CONNECTICUT
Public Health

Report to the General Assembly

QUALITY IN HEALTH CARE PROGRAM

Adverse Event Reporting

General Statutes of Connecticut
Section 19a-127l-n
Events Reported for Year 2023

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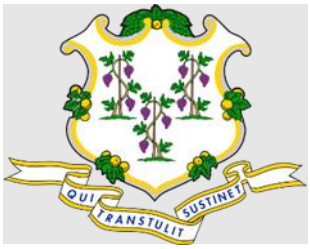

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State of Connecticut Department of Public Health
Legislative Report to the General Assembly Adverse Event Reporting
Adverse Event Reporting
2023
Quality of Health Care Program

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EXECUTIVE SUMMARY

Adverse event reporting by hospitals and ambulatory care facilities to the Department of Public Health is required under CGS 19a-127n. The purpose of this report is to inform the legislature of the trends in adverse events in healthcare facilities and to increase hospital transparency and accountability to healthcare quality and safety. The number of adverse events reports in 2023 were 454. These events were reported by Connecticut healthcare facilities that accounted for over 2 million inpatient days annually, in addition to outpatient visits.

The most common adverse event reported this year was stage 3-4 or unstageable pressure ulcers acquired after admission to a healthcare facility, accounting for 49% of reports this year. Following this was falls resulting in serious disability or death, making up 22% of reports. Hospitals reported increased cases of wrong or no gas delivered to a patient, making up 7% of reports, while retained foreign objects after surgery dropped to the fourth most common event, at 4% of this yearly report.

Following an adverse event, facilities must submit an adverse event report including a corrective action plan. From this report, the department determines whether or not to initiate an investigation.

ADVERSE EVENT DATA

Demographic information based on reported adverse events is provided in Appendix A for 2023. Several factors may influence the report of an adverse event. These factors include varying rates of adverse events across facilities, patient case mix, quality of care, number of patients served, knowledge or interpretation of event definitions and reporting requirements, changes made to event definitions, additions to or deletions from the list of reportable events, willingness to report them, as well as the effectiveness of the institutional system to convey information from the event participants to the designated reporter, and other factors.[1] Consequently, clear conclusions about the causes of observed event fluctuations and differences across facilities cannot be derived simply from the number of reports or fluctuations in the number of reports.[2]

Appendix B presents the number of adverse events reported by year for 2013 through 2023, according to the lists of National Quality Forum events (1A-7D). As of 2017, there are no longer Connecticut-specific events.

Appendix C shows the leading reports by type for 2023. The most common adverse events reported this year were stage 3-4 or unstageable pressure ulcers, falls resulting in serious disability or death, and cases of wrong or no gas delivered to a patient.

Adverse event counts, patient days, and rate by facility and event type are shown in Appendices D-F. These represent, respectively, Acute Care Hospitals (E), Fertility Centers and Childbirth Centers (E-part 2) Ambulatory Surgical Centers and Pain Medicine Centers (E-Part2), Chronic Disease Hospitals and Hospice, and Hospitals for Mentally Ill Persons (E-Part 3).[3] Not all adverse event categories are relevant to all facilities. For example, events associated with birth are not applicable in a facility that does not handle pregnancy, labor, and deliveries. Additionally, patient populations differ considerably between types of facilities, which impacts the event counts in each facility.

For Acute Care and Chronic Care Hospitals, the calculated rates are based on adverse events that occurred in the emergency department, inpatient, or an outpatient setting (in the numerator), but only inpatient days are used for the denominator of the rate. Inpatient days are used because outpatient days could not be reliably obtained from the acute care database. Many of the choices for “Location of Event” (Appendix A) could be either inpatient or outpatient.

Significant variation in facility reporting patterns is a common characteristic of passive surveillance systems (where the responsibility for reporting falls upon the health care provider) and this is not unique to Connecticut’s adverse events reporting system. A passive surveillance system "has the advantage of being simple and not burdensome" to administer, however "it is limited by variability and incompleteness in reporting."[4] Typically, data validation is a function of an active surveillance strategy that can be used to increase the completeness of reporting, as is being done in the separate Connecticut Healthcare Associated Infections program (HAI). However, data validation is often labor intensive and expensive, which requires dedicated resources. Without such validation, it cannot be determined how complete facility reporting is. High reporting rates to DPH in this report may reflect highly complete reporting in a facility with good quality of care, or perhaps modestly complete reporting in a facility with poor care, or neither better nor worse quality care, as noted earlier. In addition, retained objects are often discovered from prior surgeries at other facilities.

Adverse Events Reported in 2023

The number of adverse events reports (n=454) in 2023 was 2% lower than 2022. These events were reported by Connecticut healthcare facilities that accounted for over 2 million inpatient days in 2023, in addition to outpatient visits. Acute care hospitals including children’s hospitals submitted 396 (88%) of the 454 adverse event reports in 2023; chronic disease hospitals, 30; hospitals for the mentally ill, 20; and outpatient surgical facilities (if not owned by a hospital), 8. Forty-six percent (46%) of reported adverse events occurred in males and 54% in females. The majority of reports concerned patients 60 years of age and older. The most common location of occurrence was reported to be the hospital adult medical ward (Appendix A).

A substantial portion of reports did not indicate race or ethnicity. Race was missing for 38% and ethnicity was missing for 36%. Of the reports that recorded race, the most common were white (46%) and black (9%). Hispanic ethnicity was recorded in 9% of reports where ethnicity was stated.

As shown in Appendix C, the most reported events in 2023 were pressure ulcers. Two hundred twenty-one (221) pressure ulcers comprised 49% of all 454 adverse events reported. The second most reported events were falls resulting in death or serious injury, with 101 reports (22%). Incidents which systems designated for oxygen or other gas to be delivered to a patient, or the wrong gas given was reported 33 times (7%). Retention of a foreign object in a patient after surgery or other procedure followed and patient suicide, attempted suicide or self-harm were both reported 18 times (4%). The next most reported event, at 12 instances (2.5%), was surgery performed on the wrong site.

CURRENT ACTIVITIES

During healthcare inspections, DPH activities include, but are not limited to, a review of medical records to ensure that care has been provided in accordance with applicable state and federal laws and regulations as well as standards of care. Not only are inpatient medical records reviewed but closed medical records are as well. Such review includes compliance with the requirements of adverse event reporting and compliance with applicable state and federal laws and regulations.

Investigation of Adverse Events

Adverse events need to be reported when they occur within a facility as well as provide the Department with a corrective action in accordance with the Connecticut Adverse Event reporting law (CGS 19a-127n).

An external investigation at a healthcare facility due to an adverse event may begin in several ways: (1) as a result of a complaint to DPH made by any person;[5] (2) following a sentinel event report by the facility to the Joint Commission, a complaint to the Joint Commission by any person,[6] or an unannounced, onsite visit to a facility by the Joint Commission during which an adverse event becomes known; or (3) as a consequence of an adverse event report sent by the healthcare facility to DPH. The last of these routes is discussed here.

The department conducts investigations regarding adverse event reports that may indicate a systems issue, or problems related to inadequate standards of care. These investigations determine regulatory compliance versus noncompliance and provide additional information that may allow one to distinguish between events that have been due to a medical error or system failure and those that have not. All investigations follow the same inspection process regardless of the origin or type of complaint, adverse event or routine certification survey. Information is gathered through onsite inspection and observation, review of clinical records, review of the institution's policies and procedures, interviews with staff and vested parties as appropriate. The results of completed investigations are public and may be obtained through eLicensing or by request, under the Freedom of Information (FOI) Act.

CONCLUSION

Pursuant to CGS 19a-127n, DPH collects annual adverse event data from healthcare facilities. This report covers the data from January 1, 2023, through December 31, 2023. Adverse event reports enable the department to ensure that Connecticut hospitals and other healthcare facilities remain committed to patient safety. This is evident in the comments submitted by facilities (Appendix G).

Following an adverse event, facilities must submit a report that includes a corrective action plan. Data sharing on adverse event trends enables the department and legislature to identify areas of improvement in facilities across the state.

Appendix A.
Demographic Data from Adverse Event Reports in the Electronic Database
Connecticut 2023

Measure	Frequency	Percent
Facility Type (n=454)		
Acute Care or Children's Hospital	396	87.2%
Chronic Disease Hospital	30	6.6%
Hospital for Mentally Ill Persons	20	4.4%
Outpatient Surgical Facility and Other[1]	8	1.8%
Patient Gender (n=454)		
Male	210	46.3%
Female	244	53.7%
Patient Age (n=454)		
0-14	8	1.8%
15-29	27	5.9%
30-44	37	8.1%
45-59	69	15.2%
60-74	161	35.5%
75-89	132	29.1%
90-104	20	4.4%
Location of Event (n=454)		
Adult Medical	138	30.4%
Adult Surgical	28	6.2%
Ambulatory Surgical	6	1.3%
Cardiac Care	39	8.6%
Cardiac Cath Lab	1	0.2%
Diagnostic Services	5	1.1%
Emergency Department	44	9.7%
Medical Intensive Care	50	11.0%
Obstetrical/Gynecological	4	0.9%
Operating Room	21	4.6%
Other	49	10.8%
Outpatient Services	10	2.2%
Pediatrics	1	0.2%
Psychiatric	41	9.0%
Rehabilitative Services	1	0.2%
Surgical Intensive Care Unit	16	3.5%

1 Includes ambulatory surgical centers not owned by a hospital, pain medicine, Fertility Clinics and Freestanding birthing center.

Appendix A. Continued
Demographic Data from Adverse Event Reports in the Electronic Database
Connecticut 2023

Measure	Frequency	Percent
Inpatient/Outpatient (n=454)		
Inpatient	401	88.3%
Outpatient	53	11.7%
Admission Type (n=454)		
Ambulatory Surgical Center	8	1.8%
Hospital Based	440	96.9%
Off Campus Satellite Site	6	1.3%
Patient Race (n=454)		
BLANK	174	38.3%
American Indian or Alaska Native	1	0.2%
Asian	4	0.9%
Black or African American	42	9.3%
Other	24	5.3%
White	209	46.0%
Patient Ethnicity (n=454)		
BLANK	161	35.5%
Hispanic or Latino	40	8.8%
Not Hispanic or Latino	242	53.3%
Other	11	2.4%
Spoken Language (n=454)		
BLANK	162	35.7%
Chinese, Mandarin	1	0.2%
English	275	60.6%
Other Language	4	0.9%
Russian	1	0.2%
Spanish	11	2.4%
English Proficiency (n=454)		
Not at All	1	0.2%
Not Well	8	1.8%
Well	63	13.9%
Very Well	89	19.6%
Unknown	293	64.5%
Interpreter Used? (n=454)		
No	439	96.7%
Yes	15	3.3%
Patient Expired (n=454)		
No	430	94.7%
Yes	24	5.3%

Frequency and percent reflect only the non-missing values

Appendix B. Counts of Adverse Event Codes 2013-2023

Event Codes	Description	Number of Reports										
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
NQF 1A	Surgery performed on the wrong site	13	15	13	18	10	11	17	14	17	10	12
NQF 1B	Surgery performed on the wrong patient	1	0	1	1	0	0	1	1	2	1	0
NQF 1C	Wrong surgical procedure performed on a patient	1	4	1	6	3	7	5	7	13	6	4
NQF 1D	Retention of a foreign object in a patient after surgery or other procedure	25	24	19	20	17	28	23	12	22	20	18
NQF 1E	Intraoperative or immediate postoperative/ post procedure death in an ASA class I patient	0	1	1	1	1	0	0	0	0	0	0
NQF 2A	Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting	0	3	0	1	1	2	1	1	1	0	2
NQF 2B	Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended	3	2	5	1	1	0	2	1	2	1	2
NQF 2C	Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting	0	0	1	0	2	1	3	0	3	1	0
NQF 3A	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	0	0	1	2	0	1	3	3	9	6	4
NQF 3B	Patient death or serious injury associated with patient elopement (disappearance)	1	0	0	0	0	0	0	1	1	2	1
NQF 3C	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	5	0	3	5	3	4	7	14	9	18	18
NQF 4A	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	6	1	7	7	4	3	6	10	10	7	10
NQF 4B	Patient death or serious injury associated with unsafe administration of blood products	0	0	0	0	0	0	0	0	0	0	0
NQF 4C	Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting	2	0	1	3	0	1	1	1	0	2	1
NQF 4D	Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	1	4	5	2	1	0	2	1	5	3	2

Appendix B Continued -Counts of Adverse Event Codes 2013-2023

Event Codes	Description	Number of Reports										
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	90	78	90	74	84	106	101	84	102	106	101
NQF 4F	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	277	245	230	186	208	194	206	221	228	241	221
NQF 4G	Artificial insemination with the wrong donor sperm or wrong egg	0	0	0	0	0	0	0	1	0	0	0
NQF 4H	Death or serious injury resulting from irretrievable loss of an irreplaceable biological specimen	3	0	0	0	0	1	1	0	0	0	0
NQF 4I	Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results	2	0	3	2	0	4	2	2	2	2	3
NQF 5A	Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting	0	0	0	0	0	0	0	0	0	0	0
NQF 5B	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	1	0	0	0	0	0	8	8	10	19	33
NQF 5C	Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting	0	1	0	4	8	2	4	2	2	2	1
NQF 5D	Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting	1	0	2	0	1	1	2	1	0	2	2
NQF 6A	Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.	0	0	0	0	0	0	0	0	0	0	0
NQF 7A	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	2	1	0	0	0	0	0	0	0	0	0
NQF 7B	Abduction of a patient/resident of any age	1	0	0	0	0	1	0	0	0	0	0

Appendix B Continued -Counts of Adverse Event Codes 2013-2023

Event Codes	Description	Number of Reports										
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
NQF 7C	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	4	9	10	24	5	5	4	4	12	9	11
NQF 7D	Death or serious injury of a patient or staff member resulting from a physical assault (i.e. Battery) that occurs within or on the grounds of a healthcare setting	3	1	0	2	2	4	5	7	5	7	8
Total Reports		442	389	393	359	351	376	404	396	455	465	454

Appendix C. Connecticut Adverse Events in 2023
Most Frequently Reported Events NQF List (1A-7D)

Event	Description	Frequency	Percent of All Events
NQF 4F	Any Stage 3, Stage 4, or unstageable pressure ulcer acquired after admission/ presentation to a healthcare setting	221	48.7%
NQF 4E	Patient death or serious injury associated with a fall while being cared for in a healthcare setting	101	22.2%
NQF 5B	Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances	33	7.3%
NQF 1D	Retention of a foreign object in a patient after surgery or other procedure	18	4.0%
NQF 3C	Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting	18	4.0%
NQF 1A	Surgery performed on the wrong site	12	2.6%
NQF 7C	Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting	11	2.4%
NQF 4A	Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	10	2.2%
NQF 7D	Death or serious injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare setting	8	1.8%
NQF 1C	Wrong surgical procedure performed on a patient	4	0.9%
NQF 3A	Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person	4	0.9%
All other reported adverse events		14	3.1%
Total		**454**	100.0%

Appendix D. Adverse Event Reports by Event Type
By Facility Type Connecticut, 2023.

Facility	1A	1B	1C	1D	1E	2A	2B	2C	3A	3B	3C	4A	4B	4C	4D	4E	4F	4G	4H	4I	5A	5B	5C	5D	6A	7A	7B	7C	7D	Total
Acute Care Hospitals	9		3	17			2		4	1	13	6		1	1	85	215			3		18	1	2				10	5	396
Chronic Disease Hospitals						2						3				5	5					15								30
Mental Health Hospitals											5					10	1											1	3	20
Fertility Childbirth Centers															1															1
Ambulatory Surgery Centers	3		1	1								1				1														7
Totals	12	0	4	18	0	2	2	0	4	1	18	10	0	1	2	101	221	0	0	3	0	33	1	2	0	0	0	11	8	454

Appendix E. Adverse Event Reports and Rates per 100,000 Inpatient Days by Facility
Acute Care Hospitals. Connecticut, 2023

Hospital	Reports Total	Patient Days 2023	Rate per 100,000 Pt. Days*
William W. Backus Hospital	14	117841	11.9
Bridgeport Hospital[1]	24	194602	12.3
Bristol Hospital	1	52193	1.9
Connecticut Children's Medical Center	5	101584	4.9
Danbury and New Milford Hospitals	12	160832	7.5
Day Kimball Healthcare	5	30922	16.2
John Dempsey Hospital	18	96068	18.7
Greenwich Hospital	15	81243	18.5
Griffin Hospital	3	57469	5.2
Hartford Hospital	24	344230	7.0
Charlotte Hungerford Hospital	12	60161	19.9
Hospital of Central Connecticut	18	157290	11.4
Johnson Memorial Hospital	8	25451	31.4
Lawrence and Memorial Hospital	17	129747	13.1
Manchester Memorial Hospital	7	74799	9.4
Middlesex Hospital	0	116690	0.0
MidState Medical Center	3	83024	3.6
Norwalk Hospital	13	78815	16.5
Rockville General Hospital		17437	0.0
Saint Francis Hospital	37	157616	23.5
Saint Mary's Hospital	4	79287	5.0
Saint Vincent's Medical Center	16	143054	11.2
Sharon Hospital	1	18833	5.3
Stamford Hospital	19	128545	14.8
Waterbury Hospital	7	83367	8.4
Windham Community Memorial Hospital	5	36714	13.6
Yale-New Haven Hospital	108	636658	17.0
All Acute Care Hospitals	396	3,264,472	12.1

*** Inpatient days are used for rate calculation**

Appendix E. Continued. Adverse Event Reports and Rates per 100,000 Inpatient Days by Facility Chronic Disease Hospitals and Hospice. Connecticut, 2023*

Facility	Reports Total	Patient Days 2023	Rate per 100,000 Pt. Days*
The Connecticut Hospice[1]	0	3,542	0.0
Gaylord Hospital	10	40,756	24.5
The Hospital for Special Care	19	81,018	23.5
Mount Sinai Rehabilitation Hospital	1	10,538	9.5
All Chronic Disease Hospitals	30	135,854	22.1

***Inpatient days are used for rate calculation**

Appendix E. Continued. Adverse Event Reports and Rates per 100,000 Inpatient Days by Facility Hospitals for Mentally Ill Persons. Connecticut, 2023*

Facility	Reports Total	Patient Days 2023	Rate per 100,000 Pt. Days*
Hebrew Home and Hospital	4	10,369	38.6
Masonicare Behavioral Health	3	14,702	20.4
Natchaug Hospital	2	17,972	11.1
Silver Hill Hospital	1	10,112	9.9
Whiting Forensic Hospital	10	76,796	13.0
All Hospitals for Mentally Ill Persons	20	129,951	15.4

***Inpatient days are used for rate calculation**

Appendix E. Continued. Adverse Event Reports and Rates, Fertility Centers and Childbirth Centers. Connecticut, 2023. *

Facility	Location	Reports	Patient Visits	Per 100,000 Pt Visits Rate
FERTILITY				
Center for Advanced Reproductive Services[2]	Farmington	0	1,300	0.0
New England Fertility Institute[1]	Stamford	0	250	0.0
Reproductive Medicine Associates of Connecticut[2]	Norwalk	0	2,040	0.0
Fertility Totals		0	3,590	0.0
CHILDBIRTH				
Connecticut Childbirth & Women's Center[2]	Danbury	1	156	641.0
Childbirth Totals		1	156	641.0

[1] 2014 patient visits data [2] 2021 patient visits data

Appendix E. Continued. Adverse Event Reports and Rate per 100,000 Visits Ambulatory Surgical Centers and Pain Medicine Centers. Connecticut, 2023. *

Facility	Location	Reports	Patient Visits	Per 100,000 Rate
Aesthetic Surgery Center	New Haven	0	410	0.0
Bloomfield ASC (formerly Dr. Felice's Youthful Images)	Bloomfield	1	6,858	14.6
Central Connecticut Endoscopy Center[1]	Plainville	0	8,543	0.0
Coastal Digestive Care Center	New London	0	6,844	0.0
Connecticut Eye Surgery Center South[2]	Milford	0	5,074	0.0
Connecticut Foot Surgery Center (Milford Surgery-CT Ortho Surgery Center)	Milford	0	2,132	0.0
Connecticut GI Endoscopy	Bloomfield	0	9,195	0.0
Connecticut Orthopaedic[1]	Hamden	0	4,056	0.0
Connecticut Surgery[3]	Hartford	1	4,743	21.1
Constitution Eye Surgery Center East	Waterford	0	8,523	0.0
Danbury Surgical Center	Danbury	1	8,852	11.3
Diagnostic Endoscopy	Stamford	0	11,267	0.0
Digestive Disease Associates Endoscopy Suite	Branford	0	3,794	0.0
Eastern Connecticut Endoscopy Center	Norwich	0	6,227	0.0
Endoscopy Center of Connecticut	Guilford/Hamden	0	8,429	0.0
Endoscopy Center of Fairfield, The	Fairfield	0	13,681	0.0
Endoscopy Center of Northwest Connecticut	Torrington	0	4,815	0.0
Evergreen Endoscopy Center	South Windsor	0	8,429	0.0
Eye Surgery Center, The	Bloomfield	0	1,216	0.0
Fairfield Surgery Center	Fairfield	0	1,748	0.0
Glastonbury Endoscopy Center, LLC	Glastonbury	0	9,372	0.0
Glastonbury Surgery Center	Glastonbury	0	3,783	0.0
Guilford Surgery Ctr	Guilford	0	2,373	0.0
Hartford Surgical Center	Hartford	1	3,136	31.9
Laser and Vision Surgery Center[4]	Manchester	0	1,966	0.0
Lighthouse Surgery Center	Hartford	0	5,918	0.0
Litchfield Hills Surgery Center	Torrington	0	1,385	0.0
Middlesex Endoscopy Center	Middletown	0	7,430	0.0
Middlesex Center for Advanced Orthopedic Surgery	Middletown	0	3,411	0.0
NEMG Gastroenterology	Trumbull	0	5,385	0.0
New Vision Cataract Center	Norwalk	0	2,561	0.0
North East Alliance Surgery Center	Hamden	0	2,357	0.0
North Haven Surgery/Pain Medicine Center	North Haven	0	3,540	0.0
Norwalk Surgery Center	Norwalk	0	1,971	0.0
Orthopaedic & Neurosurgery Center of Greenwich (Stamford ASC)	Greenwich	0	5,452	0.0
Orthopedic Associates Surgery Center	Rocky Hill	0	9,718	0.0
Ortho Specialty Surgery Center	Danbury	0	2,830	0.0

Appendix E. Continued. Adverse Event Reports by Event Type and Rates per 100,000 Visits Ambulatory Surgical Centers and Pain Medicine Centers. Connecticut, 2023. *

Facility	Location	Reports	Patient Visits	Per 100,000 Rate
River Valley Ambul Surg/Connecticut Surgical Arts	Norwich	0	4,308	0.0
Rocky Hill Surgery Center	Rocky Hill	1	5,833	17.1
Sasco Hill Surgery Center	Southport	1	885	113.0
Saint Francis GI Endoscopy	Windsor	0	7,497	0.0
Shoreline Colonoscopy Suites[1]	Old Saybrook	0	674	0.0
Shoreline Surgery Center[5]	Guilford	0	7,794	0.0
Southington Surgery Center	Southington	0	3,030	0.0
Southwest CT Surgery Center	Wilton	0	2,145	0.0
Specialty Surgery Center[3]	Stamford	0	1,914	0.0
Split Rock Surgical Associates[5]	Wilton	0	227	0.0
Surgery Center of Fairfield County	Bridgeport	0	4,678	0.0
Surgical Center of CT-CT Hand	Bridgeport	0	1,703	0.0
Wallingford Surgery Center (Endoscopy)[1]	Wallingford	0	6,931	0.0
Waterbury Outpatient Surgical Center (Refocus)	Waterbury	0	1,295	0.0
Waterbury Surgery Center	Waterbury	0	7,373	0.0
Western CT Ortho Surgical Ctr	Danbury	1	4,130	24.2
Wilton Surgery Center	Wilton	0	6,897	0.0
Yale University Health Services ASC[2]	New Haven	0	1,504	0.0
All Facilities		7	266,242	2.6

Appendix E. Continued. Adverse Event Reports by Event Type and Rates per 100,000 Inpatient Days Hospitals for Mentally Ill Persons. Connecticut, 2023. *

Facility	Reports Total	Patient Days 2023*	Rate per 100,000 Pt. Days
Hebrew Home and Hospital	4	10,369	38.6
Masonicare Behavioral Health	3	14,702	20.4
Natchaug Hospital	2	17,972	11.1
Silver Hill Hospital	1	10,112	9.9
Whiting Forensic Hospital	10	76,796	13.0
All Hospitals for Mentally Ill Persons	20	129,951	15.4

***Inpatient days are used for rate calculation**

Appendix F. Primary Payer (%) of Inpatient Hospital Bills
Acute Care Hospitals. Connecticut, CY 2023

Hospital	Self-Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
William W. Backus Hospital	2.5	17.58	31.59	22.9	25.41
Bridgeport Hospital	7.42	17.67	30.7	18.4	25.82
Bristol Hospital	3.01	16.42	32.51	20.09	27.98
Connecticut Children's Medical Center	1.24	0.18	62.55	34.9	1.13
Danbury and New Milford Hospitals	3.88	25.67	21.54	28.14	20.77
Day Kimball Healthcare	1.75	17.62	30.63	26.35	23.65
John Dempsey Hospital	1.7	18.58	27.52	32.24	19.97
Greenwich Hospital	12.72	25.86	8.91	41.12	11.37
Griffin Hospital	3.12	15.67	30.04	24.19	26.97
Hartford Hospital	3.14	18.23	29.03	21.68	27.94
Charlotte Hungerford Hospital	2.44	20.56	31.33	21.39	24.27
Hospital of Central Connecticut	3.19	16.2	38.23	18.35	24.03
Johnson Memorial Hospital	2.49	15.58	26.44	24.22	31.26
Lawrence and Memorial Hospital	6.23	19.3	27.35	20.11	27
Manchester Memorial Hospital	2.62	14.42	34.54	24.96	23.46
Middlesex Hospital	1.85	20.26	21.91	31.21	24.77
MidState Medical Center	3.25	18.17	28.6	22.23	27.75
Norwalk Hospital	5.76	26.43	25.73	24.99	17.09
Rockville General Hospital	3.76	10.37	38.07	27.14	20.66
Saint Francis Hospital	2.77	16.32	33.98	17.31	29.63
Saint Mary's Hospital	5.16	13.5	45.47	14.29	21.59
Saint Vincent's Medical Center	5.52	17.21	34.05	19.65	23.56
Sharon Hospital	3.23	33.44	8.79	34.46	20.07
Stamford Hospital	6.43	22.94	27.97	28.94	13.73
Waterbury Hospital	2.46	20.65	37.36	17.83	21.69
Windham Community Memorial Hospital	4.06	13.08	37.74	21.65	23.47
Yale-New Haven Hospital	7.27	16.99	32.31	19.76	23.67
Total	2.6%	42.4%	25.2%	18.2%	11.6%

Appendix F. Continued. Case Mix or Primary Payer (%) of Bills
Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Outpatient Childbirth Centers. Connecticut, CY 2023

Facility	Self-Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
Connecticut Childbirth & Women's Center[1]	5.0		31.0	64.0	
Aesthetic Surg Center	85.0			15.0	
Bloomfield ASC (formerly Dr Felice Youth Images)	0.3	54.6	7.4	32.0	5.4
Center for Advanced Reproductive Services[2]	20.0			80.0	
Central Connecticut Endoscopy Center[1]	1.0	23.0	9.0	64.0	3.0
Coastal Digestive Care Center	1.0	13.0	12.0	27.0	47.0
Connecticut Eye Surgery Center South[3]	0.4	50.8	3.9	30.4	14.0
Connecticut Foot Surgery Center (Milford)	1.0	10.0	2.0	58.0	29.0
Conn GI Endoscopy	1.0	8.0	6.0	84.0	1.0
Conn Orthopedic [1]		15.6	1.0	38.3	43.8
Conn Surgery [2]	2.0	13.0	7.0	75.0	3.0
Constitution Eye Surgery Center, East	0.4	56.0	3.0	33.7	6.9
Danbury Surgical Center	2.0	31.0	2.0	23.0	43.0
Diagnostic Endoscopy	0.5	14.0		85.4	0.1
Digestive Dis Endosc (100% gastro)		36.0	4.0	29.0	31.0
Eastern Ct Endoscopy	1.0	34.0	17.0	46.0	0.0
Endoscopy Center of Ct	0.6	28.0	8.6	63.2	0.2
Endoscopy, Fairfield (100% gastro)	0.2	11.7		83.3	4.6
Endoscopy, Northwest	1.0	12.0	12.0	23.0	52.0
Evergreen Endoscopy	1.0	8.0	11.0	32.0	48.0
Eye Surgery Center	1.0	46.0	2.0	46.0	5.0
Fairfield Surgery	10.0	19.0	1.0	70.0	
Glastonbury Endoscopy	1.0	7.0	6.0	86.0	
Glastonbury Surgery	0.1	32.6	5.8	61.5	
Guilford Surgery Center	2.0	33.0	2.4	60.6	1.3
Hartford Surgical	0.2	25.1	17.6	57.1	
Laser and Vision Surg[4]	1.0	58.0	4.0	29.0	8.0
Lighthouse Surgery	0.1	32.0	6.0	56.0	6.0
Litchfield Hills Surgery	0.2	22.0	0.7	52.0	25.0
Middlesex Endoscopy		27.1	7.9	65.0	
Middlesex Orthopedic	0.2	24.9	2.6	63.4	8.9
NEMG Gastro	0.3	31.3	4.8	30.8	32.9
New England Fertility[5]	80.0			20.0	
New Vision Cataract	7.0	71.0	8.0	10.0	4.0
North East Alliance Surgery Center	14.3	42.0	5.2	31.9	6.7
North Haven Surgery	0.3	17.1	20.3	60.5	2.3
Norwalk Surgery	17.0	23.0	10.0	50.0	
Orthopedic Neurosurg (Stamford ASC)		29.0		67.0	4.0

Appendix F. Continued. Case Mix or Primary Payer (%) of Bills
Ambulatory Surgical Centers, Pain Medicine Centers, Fertility Centers, and Outpatient Childbirth Centers. Connecticut, CY 2023

Facility	Self-Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
Orthopedic Associates		20.9	3.1	76.0	
Ortho Specialty Surgery Center	6.0	21.0	2.0	40.0	31.0
Reproductive Medicine[2]	25.0			75.0	
River Valley/Ct Surg Arts	3.0	29.0	9.0	53.0	6.0
Rocky Hill Surgery Center	0.2	77.0	3.8	18.9	0.1
Sasco Hill Surgery Center	23.0	29.0	13.0	22.0	13.0
St Francis GI Endosc	0.1	17.2	16.9	65.9	
Shoreline Colonoscopy[2]		22.0	3.0	75.0	
Southington Surgery	0.3	11.2	4.7	49.6	34.2
Shoreline Surgery[6]		28.8	1.7	69.3	0.1
Southwest CT Surgery Center	0.3	33.2	6.8	55.0	4.7
Specialty Surgery Ctr[2]	2.0	16.0	1.0	79.0	2.0
Split Rock Surgical[6]	92.5			7.4	
Surg Center Fairfield	8.0	32.0	5.2	21.6	33.5
Surg Center-Ct Hand	1.0	17.0	2.0	22.0	58.0
Wallingford Surgery Center[1]	1.0	7.0	17.0	73.0	2.0
Waterbury Outpatient (Refocus)	1.0	68.0	9.0	10.0	12.0
Waterbury Surgery Center	2.0	15.0	10.0	68.0	5.0
Western CT Ortho Surg		30.0	1.0	64.0	5.0
Wilton Surgery	1.0	46.0	5.0	17.0	31.0
Yale Health Services[1]					100.0

Appendix F. Continued. Case Mix or Primary Payer (%) of Bills
Chronic Disease Hospitals and Hospice. Connecticut, CY 2023

Facility	Self-Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
The Connecticut Hospice[1]		83.8	4.8	10.5	0.8
Gaylord Hospital	0.2	43.6	12.0	37.0	7.1
The Hospital for Special Care		8.4	81.2	10.4	
Mount Sinai Rehabilitation Hospital		62.2	21.7	15.0	1.1

Appendix F. Continued. Case Mix or Primary Payer (%) of Bills Hospitals for Mentally Ill Persons. Connecticut, CY 2023

Facility	Self Pay	Medicare	Medicaid	Blue Cross & Commercial	Other
Hebrew Home and Hospital	1.5	57.9	6.3	33.5	1.0
Masonicare Behavioral Health		77.1		22.8	
Natchaug Hospital	0.0	16.1	33.4	23.5	26.9
Silver Hill Hospital	83.0	8.0	0.0	0.0	9.0
Whiting Forensic Hospital					100*

***2022 Data**

Appendix G: Comments Submitted by Facilities

In accordance with legislation, facilities that are required to report adverse events to DPH may submit comments to the department for inclusion in the annual report to the legislature. Submitting comments is optional, not required. DPH encourages comments describing how a facility used data to measure or track adverse events or quality of care and measurably improve care or decrease adverse events.

Facilities providing comments:

- CT Behavioral Health Hospital of Hebrew Senior Care
- Hospital for Special Care
- Middlesex Health
- Nuvance Health System
- UCONN Health John Dempsey Hospital

CT Behavioral Health Hospital of Hebrew Senior Care

The CT Behavioral Health Hospital of Hebrew Senior Care takes great pride in our ongoing efforts to keep our patients safe and to reduce harm. Ensuring patient safety and dignity is embedded in all patient interventions. A comprehensive review of our “Restraint and Seclusion Policy” and of our “Fall Prevention Policy” was completed in 2023.

Interdisciplinary staff completed additional training to remain current regarding these policies that are a key component of our patient safety initiatives. Clinical staff participated in targeted de-escalation training that highlighted interventions that can be used to reduce the need for restraint and/or seclusion. In addition, clinical staff participated in a review of fall prevention strategies to reduce harm.
In 2023, the CT Behavioral Health Hospital of Hebrew Senior Care reported four adverse events related to a fall with injury. Our hospital is dedicated to reducing harm and is proud of our ongoing efforts to do so.

Hospital for Special Care

Patient safety comes first at Hospital for Special Care (HFSC). We are a High Reliability Organization and committed to continuing to transparently identify areas of opportunity to provide the safest care for all of our patients.

In 2023, we achieved a 25% reduction in wound adverse events compared to 2022. HFSC healed 75% of the wounds that were present at the time of a patient's admission to our facility by the time the patient was discharged. Those wounds were acquired in other care settings or at home. HFSC met or exceeded the CMS Quality Reporting program national benchmarks for Long Term Acute Care Hospitals for hospital acquired infections and falls with major injury.

Adverse event falls with injury were reduced by 42% in 2023 compared to 2022. In 2024, HFSC has initiated Apparent Cause Analysis, inclusive of the front-line care team, on every unassisted patient fall to better understand the contributing factors and to implement counterstrategies to further prevent falls from occurring. There are several unusual patterns in event reporting for HFSC in 2023 that warrant explanation. Some HFSC patients were afflicted by an international product contamination, which was investigated collaboratively with state and federal infectious disease experts. Our collaboration ultimately contributed to a break in the investigation which led to the national recall of the contaminated product. It is extremely unfortunate that HFSC patients were impacted by this situation. However, it is important to note that HFSC in no way contributed to the product contamination or knowingly administered any products which were contaminated.

Secondly, HFSC, like many hospitals in the state of CT, had a realized increase in reported adverse events in the NQF5B category as a result of a focused effort educating staff on the requirements of the adverse event. This event is one of a few which are required to be reported regardless of patient impact. As HFSC staff were educated on this event type, transparent reporting ensued across the organization. There were no patients harmed as a result of these events and continued vigilance has resulted in no further concerns. The hospital implemented a validation process for all oxygen hook up to ensure seamless and effective treatment 100% of the time.

Our patient population includes individuals living with complex and chronic medical conditions, as well as unique patient populations impacted by autism and neurobehavioral challenges. Our care environment balances patient safety with individual autonomy and choice. We provide extensive clinical education and support to ensure each patient has the resources they need to make informed decisions about their health care and activities and understand the impact of their choices on skin health, wound risk, falls, peer interactions and other associated issues.

Middlesex Hospital

The employees, physicians, and leaders of Middlesex Health are dedicated to providing the safest, highest - quality care and the best possible experience to the community we serve. It is our mission and the reason we exist as a health care system. There is no issue more important to us than the safety of our patients, visitors and staff. The science behind the concept of High Reliability is proven to decrease human and systems errors and eliminate preventable harm. To that end, Middlesex made the decision to become one of the first in a group of Connecticut Hospitals to collaborate through the Connecticut Hospital Association to learn and implement the tools and techniques of High Reliability.

Our work began in 2013 with the training of 100% of our employees and medical staff who, once trained, began to implement the mandatory use of a standardized set of tools in their daily work, patient care, and communication with each other. This was the beginning of a transformational change which is now constant and widely accepted as the way we do business: all of us, every day, in every situation, and with every patient. In this transformation to zero harm we remained committed to decrease the number of serious safety events and have decreased that number by over 90% with sustainment. One specific example of the work we have done to improve and sustain outcomes is related to the prevention of patient falls. The following extensive actions have been sustained and maximized to improve our identification of those patients at risk for falling and target actions specific to the individual patient to prevent the chance of a fall: the use of a validated fall risk assessment tools; leveraging the sophisticated bed sensors and alarms to alert staff of a specific patient attempt to get out of bed; patient and family engagement in how to assist us in preventing falls through visual signage and ongoing education; and performing a causative factor investigation and review for every fall. In addition, a deep dive analysis tool was created with the intent to better understand contributing fall factors for post fall analysis.

As a result, these efforts have reduced our overall rate of falls with serious injury to 0% for CY 2023 with 0 reportable fall adverse events. We believe this excellent achievement correlates with excellent processes of care to reduce fall adverse events. Our transformation to becoming harm-free is a long term and ongoing process. We continue to collaborate with other hospitals and organizations to learn and implement new way of improving reliability, care, and outcomes. Again, it is our mission and, as such, will always be the top priority.

Finally, to anyone who has been affected by an adverse event while a patient at Middlesex Health, to their family members and loved ones, we sincerely apologize for any impact of such an event, and assure you that we strive to learn as much as we can from any event in order to do our best to prevent it from happening again.

Nuvance Health System

As part of Nuvance Health System, Danbury, New Milford, Norwalk and Sharon Hospitals strive to improve the health of every person served through the efficient delivery of excellent, innovative and compassionate care. While each hospital has local leadership to ensure a keen eye on local community needs, collaboration at all levels across the system occurs to ensure delivery of the highest quality of care.

All hospitals are engaged and committed to a robust Quality and Patient Safety Plan with an emphasis on diverse community needs, improvement, learning, transparency, honesty and ethical behavior. We better serve our patients by overcoming barriers, pivoting with efficiency and staying open-minded.

Nuvance Health hospitals are actively engaged in local and statewide initiatives to deliver safe care to our communities. Danbury, New Milford, Norwalk and Sharon Hospitals are members of the Connecticut Hospital Association's Patient Safety Organization and actively participate in the statewide high reliability collaborative to reduce patient harm across the state. We continue to recognize and review every adverse event for lessons learned to hardwire interventions to permanently reduce preventable harm to zero.

Some of the patient safety initiatives we have implemented to improve the quality and safety of the of our patients include the following:

Safety Event Review Team (SERT): Standardized approach to review and categorize safety events utilizing the HPI/Press Ganey safety event review process. This allows us to identify pre-cursor safety events and serious safety events in a timely and standardized manner. The process enables us to monitor for trends in event types, frequency, and severity of events as well as our individual entity and systemwide serious safety event rate (SSER).

HEDI for Safety: All events that are reviewed during our SERT process are also reviewed through the HEDI lens. An algorithm is utilized and if opportunities are recognized related to health equity, diversity or inclusion causes, actions are put in place to address.

CHAMP for SAFETY Safety Coaches: Unit based safety coaches are front line staff who are trained in the principles of high reliability and the safety habits and behaviors that should be utilized to keep our patients safe. They act as peer influencers in their departments and units to encourage safe behavior and as champions for our patient safety initiatives.

SBARs for System Wide Learning: Written SBARs are generated and disseminated across the system following events of harm or potentially catastrophic events where systemwide implications are identified. This heightens awareness, increases transparency and aids in immediate enterprise-wide safety plan for our patients.

Just Culture: All people managers are required to attend an interactive 4 hour Just Culture workshop where they are trained in the principles of Just Culture and application of the Just Culture algorithm utilizing real life scenarios. Additionally, all staff are required to view a 10-minute video during mandatory annual training related to Just Culture so there is a clear understanding of how they will be treated when errors occur.

BRAVO, Safety Stars: Great catch program where employees are recognized and celebrated for practicing high reliability safety behaviors in high-risk situations that allows us to make great catches and keep our patients safe.

PACT (Provider Associate Care Team): Peer to peer support program that supports our front line when they are impacted by trauma related to medical error, workplace violence, unanticipated outcomes, burnout, and moral distress.

We are proud of our efforts to outperform established national standards to meet the needs of our community. We believe in our community and take very seriously the trust it places in our healthcare system.

UCONN Health John Dempsey Hospital

UConn Health is committed to providing the highest level of quality care to our patients, the citizens of the state of Connecticut, and the communities we serve. We take tremendous pride in focusing on the safety of patients, visitors and staff. When an Adverse Event occurs, we use the tools that the Connecticut Hospital Association recommended to thoroughly investigate the event, performing either a Root Cause Analysis or Apparent Cause Analysis with a multidisciplinary team within our organization. We work to determine any potential individual or system errors that may have contributed to an adverse event that we can mitigate to prevent the event from reoccurring in the future.

In addition to the High Reliability tools and education that is provided to all of our staff, we have demonstrated our commitment to improve patient safety and quality at UConn Health in new and expanded ways:

Carechex Award by Quantros: UConn Health has been recognized as being within the top 10% in the nation for Patient Safety in Overall Medical Care through the CareChex ratings based on a comprehensive risk-adjustment methodology and does not include any self-reported data.

Women's Choice Award for Patient Safety: UConn John Dempsey Hospital has been named one of America's 2024 Best Hospitals for Patient Safety. The award signifies that John Dempsey Hospital is in the top 5% of 4,728 U.S. hospitals for patient safety in safe surgery practices and lower rates for complications and infections.

7 Consecutive "A" Leapfrog Safety Grade Rating: As of the Spring 2024 release of Hospital Safety Grades from The Leapfrog Group UConn Health has earned straight A's in patient safety and this is its seventh consecutive top A rating in patient safety.

Wound Care and Hyperbaric Medicine: UConn Health is now home to a specialized outpatient wound care and hyperbaric medicine treatment center. It is one of only a few dedicated wound centers in Connecticut offering critical access to multidisciplinary wound care services and specialists all in one place.

Bone Marrow Transplant Unit: UConn Health's Carole and Ray Neag Comprehensive Cancer Center is now offering blood and marrow transplants to patients in need. The unit's specialized hematologists-oncologists and skilled oncology nurses are providing patients comprehensive care including access to necessary special labs and tests, and psychosocial, palliative, dietary, and physical therapy support resources.

Falls Prevention Initiative: Beginning in 2023, UConn Health has been advancing our consistent fall prevention efforts with new interventions such as initiating regular leadership rounds, incorporation of new equipment, enhancing fall prevention workflows in the electronic medical record, developing competencies, and launching best practice campaigns.

HRO Forward initiative: In the pursuit of advancing and improving upon UConn Health's continued dedication to High Reliability principles and patient safety, we have entered in a statewide collaborative initiative through the Connecticut Hospital Association, known as HRO Forward.

This has involved a focus on the four domains of the Institute for Healthcare Improvement's National Action Plan,

- Culture, Leadership, and Governance
- Workforce Safety
- Patient and Family Engagement
- Learning System

UConn Health remains committed to patient safety, quality, and proactive adverse event mitigation. According to Becker's Hospital Review, UConn John Dempsey Hospital was the only Connecticut hospital to be highly recommended by patients. At UConn Health we are dedicated to continuous quality improvement across all of our service areas in order to best serve the patients of the state of Connecticut.