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

Health Care Quality Steering Committee Minutes
November 14, 2005

Present: T Almon, A Frazzano, D Gifford, H Zuffoletti, D Policastro, S Pugsley, E Roberts, A Santos, A Tavares, C Duquette, J Buechner, S Oberbeck, M Richards

Guests: M Brinson, A Powers, K Park, J Muri, G Levesque, E Desmarais, M Marsella, B Koconis, F Minichello, J Ehmann, B Stewart, M Doherty

Dr. Buechner welcomed the attendees.

Janet Muri, Vice President of Quality Analytic Services presented an update on the public report of “Rhode Island Trends in AHRQ Quality Indicators for Patient Safety, Prevention, and Inpatient Quality.” The project will be similar to a previous report co-authored by Ms. Muri in 2001, “Trends in Quality Indicators for Health Care in Rhode Island (1994-1998): Hospital Care, Access to Care, and Utilization of Inpatient Procedures.”

The current report will focus on Rhode Island trends in the AHRQ indicators for 1999-2004. The measures have been expanded into three areas with 76 indicators: patient safety (29 provider level rates and 6 area level rates), prevention (16 indicators), and inpatient quality (25 provider rates sub divided by volume, post-procedural mortality, inpatient mortality, and utilization rates). The national comparative rates are from the National Inpatient Sample- 2002.

The patient safety indicators are designed to screen for problems resulting from exposure to the healthcare system that are amenable to prevention by changes at the system or provider level. The prevention quality indicators are ambulatory care sensitive conditions that result in hospital admissions that could have been avoided through high quality outpatient care or that reflect conditions that could be less severe, if treated early and appropriately. The inpatient quality indicators reflect quality of care inside hospitals and include inpatient mortality; utilization of procedures for which there are questions of over use, under use, or misuse; and volume of procedures for which there is evidence that a higher volume of procedures is associated with lower mortality.

The current report will include background and process information, a technical report, a summary report, and a web-based report. As in the previous report, there will be a summary table with the indicator listed, the preferred trends, the Rhode Island trend, a diamond rating comparing the Rhode Island rates to the national rates for each year that a comparison is possible (a trend is a statistical calculation over 5 years), and there will be a comment section about the indicator. There will also be a descriptor of each indicator

that includes how the measure is calculated, which patients are included, why it is important, what the Rhode Island trend tells us, and how to interpret the accompanying graph.

The process has included Rhode Island discharge data from 1999-2004, Healthcare Cost and Utilization Project (HCUP) software and Rhode Island trends at a population level. The data will be presented at the state level, not the hospital level. The targeted audience will be providers first and then consumers. AHRQ sees value in reporting back to hospitals before the public so that providers can use the information as a screening tool to focus attention on data quality, coding quality, and quality of care.

Discussion following the presentation focused on the fact that few consumers would use this to change providers, yet there is an opportunity to fill in the information gap where there are requests from consumers. In large part this is being driven by consumers, and they need to be included in discussions about what drives the rates on issues flagged in this report. The intent of the Health Care Quality Performance Measurement and Reporting Program is to have information used, and we need to be creative in linking the information to other discussions and journals for explanation.

Ms. Muri will plan to attend the next Hospital Measures Subcommittee meeting to address concerns about appropriate information being provided in the descriptor comments.

Richard Gamache, Vice President at Roger Williams Medical Center and Administrator of Elmhurst Extended Care Facility presented “Eden and Elder Care: Opportunities and Innovations.” Elmhurst Extended Care is a 192 bed skilled nursing facility owned and operated by Roger Williams Medical Center. It has sub-acute and dementia/Alzheimer’s special care programs.

Mr. Gamache began by noting the differences between our lives where we have control and maintain our identities to that of nursing homes where this is lost. Most families describe the admission process as the most difficult one they make in life. Mr. Gamache asked, “What if nursing homes were models of customer service and care? ...and aren’t they?” He noted there are three systems that support hospitals: regulatory, financial, and workforce and they are all broken. There is over-regulation (120,000 pages of regulations for nursing homes), chronic under-funding (money is lost on every Medicaid patient), and high turnover due to the medical model (90-200% turnover due to workplace). Workforce (leadership/decisions/actions) is the truest indicator of success or failure in a nursing home. Mr. Gamache stated that when a nursing home succeeds it is not because the “system” worked, but rather that the leadership made it work in spite of the system. When a nursing home fails the approach has been to add more regulations, which burdens the workforce, causing people of all ability levels, including talented ones, to become frustrated and leave the field.

In our society, we institutionalize two groups: prisoners and the elderly. Some pioneers developed alternative approaches to nursing home care. In 2002, Elmhurst pursued the Eden Alternative, a philosophy of elder care developed by Dr. William Thomas, which is now used worldwide. Dr. Thomas found three plagues in nursing homes: loneliness, helplessness, and boredom. His antidotes to these plagues are: close, continual contact with children, plants, and animals; loving companionship; meaningful activity; variety and spontaneity; and a life worth living.

The first change made in the process of developing the Eden Alternative model was management culture realignment because the way managers treat staff is the way staff treat elders. The areas addressed in the management culture realignment were: fairness, equity, consistency, affection, respect, and compassion.

The early successes and lessons learned were: the importance of education (in addition to Eden training, a career ladder for nursing assistants –the LEAP program, a gerontologic nursing course, and a National Association for Geriatric Nursing Assistants chapter were developed); permanent assignments created opportunities for sustained relationships; neighborhoods rather than units provided a more homelike atmosphere and approach to living situations; pets are an important part of the community; and empowerment is very important.

Empowerment of the staff and elders resulted in environmental changes (décor, play areas for children, plants, and gardens); dining changes (staff eating with residents, offering dining in a manner closer to that of home environments), a change in how staff and elders responded to the death of other residents (“no one should be alone”, time for grief and remembrances). Currently, Elmhurst is working on: better responses to call lights, allowing patients to get up when they want and accommodating their schedules, child day care, private rooms, and greenhouses.

Mr. Gamache provided a statistical analysis of “a life worth living.” Since 2002, admissions have declined, average occupancy has increased, discharges to hospitals have decreased, expirations have decreased, geriatric depression scales have decreased, mini mental status exams scores have increased, satisfaction surveys have improved, and staff turn over has decreased. Although the occupancy has increased, so have the costs.

For the future, Mr. Gamache noted there will be 180,000 new seniors in Rhode Island within the next 15 years. This will create an unprecedented demand upon the healthcare system. He advocates developing an eldercare system that works and includes culture change, person-centered care, and collaboration among providers, regulators, advocates, and elders. He noted that Rhode Island has been a leader in quality indicators, culture change, and independent thoughts and actions. Mr. Gamache is looking for more volunteer programs, and would like to model more public/private funding such as with Dr. Mor at Brown. He credited Dr. Gifford for his work in the quality of life of elders and Ray Rusin from the Department of Health Facilities Regulation for his willingness to consider change. Members of the audience commended his education programs and encouraged him to offer these throughout the state.

For additional information, Mr. Gamache recommends the following websites:

www.elmhurstextendedcare.org

www.edenalt.com

www.nagna.org

www.matherlifeways.org

He also welcomes feedback or ideas about potential partnerships.

(For electronic copies of the presentations, please email Sue Oberbeck at

SusanO@doh.state.ri.us.)

Meeting Adjourned: 4:45 PM

Next Scheduled Meeting: Monday, January 9, 2006

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA