REPORT TO THE GENERAL ASSEMBLY

AN ACT CREATING A PROGRAM FOR QUALITY IN HEALTH CARE

JUNE 30, 2016

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ANNUAL REPORT

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I. INTRODUCTION AND BACKGROUND

Connecticut General Statutes sections 19a-127 l through n require the Department of Public Health (DPH) to establish a quality in care (QIHC) 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 appear in section II.

The health care quality performance measurement and reporting requirement is met and superseded by the federal CMS Hospital Compare reporting. The 2009 QIHC annual report announced that hospital performance comparisons reports were not required annually and had been discontinued. Prior to that time DPH was reporting the 10 original CMS measures and had no resources to expand. CMS was reporting 40 measures in Hospital Compare in 2009 and has expanded since that time both in measures and facilities included. See https://www.medicare.gov/forms-help-and-resources/find-doctors-hospitals-and-facilities/quality-care-finder.html.

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, 2016.

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

Advisory Committee

In January 2016 Dr. Raul Pino became Commissioner of the Department of Public Health.

The QHCAC held meetings in October 2015 and April 2016. At the meetings, Commissioner Pino asked the group to consider the future of this Committee. To help the discussion, Wendy

Furniss led the group in reviewing the Statutory Requirement Grid handout. The grid notes all of the statutory requirements for the Committee and notes where other committees/councils/workgroups are performing the same or similar work. Group members discussed, at length, the purpose of the Committee, considered recommendations for future work that might be performed by the Committee and discussed changes to the statute. Group members voted unanimously to change the statute to reflect that the Committee "may meet" rather than requiring the Committee to meet twice a year.

The "Know Where to Go for Healthcare" document helps consumers select the right healthcare setting for different illnesses and situations. It was developed and discussed by the Committee, completed, and is available on the DPH website, on the Health Care Quality page at http://www.ct.gov/dph/lib/dph/facility_licensing_and_investigations/pdf/kwtg_cons_guide_10-22-15.pdf . Additionally, the document was shared with Infoline who has posted it to their website and will use it as a guide to respond to phone inquiries they receive. Group members discussed the usefulness of the document and the need for patient education.

III. RECENT AND FUTURE PLANNED DPH PROGRAM ACTIVITIES

Reporting of Adverse Events

In October 2015 DPH produced its annual adverse event report, which is available at http://www.ct.gov/dph/lib/dph/AdverseEventReport2015.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 list of events was reviewed by an existing DPH/hospital work group for possible modification or publication of more detailed guidance for reporting facilities. Recommendations will be presented to the Commissioner. The NQF list will not be modified, in order to allow cross-state comparison.

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 four PSOs: the Qualidigm Patient Safety Organization, the Connecticut Hospital Association Patient Safety Organization, the Ambulatory Surgical Center Patient Safety Organization, and the QA to QI Patient Safety Organization. The following information, which was provided by the PSOs, covers activities since the June 30, 2015 report.

Qualidigm PSO

During the 2015-2016 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. The PSO continues to represent a wide group of settings, and approaches this diverse group by focusing on the common issues shared by the facilities while simultaneously addressing the distinctive patient safety concerns in each facility. The programs, activities, and information offered this year are summarized below.

Educational Events

Qualidigm PSO members were invited to attend numerous educational events and webinars sponsored by Qualidigm during the 2015-2016 year. One of these was a full-day Care Transitions Leadership Academy educational event, ***Showcase of Community Best Practices to Improve Transitions***, with expert panel presentations on medication best practices, innovative practices in care coordination, palliative care practices, INTERACT, and community building. PSO members were also encouraged to attend the Better Health Conference in June 2016 at the Foxwoods Resort and Casino, where they had the opportunity to participate in informative sessions on addressing Alzheimer's, helping your patients make effective healthcare choices, bridging cultural understanding, planning for aging, 2-1-1 community supports, medication safety, caring for veterans, and patient engagement.

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:

- *The ABCs of Antimicrobial Stewardship* sponsored by Maine Quality Counts (9/15)
- *Infection Prevention Collaboration: Hospitals and Nursing Homes* (10/15)

- *Improving Patient Outcomes Using a Collaborative Inter-professional Approach to CAUTI Prevention in the ICU* (11/15)
- *Review of the National Healthcare Safety Network (NHSN) December 2015 Newsletter* (11/15)
- *Efforts to Enhance Medication Safety* (3/16)
- *Improving Clinical Outcomes and Unit Culture through the Development of Safety Attitudes Questionnaire Action Plan* (4/16)
- *Moving from Volume to Value* (4/16)
- *Review of the NHSN March 2016 Newsletter* (5/16)

Patient Safety Summit
This year, the 2016 CHA Patient Safety Summit, co-sponsored by Qualidigm, was promoted 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 offered multiple sessions and perspectives on worker safety and worker engagement with Pamela Cipriano, PhD, President of the American Nurses Association as guest speaker. The summit included presentation on workplace safety initiatives underway in long-term-care facilities, and a closing presentation from Jackie Conrad, Cynosure Health Solutions, a consultant with AHA's Partnership for Patients HEN 2.0 collaborative, on worker safety.

PSO Newsletter and Resource Center
The Qualidigm PSO members receive a quarterly newsletter full of current news, up-to-date research, articles, tools, and government mandates related to patient safety. The e-newsletter is distributed to the members in a handy quarterly format, and this content is key to keeping our membership informed about the most current resources and tools offered by the Joint Commission, AHRQ, National Quality Safety, NPSF, and other national patient safety leaders. This year, the newsletter received an Aster Award for an e-newsletter series, recognizing the valuable content it offers our members.

It is our hope that these newsletters, which represent a robust compilation of resources in every issue, are not only read by our members, but also filed as resources to quickly and easily find topics that will help quality managers and patient safety staff members in their decisions and programmatic choices. The editors continue to stay abreast of current news and concerns, and to regularly report these and other topics in each issue. Selected topics covered by the newsletter this year have included: Antimicrobial Stewardship; National Patient Safety Goals; Patient and Family Engagement; Preventing Falls and Related Injuries; Ebola Preparedness; Infection Prevention and HAI; Patient Safety Issues; NHSN Reporting; Hospital Readmissions; Unintended Retained Foreign Objects (URFOs); Medicare Payment Reform; Adverse Events; Hospital Safety Score, and Workplace Safety.

Adverse Event Reporting Resource Book
The PSO has distributed an updated copy of the *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 event 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, run under the auspices of the Connecticut Healthcare Research and Education Foundation of the Connecticut Hospital Association, supports this mission by facilitating hospital culture change with an emphasis on the six tenets of the Institute of Medicine, from the 2001 treatise *Crossing the Quality Chasm*: safe, effective, person-centered, efficient, timely and equitable care. The CHA PSO is primarily focused on the safety of patients as an underpinning to the other tenets.

This year the CHA PSO achieved several milestones. Because of the desire to participate in the high reliability collaborative, additional organizations have joined the CHA PSO. There are now 28 short-term acute care hospitals, two long-term acute care hospitals, numerous ambulatory practices, behavioral health facilities, and long-term care facilities in the CHA PSO. In addition, the CHA PSO rolled out high reliability to a number of Rhode Island hospitals and is working with Delaware hospitals as a way to reduce preventable adverse events in those states. All of the facilities are dedicated to finding safe reliable ways to improve care.

The high reliability safety movement continues to generate momentum. Since 2011, through the PSO's high reliability collaborative, more than 50,000 staff and physicians in health care organizations across the state have been trained in high reliability safety behaviors at CHA and member organizations. The model for behaviors in highly reliable safe care in Connecticut is CHAMP: Safety Starts with Me. CHAMP includes behaviors in communication, hand-offs, attention to detail, mentoring others—and being mentored, and practicing a questioning attitude. In April of this past year, the CHA PSO was pleased to have a paper accepted for publication in the Journal of Nursing Regulation that discussed the movement toward highly reliable safe care in Connecticut, and the article offered a readiness checklist for hospitals and other healthcare organizations that are interested in the same journey ("Implementing High Reliability for Patient Safety," authors Cooper Mary Reich, Hong Alison, Beaudin Elizabeth, Dias Anthony, Kreiser Steve, Ingersol Clinton P., Jackson Jennifer *Journal of Nursing Regulation*, Volume 7 , Issue 1 , 46 – 52 DOI http://dx.doi.org/10.1016/S2155-8256(16)31041-9

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 continued that effort with the Hospital Engagement Network HEN 2.0 which began in September 2015, and current plans are underway for a three year contract with CMS through the Health Research and Education Trust of the American Hospital Association to continue work on the preventable adverse events started in HEN 1.0. Results through June of 2016 include a decline in early elective deliveries from 12% in January 2013 to 3.49% in January 2015, the most recent publicly reported data available; a standardized infection ratio (SIR) for catheter-associated urinary tract infections of more than twice the national average in 2012 to about half the national ratio in the first quarter of 2016; and a bloodstream infection SIR that has consistently been around half the national average.

This year the CHA PSO continued its work implementing statewide collaboratives to decrease the SIRs in surgical site infections, namely colon surgery and hysterectomies. Through the CHA PSO's partnership with the CDC's Emerging Infections Program (EIP) with the Connecticut Department of Public Health's Healthcare-Associated Infections (HAI) Division, hospitals are also focused on further reducing central line-associated bloodstream infections, C. difficile, methicillin-resistant Staphylococcus aureus (MRSA), and multiple drug-resistant organisms, as well as partnering with the Connecticut Choosing Wisely Collaborative to focus on antimicrobial stewardship.

Partnering with the Connecticut Surgical Quality Collaborative to improve Connecticut hospital performance on key publicly reported infection measures, and driving improvement through peer learning, best practice education, hospital-specific reporting, and targeted interventions, the CHA PSO has identified a number of practices on which they are working. 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. The first statewide data repository for collecting CT scan data has been built at CHA in partnership with Bayer, and analyses of current practices have begun.

The most productive partnership this past year was with the patients, family members, and patient advocates. Beginning with a large conference to assess the state of Patient Family Advisory Councils, and continuing with conferences to assess the availability of information, discuss the prevalence and incidence of infections, and utilizing patients to tell their personal stories of harm at every venue, the CHA PSO enlarged their footprint in the patient and family engagement space. There is still work to do, but working with the Connecticut Center for Patient Safety and the Connecticut Partnership for Patient Safety, there has been so much forward movement.

Last, the CHA PSO has relied time and again on its partner in the Quality Improvement Network arena, Qualidigm, and its relationship with the Department of Public Health. Whether co-sponsoring conferences, marshalling resources to decrease infections, or improving care across the continuum, Connecticut is a model for collaboration, and is fast becoming a model for healthcare safety.

Ambulatory Surgical Center PSO

The ASCPSO remained focused on creating and maintaining an Environment and Culture of Safety within the state's Ambulatory Surgery Centers this year. Mandatory meetings as well as the introduction of some new programs and projects kept our approach consistent and focused.

We kicked off our programming with a presentation driven by the One and Only Campaign, learning from the breakdown in infection control that led to a hepatitis C outbreak in Nebraska. Additional programming focused on Protecting Patients from Infections and Safe Medication Management. We rounded out the year focused on Violence in the Health Care Setting, working with the CDC on a presentation designed to protect patients and providers alike.

Awards

We recently lost a pioneer in the ASC community as Louise DeChesser faced an aggressive cancer and a surprising diagnosis. In honor of her longstanding commitment to patient safety, the ASCPSO established the Louise DeChesser Shining Star Award to recognize an innovator, teacher and leader who emulates the mission of our organization. Already, we had established the Elizabeth B. Bozzuto Patient Safety Award to recognize an outstanding leader who fosters an environment of safety and leads by example. The selection committee welcomed nominations and was pleased to recognize two well-respected individuals this year.

The first Louise DeChesser Shining Star Award was presented to Evyleen McGucken, one of the true pioneers in the development of Connecticut's ambulatory surgery services. She has been a mentor and successful strategist in navigating the development of one of Connecticut's first centers and for decades thereafter assured that her facilities, as well as those she advised, prioritized patient safety. She shared with Louise unwavering voluntary participation in guideline and policy development that continues to serve all of our patients and staff today.

The 2015 Elizabeth B. Bozzuto Patient Safety Award was presented to Betty Windhom, an exceptional advocate who aligns perfectly with both the mission of our organization, as well as meeting and exceeding the established criteria for the award. She stands eager and competent to assist her colleagues with her vast experience in the clinical, administrative, and regulatory arenas. Betty's commitment to patient safety leads her facility and her larger organization in a reliable and focused manner. Time after time her counsel has stood as a framework for others to emulate, and her belief that when you coach the providers and they do well, that you have done well for the patients as well. Betty is unwavering in her pursuit of assurance of patient safety, through her initiatives and intolerance of deviation from best practices.

Break Out Sessions
Recognizing that different kinds of facilities have different needs and patient safety concerns, we continue to foster discussion and an exchange of ideas within our membership through facilitated breakout sessions that have become a regular component of our membership meetings. These sessions give facility staff an opportunity to discuss specific concerns with a facilitator and their peers and keep a checklist of areas of interest. The discussions also help to guide our program development and planning as well.

At the same time, we have developed specialty specific group emails for safety discussion purposes and have developed a blog area on our website for membership discussion across the continuum and within specific specialty areas.

Flu Vaccine
The Flu Vaccine was a critical element of our patient education focus this year and dovetailed nicely with our commitment to patient safety through a goal of 100% compliance for staff. The PSO rolled out a campaign in partnership with our infection control consultant that focused on encouraging compliance for staff and educational materials for providers and patients alike.

Creative posters were developed to encourage patients and providers to get the flu vaccine and a patient flyer was developed and cross-promoted with the Department of Public Health that provided important information, with input from the CDC, on the importance of the flu vaccine and steps that can help prevent the spread of illness.

HONORe Campaign
One and Only Campaign.
We were pleased to partner with the HONORe Campaign and, supported with information from the One and Only Campaign, to provide an exceptional program to the PSO membership. Dr. Evelyn McKnight contracted hepatitis in one of the worst viral outbreaks in American history. While battling cancer, infection control lapses in Nebraska led to her exposure. As a health care provider herself, Dr. McKnight has championed the cause with the HONORe Campaign to spread the word to providers around the country with the goal of preventing future exposures.

Using the money awarded through her legal settlement, Evelyn, her husband, Dr. Tom McKnight, and Nebraska attorney, Travis Bennington, co-founded HONOReform, a public policy organization, and HONOReform Foundation, a 501(c)(3). Through these organizations, Evelyn is fighting to improve America's injection safety practices.

Her presentation, A "Never Event": Don't Let it Happen in Your Facility, was hailed as one of the best we've had to date. Materials on safe injection practices, provided by the One and Only Campaign, were shared with the membership to be used as part of in-service programs at each facility.

Creating an Environment of Safety
With growing concerns over workplace violence and the inherent safety issues within the health care setting, the ASCPSO focused on creating an environment of safety this year. By bringing together subject area leaders and beginning the dialogue, we rolled

out our workplace safety initiative. Mazen El Ghaziri, College of Health Sciences, UMASS presented on Violence in the Health Care Setting to identify areas of concern and provide facilities with a roadmap of what they need to think about. The session included a panel discussion and Q&A with facility leaders, PSO leadership, Mazen El Ghaziri and Richard Klett, Dir. Of Security, Newington Board of Education. We also worked with the CDC on the session and discussed the opportunity to be involved in the development of CDC modules designed to focus on ASCs and other health care settings.

We rounded out the session with a variety of resources that were provided to facilities as well as posters provided by CONNSACS in Spanish and English that provide information on domestic violence for patients and providers alike.

Quarterly Meeting with DPH
Maintaining open channels of communication with the Department of Public Health has remained a focus of the ASCPSO. The meetings provide a good opportunity for discussion about issues and points of focus.

Adverse Events
This study dovetails the state's Adverse Event Data Reporting program, but takes a more in-depth look at the kinds of events that have occurred in ASCs. We expect to use this data to identify opportunities to implement programs and recommendations to reduce the incidence of specific adverse events. As always, the program will include patient materials, policy recommendations and membership programming by leaders in the field.

Conclusion
Membership in the ASC PSO has remained steady with 61 ASCs actively participating in our mandatory membership meetings and data gathering initiatives. In addition to various resource materials developed by the PSO, we also provide newsletters, email alerts and patient flyers on important patient safety topics. We will continue with our "Culture of Safety" programming and expect to focus on creating High Reliability Organizations in the coming months, facility visits and other initiatives.

QA to QI PSO

QA to QI LLC has operated a Patient Safety Organization under the federal Patient Safety Act since 2010 and also under Connecticut statute since 2011.

QA to QI Patient Safety Organization conducted a site assessment for a surgical center and later assisted that same facility in identifying changes to mitigate future risk of infectious disease transmission from employees to patients.

Over the past year, the PSO has continued to work at the national level to identify and remove barriers to the attainment of high reliability in quality and safety in healthcare. This includes raising awareness of the intimate connection of this issue to physician peer review practices. Dr.

Marc Edwards recently published An Organizational Learning Framework for Patient Safety. *Am J Med Qual*. 2016 doi:10.1177/1062860616632295 (2/25/16). The paper analyzes the barriers to achieving high reliability in healthcare and points a way forward.

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 through 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 through o. The group advises the department with respect to the development, implementation, operation and monitoring of a mandatory reporting system for healthcare associated infections, and to 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 to 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. The December 2015 report of the HAI program is at http://www.ct.gov/dph/lib/dph/hai/pdf/hai_legislative_report_2013.pdf

VI. Connecticut Partnership for Patient Safety (CPPS)

The Connecticut Partnership for Patient Safety's mission is to "promote a culture of patient safety across the healthcare continuum through statewide collaboration to provide education and consultation." In 2015-16 the partnership strengthened its organization and purpose by creating a strategic action plan. The partnership built a website, signed an administrative services contract with Qualidigm, and co-sponsored 3 patient safety conferences. The CPPS informed the public by creating a patient information presentation on how to read and understand health care measures. The CPPS distributed this learning tool to the various Patient Family Advocacy Councils located in CT as well making it available on our own website.

During 2016-17, focusing on Connecticut's health care continuum, our patient safety "information aggregator" portfolio to inform the public, health care providers, and policy-makers will be launched. Comprised of website and social media outlets, patient safety updates, measures and information is disseminated throughout the state. Working in partnership with patient safety experts at Consumer Reports and CT DPH, the site is designed to provide easy to understand information on key patient safety factors.

Its board members represent CPPS at a variety of state and national patient safety entities. CPPS leadership includes public and private CT groups including CT Office of Healthcare Advocate, CT Hospital Association, CT Medical Society, Anthem Insurance, HealthyCT, CT Center for Patient Safety Qualidigm and the American College of Health care Executives–CT.