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

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**Health Care Quality Steering Committee Minutes**

July 10, 2006

Present: J Buechner, N Galinko, L McDonald, C Guglielmetti, R Rodriguez, G Rocha, A Tavares, H Zuffoletti, M Richards, S Oberbeck

Guests: B Isaiah, S LaSalle, C Koller, R Wood, J McLaughlin, J McLaughlin, J Muki, B Stewart, S Wood, E Desmarais, G Levesque, C Bourgeois, M Marsella, J Vincent

Dr. Buechner welcomed the attendees and introductions were made.

Dr. Buechner made two announcements:

- 1) Qualidigm's contract for this program ended June 30, 2006, but was extended for three months, until September 30, 2006. Due to changes since the inception of the program, a new RFP is being issued for a vendor to continue with the current activities and assist with the development of future activities.
- 2) As part of the Governor's Health Policy Agenda, a new law was passed last week that is now part of the Health Care Quality Performance Measurement and Reporting Program. The Rhode Island Health Care Affordability Act of 2006-Part II- Transparency of Information on Health Care Quality and Cost is available at: <http://www.rilin.state.ri.us/Billtext/BillText06/SenateText06/S3170Aaa.pdf>. This new legislation resulted in a late change in our agenda, so that Christopher Koller, the Rhode Island Health Insurance Commissioner could address this group about the law.

Christopher Koller, the Rhode Island Health Insurance Commissioner presented an overview and background of the new legislation noted above. The Governor was seeking a more coordinated health policy agenda and created the Directors Health Care Group to coordinate efforts among state agencies. The group is comprised of Dr. Gifford of the Department of Health, Jane Hayward of the Department of Health and Human Services, Saul Kaplan of the RI Economic Development Corporation, Beverly Najarian of the Department of Administration, Adelita Orefice of the Department of Labor and Training, Ellen Nelson of the Department of Mental Health, Retardation and Hospitals, and Chris Koller of the Insurance Commission. The Governor's agenda included wellness, a balanced health care delivery system including inpatient centers of excellence and primary care, health information technology, affordable health care, and state purchasing. The workgroup was charged with coordinating state agencies to look at the transparency of health care costs, as insurance deductibles were increasing and pricing showed wide variation.

The legislature was not only interested in cost, but in quality and thus extended the legislation to develop a process to address quality, not only at the facility level, but at the health care provider level. Specifically, the legislation for the “Health Care Quality Program” was changed to add health care provider as defined as “any physician or other licensed practitioners with responsibility for the care, treatment, and services rendered to a patient.” The law does not change the current process of method selection currently used by the Steering Committee rather it gives the group the ability to work in other ambulatory care facilities.

Mr. Koller reported that Rhode Island currently mandates information at the health plan level. Massachusetts publicly reports specific quality information at the provider level at Massachusetts Health Quality Partners, and other states are doing this as well. He does not think that HEDIS drives consumer choice, although health plans to look at HEDIS data for comparison. In New York they are publicly reporting cardiac surgery and mortality rates by provider. This has generated consumer interest.

A question was raised about the transparency of pricing with regard to home care and hospice providers. Mr. Koller said the question is what do the health plans pay. As consumers have higher deductibles and need to pay out of pocket, they need additional information about what the health plans pay for services. The responsibility for cost transparency does not lie with the Department of Health, but rather Mr. Koller’s work group.

It was noted that this new provider level is much like the beginning of the program when approaching facilities: there is not a standard for sources of data, there is not a consensus on measures, and there is not a sense if the resources necessary to accomplish this.

A question was raised about previous discussion about pursuing quality measurement in ambulatory surgery centers next. The plan has been to move forward with community health centers, but that has been delayed due to the resource requirements of current efforts with nursing homes and home health care agencies. The thought at this time is to start seeking consensus in the health care provider arena by developing two subcommittees, one for chronic and primary care measures, and one for surgical procedures. It was recommended that we collaborate with groups already addressing chronic disease management and performance improvement. Another comment was made that since there are national groups such as AHRQ and the Ambulatory Care Quality Alliance already looking at these issues. Given that no additional resources were provided for this mandate, there is no plan to re-invent the wheel and will review what is already available.

A motion was made, seconded, and unanimously approved to establish two subcommittees, one to develop primary care and chronic disease measures, and one to address surgical procedures to be measured.

Meg Richards, PhD of Qualidigm Quality Partners presented ‘Ambulatory Care Quality Measures and Public Reporting: An Environmental Scan, on behalf of the authors Judith Barr, ScD and Tierney Giannotti, MBA of Qualidigm. The authors were unable to attend the Steering Committee meeting to present the report. Dr. Richards reviewed that over the course of this program, an environmental scan has been performed as the first step in developing an operational plan to implement public reporting in any new facility- based setting. This particular scan was to report on the current state of measurement and reporting of ambulatory health care quality. Although the plan is to work with community health centers, Dr. Buechner recommended a broader scan of ambulatory measures- which appears to be beneficial given the recent legislative change to include health care providers.

Community health centers (CHCs) are the fourth facility/ setting to be measured under this program. CHCs are mandated by the federal government to provide primary care with comprehensive ambulatory services in medically underserved areas. CHCs differ from previously publicly reported licensed facilities in that care is delivered in an outpatient, office-based setting, where fees are adjusted according to the ability to pay, and the patients are mostly low income and under/uninsured.

The objectives of the environmental scan are to review: the types of measures available, existing reports from other states or regions, and existing Rhode Island data sets that might serve as a resource. The environmental scan also develops recommendations to HEALTH regarding ambulatory measures and patient satisfaction (also referred to as the patient “experience”) in support of CHC public reporting.

The ambulatory care environmental scan looked at a variety of providers and settings, including CHCs, medical group practices, health plans and HMOs, and independent office-based practices. In terms of populations that could be measured, children and adults, private/public/ uninsured patients, veterans and non-veterans were identified. The environmental scan was accomplished through three sources of information: literature review, website/document review, and key informant interviews.

At a national level, the key findings of the ambulatory care environmental scan are that ambulatory care measures are in two categories: processed of care, and the patient experience. The most widely supported measures are diabetes care and prevention and the CAHPS satisfaction surveys. Public reporting has focused mostly on medical groups and health plan, and involves primarily HEDIS measures. In terms of CHCs, no public reporting examples were found. The Bureau of Primary Health Care has aggregate data, focused on utilization and cost of care. Published studies of satisfaction showed that in 2001, 63% of CHC patients were “very satisfied.”

The key findings for Rhode Island are that there are 12 CHCs in Rhode Island, with 24 locations. Seven of these are federally qualified health centers. They all offer primary and preventive care services, as well as interpretation services. Many offer dental services, and a few offer mental health services. Existing ambulatory care data sets are Rhode Island Health Center Association’s (RICHA) database which includes

demographic and claims data that can be reported at the facility or provider level, and Neighborhood Health Plan of Rhode Island's (NHPRI) HEDIS reports for 10 CHCs which are reported to NCQA and HEALTH. These data include clinical performance and patient experience measures. Other existing Rhode Island data sets include: Medicaid MIS, KIDSNET, Lead Elimination Surveillance System (LESS), and HEALTH's laboratory data base.

There is no single local database that meets all of the requirements for public reporting. Nationally, health plans and medical groups have the most robust history of ambulatory care quality data. Locally, RICHA and NHPRI offer the best potential sources of data.

The recommendations of the environmental scan are:

- 1) Build on health plan and medical group practice measures and reporting, beginning with HEDIS- type measures. (This forces the exclusion of Medicare and uninsured patients).
- 2) Develop a plan for collaboration between CHCs and organizations that represent or support the CHCs (such as RIHCA and NHPRI).
- 3) Work through CHC-representative organizations (RIHCA, NHPRI) for planning, decision-making, and implementation.

Dr. Buechner noted that the report was very well done and included a very comprehensive matrix that will be helpful to the CHCs and the ambulatory provider community. He also noted that it has not yet been decided to exclude all but NHPRI members. The report noted that HEDIS is a good starting point, and that chart review is problematic in that it is unclear who would be able to pay for it and who had the resources to perform chart reviews.

A motion was made to accept and publish the environmental scan. It was seconded and unanimously approved.

Janet Muri, MBA of Quality Analytic Services presented "Rhode Island Trends in AHRQ Quality Indicators for Patient Safety, Prevention and Inpatient Quality." Ms. Muri summarized the background and process of the report regarding trends in RI from 1999-2004, reviewed the finalized report, and made recommendations for next steps.

There are three sets of indicators in the report: patient safety, prevention, and inpatient quality. The national comparative rates are from the National Inpatient Sample 2002/2003. The process looked at Rhode Island discharge data from 1999-2004. The HCUP software was used to mark numerator and denominator cases, and then Rhode Island statewide trends were created.

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. There are 35 indicators, 17 of which are profiled in detail on the Technical /Summary report. 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. There are 14 indicators, risk adjusted by age and sex. 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. There are 30 provider level indicators.

The value to providers is that this serves as a screening tool for where to focus attention. It has also driven improved data quality, coding quality, and quality of care. It has enhanced a state-provider partnership. For the consumer, there is questionable value, and a committee is being created at the national level to address composite measures. Ms. Muri is a member of that committee.

The report itself is able to be posted on the Department of Health website. It mirrors previous reports, is simple to understand, includes cautionary comments, and directs more sophisticated readers to additional information.

Virtually every state is reporting this at the state level. Texas and Pennsylvania have reported this at the hospital level. With pay-for-performance, this information is gathering attention. In 12 states (including Connecticut and Maine), Anthem BC/BS rewards providers who initiate quality enhancement and improve outcomes based on clinical measurements in patient safety, emergency room care, and cancer care.

The recommendations for next steps in Rhode Island are to continue a leadership role in public reporting and continue to track developments around AHRQ indicators and other public reporting initiatives. Locally, run hospital specific rates and develop a process for feedback and data validation through key contacts at each hospital. Finally, design and publish reports that promote quality of care and inform all stakeholders.

A comment was made that AHRQ has asked the National Quality Forum to validate these measures. It was noted that the measures themselves have been validated, what has not been validated is the quality of the underlying data. Ms. Muri noted that over time, there has been more detailed data provided, with a better quality control process, and there has been an effort to improve the information.

A motion was made to accept the report and refer the question of reporting at the hospital level to the Hospital Measures Subcommittee for review and comments to the Steering Committee. This was seconded and unanimously approved.

Sue Oberbeck, MSW, MHA of HEALTH presented a brief overview of the draft interactive HEALTH based web query tool that will be available to assist consumers, health care providers and interested parties in seeking a nursing home. The development of this format was approved by the Steering Committee at prior meeting. The plan is to make this tool available when the patient and resident satisfaction surveys are made public in late September. There will also be static reports regarding the surveys on the HEALTH website. The final version will be determined by the Nursing Home Subcommittee meeting later in the week.

The query tool is much like searching for a home on line, with selection of limited criteria. The criteria are location (with a drop down tool of cities and towns), types of care, services, and types of payment accepted. The town listing is limited to what users from out of state would find on a map.

Once the criteria are submitted, a list of nursing homes meeting the criteria will appear, and users can go to a one page information sheet for each licensed nursing home. Information sheets about each licensed nursing home facility will include a link to the facility's website, address and contact information, mapping capability, links to other publicly reported data such as state survey information, clinical indicators and family and resident satisfaction surveys, and additional links such as 'Guide to Choosing a Nursing Home.' The sheets were designed for limited maintenance requirements by HEALTH.

A question was raised about adding in capability to choose location by a range of miles. The system is not yet capable of this, but staff said it will be a future consideration. At the moment, they do not want this to impede implementation. Another question was raised about nursing home quality measurement website include a reference or link to the long-term care ombudsman as a resource in selecting a nursing home. Staff agreed that such a link was appropriate and recommended this be referred to the Nursing Home Subcommittee for discussion.

A motion was made to approve of the public reporting format for nursing homes. It was seconded and unanimously approved.

Meeting Adjourned: 5:00 PM

Next Scheduled Meeting: Monday, September 11, 2006

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA