Agenda

I. Welcome 
   Kristin Vandersluis
II. Overview 
   Jean Iacino
III. Hubbert Recommendation Updates 
   Jean Iacino
IV. Performance Metrics Update 
   CJ Howard
V. General Acute Care Hospital 
   Re-Licensing Surveys 
   Virginia Yamashiro
VI. 3.5 Staff Direct Care Hours Regulations 
   Chelsea Driscoll
VII. Quality Accountability Supplemental 
    Payment Program 
    Mike Shults
VIII. General Q & A 
    CHCQ Team
Welcome

* Kristin Vandersluis
  Facilitator
* July 1, 2017 Budget Augmentations
  * Increase of $2.0 million expenditure authority from the Internal Departmental Quality Improvement Account
  * Increase of $1.1 million to fund the Los Angeles County contract for union-negotiated salary increases effective October 2016, October 2017, and April 2018.

* CDPH Website Redesign

* Continued Reduction in Antipsychotic Use in SNFs
  * percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington’s Disease or Tourette’s Syndrome
  * Quarter 1 2017 CA was at 12.3%, fifth lowest in the nation
  * See more at the National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (July 2017): https://www.nhqualitycampaign.org/files/AP_package_20170717.pdf
Goal #1: All vacant senior management positions are filled permanently with individuals who meet defined leadership qualifications; leadership development training has been completed; leadership qualities, competencies, and skills have been defined and communicated; and a process for ongoing evaluation of executives’ performance is in place.

Completion Report: All senior management (Branch Chief and above) positions vacant at the time of the Hubbert remediation report, as well as three new Career Executive Assignment positions, have been filled. These senior managers have completed the adopted standard of the CDPH Leadership Development Program. Further leadership development training is ongoing, including StrengthsFinder, Leading Change, and Exemplary Leadership Practices. The CDPH Individual Development Plan process is completed.
Goal #20: Updated L&C policies and procedures are current and easily accessible to all staff. In addition, the infrastructure and necessary resources will be in place to ensure the Program’s policies and procedures remain current.

Completion Report: CHCQ has created the infrastructure to bring and keep policies and procedures current. CHCQ has assigned dedicated resources to policy and procedure development within the reorganized Policy Section. The Policy team has created improved policy development and dissemination processes, including improved policy and procedure accessibility to staff.
Other significant workplan updates include:

- Goal 2: Create a Change Management and Governance Structure
  - Change management plan under final review
- Goal 11: Design and Implement a HFEN Recruitment Strategy and Campaign
  - Continuous statewide recruitment underway with HFEN interviews being tracked and reported at all district offices; consultants guiding multichannel advertising campaign; S. CA nursing outreach fair
Other significant workplan updates include:

* Goal 13: Improve HFEN On-Boarding and Initial Training
  * New surveyor training academy redesigned
* Goal 16: Develop and Implement a Leadership and Management Skills Development Program
  * Implemented StrengthsFinder training for all senior management and are extending training throughout the Center
Hubbert Recommendation Updates

* Full text workplan and goal completion reports available at:
  https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/WorkPlanUpdates_GoalCompletionReports.aspx
Performance Metrics Update

* CHCQ released the metrics for Quarter 3 Fiscal Year 2016-17 on Monday August 14.
  * Available at https://archive.cdph.ca.gov/programs/Pages/CHCQPerformanceMetrics.aspx

* The next quarter metrics will have a revised presentation format at style.
  * CHCQ is moving away from the quarterly PDF documents, and is creating interactive dashboards.
The revised dashboards will enable users to:

* More easily make comparisons across time.
* Filter and sort the displays to reveal the information they find most pertinent.
* Access more data at a glance; reduce the need to sort through more than 50 pages of PDF documents.
* Access all the information that was available in the PDF displays.
Performance Metrics Update

2016-2017 Fiscal Year

Quarter Ending 12/31/16

Intakes Received: 11,220
Intakes Completed: 8,963
% of Intakes Initiated in 24 Hours: 96.7%

Quarter Ending 9/30/16

Intakes Received: 11,220
Intakes Completed: 8,963
% of Intakes Initiated in 24 Hours: 96.7%

Summary Table for FY 2016-17 Q3
Facility Type: Long-Term Care & Non-Long-Term Care
Intake Type: Complaint & Entity Report Incidents

Intakes Received: 11,220
Intakes Completed: 8,963
% of Intakes Initiated in 24 Hours: 96.7%
The purpose of a GACH Relicensing Survey (GACHRLS) is to promote quality of care in hospitals, verify compliance with State regulations and statutes, and ensure a program wide consistency in the hospital survey methodology.

The GACH Relicensing Survey was implemented on March 1, 2016 – on a three year cycle.

California’s licensing regulations and statute requirements with elements of the former stand-alone Medication Error Reduction Plan (MERP) survey and Patient Safety Licensing Survey (PSLS) into one survey process.
Follows MERP schedule- unannounced
Completed 89 surveys for Year 1 (every 3 year cycle)
Year 2: March 2017-February 2018: scheduled 118 total surveys- 14 in Los Angeles
Focus on hospitals with HAI issues based on program report. Infection Control consultant with team on 13 hospitals.
General Acute Care Relicensing Survey Page: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/GeneralAcuteCareRelicensingSurvey.aspx
Data will be collected on the top deficiencies cited and will be shared.
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<th>Regulation Description</th>
<th>Count</th>
<th>Top 10 Ranking</th>
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<td>Infection Control Program / T22 DIV5 CH1 ART7-70739(a)-(b)-(1)-(4)</td>
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<td>Planning and Implementing Patient Care / T22 DIV5 CH1 ART3-70215(a)-(d)-(1)-((10)</td>
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<td>4</td>
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<td>Patients' Rights / T22 DIV5 CH1 ART7-70707(a)-(d)-(1)-(9)</td>
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### Top 10 Deficiencies
GACHRLS 1/1/2015 – 12/31/2016

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<th>Description</th>
<th>No.</th>
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<td>General Safety and Maintenance / T22 DIV5 CH1 ART8-70837(a)-(c)</td>
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<td>Health &amp; Safety Code / HSC 1255.8(b)-(e)-(1)(3)-(4)</td>
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<tr>
<td><strong>Total</strong></td>
<td>701</td>
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</table>
General Acute Care Hospital Relicensing Survey

  * Corrective action to be taken for each individual affected by the deficient practice, including any system changes that must be made
  * The position of the person who will monitor the corrective action and frequency of monitoring
  * Dates each corrective action will be completed

* The required POC was must be returned to the DO within 10 calendar days after the receipt of the 2567. In special circumstances, the facility may request for an extension of the due date from the DO

A “rebuttal” is not considered a POC
SB 97

* Effective July 1, 2018 SNFs must provide a minimum of 3.5 direct care hours

  * Excludes D/P of a GACH or state-owned hospital or developmental center
SB 97 Implementation

* Develop emergency regulations
* Establish two staffing requirement waivers
* Develop schedule to issue penalties
* Evaluate impact of staffing changes
SB 97 Next Steps

* Stakeholder meetings

* Commitment to transparency
QASP Update

- Proposed antipsychotic measure (Dementia)
- Analyzing quality measure retirement
- Setting a data completeness standard
California average rates of antipsychotic use in SNFs:
* All-Resident: 11.9%
* Dementia-only: 13.7%

Literature review
* Antipsychotics use, dementia, and death*

Quality measure review
* One year evaluation began July 1, 2017
  * not a scored measure in 2017-18
* Stakeholder consultation April – June 2017
  * Posted methodology and facility rates
  * Requested feedback to QASP@cdph.ca.gov
Stakeholder feedback
* Evaluate antipsychotic use in all residents and all facilities
  * Not dementia only
* Potential for admission bias
* Concern about overall number of QASP measures
CHCQ is reviewing current measures for potential retirement

Analysis of CMS published guidelines for retirement


“Normal distribution” versus “topped out” measures
**QASP MDS Data Completeness**

**GOAL:** Improve data quality and validity of measurement used for QASP payments
- Recommend data completeness as an eligibility requirement
- Exclude facilities with high percentages of missing data from payments

<table>
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<tr>
<th>Missing MDS Assessment</th>
<th>Number of facilities</th>
<th>Percentage of facilities</th>
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</thead>
<tbody>
<tr>
<td>50% Or More</td>
<td>11</td>
<td>0.92%</td>
</tr>
<tr>
<td>40% Or More</td>
<td>15</td>
<td>1.26%</td>
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<tr>
<td>25% Or More</td>
<td>29</td>
<td>2.43%</td>
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<tr>
<td>20% Or More</td>
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<td>3.35%</td>
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<td>15% Or More</td>
<td>66</td>
<td>5.53%</td>
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<td>108</td>
<td>9.05%</td>
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<tr>
<td>5% Or More</td>
<td>276</td>
<td>23.13%</td>
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![Bar chart showing percentages of stays with 150+ days of gap](chart.png)
Proposed goal for data improvement: Reduce the number of resident stays missing an MDS assessment

- Year 1: 20%
- Year 2: 15%
- Year 3: 10%
Additional questions? Feedback?

Email the Stakeholder Forum mail box at:
CHCQStakeholderForum@cdph.ca.gov
Next CHCQ Stakeholder Forum
February 2017
Date and Time TBD