CONNECTICUT DEPARTMENT OF
PUBLIC HEALTH

Keeping Connecticut Healthy

REPORT TO THE GENERAL ASSEMBLY

AN ACT CREATING A PROGRAM FOR QUALITY IN HEALTH CARE

JUNE 2008

J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
Norma D. Gyle, R.N., Ph.D., Deputy Commissioner

State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Acknowledgments

Individuals from several organizations contributed to this report. Subcommittees of the Quality in Health Care Advisory Committee listed below are not exhaustive but reflect section writing.

Connecticut Department of Public Health

Jon Olson

Karen Buckley-Bates

Jennifer Filippone, Subcommittee on Physician Profiles

Joan Foland, Subcommittee on Promotion of Quality and Safe Practices and Working Group I: Hospital Performance Comparisons

Wendy Furniss

Joan Leavitt, Subcommittee on Regulations

Lloyd Mueller

Donna Ortelle, Subcommittee on Cardiac Care Data

Diane Smith, Subcommittee on Best Practices and Adverse Events

Additional Contributors

Mag Morelli, Connecticut Association of Not-for-Profit Providers for the Aging
Subcommittee on Continuum of Care

Julie Petrellis, Connecticut Healthcare Research and Education Foundation PSO

Nancy Safer, Qualidigm PSO

Lisa Winkler, Ambulatory Surgical Center PSO

State of Connecticut
Department of Public Health

Report to the General Assembly
June 30, 2008

An Act Creating a Program for Quality in Health Care

Table of Contents

ANNUAL REPORT

JUNE 30, 2008

I. INTRODUCTION AND BACKGROUND

Sections 19a-127*l* through 19a-127n of the Connecticut General Statutes require the Department of Public Health (DPH) to establish a quality of care program for health care facilities. The statutes also direct DPH to develop a health care quality performance measurement and reporting system initially applicable to the state's hospitals. Other health care facilities may be included in the quality program in later years as it develops. An advisory committee, chaired by the DPH commissioner or designee, advises the program.

Responsibility for the quality of care program within DPH lies with the Health Care Systems Branch and, in the Planning Branch, with the Health Care Quality, Statistics, Analysis, and Reporting (HCQSAR) unit. The Healthcare Associated Infections Advisory Committee was established by separate legislation and its activities are not included in this report unless they overlap with the quality of care program.

.

In compliance with the reporting requirement in the statute, the current report describes the activities of the quality of care program over the past year, as of June 30, 2008. In addition to this report, DPH submitted the sixth adverse event report to the General Assembly (dated October 2007). DPH also published the fourth hospital performance comparisons report (dated April 2008, presenting data from 2006).

II. QUALITY IN HEALTH CARE ADVISORY COMMITTEE AND SUBCOMMITTEE ACTIVITIES

Advisory Committee

The Quality in Health Care Advisory Committee (QHCAC) held meetings this past year in July 2007, October 2007, and April 2008. In the future the QHCAC will be meeting only in the fall and spring, rather than quarterly. A synopsis of current year activities and plans for next year is provided below for each of the subcommittees.

Subcommittee on Continuum of Care

The subcommittee has been charged with addressing the prevalence of pressure ulcers across the continuum. The subcommittee will be focusing on developing a pilot model system of coordinating the prevention, assessment and treatment of pressure ulcers throughout the continuum of home care, skilled nursing facilities and hospitals. The subcommittee has identified a referral cluster within the state consisting of a hospital, skilled nursing facility, and

two home health agencies. The subcommittee has been meeting regularly and is in the process of developing a set of shared standards to ensure the use of common language, terms and tools. The pilot will emphasize improved communication between segments of the continuum and in doing so will attempt to address the inadequacy of the current W-10 form.

Subcommittee on Physician Profiles

Assuring the ongoing competence of physicians continues to be identified as a major challenge at the national level, and as a result, there are several national initiatives related to physician accountability and competence. The Department of Public Health continues to monitor these initiatives to determine the impact any resulting recommendations will have on physicians in Connecticut.

Physician license portability is also an issue that has gained national attention. The Department of Public Health is participating in a Physician License Portability demonstration project with the Federation of State Medical Boards (FSMB). Connecticut is one of 14 states participating in this demonstration project. The project is funded by the Department of Health and Human Services's Office for the Advancement of Telehealth and is designed to facilitate the mobility of physicians to practice across states. Participation in this demonstration project facilitates the Department's ability to carry out regulatory mandates related to physicians and promotes interstate mobility for workforce as well as emergency response capacity. Implementation of this project will allow state licensure authorities to access and share information to allow for an expedited licensure process.

Finally, Public Act 08-109 An Act Extending the State Physician Profile to Certain Other Health Care Providers was passed during the 2008 session of the Connecticut General Assembly and becomes effective January 1, 2010. Within available appropriations, the Department of Public Health will be required to collect and publish information, comparable to that which is collected as part of the physician profile, for the following additional licensed health care professions: dentists, chiropractors, optometrists, podiatrists, naturopathic physicians, dental hygienists and physical therapists.

Subcommittee on Regulations

The revised hospital regulations have been in effect for one year now. No other hospital-related regulations are in process.

Subcommittee on Promotion of Quality and Safe Practices

Working Group I: Hospital Performance Comparisons

Although Working Group I had planned to meet in June 2008, the meeting had to be postponed due to conflicting quality of care initiatives. The Group is tentatively re-scheduled to meet in

September to discuss the results of the latest Hospital Performance Comparisons Report produced by DPH.

At the national level, new health care quality indicators continue to be developed. Under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, CMS reduces the standardized inpatient operating amounts for hospitals not submitting data on CMS-established quality indicators. For FYs 2005 and 2006, hospitals were required to submit data on a "starter set" of ten industry-accepted quality indicators related to treatment and assessment procedures for heart attack, heart failure, and pneumonia. These are the ten performance measures that DPH reports on annually.

In FY 2007 (October 1, 2006 – September 30, 2007), eleven additional quality measures were added to the RHQDAPU requirements. They included additional treatment and assessment procedures for heart attack (3 new measures), heart failure (2 new measures), pneumonia (4 new measures), and surgical infection prevention (2 new measures).

For FY 2008, CMS added six new quality measures: three surgical care improvement project quality measures, two mortality measures for heart attack and heart failure, and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey ratings.

Subcommittee on Best Practices and Adverse Events

The subcommittee on Best Practices and Adverse Events met in May, June, August, October, and November 2007 and January, February, March and April 2008.

Public Act 06-195 charged the subcommittee to study and make recommendations to the Department of Public Health "concerning best practices with respect to communications between a patient's primary care provider and other providers involved in a patient's care, including hospitalists and specialists." The subcommittee met with physician representatives from the Society of Hospital Medicine and community physicians to gather information on standards and practical approaches to improve communication along the entire continuum of care. The subcommittee submitted their recommendations to DPH in January 2008, and the report was posted to the department's website at: http://www.ct.gov/dph/lib/dph/governmental_relations/2008_reports/bp_care_transitions_finalapril.pdf.

The subcommittee's "health messaging" campaign was concluded and the subcommittee shared Hand Hygiene brochures developed with the Department's Healthcare Associated Infection (HAI) Program. This information was included in the materials that was made available at the June 13, 2008 statewide HAI "Kick-Off" at the Capitol.

Subcommittee on Cardiac Care Data

The Cardiac Care Data Committee Report was forwarded to the Legislature's Public Health Committee as required by Public Act 05-167 on December 1, 2007. The report is posted at http://www.ct.gov/dph/lib/dph/governmental_relations/2007reports/cardiac_care_report_2007.pdf. The report states,

In the context of current trends towards creating public value and transparency in health care, publicly reported comparisons of cardiac outcomes is a desirable goal. As such it is the recommendation of the Committee that the State should collect patient-level data from all cardiac surgery programs in Connecticut, using the Society of Thoracic Surgeons' data collection instrument. The State should also collect patient-level data from all hospitals performing PCI, using the American College of Cardiology National Cardiovascular Data Registry. The State should report annually on risk-adjusted 30-day mortality for CABG surgery and PCI procedures by hospital. The State should contract with an organization with clinical and statistical expertise to collect, process, edit, audit, analyze, risk-adjust, and report on cardiac care data. A Cardiac Care Advisory Board should be created to provide oversight on clinical and statistical considerations, and two Data Adjudication Committees, one for cardiac surgery and a second for percutaneous coronary interventions should be created to review selected cases. Funding will be needed to implement and sustain these recommendations.

No bill was raised by the Public Health Committee during the FY08 session to fund the recommended data collection initiative.

III. RECENT AND FUTURE PLANNED DPH PROGRAM AND PATIENT SAFETY ORGANIZATION ACTIVITIES

Hospital Clinical Performance Measures

In April 2008, DPH produced its fourth Hospital Performance Comparisons Report, which is available on the DPH website. Data were collected from all 30 adult acute care hospitals in Connecticut on patients with a diagnosis of heart attack, heart failure, or pneumonia, who were discharged between January 1, 2006 and December 31, 2006. Performance rates are provided for 10 clinical process measures.

Based upon 2006 data, average performance rates in Connecticut hospitals continue to exceed national average rates on all ten of the clinical measures, and are statistically significantly better on nine of the ten measures.

Between 2005 and 2006, Connecticut hospitals' performance rates improved significantly on all ten measures. The greatest improvement occurred with the pneumonia vaccination measure, where statewide rates increased from 67% to 79% between 2005 and 2006. This is primarily due to the implementation of "standing orders" for vaccinations, following the passage of legislative regulations in the fall of 2005.

Future DPH program activities include ongoing data collection for the 10 clinical measures; participating in the ongoing Quality Advisory Committee and Subcommittee activities; and

monitoring public reporting efforts on hospital clinical performance measures at the national level.

Implementation of P.A. 04-164

List of Adverse Events

In October 2007 DPH produced its sixth adverse event report, which is available on the DPH website at two locations: "Mandated Reports" http://www.ct.gov/dph/lib/dph/governmental_relations/2007reports/adverse_event_report_-_october_2007.pdf, and "Health Care Quality Reports" http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/adverseeventreportoct2007.pdf

Quality of Care Information on the DPH Web Site

Descriptions of the activities of the Health Care Systems Branch are listed in the *Licensing & Certification* section of the Main Menu for the DPH website (www.ct.gov/dph). Annual Adverse Event reports, Hospital Performance Comparisons reports, and annual reports to the legislature about the Quality in Health Care Program are posted in *Statistics & Research* under *Health Care Quality*.

Patient Safety Organizations

P.A. 04-164 allowed DPH to designate "Patient Safety Organizations" (PSOs). The primary activity of a PSO is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis or processing of medical or health care related information submitted to the PSO by the health care provider. This "patient safety work product" may include reports, records, analyses, policies, procedures, or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. The PSO will disseminate appropriate information or recommendations on best medical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality of Health Care Advisory Committee, and the public. DPH has designated three PSOs, including the Qualidigm Patient Safety Organization, the Connecticut Healthcare Research and Education Foundation Patient Safety Organization (CHREF PSO), and the Ambulatory Surgical Center Patient Safety Organization (ASC PSO). The following information covers activities since the June 30, 2007 report.

Qualidigm PSO

The Qualidigm PSO is comprised of long term care, specialty and behavioral health facilities, outpatient surgical centers, and an acute care hospital. This diverse group of health care organizations provides a unique opportunity among Connecticut PSOs to acknowledge and address the distinctiveness and commonalities of patient safety issues across settings. The

Qualidigm PSO believes that, while safety and quality issues in health care are national concerns, most of the solutions need to be "local." With that in mind, the Qualidigm PSO continues to offer programs, activities, and information that can be adapted to best meet the participant's unique organizational environments.

This year the Qualidigm PSO education programs have included a data collection and reporting workshop, a program on managing anticoagulation therapy, and co-sponsorship with the CHREF PSO of an annual Patient Safety Summit. The Qualidigm PSO is also partnering with the CHREF PSO in two statewide collaboratives: Multi Drug Resistant Organisms (MDRO) and Pressure Ulcer Prevention.

Each participating facility submits case studies to the PSO that are de-identified and discussed in a facilitated forum leading to further collaboration among member facilities.

Electronic *PSO News Flashes* are distributed to participants monthly. These news flashes contain links to recent patient safety related articles, tools, reminders, and upcoming events. Past issues of the *PSO News Flash,* as well as materials from education programs and national initiatives, are available on a password protected PSO page on the Qualidigm website (www.Qualidigm.org).

As the Qualidigm PSO and its participants grow more comfortable, active and supportive of the Patient Safety Organization concepts and functions, the programs and offerings continue to mature. This includes more in depth and open group case study discussions and sharing of best practices as well as more developed data collection and analysis integration into patient safety activities by the participating organizations.

Qualidigm actively solicits and welcomes feedback and suggestions to improve and strengthen the PSO and best meet the expectations of participants.

Ambulatory Surgical Center PSO

The ASC PSO has expanded its focus this year, developing studies that address the individual safety concerns across specialties. With the new requirement for office-based licensure, the PSO enrolled several new centers in the field of plastic surgery this year, bringing a new dynamic to our discussions.

The ASC PSO has also incorporated breakout sessions into its mandatory membership meetings, which have led to interesting discussions and positive feedback. As a result of this new meeting component, the ASC PSO was able to identify key areas of particular interest to each specialty.

Prophylactic antibiotic use in plastic surgery, orthopedics and multi specialty facilities was examined in the first round of specialty studies. In ophthalmology, the ASC PSO examined vitrectomies and in gastroenterology the ASC PSO looked at colonoscopy withdrawal times and their impact on successfully identifying polyps. This new specialty study project has enabled facilities to benchmark against other providers in the state, while looking at key patient safety issues relevant to their specialty and the development of best practices.

This year, the ASC PSO also focused on adverse event reporting and OR burns. The OR burn initiative was kicked off by a presentation from the SIM Center at Hartford Hospital. The interactive lecture was an eye opening experience for ASC staff and enabled members to see the actual responses of surgical staff when faced with a surgical fire. After the meeting, the ASC PSO also developed materials for inclusion in the PSO binder, and followed up with a PSO newsletter that included specific protocols on extinguishing fires in the surgical patient.

On the patient education side, the ASC PSO's efforts focused on MRSA this year, developing a new flyer aimed at providing patients with the facts on MRSA. Specifically, the document provided information on what MRSA is, how it is transmitted, and how to protect yourself as a patient. The PSO believed this was an important issue to address in light of the increased incidence of MRSA and the media's focus on it.

Overall, the ASC PSO has had tremendous success again this year and looks forward to completing the next round of projects. The PSO recently presented at the national ASC Association meeting in San Antonio, where several states again expressed an interest in developing a similar model to improve patient safety within the ambulatory setting.

Connecticut Healthcare Research and Education Foundation PSO

All 29 of Connecticut's not-for-profit hospitals continue to participate in the CHREF PSO that assists hospitals in improving the quality of care provided and patient safety. During the past year, the CHREF PSO has engaged in a variety of activities to support its members in those goals.

The CHREF PSO initiated two collaboratives -- addressing prevention of Pressure Ulcers and prevention and control of Multiple-drug Resistant Organisms (MDRO). The CHREF PSO is partnering with the Qualidigm PSO in these efforts. The collaboratives include educational sessions with nationally known speakers, biweekly conference calls with all members, a website, a member listserv and on site visits. The Pressure Ulcer Collaborative has also had a second session in which members received additional education and shared their activities and successes via presentations and posters. The MDRO Collaborative will be having a second session in July.

A monthly Patient Safety newsletter was started in January 2008. The monthly newsletters provide detailed information on a specific topic each month as well as updating all members on the activities of the collaboratives.

Education is an important part of the CHREF PSO function. The PSO again sponsored the annual Patient Safety Summit in conjunction with the Qualidigm PSO. The annual Patient Safety Summit brings national patient safety experts to Connecticut and this year featured Lucian Leape, M.D.

The CHREF PSO also initiated two educational series to meet the differing needs of members. The *Achieving Excellence* series was designed by the CHREF PSO for professionals in quality and patient safety and provides up-to-date and innovative tools to drive quality improvement and patient safety. The *Quality 101* series is designed for hospital staff not directly involved in

quality or patient safety initiatives, but who must have a working knowledge of the common causes of errors and practical strategies for reducing them.