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Senate Health Committee Oversight Hearing
California Department of Public Health
Hospital Licensing and Enforcement:
Adverse Events
October 20, 2010

First, Madame Chair and committee members, thank you for the opportunity to testify on this panel on adverse events.

Beth Capell, speaking on behalf of the Service Employees International Union: We represent every kind of worker who works in health care: we represent doctors, nurses, housekeepers, clerks and every other worker involved in minimizing adverse events. We also represent the nurses and other public employees at the CDPH Licensing and Certification and LA County who survey hospitals and respond to complaints and reports of adverse events. In that regard, I want to begin by noting that the recent furloughs of our Local 1000 members undermine the effectiveness of adverse event reporting and complaint investigations: it is hard to be effective when a worker is not working.

As the Chair noted, in 2006, SB1301 requiring the reporting of a specific set of adverse events was enacted into law.

An adverse event is an event that should never have happened. Public reporting of such events is intended to create incentives to reduce their frequency, improving quality while saving money by providing the right care in the first place.

While we are pleased that the Department has begun to implement the law, there is more to be done.

We are pleased that the Department is doing a better job of inspecting within the timelines required by law. We are also pleased that the Department has used its statutory authority to fine hospitals that have not reported timely and to fine hospitals where patients faced immediate jeopardy.

However, we are very troubled by the astonishing under-reporting of adverse events and the failure of the Department to use readily available sources of data to cross-check the reporting by hospitals. We are deeply concerned about the implications for reporting of HAIs as well. We are also troubled that the Department appears not to check for adverse events and HAIs when considering approval of change of ownership.

What do we mean by this?

A few examples:

An analysis done in 2009 using OSHPD hospital discharge data found over 300,000 patient days attributable to adverse events for just four adverse events: foreign object, air embolism, blood incompatibility and falls/trauma. And the analysis also found over two *million* patient days attributable to catheter-associated urinary tract infections.

Yet in 2008-09, fewer than 200 adverse events associated with retention of a foreign object, only 3 adverse events related to air embolism, only one related to blood incompatibility, and only 42 patient deaths associated with falls were reported to CDPH.

An analysis done by SEIU found that five hospitals operated by Prime health care had the highest rates of septicemia or blood infections: five of the six highest infection rates in the country occurred at Prime hospitals and the company-wide rate was four and a half standard deviations above the mean. The first round of analysis was done using Medicare claims data and a second round was done using OSHPD data on Medi-Cal claims.

Hospitals reported 1,015 stage three and four pressure ulcers to CDPH but 117,725 claims for skin ulcers in 2008 to OSHPD. While not every claim for a skin ulcer represents a stage three or four pressure sore, the disparities in numbers raises serious questions.

While we recognize that the OSHPD data and the Medicare claims data are not perfect matches for the reporting requirements under SB1301, these data are helpful in several respects:

First, the data indicate that adverse events are under-reported by several orders of magnitude.

Second, in our view, prior to a routine licensing survey or prior to a complaint investigation regarding adverse events, the surveyor should have in hand both OSHPD data and Medicare claims data for the prior year for adverse events and HAIs. If a hospital reports few or no adverse events but the OSHPD data or Medicare data show a significant number of patient days or add-on payments associated with adverse events or HAIs, that fact should be known to the surveyor prior to inspection and should raise questions about whether the hospital is reporting appropriately.

Third, prior to approving a change of ownership, the Department should cross-check its data with the OSHPD data and the Medicare claims data to see what the data show in terms of patient days and add-on payments associated with adverse events and HAIs.

Fourth, like others, we were initially shocked by the prevalence of stage 3 and 4 ulcers in hospitals reported to CDPH. But given the claims data reported to OSHPD, we now ask whether hospitals are reporting appropriately to CDPH.

We do not know today what cases of septicemia Prime Health Care reported to CDPH but we do know that they billed Medicare and Medi-Cal for extraordinarily high levels of septicemia, septicemia at a rate three times the national average, and 70% higher than the second highest health care system in the country.

We also know that there were hundreds of thousands of patient days associated with falls and several million associated with urinary tract infections.

Yet in its public reporting to date, the Department has reported fewer than 1500 adverse events per year.

While we recognize that the OSHPD data and the Medicare claims data are not a perfect match for the hospital reporting required by CDPH, something does not add up here. Either hospitals are under-reporting to CDPH or they are over-reporting to OSHPD and Medicare.