to Shape the Future of Public Health - Key Objective
 - Strengthen Statewide Infrastructure to Improve Health
 - ✓ Enforce laws and regulations to ensure safety and protect health.
 - Expand and Strengthen Collaborations and Partnerships
 - Make Continuous Quality Improvement a Way of Life in the Department

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