REPORT TO THE GENERAL ASSEMBLY

AN ACT CREATING A PROGRAM FOR QUALITY IN HEALTH CARE

JUNE 2010

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State of Connecticut
Department of Public Health

Report to the General Assembly
June 30, 2010

An Act Creating a Program for Quality in Health Care

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ANNUAL REPORT

JUNE 30, 2010

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 briefly 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, 2010.

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 2009 and April 2010. 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's Milford Pressure Ulcer Collaborative Campaign was launched in April of 2009. The campaign is entitled *Have You Loved Your Skin Today?* The collaborative includes Milford Hospital, Golden Hill Nursing Health Care Center, New England Home Care, and Home Care Plus. The Department of Public Health, Qualidigm, Connecticut Association of Not-for-Profit Providers for the Aging, Connecticut Association of Home Care and Hospice, Connecticut Hospital Association, and the Connecticut Association of Health Care Facilities are also working together on this project.

This collaborative pilot project attempts to increase and clarify communication across health care settings related to skin integrity and pressure ulcers. The focus is to prevent the development of pressure ulcers by clearly and quickly communicating the fact that a transferred patient is at risk.

The Collaborative's activities include:

- education of family, patients, and staff
- use of common language related to support surfaces
- use of common language related to pressure ulcer treatment
- increased communication and awareness of those deemed "at risk" throughout the continuum, and
- use of national pressure ulcer staging guidelines throughout the continuum.

The Milford Pressure Ulcer Collaborative began with education of family, patients and staff and increased communication and awareness of those deemed "at risk" throughout the continuum. Campaign materials include a variety of posters and awareness materials including a "pressure ulcer risk stamp" that is being used on transfer documents such as the W-10. A new educational brochure has been developed since the last subcommittee report.

The work of the collaborative continues and the members are prompted to change their posters and signs in scheduled intervals. The initial results were that the participants reported a vast improvement in communication between settings. The collaborative participants will be meeting on a quarterly basis this year to review their progress and to discuss the measurement of improvement in prevention. It will also discuss expanding distribution of all the collaborative materials to other providers statewide as was done with the stamp.

CHA and Qualidigm have a new collaborative on heart failure readmissions. They are looking at several ways to prevent heart failure patient readmissions. Home care agencies, nursing homes and hospitals are participating voluntarily. They are working together to find why patients are readmitted.

Subcommittee on Physician Profiles

The Department went live with online renewals (eLicense) for physicians, dentists and nurses in July 2009. Paper renewal is still available, but the online method is quite easy. DPH is sharing the database with the Department of Consumer Protection (DCP), which allows DPH to leverage resources related to maintaining the system and implementing enhancements. DPH continues to work toward implementing online initial applications and will start with physicians, dentists and nurses. Health care facilities regulated by DPH were also merged into the eLicense system in May 2010. DPH plans to implement on-line renewals for additional health care professions over the coming year.

As of June 1, 2010, 13,880 physicians, dentists and nurses have renewed their licenses on-line since the system was implemented in July 2009. To date, on average approximately 16% of

licensees are renewing on-line. Through this effort, the Department will be able to capture workforce data more efficiently, and it will be helpful with recruitment as well.

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, funding has not been available to implement these provisions of the act.

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

This committee will be maintained in abeyance.

Subcommittee on Best Practices and Adverse Events

The Best Practices Subcommittee met June 24, 2009 and January 6, 2010.

During 2008-2009 the Best Practices subcommittee considered the problem of long Emergency Department (ED) wait times. Initial interest centered on ED patients being triaged in a timely manner. Later the scope of the issue was recognized to be broader, including ED patient flow as well as many other operations within the entire hospital.

Over the past year, numerous hospital representatives shared work products they developed to address ED flow problems. A variety of metrics and algorithms have been developed by individual facilities to ensure timely triaging and patient flow through the ED. A common theme was internal patient flow problems within the hospital infrastructure, and best practices were suggested that each institution could evaluate and then implement changes to existing processes in order to promote improvement.

Relevant work has been done on a national level as well as within our state regarding ED crowding resulting in long wait times to see a physician. A number of Best Practice recommendations have been published to improve triage and wait time in the ED. A list of resources is provided at the end of Appendix A of this report.

The Subcommittee is currently examining best practices for hospital security, included that of infants, prohibition of weapons, etc.

Subcommittee on Cardiac Care Data

This committee will be maintained in abeyance.

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Implementation of P.A. 04-164

List of Adverse Events

In October 2009 DPH produced its eighth adverse event report, which is available on the DPH website at http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/adverseeventreportoct2009.pdf

In accordance with Connecticut General Statute 19a-127n(a)(2), on January 1, 2010, an additional adverse event category (7G) entitled, "Patient death or serious disability associated with surgery" specific to Connecticut was added to the list of reportable adverse events. This category includes significant hemorrhage and/or unanticipated death in an ASA Class 2 patient.

DPH has begun to screen mortality data based on cause of death codes. The department will gather additional information to determine if reportable fatal adverse events occurred, and whether such events were reported to DPH.

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*.

Implementation of 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 (substitute SB 248) was signed into law June 8, 2010. Passages relevant to the quality of care program are:

"For annual reports submitted on or after July 1, 2011, the commissioner shall include hospital and outpatient surgical facility adverse event information for each facility identified (1) by the

National Quality Forum's List of Serious Reportable Events category, and (2) in accordance with any list compiled by the commissioner and adopted as regulations pursuant to subsection (c) of this section. Such reports shall be prepared in a format that uses relevant contextual information. For purposes of this subsection "contextual information" includes, but is not limited to, (A) the relationship between the number of adverse events and a hospital's total number of patient days or an outpatient surgical facility's total number of surgical encounters expressed as a fraction in which the numerator is the aggregate number of adverse events reported by each hospital or outpatient surgical facility by category as specified in this subsection and the denominator is the total of the hospital's patient days or the outpatient surgical facility's total number of surgical encounters, and (B) information concerning the patient population served by the hospital or outpatient surgical facility, including such hospital's or outpatient surgical facility's payor or case mix. In addition, a hospital or outpatient surgical facility may provide informational comments relating to any adverse event reported to the commissioner pursuant to this section. On and after July 1, 2011, any report submitted by the commissioner pursuant to this subsection shall include any informational comments received concerning an adverse event that is included in the report."

"The advisory committee shall establish methods for informing the public regarding access to the department's consumer and regulatory services."

The Department has begun to consider how to present "contextual information" about adverse events, as defined in the above paragraph. The Department will be in close communication with the advisory committee regarding public access to consumer and regulatory services.

IV. 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 Hospital Association Patient Safety Organization (CHA PSO), and the Ambulatory Surgical Center Patient Safety Organization (ASC PSO). The following information covers activities since the June 30, 2009 report.

Qualidigm PSO

The Qualidigm PSO includes providers from long term care, acute care, specialty and behavioral health facilities and outpatient surgical centers. This diverse group of health care organizations

provides an opportunity to acknowledge and address the distinctiveness and commonalities of patient safety issues across settings of care. The Qualidigm PSO believes that, while safety and quality issues in health care are of national concern, most of the solutions need to be local. Following the principles of adult learning, the Qualidigm PSO continues to offer inter-active programs and information that can be adapted to best meet the participant's unique organizational environments.

In 2009-2010, the Qualidigm PSO offered four full day education programs and one half day program to its members. The PSO's first educational offering responded to the overarching concerns of the public and health care providers to protect everyone from the novel H1N1 "Swine Flu". A full day program featuring representatives from the Department of Public Health, epidemiologists and Qualidigm staff addressed how PSO members could "Ban the Bug" and significantly decrease the impact of Seasonal or Swine Flu on their organizations. Complete kits including posters, flyers, "Train the Trainer" materials and staff communication samples were provided to all attendees on user-friendly CDs.

"Ban the Bug" was followed in November with a half day program on performing successful Root Cause Analysis. The Qualidigm PSO continued its active partnering relationship with the Connecticut Hospital Association (CHA) PSO, co-sponsoring the Pressure Ulcer Collaborative, the annual Falls Symposium and Patient Safety Summit. Partnering with the CHA and other patient care centered groups enables the Qualidigm PSO to provide a broader range of resources and activities focused on improving and protecting the safety of patients.

Spring was focused on strategies for "Reducing Healthcare Acquired Infections (HAI)" combined with an intensive "Train the Trainer for Hand Hygiene" educational session. Content experts from the Centers for Disease Control (CDC), the state DPH, and a local infectious disease clinician provided a panel discussion regarding HAI trends, challenges, and mitigation strategies. This final program, attended by health care professionals from across the continuum, and sponsored in part by a grant from the DPH encouraged all providers to become active participants in the World Health Organization's annual campaign to improve hand hygiene.

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

In the face of the recession that forced many people to cut back on their health care, the ASC PSO partnered with the state Department of Public Health on a public education effort to remind people to take the vital steps necessary to protect their health.

In addition to strategically placed billboards in communities around the state, the PSO developed a patient flyer (http://ctascpatientsafety.org/). These reminded patients to protect their most important asset by investing in preventive care such as regular physicals, mammograms, eye exams, colon cancer screenings and making good lifestyle choices.

Following this campaign, the PSO focused its efforts in 2010 on infection control. Certified Infection Control (CIC) specialists introduced PSO members to the tools necessary to implement effective infection control programs. Later the PSO contracted with a CIC specialist to spearhead ongoing infection control initiatives.

The PSO also developed a Healthcare Associated Infection survey tool that measured key indicators of regulatory compliance and best practices among facilities. The resulting dataset maintains the confidentiality of each facility but allows for benchmarking within each specialty and across the full spectrum of ASCs in Connecticut. The survey findings were analyzed and presented to the group.

Public education materials were developed to provide information on Surgical Site Infections (SSI) and the importance of hand washing. Facilities were provided signs to post within their waiting rooms, encouraging patients and their family members to partner with the facility in preventing the spread of infection by regularly using the hand sanitizers provided.

The next study of the PSO will involve SSI surveillance and Hand Washing Compliance. This study will include ongoing data reporting beginning September 1st, compliance monitoring and field validation through random site visits. During the summer, conference calls will be held to ensure observation tools are understood and used effectively in the data gathering phase of this project. The study will also include a staff pledge and public education material.

Membership in the ASC PSO has continued to grow with 45 ASCs actively participating in mandatory membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, it also provided quarterly newsletters and email alerts on important patient safety topics.

Connecticut Hospital Association (CHA) PSO

The CHA PSO, offered through CHA's research and education affiliate, the Connecticut Healthcare Research and Education Foundation, was designated by DPH in 2007, and achieved federal PSO status in December 2009. The federal designation will give CHA a new and significant avenue for collaboration with healthcare organizations throughout the United States.

All but two of Connecticut's not-for-profit hospitals participate in the PSO, which helps hospitals improve patient safety and quality of care through clinical collaboratives, learning communities, education, and resource sharing.

Statewide Clinical Collaboratives

Since 2007, CHA has launched four statewide clinical collaboratives. Through a dedicated website, data collection, educational conferences, conference calls, onsite visits, and listservs, staff from hospitals across the state share information on successes and best practice almost instantaneously. The collaboratives are:

- **Pressure Ulcer Prevention Collaborative:** This was CHA's first clinical collaborative, launched in late 2007. While the 25 participating teams have completed the active data collection and reporting phase, they continue to focus on consistent implementation of proven prevention strategies. Hospital-acquired pressure ulcers (bed sores) have been dramatically reduced as a result of the pressure ulcer collaborative.
- **Multiple Drug-Resistant Organisms Collaborative:** CHA partnered with Qualidigm, which has taken the lead on this collaborative. Multiple drug-resistant organism (MDRO) healthcare-acquired infections, such as methicillin-resistant *Staphylococcus Aureus* (commonly called MRSA) have been reduced at hospitals participating in the MDRO collaborative.
- **Patient Falls with Injury Collaborative:** The 2009 collaborative has already resulted in a reduction in patient falls. Patient falls are a complex problem requiring multi-disciplinary problem-solving, and this collaborative will continue throughout 2010.
- **Reducing Heart Failure Readmissions Collaborative:** In February 2010, CHA, in partnership with Qualidigm, hosted a collaborative kick-off on Reducing Heart Failure Readmissions, aimed at reducing readmissions through improving and standardizing the processes related to the care of the heart failure patient. Millions of people annually are diagnosed with heart failure, and many will be readmitted to the hospital unnecessarily. This collaborative focuses on helping hospitals implement best-practice guidelines proven to reduce preventable readmissions.

CHA PSO Learning Communities

Through CHA's PSO, hospitals are also participating in a national project aimed at preventing central line-associated blood stream infections (CLABSI). Thanks to generous funding from philanthropists and the Agency for Healthcare Research and Quality, The Johns Hopkins University Quality and Safety Research Group (QSRG) is now working with all 50 states to achieve improvements through a project titled "STOP BSI." In Connecticut, the "STOP BSI" project was launched by the CHA PSO in April 2009 with 17 ICU teams participating from 14 hospitals in a meeting with Dr. Peter Pronovost and his team from Johns Hopkins. The 14 Connecticut hospitals currently participating in the project have committed their ICU teams to working collaboratively to eliminate CLABSI within two years by implementing safety checklists, standardizing processes, doing communication training, and measurably improving the culture of safety in the ICU.

Another PSO learning community is participating in the National Surgical Quality Improvement Project, the first nationally-validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care; while another is involved in a campaign to improve surgical safety by piloting a checklist developed by the World Health Organization (WHO).

Patient Safety Summit

Since 2003, CHA has been proud to offer an annual educational summit for healthcare leaders focused on the topic of quality and patient safety. The summit brings experts from around the globe to share the science and improvement strategies known to enhance quality and patient safety. This year, the Patient Safety Summit, sponsored by CHA in partnership with Qualidigm and the Connecticut Association of Healthcare Executives, hosted more than 125 clinicians and healthcare executives, who heard from national experts on safety and quality.

CHA Quality Institute

CHA's Quality Institute offers a broad series of education curricula to provide Connecticut's hospitals with the skills needed to drive quality and patient safety improvements throughout their organizations. Designed for a variety of audiences, from senior leaders to front-line caregivers, Quality Institute programs this year focused on the basics of quality care, quality and patient safety for senior leaders, process improvement tools, and communications tools.

Resources for Patients and Their Families

Connecticut's hospitals have a long-standing commitment to measuring and publicly reporting hospital quality and safety information. Connecticut was the first state in the nation to have 100 percent of its hospitals voluntarily reporting quality data to the Centers for Medicare and Medicaid Services (CMS); and Connecticut's hospitals, through CHA, were among the first in the country to develop a quality performance reporting system that provides information directly to patients and consumers.

To be effective and useful, reporting systems must clearly explain in consumer-friendly language what aspects of hospital quality and safety are being measured and how consumers can use the information. In 2009, the CHA Hospital Quality Reporting website was redesigned to be patient-friendly, clear, and easy-to-use. A new section on CHA's website (www.chime.org), *A Patient's Guide to Participating in Quality Hospital Care*, was developed to provide patients and families with the information and tools they need to ensure a high quality, safe hospital experience.

V. Publicly Reported Hospital Measures of Patient Safety and Healthcare Quality

Einstein's witticism "Not everything that counts can be counted" is as true as the Institute for Healthcare Improvement's motto "Soon is not a time; some is not a number." The culture of an organization dedicated to quality improvement may be expressed in such activities as executive 'walk-arounds' in all areas of the hospital, redesign of the hospital discharge process, or installation of beds designed to prevent pressure ulcers. Readers may wish to ask the staff at

health care facilities what they do to improve patient safety and quality. However, 'walk-arounds' and several other good activities or structures are not discussed here. Presented below is one aspect of quality: self-measurement by institutions and tracking results over time.

Website information was gathered directly from exploration of the Centers for Medicare & Medicaid Services (CMS) and individual hospital websites. Through emails sent in May 2010, hospitals were also invited to revise this part of the quality report. Information about self-measurement and tracking that is publicly available within acute care hospitals was voluntarily sent by hospitals by June 15 in response to emails from DPH. If a hospital is not mentioned below it is either because it did not submit material, or because the material was not measurement data (other than the CMS measures) but rather some other activity not covered here. No request was sent to facilities other than acute care hospitals at this time, although patient safety and quality are important in all health care settings.

Hospital Patient Safety and Healthcare Quality Data on Websites

Hospital Compare was created through the efforts of the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services, and other members of the Hospital Quality Alliance: Improving Care Through Information. The information on this website (www.hospitalcompare.hhs.gov) comes from hospitals that have agreed to submit healthcare quality information for Hospital Compare to make public.

The types of measures shown are:

(1) Processes in the care of heart attack, heart failure, pneumonia, surgery, and children's asthma. Example: giving aspirin to heart attack patients upon arrival at the hospital unless contraindicated;
(2) Outcomes of care. Example: hospital readmission within 30 days for the same condition;
(3) Structural measures, which reflect the environment in which care is given. Example: whether electronic health care records are used;
(4) Patient satisfaction survey results. Example: How often was pain well controlled?
(5) Medicare payment and volume by diagnosis-related group.

Data from all of Connecticut's non-federal acute care hospitals can be found on Hospital Compare. Many Connecticut hospitals also post this data on their websites or link to the CMS website. Some hospitals make more comprehensive data available (below). Such public data-sharing is an excellent tool for hospital self-improvement and a sign of commitment to patient safety and health care quality.

Danbury Hospital participates in the National Surgical Quality Improvement Project.

The Danbury Hospital web page Performance Reports of Quality and Safety http://www.danburyhospital.org/en/Quality-and-Safety/Performance-Reports.aspx has links to hospital data about Falls, Central Line Infections, Ventilator Associated Pneumonia, and Surgical Infections.

The Eastern Connecticut Health Network (Manchester and Rockville Hospitals) plans to post infection rates after a website update this summer.
http://www.echn.org/about/who/measures.aspx

Griffin Hospital posts data about device-associated infections and timeliness:

Ventilator Associated Pneumonias, central line associated Blood Stream Infections, and Urinary Tract Infections; Surgical Site Infections
http://www,griffinhealth.org/Performance/infectionrates.aspx;
and Convenient Care turn-around time during fiscal year 2004-2008
http://www.griffinhealth.org/performance/operatingandclinicalindicators.aspx.

Hartford Hospital's Patient Safety Action Group makes available trend data.

The Hartford Hospital Patient Safety & Quality page is
http://www.harthosp.org/quality/default.aspx. This page links to weekly updates of the Patient Safety Action Group and to graphs with data about Catheter Related Bloodstream Infections, Fall Prevention, Hand Hygiene Compliance, and Pressure Ulcer Prevention. A sample of data in weekly updates is shown below.

The December 17, 2009 Newsletter included Agency for HealthCare Research and Quality (AHRQ) Survey Results and Trends 2007-2009, and Self-Assessment of Organization-Wide Safety Culture. Other newsletters included trends in the web-based Internal Event Reporting system (Nov 19, 2009), Hand Hygiene and Isolation Compliance (Jan 28, 2010), Decrease in ICU Bloodstream Infections between FY 2008 and FY 2009 (Nov 12, 2009), Trends in Patient Falls per 1000 patient days (Sept 10, 2009 and Feb 18, 2010), and Use of Unapproved (hence unclear) Abbreviations in Medical Records (June 3, 2010).

Lawrence & Memorial Hospital in Fall 2010 will display Quality & Patient Safety Data for Falls, Ventilator Associated Infections, Hospital Acquired Pressure Ulcers, Central Line Associated Infections, and the CMS Publically Reported Measures.

Yale-New Haven Hospital provides data about cystic fibrosis and about hand hygiene.

Lung Function in children with cystic fibrosis
http://www.ynhh.org/ynhch/quality/lungfunction.html
Hand Hygiene compliance
http://www.ynhh.org/medstaff/med_bull/09nov.html (Nov 2009 Medical Staff Bulletin)

Patient Safety and Healthcare Quality Data Posted in Hospitals for Public Viewing

This information was provided by the hospitals named, and was edited at DPH.

Day Kimball Hospital posts hand hygiene data in the following locations:

ICU / ITEL Hallway; Med / Surg / Peds Hallway; ED Waiting Room; ACU Waiting Room; MCH (Maternal Child Health) Hallway; PIP (Inpatient Psych) Hallway; Diagnostic Imaging Waiting Room. The last location also includes Outpatient Efficiency Measures

Lawrence & Memorial Hospital posts graphs on a monthly rotational basis.

The data, in the Main 2nd Floor corridor near the cafeteria, includes data such as Hand Hygiene Compliance, Hospital Acquired Clostridium difficile, Readmission Rates, Average Length of Stay, Central Line Infection Rates, and Compliance with National Patient Safety Goals.

Saint Vincent's Medical Center posts their monthly Board Report on Quality.

The Board Report lists measures of quality, the 2009 rate for each measure, 2010 goal, and 2010 results to date. Monthly or quarterly data trends for several measures appear in charts. The Board Report is posted near the front lobby, cafeteria, and other places in the facility.

Sharon Hospital posts quality and safety data.

Sharon Hospital displays the goals and results (updated monthly) for skin care/ pressure ulcer data, patient falls, core measure compliance, and patient satisfaction within the hospital both in individual departments and in public areas.

Other hospitals

Many of the patient-care units in Yale-New Haven Hospital and Bridgeport Hospital post performance data (including hand hygiene at Yale) where patients can view it. In coming months, Norwalk Hospital anticipates the presentation in public forums of performance data on patient falls, pressure ulcers, ventilator-acquired pneumonia, medication errors, mortality, and central line infections. The hospital's Community Relations Department coordinates announcements of public forums. Windham Hospital plans to add metrics for blood stream infections and pressure ulcers to the CMS measures presently reported publicly.

VI. Healthcare Associated Infections Committee

The Healthcare Associated Infections (HAI) Committee, established by legislation, is separate from the Quality in Health Care Advisory Committee. The 2009 HAI Initiative annual report, available at http://www.ct.gov/dph/lib/dph/hai/pdf/annual_hai_report_2009.pdf, presents Central-Line Associated Blood Stream Infection (CLABSI) rates according to hospital size. The HAI committee plans to develop facility-specific reporting and to post data for the period October 2009 through September 2010 on the DPH HAI website in or around January 2011.

On May 27, 2010, the Centers for Disease Control and Prevention released the first state-specific Healthcare Associated Infections summary data report, comparing CLABSI infection rates during 2009 with rates during 2006-2008 among hospitals that follow the National Healthcare Safety Network (NHSN) protocols. Connecticut data are included.
http://www.cdc.gov/hai/pdfs/stateplans/SIR_05_25_2010.pdf

Appendix A

Connecticut Quality of Health Care Advisory Committee
Subcommittee on Best Practices

Emergency Department Crowding, Triage, and Workflow

January 20, 2010

Emergency Department (ED) crowding is a serious and growing problem in the United States. Wait times have increased, and in many instances exceed recommended time frames. Between 2003 and 2006 the average ED wait time to see a physician increased from 46 minutes to 56 minutes. From 2001 to 2006 the average length of stay in the ED and the percentage of patients who left after triage (assessment of how urgently they needed to be seen) but before a medical examination also increased.

Average Wait Time to See a Physician and Percentage of Visits in Which Wait Time to See a Physician Exceeded Recommended Time Frames by Acuity Level, 2006[1]

Patient acuity level (recommended time frame)	Average wait time in minutes	Percentage of visits in which wait time exceeded recommended time frames
Immediate (less than 1 minute)	28	73.9
Emergent (1 to 14 minutes)	37	50.4
Urgent (15 to 60 minutes)	50	20.7
Semiurgent (greater than 1 to 2 hours)	68	13.3
Nonurgent (greater than 2 to 24 hours)	76	0

Per capita ED use has increased nationally. An aging population and decreased access to primary health care appear to contribute to greater ED use.[2]

During 2008-2009 the Best Practices subcommittee considered the problem of long ED wait times. Initial interest centered on ED patients being triaged in a timely manner. Later the scope of the issue was recognized to be broader, including ED patient flow and indeed many operations within the entire hospital.

Experts recognize that quality and efficiency improvement are linked to the measurement and tracking of results. The subcommittee therefore sought to identify measures and best practices that could be adopted by all hospitals in Connecticut on a voluntary basis. Fortunately, relevant work has been done on a national level as well as in our state. The subcommittee therefore makes the following resources available to our statewide partners.

[1] Source: Government Accountability Office analysis of data from Health and Human Service's National Center for Health Statistics (NCHS). NCHS developed acuity levels based on a five-level emergency severity index recommended by the Emergency Nurses Association.

[2] Source: Leora I. Horwitz and Elizabeth H. Bradley, Percentage of US Emergency Department Patients Seen Within the Recommended Triage Time. Archives of Internal Medicine 2009; 169(20): 1857-1865. November 9.

Appendix A

Resources

United States Government Accountability Office, Report to the Chairman, Senate Finance Committee, *Hospital Emergency Departments, Crowding Continues to Occur, and Some Patients Wait Longer Than Recommended Time Frames*, April 2009. Especially, Table 5: Strategies to Address Indicators of Emergency Department Crowding; Table 11: Proposed Measures of Emergency Department Crowding. GAO was asked to examine information made available since 2003 on emergency department crowding. GAO examined three indicators of ED crowding-ambulance diversion, wait times, and patient boarding-and factors that contribute to crowding. To conduct this work, GAO reviewed national data; conducted a literature review of 197 articles; and interviewed officials for HHS, and professional and research organizations, and individual subject-matter experts.
http://www.gao.gov/new.items/d09347.pdf

Leora I. Horwitz and Elizabeth H. Bradley, Percentage of US Emergency Department Patients Seen Within the Recommended Triage Time. *Archives of Internal Medicine* 2009; 169(20): 1857-1865. November 9.

Amy C. Smith, Robert Barry, and Clifford E. Brubaker, *Going Lean: Busting Barriers to Patient Flow*. Chicago: Foundation of the American College of Healthcare Executives, 2008.

Kirk Jensen, Thom A. Mayer, Shari J. Welch, and Carol Haraden, *Leadership for Smooth Patient Flow: Improved Outcomes, Improved Service, Improved Bottom Line.* Chicago: Foundation of the American College of Healthcare Executives, 2007.

ED Manag. 2008 Oct;20(10):115-6. 'Smart card' speeds triage, boosts safety.

ED Manag. 2008 Mar;20(3):29-30. Streamlined process cuts time to triage in half.

Institute for Healthcare Improvement Topic "Flow". http://www.ihi.org/IHI/Topics/Flow/.
Forming the team, setting aims, establishing measures (outcome, process, and balancing measures), selecting changes, testing changes (plan-do-study-act cycle).

Related material: *Queuing Toolpak 4.0*, a Microsoft Excel add-in for waiting line analysis.
http://www.ihi.org%2fIHI%2fTopics%2fFlow%2fPatientFlow%2fTools%2fQueueingToolPak.htm

Valerie Allusson and Rich Klemm. Medical Senior Physician involvement during the admitting process in the emergency department helps improve patient throughput and decrease overall patient length of stay. International Forum on Quality and Safety in Health Care, Nice, France, April 2010, poster 1162.
http://internationalforum.bmj.com.online.uchc.edu/doc/2009/posters/1162%20Allusson%20HMyDocumentsabstractsMMH-ed-poster1.pdf

Appendix A

Agency for Healthcare Research and Quality (AHRQ) sponsored research at AHRQ Health Care Innovations Exchange.

Adopting Flow Management, May 12, 2008.
http://www.innovations.ahrq.gov/content.aspx?id=1714

Team Triage Reduces Emergency Department Walkouts, May 13, 2009.
http://www.innovations.ahrq.gov/content.aspx?id=1735

Two-track ED Process Reduces the Number of Untreated Patients, Lengths of Stay, and Waiting Times, May 27, 2009. http://www.innovations.ahrq.gov/content.aspx?id=1754. Related website: Banner Health Door-to-Doc Patient Safety Toolkit. Reduced time for patients to be seen by a physicians and rate of left without being seen.
http://www.bannerhealthinnovations.org/DoortoDoc/About+D2D.htm

Comprehensive Emergency Department and Inpatient Changes Improve Emergency Department Patient Satisfaction, Reduce Bottlenecks that Delay Admissions, June 9, 2009.
http://www.innovations.ahrq.gov/content.aspx?id=1757

Emergency Department Tracks and Streamlines Patient and Staff Flow, Leading to Shorter Treatment Time, Fewer Walkouts, and Higher Patient Satisfaction, June 30, 2009.
http://www.innovations.ahrq.gov/content.aspx?id=2111

Redesign of Telemetry Unit Admission and Transfer Criteria Leads to Improved Patient Flow and Reduced ED Waiting Times, September 2, 2009.
http://www.innovations.ahrq.gov/content.aspx?id=2239

Asthma "Lounge" Within Emergency Department Reduces Waiting Times, Return Visits, and Hospitalizations, May 11, 2009. http://www.innovations.ahrq.gov/content.aspx?id=2269

Pagers Enable Patients Awaiting Test Results to Leave Pediatric Emergency Department, Improving Patient Flow and Patient Satisfaction, December 22, 2008.
http://www.innovations.ahrq.gov/content.aspx?id=2308

Patient Flow Improvements Eliminate Ambulance Diversions and Reduce Waiting Times for Inpatient Beds, September 30, 2009.
http://www.innovations.ahrq.gov/content.aspx?id=2491.

AHRQ Web M & M (Morbidity and Mortality Rounds Case & Commentary)

Triage Time Bomb (January 2004)
http://webmm.ahrq.gov/case.aspx?caseID=44

Appendix A

Presentations to Best Practices Subcommittee.

Yale New Haven Hospital *Safe Patient Flow Initiative* (begun June 2008; presentation June 2009). Changes throughout hospital: transport deployment, housekeeping schedule, medical staff defines patient discharge status daily using clinical information system, earlier discharge planning, ED and other metrics in Daily Operation Reports, computerized bed management system, coordinator of patient transport out of ED, Executive Throughput Scorecard.

Dr. Louis Graff, *Emergency Department & Hospital Workflow: Addressing Overcrowding* (January 2009). Related materials: Emergency Department Crowding: Consensus Development of Potential Measures. *Annals of Emergency Medicine* 2003;42:824-834.

Dr. Thomas J. Van Hoof, *Evidence-Based Practices of Effective Continuing Medical Educa*tion (January 2009).

Best Practices Subcommittee ED Triage Survey, Results, and Summary (November 2008). Twenty responses among ED directors. Almost all stated that door to triage time and door to evaluation time were measured, and that an ED patient satisfaction survey was used. None agreed that patients must provide insurance information prior to seeing a licensed staff member.

National Quality Forum, *National Voluntary Consensus Standards to Address Care Coordination and Efficiency in Hospital Emergency Departments* (October 2008). Includes 5 measures related to waiting time:

- Median time from ED arrival to ED departure for admitted ED patients;
- Median time from ED arrival to ED departure for discharged ED patients;
- Admit decision time to ED departure time for admitted patients;
- Door to provider (MD)
- Left without being seen

http://www.qualityforum.org/News_And_Resources/Press_Releases/2008/NQF_ENDORSES_MEASURES_TO_ADDRESS_CARE_COORDINATION_AND_EFFICIENCY_IN_HOSPITAL_EMERGENCY_DEPARTMENTS.aspx

Appendix A

Joint Commission Leadership Standard LD.04.03.11 (effective January 2009)

1. The hospital has processes that support the flow of patients throughout the hospital.
2. The hospital plans for the care of admitted patients who are in temporary bed locations, such as the postanesthesia care
unit or the emergency department.
3. The hospital plans for care to patients placed in overflow locations.
4. Criteria guide decisions to initiate ambulance diversion.
5. The hospital measures the following components of the patient flow process:
• The available supply of patient beds
• The efficiency of areas where patients receive care, treatment, and services
• The safety of areas where patients receive care, treatment, and services
• Access to support services
6. Measurement results are provided to those individuals who manage patient flow processes. (*See also* Standard NR.02.02.01, EP 4.)
7. Measurement results regarding patient flow processes are reported to leaders.
8. Measurement results guide improvement of patient flow processes.

http://www.jcrinc.com/common/PDFs/Pubs/Periodicals/Source%20sample%20issue.pdf

Urgent Matters:
An Initiative to Improve Hospital Patient Flow and Reduce Emergency Department Crowding.
Robert Wood Johnson Foundation and
George Washington University School of Public Health and Health Sciences
http://urgentmatters.org/345616/overview

Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments
Lessons Learned by the Urgent Matters Learning Network. (September 2004)
http://urgentmatters.org/media/file/reports_UM_WhitePaper_BurstingAtTheSeams.pdf

The Synthesis Project, Emergency Department Utilization and Capacity (July 2009)
http://urgentmatters.org/media/file/RWJF%20-%20ED%20Synthesis%20Report%20-%20Final_1.pdf

Urgent Matters E-Newsletter
http://urgentmatters.org/current_issue

Urgent Matters Webinars
http://urgentmatters.org/318851

Appendix B

25 May 2010 Email to Acute Care Hospitals from DPH

Dear Patient Safety and Hospital Quality Directors,

In response to feedback on the email I sent in mid May, I want to expand on it in five ways:

(1) The due date for hospitals to respond so as to be included in the upcoming report is June 15.
(2) I will be mentioning not only hospitals that post patient safety or quality data on their website, but also hospitals that post data in the hospital where the public can see it.
(3) I explain below what kinds of data would or would not be mentioned in my report.
(4) I have expanded the draft paragraphs to include a fourth hospital (so far).
(5) I mention the Healthcare Associated Infections committee in the draft.

The Connecticut Department of Public Health (DPH) produces an annual report to the General Assembly about the statewide Quality in Health Care Advisory Committee and activities in relation to *An Act Creating a Program for Quality in Health Care*. The June 2009 report is at http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/generalassemblyannualreportjune2009.pdf.

Starting with the upcoming June 2010 report, DPH would like to celebrate Connecticut hospitals that make patient safety and healthcare quality data available to the public. Shown below is a draft of paragraphs as they might appear. It is possible that additional hospitals would make data available, since all presumably measure, analyze, and track quality indicators, including adverse patient events. DPH is not seeking to compel data disclosures. However, other hospitals may wish to have their efforts recognized in the Quality in Healthcare report. If you make information available to the public that you would like noted in the report, please contact me by June 15 at

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(The remainder of the email is omitted)