CONNECTICUT DEPARTMENT OF
PUBLIC HEALTH

Keeping Connecticut Healthy

REPORT TO THE GENERAL ASSEMBLY

AN ACT CREATING A PROGRAM FOR QUALITY IN HEALTH CARE

JUNE 2007

J. Robert Galvin, M.D., M.P.H., M.B.A., Commissioner
Norma D. Gyle, R.N., Ph.D., Deputy Commissioner

State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

Acknowledgments

Individuals from several organizations contributed to this report. Subcommittees of the Quality in Health Care Advisory Committee listed below are not exhaustive but reflect section writing.

Connecticut Department of Public Health

Jon Olson
Assembling and Drafting of Report

Karen Buckley-Bates

Jennifer Filippone
Subcommittee on Physician Profiles

Joan Foland
Subcommittee on Promotion of Quality and Safe Practices
Working Group I: Hospital Performance Comparisons

Wendy Furniss
Subcommittee on Best Practices and Adverse Events
Subcommittee on Cardiac Care Data

Joan Leavitt
Subcommittee on Regulations

Lloyd Mueller

Donna Ortelle
Subcommittee on Cardiac Care Data

Diane Smith, Connecticut Department of Public Health
Subcommittee on Best Practices and Adverse Events

Additional Contributors

Mag Morelli, Connecticut Association of Not-for profit Providers of Care for the Aging
Subcommittee on Continuum of Care

Julie Petrellis, Connecticut Healthcare Research and Education Foundation PSO

Nancy Safer, Qualidigm PSO

Lisa Winkler, Ambulatory Surgical Center PSO

Special thanks to Margi Brault, Administrative Assistant, Connecticut Hospital Association

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Report to the General Assembly
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An Act Creating a Program for Quality in Health Care

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ANNUAL REPORT

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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.

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, 2007. In addition to this report, DPH submitted the fifth adverse event report to the General Assembly (dated October 2006), and third hospital performance comparisons report (dated December 2006).

II. QUALITY IN HEALTH CARE ADVISORY COMMITTEE AND SUBCOMMITTEE ACTIVITIES

Advisory Committee

The Quality in Health Care Advisory Committee (QHCAC) held four meetings this past year in July 2006, October 2006, January 2007, and April 2007. Much of the work was divided among several subcommittees and working groups. 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 on Continuum of Care was asked this year to reconvene to address two issues raised by the Committee. The first issue is the need to encourage coordinated efforts to reduce, prevent and treat pressure ulcers throughout the health care system. The second issue is the need to improve the transfer and placement of individuals throughout the continuum.

The subcommittee met in April and May of 2007 and has established two initial goals. The first goal is to initiate a pilot pressure ulcer program within a referral cluster that can be studied and

duplicated. The second goal is to develop a better transfer document for providers to use when individuals are transferred between settings, in order to promote continuity of care.

Subcommittee on Health Promotion and Illness Prevention

This subcommittee was folded into the Best Practices and Adverse Events subcommittee. A description of the Best Practices subcommittee activities appears later in this report.

Subcommittee on Physician Profiles

The focus of this subcommittee has shifted toward addressing issues related to physician competence. Assuring the ongoing competence of physicians has been identified as a major challenge at the national level, and as a result, there are several national initiatives related to physician accountability and competence. This subcommittee continues to monitor these initiatives to determine the impact any resulting recommendations will have on physicians in Connecticut.

In the coming year, the Physician Profile subcommittee has been requested to review issues related to physician performance and the aggregation of HEDIS (Health Plan Employer Data and Information Set) data. HEDIS is a tool created by the National Committee for Quality Assurance (NCQA) and is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The information is ultimately shared with purchasers of health insurance. Although physicians see patients from a number of payers, the health plans that provide HEDIS data only have physician information for their enrollees. In order to get a better picture of physician performance, the subcommittee has been asked to assess the possibility of aggregating this data across Connecticut health plans, for individual physicians.

Subcommittee on Regulations

The hospital regulations were revised to reflect current standards within the healthcare industry. The proposed draft hospital regulations were initially rejected “without prejudice” by the Legislative Regulations Review Committee. Department and hospital representatives responded to the substantive and technical concerns of the Regulations Review Committee, and the regulations were resubmitted. They were approved as this report was being prepared.

Subcommittee on Promotion of Quality and Safe Practices

Working Group I: Hospital Performance Comparisons

Working Group I met in March 2007 to discuss public reporting for quality of care in Connecticut subsequent to the release of the third Hospital Performance Comparisons Report produced by DPH in December 2006. The Group reviewed DPH’s current data collection efforts

and the additional clinical measures being collected at the national level as part of the Hospital Quality Alliance. In addition to the 10-measure starter set, there are 11 new clinical measures now being required at the national level in order for hospitals to receive their prospective payment system annual payment update.[1] They include:

- 3 new measures for AMI
- 2 for Heart Failure
- 4 for Pneumonia
- 2 measures under the new category of the Surgical Care Improvement Project (SCIP).

It is also anticipated that other additional measures will be collected during 2007 on a voluntary basis, including 3 additional SCIP measures and risk-adjusted, 30-day mortality outcomes for AMI and Heart Failure.

The Work Group recommended to the full Committee that DPH continue to collect data on the 10 clinical measures on which it currently reports. The Work Group also recommended that DPH expand the performance measures on which it reports to include those 11 clinical measures now required at the national level for hospitals to receive their payment updates, recognizing that additional resources would be required for DPH to implement this recommendation.

When the full Quality Advisory Committee met in April, it was indicated that because no additional resources were available, DPH should just continue reporting on the 10-measure starter set.

Subcommittee on Best Practices and Adverse Events

The subcommittee on Best Practices and Adverse Events met in July, September, and November 2006 and January, February, March and April 2007.

The Connecticut Collaboration for Fall Prevention provided information to the subcommittee in July 2006 concerning fall prevention initiatives in Connecticut.[2] Fall prevention presentations are being provided by the Collaboration in senior centers, with nurses being trained to perform fall assessments at a number of centers.

Public Act 06-195 charged the subcommittee to study and make recommendations to the Department of Public Health "concerning best practices with respect to communications between a patient's primary care provider and other providers involved in a patient's care, including hospitalists and specialists." The subcommittee has met with physician representatives from the

[1] http://www.cms.hhs.gov/HospitalQualityInits/20_HospitalRHQDAPU.asp#TopOfPage

[2] Hhttp://www.fallprevention.org/H. In early 2000 the Connecticut Hospital Association; the Connecticut Association for Home Care, Inc.; Gaylord Hospital; Qualidigm; Yale School of Medicine; and University of Connecticut School of Medicine proposed an interdisciplinary fall prevention effort to translate Horiginal work at Yale UniversityH into protocols that could be used in clinical and community settings. This effort was named The Connecticut Collaboration for Fall Prevention (CCFP) and was funded by the Donaghue Medical Research Foundation.

Society of Hospital Medicine and community physicians to gather information on standards and practical approaches to improve communication along the entire continuum of care. The subcommittee will be submitting their recommendations to the Department not later than January 1, 2008.

The subcommittee's "health messaging" campaign has concentrated on providing educational information to consumers, including medication reconciliation and hand hygiene. A wallet sized "medicard" which may be used to list an individual's medications was provided to all State of Connecticut employees in January 2007 (accompanying pay envelopes) as well as to some hospitals' staff members. A downloadable electronic version of the medicard was placed on the DPH website (http://www.dph.state.ct.us/hcquality/hcquality.htm). The medicard is also posted on the Connecticut Hospital Association and Qualidigm websites. Hand Hygiene information will be included in a planned statewide educational campaign, and is targeted for release in October 2007 in conjunction with national Infection Control Week.

Subcommittee on Cardiac Care Data

Public Act 05-167, An Act Concerning the Improvement of Cardiac Care, requires the Quality in Health Care Advisory Committee to evaluate and examine possible approaches that would aid in the utilization of an existing data collection system for cardiac outcomes, and the potential for state-wide use of data collection systems for cardiac outcomes, for the purpose of continuing the delivery of quality cardiac care services in the state. The Act further requires the Advisory Committee to submit a report of the results of the examination along with any recommendations to the Governor and the Legislature by December 1, 2007. The legislation recognizes that funding may be needed in order to implement the Committee's recommendation.

The Cardiac Care Data Committee includes cardiac surgeons, interventional cardiologists, representatives of hospitals and of the Department of Public Health, and others. Members have met regularly since April 2006 and have reviewed and evaluated existing data collection systems. The data systems reviewed included the Office of Health Care Access Cardiac Data Registry, national data registries, Centers for Medicare and Medicaid Services' Hospital Compare, American Heart Association's Get with the Guidelines, and other states' systems. Meetings and discussions have included review of data elements to collect, timeliness of data collection, auditing parameters, analytic methodology for risk-adjustment, information to be reported to the public, and costs of funding implementation. The Committee is currently in the process of drafting the report with recommendations.

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

Hospital Clinical Performance Measures

In December 2006, DPH produced its third hospital performance comparisons report, which is available on the DPH website. Data were collected from all 30 adult acute care hospitals in Connecticut on patients with a diagnosis of heart attack, heart failure, or pneumonia, who were discharged between January 1, 2005 and December 31, 2005. Performance rates are provided for 10 clinical process measures.

Based upon 2005 data, Connecticut hospitals continue to do better on average than those in the U.S. on all ten of the clinical measures, and statistically significantly better on six of the ten measures.

Between 2004 and 2005, Connecticut hospitals' performance rates improved significantly on four of the ten measures and remained stable on the remaining six measures.

The definition of measures AMI-3 and HF-2 changed from "percentage of patients given an ACE inhibitor at discharge" to "percentage of patients given an ACE inhibitor ***or an ARB*** at discharge," effective January 1, 2005. This change had no impact on Connecticut AMI patients – the average rate remained stable – 83% in 2004 and 82% in 2005. However, the average Heart Failure performance rate significantly increased from 79% to 83%, bringing it into alignment with the AMI measure. It is believed that there is still a problem with proper documentation of contraindications for recommended medications.

Future DPH program activities include ongoing data collection for the 10 clinical measures presented in the first three reports; participating in the ongoing Advisory Committee and Subcommittee activities; and monitoring public reporting efforts on hospital clinical performance measures at the national level.

Implementation of P.A. 04-164

List of Adverse Events

In May 2007, hospitals and ambulatory surgical centers were provided with the updated National Quality Forum's List of Serious Reportable Events and the revised list compiled by the Commissioner of Public Health. A new category was included in the National Quality Forum's list related to fertility clinics. Notably, the National Quality Forum's category "falls resulting in death" was expanded to include death or "falls resulting in serious injury." This expansion was attributed to the information gathered in Connecticut through the list of events compiled by the Commissioner of Public Health. Since mandatory adverse event reporting was initiated in 2002, Connecticut has required reporting of serious injuries related to falls.

Quality of Care Information on the DPH Web Site

Descriptions of the activities of the Health Care Systems Branch are listed under *Health Care Quality* in the Quick Links section of the DPH website (www.dph.state.ct.us). Descriptions for the activities of HCQSAR are listed under *Quality of Care* in the Publications section of the DPH

website, and are also linked through the *Health Care Quality* page under "Health Care Quality Program Reports". Annual Adverse Event reports, Hospital Performance Comparisons reports, and annual reports to the legislature about the Quality in Health Care Program are also posted on the website.

Patient Safety Organizations

P.A. 04-164 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). Representatives from these PSOs presented summaries of their activities at the October 2006 Quality in Health Care Advisory Committee meeting. The following information primarily covers activities since that time.

Qualidigm PSO

The Qualidigm PSO is comprised of long term care 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 most safety and quality issues in health care are national concerns, most of the solutions need to be "local". With that in mind, the Qualidigm PSO continues to offer programs, activities and information that can be adapted to best meet the members' unique organizational environments.

This year the Qualidigm PSO programs have included current infection control issues, a workshop on the SBAR (situation, background, assessment, recommendation) communication tool, and co-sponsorship with the CHREF PSO of an annual Patient Safety Summit. Electronic News Flashes are distributed to participants at least monthly. These News Flashes contain links to recent patient safety related articles, tools, reminders and upcoming events. Additionally, each participating facility submits case studies to the PSO that are "scrubbed" and discussed quarterly in a facilitated forum.

Ambulatory Surgical Center PSO

The ASC PSO has undertaken several key studies in its first year. Led by an experienced and knowledgeable advisory board, the PSO identified anesthesia safety, informed consent and three components of the 2007 national patient safety goals-verbal orders, patient identification and medication reconciliation as top priorities. Study results were presented at mandatory membership meetings and personalized facility reports provided to each member of the PSO following each study.

A website, www.ctascpatientsafety.org, has been developed providing another resource to the members and the public as well. The PSO also produces a newsletter with relevant and cutting-edge patient safety information as well as patient education flyers which are provided to each facility for distribution within the waiting rooms and other areas of the ASCs.

Membership in the PSO has grown to 33 facilities and overall feedback has been very positive. Each study incorporates a new component, with random facility visits used to verify aspects of the 2007 safety goal study and risk management rounds incorporated into the informed consent project. A web-based, Continuing Medical Education (CME) approved module was also created for the informed consent initiative which is also available by CD-ROM for physicians, or under the password protected section of the website. The PSO was recently unveiled at the national Foundation for Ambulatory Surgery in America (FASA) meeting in New Orleans, where several states expressed an interest in developing a similar model.

The next round of studies will include operating room burns, adverse events and specialty studies identified as priorities by each specialty group within the organization. This new study project will allow facilities to benchmark against other providers in the state and nationally, while looking at key patient safety issues relevant to their specialty.

Connecticut Healthcare Research and Education Foundation PSO

All of Connecticut's not-for-profit hospitals continue to participate in the CHREF PSO, which has a mission of promoting patient safety by identifying and disseminating reliable information that can be used to reduce adverse events and enhance the quality of healthcare provided in Connecticut. During the past year, the CHREF PSO has continued to develop a data collection and reporting system to allow hospitals to share information about potential patient safety hazards, coordinated statewide patient safety initiatives, and provided patient safety education.

The CHREF PSO continued two statewide patient safety improvement projects initiated last year related to medication reconciliation and patient safety literacy. The medication reconciliation initiative, in conjunction with partners including DPH and Qualidigm, began dissemination of a wallet medication card to hospitals and agencies throughout the state as well as making it available on the Connecticut Hospital Association (CHA) and DPH web sites. The wallet medication card assists patients to participate in their care by helping them provide current accurate medication information to their healthcare providers.

The CHREF PSO, as well as DPH, Qualidigm, CHA, and Southern Connecticut State University are participating in the patient safety literacy initiative that includes the wallet medication card and development and dissemination of patient education materials regarding hand hygiene and

respiratory etiquette. This past spring the CHREF PSO worked with a graduate student from Southern Connecticut State University who developed patient education materials including brochures, posters and public service announcements. These materials will be disseminated in partnership with DPH, as one activity of the Best Practices subcommittee and the Quality in Health Care Advisory Committee.

The CHREF PSO continues to provide patient safety focused education programs targeted to hospital staff responsible for overseeing patient safety activities in their institutions as well as frontline staff members. The programs, attended by more than 200 professionals committed to improving their ability to provide safe care, provided education in advanced root cause analysis, more effective use of failure mode effects analyses, improving clinical care and improving communication with patients, families and the healthcare team.