REPORT TO THE GENERAL ASSEMBLY

AN ACT CREATING A PROGRAM FOR QUALITY IN HEALTH CARE

JUNE 30, 2011

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Table of Contents

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. The Healthcare Associated Infections Advisory Committee was established by separate legislation and its activities are briefly summarized in section V.

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, 2011.

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 2010 and April 2011. 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 "*Have You Loved Your Skin Today?"* was launched in April of 2009. The collaborative includes Milford Hospital, Golden Hill Health Care Center, New England Home Care, and Home Care Plus, and was expanded to include West River Health Center, a skilled nursing facility. 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.

The focus of the project has been on preventing the development of pressure ulcers by clearly and quickly communicating the fact that a transferred patient is at risk of developing a pressure ulcer.

The collaborative campaign includes:

- education of patients, residents, family members, 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.

Campaign tools include an educational brochure, a variety of posters and the "pressure ulcer risk stamp" that is being used on transfer documents such as the W-10 form.

In September 2010, Milford Hospital presented incidence and prevalence data for hospital acquired ulcers showing an improvement in all stages, but the incidence of community acquired ulcers (residents entering from outside of the collaborative) continued to increase. In response, Milford Hospital scheduled a community educational event for caregivers, and the members of the collaborative agreed to help publicize the event.

All members of the collaborative will continue to meet to analyze data in an effort to measure the success of the program and publish a final report. Qualidigm will be consulted on this aspect of the project.

Subcommittee on Physician Profiles

On-line license renewal was implemented in July 2009 for physicians, dentists and nurses. Approximately 24% of renewing physicians, dentists and nurses are now utilizing the on-line system, which is an increase from approximately 19% from the last reporting period. The goal remains to open on-line licensing, including both initial applications and renewals, to all licensed professions, and to fully populate a healthcare workforce data base.

DPH received a federal grant for close to $2 million to implement mandatory criminal history and patient abuse background searches for individuals who will have direct patient access in long term care facilities. For purposes of this program "long term care facility" means any facility, agency or provider that is a nursing home, as defined in section 19a-521 of the general statutes, a home health agency, as defined in section 19a-490 of the general statutes, an assisted living services agency, as defined in section 19a-490 of the general statutes, an intermediate care facility for the mentally retarded, as defined in 42 USC 1396d(d), a chronic disease hospital, as defined in section 19a-550 of the general statutes, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x. Enabling legislation was passed during the 2011 Legislative

session. DPH will be working closely with the Department of Public Safety and other key stakeholders to implement this program.

This subcommittee is requesting to be disbanded. The subcommittee's purpose and topics have all been completed. DPH staff will attend future meetings to provide updates on any of the Practitioner Licensing and Investigation Section activities, including but not limited to, activities related to physician profiles, eLicense and the new mandatory criminal history and patient abuse background search program.

Subcommittee on Regulations

This committee will be maintained in abeyance until needed again.

Subcommittee on Promotion of Quality and Safe Practices

This committee will be maintained in abeyance.

Subcommittee on Best Practices and Adverse Events

The Subcommittee is currently examining best practices related to three patient safety topics: violence in the hospital setting, prevention of infant drops, and use of patient-owned equipment. Workgroups have convened and are in the process of collecting data. The goal of these work groups is to develop model policies and procedures based on best practices for hospitals to utilize, which can be tailored to the needs of each institution.

Members of the "infant falls prevention workgroup" have been asked to comment on a list of elements to be considered in the initial assessment of mothers for risk of infant falls. The assessment (e.g. maternal fatigue, side effects of medications) will be conducted by a registered nurse or higher-licensed individual. It serves as the basis for the plan of care with regard to infant fall prevention. Connecticut Hospital Association (CHA) staff met with experts in pediatric trauma and care at Connecticut Children's Medical Center to discuss recommended actions to be taken if an infant fall occurs. CHA is developing components of draft guidance on infant fall prevention for future discussion and finalization with the Department of Public Health.

Discussions within the workgroup on patient-owned equipment have focused largely on continuous positive airway pressure (CPAP) equipment, but there are many other types of equipment still to be discussed and considered. At times, based on the patient's condition, the settings to operate the equipment are unknown, posing a risk to the patient. The group is discussing ways to best allow the patient to use their equipment while maintaining safety, especially for those patients whose physicians prefer to have them use their own equipment. This complex area will require a multi-faceted approach to identify recommended practices dependent on the device, patients' clinical needs and other factors. A distinction in recommended practices will likely be made between planned and emergency admissions.

In accordance with **Public Act 10-122**, the Annual Adverse Event Report to The General Assembly, submitted on or after July 1, 2011, must include hospital and outpatient surgical facility adverse event information for each facility. Department staff has been working with hospitals and surgical facilities to present clear, understandable information.

This adverse event information will be presented as a fraction in which the numerator is the number of adverse events reported by a facility. For a hospital, the denominator is expressed as the hospital's total number of patient days. For an outpatient surgical facility, the denominator is the facility's total number of surgical encounters (or # of procedures). This fraction is the rate of reported adverse events.

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. DPH is working with the ASC and hospital staff to determine how to best gather the "contextual information".

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 2010 DPH produced its ninth adverse event report, which is available on the DPH website at http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/adverseeventreportoct2010.pdf

DPH is screening mortality data based on cause of death codes. The department gathers 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 is considering how to best 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, and the Ambulatory Surgical Center Patient Safety Organization. The following information covers activities since the June 30, 2010 report.

Qualidigm PSO

The Qualidigm PSO membership continues to include providers from long term care, acute care, specialty and behavioral health facilities, and ambulatory surgical centers. This diverse group of health care organizations provides a unique opportunity to acknowledge and address the distinctiveness and commonalities of patient safety issues across settings of care. Patient safety and quality issues in health care are of national concern, and the solutions need to be evidence-based and easily adaptable to each unique setting. Following the principles of adult learning, the Qualidigm PSO continues to offer inter-active programs with information that can be utilized to meet the participant's unique organizational environments.

In 2010-2011, the Qualidigm PSO offered four full-day educational programs and one half-day program to its members. Each program had a specific patient safety agenda and targeted practical strategies that could be implemented at each facility.

The first day long program occurred in the fall of 2010. This interactive program was designed to engage the participants in developing practical, usable, and supportable approaches to prevent falls while avoiding the use of physical restraints and alarms. Also in the fall, Qualidigm provided a half-day workshop on preventing pressure ulcers focusing on the non-Caucasian patient. In this workshop, a national expert discussed skin and wound considerations in the non-Caucasian patient as well as signs and symptoms of skin breakdown in this population. As winter faded into spring, the Qualidigm PSO continued its active "partnering relationship" with the Connecticut Hospital Association PSO, co-sponsoring the Heart Failure Readmissions Collaborative, the annual full day-long Falls Symposium, and the Annual Patient Safety Summit. Partnering with the CHA and other health care providers enables the Qualidigm PSO to provide a broader range of resources and activities focused on improving and protecting the safety of patients.

In 2010, Qualidigm also partnered with the DPH to provide a full day-long program with three nationally known experts focusing on strategies for reducing and preventing *Clostridium difficile* infections. This was combined with an intensive educational session on strategies used to promote a culture change to sustain the improvements that are made. These experts also provided a panel discussion regarding *Clostridium difficile* infection trends, challenges, and mitigation strategies. This final program was attended by health care professionals from across the health care continuum and was sponsored in part by a grant from the DPH.

An electronic newsletter, the *PSO News Flash*, is distributed to PSO participants on a monthly basis. These news flashes contain information and 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 with the PSO concepts and functions, the programs and offerings continue to mature. These activities include more in-depth one-

to-one needs assessments with each PSO member and our quality improvement expert, plus the sharing of best practices by the participating organizations.

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

Ambulatory Surgical Center (ASC) PSO

Creating a culture of compliance for infection control remained the focus of the ASC PSO in 2010-2011. With the assistance of a Certified Infection Control (CIC) specialist, the PSO developed an on-going study involving monthly reporting of hand hygiene (HH) compliance among facilities. In-service training was provided to each facility to ensure effective observation and reporting. An observation tool was developed, based on Centers for Disease Control (CDC) guidelines, and reporting began in September 2010. Observation anonymity was encouraged in order to effectively gauge compliance. Random site visits will provide another layer of review and further opportunity for facility education.

The HH study results were compiled into a dataset that maintains the confidentiality of each facility but allows for benchmarking within each specialty and across the spectrum of ASCs in Connecticut. National statistics maybe incorporated into the dataset at a later date.

Facilities have been provided tools to encourage staff compliance, including new posters and staff pledge materials. An innovative HH compliance improvement grid provides monthly staff intervention tools, and an action checklist encourages quality reporting. Patient education materials have been developed, and the ASC PSO staff is completing a Spanish hand-washing flyer to accommodate an even greater patient base.

Safe injection practices became another focus of the PSO this year. The “One and Only Campaign” video was presented to the membership, along with a pre and post study to gauge knowledge and improvement. Copies of the video were secured from the CDC and made available to each facility for staff programming. Extensive programs were also provided on Surgical Care Improvement Project (SCIP) measures, other areas of infection control, and quality improvement programs.

The ASC PSO is exploring specialty topics relative to safety and quality and adverse event reporting. In the coming months, the organization will be completing the process for national PSO listing with the Department of Health and Human Services.

Membership in the ASC PSO has continued to grow, with 60 ASCs actively participating in mandatory membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, the PSO 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 2004, and achieved federal PSO status in December 2009. 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 rapidly share information on successes and best practices. 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 collaborative, which began in 2009, has resulted in enhanced hospital-wide fall prevention programs. Reducing patient falls is a complex problem that requires a multi-disciplinary approach and standardizing fall prevention strategies hospital-wide. Rigorous data collection and a process to identify the common causal factors are necessary to sustain successful fall prevention programs. This year, in an adjunct session, collaborative teams came together to hear about fall prevention programs in six communities that reach across the continuum of care. Presentations by hospitals and healthcare organizations and a keynote address by the director of the Division of Unintentional Injury Prevention, Centers for Disease Control, were featured.
- **Reducing Heart Failure Readmissions Collaborative:** In February 2010, CHA, in partnership with Qualidigm, began a two-year collaborative aimed at reducing heart failure readmissions. Strategies include standardizing the processes related to the care of the heart failure patient from admission to discharge, and to the next level of care. 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. Now in its second year, the collaborative teams are conducting trial interventions and continuing to share and learn from each other and national subject experts on webinars and learning sessions.

CHA PSO Learning Communities

For the third year, through CHA's PSO, hospitals are participating in a national project aimed at preventing central line-associated blood stream infections (CLABSI). The Stop BSI project has 44 states currently participating. In Connecticut, the STOP BSI project was launched in January 2009 with 17 intensive care unit (ICU) teams participating from 14 hospitals. The Connecticut hospitals currently participating in the project have committed their ICU teams to work collaboratively to prevent CLABSIs by standardizing processes related to the insertion, maintenance, and removal of central-lines, and measurably improving the culture of safety in the ICU. In this final year of the project, teams are continuing to spread their successful interventions hospital-wide and will attend a final session to celebrate their collective achievement.

In the fall of 2011 CHA is expanding the Stop BSI project to encompass the Stop CAUTI project, a national initiative aimed at reducing catheter-associated urinary tract infections (CAUTI). The goal of the project is to reduce CAUTIs by 25 percent through the implementation of best practices for the appropriate placement, continuance, and timely removal of urinary tract catheters, and improve the culture of safety in the hospital by utilizing the Comprehensive Unit Based Safety Program. For more information see http://www.safercare.net/otcsbsi/hopkins_direct/entries/2009/9/29_connecticut.html.

This project's objectives align with those of the Department of Health and Human Services' *Action Plan to Prevent Healthcare-Associated Infections national goal to prevent CAUTIs.*

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.

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, CHA sponsored the ninth Patient Safety Summit, in partnership with Qualidigm and the Connecticut Association of Healthcare Executives, and 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; 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 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. HEALTHCARE ASSOCIATED INFECTIONS COMMITTEE

The Healthcare Associated Infections (HAI) Committee, established by legislation, is separate from the Quality in Health Care Advisory Committee. The Connecticut 2011 HAI Hospital-specific report, available at http://www.ct.gov/dph/cwp/view.asp?a=3136&q=474086, presents Central-Line Associated Blood Stream Infection rates according to facility.