



REPORT TO THE GENERAL ASSEMBLY

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

JUNE 30, 2015

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**State of Connecticut
Department of Public Health**

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ANNUAL REPORT

JUNE 30, 2015

I. INTRODUCTION AND BACKGROUND

Connecticut General Statutes sections 19a-1271-n require the Department of Public Health (DPH) to establish a quality in care program for health care facilities. This legislation also directs DPH to develop a health care quality performance measurement and reporting system initially applicable to the state's hospitals. Other health care facilities may be included in the quality program in later years as it develops. An advisory committee, chaired by the DPH commissioner or designee, advises the program. Committee activities are summarized in section II.

Responsibility for the quality of care program within DPH lies with the Health Care Quality and Safety Branch and with the Health Statistics and Surveillance Section. DPH activities appear in section III. Patient Safety Organization activities, established by CGS 19a-127o, are summarized in section IV. The Healthcare Associated Infections Advisory Committee was established by separate legislation and its activities are briefly summarized in section V. The Connecticut Partnership for Patient Safety is described in section VI.

In compliance with the reporting requirement in the statute, the current report describes the activities of the quality in care program over the past year, as of June 30, 2015.

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

Advisory Committee

The QHCAC held meetings in October 2014 and April 2015. During the October 2014 QHCAC meeting, Deputy Commissioner Lewis asked the group to consider the purpose and direction of this Committee. Wendy Furniss provided a detailed history of the Committee, its purpose, and past work. Much of that work is now being done by other committees and workgroups.

At the April 2015 meeting Jean Rexford asked if the QHCAC is doing enough to make information public. She also asked if the Committee should be doing something about the perceived under-reporting of adverse events. DPH cross-checks death reports as one way to ensure complete reporting. Only one violation has been cited for failure to report an adverse event. Ms. Rexford will compile a report for the next meeting.

The Committee decided it would be helpful to have a grid of statutorily required activities and how those activities are either completed or being done by other workgroups. The grid will then be shared with the Committee for discussion.

Subcommittee on Best Practices and Adverse Events

The full subcommittee did not meet during the past year, but DPH members reported to the QHCAC about Adverse Event reports received during 2014. NQF 4F appears to show a significant increase in pressure ulcers between 2012 and 2013. The reason for the increase was due to a change in the definition to include “Unstageable pressure ulcers”.¹

Subcommittee on Access to Care

Definitions Workgroup:

A table titled “Know Where To Go For HealthCare” was drafted using simple language to help consumers select the right healthcare setting for different illnesses and situations. It was a collaborative work with elements derived from a similar chart done by Consumer Reports Magazine. The table was shared with the Committee members for their input at the April 2015 QHCAC meeting. After updating and final review, the Committee will discuss making the document available to consumers.

Research Workgroup:

Members researched literature regarding care settings based on outcome, cost and quality, and provided a summary of each article. There was little evidence available to support using or not using an urgent care center or retail-based clinic. These settings may be beneficial for some who are looking for convenience. However, these settings do not promote a Patient Centered Medical Home model and may negatively impact continuity of care. From the research conducted, a report was drafted and shared with the QHCAC. Some of the information regarding operational models of urgent care or retail-based clinics and overall or national usage for these settings of care was also included in the OHCA’s 2014 Statewide Health Care Facilities and Services Plan.

Subcommittee on Physician Profiles

The Department went live with online renewals for physicians, dentists and nurses in July 2009. Through this effort, the Department is able to capture workforce data more efficiently, and it will be helpful with recruitment as well. The subcommittee on Physician Profiles was retired in 2014 after completing their work, to which the Physician Survey is related.

The Physician Survey was part of a SIM initiative and was completed by UConn. The 21 page survey was mailed to 3200 physicians and had a 39% return rate. A group of DPH staff has begun to review the questions asked to physicians during the e-License renewal process. The group hopes to expand the list of questions to include data that will be helpful to the Department.

¹ See <http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/AdverseEventReport2014.pdf>

The Committee suggested having a group of physicians act as beta testers once the list of questions has been expanded.

Subcommittees Maintained in Abeyance

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

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Reporting of Adverse Events

In October 2014 DPH produced its thirteenth annual adverse event report, which is available at <http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/AdverseEventReport2014.pdf> . Pursuant to P.A. 10-122, *An Act Concerning the Reporting of Adverse Events at Hospitals and Outpatient Surgical Facilities and Access to Information Related to Pending Complaints Filed with the Department of Public Health*, facility-level counts, rates, payer or case mix information, and comments from facilities were included.

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

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

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

Quality of Care Information on the DPH Web Site

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

IV. PATIENT SAFETY ORGANIZATIONS

Connecticut General Statutes section 19a-127o allows DPH to designate “Patient Safety Organizations” (PSOs). The primary role of a PSO is to improve patient safety and the quality of care delivered to patients through the collection, aggregation, analysis or processing of medical or health care-related information submitted to the PSO by the health care provider. This “patient safety work product” may include reports, records, analyses, policies, procedures, or root cause analyses prepared exclusively for the purpose of disclosure to the PSO. The patient safety work product is confidential and not subject to use or access except to the PSO and the health care provider. The PSO will disseminate appropriate information or recommendations on best medical practices or potential system changes to improve patient care to the health care providers, DPH, the Quality in Health Care Advisory Committee, and the public. DPH has designated three PSOs, including the Qualidigm Patient Safety Organization, the Connecticut Hospital Association Patient Safety Organization, and the Ambulatory Surgical Center Patient Safety Organization. The following information, which was provided by the PSOs, covers activities since the June 30, 2014 report.

Qualidigm PSO

Qualidigm PSO

During the 2014-2015 year, the Qualidigm PSO has continued to engage providers from a diverse group of long term care, acute care, behavioral health, and rehabilitation hospitals to identify effective solutions and resources to improve their patient safety practices. As the PSO represents a wide group of settings, its approach has been to address the common issues shared by the facilities while simultaneously addressing the unique and distinctive patient safety concerns found in specific settings. The programs, activities, and information offered this year are summarized below:

Educational Events

Members of the Qualidigm PSO were invited to attend numerous educational events and webinars throughout the 2014-2015 year. One of these was a full-day Care Transitions leadership academy event focused on COPD and Preventing Readmissions with sessions related to COPD from a clinical perspective, medication reconciliation, pulmonary rehab, panel presentations, and patient resources. Members were also encouraged to attend the Better Health Conference in June 2015, which was held at the Foxwoods Resort and Casino, with informative sessions on the future of patient care, advanced care planning, the nurse’s role in patient

engagement, the patient's role in patient engagement, chronic care management, and transitions of care.

PSO member facilities were also invited to and participated in a series of regional webinars hosted by the New England Quality Improvement Network/Quality Improvement Organization on the following topics:

- National Healthcare Safety Network (NHSN) Reporting for the Center for Medicare and Medicaid Services (CMS) Required Healthcare Associated Infection (HAI) Measures for Acute Care Hospitals (11/14)
- *Clostridium Difficile* Infection (CDI): A Growing Threat to Public Health (2/15)
- The Journey of Catheter Associated Urinary Tract Infection (CAUTI) Prevention (3/15)
- Comprehensive Unit-based Safety Program (CUSP) for Hospital Associated Infections (4/15)
- National Healthcare Safety Network (NHSN) Reporting for Hospital Associated Infections (HAI): Understanding Your Data (5/15)

Patient Safety Summit

This year, the 2015 Connecticut Hospital Association (CHA) Patient Safety Summit, co-sponsored by Qualidigm, was open to all of the Qualidigm PSO members. The summit, held at CHA, continues CHA and Qualidigm's successful statewide initiative to eliminate all-cause preventable harm by using evidence-based methods to create a culture of safety. This year's summit was focused on health outcomes, health distribution within a population, health determinants, and the policies and strategies needed to improve patient safety and population health in the transition to value-based care. The Summit included a discussion on how population health impacts vulnerable populations, a thought-provoking patient advocate presentation, a session on safety considerations for elder care, and a presentation on reducing hospital readmissions through population-based interventions.

Site Visit and Needs Assessment

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

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

Newsletter

Based on a commitment to continue to provide a robust and comprehensive source of patient safety information to the Qualidigm PSO members, the newsletter the members receive quarterly has been expanded and enhanced with the most current latest research, articles, tools, and government mandates related to patient safety. The e-newsletter in its quarterly format, which was launched in March 2014, is very well read by the membership. The editors continue to stay abreast of current concerns and Joint Commission updates and to regularly report these and other topics in each issue. The topics covered by the newsletter have included: Ebola preparedness, NHSN reporting, issues and trends in patient safety, Joint Commission resources, upcoming

Patient Safety events, patient and family engagement, conditions of participation, and resources to help with patient hand-off, health communication, and teamwork.

Adverse Reporting Resource Book

The PSO has developed and distributed an updated *Adverse Reporting Resource* book. The book was originally created as a “go to book” for adverse event reporting for our PSO members, and includes all of the Connecticut Department of Health adverse event reporting forms, definitions of mandatory adverse events reporting requirements, and other helpful information for adverse reporting.

Technical Assistance

The Qualidigm PSO has intentionally positioned itself as a resource to its member agencies, and several of these agencies have called upon the PSO for assistance with potential adverse event submission to the CT Department of Public Health.

Connecticut Hospital Association (CHA) PSO

Central to the mission of every hospital is a dedication to providing high quality, safe care for all. The CHA PSO supports this mission by facilitating hospital culture change focused on safety and quality and on patient-centered care redesign.

The high reliability safety movement continues to generate momentum. Since 2011, through the PSO’s high reliability collaborative, more than 25,000 staff and physicians in hospitals across the state have been trained in high reliability safety behaviors at CHA and member organizations. Hospitals are learning, sharing, and applying nationally recognized, evidence-based practices to achieve the highest standards of quality and safety – saving lives every day, and serving as a national model for positive culture change, innovation, and leadership in patient safety.

In December 2014, CHA and Connecticut hospitals completed participation in the largest patient safety improvement initiative ever undertaken as the national three-year Medicare & Medicaid Services (CMS) Partnership for Patients program drew to a close. The Partnership for Patients was designed to reduce preventable inpatient harm by 40 percent and readmissions by 20 percent. During the course of the project, Connecticut was a consistent top-performing state and ended the project in the top quarter. In its summary, the American Hospital Association’s Health Research & Educational Trust (HRET) estimated that over the course of the project, Connecticut reduced events of preventable harm by nine percent, with more than 13,400 events prevented. CHA will coordinate Connecticut hospital participation in a new Partnership for Patients program expected to begin in August 2015.

This year CHA began implementation of a statewide initiative to improve Connecticut hospital performance on key publicly reported infection measures, focusing initially on catheter-associated urinary tract infections (CAUTIs) and driving improvement through peer learning, best practice education, hospital-specific reporting, and targeted interventions. Through CHA, hospitals are also focused on reducing central line-associated bloodstream infections, *C. difficile*,

methicillin-resistant *Staphylococcus aureus* (MRSA), and multiple drug-resistant organisms through the CDC's Emerging Infections Program (EIP) with the Connecticut Department of Public Health's Healthcare-Associated Infections (HAI) Division.

Connecticut hospitals participated with CHA in a surgical quality collaborative that assesses risk factors for surgical complications and shares best practices to reduce the likelihood of surgical site infections, blood clots, perforations, and bleeding. CHA also embarked on a first-of-its kind statewide radiation dose management (RDM) initiative in which healthcare providers across the continuum will collaborate to minimize radiation exposure across the population.

V. HEALTHCARE ASSOCIATED INFECTIONS COMMITTEE

The DPH HAI Program and the state HAI Advisory Committee are summarized here since they represent an important dimension of healthcare quality improvement efforts in Connecticut.

Advisory Committee

The Healthcare Associated Infections (HAI) Committee, established by legislation (CGS 19a-490 n-o), is separate from the Quality in Health Care Advisory Committee.

The Connecticut HAI Advisory Committee (HAIC) focuses primarily on policy changes affecting healthcare associated infections, on public reporting as mandated by CGS 19a-490 n-o. The group advises the department with respect to the development, implementation, operation and monitoring of a mandatory reporting system for healthcare associated infections, identify, evaluate and recommend to the department appropriate standardized measures, including aggregate and facility-specific reporting measures for healthcare associated infections and processes designed to prevent healthcare associated infections in hospital settings and any other healthcare settings deemed appropriate by the committee. The group also discusses ways to collaborate with multidisciplinary local and regional partners, as well as identify specific HAI prevention targets consistent with HHS and CMS priorities.

The Committee provides technical advice to the DPH Healthcare Associated Infections Program for HAI surveillance including advice on medical care, epidemiology, statistics, infectious diseases etc. It also advises the department on the education and training about healthcare associated infections and prevention of healthcare associated infections to applicable persons and healthcare disciplines.

DPH HAI Program

The DPH HAI Program aims to eliminate the preventable fraction of HAIs across the spectrum of healthcare settings through high quality HAI surveillance, dissemination of best practices for prevention, and communication with providers and the public. The HAI program is in the Infectious Disease Section, PHI Branch, distinct from healthcare facility inspections and regulation.

Currently the Program tracks the several HAIs through the National Healthcare Safety network (NHSN) that the federal Centers for Medicaid and Medicare Services (CMS) requires for their healthcare facility quality improvement programs. This includes HAIs from acute care hospitals (such infections associated with central (bloodstream) line and urinary catheters, infections associated with two types of surgery (colon surgeries and abdominal hysterectomies), *Clostridium difficile*, and Methicillin resistant *Staphylococcus aureus* (MRSA). Some of these infections are also reported from Long Term Acute Care Hospitals and Inpatient Rehabilitation Facilities. Outpatient Dialysis Centers report “dialysis events” that include bloodstream infections. The DPH HAI Program is also engaged in surveillance of antimicrobial resistant pathogens, especially Carbapenem-resistant Enterobacteriaceae, which is a group of resistant organisms of special concern by the CDC because of its high morbidity, mortality, and spread. The HAI program has worked with healthcare facilities to foster antimicrobial stewardship to ensure that antibiotics are prescribed appropriately to reduce the development of organisms resistant to antibiotics. It has completed a survey of antimicrobial stewardship programs in hospitals, and will track the adoption of these programs.

Ebola Supplemental Funding

Connecticut was awarded CDC Ebola Supplemental Funding to Epidemiology and Laboratory Capacity to develop and implement a Healthcare Infection Control Assessment and Response (ICAR). This project will include planning, training of healthcare providers and assessment of Ebola readiness among Connecticut Hospitals, which will lead to gap analysis and mitigation of those gaps.

VI. Connecticut Partnership for Patient Safety

The Connecticut Partnership for Patient Safety (CPPS) was officially launched in July 2014. This statewide public private collaborative represents patients, health care providers, payers and employers. The CPPS mission is to create a culture of patient safety across the healthcare continuum through its statewide collaboration which provides education and consultation. CPPS will link patient safety experts with front line providers, payers, employers and health care institution boards of directors throughout the state. The vision of CPPS is “Connecticut leads the nation in patient safety.”

Among the 19 CPPS board members are significant CT leaders including the Center for Patient Safety, CT Hospital Association, CT Medical Society, CT Nurses Action Coalition, Qualidigm and HealthyCT. In November, CPPS sponsored a medication management safety conference attended by 200 health care providers and patients. In March, consultation was provided to US Senators Blumenthal and Murphy at a patient safety issues roundtable.

The board developed and approved a 3 year strategic plan funded in part by CT Office of the Healthcare Advocate. The 2015-16 action plan is in development with a second conference in the planning stages for September 2015. Members of the board are developing a communications plan for the public, healthcare providers, and policy makers. Additional funds to support CPPS are also being solicited.