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

Health Care Quality Steering Committee Minutes
January 10, 2005

Present: K Clark, N Galinko, P Nolan, P Parker, S Pugsley, A Santos, C Duquette, B Waters, S Oberbeck

Guests: G Rocha, J Barr, M Brinson, M Maignet, G Levesque, J Buhler, C Swift, D Smith, S Wood, M Doherty, S Sawyer, P McBride, B Briden, P Mottshaw, M Richards, S Marable

Dr. Nolan welcomed the attendees.

Dr. Waters recognized Jean Marie Rocha, RN, MPH for her three and a half years as Project Coordinator of the Performance Measurement and Reporting Program. During her tenure, she helped with the growth and success of the program. She has recently been promoted to Director of Nurse Registration and Nursing Education for Rhode Island. Dr. Nolan commented that in her brief time in her new capacity, Ms. Rocha has already brought insights from her experience with quality improvement and root cause analysis to her new role.

Gwen Uman, RN, Ph.D. of Vital Research, LLC presented “Rhode Island Nursing Home Resident Satisfaction Survey Project, August-December 2004.” The presentation gave an overview of the pilot nursing home family and patient satisfaction survey that is currently underway. The purpose of the satisfaction surveys is to guide quality improvement efforts, and consumer selection of nursing homes. The project team includes: HEALTH, Quality Partners of Rhode Island, RI Health Care Association, RI Association of Facilities and Services for Aging, Vital Research, and consultants from Ohio (where the nursing satisfaction survey was developed and conducted in 2002 in over 900 nursing homes).

The timelines for the Year 1 Pilot Project are to complete the data collection for the family satisfaction survey by the end of January, and deliver a report to Quality Partners for distribution to nursing homes in April. The data collection for the resident satisfaction surveys will occur in April and May of 2005, with a report in September. The pilot project is not for public reporting, but will give information to nursing homes, with comparative state data. The costs for the pilot surveys, including the Quality Partners Management fee are \$12.62 per bed for the family survey, and \$45.78 per completed interview for the resident survey. A sample of approximate 1/3 of the residents will be surveyed. It is projected that the costs will be slightly less in the Year 2 Public Reporting surveys.

97 nursing homes with 9,537 licensed beds, including short stay facilities, were identified for participation in the family survey. To date, 100% of the nursing homes paid the Phase I invoice, and surveys were mailed to families of 94 of the 97 homes (97%). There has been a high statewide response rate of 43%, with overall positive responses. The range of rates responses by facility is 0%-88%.

There have been data collection challenges such as timely payment, receiving required information in a timely and accurate manner, as well as some problems with survey completion. The recommendations for future surveys are to use fax as the preferred method of communication with nursing homes, more clearly define "family member", consider eliminating scannable forms, establish deadlines, and communicate consequences for not meeting deadlines.

The upcoming activities for the family satisfaction survey are to complete the data collection, perform data analysis and scoring, design the report, and seek nursing home feedback on the process. For the resident satisfaction survey, local interviewers need to be recruited and trained, invoices will be sent out, a sample of residents to be interviewed will be identified, and the interviews will be scheduled.

Dr. Cathy Duquette raised concern about the long timeframe for data collection. Dr. Uman noted this will be more compact in the Year 2 survey. Another concern was raised that the question regarding the family member's relationship to the resident did not offer an option for gay partners. This will be reviewed prior to the next survey.

Judith Barr, ScD of Qualidigm presented "Physicians' Views on Public Reporting of Hospital Quality Data." This was previously presented at the American Public Health Association meeting by the project team of Dr. Barr and colleagues from Qualidigm, RTI International, Baruch College, and CMS. The purpose of the project was to understand physicians as users of hospital-quality-of-care measures with regard to referral and treatment decisions, as information intermediaries for patients, for patient-initiated discussions of quality data, and for quality improvement in hospitals. Additionally, feedback was to be provided to CMS to inform public reporting initiatives.

The three research questions were: How will physicians react to patients who raise questions about public reports on hospital quality? Will physicians make changes, especially in referral decisions, in response to patient questions about hospital quality? What factors are important to physicians in their assessment and use of data reports on hospital quality? The methods used were one hour face-to-face interviews conducted with physicians in three specialties in three states, recruited through key informant physicians. The physicians had to have admitting privileges, not be employed by a hospital, and not an expert in quality improvement. Varied, realistic patient scenarios were used, and qualitative analysis of the interviews was conducted.

With regard to patient questions, the most common responses were to reassure the patient, talk to the referring physician and/ or hospital, and to review the report with the patient. With regard to referral patterns, the physicians were more willing to change

hospitals and less willing to change physicians, but would ultimately defer to patient preference. With regard to factors important to physicians in public reporting, the most consistent response was the methodological rigor of the quality reporting: the validity of the data, sponsorship, sample size, and risk adjustment. For quality measures, they were concerned with volumes and outcomes, patient satisfaction, and relevance. They also noted value to internal hospital reports which might offer outlier information and guidelines.

The recommendations are: educate physicians about the uses of public reports, encourage patient-initiated discussions, consider physician influence on quality improvement, hospitals should continue disseminating public reports to physicians, and public reports must describe sound methods used and present these on websites. The lessons learned are that the methodology was successful, and more research is needed.

Mary Brinson, OT, MS of Butler Hospital presented the Hospital Public Report on Quality Improvement, "Butler Hospital: A Tradition of Hope and Healing." Butler Hospital was established 160 years ago as the first hospital in Rhode Island, and one of the first psychiatric facilities in the country. The focus was on "moral treatment" which consisted of light, air, water, a work program, and trained staff. At that time, lengths of stay were measured in years, there were less than 100 admissions per year, and room & board was 29¢ per day. Today, there are 117 licensed beds 1/3 of which are designated to children and adolescents, 4500 admission per year, an average length of stay of 8.3 days, 1,500-2,000 Emergency Room evaluations per year, inpatient and partial programs, and specialized treatment units. 95% of the patients are Rhode Island residents.

In response to concern about patient satisfaction surveys, Butler Hospital began analyzing patient satisfaction surveys, focus groups, and comparison groups and shifted its focus from numbers to process. They drilled down to develop a group of service standard initiatives where potential areas of improvement were identified with regard to confidentiality, safety, appearance, respect, and communication. These evolved into Butler Service Standards, COMPASSION: caring attitude, otward appearance, make their day, present, active listening, safety, solve the problem, improve, on-time, non-judgmental.

Using measures from Press-Ganey patient satisfaction surveys and the staff surveys, Butler transitioned from service initiatives to service themes: compassion care index, access index (ER waiting time), raise the bar index (operations), leadership index (what staff can expect from leadership), and physician index (making physicians part of the team). They then integrated the themes into action by reporting through the system on dashboards, made them the focus of training and education, as well as part of annual management and supervisory goals. The Butler Hospital performance dashboard for 2004-2005 utilizes a variety of sources (Press- Ganey, employee survey, human resources, '04-'05 budget, environment of care rounds and ORYX) to address: Satisfaction: What is most important to our customers?; Financial: How do we know that we have been successful?; Operations: What do we know we have to do to be successful

now?; and Clinical Quality: What steps must we take today to be more successful in the future?

There are currently no core measures for inpatient psychiatric hospitals. Butler Hospital is one of 17 sites participating in a pilot study on a collaborative performance measurement project conducted by the National Association for Psychiatric Health Systems and the National Research Institute. This project includes collaboration between public and private sector facilities in order to develop meaningful indicators and to speak with a common voice for behavioral health. The measures being collected via a website are: readmission rates, client injury, staff injury, restraint, and seclusion. The plan is to increase reporting of non-core measures from 6 to 9, and to partner with JCAHO to develop core measures.

Meeting Adjourned: 4:40 PM

Next Scheduled Meeting: Monday, March 14, 2005

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA