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

Health Care Quality Steering Committee Minutes

November 6, 2006

Present: T Almon, A Frazzano, N Galinko, L McDonald, S Pugsley, G Rocha, A Santos, A Tavares, H Zuffoletti, M Richards, J Buechner, S Oberbeck

Guests: J Ehmman, S LaSalle, R Wood, C Lamoureux, R Baute, M Doherty, B Stewart, S Wood, E Desmarais, G Levesque, W White

Dr. Gifford welcomed the attendees and introductions were made.

Program Updates:

Sue Oberbeck, MSW, MHA provided an update of program activities. The *“Family and Resident Satisfaction with Nursing Home Care in Rhode Island”* is targeted for a press release from the Governor’s office on Friday, November 10th. A consumer report, a technical report, and static tables will be available on the website on Friday. The tables will be in the diamond format used in other consumer reports. The web query tool is not yet ready. When it is, the static tables will be removed, as consumers will be able to search the website for the same information. The nursing homes have already received their data which includes their scores for the pilot study and the public study. These data were released after they were validated by an external consultant.

The Home Health Patient Satisfaction survey pilot is underway. It took approximately 6 months to secure contracts from all of the agencies. Of the 52 agencies participating, over 67% are sending uploads. The barriers encountered by the others are high turnover among the staff, or the fact that IT is outsourced and they need to re-engage their IT contacts in the process. Unlike other surveys, this will be a condensed time frame. The pilot surveys will be collected through the last week of December/ first week of January. The agencies will receive reports on February 22, 2007. The public wave will begin in September 2007, with a public report anticipated in early 2008.

With regard to the hospital satisfaction surveys (H-CAHPS), all but two of the hospitals participated in the first pilot/ “dry run.” One hospital was in the middle of changing its IT system, and the other had significant staff turnover. Press Ganey is working to get both into the second pilot in March 2007. The remaining hospitals are currently uploading their discharges from October 2006- June 2007. Discharges for July, August, and September of 2007 will be publicly reported in November/ December 2007.

A workgroup has been meeting to develop a format for the Annual Hospital Core Staffing Plan. Per the recommendation of Facilities Regulation, the format will not go through the formal regulation process, but will be referenced in the regulations in the same manner as

the Continuity of Care form. An informal community review will be held at the December 12th Hospital Measures Subcommittee meeting. The format will be presented at the January 8th Steering Committee for approval for distribution to hospitals for their 2007 reporting.

The Subcontract that we have had with Qualidigm since the inception of this program was unable to be renewed and was re-bid. One bidder responded to the request for proposal. The bid was approved by an internal review committee and referred to the Department of Administration for final approval. They are expected to make their decision on November 15th.

During the discussion, questions were raised about how much choice consumers have with regard to home health care. Legally, there is choice, but the process was described as being as good as that of choosing a hospital or nursing home. Public reporting, in Rhode Island and nationally, has been the greatest driver for change by facilities. It has also empowered patients and families by encouraging them to ask questions of the providers.

An additional question was asked about the JCAHO ORYX initiative and the quality measures being reported through that system. There are more measures collected than those that are publicly reported. In addition to the chore measures, hospitals have the ability to decide which measures they want to publicly report.

Dr. Buechner recognized Qualidigm/ Quality Partners as the subcontractor for this program. He noted they deserve much credit for taking the lead on the efforts undertaken in hospitals, nursing homes and home health.

Pressure Ulcer Reporting Update:

Dr. Gifford introduced Meg Richards, PhD of Qualidigm/ Quality Partners to present a summary report and updates on the pressure ulcer pilot study. Dr Gifford noted that this is an important issue as a large number of pressure ulcers are present upon admission to nursing homes. Dr. Richards reviewed the pressure ulcer pilot study conducted on behalf of the Hospital Measures Subcommittee. This study looked at whether skin and risk assessments were completed within 24 hours of admission. In total, 199 records were abstracted at 11 hospitals. The average time to abstract a record took two minutes, with a range of 1-4 minutes. 95% of the admissions had a skin assessment upon admission. Of these, 10 % (19) had a pressure ulcer noted. 86% of all of the records had a total risk assessment completed upon admission. The Braden tool was the universal assessment tool at all hospitals for total risk assessments.

The Continuity of Care Form was looked at only to determine how well information was being communicated between facilities. Many of the hospitals complete pages 1-2 of the Continuity of Care Form for all discharges, whether they are going to another facility/ agency or not. This chart review did not correct for the appropriate use of the Continuity of Care Form. The information gathered on pressure ulcers noted at admission and on the

discharge Continuity of Care form (in 14 of 28 records) was not a solid one-to-one match.

Following the pilot study, the workgroup then met with representatives of hospitals, nursing homes, and home health agencies, to see if there were common process and communication measures that could be reported across the settings. No common reportable measures were found for public reporting. Quality improvement efforts across the settings were referred back to efforts already underway with Facilities Regulation and Quality Partners. Dr. Richards noted that the workgroup has frequently expressed two concerns about selecting an appropriate pressure ulcer measure: 1) adequate risk adjustment of an outcome measure, and 2) the data collection burden.

Dr. Richards reported that Qualidigm was selected by CMS to develop the algorithm for the Medicare Patient Safety Monitoring System (MPSMS) Hospital Acquired Pressure Ulcers to be reported in the National Health Care Quality Report. Dr. Courtney Lyder, a national expert, served as an advisor on the development of the algorithm. The data comes from the Medicare Clinical Data Abstraction Center (CDAC) and Medicare enrollment and claims databases. Qualidigm is developing a free access database for hospitals to track hospital acquired pressure ulcers, using a random sample of patients. Qualidigm did state that this is part of a surveillance system and was not designed for public reporting. The database will be available to hospitals in January 2007. Nancy Verzier of Qualidigm will provide a presentation on this at the Hospital Measures Subcommittee meeting on December 12th.

Discussion followed that the Hospital Subcommittee plans to continue reviewing process and outcome measures. A question was raised about whether the rate of hospital acquired pressure ulcers should be zero, and whether pressure ulcers are for the most part preventable. In terms of risk-adjustment, there is no “adequate” risk adjustment. As no measure is perfect, the question was raised should we let perfect be the enemy of good. It was recommended that nationally endorsed measures be considered. One comment was that DOH should provide risk adjustment of data. It was noted that the nursing home MDS risk adjustment could be reviewed, and that the Braden Scale already used by hospitals is a form of risk adjustment.

A motion was made, seconded and approved (9-0) to have the Hospital Measures Subcommittee continue their search for a pressure ulcer measure and report back to the Steering Committee at the May 2007 meeting.

Recommendations for Program Activities:

Jay Buechner, PhD of HEALTH gave recommendations for program activities that require approval of the Steering Committee. The first item to be voted on was whether to restrict our reporting measures to national consensus measures that have been validated wherever they are available. The Health Care Quality Program does not have adequate financial or intellectual resources to develop local measures. Historically the program has

drawn from the expertise and resources of others such as the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), or JCAHO.

The discussion focused on the fact that although a perfect measure may not be available, in health care or any business, there is a need to measure to prevent progress assassination. It was recommended that if a group such as NQF or AHRQ adopts a new measure, the measure should be sent to the Subcommittee to inform the Steering Committee about why it can or cannot be publicly reported.

A motion was made, seconded and approved (9-0) for the Health Care Quality Performance Measurement and Reporting Program to use nationally endorsed, consensus measures wherever they exist, rather than developing Rhode-Island specific measures.

The second program activity recommended is an evaluation of the usefulness of the website for consumers. It is a complex website, and the program staff members are not the most qualified judges for evaluating it. Evaluation of the public reporting formats was one of the recommendations of the Technical Expert Panel held in the fall of 2005. The panel consisted of national experts in this area. An evaluation of the ability of consumers to access and understand our products has not been undertaken since the inception of the program. We are interested in knowing how we can improve upon the public reporting aspect of the program.

A question was raised about funding an evaluation that includes focus groups. With this in mind, a proposal for this was requested in our recent subcontract RFP. AHRQ has a workgroup looking into how to publicly report information on health sites nationwide, to have a similar look and feel. We are awaiting information from that workgroup. Although the program conducted focus groups with regard to formatting and understanding some of the reports, it was never looked at how consumers access the website. The program is no longer able to measure “website hits”, as the program for that (Webtrends) was discontinued.

A motion was made, seconded and approved (9-0) to initiate an evaluation of the website and revise the consumer products using methods that include conducting focus groups for consumers. The Steering Committee would like a report of this effort at the July 2007 meeting.

A new charge of the program this year is: *Consideration of measures associated with hospital-acquired infections with consultation of infections controls experts.* This information is already being publicly reported in other states. It is an important issue that is part of the National Patient Safety Standards.

The discussion noted that perhaps the data being looked at by the ICU collaborative could be considered. Since the 1970's there has been a great deal of progress made with regard to hospital acquired infections, but the situation is now complicated by the fact organisms

are now present in the general public and are not just facility-based. It is not inappropriate to report, and may be painful the first year, but will eventually lead to quality improvement. It was recommended that the national models be reviewed.

A motion was made, seconded, and approved (9-0) to charge the Hospital Measures Subcommittee to identify a workgroup of infection control experts, research public reporting efforts in other states, make a recommendation for hospital acquired public reporting measures to the Steering Committee, and report this at the November 2007 meeting.

Another charge of the program is: *Consideration of the relationship between human resources and quality, beginning with measurement and reporting for nursing.* This is in addition to the required annual hospital core staffing plan reporting. The recommendation is for both the Hospital and Nursing Home Subcommittees to develop public reporting measures for staff turnover, retention, use of agency staff, and use of overtime (elective and mandatory).

The discussion focused on a lack of nationally endorsed consensus measures for these areas. It was reported that since 2002, JCAHO has not found a correlation between human resources and quality, and no longer requires reporting this. In nursing homes, a correlation has been shown. Nursing homes publicly report the number of staff nursing hours and CNA hours per resident per day on "Nursing Home Compare." It was recommended that the two Subcommittees look at the data and report back to the Steering Committee.

A motion was made and seconded not to approve the charge that the Hospital and Nursing Home Subcommittees develop measures for staff turnover, retention, use of agency staff and use of overtime (elective and mandatory). The motion did not pass by a vote of 1-to-8. A second motion was made, seconded and approved (8-1) to recommend the Hospital and Nursing Home Subcommittees review the feasibility of developing measures for staff turnover, retention, use of agency staff and use of overtime (elective and mandatory) and report this back to the Steering Committee at the September 2007 meeting.

There being no further business, the meeting was adjourned at 5:00 PM.

Next Scheduled Meeting: Monday, January 8, 2007

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA

