



Health Care Quality Performance (HCQP) Program

STEERING COMMITTEE

May 18, 2009, 3:00-4:30pm
Department of Health, Room 401

Goals/Objectives

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

Voting Members (Quorum = 8+ Members)

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

* Voted on the hospital topics in absentia

Time Topic/Votes

3:00pm **Welcome & Remarks**
David Gifford, MD, MPH, HEALTH
– Dr. Gifford opened the meeting at 3:05pm.

HCQP Program Updates (see slides)
Samara Viner-Brown, MS, HEALTH
Rosa Baier, MPH, Quality Partners

- 3:05pm **1. Administrative**
- The current fiscal year (FY 2009) ends June 30. In preparation, Sam and Rosa:
 - o Submitted the Quality Partners budget continuation, which includes the anticipated scope of work for FY 2010 (*handout*), and
 - o Began the draft Annual Report, which will be completed ~July 2009, shared with the Steering Committee, and then submitted to the legislature.
 - There are several Web updates, which pertain to all settings:

Time	Topic/Votes
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- There is a new process for updating the Program’s Web site, which involves submitting text and reports through HEALTH’s Public Informations Officer (PIO), Annemarie Beardsworth, who reviews/approves the changes and gives them to Webmaster, Sally Johnson. This can result in delays, which we are working to minimize, but helps to ensure HEALTH’s consistency and awareness of all changes that have public relations implications.
- As part of this new process, Annemarie and Sally have requested that the Program update all reports (going forward) to adhere to HEALTH’s formatting requirements (font, logo, footer, etc.). The draft SCIP report (*handout*) is an example of the updated report formatting.
- **Vote:** The Steering Committee approved the changes to report formats (yes – 8, no – 0, abstained – 0).
- The Webmaster is interested in exploring how to take the static PDF reports and make them interactive. This would improve the overall function and usability of the Web site by allowing consumers to interact with, or customize, the data they see.
- **Vote:** The Steering Committee approved the provision of raw data to Webmaster (yes – 8, no – 0, abstained – 0), and requested that the Committee vote on the implementation of any interactive formats, since this involves changing the format in which data is publicly available.
- As an FYI, HEALTH is beginning the process of redesigning its entire Web site (including the Program’s portion). As decisions are made about organizing the site—e.g., around audience or specific programs—there may be implications for the public reporting program. This also means that redesigning our portion of the site will be on hold until the more global Web site decisions are made; but we can make small changes as we upload new reports. To that end, the Nursing Home Subcommittee has formed a Web Workgroup that will work with the Program to identify and suggest ‘easy win’ updates for that section.
- **Action items:**
 - Rosa will send Sally the raw data for the nursing home diamond reports and connect her with the Nursing Home Web Workgroup.
 - Sally and the Web Workgroup will vet interactive formats, and then return to the Steering Committee with recommendations.

3:15pm **2. Hospital-Acquired Infections (HAI) Subcommittee**

Chairs: Leonard Mermel, DO and Samara Viner-Brown, MS

- The Subcommittee has been meeting approximately every 2-3 weeks (see HAI Subcommittee Minutes, sent with agenda). To date, the following measure/sequence has been identified:
 - Surgical Care Infection Program (SCIP; handouts) – Ready (with edits)
 - Central line-related bloodstream infections (CLABSI) } Awaiting data
 - Employee flu vaccination } Awaiting data
 - MRSA process measures (handout) } Finalizing measures/data
 - MRSA outcome measure(s) } collection strategy
- This means that SCIP data will be published in May/June and CLABSI and employee flu vaccination data in June/July. This aggressive timeline exceeds the legislative mandate to report annual data by October 2010.

Time	Topic/Votes
	<ul style="list-style-type: none"> - At today's Subcommittee meeting, members requested several edits to the SCIP graphs (e.g., inclusion of national average) and the addition of (1) a Frequently Asked Questions (FAQ) document describing the data limitations and (2) the opportunity for hospitals to comment and have their comments published together with the report. - Votes: The Steering Committee discussed these suggestions, which have policy implications, and voted as follows: <ul style="list-style-type: none"> o The Committee approved the release of the SCIP reports (with the Subcommittee's edits; yes – 9, no – 0, abstained – 0). o The Committee approved the creation/release of an FAQ, with the request that Committee members review the draft and provide comment (yes – 9, no – 0, abstained – 0). o The Committee rejected the inclusion of hospital comments with the reports (yes – 1, no – 8, abstained – 0), since this would involve 'policing' comments and determining which to include (a slippery slope); but requested the inclusion of (1) a generic statement on all reports advising people to contact the providers with questions and (2) links to the hospitals' Web sites from the hospital public reporting page. - Action items: <ul style="list-style-type: none"> o Rosa will create an FAQ for the Steering Committee's input by Wednesday, 5/27. o Steering Committee members will provide feedback via email by COB on 6/1. - Next meeting: Tentatively scheduled for June 1, 2009
3:30pm	<p>3. Home Health Measures Subcommittee <i>Chair: Rosa Baier, MPH, Chair</i></p> <ul style="list-style-type: none"> - The clinical measure graphs were updated in April. - The home health setting is currently surveying patients for satisfaction every two years; the next survey period is September to November. Most recently, <ul style="list-style-type: none"> o Rosa sent an update to the Subcommittee about the status of Home Health CAHPS (a new Medicare survey instrument), schedule for reconvening the Subcommittee, and schedule for this year's satisfaction surveys (<i>handout</i>), and o Press Ganey drafted a memo for the Rhode Island agencies, describing their preparations for the implementation of Home Health CAHPS (<i>handout</i>). - The Subcommittee's next meeting is contingent upon Medicare's finalization of the CAHPS instrument, but is anticipated to be in the next 1-2 months. There are several important topics for discussion, including: <ul style="list-style-type: none"> o Rhode Island's continued use of single vendor. This may be a moot point if all of the vendors are using the same instrument; and yet, there are economies of scale if all Rhode Island agencies use the same vendor. o The applicability of CAHPS to non-Medicare-certified agencies. Previously, all agencies (regardless of certification) participated in the satisfaction survey process, but we do not yet have any information about the applicability of Medicare's survey to non-Medicare-certified agencies and may need to change approaches. - Next meeting: To be scheduled after receipt of information from Press Ganey

Time	Topic/Votes
3:45pm	<p data-bbox="310 163 769 191">4. Hospital Measures Subcommittee</p> <p data-bbox="358 199 737 226"><i>Chair: Samara Viner-Brown, MS</i></p> <ul style="list-style-type: none"> <li data-bbox="358 254 1003 281">- The clinical measure graphs updated were in April. <li data-bbox="358 308 1370 336">- The Subcommittee is moving forward with two types of pressure ulcer measures: <ul style="list-style-type: none"> <li data-bbox="407 363 1419 558">○ <u>Process measures</u>. As of 5/15, all three data points have been collected and submitted to IHI. Rosa has requested a data update from IHI and will populate the public reports ASAP (using the same format as other hospital reports; see <i>handout</i>). We anticipate having the public report by the end of May. The process measures will be reported once, as previously approved, and then cease once the incidence measure is reported. <li data-bbox="407 585 1419 821">○ Votes: The Subcommittee approved: <ul style="list-style-type: none"> <li data-bbox="440 636 1419 699">▪ The format for the ~May 2009 pressure ulcer process measure report (yes – 8, no – 0, abstained – 0), and <li data-bbox="440 726 1419 821">▪ The release of the report, once populated (yes – 8, no – 0, abstained – 0), with the request that the format include a notation that this is a one-time report, which will be followed by incidence data. <li data-bbox="407 848 1419 1241">○ <u>Incidence measure</u>. As discussed and approved previously: <ul style="list-style-type: none"> <li data-bbox="440 898 1419 961">▪ We will use the Hospital Discharge Data Set (HDDS) to calculate an AHRQ-recommended incidence measure. <li data-bbox="440 989 1419 1083">▪ HEALTH estimates that these data will be available in June 2009 for a preview report to the hospitals; after a 60-day preview, during which hospitals can contest their numerator, the data will be reported in ~August 2009. <li data-bbox="440 1110 1419 1241">▪ Once the present on admission (POA) indicator is incorporated into the HDDS, the Program will use the POA to measure incidence and cease using a preview period. We are currently working with the Hospital Association to incorporate the POA into the vendor’s software. <li data-bbox="358 1268 1419 1289">- Next meeting: To be scheduled when incidence preview reports are available (~June)
4:05pm	<p data-bbox="310 1331 841 1358">5. Nursing Home Measures Subcommittee</p> <p data-bbox="358 1367 602 1394"><i>Chair: Gail Patry, RN</i></p> <ul style="list-style-type: none"> <li data-bbox="358 1421 1247 1449">- The clinical measure diamond reports were updated this month (May). <li data-bbox="358 1476 1360 1539">- The Subcommittee is finishing its review of the 2008 family/resident satisfaction survey process and beginning to plan for 2009: <ul style="list-style-type: none"> <li data-bbox="407 1566 1419 1728">○ Follow-up: Ray Rusin from Facilities Regulation is following up with select nursing homes, based on how their survey distribution rates for residents and families compare to their estimated occupancy rates (<i>handout</i>). Responses were due to HEALTH at the end of April and are currently being reviewed. Facilities without adequate explanations may receive a state citation. <li data-bbox="407 1755 1419 1885">○ Planning: The nursing homes usually attend a mid-summer session about how to use their survey results; last year’s was co-sponsored by RIHCA and RIAFSA. The Subcommittee is working to identify potential summer learning session topics, and to determine if they are value-added to RIHCA’s planned seminar series.

Time	Topic/Votes
	<ul style="list-style-type: none"> - At the last Subcommittee meeting (minutes sent with agenda), participants formed a Web Workgroup (see Administrative update). - Next meeting: 3-4:30pm, June 16, 2009, RIHCA
4:15pm	<p data-bbox="310 296 743 331">6. Physician Measures Workgroup</p> <p data-bbox="358 331 699 367"><i>Chair: Rebekah Gardner, MD</i></p> <ul style="list-style-type: none"> - The 2008 Physician Health Information Technology (HIT) Survey results are posted on the Web site, and have been since March. The accompanying press release was picked by NPR as part of a story about community health centers' HIT use. A public-use data file is currently being finalized and will also be posted. - Rebekah and Rosa continue to work with the Rhode Island Quality Institute, Blue Cross & Blue Shield of Rhode Island, and UnitedHealthCare of New England to ensure that the data help them meet their goals to track HIT adoption and allocate physician incentives. - The Agency for Healthcare Research and Quality (AHRQ) has included the Rhode Island survey among its compendium of HIT surveys for the 2nd year. - Next meeting: None scheduled
4:25pm	<p data-bbox="310 856 464 892">Open Forum</p> <p data-bbox="310 892 708 928">David Gifford, MD, MPH, HEALTH</p> <ul style="list-style-type: none"> - Dr. Gifford adjourned the meeting at 4:15pm. <p data-bbox="310 1014 792 1050">Next Meeting – 3-4:30pm, July 20, 2009</p>



Steering Committee: HCQP Program Updates

Samara Viner-Brown, MS, HEALTH
Rosa Baier, MPH, Quality Partners of Rhode Island

May 18, 2009

Administrative



- Planning**
 - Budget continuation for Quality Partners contract:
 - Submitted May 12, 2009
 - Anticipated FY2010 activities included (*handout*)
 - Annual Report, ~July 2009

- Web Site**
 - New/updated reports:
 - Submitted to Public Informations Officer (PIO)
 - Sent from PIO to Webmaster
 - May result in some delays; working to improve system (e.g., only approval for reports with associated press releases)

Administrative



- Web Site (Cont'd)**
 - Report format:
 - Request to adhere to HEALTH formats, including:
 - HEALTH logo, colors
 - Date last updated
 - Georgia font, etc.
 - Interactive capability
 - **Vote:** Approve changes to formatting and provision of raw data to Webmaster
 - Web site content:
 - HEALTH Web redesign efforts, including:
 - Program vs. audience branding – should HCQP reports be grouped or interspersed throughout?
 - Nursing Home Web Workgroup

HAI Subcommittee

Leonard Mermel, DO, ScM, and Sam Viner-Brown, MS, Co-Chairs



- Goal**
 - To collect and regularly report quarterly hospital-acquired infections (HAI), beginning with easy-to-report measures and expanding over time.
- Update**
 - Reminders:
 - The HAI legislation calls for quarterly submission of data, for an annual report no later than October 2010
 - Selected four measure categories (next slides)
 - Met with Ohio's Health Department:
 - Ohio's public reporting program includes employee flu vaccination and hand hygiene
 - Currently in similar stage (not yet implemented)

HAI Subcommittee

Leonard Mermel, DO, ScM, and Sam Viner-Brown, MS, Co-Chairs



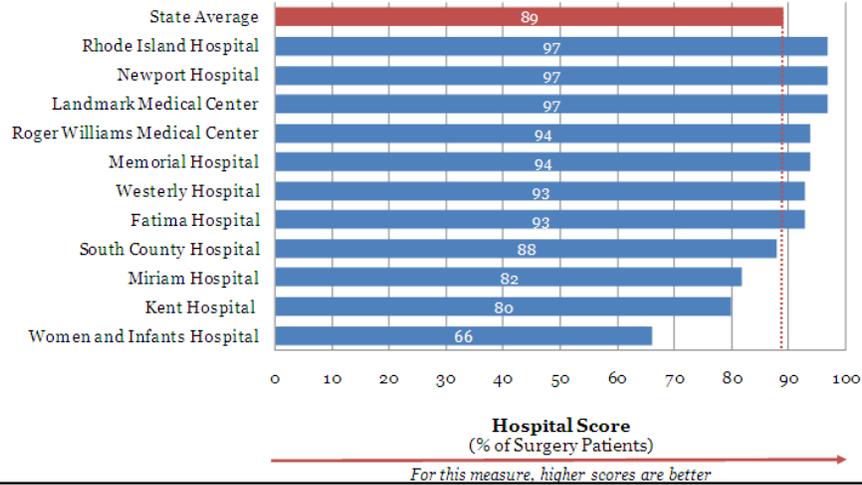
- Update (Cont'd)**
 1. Surgical Care Improvement Project (SCIP) Measures
 - Q3 2009 data available via Hospital Compare
 - Graphs and technical page ready to report (*handouts*)
 - See color/format on next slide
 - Subcommittee met this morning and requested several edits/additions:
 - Addition of national average
 - Creation of FAQ outlining data limitations
 - Opportunity for hospital comments
 - **Votes:**
 1. Release of SCIP reports (with edits),
 2. Creation/release of an FAQ, and
 3. Implementation of hospital comments.

HAI Subcommittee

Leonard Mermel, DO, ScM, and Sam Viner-Brown, MS, Co-Chairs



Figure 1: Percent of surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection



HAI Subcommittee

Leonard Mermel, DO, ScM, and Sam Viner-Brown, MS, Co-Chairs



Update (Cont'd)

2. Central Line-Associated Bloodstream Infections (CLABSI)

- Available for adult ICUs through the Collaborative
- Need to collect from NICU and PICU
- Definitions changed in January 2009
- Awaiting Q1 data (due last Friday) w/ new definitions
- Available ~June 2009, can be reported then

3. Employee flu vaccination compliance

- Working with John Fulton to:
 - Send provider letters
 - Implement revised form with hospitals or all settings
- Awaiting 2008-2009 flu season data
- Available ~June 2009, report available ~July
 - Report ASAP, given H1N1 flu attention/urgency

HAI Subcommittee

Leonard Mermel, DO, ScM, and Sam Viner-Brown, MS, Co-Chairs



Update (Cont'd)

4. MRSA process measures (*handout*)
 - Creating measures re: hand hygiene:
 - Clinical staff trained in hand hygiene and glove use
 - Hand hygiene compliance measured at least quarterly
 - Hand hygiene compliance data shared with hospital staff and executives at least quarterly
 - Will be collected from hospitals via survey
5. MRSA outcome measure(s)
 - Hospital-wide primary blood stream infections (BSIs)
 - Based on NHSN definitions
 - Working to finalize definitions (e.g., denominator)

Next steps

- Release data incrementally, as it is available
- Subcommittee meeting: 6/1, 8-9am, in Room 401

Home Health Subcommittee

Rosa Baier, MPH, Chair



Goal

- To collect and report patient satisfaction every two years; the next survey period is anticipated to be September-November 2009.

Update

- Clinical measure graphs updated in April
- Update sent to Subcommittee:
 - Status of Home Health CAHPS (*handout*)
 - Memo from Press Ganey (*handout*)

Next steps

- The Subcommittee will reconvene when the CAHPS instrument is finalized, to discuss:
 - Use of a single vendor
 - Applicability of CAHPS to non-Medicare agencies

Hospital Subcommittee

Samara Viner-Brown, MS, Chair



- Goal**
 - Collect and report pressure ulcer (PU) process and incidence measures
- Updates**
 - Clinical measure graphs updated in April
 - Process measures:
 - Data collection is complete
 - Sent a 5/15 data submission reminder
 - Following up with IHI to obtain the data
 - Draft graphs (*handout*) can be populated this month
 - As a reminder:
 - Will report once, then switch to the incidence measure
 - The 4th scheduled process measure data point (July 2009) has been cancelled
 - **Vote:** Approve (1) report format and (2) release

Hospital Subcommittee (Cont'd)

Samara Viner-Brown, MS, Chair



- Updates (Cont'd)**
 - Incidence measure:
 - Previously, the Subcommittee recommended using:
 - Hospital Discharge Data Set (HDDS) with the new Present on Admission (POA) indicator (data source)
 - AHRQ measure specifications (measure calculation)
 - Because it will take time to incorporate the POA into the HDDS, the Steering Committee recommended:
 - Using the original AHRQ measure specifications with a 60-day hospital preview (ability to contest numerator) until the POA indicator is in the HDDS
 - Once the POA indicator is available, using the revised AHRQ measure specifications (without a preview)

Hospital Subcommittee (Cont'd)

Samara Viner-Brown, MS, Chair



Updates (Cont'd)

- Incidence measure (cont'd):
 - Continue to partner with HARI to explore the addition of the POA into the HDDS vendor's software:
 - Indications are that it is feasible within several months
 - HARI is convening a User's Group meeting to discuss the hospital-side logistics
 - Involves some time, cost
 - But, consistent with hospitals' desire to use the POA
 - The Program will email Subcommittee members, so that they can communicate with their hospital's representative about the meeting

Hospital Subcommittee (Cont'd)

Samara Viner-Brown, MS, Chair



Updates (Cont'd)

- Reminder: The *estimated* timeline is:
 - May 2009 – HEALTH receives/cleans Q4 2008 data
 - June 2009 – 60-day preview begins [expanded]
 - August 2009 – 1st public report
 - New reports quarterly thereafter

Next steps

- Subcommittee meeting: Awaiting preview data
- 1-2 meetings anticipated prior to public report, to (1) finalize the report format, and (2) review the preview data.

Nursing Home Subcommittee

Gail Patry, RN, Chair



- Goal** ■ Review 2008 nursing home satisfaction data/process, and begin to prepare for 2009 satisfaction reporting.
- Update** ■ Clinical measure graphs updated this month (May)
 - Family and resident satisfaction:
 - 2008 review:
 - Facilities Regulation followed up with select nursing homes, based on survey distribution (*handout*)
 - Received responses 4/30; next steps are to vet them
 - Preliminary planning for summer training session
 - Web Workgroup formed to generate ideas, feedback (see Administrative update)
- Next steps** ■ Subcommittee meeting: June 16, 3-4:30pm, RIHCA

Physician Workgroup

Rebekah Gardner, MD, Chair



- Goal** ■ Publicly report/disseminate the Physician Health Information Technology (HIT) Survey results
- Update** ■ Reminder, two reports are posted in March:
 1. Physician Report: Physician-level results (180 pages!)
 2. Summary Report: Aggregate results
 - Updated survey instrument shared with the Agency for Healthcare Research and Quality (AHRQ) for inclusion in their HIT Survey Compendium
 - Partnership activities continue:
 - Ad hoc data for RIQI
 - Public-use data files ready for release:
 - To inform BCBSRI and UnitedHealthCare's work
 - Available to all interested

Physician Workgroup

Rebekah Gardner, MD, Chair



- Next steps**
- Release public-use data file on Web site
 - Continue partnership activities
 - Seek opportunities to publicize data:
 - Previously featured in NPR story about EMRs in the CHCs
 - *Medicine/Health RI?*
 - Other publication opportunities
 - Workgroup meeting: None scheduled



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Health Care Quality Performance (HCQP) Program

ANTICIPATED SCOPE OF WORK*

5/11/09

SETTING/TASK	DESCRIPTION*	(FREQUENCY or DATE)
General Contract Support	▪ Provide analytic and methodological support and leadership	(ongoing)
	▪ Develop and maintain stakeholder relationships and consensus	(ongoing)
	▪ Conduct research:	
	○ Environmental scans	(as needed)
	○ Measure development and validation efforts	(ongoing)
	○ Relevant clinical literature and best practices	(ongoing)
	▪ Perform contract oversight (fiscal and managerial)	(ongoing)
	▪ Write Program documents:	
	○ Annual Report	(Jul 2009)
	○ Press releases	(as needed)
	▪ Maintain committee member contact lists	(as needed)
	▪ Post information on state's Open Meetings site:	
	○ Committee agendas	(2 days prior)
	○ Committee minutes	(5 days after)
▪ Attend Center for Health Data and Analysis meetings	(monthly)	
▪ Present Program information to internal/external audiences	(as requested)	
▪ Perform other tasks (e.g., media interviews)	(as requested)	
Home Health	▪ Convene the Home Health Measures Subcommittee	(as needed)
	▪ Chair the Subcommittee	(ongoing)
	▪ Generate reports and technical files:	
	○ Quarterly clinical quality measures	(Jan/Apr/Jul/Oct)
	○ Bi-annual satisfaction data	(Dec 2010)
	▪ Communicate regularly with stakeholders	(as needed)
	▪ Respond to home health agency and trade association inquiries:	
	○ General questions	(as needed)
	○ Technical assistance (e.g., survey completion, data interpretation)	(as needed)
	○ Programmatic questions (e.g., legislative mandate, requirements)	(as needed)
▪ Serve as liaison with satisfaction vendor	(ongoing)	
▪ Serve on CMS's Home Health CAHPS Technical Expert Panel	(ongoing)	

* All tasks described are contingent upon available funding and subject to prioritization with HEALTH. Depending on the level of effort needed to accomplish each task listed, it may not be possible to complete all upcoming tasks within the existing budget.

SETTING/TASK	DESCRIPTION*	(FREQUENCY or DATE)
Hospital	<ul style="list-style-type: none"> ▪ Convene the Subcommittees: <ul style="list-style-type: none"> ○ Hospital Measures ○ Hospital-Acquired Infections (HAIs) ▪ Collect data (e.g., HAI process measures submitted by hospitals) 	<ul style="list-style-type: none"> (as needed) (as needed) (as needed)
Hospital (cont'd)	<ul style="list-style-type: none"> ▪ Generate reports and technical files: <ul style="list-style-type: none"> ○ Quarterly clinical quality measures ○ Quarterly HAI measures ○ Quarterly pressure ulcer incidence ▪ Communicate regularly with stakeholders ▪ Respond to hospital and trade association inquiries: <ul style="list-style-type: none"> ○ General questions ○ Technical assistance (e.g., survey completion, data interpretation) ○ Programmatic questions (e.g., legislative mandate, requirements) 	<ul style="list-style-type: none"> (Jan/Apr/Jul/Oct) (TBD) (as needed) (as needed) (as needed) (as needed)
Nursing Home	<ul style="list-style-type: none"> ▪ Convene the Nursing Home Measures Subcommittee ▪ Satisfaction survey process: <ul style="list-style-type: none"> ○ Co-host annual seminar (with trade associations) ○ Follow-up on vendor contracts ○ Assist HEALTH with follow-up on provider non-compliance ▪ Generate reports and technical files: <ul style="list-style-type: none"> ○ Quarterly clinical quality measures ○ Annual satisfaction data ▪ Communicate regularly with stakeholders ▪ Respond to nursing home and trade association inquiries: <ul style="list-style-type: none"> ○ General questions ○ Technical assistance (e.g., data interpretation) ○ Programmatic questions (e.g., legislative mandate, requirements) ▪ Serve as liaison with satisfaction vendor 	<ul style="list-style-type: none"> (Feb/Apr/Jun/Aug/Oct/Dec) (Jul/Aug 2010) (Aug-Oct 2010) (as needed) (Jan/Apr/Jul/Oct) (Dec 2010) (as needed) (as needed) (as needed) (as needed) (as needed) (as needed) (ongoing)

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SETTING/TASK	DESCRIPTION*	(FREQUENCY or DATE)
Physician	<ul style="list-style-type: none"> ▪ Convene the Physicians Measures Workgroup ▪ Re-administer the Physician HIT Survey ▪ Perform survey analysis: <ul style="list-style-type: none"> ○ Validate reporting measures ○ Create public report ○ Create public-use data file ○ Generate ad hoc data analysis for stakeholder partners ▪ Meet with key collaborators: <ul style="list-style-type: none"> ○ Blue Cross & Blue Shield of Rhode Island ○ UnitedHealthCare of New England ○ Rhode Island Quality Institute ▪ Communicate regularly with stakeholders ▪ Respond to physician inquiries: <ul style="list-style-type: none"> ○ General questions ○ Technical assistance (e.g., survey completion, data interpretation) ○ Programmatic questions (e.g., legislative mandate, requirements) 	<ul style="list-style-type: none"> (as needed) (Jan 2010) (as needed) (Feb 2010) (Mar 2010) (as requested) (ongoing) (ongoing) (ongoing) (as needed) (as needed) (as needed) (as needed) (as needed) (as needed)
Steering Committee	<ul style="list-style-type: none"> ▪ Coordinate the Committee’s meetings, presentations ▪ Communicate regularly with stakeholders ▪ Respond to Committee Members’ inquiries: <ul style="list-style-type: none"> ○ General questions ○ Technical assistance (e.g., data interpretation) ○ Programmatic questions (e.g., legislative mandate, requirements) 	<ul style="list-style-type: none"> (Jan/Mar/May/Jul/Sep/Nov) (as needed) (as needed) (as needed) (as needed) (as needed)
Website	<ul style="list-style-type: none"> ▪ Post data reports ▪ Update Website content ▪ Collaborate with HEALTH on overall Website redesign 	<ul style="list-style-type: none"> (as needed) (as needed) (as needed)

* All tasks described are contingent upon available funding and subject to prioritization with HEALTH. Depending on the level of effort needed to accomplish each task listed, it may not be possible to complete all upcoming tasks within the existing budget.



Health Care Quality Performance (HCQP) Program

SURGICAL CARE IMPROVEMENT PROJECT (SCIP) MEASURES

Data Report
April-June (Quarter 2), 2008

The SCIP measures are [reported on the Department of Health's \(HEALTH's\) Web site](#) as part of the HCQP Program's Hospital-Acquired Infections work. You can learn more about the measures—including their data source, how they are calculated, and why each is important—by reading the Technical Page.

Figure 1: Percent of surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection

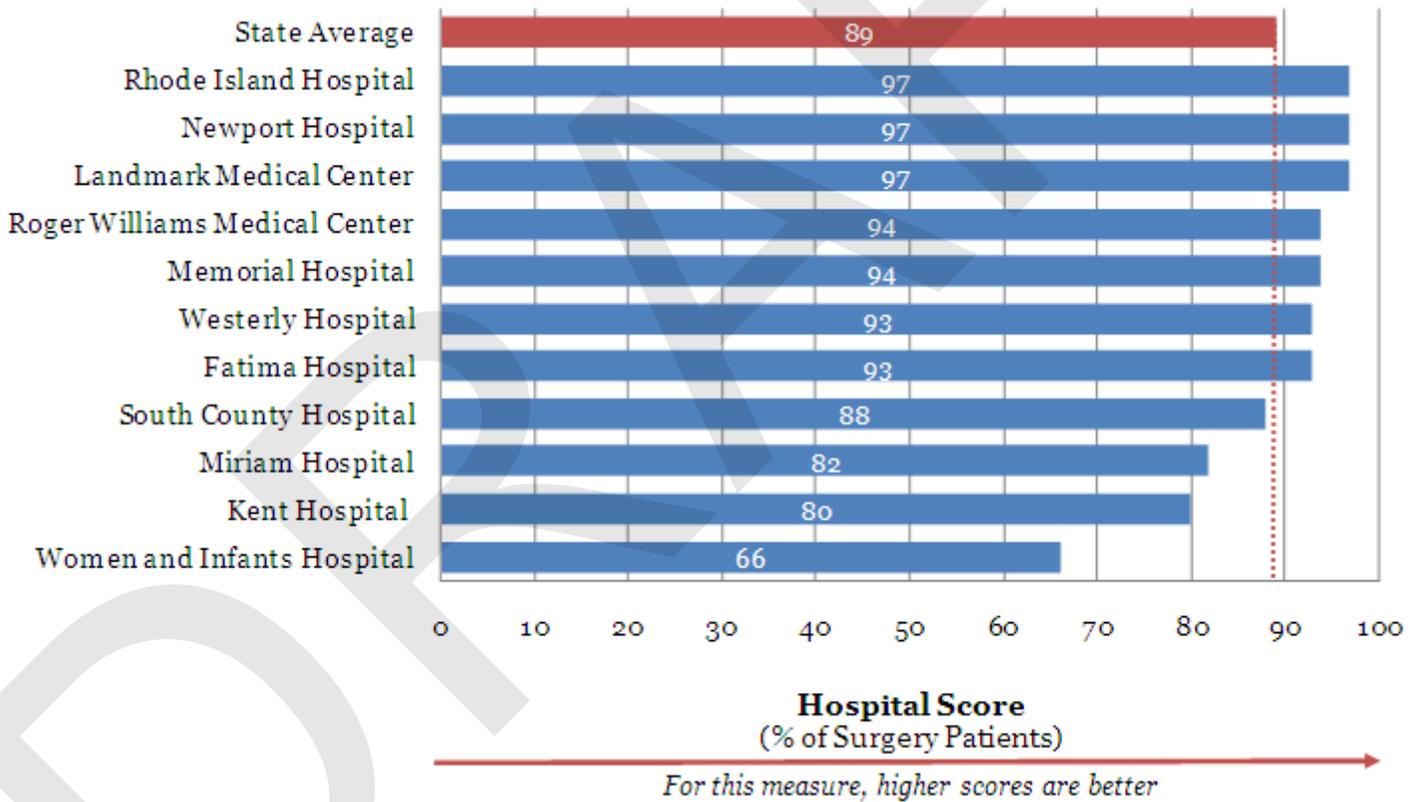


Figure 2: Percent of surgery patients who were given the right kind of antibiotic to help prevent infection

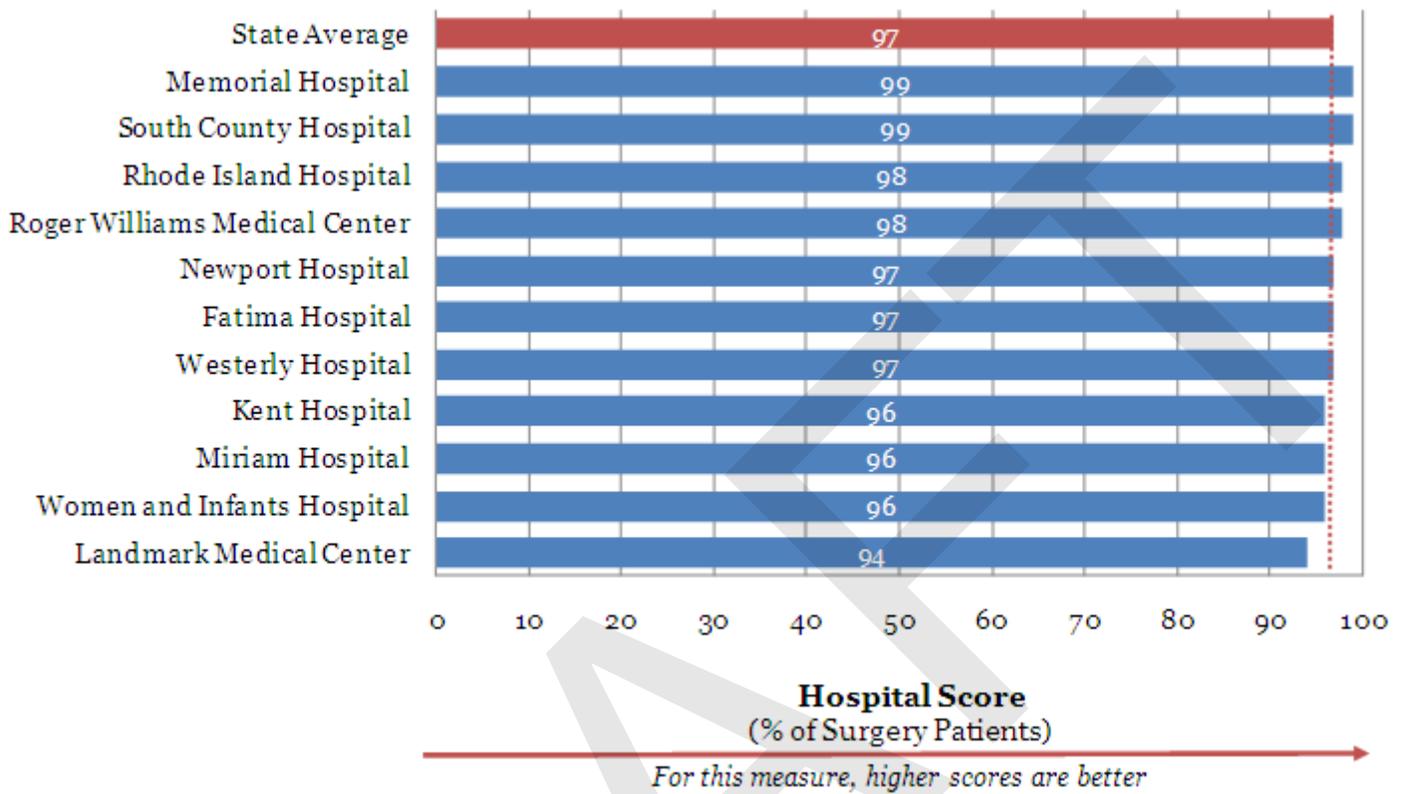
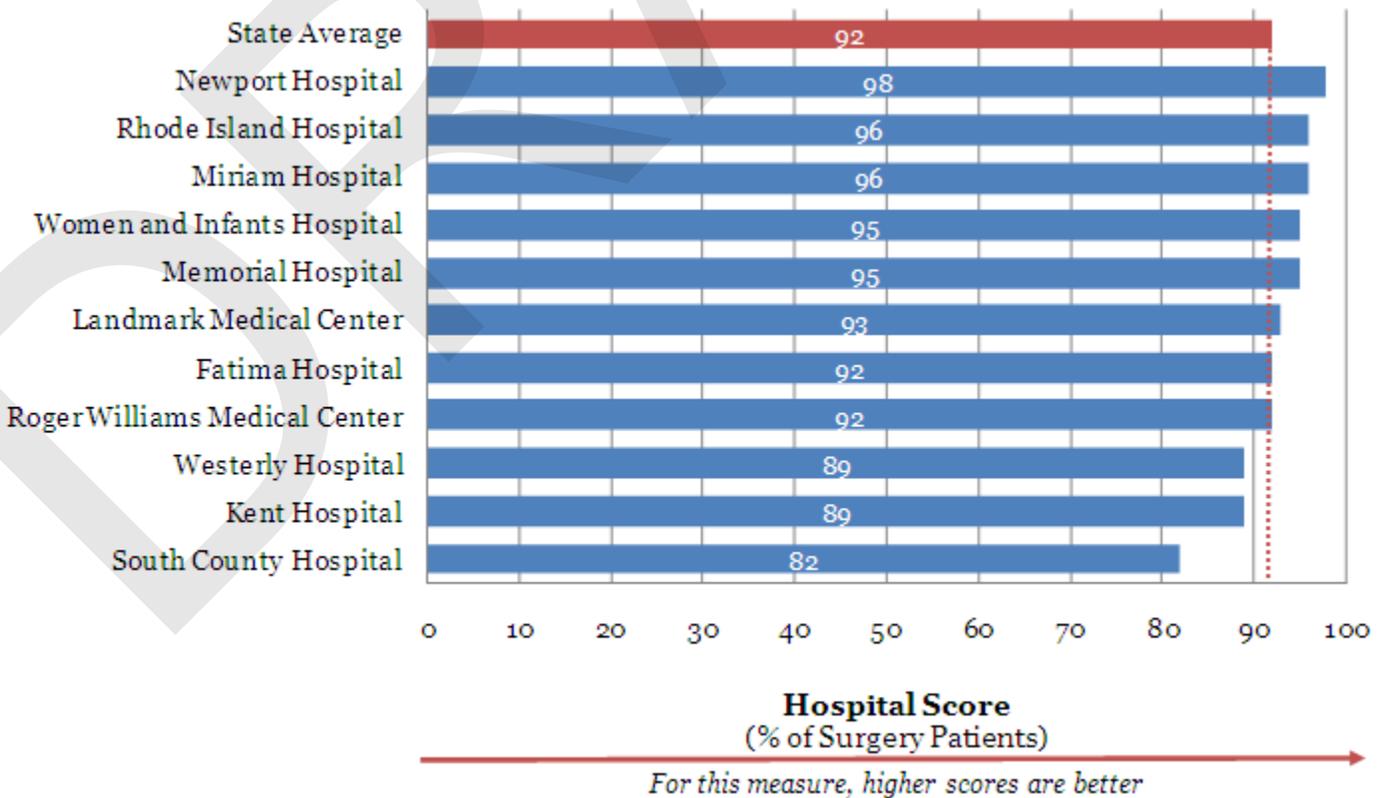


Figure 3: Percent of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)





Health Care Quality Performance (HCQP) Program

SURGICAL CARE IMPROVEMENT PROJECT (SCIP) MEASURES

Technical Page

The SCIP measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital-Acquired Infections work. The information on this page provides additional details about the measures, including their data source, how they are calculated, and why each is important.

Data Source

HEALTH’s public reports include three of these surgical infection measures from Medicare’s [Hospital Compare](#):

- 1. Percent of surgery patients given antibiotics within one hour prior to surgery
 - 2. Percent of surgery patients given the right kind of antibiotics before surgery
 - 3. Percent of surgery patients who stop receiving antibiotics within 24 hours of surgery
- } Higher is better

Measure Calculation

For each measure, the score is calculated as follows:

$$\text{Percent of patients} = \frac{\text{(patients receiving indicated care)}}{\text{(all surgical patients who should receive the care)}}$$

The number of patients who receive the indicated care (e.g., appropriate antibiotics) is the **numerator**. The number of surgical patients who should receive the care (are eligible for it) is the **denominator**. The percent of patients, or **measure score**, is the numerator divided by the denominator. Hospitals’ measure scores are compared to one another and to the state average.

Measure Information (adapted from Medicare)

Measure	Why is this information important?
1. Percent of surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	Surgical wound infections can be prevented. Getting an antibiotic within one hour before surgery reduces the risk of wound infections. Hospital staff should make sure surgery patients get antibiotics at the right time. This measure shows how often hospital staff make sure surgery patients get antibiotics at the right time.
2. Percent of surgery patients who were given the right kind of antibiotic to help prevent infection.	Surgical wound infections can be prevented. Some antibiotics work better than others to prevent wound infections for certain types of surgery. Hospital staff should make sure patients get the antibiotic that works best for their type of surgery. This measure shows how often hospital staff make sure patients get the right kind of antibiotic medication for their surgery.
3. Percent of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	Taking preventive antibiotics for more than 24 hours after routine surgery is usually not necessary. This measure shows how often hospitals stopped giving antibiotics to surgery patients when they were no longer needed to prevent surgical infection.



Health Care Quality Performance (HCQP) Program

HAND HYGIENE COMPLIANCE

Technical Page

The hand hygiene compliance measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital-Acquired Infections work. This information provides additional details about the measures, including their data source, how they are calculated, and why each is important.

Measures

The Program has defined three hand hygiene compliance measures:

Measure	Why is this information important?
1a. Physicians trained in proper hand hygiene and glove use 1b. All other clinicians trained in proper hand hygiene and glove use	Clean hands are the single most important strategy to prevent germs from spreading in hospitals. Making sure that staff know hand hygiene—how to clean their hands with an alcohol-based product or soap and water—and how to use gloves is important.
2. Hand hygiene compliance measured	
3. Hand hygiene compliance data shared with hospital staff and executives	Going to different parts of the hospital (wards, clinics, etc.) to see if staff are actually cleaning their hands properly before and after caring for patients is important. This information helps hospitals know how often staff are cleaning their hands properly. They can then use this information to improve hand hygiene compliance, and help to prevent the spread of germs. It is important for hospitals to use the information they collect about how staff are cleaning their hands to provide feedback. This feedback should include the staff who were observed and also as s the hospital administration. This tells them if they are doing a good job or need to improve.

These measures are process measures. Process measures look at *how* hospitals work. The goal is for every hospital to have a ‘Yes’ for all three measures.

Data Source

The hand hygiene compliance measures are calculated based on information collected each year from hospitals in Rhode Island. Hospitals answer the following questions:

1. **Does your hospital teach the following prior to direct patient contact?** *(Select all that apply.)*

	Principles of hand hygiene	Proper glove use	Neither
Physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All other clinicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. **Does your hospital teach the following annually?** *(Select all that apply.)*

	Principles of hand hygiene	Proper glove use	Neither
Physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All other clinicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Definitions

To make sure that hospitals answer the above questions the same way, the program has defined some key terms included in the questions. These definitions are:

Key Term/Phrase	Definition
Clinicians	<ul style="list-style-type: none"> ▪ Healthcare workers engaged in direct patient contact, including: <ul style="list-style-type: none"> – Certified nursing assistants (CNAs) – Licensed practical nurses (LPNs) – Registered nurses (RNs) – Physician assistants (PAs) – Nurse practitioners (NPs) – Physicians (MDs and DOs) ▪ Includes clinicians who are hospital employees and also those who are not hospital employees.
Direct patient contact	<ul style="list-style-type: none"> ▪ Any face-to-face interaction with patients.
Executive leadership	<ul style="list-style-type: none"> ▪ High-level hospital administrative staff who run the hospital, including people such as the president and vice president, chief executive officer (CEO), chief financial officer (CFO), chief medical officer (CMO), chief nursing officer (CNO), chief operating officer (COO), and others.
Hand hygiene	<ul style="list-style-type: none"> ▪ A general term that applies to cleaning hands with soap and water or using an antiseptic (e.g., alcohol) hand rub, gel, or foam (e.g., hand sanitizer).
Measuring compliance	<ul style="list-style-type: none"> ▪ The act of collecting data on hand hygiene compliance by collecting data.
Monitoring compliance	<ul style="list-style-type: none"> ▪ The act of using collected data to look at how hospitals' compliance rates change over time (e.g., looking at trends). ▪ May be part of a program or quality improvement initiative to improve the hospital's hand hygiene compliance.
Physicians	<ul style="list-style-type: none"> ▪ Includes both Medical Doctors (MDs) and Doctors of Osteopathy (DOs). ▪ Includes physicians who are hospital employees (e.g., hospitalists) and also those who are not hospital employees, but have direct patient contact with patients at the hospital.
Program to improve rates	<ul style="list-style-type: none"> ▪ A team of staff, usually with different types of experience, who meet regularly to review data, identify improvement opportunities, and implement projects to improve the hospital's performance.



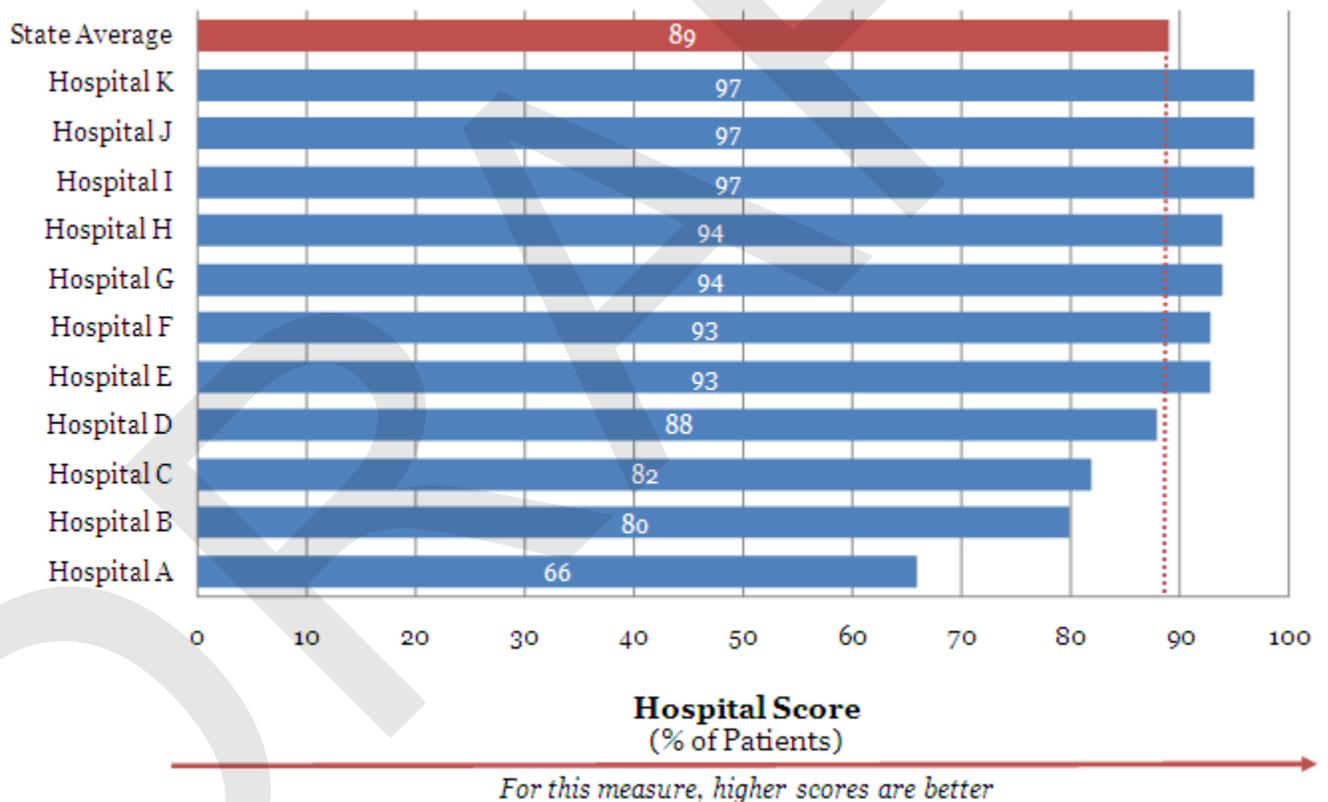
Health Care Quality Performance (HCQP) Program

PRESSURE ULCER PROCESS MEASURES

Data Report

Pressure ulcers (also called “bed sores”) are skin wounds caused by pressure from lying or sitting in one position too long.¹ The pressure ulcer process measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital work. You can learn more about the measures—including how they are calculated and why each is important—by reading the [Technical Page](#) or the Measure Information Forms for [Admission Assessment](#) or [Daily Reassessment](#).

Figure 1: Percent of patients receiving pressure ulcer admission assessment (October 2008-April 2009)

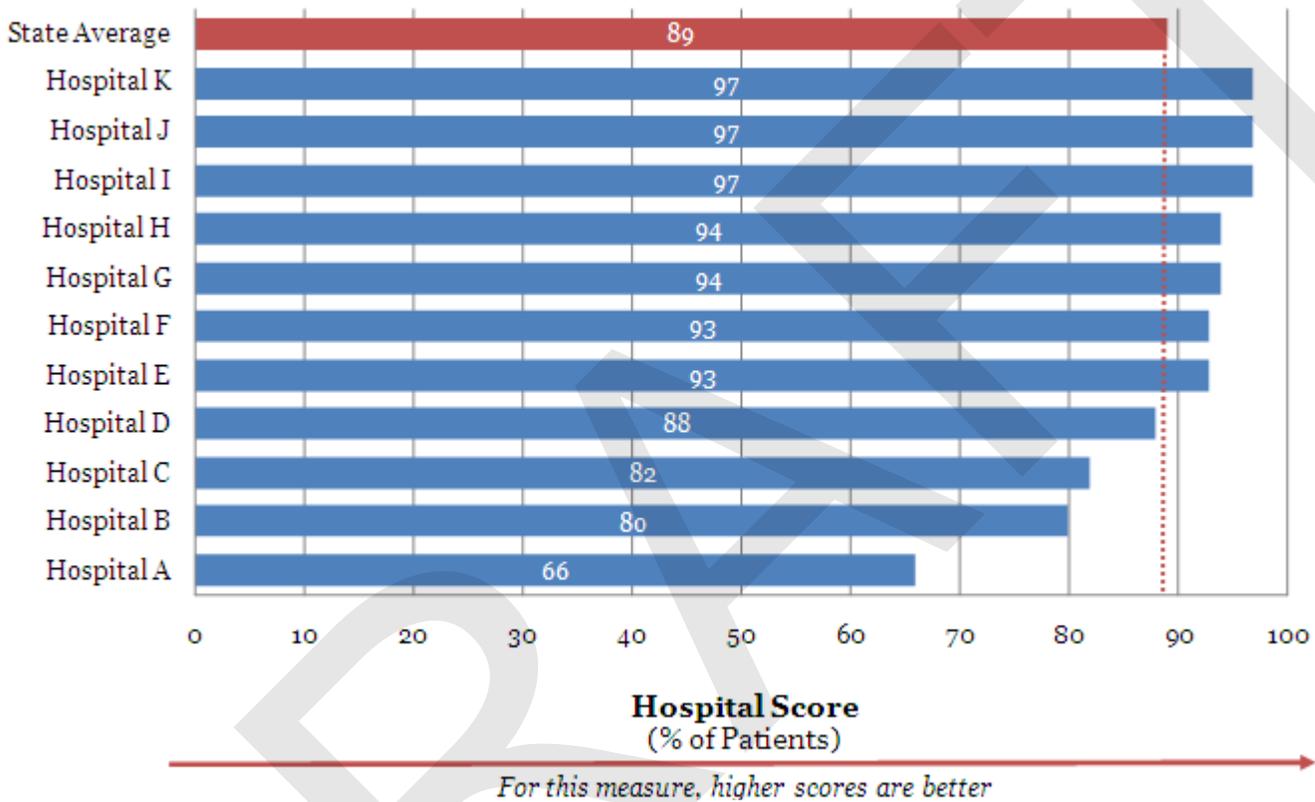


Hospital	Patients Receiving Care	Patients Eligible for Care	Score
Hospital A	XX	XX	XX%
Hospital B	XX	XX	XX%
Hospital C	XX	XX	XX%
Hospital D	XX	XX	XX%
Hospital E	XX	XX	XX%
Hospital F	XX	XX	XX%

¹ Institute for Healthcare Improvement. What you need to know about pressure sores [Available]. Online: http://www.ihl.org/NR/rdonlyres/F2EF9AB3-BB0F-4D3D-A99A-83AC7E0FB0D3/5862/WhatyouneedtoknowPU_1022.pdf, accessed 13 May 2009

Hospital G	XX	XX	XX%
Hospital H	XX	XX	XX%
Hospital I	XX	XX	XX%
Hospital J	XX	XX	XX%
Hospital K	XX	XX	XX%
State Average	XX	XX	XX%

Figure 2: Percent of patients receiving daily pressure ulcer reassessment (October 2008-April 2009)



Hospital	Patients Receiving Care	Patients Eligible for Care	Score
Hospital A	XX	XX	XX%
Hospital B	XX	XX	XX%
Hospital C	XX	XX	XX%
Hospital D	XX	XX	XX%
Hospital E	XX	XX	XX%
Hospital F	XX	XX	XX%
Hospital G	XX	XX	XX%
Hospital H	XX	XX	XX%
Hospital I	XX	XX	XX%
Hospital J	XX	XX	XX%
Hospital K	XX	XX	XX%
State Average	XX	XX	XX%



Health Care Quality Performance (HCQP) Program

PRESSURE ULCER PROCESS MEASURES

Technical Page

Pressure ulcers (also called “bed sores”) are skin wounds caused by pressure from lying or sitting in one position too long.¹ The pressure ulcer process measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital work. The information on this page provides details about the measures, including their data source, how they are calculated, and why each is important.

Data Source

For one day every three months—in October 2008, January 2009, and April 2009—each hospital collected data on two care processes:

- 1. Percent of patients receiving pressure ulcer admission assessment
 - 2. Percent of patients receiving daily pressure ulcer risk reassessment
- } *Higher is better*

These care processes are some ways that doctors and nurses can help prevent pressure ulcers. Pressure ulcers most often occur in bony areas such as the heels, elbows, or buttocks. They can be mild or severe. Millions of people get pressure ulcers each year.

Measure Calculation

For each measure, the score is calculated as follows:

$$\text{Percent of patients} = \frac{\text{(patients receiving indicated care)}}{\text{(all patients who should receive the care)}}$$

The number of patients who receive the indicated care (e.g., a pressure ulcer assessment) is the **numerator**. The number of patients who should receive the care (are eligible for it) is the **denominator**. The percent of patients, or **measure score**, is the numerator divided by the denominator. Hospitals’ measure scores are compared to one another and to the state average.

Some patients are excluded from the measures; for example, if there were admitted too recently. Additional details are available in the Measure Information Forms that the hospitals used to ensure they all collected the same information, in the same way.

Measure Information ([adapted from the Institute for Healthcare Improvement](#))

Measure	Why is this information important?
1. Percent of patients receiving pressure ulcer admission assessment.	When patients are admitted to the hospital, doctors and nurses should (1) evaluate them to see if they are at high-risk for developing pressure ulcers and (2) look at their body to find any pressure ulcers that are already present.
2. Percent of patients receiving daily pressure ulcer risk reassessment.	After a patient is admitted to the hospital, doctors and nurses should look all over a person’s body every day to find any skin changes or sores.

¹ Institute for Healthcare Improvement. What you need to know about pressure sores [Available]. Online: http://www.ihl.org/NR/rdonlyres/F2EF9AB3-BBoF-4D3D-A99A-83AC7EoFB0d3/5862/WhatyouneedtoknowPU_1022.pdf, accessed 13 May 2009



Health Care Quality Performance (HCQP) Program

PERCENT OF PATIENTS RECEIVING PRESSURE ULCER ADMISSION ASSESSMENT

Measure Information Form,¹ last updated 10/01/07

This measure is [reported on the Department of Health's \(HEALTH's\) Web site](#) as part of the HCQP Program's Hospital work. The Hospital Subcommittee detailed the following information, based on measures developed by the Institute for Healthcare Improvement, so that all Rhode Island hospitals would collect the same information, in the same way.

Measure

Intervention(s): Prevent Pressure Ulcers

Definition: The percentage of patients for whom all components of proper pressure admission assessment were performed and documented within 24 hours of an inpatient admission. If a component of the admission assessment was not applied due to a documented contraindication, count it as appropriately performed for the purposes of this measure. Proper pressure ulcer admission assessment includes the following two components:

1. Assessment of pressure ulcer risk using the Braden Scale; and
2. Skin assessment to identify existing pressure ulcers.

Goal: 100%

Calculation Details

Numerator Definition: The number of patients for whom:

- All components of proper pressure admission assessment (Braden Scale and skin assessment to identify existing ulcers) were performed and documented within 24 hours of an inpatient admission; or
- An appropriate contraindication was documented for each component of the admission assessment that was not provided.

Numerator Exclusions: Same as denominator exclusions

Denominator Definition: All patients on the unit during data collection

Denominator Exclusions:

- Patients admitted less than 24 hours prior to data collection
- Patients not on the unit during data collection
- Patients that fall into one of the sampling exclusion categories (p. 2)

¹ Adapted from IHI's document (v01 – 12/12/2006) by the Hospital Workgroup and last updated 10/01/07.

Measurement Period: One day of the hospital's choice per quarter, during a week identified by the Department of Health

Definition of Terms:

- Admission = Admission to an inpatient bed or unit
- All components of proper pressure admission assessment = Assessment of pressure ulcer risk using the Braden Scale and skin assessment to identify existing pressure ulcers
- Appropriate contraindications = Refusal; must be documented in writing in the medical record
- Documented = Written documentation in the medical record (hard copy or electronic medical record)

Calculate as: (numerator / denominator) x 100; as a percent

Collection Strategy

This is an "all-or-none" measure. If either or both of the components are not documented, do not count the patient in the numerator. If a single bundle component (e.g., the risk assessment) is contraindicated for a particular patient and this is documented appropriately in the medical record, count it as appropriately performed for the purposes of measuring compliance.

Sampling Plan

Conduct the sample on one day per quarter, during a week identified by HCQP. Collect data for 100% of the patients who meet the below inclusion criteria and who are on the unit during data collection.

Inclusions:

- All patients who are not in the exclusion category
- Patients admitted 24 or more hours previously

Exclusions: Patients in the following categories:

- Comfort measure only (CMO)
- Emergency Department (ED) only
- Hospice
- Observation only
- Obstetrics-Gynecology
- Palliative care status
- Pediatrics
- Psychiatric



Health Care Quality Performance (HCQP) Program

PERCENT OF PATIENTS RECEIVING DAILY PRESSURE ULCER RISK REASSESSMENT

Measure Information Form,¹ last updated 10/01/07

This measure is [reported on the Department of Health's \(HEALTH's\) Web site](#) as part of the HCQP Program's Hospital work. The Hospital Subcommittee detailed the following information so that all Rhode Island hospitals would collect the same information, in the same way.

Measure

Intervention(s): Prevent Pressure Ulcers

Definition: The percentage of patients for whom a pressure ulcer risk reassessment (using the Braden Scale) was documented as performed daily or with greater frequency (or for whom an appropriate contraindication was documented).

Goal: 100%

Calculation Details

Numerator Definition: The number of patients for whom:

- A pressure ulcer risk reassessment (using the Braden Scale) was documented as performed daily or with greater frequency; or
- An appropriate contraindication was documented.

Numerator Exclusions: Same as denominator exclusions

Denominator Definition: All patients on the unit during data collection

Denominator Exclusions:

- Patients admitted less than 48 hours prior to data collection
- Patients not on the unit during data collection
- Patients that fall into one of the sampling exclusion categories (p. 2)

Measurement Period: One day of the hospital's choice per quarter, during a week identified by the Department of Health

¹ Adapted from IHI's document (v01 – 12/12/2006) by the Hospital Workgroup and last updated 10/01/07.

Definition of Terms:

- Appropriate contraindications = refusal; must be documented in writing in the medical record
- Documented = Written documentation in the medical record (hard copy or electronic medical record)
- Performed daily = Documented in writing in the medical record at least once during the 24 hours preceding data collection (i.e., the time the chart was pulled)

Calculate as:

(numerator / denominator) x 100; as a percent

Collection Strategy

Use the patient medical record as your data source. Review for documentation of pressure ulcer risk assessment within the previous 24 hours. An important aspect of this intervention is the use of standardized forms to ensure that providers track patient pressure ulcer information and status reliably; these forms will also serve as the source of your measure data.

Sampling Plan

Conduct the sample on one day per quarter, during a week identified by the Department of Health. Collect data for 100% of the patients who meet the below inclusion criteria and who are on the unit during data collection.

Inclusions:

- All patients who are not in the exclusion category
- Patients admitted 48 or more hours previously

Exclusions:

Patients in the following categories:

- Comfort measure only (CMO)
- Emergency Department (ED) only
- Hospice
- Observation only
- Obstetrics-Gynecology
- Palliative care status
- Pediatrics
- Psychiatric

From: Rosa Baier
To: Home Health Subcommittee
Subject: HCQP - Home Health Subcommittee, Satisfaction Updates
Date: 4/23/2009 at 1:24 PM

Home Health Subcommittee:

It's been several months since we last met, and we wanted to give you a brief update and let you know that we plan to schedule a meeting in the next 1-2 months.

As a reminder, the Subcommittee's recommendation to collect satisfaction data every 2 years was approved by the Steering Committee last summer. Since then, the Subcommittee has been on hiatus. However, in anticipation of the next round of data collection (Sept-Nov 2009), HEALTH has been working in partnership with Press Ganey to: (1) convey your thoughts and ideas about ensuring a smooth process and working relationship, and (2) prepare for the switch to the HH CAHPS instrument. (All vendors are switching to HH CAHPS this year, as required by CMS.) Jennifer Woods and Karen Voll are our primary contacts at Press Ganey, and are committed to ensuring that you have the information and support you need.

The HH CAHPS questions are being finalized this month (April 2009), in a process that involves consumer focus group testing here in Providence. (This work is unrelated to the Department of Health, but you may hear about the testing or know people who are participating.) Please see the attached memo from Press Ganey about their preparation for using Home Health CAHPS. As soon as the HH CAHPS questions are finalized and Press Ganey has more information about the tool, we will send a 'Save the Date' notice for a meeting. The goal will be to ensure there is plenty of time to ask questions and revise the process, as needed, and that the new survey reflects Rhode Island's needs, and prepare for submission of mailing lists.

In the meantime, please let me, Jennifer (JWoods@pressganey.com), or Karen (kvoll@pressganey.com) know if you have any questions.

Thanks,
Rosa

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Memo

To: Home Health Subcommittee
From: Karen H. Voll, Primary Consultant, Home Health
CC: Rhode Island Department of Health
Date: 4/22/2009
Re: Home Health CAHPS (“HH CAHPS”) Survey Instrument

HH CAHPS Schedule

CMS is not mandating use of the HH CAHPS questions this year, but is offering potential voluntary participation in the HH CAHPS survey process. If CMS has initiated the HH CAHPS voluntary participation process prior to or at the start of your survey process, we can offer you an integrated survey- your current PG questions and the HH CAHPS questions. This integrated survey will allow you to gather HH CAHPS question responses while maintaining your benchmarking for PG questions.

As of this date, 4/21/2009, the actual deployment timeline and protocols for the voluntary use of HH CAHPS have been discussed, but not finalized. The deployment of this process is contingent on a number of factors including but not limited to CMS’s OMB (Office of Management and Budget) approval, modality testing and outcomes and vendor education and certification. We plan to become a certified HH CAHPS vendor to insure we are prepared to offer this service to our clients on day one of the voluntary participation stage.

In addition, we are developing HH CAHPS specific improvement consulting to insure our clients the maximum benefit of their partnership with Press Ganey. We are waiting on CMS to announce firm dates for scheduling/completion of the deployment process and will keep you updated as these steps are finalized. If CMS has not announced the start of voluntary HH CAHPS participation prior to the onset of your survey process, we recommend using the current Press Ganey survey.

Switching to HH CAHPS

Press Ganey has an entire department dedicated to ensuring a smooth transition to the HH CAHPS instrument, and plans to offer an integrated survey to ensure that you continue to receive the benefits of Press Ganey benchmarking and other beneficial report instruments.

While planning ahead as much as possible, Press Ganey is waiting for final survey instrument before moving ahead with HH CAHPS training. Once the questions have been finalized, we will offer an implementation and educational process designed to insure as smooth a transition as possible. This will include an educational binder, Webinar conferences, and other tools.

What HH CAHPS Means for Rhode Island

The Rhode Island Department of Health's (HEALTH's) mandatory survey process is scheduled for September to November 2009 (approximately Labor Day through Thanksgiving). By then, Press Ganey will have completed a HH CAHPS pilot test (currently underway) and have several months' experience with the new survey instrument.

We look forward to a smooth transition into HH CAHPS. If you have any other questions regarding HH CAHPS, please feel free to contact me:

- Karen H. Voll, Primary Consultant, Home Health: 888-773-7742, ext. 326 or kvoll@pressganey.com

Note: The Rhode Island Department of Health's mandatory survey process differs from the proposed HH CAHPS survey process. Based on information available to date, the HH CAHPS process may require surveying throughout the year on a regular basis. This may affect the Home Health Subcommittee's recommendations for public reporting. If you have questions about public reporting specifically, please contact:

- Rosa Baier , Chair of the Home Health Subcommittee: 401-528-3205 or rbaier@riqio.sdps.org
- Samara Viner-Brown, Project Director: 401-222-5122 or samara.viner-brown@health.ri.gov



Health Care Quality Performance (HCQP) Program

NURSING HOME SATISFACTION SURVEY AUDIT METHODS

April 21, 2009, 3:00-4:30pm

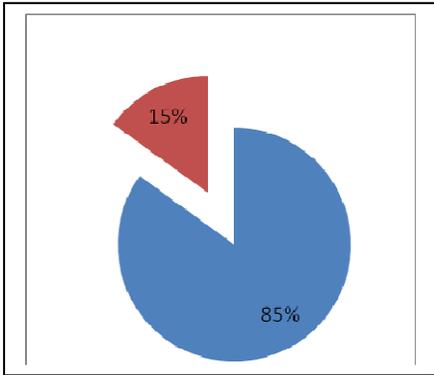
- Assuming that nursing homes do not have every bed filled, we estimated that 85% are currently occupied. This is the **estimated occupancy**.
- Short term care/acute care patients are exempt from the surveys. We estimated that, generally, 30% of the total beds in a facility would be used for short term care/acute care. Estimated occupancy minus short term care beds leaves only the **occupied long term care** beds.
- Nursing homes are expected to send surveys to residents and families of residents in occupied LTC beds.
- In setting benchmarks, we looked at number of surveys **distributed**, not returned—realizing that nursing homes have little control over whether people return their surveys or not.
- For family surveys: we expect that at least half (and hopefully $2/3^{\text{rds}}$) of the families would be sent surveys.
- For resident surveys, we estimated that only 60% of the occupied long term care beds are actually **cognitively intact**. Nursing homes do not need to survey those who are not cognitively intact.
- For resident surveys: we expect that at least half (and hopefully $2/3^{\text{rds}}$) of cognitively intact residents would be sent surveys.

Flowchart: Method of Analysis

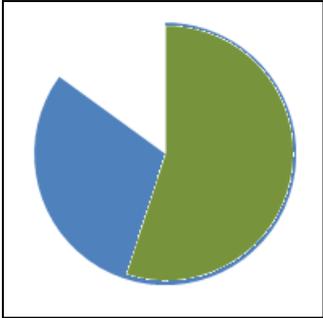
Total beds = 100%

Not all beds are occupied

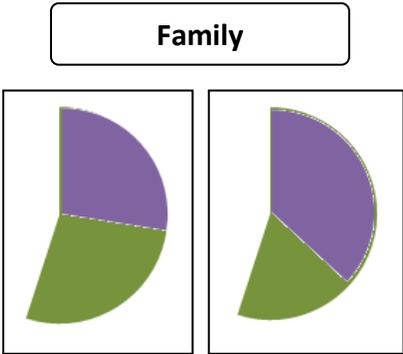
Estimated Occupancy (85% of total beds)



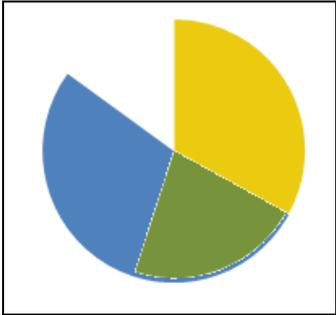
Exclude short term/sub-acute beds (30% of total beds).



Benchmarks
50% and 67% of occupied LTC beds



For residents, exclude another 40% to leave only those who are cognitively intact.



Benchmarks
50% and 67% of occupied LTC beds

Resident

