CALIFORNIA
HOSPITAL
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Providing Leadership in
Health Policy and Advocacy

May 30, 2008

The Honorable Henry Waxman
Chairman
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

Thank you for your letter dated May 6, 2008, addressing health care-associated infections (HAIs) in California hospitals. This issue is of primary importance to California hospitals and the California Hospital Association (CHA). CHA, our Regional Associations and member hospitals are committed to identifying and reducing HAIs using a variety of methods.

The CHA Board of Trustees, at its April 25, 2008, meeting, endorsed adopting initiatives that will reduce HAIs. It also recommended that the California Hospital Patient Safety Organization (CHPSO) create programs that focus on the reduction of HAIs by reducing central-line blood stream infections to a median of zero. Because many California hospitals involved in collaboratives have already met this goal, the CHA Board believes it is important to continue work to reduce all infections.

In 2005, the Patient Safety and Quality Improvement Act was enacted to authorize Patient Safety Organizations (PSO) to collect and aggregate voluntary quality reports, analyze the aggregate data, and suggest measures or practices to eliminate or reduce medical errors. The U.S. Department of Health and Human Services (HHS) recently published a proposed rule implementing this voluntary, non-punitive, national patient-safety reporting program, more than two years after it was authorized by the Patient Safety and Quality Improvement Act.

Upon approval in 2006 by the CHA Board to create a PSO for California hospitals, CHA developed CHPSO, a statewide organization to help hospitals evaluate errors and develop effective strategies to improve patient safety. CHPSO is a not-for-profit public benefit corporation, seeking 501(c)(3) designation from the Internal Revenue Service. CHPSO has submitted a letter of intent to the HHS to seek designation as a PSO.

Patient safety is a goal that can be optimally achieved if hospitals and their medical staffs and employees embrace it as essential. The business case and moral imperative for a safe environment for patients are irrefutable. Leadership, a "no blame" culture, openness, commitment to quality and safety, reliance on objective data and best practices, inter-dependence, core-driven culture for change and measurement of improvement are components of a successful patient-safety program. CHPSO will assist by analyzing patient-care data, distributing information and making recommendations to implement specific changes that will improve patient safety. Systems improvement and changes in procedures and practices will produce the outcomes that all hospitals seek.

CHPSO will help hospitals improve quality and patient safety; reduce medication and medical errors; reduce HAIs; better integrate with evolving information and communications systems; facilitate standard reporting and accountability measures; improve the public's trust in hospitals; and improve efficiency. By combining and integrating programs to address patient safety, quality and efficiency, CHPSO will be a catalyst for improvements in hospital performance.

The first CHPSO Board meeting will be held in mid June 2008. The CHPSO Board will adopt a work plan and a preliminary budget. The CHPSO work plan will consider HAIs, medication safety, adverse events and other prevalent patient-safety measures. CHPSO will work with the existing Regional Association patient-safety collaboratives, and will build on that model to include every California hospital in a collaborative learning process for improvement in quality and patient safety. Attached are supporting documents regarding CHPSO (Attachments A.1. through A.3.).

CHA and our Regional Association partners have developed three patient-safety collaboratives in California to work on a variety of issues, including HAIs. The Beacon Collaborative, a 39-hospital peer-to-peer learning collaborative that encompasses all hospitals in the five-county Bay Area (San Francisco, Marin, Alameda, Santa Clara and San Mateo), has been active for nearly three years. The Southern California Patient Safety Collaborative (SCPSC), which has 122 hospitals in six Los Angeles area counties (Los Angeles, Santa Barbara, Venture, Orange, Riverside and San Bernardino), began its work in late 2007. Beacon has HAI rates, discussed below, whereas SCPSC will not have data until summer 2008. The San Diego Patient Safety Collaborative has not initiated HAI work yet, but has done significant work on standardizing medication concentration and other medication-safety projects.

Attached is a summary of the California patient safety collaborative initiatives compared to the Michigan Keystone Center for Patient Safety & Quality project (Attachment B.1.) and other California HAI Collaborative Initiatives (Attachment B.2.).

Beacon Collaborative
Beacon is the longest running collaborative in California and has made the most progress in accelerating the change needed to improve patient-care quality and patient safety. Beacon initiatives target central-line blood stream infections (CL-BSIs), surgical care, ventilator-associated pneumonia (VAP), Sepis, Methacillin-resistant Staphylococcus aureas (MRSA) infections, high-alert medications, medication reconciliation, hospital-acquired pressure ulcers, rapid response teams, heart failure and acute myocardial infarction. Beacon is funded by the Gordon and Betty Moore Foundation and the Hospital Council of Northern and Central California.

During the 21-month study period, hospitals participating in the collaborative reduced VAP by 60 percent and CL-BSIs by 66 percent. This resulted in 720 fewer infections than projected during the study period. The VAP improvement exceeds the best results reported by the National Healthcare Safety Network for 2006. The CL-BSI improvement meets or exceeds results reported in December 2006 in the *New England Journal of Medicine* for the highly respected Keystone Center for Patient Safety & Quality in Michigan. The Beacon CL-BSI is at a median of zero after 21 months of the collaborative. The Beacon VAP rate is zero per 1,000 ventilator days.

Based on the Beacon analysis, the 120 deaths that were avoided by reducing VAP saved approximately $1.2 million, and the 74 deaths avoided by reducing CL-BSI infections saved approximately $2.7 million.

The Beacon Institute was developed to penetrate deeper into Beacon hospitals by providing training and education for staff involved with patient safety and quality-improvement interventions. Currently, the standard Beacon educational model addresses specific clinical interventions and, as a corollary, introduces basic improvement concepts. The Beacon Institute is designed to reach hospital staff with limited exposure to basic improvement principals and skills in order to enhance the capacity for improvement at Beacon hospitals.

Along with expanding the capacity at multiple levels within the organization, the Beacon Institute will also periodically address more advanced topics that help experienced professionals better generalize from specific clinical interventions to other important topics in order to accelerate improvement and broaden the types of practices addressed.

To identify the participants perception of value regarding their learning and ability to apply it to improvement priorities, all courses are to receive greater than 95 percent excellent or good ratings on the post-course survey. The survey will be completed on the website where participants will immediately receive CEU certification after completion of the survey.

Surveys results are used for small tests of change to improve future courses. Specific outcomes include:

"Introduction to Quality" will have greater than 75 percent of participants with limited knowledge of improvement concepts prior to the class to ensure that more staff are introduced to quality principles.

"Project-Based Team Leader Training" will earn greater than 75 percent accuracy on the post-course knowledge test, when given. Attached are associated Beacon documents (Attachments C.1. through C.6.).

Southern California Patient Safety Collaborative

SCPSC is a tool by which large numbers of hospitals are able to share ideas and accelerate the implementation of evidence-based practices. SCPSC has in-person meetings on a quarterly basis to exchange tips and strategies to overcome barriers and expedite the deployment of state-of-the-art practices. SCPSC also conducts web seminars, monthly conference calls and a listserv that allows members to ask questions and gain experience from each other. Based on experience with other learning collaboratives, participants report significant breakthroughs when they learn using this model.

SCPSC is a partnership of the National Health Foundation (NHF), Hospital Association of Southern California (HASC) and Convergence Health Consulting, Inc. (CHC). The work is supported by grants from the UniHealth Foundation, Blue Shield of California Foundation and California HealthCare Foundation. NHF and HASC provide the operational and meeting infrastructure, communications and coordination with the participating hospitals. CHC provides the clinical content and meeting facilitation using nationally accepted evidence-based practices.

Because the project is financially supported by the UniHealth Foundation and Blue Shield of California Foundation, program registration and materials are complementary. The size of the group is limited to provide a critical mass of new ideas to test in an intimate and trusting setting where participants can speak freely and easily share ideas. Attached are associated SCPSC documents (Attachments D.1. through D.7.).

Methicillin-Resistant Staphylococcus Aureus

Late last year, the CHA Board of Trustees endorsed guidelines to reduce MRSA, which is the leading cause of HAIs among clinically relevant, antibiotic-resistant pathogens. Increased lengths of stay, costs and mortality are associated with MRSA infections. In 2007, new studies about the growing problem of MRSA within the health care environment and mounting public concern converged. This compelled hospitals to begin to collectively adopt well-established care practices;

enhance training of all hospital workers; and provide patient education to reduce the prevalence and transmission of MRSA infections.

CHA completed a statewide assessment of current practices in 2007, and CHA's Hospital Quality Committee assembled experts to lead the development of a menu of statewide MRSA policies and procedures, educational materials and other resources for use by all member hospitals. A follow-up survey on the progress of adoption will be completed in summer 2008. This statewide initiative will increase the momentum for swift and sustainable action for all hospitals to actively focus their priorities on MRSA reduction.

Based on the *Guidelines for the Management of Multidrug-Resistant Organisms in Healthcare Settings* by the Centers for Disease Control and Prevention (CDC), and *Guide to the Elimination of Methicillin-Resistant Staphylococcus Aureus (MRSA) Transmission in Hospital Settings* by the Association for Professionals in Infection Control and Epidemiology, CHA recommends that hospitals implement specific steps to reduce the probability of MRSA infections. Supporting documentation is attached (Attachment E.1.).

Working With the QIO

While California hospitals have been building on successes with initiatives aimed at preventing surgical infections' Lumetra, California's Quality Improvement Organization (QIO), joined the national Surgical Care Improvement Project (SCIP) in July 2005. SCIP's goal is to reduce the national incidence of surgical complications by 25 percent by the year 2010.

Lumetra has established the California SCIP Collaborative to assist selected hospitals in their commitment to improve surgical care in at least two of four areas of focus: surgical-site infection, venous thromboembolism, adverse cardiac events and ventilator-associated pneumonia. Attached are the associated SCIP documents (Attachment F.1.). More than 40 hospitals participated in this initiative.

IHI Campaign

The Institute for Healthcare Improvement (IHI) and its partner organizations and nodes launched the 100k Lives Campaign and the 5 Million Lives Campaign to reduce preventable deaths and patient harm in U.S. hospitals. To date, more than 250 California hospitals have joined this national effort. CHA, our Regional Associations, the American Heart Association, Lumetra and American Association of California Nurse Leaders makeup the leadership of the IHI California node. The node recruits hospitals into the campaign, and provides support for the program and education across the state to further the aims of the campaign. In 2008, the node will offer nine free educational opportunities for hospitals to increase their performance in the 12 planks of the IHI campaign. IHI includes five infection-related initiatives that are the basis of most hospital work on reducing HAIs:

- Prevent Central-Line Infections — by implementing a series of interdependent, scientifically grounded steps.
- Prevent Surgical-Site Infections — by reliably delivering the correct preoperative antibiotics at the proper time.
- Prevent Ventilator-Associated Pneumonia — by implementing a series of interdependent, scientifically grounded steps.
- Reduce Surgical Complications — by reliably implementing all of the changes in care recommended by SCIP.
- Reduce Methicillin-Resistant Staphylococcus Aurous (MRSA) infection — by reliably implementing scientifically proven infection control practices.

Attached are flyers with the topics and speakers for some of the educational offerings in 2008 (Attachments G.1. through G.5.) as well as the list of IHI-participating hospitals (Attachment G.6.).

California Department of Public Health HAI Initiatives
The Healthcare-Associated Infection Advisory Committee (HAI AC) is a legislatively mandated advisory committee charged with making recommendations to the California Department of Public Health (CDPH) on the prevention of HAIs. The authorizing legislation also requires hospitals to report central-line insertion practices, surgical infection prevention measures and influenza vaccinations for staff and others. HAI AC has also recommended a standardized definition to reporting MRSA central-line infections. CDPH has not issued this mandate, but it is anticipated soon.

HAI AC has recommended the use of the CDC National Healthcare Safety Network (NHSN) as the data collection tool for central-line insertion practices. However, NHSN is not current on each measure it requires to be reported (e.g., the use of antibiotic ointment is no longer the standard of practice for insertion, but remains on the form).

Adverse Event Reporting in California
In 2006, the California Legislature passed, and Governor Schwarzenegger signed, legislation requiring general acute-care hospitals, psychiatric hospitals and special hospitals to report specified adverse events to the California Department of Health Care Services (DHCS). This reporting requirement became effective July 1, 2007.

An adverse event includes surgical events, product or device events, patient-protection events, care-management events, environmental events, criminal events and one other item described below. The term "serious disability," which is used in many places in the list of adverse events, means "a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than

seven days or is still present at the time of discharge from an inpatient health facility, or the loss of a body part."

California hospitals are working diligently to reduce and eliminate adverse events. The work of CHPSO will assist in these efforts. Attached are the associated documents related to reporting adverse events in California (Attachments H.1. through H.5.).

Color-Coded Wristbands Standardization in California
The CHA Board of Trustees has approved the use of three color-coded patient identification wristbands — purple for "do not resuscitate (DNR)," red for "allergies" and yellow for "fall risk" — for hospitals that choose to use color-coded wristbands. The board also requested that these hospitals adopt, as soon as feasible, a policy for using this color-coded system. CHA recommends that hospitals should stop using other colors to identify patients for DNR, allergies and fall risk.

Color coding of patient identification wristbands is an increasingly popular method for reducing medical errors and increasing patient safety. However, standardization is needed. In 2006, the Hospital Council of Northern and Central California Board of Directors approved the concept for this patient-safety project and, in partnership with CHA and the Association of California Nurse Leaders (ACNL), conducted a survey of nurse executives throughout California to evaluate support for the development of a statewide standard. The survey revealed that seven solid colors and various multi-color bands are used to represent 29 different conditions in California hospitals. The support for standardizing color-coded wristbands was overwhelmingly positive and validated by a workgroup.

This issue gained national attention when, in December 2005, a patient-safety advisory was issued from the Pennsylvania Patient Safety Reporting System. The advisory reported an incident that occurred in a hospital in which clinicians nearly failed to resuscitate a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as DNR. The source of the confusion was a nurse who incorrectly placed a yellow wristband on the patient with the understanding that it meant "restricted extremity," as it did in another hospital where she worked. However, it meant DNR in that hospital. The results from the California survey validated that California hospitals are at risk of a similar type of incident.

California, along with the Arizona Hospital and Healthcare Association, several western state associations, including the Colorado Hospital Association, Nevada Hospital Association, New Mexico Hospitals and Health Systems Association, and Utah Hospitals and Health Systems Association, adopted and are in the process of implementing this standardized colors for use in all facilities to ensure safety when nurses and other staff move from state to state or facility to facility.

Attached are the associated documents related to color-coded wristband standardization (Attachments I.1. through I.4).

California Hospital Assessment and Reporting Task Force
The California Hospital Assessment and Reporting Task Force (CHART) was publicly launched March 6, 2007, at CalHospitalCompare.org. This landmark website is the culmination of four years of hard work and consensus building by hospitals, health plans, payers and patient advocates. Reflecting the deep involvement of many stakeholder groups, the project has in-kind and financial support from more than 220 California hospitals, the California HealthCare Foundation, Blue Shield of California Foundation and many California health plans. All key project decisions are made by a Steering Committee consisting of representatives of consumers, purchasers, health plans, hospitals, physicians, nurses and regulators.

As the demand for reliable, useful information about the quality of care continues to grow, pressure will mount on California hospitals to publicly report quality data. Rather than waiting for policymakers to mandate this reporting, hospitals across the state have a unique opportunity to shape their own future by participating in the CHART program.

The current CHART report, at CalHospitalCompare.org, includes more than 55 measures, including heart attack care, pneumonia care, ICU mortality, patient experience data, cesarean selection rates, surgical-infection prevention measures, ventilator-associated pneumonia prevention measures, hospital-acquired pressure ulcers and many more.

Attached are associated documents, including the 2008 measures collected and reported by CHART (Attachments J.1. through J.3.).

California law requires hospitals to implement a medication safety plan to reduce medication errors. Plans must include creating a process to evaluate and update the plan annually; a system or process to proactively identify actual or potential medication-related errors; concurrent and retrospective review of clinical care; a multidisciplinary process to develop and evaluate the plan. Hospitals are also required to include strategies to use technology to enhance medication safety. CHA and the Regional Associations in collaboration with the California Department of Public Health are providing in person seminars and web seminars to assist hospitals improve their plans and increase medication safety. These seminars provide the legal requirements of the law, interaction with the department as well as practical tools to improve medication safety.

Conclusion
CHA and the Regional Associations are engaged in numerous programs and activities to help hospitals improve quality of care and reduce errors. Patient safety is a high priority. Launching CHPSO in 2008 along with the collaboratives

of the Regional Associations are significant steps in achieving our goals. We are committed to working with you to help you fully understand the exciting and constructive work that is being done in California to improve the quality of care for all our patients. If you think it would be helpful, we would be pleased to take you on a tour of one of the many facilities in California that is making significant progress toward solving the problem of HAI. Please contact me at (916) 552-7547 or cddauner@calhospital.org, or Anne O'Rourke in our Washington, D.C., office at (202) 488-4494 or aorourke@calhospital.org, if you need additional information.

Sincerely,

C. Duane Dauner
President and CEO

CDD:bjp
Attachments

cc: The Honorable Tom Davis
Senior Vice President Anne O'Rourke
Vice President Debby Rogers