February 19, 2014

The Honorable Barbara Boxer
112 Hart Senate Office Building
Washington, DC 20519

Dear Senator Boxer:

The California Hospital Association (CHA) and our newly formed Hospital Quality Institute (HQI) are pleased to add our response to those you requested from 283 acute care hospitals in California, underscoring the ongoing efforts by hospitals across the state to eliminate harm and aggressively pursue the aim of zero preventable deaths. We very much appreciate your interest in the work of California hospitals to address this critically important health care issue.

As you know, this is complicated work, requiring investments in people, process and technology. California hospitals are making these investments and seeing the results in reduced readmission and infection rates across the state. But quality improvement is a marathon — not a sprint — requiring strength and endurance to sustain improvement beyond initial success. As you noted, California hospitals are active participants in the Partnership for Patients campaign, in pursuit of the “triple aim” for better care, better health and lower cost. California has a long and distinguished history of improvement and innovation in health care, placing the state in the nation’s top quartile for best outcomes in mortality as measured by the Centers for Medicare & Medicaid Services (CMS).

California hospitals have demonstrated their commitment as leaders in the public reporting of hospital quality measures, including health care-acquired and surgical care infections, despite the tremendous resources needed to comply with administratively burdensome regulations. California hospitals report more than 65 federal clinical quality measures, 25 of which require detailed chart abstraction by trained clinical staff.

California hospitals must report more quality measures at the state level. For example, while CMS requires hospitals to report two surgical site infection (SSI) measures, California hospitals must report an additional 27 SSIs to the state.

In order to meet all of these requirements, significant investments in infrastructure for data capture, chart review and reporting have been made, adding to the financial challenges of already stressed hospital organizations. It is through this active monitoring that we have demonstrated success in a number of areas and are building our capacity to do even more.

Some of our notable achievements include the following:

**California Hospital Engagement Network (CalHEN)**

As part of the American Hospital Association’s Hospital Engagement Network (HEN), the CalHEN is one of 31 state associations focused on a 40 percent reduction in 10 areas of hospital-acquired patient harm and a 20 percent reduction in 30-day all-cause readmissions. Clinical improvement advisors coach, support and facilitate adoption of evidence-based practices though partnerships with more than 172 hospitals, with a geography encompassing more than 163,700 miles.
CalHEN has facilitated evidence-based, statistically significant improvement in four areas of harm: early elective deliveries (EED), central line associated blood stream infections (CLABSI), falls and surgical site infections (SSI). More than half of the participating CalHEN hospitals reported a 30 percent to 39 percent improvement or maintained zero harm for six to 11 months in nine of 10 harm areas. Additionally, CalHEN hospitals reported a 40 percent improvement or sustained zero harm for the past 12 to 24 months in six of the 10 harm areas. Continued engagement is planned in 2014 to ensure that all participating CalHEN hospitals fully realize the 40/20 improvement goals.

Participating hospitals show significant improvement in CLABSI, EED and SSI, as shown in Figures 1, 2 and 3.

Table 1: CalHEN Outcome Metrics. Source: CalHEN, 2013

<table>
<thead>
<tr>
<th>Hospital Acquired Condition</th>
<th># of Participating Hospitals</th>
<th>Hospitals Improving 30 – 39% Over 2011 Baseline or Maintained Zero for the past 6-11 Months</th>
<th>Hospitals Improving 40% Over 2011 Baseline or Maintained Zero for the past 12-24 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>159</td>
<td>86%</td>
<td>82%</td>
</tr>
<tr>
<td>EED</td>
<td>76</td>
<td>83%</td>
<td>71%</td>
</tr>
<tr>
<td>VAP</td>
<td>115</td>
<td>82%</td>
<td>68%</td>
</tr>
<tr>
<td>HAPU</td>
<td>147</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>VTE</td>
<td>85</td>
<td>67%</td>
<td>36%</td>
</tr>
<tr>
<td>SSI</td>
<td>127</td>
<td>63%</td>
<td>54%</td>
</tr>
<tr>
<td>Falls</td>
<td>143</td>
<td>59%</td>
<td>46%</td>
</tr>
<tr>
<td>CAUTI</td>
<td>154</td>
<td>56%</td>
<td>47%</td>
</tr>
<tr>
<td>ADE</td>
<td>69</td>
<td>53%</td>
<td>32%</td>
</tr>
<tr>
<td>OB Harm</td>
<td>44</td>
<td>43%</td>
<td>50%</td>
</tr>
</tbody>
</table>

1. CLABSI - Central Line Associated Blood Stream Infections; EED – Early Elective Deliveries; VAP - Ventilator-Associated Pneumonia; HAPU – Hospital-Acquired Pressure Ulcers; VTE - Venous Thromboembolism; SSI – Surgical Site Infections; CAUTI - Catheter-Associated Urinary Tract Infections; ADE – Adverse Drug Events; OB – Obstetrical Adverse Events.
**Patient Safety First (PSF)**

PSF, a California Partnership for Health, was launched in 2010 to improve quality of care, save lives and reduce health care costs by improving patient safety and perinatal care in California. PSF is a partnership among the National Health Foundation, California's regional hospital associations, Anthem Blue Cross and more than 180 hospitals across the state, making it the largest such collaborative in the nation.

Significant strides have been made toward the goals for reducing sepsis mortality, ventilator-acquired pneumonia (VAP), catheter associated urinary tract infections (CAUTI), and EED prior to 39 weeks gestational age.

Outcomes achieved include a 57 percent reduction in VAP, 74 percent reduction in EED prior to 39 weeks gestational age and 24 percent reduction in CAUTI. In addition, PSF hospitals reduced CLABSI by 43 percent and sepsis mortality by 26 percent. This represents 3,576 lives saved and an estimated $64 million in health care costs avoided.

Due to the tremendous work by California hospitals, PSF was recently recognized by The National Quality Forum and The Joint Commission and honored as a 2013 recipient of the national John M. Eisenberg Patient Safety and Quality Awards.

**California Hospital Patient Safety Organization (CHPSO)**

CHPSO, created in 2008 by CHA, is a federally designated Patient Safety Organization dedicated to eliminating preventable harm and improving the quality of health care delivery in hospitals. CHPSO shares a commitment with more than 280 California hospitals to eliminate preventable harm to patients and their families by providing a safe and secure reporting and learning environment. The convening of Safe Tables throughout the state provides confidential reviews of actual case studies of events by frontline physicians and staff, allowing for advances in learning and risk mitigation. CHPSO is also a leader in national safety initiatives.

Building on the success and momentum of this great work, and to assist hospitals and join forces, to eliminate harm and improve care, CHA and the state’s regional hospital associations established HQI in 2013.

Bringing all of these initiatives under one umbrella, HQI engages stakeholders at local and state levels, from frontline physicians, nurses and staff directly caring for and serving patients, to governance boards, executive and physician leaders, consumers and community organizations. HQI is a platform to integrate and take excellence to scale, as well as aggregate, monitor and report quality performance for our hospitals.
HQI’s mission is to advance and accelerate patient safety and quality improvement for coordinated statewide impact, with aims to achieve zero defects, optimize clinical effectiveness, and enhance patient and family experience in health care. Its vision, created through the collective aspirations of leaders in California, is that California hospitals will lead the nation in patient safety and quality performance with high reliability and zero defect in care on behalf of the people and communities they serve and that hospitals will lead through respect for people and a culture of habitual excellence.

To advance patient safety, quality and reliability, HQI has launched eight long-range strategies — all based on a model to cultivate and protect a statewide culture of transparency, learning and innovation. The strategies include shared leadership, physician engagement, strategic planning, customer knowledge, infrastructure of technical and facilitative resources, systemic and rigorous measurement, evidence-based medicine across the full continuum of care, and a culture of professionalism and teamwork.

Results are being achieved in California. For example, Marshall Medical Center in Placerville has reduced harm across the board by 81 percent, with a savings of approximately $1.5 million. There are many similar success stories across the state.

Discovery, innovation and spread are hallmarks of California improvement strategies. Core programs and engagement networks are the vehicles to learn, accelerate, change and build implementation evidence.

Examples of this approach include:

- Regional Quality Leader Networks bring together improvement-minded thought leaders to share ideas and expertise, and engage in continuous learning for ongoing improvement.
- PSF and CalHEN are the largest collaborations of their kind across the nation, creating a large constituency for communication, learning and spread.
- Structured peer-to-peer learning encourages hospitals to share their successful tools and resources with each other.
- Seminars and webinars keep staff up-to-date on the latest ideas, processes and goals.
- Mobile Sepsis Simulation vans visit requesting hospitals for staff to attend training in detection and early goal directed therapy for sepsis.
- Rigorous and continuous measurement provides feedback to staff to monitor and gauge progress and establish accountability for performance.
- CalHEN clinical improvement advisors provide tailored interventions that include regularly scheduled on-site meetings with hospital improvement teams and senior leadership; and focused work with under-performing hospitals.
- Celebrations and recognition of success provide positive reinforcement of results achieved as well as model that goals are attainable.
- Community outreach and engagement, such as with the March of Dimes, enhances the visibility and success of projects.

California hospitals have improved — and will continue to improve — because of their dedication to a common aim of zero harm and zero preventable deaths.

To better understand the ongoing activities, we invite you to visit one of our hospitals to meet the CEO, physicians, nurses and care teams that are delivering these results. Also, when you come to Sacramento, we invite you to visit CHA to meet with us and the members of the Hospital Quality Institute for California. To facilitate either of these meetings, please contact Anne O’Rourke, CHA senior vice president, federal relations, in CHA’s Washington, DC, office at aorourke@calhospital.org.
Trust that California will relentlessly pursue the aim of 40 percent reduction of harm on the journey to zero harm in the 10 target areas you listed and in all aspects of care delivery.

Thank you for your interest in California hospitals, and we look forward to continuing this important conversation about the work of hospitals across the state to eliminate harm and improve quality.

Sincerely,

C. Duane Dauner
President/CEO
California Hospital Association

Julianne Morath, RN, MS
President/CEO
Hospital Quality Institute