
**Rhode Island Health Care Quality
Performance Measurement and Reporting Program**

**Health Care Quality Steering Committee Minutes
November 15, 2004**

Present: T Almon, A Frazzano, G Almonte, P McCue, L McDonald, P Nolan, P Parker, R Rodriguez, A Santos, H Zuffoletti, C Duquette, B Waters, S Oberbeck

Guests: Tierney Sherwin, B Briden, M Doherty, S Sawyer, A Greenbaum, K Gatants, M Connell, S Dunn, K Kowalski, R Wood, M Glynn, D Collins, S Montminy, G Levesque, K Hagan, C Lamoureux, J Fedo, S Wood, J Astrella, D Smith, P McBride, J McLaughlin, J McLaughlin, G Rocha

Dr. Nolan welcomed the members and guests.

Lauren Williams, RN, EDM presented the Nurse Sensitive Patient Outcomes Monitoring Report. This included on-going monitoring of the literature and the Rhode Island occurrence rates for 2002 and 2003. The literature review (post 2002) of the relationship between nurse staffing and adverse patient outcomes revealed four new studies of relevance, one at the institutional level, and three at the unit level. Across the studies, the adverse outcomes sensitive to nursing care were: UTI, pressure ulcers, pneumonia, and LOS. A hospital study by Cho (2003) showed a statistically significant inverse relationship to pneumonia, and a positive relationship to pressure ulcers. A study by Boyle (2004) at the unit level showed statistically significant inverse relationships between the perceptions of: 1) autonomy/collaboration and failure to rescue and UTI, 2) nurse management support and lower death and pressure ulcers, but higher rates for failure to rescue, and 3) high continuity/specialization and lower pneumonia, cardiac arrest, and LOS. Dr. Williams' impression was the literature indicates continued support for monitoring pneumonia and pressure ulcers, and not adding additional adverse outcomes based on hospital-level empirical studies. She added that there is little consistency across studies, which was the original charge for this research.

The occurrence monitoring in Rhode Island looked at cases where it was likely that the complications (UTI, pressure ulcer, and pneumonia) were not present on admission and were the secondary diagnosis in two risk pools: medical and major surgical. From 2002 to 2003, the outcome rates increased and decreased only slightly, and the occurrence rates were comparable or favorable to the overall comparison group with the exception of major surgical pneumonia which increased and exceeds the overall comparison rate. Because of annual coding rule changes to the Needleman algorithm requiring adjustments, Dr. Williams commented that in order to continue this study, one needs to be aware of the changes.

Mr. Almon asked what this all means, in terms of staffing levels. Dr. Williams noted that staffing levels were not studied. Pamela McCue referenced indicators that are being evaluated by the National Database of Nursing Quality Indicators (NDNQI). This is a database of 663 hospitals (5 of which are in Rhode Island) that are reporting unit per unit analyses of falls and pressure ulcers, controlling for variables, and providing national benchmarks. Carol Lamoureaux noted that nurse staffing is not wholly accountable for outcomes, and there are limitations with the use of administrative data. Dr. Williams noted that use of administrative data is recognized as being problematic in all studies. In reference to NDNQI, Rosemary Wood noted that risk-adjustment needs to be ensured for public reporting. Dr. Nolan added there has not been much success with risk adjustment. In essence, these are databases in infancy, not collected consistently, and not comparative because not all of the data is the same.

Mr. Almon asked how we can reach conclusions, and questioned performing a controlled study. Dr. Nolan noted that we still have a long way to go to have indicators we can rely on. Dr. Waters commented that the state legislature requested that the Steering Committee look at this and publicly report its findings. They are concerned with how to improve quality outcomes. Mr. Almon asked whether HEALTH could provide funding for targeted research. He also wondered about what kinds of information to publicly report. Dr. Nolan noted that JCAHO and CMS publicly report data. HEALTH was not asked about nurse staffing, nor does it have funds to collect data. Per legislative request, HEALTH can scan the data to find indicators. Dr. Waters commented that we have an understanding of the literature which has been replicated by Dr. Williams over two years; however the study we have been using for comparison to Rhode Island data is decaying because it has not been kept up to date by its authors. The national study, NDNQI, may be the next logical course to pursue. This is an unclear area, but we need to follow the research to be sure we are current.

Dr. Nolan asked that for the next Steering Committee Meeting that a subgroup (perhaps including the nurses associations and the hospital association) formulate a question to pose to the Committee, based upon where we are. Is there something we should be regularly reporting?

Maureen Doherty, RN presented “The ‘Rhode’ to Patient Safety: Improving the Reporting of ‘Close Call’ Events”, a presentation of the Patient Safety Improvement Corps, a three year partnership between the Agency for Healthcare Research & Quality (AHRQ) and the Veterans’ Administration. The goal of the project was to improve patient safety by providing training in patient safety techniques to state staff in the field and the state’s selected hospitals. The Attorney General’s office was invited by AHRQ to apply. Rhode Island’s success in applying (with one week notice) was attributed to the collaborative relationships developed in the Quality Measurement and Public Reporting Program. Rhode Island was part of the first group of 15 states; the smallest state with the largest team. Its members included representatives from the Attorney General’s office, HEALTH, HEALTH/Quality Partners of Rhode Island, Kent County Memorial Hospital, and Rhode Island Hospital.

Initially, the Rhode Island Team had hoped to refine current models of reporting, investigating, and preventing medical errors within hospitals, with an emphasis on a collaborative approach. The team also wanted to increase the skill and knowledge of the participants in analyzing and addressing patient safety problems- to benefit their own organizations, and to share among other hospitals. The team wanted to utilize this new information to reduce the incidence of patient falls and do a root cause analysis of this by reviewing one hospital. Roadblocks were encountered with lack of peer review protection and sharing of information among a multi-institution team. Thus the goals had to be revised.

The revised goals were to: facilitate discussions within and among Rhode Island hospitals and state agencies to increase patient safety, identify and address legal and other obstacles to inter-institutional collaboration, and to develop a generic framework for internal reporting of errors and close calls that could be shared with other hospitals.

The methodology consisted of: individual hospitals' utilizing the VA approach to root cause analysis, internal discussions by team members of key concepts learned during the training sessions (non-punitive reporting, "blameworthy" behavior, accountability and participation, anonymous reporting and feedback, etc.), and the AG's office reviewing relevant state and federal statutes, regulations and case law regarding institutional concerns about confidentiality and other barriers to collaboration. Maureen Glynn, Esq. reported that the Rhode Island peer review statute also includes patient safety and is protected. This issue has not been tested, nor does it address sharing of information between hospitals and what privileges might be lost. At the federal level, there is proposed legislation, the Patient Safety Quality Improvement Act. This may need to be re-introduced in the next legislative session.

The methodology also included a presentation by Dr. James Bagian of the VA National Center for Patient Safety at a CEO breakfast to hospital leadership, risk managers and QI/patient safety staff, and a session with HEALTH. An additional presentation was given to hospital QI managers at a Quality Partners of Rhode Island Meeting.

The methodology framework included healthcare failure modes and effects analysis (HFMEA) which focuses on the step where an individual makes a decision to report or not report a "close call" within a hospital. The rationale is as follows: healthcare views error as a failure of an individual, "error" vs. "harm", "No harm, no foul"- and therefore no action required (10 close calls before a sentinel event occurs), and a close call event is an early warning system.

In improving reporting of close calls, the question was asked, "Why do staff decide NOT to report?" The reasons were: the event is not seen in the context of the "big picture", fear, embarrassment, confidentiality, "nothing will change", and reporting method are not user-friendly.

The action plan proposed was a re-design of in-hospital reporting systems to address root causes as follows:

- Standardize reporting process with readily accessible reporting tools (electronic and paper)
- Customize and standardize data elements to be collected for the type of event being reported
- Regular aggregation of reports and subsequent actions take, for distribution to leadership
- Dissemination of reports on patient safety improvements to staff
- Reward and recognition of staff who report- “heroes”
- Ongoing system improvement based on staff and leadership feedback

The next steps are to: assess interest of other hospitals in learning the VA approach to root cause analysis and healthcare failure modes and effects analysis, investigate other states’ models for sharing information about patient safety, continue contact with AHRQ for potential future projects and funding, and to continue to evaluate future opportunities for collaboration among hospitals, state agencies, and other stakeholders. For additional information, the VA National Center for Patient Safety website was recommended: www.patientsafety.gov.

Cathy Duquette, PhD, RN, CPHQ of the Hospital Association of Rhode Island presented “Hospital Clinical Measures III, Future Directions.” Her objectives were to: provide an update on the timeline for national hospital clinical measures public reporting initiatives, provide issues and opportunities regarding the expanding nation efforts surrounding clinical measures public reporting, and to identify recommendations for the future direction of hospital clinical measures reporting in Rhode Island.

JCAHO “Quality Check” data was made available on July 15, 2004 (www.jcaho.org) and includes accreditation decision and effective date, accreditation services, achievement of national quality improvement goals (core measures), achievement of national patient safety goals, special quality awards, and optional organizational commentary. (All hospitals in Rhode Island must be accredited for licensure, and all eligible hospitals are participating in public reporting.)

The National Voluntary Hospital Reporting Initiative, now called “The Hospital Quality Alliance”, has data available that will be refreshed November 18, 2004 (www.cms.hhs.gov) with first quarter 2004 data from approximately 4,000 hospitals and will eventually build out to a rolling four quarters of data. Like JCAHO, it will display data for individual hospitals for all process measures regardless of the number of cases. In February 2005, the data will be available in a consumer-friendly format in “Hospital Compare”, similar to “Home Health Compare” and “Nursing Home Compare.” In the spring, 2005, there will be a public release of voluntary additional measures in three existing clinical conditions. The implication for Rhode Island is that the expanded measure set includes measures that the Steering Committee previously decided to exclude. In the summer of 2005, additional voluntary measures will be publicly released. These include additional pneumonia measures and the addition of surgical infection prevention (SIP) measures for seven procedures. While many hospitals in Rhode Island

are collecting SIP measures, they are not collecting data for all seven procedures, thus making use in Rhode Island difficult.

On a positive note, hospital quality improvement efforts are underway, and working. With regard to data collection, national efforts have reduced the work for HEALTH for public reporting, while they have maintained the data collection work for hospitals for public reporting. Data collection efforts for heart attack, heart failure, and pneumonia are on-going.

Dr. Duquette's recommendations for future hospital clinical reporting are:

- Continue direct alignment with national efforts
- Add link on HEALTH website to JCAHO website (which has been completed)
- With November Hospital Quality Alliance refresh, add link to CMS website on HEALTH website
- With February consumer-friendly version, add link to Medicare website to HEALTH website with media interaction
- Continue opportunities for hospitals to share on-going improvement activities and the results of these efforts

Regarding "expansion of the program", Dr. Duquette recommended:

- Continue direct alignment with national efforts
- Resist temptation to "expand" measures with significant data collection burden
- Explore the Pregnancy and Related conditions measure set as a possible expansion for measures that cover OB care

Sandra Brasil was not available, but will be asked to present at a future date.

Dr. Nolan commented on several points to consider in formulating questions for the next Steering Committee Meeting. She noted that originally the thoughts were that healthcare costs were too high and that quality improvements would bring down costs. There is no evidence that this is true. The use of information technology to improve quality and reduce duplication and errors is being explored with the Rhode Island Quality Institute.

How are we going to collaborate if the system remains competitive? Healthcare has been compared to the airline and banking industries, both highly competitive. In healthcare, we need to develop functional and structural methods to collaborate without violating anti-trust statutes.

Does publishing quality information actually lead to quality improvement? This has not been proven. We do know that status quo is not acceptable and we need to push forward. Dr. Waters commented that in healthcare we have moved from one focus to another: access, cost, and now quality. As a nation we have not found an answer as to how we can fit this together.

Mr. Almon commented that in industry there is a cost for poor quality. He noted that doing something on a national level may be frustrating, but within our local arena it may

be possible. Dr. Nolan agreed that it is easier to work with only 12 hospitals and 3,000 physicians. What is not clear is that consumers are being encouraged to use the information. The evidence of what changes our behavior is difficult to sustain. Mr. Rodriguez questioned the Hawthorne effect of focusing on one area engendering improvement. There are inter-professional differences about what constitutes quality. If you change systems, there are consequences of individual change. For example, with pressure ulcers, some institutions do better, but it is not across the entire system. What works? We need to keep experimenting.

Dr. Waters noted if information is made available, it can change behavior. No one wants to be an outlier, and some are not aware of where they are in relation to the norm. There is typically a convergence toward the norm. Thus sharing information helps move behavior in the right direction. Dr. Nolan reiterated that the literature is unclear. We need to remain positive, participate in the research, and document what works.

Meeting Adjourned: 4:30 PM

Next Scheduled Meeting: Monday, January 10, 2005

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA