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Message from Our
Chief Executive Officer

Hartford HealthCare’s vision emphasizes two of our core values: safety and excellence. We aspire to be “nationally respected for quality in patient care and most trusted for personalized, coordinated care.” The national respect for our quality is not an end in itself. It is outside recognition of the consistently excellent care we provide to our patients and families. We earn the trust in “most trusted” by pledging to do no harm. Safety is at the heart of everything we do.

The 2015 Hartford HealthCare Safety and Quality Report describes our efforts to uphold and sustain these two values across our continuum.

We began our system-wide approach to advancing quality and safety by identifying “hot spots” — critical patient-safety areas. We have had great success, including hand-hygiene compliance, in which we have moved from 54 percent compliance to 94 percent and become a national leader. Over two years, catheter-associated urinary tract infections have dropped by 21 percent. We have seen a 30 percent reduction in our mortality rate and a 34 percent reduction in length of stay for severe sepsis. And our rate of severe safety events has been dropping steadily for three years.

These are not isolated successes. We are building a culture of safety and the organizational infrastructure to support it. All of our efforts are overseen by our 33 clinical councils, which are led by caregivers. We have married our enhanced safety-and-quality focus to our cultural-transformation platform, How Hartford HealthCare Works (H3W). We have trained more than 12,000 Hartford HealthCare staff members in high-reliability practices that dovetail with the Lean practices we are incorporating into H3W. And, through our CareConnect program, we are building out our electronic health record and our analytics capabilities. CareConnect, by seamlessly and securely connecting providers and patients with health information, will help us strengthen our safety and further advance our quality.

I invite you to read this annual report as a snapshot of our journey toward providing the best care and highest possible level of safety. We have made tremendous progress, but we still are on the path. I know that the people of Hartford HealthCare will continue to move ahead, creating healthier communities and ensuring that we will continue to be the high-value care choice for people across Connecticut.

Sincerely,

Elliot Joseph
President and CEO
Hartford HealthCare
Message from Our Chief Medical Officer

Our Quality and Safety Journey at Hartford HealthCare

Six years ago, Hartford HealthCare laid out its vision to become “nationally respected for excellence in patient care and most trusted for personalized coordinated care.” The vision drives our intent to provide the highest-quality care and the best possible outcomes.

Many healthcare systems heightened their focus on quality in the wake of “To Err is Human,” the 1999 report from the Institute of Medicine that increased awareness of medical errors. The report, based on a number of studies, concluded that anywhere from 44,000 to 98,000 people die every year due to preventable medical errors.

The Hartford HealthCare leadership team made consistent high quality an element of our core vision, and from the outset, we recognized that mere competence with regard to quality and safety was not enough. The aspiration is to be nationally ranked in this area. This would be our calling card.

The Hartford HealthCare system — in the early phases of full integration — set out to create an organization-wide quality program. This report reviews the journey and progress made and describes the challenges that remain in an environment increasingly dominated by consumer choice.

Sincerely,

Rocco Orlando, MD
Senior Vice President & Chief Medical Officer
Hartford HealthCare
Quality, Safety and Value
An Overview of Our Path

The Hartford HealthCare safety journey has been devoted to increasing safety and quality across the board in our hospitals and outpatient settings. Our system has made great progress in measuring and improving performance and is committed to leading the region in making the transition from volume-based payments to value-based payments.

High quality has a proven ability to lower costs — both for employers and healthcare consumers. Our value proposition to the community also must extend from performance monitoring to reducing the prevalence and severity of diseases such as hypertension and diabetes. Better care results in better quality of life and a decrease in the use of high-cost interventions, such as hospitalizations and surgery. We must develop better tools to evaluate the effectiveness of treatments: Are our diabetic patients having fewer heart attacks, fewer amputations and less kidney failure?

Reducing chronic disease, through improved care coordination and management, is our goal.
Integrated Care Partners:
Delivering Value to Consumers, Employers and Payers

Integrated Care Partners (ICP) is a clinically integrated provider network that unites Hartford HealthCare system hospitals, employed physicians and community private practice physicians in a coordinated effort to improve the health of our patients and the communities we serve. ICP physicians collaborate to improve quality and safety, enhance the patient experience, and reduce the cost of care. ICP has more than 1,800 providers, including nearly 350 primary care providers, and is leading the way in our journey to improve population health and drive value.

Driving Meaningful Change
Healthcare is in the midst of dramatic changes across our country. The Centers for Medicare & Medicaid Services (CMS) is leading the move away from traditional fee-for-service payment toward alternative payment models and value-based care. ICP’s goals are focused on the need to coordinate care, create value for all constituents (patients, physicians and Hartford HealthCare), and accept accountability for the cost of care by accepting risk. ICP helps physicians manage the evolving healthcare environment in several ways:

- Establishing best practices and standards of care.
- Delivering on those standards for patients.
- Collaborating with a team of care managers (registered nurses, social workers and health coaches) to improve clinical outcomes and lower the cost of care.
- Collaborating with behavioral health clinicians and pharmacists to help manage the complex nature of chronic illnesses.
- Providing access to a uniform electronic health record (EHR) or the ability to integrate with an existing EHR.
- Providing access to data analytics to help physicians understand how they are performing with respect to standard cost and quality measures.

Through ICP, Hartford HealthCare participates in Medicare Shared Savings Plans — Medicare Accountable Care Organizations (ACOs) to do this important work. Our scores for the quality measures established by CMS have placed us (in 2014) in the top 20th percentile in a year when our ACO generated $5.6 million in savings.

Hartford HealthCare Ranks in the Top 20th Percentile for ACO Savings Compared to National Peers
Consumer-Driven Healthcare

Ultimately, our quality metrics are for our customers. We speak frequently about “activated” consumers — the healthcare customers paying a larger share of the cost of care than ever before. Nearly 25 percent of Americans with employer-sponsored health coverage are in high-deductible plans, up from 12 percent in 2010. Industry observers expect these patients to shop for care more aggressively over time as their share of costs increases. There is little evidence that this is happening in a big way yet. A recently published research letter concluded that consumers don’t yet have all the information they need to make informed choices about care.

The quality information now available is highly variable and difficult for the average consumer to navigate. Most of these data are made available to the public on Center for Medicare & Medicaid Services (CMS) websites. However, the various CMS sites, including Hospital Compare and Physician Compare (coming online in FY 2016), are just a few of a growing number of consumer sites that report on healthcare quality. These include Consumer Reports (magazine and website), U.S. News & World Report, Healthgrades, Leapfrog Group, Castlight, and various health plans. In addition, nontraditional, user-review sites, including Angie’s List and Yelp, have begun ranking healthcare providers. Health insurers and some state-based rating groups also rank hospitals and other provider organizations.

Unfortunately, this collection of reviewers comprises a quality-measuring Tower of Babel. Each uses its own methods and emphasizes different aspects of care. As a result, no hospital was rated as a high performer by all four national ratings systems: Consumer Reports, Leapfrog, Healthgrades and U.S. News & World Report. Only 10 percent of the 844 hospitals rated as high-performers by one rating system were highly rated by any of the others (Austin et al., 2015). In addition to variation among ranking organizations, each group also modifies its criteria with some frequency.

While we consider the rankings important as a guide to consumers, we note that our program of quality improvement includes metrics that are common to the various scoring structures: patient experience, patient safety indicators, readmissions and hospital-acquired infections. We believe that if we continue our focused approach to quality in these areas, we will raise the bar on consistent high quality for our customers and, coincidentally, improve our ranking in various consumer-facing listings.
Looking FORWARD

As consumers become more sophisticated in comparing services, we must be prepared to share outcomes data that currently are not part of the mix. For example, our customers will want to know their chances of dying as a result of an operation or procedure. Our cancer patients will want to know the five-year survival rate for a particular tumor when they are under our care, rather than survival-rate statistics from studies conducted at other cancer centers. Hartford HealthCare has this information to share for cardiac surgery, angioplasty and a number of surgical procedures and is building the capabilities to answer these questions for an increasing number of conditions.

A handful of hospitals and healthcare systems go beyond the required Centers for Medicare & Medicaid Services (CMS) metrics. Some national leaders offer outcomes and volume data on a range of its service lines, from cardiovascular care and gastroenterology to transplant programs and breast cancer care. In breast cancer care, some institutions offer comparative scores on access, patient experience, compliance with the standards of the National Accreditation Program for Breast Centers, and five-year survival rates.

At Hartford HealthCare, we strive to share quality measures in a way that is meaningful to consumers of healthcare: What information about quality and outcomes do consumers need to help them make critical decisions about seeking care?

How we share performance metrics will have both internal and external consequences. The issue of how — and to whom — to attribute performance metrics is complex and thorny. The ways in which we deploy, display and describe our metrics will be crucial to our success in the emerging consumer era. Even high-quality performance will be lost on patients and families if it is not understandable and comparable to other provider organizations. As a leader in integrated care, Hartford HealthCare will be among the providers helping to shape the national performance-reporting parameters.

Some hospitals and healthcare systems approach quality improvement as a series of distinct initiatives that achieve their goals and are largely abandoned. Hartford HealthCare has evolved beyond this mentality, which exhausts staff members and does little to build consistent high quality.

“It is our vision to provide consistently excellent and well-coordinated care across the continuum. We are fulfilling our vision by becoming a safer and higher-performing healthcare system and sustaining our successes on behalf of our customers while working to reduce the cost of care.”
LEADING THE WAY:
Coordinating Care across the Continuum to Improve Quality and Health

Integrated Care Partners (ICP), our physician clinical integration organization, is focused on improving patient outcomes and reducing the cost of care and has taken a number of steps to achieve those goals.

Assessing High-Risk Patients at Admissions
One example of ICP’s work to improve patient outcomes and reduce readmissions is the implementation of the RightCare software platform at all Hartford HealthCare hospitals and other member organizations. RightCare helps inpatient case managers assess patients at the time of admission to determine the risk for readmission and make recommendations for the appropriate level of post-acute care. Use of the tool for admitted patients is extremely high, running at more than 95 percent.

RightCare, together with the care management team, is part of ICP’s multipronged approach to lower the total cost of care by lowering admissions and readmissions.

In 2015, Hartford HealthCare experienced a steady drop in admissions of about 1,000 patients for both our Medicare Shared Savings Program and our commercial shared savings programs.
# Bringing Care Management into the Home and Primary Care Office

There are many elements of customer care that affect quality and safety beyond the actual clinical encounter. One of the most important is care coordination, because transitions and handoffs can be risky for patients. Care coordination in the ambulatory environment will become a core competency in the transition to value. The hospital readmission rate has been the key measure used to assess the efficacy of care coordination.

Through Integrated Care Partners’ (ICP’s) Care Management Program, Hartford HealthCare is working to not only improve patient quality, but also to improve patient safety. Community-based care managers are assisting high-risk patients as they transition from acute-care settings back into the community.

Care managers reach out to patients to review discharge plans, connect them with their primary care physician for follow-up, assess and confirm the need for community-based services, and conduct a medication review. If a high-risk safety or medication concern is identified, a home care visit is conducted in collaboration with Hartford HealthCare at Home, an ICP care manager, and/or the ICP clinical pharmacist. The team collaborates with the patient and the primary care physician to initiate and update the community care plan to include activation of services and resources; medication management and adherence goals; and overall patient-centered, achievable health goals.

The ICP Care Management Team has had a primary focus on patients attributed to our Medicare Shared Savings accountable care organization and Hartford HealthCare employees. The team has developed robust care management capabilities to coordinate care and improve outcomes. All team members have undergone a rigorous six-week training course to become certified by the American Care Management Association.

In 2015, the Care Management Team completed more than 19,000 preventive screenings for Hartford HealthCare Medical Group patients and currently has more than 3,300 patients under active care management. In 2016, the ICP Care Management Team will further expand its coverage to all ICP primary care practices and patients in all value-based contracts.
Integrated Care Partners’ Pharmacy Expert Puts ‘Eyes in the Home’

Sean Jeffery, PharmD, a pharmacist specializing in geriatrics, does something most pharmacists don’t do: He makes house calls.

Through Integrated Care Partners’ (ICP’s) partnership with the University of Connecticut (UCONN) School Of Pharmacy, Jeffery, a clinical professor at UCONN, is the director of ICP’s Clinical Pharmacy Services. He collaborates closely with ICP care managers as they help high-risk patients manage their chronic illnesses more effectively, which includes coordinating care and identifying patients who might benefit from a higher level of medication management.

Jeffery initially collaborates on pharmacy issues with providers via email and phone consultations. When possible, he sees patients at the provider’s office and, when necessary, will visit the patient at home.

“I often see people taking 14 or 15 medications, so there’s a lot of opportunity for a pharmacist to reduce the cost of care, improve outcomes and improve the patient’s quality of life by keeping medications simple and helping people take their medication regimen seriously,” Jeffery said.

“Medication costs, unclear patient expectations, fear of potential adverse effects and worries over drug interactions are some of the most common reasons patients don’t adhere to their medication regimens,” he said. “Managing population health includes aligning the goals of care. We need to determine what is most important for the patient.

“Providers should try asking their patients, ‘If I were to stop a medication, which one won’t you let me stop? If you were to stop a medication, what would be the first medication you would stop?’ The answers often lead to a better mutual understanding of what providers are trying to achieve and what patients are willing to tolerate.”
A Care Management Success Story

A woman was hospitalized due to an acute kidney injury. Her care plan included the use of multiple diuretics, a fluid-restricted diet due to heart failure, and diabetes.

At discharge, Stephanie Wakelan, RN, the Integrated Care Partners (ICP) care manager, connected with the patient and the provider. Wakelan quickly identified potential medication and safety issues and referred the case to ICP’s pharmacist, Sean Leone, PharmD, and Monica Leone, transitional care nurse with Hartford HealthCare at Home.

Jeffery and Leone visited the patient’s home and discovered the woman was taking 34 medications.

The visit and subsequent case review with the patient’s primary care provider and team resulted in stopping anticoagulant therapy because the patient was at high fall risk, liberalizing her diabetes management, and clarifying her diuretic therapy. She is successfully being managed on her meds and now has home services to assist in her self-care.

Enhancing Medication Management

Another way Integrated Care Partners (ICP) is working to improve outcomes and reduce costs is medication management. The cost and complexity of managing medications is a challenge, especially among the elderly. Expensive new medications have radically changed care for patients. These medicines offer more effective treatments for certain chronic conditions, but often come with a steep price tag.

About one-quarter to one-third of the increase in the cost of care in 2015 was due to increases in pharmacy expenses. ICP has partnered with the University of Connecticut School of Pharmacy to enhance pharmacy management, both for patients and providers, to improve outcomes and reduce costs.

Improving Home Care Transitions and Quality of Life

Hartford HealthCare at Home’s Transitional Care Nurse (TCN) Program began in July 2014. The program originally was developed with Integrated Care Partners to provide insight into the patient’s home setting. As the program matured and evolved, word began to spread about its successes, and referrals arose from other sources, including community providers and acute-care settings.

The TCN Program is a complimentary service which has displayed staggeringly positive quality outcomes for patients with a reduction in hospitalization and readmissions falling far below the national average.

A TCN provides patient-centered, free visits to people in the community who are not receiving certified home care services. The goal is to keep people healthy and safe in their homes. The TCN provides health education and assistance in connecting patients to community resources and communicates with the patient’s provider, case manager and other members of the healthcare team. If a patient is homebound, the TCN contacts the provider and initiates certified home care services while identifying barriers and empowering patients to take control of their health. If the individual is not homebound, the TCN will follow the patient for a minimum of 30 days telephonically to continue to coordinate care, answer health questions and communicate any concerns to the provider.

TCNs receive referrals for extremely complex patients. Each patient is risk-stratified through the BOOST (Better Outcomes for Older Adults Through Safe Transition) tool. Approximately 40 percent of TCN patients live alone with minimal to no family support. These patients have been identified as high-risk for readmission. This patient-centered program has enabled individuals to remain in their community, thanks to communication with providers and the coordination of care. The hospitalization rate for TCN patients is only 9.2 percent. The hospital readmission rate for FY 2015 was 11 percent and for the first quarter of FY 2016, 8 percent, which is far below the national average of 15.9 percent.

The TCN Program started in 2015, with a total of 168 patients. In the first six months of FY 2016, we have had a 45 percent increase in patients.
Transitional Care Program Changes a Life

A female was admitted to The Hospital of Central Connecticut of New Britain with a rapid-heart rate, chronic obstructive pulmonary disease (COPD), diabetes, high blood pressure, and anxiety. She had four Emergency Department visits in a two-month span and six hospital admissions over the last year.

A transitional care nurse (TCN) referral was placed through the resource coordinator at Hartford HealthCare’s Center for Healthy Aging. Upon the patient’s discharge, the TCN scheduled a home visit. During that visit, the patient confided in the TCN that she hadn’t checked her blood sugar in two months, because she didn’t have any testing supplies. She wasn’t following her medication treatment program or her diet plan. The TCN also uncovered that the patient didn’t have enough medication to treat her diagnosis and wasn’t aware that she would be on this medication for life.

The TCN provided the patient with a pill box and filled it with her with all of her medicines for each day. The TCN told the patient when to contact her physician, explained what each medication was used for, and taught her about diabetes and how to follow a weekly meal plan. A personal health record was provided and completed with the TCN’s assistance in an effort to provide current medical information to the patient’s medical team.

The patient was determined to be homebound per Medicare criteria. The TCN contacted her provider and received an order for certified home care services for nursing and occupational therapy services. The TCN also arranged for the patient to have lifeline services. The patient has not had a hospitalization or Emergency Department visit in more than seven months.

“I can’t believe how much time you spent with my husband and I prior to his hip-replacement surgery. We were so worried about how we were going to manage at home when he returned. We were not aware of all the resources and support we could have through this program. We feel like you really care.”

—L.S., Glastonbury, a transitional care nurse program patient

Monica Leone, RN, a transitional care nurse, works with a patient.
Personalizing Care for Better Outcomes

Caring for people with dementia is a challenging job for any caregiver and can be especially difficult for an informal caregiver. Dementia, one of the fastest-growing diseases, has no cure, and its prevalence is expected to triple by 2050. This year, Hartford HealthCare’s Connecticut Center for Healthy Aging (CTCHA) demonstrated their commitment to serve the growing population of older adults with dementia, as well as their caregivers and families, through community education and individualized coaching. In FY15, CTCHA connected with more than 6,000 people across the State of Connecticut and made more than 975 referrals to services within the Hartford HealthCare network.

Dementia care requires a person-centered approach, which includes the patient’s family and a review of all aspects of the patient’s life. In the current state, the transitions of care needed to help and support people with dementia are not always coordinated on an individual basis. CTCHA is working to change this.

With the addition of two dementia Alzheimer’s specialists, CTCHA has reached an additional 20 client families per month on an individualized basis for dementia coaching. CTCHA also has created a Dementia Resource Guide that has reached more than 2,000 people and is facilitating a five-week dementia and caregiving educational series throughout Central Connecticut. Service lines, such as CTCHA, help seniors and their families connect the dots of our system, allowing us to excel at personalized, coordinated care; live our values of safety, caring, integrity and excellence; and spread our positive impact in Connecticut and beyond.

The Connecticut Center for Healthy Aging’s Dementia Caregiver Resource guide is available online at www.hhcseniorservices.org.

A Patient Story

A son reached out to the Connecticut Center for Healthy Aging (CTCHA) via a local senior center after his mother received a diagnosis of dementia from her primary care physician. He was overwhelmed with his mother’s condition and with how to provide the best care for her.

After a resource coordinator made an initial assessment, the son was set up with an individual coaching session with one of CTCHA’s dementia specialists. His mother then received a referral to see a geriatrician at Hartford Hospital’s Senior Primary Care Clinic at Duncaster. The geriatrician identified a medication which may cause confusion and significantly reduced the dosage. Due to the change in dosage, the client’s mother was diagnosed with a mild, cognitive impairment, rather than dementia, and she was able to drive and cook again.

This is only one of many stories about how CTCHA has changed the lives of the people they serve. CTCHA’s paramount goal is to improve quality of life by using a caring approach that assists people in transitioning through Hartford HealthCare’s robust system of care.
Working Collaboratively to Improve Outcomes for Seniors
As part of an initiative to improve outcomes for senior patients, Integrated Care partners created a geriatric and palliative care task force to work with Hartford HealthCare’s Center for Healthy Aging to form a Preferred Provider Network of 38 skilled-nursing facilities across the state.

Hartford HealthCare’s five hospitals, Senior Services and Hartford HealthCare at Home have collaborated closely to improve care coordination for high-risk patients when those patients leave acute-care settings.

Clinical partnerships were established with 38 skilled-nursing facilities after those facilities met very stringent quality metrics, including staffing ratios and ratings from the Centers for Medicare & Medicaid Services.

“Care managers work with patients transitioning from the skilled-nursing facilities to their homes,” said Kathryn Ruszczzyk, Integrated Care Partners director of Clinical Collaboration. “We keep patients connected. We are focusing on this very high-risk population. Some of the facilities in the network made significant investments in order to take our patients, who often are very high-acuity and need care for chronic illnesses at the community level.”

“By partnering with the highest-quality skilled-nursing facilities, we can affect the patient experience,” said Sharon Robinson, RN, BSN, MHA, director of Senior Care Coordination, Hartford HealthCare Senior Services. “Our alignment with high-performing skilled-nursing facilities that are outside of our network helps us strengthen our ability to move patients to the lowest-cost and highest-quality post-acute service.

“Another important benefit is the relationships we’ve built across the system and beyond,” she added. "And the project has an especially positive impact on the frail seniors who need it most."

Integrating Behavioral Health and Primary Care: Coordination Makes Great Strides
The Hartford HealthCare Behavioral Health Network (BHN), working with Integrated Care Partners, is making great progress in integrating behavioral health services into primary care practices across the region — so much so that plans are now underway to expand to an additional four to six primary care practices over the next several months.

The decision to continue expanding the program is based on data showing that patients who have been referred to BHN specialists within the primary care setting are much more likely to show improvement in their condition — and may well improve their overall health. Data also shows that such patients are less likely to utilize an emergency department for their health needs — in some cases, patients have reduced their emergency department use by as much as 30 percent.

“The results that we are seeing so far have been very encouraging, and we see this trend continuing as we expand to other practices across the region,” said James O’Dea, PhD, MBA, vice president of Operations for the BHN.

“A lot of our success is due to the great teamwork that is developing between our behavioral health specialists and the primary care physicians they have been collaborating with.”

The goal behind the program is to overcome traditional barriers that have made it difficult for primary care providers to effectively refer their patients for care when they suspect they may be suffering from a behavioral health issue.
Hartford HealthCare’s implementation of the Epic electronic health record (EHR), dubbed CareConnect, is a system-wide initiative to continue to drive quality improvement and transform the way healthcare is delivered.

A single EHR will align clinicians and caregivers around the patient in every setting, from inpatient to ambulatory care, including community physicians. Every caregiver — both within our system and beyond — will see one medical record, which will reduce medication errors and duplicate testing, improving quality and reducing costs.

With the industry-leading Epic software as a tool, we will improve the way we provide coordinated care. Epic will equip us with ways to move and use information so that we can more effectively provide the right care, at the right time, and at the right place for everyone, every time.

Epic improves patient engagement by providing them with the ability to privately view their own medical records through a secure, digital portal called MyChartPLUS. Patients can make appointments; track test results and medications; view medical record information, including health summaries and medical history; complete health- and visit-related questionnaires; pay bills and review balances; and more. Their personal health information will be easily accessible, adding value to their experience and to the care we deliver.

The implementation of Epic represents more than just a replacement of current technology systems. It is a culture change affecting the workflows and methods of thousands of staff members. Epic is providing us with a new foundation and platform for collaboration, coordination, minimizing unnecessary variation, and shared accountability. It is creating more value for our patients by improving patient safety, the integration of care and care transitions.

The Epic electronic health record went live in August 2015 at all Hartford HealthCare Medical Group primary care offices and is under implementation throughout the Hartford HealthCare system.
Safety Focus Produces Results
Key Measures of Success

Reducing Serious Safety Events
Safety is Hartford HealthCare’s primary core value. The first step in our journey toward reliable high-quality care was to create a consistent, system-wide approach to safety. Because moving from aspiration to behavior requires cultural change, our new approach to safety was integrated with Hartford HealthCare’s cultural-transformation platform, How Hartford HealthCare Works (H3W). The principles of H3W include open communication, shared values and goals, customer focus, and a commitment to excellence.

Using H3W, the system began the process of providing high-reliability training to clinical staff. To date, more than 12,000 Hartford HealthCare staff members have been trained in high-reliability practices, which focus on the use of process verification and technology to reduce the chance that human error will result in patient harm.

The key aim of high-reliability training is to reduce the number of Serious Safety Events (SSEs). The SSE is a deviation from a known policy, procedure or standard of care that results in moderate-to-severe harm (including death) to a patient.

Hartford HealthCare’s SSE rate has been dropping steadily during the three years of this program. The goal is zero, as we move continuously toward the “excellence” of our vision. As the SSE rate drops, Hartford HealthCare clinicians increasingly are focused on the precursor safety events and the near misses. These events are instructive and provide an opportunity to make further safety-enhancing changes. Hartford HealthCare has reduced the SSE rate dramatically in the past year. Our progress is illustrated on the chart below.

Hartford HealthCare’s Serious Safety Event Rates Have Been Steadily Declining
Hartford HealthCare’s approach to high reliability applies to all clinical activities. Leadership has used growing data resources to identify specific areas of underperformance that can significantly affect patients, as well as those areas that are publicly reported to the Centers for Medicare & Medicaid Services, for which we can be penalized for poor performance. Some clinical areas fall into both categories.

In addressing these so-called “hot spots,” Hartford HealthCare takes a uniform, disciplined approach that is similar to the H3W Lean practices being adopted across the system. These quality initiatives are marked by accountability, data transparency, open communication, and frequent re-evaluations of performance-driving modifications. This consistent level of focus has yielded significant results to date. They include the following:

**Hand-Hygiene Compliance: A Key Driver of Infection in Hospitals**

In only two years, Hartford HealthCare’s rate of hand-hygiene compliance increased from 54 percent to 94 percent. Continued focus has resulted in sustained performance that places Hartford HealthCare among the national leaders in this crucial metric. The goal to be “nationally respected” spelled out in our vision has been achieved in the category of hand hygiene.
Fewer Urinary Tract Infections (UTIs)
The same rigor, discipline and education that were applied to hand hygiene has been deployed across the system to reduce UTIs. We successfully reduced the frequency of this complication to low single digits from 20 to 30 infected patients per month. The Hartford HealthCare Catheter-Associated UTI (CAUTI) Collaborative devised standards for catheter care. They partnered with the Center for Education, Simulation and Innovation to develop and disseminate a standardized best-practice training module. More than 1,700 nurses throughout Hartford HealthCare hospitals to date have been validated on their insertion technique. That, coupled with an extensive auditing process, led to a decrease in CAUTIs by 21 percent over two years across the system, and Hartford HealthCare’s community hospitals can go eight to 12 months with no hospital-acquired UTIs.

Reducing the Frequency of Catheter-Associated Urinary Tract Infections

Decreasing the Toll of Sepsis
In June of 2014, the Hartford HealthCare Quality Council instituted the Sepsis Collaborative. Sepsis results from overwhelming infection and when severe, can result in death. It can develop as a complication during a hospital stay. Our goal was to implement an evidence-based model so staff would be aware of the warning signs of sepsis and would be able to more effectively manage it. The Collaborative created standard education and training to enable staff and providers to identify sepsis early and treat it quickly. This has significantly improved outcomes with a 30 percent reduction in mortality rate and a 34 percent reduction in length of stay for severe sepsis.

Improving Post-Operative Sepsis Outcomes by Reducing Mortality Rate & Length of Stay
Surgical Weight Loss at Hartford Hospital Greatly Impacts Readmission Reduction

Hartford HealthCare has numerous programs in place to reduce readmissions, a key measure of care coordination. A major initiative by the Hartford HealthCare Centers for Surgical Weight Loss at Hartford Hospital has made a big impact on readmissions reduction.

The Center, led by Drs. Darren Tishler and Pavlos Papasavas, performs an average of 500 bariatric (weight-loss) procedures per year. Bariatric surgical procedures are cost-effective options for the treatment of obesity with very low mortality and complication rates. Reducing 30-day hospital readmissions following bariatric surgery has been a key objective in improving the quality of care provided to this high-risk patient population.

The Center has analyzed 30-day readmissions to any Hartford HealthCare hospital for any duration and reason. Surgical cases are tracked in a national registry and monitored for 30-day events by the Center’s surgical clinical reviewer. Readmissions are reviewed with the Center’s surgeons to confirm the reason for the readmission and to develop improvement strategies.

Through this review process, fluid and electrolyte depletion were identified as the most common reason for readmission. Hartford Hospital’s bariatric program participated with the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program’s year-long initiative to decrease 30-day readmissions. This national study, titled “Decreasing Readmissions Through Opportunities Provided (DROP),” required participating centers to incorporate multiple interventions, including post-discharge nursing phone calls, inpatient nutrition consultations, and a nutrition visit within 30 days of discharge.

Earlier identification of patients struggling with oral intake or other preventable complications has led to a decrease in the number of 30-day preventable readmissions.
Clinical Councils: Improving Results Across the System

One of our primary engines for improving quality and eliminating unnecessary variation is our clinical councils. Hartford HealthCare has 33 clinical councils, each with a quality dashboard to monitor progress. The councils are multidisciplinary, and each has a senior leader as an executive sponsor.

Hartford HealthCare clinical councils work collaboratively, with embedded support from Quality, Supply Chain, and Informatics. For example, the Pharmacy and Therapeutics Council works with most of the other councils to develop the safest, most effective, and most cost-efficient approaches to using medications. In addition, the councils have become critical elements of the system-wide service lines. As our pathfinder, the Hartford HealthCare Cancer Institute has the most advanced council structure with an overall Cancer Executive Committee and a number of sub-councils (disease management teams) organized around cancer types and disciplines (such as radiation oncology, medical oncology, and surgical oncology).

The councils are key to engaging physicians in the quality journey. Over the past 20 years, providers have become disenchanted with “quality” metrics set by the government and insurance companies. Providers have received “report cards” with erroneous data based on claims that reflect economic efficiency more than clinical outcomes. Federal programs, such as the Physician Quality Reporting System and Meaningful Use (the regulations guiding implementation of electronic health records), have resulted in dissatisfaction in regard to metrics that are seen to add little value to patients and providers.

The councils allow clinicians to decide what is clinically important. Our quality analytics fully support this. While our quality dashboards include required regulatory metrics, they also include measures chosen by — and trusted by — providers. This allows clinical teams to transcend necessary “boilerplate” metrics in order to pursue above-and-beyond results for those in our care.
Achieving Excellence in Quality

Dedication to continuous improvement is evident throughout the Hartford HealthCare system. An example is the re-accreditation of the Hartford Hospital Rehabilitation Network by the Commission on Accreditation of Rehabilitation Facilities (CARF) International, an independent, nonprofit accreditor of health and human services.

To receive accreditation, an organization must meet specific international quality standards and deliver optimal outcomes. The CARF standards have been developed for over 40 years by international teams of service providers, policy makers, payers, family members, and consumers and have been submitted to the public for review. The accreditation process is intensive and reflects our commitment to the highest quality of service.

A Healthcare Hero’s Story

One of the most challenging and rewarding professional experiences for occupational therapist Ruth Satterberg occurred earlier this year when she was confronted with the task of helping a man regain the use of his right hand after he lost a thumb and crushed his fingers in a work accident.

Satterberg needed to think out of the box and, after working for weeks to restore motion to the man’s remaining fingers, she created a prosthetic thumb by attaching a piece of splint material to a thumb brace and covering it with a rubber tip.

Her patient, who resettled in Berlin, Connecticut from India in 2006, could not be more appreciative of Satterberg’s help. “In my country, they probably wouldn’t fix the hand, they would just cut it off,” he said.

Through his continuing therapy sessions with Satterberg, he now has enough dexterity in his hand to pinch, grab and lift small and large objects. Together, they are planning for the day when surgeons can implant a permanent thumb on his hand.

“The first time he picked up a pen and wrote his name was awesome,” Satterberg said.

For her work as an occupational therapist, Satterberg was recently honored as a Hartford Business Journal Health Care Hero. “I am appreciative of the hero award and am happy to receive it on behalf of all my therapy coworkers who change lives every day,” she said.

For its high quality of service, the Hartford Hospital Rehabilitation Network was reaccredited by the Commission on Accreditation of Rehabilitation Facilities.

Occupational therapist Ruth Satterberg, a local HealthCare Hero.

2015 Quality and Safety Annual Report
Responding to a State Opioid Health Epidemic

In 2015, a widespread health epidemic continued to ravage Connecticut and the nation — opioid abuse, dependency and overdose. Deaths from opioids, a category of drug that includes prescription painkillers and heroin, have increased by more than 200 percent since 2012. Across the country, more than 40 people die each day from prescription pain killers. Last year in Connecticut, opioid-related deaths took an unprecedented 657 lives.

In the midst of the emerging opioid crisis, the Hartford HealthCare Behavioral Health Network (BHN) has been working hard to be part of the solution. The BHN, which includes Rushford; Natchaug Hospital; the Institute of Living at Hartford Hospital; and the behavioral health departments at Backus Hospital, The Hospital of Central Connecticut and MidState Medical Center, used its position as the largest provider of acute behavioral health and addiction services to raise awareness, educate and provide services aimed at stemming the tide of morbidity.

In 2015, Rushford and Natchaug treated more than 3,500 people with opioid-use disorders, providing education on the signs and symptoms of opioid overdose and use of naloxone, the opioid overdose reversal drug. At Rushford, the number of clients and families receiving naloxone prescriptions increased by 150 percent over the last 12 months. At the Middletown site alone, 479 prescriptions were given over the last five months. In Central Connecticut, our prevention department utilized bilingual letters/flyers; a billboard; 5,000 magnets; and distribution of 2,000 messaged reusable bags to promote appropriate storage and disposal of prescription medications. In 2015, 208 pounds of prescription drugs were collected at the Middletown site. The BHN has worked with state and federal lawmakers and testified on legislation targeting opioid overdoses. We worked with the Department of Consumer Protection to develop the pharmacist naloxone certificate training and have participated on the newly reformed Alcohol and Drug Policy Committee. The BHN has participated in dozens of forums, panels and roundtable discussions and has had a prominent role on television, radio and in newsprint speaking on the problem and identifying solutions.

With the rise in opioid addiction and overdoses, physicians have come under scrutiny for their prescribing practices. As this year’s mandatory Medical Risk Management Program, Hartford HealthCare, partnering with the BHN, began training physicians from across the healthcare system on how to safely prescribe opioids. In addition, the Rushford Addiction Medicine Fellowship Program, which educates physicians about prevention, diagnosis and treatment of substance-use disorders, expanded to include Natchaug Hospital by adding a second position.

As the number of people dependent on opioids rose, so did the demand for services. Evidence shows that medication-assisted treatment is most effective. Rushford and Natchaug increased the number of clients receiving buprenorphine-based treatments from 141 in 2014 to 317 in 2015.

To increase accessibility of services and meet community needs, for 2016, the BHN introduced Medication-Assisted Treatment, Close to Home or MATCH. MATCH helps people into recovery using a combination of medications such as Suboxone® or Naltrexone, which reduce opiate cravings, in combination with small relapse-prevention groups and support services. With sites in Cheshire, Dayville, Glastonbury, Groton, Mansfield, New Britain and Vernon, Connecticut, MATCH offers the local support and treatment that people need to reach and maintain sobriety.
Hartford HealthCare’s Center for Education, Simulation and Innovation (CESI) is a national leader in the use of medical simulation to improve quality. CESI’s vision is to be a premier global center for comprehensive experiential learning and innovation using simulation and other leading-edge training technologies.

The CESI team has been involved in a number of quality and safety projects. CESI and the MRM Group LLC designed a curriculum to train labor and delivery staff members in managing severe complications that can occur during childbirth. The team has developed a ground-breaking approach to train in the management of shoulder dystocia — a rare obstetrical emergency with rates of occurrence anywhere between 0.5 percent and 2 percent in all vaginal deliveries. Up to 20 percent of all occurrences of shoulder dystocia can result in injury to the neonate. Using life-like manikins in a realistic delivery room environment within the CESI facility, entire delivery room teams now train in recognition and prevention of this complication.

CESI also works to improve clinical outcomes with a mobile unit that provides training at skilled-nursing facilities with the aim to reduce unnecessary hospital readmissions. The program brings training to the nursing facilities to help train staff in their actual care environment.

This year, the mobile program has worked with the nursing facility leadership teams to create a steering committee to help drive the training toward important patient outcomes that will enhance safety and quality in this arena.

Maternity staff members train at CESI.
Awards and Recognition

The Hartford HealthCare Cancer Institute at Hartford Hospital and The Hospital of Central Connecticut were recognized with Outstanding Achievement Awards by the American College of Surgeons Commission on Cancer. Only 75 programs nationwide receive the annual reward.

The Center for Education, Simulation and Innovation was recognized by the U.S. Centers for Disease Control and Prevention for setting a national standard in training staff in use of personal protective equipment in treating Ebola patients.

Hartford Hospital received the Women’s Choice Award® for America’s Best Stroke Centers, the first distinction of its kind in the United States, which is awarded to hospitals with above-average patient recommendation scores and which have been certified as an Advanced Primary Stroke Centers or Advanced Comprehensive Stroke Centers by the Joint Commission. Only 250 hospitals nationwide have this seal.

The heart, kidney and liver transplant programs at Hartford Hospital were accepted as Anthem Centers of Excellence, and the heart and kidney programs are among Aetna’s Centers of Excellence. The kidney and heart transplant teams were accepted into OPTUM’s Center of Excellence for Transplants.

The Hartford Hospital Heart Transplant Program, one-year 96 percent survival rate was named as one of best in the Northeast, according to the Scientific Registry of Transplant Recipients, for the one-year period from July 1, 2013 to June 30, 2014.

Hartford Hospital once again was verified as a Level I Trauma Center (through Sept. 8, 2017) by the Verification Review Committee of the Committee on Trauma of the American College of Surgeons.

Hartford HealthCare Medical Group’s Center for Surgical Weight Loss at Hartford Hospital received Center of Excellence designation from the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint program of the American College of Surgeons and the American Society of Metabolic and Bariatric Surgery.

Hartford HealthCare Senior Primary Care at Duncaster in Bloomfield received the National Committee for Quality Assurance Patient-Centered Medical Home recognition for using evidence-based, patient-centered processes focusing on highly coordinated care and long-term, participative relationships.

Backus Hospital was named a 2014/2015 Consumer Choice Award winner by the National Research Corporation. The award identifies hospitals across the United States that consumers choose as having the highest quality and image.

Backus Hospital was named a Top Performer on Key Quality Measures by the Joint Commission, which recognized the hospital’s “commitment to assuring that evidence-based interventions are delivered in the right way and at the right time.” Backus was recognized for achieving key quality measures for heart attack, heart failure, pneumonia, and surgical care.

The Backus Hospital Breast Center earned full three-year reaccreditation from the National Accreditation Program for Breast Centers with the surveyor also selecting the program as a “Best Practice Repository,” establishing Backus as a national leader in breast care.

The Orchards at Southington, a residential facility, was recognized with a national Best of 2015 Award for senior-living and home care providers that consistently receive high ratings and positive reviews from their residents, families and visitors.

Jefferson House (Hartford Hospital), along with Hartford HealthCare’s Jerome Home and Southington Care Center, received the highest possible rating for a nursing facility — a Five-Star Quality Rating from the Centers for Medicare & Medicaid Services.

MidState Medical Center’s Advanced Wound Care and Hyperbaric Medicine team received the 2014 Excellence in the Workplace Award from the Connecticut Nurses Association for creating a work environment promoting professional autonomy and quality nursing practices.

MidState Medical Center earned The Joint Commission’s Gold Seal of Approval for its Knee and Hip Replacement Program, meeting national standards for healthcare quality and safety in disease-specific care.

The Hospital of Central Connecticut received the Mission: Lifeline® Silver Receiving Quality Achievement Award for implementing specific quality improvement measures outlined by the American Heart Association for treating patients suffering severe heart attacks.
About Hartford HealthCare

Hartford HealthCare represents the next generation of integrated healthcare systems, marked by a strong patient focus; heightened efficiency; consistent quality performance; and open, collaborative sharing of best practices and a drive to deliver value to those we serve.

Hartford HealthCare is dedicated to providing patients with an exceptional, coordinated care experience and a single, high standard of service. A hallmark of Hartford HealthCare’s vision is to strengthen access to care close to home for patients by enhancing local healthcare delivery capabilities. In addition, Hartford HealthCare aims to create a culture and organizational structure where clinical care, education and research are supported to bring the latest technology and discoveries, clinical excellence, and innovation to the patient and community.

Hartford HealthCare’s partners include a tertiary-care teaching hospital, an acute-care community teaching hospital, an acute-care hospital and trauma center, two community hospitals, two regional behavioral health centers, a primary care physician practice group, a regional home care system, and a physical therapy and rehabilitation network.

Our vision:
To be nationally recognized for excellence in patient care and most trusted for personalized coordinated care.

Our values:

- **Integrity** – We do the right thing. Our actions tell the world what Harford HealthCare is and what we stand for. We act ethically and responsibly in everything we do and hold ourselves accountable for our behavior. We bring respect, openness and honesty to our encounters with patients, families and coworkers and support the well-being of the communities we serve.

- **Caring** – We do the kind thing. Every Harford HealthCare staff member touches the lives of the patients and families in our care. We treat those we serve and each other with kindness and compassion and strive to better understand and respond to the needs of a diverse community.

- **Excellence** – We do the best thing. In Harford HealthCare, only the best will do. We work as a team to bring excellence, advanced technology and best practices to bear in providing the highest-quality care for our patients and families. We devote ourselves to continuous improvement, excellence, professionalism and innovation in our work.

- **Safety** – We do the safe thing. Patients and families have placed their lives and health in our hands. At Harford HealthCare, our first priority — and the rule of medicine — is to protect them from harm. We believe that maintaining the highest safety standards is critical to delivering high-quality care and that a safe workplace protects us all.
Hartford HealthCare

Integrated Care Partners
Unifying Hartford HealthCare and its affiliated physicians

Hartford HealthCare Medical Group

Hospitals
Backus Hospital, Norwich
Hartford Hospital, Hartford
The Hospital of Central Connecticut,
New Britain General Campus, New Britain
Bradley Memorial Campus, Southington
MidState Medical Center, Meriden
Windham Hospital, Windham

Behavioral Health Network
The Institute of Living
Natchaug Hospital
Rushford

Rehabilitation Services
Hartford HealthCare Rehabilitation Network

Hartford HealthCare at Home
Visiting nurses, hospice care, independence at home

Senior Services
Jefferson House
Center for Healthy Aging
Jerome Home
Arbor Rose at Jerome Home
Cedar Mountain Commons
Southington Care
Mulberry Gardens
Marion Heights Adult Day Care Center
The Orchards at Southington
