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

Health Care Quality Steering Committee Minutes
March 14, 2005

Present: T Almon, Sr., K Clark, C Holmes, A Frazzano, D Gifford, H Zuffoletti, P McCue, L MacDonald, S Pugsley, A Tavares, R Urciuoli, C Duquette, B Waters, J Buechner S Oberbeck

Guests: G Rickabaugh, B Briden, M Barros, J Smith, E Quinlan, J Ehmann, P Sparfven, M Ducharme, J Spinelli, C Sharkey, S Mailey, N Towers, E Davis, E Viera Desmarais, M Linn Hamilton, B Staples, C Cairns, M Brunell, N Fogarty, D Dupre, G Rocha, K Lyon, A Luby, A Kenny, K Shatran, R Picard, L McNicoll, J McLaughlin, J McLaughlin, D Collins, B Novak, D Poluntri, S Weber, M J Schumann, I Qi, C Bourfect, R Wood, M Maigret, S Wood, G Sheahan, K Chagnon, M Doherty, C Quattrucci, M Richards

Dr. Gifford welcomed the attendees.

Nancy Fogarty, BS, CPHQ and Mary Brunell, EdD, RN of Roger Williams Medical Center (RWMC) presented on the hospital public report for quality improvement. RWMC is over 125 years old, with 1,400 employees, specializing in care of cancer and geriatric patients. It is the home to the state's only Bone Marrow Transplant Unit and Center for Stem Cell Biology. The Research Department recently received a \$13.5 million COBRE grant to further explore the use of stem cells, while training the next generation of researchers. RWMC has trained over 500 physicians in School of Medicine Program.

In FY 2004, RWMC had 220 licensed beds, 24,729 Emergency Department Visits, 8,556 admissions with an average length of stay of 4.92 days, 65,421 home care visits, and 10,267 outpatient visits. The quality structure encompasses the entire organization: the Board of Trustees, the Quality and Credentials Committee, the Medical Executive Committee, the Quality Council, the Strategic Planning Committee, and the Hospital and Medical Staff Departments and Committees. The quality initiatives fall into three areas: Patient Safety, ORYX Measures, and Patient Satisfaction.

Patient Safety includes:

- National Patient Safety Goals (This includes: patient identifiers, communication, high alert medication, infusion pumps, infection control, medication reconciliation, reduce risk of falls, and universal protocol.)
- Medication Error Prevention System (MEPS) (A multidisciplinary look at what systems are failing when errors occur and fix those systems, MEPS line available in all patient care areas, and staff surveyed on willingness to report an error. Medication errors have steadily declined since implementing this system.

Strategies for improvement include: unacceptable dose range orders and the electronic Medication Administration Record, antibiotic renewals – doses missed for non renewals down to zero, unacceptable abbreviations, epidurals vs anticoagulation therapy, latex allergies – preventing medications with latex from being used)

- Nursing Peer Review (An incident is reported by the nurse verbally or in writing, Risk Management is notified, Clinical Nurse Manager/Off shift educator reviews incident and initiates action, it is reported to DON and VP PCS within 24 hours, and an investigation initiated within 48 hours of incident. The types of occurrences have decreased since initiating this process. The strategies for improvements are: patient falls, pressure ulcers, and medication errors.)
- Clinical Events Variance Committee (Provides a quick response team in order to enhance the effectiveness of risk management activities and to increase involvement of key individuals involved in the review/analysis of clinical events. If an event is determined to be a sentinel event /near miss, then the appropriate team will conduct a root cause analysis and a failure mode and effects analysis.

ORYX Measures opportunities for improvement include: complete discharge instructions for CHF patients, aspirin and beta blocker at arrival for AMI patients, blood culture prior to antibiotic for PNE patients, vaccination for PNE patients, and prophylactic antibiotic discharged with in 24 hours of surgery. The strategies for improvement are: electronic medical record which went live 3/7/05, nursing competencies developed and implemented for ORYX measures, dashboard reports generated and discussed at monthly meetings, and a target of 90% on all ORYX measures.

Patient satisfaction surveys are conducted in the following areas: Inpatient, Emergency Department, Home Care, Addiction Medicine, Outpatient Surgery, and Sub Acute. The opportunities for improvement include: staff attitude towards request, staff kept you informed, staff sensitivity to inconvenience, and response to concerns and complaints. The strategies for improvement are a target of 75% ranking with Press Ganey, dashboard reviewed at all departmental monthly meetings, Service Excellence Program, employee survey, Director rounding, performance evaluation, enhance environment of care, standardized appearance, and create a Family Liaison position in the ED. FY 2005 YTD, survey indicate that all opportunities for improvement have improved since 4th quarter 2004.

Sue Oberbeck, MSW, MHA of HEALTH presented an update of the Rhode Island Health Care Quality Performance Measurement and Reporting Program. The program includes all licensed health care facilities in Rhode Island, and has two requirements: 1) a standardized data set of risk adjusted performance measures, and 2) comparable, statistically valid patient satisfaction measures. Since 1999, the clinical requirements have been met in hospitals, nursing homes, and home health care. Hospitals have reported on patient satisfaction surveys, healthcare cost and utilization project quality indicators. Nursing homes are currently in the pilot year of patient and family satisfaction surveys, and home health care agencies are currently meeting to address this

issue. Finally, nurse sensitive indicators have been reported annually, and continue to be addressed. All of these reports are available on the website, and HEALTH encourages its use, so that the value of the website and the program can be evaluated.

Other licensed health care facilities that fall under this program are (including the number licensed in RI as of 2/23/05): free standing emergency care facilities (1), hospice care (9), kidney treatment centers (14), organized ambulatory care facilities (43), rehabilitation hospital centers (1), birth centers (0), freestanding ambulatory surgical centers (8), school-based health centers (8), and physician and podiatry ambulatory surgery centers (4).

To date, the program's success can be attributed to: 1) collaboration of all participants, 2) utilization of existing data sources, and 3) standardization of existing satisfaction survey tools. Going forward, several program challenges have been identified: 1) lack of comparable databases of risk-adjusted clinical performance measures for other healthcare facilities, 2) significant resource burden in the collection of new data, 3) lack of comparable, statistically valid patient satisfaction measures for other healthcare facilities, and 4) moving to smaller healthcare facilities where the costs of data collection have greater impact on the bottom line.

David Gifford, MD, MPH facilitated a discussion among the Steering Committee Members, "What's Next? Which Setting?" The Steering Committee guides the direction of the Rhode Island Health Care Quality Performance Measurement and Reporting Program, and Dr. Gifford encouraged participation in this process. He noted that at this point, the program could continue with the current settings (hospital, nursing home, and home health care), or expand into other areas. No time frames are prescribed for adding new settings.

Members of the committee and the audience offered several suggestions and comments. The not-for-profit hospices have recently begun to address some of these issues, and the National Quality Forum is beginning to look at hospices. With the shift to out patient surgery from inpatient settings, freestanding ambulatory surgery centers would benefit from oversight. The need to pursue nurse sensitive indicators was addressed in a previous Steering Committee meeting. The community health centers, which represent the largest numbers under organized ambulatory care facilities and school based health centers, are JCAHO accredited and my have something to offer. Patient safety, such as the AHRQ quality indicators was also identified as a potential area to pursue.

Overall, the recommendations were to look for settings with state and national databases, and to take advantage of synergy. The question remained about a policy as to whether the state should support these efforts, or whether the legislature should be notified that resources are needed for this program. One member wanted to go on record that the cost of data collection is borne by the facilities, and there is also legislation not to put small businesses out of business. For the next meeting, the plan is to layout an agenda for the

next few years, of 4 areas to target, which will include nurse sensitive indicators, and patient safety in hospitals.

Mary Jean Schumann, MSN, RN, MBA, CPNP of the American Nursing Association (ANA) presented an Overview of National Database of Nursing Quality Indicators (NDNQI). This was established in 1998 as part of ANA's Safety and Quality Initiative, and is supported by the ANA and through fees for participation. The two goals for NDNQI are to: 1) provide comparative information to hospitals for use in **quality improvement** activities, and 2) develop national data for **research** on the relationship between nurse staffing and patient outcomes. There are 708 hospitals (13 % of all general hospitals) participating nationally, 7 of them are hospitals in Rhode Island. It is not a random sample as participation is voluntary and larger hospitals are more likely to participate.

The data includes 22 quarters of data from Q3 '99 to Q4 '04. NDNQI uses unit types as a means of risk stratification. Quarterly data is available at the following unit levels: Critical Care, Step Down, Medical, Surgical, Combined Med-Surg, Rehabilitation, Pediatrics, and Psychiatry. The RN satisfaction survey is available on all units. The quality indicators include 3 consensus measures from the National Quality Forum (nursing hours per patient day, skill mix (%RN), and fall rate), as well as RN education & certification, hospital acquired pressure ulcer rate, pediatric IV Infiltration, pediatric pain assessment cycle, and psychiatric injury assault rate.

The RN satisfaction survey has been collected for 3 years. In 2004, greater than 76,000 nurses in 206 hospitals representing over 6,000 units participated. The data includes satisfaction with: task, RN-RN communication, RN-MD communication, decision making, autonomy, professional status, pay, professional development, supportive nurse management, and nursing administration. It also asks about job enjoyment, opinions on quality of care, job plans, floating/ overtime, and demographics.

The comparative information includes risk stratification of hospital staffed bed size and unit type. Within each table provided, there is a national mean (risk stratified), unit/national significance tests, and upper & lower quartiles. The uses for the outcome measures are to support quality initiatives, customer decisions, and risk management.

Ms. Schumann outlines the differences between risk-adjustment and risk stratification. Risk –adjustment controls for the level of acuity of the patients being studied/cared for-average case mix, reduces the inclination to selectively report, is not available at the unit level where the care occurs, but rather by CPT-codes or ICD-9 codes, is tied to billing and average charge rates, and is not standard. Risk stratification creates a comparison pool-people like you, allows for comparisons within pools, allows for defining relationship between staffing and outcomes for a unit type, stratifies at the hospital level by case mix and size and magnet, non-magnet, and teaching status, and the fall rate is adjusted at pt levels by age, gender, prior risk assessment.

Using NDNQI allows for:

- Quality improvement activities to be measurable on a unit by unit basis
- Staffing data
- Some risk adjustment based upon the patients cared for in that type of hospital, that type of unit, and other factors
- Hospitals to be compared nationally and not just with each other
- Benchmarking opportunities via national comparisons

To participate in NDNQI, hospitals must sign a contract, pay an annual fee, and provide staff to collect and submit data.

Meeting Adjourned: 5:05 PM

Next Scheduled Meeting: Monday, May 16, 2005

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA