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

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**Health Care Quality Steering Committee Minutes**  
March 12, 2007

**Voting Members Present:** A Santos (RIHCA), N Galinko (UHC/NE), D Gifford (HEALTH), C Novak (RIAFSA), S Pugsley (BCBS/RI), G Rocha (HARI), A Tavares (RIPHC), H Zuffoletti (Alliance for BLTC)

**HCQP Staff & Contractors:** J Buechner (HEALTH), M Richards (Quality Partners)

**Guests:** S Brasil, J D'Agostino, E Donahue, J Gage, S Gravenstein, S Kissam, G Levesque, J McLaughlin, J McLaughlin, R Wood

Dr. Buechner (who chaired the meeting until Dr. Gifford arrived) welcomed the attendees and introductions were made starting at 3:10 PM.

Home Health Update

Meg Richards, PhD presented an update on the Home Health Satisfaction Pilot Survey (see associated slides). The statewide response rate was 29.5%, with 8576 surveys mailed and 2530 returned. Of the 53 agencies mandated to participate, only 48 agencies were active in the pilot. Of these 48 agencies, only 20 met the proposed minimum of 30 reports for public reporting. Problems identified with either the survey instrument or the process – along with potential solutions – were discussed and are included in the slides.

Steering committee members and guests asked for clarification on these issues:

- How many of the 20 agencies that met the proposed minimums of 30 reports are Medicare Certified vs. non-Medicare Certified? [Answer: 14 MC versus 6 non-MC.]
- Was (can) the survey (be) sent out in versions other than English? [Answer: If an agency indicates that a patient or client is non-English speaking, Press Ganey can send out a Spanish or Portuguese version of the survey. The cover letter that accompanies the mailed survey has statements in Spanish and in Portuguese to this effect. However, in the pilot, no such surveys were requested.]
- Must the large agencies survey as many as 1,000 patient/clients, or can they stop when they get to a certain number (for example, 100) suitable for public reporting? [Answer: The agencies make these arrangements with Press Ganey, but it's worth pointing out that even the most active agency – the agency that mailed out 1129 surveys and received 383 back – generated a very respectable but *not* stunning response rate of 34.6%. Had that agency stopped at 100 returns, their overall response rate would have been less than 10%, and very possibly biased. Higher response rates translate to a more representative sampling and more robust estimates of satisfaction with care.]

- Will Press Ganey allow for the use of two instruments (skilled and nonskilled) in the public survey wave, and will this effect RI agencies' ability to benchmark nationally? Does Press Ganey split their national database into skilled and non-skilled results (or MC and non-MC results), and will Rhode Island elect to report results for these two types of services separately? [Answer: Press Ganey does not currently make any such distinctions in their national database. The Rhode Island agencies, with some exceptions, appear to want to survey and report skilled and non-skilled care data separately. This will make benchmarking against a national database a muddier proposition, EXCEPT for the core questions that all three surveys – Press Ganey standard, proposed RI skilled, and proposed RI non-skilled – will share. It is worth noting that the Home Health Subcommittee modified the Press Ganey standard survey rather significantly – in terms of question wording, order, and formatting - to begin with. The two-survey issue will be a principal topic of discussion on April 9.]
- Can we offer the agencies a chance to run a second pilot before we survey and report satisfaction in the public wave? It seems like the agencies won't have sufficient time to engage in quality improvements or to make the necessary fixes to the survey/survey process. [Answer: Sadly, no. We negotiated costs with Press Ganey based on a 21-month timeline, and we are already well outside of that timeline.]

#### Nursing Home Update

Stefan Gravenstien, MD, presented the Nursing Home Subcommittee's recommendation that R.I. nursing homes try a new satisfaction vendor this year. From 2004-2006, Vital Research surveyed residents and family members in R.I. nursing homes; in 2007 the Subcommittee wishes to engage in a trial with MyInnerview. Perceived advantages with MyInnerview include: lower costs, a large national database for benchmarking, built-in quality improvement feedback support, an optional staff satisfaction module, and the ability to monitor feedback reports on-line and over time. Vital Research's clear advantage is the conduct of face-to face interviews with mildly-to-moderately cognitively impaired residents and – according to Dr. Melissa Clark of Brown (who conducted an independent side-by-side assessment of the surveys) – a higher quality questionnaire.

Dr. Gifford emphasized that Vital Research was chosen in 2003 because of their ability to interview residents – including impaired residents – face to face. He also noted that though MyInnerview submitted a written bid on the project in 2003, they were not among those invited to present as they were considered to be non-responsive. It was asked whether or not the state could contract with MyInnerview without issuing a new RFP; Dr. Gifford responded that this is not the state's contract with MyInnerview but rather, the individual homes'. It was also asked whether or not the nursing homes would choose to measure and publicly report staff satisfaction. That has not yet been determined, but it is likely that in this first year, some homes will choose to survey their staff whereas others will not. A question was asked about future use of the NH-CAHPS; that survey is still in development and is not thought to be available in the near future.

A motion was made to allow the nursing homes to try MyInnerview for one year; the motion was carried. Dr. Gifford asked that an update with respect to the scope, cost,

process, and timeline of a 2007 MyInnerview effort in R.I. be shared at the May 14<sup>th</sup> Steering Committee meeting.

Ambulatory Care / Provider Transparency (AC/PT) Update

Meg Richards, PhD presented an update on efforts regarding the Ambulatory Care / Provider Transparency efforts mandated by SB 3170 in June 2006 (see associated slides). This is the bill that amended the HCQP legislation to include performance measurement reporting at the individual provider level. Although the Subcommittees (primary care/chronic disease and surgical procedures) that will provide stewardship for AC/PT are still being formed, it was HCQP staff members' desire to share some of the early discussions around AC/PT with the Steering Committee. One idea that has been discussed is to begin individual provider reporting with structure measures, that is: mapping providers geographically and in terms of group practices, and also making access information (e.g. evening and weekend hours, use of electronic prescribing and scheduling, etc.) available to consumers. Steering Committee members questioned the relationship between structure measures and outcomes, and whether or not structure measures served HCQP's quality measures agenda. Dr. Gifford responded that structure measures would be reported separately, and not billed as 'quality measures' but rather as 'profile measures'. The latter would be provided *only* as a means of supporting consumer choice. An update will be provided on the formation, structure, and function of the above-referenced subcommittees at the May 14<sup>th</sup> Steering Committee meeting.

The meeting was adjourned at 4:30 PM

Next scheduled meeting: Monday, May 14, 2007

Respectfully submitted,

Meg Richards, PhD