CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Testimony of
The California Hospital Association
In Response to the Request from the Little Hoover Commission
Assessment and Challenges 1-Year Post Division of the Department of Health Services

Before the
State of California
Little Hoover Commission

August 28, 2008

CDPH Administration:

Hospital representatives that have direct contact with Deputy Director Billingsley and her staff have, for the most part, experienced improved communication and a much more positive attitude as compared to the previous Deputy Director and her staff. Hospitals are receiving more negative reports than previously but there is a more collegial atmosphere on a one-to-one basis. For example, Ms Billingsley personally contacts every hospital CEO prior to the public release of the issuance of administrative penalties.

Administrative practices have been put in place that assist providers when seeking information or working with the Department. For example, it was very difficult to consistently obtain All Facilities Letters (AFL) in a timely manner. A system is now in place that assures the AFLs are provided and can be shared with all who have a need to know. Staff returns phone calls much more promptly than in prior years.

CHA staff has experienced a level of accessibility to Licensing and Certification staff that did not exist in the past. It is a much more collaborative process now. In addition, Ms Billingsley and members of her staff attend the quarterly meetings of the CHA Joint Committee on Accreditation and Licensing. Many items that affect hospitals across the state are discussed and resolved at these meetings.

There are still many areas that need to be addressed. A major concern is the lack of standardization in policy and practice. Many of the health care systems people that work with hospitals in different geographic areas within California receive different answers to the same questions. Because T.22, the regulations that govern hospitals, is out of date, hospitals frequently apply for flex. Flex can be granted for regulations that are out dated or do not fit the circumstances of the particular hospital. One district office will grant flex while the exact same request made to a different district office will be denied. It is our suggestion that granting of

flexes be centralized. This way a few people could become experts on "flex" requests. In addition to increased standardization and eliminating confusion it would also be more efficient for the Department.

Surveyors also interpret T.22 in a variety of ways partly because they do not understand the inner workings of a hospital. CHA staff and hospital representatives have volunteered to assist with the training of surveyors. Many of the surveyors have spent little or no time working a hospital. We think joint training would be advantageous to the Department and help surveyors to understand how a hospital functions.

Hospitals are regularly cited for non-compliance to T.22. The report generated is form 2567. California is one of the few states in the country that does not use computer generated forms. To provide a plan of correction which is required, for the most part within ten days of receipt, the hospital must respond using a type writer – not a computer. A type writer must be kept specifically for this purpose. The citations are difficult to track for the Department because the entire process is manual including the multiple copies that are filed in various areas. This process needs to be improved for the sake of accuracy, efficiency and to bring us all into the 21st century.

Subject Specific Items:

The clinics DPH ELMS data base does not allow nor support the ability for the Department or their local district offices to produce accurate lists of providers by category or geographic regions. A specific example is that during the fires in San Diego hospital based outpatient clinics were not on the list provided to local Emergency Medical Services as requested. The list only contained individually licensed community clinics not those operating as a supplemental service-outpatient clinic on the hospitals license. CHA sponsored legislation, SB 1260, in an effort to improve the data but implementing the process will require the department to make this a priority.

Another example is AFL's related to medication recalls. These AFLs never go directly to hospital based outpatient clinics (HBOC's). Instead they go to the parent hospital. This results in delays that can result in life-threatening situations
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The DPH website is unclear. There remains significant confusion about how HBOCs are licensed and certified including the fees they must pay and to whom they must submit their applications. The DPH website only adds to the confusion because it does not clearly delineate the difference between provider based and community clinics. This is also true at the DPH training academy. They have developed a training module for their surveyors for community clinics which excluded specific training and accurate info on HBOCs.

Hospital-acquired Infection Reduction:

The HAI surveillance and prevention programs were partly prescribed by law and designed to provide oversight of healthcare facility infection control programs and education to CDPH staff, investigate an electronic reporting mechanism, and update the regulations to incorporate the

Centers for Disease Control recommendations. The department has implemented these duties within the confines of limited budget funding.

The department is responsible to appoint and convene the Healthcare Associated Infection (HAI) Advisory Committee. The work of the committee has been slowed by limited budget funding (funding vetoed in budget year 2007-08 and the Legislature rejected the proposed $1.3 million augmentation for budget year 2008-09).

CDHS, upon the recommendation of the Committee, has created standard reporting requirements for Central Line Insertion Practice (CLIP) reporting, influenza vaccination of employees and patients, and surgical antimicrobial prophylaxis. Statute requires this data be made public, but again, budget constraints have slowed this effort.

CDPH has also made recommendations for hospitals to voluntarily report central line blood stream infections caused by Methicillin-resistant Staphylococcus aureus (MRSA). Statutory authority does not currently exist for the department to require this reporting.

The Legislature is poised to pass two bills related to healthcare associated infections this year. This will provide CDPH with the authority to collect and publicly report data on several HAIs including central line infections, surgical site infections as well as healthcare-associated MRSA blood stream infection, healthcare-associated clostridium difficile infection, and healthcare-associated Vancomycin-resistant enterococcal blood stream infection. CDPH and the committee will be very involved in the implementation of the new requirements.

Laboratory/Surveillance Capabilities:

The sooner public health professionals can detect diseases or other health threats and investigate their causes and effects in the community, the more quickly they can minimize population exposure. To this end, CDPH has been able to upgrade biological and chemical laboratories, develop a new emergency operations center, and develop protocols compliant with federal standards. The state has greatly improved its preparedness capability at both the state and local levels to address potential public health threats. However, once again budget constraints have limited the progress beyond the bio-safety Level III.

The administration has implemented a 10 percent across the board, a$340,000 reduction in expenses which will eliminate five of the 20 Public Health Microbiologist staff positions in this laboratory. CDPH states that day-to-day requests for influenza, West Nile Virus, HIV/AIDS, Hepatitis C, rabies testing, and gastrointestinal outbreaks verification will be reduced.

The Governor is proposing a reduction of $250,000 (General Fund), or 10 percent, to the state's discretionary fund provided for training, outreach and education, doctoral candidate stipends, and postdoctoral fellow and assistant laboratory director salaries under the Laboratory Director Training Program.

The CDPH laboratory services budget constraints have and will continue to limit the department's ability to do adequate surveillance of contagious diseases.

In summary, there have been many improvements made since the division of the former Department of Health Services into two distinct departments. However, there is much work to be done. CHA is most interested in working with the Little Hoover Commission and the Agency to assure the safest and most efficient processes to provide safe care are in place.

Testimony of
Cheri Hummel
Vice President, Disaster Preparedness

Before the
State of California
Little Hoover Commission

August 20, 2008

In review and response to the Little Hoover Commission study on California's Department of Public Health Emergency Preparedness Responsibilities and Activities, CHA provides the following comments:

To date, the new California Department of Public Health (CDPH) has made great strides considering the challenges they face. CHA has reviewed the recently released strategic plan for the department. Although emergency preparedness is difficult to measure, it is encouraging to know the new department proposes to set performance measures to evaluate their progress. The new department director, Dr. Mark Horton has taken an active and visible role in seeking interviews with stakeholders to determine the department's strengths and weaknesses. The director maintains ongoing communications with the stakeholders as well.

The CDPH completed a comprehensive project on healthcare surge standards and guidelines earlier this year. The guidance was developed for state and local government officials, hospitals and health care partners. It relates to obstacles that hospitals and health systems will face in an overwhelming influx of patients due to a catastrophic event or influenza pandemic. An event of this nature requires hospitals to transition from normal operations to operating under extreme conditions. Therefore, various regulation waivers will be necessary due to their heavily regulated environment and enable them to meet the demand subsequent to the event.

CDPH continues to work on this project by moving toward phase II which addresses the needs and issues of other health care partners such as primary care clinics and long term care.

It is worth noting, however, that one key area not included or addressed in either phase I or phase II of this project is the pre-hospital/emergency medical services discipline. Thus, allowing a significant gap in addressing the needs of the entire health care continuum.

Although the CDPH Emergency Preparedness Office has had continuity in the area of leadership, they have had significant staff turnover leaving increased vacancy rates. This affects program and project continuity. Additionally, it has been difficult for them to find qualified professionals with a background in hospital operations and healthcare emergency management.

Improvements have been made between the CDPH and the Emergency Medical Services Authority in the area of collaboration and planning. However, more can be done in this area. The two departments play key significant roles in California's medical/health disaster planning and

response. The complex issues surrounding the state's medical and health disaster response require blending of public and private entities working together. Regardless, the roles of both CDPH and EMSA should be clearly defined. These departments should map out their response system and align their planning activities accordingly.

Another key area of significance is the role of statewide exercising of the medical and health system. Exercises are paramount to any organization, community and state preparedness. The current Golden Guardian Exercise and the Statewide Medical & Health Disaster Exercise do not exactly meet this need. The Golden Guardian exercise is funded with homeland security grant funding. It is coordinated by the Governor's Office of Homeland Security (OHS) and is designed for specific regions in the state. These regions receive specific OHS funding. It has a law enforcement emphasis with minimal hospital participation. The statewide medical & health disaster exercise is not effectively managed. It is unclear whether EMSA or CDPH maintains responsibility for this exercise. A strategic planning advisory body should be established with representatives from various health system disciplines (local public health, local emergency medical services authority, local OES, hospital, clinic, long term care, ambulance providers.) Further evaluation of these exercises should be completed to identify gaps and improve the process.

The role of the CDPH Licensing and Certification (L&C) process as it relates to emergency preparedness needs to be evaluated for a more efficient and effective process. Considerations of statewide policy should be developed so all regional L&C offices are making consistent decisions based upon the policy(ies). One example is in the area of re-populating hospitals following an evacuation due to an emergency or catastrophic disaster. Hospitals and health systems need guidance from L&C to assist them in re-populating their facilities following evacuation.

Various departments under Health and Human Services Agency are responsible for specific aspects of the medical/health disaster response in California. Given this fact, coordination and accountability are vital. Perhaps the recent appointment of Dr. Howard Backer is an effort to address this need.