



REPORT TO THE GENERAL ASSEMBLY

ON THE QUALITY IN HEALTH CARE PROGRAM

JUNE 30, 2017

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**State of Connecticut
Department of Public Health**

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On the Quality in Health Care Program

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ANNUAL REPORT

JUNE 30, 2017

I. INTRODUCTION AND BACKGROUND

Connecticut General Statutes sections 19a-127 l through n require the Department of Public Health (DPH) to establish a Quality in Health Care (QHC) 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 hospitals. An advisory committee, chaired by the DPH commissioner or designee, advises the program. Committee activities appear in section II.

The health care quality performance measurement and reporting requirement is met and superseded by the federal Centers for Medicare & Medicaid Services (CMS) [Hospital Compare reporting](#). The 2009 QHC annual report announced that hospital performance comparisons reports were not required annually and had been discontinued. Prior to that time DPH was reporting the 10 original CMS measures and had no resources to expand. CMS was reporting 40 measures in 2009 and has expanded since that time both in measures and facilities included.

Responsibility for the quality in care program within DPH lies with the Health Care Quality and Safety Branch and with the Health Statistics and Surveillance Section. DPH activities appear in section III. Patient Safety Organization activities, established by CGS 19a-127o, are summarized in section IV. The Healthcare Associated Infections Advisory Committee was established by separate legislation and its activities are briefly summarized in section V. The Connecticut Partnership for Patient Safety is described in section VI.

In compliance with the reporting requirement in the statute, the current report describes the activities of the quality in care program over the past year, as of June 30, 2017.

II. QUALITY IN HEALTH CARE ADVISORY COMMITTEE, SUBCOMMITTEES, AND RELATED ACTIVITIES

Advisory Committee

The QCAC held meetings in October 2016 and April 2017. Meeting minutes are on the [DPH website](#).

Recommendations were made to the Commissioner by a DPH/hospital work group to change some of the adverse event measures and retire some measures that are no longer useful for quality improvement. These recommendations were accepted. Starting January 2017, the two Connecticut-specific categories are no longer reportable to DPH. Clarifying guidance was also introduced to reduce the number of unsubstantiated sexual abuse reports going forward.

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Reporting of Adverse Events

In October 2016 DPH produced its annual adverse event [report](#). 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), 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.

In May 2017 the Department of Public Health introduced a web-based adverse events reporting system. The shift to the new electronic system allows for easier data mining as well as more timely data submission.

Quality of Care Information on the DPH Web Site

Annual Adverse Event reports and annual reports about the Quality in Health Care Program, both of which are sent to the Legislature, 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". The primary role of a Patient Safety Organization (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 four PSOs: the Qualidigm Patient Safety Organization, the Connecticut Hospital Association Patient Safety Organization, the Ambulatory Surgical Center

Patient Safety Organization, and the QA to QI Patient Safety Organization.¹ The following information, which was provided by the PSOs, covers activities since the June 30, 2016 report.

Qualidigm PSO

During the 2016-2017 year, the Qualidigm PSO engaged providers from a diverse group of long term care, acute care, behavioral health, and rehabilitation hospitals, providing assistance in identifying needs and implementing effective solutions to improve their patient safety practices. The PSO continues to represent a wide group of patient care settings, and approaches this diverse group by focusing on the common issues shared by the facilities while simultaneously addressing the distinctive patient safety concerns in each facility. The programs, activities, and information that the Qualidigm PSO has offered this year are summarized below.

Educational Events

Qualidigm PSO members were invited to attend numerous educational events and webinars sponsored by Qualidigm during the 2016-2017 year. One of these was a full-day Care Transitions Leadership Academy educational event, *The Impact of Social Determinants of Health and Sharing Community Best Practices to Support the Behavioral Health Population*, with expert panel presentations on the social determinants of health, home health practices for behavioral health, nursing home best practices for behavioral health, and the integration of behavioral health into primary care. The Care Transitions Leadership Academy is an educational series that Qualidigm developed under contract with the Centers for Medicare and Medicaid Services for providers to improve the coordination across the continuum of care and ultimately decrease preventable hospital readmissions in the State of Connecticut.

PSO members were also invited to attend the *Better Health Conference* in June 2017 at the CT Convention Center, which offered noted speakers and experts on engaging patients and coordinating care, motivational interviewing, planning for end-of-life care, the opioid epidemic, antibiotic stewardship, care management solutions, population health, health information, and young adults in recovery.

PSO member facilities also participated in a series of regional webinars hosted by the New England Quality Improvement Network/Quality Improvement Organization on the following topics:

- *Bridging the Divide: An Inpatient Psychiatric Hospital's Approach; best practices from Butler Hospital (6/16)*
- *A Holistic Approach for Safe Transitions (9/16)*

¹ The organization's website at <https://www.qatoqi.com> states "QA to QI comes from dialogue with physician leaders on the Quality Improvement Model for clinical peer review in contrast with the prevailing dysfunctional Quality Assurance Model." Thus QA stands for Quality Assurance and QI stands for Quality Improvement.

- *The New England Journey: Enhancing Patient Safety (9/16)*
- *How to use the Value Based Purchasing Calculation Tool (11/16)*
- *Inpatient Psychiatric Facility Forum (9/16)*
- *Shot from the Heart: Describing the Immunization Cycle (1/17)*
- *Crossing the Medication Safety Chasm (1/17)*
- *Achieving the Triple Aim for a Triple Challenge: Defining Geriatric Syndromes (1/17)*
- *Breaking the Back of the Beast: Targeting Sepsis (1/17)*
- *Antibiotic Stewardship Across the Continuum (3/17)*
- *Antibiotic Stewardship: Strategies for Implementation (3/17)*

Patient Safety Summit

This year, the 2017 Connecticut Hospital Association (CHA) Patient Safety Summit, co-sponsored by Qualidigm, was promoted to all of the Qualidigm PSO members. The summit, held at CHA, continues CHA and Qualidigm's successful statewide initiative to eliminate all-cause preventable harm by using evidence-based methods to create a culture of safety. This year's summit offered multiple sessions and perspectives on reducing patient harm in the hospital setting. The summit included a keynote presentation by Tiffany Christensen, Patient Advocate and author, on Partnering with Patients. Rana Lee Adawai Awdish, MD, Director of the Pulmonary Hypertension Program at Wayne University School of Medicine, presented a session on Creating a Culture of Caring, and several patients shared their stories of experiencing harm in the hospital.

PSO Newsletter and Resource Center

The Qualidigm PSO members receive a quarterly newsletter full of current news, up-to-date research, articles, tools, and government mandates related to patient safety. The e-newsletter is distributed to the members in a handy quarterly format, and this content keeps our membership informed about the most current resources and tools offered by the Joint Commission, AHRQ, National Quality Safety, NPSF, and other national patient safety leaders.

It is our hope that these newsletters, which represent a robust compilation of resources in every issue, are not only read by our members, but also filed as resources to quickly and easily find topics that will help quality managers and patient safety staff members in their decisions and programmatic choices. The editors continue to stay abreast of current news and concerns, and to regularly report these and other topics in each issue. Selected topics covered by the newsletter this year have included:

- Hospital Improvement Innovation Networks and CT Hospitals
- Medication Safety
- U.S. News Hospital Ranking System
- Foundations for Safe, Quality Transitions of Care

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Developing a patient safety culture
- Zika Virus response plan
- Adverse events
- Workplace violence / safety resources
- Leadership's role in patient safety
- Patient Safety Awareness Week
- Trigger Tools
- Diagnostic Errors
- Patient Centered Care
- Top patient safety concerns

Adverse Reporting Resource Book

The PSO has distributed an updated copy of the *Adverse Reporting Resource* book. The book was originally created as a “go to book” for adverse event reporting for our PSO members, and includes the Connecticut Department of Health adverse event reporting forms, definitions of mandatory adverse events reporting requirements, and other helpful information for adverse reporting.

Technical Assistance

The Qualidigm PSO has intentionally positioned itself as a resource to its member agencies, and several of these agencies have called upon the PSO for assistance with potential adverse event submission to the Connecticut Department of Public Health.

Connecticut Hospital Association (CHA) PSO

Connecticut hospitals are leaders in high reliability – a patient safety movement that continues to gain momentum. This year, CHA facilitated the adoption of high reliability across the continuum of care and in other states; collaborations are in place with the New Jersey Hospital Association and the Hospital Association of Rhode Island. Additionally, the high reliability movement broadened to include worker safety. The new initiative will use high reliability principles and practices designed to keep healthcare workers safe. CHA in partnership with American Hospital Association (AHA), has continued its participation in the national patient safety movement, the Hospital Improvement Innovation Network, aimed at eliminating Hospital-Acquired Conditions and readmissions. The initiative builds on the work already done through the Centers for Medicare & Medicaid Services Partnership for Patients initiative. In addition to the high reliability programming, the PSO meets regularly to advance quality and patient safety through peer-to-peer learning sessions and the adoption of best practices. In partnership with

Qualidigm, the PSO hosts an annual Patient Safety Summit to convene safety champions to advance knowledge and support innovation. The focus of this year's event was engaging patients and families, patient activation, and incorporating the voice of the patient. Since the Summit, CHA has established a statewide patient family advisory council to assist in the identification of strategies to advance clinical excellence and patient care delivery.

Ambulatory Surgical Center PSO

The Ambulatory Surgical Center Patient Safety Organization (ASCPSO) remained focused on creating and maintaining an Environment and Culture of Safety within the state's Ambulatory Surgery Centers this year. Mandatory meetings as well as the introduction of some new programs and projects kept our approach consistent and focused.

In 2016, our topics for educational programming included:

- High Reliability Organizations
- Service Animals within ASCs
- Quality Reporting
- Med Safety
- Surgical Attire
- Safe Injection Practices

We kicked off our programming with an incredible presentation on High Reliability Organizations. Steve Kreiser from Healthcare Performance Improvement (HPI) walked the membership through what High Reliability is and why it is needed in healthcare. He outlined the five principles of high reliability and how they can be applied to the healthcare environment to reduce harm by using lessons from other industries. A critical take away for the membership included the specific actions leaders, staff and physicians can take to build and sustain a culture of safety and reliability.

The issue of service animals in the ambulatory surgical center (ASC) setting was another topic of discussion this year. The membership participated in a terrific program in which Amanda Gunthel outlined the issues, included the Americans with Disabilities Act (ADA) requirements and the needed policy standards to ensure safety within the ASC setting. Members were armed with all of the tools necessary to ensure patient and staff safety and compliance with regulatory standards.

The PSO also looked at Quality Measures in 2016. Gina Throneberry, RN, MBA, CASC, CNOR provided an extensive update to the membership on the new required measures and the public aspect of reporting. Ensuring patients have access to accurate information remained an important element of the discussion. The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) was a key component of the program.

Additional presentations focused on providing guidance and recommendations on Infection Control, including the implications of surgical attire as well as Safe Medication Management.

Following each educational program, members are armed with the necessary tools to implement key recommended changes within their facilities. This information is reinforced in our member newsletters as well.

Awards

Last year, the ASCPSO established the Louise DeChesser Shining Star Award in honor of Louise's longstanding commitment to patient safety. The award recognizes an innovator, teacher and leader that emulates the mission of our organization. Already, we had established the Elizabeth B. Bozzuto Patient Safety Award to recognize an outstanding leader who fosters an environment of safety and leads by example. The selection committee welcomed nominations and was pleased to recognize two well-respected individuals this year.

The Louise DeChesser 2016 Shining Star Award was presented to Joanie Darling.

Louise, also known as Lou, inspired us all with her passion for patient care and purpose driven work ethic. When she left this world she left behind a tremendous legacy.

Following in Louise's footsteps, and under her leadership, Lou's spirit is best epitomized in Joanie Darling RN. Joanie serves as Operating Room Chief of Nursing at Middlesex Center for Advanced Orthopedic Surgery (MCAOS). Joanie has always stood out as a kind and caring dedicated nurse and is always finding ways to make things happen and advocating for her patients.

Louise mentored Joanie on a daily basis and contributed to her professional growth. What was a great, dedicated staff nurse soon became a strong leader and manager under Lou's tutelage. Despite the significantly increased workload and responsibility, Joanie continued her passion for clinical excellence and care at the OR bedside. She is often mentioned by name in our patient surveys. During hurricanes, storms and power outages, Joanie is always at work making a difference and setting an example for staff. Lou's passion for nursing, purpose and people are on display every day of the week through Joanie's commitment and dedication.

The 2016 Elizabeth B. Bozzuto Patient Safety Award was presented to Amanda Gunthel.

Amanda has, over the course of many years, nurtured and grown the Wilton Surgery Center (WSC) into the busy, successful multi-specialty ASC that it is today.

While running the center with an unceasing attention to detail, she never fails to prioritize what is right for the patient. She will not hesitate to personally call a patient who has had a cause for concern. WSC has a strong culture of patient safety as a result of her strong leadership.

She has shepherded WSC through the addition of multiple surgical specialties, and she consistently recruits and retains top-level nursing and administrative staff. Although she is extremely busy, she maintains an open door policy for all staff, which reinforces the staff's commitment to both the center and their patients.

At the state level, Amanda is a leader in the industry providing guidance, direction and leadership to ensure the highest possible standards are met and established.

Break Out Sessions

Recognizing that different kinds of facilities have different needs and patient safety concerns, we continue to foster discussion and an exchange of ideas within our membership through facilitated breakout sessions that have become a regular component of our membership meetings. These sessions give facility staff an opportunity to discuss specific concerns with a facilitator and their peers and keep a checklist of areas of interest. The discussions also help to guide our program development and planning as well.

At the same time, we have developed specialty specific group emails for safety discussion purposes and have developed a blog area on our website for membership discussion across the continuum and within specific specialty areas.

Posters, Flyers and Newsletters

Patient materials remain a key element of our educational content. Materials were developed on hand washing and the flu vaccine and provided to the membership. Rape crisis information, in both English and Spanish was provided to centers in conjunction with the Rape Crisis Center.

Creative posters were developed to encourage patients and providers to get the flu vaccine, encouraging 100% compliance within each facility. A patient flyer was developed and cross-promoted with the Department of Public Health that provided important information, with input from the Centers for Disease Control and Prevention (CDC), on the importance of the flu vaccine and steps that can help prevent the spread of illness.

Newsletters are developed periodically and distributed to the membership that provide additional information and resources on topics identified in our programming and during breakout sessions.

Quarterly Meetings with DPH

Maintaining open channels of communication with the Department of Public Health has remained a focus of the ASCPSO. Quarterly meetings provide a good opportunity for discussion about issues and points of focus. Topics for educational programming are often identified within these discussions and help to focus on patient safety efforts.

Adverse Events

This study dovetails 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. We expect to use these data to identify opportunities for improvement. As always, the improvement efforts will include patient materials, policy recommendations and membership programming by leaders in the field.

ASC PSO Conclusion

Membership in the ASC PSO has remained steady with 61 ASCs actively participating in our mandatory membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, we also provide newsletters, email alerts and patient flyers on important patient safety topics. We will continue with our "Culture of Safety" programming and expect to focus on Life Safety Code Changes, facility visits, and possibly providing educational content through the addition of webinars on key topics and other initiatives.

QA to QI PSO

QA to QI Patient Safety Organization has continued its work at the national level to identify and remove barriers to the attainment of high reliability in quality and safety in healthcare. This includes raising awareness of the intimate connection of this issue to clinical peer review practices.

Dr. Marc Edwards has two manuscripts under review for publication derived from an eight-year follow up of clinical peer review practices in a cohort of 457 U.S. hospitals. Clinical peer review is the primary method by which adverse events are analyzed and the process has not otherwise been well-studied.

The primary report from the 2016 study, "In Pursuit of Quality and Safety: an Eight-Year Study of Clinical Peer Review Best Practices in U.S. Hospitals", provides normative data on the goals of clinical peer review and their relationship to program effectiveness. It also further refines the best practice model and related program self-assessment inventory, and quantifies the interval progress towards best practice adoption from 2007 to 2015.

The other manuscript, "An Assessment of the Impact of Just Culture on Quality and Safety in U.S. Hospitals", combines data from the Longitudinal Clinical Peer Review Practices Study with publically-reported data from the Hospital Compare and Agency for Healthcare Research and Quality (AHRQ) Survey of Patient Safety Culture databases to determine the extent to which large scale adoption of Just Culture eliminated the culture of blame or the reluctance to report which it targeted. The data suggests that, even though individual organizations believe they obtained benefit, in aggregate Just Culture *per se* is neither necessary nor sufficient to achieve these aims.

V. HEALTHCARE ASSOCIATED INFECTIONS (HAI) COMMITTEE AND PROGRAM

The DPH HAI Program and the state HAI Advisory Committee are summarized here since they represent an important dimension of healthcare quality improvement efforts in Connecticut.

Advisory Committee

The Healthcare Associated Infections (HAI) Committee, established by CGS 19a-490 n through o, is separate from the Quality in Health Care Advisory Committee.

The Connecticut HAI Advisory Committee focuses primarily on policy changes affecting healthcare associated infections, on public reporting as mandated by CGS 19a-490 n through o. The group advises the department with respect to the development, implementation, operation and monitoring of a mandatory reporting system for healthcare associated infections, and to identify, evaluate and recommend to the department appropriate standardized measures, including aggregate and facility-specific reporting measures for healthcare associated infections, and processes designed to prevent healthcare associated infections in hospital settings and any other healthcare settings deemed appropriate by the committee. The group also discusses ways to collaborate with multidisciplinary local and regional partners, as well as to identify specific HAI prevention targets consistent with Health and Human Services (HHS) and CMS priorities.

The Committee provides technical advice to the DPH Healthcare Associated Infections Program for HAI surveillance including advice on medical care, epidemiology, statistics, infectious diseases etc. It also advises the department on the education and training about healthcare associated infections and prevention of healthcare associated infections to applicable persons and healthcare disciplines.

DPH Healthcare Associated Infection (HAI) Program

The DPH HAI Program aims to eliminate the preventable fraction of HAIs across the spectrum of healthcare settings through high quality HAI surveillance, dissemination of best practices for prevention, and communication with providers and the public. The HAI program is in the Infectious Disease Section, PHI Branch, distinct from healthcare facility inspections and regulation. The 2017 DPH HAI [Progress Report](#), is based on 2015 data and provides an update to previous reports detailing progress toward the ultimate goal of eliminating HAIs. The DPH HAI Progress Report consists of state summaries of six HAI types. The report helps measure progress toward the HAI prevention goals outlined in the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination (HAI Action Plan) set by the US Department of Health and Human Services (HHS). Progress is measured using the standardized infection ratio (SIR), a summary statistic that can be used to track HAI prevention progress over

time. Previous reports included facility-specific and unit level data from CT acute care hospitals, long term acute care hospitals, and inpatient rehabilitation facilities. For the first time, this report includes cumulative data from CT outpatient dialysis facilities on bloodstream infection (BSI), and local access site infection (LASI).

The CT DPH HAI Program received funding from the Centers for Disease Control and Prevention (CDC) as part of a three-year nationwide program (2015-2018) to reduce healthcare associated infections (HAIs). With this cooperative agreement, CT DPH established the Infection Control Assessment and Response (ICAR) team to assist CT health care facilities (HCF) in reducing the number of HAIs by assessing their infection prevention programs, providing educational resources, and sharing best practices identified in HCF throughout the state. The ICAR team bolsters infection control practice and competency across the healthcare spectrum using on-site assessments, trainings, and evaluations of existing capacities and policies. In CT, the HAI ICAR team has assessed a variety of patient care settings including acute care hospitals, long term acute care hospitals, outpatient hemodialysis centers, and long term care (nursing home) facilities.

Serious antibiotic resistant bacteria, such as Carbapenem-resistant Enterobacteriaceae (CRE) are an important target for infection prevention, due to their ease of spread and high mortality. In 2014 Connecticut made CRE a laboratory reportable condition. However, it has been recognized both in Connecticut and nationally that this case definition is complex, and potentially difficult for laboratories to implement. Accordingly, in June 2015, the Council for State and Territorial Epidemiologists (CSTE), an organization representing state public health epidemiologists, adopted a new CRE case definition and recommended it for state reporting. The Centers for Disease Control concurred with this recommendation, and Connecticut has adopted this change to reporting for Connecticut beginning January 1, 2016. The purpose of the change in definition was to: Provide comparable measures of CRE both within and across public health jurisdictions to facilitate reporting of CRE data to professional audiences, policy makers, and the public; and to establish actionable epidemiology for healthcare facilities about CRE detection and response.

VI. CONNECTICUT PARTNERSHIP FOR PATIENT SAFETY

The Connecticut Partnership for Patient Safety identified and prioritized public reporting of patient safety outcomes in CT hospitals and health care service locations. Various reporting web-based sites including CDC, Consumer Reports, Leapfrog and the state of CT DPH were assessed for accuracy, ease of use, readability and patient-friendly information for patients, their families, and the general public. Following our assessment, the board believes no one site meets the criteria for ease of use, readability and concise patient information and the board designed an online framework for public information.

Unfortunately, we were unable to raise funds for the effort and on April 13, 2017, the board voted to disband this not-for-profit, statewide public private coalition. Patients and providers alike will be at a disadvantage with the loss of this collaborative entity.

VII. SUMMARY

The Connecticut Department of Public Health received accreditation by the Public Health Accreditation Board in 2017. Quality improvement and performance management is a priority both internally and with our community partners. DPH will continue to focus on statewide efforts to improve the quality of health care delivered to our citizens. Heightening provider awareness through the PSO process and the publication of annual reports and statistics is one way to keep quality improvement efforts in the forefront of caregivers' attention. It is also an important way to share these efforts with the public, who are the consumers of this care. Providers and the public feel a partnership with the Department in this effort. Payers on both the Federal and state levels are demanding "value" for their dollars. The Department's focus on improving safety and quality is one way to ensure such "value". In addition, the work done by Connecticut PSOs supplements the data gathering and reporting done by DPH. Providers' engagement with their PSOs contributes to quality improvements in our state.