CONNECTICUT DEPARTMENT OF
PUBLIC HEALTH

Keeping Connecticut Healthy

REPORT TO THE GENERAL ASSEMBLY

AN ACT CREATING A PROGRAM FOR QUALITY IN HEALTH CARE

JUNE 2009

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Acknowledgments

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Report to the General Assembly
June 30, 2009

An Act Creating a Program for Quality in Health Care

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ANNUAL REPORT

JUNE 30, 2009

I. INTRODUCTION AND BACKGROUND

Connecticut General Statutes section 19a-127l-n requires the Department of Public Health (DPH) to establish a quality of care program for health care facilities. This legislation also directs DPH to develop a health care quality performance measurement and reporting system initially applicable to the state's hospitals. Other health care facilities may be included in the quality program in later years as it develops. An advisory committee, chaired by the DPH commissioner or designee, advises the program.

Responsibility for the quality of care program within DPH lies with the Health Care Systems Branch and, in the Planning Branch, with the Health Care Quality, Statistics, Analysis, and Reporting (HCQSAR) unit. The Healthcare Associated Infections Advisory Committee was established by separate legislation and its activities are not included in this report unless they overlap with the quality of care program.

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, 2009. In addition to this report, DPH submitted the seventh adverse event report to the General Assembly (dated October 2008).

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 2008 and April 2009. A synopsis of current year activities and plans for next year is provided below for each of the subcommittees.

Subcommittee on Continuum of Care

The subcommittee has been charged with addressing the prevalence of pressure ulcers across the continuum. The subcommittee will be focusing on developing a pilot model system of coordinating the prevention, assessment and treatment of pressure ulcers throughout the continuum of home care, skilled nursing facilities and hospitals. The subcommittee has identified a referral cluster within the state, consisting of a hospital, skilled nursing facility, and two home health agencies. The subcommittee has been meeting regularly and is in the process of developing a set of shared standards to ensure the use of common language, terms and tools.

Named the *Milford Pressure Ulcer Collaborative Campaign*, it was launched on April 1, 2009. It will emphasize improved communication between segments of the continuum and in doing so will attempt to address identification of at risk patients upon transfer, prevention of pressure ulcers, and the inadequacy of the current Interagency Patient Referral (W-10) form. The target audiences are residents, families and staff.

Qualidigm is working with a different subset of nursing homes that had a larger number of pressure ulcers then normal. In addition, DPH has $50,000 set aside for an educational program in the fall to look at pressure ulcers and training of nurses.

Subcommittee on Physician Profiles

Assuring the ongoing competence of physicians continues to be identified as a major challenge at the national level, and as a result, there are several national initiatives related to physician accountability and competence. DPH continues to monitor these initiatives to determine the impact any resulting recommendations will have on physicians in Connecticut.

Physician license portability is also an issue that has gained national attention. DPH is participating in a Physician License Portability demonstration project with the Federation of State Medical Boards (FSMB). Connecticut is one of 14 states participating in this demonstration project. The project is funded by the Department of Health and Human Services/Office for the Advancement of Telehealth and is designed to facilitate the mobility of physicians to practice across states. Participation in this demonstration project enhances the Department's ability to carry out regulatory mandates related to physicians and promotes interstate mobility for workforce as well as emergency response capacity. Implementation of this project will allow state licensure authorities to access and share information to allow for an expedited licensure process.

DPH has also been mandated to implement an on-line license renewal system for physicians, dentists and nurses, and expects to be renewing these licenses on-line by July 15, 2009. The on-line renewal system has been configured to allow for the collection of valuable workforce data that are currently unavailable but critical in identifying and addressing healthcare workforce shortage issues. It is anticipated that it will take approximately a year to fully populate the database, as licensees renew in their birth month.

Public Act 08-109 *An Act Extending the State Physician Profile to Certain Other Health Care Providers* was passed during the 2008 session of the Connecticut General Assembly, effective January 1, 2010. Within available appropriations, DPH will be required to collect and publish information, comparable to that which is collected as part of the physician profile, for the following additional licensed health care professions: dentists, chiropractors, optometrists, podiatrists, naturopathic physicians, dental hygienists and physical therapists. To date, resources have not been made available for the implementation of this program.

Subcommittee on Regulations

This committee will be maintained in abeyance until needed again.

Subcommittee on Promotion of Quality and Safe Practices

Working Group I: Hospital Performance Comparisons

At the national level, the number of performance measures continues to grow. The Centers for Medicare and Medicaid Services (CMS) is reporting on 40 measures, of which 10 relate to patients' hospital experiences. There are no DPH resources available to expand beyond the 10 measures that Connecticut was reporting on. It was indicated that there is no mandate for annual reporting. This committee will be maintained in abeyance.

Subcommittee on Best Practices and Adverse Events

The Best Practices Subcommittee met in November, 2008, and January and March, 2009.

The subcommittee chose Hospital Emergency Department (ED) Triage procedures for discussion to find opportunities to improve time required to initiate triage and to then fully evaluate patients within the ED.

The first step included a survey to the ED directors regarding their present procedures and their evaluation of their procedures related to triage time. This was a very basic survey with only 10 questions. The results were reviewed at the November meeting. While the results were interesting, they did not provide clear direction for the next step.

The January meeting included presentations by Louis Graf MD, Medical Director for Quality and Associate Director of Emergency Medicine at the Hospital of Central CT, and by Thomas Van Hoof MD, EdD of the University of CT School of Nursing. Dr. Graf discussed measures to improve workflow throughout the ED experience and utilize data gathered for each aspect of the workflow in order to improve quality. Dr. Van Hoof spoke of how to effect behavioral changes in adults in order to implement improvement measures. Both physicians stressed the need for assessment and data collection in order to proceed with improvement of quality.

The March meeting included a discussion on the best way to gather data, stressing that the subcommittee would review non-identifiable aggregate data. The one consistent piece of data collected across hospitals is patients who left without being seen. Another ED directors meeting was being held the following day, so it was decided to speak further to the group regarding available data that each ED collects. The subcommittee's next step will depend on the information gathered.

Subcommittee on Cardiac Care Data

No bill was raised by the Public Health Committee during the FY09 session to fund the data collection initiative that was recommended in the December 2007 subcommittee report. This committee will be maintained in abeyance.

III. RECENT AND FUTURE PLANNED DPH PROGRAM AND PATIENT SAFETY ORGANIZATION ACTIVITIES

Implementation of P.A. 04-164

List of Adverse Events

In October 2008 DPH produced its seventh adverse event report, which is available on the DPH website at
http://www.ct.gov/dph/lib/dph/governmental_relations/2008_reports/oct2008_adverseeventreport_finaldraft.pdf

Quality of Care Information on the DPH Web Site

Descriptions of the activities of the Health Care Systems Branch are listed in the *Licensing & Certification* section of the Main Menu for the DPH website (www.ct.gov/dph). Annual Adverse Event reports, Hospital Performance Comparisons reports, and annual reports to the legislature about the Quality in Health Care Program are posted in *Statistics & Research* under *Health Care Quality*.

Patient Safety Organizations

Connecticut General Statutes section 19a-127o allowed DPH to designate "Patient Safety Organizations" (PSOs). The primary activity of a PSO is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis or processing of medical or health care related information submitted to the PSO by the health care provider. This "patient safety work product" may include reports, records, analyses, policies, procedures, or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. The PSO will disseminate appropriate information or recommendations on best medical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality of Health Care Advisory Committee, and the public. DPH has designated three PSOs, including the Qualidigm Patient Safety Organization, the Connecticut Healthcare Research and Education Foundation Patient Safety Organization (CHREF PSO), and the Ambulatory Surgical Center Patient Safety Organization (ASC PSO). The following information covers activities since the June 30, 2008 report.

Qualidigm PSO

The Qualidigm PSO continues to include providers from long term care, specialty and behavioral health facilities, outpatient surgical centers, and an acute care hospital. 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 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 participant's unique organizational environments.

This year the Qualidigm PSO offered four education programs to its members. STEPPES (*Strategies and Tools to Enhance Performance and Patient Safety*) training in the fall of 2008 provided exposure to an exceptional methodology for implementing effective positive change. The spring workshop focused on "Reducing Healthcare Acquired Infections". In partnership with CHA, Qualidigm PSO members have also participated in the 2009 Falls Symposium and the 2009 Patient Safety Summit. The Qualidigm PSO is also partnering with the CHREF PSO in two statewide collaboratives: *Multi Drug Resistant Organisms* (MDRO) and *Pressure Ulcer Prevention*. These relationships broaden the resources available to PSO members and enable them to access resources they need for their own specific institutions. As a final aspect of Qualidigm's educational efforts for the 2009 year, the Qualidigm PSO has registered as a participant in the World Health Organization *Clean Care is Safe Care Initiative* and provided every member with all of the organizational assessment, education and training materials included in this ongoing program.

Each participating facility submits case studies to the PSO that are de-identified and discussed in a facilitated forum leading to further collaboration among member facilities.

Electronic *PSO News Flashes* are distributed to participants monthly. These news flashes contain links to recent patient safety related articles, tools, reminders, and upcoming events. Past issues of the *PSO News Flash,* as well as materials from education programs and national initiatives, are available on a password protected PSO page on the Qualidigm website (www.Qualidigm.org).

As the Qualidigm PSO and its participants grow more comfortable, active and supportive of the Patient Safety Organization concepts and functions, the programs and offerings continue to mature. This includes more in-depth and open group case study discussions and sharing of best practices as well as more developed data collection and analysis integration into patient safety activities by the participating organizations.

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

Ambulatory Surgical Center (ASC) PSO

The ASC PSO continues to build membership and expand its activities. Membership meetings included breakout sessions by specialty. Facilitators provided members with an opportunity to discuss safety issues relevant to certain practice areas.

During 2008-2009, an initiative included a presentation on "the Environment of Safety," a field study designed to query members on their own practices, and random site visits. An article appeared in the ASC PSO *Patient Safety News* on HVAC filter changes and infection control implications. Through the mandatory membership meeting and presentation, members learned of resources and best practices relative to patient safety and the environmental setting within the ambulatory surgical center.

On the patient education side, efforts focused on proper hand washing. A flyer was developed in conjunction with DPH and distributed within the ASCs. The ASC PSO also developed a survey tool for patients on their experience within the ASC. The PSO is in the process of gathering and compiling survey information.

In the future, the PSO plans to focus on sleep apnea and its patient safety implications, as well as to hold a special training session related to infection control, as required by the new Medicare Conditions of Coverage. The ASC PSO is embarking on a broader public education campaign, involving DPH, and aimed at making health care a priority despite the recent economic downturn.

Connecticut Healthcare Research and Education Foundation (CHREF) PSO

Connecticut's not-for-profit hospitals participate in the CHREF PSO that assists hospitals in improving the quality of care provided and patient safety. During the past year, the CHREF PSO has engaged in a variety of activities to support its members in those goals.

The CHREF PSO initiated one collaborative in partnership with Qualidigm -- addressing prevention of patient falls. The collaborative includes educational sessions with nationally known speakers, biweekly conference calls with all members, a website, a member ListServ, and on-site visits. The PSO has also initiated two learning communities – addressing elimination of central line associated blood stream infections in intensive care units (*Stop BSI*) and adoption of the World Health Organization's *Surgical Check List*. The *Stop BSI* project is part of a larger national initiative being led by Dr. Peter Pronovost at John Hopkins. The learning communities are supported by conference calls, on-site learning sessions, and a ListServ.

The PSO produces a monthly Patient Safety newsletter, started in January 2008. The newsletter provides detailed information on a specific topic each month, reviews pertinent articles in the medical literature, and updates all members on the activities of the collaboratives.

Education is an important part of the CHREF PSO function. The PSO again sponsored the annual Patient Safety Summit in conjunction with the Qualidigm PSO. The Summit brings

nationally recognized patient safety experts to Connecticut, this year featuring Brent James, M.D.

The CHREF PSO also initiated two educational series to meet the differing needs of members. The *Quality and Patient Safety for the Clinical Manager* series was designed for front line clinical managers and provides up-to-date and innovative tools to drive quality improvement and patient safety. The *Quality and Patient Safety for the Senior Leader* series is designed for hospital executive leaders and addresses such topics as creating a culture of patient safety and getting hospital "boards on board" with quality and patient safety initiatives.