



REPORT TO THE GENERAL ASSEMBLY

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

JUNE 30, 2013

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ANNUAL REPORT

JUNE 30, 2013

I. INTRODUCTION AND BACKGROUND

Connecticut General Statutes sections 19a-1271-n require 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 with the Health Statistics and Surveillance Section. 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, 2013.

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 2012, April 2013, and June 2013 (by conference call). At the October meeting the Committee discussed the importance of e-licensure and the effects of requiring providers to obtain pediatric vaccines through DPH in most cases. At the April meeting DPH deputy commissioner Lewis asked what types of issues the Committee wanted to address in the future that were important for DPH and received suggestions. A few suggestions related to legislative bills that were awaiting votes. At both meetings proposed changes in data collection for the adverse event report were discussed.

The June advisory committee conference call provided several updates:

- The State Innovation Model Grant (SIM) and the Health Information Technology Exchange (HITE) grant use electronic medical records to measure outcomes in patients who could appropriately receive care outside the hospital.
- Public Act 13-55, enacted May 28, 2013, establishes a palliative care advisory council to advise DPH and to annually report to the DPH Commissioner and Public Health Committee of the legislature, starting no later than January 1, 2015, on matters related to

improving palliative care and the quality of life for people with serious or chronic illnesses. The QHCAC will review future palliative care advisory council recommendations for possible action by a QHCAC subcommittee.

- The Legislative Program Review and Investigation Committee (LPRIC) is conducting a Program Review study of Hospital Emergency Department Use and Its Impact on the State Medicaid Budget. The QHCAC will review the recommendations made by the LPRIC report once it is completed, for possible action by a subcommittee.
- Qualidigm and a coalition with roughly 40 stakeholders are working together to conduct a symposium on September 17th at the Convention Center. The symposium will educate providers and consumers about access to care and engagement with the healthcare system from both the clinical and insurance perspectives.
- Backus Hospital is using an algorithm from the National Health Service (UK) to identify medical errors resulting in near misses for adverse events.
- The CT Pharmacists Association is working with pharmacists to conduct face to face discussions with patients and providing the patients with an updated medication list.
- CHA has been partnering with the March of Dimes to reduce the incidence of preterm elective deliveries.
- The topic of Care Transitions was addressed by the Best Practices and Adverse Events subcommittee in a report to the DPH Commissioner in January 2008.¹ See Appendix A below for quality and patient safety issues addressed by PSOs and facilities in recent years.

Going forward, QCAC subcommittees may be formed around the following topics:

1. Ensuring patients receive services in the proper setting: once the LPRIC report recommendations are available a subcommittee may address those recommendations;
2. Benchmarks for community-based care: a subcommittee may develop benchmarks, based upon those currently available nationally, to make recommendations for community-based care delivery in Connecticut.
3. March of Dimes Early Elective Deliveries: working with the Family Health Section of DPH, community partners, Federally Qualified Health centers (FQHCs) and School Based Health Centers (SBHCs), may develop tools (messages, education for patients and providers) around reduction of elective pre-term deliveries.

Subcommittee on Continuum of Care

The subcommittee has posted information about reducing pressure ulcers on the website. The subcommittee is awaiting a new project assignment from the Committee.

¹ Located at the Health Care Quality page of the DPH website, http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/Transitions_of_Health_Care_and_Health_Care_Handoffs_2008.pdf

Subcommittee on Physician Profiles

This committee will be maintained in abeyance.

Subcommittee on Regulations

This committee will be maintained in abeyance.

Subcommittee on Promotion of Quality and Safe Practices

This committee will be maintained in abeyance.

Subcommittee on Best Practices and Adverse Events

The subcommittee discussed the issue of patient-owned respiratory equipment in hospital settings, and has drafted guidance that may be used by hospitals. The subcommittee has shared information with hospitals and with the WIC and Maternal/Child sections of DPH regarding reduction of infant falls.

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 December 2012 DPH produced its eleventh adverse event report, which is available on the DPH website at <http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/adverseeventreportoct2012.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*, facility-level counts, rates, payer or case mix information, and comments from facilities were included.

The Adverse Event Report System uses a list of events identified by the National Quality Forum (NQF), 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*² 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. The new items are: (1) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy; (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; (4) death or serious injury of a patient associated with the introduction of a metallic object into the MRI area. Two retired NQF items, relating to hypoglycemia and kernicterus, remain reportable under the NQF 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. For more information, see the October 2012 Adverse Event report.

In November 2012 DPH conducted training for facilities about changes to the list of reportable adverse events. In January 2013 DPH began using the new list.

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 allows DPH to designate “Patient Safety Organizations” (PSOs). The primary role 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 in 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, 2012 report.

² http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx

Qualidigm PSO

The Qualidigm Patient Safety Organization (PSO) is comprised of long term acute care and behavioral health facilities, an acute care hospital, and a rehabilitation facility. This diverse group of health care organizations provides a unique opportunity among Connecticut PSOs to acknowledge and address the distinctiveness and commonalities of patient safety issues across settings. The Qualidigm PSO believes that while most safety and quality issues in health care are national concerns, most of the solutions need to be “local”. With that in mind, the Qualidigm PSO continues to offer programs, activities and information that can be adapted to best meet the members’ unique organizational environments.

This year, members of the Qualidigm PSO were invited and encouraged to participate in multiple educational events and webinars. These included three full-day Care Transitions Leadership Academy events, featuring noted speakers, panelists, and interactive activities, and covering the patient safety topics of Hospice Care, Motivational Interviewing, and Medication Reconciliation. PSO members also received invitations to three half-day educational programs co-sponsored with the Connecticut DPH on the Prevention and Control of Healthcare-Acquired Infections (HAIs). These programs focused on building an antibiotic stewardship program, and CMS’s mandatory reporting requirements for specific HAIs in the National Healthcare Safety Network (NHSN). Several webinars related to reducing HAIs were also made available to the PSO members, including NCC CLABSI Validation, Antimicrobial Stewardship, Prevention and Control of *C. difficile*, HAI IQR Update (CMS), Reducing HAIs (CMS), and NHSN Analysis.

The Qualidigm PSO co-sponsored the annual Patient Safety Summit in March with the CHA PSO. The 2013 Patient Safety Summit focused on strategies and tools that drive high reliability organizations. PSO Members also receive e-news “flashes” and updates in their inbox on a monthly basis. The Qualidigm Patient Safety Update is a visual reminder and link to keep members informed of the latest important findings, tools, and government mandates related to patient safety, including: preventing *C. difficile*, CDC materials and toolkits, Medicare payment policies, CMS reporting guidelines, Joint Commission Patient Safety Goals, and AHRQ evidence-based practices and strategies. The Patient Safety Update also contains links to recent patient safety-related articles, reminders and patient safety awareness events.

Ambulatory Surgical Centers PSO

Creating a “Culture of Safety” within ASCs has been the ongoing focus of the ASC PSO in 2012-2013. Its approach has remained consistent, with mandatory meetings for members as well as the introduction of some additional programs and projects this year. The ASC PSO also included a presentation by DPH in its meeting with the opportunity for Q&A by the membership. It was well received and provided a great opportunity to understand the focus of the Department and the concerns of the facilities. The ASC PSO hopes to make this an ongoing aspect of meetings. Below is a summary of activities.

Break Out Sessions and Specialty Focus

Recognizing that different kinds of facilities have different needs and patient safety concerns, the ASC PSO has made breakout sessions a regular component of membership meetings. These sessions give facility staff an opportunity to discuss specific concerns with a facilitator and their peers and keep an on-going checklist of areas of interest. These discussions help to guide program development and planning.

At the same time, the PSO has developed specialty-specific group emails for safety discussion purposes and is in the process of developing a web based tool for membership discussion across the continuum and within specific specialty areas.

Site Visit Program

The site visit program kicked off this year with a web based survey to identify patient safety areas of concerns within facilities. Ten facilities were then selected to participate in the first module of actual site visits. Two nationally credentialed surveyors are visiting each facility for a comprehensive review, using the generally applied expectations of various accrediting bodies. The Medicare Physical Plant requirements, however, are not part of the site visit program.

Although educational in nature, the information gleaned from the visits will help the PSO identify good educational programming opportunities. The results of the visits will be presented at the September/October PSO meeting along with policy and procedure recommendations.

Hand Hygiene

With the assistance of a Certified Infection Control (CIC) specialist, the PSO had developed an on-going study in 2012 on hand hygiene compliance among facilities. In-service training was provided to each facility to ensure effective observation and reporting. An observation tool was developed, based on CDC guidelines, and reporting continued throughout the year. Observation anonymity was encouraged in order to effectively gauge compliance at the facility level.

The Hand Hygiene (HH) study results were compiled into a dataset that maintained confidentiality but allowed for benchmarking within each specialty and across the full spectrum of ASCs in Connecticut. As part of the program, facilities were provided a variety of tools to encourage staff compliance. The campaign “Healthcare is a Hands on Business...So make sure YOURS ARE CLEAN” included posters, pledge materials and an innovative HH compliance improvement grid that provided monthly intervention tools, an action checklist, and encouraged quality committee reporting. The PSO developed and distributed a Spanish and English patient flyer to promote the importance of hand hygiene among the patient population.

The PSO is continuing with this project and adjusting the reporting requirements from monthly to twice a year.

Adverse Events

This study dovetails with the state’s Adverse Event Data Reporting program, but takes a more in-depth look at the kinds of events that have occurred in ASCs. The PSO expects to use this data to identify opportunities to implement programs and recommendations to reduce the incidence of

specific adverse events. As always, the program will include patient materials, policy recommendations and membership programming by leaders in the field.

ASC Patient Safety Award

The PSO again awarded 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 and Dotti Murphy from St. Francis GI was the 2013 award recipient. The ASC PSO will continue to accept nominations for future nominees and recipients.

Conclusion

Membership in the ASC PSO has remained steady with 62 ASCs actively participating in membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, it also provides newsletters, email alerts and patient flyers on important patient safety topics. The PSO will continue with its “Culture of Safety” programming and expects to focus on Advance Directives in the coming months.

Finally, the PSO has completed the application for national PSO listing with HHS and it is currently under review by the agency.

Connecticut Hospital Association (CHA) PSO

Central to the mission of every hospital is a dedication to providing high quality, safe care for all. Through CHA, hospitals are working collaboratively to share, learn, and apply nationally recognized, evidence-based practices to achieve the highest standards of quality and safety.

This year, Connecticut hospitals set themselves apart by leading the nation with an ambitious statewide initiative to eliminate all-cause preventable harm using high reliability science to create a culture of safety. All acute care hospitals are participating in CHA’s statewide initiative to eliminate harm. Twenty-four of CHA’s 28 hospitals also committed to the “high reliability journey.” To date, nearly 2,000 hospital staff, leaders, and physicians have been trained in high reliability science and behaviors. The high reliability process reduces the number of serious safety events by reducing human errors and improving system reliability. Through extensive training and hands-on interactive workshops, hospital leaders are developing skills and learning to use practical tools that will enable them to create a culture of safety and fix systemic problems that lead to patient harm, decreasing events of preventable harm.

At CHA’s 11th annual Patient Safety Summit in March 2013, Mark Chassin, MD, FACP, MPP, MPH, President of The Joint Commission, discussed the importance of hospitals becoming high reliability organizations. “High reliability is not a project,” he said. “Tough and complex problems require targeted interventions directed to the specific cause.”

Through the High Reliability Safety Culture Collaborative, hospitals came together to study common causes of serious safety events and develop and implement behavior-based error

prevention strategies and evidence-based leadership methods for performance reliability. In the months ahead, several hundred hospital staff members will be certified in train-the-trainer sessions, enabling them to build and strengthen their hospitals' safety cultures by spreading the use of these skills and tools throughout each organization.

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 web page for the HAI Program on the DPH website is at <http://www.ct.gov/dph/cwp/view.asp?a=3136&q=417318>

Appendix A: Discussion Topics and Activities related to Quality of Health Care from 2010-2012 DPH Reports on Quality in Health Care Program and Adverse Events³

- Patient Safety, Preventable Harm: Partnership for Patients
- Care Transitions: preventable readmissions, heart failure readmissions collaborative, communication handoffs, Culture of Safety: communication openness
- Healthcare Acquired Infections: CAUTI, Surgical Site Infections, On the CUSP: Stop CAUTI, Stop BSI, C. difficile, Multi-drug resistant organisms, Hand Hygiene
- Fall prevention, Infant “drops”
- Pressure ulcers
- Safe Surgical Checklists, National Surgical Quality Improvement Project
- Anesthesia Safety
- Safe Injection Practices
- Violence in the healthcare setting
- Equipment Safety, Patient owned equipment
- Influenza vaccination of employees, decrease the impact of seasonal flu
- National Database of Nursing Quality Indicators
- Medication errors: smart technology, CPOE with decision support
- Ventilator associated pneumonia
- Reduce perforations during colonoscopy
- Patient and Family Advisory Board: care partner visitor program, patient and family initiated medical emergency response team.
- Blood clots (VTE)
- ED wait times
- Preventive care: cancer screening, eye exams, good lifestyle choices

³ http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388090&dphNav_GID=1601&dphPNavCtr=#Gen