



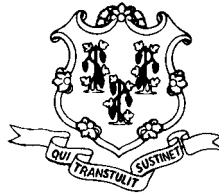
Keeping Connecticut Healthy

REPORT TO THE GENERAL ASSEMBLY

**AN ACT CREATING A PROGRAM FOR
QUALITY IN HEALTH CARE**

JUNE 30, 2004

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**State of Connecticut
Department of Public Health**

Report to the General Assembly

An Act Creating a Program for Quality in Health Care

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ANNUAL REPORT

JUNE 30, 2004

I. INTRODUCTION

Connecticut General Statutes section 19a-127i requires the Department of Public Health (DPH) to establish a quality of care program for health care facilities (Appendix A). This provision also directs 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, advises the program.

The statute directs the Commissioner to report on the quality of care program on or before June 30th of each year. In compliance with this reporting requirement, the current report describes the activities of the quality of care program over the past year, as of June 30, 2004. In addition to this report, DPH submitted the second annual adverse event report to the General Assembly in March 2004, and released the first hospital comparison report, based on clinical performance measures developed under the quality of care program, in April 2004.

Public Act (P.A.)04-164 amends the Quality in Health Care program (Appendix B), effective July 1, 2004. The Adverse Events Working Group's four summary points appear below. The Office of Legislative Research analysis and the National Quality Forum (NQF) list of serious reportable events appear in Appendix C.

P.A. 04-164 revises sections l and n of C.G.S.19a-127, which requires hospitals and outpatient surgical facilities to report adverse events to DPH. Specifically, it will:

1. Replace the existing adverse event classification system with a list of reportable events identified by the National Quality Forum (NQF) and a list compiled by DPH;
2. Extend the reporting time to DPH of adverse events (excluding emergent events) and for filing corrective action plans;
3. Modify disclosure of adverse event reports, all those requiring a DPH investigation will be disclosable at the conclusion of the investigation; and
4. Allow DPH to designate as a "patient safety organization" (PSO) entities, whose primary mission involves patient safety activities. The PSO will make recommendations to improve patient safety and overall quality of care.

It requires the existing Quality of Care Advisory Committee, which advises DPH on quality issues, to establish a standing subcommittee on best practices.

The act requires hospitals and outpatient surgical facilities to contract with one or more such organizations as they become available. These organizations must provide hospitals and others, as appropriate, with information on best practices; they must have appropriate safeguards in place to protect the confidentiality of patient safety work product.

Finally, the act allows a hospital to administer influenza and pneumococcal polysaccharide vaccines to patients without a physician's order. It can do this according to a physician-approved hospital policy after assessing the patient for contraindications. The bill requires DPH to adopt implementing regulations before the implementation of the program.

II. BACKGROUND

Program Activities

C.G.S. 19a-1271 establishes a quality of care program within DPH. The Office of Health Care Quality and Best Practices was created within DPH to assume this responsibility. In 2004 it was renamed the Health Care Quality, Statistics, Analysis, and Reporting (HCQSAR) section, and reorganized into the Bureau of Community Health. The Bureau of Health Care Systems is also very active in supporting the program.

The Quality in Health Care Advisory Committee first convened in August 2002, at which time subcommittees and working groups were created as follows:

Sub-Committee

1. Health Promotion and Illness Prevention
2. Physician Profiles
3. Continuum of Care
4. Regulations
5. Settlement Agreements/Tort Reform
6. Promotion of Quality and Safe Practices
 - Working Group I Hospital Performance Comparisons
 - Working Group II Patient Satisfaction Survey
 - Working Group III Best Practices
 - Working Group IV Adverse Event Reporting

In 2003, a new legislative subcommittee was created (see Appendix D). The legislative and tort reform subcommittees have not met this year and are therefore not discussed in this report. The Electronic Records subcommittee is discussed under Continuum of Care. The Physician Profiles subcommittee did not meet, but members have been monitoring the medical malpractice legislation. Under P.A. 04-164, Best Practices moves from a working group to a subcommittee, beginning July 2004.

DPH staff were assigned to co-chair the numerous subcommittees and working groups. Much of the work of the Health Care Quality, Statistics, Analysis, and Reporting ("HCQSAR") section has been performed in conjunction with the activities of the working groups. The work of the HCQSAR is described in more detail in Section III.

DPH/CMS Quality Initiative

At the national level, the Centers for Medicare & Medicaid Services (CMS), in conjunction with other national health care agencies and organizations, announced in December 2002 a voluntary hospital quality reporting program that is open to all hospitals in the country. CMS awarded pilot grants for this national hospital quality initiative to three states—New York, Maryland, and Arizona—to test the most effective ways of communicating about hospital quality of care with consumers. This effort is referred to as the “Three State Pilot.”

The Commissioner of the Connecticut Department of Public Health (DPH) recognized a unique opportunity for CMS and DPH to collaborate on a joint quality initiative that would utilize resources efficiently and minimize duplication of effort for all parties involved.

As a result, the DPH and the CMS formally partnered in June 2003 in an effort to provide useful and valid information about hospital quality to the public. The purpose of the collaboration was two-fold. One purpose was to support Connecticut hospitals’ efforts to comply with the public reporting of comparative patient satisfaction and clinical performance measures mandated by Section 19a-127l of the Connecticut General Statutes. The second purpose was to support the National Voluntary Hospital Reporting Initiative being developed and implemented by CMS. The project was unique in that it established a working collaboration between federal, state, and private sector agencies and organizations. Although the national initiative is voluntary, all 30 adult general acute care hospitals in Connecticut are participating. Connecticut was the first state to pledge 100% participation.

Qualidigm, which is the CMS Quality Improvement Organization for Connecticut, has been an integral partner of the DPH in this public reporting initiative. The Connecticut Hospital Association has also actively facilitated the project in the recruitment of hospital participation and the collection of data for public reporting. Weekly conference calls among the various partners were held to inform the process and to identify obstacles and solutions to the reporting initiatives.

The joint quality initiative consists of two main components:

- 1) The first component provides information by hospital on 10 clinical performance measures related to the delivery of services that scientific evidence has shown to be effective in the management of acute myocardial infarction (AMI), heart failure, and pneumonia. For example, "giving aspirin to an AMI patient within 24 hours of arrival at the hospital" is one of the measures.
- 2) The second project component involves participation in the development of a standardized hospital patient experience survey known as the Hospital Consumer Assessment of Health Plans CAHPS or H-CAHPS. Twenty-six Connecticut

hospitals participated in the pilot-test of the H-CAHPS survey instrument with 1,648 completed questionnaires. The survey consisted of 66 questions that pertain to a patient's hospital experience regarding (1) respect for patients' values, preferences, and needs; (2) coordination and integration of care; (3) information, communication and education; (4) physical comfort; (5) emotional support; (6) involvement of family and friends; (7) continuity and transition of care; and (8) access to care. Survey results from the Three State Pilot have been used to develop a core set of questions that are most useful for public reporting in the future. The Connecticut results for this pilot survey were provided directly to each participating hospital and were not made public. These results have provided additional validation of the survey instrument. Testing of the H-CAHPS instrument in Connecticut has also given the participating hospitals valuable information regarding their patients' experience in the eight key areas of care.

This joint initiative coincided with the recommendations of several Quality in Health Care Advisory Committee working groups as described in the section on Subcommittee Activities, and has enhanced the Department's capacity to meet the reporting requirements of C.G.S Section 19a-1271.

During the past year there have been three postings on the CMS website of the ten clinical performance measures for hospitals participating in the National Voluntary Hospital Reporting Initiative. They are as follows:

Public Release Date	Reporting Period
October 2003	July 2002 - December 2002
February 2004	January 2003 - June 2003
May 2004	January 2003 - September 2003

Results for Connecticut hospitals can be found at www.cms.hhs.gov/quality/hospital. The latest reporting period overlaps the reporting period (July - September 2003) covered in the April 2004 DPH report on Connecticut's quality initiative described under DPH Program Activities.

The formal collaboration between CMS and DPH ended on March 31, 2004. However, DPH expects to continue working with Qualidigm and the Connecticut Hospital Association on future clinical data reporting pertaining to Connecticut hospitals.

III. Quality in Health Care Advisory Committee and Subcommittee Activities

Advisory Committee

The Quality in Health Care Advisory Committee (QHCAC) held four meetings this past year in July 2003, October 2003, February 2004, and April 2004. A membership list can be found in Appendix C. Much of the work was divided among several subcommittees

and working groups. Recommendations from several of the subcommittees are currently under review by the Advisory Committee. A synopsis of current year activities and plans for next year is provided below for each of the subcommittees.

Subcommittee on Health Promotion and Illness Prevention

Currently, twelve of the fifty-two categories of health and health-related practitioners licensed and certified by the Department of Public Health are required by statute to participate in continuing education activities as a condition of license or certificate renewal.

Literature does not demonstrate a definitive link between improved practice and adherence to continuing education programs. However, the subcommittee also reviewed regulations and practices, in Connecticut and other states, relating to requirements for continuing education activities. The subcommittee also considered the necessity of maintaining current competence and its relationship to quality of health care services provided, as well as public perception. This subcommittee recommends that the Department of Public Health and provider organizations support requests by professional organizations for mandatory continuing education requirements as a condition of license or certificate renewal.

The subcommittee determined that restraints are already heavily regulated or studied in most settings in which they are used. However, it identified no regulations for the use of restraints in pediatric dental practices. The subcommittee is currently researching national practices and education programs in dental schools. Based on the information obtained, the subcommittee plans to develop a recommendation for either new legislation under the dental statutes or recommendations for continuing education programs.

Subcommittee on Continuum of Care

The Continuum of Care subcommittee has met over the past year, during which time it has discussed how patient information was shared among health care providers to provide for a continuum of care. Discussion included the type of information and the mechanism for information transmittal between the various levels of health care that included home care, hospitals, nursing homes, etc. The subcommittee focused on a study published by Qualidigm entitled the INFObridge Project. This project identified thirty-nine (39) Core Clinical Elements. These elements included components of medical, psycho-social and demographic information that were felt to be of value in the assessment of a patient's needs. The subcommittee's task for the upcoming year will be to identify a mechanism whereby this information can be accessed by health care providers.

Due to the large list of Core Clinical Elements, revision of a W-10 form was thought to be unwieldy; therefore efforts have moved toward exploring electronic methods of information access or transfer. The Quality of Care Advisory Committee recommended the creation of the Electronic Records Subcommittee. As most members of the

Continuum of Care Subcommittee volunteered to serve on the new group, the Continuum of Care Subcommittee thinks it advisable to merge the two subcommittees.

Subcommittee on Regulations

Subcommittee members have been provided with "draft revisions" to the Regulations of Connecticut State Agencies for Hospitals for review and comments. Currently, it is felt that no further actions will be initiated until such time as "Interpretive Guidelines" are developed for the current hospital regulations. Postponing the submission of the draft revisions in order to address the guidelines will enable the Committee to review the changes and determine if additional revisions are necessary, or to pursue other avenues of action, such as drafting new hospital regulations.

Subcommittee on Promotion of Quality and Safe Practices

Working Group I: Hospital Performance Comparisons

Working Group I consists of representatives of the hospital industry, health care plans, businesses, consumer groups, and the Department of Public Health. Working Group I met three times from July 2003 through June 2004 to continue developing recommendations related to the measurement of hospital clinical performance. Working Group I was given responsibility to identify, review, and develop recommendations on hospital clinical performance measures, data collection, and report format as described in C.G.S Section 19a-127l. During the year prior to June 2003, recommendations were developed regarding specific performance measures and data collection and were discussed in the June 2003 report to the General Assembly. This past year focused on the public reporting process. Working Group I reported its final findings and recommendations to the full Advisory Committee on February 18, 2004.

As part of the process, Working Group I reviewed examples of hospital comparative performance reports that were already available from other states and health care organizations. The Group debated the strengths and weaknesses of various presentation approaches, such as graphs versus data tables. The Group also looked at possible comparison groups that would be useful to include, such as statewide averages and national averages.

For the 10 clinical performance measures related to the three common medical conditions of heart attack, heart failure, and pneumonia, the Group recommended the following:

- Use simple bar graphs to display the hospital performance results. They are easy to understand and they quickly show relative hospital performance as well as the highest rate achieved by any hospital.
- For comparison groups, use both statewide and national averages. This allows hospitals to see how well they are doing within Connecticut, and it indicates how well the state is doing relative to other states.

- Within the report, include a section that educates consumers about the performance measures, why they are important, and how to use the information.
- Post the results on the DPH website in a location that is readily accessible and in a format that is easy to navigate.

DPH took these recommendations under advisement as they produced their first public report on hospital performance comparisons in April 2004.

Although Working Group I has completed its original scope of work, it will reconvene during the next year to review additional measures for inclusion in future reports or to discuss other issues that may arise related to public reporting of hospital performance.

Subcommittee on Promotion of Quality and Safe Practices

Working Group II: Patient Satisfaction Survey

Working Group II was given responsibility to identify, review, and develop recommendations on patient satisfaction measures, instruments, data collection, and report format as described in C.G.S. 19a 1271. The group consisted of representatives of the hospital industry, businesses, consumer groups, and the DPH. Working Group II met once in November 2003 to discuss updates of its April 2003 recommendations to the Quality in Health Care Advisory Committee, to review its tasks for 2004, and to get an update on the H-CAHPS survey instrument development and pilot-test results. The working group's tasks for 2004 include recommendations for: 1) data collection strategies, 2) data analytic strategies, and 3) public reporting formats for the patient survey. The working group also made specific recommendations to the DPH to expand its membership to include representatives of ethnically diverse consumer groups.

Subcommittee on Promotion of Quality and Safe Practices

Working Group III: Best Practices

Working Group III consists of representatives of the state's medical society, quality improvement organization, hospital industry, health care plans, and Departments of Public Health and Consumer Protection. The Best Practices Working Group met three times from July 2003 through June 2004.

The April 2003 report of the working group made several recommendations, including expanded collaborative activities for sharing methods to improve health care, support of hospital performance measures, and that a conference be convened on bar coding. In October 2003 the Best Practices working group was assigned by the Advisory Committee to address the topics of:

1. preventing surgical fires;
2. pneumococcal vaccination;
3. promoting best practices related to the CMS 10 measures of medical care in myocardial infarction, heart failure, and pneumonia, and additional best practices.

Best practices for preventing surgical fires have been developed by ECRI and endorsed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (www.jcaho.org; Sentinel Event Alert issue 29; June 24, 2003). CHA and Qualidigm co-sponsored a March 12th Patient Safety Summit, which included a presentation about preventing surgical fires. In April the Advisory Committee indicated its desire that the working group facilitate distribution of the ECRI/JCAHO materials to all Connecticut hospitals and surgical centers.

P.A. 04-164, *An Act Concerning the Quality of Health Care*, takes effect July 1, 2004. It allows a hospital to administer an influenza or pneumococcal vaccine according to a physician-approved hospital policy, without a specific physician's order. The working group will promote best practices for implementing standing orders for vaccinations after new regulations are promulgated by DPH, and will contribute to the development of those regulations.

P.A. 04-164 also directs the Quality of Care Advisory Committee to establish a standing subcommittee on best practices. The subcommittee shall advise the department on effective methods for sharing the quality improvement information learned from the department's review of adverse event reports and corrective action plans.

The working group agreed that best practices relating to the CMS ten measures could be promoted to clinicians through social networks, conferences, symposiums, "best practices tool kits," or other means. The group has discussed developing outside funding sources, partnering, and joint sponsorships for these activities. DPH continues to partner with Qualidigm, CHA, and other organizations around the state. Qualidigm and CHA are co-sponsoring a series of workshops, beginning in May, on topics such as cardiac care, surgical infections, and care of pneumonia. The working group continues to seek outside funding sources for advancing its goals.

Subcommittee on Promotion of Quality and Safe Practices

Working Group IV: Adverse Event Reporting

Working Group IV has continued to focus on the implementation of adverse event reporting by hospitals and outpatient surgical centers. This section of the law initially took effect October 1, 2002. Planning and educational activities in collaboration with the involved healthcare providers occurred prior to and during implementation. The working group has been evaluating feedback from providers about the reporting process and timeframes, as well as working to clarify and provide guidance on the definitions of the types of reportable events as written in the law. The recent survey by Connecticut's Patient Safety Improvement Corps team identified several barriers to effective reporting and sharing of information. The new legislative provisions of P.A. 04-164 clarify reporting requirements, extend reporting timeframes and promote public accountability. The PSIC recommendations and the legislation have a common goal to continually improve the quality and consistency of information reported to the Department of Public Health, which is critical in order for the adverse event reporting system to be effective in improving quality and patient safety.

Public Act 04-164 represents the collaborative efforts of key legislators, the Department of Public Health's Quality in Healthcare Advisory Committee, and hospitals to improve the quality and consistency of adverse event reporting. The working group made recommendations which were approved by the full Advisory Committee and were later incorporated into the new legislation. The Public Act, effective July 1, 2004, will:

1. Replace the existing adverse event classification system with a list of reportable events identified by the National Quality Forum (NQF) and a list compiled by the DPH;
2. Extend the reporting time to DPH of adverse events (excluding emergent events) and for filing corrective action plans;
3. Modify disclosure of adverse event reports, all those requiring a DPH investigation will be disclosable at the conclusion of the investigation; and
4. Allow DPH to designate as a "patient safety organization" (PSO) entities, whose primary mission involves patient safety activities. The PSO will make recommendations to improve patient safety and overall quality of care.

The workgroup will develop and implement a new reporting form, by July 1, 2004, as well as the regulations required by the Act later in the year.

The working group's future plans include developing the capacity for hospitals to provide electronic submission of adverse event reports directly to DPH. Data will continue to be collected and analyzed to facilitate quality improvement efforts by providers and to inform DPH in its efforts to provide regulatory oversight and sharing of information to facilitate the development of best practices.

IV. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Implementation of New Hospital Reporting *Clinical Performance Measures*

DPH has been working closely with CMS to align data collection and reporting efforts on 10 clinical performance measures. Qualidigm and the Connecticut Hospital Association (CHA) have also been important partners, providing training for hospital medical record data abstractors and facilitating data collection and data quality assurance. Qualidigm coordinated the data flow from hospitals to data vendors to DPH. Weekly conference calls were held among the partners to facilitate the reporting process.

Data was 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 July 1, 2003 and September 30, 2003.

As required under Section 19a-1271 of the Connecticut General Statutes, DPH produced a hospital performance comparison report, *A Report on Quality of Care in Connecticut Hospitals*, in April 2004. The report is available on the DPH website.

Because data was collected for only a three-month period of time, many hospitals treated only a small number of patients for some of the performance measures. Such performance measure results were deemed too unreliable for public reporting. As such, 23% of the 390 performance results were not presented. As more data is collected over time, this problem will diminish.

At the national level, and as part of the CMS National Voluntary Hospital Reporting Initiative, future activities include the planned expansion of the number of measures from 10 to 17 for the current three medical conditions. This expansion, which is voluntary, begins with patients discharged from 3/1/04 - 6/30/04. Further expansion will occur for discharges from 7/1/04 - 10/30/04 to include two additional pneumonia measures and three measures related to surgical infection prevention.

As stated in the new Medicare Prescription Drug, Improvement and Modernization Act (MMA) signed by President Bush in December 2003, all hospitals currently reimbursed under the Prospective Payment System that wish to qualify for full market basket update beginning in federal fiscal year 2005 will be required to submit quality data to CMS pertaining to the 10-measure "starter set." Such data submission is currently voluntary. Hospitals not submitting the required quality data will have their market basket update reduced by 0.4%. Because Connecticut hospitals began this process early on, they will not be adversely affected.

Future DPH program activities include ongoing data collection for the 10 clinical measures presented in the April 2004 report, participating in the ongoing Advisory

Committee and Subcommittee activities, and monitoring public reporting efforts on hospital clinical performance measures at the national level.

Patient Experience Survey Data

In the summer of 2003, the Connecticut Department of Public Health entered into a collaborative agreement with CMS for a joint quality of healthcare initiative, as described in Section II. One project component involved participation in a hospital patient experience survey, known as the HCAHPS (pronounced “eych-caps”). The 66-item HCAHPS instrument was developed by the Agency for Healthcare Research and Quality (AHRQ) in conjunction with CMS and later pilot-tested in three states and Connecticut. The National Opinion Research Corporation (NORC) at the University of Chicago conducted the survey.

Twenty-six Connecticut hospitals participated in the HCAHPS survey project. A total of 1,648 mailed surveys were completed between October and December of 2003 with a 35.8% response rate for Connecticut. The results of the patient survey were reported back to the individual hospitals in April 2004. These results should help facilitate Connecticut hospitals’ transition to the revised HCAHPS survey instrument that will eventually be implemented.

The HCAHPS survey instrument will undergo additional pilot testing and revisions during 2004. Testing should be finished by September 2004. A revised instrument is expected in early 2005. Once the HCAHPS survey instrument is finalized, the DPH plans to use the survey instrument for purposes of comparative public reporting of patient satisfaction/experience in Connecticut hospitals as required by C.G.S. 19a-127l.

DPH staff have developed an estimate of funds needed to conduct a comparative hospital patient survey in consultation with the University of Connecticut Center for Survey Research and Analysis. The estimate ranges from \$68,000 (mailed survey, analysis, and report with a sample size of 9,000 medical patients) to \$105,000 (mailed survey, analysis, and report with a sample size of 18,000 medical, surgical, and obstetric patients). DPH plans to identify sources of funding for a comparative hospital patient survey in the coming year.

Adverse Events

In March 2004, DPH released the second annual report to the legislature based upon the adverse events reporting program. This report noted a decline in the volume of reporting over the first 15 months of the program, and the recommendations of the Advisory Committee for changes in the reporting process and reporting form. Pursuant to the changes to adverse event reporting made by P.A. 04-164 (which adopted these recommendations), DPH began revising the data collection form. Training for hospitals and outpatient surgical centers in adverse event reporting under the new law is planned.

Regulations for adverse event reporting will also be promulgated, to further support the implementation of the revised law.

Patient Safety Improvement Corps

Connecticut was among fifteen states chosen for the first Patient Safety Improvement Corps, a joint partnership of the Agency for Healthcare Research and Quality and the Veterans Administration National Center for Patient Safety. The Connecticut team consisted of two members each from DPH and the Connecticut Hospital Association. The program entailed three periods of training in the Washington, D.C. area between September 2003 and May 2004 on such topics as adverse event and medical error reporting, root cause analysis, healthcare failure mode and effect analysis, human factors engineering, the business case for safety, analyzing patient safety data and programs, creating a just patient safety culture, and characteristics of high reliability organizations.

The Connecticut team completed a project to suggest improvements in adverse event reporting to DPH. The project included interviews with hospital staff responsible for reporting adverse events and with DPH staff who receive and respond to the reports. A confidential survey was sent to all reporting facilities. Based on the interviews and survey responses, the team identified potential barriers to complete and accurate reporting under the original law, and aspects in which the reporting system was contributing to or failing to advance patient safety. The team recommended:

- clarification of the definitions of the classes of adverse events;
- review of timelines for reporting adverse events;
- review of the reporting document format and information;
- review of options relative to protecting the confidentiality of the adverse event reports.

The project recommendations are reflected in changes to the adverse event reporting law proposed by the Quality of Care Advisory Committee, which were adopted in P.A. 04-164.

APPENDIX A
CGS 19a-127l-m



CGS 19a-127l-m

Sec. 19a-127l. Quality of care program. (a) There is established a quality of care program within the Department of Public Health. The department shall develop for the purposes of said program (1) a standardized data set to measure the clinical performance of health care facilities, as defined in section 19a-630 of the general statutes, and require such data to be collected and reported periodically to the department, including, but not limited to, data for the measurement of comparable patient satisfaction, and (2) methods to provide public accountability for health care delivery systems by such facilities. The department shall develop such set and methods for hospitals during the fiscal year ending June 30, 2003, and the committee established pursuant to subsection (c) of this section shall consider and may recommend to the joint standing committee of the General Assembly having cognizance of matters relating to public health the inclusion of other health care facilities in each subsequent year.

(b) In carrying out its responsibilities under subsection (a) of this section, the department shall develop the following for the quality of care program:

- (1) Comparable performance measures to be reported;
- (2) Selection of patient satisfaction survey measures and instruments;
- (3) Methods and format of standardized data collection;
- (4) Format for a public quality performance measurement report;
- (5) Human resources and quality measurements;
- (6) Medical error reduction methods;
- (7) Systems for sharing and implementing universally accepted best practices;

(8) Systems for reporting outcome data;

(9) Systems for continuum of care;

(10) Recommendations concerning the use of an ISO 9000 quality auditing program;

(11) Recommendations concerning the types of statutory protection needed prior to collecting any data or information under this act; and

(12) Any other issues that the department deems appropriate.

(c) There is established a Quality of Care Advisory Committee which shall advise the Department of Public Health on the issues set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section. The advisory committee shall meet at least quarterly.

(d) The advisory committee shall consist of (1) four members who represent and shall be appointed by the Connecticut Hospital Association, including three members who represent three separate hospitals that are not affiliated of which one such hospital is an academic medical center; (2) one member who represents and shall be appointed by the Connecticut Nursing Association; (3) two members who represent and shall be appointed by the Connecticut Medical Society, including one member who is an active medical care provider; (4) two members who represent and shall be appointed by the Connecticut Business and Industry Association, including one member who represents a large business and one member who represents a small business; (5) one member who represents and shall be appointed by the Home Health Care Association; (6) one member who represents and shall be appointed by the Connecticut Association of Health Care Facilities; (7) one member who represents and shall be appointed by the Connecticut Association of Not-For-Profit Providers for the Aging; (8) two members who represent and shall be appointed by the AFL-CIO; (9) one member who represents consumers of health care services and who shall be appointed by the Commissioner of Public Health; (10) one member who represents a school of public health and who shall be appointed by the Commissioner of Public Health; (11) one member who represents and shall be appointed by the Office of Health Care Access; (12) the Commissioner of Public Health or said commissioner's designee; (13) the Commissioner of Social Services or said commissioner's designee; (14) the Secretary of the Office of Policy and Management or said secretary's designee; (15) two members who represent licensed health plans and shall be appointed by the Connecticut Association of Health Care Plans; (16) one member who represents and shall be appointed by the federally designated state

peer review organization; and (17) one member who represents and shall be appointed by the Connecticut Pharmaceutical Association. The chairperson of

the advisory committee shall be the Commissioner of Public Health or said commissioner's designee. The chairperson of the committee, with a vote of the majority of the members present, may appoint ex-officio nonvoting members in specialties not represented among voting members. Vacancies shall be filled by the person who makes the appointment under this subsection.

(e) The chairperson of the advisory committee may designate one or more working groups to address specific issues and shall appoint the members of each working group. Each working group shall report its findings and recommendations to the full advisory committee.

(f) The Commissioner of Public Health shall report on the quality of care program on or before June 30, 2003, and annually thereafter, in accordance with section 11a-4 of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health and to the Governor. Each report on said program shall include activities of the program during the prior year and a plan of activities for the following year.

(g) On or before April 1, 2004, the Commissioner of Public Health shall prepare a report, available to the public, that compares all licensed hospitals in the state based on the quality performance measures developed under the quality of care program.

(h) The Department of Public Health may seek out funding for the purpose of implementing the provisions of this section. Said provisions shall be implemented upon receipt of said funding.

Sec. 19a-127m. Implementation of performance improvement plans by hospitals. Submission of plans to department as condition of licensure. All hospitals, licensed pursuant to provisions of the general statutes, shall be required to implement performance improvement plans. Such plans shall be submitted on or before June 30, 2003, and annually thereafter by each hospital to the Department of Public Health as a condition of licensure.

APPENDIX B
PUBLIC ACT 04-164



Substitute Senate Bill No. 566

Public Act No. 04-164

AN ACT CONCERNING THE QUALITY OF HEALTH CARE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-127n of the general statutes, as amended by section 123 of public act 03-278, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) (1) For purposes of this section, an "adverse event" means **[an injury that was caused by or is associated with medical management and that results in death or measurable disability. Such events shall also include those sentinel events for which remediation plans are required by the Joint Commission on the Accreditation of Healthcare Organizations]** any event that is identified on the National Quality Forum's List of Serious Reportable Events or on a list compiled by the Commissioner of Public Health and adopted as regulations pursuant to subsection (d) of this section; and "corrective action plan" means a plan that implements strategies that reduce the risk of similar adverse events occurring in the future, and measures the effectiveness of such strategies by addressing the implementation, oversight and time lines of such strategies.

(2) The commissioner shall review the list of adverse events periodically, but not less than annually, to ascertain whether any additions, deletions or modifications to the list are necessary.

[(b) Adverse events shall be classified into the following categories:

(1) "Class A adverse event" means an event that has resulted in or is associated with a patient's death or the immediate danger of death;

(2) "Class B adverse event" means an event that has resulted in or is associated with a patient's serious injury or disability or the immediate danger of serious injury or disability;

(3) "Class C adverse event" means an event that has resulted in or is associated with the physical or sexual abuse of a patient; and

(4) "Class D adverse event" means an adverse event that is not reported under subdivisions (1) to (3), inclusive, of this subsection.]

[(c) (b) On and after October 1, 2002, a hospital or outpatient surgical facility shall report adverse events to the Department of Public Health [on Class A, B and C adverse events] as follows: (1) [A verbal report shall be made not later than twenty-four hours after the adverse event occurred; (2) a] A written report and the status of any corrective steps shall be submitted not later than [seventy-two hours] seven days after the adverse event occurred; and [(3)] (2) a corrective action plan shall be filed not later than [seven] thirty days after the adverse event occurred. Emergent reports, as defined in the regulations adopted pursuant to subsection (c) of this section, shall be made to the department immediately. Failure to implement a corrective action plan may result in disciplinary action by the Commissioner of Public Health, pursuant to section 19a-494.

[(d) A hospital or outpatient surgical facility shall report to the Department of Public Health on Class D adverse events on a quarterly basis. Such reports shall include corrective action plans. For purposes of this subsection and subsection (c) of this section, "corrective action plan" means a plan that implements strategies that reduce the risk of similar events occurring in the future. Said plan shall measure the effectiveness of such strategies by addressing the implementation, oversight and time lines of such strategies. Failure to implement a corrective action plan may result in disciplinary action by the Commissioner of Public Health, pursuant to section 19a-494.]

[(e) (c) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section. Such regulations shall include, but shall not be limited to, a list of adverse events that are in addition to those contained in the National Quality Forum's List of Serious Reportable Events and a prescribed form for the reporting of adverse events pursuant to [subsections (c) and (d)] subsection (b) of this section. The commissioner may require the use of said form prior to the adoption of said regulations.

[(f) (d) On or before [March] October first annually, the commissioner shall report, in accordance with the provisions of section 11-4a, on adverse event

reporting, to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

[(g)] (e) Information collected pursuant to this section shall not be **[required to be]** disclosed pursuant to subsection (a) of section 1-210, as amended, **[for a period of six months from the date of submission of the written report required pursuant to subsection (c) of this section and]** at any time, and information collected pursuant to this section shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except as otherwise specifically provided by law. Nothing in this section shall be construed to limit access to or disclosure of investigative files, including any adverse event report contained in such files, maintained by the department as otherwise provided in section 19a-499.

(f) If the department determines that it will initiate an investigation of an adverse event that has been reported, such investigation may include review by one or more practitioners with clinical expertise of the type involved in the reported adverse event.

[(h)] (g) The Quality of Care Advisory Committee established pursuant to section 19a-127l shall establish methods for informing the public regarding access to the department's consumer and regulatory services.

Sec. 2. (NEW) (*Effective July 1, 2004*) (a) For purposes of this section:

(1) "Patient safety organization" means any public or private organization, or component of any such organization, whose primary activity is to improve patient safety and the quality of health care delivery for patients receiving care through the collection, aggregation, analysis or processing of medical or health care-related information submitted to it by health care providers;

(2) "Patient safety work product" means any information, documentation or communication, including, but not limited to, reports, records, memoranda, analyses, statements, root cause analyses, protocols or policies that (A) a health care provider prepares exclusively for the purpose of disclosing to a patient safety organization, (B) is created by a patient safety organization, or (C) contains the deliberations or analytical process of a patient safety organization or between a patient safety organization and health care providers participating in the evaluation of patient care; and

(3) "Health care provider" or "provider" means any person, corporation, limited liability company, facility or institution operated, owned or licensed by this state

to provide health care or professional services, or an officer, employee or agent thereof acting in the course and scope of his or her employment.

(b) (1) Any private or public organization or a component of any private or public organization may apply to the Department of Public Health to be designated as a patient safety organization.

(2) The department may designate as a patient safety organization each applicant that (A) has a mission statement indicating its primary purpose is to conduct activities to improve patient safety, (B) has qualified staff and professionals capable of reviewing and producing patient safety work product, (C) is not a component of a health insurer or other entity that provides health insurance to individuals or group health plans, and (D) certifies that its mission does not create a conflict of interest with the health care providers who will submit patient safety work product to it. Each hospital or outpatient surgical facility shall seek to work with one or more patient safety organizations as they become available. The department shall assist hospitals and outpatient surgical facilities in developing working relationships with patient safety organizations.

(c) A health care provider shall enter into a written contract with each patient safety organization to which it sends patient safety work product. Each contract shall require the provider to maintain a document log itemizing the types of documents submitted to patient safety organizations without indicating the content of such documents. Such document log shall be accessible to the department for the sole purpose of allowing the department to verify the type of information submitted to patient safety organizations. The department shall not have access to patient safety work product. Notwithstanding the provisions of sections 1-210, as amended, 1-211 and 1-213 of the general statutes, such document log shall not be subject to disclosure to, or use by, any person or entity, other than the patient safety organization and the provider with which it has contracted, and by the department for the sole purpose provided in this subsection.

(d) A patient safety organization shall, as appropriate, disseminate to health care providers, the department, the Quality of Care Advisory Committee, as established by 19a-127l of the general statutes, and the public, information or recommendations, including suggested policies, procedures or protocols, on best medical practices or potential system changes designed to improve patient safety and the overall quality of care.

(e) A patient safety organization shall have in place appropriate safeguards and security measures to ensure the technical integrity and physical safety of any patient safety work product. Patient safety work product shall be confidential,

and shall not be subject to any discovery, access or use by any person or entity other than the patient safety organization and the provider with which the patient safety organization has contracted. Patient safety work product, if submitted to a public or governmental organization, shall not be subject to the provisions of section 1-210, as amended, 1-211 or 1-213 of the general statutes. Nothing in this subsection shall prohibit a patient safety organization from choosing to disclose patient safety work product, or portions of patient safety work product, in conformity with its mission and within its contractual obligations to the provider submitting the information. No patient safety organization may release protected health information or patient identifying information without meeting the requirements of state laws and the federal Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

(f) A provider's disclosure of patient safety work product to a patient safety organization shall not modify, limit or waive any existing privilege or confidentiality protection.

Sec. 3. Subsection (c) of section 19a-127l of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(c) (1) There is established a Quality of Care Advisory Committee which shall advise the Department of Public Health on the issues set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section. The advisory committee shall meet at least quarterly.

(2) Said committee shall create a standing subcommittee on best practices. The subcommittee shall advise the department on effective methods for sharing with providers the quality improvement information learned from the department's review of reports and corrective action plans, including quality improvement practices, patient safety issues and preventative strategies. The department shall, at least quarterly, disseminate information regarding quality improvement practices, patient safety issues and preventative strategies to the subcommittee and hospitals.

Sec. 4. (NEW) (*Effective July 1, 2004*) A hospital may administer influenza and pneumococcal polysaccharide vaccines to patients, after an assessment for contraindications, without a physician's order in accordance with a physician-approved hospital policy. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to carry out the provisions of this section.

**APPENDIX C
OLR BILL ANALYSIS AND
NQF LIST OF SERIOUS REPORTABLE EVENTS**

OLR BILL ANALYSIS

PA 04-164

Previously sSB 566 (File 457, as amended by Senate "A")

AN ACT CONCERNING THE QUALITY OF HEALTH CARE

SUMMARY:

This bill revises the law requiring hospitals and outpatient surgical facilities to report adverse events to the Department of Public Health (DPH). Specifically, it:

1. replaces an existing adverse event classification reporting system with a list of reportable events identified by the National Quality Forum (NQF) or by DPH;
2. changes the timing for reporting to DPH and requires immediate reports of events DPH defines as emergent;
3. restricts disclosure of adverse events reports; and
4. allows DPH to use practitioners with clinical expertise of the type involved in an adverse event in investigating reports.

It requires the existing Quality of Care Advisory Committee, which advises DPH on quality issues, to establish a standing subcommittee on best practices.

The bill also allows DPH to designate as a "patient safety organization," a public or private organization whose primary mission involves patient safety improvement activities. An organization must apply to DPH for such designation. An organization must be engaged in "patient work safety product," which means information, documentation, or communication, such as reports, records, analyses, protocols, or policies that (1) it creates, (2) contain its deliberations or analyses or those between the organization and health care providers involved in evaluating patient care, or (3) a health care provider prepares exclusively for disclosure to the organization.

The bill requires hospitals and outpatient surgical facilities to seek to work and contract with such organizations as they become available. These organizations must provide providers and others, as appropriate, with information on best

practices. And they must have appropriate safeguards and safety measures in place to protect the patient safety work product.

Finally, the bill allows a hospital to administer influenza and pneumococcal polysaccharide vaccines to patients without a physician's order. It can do this according to a physician-approved hospital policy after assessing the patient for contraindications. The bill requires DPH to adopt implementing regulations.

**Senate Amendment "A"* requires facilities to submit the status of any corrective steps concerning an adverse event; requires filing the corrective action plan with DPH within 30, instead of 7, days after the adverse event; requires the establishment of the subcommittee on best practices; defines "health care provider" for purposes of patient safety organizations and includes a health care institution in the definition; and adds the provisions on vaccine administration.

EFFECTIVE DATE: July 1, 2004

ADVERSE EVENT REPORTING

Definition of Adverse Event; National Quality Forum List

By law, hospitals and outpatient surgical facilities must report adverse events to DPH. An "adverse event" is an injury caused by or associated with medical management that results in death or measurable disability. Under current law, it includes those sentinel events for which remediation plans are required by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). A "sentinel event" is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The law creates four categories of adverse events: Class A, patient death or immediate danger of death; Class B, patient seriously injured or disabled; Class C, patient physical or sexual abuse; and Class D, adverse event not reported under A through C.

The bill eliminates the Class A through D adverse event reporting and substitutes reporting any event identified on the National Quality Forum's List of Serious Reportable Events or on a list compiled by the DPH commissioner and adopted in regulations (see BACKGROUND). The bill requires the commissioner to review the list at least annually, to determine if any changes are necessary. NQF is a not-for-profit membership organization created to develop and implement a national strategy for health care quality management and reporting.

Adverse Event Reporting

Current law requires hospitals and outpatient surgical facilities to report Class A, B and C adverse events to DPH as follows: (1) a verbal report within 24 hours of

the event, (2) a written report within 72 hours, and (3) a corrective action plan within seven days. They must report Class D adverse events quarterly and include corrective action plans.

The bill instead requires facilities to submit to DPH a written report and the status of any corrective steps on an adverse event, as identified on the NQF or DPH list, within seven days after the event occurs. A corrective action plan must also be filed with DPH not later than 30 days after the event. Emergent reports, to be defined in DPH regulations, must be reported immediately to DPH.

Reporting and Information Disclosure

The bill requires DPH to report annually to the Public Health Committee by October 1, instead of March 1, on adverse events reported to it. Under current law, information collected on adverse events does not have to be disclosed for a six-month period from the date the required report is submitted (72 hours after the event). The bill instead specifies that the information never need be disclosed and, as under existing law, is not subject to subpoena, discovery, or introduction into evidence in any judicial or administrative proceeding, except as specifically provided by law.

The bill also specifies that it should not be construed as limiting access to or disclosure of investigative files maintained by DPH, including adverse event reports. Existing law provides that information DPH receives through filed reports must not be disclosed publicly in a way that identifies any patient or institution, except in limited circumstances. By law, all records DPH obtains in connection with any investigation must not be disclosed to the public (1) for six months from the date of the petition or other event initiating the investigation or (2) until the investigation is terminated pursuant to a withdrawal or other informal disposition or a hearing is convened, whichever is earlier.

The bill allows DPH, if it decides to investigate a reported adverse event, to include review by one or more practitioners with clinical expertise of the type involved in the event.

Quality of Care Advisory Committee-Subcommittee on Best Practices

This committee, established by PA 02-125, the act that also established the adverse events reporting provisions, advises DPH on quality of care issues. The 24-member committee must meet at least quarterly and is chaired by the DPH commissioner, or his designee. The Department of Social Services commissioner and Office of Policy and Management secretary are also members. Other members represent health care providers and institutions, professional

organizations, the business community, organized labor, health plans, and others involved in quality of care issues.

The bill requires the committee to establish a standing subcommittee on best practices. It must advise DPH on effective methods for sharing with providers quality improvement information obtained from DPH's review of reports and corrective action plans, including quality improvement practices, patient safety issues, and preventative strategies. DPH must disseminate information on quality improvement practices, patient safety, and preventative strategies, at least quarterly, to the subcommittee and hospitals.

PATIENT SAFETY ORGANIZATIONS

Definitions

The bill defines a "patient safety organization" as any public or private organization, or part of one, whose primary activity is improving patient safety and quality of health care delivery for patients. The organization must do this through the collection, aggregation, analysis, or processing of medical or health care-related information it receives from health care providers.

The bill defines "patient work safety product" as any information, documentation, or communication, including reports, records, memoranda, analyses, statements, root cause analyses, protocols, or policies that (1) a health care provider prepares exclusively for the purpose of disclosure to a patient safety organization, (2) is created by a patient safety organization, or (3) contains the deliberations or analytical process of a patient safety organization or between an organization and health care providers participating in evaluating patient care.

A "healthcare provider" is any person, corporation, limited liability company, facility, or institution operated, owned, or licensed by the state to provide healthcare or professional services, or an officer, employee, or agent of any of these acting in the course of his employment.

DPH Designation as Patient Safety Organization

The bill allows any public or private organization or part thereof, to apply to DPH for designation as a patient safety organization. It authorizes DPH to designate as a patient safety organization an applicant that (1) has a mission statement indicating that its primary purpose concerns patient safety improvement activities, (2) has qualified staff capable of reviewing and producing patient work safety product, (3) is not part of a health insurer or other entity providing health insurance to groups or individuals, and (4) certifies that

its mission does not create a conflict of interest with the health care providers who will submit patient safety work product to it.

The bill requires each hospital or outpatient surgical facility to try to work with one or more patient safety organizations as they become available. DPH must assist these facilities in developing such working relationships.

Contracts with Patient Safety Organizations

The bill requires health care providers to enter into written contracts with each patient safety organization to which it sends patient safety work product. Each contract must require the provider to keep a log that itemizes the types of documents it submits to the patient safety organizations without indicating their content. This log must be available to DPH solely to allow it to verify the type of information submitted to patient safety organizations. DPH does not have access to patient safety work product under the bill. The document log cannot be disclosed to or used by any person or entity other than (1) the patient safety organization and the provider with which it has contracted and (2) DPH, for purposes listed above.

Best Practices

The bill requires a patient safety organization, as appropriate, to give to providers, DPH, the Quality of Care Advisory Committee, and the public information or recommendations on best medical practices or potential system changes designed to improve patient safety and overall quality of care. This can include suggested policies, procedures, or protocols.

Security Measures and Safeguards; Disclosure of Information

The bill requires a patient safety organization to have appropriate safeguards and safety measures to ensure the technical integrity and physical safety of any patient safety work product. Such work product must be confidential and not subject to any discovery, access, or use by any person or entity other than the patient safety organization and the provider or institution with which it contracts. Patient safety work product submitted to a public or governmental organization is not public information.

The bill specifies that it does not prohibit a patient safety organization from choosing to disclose patient safety work product, in conformity with its mission and within contractual obligations to the provider submitting the information. The bill prohibits a patient safety organization from releasing protected health information or patient identifying information unless requirements of state law and the federal Health Insurance Portability and Accountability Act are met.

Finally, the bill specifies that a provider's disclosure of patient safety work product to a patient safety organization does not modify, limit, or waive any existing privilege or confidentiality protection.

BACKGROUND

NQF's List of Reportable Events in Healthcare

In March 2002, NQF released a report, *Serious Reportable Events in Healthcare: A National Quality Forum Consensus Report*, designed to form the basis for a national, state-based adverse events reporting system. The report identifies 27 adverse events in six major categories: (1) surgical events, (2) product or device events, (3) patient protection events, (4) care management events, (5) environmental events, and (6) criminal events.

Table 1 presents the list of serious reportable events.

Table 1: NQF's List of Serious Reportable Events

<i>Event</i>	<i>Additional Specifications</i>
<p>1. SURGICAL EVENTS</p> <p>A. Surgery performed on the wrong body part</p>	<p>Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient.</p> <p>Excludes emergent situations that arise in the course of surgery and/or whose exigency precludes obtaining informed consent.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<p>B. Surgery performed on the wrong patient</p>	<p>Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<p>C. Wrong surgical procedure performed on a patient</p>	<p>Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient.</p> <p>Excludes emergent situations that arise in the course of surgery and/or whose exigency precludes obtaining informed consent.</p> <p>Surgery includes endoscopies and other</p>

	invasive procedures.
D. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentional implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.
E. Intraoperative or immediately post-operative death in an American Society of Anesthesiologists (ASA) Class I patient	Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. "Immediately post-operative" means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.
2. PRODUCT OR DEVICE EVENTS	
A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.
B. Patient death or serious disability associated with the use of function of a device in patient care in which the device is used or functions other than as intended	Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	Excludes deaths associated with neurosurgical procedures know to present a high risk of intravascular air embolism.
3. PATIENT PROTECTION EVENTS	
A. Infant discharged to the wrong person	
B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	Excludes events involving competent adults.
C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	Defined as events that result from patient actions after admission to a healthcare facility. Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the healthcare facility.
4. CARE MANAGEMENT EVENTS	
A. Patient death or serious disability associated with a medication error (<i>e. g.</i> , errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route	Excludes reasonable differences in clinical judgment on drug selection and dose.

of administration)	
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of incompatible blood or blood products	
C. Maternal death or serious disability with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	Includes events that occur within 42 days after delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	Hyperbilirubinemia is defined as a bilirubin levels >30mg/dl. "Neonates" refers to the first 28 days of life.
F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	Exclude progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
G. Patient death or serious disability due to spinal manipulative therapy	
5. ENVIRONMENTAL EVENTS	Excludes events involving planned treatments such as electric countershock.
A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility	
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	
D. Patient death associated with a fall while being cared for in a healthcare facility	
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	
6. CRIMINAL EVENTS	
A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	

B. Abduction of a patient of any age	
C. Sexual assault on a patient within or on the grounds of a healthcare facility	
D. Death or significant injury of a patient or staff member resulting from a physical assault (<i>i. e.</i>, battery) that occurs within or on the grounds of a healthcare facility	

**APPENDIX D
ADVISORY COMMITTEE MEMBERSHIP LIST**

Quality in Health Care Advisory Committee

Health Promotion & Disease Prevention

Ann L. Anthony
Liz Beaudin
Kathleen Boulware
Jennifer Filippone
Allen Hindin
David LaPierre

Physician Profiles

Liz Beaudin
Kenneth Ferrucci
Jennifer Filippone
Alfred Herzog
Thomas Meehan

Continuum of Care

Ann L. Anthony
Christine Ceccarelli
Toni Fatone
Sharon Guerette
Patricia Duclos-Miller
Anne Marie Montemerlo
Mag Morelli
Julie Petrellis
Ann Spenard
Marie Vitarelli

Regulations

Carolyn Brady
Kenneth Ferrucci
Joan Leavitt
Nancy S. Nicolescu
Jim Rush

Settlement Agreements/Tort Reform

Pat Monahan
Stanley Peck
Mike H. Summerer

Electronic Records

Ann L. Anthony
Kenneth Ferrucci
David LaPierre
Mag Morelli
Julie Petrellis
Marcia K. Petrillo

Legislative Sub-Committee

Karen Buckley Bates
Carolyn Brady
Joanne Chapin
Peter Herbert
Alfred Herzog
Steven Schneider

Promotion of Quality and Safe Practices

Judith Barr
Nancy Bafundo
Karen Buckley Bates
Christine Berman
Noel Bishop
Paul Bluestein
Carolyn Brady
Joanne Chapin
Patrick A. Charmel
Michael M. Deren
Judith Dowd
Anne Elwell
Ann Errichetti
David Pearson
Kenneth Ferrucci
Joan Foland
Wendy Furniss
John Gadea
Andrea Gelzer
Gregory Gousse
Norma Gyle
Mary Heffernan
Peter Herbert
Marianne Horn
Margaret Hynes
Edward A. Kamens
Brenda J. Kelley
Leona Mariani
Thomas Meehan
Susan Menichetti
Matthew Miller
Doug Moore
Nancy S. Nicolescu
Jon C. Olson
David Parrella
Julie Petrellis
Marcia K. Petrillo
Deborah Quetti
Robert Ritz
Jesse Samuels
Steven Schneider
Jeanne Scinto
Eleanor C. Seiler
Jan Spegele
Christine Vogel
Bruce R. Wallen

