NH Health Care

Quality and Patient Safety Commission

Annual Report of the New Hampshire Health Care Quality and Patient Safety Commission

June 1, 2024

RSA 151-G: 1 established the New Hampshire Health Care Quality and Patient Safety Commission. Its intent is *to enable health care providers to share information about adverse outcomes and prevention strategies 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.*

Members of the New Hampshire Health Care Quality and Patient Safety Commission (NHHQPSC) include one representative from each hospital and free-standing ambulatory surgical center (ASC), a designee of the Commissioner of the Department of Health and Human Services, and three 'at large' public members.

Members of the Executive Committee include:

Chair	**Rori Dawes-Dyment,** MS, RN, CNL, CPHQ Patient Safety Officer Southern New Hampshire Health, Nashua
Vice-Chair	**Karen Chandler,** RN, MSN, CPPS, CNML (vacated 12/2023) Senior Director of Quality Assurance and Safety Dartmouth-Hitchcock Medical Center, Lebanon
At Large	**Mallory Hamilton,** MSN, RN, CPHQ, CPPS Senior Director of Quality & Patient Safety Exeter Hospital, Exeter
	Kelly Hussey Director, Quality & Risk Management Cottage Hospital, Woodsville
	Sue Majewski, CASC Chief Operating Officer Bedford Ambulatory Surgery Center, Bedford
	Hannah Sharp, MS, RN, CNL, CPPS Patient Safety Officer Elliot Hospital, Manchester
	Helene Thibodeau, DNP, RN, CCRN, NEA-BC Chief Operating Officer/ Chief Clinical Officer Northeast Rehab Hospital Network, Salem
	Carlene T. Whitcomb, RN, BSN, MBA (vacated 1/2024) Director of Quality Services Littleton Regional Healthcare, Littleton
	Laura Hagley, DPT, FACHE, LSSBB, CPHQ Senior Director of Quality, Valley Regional Hospital
	Denise Lord, RN BSN, MS, CPHQ, LSSBB Vice President of Organizational Performance Monadnock Community Hospital

Executive Summary

The following principles were utilized as a guide by the Commission in our efforts to promote high quality and safe care to all patients seeking services in our organizations. Agenda planning incorporated these principles, including timely topics that support those principles.

Guiding Principles:

Promote	Promote High Reliability Organizations •Improving systems and standardizing processes to yield best outcomes, and to detect and manage unexpected events before they escalate into situations resulting in harm to patients or employees.
Establish	Establish 'Just Cultures' within our Organizations •Creating cultures of safety where staff and providers involved in an error are treated fairly in the investigation process and we clearly understand contributing factors that involve differentiating system and human failures from reckless behavior.
Adopt	Adopt Evidence-Based Best Practices to Improve Outcomes •Using scientific studies to select interventions that are proven to improve outcomes and avoid harm.
Ensure	Ensure Health Equity, Diversity and Inclusion •Incorporate the voice of the patient in adverse event investigation and root cause analysis, pro-active risk assessment and health care system design. Utilize REaL, and other equity data in quality improvement.

Organizational Structure and Activities

The Commission is working under the protection of RSA 151:13a and RSA 329.29A. Commission membership includes one representative from each of the 26 acute care hospitals, the 4 specialty hospitals, and 15 of the 33 free standing ambulatory surgical centers (ASC); a designee of the Commissioner of the Department of Health and Human Services and three "at large" public members. The average number of attendees at Commission meetings is 35-40 members.

All new members received an orientation and signed confidentiality agreements to allow for free exchange of sensitive information among members. All meetings were coordinated, and minutes recorded, by an administrative representative of the Foundation for Healthy Communities.

The Commission had 2 public members who provided the unique perspective of healthcare consumer in the realm of healthcare delivery and quality improvement. Their presence improves the richness of our learning and our effectiveness in what we are trying to accomplish. This year, public members offered feedback and general observations about

meeting topics and discussions, and they were integral to enhancing the collaboration and sharing amongst members.

In its nineteenth year, the Commission met five times on the following dates:
August 4, 2023
October 6, 2023
January 12, 2024
March 8, 2024
May 3, 2024
All meetings were in-person with a virtual Zoom option for extenuating circumstances. The Executive Committee met immediately after each meeting to debrief and to set agendas for future meetings with suggested topics that reflected current priorities focused on eliminating harm and improving quality.

This year, we utilized a combination of Ice Breaker, Round Robin, and Story Telling tactics to elicit feedback and sharing from all members on priority issues. Topics included innovations regarding falls prevention, sharing of success stories, pain points and challenges, meaningful quality metrics for medical staff, and legislative review of bills impacting quality and patient safety.

Prevention of Harm Topics the Commission Focused on this Year Included:

☑ Health Equity and Standardization of Care

The Director of the Office of Health Equity (OHE) at NH Department of Health and Human Services (DHHS) educated the commission on the purpose and goals of the office as it works to support marginalized groups and refugees across the state. Information on trainings and technical assistance available to health care organizations and professionals was shared.

The goal of collecting comprehensive quality demographic data to achieve standardization was discussed as well as how to align state data with national regulatory agencies such as the Centers for Medicare and Medicaid (CMS) and The Joint Commission (TJC). The OHE will be creating a survey for health care entities to explain the data points and systems they currently have in place to assess health equity, which will ultimately help inform state data collection initiatives and processes.

The OHE is a resource for interpreter assistance for hospitals and ASCs and can be especially helpful for rare languages. Members discussed challenges and solutions for providing interpreter services as well as shared projects they have underway, or are considering, to advance health equity. Health equity teams include representatives from population health, community partners, administrators, quality leaders, social workers, clinicians, information technology and care partners.

☑ Journey to Zero – Surgical Smoke, Protect the Air You Breathe

The President of the NH Chapter of the Association of Peri-Operative Nurses (AORN) explained the goals and initiatives of peri-operative nurses including patient safety, quality initiatives and standardization, and peer to peer support for perioperative nurses. Members learned about the hazards of surgical smoke and its impact on health care workers (HCW). Smoke evacuation options and solutions were discussed, as well as potential barriers to implementation and strategies to overcome these barriers. Executive leadership support is essential, as well as review by purchasing and finance related to cost and reimbursement considerations. Members shared information on initiatives they have implemented to decrease surgical smoke and details on AORN's clean air designation were presented.

☑ Regulatory Deficiencies/Lessons Learned from CMS & Accreditation Surveys

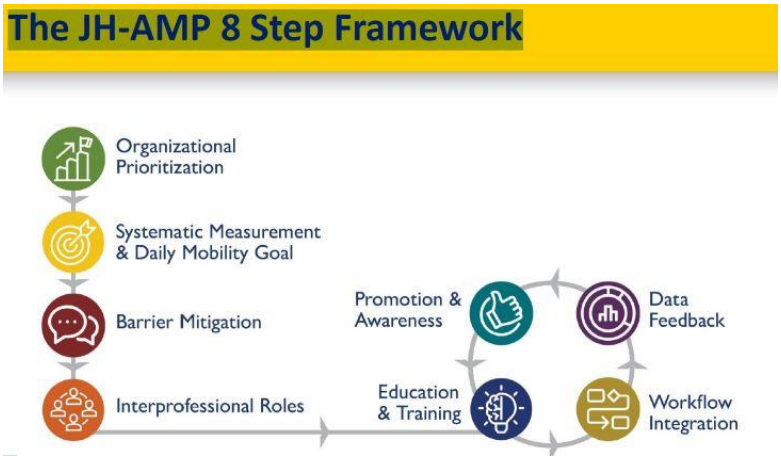
Hospitals and ASCs regularly undergo rigorous CMS or Accrediting agency (i.e., TJC or Det Norske Veritas (DNV)) surveys to ensure compliance with CMS Conditions of Participation and state licensing requirements. Members openly shared survey results and focus areas including physical environment requirements; root cause analysis documentation; quality measures and tracking in contracts; ligature risk assessment documentation; life safety compliance; antimicrobial stewardship; consent forms, and specific requirements for stroke centers.

☑ Innovations for Fall Prevention and Johns Hopkins Activity & Mobility Promotion Program

Members discussed activities planned to raise fall prevention awareness during National Falls Prevention Week. Preventing patient falls and preventing injury to patients at high risk for falling, continues to challenge health care teams. Members shared innovations and strategies positively impacting fall rates including:

- Video surveillance monitoring to provide additional support to the care team and to allow for immediate engagement and intervention with patients.
- Continued focus on early mobilization of patients and increased mobility during hospitalization.
- Use of tools and assistive devices (i.e., gait belts, sit to stand devices, etc.) to support balance while providing safety for patients and health care workers.
- Engagement with patients' families as care partners, including education on mobility goals and fall prevention measures.

Leaders of the Johns Hopkins Activity & Mobility Prevention (JH-AMP) program met with the commission to explain the JH-AMP 8 step framework to increase patient mobility with the goal that every day, every patient, has a mobility goal included in their care plan. Increasing patient mobility is the responsibility of the entire care team and clear role delineation, accountability, and data collection and measurement are cornerstones of a successful fall prevention program.



☑ Drug Diversion Prevention- Lessons Learned, Initiatives & Tactics

A member presented their drug diversion prevention program and shared common themes among high profile drug diversion cases occurring across the United States. The value of software-based analytic tools to enhance monitoring and auditing of controlled substance administration was discussed, as well as the need to look at individual practice patterns to identify variability and outlier behaviors not typically expected within a peer group. Information was provided on the resources of the International Health Facility Diversion Association and an evidence-based checklist outlining typical diversion behaviors was shared.

☑ CMS National Quality Strategy & the Future of Quality Measurement

The Chief Medical Officer, Quality Measurement and Value-based Incentives Group, Center for Clinical Standards and Quality, CMS, traveled to NH to meet members and to explain the strategic plan and goals for federal health quality measurement. CMS Quality Incentive Programs and Care Compare programs were reviewed as well as lessons learned from COVID-19 and how they are influencing national safety strategy. These include expansion of digital and telehealth capabilities; rapid scientific advancements; stark equity gaps; nursing home care issues; need for interoperable data; frailty of safety systems; resilience challenges including workforce; and struggling healthcare systems.

Quality measurement will continue to prioritize patient safety, digital transformation, maternal health, behavioral health, patient centered care and health equity including social drivers of health.

☑ Preventing Pressure Injuries

Members took a deep dive into the root cause analyses (RCA) and demographic data for 2023 reportable pressure injuries. Key finding include:

- Increased acuity and presence of stage 2 pressure injury from long-term care settings.
- Inconsistency with 'present on admission' documentation and the need for shorter timeframe for pressure injury risk assessment upon admission.
- Skin integrity discussions by the multi-disciplinary team during patient rounds.
- Wound specialists for each high-risk in-patient unit and just in time education for clinicians.
- Wound specialist leading multi-disciplinary RCA for all stage 3 & 4 pressure injuries, with dietary and physical therapy key to the process.
- Skin assessments in Emergency Departments (ED) to identify concerns immediately and initiate early interventions.

Rapid-cycle Improvement Program
Pressure Injuries Assessment

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

The Eastern US Quality Improvement Collaboration (EQIC) Rapid-cycle Improvement Program for Pressure Injuries Assessment was shared which provides a mechanism for organizations to identify gaps in practice compared to evidence-based interventions.

☑ Multidrug- Resistant Organism Case Review & Investigation

Presentation by member on the process for investigating a cluster of infections involving multidrug- resistant organism within the hospital and community homeless shelters. Member described actions taken by the organization, NH DPH, and the Centers for Disease Control (CDC) to determine mode of transmission and to conduct screening, testing, observations, and environmental sampling to prevent additional infections. Tools and resources were shared.

☑ Improving Substance Use Disorder Care- Lessons from the Field

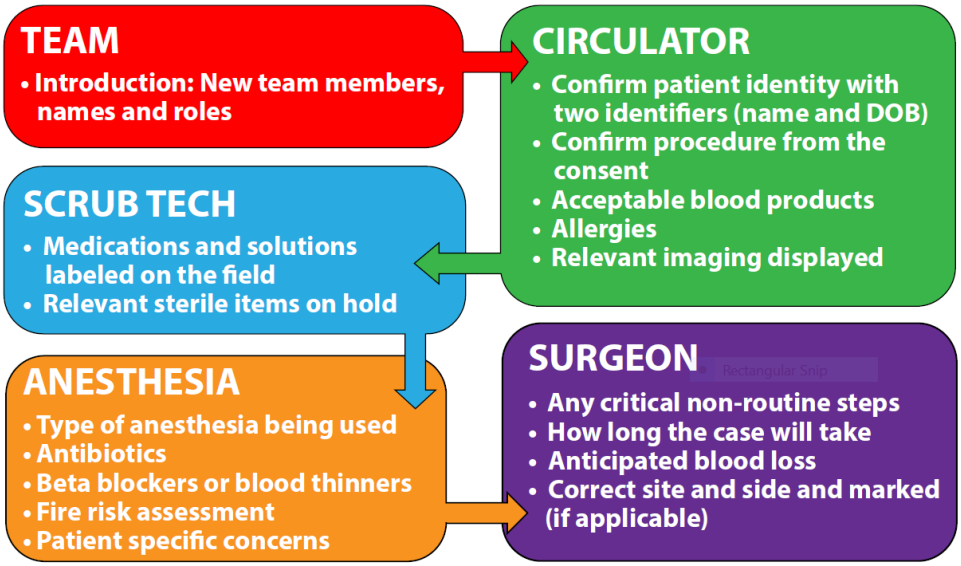
Foundation for Healthy Communities Director of Substance Use Disorder (SUD) Treatment Project joined the commission to disseminate information on three projects aimed at improving care for patients with SUD:

- NH hospitals' commitment to offering medication assisted therapy in emergency departments to patients with opioid use disorder; providing Narcan at discharge to these patients; and facilitating referrals to treatment and recovery, by December 31, 2024.
- The MOSAIC- Reverse the Cycle project with goals to streamline ED overdose responses and medication assisted therapy and interventions lead by peer recovery coaches.
- The Hospital Substance Use Disorder Treatment Project continues to engage hospitals in SUD quality improvement projects with focus areas including ED, in-patient units, and outpatient care settings.

☑ Adverse Events Review

Ongoing collaboration with the State of NH Licensing and Regulation Services staff includes quarterly adverse event reports, including summary demographic information on falls and pressure injuries which provide members increased opportunity to validate data, ensure adherence to the adverse events reporting process, and plan for improvement to prevent future events.

Members engaged in a 'story telling' exercise by all organizations who reported a wrong site surgery, providing details of contributing factors and corrective action plans following root cause analysis. Common themes include increased errors when staff are rushed during high turnover cases; patients and families may identify the wrong site during pre-procedure validation and a hard stop must be called if any confusion arises; post procedure huddles conducted in real time help identify 'near misses'; there must be a culture where staff feels comfortable 'stopping the line' for a safety concern; and strict adherence to the Universal Protocol/Time Out procedure is essential:



☑ Public Health Updates and Information Sharing

Collaboration between healthcare partners and public health is essential for the quality and safety of patient care in NH. For this reason, there is dedicated agenda time at each Commission meeting for the NH State Epidemiologist to provide updates on relevant topics and for members to ask questions and provide feedback. Topics included:

- Food and Drug Administration's Vaccines and Related Biological Products Advisory Committee (VRBPAC) recommendations for updated COVID-19 vaccines for use in the United States in Fall 2023.
- New RSV vaccine recommendations for people aged 60 plus years; maternal immunization to prevent RSV in infants; nirsevimab vaccine for infants and high-

risk children. Members suggested that Department of Public Health (DPH) create a 2023 respiratory season vaccine guide as new recommendations can be confusing.

- Review of mosquito and tick born transmission of disease and public heath's efforts to raise public awareness and increase preventative measures.
- An overview of carbapenem resistant organisms and carbapenemases in NH and how they have increased across the United States. Mechanisms for transmission and prevention were reviewed.

Quality and Patient Safety Considerations in the Post Pandemic Era

May 11, 2023, marked the end of the three- year Federal COVID-19 Public Health Emergency. An article in the February, 2022 edition of the New England Journal of Medicine explained how the COVID-19 pandemic put enormous strain on the health care system, disrupted normal operations for hospitals and other health care facilities, and caused safety concerns for patients and staff.[1] Years of national downward trend of adverse event rates and health care associated infections were reversed during the pandemic with both rising substantially in the post-pandemic era.[2] The Joint Commission's voluntary reporting of sentinel events shows reporting patterns for the first 6 months of 2023 similar to 2022, with a continued increase in events as compared to pre-pandemic timeframes[3]:

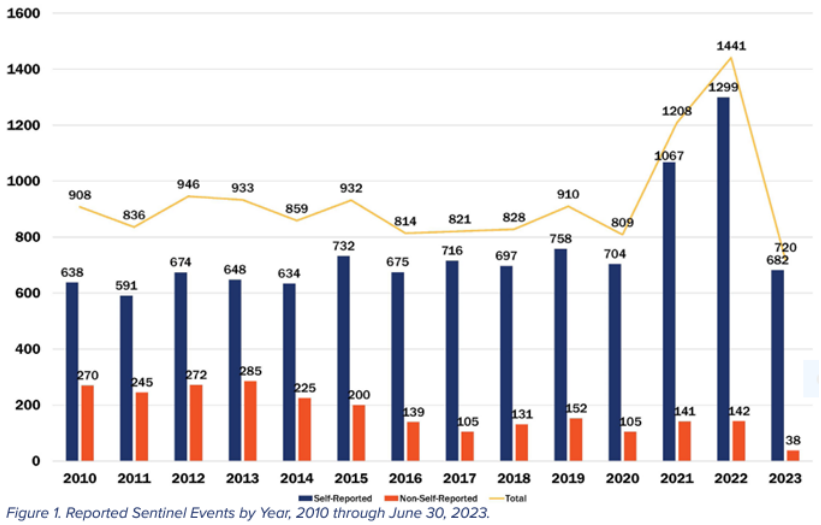


Figure 1. Reported Sentinel Events by Year, 2010 through June 30, 2023.

[1] Fleisher, L. E., Schreiber, M., Cardo, D., & Srinivasan, A. "Health Care Safety during the Pandemic and Beyond-Building a System that Ensures Resilience." *New England Journal of Medicine* 386, no.7 (February 2022); 609-611.
[2] Bates, D.W, et al. "The Safety of Inpatient Health Care" *New England Journal of Medicine* 388, no.2 (January 2023; 142-153). DOI:10.1056/NEJMsa2206117.
[3] https://www.jointcommission.org/resources/sentinel-event/

While the NH experience with adverse events in 2023 is like national trend, hospitals and ASCs saw decreasing events each quarter as the year progressed. Members explained factors contributing to this positive trend including:

- Decreasing reliance on contract staff.
- A more consistent supply chain and clinicians more familiar with products and supplies.
- Quality leaders resuming normal activities and rebuilding broken processes.
- Rebuilding cultures of safety and re-establishing procedures and structures (i.e., unit-based quality improvement councils) to improve quality and safety.

Factors continuing to hamper improvement efforts include longer lengths of stay for medically cleared patients awaiting discharge disposition and a backlog of patients waiting in EDs for an inpatient bed; catch-up for surgical procedures with packed schedules and pressure on clinicians often feeling rushed; and exodus of experienced staff who practiced proactively rather than being focused on the task at hand.

The commission continues to acknowledge the relationship between quality and an adequate health care work force, and it urges legislators to enact programs and policies to support and to rebuild this precious commodity in NH.

Summary

In its 19th year, the Commission returned to in-person requirement for meetings, furthering teamwork and collaboration among members, as they engaged in learning, sharing, and problem-solving to prevent medical harm. Commission topics continued to align with other efforts in the state including the work of many divisions within the Department of Health and Human Services, the Eastern US Quality Improvement Collaborative, CMS Quality Improvement Organizations, and other professional organizations, to avoid redundancy and maximize efficient use of resources and to compliment work.

The Commission recognizes the goal of Zero Harm in health care, and it will continually focus efforts on this goal as it begins Year 20 in August 2024. Promoting high reliability organizations, cultivating 'Just Cultures' in hospitals and ASCs, adopting evidence-based best practices and incorporating the voice of the patient will remain at the forefront as we also consider the role diversity, equity and inclusion play in harm reduction. All public documents related to the Commission can be found at www.healthynh.org.

For questions, please call: Rori Dawes-Dyment, Commission Chair: (603) 281-6831 or Kris Hering, Administrator: (603) 415-4271.

Respectfully submitted,

Kris Hering

Kris Hering,
Administrator, NH Health Care Quality and Patient Safety Commission

Foundation for Healthy Communities
Partnering to improve health for all.