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Consumers Union
before
California Senate Health Committee
October 20, 2010

Good afternoon and thank you for this opportunity to testify about a subject so important to Consumers Union: stopping the occurrence of medical harm to patients at California hospitals. Consumers Union has focused on this issue for many years, including by sponsoring SB 1487, the 2004 hospital infection reporting law that was vetoed.

For the past seven years, our Safe Patient Project has focused on "getting to zero" hospital-acquired infections and medical errors nationwide, emphasizing public reporting of outcome data to spur hospitals to work harder to protect patients from preventable harm. We have worked closely with a network of California patient safety activists, including Carole Moss who will also be testifying today, who have pushed steadfastly to support enactment and implementation of the California laws that are the subject of this hearing.

Overall, our perception is that the implementation of these strong patient safety laws – among the strongest in the nation – has been a struggle in California. We have yet to see the state agency assert a leadership role on this and, truly, that is what must happen to successfully implement these life-saving laws. Leaders in the Legislature carried and passed these laws, but there have not been leaders to carry it forward. We understand there have been funding issues, staffing issues, Department reorganizations, and budget shortfalls. But as we have worked on implementation of similar laws throughout the country, we have seen a range of state agency reactions: some have actively embraced their role as a protector of patients, some have simply resigned themselves to fulfilling their duties. But almost all have had to work with less financial support than they needed. Most did something right away.

In our effort to see what the Department has accomplished, we have attended all its advisory committee meetings, we have met with Department staff, we have made an extensive Public Records Act request to see the data that has been collected so far, and we have issued two reports (attached) to bring our concerns to the public. We see heartening progress in the Department's work in the area of medical errors - assessing fines, requiring hospitals to report, and publishing and publicizing assessments of poor quality care.

We remain concerned, however, that the Department is not on track to produce reliable reports on hospital infections in 2011 and that it is just now beginning to assess whether hospitals are complying with infection prevention laws put in place years ago to protect patients. We have offered, and continue to offer, our support and assistance to the Department of Public Health, in realizing the promise of these laws and are pleased to share with you our observations about their implementation.

Enforcement of policies to prevent hospital-acquired infections

The Department's record of ensuring that hospitals are complying with recent state laws and CDC recommendations to minimize hospital-acquired infections and to make patient safety information available to the public has been troubling. Its performance has been marked by obstructions that have undermined patient safety and quality improvement efforts.

California hospitals are required by law to report certain patient safety data to the Department so that it can be disclosed to the public. Of course, the quality and accuracy of this information depends on how carefully hospitals collect and report it to DPH and the Centers for Disease Control and Prevention (CDC) through the designated National Healthcare Safety Network (NHSN). That is why it is so critical that hospitals and the Department are held accountable for complying with these public reporting requirements in a timely and accurate manner.

In March of this year, Consumers Union released a report that concluded that the Department of Public Health (DPH) had failed to use its authority to implement a number of state patient safety laws aimed at reducing hospital-acquired infections. In the months since our report was released, the Department slowly has been taking steps to improve its compliance with these laws. But our review of the Department's responses to the Committee's questions, still reveals that it is falling short of what is statutorily required:

- The Department was required by SB 739 (2006) to issue regulations by January 2008 that incorporate CDC guidelines for hospitals to prevent hospital-acquired infections. However, the Department has failed to do so. Instead, it has indicated that it "collaborates with hospitals" to make recommendations for intervention strategies to reduce infections.

- By July 2008, the Department was required by SB 739 to publicly post information on whether hospitals are complying with CDC protocols to prevent deadly central line bloodstream and surgical infections. Again, it has failed to do so. Surgical infection prevention protocols are published by the federal government, but many states also provide that information on a state site, as was intended by SB 739.

- Beginning in January 2009, the Department was required by SB 1058 (2008) to ensure that hospitals are screening high risk patients for MRSA and that a mandated group of infection control procedures to prevent the spread of MRSA infections are included in all hospitals' infection control policies. The Department has indicated that last month – 21 months after it was required to begin verifying hospitals' compliance with MRSA screening requirements – it has begun to use its new Patient Safety Licensing Survey to do so. In an All-Facilities letter from July 2010, the Department stated that the new survey would be pilot-

tested over the next couple months, so it is unclear whether the survey is actually being used in hospitals today.

- By March 2010, the Department was required by SB 739 (2006) to publicly disclose flu vaccination rates for hospital workers. The Department finally did so six months after the deadline and only after Consumers Union issued a report disclosing the flu vaccination data obtained through a Public Records Act request. The Department found what Consumers Union had previously reported: half of hospital workers were not vaccinated during the 2008-2009 flu season. We look forward to the Department's publication of the 2009-2010 to see if there has been any improvement, but it is still unclear when this report will be issued.

- Under SB 739, the Department had the authority beginning in 2007 to require hospitals to report to the CDC's National Healthcare Safety Network (NHSN) on their compliance with CDC guidelines to prevent central line and surgical site infections. Instead the Department engaged in "consultation efforts" with hospitals to encourage NHSN participation and was unable to determine that it had the authority to require participation until April 2010. At the most recent meeting of the HAI Advisory Committee, the Department stated that there were still several hospitals that had not signed up for the NHSN reporting and that, among hospitals that had signed up for NHSN reporting there were many who had not taken the necessary steps to allow the Department to view their data.

- The Department has indicated that it will publish hospital-specific rates for infections caused by "superbugs" MRSA, C-difficile and VRE by January 2011, as it is required to do under SB 1058 (2008). Likewise, DPH states that it will publish the hospital-specific rates of central line-associated bloodstream infections starting in January 2011. We commend the Department for pledging to abide by these statutory requirements, but are concerned that it has not taken the steps needed to ensure the accuracy of the data it will report.

The Department maintains that it lacked resources and until December 2009could not use licensing fees for the hospital-acquired infection program as directed by the 2008 law. But its answers (p.2, Department's Responses) to the Committee's questions suggest that this was due to its own failure to put infection control under the Licensing and Certification Division until Dec. 2009. It appears the Department had the authority to make that structural move all along, which would have made these funds available much earlier. The Department's failure to do so is one illustration of its lack of will to make infection control a priority, notwithstanding strong, clear and repeated direction from state lawmakers since 2006.

One broad area in which the Department has the tools and authority, but has not exercised them effectively, is in making reports and results readily available to the public. For example, it appears that the Department made little effort to publicize to the media and the public its September 30th report on hospital flu vaccination rates. Without a news release (which DPH does issue for periodic adverse event reports) or some clear direction

on the web site about where the report is posted, very little media attention resulted about the Department's report and the public likely did not hear about it. Consumers Union believes that public reporting of infection rates and prevention practices will put pressure on poorer performing hospitals to improve – but only if the Department makes a concerted effort to publicize this information widely.

The Department's responses to the committee do not detail any major areas in which it needs new authority. The Patient Safety Licensing Survey (which did not require statutory authority) has been developed and tested, and is being used according to the Department for both infection and adverse event monitoring. While this is a positive development, it is unclear why it took so many years to develop this tool. Also, since hospitals are only required to be surveyed once every three years, it could be 2013 before each facility is surveyed for compliance with a 2006 law. In our opinion, this is an unacceptably slow accountability process.

We believe the Department needs to take a comprehensive and integrated approach to eliminating hospital-acquired infections. That requires interaction between the Licensing and Certification Division and the HAI Program, whose enforcement activities seem to be separated from each other. If the Licensing and Certification Division surveys a hospital and finds problems with its infection control, the HAI Program should be aware of it; when the HAI Program finds high rates of infection reported by a hospital, the Licensing and Certification Division should be aware of that. Also, as discussed below, other agencies within the state have information that could be helpful in more completely understanding which hospitals have the biggest problems and need the most attention.

Until just last month, the Department was not performing regular hospital surveys that included monitoring of HAI prevention practices. As a result, hospitals have not been held accountable for improving infection prevention and the lack of state regulations requiring hospitals to follow CDC infection prevention guidelines further undermines accountability efforts. Eliminating infections is a realistic goal that will take time to reach. In California, as long as movement toward this goal remains sluggish, too many patients will continue to suffer.

We sincerely hope that the recent steps by the Dept. to push ahead with inspections and public reporting signal a new era of leadership in the war against hospital-acquired harm.

Adverse Events Reporting

The Department seems to be making more headway in prioritizing implementation of the adverse event law, SB 1301 (2006). The Department is issuing fines for practices that have jeopardized patients' safety and when hospitals fail to report adverse events within the statutory time frames, and it has widely publicized these actions.

The Health Facilities Consumer Information System on the DPH web site is a good start to making this information publicly available. However, the web site where adverse events are posted is hard to find and difficult to decipher. For example, survey

deficiencies that result in penalties following adverse events are coded without any information to help consumers interpret what the codes mean.

In addition, hospitals are required to create patient safety plans, including committees and internal reporting systems that would allow anyone to report an adverse event. Even though the Department has been authorized to inspect hospitals to ensure they are complying with these requirements since 2009, it has only begun to use the Patient Safety Licensing Survey to do so since last month. Thus, the public has no idea whether hospitals are complying with this important law.

In addition, the Department has acknowledged that adverse events are being reported late by some hospitals and under-reported by others. Some hospitals have not been reporting incidents at all. Just a few days ago, we received an answer to our February 2010 Public Records Act request regarding which hospitals had reported no adverse events: 89 hospitals reported no adverse events from July 1, 2007 to October 4, 2010. While we have not had time to analyze this information, it is highly unlikely that these hospitals have had no incidents in more than three years.

At a hearing several years ago when this problem surfaced, Consumers Union suggested that the Department enter into a collaborative, information sharing arrangement with OSHPD, which has discharge data that would reveal hospital-acquired infections and adverse events through billing codes. We are anxious to know if that comparison of data has occurred yet.

Again, the Department's approach to under-reporting appears to be timid: to simply remind hospitals of their responsibility to report adverse events within 5 days of detection or within 24 hours if the adverse event presents an ongoing urgent or emergent threat to the health, welfare or safety of patients, personnel or visitors. The charts provided by the Department in response to the committee's questions (p. 24) indicate declining numbers of immediate jeopardy events. But it is unclear whether adverse events have actually decreased or if reporting has simply dropped off. What does OSHPD's discharge data show on this? Also, while the Department's response time to these adverse events appears to have improved, it is still too slow given that lives are at risk.

We urge a more focused effort to ferret out prospective unreported or late reported events using OSHPD's vast data resources.

The Department says it needs statutory authority to cite hospitals for misreporting or inaccurate reports. Staff also expressed, at a meeting two years ago, that it was not implementing reporting on some severe incidents because these incidents "fell through the cracks" of definitions, e.g. certain very severe bedsores that had a different label than the current statute's requirement for reporting "class 3 or 4 pressure ulcers." This is an issue nationally (and recently the subject of a series of articles about the Washington State program), where precise definitions are the culprit of underreporting.

If medical harm occurs but it doesn't precisely fit the definition, it does not have to be reported. While standardization of measures is the foundation of public reporting, overly specific enumerations of events can be a barrier to identifying harm to patients. This should be investigated further to determine whether regulatory clarification would be sufficient to address the problem.

The Legislature took steps to establish a "culture of safety" within California hospitals with the passage of SB 158 in 2008. Similarly, hospitals have been required to notify patients when an adverse event occurs. We do not know if they are following through on this obligation because the Department has not been surveying hospitals for compliance with this mandate until last month. Currently, the public is unable to review a hospital's performance on regulatory surveys, which the Department maintains are confidential. Without public accountability for hospitals' policies and performance, unnecessary and preventable harm will continue to occur.

Further, the public has not been presented with hospital-specific information about medical harm. The statute requires the Department to publish this information on its web site by 2015, but it would allow earlier publication. It also instructs the Department to make reports readily accessible to consumers throughout California starting January 1, 2009. The law requires that such information be made available if requested and the Department has provided it to the media and others, including Consumers Union. We recommend that in the coming year the Department publish the information it is collecting for greater public access to the data. We believe that will be a strong motivator for hospital efforts to reduce harm to patients.

We appreciate the opportunity to offer this testimony and look forward to working with the Committee and the Department on fully implementing these critical patient safety laws.