



# Center for Health Care Quality Semiannual Stakeholder Forum

September 4, 2015

# Agenda

- Welcome and Overview
- Program Updates
- Healthcare Associated Infections Program
- Skilled Nursing Facilities Nursing Hours Per Patient Day
- Open Dialogue
- Next Steps



# Welcome and Overview



# Process Overview and Ground Rules



# Center for Health Care Quality Program Updates



# CDPH Leadership

Karen Smith, MD, MPH	Director and State Health Officer
Claudia Crist, RN	Chief Deputy Director of Policy and Programs
Brandon Nunez	Chief Deputy Director of Operations
Susan Fanelli	Assistant Director
Jean Iacino	Deputy Director, CHCQ
Scott Vivona	Assistant Deputy Director CHCQ
C.J. Howard	Chief, Policy & Planning CHCQ
Recruiting for 2 Field Operations Chiefs - LTC/NLTC	

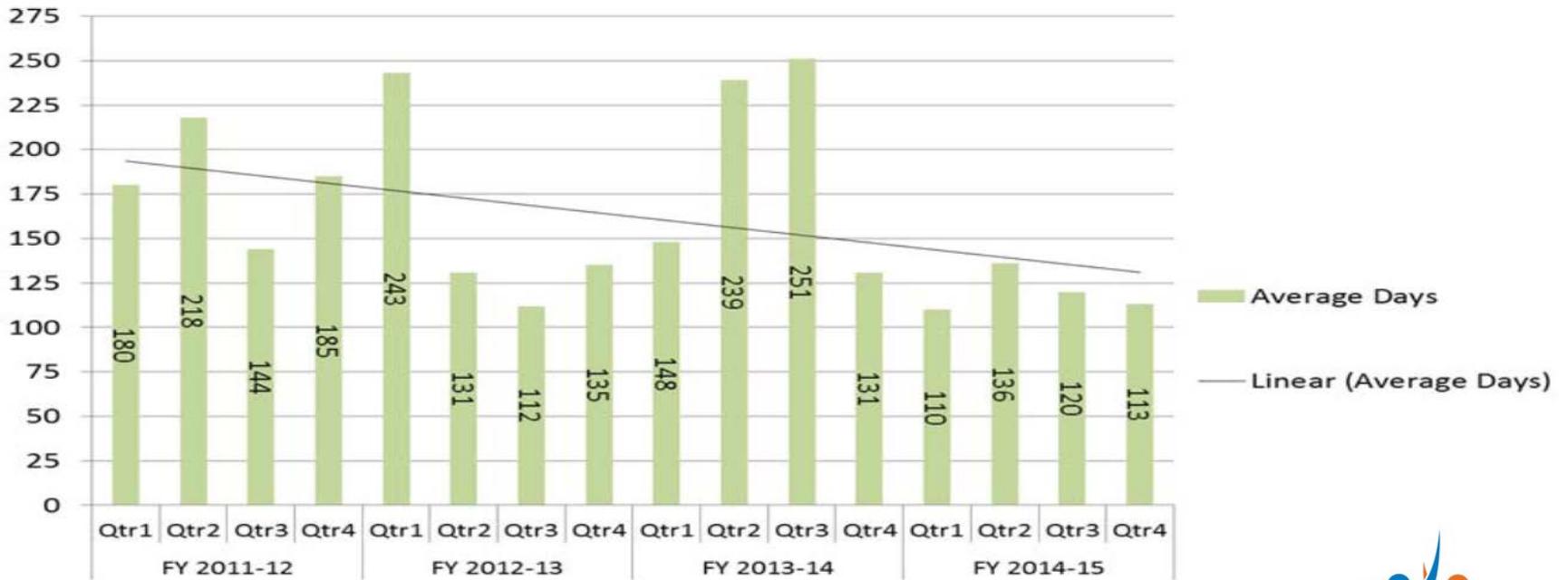


# Long-Term Care Complaints Investigation Timeliness by District Office July 1, 2014 – June 30, 2015

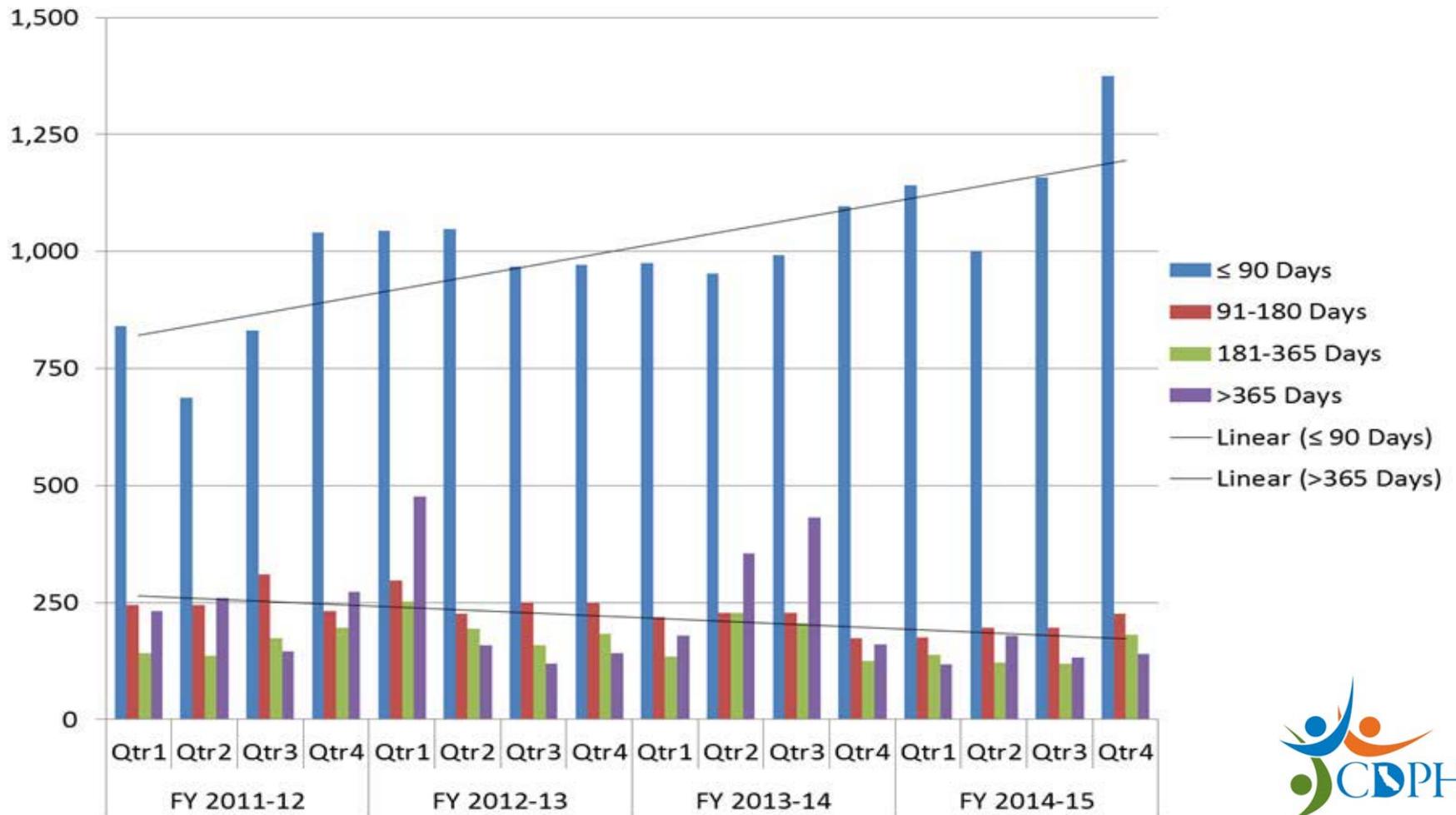
## TIMELINESS

District Office / Statewide	A	B	C		D		E				F				O	P
	Complaints Received During Reporting Period	Complaints Completed During Reporting Period (Regardless of Receipt Date)	Immediate Jeopardy (IJ)		Non-Immediate Jeopardy		Number of Complaints Completed During Reporting Period by Working Days from Receipt to Completion				Complaints Completed by Working Days from Receipt to Completion, as a Percentage of Total Completed During					
			(24 hours)		(10 working days)		≤90	91-180	181-365	>365	≤90	91-180	181-365	>365		
Number Received	Percent Initiated Timely	Number Received	Percent Initiated Timely	≤90	91-180	181-365	>365	≤90	91-180	181-365	>365	Avg Days to Complete Complaints During Reporting Period	Average Age of Open Complaints			
<b>California</b>	<b>7,605</b>	<b>6,597</b>	<b>529</b>	<b>97%</b>	<b>6,757</b>	<b>97%</b>	<b>4,677</b>	<b>792</b>	<b>559</b>	<b>569</b>	<b>71%</b>	<b>12%</b>	<b>8%</b>	<b>9%</b>	<b>119</b>	<b>268</b>
Bakersfield	328	325	33	100%	286	99%	303	17	4	1	93%	5%	1%	0%	46	22
Chico	296	242	38	97%	248	100%	105	87	46	4	43%	36%	19%	2%	118	136
East Bay	530	521	4	100%	489	98%	487	31	3	0	93%	6%	1%	0%	39	35
Fresno	404	345	72	90%	301	91%	290	46	8	1	84%	13%	2%	0%	51	64
Los Angeles County	1,774	1,001	200	99%	1,537	95%	416	177	175	233	42%	18%	17%	23%	246	378
Orange County	244	242	0	0%	224	99%	235	7	0	0	97%	3%	0%	0%	37	22
Riverside	442	503	18	100%	412	99%	350	52	70	31	70%	10%	14%	6%	112	108
Sacramento	619	605	70	100%	541	98%	587	16	1	1	97%	3%	0%	0%	41	32
San Bernardino	475	484	46	98%	427	96%	424	29	2	29	88%	6%	0%	6%	87	40
San Diego North	413	408	11	91%	393	97%	298	90	19	1	73%	22%	5%	0%	70	132
San Diego South	458	354	2	100%	423	100%	189	100	64	1	53%	28%	18%	0%	105	116
San Francisco	286	342	0	0%	274	98%	175	45	39	83	51%	13%	11%	24%	279	272
San Jose	349	322	2	100%	340	99%	319	0	0	3	99%	0%	0%	1%	37	29
Santa Rosa/Redwood Coast	348	360	25	96%	311	97%	135	48	86	91	38%	13%	24%	25%	227	204
State Facilities Section	383	300	3	100%	307	96%	134	38	40	88	45%	13%	13%	29%	200	172
Ventura	256	243	5	80%	244	96%	230	9	2	2	95%	4%	1%	1%	52	40

# Long-Term Care Complaints Average Days from Receipt to Completion



# Long-Term Care Complaints Completion Time by Intervals



# Long-Term Care Entity-Reported Incidents Investigation

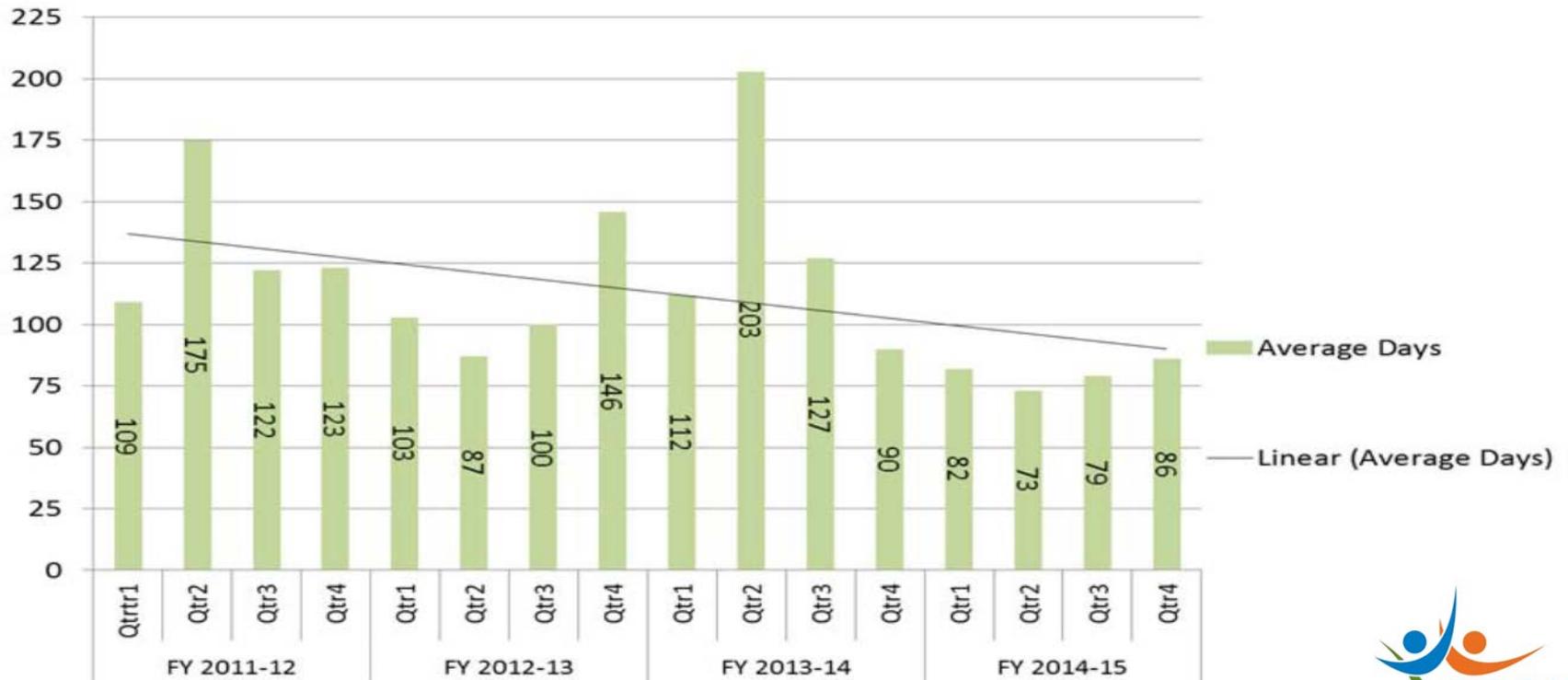
## Timeliness by District Office

### July 1, 2014 – June 30, 2015

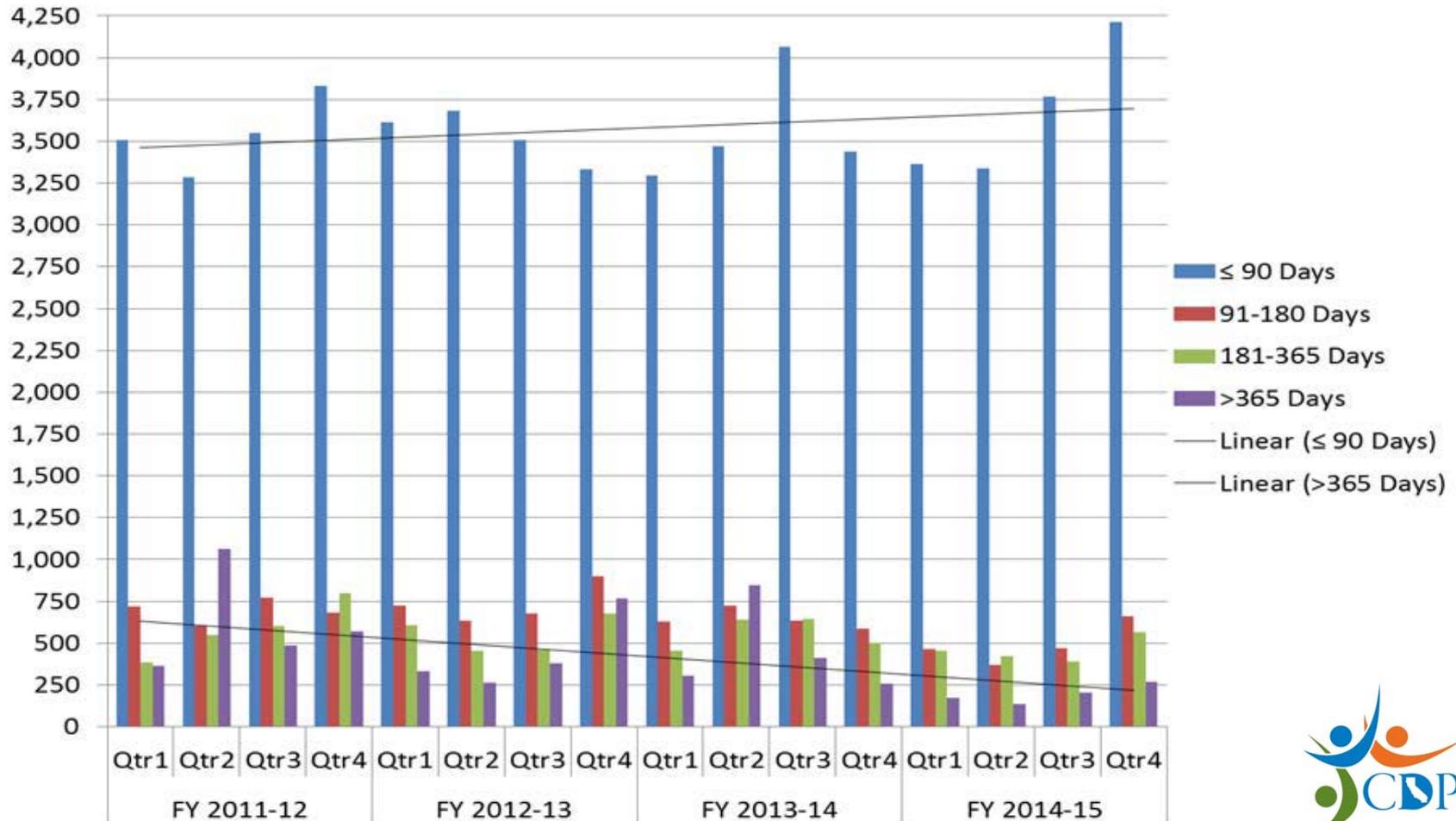
#### TIMELINESS

Reporting Period	ERIs Received During Reporting Period	ERIs Completed During Reporting Period (Regardless of Receipt Date)	Immediate Jeopardy (I)		Number of ERIs Completed During Reporting Period by Working Days from Receipt to Completion				ERIs Completed by Working Days from Receipt to Completion, as a Percentage of Total Completed During Reporting Period				Avg Days to Complete ERIs During Reporting Period	Average Age of Open ERIs
			(24 hours)		≤90	91-180	181-365	>365	≤90	91-180	181-365	>365		
			Number Received	Percent Initiated Timely										
A	B	C	D	E	F	G	H	I	J	K	L	M	N	
<b>California</b>	<b>20,265</b>	<b>19,263</b>	<b>461</b>	<b>97%</b>	<b>14,682</b>	<b>1,967</b>	<b>1,830</b>	<b>784</b>	<b>76%</b>	<b>10%</b>	<b>10%</b>	<b>4%</b>	<b>81</b>	<b>188</b>
Bakersfield	1,360	1,369	5	100%	1,337	22	9	1	98%	2%	1%	0%	18	26
Chico	598	572	8	100%	219	202	136	15	38%	35%	24%	3%	138	131
East Bay	995	961	5	100%	897	57	6	1	93%	6%	1%	0%	34	50
Fresno	1,928	1,874	69	94%	1,753	93	27	1	94%	5%	1%	0%	27	65
Los Angeles County	3,585	2,377	169	98%	1,466	341	446	124	62%	14%	19%	5%	109	263
Orange County	730	672	1	100%	660	10	0	2	98%	1%	0%	0%	34	40
Riverside	869	915	9	100%	719	54	74	68	79%	6%	8%	7%	98	102
Sacramento	1,819	1,753	37	100%	1,725	23	4	1	98%	1%	0%	0%	26	25
San Bernardino	1,242	1,371	64	91%	1,064	202	85	20	78%	15%	6%	1%	59	144
San Diego North	635	669	24	100%	507	126	33	3	76%	19%	5%	0%	65	138
San Diego South	482	480	2	100%	339	95	45	1	71%	20%	9%	0%	66	125
San Francisco	746	1,053	0	0%	472	106	246	229	45%	10%	23%	22%	241	210
San Jose	717	690	1	100%	689	1	0	0	100%	0%	0%	0%	27	33
Santa Rosa/Redwood Coast	821	854	59	98%	508	125	143	78	59%	15%	17%	9%	125	168
State Facilities Section	2,979	2,929	7	100%	1,667	477	563	222	57%	16%	19%	8%	126	164
Ventura	759	724	1	100%	660	33	13	18	91%	5%	2%	2%	57	36

# Long-Term Care Entity Reported Incidents Average Days from Receipt to Completion



# Long-Term Care Entity Reported Incidents Completion Time by Intervals



# FY 15/16 Budget

- \$30.4 million and 237 additional positions to conduct licensing and certification activities
- \$14.8 million additional funding for Los Angeles County contract
- \$2.5 million to implement quality improvement projects
  - dashboards
  - recruiting and retention strategies
- \$378,000 and 3 positions to provide on-site oversight and perform workload management, training, and quality improvement activities in Los Angeles County



# Health Facility Evaluator Nurse (HFEN) Mass Hiring

- Mailed 594 recruitment letters to HFEN candidates throughout the state.
- Received and screened approximately 175 applications for minimum qualifications
  - Approximately 150 met the minimum qualifications
- District Offices began interviewing the week of July 20<sup>th</sup>.
- As of 8/27/15, 64 pending hires



# LTC Complaint Investigation Timelines

SB 75 established LTC complaint investigation timelines:

- Beginning July 1, 2016, complete IJ-level complaints within 90 days of receipt.
- Beginning July 1, 2017, complete ALL LTC complaints within 90 days of receipt.
- Beginning July 1, 2018 complete all LTC complaint within 60 days of receipt.
- Beginning July 1, 2016 issue state citations within 30 days of completing investigation



# Quality Improvement Projects

- Complaint Investigations – Improve completion timeliness of complaints
- Citations – Improve timeliness of issuing state citations
  - Workgroups map processes and identify delays and barriers
  - Identify best practices
  - Implement test phase using Plan, Do, Check, Act



# Questions and Comments



# CHCQ Healthcare-Associated Infections (HAI) Program

Lynn Janssen, MS, CIC, CPHQ  
Branch Chief



# Objectives

1. Describe our Program activities for preventing HAI (defined as infections that occur as a result of healthcare)
2. Discuss new defined roles for public health in
  - HAI surveillance and prevention
  - Regional approaches for the control of antimicrobial resistant infections and *C difficile* diarrheal infections



# HAI in California Hospitals Annual Report

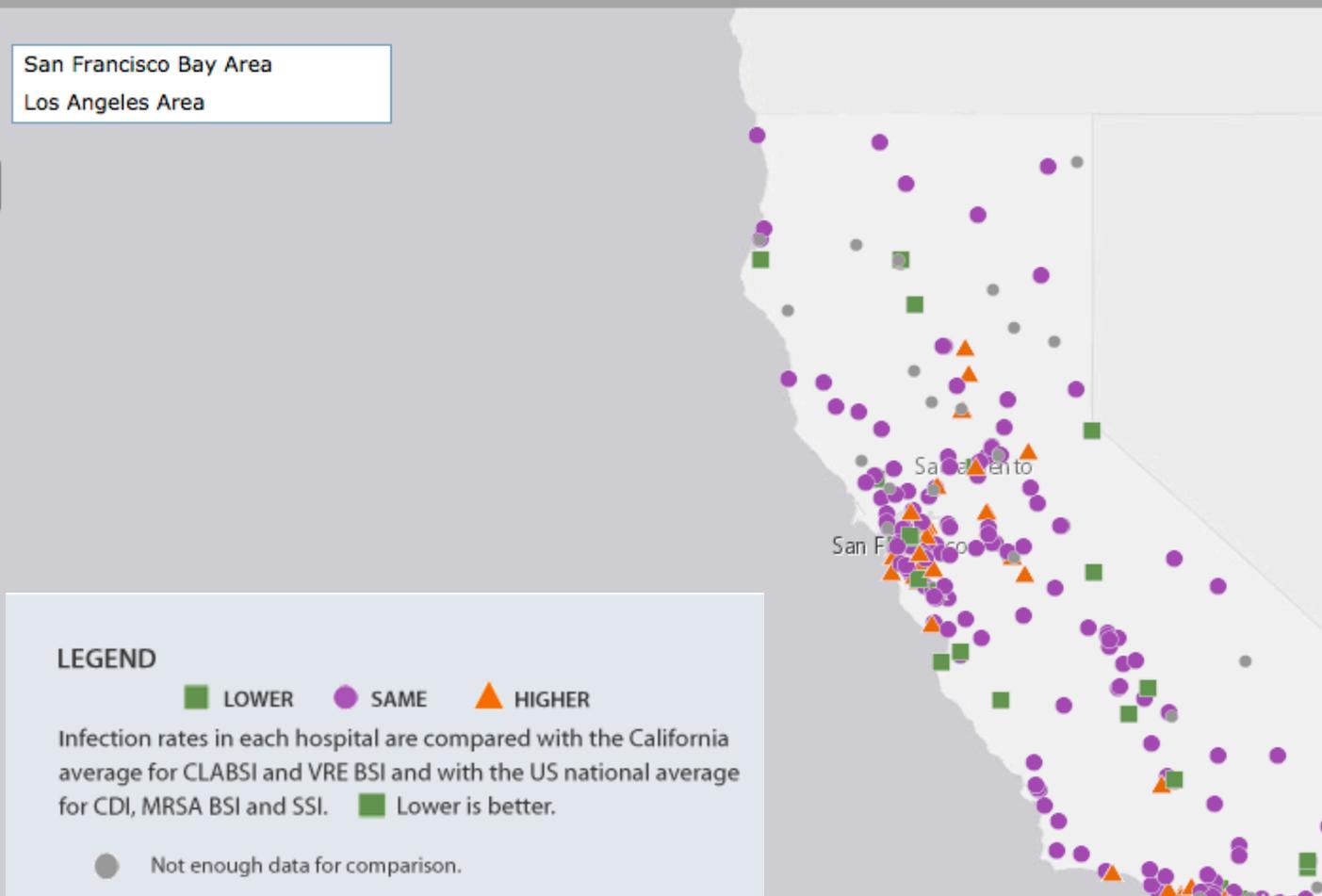
- Data reported by 400 acute care hospitals (no exclusions for size) to the National Healthcare Safety Network (NHSN)
- Published via a web page that includes
  - Summary report of key findings and public health action
  - 90 data tables
  - Interactive map
  - Technical reports for each infection type



## My Hospital's Infections

[Hospital Data](#)
[CDI](#)
[CLABSI](#)
[MRSA](#)
[VRE](#)
[SSI](#)



### LEGEND

■ LOWER   
 ● SAME   
 ▲ HIGHER

Infection rates in each hospital are compared with the California average for CLABSI and VRE BSI and with the US national average for CDI, MRSA BSI and SSI. ■ Lower is better.

● Not enough data for comparison.

# Annual Report of HAI in California Hospitals, 2013

	No. of HAI Reported by California Hospitals in 2013	2013 California HAI Data Compared with National Baselines*
<b>CDI</b>	10,553	↑ 5% since 2011
<b>CLABSI</b>	2836	↓ 48% since 2008
<b>MRSA BSI</b>	698	↓ 27% since 2011
<b>VRE BSI</b>	753	<i>No national baseline</i>
<b>SSI – All Surgeries</b>	3,940	↓ 44% since 2008
<b>SSI – Colon Surgery</b>	686	↓ 18% since 2008
<b>SSI – Hysterectomy</b>	152	↓ 28% since 2008

CDC 2013 HAI Progress Report



# Influenza Vaccination Among Health Care Personnel (HCP) in California Hospitals - Annual Report

- Data reported by 400 acute care hospitals to NHSN
- Published via a web page that includes report of key findings and public health actions, 5 data tables, technical report
- 2013-2014 flu season data continued to show incremental improvement in HCP vaccination rates
  - Employees – 81%
  - Non-employee HCP – 63%



# Liaison Infection Preventionist (IP) Program

- Regionally-based Liaison IPs, highly experienced, certified in infection control and epidemiology (CIC)
- Assigned approximately 45 hospitals each to perform assessments/consult if high HAI rates
- Conduct monthly regional calls to connect with their area hospitals and relay updates from CDPH HAI Program
- Expanding to non-hospital settings through Mar 2018

Example: Oct – Mar 2016

- 60 high HAI incidence hospitals (based on 2014 published data)
- 80 LTC facilities identified by CDPH L&C district offices
- 68 Outpatient hemodialysis clinics
- 30 Outpatient facilities at risk for unsafe injection practices



# California Campaign to Prevent Bloodstream Infections in Hemodialysis Patients

- 514 outpatient hemodialysis centers in California
- HAI Program staff include a full-time Dialysis Liaison IP and part-time nurse consultant
- Five-year plan to provide onsite assessments and strategies to prevent bloodstream infections
  - One-day assessments of adherence to CDC prevention strategies with same day feedback
  - Webinars, website, and a one-day infection prevention class



# Coordination of Ebola Hospital Preparedness

- CDPH & CDC onsite assessments of Ebola Treatment Hospitals Nov-Dec 2014
  - 5 University of California Medical Centers:  
UC Davis, UC San Francisco, UCLA, UC Irvine, UC San Diego
  - 3 Kaiser-Permanente Hospitals:  
South Sacramento, Oakland, Los Angeles
- In coordination with local public health and EMS



# Core Actions to Address Antimicrobial Resistance (AR)

- **Improve antimicrobial prescribing** through antimicrobial stewardship
- **Preventing infections and transmission** of antimicrobial resistant pathogens
- **Tracking antimicrobial resistance** patterns

# California is a Leader in Antimicrobial Stewardship Legislation

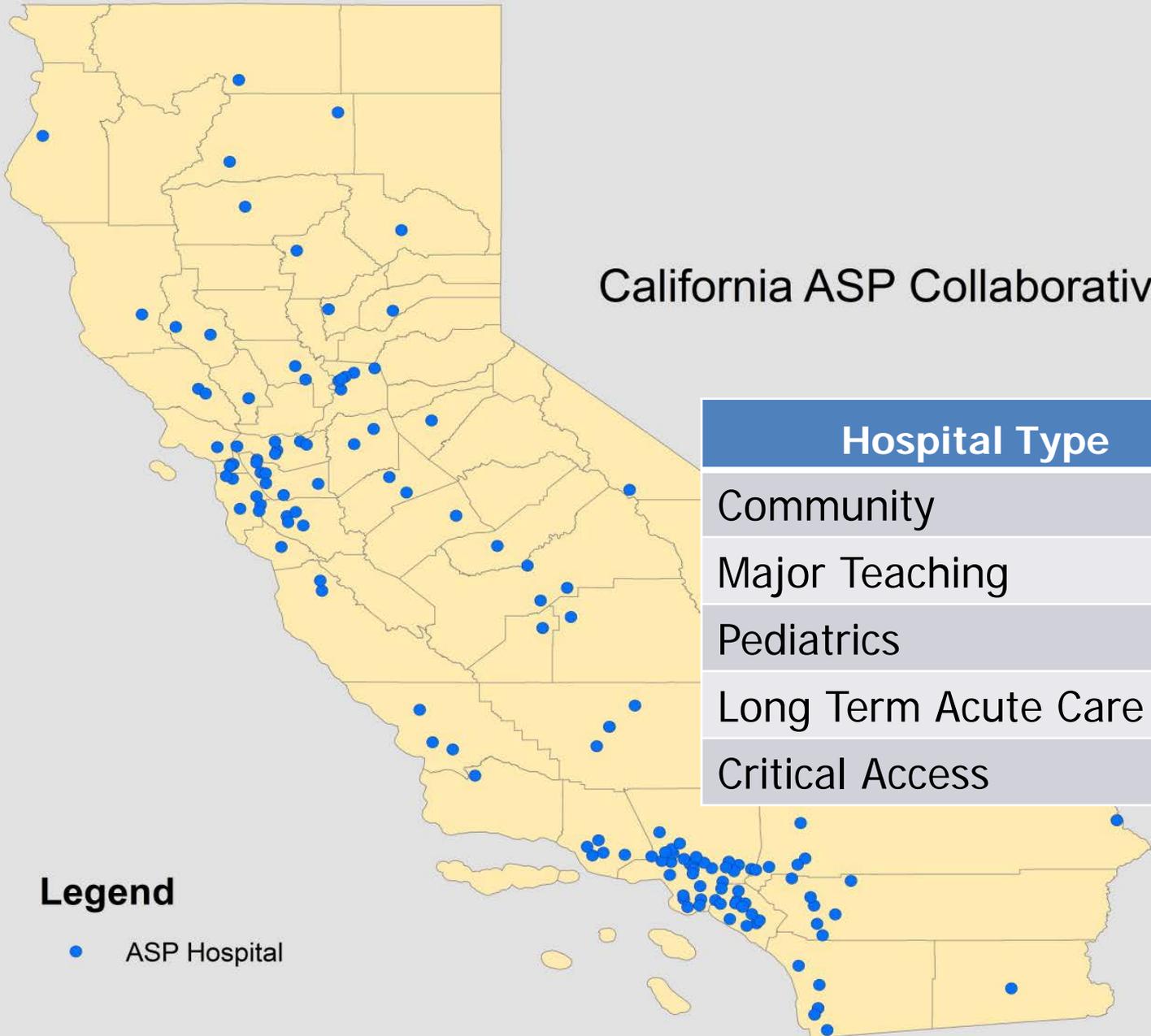
- **Senate Bill 739** – By January 1, 2008
  - Hospitals required to develop process for monitoring judicious use of antibiotics, sharing results with quality improvement committee(s)
- **Senate Bill 1311** – By July 1, 2015

Hospitals required to have

  - Antimicrobial stewardship policy in accordance with federal/professional guidelines
  - Physician-supervised multidisciplinary committee
  - Physician or pharmacist with AS knowledge/training
  - Report to quality improvement committees



# California ASP Collaborative Hospitals



### Legend

• ASP Hospital

Hospital Type	No. (%)
Community	122 (81)
Major Teaching	5 (3)
Pediatrics	8 (5)
Long Term Acute Care	9 (6)
Critical Access	7 (5)

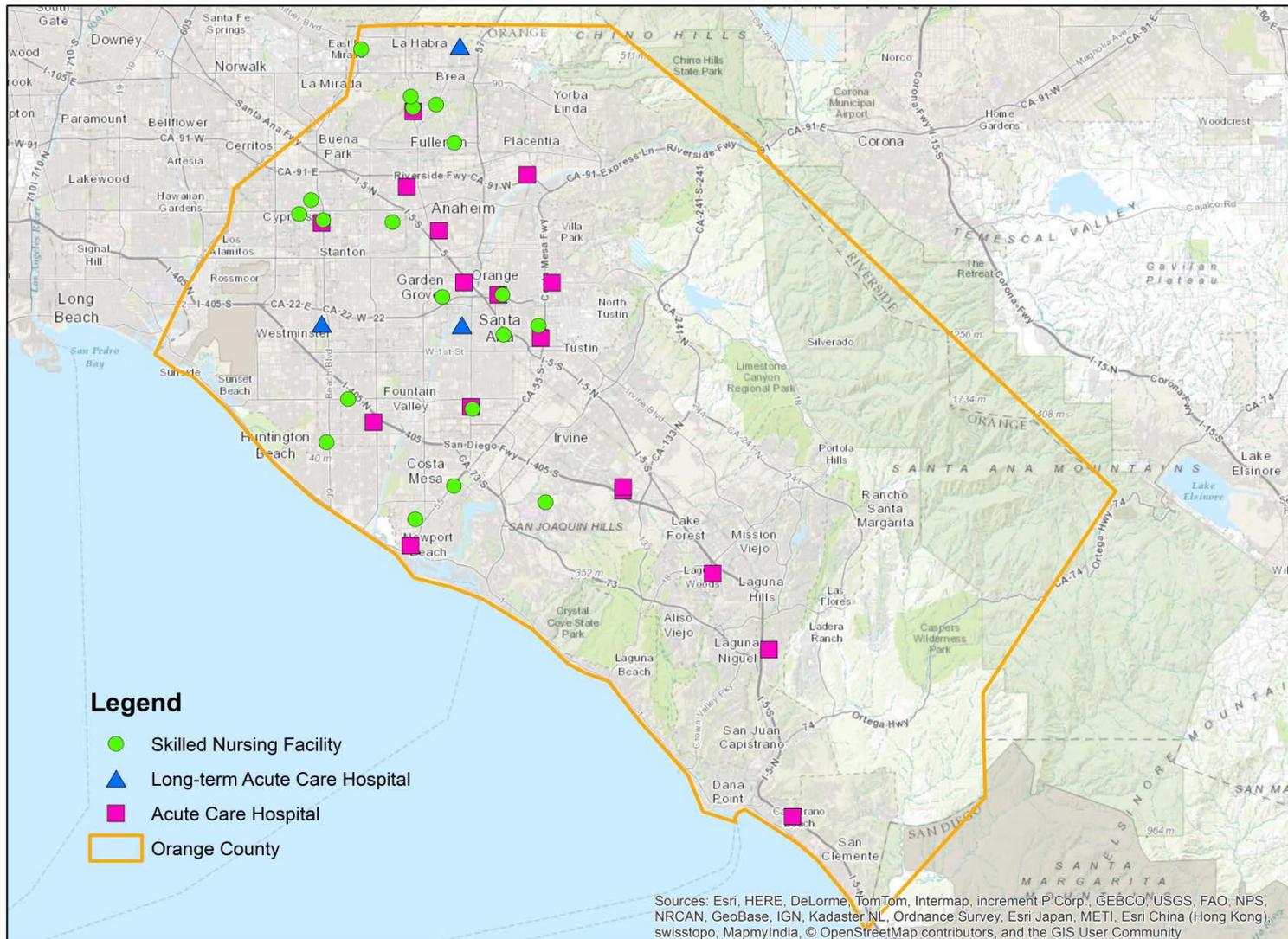


# Regional Approach to Antimicrobial Resistance and CDI Prevention

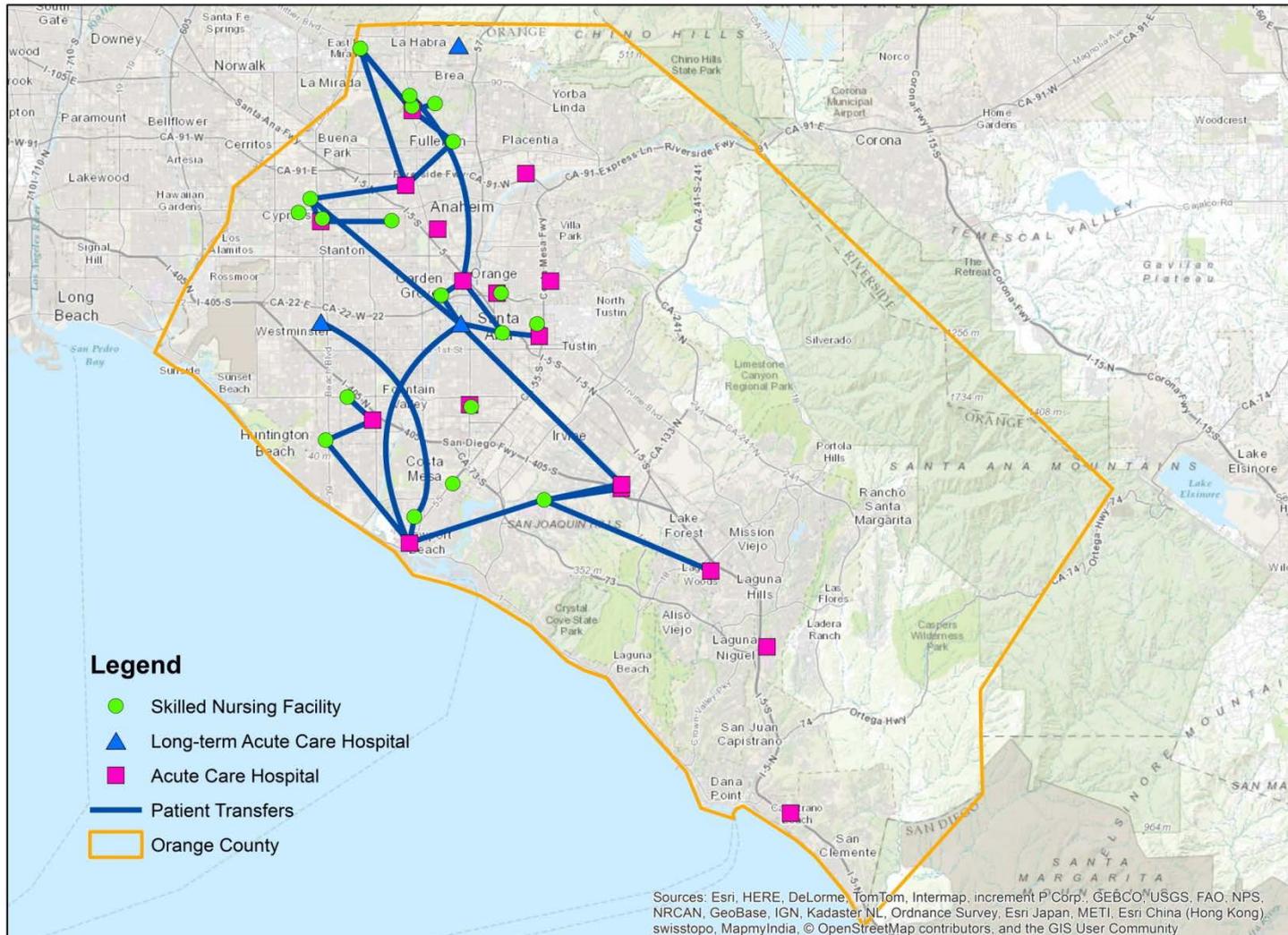
1. **Monitor adherence** to infection prevention practices in hospitals and long-term care facilities
  - Contact precautions
  - Hand hygiene
  - Communication when transferring patients with CDI/AR
2. Start or enhance an **antimicrobial stewardship program** with particular attention to CDI
3. Evaluate and enhance **environmental cleaning**



# Orange County CDI Prevention Collaborative



# Documented Patient Sharing Among Orange County CDI Collaborative



**en Español**

→ [Su salud en su idioma](#)

**Most Popular Links**

- [Birth, Death, & Marriage Certificates](#)
- [Licensing and Certification](#)
- [WIC](#)

**Quick Links**

- [About Us](#)
- [CDPH Open Data Portal](#)
- [Decisions Pending & Opportunities for Public Participation](#)
- [Diseases & Conditions](#)
- [Job Opportunities](#)
- [Language Access Complaint Process](#)
- [Local Health Services](#)
- [Newsroom](#)
- [Public Availability of Documents](#)

**Related Links**

- [California Health and Human Services Agency](#)
- [Department of Health Care Services \(includes Medi-Cal\)](#)
- [State Agencies Directory](#)

[Home](#) > [Programs](#) > [Healthcare Associated Infections Program](#)

## Healthcare-Associated Infections (HAI) Program

The Healthcare-Associated Infections (HAI) Program is one of two programs in the [Center for Health Care Quality](#) of the [California Department of Public Health](#). The Program was created by mandate to oversee the prevention, surveillance and reporting of healthcare-associated infections in California's general acute care hospitals. HAIs are the most common complication of hospital care. It is estimated that each year there are 722,000 infections, 75,000 deaths, and 1 in 25 hospital patients at any given time has an infection contracted during the course of their hospital care. HAIs result in an estimated \$30 billion in excess healthcare costs nationally each year. Since 2010, the HAI Program has: produced annual public reports of hospital HAI data to inform choices of healthcare consumers and prompt providers to take actions to prevent infections; actively engaged in HAI prevention by performing site visits to hospitals with high infection rates, convening prevention collaboratives, and providing infection prevention education; and provided consultation and assistance to local public health for infection outbreaks that occur in healthcare facilities. The vision of the HAI Program is to eliminate HAIs for all Californians.

### What You Can Do To Prevent HAI

[Me And My Family](#)



[Healthcare Providers](#)



[Public Health Partners](#)



[HAI Committee & Laws](#)



[My Hospital's Infections Map](#)



[Annual HAI Report](#)



#### Healthcare Associated Infections - Advisory Committee

→ [HAI Advisory Committee](#)

#### Antimicrobial Resistance

→ [New CDPH Antimicrobial Stewardship Program \(ASP\) Toolkit 2015](#)

→ [Antimicrobial Resistance](#)

→ [California Antimicrobial Stewardship Program Initiative](#)

→ [Spotlight on Antimicrobial Stewardship Program Project Invitation 2014](#)

#### Public Reporting - Preventing Hospital Infections

→ [New HAI Information and Reports 2013 HAI Annual Report Now Published](#)

→ [New My Hospital's Infections Map Interactive Map 2013 Data](#) -- This map can be used with some mobile devices and tablets.

→ [New Healthcare Personnel Influenza Vaccination Reports Annual Report Now Published for 2013-2014 Respiratory Season](#)

#### HAI Education for Healthcare Professionals

→ [New California One and Only Campaign - Injection Safety](#)

→ [Updated Basics of Infection Prevention Guidelines Two-Day Mini Course](#)

→ [Sustaining Infection Prevention Progress](#)

→ [Educational Offerings by HAI Program Staff -- 2015 Educational Calendar](#)

#### Resources

→ [Association of Professionals in Infection Control and Hospital Epidemiology \(APIC\) -- selected links](#)

→ [Centers for Disease Control and Prevention \(CDC\) -- selected links](#)

→ [Society for Healthcare Epidemiology of America \(SHEA\) -- selected links](#)

→ [Infectious Diseases Society of America \(IDSA\) \(New Window\) -- selected links](#)

→ [UCSD Infection Prevention Course -- Designed to Meet CA SB 158 Requirements \(PDF, New Window\)](#)

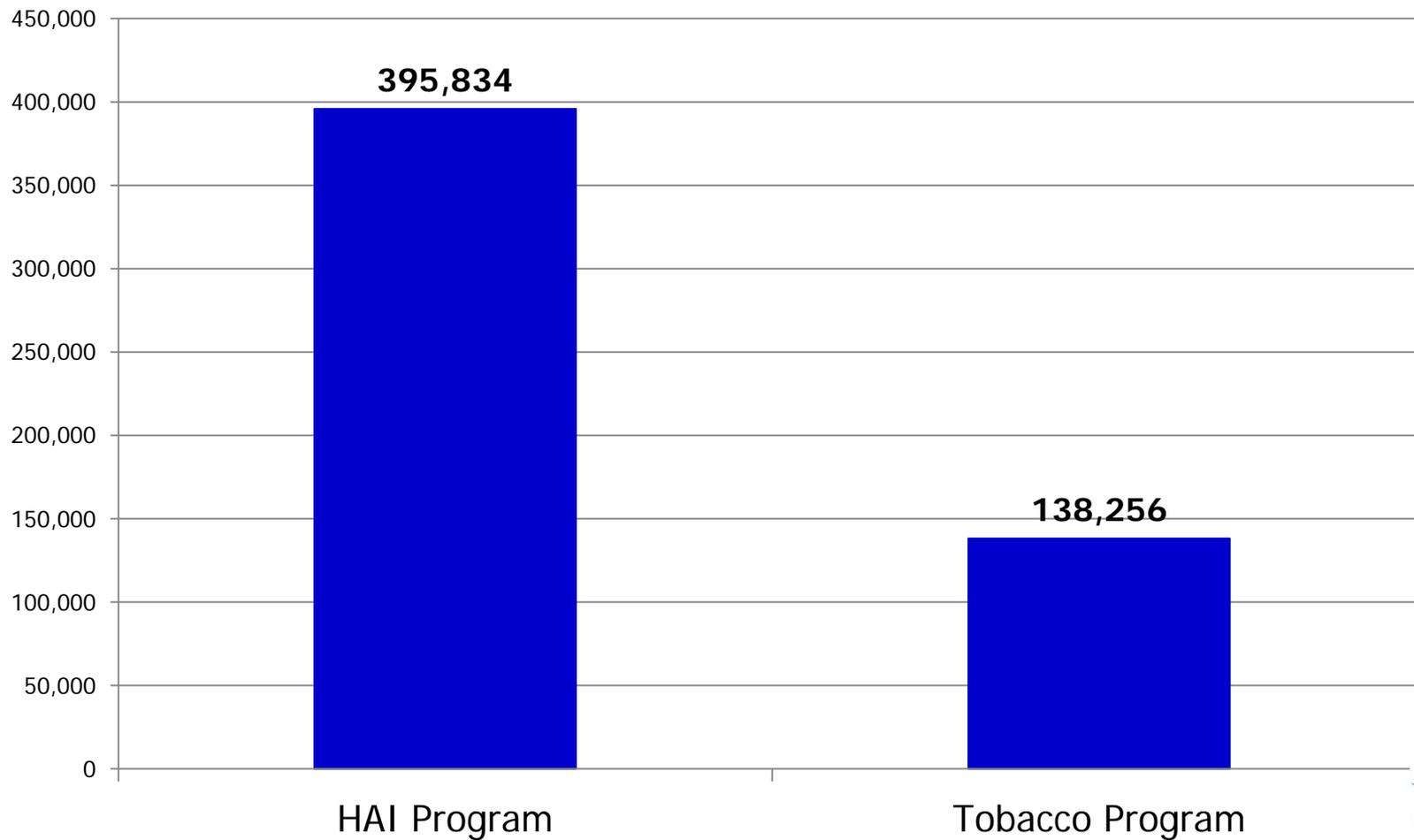
# 2015 Top Ten HAI Page Views

	Pages	Avg Time Viewed (Seconds)
1	Healthcare-Associated Infections - Main Page	73
2	California Antimicrobial Stewardship Program Initiative	180
3	HAI Information and Current Reports	124
4	Cleaning, Disinfection and Sterilization ( <i>Basics of IP course</i> )	190
5	Who is at Risk of Getting a MRSA Infection?	84
6	What is a CLABSI?	97
7	Vancomycin-resistant Enterococci (VRE)	89
8	Carbapenem-Resistant Enterobacteriaceae (CRE)	137
9	MRSA: Methicillin-Resistant Staphylococcus aureus	97
10	Clostridium Difficile Infection (CDI)	79



# Total Views – By Program

## January - July 2015



# California Injection Safety Program



## California

### News & Events

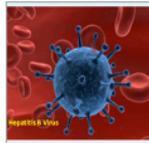
#### » Injection Safety is Everyone's Responsibility



The Centers for Disease Control and Prevention (CDC) estimate that in recent years, unsafe injection practices have affected more than 150,000 patients in the United States, including 11,500 in California. CDC recommends that healthcare providers NEVER administer medications from the same syringe to more than one patient, even if the needle is changed. It is your right to know that your provider will use a new syringe and new needle every time.

The California One & Only Campaign encourages healthcare organizations and individuals to promote public awareness of safe injection practices. **To become a member of the California One & Only campaign, [click here](#)**

#### » Hepatitis B and C Outbreaks in California



CDC summarized 44 healthcare-associated outbreaks of hepatitis B and C in non-hospital settings from 2008-2014. Six of the outbreaks occurred in California; 2700 people were notified of possible exposure and 27 patients were found to be infected. The outbreaks occurred in two skilled nursing facilities, two assisted living facilities, a pain management clinic, and an outpatient dialysis clinic.

Unsafe injection practices that resulted in these infections included reusing syringes, contaminated multi-dose medication vials, and single-dose vials used for more than one patient.

### USE AN INJECTION SAFETY CHECKLIST



It is every patient's right to receive a safe injection. Are healthcare workers always following safe

injection practices at YOUR facility? Safe injection practices are a set of measures that define how to give injections in a safe manner for patients and healthcare providers. The California One & Only Campaign encourages healthcare workers to review and use the Injection Safety Checklist to assess their practices. The checklist, developed by CDC and the Safe Injection Practices Coalition, includes nine observations to help healthcare workers ensure they are adhering to safe injection practices during the care of patients. To download and share the Injection Safety Checklist, [click here](#)

**WHEN IN DOUBT, THROW IT OUT!**



# CDPH HAI Program Role in Outbreak Investigations

- Subject matter experts in infection prevention and control
- Provide consultation and support to local public health agencies
- Provide guidance and recommendations to CDPH L&C and other regulatory agencies
- Coordinate with CDC content experts for up-to-date guidance and recommendations
- Coordinate outbreak investigations that cross local health jurisdiction boundaries



# Notable HAI Investigations in the Past Year

1. 09/2014: Evaluation of bloodstream infections in dialysis clinics in collaboration with CDC - throughout California
2. 11/2014: Transmission of HCV in Regenerative Medicine Clinic – Santa Barbara County
3. 01/2015: Transmission of CRE via endoscopy procedures – Los Angeles County
4. 05/2015: Transmission of CRE in 13 patients at SNF – Alameda County



# Summary

- The HAI Program is committed to reducing HAI in California
  - Using Data for Action to prioritize and focus on hospitals with high HAI incidence
  - Modeling a regional approach for AR; CDI prevention is a high priority
  - Ensuring preparedness for Ebola and other emerging infectious diseases
  - Seeking input from the HAI Advisory Committee, providers, regulators, and local public health to enhance our efforts



# Skilled Nursing Facilities

## Nursing Hours Per Patient Day



# Staffing Audit Process

- Unannounced visits.
- 24 randomly selected dates.
- Facility must:
  - Document and delineate nursing service hours.
  - Provide average census for each audited day.
  - Provide exact patient day start time.
- Only direct caregivers counted toward NHPPD.



# Staffing Audit Process

	IN	OUT	IN	OUT	IN
Mon 12/01	02:27 PM	07:51 PM M	08:22 PM	11:37 PM M	
Tue 12/02	02:54 PM	07:22 PM M	07:53 PM	11:53 PM M	
Wed 12/03	02:54 PM	07:35 PM	08:07 PM	11:32 PM	
Sat 12/06	02:53 PM	07:22 PM	08:00 PM	11:37 PM	
Sun 12/07	02:53 PM	07:35 PM	08:05 PM	11:29 PM	
Mon 12/08	02:54 PM	07:36 PM	08:08 PM	11:30 PM	
Tue 12/09	02:53 PM	07:43 PM M	08:13 PM	01:08 AM M	
Fri 12/12	02:54 PM	07:31 PM	08:03 PM	11:46 PM	

*Payroll punch Detail*

State of California-Health and Human Services Agency California Department of Public Health

### Census and Nursing Hours Per Patient Day (NHPPD)

1. PATIENT DATE (MM/DD/YY) \_\_\_\_\_ 2. PATIENT DATE START TIME (HH:MM AM/PM) \_\_\_\_\_

3. TOTAL LICENSED SKILLED NURSING BEDS \_\_\_\_\_ 4. CDPH LICENSE # \_\_\_\_\_

5. FACILITY NAME \_\_\_\_\_

6. FACILITY ADDRESS \_\_\_\_\_

7. ADMINISTRATOR \_\_\_\_\_

8. DIRECTOR OF NURSING/DESIGNEE \_\_\_\_\_

9. ESTIMATED NURSING HOURS and NHPPD			
BEGINNING PATIENT CENSUS:	SCHEDULED TOTAL NURSING HOURS:	SCHEDULED NHPPD:	

10. DAILY CENSUS CHANGES			
Add or subtract from the beginning census each event during the designated census period			
	Method (a): SHIFT 1 or Method (b): Beginning of patient day	Method (a): SHIFT 2 or Method (b): 8 hours after beginning of patient day	Method (a): SHIFT 3 or Method (b): 16 hours after beginning of patient day
BEGINNING CENSUS			
ADMISSIONS			
DISCHARGES			
TRANSFERS			
DEATHS			

*Census Data*

State of California-Health and Human Services Agency California Department of Public Health

### NURSING STAFFING ASSIGNMENT AND SIGN-IN SHEET

1. FACILITY NAME \_\_\_\_\_ 2. DATE OF PATIENT DAY (MM/DD/YY) \_\_\_\_\_

3. DIRECTOR OF NURSING/DESIGNEE \_\_\_\_\_

4. SHIFT 1 2 3 5. SHIFT START TIME (HH:MM AM/PM) \_\_\_\_\_

6. STATION/WING/UNIT/FLOOR \_\_\_\_\_

7. \_\_\_\_\_

NURSING SERVICES ASSIGNMENT	EMPLOYEE NAME	DISCIPLINE	SHIFT START/END	MEAL BREAK START/END	EMPLOYEE SIGNATURE
					X
					X

*Assignment Sheets*

day:	
ACTUAL NHPPD:	FINAL NHPPD:

and acknowledge the information is \_\_\_\_\_

1



# Quality Assurance Review and Appeal Hearings

- Quality Assurance Review Team:
  - Conducts final review.
  - Issues Statement of Deficiency outlining final audit results.
  - Issues Administrative Penalty for Non-compliance of more than 5% of audited days.
- Facility May Appeal Administrative Appeal



# Performance Metrics (as of July 31, 2015)

<b>Facility Audit Status (% Audited)</b>	824	74.98%
Compliant	754	91.50%
1-Day Non-Compliant	48	5.83%
2-11 Days Non-Compliant (\$15,000 penalty)	19	2.31%
12-24 Days Non-Compliant (\$30,000 penalty)	3	0.36%
Not audited (Facility closed, sold, not a Skilled Nursing Facility, etc.)	0	0.00%
<b>Penalties Issued</b>	<b>6</b>	
\$15,000 penalty	5	
\$30,000 penalty	1	
<b>Status on Penalties Issued</b>	<b>6</b>	
Penalty not issued (Facility closed, sold, etc.)	0	
Appeal hearing denied by Office of Administrative Hearings and Appeals	0	
Facility did not appeal	3	
Appeal overturned (Administrative Penalty stands)	0	
Appeal upheld (Administrative Penalty withdrawn)	0	
Appeal hearing pending	3	
<b>Penalty amount assessed</b>	<b>\$ 90,000</b>	
Penalty amount rescinded (Appeal upheld)	\$ -	
Penalty amount due	\$ 45,000	
Total penalty amount collected	\$ 45,000	

<http://www.cdph.ca.gov/programs/LnC/Documents/PP1-PP4-FOR-WEBSITE.PDF>

# Skilled Nursing Facility Nurse Staffing Survey

# Skilled Nursing Facility Nurse Hours per Patient Day

- Do you think the 3.2 nursing hours per patient day standard is sufficient?
- Please share your reasoning for your response, including any supporting data.

# LTC Nurse Staffing Standards

- If you think the 3.2 nursing hours per patient day standard is not sufficient for long-term care, what standard would you recommend?
- Please include any supporting data.

# Long-term Care Nurse Staffing Composition

- Do you think long-term care nurse staffing standards should have requirements specific to CNAs, LVNs, and RNs?

# Long-term Care Nurse Staffing Composition

- If you think that long-term care nurse staffing standards should have requirements specific to CNAs, LVNs and RNs, what do you think would be an appropriate staffing mix?

# Questions and Comments



# Open Dialogue



# Meeting Record and Follow-Up

Questions may be sent to:

[CHCQStakeholderForum@cdph.ca.gov](mailto:CHCQStakeholderForum@cdph.ca.gov)

Meeting report and updates will be posted  
at:

[http://cdphinternet/programs/Pages/CHCQS  
takeholderForum.aspx](http://cdphinternet/programs/Pages/CHCQS<br/>takeholderForum.aspx)



# Save the Date!

Next Semi-Annual Stakeholders' Forum will be:

Thursday, February 25, 2016

2 p.m. to 4 p.m.

