Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:00am, 12/17/12 at Healthcentric Advisors

Goals/Objectives
▪ To discuss HAI work to date and make policy recommendations for pending and upcoming reports

Members		
✓ Nicole Alexander, MD	✓ Maureen Marsella, RN, BS	✓ Sheila Turner, RN, MA
✓ Rosa Baier, MPH	✓ Linda McDonald, RN	☐ Lee Ann Quinn, RN, BS, CIC
✓ Utpala Bandy, MD	✓ Leonard Mermel, DO, ScM	✓ Janet Robinson, RN, Med, CIC
✓ Marlene Fishman, MPH, CIC	☐ Pat Mastors	✓ Nancy Vallande, MSM, MT, CIC
✓ Yongwen Jiang	☐ Robin Neale, MT (ASCP), SM,CIC	☐ Cindy Vanner
✓ Julie Jefferson, RN, MPH, CIC	☐ Kathleen O'Connell, RN,BSN,CIC	✓ Samara Viner-Brown, MS

Time	Topic/Notes

8:00am **Welcome & Administrative Updates**

Leonard Mermel, DO, ScM

Samara Viner-Brown, MS

- Len opened the meeting and reviewed the agenda topics.
- The group then reviewed the action items from the previous meeting:
  - **Distribute CRE lab survey results** (Nicole/Cindy) – Pending

    Rosa included the CRE lab survey results to the Subcommittee and the CDC; Cindy is planning to update the report to include blinded lab-specific data and then send those results to the lab directors.
  - **Update the *C. difficile* infection (CDI) white paper** (Rosa) – Complete

    Rosa incorporated the group's edits into the CDI white paper.
  - **Send the CDI white paper for the 5-day preview period** (Ann) – Complete

    Ann sent the CDI white paper to the hospitals for review.
  - **Obtain Communications approval for the CDI white paper** (Sam) – Pending

    Communications requested that we use their "Issue Brief" format, so we will incorporate the final CDI (and MRSA CLABSI) content into that format, when we receive it. In the meantime, the white paper format has been published.
  - **Share flu vaccination form discussion results with John Fulton** (Rosa) – Complete

    Rosa outreached to John after the November discussion to share the group's recommendations for aligning the state and NHSN due dates and obtaining the

state data from NHSN directly.

- **Check with John re: the rationale for the 1/15/13 deadline** (Sam) – Pending

  Sam and Rosa did not receive clarification from John, but Dr. Bandy shared that data collection will be administered by Sam's department going forward, and that there will be an interim due date of 1/31/13 and a final due date of 5/15/13 (same as NHSN). The interim data can be the same as the final data, but are important to help HEALTH assess healthcare worker compliance with the new *Rules and Regulations*.

- **Request NHSN rights to access flu vaccination data** (Maureen) – Pending

  Maureen is in the process of obtaining NHSN rights for both flu vaccination and MRSA CLABSI (listed below) from hospitals; she is awaiting conferred rights from two of the 11 hospitals.

- **Request NHSN rights to access MRSA CLABSI** (Maureen) – Pending

  See above. For MRSA CLABSI, Maureen will be able to sort through the MRSA data to identify MRSA CLABSI cases, since pathogen is included in the data.

  The Subcommittee may want to recommend that HEALTH use these data for the MRSA CLABSI report, rather than continue to use SurveyMonkey.

- **Begin reporting ICU level data at the facility level** (Blake)

  Blake is incorporating the facility level and 95% confidence interval methods changes into recurring reports, beginning with the MRSA CLABSI white paper, which should be published today (12/17/12).

- **Begin using 95% confidence intervals for SIR-based reports** (Blake)

  See above.

8:15am **Updates**
Rosa Baier, MPH

- <u>CRE write-up</u>

  Nicole is planning to take the lead authoring a manuscript regarding CRE lab detection methods in Rhode Island, and will begin by summarizing the data for a CSTE Abstract. Nicole will share the Abstract with the group. The CDC is also inviting Rhode Island to participate in a panel discussion about CRE.

- <u>Comparison of CDI vs. Lab ID</u>

  As discussed in November, six of the 11 hospitals submitted Q3 2012 CDI data via the SurveyMonkey link. Rosa will compare these data to the NHSN Lab ID rates, as soon as the NHSN data are available.

- <u>Healthcare worker influenza vaccination data submission</u>

  As discussed above, Dr. Bandy shared that data collection will be administered by Sam's department going forward, and that there will be an interim due date of 1/31/13 and a final due date of 5/15/13 (same as NHSN). The interim data can be the same as the final data, but are important to help HEALTH assess healthcare worker compliance with the new *Rules and Regulations*.

  Note that the state requirement is broader than Medicare's for the current flu season, since Medicare's data collection period doesn't *begin* until January 2013 and Rhode Island's will include the entire 2012-2013 flu season.

- MRSA CLABSI white paper format

  Because the CDI white paper format (i.e., FAQs) proved so popular, we adopted a similar format for the MRSA CLABSI report update. We will update that report to reflect the Communications "Issue Brief" format, when we receive it. In the meantime, the white paper format is expected to be published today (12/17/12).

8:30am **Review Rhode Island HAI Plan**
Rosa Baier, MPH

- The Rhode Island HAI Plan was completed in 2009 and the Subcommittee has not reviewed it since it was submitted to the CDC. Rosa asked the group to review the plan and suggest any updates or changes. Rosa will go through and update the completion dates in the right-hand column.
- The group discussed the Rhode Island HAI Plan, with particular emphasis on expanding it to include nursing homes:
  - Janet shared that HHS's national action plan was recently updated to include long-term care; this group authored a letter in support of that revision. She asked if HEALTH knew how that plan would be implemented at the state level. Although Sam did apply for funds for a nursing home and hospital collaborative, that application was separate from the HHS action plan. HHS has not communicated any information about the long-term care plan).
  - The group recommended that HEALTH consider forming a group to strategize about a Nursing Home HAI Plan, setting forth a road map regarding human and IT resource requirements, educational needs and public reporting plans. Rosa and Sam will share that recommendation with the Steering Committee and the Nursing Home Subcommittee. (The Nursing Home Subcommittee is another of the five workgroups that advise the Steering Committee on public reporting policy and implementation.)

8:45am **Requirement to Inform Patients of Infection Risk**
Rosa Baier, MPH
Pat Masters

- In July, the group discussed the legislative requirement:
  - "The advisory committee shall recommend written guidelines to be given to every individual before and if necessary during their hospitalization for the purpose of preventing hospital-acquired infections. In emergency hospitalizations, written guidelines shall be given within a reasonable period of time." (R.I.G.L. Chapter 23-17.17)
- We also discussed various hospital policies and educational materials, e.g., the Joint Commission's Speak Up campaign.
- Rosa asked the group to consider:
  - How are hospitals measuring compliance?
  - Are there existing data?
  - Should the program consider reporting process measures?
- The group had some preliminary discussion of existing data and the priority for expanding reporting to include such measures, but deferred recommendations until a Pat is able to attend and participate in the discussion.

8:55am **Open Forum & Action Items**
Rosa Baier, MPH

- Rhode Island Hospital data

  Len shared some data that tied in to the above discussion concerning skilled nursing facilities. He noted that from 2006 through 2011, the number of patients infected with extended-spectrum producing microorganisms detected at Rhode Island Hospital increased about four-fold. The majority of this increase involved patients who were from a skilled nursing facility or who had a prior hospitalization at any acute-care facility over the preceding three months.

  Additionally, Len reviewed data collected at Rhode Island Hospital involving rectal swabs of 500 patients admitted from skilled nursing facilities. The data is still being analyzed; but at least 1% and possibly as many as 5% were colonized with a microorganism resistant to carbapenem antibiotics.

- **Action items:**

  - Share the CRE abstract submission with the Subcommittee (Nicole)
  - Compare CDI and LabID data (Rosa/Maureen)
  - Update the Rhode Island HAI Plan completion column (Rosa)
  - Recommend a Nursing Home HAI Plan to the Steering Committee (Sam/Rosa)
  - Continue discussion of reporting patient information about HAI (Subcommittee)

- Rosa asked the group to note the following 2013 meeting dates. All meetings are 8am at Healthcentric Advisors:

  - 1/28*
  - 2/25*
  - 3/18
  - 4/15
  - 5/20
  - 6/17
  - 7/15
  - 8/19
  - 9/16
  - 10/21
  - 11/18
  - 12/16

  *Most of these dates are the third Monday of the month; January and February are exceptions (because of Monday holidays) and are the fourth Monday.

- **Next meeting:** 1/28/13

MRSA Bloodstream Infections *in Rhode Island Hospitals*

What are Methicillin-resistant *Staphylococcus Aureus* (MRSA) bloodstream infections*?*

"MRSA bloodstream infections" are infections where a germ gets into your blood. This germ can enter the body in many ways, like through a catheter, or medical tube in your vein such as a "central line" that you may have when you are very sick in the hospital.

Why should we care about this kind of infection?

Although the number of people with MRSA bloodstream infections is lower than a few years ago, these infections can be dangerous.

Who has the highest chance of getting MRSA bloodstream infections?

You could get MRSA bloodstream infections if you have a catheter in your vein.

What are hospitals doing to protect you?

MRSA bloodstream infections may be prevented, mainly by caring for the catheters in your veins, such as "central lines." Hospitals take steps to prevent MRSA bloodstream infections, like making sure workers clean your skin before putting in a catheter.

Workers should also clean their hands before and after touching you, clean their hands before putting medications in your catheters, and wear gowns and gloves when caring for some patients with infections.

How can we compare the number of people who get MRSA bloodstream infections at each hospital?

Hospitals collect information about MRSA bloodstream infections among patients in their intensive care units. We use that information to give each hospital a single rating that includes all of their intensive care units. This helps you to compare hospitals:

- ♦ **more** than expected
- ♦♦ **about as many** as expected
- ♦♦♦ **fewer** than expected

Why do we compare hospitals using diamonds?

The diamonds help to explain the numbers. It can be hard to make sense of the numbers without knowing what is "good" and what is "bad." Remember, the diamonds are only one piece of information to help you make healthcare choices.

Why do some hospitals do better and some worse?

Hospitals have taken steps to prevent MRSA bloodstream infections. But some hospitals may have more infections than others, even if they provide good care, for example if they:

- Care for more patients at greater risk of infection
- Are more likely to test their patients and find infections

What should you do if you have more questions?

Call 401-222-2577 or visit health.ri.gov and choose "Infection Diseases A to Z List" from "Topics and Programs."

You can also ask your doctors and nurses how to prevent infections.

Hospital (Alphabetical)	*MRSA* Rating*
Kent Hospital	♦♦♦
Landmark Medical Center	♦♦♦
Memorial Hospital	♦♦♦
The Miriam Hospital	♦♦♦
Newport Hospital	♦♦♦
Our Lady of Fatima Hospital	♦♦♦
Rhode Island Hospital	♦♦♦
Roger Williams Medical Center	♦♦♦
South County Hospital	♦♦♦
Westerly Hospital	♦♦♦
Women & Infants Hospital	♦♦♦

♦ **more** than expected, ♦♦ **about as many** as expected, ♦♦♦ **fewer** than expected

* *Compares hospital-associated cases in the intensive care units (ICUs) from Jul-Sep 2012 to national ICU benchmarks from 1997-2007.*

How can you protect yourself and others from MRSA bloodstream infections?

These steps can help:

1. Clean your hands.
2. Wear gowns and gloves when visiting patients with MRSA infections in the hospital.
3. Make sure your doctors and nurses clean their hands before and after touching you in the hospital.

RHODE ISLAND

HEALTHCARE-ASSOCIATED INFECTIONS PLAN

JANUARY 1,2010

Submitted by

The Rhode Island Department of Health

1. Develop or Enhance HAI program infrastructure

Table 1: State infrastructure planning for HAI surveillance, prevention and control.

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Level I			1. Establish statewide HAI prevention leadership through the formation of multidisciplinary group or state HAI advisory council.	
	☒	☐	i. Collaborate with local and regional partners (e.g., state hospital associations, professional societies for infection control and healthcare epidemiology, academic organizations, laboratorians and networks of acute care hospitals and long-term care facilities).	Complete
	☒	☐	ii. Identify specific HAI prevention targets consistent with HHS priorities.	Q1 2010
			Other activities or descriptions (not required): • Rhode Island has an established HAI Subcommittee, comprised of the above stakeholder and provider groups. • The HAI Subcommittee will meet monthly between October and January to finalize the HAI Plan by 12/21/09 and then prioritize ongoing work based on the HHS priorities.	
	☒	☐	2. Establish an HAI surveillance prevention and control program. i. Designate a state HAI Prevention Coordinator.	12/21/09
	☐	☒	iii. Develop dedicated, trained HAI staff with at least one FTE (or contracted equivalent) to oversee the four major HAI activity areas (Integration, Collaboration, and Capacity Building; Reporting, Detection, Response and Surveillance; Prevention; Evaluation, Oversight and Communication).	Q1 2010

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
			Other activities or descriptions (not required): • The Department of Health will identify both internal and external HAI subject matter experts (to ensure a range of clinical and epidemiological skill sets), comprising at least 1.0 FTE. • Rhode Island's contractor for the HAI Plan is Quality Partners of Rhode Island, the state's Quality Improvement Organization (QIO). This enables the state to align the HAI Plan work with the QIOs' HAI and NSHN expertise/focus. Two hospitals are working with Quality Partners to use NHSN (Our Lady of Fatima Hospital and Roger Williams Medical Center).	
	☐	☒	3. Integrate laboratory activities with HAI surveillance, prevention and control efforts. i. Improve laboratory capacity to confirm emerging resistance in HAI pathogens and perform typing where appropriate (e.g., outbreak investigation support, HL7 messaging of laboratory results).	Ongoing
			Other activities or descriptions (not required): • In response to this grant a representative from the state's Special Pathogens Laboratory has joined the HAI Subcommittee and will assist with coordination between the public reporting program and the state laboratories. The Special Pathogens Laboratory conducts regular testing and sends results to the CDC, as appropriate. • Additionally, we propose to accomplish capacity building by standardizing and overseeing hospital laboratory activities through the State Laboratory.	
Level II	☒	☐	4. Improve coordination among government agencies or organizations that share responsibility for assuring or overseeing HAI surveillance, prevention and control (e.g., State Survey Agencies, Communicable Disease Control, State Licensing Boards).	12/21/09

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
			Other activities or descriptions (not required): • The HAI Subcommittee includes Department of Health representatives who are involved in epidemiology, physician licensing, and other activities that help to ensure shared responsibility for HAI surveillance, prevention, and control.	
	☐	☐	5. Facilitate use of standards-based formats (e.g., Clinical Document Architecture, electronic messages) by healthcare facilities for purposes of electronic reporting of HAI data. i. Provide technical assistance or other incentives for implementations of standards-based reporting can help develop capacity for HAI surveillance and other types of public health surveillance, such as for conditions deemed reportable to state and local health agencies using electronic laboratory reporting (ELR). ii. Facilitate use of standards-based solutions for external reporting also can strengthen relationships between healthcare facilities and regional nodes of healthcare information, such as Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs).	n/a n/a
			Other activities or descriptions (not required): • While the Department of Health encourages the use of standards-based formats to ensure interoperability and consistency of HAI and other reporting efforts, this was not part of the scope of work proposed by the Department for this grant. • There is a state HIE in the early stages of implementation. It requires patients to opt-in, and will take time for sufficient patients to accrue in order to make it a useful tool for HAI.	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Please note: • Due to a state fiscal crisis, the state's 11-year-old public reporting program is being eliminated from the current fiscal year's budget, effective 12/31/09. While the HAI Subcommittee, which was established as part of the public reporting program, will continue under the CDC funding, this means that the programmatic oversight and infrastructure in existence when the grant was awarded will be eliminated. As a result, the HAI Subcommittee has updated the HAI Plan to reflect a stand-alone project limited to the CDC funding. Regardless, the state and its providers remain committed to transparency and reporting, and have a long-standing track record and culture of collecting and disseminating data about quality of care and patient satisfaction. • The Department of Health applied for a CDC Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) grant to implement a MDRO Collaborative, with focus topics to include c-diff and MRSA—but was notified in December 2009 that funding was *not* awarded. These funds would have enabled the Department to increase the FTE allocated to Rhode Island HAI efforts. In the absence of this funding, the HAI Plan cannot support and does not propose to expand NHSN use within Rhode Island. The HAI Subcommittee's prioritization and implementation of the HHS targets will reflect this limitation. • Rhode Island has already published two HAI reports: (1) Surgical Care Infection Program (SCIP) Measures I, II, and III; and (2) Central Line-Associated Bloodstream Infections (CLABSI). These reports are updated quarterly. The next HAI report is anticipated to be employee influenza vaccination data, beginning with data from the 2008-2009 flu season. • Rhode Island is the only state in the nation to have 100% of adult ICUs participating in the ICU Collaborative. The multi-year collaborative has achieved significant improvement on measures such as CLABSI, as well as lives saved and cost savings.				

2. Surveillance, Detection, Reporting, and Response

Table 2: State planning for surveillance, detection, reporting, and response for HAIs

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Level I			1. Improve HAI outbreak detection and investigation.	
	☒	☐	i. Work with partners including CSTE, CDC, state legislatures, and providers across the healthcare continuum to improve outbreak reporting to state health departments.	Ongoing
	☒	☐	ii. Establish protocols and provide training for health department staff to investigate outbreaks, clusters or unusual cases of HAIs.	Ongoing
	☒	☐	iii. Develop mechanisms to protect facility/provider/ patient identity when investigating incidents and potential outbreaks during the initial evaluation phase where possible to promote reporting of outbreaks.	Ongoing
	☒	☐	iv. Improve overall use of surveillance data to identify and prevent HAI outbreaks or transmission in HC settings (e.g., hepatitis B, hepatitis C, multi-drug resistant organisms [MDRO], and other reportable HAIs).	Ongoing
			Other activities or descriptions (not required): • Surveillance is currently done daily by hospital Infection Control Practitioners (ICPs), with results reported to the state's epidemiologists. The HAI Subcommittee will work with the epidemiologists to learn what is reported, at what thresholds, and what steps are followed, as well as to explore guidelines for non-reportable infections.	
	☐	☐	2. Enhance laboratory capacity for state and local detection and response to new and emerging HAI issues.	n/a

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
			Other activities or descriptions (not required): • Without additional staff and funding, enhanced laboratory capacity is not possible within the Department. The state is currently in a fiscal crisis, with hiring freezes and budget cuts.	
Level II	☒	☐	3. Improve communication of HAI outbreaks and infection control breaches. i. Develop standard reporting criteria including, number, size and type of HAI outbreak for health departments and CDC.	Complete
	☒	☐	ii. Establish mechanisms or protocols for exchanging information about outbreaks or breaches among state and local governmental partners (e.g., State Survey agencies, Communicable Disease Control, state licensing boards).	Complete
			Other activities or descriptions (not required): • Guidelines for these activities exist and will be shared by the Department of Health with the HAI Subcommittee. As mentioned previously, surveillance is currently done daily in hospital Infection Control Practitioners (ICPs), with results reported to the state's epidemiologists.	
			4. Identify at least 2 priority prevention targets for surveillance in support of the HHS HAI Action Plan.	1/25/10 to prioritize among topics
	☒	☐	i. Central Line-Associated Bloodstream Infections (CLABSI)	
	☐	☐	ii. *Clostridium difficile* Infections (CDI)	
	☐	☐	iii. Catheter-associated Urinary Tract Infections (CAUTI)	
	☒	☐	iv. Methicillin-resistant Staphylococcus aureus (MRSA) Infections	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
	☒	☐	v. Surgical Site Infections (SSI) [via Surgical Care Infection Program (SCIP) Measures I, II, and III – **not NHSN**]	
	☒	☐	vi. Ventilator-associated Pneumonia (VAP) (via the ICU Collaborative)	
			Other activities or descriptions (not required): • Rhode Island has an established HAI Subcommittee that has begun prioritizing HAI reporting topics and will expand its existing work to identify at least two HHS priority topics from the above list. However, in light of the fact that Rhode Island's recent application for ELC funding to implement a MDRO Collaborative was denied, the HAI Plan cannot support and does not propose to expand NHSN use within Rhode Island. The HAI Subcommittee's prioritization, implementation of, and measurement of the HHS targets will reflect this limitation. • The HAI Subcommittee met monthly between October and December 2009 to finalize the HAI Plan and will begin to meet in January 2010 to finalize prioritization of ongoing work based on the HHS priorities. • As mentioned previously, the public reporting program has already published two HAI reports: (1) Surgical Care Infection Program (SCIP) Measures I, II, and III; and (2) Central Line-Associated Bloodstream Infections (CLABSI). These reports are updated quarterly. The next HAI report will be employee influenza vaccination data, beginning with data from the 2008-2009 flu season. Please note that none of these reports use NHSN reporting or data. • The ICU Collaborative participants (all adult ICUs) submit and monitor VAP through the Collaborative's reporting system, not NHSN.	
			5. Adopt national standards for data and technology to track HAIs (e.g., NHSN).	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
	☐	☒	i. Develop metrics to measure progress towards national goals (align with targeted state goals). (See Appendix 1.)	Incremental, beginning Q1 2010
	☐	☒	ii. Establish baseline measurements for prevention targets.	(see note)
			Other activities or descriptions (not required): • Rhode Island's contractor for the HAI Plan is Quality Partners, the state's QIO, which is currently working with select hospitals on NHSN reporting. This enables the state to leverage existing NSHN training/ expertise for hospitals currently enrolled in NHSN or planning to implement it. • That said, the expansion of NHSN reporting and use of it to establish a baseline was contingent upon the Department's receipt of additional ELC funding to form a 12-month MDRO Collaborative and provide hospitals with technical assistance and support to register with and/or expand their use of NHSN. In light of the fact that Rhode Island's application was denied, the HAI Plan cannot support and does not propose to expand NHSN use within Rhode Island. The HAI Subcommittee's prioritization, implementation of, and measurement strategies for the HHS targets will reflect this limitation.	
	☐	☐	6. Develop state surveillance training competencies. i. Conduct local training for appropriate use of surveillance systems (e.g., NHSN) including facility and group enrollment, data collection, management, and analysis.	n/a

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
			Other activities or descriptions (not required): • Rhode Island's contractor for the HAI Plan is Quality Partners, the state's QIO, which is currently working with two hospitals on NHSN reporting (Our Lady of Fatima Hospital and Roger Williams Medical Center). Quality Partners' experience enables the State to leverage existing NSHN training/expertise. • Two additional hospitals, Rhode Island Hospital and Women and Infants' Hospital, have also begun using select NHSN modules.	
	☒	☐	7. Develop tailored reports of data analyses for state or region prepared by state personnel.	Quarterly
			Other activities or descriptions (not required): • Rhode Island's 11-year-old public reporting mandate (which will be unfunded beginning 1/1/10) uses a stakeholder-guided consensus process to develop and disseminate public reporting formats. The Department of Health will use the HAI Subcommittee to fulfill the above objective. • HAI reporting is already underway, with SCIP, CLABSI, and employee influenza vaccination measures published regularly.	
Level III			8. Validate data entered into HAI surveillance (e.g., through healthcare records review, parallel database comparison) to measure accuracy and reliability of HAI data collection.	
	☐	☐	i. Develop a validation plan.	n/a
	☐	☐	ii. Pilot test validation methods in a sample of healthcare facilities.	n/a
	☐	☐	iii. Modify validation plan and methods in accordance with findings from pilot project.	n/a

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
	☐	☐	iv. Implement validation plan and methods in all healthcare facilities participating in HAI surveillance.	n/a
	☐	☐	v. Analyze and report validation findings.	n/a
	☐	☐	vi. Use validation findings to provide operational guidance for healthcare facilities that targets any data shortcomings detected.	n/a
			Other activities or descriptions (not required): • These activities are not included under Part A funding.	
			9. Develop preparedness plans for improved response to HAI.	
	☒	☐	i. Define processes and tiered response criteria to handle increased reports of serious infection control breaches (e.g., syringe reuse), suspect cases/clusters, and outbreaks.	Complete
			Other activities or descriptions (not required): • Guidelines for these activities exist within the Department of Facilities Regulations at the Department of Health, and will be shared with the HAI Subcommittee.	
	☒	☐	10. Collaborate with professional licensing organizations to identify and investigate complaints related to provider infection control practice in non-hospital settings, and to set standards for continuing education and training.	Ongoing
			11. Adopt integration and interoperability standards for HAI information systems and data sources.	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
	☐	☒	i. Improve overall use of surveillance data to identify and prevent HAI outbreaks or transmission in HC settings (e.g., hepatitis B, hepatitis C, multi-drug resistant organisms (MDRO), and other reportable HAIs) across the spectrum of inpatient and outpatient healthcare settings.	Ongoing
	☐	☒	ii. Promote definitional alignment and data element standardization needed to link HAI data across the nation.	Ongoing
			Other activities or descriptions (not required): • Surveillance is currently done daily by hospital Infection Control Practitioners (ICPs), with results reported to the state's epidemiologists. As discussed previously, the HAI Subcommittee will work with the epidemiologists to learn what is reported, at what thresholds, and what steps follow, as well as to explore guidelines for non-reportable infections. • Improved use of the surveillance data will result from the inclusion of Dr. Utalpa Bandy, state epidemiologist, and Cindy Vanner, from the state's Special Pathogens Laboratory, on the HAI Subcommittee. They will assist with coordination between the public reporting program and the state epidemiology and laboratory work.	
			12. Enhance electronic reporting and information technology for healthcare facilities to reduce reporting burden and increase timeliness, efficiency, comprehensiveness, and reliability of the data.	
	☒	☐	i. Report HAI data to the public.	Ongoing

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
			Other activities or descriptions (not required): • Rhode Island has a long-standing public reporting mandate and, as mentioned previously, has already published two HAI reports: (1) Surgical Care Infection Program (SCIP) Measures I, II, and III; and (2) Central Line-Associated Bloodstream Infections (CLABSI). These reports are updated quarterly. The next HAI report will be employee influenza vaccination data, beginning with data from the 2008-2009 flu season.	
	☒	☐	13. Make available risk-adjusted HAI data that enables state agencies to make comparisons between hospitals.	Ongoing
			Other activities or descriptions (not required): • Rhode Island has a long-standing public reporting mandate, although the public reporting program (as noted previously) will be eliminated from state funding on 12/31/09. The program reports risk-adjusted clinical quality measures and patient satisfaction to enable healthcare consumers, providers, and other stakeholders to make between-facility comparisons. • HAI reporting is already underway, with SCIP and CLABSI published regularly, and employee influenza vaccination reporting planned. Please note that none of these reports use NHSN reporting or data.	
	☐	☐	14. Enhance surveillance and detection of HAIs in non-hospital settings.	
			Other activities or descriptions (not required): • This activity is not included under Part A funding, although physician reporting of reportable HAIs is mandated.	

3. Prevention

Table 3: State planning for HAI prevention activities

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Level I	☒	☐	1. Implement HICPAC recommendations. i. Develop strategies for implementation of HICPAC recommendations for at least 2 prevention targets specified by the state multidisciplinary group.	Q1 2010
			Other activities or descriptions (not required): • The HAI Subcommittee will prioritize the HHS prevention targets and identify measurement strategies for those targets selected for implementation (e.g., hand hygiene process measures for MRSA containment). • However, in light of the fact that Rhode Island's recent application for ELC funding to implement a MDRO Collaborative was denied, the HAI Plan cannot support and does not propose to expand NHSN use within Rhode Island. The HAI Subcommittee's prioritization, implementation of, and measurement strategies for the HHS targets will reflect this limitation.	
	☐	☐	2. Establish prevention working group under the state HAI advisory council to coordinate the state HAI collaborative. i. Assemble expertise to consult, advise, and coach inpatient healthcare facilities involved in HAI prevention collaborative.	n/a
			Other activities or descriptions (not required): • The Department of Health did not propose a HAI prevention collaborative as part of the grant application. This work is not funded. • Rhode Island HAI Subcommittee already exists and is comprised of the above stakeholder and provider groups.	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
			3. Establish HAI collaboratives with at least 10 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions).	
	☐	☐	i. Identify staff trained in project coordination, infection control, and collaborative coordination.	n/a
	☐	☐	ii. Develop a communication strategy to facilitate peer-to-peer learning and sharing of best practices.	n/a
	☐	☐	iii. Establish and adhere to feedback of a clear and standardized outcome data to track progress.	n/a
			Other activities or descriptions (not required): • The Department of Health did not propose a HAI prevention collaborative as part of this grant application. This work is not funded. • The Department of Health will identify both internal and external HAI subject matter experts, to ensure a range of clinical and epidemiological skill sets, comprising at least 1.0 FTE.	
	☐	☐	4. Develop state HAI prevention training competencies. i. Consider establishing requirements for education and training of healthcare professionals in HAI prevention (e.g., certification requirements, public education campaigns and targeted provider education) or work with healthcare partners to establish best practices for training and certification.	n/a
			Other activities or descriptions (not required): • The HAI Subcommittee will review the state's education and training standards and consider any opportunities for alignment with national standards, but this work is not specifically funded under the CDC grant.	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Level II			5. Implement strategies for compliance to promote adherence to HICPAC recommendations.	
	☐	☐	i. Consider developing statutory or regulatory standards for healthcare infection control and prevention or work with healthcare partners to establish best practices to ensure adherence.	n/a
	☐	☐	ii. Coordinate/liaise with regulation and oversight activities such as inpatient or outpatient facility licensing/accrediting bodies and professional licensing organizations to prevent HAIs.	n/a
	☐	☐	iii. Improve regulatory oversight of hospitals, enhancing surveyor training and tools, and adding sources and uses of infection control data.	n/a
	☐	☐	iv. Consider expanding regulation and oversight activities to currently unregulated settings where healthcare is delivered or work with healthcare partners to establish best practices to ensure adherence.	n/a
			Other activities or descriptions (not required): • The HAI Subcommittee is comprised of Infection Control Practitioners (ICPs), hospital staff, Department staff, and other stakeholders with vested interests in limiting HAI in Rhode Island. These Subcommittee members will assist with establishing collaborative partnerships and policies and procedures that further reduce HAI in the state, although this work is not specifically funded by the CDC grant.	
	☐	☐	6. Enhance prevention infrastructure by increasing joint collaboratives with at least 20 hospitals (i.e., this may require a multi-state or regional collaborative in low population density regions)	
			Other activities or descriptions (not required): • The Department of Health did not propose a HAI prevention collaborative as part of the grant application. This work is not funded.	n/a

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
	☐	☐	7. Establish collaborative to prevent HAIs in nonhospital settings (e.g., long term care, dialysis)	n/a
			Other activities or descriptions (not required): • The Department of Health did not propose a HAI prevention collaborative as part of the grant application. This work is not funded.	

Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.

- The Department of Health applied for a CDC Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) grant to implement a 12-month MDRO Collaborative. If funded, this project would have aligned with the existing state HAI Plan and ongoing public reporting work, and would have provided a mechanism for the Department to expand the Plan to include the activities listed in Table 3. Unfortunately, this application for funding was denied.

4. Evaluation and Communications

Table 4: State HAI communication and evaluation planning

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Level I			1. Conduct needs assessment and/or evaluation of the state HAI program to learn how to increase impact.	
	☐	☒	i. Establish evaluation activity to measure progress towards targets, and	Q1 2010
	☐	☒	ii. Establish systems for refining approaches based on data gathered.	Q2 2011
			Other activities or descriptions (not required): • The HAI Subcommittee will continually review the publicly reported data to observe trends and make recommendations to the Department and, possibly, to the hospitals. Please note that this funding does not establish a MDRO Collaborative to specifically implement, measure, or refine improvement strategies.	
	☐	☒	2. Develop and implement a communication plan about the state's HAI program and progress to meet public and private stakeholders' needs. i. Disseminate state priorities for HAI prevention to healthcare organizations, professional provider organizations, governmental agencies, non-profit public health organizations, and the public.	Q2 2010
			Other activities or descriptions (not required): • Rhode Island's established HAI Subcommittee is comprised of the above stakeholder and provider groups, and often outreaches to Infection Control Practitioners (ICPs) and others in the state with an interest in HAI surveillance and prevention. The communication plan will enable more formal dissemination of information.	

Planning Level	Underway	Planned	Items Planned for Implementation	Target Dates
Level II	☒	☐	3. Provide consumers access to useful healthcare quality measures.	Ongoing
			Other activities or descriptions (not required): • Rhode Island's public reporting program (which will be eliminated from funding on 12/31/09) publishes information on healthcare quality, including clinical outcomes and patient satisfaction, on the Department of Health's website. The HAI Subcommittee's work to date is included there. As a result of the funding Rhode Island received for Activity A, some level of public reporting will be continued for HAI.	
Level III	☒	☐	4. Identify priorities and provide input to partners to help guide patient safety initiatives and research aimed at reducing HAIs.	Ongoing
			Other activities or descriptions (not required): • Rhode Island's contractor for the HAI Plan is Quality Partners of Rhode Island, the state's Quality Improvement Organization (QIO), which is implementing Medicare's National Patient Safety Initiative (NPSI) with local nursing homes and hospitals. The NPSI work in the hospital setting involves improving MRSA rates. • However, in light of the fact that Rhode Island's recent application for ELC funding to implement a MDRO Collaborative was denied, the HAI Plan cannot support and does not propose to expand NHSN use within Rhode Island. The HAI Subcommittee's prioritization, implementation of, and measurement of the HHS targets will reflect this limitation.	

Appendix 1.

The HHS Action plan identifies metrics and 5-year national prevention targets. These metrics and prevention targets were developed by representatives from various federal agencies, the Healthcare Infection Control Practices Advisory Committee (HICPAC), professional and scientific organizations, researchers, and other stakeholders. The group of experts was charged with identifying potential targets and metrics for six categories of healthcare-associated infections:

- Central Line-associated Bloodstream Infections (CLABSI)
- Clostridium difficile Infections (CDI)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Methicillin-resistant Staphylococcus aureus (MRSA) Infections
- Surgical Site Infections (SSI)
- Ventilator-associated Pneumonia (VAP)

Following the development of draft metrics as part of the HHS Action Plan in January 2009, HHS solicited comments from stakeholders for review.

Stakeholder feedback and revisions to the original draft Metrics

Comments on the initial draft metrics published as part of the HHS Action Plan in January 2009 were reviewed and incorporated into revised metrics. While comments ranged from high level strategic observations to technical measurement details, commenters encouraged established baselines, both at the national and local level, use of standardized definitions and methods, engagement with the National Quality Forum, raised concerns regarding the use of a national targets for payment or accreditation purposes and of the validity of proposed measures, and would like to have both a target rate and a percent reduction for all metrics. Furthermore, commenters emphasized the need for flexibility in the metrics, to accommodate advances in electronic reporting and information technology and for advances in prevention of HAIs, in particular ventilator-associated pneumonia.

To address comments received on the Action Plan Metrics and Targets, proposed metrics have been updated to include source of metric data, baselines, and which agency would coordinate the measure. To respond to the requests for percentage reduction in HAIs in addition to HAI rates, a new type of metric, the standardized infection ratio (SIR), is being proposed. Below is a detailed technical description of the SIR.

To address concerns regarding validity, HHS is providing funding, utilizing Recovery Act of 2009 funds, to CDC to support states in validating NHSN-related measures and to support reporting on HHS metrics through NHSN. Also, most of the reporting metrics outlined here have already been endorsed by NQF and for population-based national measures on MRSA and *C. difficile*, work to

develop hospital level measures will be conducted in the next year utilizing HHS support to CDC through funds available in the Recovery Act.

Finally, to address concerns regarding flexibility in accommodating new measures, reviewing progress on current measures, and incorporating new sources of measure data (e.g., electronic data, administrative data) or new measures, HHS and its constituent agencies will commit to an annual review and update of the HHS Action Plan Targets and Metrics.

Below is a table of the revised metrics described in the HHS Action plan. Please select items or add additional items for state planning efforts.

Metric Number and Label	Original HAI Elimination Metric	HAI Comparison Metric	Measurement System	National Baseline Established (State Baselines Established)	National 5-Year Prevention Target	Coordinator of Measurement System	Is the metric NQF endorsed?
1. CLABSI 1	CLABSIs per 1000 device days by ICU and other locations	CLABSI SIR	CDC NHSN Device-Associated Module	2006-2008 (Proposed 2009, in consultation with states)	Reduce the CLABSI SIR by at least 50% from baseline or to zero in ICU and other locations	CDC	Yes*
2. CLIP 1 (formerly CLABSI 4)	Central line bundle compliance	CLIP Adherence percentage	CDC NHSN CLIP in Device-Associated Module	2009 (Proposed 2009, in consultation with states)	100% adherence with central line bundle	CDC	Yes†
3a. C diff 1	Case rate per patient days; administrative/discharge data for ICD-9 CM coded *Clostridium difficile* Infections	Hospitalizations with *C. difficile* per 1000 patient discharges	Hospital discharge data	2008 (Proposed 2008, in consultation with states)	At least 30% reduction in hospitalizations with *C. difficile* per 1000 patient discharges	AHRQ	No
3b. C diff 2 (New)		*C. difficile* SIR	CDC NHSN MDRO/CDAD Module LabID‡	2009-2010	Reduce the facility-wide healthcare facility-onset *C. difficile* LabID event SIR by at least 30% from baseline or to zero	CDC	No

Metric Number and Label	Original HAI Elimination Metric	HAI Comparison Metric	Measurement System	National Baseline Established (State Baselines Established)	National 5-Year Prevention Target	Coordinator of Measurement System	Is the metric NQF endorsed?
4. CAUTI 2	# of symptomatic UTI per 1,000 urinary catheter days	CAUTI SIR	CDC NHSN Device-Associated Module	2009 for ICUs and other locations 2009 for other hospital units (Proposed 2009, in consultation with states)	Reduce the CAUTI SIR by at least 25% from baseline or to zero in ICU and other locations	CDC	Yes*
5a. MRSA 1	Incidence rate (number per 100,000 persons) of invasive MRSA infections	MRSA Incidence rate	CDC EIP/ABCs	2007-2008 (for non-EIP states, MRSA metric to be developed in collaboration with EIP states)	At least a 50% reduction in incidence of healthcare-associated invasive MRSA infections	CDC	No
5b. MRSA 2 (New)		MRSA bacteremia SIR	CDC NHSN MDRO/CDAD Module LabID‡	2009-2010	Reduce the facility-wide healthcare facility-onset MRSA bacteremia LabID event SIR by at least 25% from baseline or to zero	CDC	No
6. SSI 1	Deep incision and organ space infection rates using NHSN definitions (SCIP procedures)	SSI SIR	CDC NHSN Procedure-Associated Module	2006-2008 (Proposed 2009, in consultation with states)	Reduce the admission and readmission SSI§ SIR by at least 25% from baseline or to zero	CDC	Yes¶
7. SCIP 1 (formerly SSI 2)	Adherence to SCIP/NQF infection process measures	SCIP Adherence percentage	CMS SCIP	To be determined by CMS	At least 95% adherence to process measures to prevent surgical site infections	CMS	Yes

* NHSN SIR metric is derived from NQF-endorsed metric data
† NHSN does not collect information on daily review of line necessity, which is part of the NQF
‡ LabID, events reported through laboratory detection methods that produce proxy measures for infection surveillance
§ Inclusion of SSI events detected on admission and readmission reduces potential bias introduced by variability in post-discharge surveillance efforts
¶ The NQF-endorsed metric includes deep wound and organ space SSIs only which are included the target.

Understanding the Relationship between HAI Rate and SIR Comparison Metrics

The Original HAI Elimination Metrics listed above are very useful for performing evaluations. Several of these metrics are based on the science employed in the NHSN. For example, metric #1 (CLABSI 1) for CLABSI events measures the number of CLABSI events per 1000 device (central line) days by ICU and other locations. While national aggregate CLABSI data are published in the annual NHSN Reports these rates must be stratified by types of locations to be risk-adjusted. This scientifically sound risk-adjustment strategy creates a practical challenge to summarizing this information nationally, regionally or even for an individual healthcare facility. For instance, when comparing CLABSI rates, there may be quite a number of different types of locations for which a CLABSI rate could be reported. Given CLABSI rates among 15 different types of locations, one may observe many different combinations of patterns of temporal changes. This raises the need for a way to combine CLABSI rate data across location types.

A standardized infection ratio (SIR) is identical in concept to a standardized mortality ratio and can be used as an indirect standardization method for summarizing HAI experience across any number of stratified groups of data. To illustrate the method for calculating an SIR and understand how it could be used as an HAI comparison metric, the following example data are displayed below:

Risk Group Stratifier	Observed CLABSI Rates			NHSN CLABSI Rates for 2008 (Standard Population)		
Location Type	#CLABSI	#Central line-days	CLABSI rate*	#CLABSI	#Central line-days	CLABSI rate*
ICU	170	100,000	1.7	1200	600,000	2.0
WARD	58	58,000	1.0	600	400,000	1.5

$$SIR = \frac{observed}{expected} = \frac{170+58}{100000\times\left(\frac{2}{1000}\right)+58{,}000\times\left(\frac{1.5}{1000}\right)} = \frac{228}{200+87} = \frac{228}{287} = 0.79$$

95%CI = (0.628,0.989)

*defined as the number of CLABSIs per 1000 central line-days

In the table above, there are two strata to illustrate risk-adjustment by location type for which national data exist from NHSN. The SIR calculation is based on dividing the total number of observed CLABSI events by an "expected" number using the CLABSI rates from the standard population. This "expected" number is calculated by multiplying the national CLABSI rate from the standard population by the observed number of central line-days for each stratum, which can also be understood as a prediction or projection. If the observed data represented a follow-up period such as 2009 one would state that an SIR of 0.79 implies that there was a 21% reduction in CLABSIs overall for the nation, region or facility.

The SIR concept and calculation is completely based on the underlying CLABSI rate data that exist across a potentially large group of strata. Thus, the SIR provides a single metric for performing comparisons rather than attempting to perform multiple comparisons across many strata, which makes the task cumbersome. Given the underlying CLABSI rate data, one retains the option to perform comparisons within a particular set of strata where observed rates may

differ significantly from the standard populations. These types of more detailed comparisons could be very useful and necessary for identifying areas for more focused prevention efforts.

The National 5-year prevention target for metric #1 could be implemented using the concept of an SIR equal to 0.25 as the goal. That is, an SIR value based on the observed CLABSI rate data at the 5-year mark could be calculated using NHSN CLABSI rate data stratified by location type as the baseline to assess whether the 75% reduction goal was met. There are statistical methods that allow for calculation of confidence intervals, hypothesis testing and graphical presentation using this HAI summary comparison metric called the SIR.

The SIR concept and calculation can be applied equitably to other HAI metrics list above. This is especially true for HAI metrics for which national data are available and reasonably precise using a measurement system such as the NHSN. The SIR calculation methods differ in the risk group stratification only. To better understand metric #6 (SSI 1) see the following example data and SIR calculation:

Risk Group Stratifiers		**Observed SSI Rates**			**NHSN SSI Rates for 2008 (Standard Population)**		
Procedure Code	**Risk Index Category**	**#SSI†**	**#procedures**	**SSI rate***	**#SSI†**	**#procedures**	**SSI rate***
CBGB	1	315	12,600	2.5	2100	70,000	3.0
CBGB	2,3	210	7000	3.0	1000	20,000	5.0
HPRO	1	111	7400	1.5	1020	60,000	1.7

$$\text{SIR} = \frac{\text{observed}}{\text{expected}} = \frac{315+210+111}{12600\times\left(\frac{3.0}{100}\right)+7000\times\left(\frac{5.0}{100}\right)+7400\left(\frac{1.7}{100}\right)} = \frac{636}{378+350+125.8} = \frac{636}{853.8} = 0.74 \qquad 95\%\text{CI} = (0.649, 0.851)$$

† SSI, surgical site infection

* defined as the number of deep incision or organ space SSIs per 100 procedures

This example uses SSI rate data stratified by procedure and risk index category. Nevertheless, an SIR can be calculated using the same calculation process as for CLABSI data except using different risk group stratifiers for these example data. The SIR for this set of observed data is 0.74 which indicates there's a 26% reduction in the number of SSI events based on the baseline NHSN SSI rates as representing the standard population. Once again, these data can reflect the national picture at the 5-year mark and the SIR can serve as metric that summarizes the SSI experience into a single comparison.

There are clear advantages to reporting and comparing a single number for prevention assessment. However, since the SIR calculations are based on standard HAI rates among individual risk groups there is the ability to perform more detailed comparisons within any individual risk group should the need arise. Furthermore, the process for determining the best risk-adjustment for any HAI rate data is flexible and always based on more detailed risk factor analyses that provide ample scientific rigor supporting any SIR calculations. The extent to which any HAI rate data can be risk-adjusted is obviously related to the detail and volume of data that exist in a given measurement system.

In addition to the simplicity of the SIR concept and the advantages listed above, it's important to note another benefit of using an SIR comparison metric for HAI data. If there was need at any level of aggregation (national, regional, facility-wide, etc.) to combine the SIR values across mutually exclusive data one could do so. The below table demonstrates how the example data from the previous two metric settings could be summarized.

	Observed HAIs			**Expected HAIs**		
HAI Metric	**#CLABSI**	**#SSI†**	**#Combined HAI**	**#CLABSI**	**#SSI†**	**#Combined HAI**
CLABSI 1	228			287		
SSI 1		636			853.8	
Combined HAI			228 + 636 = 864			287+853.8 = 1140.8

$$\text{SIR} = \frac{\text{observed}}{\text{expected}} = \frac{228+636}{287+853.8} = \frac{864}{1140.8} = 0.76 \qquad 95\%\text{CI} = (0.673, 0.849)$$

† SSI, surgical site infection

RHODE ISLAND

2012

EXECUTIVE SUMMARY

Prepared by

MY INNERVIEW

BECAUSE KNOWING MORE MATTERS MOST™

This report provides information needed to initiate quality improvement efforts, track referral sources, improve staff recruitment and retention, and evaluate outcomes of previous initiatives.

Includes:

RESIDENT SATISFACTION

FAMILY SATISFACTION

EMPLOYEE SATISFACTION

Published date: December 6, 2012

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WHAT'S INSIDE

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RESIDENT SATISFACTION

	2012	2011	2010
RESPONSE RATE	62%	65%	61%
FACILITIES SURVEYED	83	84	89
SURVEYS RECEIVED	2,125	2,040	1,909

MY INNERVIEW
BECAUSE KNOWING MORE MATTERS MOST™

RHODE ISLAND

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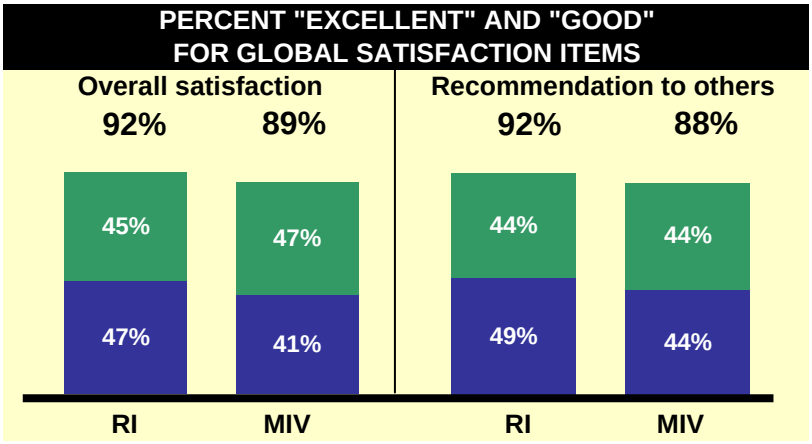
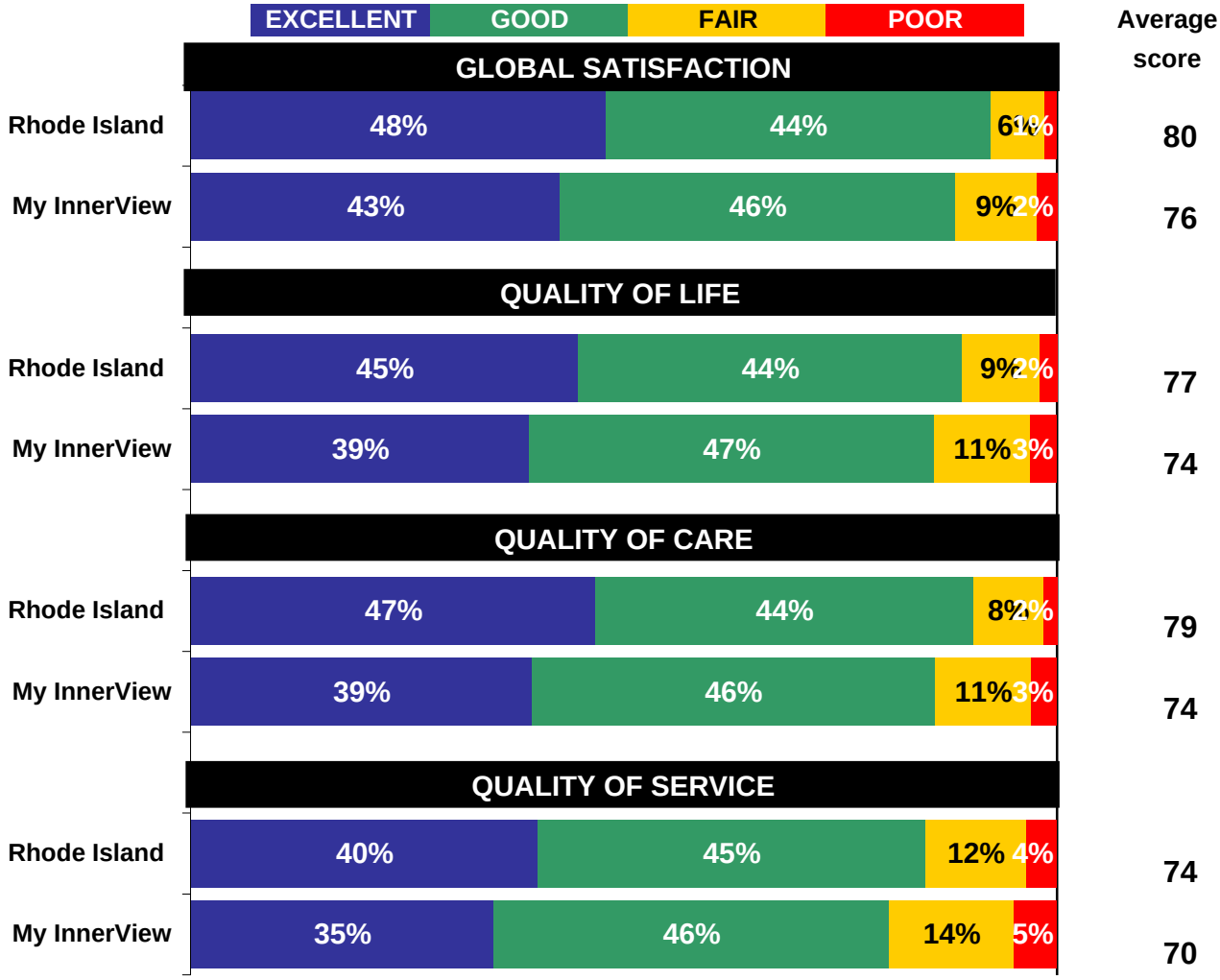
RESIDENT SATISFACTION

GLOBAL SATISFACTION AND RATINGS BY DOMAIN FOR 2012



(The total percentage listed may be higher or lower than individual rating totals due to rounding)



(May not total 100% due to rounding.)

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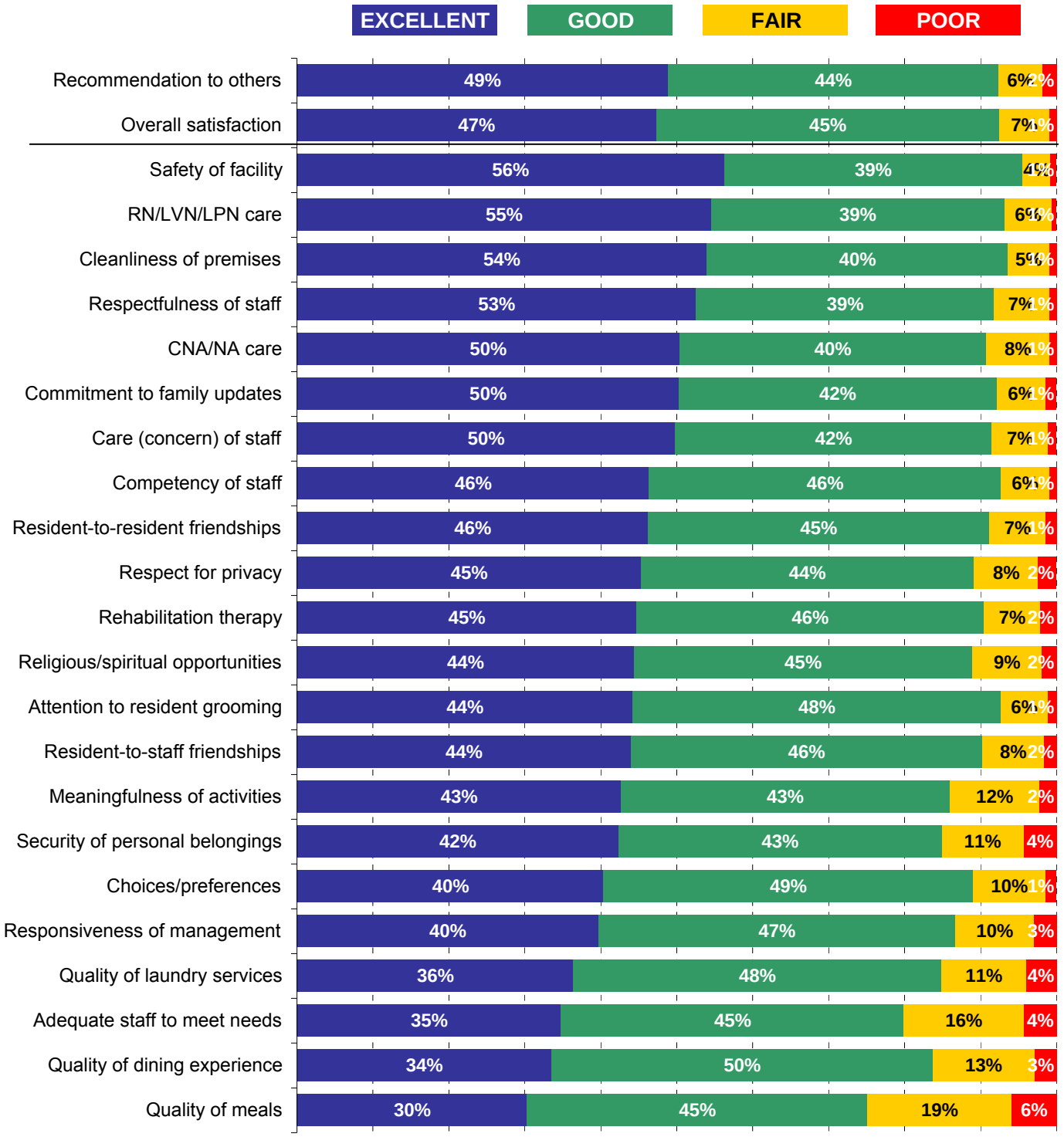
RESIDENT SATISFACTION

ITEMS RANKED BY PERCENT "EXCELLENT" FOR 2012



Items are ranked from highest to lowest on the percent of responses rated "Excellent." The percentages reflect averages survey respondents. *(May not total 100% due to rounding.)* See chart 4 for comparison to prior years.

RHODE ISLAND

RESIDENT SATISFACTION
QUADRANT ANALYSIS: STRENGTHS AND OPPORTUNITIES

A

Quadrant A shows items of *lower* importance to "Recommendation" with a *higher* average score

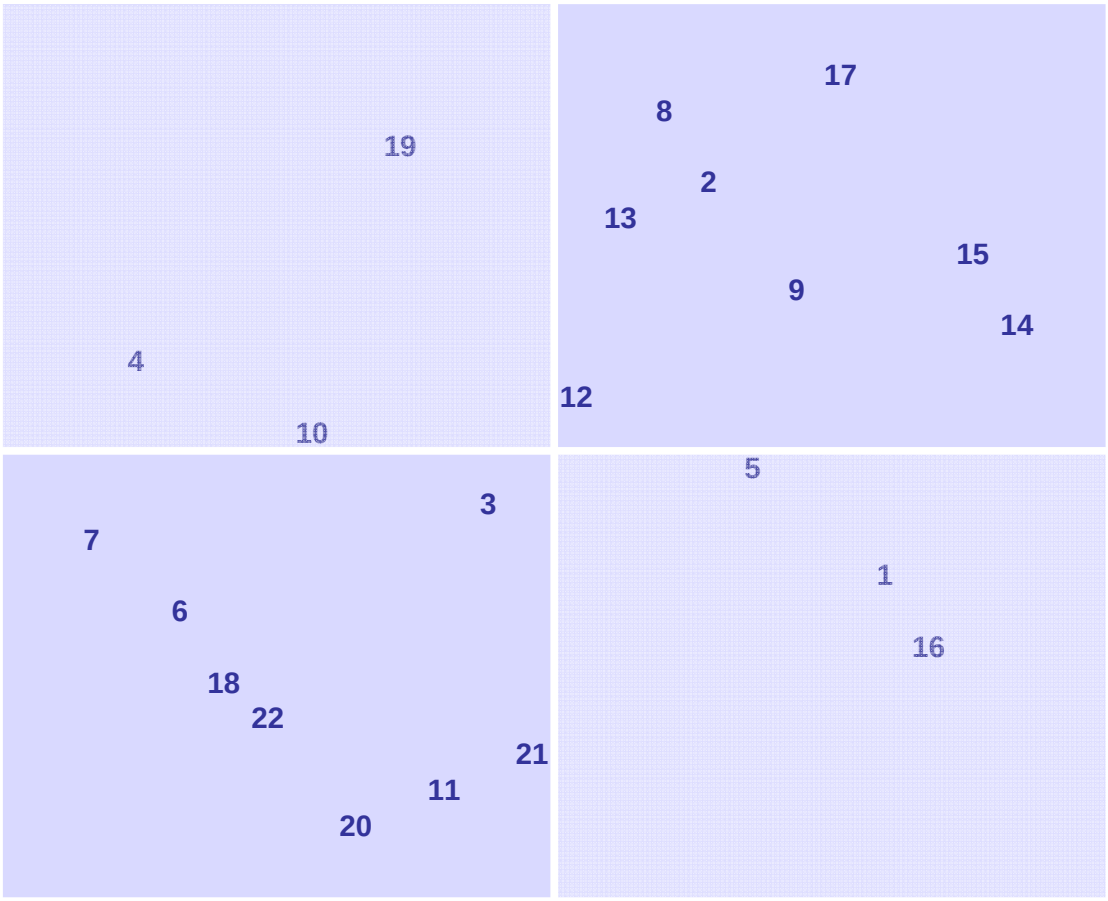
Quadrant B shows items of *higher* importance to "Recommendation" with a *higher* average score

B

SECONDARY STRENGTHS

PRIMARY STRENGTHS

HIGH ↑ YOUR AVERAGE SCORE FOR EACH ITEM ↓ LOW



SECONDARY OPPORTUNITIES

PRIMARY OPPORTUNITIES

C

LOW ← IMPORTANCE TO RECOMMEND THIS FACILITY TO OTHERS → **HIGH**

D

Quadrant C shows items of *lower* importance to "Recommendation" with a *lower* average score

Quadrant D shows items of *higher* importance to "Recommendation" with a *lower* average score

The quadrant analysis plots the percentile rank of the average score on the satisfaction items against the percentile rank of the average "importance" score of each item and the question **What is your recommendation of this facility to others?** Items in the lower right quadrant are those that are most important to "Recommendation" but received the lowest scores.

See actual satisfaction items and report labels at end of section

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A SECONDARY STRENGTHS

Items with average scores above the midline but not as important to "Recommendation"

10 Rehabilitation therapy
4 Resident-to-resident friendships
19 Cleanliness of premises

B PRIMARY STRENGTHS

Items with average scores above the midline and more important to "Recommendation"

14 Competency of staff
15 Care (concern) of staff
9 CNA/NA care
12 Attention to resident grooming
2 Respectfulness of staff
17 Safety of facility
13 Commitment to family updates
8 RN/LVN/LPN care

C SECONDARY OPPORTUNITIES

Items with average scores below the midline but not as important to "Recommendation"

21 Quality of dining experience
11 Adequate staff to meet needs
20 Quality of meals
22 Quality of laundry services
3 Respect for privacy
18 Security of personal belongings
6 Meaningfulness of activities
7 Religious/spiri

D PRIMARY OPPORTUNITIES

Items with average scores below the midline and more important to "Recommendation"

These are areas that represent a good opportunity for improvement.

PRIORITY ACTION AGENDA ™

The top FIVE items in Quadrant D *(Primary Opportunities)* comprise your Priority Action Agenda and provide a focus for improving willingness to recommend your facility to others.

If Quadrant D has less than five items, the Priority Action Agenda will list only those items in the quadrant.

16	**Responsiveness of management**
1	**Choices/preferences**
5	**Resident-to-staff friendships**

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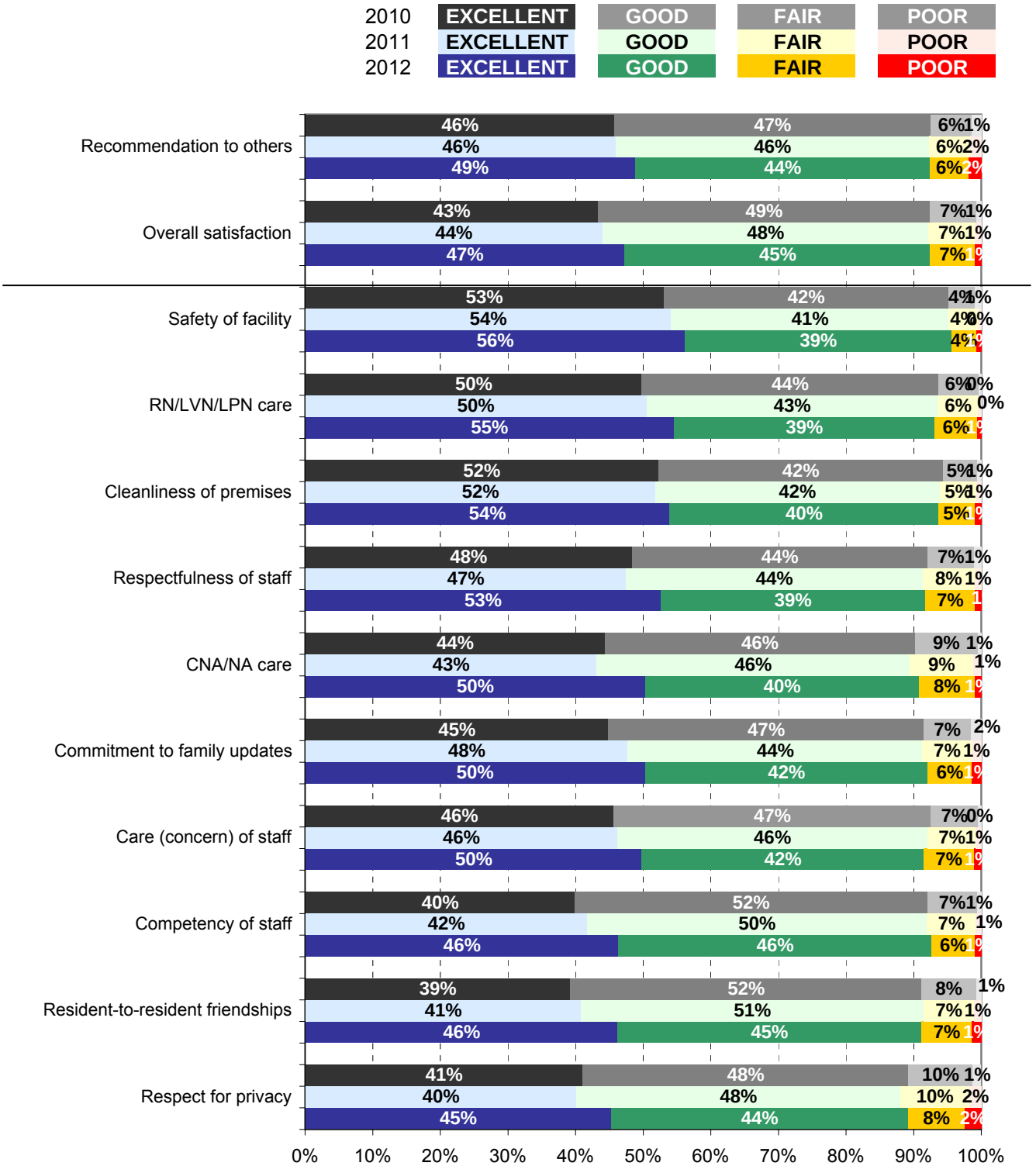
RESIDENT SATISFACTION

ITEMS RANKED BY PERCENT "EXCELLENT" FOR 2010, 2011 AND 2012



Items are ranked from highest to lowest on the percent of responses rated "Excellent" for the most recent year. *(May not total 100% due to rounding.)*

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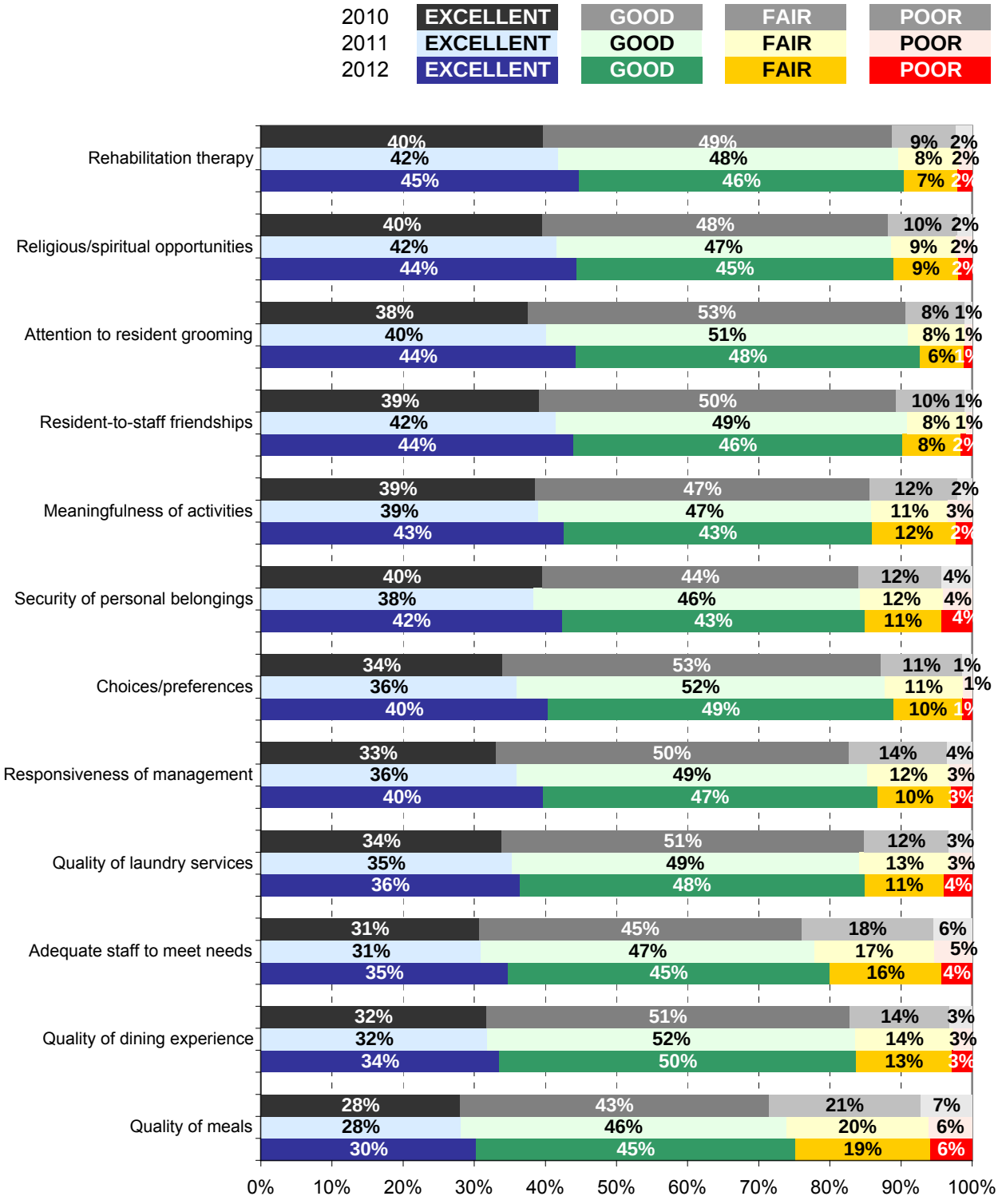
RESIDENT SATISFACTION

ITEMS RANKED BY PERCENT "EXCELLENT" FOR 2010, 2011 AND 2012



Items are ranked from highest to lowest on the percent of responses rated "Excellent" for the most recent year. *(May not total 100% due to rounding.)*

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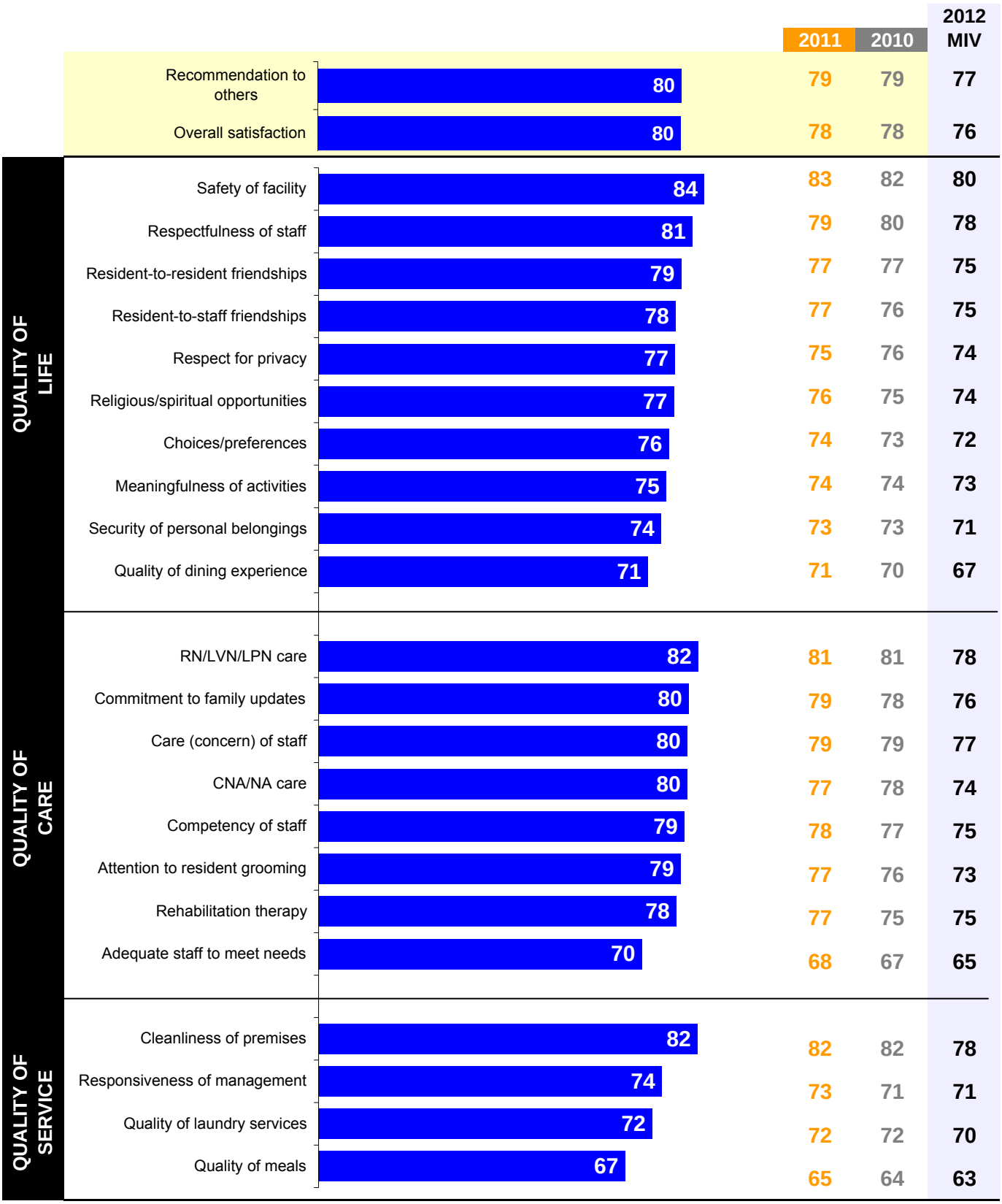
RESIDENT SATISFACTION

ITEMS RANKED WITHIN DOMAIN BY AVERAGE SCORES FOR 2012



RHODE ISLAND

RESIDENT SATISFACTION

AVERAGE SCORES BY ITEM BY LOCATION TYPE FOR 2012

		Rhode Island	Rural	Suburban	Urban
	Overall satisfaction	80	81	82	77
	Recommendation to others	80	82	82	77
QUALITY OF LIFE	Safety of facility	84	85	85	82
	Respectfulness of staff	81	81	82	80
	Resident-to-resident friendships	79	80	79	78
	Resident-to-staff friendships	78	79	78	76
	Respect for privacy	77	76	78	77
	Religious/spiritual opportunities	77	79	78	75
	Choices/preferences	76	76	77	76
	Meaningfulness of activities	75	78	77	73
	Security of personal belongings	74	75	76	73
	Quality of dining experience	71	73	72	70
QUALITY OF CARE	RN/LVN/LPN care	82	84	83	80
	CNA/NA care	80	81	81	78
	Commitment to family updates	80	82	81	79
	Care (concern) of staff	80	79	82	79
	Attention to resident grooming	79	79	79	78
	Competency of staff	79	80	81	77
	Rehabilitation therapy	78	80	79	75
	Adequate staff to meet needs	70	69	71	71
QUALITY OF SERVICE	Cleanliness of premises	82	83	84	80
	Responsiveness of management	74	73	75	74
	Quality of laundry services	72	72	74	71
	Quality of meals	67	68	66	67

All scores represent average scores across survey respondents. Each item was measured on a four-point scale:
Poor = 0 Fair = 33.3 Good = 66.7 Excellent = 100
Items are listed by domain as they appear in the survey. The shading in the Rural, Suburban and Urban columns reflects a comparison to the state average: Green = higher than the state average; yellow = same as the state average; red = lower than the state average.

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RESIDENT

Gender of resident	
Female	72%
Male	28%

Age of resident	
19 or under	0%
20 to 29	0%
30 to 39	0%
40 to 49	1%
50 to 59	4%
60 to 69	11%
70 to 79	19%
80 to 89	40%
90 or older	25%

FACILITY CHOICE

Homes visited	
None	38%
Only this one	30%
Two	20%
Three	8%
Four	2%
Five or more	2%

Reason for choosing		
Convenient location	22%	
Good reputation	31%	
Doctor or hospital	21%	**66%**
Relative or friend	14%	
Insurance requirement	1%	
Other reason	11%	

Length of stay		
Less than 1 month	1%	
1 to 3 months	3%	
3 to 6 months	7%	
6 months to 1 year	15%	
1 to 3 years	39%	**74%**
3 or more years	34%	

VISITOR

Person visiting most	
Spouse	8%
Child	52%
Brother or sister	13%
Grandchild	3%
Friend	10%
Another person	15%

How often visited		
Less than once a year	1%	
Once a year	3%	
Once every 3 months	6%	
Once a month or more	16%	
Once a week or more	51%	**74%**
Almost daily	23%	

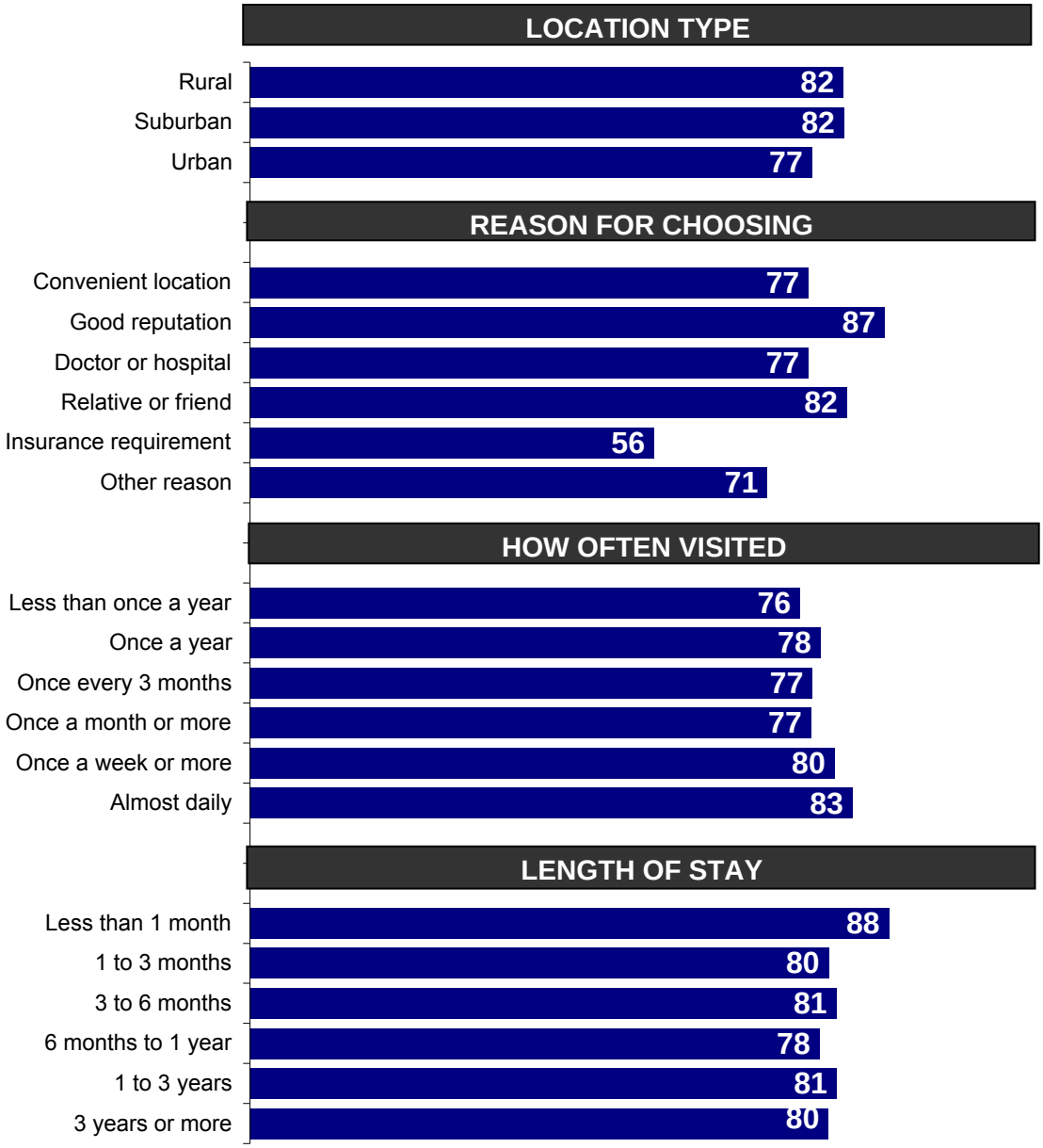
Assistance with survey	
By myself	22%
With facility staff	49%
With family or friend	17%
With another resident	1%
With another person	11%

(May not total 100% due to rounding.)

This CONFIDENTIAL Executive Summary was prepared by My InnerView.

RESIDENT SATISFACTION

AVERAGE SCORES FOR "RECOMMENDATION TO OTHERS" BY DEMOGRAPHICS FOR 2012



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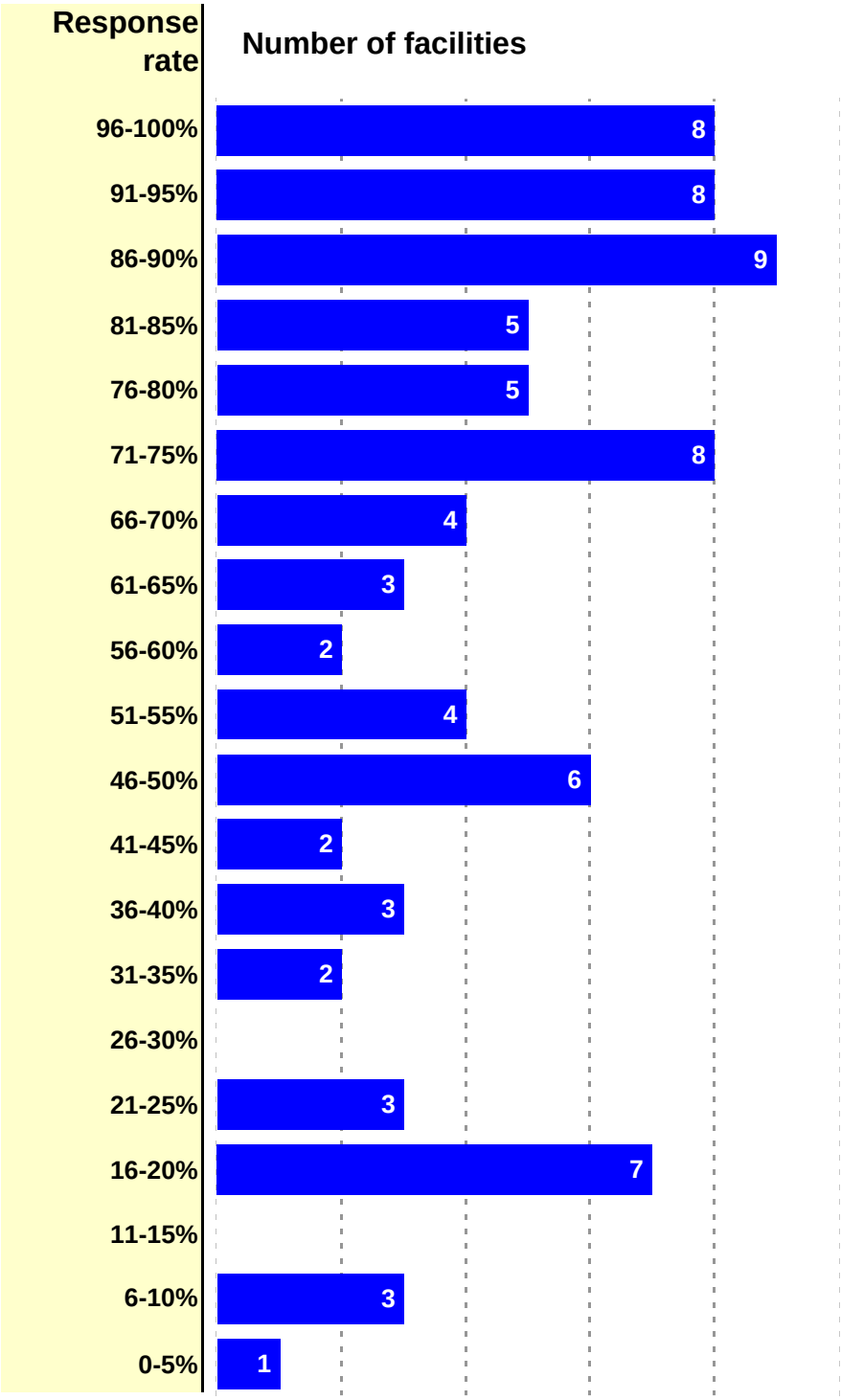
Results are for 83 participating facilities.



SUMMARY
Lowest response rate **0%**
Highest response rate **100%**
Overall state response rate **62%**

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RESIDENT SATISFACTION

SKILLED NURSING RESIDENT SATISFACTION SURVEY REFERENCE

ITEM NUMBER/LABEL	ORIGINAL SURVEY STATEMENT
GLOBAL SATISFACTION DOMAIN	
23 Overall satisfaction	How would you rate your overall satisfaction with this facility?
24 Recommendation to others	What is your recommendation of this facility to others?
QUALITY OF LIFE DOMAIN	Rate this facility on ...
1 Choices/preferences	Meeting your choices and preferences
2 Respectfulness of staff	The respect shown to you by staff
3 Respect for privacy	Meeting your need for privacy
4 Resident-to-resident friendships	Offering you opportunities for friendships with other residents
5 Resident-to-staff friendships	Offering you opportunities for friendships with staff
6 Meaningfulness of activities	Offering you meaningful activities
7 Religious/spiritual opportunities	Meeting your religious and spiritual needs
17 Safety of facility	How safe it is for you
18 Security of personal belongings	The security of your personal belongings
21 Quality of dining experience	How enjoyable your dining experience is
QUALITY OF CARE DOMAIN	Rate this facility on ...
8 RN/LVN/LPN care	The quality of care provided by the nurses (RNs/LVNs/LPNs)
9 CNA/NA care	The quality of care provided by the nursing assistants (CNAs/NAs)
10 Rehabilitation therapy	The quality of rehabilitation therapy (occupational, physical, speech)
11 Adequate staff to meet needs	Providing an adequate number of nursing staff to meet care needs
12 Attention to resident grooming	Meeting your grooming needs
13 Commitment to family updates	Keeping you and your family informed about you
14 Competency of staff	The competency of staff
15 Care (concern) of staff	The staff's care and concern for you
QUALITY OF SERVICE DOMAIN	Rate this facility on ...
16 Responsiveness of management	Management's responsiveness to your suggestions and concerns
19 Cleanliness of premises	The cleanliness of your room and surroundings
20 Quality of meals	The quality of the meals
22 Quality of laundry services	The quality of laundry services
DEMOGRAPHICS AND BACKGROUND INFORMATION	
25 Length of stay	How long have you lived at this facility?
26 Person visiting most	Who visits you most often?
27 How often visited	How often does this person visit the you?
28 Homes visited	How many nursing homes did you (or your family) visit before choosing this facility?
29 Reason for choosing	What is the most important reason you (or your family) chose this facility?
30 Gender of resident	What is your gender?
31 Age of resident	What is your age?
32 Assistance with survey	How is this survey being completed?

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FAMILY SATISFACTION

	2012	2011	2010
RESPONSE RATE	36%	39%	40%
FACILITIES SURVEYED	84	85	90
SURVEYS RECEIVED	1,844	1,948	2,194

MY INNERVIEW
BECAUSE KNOWING MORE MATTERS MOST™

RHODE ISLAND

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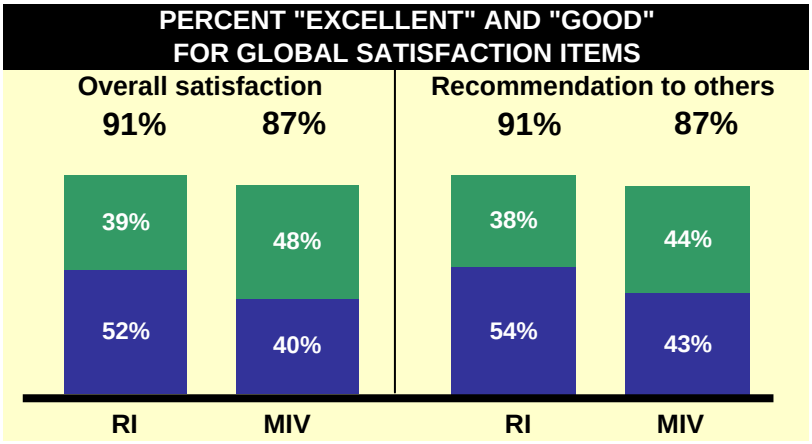
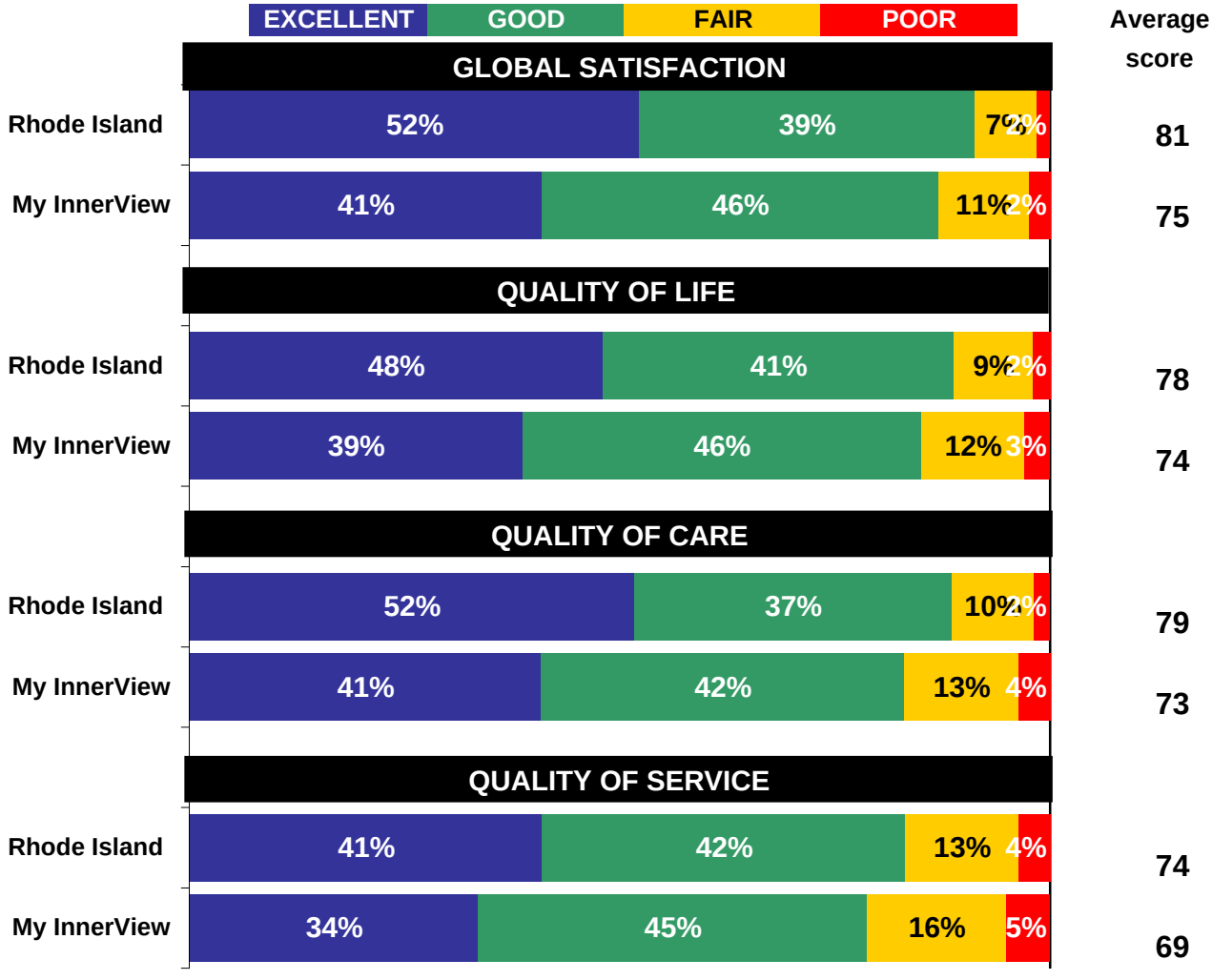
FAMILY SATISFACTION

GLOBAL SATISFACTION AND RATINGS BY DOMAIN FOR 2012



(The total percentage listed may be higher or lower than individual rating totals due to rounding.)



(May not total 100% due to rounding.)

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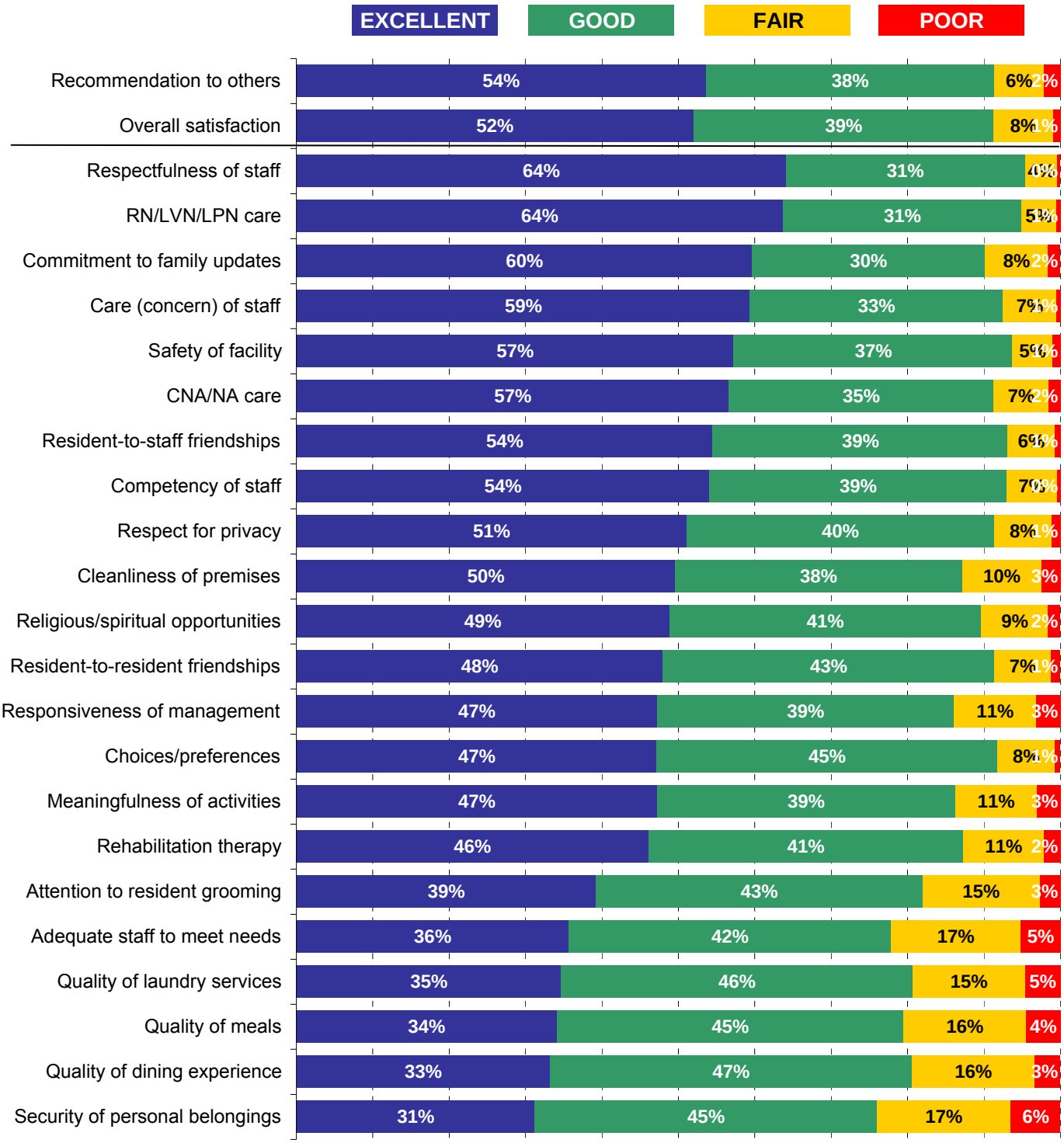
FAMILY SATISFACTION

ITEMS RANKED BY PERCENT "EXCELLENT" FOR 2012



Items are ranked from highest to lowest on the percent of responses rated "Excellent." The percentages reflect averages across survey respondents. *(May not total 100% due to rounding.)* See chart 4 for comparison to prior years.

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FAMILY SATISFACTION

QUADRANT ANALYSIS: STRENGTHS AND OPPORTUNITIES

A

Quadrant A shows items of *lower* importance to "Recommendation" with a *higher* average score

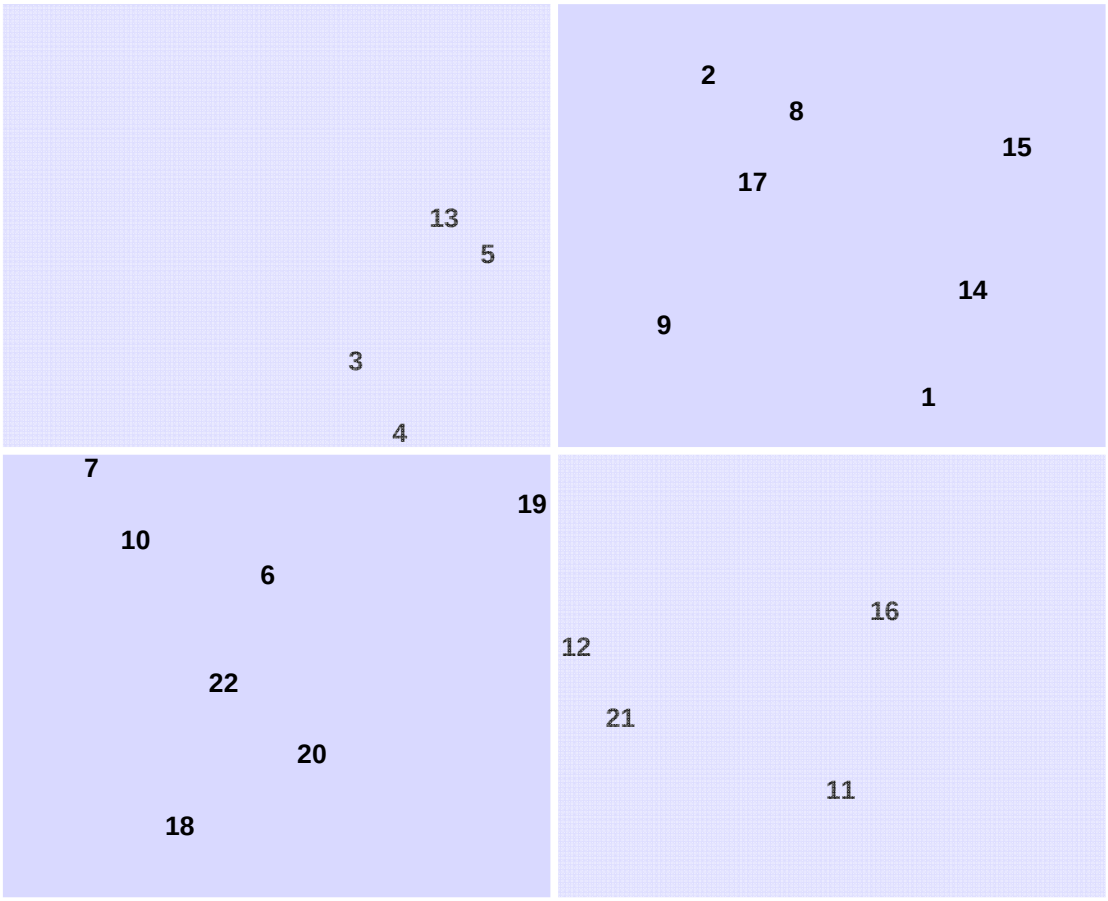
Quadrant B shows items of *higher* importance to "Recommendation" with a *higher* average score

B

SECONDARY STRENGTHS

PRIMARY STRENGTHS

HIGH ↑ YOUR AVERAGE SCORE FOR EACH ITEM ↓ LOW



SECONDARY OPPORTUNITIES

PRIMARY OPPORTUNITIES

C

LOW ← IMPORTANCE TO RECOMMEND THIS FACILITY TO OTHERS → **HIGH**

D

Quadrant C shows items of *lower* importance to "Recommendation" with a *lower* average score

Quadrant D shows items of *higher* importance to "Recommendation" with a *lower* average score

The quadrant analysis plots the percentile rank of the average score on the satisfaction items against the percentile rank of the average "importance" score of each item and the question **What is your recommendation of this facility to others?** Items in the lower right quadrant are those that are most important to "Recommendation" but received the lowest scores.

See actual satisfaction items and report labels at end of section

FAMILY SATISFACTION

QUADRANT ANALYSIS: STRENGTHS AND OPPORTUNITIES

A SECONDARY STRENGTHS

Items with average scores above the midline but not as important to "Recommendation"

4 Resident-to-resident friendships
5 Resident-to-staff friendships
3 Respect for privacy
13 Commitment to family updates

B PRIMARY STRENGTHS

Items with average scores above the midline and more important to "Recommendation"

1 Choices/preferences
14 Competency of staff
15 Care (concern) of staff
9 CNA/NA care
17 Safety of facility
8 RN/LVN/LPN care
2 Respectfulness of staff

C SECONDARY OPPORTUNITIES

Items with average scores below the midline but not as important to "Recommendation"

20 Quality of meals
18 Security of personal belongings
19 Cleanliness of premises
22 Quality of laundry services
6 Meaningfulness of activities
10 Rehabilitation therapy
7 Religious/spiritual opportunities

D PRIMARY OPPORTUNITIES

Items with average scores below the midline and more important to "Recommendation"

These are areas that represent a good opportunity for improvement.

PRIORITY ACTION AGENDA ™

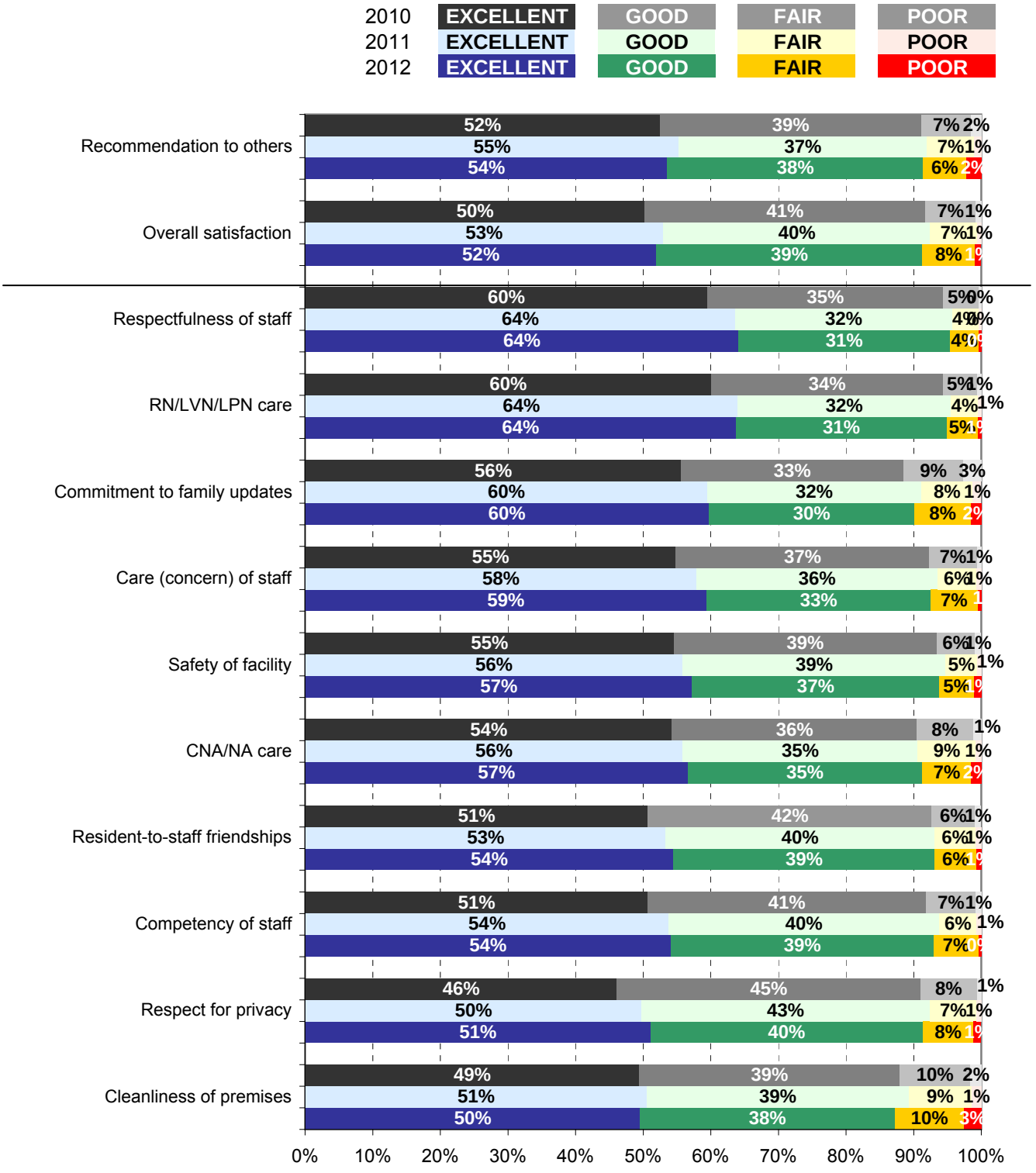
The top FIVE items in Quadrant D *(Primary Opportunities)* comprise your Priority Action Agenda and provide a focus for improving willingness to recommend your facility to others.

If Quadrant D has less than five items, the Priority Action Agenda will list only those items in the quadrant.

11	**Adequate staff to meet needs**
16	**Responsiveness of management**
21	**Quality of dining experience**
12	**Attention to resident grooming**

FAMILY SATISFACTION

ITEMS RANKED BY PERCENT "EXCELLENT" FOR 2010, 2011 AND 2012



Items are ranked from highest to lowest on the percent of responses rated "Excellent" for the most recent year. *(May not total 100% due to rounding.)*

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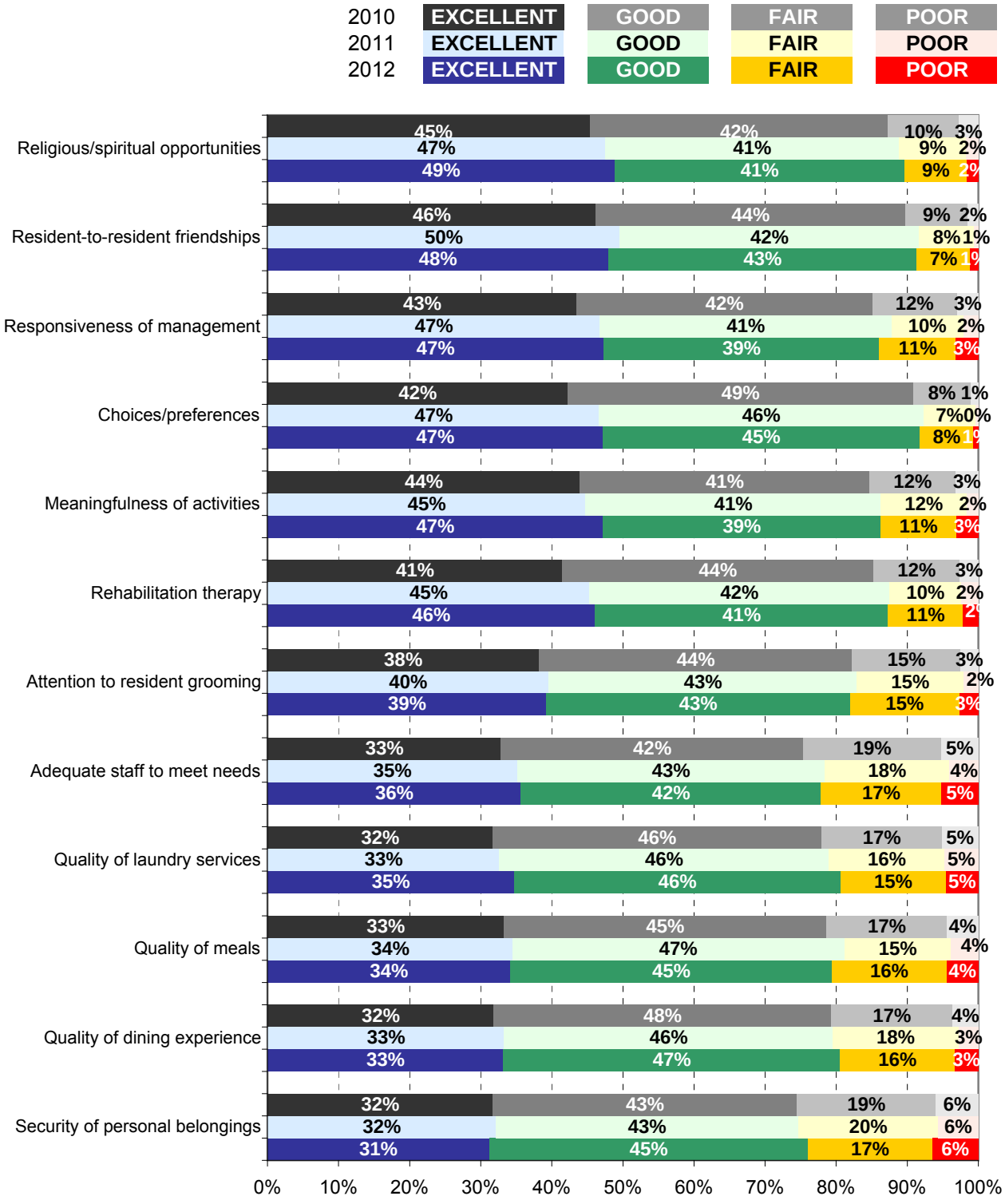
FAMILY SATISFACTION

ITEMS RANKED BY PERCENT "EXCELLENT" FOR 2010, 2011 AND 2012

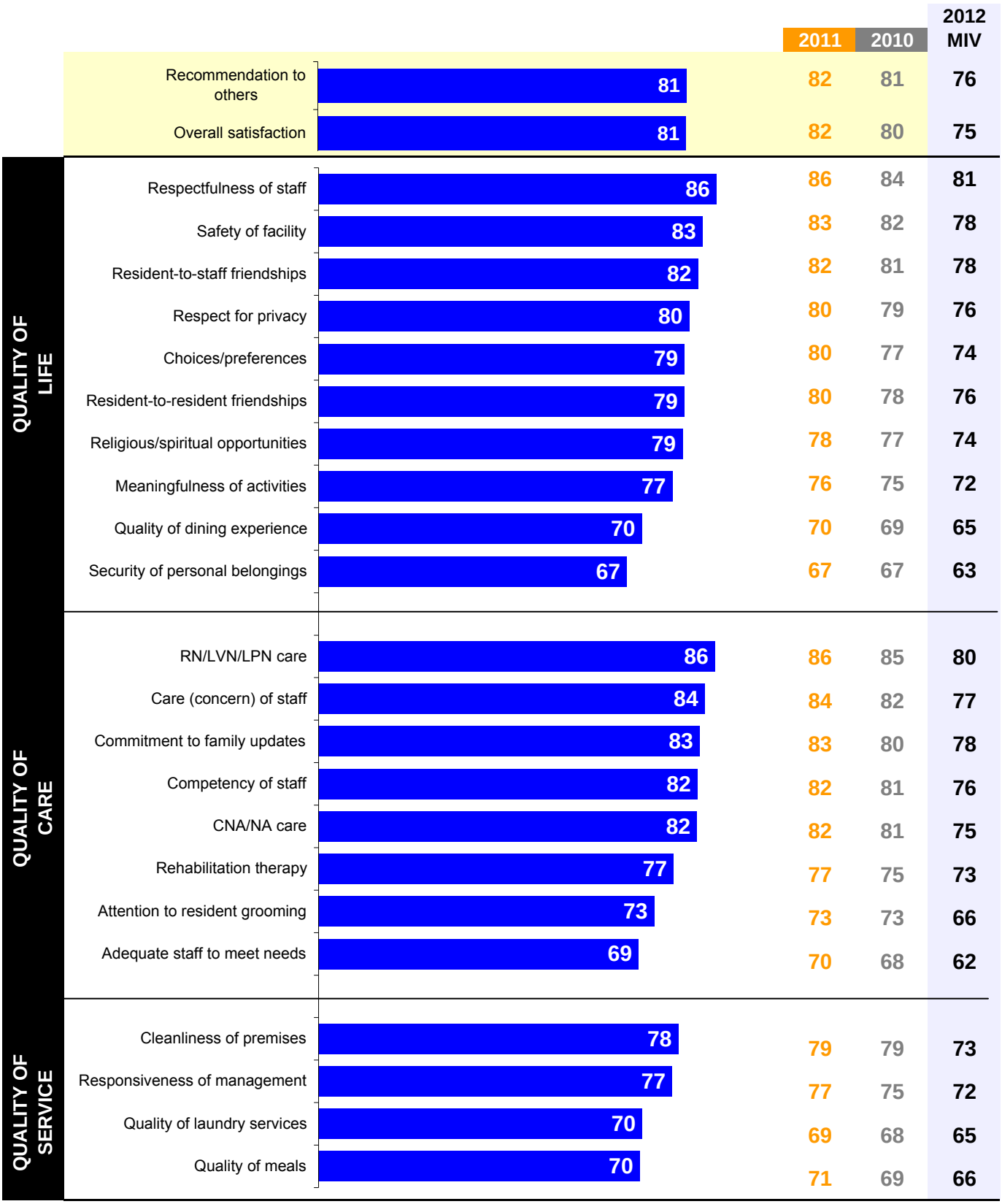


Items are ranked from highest to lowest on the percent of responses rated "Excellent" for the most recent year. *(May not total 100% due to rounding.)*

FAMILY SATISFACTION

ITEMS RANKED WITHIN DOMAIN BY AVERAGE SCORES FOR 2012

5



RHODE ISLAND

FAMILY SATISFACTION

AVERAGE SCORES BY ITEM BY LOCATION TYPE FOR 2012

		Rhode Island	Rural	Suburban	Urban
	Overall satisfaction	81	82	82	78
	Recommendation to others	81	83	82	78
QUALITY OF LIFE	Respectfulness of staff	86	87	88	83
	Safety of facility	83	84	85	81
	Resident-to-staff friendships	82	84	83	80
	Respect for privacy	80	82	81	78
	Choices/preferences	79	80	80	78
	Resident-to-resident friendships	79	81	80	77
	Religious/spiritual opportunities	79	81	80	76
	Meaningfulness of activities	77	78	78	74
	Quality of dining experience	70	71	72	67
	Security of personal belongings	67	66	70	64
QUALITY OF CARE	RN/LVN/LPN care	86	87	87	84
	Care (concern) of staff	84	85	84	82
	Commitment to family updates	83	85	83	81
	CNA/NA care	82	82	83	81
	Competency of staff	82	84	83	80
	Rehabilitation therapy	77	80	78	74
	Attention to resident grooming	73	74	73	71
	Adequate staff to meet needs	69	70	70	68
QUALITY OF SERVICE	Cleanliness of premises	78	79	79	77
	Responsiveness of management	77	78	77	76
	Quality of meals	70	73	71	65
	Quality of laundry services	70	71	73	66

All scores represent average scores across survey respondents. Each item was measured on a four-point scale:
Poor = 0 Fair = 33.3 Good = 66.7 Excellent = 100
Items are listed by domain as they appear in the survey. The shading in the Rural, Suburban and Urban columns reflects a comparison to the state average: Green = higher than the state average; yellow = same as the state average; red = lower than the state average.

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RESIDENT

Gender of resident	
Female	75%
Male	25%

Age of resident	
19 or under	0%
20 to 29	0%
30 to 39	0%
40 to 49	0%
50 to 59	2%
60 to 69	4%
70 to 79	12%
80 to 89	41%
90 or older	41%

FACILITY CHOICE

Homes visited	
None	32%
Only this one	13%
Two	25%
Three	18%
Four	8%
Five or more	5%

Reason for choosing		
Convenient location	26%	
Good reputation	39%	
Doctor or hospital	11%	**59%**
Relative or friend	10%	
Insurance requirement	1%	
Other reason	13%	

Length of stay		
Less than 1 month	1%	
1 to 3 months	5%	
3 to 6 months	5%	
6 months to 1 year	14%	
1 to 3 years	38%	**75%**
3 or more years	36%	

SURVEY RESPONDENT

Relationship to resident	
Spouse	12%
Child	61%
Brother or sister	8%
Grandchild	1%
Friend	2%
Other relationship	15%

VISITOR

Person visiting most	
Spouse	14%
Child	60%
Brother or sister	9%
Grandchild	1%
Friend	4%
Another person	11%

How often visited		
Less than once a year	0%	
Once a year	1%	
Once every 3 months	3%	
Once a month or more	11%	
Once a week or more	50%	**86%**
Almost daily	36%	

(May not total 100% due to rounding.)

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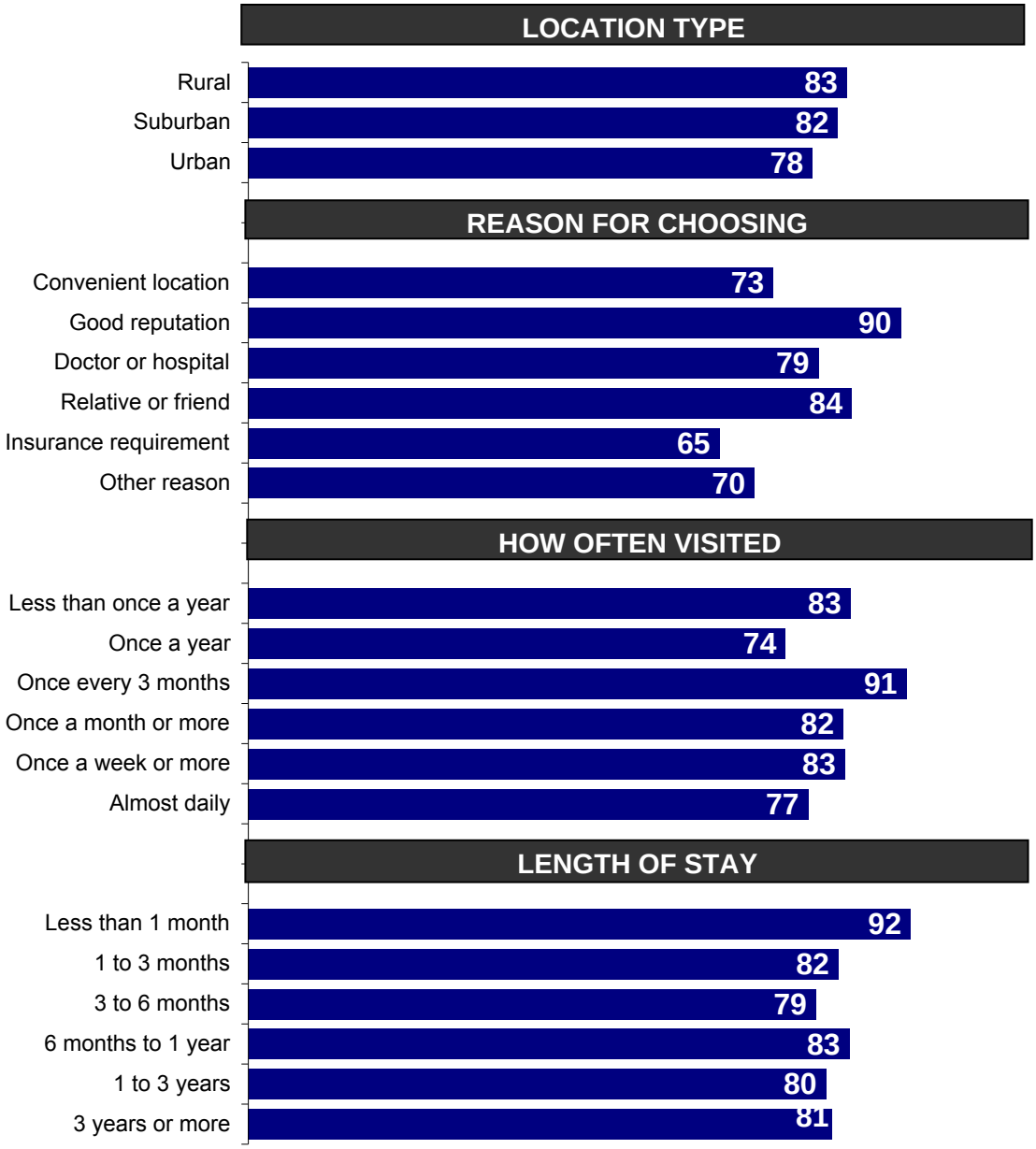
FAMILY SATISFACTION

AVERAGE SCORES FOR "RECOMMENDATION TO OTHERS" BY DEMOGRAPHICS FOR 2012



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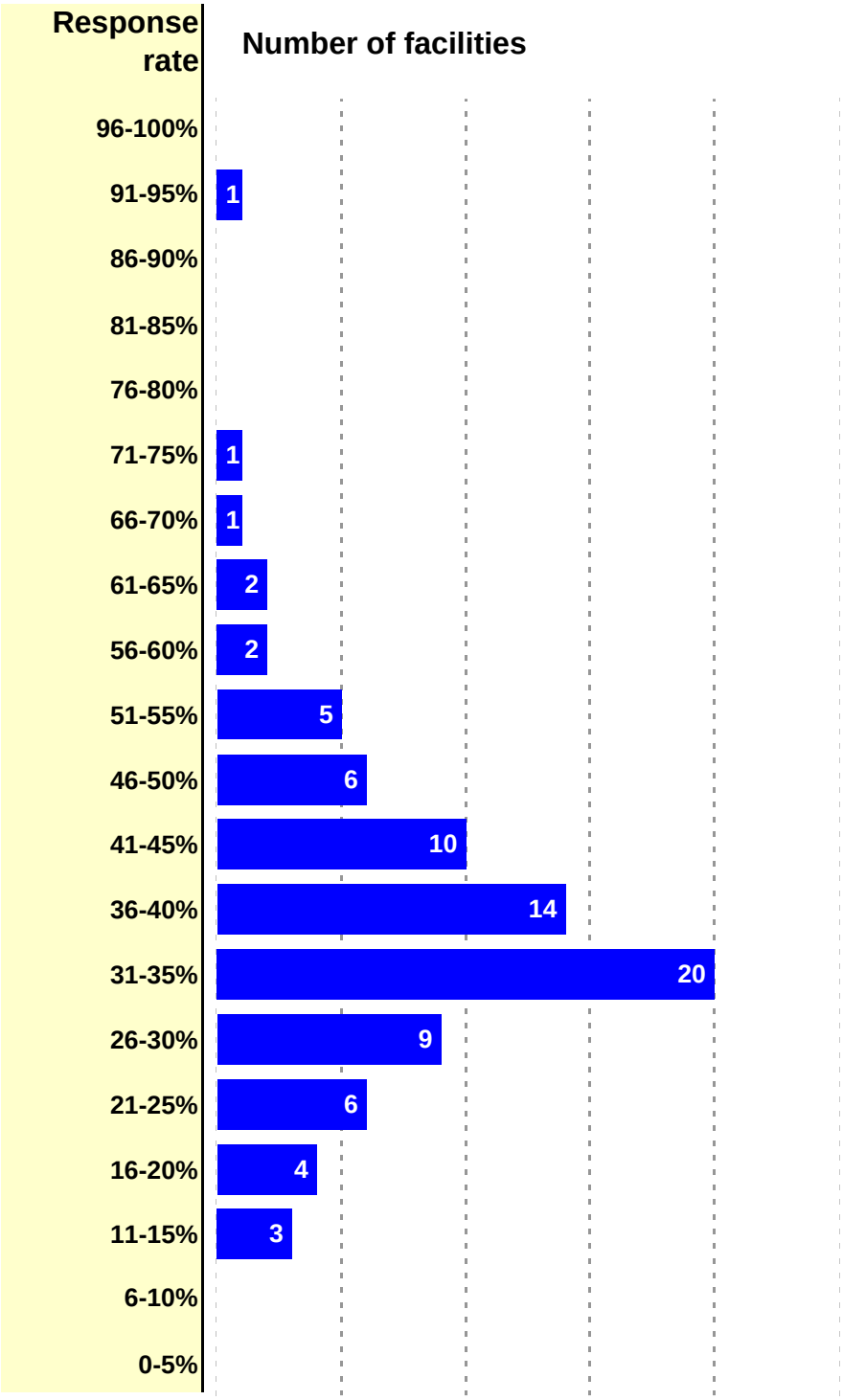

SUMMARY
Lowest response rate **14%**
Highest response rate **91%**
Overall state response rate **36%**

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FAMILY SATISFACTION

SKILLED NURSING FAMILY SATISFACTION SURVEY REFERENCE

ITEM NUMBER/LABEL	ORIGINAL SURVEY STATEMENT
GLOBAL SATISFACTION DOMAIN	
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24 Recommendation to others	What is your recommendation of this facility to others?
QUALITY OF LIFE DOMAIN	Rate this facility on ...
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2 Respectfulness of staff	The respect shown to the resident/patient by staff
3 Respect for privacy	Meeting the resident's/patient's need for privacy
4 Resident-to-resident friendships	Offering the resident/patient opportunities for friendships
5 Resident-to-staff friendships	Offering the resident/patient opportunities for friendships with staff
6 Meaningfulness of activities	Offering the resident/patient meaningful activities
7 Religious/spiritual opportunities	Meeting the resident's/patient's religious and spiritual needs
17 Safety of facility	How safe it is for the resident/patient
18 Security of personal belongings	The security of the resident's/patient's personal belongings
21 Quality of dining experience	How enjoyable the dining experience is for the resident/patient
QUALITY OF CARE DOMAIN	Rate this facility on ...
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11 Adequate staff to meet needs	Providing an adequate number of nursing staff to meet care needs
12 Attention to resident grooming	Meeting the resident's/patient's need for grooming
13 Commitment to family updates	Keeping you and your family informed about the resident/patient
14 Competency of staff	The competency of staff
15 Care (concern) of staff	The staff's care and concern for the resident/patient
QUALITY OF SERVICE DOMAIN	Rate this facility on ...
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20 Quality of meals	The quality of the meals
22 Quality of laundry services	The quality of laundry services
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26 Person visiting most	Who visits the resident/patient most often?
27 How often visited	How often does this person visit the resident/patient?
28 Homes visited	How many nursing homes did you (or your family) visit before choosing this facility?
29 Reason for choosing	What is the most important reason you (or your family) chose this facility?
30 Gender of resident	What is the resident's/patient's gender?
31 Age of resident	What is the resident's/patient's age?
32 Relationship to resident	What is your relationship to the resident/patient?

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