



REPORT TO THE GENERAL ASSEMBLY

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

JUNE 30, 2014

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ANNUAL REPORT

JUNE 30, 2014

I. INTRODUCTION AND BACKGROUND

Connecticut General Statutes sections 19a-1271-n require the Department of Public Health (DPH) to establish a quality in 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. Committee activities are summarized in section II.

Responsibility for the quality of care program within DPH lies with the Health Care Quality and Safety Branch and with the Health Statistics and Surveillance Section. DPH activities appear in section III. Patient Safety Organization activities, established by 19a-127-o, 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 March of Dimes Early Elective Deliveries Initiative activities are summarized in section VI.

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, 2014.

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

Advisory Committee

During 2013 two new topics were taken up: the March of Dimes Early Elective Deliveries, working through the Coalition to Improve Birth Outcomes, and Access to Care, working in collaboration with the Office of Health Care Access (OHCA). The March of Dimes initiative aims to measure and reduce the rate of pre-term deliveries resulting from C-sections that are not medically indicated. While Early Elective Deliveries is not a QHCAC subcommittee, QHCAC members participate in the Coalition. The Access to Care subcommittee addresses the provision of care in so-called Urgent Care and Retail-Based Centers.

Public Act 13-55 establishes a Palliative Care Advisory Council to advise DPH and to annually report to the DPH Commissioner and Public Health Committee of the legislature, starting no later than January 1, 2015, on matters related to improving palliative care and the quality of life

for people with serious or chronic illnesses.¹ The Quality in Health Care Advisory Committee (QHCAC) will review future palliative care advisory council recommendations for possible action by a QHCAC subcommittee.

The Legislative Program Review and Investigation Committee (LPRIC) is conducting a Program Review study of Hospital Emergency Department Use and its Impact on the State Medicaid Budget. The QHCAC will review the recommendations made in the LPRIC report once it is completed, for possible action by a subcommittee.

The QHCAC held meetings in October 2013 and April 2014. At the October meeting the Committee voted to retire the Continuum of Care and Physician Profiles subcommittees because their work had been completed. At the April meeting the QHCAC discussed the lack of and need for a common definition for the various types of retail-based clinics and urgent care centers. At both meetings changes in data collection for the adverse event report were discussed.

The QHCAC discussed Quality of Care work being done in other committees or workgroups. At the April meeting DPH deputy commissioner Lewis read aloud the 12 charges in the statute creating the QHCAC. She asked the Committee members to be prepared to discuss the role of this committee going forward, and whether changes to legislation would need to be recommended to address changing role/needs given the activities of various other committees and organizations. DPH Health Care Quality and Safety Branch chief Wendy Furniss indicated that many of the QHCAC charges were either accomplished or required funding in order to accomplish. It was also noted that certain items in the charge would continue to be done whether or not the QHCAC existed.

Subcommittee on Best Practices and Adverse Events

The full subcommittee did not meet during the past year, but DPH members reported to the QHCAC about Adverse Event reports received during 2013.

Subcommittee on Access to Care

Originally this subcommittee was formed when OHCA was considering releasing a physician survey as part of a mandatory update to their Statewide Health Care Facilities and Services Plan. However, after further review it was decided that OHCA would not be sending out a full survey. Instead, to reduce duplication of similar efforts, OHCA plans to tag onto the work that is already being done by the State Innovation Model (SIM) group to assess primary care provision in Connecticut.

The SIM survey has not been finalized yet. They have not yet received funding, but plan to proceed with the survey whether funding is received or not. They anticipate having results available by fall 2014.

¹ Minutes of the Palliative Care Advisory Council are at <http://www.ct.gov/dph/cwp/view.asp?a=3117&q=537876>.

Next steps for the Access to Care subcommittee are:

- Review and summarize available studies on retail-based clinics and urgent care clinics
- Define what an urgent care center (or specifically a retail based clinic) is for these purposes
- Create guidance on what type of services/settings is most beneficial to the patient, under what circumstances

Subcommittees Retired because Their Work has been Completed

- Continuum of Care
- Physician Profiles

Subcommittees Maintained in Abeyance

- Regulations
- Promotion of Quality and Safe Practices
- Cardiac Care Data

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Reporting of Adverse Events

In October 2013 DPH produced its twelfth adverse event report, which is available at <http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/AdverseEventReport2013.pdf> . Pursuant to P.A. 10-122, *An Act Concerning the Reporting of Adverse Events at Hospitals and Outpatient Surgical Facilities and Access to Information Related to Pending Complaints Filed with the Department of Public Health*, facility-level counts, rates, payer or case mix information, and comments from facilities were included.

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

The NQF document *Serious Reportable Events in Healthcare-2011 Update*² added four items, retired three items, and revised definitions and specifications for the remaining 25 items. The updated NQF list includes 29 serious reportable events. The new items are: (1) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy; (2) patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen; (3) patient death or serious injury from failure to follow up or communicate laboratory, pathology, or radiology test results; (4) death or serious injury of a patient associated with the introduction of a metallic object into the MRI area. Two retired NQF items, relating to hypoglycemia and kernicterus, remain reportable under the NQF categories of medication management and care management events, respectively. The third retired item, related to spinal manipulation, involves individual behavior rather than facility safety systems. The new categories were first used in 2013 and facility reports to DPH during 2013 will appear in the October 2014 Adverse Event Report by DPH to the Legislature. For more information, see the October 2012 Adverse Event Report on the DPH website.

Quality of Care Information on the DPH Web Site

Annual Adverse Event reports and annual reports to the legislature about the Quality in Health Care Program are posted through the *Statistics & Research* link, under *Health Care Quality*.

IV. PATIENT SAFETY ORGANIZATIONS

Connecticut General Statutes section 19a-127o allows DPH to designate “Patient Safety Organizations” (PSOs). The primary role of a PSO is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis or processing of medical or health care-related information submitted to the PSO by the health care provider. This “patient safety work product” may include reports, records, analyses, policies, procedures, or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. The PSO will disseminate appropriate information or recommendations on best medical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality in Health Care Advisory Committee, and the public. DPH has designated three PSOs, including the Qualidigm Patient Safety Organization, the Connecticut Hospital Association Patient Safety Organization, and the Ambulatory Surgical Center Patient Safety Organization. The following information covers activities since the June 30, 2013 report.

Qualidigm PSO

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

During 2013-2014, the Qualidigm PSO has focused on providing local solutions and resources to a diverse group of long term, acute care, behavioral health, and rehabilitation hospitals. With such a wide range of settings represented in the PSO, the approach has been to address the common issues shared by the facilities while maintaining a focus on the unique and distinctive patient safety concerns found in specific settings. The programs, activities, and information offered this year are summarized below:

Educational Events

Members of the Qualidigm PSO were invited to attend numerous educational events and seminars throughout the 2013-2014 year. Among these were:

- A full-day care transitions leadership academy event on Decreasing Readmissions from Nursing Homes with interactive presentations, step-by-step instruction, success stories, and a noted speaker.
- The Better Health Conference on Patient Engagement in September 2013, held at the Connecticut Convention Center, with numerous speakers and informative health sessions on topics including medication management, effective patient-provider communication, advance care planning, patient engagement through technology, patient-centered care, and what the Affordable Care Act means for Connecticut residents.
- The Antimicrobial Stewardship project (AMS) kick-off meeting.
- The Clostridium difficile (CDI) project kick-off meeting with the Connecticut Department of Public Health (DPH).
- Subsequent webinars to monitor the progress of the projects for both AMI and CDI initiatives.
- DPH Healthcare-Acquired Infections (HAI) Update training sessions for the Infection Preventionists from Acute Care and Long Term Care hospitals.

Webinars

Acting as a source to share information on national provider calls, the Qualidigm PSO invited their members to over 30 calls on topics such as health literacy, reducing HAIs, Electronic Clinical Quality Measure Reporting (eCQM), Inpatient and Outpatient Quality Reporting Programs, and the Two-Midnight Rule. PSO members were also invited to participate in webinars on *Reporting the New PC-01 Measure and Interventions for Successful Catheter-Associated Urinary Tract Infections (CAUTI) Rate Reduction*.

Patient Safety Summit

This year, the 2014 Connecticut Hospital Association (CHA) Patient Safety Summit, co-sponsored by Qualidigm, was open 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 featured health technology and its impact on patient safety.

Site Visit and Needs Assessment

In March, the Qualidigm PSO manager conducted on-site facility visits with patient safety teams at all of the PSO member facilities to identify each facilities' patient safety concerns through a comprehensive needs assessment.

From the information gleaned during the discussions and completion of the needs assessment at each of the facility visits, the Qualidigm PSO developed a plan to distribute resources that would effectively connect with each facility's patient safety concerns.

Newsletter

The Qualidigm PSO has continued to send monthly e-newsletters to PSO members with information on the latest research, tools, and government mandates related to patient safety. The e-newsletter was re-designed and expanded in the first part of 2014, with the first quarterly issue reaching inboxes in March. The topics covered by the newsletter relate directly to the PSO member facilities and their areas of concern identified in the needs assessment, and included: articles on Medicare penalties, hand hygiene, medical errors, patient engagement, national patient safety goals, technology hazards, adverse events, infection prevention week, high reliability organizations, Joint Commission; and resources to help with patient hand-off, health communication, and teamwork.

Adverse Reporting Resource Book

Responding to another area identified in the needs assessment, the PSO has developed and distributed an *adverse reporting resource book*. The book was created to aid the PSO members by providing a "go to book" for adverse event reporting which includes all of the Connecticut Department of Health adverse event reporting forms, definitions of mandatory adverse events reporting requirements, and other helpful information for adverse reporting.

Ambulatory Surgical Centers PSO

Maintaining a "Culture of Safety" within ASCs became the focus of the ASC PSO in 2013. The approach remained consistent, with mandatory meetings for members as well as the introduction of some additional programs and projects this year. The ASC PSO kicked off programming with a presentation by DPH that focused on survey readiness and included an opportunity for Q&A. It was very well received and provided a great opportunity to understand the focus of the department and the concerns of the facilities. The PSO tied in the concept that survey readiness = patient safety and continued with the theme throughout the year. Programming focused on Advance Directives, National Patient Safety Goals, the Culture of Safety, OSHA's new Hazard Communication Standards, as well as Case Reviews.

Break Out Sessions

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

At the same time, the PSO has developed specialty specific group emails for safety discussion purposes and has developed a new blog for membership discussion across the continuum and within specific specialty areas.

Site Visit Program

The site visit program continued with a web based survey to identify patient safety areas of concerns within facilities. (10 facilities were selected to participate in the first module of actual site visits.) Two nationally credentialed surveyors visited each facility for a comprehensive review, using the generally applied expectations of various accrediting bodies. The Medicare Physical Plant requirements, however, are not part of the site visit program.

Although educational in nature, the information gleaned from the visits helped the PSO identify good educational programming opportunities. The results of the visits were presented by the surveyors, along with policy and procedure recommendations so that the entire membership could benefit from the visits and not only the individual ASC that participated. The PSO will continue this program with future visits.

Instrument Sterilization Program

With the help of its CIC specialist, the PSO developed a full-day CE program for facility staff involved in instrument sterilization. The program was designed as a certification preparation course. Specific learning objectives for the meeting included:

- Understand how Life sciences (Anatomy, Physiology, and microbiology) apply to CSS/SPD. Emphasis on blood borne pathogens and OSHA. Basic medical terminology knowledge as related to instruments and sets and their associated surgical procedures will be elaborated. AAMI ST79 and AORN recommended practices will be cited and reviewed.
- Understand steps for cleaning, decontamination, and disinfection with emphasis on instrument manufacture instructions for use. Orthopedic, MIS (Minimally Invasive Surgery), and Robotic instrument manufacture instructions for use documents will be reviewed. AAMI ST79 and AORN recommended practices will be cited and reviewed.
- Identify various sterilization methods and types of sterilizers (dry heat, ETO, hydrogen peroxide, and steam sterilization cycles and parameters and their documentation). The methods of monitoring each in addition to their associated packaging and storage

requirements will also be reviewed. AAMI ST79 and AORN recommended practices will be cited and reviewed.

An additional program will be developed in the future specifically for endo/gastro sites that use high-level disinfection.

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. The PSO expects to use this data to identify opportunities to implement programs and recommendations to reduce the incidence of specific adverse events. As always, the program will include patient materials, policy recommendations and membership programming by leaders in the field.

Conclusion

Membership in the ASC PSO has remained steady with 61 ASCs actively participating in mandatory membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, it also provides newsletters, email alerts and patient flyers on important patient safety topics. The PSO will continue with its "Culture of Safety" programming and expect to focus on Surgical Site Infections, as well as Immunization issues and potential risks today.

National PSO Update

Federal requirements prohibit a State PSO from being listed as a National PSO, because of reporting requirements and other liability issues. The PSO is in the process of creating a separate entity to become nationally listed and expects to move its Hand Hygiene program to the National PSO in the coming months.

Connecticut Hospital Association (CHA) PSO

Central to the mission of every hospital is a dedication to providing high quality, safe care for all.

The CHA PSO supports this mission by facilitating hospital culture change focused on safety and quality and on patient-centered care redesign. Connecticut hospitals are recognized as national leaders in reducing all-cause preventable harm through CHA's statewide collaborative to empower hospitals to become high reliability organizations, creating cultures with a relentless focus on safety. As winners of the American Hospital Association's 2014 Dick Davidson Quality Milestone Award for Allied Association Leadership, CHA is particularly proud of the work of Connecticut hospitals that have collaborated to share, learn, and apply nationally recognized, evidence-based practices to achieve the highest standards of quality and safety.

Through the PSO's high reliability collaborative, hospital leaders have embraced the challenge of hardwiring patient safety into their organizational culture through high reliability science. Every day, staff, department heads, and executives are communicating in daily safety huddles, finding solutions to problems, and becoming more accountable for outcomes. Hospitals encourage critical thinking and questioning from all levels, and they "stop the line" whenever a

concern is raised. They are standardizing communication and improving interdisciplinary teamwork across all settings. This work is saving lives, and the supportive and collaborative environment is strengthening hospitals. To date, more than 10,000 hospital staff and physicians have been trained in high reliability safety behaviors.

Twenty-four of 28 hospitals have committed to training all of their employees and medical staff; several hospitals have completed the training. At CHA's 12th annual Patient Safety Summit in March 2014, Tejal Gandhi, MD, MPH, CPPS, President of the National Patient Safety foundation, praised Connecticut hospitals' work to eliminate harm. "Connecticut hospitals have been putting substantial time and effort into working together for the zero harm initiative," she said. "I want to applaud the Connecticut hospitals for their efforts in patient safety."

Integrated with this groundbreaking statewide effort is CHA's work with the American Hospital Association's Health Research & Educational Trust (HRET) on Partnership for Patients, a national CMS initiative designed to reduce preventable inpatient harm by 40 percent and readmissions by 20 percent. Connecticut hospitals have achieved the 40 percent reduction target in five categories and the target for 20 percent reduction in readmissions; hospitals remain committed to achieving all ten areas of reduction by the end of the project in December 2014. Connecticut hospitals have been recognized repeatedly for participation and performance in Partnership for Patients, with numerous opportunities for presentations to national audiences.

With CHA, all Connecticut hospitals have engaged in comprehensive programming aimed at preventing adverse drug events, falls, catheter-associated urinary tract infections, perinatal and maternal harm, central line-associated bloodstream infections, pressure ulcers, surgical site infections, venous thromboembolism and ventilator-associated events, and reducing preventable readmissions.

V. HEALTHCARE ASSOCIATED INFECTIONS COMMITTEE

The Healthcare Associated Infections (HAI) Committee, established by legislation, is separate from the Quality in Health Care Advisory Committee. Nevertheless, HAI Committee and related program activities are summarized here since they represent an important dimension of healthcare quality improvement efforts in Connecticut.

In 2006, the Connecticut General Statutes Section 19a-490n-o of the Connecticut General Statutes (*Substitute Senate Bill No. 60, Public Act No. 06-142: An Act Concerning Hospital Acquired Infections*) mandated the public reporting of HAIs in Connecticut. The authorizing legislation created a Healthcare Associated Infections Committee to advise DPH on what measures should be reported and on means of raising public awareness.

The Connecticut HAI Advisory structure that was used from 2008 until the spring of 2014 consisted of the Advisory Committee and the Education Subcommittee. The Advisory Committee had 11 legislatively designated "voting" members and 72 non-voting "participants" representing diverse stakeholders: infectious disease physicians, Connecticut State Medical

Society (CSMS), the Connecticut Hospital Association, the Department of Public Health (DPH), consumers, and infection preventionists across the health continuum of care. The Committee advised DPH on the development, operation and monitoring of HAI reporting system and policy issues. The committee met in-person quarterly. The HAI Advisory Committee Education Subcommittee advised the DPH HAI program on educational initiatives targeting providers and the public on HAIs and their prevention. In October 2011, the Subcommittee advised DPH on a statewide ARRA-Funded marketing campaign. The marketing company contracted by DPH for the campaign devised a full scale HAI prevention campaign with its own consistent visual scheme and themes, based on an overarching positive message that HAIs can be prevented if everyone, health providers and patients, work together- the "It's Good for You, Connecticut" public awareness campaign. Bus cards, public service announcements, and public relations were done to promote this campaign within our state through broad distribution to media.

The current Connecticut HAI Advisory structure will be changing in the summer of 2014 because the CT DPH HAI program realizes that the priorities and focus of the HAI Advisory Committee members are shifting. The new Committee structure will consist of three groups: the Healthcare Associated Infections Advisory Group (HAIAG), the Technical Advisory Group (TAG), and the Education Group (EG).

Healthcare Associated Infections Advisory Group (HAIAG) will focus on policy changes affecting healthcare associated infections, on public reporting as mandated by Connecticut general statute 19a-490n-o. The group will advise the department with respect to the development, implementation, operation and monitoring of a mandatory reporting system for healthcare associated infections, 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 will also discuss ways to collaborate with multidisciplinary local and regional partners, as well as identify specific HAI prevention targets consistent with HHS and CMS priorities. The Technical Advisory Group (TAG) and the Education Group (EG) will give reports to the Healthcare Associated Infections Advisory Group about their meeting discussions, and upcoming publications and education opportunities/materials.

The Technical Advisory Group (TAG) will provide technical advice to the DPH Healthcare Associated Infections Program for HAI surveillance including advice on medical care, epidemiology, statistics, infectious diseases etc. The committee will elect a chair, adopt rules of conduct during meetings using or adopting Roberts rules of order. The TAG is expected to provide technical and strategic advice on data collection and methods of estimation, and on the most appropriate ways of presenting and analyzing the data, and design of actions for prevention based on best practices.

The Education Group (EG) provides education and training about healthcare associated infections and prevention of healthcare associated infections to applicable persons and healthcare disciplines. The committee will design educational materials that describe ways to prevent transmission of healthcare associated infections. Evidence-based literature, best practices, and

mainstream publications will be thoroughly reviewed to assure comprehensive tools were created to be used by various groups.

Public Act 14-214, “An Act Concerning A Task Force to Study Stroke and Reporting on Health Care-Associated Infections,” requires DPH to post on its website information about both its own HAI program and the CMS Medicare Hospital Compare as regards Hospital Associated Infections, beginning October 1, 2014.

The web page for the HAI Program on the DPH website is found under “Topics A-Z” through “Health Care Associated Infections” at <http://www.ct.gov/dph/cwp/view.asp?a=3136&q=417318>

VI. MARCH OF DIMES EARLY ELECTIVE DELIVERIES

March of Dimes Perinatal Quality Improvement: A Multi-Hospital Quality Improvement Program to Decrease Elective Deliveries Before 39 Weeks of Gestation.

Choosing to deliver a baby before 39 weeks when there are no medical indications for delivery puts infants at higher risk for health problems such as respiratory distress syndrome, the need for ventilator support, and persistent pulmonary hypertension, resulting in increased NICU (Neonatal Intensive Care Unit) admissions.^{3,4} The March of Dimes (MOD) works with doctors and nurses, hospitals, hospital engagement networks, insurers, regional collaboratives, patients and their families to reduce non-medically indicated (elective) deliveries before 39 weeks completed gestation.

In 2011, in partnership with the Northern Connecticut Perinatal and Neo-natal Collaborative, Connecticut Children’s Medical Center, Aetna, and the Connecticut Hospital Association, the March of Dimes launched an awareness campaign among obstetric and neonatal providers of the risks of elective deliveries at <39 weeks gestation. In 2012, birthing hospitals were recruited to participate in a Quality Improvement (QI) project utilizing the Elimination of Non-Medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit⁵ and Quality Improvement Service Package, which complements the toolkit with data collections tools.

The core of the QI project involved each hospital developing a committed team of staff with the intention to overhaul hospital policies around elective C-section deliveries. Additionally, each hospital had to agree to standardization of a “scheduling form”, development and

³ Oshiro, B. Henry E., Wilson, J. Branch, D., Varner, M (2009). Decreasing elective deliveries before 39 weeks gestation in an integrated health care systems. *Obstet Gynecol*, 113 (4), 804-11

⁴ Tita, A.T., Landron, M.B., Spong, C.Y., et al (2009). Timing of Elective Repeat Cesarean Delivery at Term and Neonatal Outcomes. *N Eng J Med*, 360, 111-20.

⁵ Main, E., Oshiro, B., Chagolla, B., Bingham, D., Dand-Kilduff, L. & Kowalewski, L. Elimination of Non-Medically Indicated (elective) Deliveries Before 39 Weeks Gestational Age, (California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care) Developed under the contract #08-85012 with the California Department of Public Health; Maternal Child and Adolescent Health Division; First Edition published by March of Dimes, July 2010.

implementation of the “hard-stop policies”, to set up data collections IT systems (MOD data portal), train and utilize universal data portal system, to participate in hospital wide grand rounds and health professional education and utilize common consumer education materials. Hospitals participated in the program voluntarily and received no grant funding for implementation. In November 2013 the project released preliminary results demonstrating a reduction in elective C-sections prior to 39 weeks.

As a part of the 39 Weeks QI project, ASTHO (Association of State and Territorial Health Officials), in partnership with March of Dimes, issued the 2012 President’s Challenge to improve birth outcomes by reducing infant mortality and prematurity in each state.

Commissioner Jewel Mullen accepted the President’s Challenge and pledged to partner with March of Dimes specifically by:

- Adopting the goal to reduce the rate of premature birth by 8% by 2014 (measured against 2009 data)
- Initiating and supporting programs and policies that reduce the premature birth rate in the state
- Building awareness of state prematurity rates and other MCH related indicators, ie. reducing elective C-sections <39 weeks gestation.

Statewide Plan to Improve Birth Outcomes

This project aims to improve health care services delivered to pregnant women and children, with a strong focus on prenatal and perinatal care. It was first known as the National Governors’ Association Learning Network on Improving Birth Outcomes. The Connecticut chapter of the March of Dimes is Co-Chair with DPH on the Learning Network. Other partners include Liz Donahue, Health Policy Director, Governor’s Office, Dr. Robert Zavoiski, Medicaid Medical Director, CT Dept. of Social Services, and Kenn Harris, Project Director for New Haven federal Healthy Start, Foundation for Greater New Haven.

March 2013 saw the convening of first coalition of state and local partners to develop a statewide plan to improve birth outcomes and reduce infant mortality. The NGA Learning Network took on a new name: Statewide Plan to Improve Birth Outcomes (SPIBO) Coalition.

Coalition work continues through three workgroups: reproductive health, mental health and oral health. The workgroups have been meeting to develop a comprehensive and collaborative plan. The coalition has over 80 stakeholder committee members. Each member participates in at least one workgroup to identify strengths, weaknesses and opportunities to improve birth outcomes. The collaborative work has identified three areas that must be addressed in all policies, programs and interventions: addressing social determinants of health and race/ethnic disparities, incorporating the Life Course Theory. This theory posits that cumulative stresses across the lifespan cause health to decline prematurely, resulting in reduced health status during pregnancy and increased likelihood of poor birth outcomes, relative to others who have lived without these stresses. A final statewide plan is expected to be adopted by DPH and released in September 2014.