



Health Care Quality Performance (HCQP) Program

**STEERING COMMITTEE**

November 17, 2008, 3:00-4:30pm  
 Department of Health, Health Policy Forum

**Goals/Objectives**

- Obtain Steering Committee approval and input regarding ongoing Subcommittee work and recommendations

**Voting Members (Quorum = 8+ Members)**

- |  |  |  |
|--|--|--|
| ✓ Ted Almon (rep)                            | ✓ David Gifford, MD, MPH                           | ✓ Louis Pugliese                             |
| ✓ Virginia Burke, Esq.                       | ✓ Linda McDonald, RN                               | <input type="checkbox"/> Sharon Pugsley, BSN |
| ✓ Ron Cotugno, RN (rep)                      | ✓ Jim Nyberg                                       | ✓ Gina Rocha, RN, MPH                        |
| <input type="checkbox"/> Arthur Frazzano, MD | <input type="checkbox"/> Rhoda E. Perry            | <input type="checkbox"/> Corrine Russo, MSW  |
| ✓ Neal Galinko, MD, MS, FACP                 | <input type="checkbox"/> Donna Policastro, NP, RCN | ✓ Alan Tavares                               |

**Time Topic/Votes**

- 3:00pm **Welcome & Remarks**  
 David Gifford, MD, MPH, HEALTH
- Dr. Gifford opened the meeting at 3:05pm. Meeting participants welcomed two new Steering Committee attendees by introducing themselves.
  - A request was made to indicate the number of yes, no, and abstained votes to meeting minutes going forward. **Action item:** The Program will make this addition, beginning with today's minutes.
- 3:05pm **HCQP Program Updates**  
 Samara Viner-Brown, MS, HEALTH  
 Rosa Baier, MPH, Quality Partners

Time	Topic/Votes
3:05pm	<p><b>1. Elective Procedures</b></p> <ul style="list-style-type: none"> <li>- The Elective Procedures Subcommittee disbanded in December 2007 and has not reconvened. The Subcommittee was formed in response to the 2006 legislation expanding public reporting to physicians, but does not address a specific requirement for volume-quality data.</li> <li>- Before reconvening, the Program needs to complete additional volume-quality analyses and identify a new Chair; Tom Drew is unable to continue as Chair. Currently, the analyses are limited by internal resources at HEALTH. The Program will identify a schedule for future work (including reconvening the Subcommittee) when data reports are available and presented to the Steering Committee.</li> <li>- <b>Vote:</b> The Committee approved the continued suspension of the Subcommittee (yes – 8, no – 0, abstained – 1).</li> </ul>
3:10pm	<p><b>2. Hospital Subcommittee</b> Samara Viner-Brown, MS, Chair</p> <ul style="list-style-type: none"> <li>- The Hospital Subcommittee has been working to collect and report pressure ulcer process and incidence measures (see Subcommittee minutes). The Program will schedule additional meetings to finalize the incidence measure plans.</li> <li>- Process measures: <ul style="list-style-type: none"> <li>• The hospitals have now collected four pilot data points (one day every three months, Oct 07-Jan 08-Apr 08-Jul 08) and one public data point (Oct 08).</li> <li>• To ensure that all 11 hospitals can publicly report their results, the Subcommittee recommended reporting a three-quarter rolling average. This means that two additional data points (Jan 09 and Apr 09) are needed to report in ~May 2009.</li> </ul> </li> <li>- Incidence measure: <ul style="list-style-type: none"> <li>• The Subcommittee reviewed several data collection strategies and recommended using administrative data (which now includes a Present on Admission, or POA, indicator) and the Agency for Healthcare Research and Quality (AHRQ) measure specifications.</li> <li>• Because the pressure ulcer codes have recently been revised, HEALTH does not yet have Hospital Discharge Data Set (HDDS) data reflecting the new codes. Once it does, it will analyze HDDS data to estimate sample sizes based on the AHRQ exclusion criteria and determine how many months' data need to accrue before incidence measure reporting can occur.</li> <li>• <b>Action item:</b> HEALTH will conduct the HDDS analyses and report back to the Subcommittee about anticipated time frames. At the Director's request, incidence measure reporting will likely proceed without a pilot phase.</li> </ul> </li> <li>- <b>Vote:</b> The Committee approved: <ul style="list-style-type: none"> <li>• The reporting of the pressure ulcer process measures until the incidence measure is reported (yes – 5, no – 3, abstained – 1), and</li> <li>• The use of administrative data to calculate the pressure ulcer incidence measure (yes – 9, no – 0, abstained – 0).</li> </ul> </li> </ul>

Time	Topic/Votes
3:30pm	<p data-bbox="310 163 959 197"><b>3. Hospital-Acquired Infections (HAI) Subcommittee</b></p> <p data-bbox="358 201 732 264">Leonard Mermel, MD, Co-Chair Samara Viner-Brown, MS, Chair</p> <ul data-bbox="358 285 1430 653" style="list-style-type: none"> <li data-bbox="358 285 1430 495">- The Subcommittee was formed with composition reflecting the legislative mandate and has met twice (see Subcommittee minutes); a 3rd meeting will take place 11/24. During that meeting, participants will evaluate potential measures using criteria identified on 11/3. The Subcommittee plans to identify measures that can be reported relatively easily and quickly, and begin reporting with these measures. Additional measures will be added over time.</li> <li data-bbox="358 516 1430 653">- The HAI Public Reporting Scan was sent to the Subcommittee and Steering Committee on 10/1 to meet the legislative requirement. It was revised 11/3 to add a table summarizing the reporting formats and appendices with the state reports. The file is very large, but is available upon request.</li> </ul>
3:50pm	<p data-bbox="310 688 716 722"><b>4. Nursing Home Subcommittee</b></p> <p data-bbox="358 726 602 760">Gail Patry, RN, Chair</p> <ul data-bbox="358 781 1430 1037" style="list-style-type: none"> <li data-bbox="358 781 1430 886">- The Subcommittee met in October to review progress for the resident and family satisfaction data collection (see Subcommittee minutes). The Subcommittee next meets on 12/16.</li> <li data-bbox="358 907 1430 1037">- Nursing homes finished collecting data at the end of October, and should now be able to review their individual results within their My InnerView accounts. The Program will obtain facility-level data from My InnerView and plans to generate the annual public report in early 2009.</li> </ul>
4:00pm	<p data-bbox="310 1073 781 1106"><b>5. Physician HIT Adoption Workgroup</b></p> <p data-bbox="358 1110 699 1144">Rebekah Gardner, MD, Chair</p> <ul data-bbox="358 1165 1430 1661" style="list-style-type: none"> <li data-bbox="358 1165 1430 1291">- The Workgroup has been meeting with the Rhode Island Quality Institute's Clinical IT Leadership Council (CITLC) to refine the proposed measures (see handout). The updated measures more accurately reflect 'true' EMRs vs. other HIT use and also include stakeholder-driven benchmarks.</li> <li data-bbox="358 1312 1430 1417">- BCBSRI has not yet decided whether or not to use the survey results for its 2009 primary care physician fee increase; if it does, the results will be publicly available since the pilot phase has ended.</li> <li data-bbox="358 1438 1430 1585">- The Workgroup now plans to make minor revisions to the survey instrument to reflect physician comments and clarify any areas of confusion – for example, to create separate paths through the survey for hospital-based and office-based physicians. The intent will remain the same.</li> <li data-bbox="358 1606 1430 1661">- <b>Vote:</b> The Committee approved the Workgroup's plan to update and disseminate survey in January 2009 (yes – 9, no – 0, abstained – 0).</li> </ul>

Time	Topic/Votes
4:10pm	<p data-bbox="310 163 537 197"><b>6. Administrative</b></p> <ul style="list-style-type: none"> <li data-bbox="358 218 1432 281">- HEALTH submitted the FY 2008 Annual Report to the Legislature, and has not received any comments or questions in response.</li> <li data-bbox="358 302 1432 407">- As a reminder, meeting notices for the Steering Committee and all Subcommittees are posted on the Rhode Island Open Meetings Web site: <a href="http://www.sec.state.ri.us/pubinfo/openmeetings/">www.sec.state.ri.us/pubinfo/openmeetings/</a></li> </ul> <p data-bbox="407 428 1432 491">All Program meetings are open to the public; each Subcommittee also has an email distribution list for those interested in receiving the agendas and minutes.</p> <ul style="list-style-type: none"> <li data-bbox="358 512 1432 684">- The Home Health Subcommittee is currently on hold until ~Spring 2009, since the patient satisfaction data collection effort was moved to every two years. The next round of data collection will take place in Sept 2009. In the meantime, the Program is touching base with Press Ganey and learning more about the Home Health CAHPS survey, which may be available for the next round of data collection.</li> </ul>
4:15pm	<p data-bbox="310 722 461 756"><b>Open Forum</b></p> <p data-bbox="310 756 704 789">David Gifford, MD, MPH, HEALTH</p> <ul style="list-style-type: none"> <li data-bbox="358 831 943 856">- Dr. Gifford adjourned the meeting at 4:30pm.</li> </ul> <p data-bbox="310 898 732 932"><b>Next Meeting – 3-4:30pm, 1/12/09</b></p>



**Department of Health**

Three Capitol Hill  
Providence, RI 02908-5097

TTY: 711  
[www.health.ri.gov](http://www.health.ri.gov)

**PRESSURE ULCER PROCESS MEASURES**

**Aggregate Pilot Results, 09/10/08**

The following data are pilot results from the Department of Health's (HEALTH's) work with the 11 acute care hospitals to collect pressure ulcer process measure data for two Institute for Healthcare Improvement (IHI) *5 Million Lives Campaign* measures:

1. The percent of patients receiving pressure ulcer admission assessment; and
2. The percent of patients receiving daily pressure ulcer risk reassessment.

Each hospital collected and submitted data for a day of their choice in a week selected by the Hospital Subcommittee. The below results reflect all four quarters of the pilot:

Quarter	Admission Assessment	Daily Reassessment
	n (%)	
Quarter 1 (October 2007)	1,137 (89.2%)	915 (87.1%)
Quarter 2 (January 2008)	1,034 (90.3%)	918 (87.9%)
Quarter 3 (April 2008)	1,041 (95.1%)	928 (93.6%)
Quarter 4 (July 2008)	1,094 (92.2%)	1,029 (95.1%)
<b>Annual average</b>	<b>4,306 (91.7%)</b>	<b>3,790 (90.9%)</b>



Health Care Quality Performance Measurement and Reporting Program (HCQP)

**HOSPITAL SUBCOMMITTEE**

October 27, 2008, 3-4:30pm  
HEALTH, Room 401

**Goals/Objectives**

- To discuss the pressure ulcer (PrU) incidence measure specifications, data collection process, and timeline with Dr. Gifford

**Invitees**

✓ Rosa Baier	✓ Elaine Desmarais	✓ Linda Rowey
✓ Christine Baufois	✓ Denise Henry	✓ Barbara Seagraves
✓ Kerri Boyle	✓ Carol Lamoureux	✓ Michele Mahan Smith
✓ Dolores Cohen	✓ Susan Lasalle	✓ Anne Stepka
✓ Donna Collins	✓ George Levesque	✓ Barbara Stewart
✓ Margaret Cornell	✓ Debra Panizza	✓ Angela Quarter
✓ Pam DiMascio	✓ Gina Rocha	✓ Sam Viner-Brown

**Time**

**Topic/Notes**

- |        |   |
|--------|---|
| 3:05pm | <p><b>Welcome &amp; Updates</b><br/>Samara Viner-Brown (<i>Chair</i>)</p> <ul style="list-style-type: none"> <li>– Sam opened the meeting, described the meeting objectives, and provided several updates on the hospital-related public reporting:               <ul style="list-style-type: none"> <li>• The HAI Subcommittee met for the first time on October 20<sup>th</sup> and will meet again at 8am on November 3<sup>rd</sup> in Room 401 at HEALTH. The meetings are open to the public and members of this Subcommittee are welcome to attend. Agendas and minutes will be posted to the Rhode Island Open Meetings Website: <a href="http://www.sec.state.ri.us/pubinfo/openmeetings/">http://www.sec.state.ri.us/pubinfo/openmeetings/</a></li> <li>• All hospitals should have collected pressure ulcer process measure data on a single day during the week of October 20<sup>th</sup>. Program staff sent a data collection reminder.</li> <li>• <b>Action item:</b> Program staff will send a data entry reminder prior to November 15<sup>th</sup>.</li> </ul> </li> </ul> |
| 3:10pm | <p><b>PrU Incidence Measure</b><br/>David Gifford, MD, MPH</p> <ul style="list-style-type: none"> <li>– Rosa provided a brief recap of the three incidence measure methods discussed at the</li> </ul>  |

Time	Topic/Notes
	<p>September 22<sup>nd</sup> meeting, including using:</p> <ol style="list-style-type: none"> <li>1. The <b>present on admission (POA) indicator</b> and administrative data to determine whether or not any ulcers occurred during the patient’s hospitalization;</li> <li>2. <b>Primary data collection at admission and discharge</b> to mimic the above methodology, without relying on administrative data (and simultaneously helping to determine the administrative data’s accuracy); or</li> <li>3. <b>Primary data collection at two points in time:</b> (1) a single day for all patients meeting eligibility criteria, followed by (2) a day that coincides with the mean length of stay in each patient’s particular unit.</li> </ol> <ul style="list-style-type: none"> <li>– Previously, the Subcommittee weighed the data collection burden against the quality improvement utility and recommended option #3. Although this was likely the most resource-intensive option, meeting participants felt it provided the most valuable data.</li> <li>– At that meeting, participants expressed an interest in speaking to Dr. Gifford about the expected timeframe for reporting these data. Today’s meeting was scheduled based on Dr. Gifford’s availability.</li> <li>– Subsequent to the last meeting, the hospitals reviewed their POA data, met with HARI, and recommended switching to option #1, and using the following measure inclusion/exclusion criteria from AHRQ (included as an attachment with the minutes): <a href="http://www.qualityindicators.ahrq.gov/downloads/psi/psi_technical_specs_v32.pdf">http://www.qualityindicators.ahrq.gov/downloads/psi/psi_technical_specs_v32.pdf</a></li> </ul> <p>Using the POA data will reduce the data collection burden for hospitals and increase alignment with CMS reporting and the 9<sup>th</sup> Scope of Work. Hearing no dissent at today’s meeting, this will be the new recommendation.</p> <ul style="list-style-type: none"> <li>– According to Dr. Gifford, the timeline for reporting the proposed incidence measure will depend on the number of patients who meet the inclusion/exclusion criteria, and how long it will take to accrue a large enough denominator in each hospital for public reporting. If there are sufficient numbers to report in less than 6 months, there may be an opportunity for a pilot phase; if it will take longer than 6 months, there will not be a pilot phase.</li> <li>– The meeting with HARI also resulted in a recommendation to cease collecting pressure ulcer process measure data once the incidence measure data is collected and reported. Hospitals have been collecting this information periodically (5 times) since October 2007, and have now collected one data point for public reporting (October 2008). Previously, the Subcommittee recommended reporting data from October 2008, January 2009, and April 2009 in a May 2009 report.</li> <li>– <b>Action items:</b> <ul style="list-style-type: none"> <li>• Program staff will present the new PrU process and incidence measure recommendations to the Steering Committee for approval on November 17<sup>th</sup>.</li> <li>• Program staff will use the Hospital Discharge Data Set to estimate the number of patients that meet the AHRQ inclusion/exclusion criterion to limit the measure to patients with lengths of stay &gt;5 days.</li> <li>• At the hospitals’ request, HEALTH will require submission of POA into the Hospital Discharge Data Set. (This will ensure that vendors include this field at no cost.)</li> </ul> </li> </ul>
4:10pm	<p><b>Adjourn</b> Samara Viner-Brown</p> <ul style="list-style-type: none"> <li>– Sam adjourned the meeting early.</li> </ul>

### Death in Low-Mortality DRGs (PSI 2)

427	NEUROSES EXCEPT DEPRESSIVE
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL
430	PSYCHOSES
431	CHILDHOOD MENTAL DISORDERS
432	OTHER MENTAL DISORDER DIAGNOSES
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA
434	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC
435	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT WO CC
436	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY (NO LONGER
437	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY (NO
439	SKIN GRAFTS FOR INJURIES
441	HAND PROCEDURES FOR INJURIES
447	ALLERGIC REACTIONS AGE >17
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMI
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTR
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION
497	SPINAL FUSION EXCEPT CERVICAL W CC OCT06
498	SPINAL FUSION EXCEPT CERVICAL WO CC OCT06
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION WO CC
503	KNEE PROCEDURES WO PDX OF INFECTION
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT WO AMI
518	PERC CARDIO PROC WO CORONARY ARTERY STENT OR AMI OCT06
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC
522	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY WO CC
523	ALC/DRUG ABUSE OR DEPEND WO REHABILITATION THERAPY WO CC
524	TRANSIENT ISCHEMIA
527	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT WO A
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH WO AMI/HF/SHOCK

Exclude patients with any code for trauma, immunocompromised state, or cancer.

See [Appendix C: ICD-9-CM Trauma Diagnosis Codes](#)

See [Appendix D: ICD-9-CM Codes for Immunocompromised States](#)

See [Appendix E: Cancer Codes](#)

Control-click (Word) or click (PDF) to view the Appendix. Links are provided to return to the PSI Detailed Definition.

### Decubitus Ulcer (PSI 3)

#### Numerator:

Discharges with ICD-9-CM code of decubitus ulcer in any secondary diagnosis field among cases meeting the inclusion and exclusion rules for the denominator.

#### ICD-9-CM Decubitus Ulcer Diagnosis Codes:

7070*	DECUBITUS ULCER
70700	DECUBITUS ULCER SITE NOS (OCT 04)
70701	DECUBITUS ULCER, ELBOW (OCT 04)
70702	DECUBITUS ULCER, UP BACK (OCT 04)
70703	DECUBITUS ULCER, LOW BACK (OCT 04)
70704	DECUBITUS ULCER, HIP (OCT 04)
70705	DECUBITUS ULCER, BUTTOCK (OCT 04)
70706	DECUBITUS ULCER, ANKLE (OCT 04)
70707	DECUBITUS ULCER, HEEL (OCT 04)

**Decubitus Ulcer (PSI 3)**

70709 DECUBITUS ULCER, SITE NEC (OCT 04)

\*No longer valid in FY2005

**Denominator:**

All medical and surgical discharges age 18 years and older defined by specific DRGs.

See [Appendix B: Surgical Discharge DRGs](#)

See [Appendix F: Medical Discharge DRGs](#)

Control-click (Word) or click (PDF) to view the Appendix. Links are provided to return to the PSI Detailed Definition.

**Exclude cases:**

- with length of stay of less than 5 days
- with preexisting condition of decubitus ulcer (see Numerator) (primary diagnosis or secondary diagnosis present on admission, if known)
- MDC 9 (Skin, Subcutaneous Tissue, and Breast)
- MDC 14 (pregnancy, childbirth, and puerperium)
- with any diagnosis of hemiplegia, paraplegia, or quadriplegia
- with ICD-9-CM code of spina bifida or anoxic brain damage
- with an ICD-9-CM procedure code for debridement or pedicle graft **before or on the same day** as the major operating room procedure (surgical cases only)
- admitted from a long-term care facility (SID Admission Source=3)
- transferred from an acute care facility (SID Admission Source=2)

See [Appendix A: Operating Room Procedure Codes](#)

Control-click (Word) or click (PDF) to view the Appendix. Links are provided to return to the PSI Detailed Definition.

*ICD-9-CM Hemiplegia, Paraplegia, or Quadriplegia diagnosis codes (includes 4<sup>th</sup> and 5<sup>th</sup> digits):*

- 33371 ATHETOID CEREBRAL PALSY OCT06-
- 3420 FLACCID HEMIPLEGIA
- 3421 SPASTIC HEMIPLEGIA
- 3428 OTHER SPECIFIED HEMIPLEGIA
- 3429 HEMIPLEGIA, UNSPECIFIED
- 3430 INFANTILE CEREBRAL PALSY, DIPLEGIC
- 3431 INFANTILE CEREBRAL PALSY, HEMIPLEGIC
- 3432 INFANTILE CEREBRAL PALSY, QUADRIPLEGIC
- 3433 INFANTILE CEREBRAL PALSY, MONOPLEGIC
- 3434 INFANTILE CEREBRAL PALSY INFANTILE HEMIPLEGIA
- 3438 INFANTILE CEREBRAL PALSY OTHER SPECIFIED INFANTILE CEREBRAL PALSY
- 3439 INFANTILE CEREBRAL PALSY, INFANTILE CEREBRAL PALSY, UNSPECIFIED
- 3440 QUADRIPLEGIA AND QUADRIPARESIS
- 3441 PARAPLEGIA
- 3442 DIPLEGIA OF UPPER LIMBS
- 3443 MONOPLEGIA OF LOWER LIMB
- 3444 MONOPLEGIA OF UPPER LIMB
- 3445 UNSPECIFIED MONOPLEGIA
- 3446 CAUDA EQUINA SYNDROME
- 3448 OTHER SPECIFIED PARALYTIC SYNDROMES
- 3449 PARALYSIS, UNSPECIFIED
- 4382 HEMIPLEGIA/HEMIPARESIS
- 4383 MONOPLEGIA OF UPPER LIMB

**Decubitus Ulcer (PSI 3)**

4384 MONOPLÉGIA OF LOWER LIMB  
 4385 OTHER PARALYTIC SYNDROME  
 7687 HYPOXIC-ISCHEMIC ENCEPH OCT06-

*ICD-9-CM Spina Bifida or Anoxic Brain Damage diagnosis codes*

3481 ANOXIC BRAIN DAMAGE  
 74100 SPINA BIFIDA, W HYDROCEPHALUS UNSPECIFIED REGION  
 74101 SPINA BIFIDA, W HYDROCEPHALUS CERVICAL REGION  
 74102 SPINA BIFIDA, W HYDROCEPHALUS DORSAL REGION  
 74103 SPINA BIFIDA, W HYDROCEPHALUS LUMBAR REGION  
 74190 SPINA BIFIDA, W/O HYDROCEPHALUS UNSPECIFIED REGION  
 74191 SPINA BIFIDA, W/O HYDROCEPHALUS CERVICAL REGION  
 74192 SPINA BIFIDA, W/O HYDROCEPHALUS DORSAL REGION  
 74193 SPINA BIFIDA, W/O HYDROCEPHALUS LUMBAR REGION  
 7685 SEVERE BIRTH ASPHYXIA

*ICD-9-CM procedure code for debridement or pedicle graft*

8345 OTHER MYECTOMY  
 8622 EXC WOUND DEBRIDEMENT  
 8628 NONEXCIS DEBRIDEMENT WND  
 8670 PEDICLE GRAFT/FLAP NOS  
 8671 CUT & PREP PEDICLE GRAFT  
 8672 PEDICLE GRAFT ADVANCEMEN  
 8674 ATTACH PEDICLE GRAFT NEC  
 8675 REVISION OF PEDICLE GRFT

*SID Admission source*

Admission source is recorded as acute care facility (SID ASOURCE=2)  
 Admission source is recorded as long-term care facility (SID ASOURCE=3)

**Death among Surgical Inpatients with Serious Treatable Complications (PSI 4)**

**Numerator:**

All discharges with a disposition of “deceased” among cases meeting the inclusion and exclusion rules for the denominator.

**Denominator:**

All surgical discharges age 18 years and older defined by specific DRGs and an ICD-9-CM code for an operating room procedure, principal procedure within 2 days of admission OR admission type of elective\* with potential complications of care listed in Death among Surgical definition (e.g., pneumonia, DVT/PE, sepsis, shock/cardiac arrest, or GI hemorrhage/acute ulcer).

Exclude cases:

- age 90 years and older
- neonatal patients in MDC 15
- transferred to an acute care facility (SID Discharge Disposition = 2)

**NOTE: Additional exclusion criteria is specific to each diagnosis.**

FTR 2 - DVT/PE



Health Care Quality Performance (HCQP) Program

**HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE**

8:00-9:00 am, November 3, 2008  
HEALTH, Room 401

**Goals/Objectives**

- To discuss potential HAI measures to report during Quarter 1 FY 2009, as well as measures to begin collecting and reporting subsequently

**Voting Members**

- |                                    |  |                                |
|------------------------------------|--|--------------------------------|
| ✓ Utpala Bandy, MD                 | <input type="checkbox"/> Andrew Komensky, RN | ✓ Harold Picken, MD            |
| ✓ Margaret Cornell, MS, RN         | <input type="checkbox"/> Cindy Lussier       | ✓ Lee Ann Quinn, RN, BC, CIC   |
| ✓ Robert Crausman, MD              | ✓ Pat Mastors                                | ✓ Janet Robinson, RN, MEd, CIC |
| ✓ Marlene Fishman, MPH, CIC        | ✓ Leonard Mermel, DO, ScM                    | ✓ Nancy Vallande, MSM, MT, CIC |
| ✓ Julie Jefferson, RN, MPH, CIC    | ✓ Kathleen O'Connell, RN                     | ✓ Sam Viner-Brown, MS          |
| ✓ Diane Kitson-Clark, RN, MSN, CIC | ✓ Aurora Pop-Vicas, MD                       | ✓ Gloria Williams, MS          |

**Time**

**Topic/Notes**

- |         |   |
|---------|---|
| 8:00 am | <p><b>Welcome &amp; Meeting Objective</b><br/>Samara Viner-Brown, MS (<i>Co-Chair</i>)<br/>Leonard Mermel, DO, ScM (<i>Co-Chair</i>)</p> <ul style="list-style-type: none"> <li>– Len opened the meeting at 8:05 and meeting participants introduced themselves.</li> <li>– Len and Sam reviewed the results of the 10/20 meeting, as well as the materials sent with the minutes. Several of the attachments were quite long, and participants were asked to bring copies if they wanted to reference them.</li> </ul> |
| 8:10 am | <p><b>Subcommittee Expectations</b><br/>David Gifford, MD, MPH</p> <ul style="list-style-type: none"> <li>– Dr. Gifford discussed the expectations for reporting HAI. The timeframes in the legislation should be viewed as the outer limits, but data should be reported as quickly as possible.</li> </ul>  |

Time	Topic/Notes
	<ul style="list-style-type: none"> <li>- Dr. Gifford emphasized that he would like the Subcommittee to view reporting as an incremental, ongoing process, with the 'low hanging fruit' reported quickly and then successive measures added over time.</li> <li>- For example, it may be a quick win to report: <ul style="list-style-type: none"> <li>• Influenza vaccination rates for RNs/MDs,</li> <li>• SCIP I, II, III measures (already reported on Hospital Compare),</li> <li>• ICU Collaborative data (available for all but one hospital)</li> </ul> </li> <li>- Additionally, Dr. Gifford felt strongly that a MRSA measure was needed, because of widespread interest in MRSA.</li> </ul>
8:30 am	<p data-bbox="402 556 787 588"><b>Discuss Options for 1<sup>st</sup> Measure</b></p> <p data-bbox="402 592 706 623">Samara Viner-Brown, MS</p> <p data-bbox="402 627 722 659">Leonard Mermel, DO, ScM</p> <ul style="list-style-type: none"> <li>- Dr. Gifford recommended not letting "perfect" get in the way of "good enough," the Subcommittee discussed criteria to evaluate potential measures. These included (but are not limited to): <ul style="list-style-type: none"> <li>• Ability to benchmark (e.g., locally or nationally)</li> <li>• Applicability to all hospitals</li> <li>• Applicability to various adult and pediatric patients</li> <li>• Applicability to various care settings</li> <li>• Ease of collecting data (e.g., availability, staff burden)</li> <li>• Ease of validating data</li> <li>• Evidence base</li> <li>• Frequency of event (e.g., is it too rare to report meaningful data?)</li> <li>• Meaningfulness to the lay public (e.g., can they understand it? Act on results?)</li> <li>• Room for improvement</li> <li>• Usefulness for hospital internal quality improvement</li> </ul> </li> <li>- In addition to the measures noted above, others suggested include: <ul style="list-style-type: none"> <li>• Hand hygiene compliance,</li> <li>• C-diff incidence, or</li> <li>• VRE incidence.</li> </ul> </li> <li>- <b>Action items:</b> <ul style="list-style-type: none"> <li>• HCQP staff will create a measure evaluation grid with the above criteria, and circulate it to the Subcommittee with the minutes.</li> <li>• Subcommittee members will complete the grid and return it to HCQP staff prior to the 11/24 meeting.</li> </ul> </li> </ul>
8:55 am	<p data-bbox="402 1627 722 1659"><b>Action Items &amp; Next Steps</b></p> <p data-bbox="402 1663 706 1694">Samara Viner-Brown, MS</p> <p data-bbox="402 1698 722 1730">Leonard Mermel, DO, ScM</p> <ul style="list-style-type: none"> <li>- Len adjourned the meeting at 9:05 am.</li> <li>- Next meeting: November 24, 2008</li> </ul>



**HAI Subcommittee**

**HOSPITAL-ACQUIRED INFECTIONS (HAI) PUBLIC REPORTING SCAN**

**Part I: State and Federal Legislation and Reports, 10/1/08**

**Table 1:** Current HAI Public Reporting Legislation, by State

State	Date of Legislation	Date of First Report	Measures and Methods	Link
Alabama	Proposed 2007	N/A	<ul style="list-style-type: none"> <li>- Ventilator-associated pneumonia</li> <li>- Surgical site infections</li> <li>- Central line-related bloodstream infections</li> <li>- Urinary tract infections</li> </ul>	Legislation: <a href="http://alisdb.legislature.state.al.us/acas/ACTIONViewFrame.asp?TYPE=Instrument&amp;INST=SB409&amp;DOCPATH=searchableinstruments/2007RS/Printfiles/&amp;PHYDOCPATH=/alisdb/acas/searchableinstruments/2007RS/Printfiles/&amp;DOCNAMES=SB409-int.pdf">http://alisdb.legislature.state.al.us/acas/ACTIONViewFrame.asp?TYPE=Instrument&amp;INST=SB409&amp;DOCPATH=searchableinstruments/2007RS/Printfiles/&amp;PHYDOCPATH=/alisdb/acas/searchableinstruments/2007RS/Printfiles/&amp;DOCNAMES=SB409-int.pdf</a>
Alaska	None	N/A	N/A	N/A
Arizona	None	N/A	N/A	N/A
Arkansas	2007	Jan. 2010	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Central line-associated bloodstream infections</li> </ul>	Legislation: <a href="http://www.legis.state.ak.us/cgi-bin/folioisa.dll/lr06/query=hospital+reporting/doc/%7Bt1%7D?">http://www.legis.state.ak.us/cgi-bin/folioisa.dll/lr06/query=hospital+reporting/doc/%7Bt1%7D?</a>
California	2006	2008	<ul style="list-style-type: none"> <li>- Adherence to prevention practices</li> <li>- Hospital infection rates are currently reported only to the state; however, a bill being considered as of June 2008 proposes public reporting of HAI incidence (Clostridium difficile, MRSA, and Vancomycin-resistant Enterococci)</li> </ul>	Legislation: <a href="http://info.sen.ca.gov/pub/07-08/bill/sen/sb_1051-1100/sb_1058_cfa_20080623_111706_asm_comm.html">http://info.sen.ca.gov/pub/07-08/bill/sen/sb_1051-1100/sb_1058_cfa_20080623_111706_asm_comm.html</a>

State	Date of Legislation	Date of First Report	Measures and Methods	Link
Colorado	2006	Jan. 2008	<ul style="list-style-type: none"> <li>- Incidence of HAI</li> <li>- Surgical site infections: cardiac and orthopedic</li> <li>- Central line-related bloodstream infections</li> </ul>	Report: <a href="http://www.cohospitalquality.org/index.php">http://www.cohospitalquality.org/index.php</a>
Connecticut	2006	Anticipated Oct. 2008	<ul style="list-style-type: none"> <li>- Central line-related bloodstream infections</li> <li>- Additional measures TBD by committee in the future</li> </ul>	Legislation: <a href="http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/healthcare_acquired_infections_2007.pdf">http://www.ct.gov/dph/lib/dph/hisr/hcqsar/healthcare/pdf/healthcare_acquired_infections_2007.pdf</a>
Delaware	<i>Not readily available</i>	June 2009	<ul style="list-style-type: none"> <li>- Central line-associated bloodstream infections</li> <li>- Surgical site infections</li> <li>- Influenza vaccinations</li> </ul>	Legislation: <a href="http://delcode.delaware.gov/title16/c010a/index.shtml">http://delcode.delaware.gov/title16/c010a/index.shtml</a>
Florida	2004	2005	<ul style="list-style-type: none"> <li>- AHRQ Patient Safety Indicators (PSI)</li> <li>- Esp. post-op site complications, e.g. infection, sepsis, other</li> <li>- Mortality</li> <li>- Plan to include process measures (CMS SIP<sup>1</sup>)</li> <li>- Plan to include infection rates (CDC NHSN<sup>2</sup>)</li> <li>- Uses billing forms to assess HAI</li> </ul>	Report: <a href="http://www.floridahealthfinder.gov">www.floridahealthfinder.gov</a>
Georgia	None	N/A	N/A	N/A
Hawaii	None	N/A	N/A	N/A
Idaho	None	N/A	N/A	N/A
Illinois	2003	2007	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Ventilator-associated pneumonia</li> <li>- Central line-related bloodstream infections</li> </ul>	<i>Not readily available</i>
Indiana	2007 (Regulation)	N/A	<ul style="list-style-type: none"> <li>- Certain specified diseases must be reported to the health department.</li> </ul>	Legislation: <a href="http://www.in.gov/legislative/iac/T04100/A00010.PDF">http://www.in.gov/legislative/iac/T04100/A00010.PDF</a> (See p. 13)
Iowa	None; voluntary 3 <sup>rd</sup> party efforts begun 2005	N/A	<ul style="list-style-type: none"> <li>- Voluntary reporting encouraged and spearheaded by the Iowa Healthcare Collaborative (IHC)</li> <li>- Influenza vaccinations</li> <li>- Surgical site infections</li> <li>- Central line-related bloodstream infections</li> </ul>	Report: <a href="http://www.ihconline.org/toolkits/PrinterFriendlyVersion/healthcareassociatedinfections.cfm">http://www.ihconline.org/toolkits/PrinterFriendlyVersion/healthcareassociatedinfections.cfm</a>
Kansas	None	N/A	N/A	N/A

<sup>1</sup> SIP: Surgical Infection Prevention; a CMS initiative that has been renamed the SCIP initiative (Surgical Care Improvement Project)

<sup>2</sup> NHSN: National Healthcare Safety Network

State	Date of Legislation	Date of First Report	Measures and Methods	Link
Kentucky	None	N/A	N/A	N/A
Louisiana	None	N/A	N/A	N/A
Maine	None	N/A	N/A	N/A
Maryland	2006	<i>Not readily available</i>	<ul style="list-style-type: none"> <li>- Central line-related bloodstream infections</li> <li>- Health care worker influenza vaccination</li> <li>- Active surveillance testing for MRSA</li> <li>- Surgical site infections</li> <li>- Ventilator-associated pneumonia prevention bundle compliance</li> </ul>	Report: <a href="http://mhcc.maryland.gov/healthcare_associated_infections/hai_report_jan2008/report_012008.pdf">http://mhcc.maryland.gov/healthcare_associated_infections/hai_report_jan2008/report_012008.pdf</a>
Massachusetts	2006	Data are collected, but not publicly reported	<ul style="list-style-type: none"> <li>- Requires surveillance but not public reporting.</li> <li>- Surveillance and prevention activities in high proportion of hospitals (&gt;90%) for: <ul style="list-style-type: none"> <li>• MRSA<sup>3</sup></li> <li>• Bloodstream infections</li> <li>• Surgical site infections</li> <li>• Ventilator-associated pneumonia</li> <li>• Influenza</li> <li>• Clostridium difficile</li> </ul> </li> <li>- Some hospitals (59%) involved with Catheter-associated URIs</li> </ul>	Report (regarding legislation; does not include data): <a href="http://www.mass.gov/Eeohhs2/docs/dph/patient_safety/haipcp_final_report_pt2.pdf">http://www.mass.gov/Eeohhs2/docs/dph/patient_safety/haipcp_final_report_pt2.pdf</a>
Michigan	None	N/A	N/A	N/A
Minnesota	None	N/A	N/A	N/A
Mississippi	2007	Intended Jan. 2009	- Incidence of HAIs (type specified by individual facilities)	Legislation: <a href="http://www.legislature.mi.gov/documents/2007-2008/billintroduced/House/htm/2007-HIB-4158.htm">http://www.legislature.mi.gov/documents/2007-2008/billintroduced/House/htm/2007-HIB-4158.htm</a>
Missouri	2004	2006	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Ventilator-associated pneumonia</li> <li>- Central line-related bloodstream infections</li> </ul>	Report: <a href="http://www.dhss.mo.gov/HAI/index.html?target=reports.html">http://www.dhss.mo.gov/HAI/index.html?target=reports.html</a>
Montana	None	N/A	N/A	N/A
Nebraska	2005	N/A	- Surgical site infection incidence data collected but not publicly reported	<i>Not readily available</i>

<sup>3</sup> MRSA = Methicillin-resistant Staphylococcus Aureus

State	Date of Legislation	Date of First Report	Measures and Methods	Link
Nevada	2005	N/A	- HAIs reported as sentinel events to the department of health.	Legislation: <a href="http://www.leg.state.nv.us/NRS/NRS-441A.html">http://www.leg.state.nv.us/NRS/NRS-441A.html</a>
New Hampshire	Effective 2007	Intended June 2008 (still not available)	- Surgical site infections - Ventilator-associated pneumonia - Central line-related bloodstream infections - Adherence rates for preventive measures	Legislation: <a href="http://www.gencourt.state.nh.us/rsa/html/XI/151/151-33.htm">http://www.gencourt.state.nh.us/rsa/html/XI/151/151-33.htm</a>
New Jersey	2007 (pending)	N/A	- Surgical site infections - Urinary tract infections - Central line-related bloodstream infections - Ventilator-associated pneumonia - MRSA - VRE <sup>4</sup>	Legislation: <a href="http://www.njleg.state.nj.us/2006/Bills/S0500/147_11.PDF">http://www.njleg.state.nj.us/2006/Bills/S0500/147_11.PDF</a>
New Mexico	None	N/A	N/A	N/A
New York	2005	July 2008	- Surgical site infections - Ventilator-associated pneumonia - Central line-related bloodstream infections - First year was aggregate pilot data (similar to RI's and other states' processes); second year data will be publicly reported	Report: <a href="http://www.health.state.ny.us/nysdoh/hospital/report/s/hospital_acquired_infections/2007/docs/hospital-acquired_infection.pdf">http://www.health.state.ny.us/nysdoh/hospital/report/s/hospital_acquired_infections/2007/docs/hospital-acquired_infection.pdf</a>
North Carolina	None	N/A	N/A	N/A
North Dakota	None	N/A	N/A	N/A
Ohio	2006		- Price and performance data - C. difficile - Other quality measures	Legislation: <a href="http://www.legislature.state.oh.us/analysis.cfm?ID=126_HB_197&amp;ACT=As%20Enrolled&amp;hf=analyses126/h0197-rs-126.htm">http://www.legislature.state.oh.us/analysis.cfm?ID=126_HB_197&amp;ACT=As%20Enrolled&amp;hf=analyses126/h0197-rs-126.htm</a>
Oklahoma	2006 (Regulation)	N/A	- Emergency hospitals must document HAIs but report only to state or federal government or pursuant to court order	Legislation: <a href="http://www.oar.state.ok.us/viewhtml/310_667-40-11.htm">http://www.oar.state.ok.us/viewhtml/310_667-40-11.htm</a>
Oregon	None	N/A	N/A	N/A

<sup>4</sup> VRE = Vancomycin-Resistant Enterococcus

State	Date of Legislation	Date of First Report	Measures and Methods	Link
Pennsylvania	2004	July 2005	<ul style="list-style-type: none"> <li>- Indwelling catheter-associated urinary tract infections</li> <li>- Surgical site infections</li> <li>- Ventilator-associated pneumonia</li> <li>- Central line-related bloodstream infections</li> <li>- Number of Cases</li> <li>- Infection rate (per 1,000)</li> <li>- Mortality (includes death resulting to something other than HAI)</li> <li>- Length of stay (days)</li> <li>- Hospital charges (do not incl. what hospital actually receives)</li> <li>- First year data released as aggregated total due to lack of data.</li> <li>- Uses the CDC definitions of HAI and major site categories</li> <li>- Hospitals grouped according to complexity of services offered, the number of patients treated, and the percent of surgical procedures performed</li> </ul>	Reports: <a href="http://www.phc4.org/reports/hai/06/readersguide.htm">http://www.phc4.org/reports/hai/06/readersguide.htm</a> <a href="http://www.phc4.org/reports/researchbriefs/082506/docs/researchbrief2006report_mrsa.pdf">http://www.phc4.org/reports/researchbriefs/082506/docs/researchbrief2006report_mrsa.pdf</a>
Rhode Island	2008 (pending)	N/A	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Ventilator-associated pneumonia</li> <li>- Central line-related bloodstream infections</li> <li>- Urinary tract infections</li> </ul>	Legislation: <a href="http://www.rilin.state.ri.us/PublicLaws/law08/law08154.htm">http://www.rilin.state.ri.us/PublicLaws/law08/law08154.htm</a>
South Carolina	2006	Feb. 2009; preliminary report issued Aug. 2008	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Ventilator-associated pneumonia</li> <li>- Central line-related bloodstream infections</li> </ul>	Report: <a href="http://www.scdhec.net/health/disease/hai/reports.htm">http://www.scdhec.net/health/disease/hai/reports.htm</a>
South Dakota	None	N/A	N/A	N/A
Tennessee	2006	<i>Not readily available</i>	<ul style="list-style-type: none"> <li>- Intravascular catheter infections/necrosis</li> </ul>	Legislation: <a href="http://tennessee.gov/sos/acts/104/pub/pc0904.pdf">http://tennessee.gov/sos/acts/104/pub/pc0904.pdf</a>

State	Date of Legislation	Date of First Report	Measures and Methods	Link
Texas	2007	Intended June 2008 (not available as of 6/27/08)	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Distinguishes between adult/ child reportable infections</li> <li>- Central line infections</li> <li>- First-year data presented as aggregate; second year data will be facility level.</li> </ul>	Legislation: <a href="http://www.dshs.state.tx.us/idcu/health/antibiotic_resistance/educational/IDEW/HAI_Update.ppt">http://www.dshs.state.tx.us/idcu/health/antibiotic_resistance/educational/IDEW/HAI_Update.ppt</a> Legislation: <a href="http://www.dshs.state.tx.us/legislative/HAIPanelReport.pdf">http://www.dshs.state.tx.us/legislative/HAIPanelReport.pdf</a>
Utah	None	N/A	N/A	N/A
Vermont	2003	2005	<ul style="list-style-type: none"> <li>- Surgical site infections</li> <li>- Central line-associated bloodstream infections (CLABI's)</li> <li>- Adherence to preventive measures for CLABI's</li> <li>- Adherence to preventive measures for antibiotic-resistant infections</li> </ul>	Report: <a href="http://www.bishca.state.vt.us/HcaDiv/HRAP_Act53/dorway_hospital-report-cards_BISHCA-comparisons.htm">http://www.bishca.state.vt.us/HcaDiv/HRAP_Act53/dorway_hospital-report-cards_BISHCA-comparisons.htm</a> Legislation: <a href="http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&amp;Chapter=221&amp;Section=09405b">http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&amp;Chapter=221&amp;Section=09405b</a>
Virginia	2005, not effective until July 2008	Jan. 31, 2009	<ul style="list-style-type: none"> <li>- Mandate only—no specifics on what data will be collected or how; no advisory committee—board of health responsible.</li> <li>- Results available to public upon request.</li> </ul>	Legislation: <a href="http://www.secebt.org/uploads/documents/Mandatory%20Reporting%20&amp;%20Public%20Disclosure%20of%20Nosocomial%20Infections%20-%20The%20Virginia%20Experience%20-%20Michael%20Edmond,%20MD,%20MPH,%20MPA.ppt">http://www.secebt.org/uploads/documents/Mandatory%20Reporting%20&amp;%20Public%20Disclosure%20of%20Nosocomial%20Infections%20-%20The%20Virginia%20Experience%20-%20Michael%20Edmond,%20MD,%20MPH,%20MPA.ppt</a>
Washington	2007	January 2009	<ul style="list-style-type: none"> <li>- Central line-related bloodstream infections (begin collecting data July 2008)</li> <li>- Ventilator-associated pneumonia (January 2009)</li> <li>- Surgical site infections (January 2010)</li> <li>- Uses a phased-in approach to data collection: Data is collected for bloodstream infections beginning July 2008; for pneumonia January 2009; for surgical site infections January 2010 (after the first report is issued).</li> <li>- Already publicly reports adherence to certain prevention measures for pneumonia and surgical site infections.</li> </ul>	Report: <a href="http://www.wahospitalquality.org/">http://www.wahospitalquality.org/</a>
West Virginia	None	N/A	N/A	N/A
Wisconsin	None	N/A	N/A	N/A
Wyoming	None	N/A	N/A	N/A

Additional Sources for Table 1:

[http://www.apic.org/am/images/maps/mandrpt\\_map.gif](http://www.apic.org/am/images/maps/mandrpt_map.gif)

[http://cpmcnet.columbia.edu/dept/nursing/CIRAR/CIRAR\\_P20/HAI\\_Reporting\\_Table\\_10.2.07.pdf](http://cpmcnet.columbia.edu/dept/nursing/CIRAR/CIRAR_P20/HAI_Reporting_Table_10.2.07.pdf)

<http://www.statehealthfacts.org/comparabletable.jsp?ind=407&cat=8>

**Table 2:** Current Federal HAI Public Reporting Legislation\*

<b>Federal Bills Under Consideration</b>	<b>Date Introduced</b>	<b>Status at End of 2007</b>	<b>Proposed Measures and Methods</b>
Patient Safety Act H.R. 4349	11/16/05	Pending at subcommittee	- Public HAI reporting
VA Hospital Quality Report Card Act	03/02/06 (S.2358) 2/27/07 (S.692) 03/09/07 (H.R. 1448)	Pending at committee	- Public HAI reporting at VA hospitals
Hospital Quality Report Card Act S.2359	03/02/06	Pending at committee	- Public HAI reporting
Healthy Hospitals Act H.R. 1174	02/16/07	Pending at subcommittee	- Public HAI reporting - Authorizes CMS to explore financial incentives to reduce rates
Community and Healthcare- Associated Infections Reduction (CHAIR) Act	10/31/07 (S.2278) 11/15/07 (H.R.4214)	Pending at committee	- Public HAI reporting - Investigate CMS payment plan to reduce HAIs - incentives for research and development

\*Source: [http://www.extendingthecure.org/downloads/policy\\_briefs/Policy\\_Brief4\\_Jan08\\_2007\\_Legislation.pdf](http://www.extendingthecure.org/downloads/policy_briefs/Policy_Brief4_Jan08_2007_Legislation.pdf)



**HAI Subcommittee**

**HOSPITAL-ACQUIRED INFECTIONS (HAI) PUBLIC REPORTING SCAN**

**Part II: Existing State Report Formats and Classification Methods, 11/03/08**

**Common Features:**

- Space for hospitals to comment on their results.
- Disclaimer about making appropriate comparisons; encourage consumers to consult individual facilities with concerns and focus on comparison charts rather than raw percentages (which differ according to hospitals' unique populations).
- Most present both state and national averages as reference points.

**Table 3:** Existing State Report Formats and Classification Methods

State	Where to Find the Report	Generating the Report	Presentation/Classification	Level of Usability
Colorado	Website: <a href="http://www.cohospitalquality.org/index.php">http://www.cohospitalquality.org/index.php</a>	Drop -down menus to choose: <ul style="list-style-type: none"> <li>- Type of measure (what kind of stats)</li> <li>- Condition/ procedure</li> <li>- Graphics</li> <li>- Geography (facilities, regions, or comparison of up to 8 facilities).</li> </ul>	<ul style="list-style-type: none"> <li>- Detailed table available for all measures—other graphics available depending on the measure of interest.</li> <li>- Other graphics: Bar graphs; visual depiction of hospital ranges compared to the state average.</li> </ul>	High: <ul style="list-style-type: none"> <li>- Provides links or uses a rollover function to show exact numbers for each graph generated.</li> <li>- Many options for choosing the report to generate.</li> <li>- Many graphics available.</li> <li>- Gives multi-year trends for certain measures.</li> </ul>

State	Where to Find the Report	Generating the Report	Presentation/Classification	Level of Usability
Florida	Website: <a href="http://www.floridahealthfinder.gov">www.floridahealthfinder.gov</a>	Radio buttons and drop-down menus to choose: <ul style="list-style-type: none"> <li>- Geography (including a zip code option = best feature of this site)</li> <li>- Medical condition</li> <li>- Overall facility performance</li> <li>- Individual facility profiles</li> </ul>	<ul style="list-style-type: none"> <li>- Detailed tables</li> <li>- Results are classified as lower than, higher than, or as expected.</li> </ul>	Low: <ul style="list-style-type: none"> <li>- Difficult to navigate (overly-complicated series of radio buttons and drop-down menus).</li> <li>- Lack of interpretation: in one measure, two hospitals with the same rate were classified differently with no explanation (though supposedly are compared to the same state average).</li> </ul>
Iowa	Website: <a href="http://www.ihconline.org">www.ihconline.org</a> (PDFs also available)	Radio buttons to choose: <ul style="list-style-type: none"> <li>- Type of measure</li> <li>- Geography (or individual facility)</li> <li>- Condition</li> </ul>	<ul style="list-style-type: none"> <li>- Detailed tables</li> <li>- Uses a symbol system to compare facilities to state/national averages.</li> </ul>	Low: <ul style="list-style-type: none"> <li>- Uses the same symbol to denote different things for different measures (e.g. star = positive in one case, negative in another).</li> </ul>
Maryland	Website: <a href="http://www.mhcc.maryland.gov">www.mhcc.maryland.gov</a>  Via two different methods: <ul style="list-style-type: none"> <li>- Patient Guide</li> <li>- Comparison Reports</li> </ul>	Patient Guide: <ul style="list-style-type: none"> <li>- Links to choose condition</li> </ul> Comparison Reports: <ul style="list-style-type: none"> <li>- Compare services offered and accreditation status (not performance).</li> </ul>	<ul style="list-style-type: none"> <li>- Detailed tables</li> <li>- Uses a symbol system to categorize hospitals based on percentile. (Does not provide rates)</li> <li>- Bar graphs</li> </ul>	Moderate: <ul style="list-style-type: none"> <li>- Links to interpretation: good explanation of whether to look for a low/high rate for a particular measure.</li> <li>- Links to definitions: defines conditions in case patients do not recognize terms.</li> </ul>
Massachusetts	Website: <a href="http://www.mass.gov/?pageID=eohhs2constituent&amp;L=2&amp;L0=Home&amp;L1=Consumer&amp;sid=Eeohhs2">http://www.mass.gov/?pageID=eohhs2constituent&amp;L=2&amp;L0=Home&amp;L1=Consumer&amp;sid=Eeohhs2</a> PDF available: <a href="http://www.mass.gov/Eeohhs2/docs/dhcfp/qc/archives/qc2/hc_surg_infect.pdf">http://www.mass.gov/Eeohhs2/docs/dhcfp/qc/archives/qc2/hc_surg_infect.pdf</a>	List of links to choose a condition.	<ul style="list-style-type: none"> <li>- Detailed table</li> <li>- Uses a symbol system to denote significantly higher/lower than state average.</li> </ul>	Low: <ul style="list-style-type: none"> <li>- Very difficult to navigate to the reports.</li> <li>- No percentages/ rates are attached to the symbol system, which masks the magnitude of differences between facilities. (Especially in cases where all facilities have the same number of stars.)</li> </ul>

State	Where to Find the Report	Generating the Report	Presentation/Classification	Level of Usability
Missouri	Website: <a href="http://www.dhss.mo.gov/HAI/index.html?target=reports.html">http://www.dhss.mo.gov/HAI/index.html?target=reports.html</a>	Drop-down menus to choose: - Geography (multiple or individual facilities) - Condition - Type of ICU unit	- Detailed tables - Uses a symbol system to denote significantly higher/lower than state average.	High: - Provides links to data and hospital comments. - Exception: Explanations are, at times, a little too high-level (e.g. crash course in statistical significance).
New York	PDF file available at: <a href="http://www.health.state.ny.us/nysdoh/hospital/reports/hospital_acquired_infections/2007/docs/hospital-acquired_infection-full_report.pdf">http://www.health.state.ny.us/nysdoh/hospital/reports/hospital_acquired_infections/2007/docs/hospital-acquired_infection-full_report.pdf</a>	(single PDF)	- Detailed tables: separate table for each procedure linked with an infection. - Uses colored highlighting to indicate statistically significant rates (compared to state average).	Moderate: - Rates are compared against state and national averages, but at this point in time, only aggregate data is available (per phase-in allowed by the legislation)
Pennsylvania	Website: <a href="http://www.phc4.org/reports/hai/06/default.htm">http://www.phc4.org/reports/hai/06/default.htm</a> PDF file available at: <a href="http://www.phc4.org/reports/hai/06/docs/hai2006report.pdf">http://www.phc4.org/reports/hai/06/docs/hai2006report.pdf</a>	(single PDF) OR Drop-down menus to choose: - Geography - Condition - Peer group (with which to compare chosen facility)	- Detailed tables - Statewide results, peer groups, or individual facilities	Moderate: - Good text explanations of what the data means and points to consider when comparing. - Lack of graphics or use of symbols makes it difficult to compare facilities, especially since the statewide results are listed separately—no easily-accessible reference point.
South Carolina	Website: <a href="http://www.scdhec.net/health/disease/hai/reports.htm">http://www.scdhec.net/health/disease/hai/reports.htm</a>	Singe PDF file for each individual hospital.	- Detailed tables: all conditions associated with a type of infection (e.g. surgical site infections) are presented in one table.	Low: - Little interpretation is offered, and there are no instructions on how to compare. Results are not compared to any state or national averages. - If people want to compare multiple facilities, they have to pull up multiple PDFs.

State	Where to Find the Report	Generating the Report	Presentation/Classification	Level of Usability
Vermont	Website: <a href="http://www.bishca.state.vt.us/HcaDiv/HRAP_Act53/doorway_hospital-report-cards_BISHCA-comparisons.htm">http://www.bishca.state.vt.us/HcaDiv/HRAP_Act53/doorway_hospital-report-cards_BISHCA-comparisons.htm</a>	List of links to choose a condition.	- Detailed tables: all conditions associated with a type of infection (e.g. surgical site infections) are presented in one table.	Moderate: - Useful that each infection compares all hospitals as well as giving individual results, but nothing is compared against state/national averages. - Data is more thorough for certain infections.
Washington	Website: <a href="http://www.wahospitalquality.org/">http://www.wahospitalquality.org/</a>	Drop-down menus to choose: - Condition - County (though default is all hospitals)	- Detailed table: All HAI measures for multiple hospitals are presented in one table; also presents state and national averages.	High: - Table is well organized, and options to limit results geographically or highlight hospitals increase readability even though results are presented as one table.



Health Care Quality Performance (HCQP) Program

**HOSPITAL-ACQUIRED INFECTIONS MEASURE EVALUATION GRID**

Measure	(1) Ability to benchmark	(2) Applicability to all hospitals	(3) Applicability to adult/pediatric pts	(4) Applicability to various care settings	(5) Ease of collecting data	(6) Ease of validating data	(7) Evidence base	(8) Frequency of event	(9) Meaningfulness to lay public	(10) Room for improv't	(11) Usefulness for hospital QI	OVERALL RATING  1 (Don't Recommend) to 4 (Strongly Recommend)
Flu vaccination												
SCIP I, II, III, IV												
ICU Collab.: - CLABSI - VAP - VAP bundle												
MRSA												
Hand hygiene												
C-diff												
VRE												
UTIs												
(Add add'l rows)												



Health Care Quality Performance Measurement and Reporting Program (HCQP)

**NURSING HOME SUBCOMMITTEE**

October 21, 2008, 3:00-4:30pm  
RIHCA, 57 Kilvert Street, Suite 200  
Warwick, RI 02886

**Goals/Objectives**

- To share information on the satisfaction survey process and upcoming Safe Transitions Project.

**Subcommittee Attendees**

- |                        |                                   |
|------------------------|-----------------------------------|
| ✓ Rosa Baier, MPH      | ✓ Samara Viner-Brown, MS          |
| ✓ Lonnie Bisbano, Jr.  | ✓ Gail Patry, RN ( <i>Chair</i> ) |
| ✓ Virginia Burke, Esq. | ✓ Lynda Sprague                   |
| ✓ Donna Lonschein, RN  |                                   |

Time	Topic/Notes
3:00	<b>1. Welcome &amp; Updates</b> Rosa Baier, MPH <ul style="list-style-type: none"><li>– Rosa opened the meeting and described the meeting objectives.</li></ul>
3:30	<b>2. Satisfaction Surveys</b> Rosa Baier, MPH <ul style="list-style-type: none"><li>– We are on track for all nursing homes to participate in the survey process and view their results online at the beginning of November. For most nursing homes, the cut-off date for My InnerView to receive surveys is October 29<sup>th</sup> and results are available online beginning November 5<sup>th</sup>. Several homes have a schedule that is one week later.</li><li>– <b>Action item:</b> RIHCA (and possibly RIAFSA) will communicate with their memberships about the upcoming deadline, and the importance of high response rates to ensure accurate data. Rosa will ask My InnerView what happens to surveys submitted post deadline; will they be accepted?</li></ul>
3:30	<b>3. Safe Transitions Project</b> Gail Patry, RN <ul style="list-style-type: none"><li>– Gail described Quality Partners' upcoming Safe Transitions Project, which is part of the National Patient Safety Initiative work. Quality Partners was one of 14 states to receive competitive funding to work on improving care transitions. There will be a small pilot in</li></ul>

Time	Topic/Notes
	<p>December, and then project begins with a cross-setting Health Fair in January.</p> <ul style="list-style-type: none"> <li data-bbox="341 205 1435 373">– The overarching goals of the Safe Transitions Project are to reduce 30-day rehospitalization rates, improve care coordination and communication across settings, and increase patient satisfaction. For nursing homes, the project can help maintain/increase daily census and reduce the likelihood that residents return from the hospital with additional problems.</li> <li data-bbox="341 394 1435 562">– Although the project does not begin until January, Lonnie suggested that Quality Partners identify useful tools for nursing homes, and work with RIHCA and RIAFSA to disseminate them to nursing homes interested in getting a head start improving their residents’ care transitions. Gail reviewed several handouts with meeting attendees, and the group discussed the purpose and target audience of each tool.</li> <li data-bbox="341 583 1435 709">– <b>Action items:</b> Gail and Rosa will create a short “Table of Contents” for the tools, providing a brief description of the tool, who should use it, and when. RIHCA and RIAFSA will disseminate this information to their members.</li> </ul>
4:00	<p><b>4. Open Forum</b> Gail Patry, RN</p> <ul style="list-style-type: none"> <li data-bbox="341 798 1435 871">– Rosa encouraged meeting participants to submit agenda items for future meetings; this forum may be helpful to others who want stakeholder input.</li> <li data-bbox="341 882 1435 917">– Gail adjourned the meeting at 4:10.</li> </ul>



## Safe Transitions

*Together, Quality Partners, the Rhode Island Health Care Association (RIHCA), and the Rhode Island Association of Homes and Services for the Aged (RIAFSA) want to share tools and information with you about changes your nursing home can make to improve your residents' care transitions and reduce rehospitalization rates. This packet includes several tools.*

### Why safe transitions? Why now?

Rehospitalization is gaining attention nationally and can affect your nursing home's bottom line. About one in five Medicare beneficiaries is rehospitalized within 30 days of discharge, and evidence suggests that up to 50% of these hospitalizations are avoidable. Reducing avoidable hospitalizations is an important opportunity for your nursing home to remain ahead of the CMS curve—and do the right thing for your residents. You can also benefit through improved relationships with your local hospitals, home health agencies, and physicians, as well as through improved resident and family satisfaction survey results.

### Room for Improvement

The process by which patients move from hospitals to nursing homes and other care settings is increasingly problematic as hospital stays shorten and as care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that CMS measures. This can be addressed by improving patient education and system processes at and after discharge. Improvement in these processes correlates with substantial reductions in early rehospitalization for particular conditions, such as heart failure.

### System Factors

There are several factors that affect avoidable rehospitalization. These fall into two general categories:

- Patient and caregiver factors: Poor understanding of care goals; inability to manage emerging symptoms; confusion about medications; and lack of access to clinical support.
- System factors: Inaccurate, incomplete, or delayed communications with receiving providers; failure to prescribe evidence-based medications for patient conditions; inadequate patient education and expectation-setting; failure to arrange timely follow-up; and lack of support services for the patient transition process between care settings.

### Opportunity for Nursing Homes

Rhode Island's nursing homes are proactive participants in improving quality of care; you are instrumental in the dialogue on how to ensure high-quality care transitions for your residents. The enclosed tools can help your nursing home improve information transfer and patient self-management—both important factors in improving safe transitions and reducing rehospitalizations.



Health Care Quality Performance (HCQP) Program

**Physician Health Information Technology (HIT) Survey Pilot Results, 10/29/08**

Between January and March 2008, the Rhode Island Department of Health (HEALTH) administered the pilot Physician HIT Survey to approximately 2,125 physicians licensed in Rhode Island and in active practice in Rhode Island, Connecticut, or Massachusetts. The total response rate was 48.5% (n=1,030) and the results are below.

**Table:** Physician HIT Survey Pilot Results

Measure <sup>*</sup>	Population	Score
1: Physicians with EMR components in their main practice, n (%) <sup>†</sup>	1,030	551 (53.5%)
2: Physicians with qualified EMRs: <sup>‡</sup>		
2a: Without CCHIT certification, n (%)	1,030	221 (21.5%)
2b: With CCHIT certification, n (%)	1,030	152 (14.8%)
3: Use of basic EMR functionality, mean <sup>§</sup>	551	51.9
4: Use of advanced EMR functionality, mean <sup>**</sup>	551	23.1
5: Physicians who are e-prescribing, n (%)	1,030	383 (37.2%)

HEALTH worked with stakeholders to create benchmarks for Measures 3, 4, and 5:<sup>††</sup>

- Among the 551 physicians who report using EMR components:
  - 285 (51.7%) are using all **basic functionalities** at least 60% of the time, and
  - 175 (31.8%) are using all **advanced functionalities** at least 60% of the time.
- Among all 1,030 respondents, 198 (19.2%) are **e-prescribing** at least 60% of the time and through an EMR.

After measure validation using the pilot results, the measure scores will be updated, as needed, and publicly reported at the physician- and/or practice-level beginning with the 2009 data collection effort.

<sup>\*</sup> Measure specifications are defined in the “Draft Physician HIT Measures” document, which details inclusion/exclusion criteria. Measures 3 and 4 are mean scores on a 0-100 scale proportional to physicians’ use of functionalities defined in the measure specifications.

<sup>†</sup> EMR components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

<sup>‡</sup> Qualified EMRs: EMRs with specific clinical documentation, reporting, results management, decision support, and e-prescribing functionalities; see measure specifications. CCHIT: Certification Commission on Health Information Technology certification.

<sup>§</sup> Basic EMR functionality: Clinical documentation and results management functionalities; see measure specifications.

<sup>\*\*</sup> Advanced EMR functionality: Decision support, external communication, order management, and reporting functionalities; see measure specifications.

<sup>††</sup> Subset of physicians included in the measure score who used the designated EMR functionalities at least 60% of the time; see measure specifications. Percents are calculated based on the total population for that measure.



## Health Care Quality Performance (HCQP) Program

### Draft Physician Health Information Technology (HIT) Measures

*The following HIT measures are derived from the Department of Health's annual Physician HIT Survey, first administered between January and March 2008. After measure validation using the pilot results, these measures will be updated, as needed, and publicly reported at the physician and/or practice level beginning with the 2009 data collection effort. Measure validation will be completed in November 2008.*

#### 1. Physicians with EMR components in their main practice

- Aggregate: Percent yes
- Physician: Yes/No
- Numerator: Physicians who indicate that they have "EMR components" in their main practice
- Denominator: All physicians in active practice in Rhode Island
- Definition(s): EMR Components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

#### 2. Physicians with 'qualified' EMRs

- Aggregate: Percent yes
- Physician: Yes/No
- Numerator: Physicians who indicate that they have an EMR with all of the following:
- One or more **clinical documentation functionalities** (electronic visit notes, electronic lists of each patient's medications, electronic problem lists, AND/OR patient clinical summaries for referral purposes), AND
  - One or more **reporting functionalities** (clinical quality measures, patients out of compliance with clinical guidelines, AND/OR patients with a condition, characteristic, or risk factor), AND
  - One or more **results management functionalities** (lab test results via electronic interface, scanned paper lab test results, radiology test results via electronic interface, AND/OR scanned paper radiology test results), AND
  - One or more **decision support functionalities** (drug interaction warnings AND/OR prompts to providers at the point of care), AND
  - The **ability to e-prescribe** (i.e., transmit prescriptions electronically to the pharmacy), AND
  - **Certification Commission on Health Information Technology (CCHIT) certification** (see "Qualified EMR" definition, below).
- Denominator: All physicians in active practice in Rhode Island

Exceptions: Certain hospital-based practitioners (i.e., anesthesiologists, emergency department physicians, hospitalists, intensivists, pathologists, and radiologists) are excluded from the reporting functionality requirement and have an altered e-prescribing functionality requirement (i.e., computerized order entry counts as e-prescribing).

Definition(s): Qualified EMR:

- 2008-2009: An EMR that meets all of the above criteria for functionality, EXCLUDING CCHIT certification.
- 2009-2010: An EMR that meets all of the above criteria for functionality AND is CCHIT-certified.

### 3. Physicians who are using basic EMR functionality<sup>1</sup>

Aggregate: 0-100 scale

Physician: 0-100 scale

Calculation: Equal weight to each of the following 6 functionalities that physicians report, with scores proportional to the frequency of use:

- **Clinical documentation functionalities:**
  - Electronic visit notes
  - Electronic lists of each patient’s medications
  - Electronic problem lists
  - Patient clinical summaries for referral purposes
- **Results management functionalities:**
  - Lab test results via electronic interface AND/OR scanned paper lab test results
  - Radiology test results via electronic interface AND/OR scanned paper radiology test results

Population: All physicians in active practice in Rhode Island who report who indicate that they have “EMR components” in their main practice

Definition(s): Basic EMR functionality: The clinical documentation and results management functionalities within the EMR.

EMR Components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

Benchmark: Aggregate percent of physicians who meet both of the below RIQI-defined thresholds for use:

- Use of one or more **clinical documentation functionalities** (electronic visit notes, electronic lists of each patient’s medications, electronic problem lists, AND/OR patient clinical summaries for referral purposes) at least 60% of the time, AND
- Use of one or more **results management functionalities** (lab test results via electronic interface, scanned paper lab test results, radiology test results via electronic interface, AND/OR scanned paper radiology test results) at least **60%** of the time.

### 4. Physicians who are using advanced EMR functionality

Aggregate: 0-100 scale

Physician: 0-100 scale

- Calculation: Equal weight to each of the following 10 functionalities that physicians report, with scores proportional to the frequency of use:
- **Decision support functionalities:**
    - Drug interaction warnings
    - Letters or other reminders directed at patients regarding indicated or overdue care
    - Prompts to providers at the point of care
  - **External communication functionalities:**
    - Electronic referrals
    - Secure emailing with providers outside the physician’s office
  - **Order management functionalities:**
    - Laboratory order entry
    - Radiology order entry
  - **Reporting functionalities:**
    - Clinical quality measures
    - Patients out of compliance with clinical guidelines
    - Patients with a condition, characteristic, or risk factor
- Population: All physicians in active practice in Rhode Island who report who indicate that they have “EMR components” in their main practice
- Exceptions: Certain hospital-based practitioners (i.e., anesthesiologists, emergency department physicians, hospitalists, intensivists, pathologists, and radiologists) are excluded from the reporting, decision support, and e-prescribing functionalities requirements; i.e., their 0-100 score is based solely on their use of the order management functionalities in their EMR.
- Definition(s): Advanced EMR functionality: The decision support, order management, and reporting functionalities within the EMR.  
EMR Components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.
- Benchmark: Aggregate percent of physicians who meet both of the below RIQI-defined thresholds for use:
- Use of one or more **reporting functionalities** (clinical quality measures, patients out of compliance with clinical guidelines, AND/OR patients with a condition, characteristic, or risk factor) at least 60% of the time, AND
  - Use of one or more **decision support functionalities** (drug interaction warnings AND/OR prompts to providers at the point of care) at any frequency greater than 0%.

**5. Physicians who are e-prescribing**

- Aggregate: Percent yes
- Physician: Yes/No
- Numerator: Physicians who indicate that they transmit their prescriptions electronically to the pharmacy with any frequency greater than 0%
- Denominator: All physicians in active practice in Rhode Island
- Definition(s): e-prescribing: Transmitting prescriptions electronically to the pharmacy.

Transmitting prescriptions electronically: Prescriptions may be transmitted within physicians' EMRs or externally, but cannot be transmitted via fax.

Exceptions: Certain hospital-based practitioners (i.e., anesthesiologists, emergency department physicians, hospitalists, intensivists, pathologists, and radiologists) have an altered numerator definition (i.e., computerized order entry counts as e-prescribing).

Benchmark: Percent of physicians who meet the below RIQI-defined thresholds for use:

- Use of an **EMR to e-prescribe** at least 60% of the time.\*

---

\* NOTE: The benchmark is limited ONLY to e-prescribing using an EMR, whereas the measure includes physicians who e-prescribe using software outside their EMR.