Testimony of Carole Moss
to the Oversight Hearing on October 20, 2010
California Department of Public Health:
Implementation of Hospital Patient Safety Legislation

My name is Carole Moss. I am a voting member of the Governor's appointed HAI advisory committee, and Chair of the Public Reporting Subcommittee. I am also an "expert witness" on the devastating effects of Hospital Acquired Infections. My son Nile Moss died in 2006 from MRSA he contracted during routine tests at Children's Hospital.

That was the first time I had ever heard about an infection that claims the lives of nearly a 100,000 people every year. As a frequent flyer of the health care system for the 15 years of Nile's life, I was never informed, and therefore unprepared, to be an advocate for my son's life. Today, I am here as an advocate of all the people of California. I am committed to the implementation of Patient Safety procedures that will stop deadly, and preventable infections. Educating the public about the silent epidemic of HAI's has become a priority in my life.

I was extremely grateful for the support of Senator Alquist in 2007 when she authored SB1058, which was named "Nile's Law. Thank you Senator, for assembling this panel and providing us with the chance to share first-hand experience about the on-going attempts to implement the law we worked on together.

This hearing was called to assess the IMPLEMENTATION of patient safety legislation by the California Department of Public Health. We are not assembled to assess INTENTIONS. I believe we all share the desire to see these life-destroying infections stopped.

Implementation means the focus must be placed on what has been completed, executed, accomplished, realized, or put into operation. Nearly two years have passed since the Governor signed Nile's Law. The time has come to seriously evaluate the actual actions taken. It is time to test our resolve to implement life saving changes in our medical care system.

You asked us to give our opinions about how well CDPH has used their authority and resources to implement and enforce the laws. My opinion is formed by the actions I witness in the field as well as the words I hear in committees. Actions speak to the seriousness of our commitment. Actions demonstrate our true intent. Too often, during my interactions with my partners in this effort, I am left to wonder about the resolve, responsibility and commitment of CDPH to implement and enforce Patient Safety regulations like Nile's Law.

The Department was authorized to communicate and implement the requirements of the law, on behalf of the citizens of California. They were funded with $3.8 million of State and Federal tax dollars despite economic restraints, because the potential for cost saving and life savings more than warranted the investment. So far, there is a lack of transparency about spending. We have no knowledge of dollars promised, spent or remaining. We have no understanding of prioritization process.

CDPH has access to necessary research data. They are in possession of a document issued by the Society of Healthcare Epidemiologists of America (SHEA) in

2003 as a guidance for preventing MRSA infections. That report ("SHEA Guideline for Preventing Nosocomial Transmission of Multidrug-Resistant Strains of Staphylococcus aureus and Enterococcus") documented research on proven infection prevention programs in existence in other states. I believe that if those guidelines had been implemented in a timely manner, my son Nile would be alive today. That report was the basis for provisions in Nile's Law, but years later, the basic recommendations in that report have not been acted upon.

CDPH was given a clear mandate and clear deadlines to communicate specific requirements to the Health Care Providers. Responsibility for assessing compliance lies with their office. Accountability must also lie with their office. Following are a few concrete examples of where the actions do not demonstrate urgent resolve and a firm belief that the prevention programs are necessary, and likely to succeed. If CDPH does not believe in the program they are tasked with implementing, or if they do not believe the program will succeed, then it is likely it won't succeed. Therefore, people will die from preventable hospital acquired infections.

- Screening patients when they are admitted to the hospital was considered a vital part of reducing the spread of infections. Hospitals were required to begin screening since January 2009. A survey by CDPH on the number of hospitals in compliance with this policy was recommended, not conducted. We have no statistics to assess the percentage of providers in compliance. No way of tracking what has been done successfully.
- There is no firm protocol from CDPH on what to do with patients who do screen positive for MRSA and other serious infections. Patient feedback to Nile's Project has confirmed that patients are not isolated or treated any differently. Screening has little value in preventing other patients from contracting infections if a positive screen does not change current practice.
- Public reporting of results requires collection on a common system, with the same criteria. A decision was reached to use the National Reporting Tool NHSN. CDPH sent out an all facilities letter two years ago that informed all hospitals they must register with NHSN, and authorize CDPH to view their data. We have no data on compliance with those two basic steps. When we asked for information on which hospitals had complied and responded, or which had not, we were told the law didn't authorize CDPH to force compliance. More, we were told the law didn't force CDPH to share that information with our committee, and they declined. How can they enforce what they are not even able (willing?) to assess?
- A critical step in the future spread and elimination of infections like MRSA is to screen patients who have been in the hospital and are at high risk of carrying the infections unknowingly into their homes and communities. Hospitals were given three years to get a system in place to begin this. In January of 2011 the law requires testing at discharge. Hospitals claim they do not understand specifically what they must do. CDPH says they don't have anything defined, leaving interpretation of the requirements up to the hospitals. This lack of clarity inhibits the implementation of a successful

result. Hospitals asked for clarity in an AFL and the department would not commit.

- A patient safety survey was to be completed in 2008. Only a pilot program has been launched, and the details of that program have not been communicated.
- A form for reporting vaccinations of health care workers was tested in a mere 10 hospitals in California. Based on the test of these forms, the Department has decided not to include nurses and other direct patient care staff that are not directly employed by the hospital.

Two years into the implementation of a critical law and four years after the death of my son Nile, I am forced to ask: Do the actions of the CDPH communicate the INTENT TO PREVENT DEATH FROM INFECTIONS, or do their actions so far communicate THE INTENT TO PREVENT PREVENTION MEASURES FROM BEING IMPLEMENTED? Is the PACE OF IMPLEMENTATION in line with a true sense of emergency about a growing epidemic, or does the pace suggest complacency?

Enforcement of legislation is a critical step. Passing legislation that gets buried in committees is not only unhelpful--it can be harmful. If people believe something is happening to prevent further death and destruction of lives, and yet in fact is not, the problem compounds like unpaid debt. The future problem gets harder to address.

Enforcement assumes that there has been consensus about the need for change. It assumes there is a clear and achievable objective. It assumes the timetable and milestones of compliance have been widely distributed. It assumes there is sufficient communication with those held legally responsible to hold them accountable. It assumes there is a consequence for non-compliance that is greater than disregarding the law. It assumes there is a benefit to compliance that far outweighs the difficulty that always accompanies change in the way things are done. Sadly, these steps have not been implemented for the Patient Safety Legislation that passed nearly two years ago and other laws passed two years before that. Sadly, the actions NOT TAKEN to date, speak loudly about the true intentions of the California Department of Health.

Little has been done to change the trajectory of the infection rates in our hospitals. Little has been done to educate and empower the citizens of California. The spread of preventable infections continues to hit home for millions of Americans. Just last week it hit close to my family's home once again. A 50 year old cousin, treated and retreated for MRSA, was saved from death at the cost of both legs. I am a member of this committee and an expert witness to the devastation HAI's can have. I am NOT Okay, not pleased, not yet satisfied with our progress. I am committed to participating in the solution. I am committed to working with other citizen and government organizations whose intent, passion, resolve and resources are focused on eliminating preventable deaths.

Thank you for the opportunity to share my concerns today.