# Annual Report of the
# New Hampshire Health Care Quality Assurance Commission

June 1, 2006
HB 514, Chapter 157:2, Laws of 2005

House Bill 514, which was approved on June 21, 2005, established the New Hampshire Health Care Quality Assurance Commission. Its intent is to enable health care providers to share information about adverse outcomes and prevention strategies and tools in learning environments which foster candor and self-critical analysis while maintaining the confidentiality of the information submitted to the Commission, the proceedings of the Commission, and the results of the Commission's deliberations.

The members of the Commission include one representative from each acute care hospital and free standing ambulatory surgical center (ASC) and the designee of the Commissioner of the Department of Health and Human Services. Polly Campion, Director of Clinical Improvement at Dartmouth-Hitchcock Medical Center (DHMC), serves as chairperson and Rachel Rowe, Associate Executive Director of the Foundation for Healthy Communities serves as administrator of the Commission. (see Membership List, Appendix A)

During its first year, the Commission met five times on the following dates: September 16, 2005, January 13, 2006, February 10, 2006, April 7, 2006, and May 26, 2006.

Activities of the Commission

**September 16, 2005**

At the September 16th meeting of the Commission, the members elected the following officers of the Commission:

**Chair**: Polly Campion, MS, RN, DHMC
**Vice-Chair**: Stephanie Wolf-Rosenblum, MD, MMM, Southern New Hampshire Medical Center (SNHMC)
**Secretary:** Ross Ramey, MD, Monadnock Community Hospital
**Administrator**: Foundation for Healthy Communities, Rachel Rowe

The Commission members agreed to sign a Confidentiality Agreement (see Appendix B) and designate an alternate to the Commission should they not be able to attend.

The members also agreed to:

- work to identify and prevent healthcare associated infections;
- establish a baseline dataset of what information is currently collected by hospitals and ambulatory surgery centers regarding unexpected adverse events, medical errors and near misses.

Two subcommittees were established to direct these two activities:

Subcommittee on Infection Measurement and Practices
Charge: To recommend to the Commission, the scope, definitions and mechanisms for collecting and reporting measures, and policies and procedures which hospitals and ambulatory surgery centers use to prevent and manage healthcare associated infections.

Subcommittee on Data Collection and Error Measurement
Charge: To develop a survey instrument that would establish a baseline dataset of what information hospitals and ambulatory surgery centers collect, measure, and report regarding adverse events within their facilities.

The major reasons why the Commission chose to focus on the identification and prevention of infections are that:

- The Institute of Medicine (IOM), in their 2000 landmark report "To Err is Human," cites surgical infection as a major source of unexpected adverse outcomes;
- Policies and Procedures for preventing and managing surgical infections exist in New Hampshire and can be shared;
- National databases have already been established;
- Every hospital and ASC performs surgery and works to prevent infection;
- Every hospital and ASC collects information regarding surgical infection;
- Every hospital and ASC has the opportunity to improve;
- Evidence based measures already exist.

The intent is for Commission members to use this information to assess current practice in the state and to share information that stimulates meaningful discussion and leads to improved care throughout the healthcare system.

**January 13, 2006**

At the January 13th meeting of the Commission, the Commission members approved the draft Administrative Rules for the Commission and asked that the Foundation for Healthy Communities request the HHS Commissioner to adopt these rules as specified in RSA 151-G:8. That decision is pending in the Commissioner's office.

Subcommittee on Data Collection and Error Measurement:

Dr. Ramey presented the results of the Survey on Data Collection and Error Measurement.

The subcommittee reviewed a number of survey tools designed to establish a baseline dataset of what information hospitals and ambulatory surgery centers collect, measure, and report regarding occurrences within their facilities. The members agreed to use a survey that had been developed by the federal Agency for Healthcare Research and

Quality (AHRQ) with some modifications based on the Commission's focus on infections. The survey was a web-based document and institutions had 6 weeks to complete it.

Results:
As of January 9, 2006, 23 hospitals and 13 ambulatory surgical centers had responded.

Key findings:

- 100% of institutions collect information where harm has occurred or might have occurred.
- Most institutions have an anonymous and non-punitive reporting system.
- A wide variety of information is collected through the reporting system using multiple modalities.

Some areas for opportunity:

- Improve the level of education across the institution around what should be reported, how it should be reported and what is done with the information.
- Increase the number of sources by which institutions learn about occurrences, i.e. hotline, walk arounds.
- Establish a feedback system so that individuals understand the benefits of reporting.
- Improve institutional communication of how care and systems have been improved by occurrence reporting.

**February 10, 2006**

The Commission voted to approve the recommendation that hospitals collect and report quarterly, beginning with quarter 4, October 1, 2005:

1. Prophylactic antibiotic received within 1 hour prior to surgical incision;
2. Prophylactic antibiotics discontinued within 24 hours after surgery end time;
3. Ventilator-associated pneumonia rates;
4. Central line catheter-related bloodstream infection rates.

Hospitals will use the definitions and methodology described by the Institute for Healthcare Improvement (IHI) and included in its 100K Lives Campaign.

The Commission also voted to adopt the central line insertion practices recommended by the Institute for Healthcare Improvement and the Healthcare Infection Control Practices Advisory Committee and to ask hospitals to show evidence that policies and procedures addressing these practices exist and have been approved at their institutions.

Commission members representing St. Joseph Hospital (Nashua) and Lakes Region General Healthcare (Laconia, Franklin) provided excellent presentations of how their institutions create a culture of safety while maintaining accountability.

Commission members representing Frisbie (Rochester), Monadnock (Peterborough), and Androscoggin Valley (Berlin) Hospitals shared stories of how their institutions dealt with adverse events. There was meaningful discussion and unanimous agreement that this exercise provided value to the members. Presenters shared policies and tools developed to proactively prevent recurrences.

**April 7, 2006**

The Commission voted to adopt the recommendation of the Healthcare Infection Control Practices Advisory Committee (HICPAC) report that states that hospitals will vaccinate all eligible inpatients for influenza. Hospitals will submit to the Foundation for Healthy Communities by November 1, 2006, copies of policies that address this recommendation. The Ambulatory Surgery Centers will educate high risk patients (during the months October-May) about the need to be vaccinated. ASCs will submit to the Foundation for Healthy Communities copies of policies that address this recommendation.

The Commission also voted that all hospitals will participate in the surgical site infection measures defined in the national hospital-based initiative, Surgical Care Improvement Project (SCIP). These include: Prophylactic antibiotic received within one hour prior to surgical incision; prophylactic antibiotic selection for surgical patients; prophylactic antibiotics discontinued within 24 hours after surgery end time; cardiac surgery patients with controlled 6am postoperative serum glucose; postoperative wound infection diagnosed during index hospitalization; surgery patients with appropriate hair removal; colorectal surgery patients with immediate postoperative normothermia. Hospitals will provide to the Foundation for Healthy Communities by November 1, 2006, evidence that they have joined the Surgical Care Improvement Project Initiative.

The Commission member representing Concord Orthopedic Center gave an excellent presentation of their best practices related to pain management, discharge instructions, and patient education. The presentation slides and materials are posted on the Commission's secure website.

Commission members representing Dartmouth-Hitchcock Medical Center, Concord Hospital and Bedford Ambulatory Surgical Center shared stories of how their institutions dealt with an adverse event. There was meaningful discussion which followed.

The Commission members completed a survey regarding how many of the National Quality Forum's Serious Reportable Events occurred at their institutions during 2005. The results are considered an unscientific and invalidated baseline of the rate at which major sentinel events occur in the state. According to these data reported by 24 hospitals and 11 Ambulatory Surgery Centers, there are only two categories where more than 7 major events occurred statewide during 2005: Retention of a foreign object in a patient after surgery or other procedure and Stage 3 or 4 pressure ulcers acquired after admission to a health care facility.

All action items and associated due dates are listed in Appendix C.

**May 26, 2006**

The Commission voted to approve the recommendation that all Ambulatory Surgery Centers adopt a set of recommendations for the prevention of surgical site infections based on the Centers for Disease Control document, CDC Recommendations for Prevention of Infection – All Invasive Procedures (Adapted from Mangram, HICPAC and CDC 1999). ASCs will certify that they are complying with these recommendations by November 1, 2006. (see Appendix C)

Infection Reporting – Challenges and Opportunities:

For the first time in New Hampshire, all acute care hospitals reported information regarding the number of ventilator-associated pneumonias (VAPs) and central line bloodstream infections (CLBIs) that occurred in their institutions. For the 4th quarter of 2005, institutions tracked VAPs and CLBIs along with "at risk" days associated with those infections and submitted these data to the Foundation for Healthy Communities. The definitions and methodology adopted for this initiative were established by the Institute for Healthcare Improvement (IHI), as part of their 100K Lives Campaign. As is the case in any new data collection effort, this first quarter was considered a 'pilot' phase to identify the challenges related to the identification and collection of these data. It is also important to note that these data were not validated by an external organization. As such, the results of this pilot phase cannot be considered valid or comparable with other studies until there is consensus on definitions and collection methodology at the state and national level.

The Commission members reviewed the results and engaged in a lengthy discussion about the challenges and opportunities associated with identifying and collecting this information. The most important challenges are those resulting from the small numbers associated with these infections and the methodological issues regarding data collection that remain despite the IHI definitions. It became clear to Commission members that the variation in reported rates was due primarily to differences in how "at risk" days are counted and how pneumonias and infections are classified. These issues are significant enough to the members that they have questions regarding the meaningfulness of the aggregate rate reported in this pilot phase.

However, the opportunities for New Hampshire healthcare facilities with this initiative are significant. The Commission members agreed that this pilot phase was successful in prompting institutions to establish systems to identify and collect this information. There are also several methodological issues which the Commission will address over the next year to enhance our confidence in the uniformity of the data collection. As the integrity of the data improves, we will use this information to facilitate our discussion of best practices and storytelling regarding institutional events and issues and continue to focus on continuous improvement. The Commission members understand that although these metrics will not be perfect in the absence of national consensus based standards, we will improve upon our own statewide efforts to both collect more meaningful information and more importantly, improve care to patients by sharing best practices.

**Ventilator Associated Pneumonia (VAP) statewide rate**: 41 infections/4743 ventilator days or 8.64 VAPs per 1000 ventilator days. Key considerations:

- This statewide rate includes data from 23 hospitals;
- These data were submitted by the hospitals to the Foundation for Healthy Communities and have not been validated by an external organization;
- There is a need to more clearly define what is classified as a pneumonia and who assigns that classification since controversy exists over the optimal method of VAP diagnosis (clinical and culture data).
- Hospitals are working on better systems to count 'ventilator days';
- There continues to be no national consensus on how pneumonias are classified and significant variation in definitional issues and collection methodologies continue to exist among hospitals across the state and country.

**Central Line Bloodstream Infection (CLBI) statewide rate**: 22 infections/6309 central line days or 3.49 infections per 1,000 central line days. Key considerations:

- This statewide rate includes data from 23 hospitals;
- These data were submitted by the hospitals to the Foundation for Healthy Communities and have not been validated by an external organization;
- There is a need to more clearly define what is classified as a bloodstream infection and who assigns that classification;
- Hospitals are working on better systems to count 'central line days';
- There continues to be no national consensus on how central line infections are classified and significant variation in definitional issues and collection methodologies continue to exist among hospitals across the state and country;

**Surgical Infection Prevention measure 1** (Antibiotic received within 1 hour of surgery): 2180 patients received antibiotic/2874 patients underwent specified surgery or 75.85% of patients received an antibiotic within 1 hour of surgery for the specified procedures.

- This statewide rate includes data from 26 hospitals;
- 22 hospitals submitted these data to the federally designated "Quality Improvement Organization" (QIO) where it went through a validation process; 4 hospitals submitted these data to the Foundation for Healthy Communities;
- The national average is 70%.

**Surgical Infection Prevention measure 3** (Antibiotic discontinued within 24 hours after surgery): 2028 patients having antibiotics discontinued within 24 hours/2752 patients underwent specified surgery or 73.69% of patients had their antibiotic discontinued within 24 hours after surgery.

- This statewide rate includes data from 26 hospitals;

- 22 hospitals submitted these data to the QIO where it went through a validation process; 4 hospitals submitted these data directly to the Foundation for Healthy Communities;
- The national average is 53%.

See Appendix D for a summary of member participation and submission of data.

**Summary**

The members of the New Hampshire Health Care Quality Assurance Commission agreed that this first year has been remarkably successful in bringing together hospitals and ambulatory surgery centers with the goal of improving care to patients. The members engaged in a number of data collection and reporting activities as well as the sharing of best practices related to the prevention and reduction of infections. The members also shared their institution's process for identifying and reporting errors, as well as tracking serious reportable events, as defined by the National Quality Forum. There was consensus that this was a year of trust-building and organization and a significant and meaningful amount of work was accomplished.

The Commission will begin Year 2 in July with priority setting and the refinement of existing data collection initiatives. The Commission members voted unanimously to maintain the current leadership team for another year and adopt 2 year terms of office.

The Commission voted to adopt this first year report of the New Hampshire Health Care Quality Assurance Commission.

If you have any questions, please call:

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