



REPORT TO THE GENERAL ASSEMBLY

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

JUNE 30, 2012

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Acknowledgments

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**State of Connecticut
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ANNUAL REPORT

JUNE 30, 2012

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 Quality and Safety Branch and, in the Planning Branch, with the Health Care Quality, Statistics, Analysis, and Reporting unit. The Healthcare Associated Infections Advisory Committee was established by separate legislation and its activities are briefly summarized in section V.

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, 2012.

II. QUALITY IN HEALTH CARE ADVISORY COMMITTEE AND SUBCOMMITTEE ACTIVITIES

Advisory Committee

The Quality in Health Care Advisory Committee (QHCAC) held meetings this past year in October 2011 and April 2012. At the October meeting the Commissioner directed that the Committee to review its charge and determine its direction going forward. This will require reviewing related legislation. A synopsis of current year activities and plans for next year is provided below for each of the subcommittees.

Subcommittee on Continuum of Care

The subcommittee was charged with addressing the prevalence of pressure ulcers across the continuum. This is the final report for this particular project.

The Subcommittee's Milford Pressure Ulcer Collaborative Campaign was launched in April of 2009. The campaign was entitled; "Have You Loved Your Skin Today?" The collaborative included Milford Hospital, Golden Hill Nursing Health Care Center, New England Home Care, Home Care Plus, and was expanded to include West River Health Center. The Department of Public Health, Qualidigm, Connecticut Association of Not-for-Profit Providers for the Aging,

Connecticut Association of Home Care and Hospice, Connecticut Hospital Association, and the Connecticut Association of Health Care Facilities also worked together on this project.

This collaborative pilot project had a goal of improving health care outcomes related to skin integrity and pressure ulcers through improved communication across health care settings within the continuum of long term care. The focus of the project had been on preventing the development of pressure ulcers by clearly and quickly communicating the fact that a transferred patient is at risk of developing a pressure ulcer.

The collaborative campaign included:

- 1 education of patients, residents, family members, and staff;
- 2 use of common language related to support surfaces;
- 3 use of common language related to pressure ulcer treatment;
- 4 increased communication and awareness of those deemed “at risk” throughout the continuum; and
- 5 use of national pressure ulcer staging guidelines throughout the continuum.

Campaign tools included an educational brochure for consumers, a variety of posters and the “pressure ulcer risk stamp” that was being used on transfer documents such as the W-10 form.

In September of 2010, Milford Hospital presented incidence and prevalence data for hospital acquired ulcers. The data showed an improvement in all stages, but the incidence of community acquired ulcers (residents entering from outside of the collaborative) showed a continued increase. In discussing this finding, the collaborative agreed that raising public awareness of the issues related to pressure ulcer prevention was needed.

The last phase of the pilot was to analyze data in an effort to measure the success of the program and publish a final report. Qualidigm was consulted on this aspect of the project, but collaborators were unable to finalize the data gathering, being thwarted in this effort by the differences across settings in data collection and documentation instruments.

The positive outcomes from this pilot were:

- Partnerships were formed within the local health care community and a willingness to work together and discuss these issues related to transitions of care was developed and cultivated. This model has since been duplicated for other care transitions projects.
- Awareness and understanding of operations and cultures of other settings was raised, which led to a mutual understanding and improved communications and interactions during the transitions of care.
- The participants all reported that they realized improved outcomes.
- The materials and stamp that were developed can be used by others statewide.

The disappointments of this pilot:

- Inability to design a scientifically based outcome study for the pilot with limited resources. However, all of the materials that were developed and disseminated to patients and families utilized evidence based information and recognized best practices.
- The continuity of the pilot was negatively affected by turnover of key personnel.

Recommendations:

- The material should be made available on the web for other health care professionals and consumers.
- Public awareness of the issues related to pressure ulcer prevention should be raised.

The QHCAC concurred with the subcommittee's recommendations.

Subcommittee on Physician Profiles

The subcommittee's original purpose and topics have all been completed. Due to the small percentage (15-25%) of professionals that renew online, the QHCAC discussed mandating online license renewal for dentists, physicians and nurses. Unfortunately, due to cost implications, that portion of the Department's legislative proposal did not go forward. The Department will become part of the National Council of State Boards of Nursing's NURSYS data system this summer (2012).

At the April 2012 Quality in Health care meeting, there were several suggestions to encourage online license renewal:

- The Department should look into charging an extra fee to renew by mail as opposed to online.
- The Department could go to a biennial licensure.
- eHealth CT could help.
- The Connecticut Medical Society could help.

The QHCAC will not discuss the disbanding of this subcommittee at this time, as it may be helpful in identifying efforts to increase online renewals.

Subcommittee on Regulations

This committee will be maintained in abeyance until needed again.

Subcommittee on Promotion of Quality and Safe Practices

This committee will be maintained in abeyance.

Subcommittee on Best Practices and Adverse Events

The Connecticut Hospital Association and the Connecticut Department of Public Health have partnered to address the emerging issue of infant falls in hospitals, with a focus on newborns. Through the Infant Fall Prevention Work Group, Guidance related to infant falls prevention and management with current practices and resources was provided to hospitals. The following links

detail this information:

http://www.cthosp.org/images/advocacy/2012_CHA_InfantFallsGuidance.pdf

http://www.cthosp.org/images/advocacy/2012_CHA_InfantFallsSummary.pdf

These links appear on the DPH website page for Health Care Quality Reports.

Guidance for patient-owned equipment is also being drafted. The Connecticut Hospital Association will share the initial draft with the Department of Public Health. A third workgroup is addressing violence in the hospital setting—particularly Emergency Department security.

Subcommittee on Cardiac Care Data

This committee will be maintained in abeyance.

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Reporting of Adverse Events

In November 2011 DPH produced its tenth adverse event report, which is available on the DPH website at <http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/adverseeventreportoct2011.pdf>.

Pursuant to P.A. 10-122, *An Act Concerning the Reporting of Adverse Events at Hospitals and Outpatient Surgical Facilities and Access to Information Related to Pending Complaints Filed with the Department of Public Health* (substitute SB 248), facility-level counts, rates, payer or case mix information, and comments from facilities were included for the first time.

The Adverse Event Report System uses a list of events identified by the National Quality Forum, plus a Connecticut-specific list, as allowed by Connecticut General Statutes 19a-127n. The NQF criteria for inclusion are that an event is unambiguous, largely preventable, indicative of a problem in a healthcare setting's safety systems, and important for public accountability.

The NQF document *Serious Reportable Events in Healthcare-2011 Update*¹ added four items, retired three items, and revised definitions and specifications for the remaining 25 items. The updated NQF list includes 29 serious reportable events. Some of these new NQF items closely resemble items on the current Connecticut-specific list of adverse events.

Two retired NQF items, relating to hypoglycemia and kernicterus, remain reportable under the categories of medication management and care management events, respectively. The third retired item, related to spinal manipulation, involves individual behavior rather than facility safety systems. Some definitional changes have the potential to result in an increased number of

¹ http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

reports. For example, in addition to the reporting of stage 3 or 4 pressure ulcers, unstageable pressure ulcers acquired after admission to a healthcare setting are reportable. This harmonizes with the National Pressure Ulcer Advisory Panel’s position and definitions.

New Events:

- (1) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy. “Low-risk refers to a woman aged 18-39, with no previous diagnosis of essential hypertension, renal disease, collagen-vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that poses a high risk of poor pregnancy outcome.”

The corresponding Connecticut-specific event (7C) is “obstetrical events resulting in death or serious disability to the neonate.”

- (2) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.

- (3) Patient death or serious injury from failure to follow up or communicate laboratory, pathology, or radiology test results.

The corresponding Connecticut-specific event (7E) is “Laboratory or radiologic test results not reported to the treating practitioner or reported incorrectly which result in death or serious disability due to incorrect or missed diagnosis in the emergency room.”

- (4) Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

Additional clarifications include:

Revisions: All. Change “serious disability” to “serious injury.”

Surgical or Invasive Procedure Events: Broaden definition to include events outside the OR. Modify definition of end of surgery so that a standard procedure for discovery of foreign object does not create a reporting requirement.

Use of contaminated drugs: Clarify issue of detectability.

Use of device other than as intended: Add failure to properly clean and maintain a device.

Discharge of patients to other than an authorized person: Broaden from infant to any age patient who lacks decision-making capacity.

Attempted suicide: Additional specifications excluding patient on premises but not yet presented for care.

Medication errors: Additional specifications for use of contraindicated medication or failure to observe safe injection practices.

Blood products: Implementation guidance added to operationalize “unsafe.”
Electrical shock, burns, assault: Broaden to include staff injury or death.
Wrong gas: Broaden to include gas not delivered or not delivered as prescribed.
Restraints: Clarify as physical; does not include chemical restraints.
Criminal events: Add “potential” to category title and add implementation guidance.

The Department of Public Health plans to provide a revised list to the Commissioner for approval, and then to issue the revised adverse event list and implementation guidance to reflect the changes made by the NQF.

Quality of Care Information on the DPH Web Site

Descriptions of the activities of the Health Care Quality and Safety Branch are listed through the *Licensing & Certification* link on the home page of the DPH website (www.ct.gov/dph). Annual Adverse Event reports and annual reports to the legislature about the Quality in Health Care Program are posted through the *Statistics & Research* link, under *Health Care Quality*.

IV. PATIENT SAFETY ORGANIZATIONS

Connecticut General Statutes section 19a-127o allowed DPH to designate “Patient Safety Organizations” (PSOs). The primary activity of a PSO is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis or processing of medical or health care related information submitted to the PSO by the health care provider. This “patient safety work product” may include reports, records, analyses, policies, procedures, or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. The PSO will disseminate appropriate information or recommendations on best medical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality of Health Care Advisory Committee, and the public. DPH has designated three PSOs, including the Qualidigm Patient Safety Organization, the Connecticut Hospital Association Patient Safety Organization, and the Ambulatory Surgical Center Patient Safety Organization. The following information covers activities since the June 30, 2011 report.

Qualidigm PSO

The Qualidigm Patient Safety Organization membership continues to include providers from long term care, specialty and behavioral health facilities, and ambulatory surgical centers. This diverse group of health care organizations provides a unique opportunity to acknowledge and address the distinctiveness and commonalities of patient safety issues across settings of care. Patient safety and quality issues in healthcare are of national concern and the solutions need to be evidence-based and easily adaptable to each unique setting. Following the principles of adult

learning, the Qualidigm PSO continues to offer interactive programs with information that can be utilized to meet the participant's unique organizational environments.

In 2011-2012, the Qualidigm PSO offered four full-day educational programs and three half-day programs to its members. Each program had a specific patient safety agenda and targeted practical strategies that could be implemented at each facility.

The three day-long Care Transitions Leadership Academy programs occurred in the winter/spring of 2012. The fourth Academy will take place in late June. These interactive academies were designed to engage the participants in developing practical, usable, and supportable approaches to reduce preventable readmissions from any setting. Also in the winter, Qualidigm provided a half-day workshop on the prevention and control of two very common healthcare-acquired infections: catheter-associated urinary tract infections and surgical site infections. In this workshop, two national experts shared evidence-based best practices related to the prevention and control of these two serious infections as well as surveillance tips and techniques. The Qualidigm PSO continues its active "partnering relationship" with the Connecticut Hospital Association PSO, co-sponsoring the Heart Failure Readmissions Collaboratives and the Annual Patient Safety Summit. Through partnerships with the Connecticut Hospital Association and other healthcare providers, the Qualidigm PSO is able to provide a broader range of resources and activities focused on improving and protecting the safety of patients.

In 2011, Qualidigm also partnered with the Connecticut Department of Public Health to provide an educational session within their day-long training program for the hospital-based infection preventionists. This session reviewed the new Centers for Medicare and Medicaid Services (CMS) mandatory reporting requirements for the hospitals related to Healthcare-Acquired Infections.

An electronic newsletter, the *PSO News Flash*, is distributed to participants on a monthly basis. This newsletter contains information and links to recent patient safety related articles, tools, reminders, and upcoming events. Several of the patient safety links that were disseminated included; educational videos and written materials on heart failure for the licensed and the non-licensed staff, as well as for the heart failure patient and family caregivers; communication tools for healthcare providers to enhance the flow of information to the next level of care; CMS mandatory reporting for all facilities listed in the proposed rules for the upcoming year; and the new Partnership for Patients initiative which is a public-private partnership that will help improve the quality, safety, and affordability of healthcare for all Americans.

As the Qualidigm PSO and its participants grow more comfortable with the PSO concepts and functions, the programs and offerings continue to mature. These activities include more in-depth one-to-one needs assessments with each new PSO member and Qualidigm's quality improvement expert plus the sharing of best practices by the participating organizations.

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

Ambulatory Surgical Centers PSO

The Ambulatory Surgical Centers (ASC) Patient Safety Organization focused on: Hand Hygiene and Infection Control, Integrated Quality Programs, Creating Safer Patient Experiences, Adverse Events and Safe Surgical Checklists. Below is an overview of several of these issues.

As described in the previous Quality of Health Care annual report, the ASC PSO provided in-service training for hand hygiene, developed an observation tool, and in September 2010 began a hand hygiene study, which continues. Facilities have been provided tools to encourage staff compliance. During the past year, the PSO developed and distributed a Spanish and English patient flyer to promote the importance of hand hygiene.

An adverse event initiative developed a study tool to gather data and identify opportunities to implement programs and recommendations to reduce the incidence of specific adverse events. The program will include patient materials, policy recommendations and membership programming by leaders in the field.

Membership meetings provide an opportunity to discuss facility and specialty specific issues, as well as hear speakers on safety topics. Presentations during 2011-12 have included:

- Susan Keane Baker, MHA, “Speed Stuns & 7 Other Techniques for Safer Patient Experiences;”
- Donna Nucci, RNC, BSN, CIC, “Cutting Edge Hand Hygiene Initiatives;”
- Beth Derby, RN, MBA, “The ABCs of an Integrated Quality Program;”
- Louise DeChesser, “A Comprehensive Look at the Surgical Safety Checklist: What Facilities Should Know.”

Industry experts in the areas of Accreditation, Anesthesia Safety, Infection Control and Medication Safety also provided input and answered questions.

PSO contacts were provided personalized packets that include facility-specific data, policy recommendations, and the appropriate tools necessary to implement change within their facilities. Additional facility staff members were encouraged to attend sessions.

The ASC PSO added break-out sessions by specialty at the meetings to create greater opportunity for facility staff members with specific safety concerns to join with a facilitator and note-taker to discuss areas of mutual interest. The PSO is in the process of developing list-serves for each group to generate discussion and feedback on issues of importance in real time.

Membership in the ASC PSO has remained steady with 60 ASCs participating in membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, it provides newsletters, email alerts and patient flyers on patient safety topics.

This year, the ASC PSO created the “Elizabeth B. Bozzuto ASC Patient Safety Award” to honor a facility or staff member that has demonstrated an exemplary commitment to improving patient

safety. Betty Bozzuto was the first recipient of the award this year, and a committee has been established to identify future nominees and recipients.

The ASC PSO is in the process of applying for national PSO listing with the U.S. Department of Health and Human Services, and hopes to have the application completed and under review by the end of the summer.

Connecticut Hospital Association (CHA) PSO

CHA's tenth annual Patient Safety Summit in March marked the official start of a statewide initiative to eliminate preventable harm using high reliability science to create a culture of safety. Integrated with this effort is CHA's work with the American Hospital Association's Health Research & Educational Trust on *Partnership for Patients*, a national CMS initiative designed to reduce preventable inpatient harm by 40 percent and readmissions by 20 percent.

Through CHA's PSO, several other clinical collaboratives united hospitals around key safety objectives, including reducing preventable heart failure readmissions and infection prevention. Over the last two years, hospital teams and community care partners have participated in the *Heart Failure Readmission Collaborative*, a partnership between CHA's PSO and Qualidigm. Connecticut hospitals' readmission work is being broadened to include all-cause readmissions.

The *On the CUSP: Stop CAUTI* program is aimed at reducing catheter-associated urinary tract infections and implementing the comprehensive unit-based safety program (CUSP). This initiative followed the successful implementation of the Stop BSI project which addressed the elimination of central line-associated bloodstream infections.

CHA's Quality Institute offers a broad series of education curricula to provide Connecticut's hospitals with the skills needed to drive quality and patient safety improvements throughout their organizations. Designed for a variety of audiences, from senior leaders to front-line caregivers, Quality Institute programs this year focused on the basics of quality care, quality and patient safety for senior leaders, process improvement tools, and communications tools.

To be effective and useful, reporting systems must clearly explain what aspects of hospital quality and safety are being measured and how consumers can use the information. A section on CHA's website (www.chime.org), *A Patient's Guide to Participating in Quality Hospital Care*, was developed to provide patients and families with the information and tools they need to ensure a high quality, safe hospital experience.

V. HEALTHCARE ASSOCIATED INFECTIONS COMMITTEE

The Healthcare Associated Infections (HAI) Committee, established by legislation, is separate from the Quality in Health Care Advisory Committee. The Connecticut 2011 HAI Hospital-

specific report, available at <http://www.ct.gov/dph/cwp/view.asp?a=3136&q=474086> (or by entering “Health Care Associated Infections” in the Search tool on the DPH website), presents Central-Line Associated Blood Stream Infection rates according to facility.