



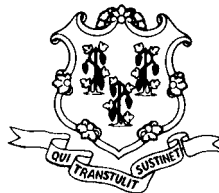
Keeping Connecticut Healthy

REPORT TO THE GENERAL ASSEMBLY

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

JUNE 2005

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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, 2005

I. INTRODUCTION and BACKGROUND

Connecticut General Statutes section 19a-1271-n requires the Department of Public Health (DPH) to establish a quality of care program for health care facilities. This legislation 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 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) section.

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, 2005. The report has been updated to reflect legislative activity into mid-July. In addition to this report, DPH submitted the third adverse event report to the General Assembly (dated October 2004), and distributed a "Six Month Summary of Adverse Event Reports, Using the New Reporting System of NQF and Connecticut-Specific Events," through the Quality in Health Care Advisory Committee, to facilities that report adverse events (Appendix A).

Public Act 04-164 amended CGS §19a-1271(c)(2) to require the Quality in Health Care Advisory Committee to establish a standing subcommittee on best practices. To meet this requirement, in the fall of 2004 the Advisory Committee combined the existing working groups for Adverse Events and for Best Practices into a subcommittee on Best Practices and Adverse Events. The subcommittee and working groups as of June 30, 2005 are:

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
7. Best Practices and Adverse Events
8. Legislative

DPH staff members were assigned to co-chair the numerous subcommittees and working groups. The legislative and tort reform subcommittees have not met this year and are therefore not discussed in this report. Working Group II: Patient Satisfaction Survey has also not met this year; however there have been related developments at the national level.

The Centers for Medicare and Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop a 66-item version of HCAHPS, a hospital survey of patient satisfaction. The HCAHPS instrument was pilot-tested in three states and Connecticut. On May 13, 2005, the National Quality Forum (NQF) endorsed the now 27-item HCAHPS instrument. According to a May 21, 2005 fact sheet posted at the CMS website (www.cms.hhs.gov/quality/hospital/HCAHPSFactSheet.pdf), training for national implementation of HCAHPS is planned for summer 2005, a “dry-run” for fall, and full voluntary national implementation for 2006. Results will be posted on the Hospital Compare website of CMS.

Public Act 05-167, *An Act Concerning the Improvement of Cardiac Care*, passed the Connecticut General Assembly and was signed into law by the governor on July 1, 2005. (Appendix B). This act directs the Quality in Health Care Advisory Committee to examine and evaluate possible approaches that would aid in the utilization of an existing data collection system for cardiac outcomes, and the potential for state-wide use of a data collection system for cardiac outcomes, for the purpose of continuing the delivery of quality cardiac services in the state. The bill becomes effective October 1, 2005 and requires the Advisory Committee to submit a report by December 1, 2007.

Public Act 05-272, *An Act Concerning Revisions to Department of Public Health Statutes*, passed the General Assembly and was signed into law on July 13, 2005. At section 30 (Appendix C), the act amended subsection (c) of section 19a-1271 of the Connecticut General Statutes, to require the standing committee on best practices, to: (B) not later than January 1, 2006, review and make recommendations concerning best practices with respect to when breast cancer screening should be conducted using comprehensive ultrasound screening or mammogram examinations.

II. 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 August 2004, November 2004, February 2005, and April 2005. Much of the work was divided among several subcommittees and working groups. 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

The subcommittee met and discussed continuing education (CE) requirements for health care professionals. By the end of 2004, twelve professional disciplines required CE by statute.

It is expected that legislation requiring physicians and dentists to complete continuing education as a condition of license renewal will be signed and become effective October 1, 2005. For other professionals who are not currently required to complete continuing education, the subcommittee continues to recommend that the Department of Public Health and provider organizations support requests by professional organizations for mandatory continuing education requirements as a condition of license renewal if proposed during future legislative sessions.

The subcommittee is completing research for a survey of dentists licensed in Connecticut regarding restraint practices currently used on pediatric patients and how they address the issues of informed consent in the use of restraints.

Subcommittee on Physician Profiles

The prior physician profile law did not require physicians to report adverse licensure actions taken in other states, nor did it require physicians to periodically update information previously submitted to the Department concerning hospital disciplinary actions, and medical malpractice judgments, arbitration awards and settlements. During the 2005 Session, the Connecticut General Assembly passed Public Act 05-275, which was signed into law on July 13. In addition to clarifying existing physician profile filing requirements, this act requires physicians to report additional information on the profile (e.g., name of professional liability insurance carrier and an indication as to whether the practitioner is actively involved in patient care). It revises the existing physician profile statutes to require physicians to report any changes or updates in mandatory reporting information, and to add adverse licensure actions taken in other states to the list of mandated reporting items.

Physicians previously were not required to complete mandatory continuing medical education as a condition of license renewal. However, most physicians who have medical staff privileges at a hospital, participate in managed care plans, and/or maintain national board certification, participate in continuing education activities. P.A. 05-275 establishes minimum requirements for completion of continuing medical education for all physicians as a condition of license renewal. The educational requirements contained in this act address current health care trends, and should qualify toward meeting any other continuing education requirements that physicians may be required to complete.

The provisions of this bill become effective October 1, 2005.

Subcommittee on Continuum of Care

The Continuum of Care subcommittee, based on discussion that included the types of information and the mechanism of information transmitted between the various levels of health care, focused on the published study by Qualidigm entitled the INFObridge Project. This project identified thirty-nine (39) Core Clinical Elements that included components of medical, psycho-social and demographic information that were felt to be of value in the assessment of patient needs across the continuum of care. The subcommittee has further identified that exploring electronic methods of information access or transfer would be beneficial to both patients and providers.

Subcommittee on Regulations

The Department in conjunction with representatives from the Connecticut Hospital Association (CHA) has reviewed the recommendations of the hospital community and drafted revisions to the regulations governing hospitals. In May 2005 the Department submitted the revisions for regulatory review. The Department believes that the revisions were necessary and reflect current standards for acute care settings that will benefit the consumers of health care services. The Adverse Event Regulations and Influenza and Pneumococcal Polysaccharide Vaccine Regulations required by P.A. 04-164 have also been submitted for regulatory review.

Subcommittee on Promotion of Quality and Safe Practices

Working Group I: Hospital Performance Comparisons

Working Group I met three times from July 2004 through June 2005 to discuss public reporting for quality of care in Connecticut subsequent to the release of the first Hospital Performance Comparisons Report produced by DPH in April 2004. The Group reviewed DPH's current data collection efforts, the availability of quality of care information, and methods to evaluate the effectiveness of information being provided. Recommendations were presented to the full Advisory Committee as follows:

- Encourage hospitals to authorize earlier release of their clinical performance measure data from the CMS Data Warehouse to DPH, because DPH is currently unauthorized to receive data from the Warehouse before it is publicly reported nationally.
- Make health care quality information more readily available on the DPH website.
- Evaluate the effectiveness of public reporting by tracking the number of times that the Hospital Performance Comparisons Report is accessed on the DPH website.
- Publicize quality of care initiatives in Connecticut via press releases or in collaboration with managed care initiatives.

These recommendations have been taken under advisement by DPH in their quality of care program activities.

Subcommittee on Promotion of Quality and Safe Practices

Working Group II: Patient Satisfaction Survey

The working group's tasks for 2004 included recommendations for: 1) data collection strategies, 2) data analysis strategies, and 3) public reporting formats for the patient survey. The working group also made specific recommendations to DPH to expand its membership to include representatives of ethnically diverse consumer groups.

DPH staff members 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).

CGS §19a-1271-m notes that conducting the patient satisfaction survey is contingent upon additional funding. The final paragraph reads:

(i) 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.

Working group II has not met since spring 2004, but will be reconvened if a source of funding is identified.

Subcommittee on Best Practices and Adverse Events

This subcommittee was formed from the previous working groups of Best Practices and Adverse Events. The subcommittee met in December 2004 and February, March, and May 2005. The subcommittee reviewed past activities of the working groups and P.A. 04-164 regarding establishment of the subcommittee, considered information about medication reconciliation projects by the Voluntary Hospitals of America and in other states, including a medication passport, discussed voluntary hospital reporting to Patient Safety Organizations (PSOs), and was apprised of current topics such as health information technology. In 2005, the subcommittee began exploring ways to assist the Commissioner's stroke prevention workgroup in producing best practices for stroke care.

Following detailed examination of adverse event reports and their corrective action plans, the subcommittee decided to prioritize dissemination of information about inpatient falls resulting in serious injury, which was the most commonly reported adverse event during the first six months under the new reporting system (Appendix A). A draft fall prevention document was distributed among the subcommittee, and the fall prevention

team from Saint Francis Hospital made a presentation to the subcommittee. The six-month adverse event summary was distributed to the Advisory Committee and to reporting facilities. After receiving feedback and comments to the fall prevention draft and six-month adverse events summary, the subcommittee intends to release a document that includes results from the state adverse event reporting program and fall prevention guidelines, tips, or recommendations derived from a variety of expert sources, without the subcommittee making a specific best practice mandatory. The rationale for this is to allow hospitals to tailor the best practice to their patient populations and institutional culture. The subcommittee is exploring additional methods of disseminating best practices to health care facilities and practitioners in Connecticut, including a fall prevention symposium. In accordance with HB 6713, the subcommittee plans to consider best practices for breast cancer screening in the latter half of 2005.

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Implementation of P.A. 04-164

List of Adverse Events

Public Act 04-164 amended the Quality in Health Care program, effective July 1, 2004 to 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. DPH developed and implemented a new reporting form (see the appendices in the October 2004 Adverse Event Report), and has submitted the new Adverse Event regulations for regulatory review (see under Regulations subcommittee). The October 2004 Adverse Event report noted the Department's use of physician consultants in an increased number of medical specialties for review of selected Adverse Event reports.

Patient Safety Organizations

P.A. 04-164 allowed DPH to designate "Patient Safety Organizations" (PSOs). The bill requires hospitals and outpatient surgical facilities to contract with one or more such organizations. These organizations must provide hospitals and others, as appropriate, with information on best practices, through the collection, aggregation, analysis, or processing of medical or health-related information, termed "patient safety work product," received from health care providers. The PSOs must have appropriate safeguards in place to protect the confidentiality of this information.

Qualidigm and the Connecticut Healthcare Research & Education Foundation (CHREF) submitted applications to DPH for designation as PSOs, met the Department's criteria, and were designated PSOs in late 2004. The two PSOs, along with Anthem Blue Cross and Blue Shield of Connecticut, sponsored a Patient Safety Summit in March 2005, featuring national experts in various aspects of patient safety. Concurrently, the Qualidigm PSO unveiled its first Patient Safety Primer, which announced plans to offer

electronic newsletters, WebEx learning sessions, and telephonic discussions of de-identified case studies. A password protected BLog for Qualidigm PSO participants has been introduced as a forum for sharing information, best practices and advice. In addition, the CHREF PSO held the first annual Patient Safety Symposium at the Legislative Office Building in Hartford in May 2005 during which all 30 of Connecticut's not-for-profit acute care hospitals and one inpatient hospice shared detailed information about many patient safety initiatives with each other, legislators, regulators, and the public.

Standing Orders for Vaccinations

P.A 04-164 allowed a hospital to administer influenza and pneumococcal polysaccharide vaccines to patients without an individual physician's order. It can do this according to a physician-approved hospital protocol after assessing the patient for contraindications. The Act required DPH to adopt implementing regulations. The Influenza and Pneumococcal Polysaccharide Vaccine Regulations have been submitted for regulatory review. DPH anticipates having such regulations in place before the start of the 2005-06 flu season.

Quality of Care Information on the DPH Web Site

Activities of the Health Care Systems Branch are organized under *Health Care Quality* in the Quick Links section of the DPH website (www.dph.state.ct.us). Activities of HCQSAR are organized under *Quality of Care* in the Publications section of the DPH website, and are also linked through the *Health Care Quality* page under “Health Care Quality Program Reports”. Annual Adverse Event reports, the Hospital Performance Comparisons report, and annual reports to the legislature about the Quality of Care Program are also posted on the website.

Hospital Clinical Performance Measures

As required under Section 19a-127l of the Connecticut General Statutes, DPH produced a hospital performance comparison report, *A Report on Quality of Care in Connecticut Hospitals*, in April 2004. Since that time, DPH has been monitoring parallel activities at the national level, including the implementation of CMS’s Hospital Compare in April 2005.

DPH has considered the recommendations put forward by the Hospital Performance Comparisons Working Group I of the Quality of Care Advisory Committee. DPH activities related to hospital clinical performance measures have progressed as follows:

Data Collection Efforts Additional public reporting of hospital performance comparisons has not occurred in Connecticut because DPH has been restricted from receiving clinical performance data from the CMS Data Warehouse due to stringent QIO confidentiality regulations. Data have only been available to DPH after they have been publicly reported

nationally by CMS. Data that have not been publicly reported nationally, such as data for fourth calendar quarter of 2003, have not been available to DPH. This has prevented DPH from collecting a year's worth of continuous data on which to report.

In an effort to overcome this limitation, the Commissioner of DPH has requested hospitals to authorize Qualidigm to transmit each hospital's data from the CMS Data Warehouse to DPH in a timely fashion. The data being requested relate to the 10 clinical measures being used by DPH for public reporting. This authorization process is currently ongoing.

Public Access to Quality of Care Information In an effort to make health care quality information more readily available on the DPH website, a Health Care Quality web page was developed that is easily accessible from the agency's home page. It provides links to reports that have been developed under the mandated Quality of Care program, including the Hospital Performance Comparisons Report.

Evaluation Efforts to Measure the Effectiveness of the Information Being Provided by DPH A simple approach to evaluate the effectiveness of public reporting is to track the number of times that the Hospital Performance Comparisons Report is accessed on the DPH website. A counter was added to the web page on March 21, 2005. During the first three months of tracking, the Report has been accessed more than 1160 times.

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.

Adverse Events

Pursuant to the changes to adverse event reporting made by P.A. 04-164, DPH revised the data collection form and provided training for hospitals and outpatient surgical centers in adverse event reporting under the new law. Regulations for adverse event reporting were also promulgated, to further support the implementation of the revised law.

In the fall of 2004, DPH released the third report to the legislature based upon the adverse events reporting program.¹ The report has more recently been updated by the "Six Month" Summary (Appendix A), which noted that the most commonly reported events were falls resulting in injury and perforations during procedures or surgery. After more than six months of use of the new reporting form, 90% of reports have a box checked to indicate that the patient or an authorized representative was informed of an adverse event, a higher percentage than was noted in the October report. The other 10% indicate either that the patient was not informed, or have neither (Yes/No) box checked. Overall, there

¹ http://www.dph.state.ct.us/oppe/quality/Adverse%20Event%20Report_Oct%202004.pdf.

appears to be a high rate of notification. Connecticut law does not require notification, but several national organizations and all Connecticut hospitals have disclosure policies.

Connecticut's experience with adverse event reporting is an important contribution to the national effort. In March 2005, the National Quality Forum hosted a teleconference involving personnel from Connecticut, Minnesota, and New Jersey. Like Connecticut, Minnesota uses the NQF list of Serious Reportable Events for adverse event reporting by hospitals. New Jersey uses the NQF list with modifications. The states are sharing their experiences with adverse event reporting, through the NQF, in order to improve the clarity of definitions and comparability of data. The most commonly reported NQF-defined event in both Connecticut and Minnesota has been development of a stage 3-4 pressure ulcer after admission to an acute care facility.

Cardiac Care Legislation

“An Act Concerning the Improvement of Cardiac Care” (Appendix B) requires the Quality in Health Care Advisory Committee to submit a report to the legislature by December 2007. DPH anticipates contributing to that report. DPH staff members are developing a state plan for cardiovascular health (CVH) in consultation with statewide partners. The CVH state plan will be released in Spring 2006.

APPENDIX A

“Six Month” Summary of Adverse Event Reports, Using the New Reporting System of NQF and Connecticut-Specific Events

*“Six Month” Summary of Adverse Event Reports,
Using the New Reporting System of NQF and Connecticut-Specific Events*

The following summary is based upon analyses using dates of **occurrence** of reports entered into the electronic database as of February 16, 2005. In actual numbers it differs slightly from analyses based upon paper reports **received** by DPH during July-December. By mid-February, 111 of the 117 events that occurred prior to January 1, 2005 were represented in the electronic database, as were 7 of 16 events that occurred in January 2005. Records are not added to the electronic database until DPH has made a determination whether the report requires further investigation.

Out of 118 events, 32, or 27% were serious reportable events as defined by the National Quality Forum. The remaining 86, or 73%, were Connecticut-specific events. The most common type of event reported was a fall resulting in a serious injury; the 52 such reports were 44% of the total. The next most common report was of a perforation during surgery, with 28 reports, or 24%. The third most commonly reported event overall, and the most common NQF-defined event was the development of a stage 3-4 pressure ulcer after admission, with 12 reports (10%). The reporting of falls and perforations was comparatively steady during the entire reporting period, while the number of pressure ulcers was too small to infer anything from month to month variation.

General hospitals submitted 106 (90%) of the adverse event reports. Hospitals for the mentally ill submitted 6 reports; chronic disease hospitals submitted 4, and outpatient surgical facilities 2.

Overall, 47% of reported adverse events occurred in males. A slight majority (52%) of those with falls were male, while most perforations (64%) occurred in females.

Overall the most common place of occurrence of an adverse event was reported to be Adult Medical units. Among fall reports, the most common place was Adult Medical (61%), followed by Psychiatric (18%). Among Perforations reports, the Operating Room was the most common site, with 43%, followed by “Other” (25%) and Diagnostic Services (14%).

Only two events (2%) were reported in children less than age 15, neither of them a fall. The majority of adverse events (63%), especially a fall (92%), involved people 65 and older. Fifty-seven percent of falls involved persons aged 80 and older. The estimated rate of serious falls per 1000 patient days increased with age and was highest for patients aged 85 and older.

Falls occurred at all hours of the day, with the fewest (1) between 8 pm and midnight, and the most (13, 25%) between midnight and 4 am. The distribution of falls across all hours of the day was also observed in specific age groups and hospital units. It might be useful (but presently may not be possible) to investigate whether the variation reflects differing risk by time according to staffing patterns, differing enthusiasm for falls’

reporting among personnel on duty at different times, or differing physical and cognitive abilities of patients, especially the elderly, at various times of day and night.

Additional information was captured as free text. Falls took place under a variety of circumstances, e.g. alone or while assisted, while on fall precautions or not on fall precautions, getting in or out of bed, sitting, lying, or walking, in the patient's room, the bathroom, or in the hall.

The most common admitting diagnosis for a hospitalization that resulted in a fall was a mental disorder; however, in only a third (18 of 52) of all falls was there a mental condition in the admitting diagnosis, and in only half of these (9) was dementia noted. The majority of fall reports in which there was an admission diagnosis that included a mental condition were from psychiatric units. For all 52 falls, other common categories of admitting diagnoses were respiratory (14, of which 6 were pneumonia), cardiovascular (12), and infectious (10). In the 20 falls among persons aged 85 and older, the admitting diagnoses varied, similar to the pattern for all ages: mental (7), cardiovascular (6), and respiratory (5).

No clear conclusions can be derived from facility-level comparisons of the number or rates of fall reports alone. Reporting is influenced not only by the rate of falling, which depends upon the patient case mix, the quality of care, and other factors, but also upon willingness to report and the institutional system in place to convey information to the designated reporter. Some factors make a high reported fall rate desirable, while others make a low reported fall rate desirable. Improvement in outcomes, caused by a fall reduction program, cannot be measured by change in fall report rates to DPH over time. Improvement **might** result in initial increase in internal institutional reporting of falls followed by long-term decrease in reporting of falls, in an environment in which no negative consequences are associated with reporting. It is certainly **possible** that under the present system, an institution with a high reported fall rate reflects an institutional culture supportive of reporting.

The fall data presented above reveal a strong association between **reported serious falls** and age (a non-modifiable risk factor), and weak associations with time of day, admitting diagnosis, unit in care facility, and gender. There was great diversity in the circumstances of the falls. Although the legislative mandate addresses best practices as well as reporting, the CT adverse event reporting program does not provide a complete foundation to generate a set of "best practices," nor does the IOM report *To Err is Human* envision mandatory reporting programs for accountability as generating best practices. Any Connecticut report about best practices for fall prevention should therefore include sources outside the state adverse event program, such as information gathered by the Patient Safety Organizations, while including the limited information from the program that could assist in preventing fall injuries.

Perforations occurred across ages from 25-97 years. Most admitting diagnoses mentioned the abdomen, rectum, or female reproductive system, including cancer (4), abdominal pain (3), cholecystitis (3), anemia (3), and rectal or GI bleed (3). Colonoscopy

was mentioned on 14 reports in connection with the injury; other reports mentioned an operation on the female reproductive system (6), gall bladder (4), prostate (2), bladder (1), and esophagus (1). Laparoscopic approach was mentioned 4 times, in disparate sites. The most commonly specified sites of injury were the sigmoid colon (5) or colon, right colon, bowel, small bowel, cecum, and rectum (7). Forty three percent (43%) of perforations occurred between 8 am and noon, primarily reported from the Operating Room and “Other”.

Development of stage 3-4 pressure ulcer after admission was reported in 7 women and 5 men, all aged 45 and older. Three types of units reported these adverse events: adult medical (5), adult surgical (4) and medical intensive care (3). The reported times that the ulcer progression occurred were all in the morning: midnight to 4 am (6), 4-8 am (2), and 8am-noon (3). Admitting diagnoses varied, and the most commonly mentioned condition was renal insufficiency or failure (3). Most reports mentioned a stage 4 ulcer (8) on the coccyx or sacrum (8), but ulcers on the lower leg, buttocks, and elbow were also reported. This issue will receive more attention during the coming year, as one of the Patient Safety Organizations is currently working on the same issue in the nursing home setting.

APPENDIX B

"AN ACT CONCERNING THE IMPROVEMENT OF CARDIAC CARE. "



Substitute House Bill No. 6304

Public Act No. 05-167

AN ACT CONCERNING THE IMPROVEMENT OF CARDIAC CARE.

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

Section 1. Section 19a-127l of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(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, 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 section and sections 19a-127m and 19a-127n; and
- (12) Any other issues that the department deems appropriate.

(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.

(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, 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) (1) The advisory committee shall examine and evaluate (A) possible approaches that would aid in the utilization of an existing data collection system for cardiac outcomes, and (B) the potential for state-wide use of a data collection

system for cardiac outcomes, for the purpose of continuing the delivery of quality cardiac care services in the state.

(2) On or before December 1, 2007, the advisory committee shall submit, in accordance with the provisions of section 11-4a, the results of the examination authorized by this subsection, along with any recommendations, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

[(h)] (i) 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.

Approved July 1, 2005

APPENDIX C

***""AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC
HEALTH STATUTES. "***

SECTION 30



Substitute House Bill No. 6713

Public Act No. 05-272

AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES.

Sec. 30. Subdivision (2) of subsection (c) of section 19a-127l of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(2) Said committee shall create a standing subcommittee on best practices. The subcommittee shall (A) 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, and (B) not later than January 1, 2006, review and make recommendations concerning best practices with respect to when breast cancer screening should be conducted using comprehensive ultrasound screening or mammogram examinations. The department shall, at least quarterly, disseminate information regarding quality improvement practices, patient safety issues and preventative strategies to the subcommittee and hospitals.