



Healthcare Quality Reporting Program

STEERING COMMITTEE

11/26/12, 3-4:30pm

Department of Health, Room 401

Facilitation: Rosa Baier, MPH and Samara Viner-Brown, MS

Recorder: Ann Messier

Voting Members

<input checked="" type="checkbox"/> Ted Almon (rep)	<input type="checkbox"/> Neal Galinko, MD, MS, FACP	<input checked="" type="checkbox"/> Paula Parker, LCSW
<input type="checkbox"/> David Ashley, MD	<input checked="" type="checkbox"/> Diane Gallagher	<input type="checkbox"/> Donna Policastro, NP, RCN
<input type="checkbox"/> Rep. David Bennett	<input type="checkbox"/> Deidre Gifford, MD, MPH	<input type="checkbox"/> Louis Pugliese
<input type="checkbox"/> Virginia Burke, Esq.	<input type="checkbox"/> Debra McDonald, RN	<input checked="" type="checkbox"/> Gina Rocha, RN, MPH
<input type="checkbox"/> Cathy Cranston	<input checked="" type="checkbox"/> Linda McDonald, RN	
<input checked="" type="checkbox"/> Michael Fine, MD (<i>Chair</i>)	<input checked="" type="checkbox"/> Jim Nyberg	

Agenda

3:00pm **Open Meeting**

Michael Fine, MD, Chair

- Dr. Fine welcomed the group and reviewed the meeting's objectives.
- Steering Committee membership:

A new Steering Committee member was appointed, Deidre Gifford, MD, MPH from the Executive Office of Health and Human Services (EOHHS). Deidre was unable to attend today, but led the Chronic Care Sustainability Initiative (CSI-RI) prior to joining EOHHS as a Medical Director and works closely with multiple OHHS agencies and initiatives to measure and improve quality.

There are two remaining vacant seats, for the Rhode Island Medical Society and the State Senate. The team is working to fill these vacancies. Cathy Cranston is also leaving the Partnership for Home Care at the end of December, so Sam and Rosa will invite her successor to join the committee when that person is named.

Rosa also asked Ann to review past minutes to see if there are Steering Committee members who have not attended, and could be re-engaged or could designate representatives in their places.

- Sam led the group's review of the previous meeting's action items:

- **Distribute the new EMR analysis reports** (Margaret) – **Complete**

Margaret completed the meaningful use and vendor selection reports based on the data shared at the September meeting. They are now available.

- **Research how Medicaid collects home health satisfaction data** (Rosa) – **Complete**

Rosa outreached to various EOHHS contacts, including Deidre, to research how

Medicaid collects home health satisfaction data. Currently, no data are reported and EOHHS is interested in learning more about the program's data collection efforts and aligning efforts. The Steering Committee discussed this further, below.

- **Research any home health or nursing home quality measurement data shared with the Integrated Care Initiative's quality measurement group (Rosa) – Complete**

Again, Rosa outreached to various EOHHS contacts to research home health and nursing home quality measurement data. EOHHS primarily tracks programmatic process measures, not clinical processes or outcomes (quality measures).

Following the meeting, Rosa contacted Debbie Morales at EOHHS; Debbie shared two reports that include Medicaid's measures. Rosa is sharing those with today's minutes.

- **Share the Medicaid nursing home data with PCPAC (Dr. Fine/Rosa) – Pending**

Rosa sent the Medicaid nursing home data to the PCP Advisory Council's coordinator, Mia Patriarca; Mia will work with Dr. Fine to place this on an upcoming PCPAC agenda, as appropriate.

- **Write an advisory letter summarizing CDI recommendations (Sam/Rosa) – Complete**

Sam and Rosa circulated a draft advisory letter for comment after the September meeting, and submitted the final version to Dr. Fine in early October. He has since drafted a response; when final, we will distribute it to the group.

Gina complimented the letter, noting that the details exactly captured the complex discussions and intent of the recommendations of the HAI Subcommittee.

3:10pm

Policy & Data Discussion Topics

Rosa Baier, MPH, Facilitator

Samara Viner-Brown, MS, Facilitator

– New/updated data reports:

The nursing home healthcare worker influenza vaccination report was published in November and letters were sent to each home health agency benchmarking their performance against the state average.

Both nursing homes and home health agencies had very low data submission rates, even though there is a long-standing requirement for all licensed facilities to submit these data to Dr. John Fulton at HEALTH. Rosa commented that there might be confusion about the difference between reporting doses (for patients) and reporting vaccination (for healthcare workers), or the notices may be going unnoticed. The emails are sent to the email address on file with licensure, although Rosa also disseminated them through statewide listservs. She also said that notices were sent to all three types of home health agencies:

Home Care Providers (HCP) – non-skilled

Home Health Agencies (HHA) – Medicare-certified, skilled

Home Nursing Care Provider (HNCP) – skilled and non-skilled, not Medicare certified

Rosa and Sam are working with Dr. Fulton to trouble-shoot the data submission barriers. Dr. Fine said perhaps the request for this data should be tied to licensure of

the facilities.

Rosa also asked the group whether the home health letters could and should serve as a pilot report, with public reporting planned for this flu season (2012-2013). The group agreed, so Sam and Rosa will capture this recommendation in an advisory letter to Dr. Fine.

The *C. difficile* infection (CDI) white paper data were shared with the committee, but will not be distributed with the minutes; the data are in the middle of a five-day preview period for hospital comment. We anticipate publishing them on 11/28. During discussion, the group noted that the Miriam Hospital (TMH) was the only hospital with just one diamond. Rosa responded that TMH has an older and sicker population, which may account for the difference. Dr. Fine suggested that the program research the demographics to be ready for any questions following the publication of the data.

Additional upcoming reports include the MRSA CLABSI report, later this month.

– State consumer websites:

There are numerous concurrent state initiatives to create consumer websites, including the Executive Office of Health and Human Services' All-Payer Claims Database (APCD) and Integrated Care Initiative, and the Office of the Health Insurance Commissioner's health insurance exchange. We are also working on improving the public reporting program's website to make it more consumer friendly, as part of our effort to shift from fostering provider-side quality improvement to helping consumers make decisions about their providers.

Rosa shared several screenshots of the current website and a new "Choose a doctor" page, and then asked for the group's thoughts about if and how to align all of the concurrent activities. Overall, the group agreed that the program was further along the development path and that the intent of the various program's differed sufficiently to preclude combining efforts, but suggested cross-linking between them.

– Home health satisfaction reporting:

Rosa reviewed previous discussions about home health satisfaction reporting, which is due every two years. It was last completed in Fall 2010, but this Spring the Subcommittee recommended the following:

Population	Subcommittee Recommendation
1. Medicare, skilled patients	Link to Home Health Compare
2. Skilled, commercial patients	Not included
3. Non-skilled patients	Stop reporting

The Medicare, skilled patient recommendation has changed to a link to Home Health Compare, since Medicare has begun publishing public reports for Home Health CAHPS data on Home Health Compare. Given the Steering Committee's previous direction to link to Home Health Compare, where data exists, the Subcommittee recommended doing the same for the satisfaction data as for the clinical quality measures.

Eliminating the requirement would alleviate a significant burden (cost and time) for home health agencies, and also conserve program resources, particularly given

problems with the past three rounds of data collection with the vendor. However, it would also mean that there are no satisfaction data published for non-skilled agencies. (All of the non-skilled patients are surveyed regularly by their agencies, but using different survey instruments; data comparison is not possible.)

After the July discussion, the Steering Committee asked Sam and Rosa to research how Medicaid collects satisfaction data for Medicaid, skilled patients (a fourth population) and patients in the nursing home diversion program. As mentioned above (see action items), Rosa outreached to various EOHHS contacts, including Deidre. Currently, a satisfaction data collection process is required, but the data themselves are not reported to EOHHS. EOHHS will require ongoing satisfaction data collection (vs. the two-year time period for the program) as part of the Integrated Care Initiative. Deidre was interested in learning more about the program's data collection efforts and aligning efforts.

The committee agreed with Rosa that additional information is necessary to make a formal recommendation, but that this discussion could be continued via email – in the interest of providing information to the agencies, who are aware that the survey was due to occur in Fall 2012. In the meantime, Paula will further research what is available through the Global Waiver Taskforce.

– Physician HIT Survey planning:

The Physician HIT survey is done annually in January. Responses are mandatory for all licensed physicians; non-response is reported as failure to use an electronic medical record (EMR) or to e-prescribing. Rosa noted that each year the Physician Workgroup, chaired by Dr. Rebekah Gardner, requests input from stakeholders before distributing the survey, with the goal of ensuring that the survey instrument meets multiple needs without increasing the data collection burden for physicians. The stakeholders include BCBSRI, EOHHS, HEALTH, Tufts, the Rhode Island Quality Institute and United Healthcare. The workgroup weighs requests for additions or edits against the value of trending data and the survey's length.

Gina suggested including advanced practice in this survey administration, and Dr. Fine and Linda agreed. Dr. Fine also suggested collecting information on what would be needed to convince physicians without EMRs to adopt them, and to quantify the additional burden of using EMRs for those who have them (e.g., how many hours of work are they doing each night?).

4:15pm **Other Business/Announcements**

Michael Fine, MD, Chair

– AHRQ Public Reporting Grant:

Rosa provided a brief update on the grant that Healthcentric Advisors received to develop and test a consumer-centric public reporting format. The grant focuses on home health reports, but is intended to develop a scalable and sustainable reporting format that the program can use for all settings. It will begin in January with home health consumer focus groups and case manager interviews, to assess needs for a web-based reporting format.

Sam and Rosa will periodically update the Steering Committee, and Rosa asked that anyone with additional questions [contact her directly](#).

- **Action items:**
 - Review past Steering Committee member attendance (Ann)
 - Outreach to engage members and fill vacant seats (Sam/Rosa)
 - Summarize recommendations in an advisory letter to Dr. Fine (Sam/Rosa)
 - Research TMH's demographics prior to releasing the CDI report (Rosa)
 - Research provider data from Global Waiver Taskforce (Paula)
 - Finalize Medicaid research re: home health satisfaction (Rosa/Sam)
 - Incorporate the group's suggestions into the Physician HIT Survey (Rosa/Rebekah)
 - Explore administering the HIT Survey to advance practice nurses (Rosa/Sam)
- **Next meeting:** Please mark your calendars for the following 2013 meeting dates:
 - January 21, 2013
 - March 25, 2013
 - May 20, 2013 (third Monday)
 - July 22, 2013
 - September 23, 2013
 - November 25, 2013

All meetings are in Room 401 at 3pm. Unless otherwise noted, meetings are on the fourth Monday of every second month.



Rosa Baier, MPH
RI Department of Health Contractor
(Facilitator)

Ted Almon
The Clafin Company
(Business Community Representative)

David Ashley, MD
Family Care Center, Memorial Hospital
of RI (Director's Appointee)

Rep. David Bennett, RN
RI House of Representatives
(House Appointee)

Virginia Burke, Esq.
RI Association of Health Care
(Licensed Facilities Representative)

Cathy Cranston
RI Partnership for Home Care
(Licensed Facilities Representative)

Neal Galinko, MD, MS, FACP
UnitedHealthcare of New England
(Health Insurer and Health
Plan Representative)

Diane Gallagher
Alliance for Better Long-Term Care
(Consumer Representative)

Debra McDonald, RN
Blue Cross & Blue Shield of RI
(Health Insurer and Health
Plan Representative)

Linda McDonald, RN
United Nursing and Allied Professionals
(Nursing Profession and Organized Labor
Representative)

Jim Nyberg
LeadingAge RI
(Licensed Facilities Representative)

Paula Parker, LCSW
RI Division of Elderly Affairs (RIDEA)
(RIDEA Appointee)

Donna Policastro, NP, RCN
RI State Nurses Association
(Nursing Profession Representative)

Louis Pugliese
Eleanor Slater Hospital
(Department of Mental Health,
Retardation and Hospitals)

Gina Rocha, RN, MPH
Hospital Association of RI
(Hospital Representative)

Samara Viner-Brown, MS
RI Department of Health
(Facilitator)

Vacant seats (3):
Department of Human Services
Rhode Island Medical Society
State Senate

Rhode Island Healthcare Quality Reporting Program Steering Committee

October 3, 2012

Michael Fine, MD
Director of Health
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

Dear Dr. Fine:

On behalf of the Healthcare Quality Reporting Program's Steering Committee, which we facilitate, we are writing to provide the committee's recommendations regarding the program's *C. Difficile* reporting.

History of *C. Difficile* Reporting

In 2008, then-Director of Health Dr. David Gifford directed the Hospital-Acquired Infections (HAI) Subcommittee to recommend outcome measures for public reporting. The Subcommittee selected *C. Difficile* because of recent increases in the frequency and severity of these infections, which cause significant morbidity, mortality and cost.¹ *C. Difficile* has also emerged as an important contributing factor to hospital readmissions; a recent Rhode Island analysis found that the ICD-9 code that includes CDI is ranked second among readmission diagnoses for fee-for-service Medicare patients.²

As a result, the Subcommittee included *C. Difficile* in the Rhode Island HAI Plan, submitted to the Centers for Disease Control and Prevention (CDC) in 2009, and began publicly reporting hand hygiene process measures that year. Working with the Infection Control Professionals of Southern New England (ICPSNE) group, the Subcommittee selected *C. Difficile* infections (CDI), one of two CDC-endorsed *C. Difficile* measures (Lab ID or CDI).¹ Infection preventionists then began submitting CDI data to the Department in January 2011 and, as of this advisory letter, have submitted six quarters of data (Q1 2011 through Q2 2012).

Barriers to Reporting

Despite the HAI Subcommittee's leadership in collecting hand hygiene and CDI data, several barriers have prevented the publication of a CDI report:

1. The CDC recommended comparing current performance against a baseline period of 6-12 months to account for variability. That required at least six quarters of data collection prior to reporting. As

¹Lab ID reflects laboratory diagnosis and can be obtained directly from laboratory data, while CDI reflects laboratory diagnosis and clinical symptoms and is generally obtained using primary data collection from patient records.

of this advisory letter, we have the required six quarters of data (Q1 2011 through Q2 2012).

2. There is variation among the hospitals' CDI testing methods, with some using nucleic acid amplification assays (with estimated 88-96% sensitivity^{3,4,5}) and others using EIA assays (40-60% sensitivity^{6,7,8}). Hospitals using a higher-sensitivity test are more likely to detect infections, which may make their rate appear artificially higher than a hospital with the same actual rate, but using a lower-sensitivity test. To address this, the Subcommittee recommended in 2011 that we stratify data to compare infection rates among hospitals using similar testing methods. However, since 2011, several hospitals have switched from EIA assay (lower sensitivity) to nucleic amplification assay (higher sensitivity) testing. This means that the six quarters of data include results collected with different testing methods, even at the same hospital, making longitudinal comparison invalid without statistical adjustment and negating the Subcommittee's earlier recommendation to stratify results by testing method.
3. In 2012, the Centers for Medicare & Medicaid Services (CMS) notified hospitals that they would be required to submit *C. Difficile* data to the National Healthcare Safety Network (NHSN), a secure, Internet-based surveillance system. The CMS data submission requirement took effect in July 2012 and requires that hospitals submit Lab ID data, the second of the two CDC-endorsed *C. Difficile* measures. This means: 1) that the CMS requirement (Lab ID) differs from the state requirement (CDI), 2) that hospitals must currently submit *C. Difficile* data twice, in two different formats, and 3) Medicare will begin publishing *C. Difficile* data in early 2014. Although Subcommittee members were aware of the possible CMS requirement at the time that they recommended the use of CDI, there is concern about double-work and the potential for consumers to be confused if *C. Difficile* data are reported in two different places (state and Medicare), using two different methods (CDI and Lab ID).

The Subcommittee selected CDI, despite knowing that Lab ID was likely to be required by CMS in the future, because local infection preventions felt (and still feel) that this method is inferior to CDI and does not result in as accurate an estimate of symptomatic, laboratory-confirmed *C. Difficile* incidence. It is our collective understanding that CMS selected Lab ID largely because it does not require manual data entry and is therefore, less resource intensive for hospitals; but, we do know their understanding of potential limitations of Lab ID vs. CDI estimates.

Subcommittee Suggestions

The Subcommittee carefully considered the barriers detailed above, which can be summarized as follows:

- Although we were awaiting sufficient data, we now have enough data to publish a report (six quarters).
- Several hospital laboratories have switched from lower-sensitivity to higher-sensitivity testing methods during the six-quarter time period, requiring us to rethink initial recommendations to stratify reporting for fair comparisons.
- Medicare is now requiring Lab ID data submission and will publicly report Lab ID in 2014.
- Infection preventionists are overburdened with data collection, which detracts from infection control.
- We do not want to confuse consumers by releasing different measures.

After considering these barriers, the Subcommittee suggested that the Steering Committee:

- Release descriptive information that details what hospitals have done to prevent CDI;
- Provide information to educate consumers about protecting themselves against CDI;
- Publish process measures that detail what protections hospitals have implemented; and
- Limit the CDI report (if released) to a one-time report that is replaced with a Lab ID report in 2014, with the CDI data submission requirement ending.

Despite the request to end the CDI data submission requirement, there was some discussion about the value of continued data collection to compare CDI vs. Lab ID. The Subcommittee may choose to continue local data

collection (not reporting), so that we make recommendations that inform national discussion and policy about *C. Difficile* reporting methods.

Steering Committee Guidance to Dr. Fine

The Steering Committee discussed the *C. Difficile* reporting issues and Subcommittee guidance at two consecutive meetings (7/23/12 and 9/24/12). A clinical expert, Dr. Stefan Gravenstein, was present for the second discussion. The Committee's resulting recommendations are that Dr. Fine:

- Publish the existing data, but in a one-time "white paper" type report that provides context;
- Recommend that the program's analysts and methodological experts make statistical adjustments to account for the various testing methods and changes over time;
- Include information in the report that provides context for hospitals' work to date to reduce CDI, including the HAI Collaborative and hospital processes; and
- Ensure that the report clearly explains what the diamonds mean and how to interpret differences.

On behalf of the committee, we suggest that you use these recommendations to issue guidance to the program and to the HAI Subcommittee, directing the release of a public report that follows the above guidance.

Sincerely,



Samara Viner-Brown, MS
Facilitator, Steering Committee
Chief, Center for Health Data and Analysis
Co-Chair, HAI Subcommittee



Rosa Baier, MPH
Facilitator, Steering Committee
Program Director, Healthcare Quality Performing Program

CC: *Steering Committee Members*
Len Mermel, DO, HAI Subcommittee Co-Chair

¹Pop-Vicas A, Butterfield K, Gardner R. Reducing the incidence of *Clostridium difficile* infections: can we do it? *Med Health RI* 2010 Sep;93(9):263-6.

²Baier R, Butterfield K, Gravenstein S, et al. Hospital readmission diagnoses for Rhode Island Medicare patients: The role of *Clostridium difficile* infections (CDI). Poster presentation.

³Stamper PD, Alcabasa R, Aird D et al. Comparison of a commercial real-time pcr assay for *tcdB* detection to a cell culture cytotoxicity assay and toxigenic culture for direct detection of toxin-producing *Clostridium difficile* in clinical samples. *J Clin Microbiol* 2009 Feb; 47 (2): 373-8.

⁴Tenover FC, Novak-Weekly S, Woods CW et al. Impact of strain type on detection of toxigenic *Clostridium difficile*: comparison of molecular diagnostic and enzyme immunoassay approaches. *J Clin Microbiol* 2010 Oct; 48 (10): 3719-24.

⁵Chapin KC, Dickenson RA, Andrea SB. Comparison of five assays for detection of *Clostridium difficile* toxin. *JMD* 2011 Jul; 13 (4): 395-400.

⁶ Stamper PD, Alcabasa R, Aird D et al. Comparison of a commercial real-time pcr assay for *tcdB* detection to a cell culture cytotoxicity assay and toxigenic culture for direct detection of toxin-producing *Clostridium difficile* in clinical samples. *J Clin Microbiol* 2009 Feb; 47 (2): 373-8.

⁷ Tenover FC, Novak-Weekly S, Woods CW et al. Impact of strain type on detection of toxigenic *Clostridium difficile*: comparison of molecular diagnostic and enzyme immunoassay approaches. *J Clin Microbiol* 2010 Oct; 48 (10): 3719-24.

⁸ Chapin KC, Dickenson RA, Andrea SB. Comparison of five assays for detection of *Clostridium difficile* toxin. *JMD* 2011 Jul; 13 (4): 395-400.



Healthcare Quality Reporting Program

NURSING HOME EMPLOYEE INFLUENZA VACCINATION STATUS

Care Outcomes Report, 2011-2012

Information about nursing home employee influenza vaccination is [reported annually on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the public reporting program. Vaccinating healthcare workers can prevent the spread of influenza, or flu, to nursing home residents. You can learn more about the rates—including their data source and how they are calculated—by reading the Methods. With questions about a nursing home’s score, please contact the nursing home directly.

NOTE: In nursing homes, some of the doctors who care for patients are nursing home employees and some are not nursing home employees, but have “privileges” to see their patients when they are staying at a nursing home. The information below includes only doctors and other healthcare workers who are nursing home employees.

Figure 1: Top 10 Nursing Homes for Healthcare Workers - Employees Influenza Vaccination

Rank	Nursing Home	Healthcare Worker Type				
		CNAs	Nurses	Doctors / Practitioners	Other Employees	All Healthcare Workers
		% Vaccinated				
1.	Summit Commons Skilled Nursing and Rehab Center	85.5	88.9	N/A	92.6	87.8
2.	Elmwood Health Center	68.8	80.0	100.0	88.9	82.2
3.	South Kingstown Nursing and Rehabilitation Center	74.6	86.4	N/A	93.3	82.0
4.	Grand Islander	64.3	88.9	N/A	85.9	78.0
5.	Chestnut Terrace Nursing and Rehabilitation Center	66.7	81.3	N/A	94.4	77.6
6.	South County Nursing and Subacute Center	74.5	73.3	100.0	N/A	77.0
7.	Scalabrini Villa	72.1	67.4	100.0	84.6	75.2
8.	Scallop Shell Nursing & Rehabilitation Center	66.7	84.6	N/A	75.9	74.6
9.	Golden Crest Nursing Centre	73.7	83.3	50.0	72.2	73.7
10.	Elmhurst Extended Care	72.0	73.7	N/A	75.8	73.4

N/A = Nursing home does not have this kind of healthcare worker

Figure 2: Nursing Home Healthcare Worker Influenza Vaccination, by Facility

Nursing Home (alphabetical)	Healthcare Worker Type				
	CNAs	Nurses	Doctors / Practitioners	Other Employees	All Healthcare Workers
	% Vaccinated				
Alpine Nursing Home Inc.	*** Unable to Submit Data ***				
Apple Rehab Clipper	*** Unable to Submit Data ***				
Apple Rehab Watch Hill	*** Unable to Submit Data ***				
Avalon Nursing Home	57.1	44.4	N/A	N/A	53.3
Ballou Home For The Aged	*** Unable to Submit Data ***				
Bannister House	33.9	16.7	N/A	N/A	32.3
Bayberry Commons	36.7	23.7	N/A	33.8	33.2
Berkshire Place Nursing and Rehabilitation Center	68.2	47.2	N/A	72.7	61.8
Bethany Home of Rhode Island	22.2	62.5	N/A	79.2	56.0
Brentwood Nursing Home	*** Unable to Submit Data ***				
Briarcliffe Manor	27.9	21.7	N/A	N/A	26.9
Cedar Crest Nursing Center	30.9	54.2	N/A	33.0	36.1
Charlesgate Nursing Center	12.4	13.5	0.0	100.0	20.1
Cherry Hill Manor	*** Unable to Submit Data ***				
Chestnut Terrace Nursing and Rehabilitation Center	66.7	81.3	N/A	94.4	77.6
Cortland Place	*** Unable to Submit Data ***				
Coventry Skilled Nursing and Rehabilitation Center	*** Unable to Submit Data ***				
Cra-Mar Meadows	*** Unable to Submit Data ***				
Crestwood Nursing and Convalescent Home	*** Unable to Submit Data ***				
Eastgate Nursing & Recovery Center	48.9	50.0	50.0	90.9	60.0
Elmhurst Extended Care	72.0	73.7	N/A	75.8	73.4
Elmwood Health Center	68.8	80.0	100.0	88.9	82.2
EPOCH Senior Healthcare on Blackstone Boulevard	*** Unable to Submit Data ***				
Evergreen House Health Center	*** Unable to Submit Data ***				
Forest Farm Health Care Center	*** Unable to Submit Data ***				
Friendly Home, The	*** Unable to Submit Data ***				
Golden Crest Nursing Centre	73.7	83.3	50.0	72.2	73.7
Grace Barker Nursing Center	*** Unable to Submit Data ***				
Grand Islander	64.3	88.9	N/A	85.9	78.0
Grandview Center	*** Unable to Submit Data ***				
Greenville Center	*** Unable to Submit Data ***				
Greenwood Care and Rehabilitation Center	*** Unable to Submit Data ***				
Hallworth House	*** Unable to Submit Data ***				
Harris Health Care North	61.1	53.3	0.0	92.3	66.0
Harris Health Center	*** Unable to Submit Data ***				
Hattie Ide Chaffee Home	*** Unable to Submit Data ***				
Heatherwood Nursing & Rehabilitation Center	*** Unable to Submit Data ***				
Hebert Health Center	*** Unable to Submit Data ***				
Heritage Hills Nursing Centre	67.9	67.7	N/A	64.9	66.9

N/A = Nursing home does not have this kind of healthcare worker

Nursing Home (alphabetical)	Healthcare Worker Type				
	CNAs	Nurses	Doctors / Practitioners	Other Employees	All Healthcare Workers
	% Vaccinated				
Holiday Retirement Home, The	*** Unable to Submit Data ***				
Hopkins Manor	66.0	52.9	N/A	54.8	60.4
Jeanne Jugan Residence	*** Unable to Submit Data ***				
John Clarke Retirement Center, The	60.0	33.3	0.0	75.0	61.3
Kent Regency	*** Unable to Submit Data ***				
Linn Health Care Center	*** Unable to Submit Data ***				
Mansion Nursing Home	64.3	21.4	N/A	55.8	53.8
Morgan Health Center	58.4	94.4	N/A	57.8	62.3
Mount St. Rita Health Centre	*** Unable to Submit Data ***				
Nancy Ann Nursing Home	*** Unable to Submit Data ***				
North Bay Retirement Living	*** Unable to Submit Data ***				
Oak Hill Nursing and Rehabilitation Center	*** Unable to Submit Data ***				
Oakland Grove Health Care Center	*** Unable to Submit Data ***				
Orchard View Manor Nursing and Rehab	49.5	32.0	100.0	43.7	44.2
Overlook Nursing & Rehabilitation Center	50.0	69.0	25.0	30.9	44.9
Park View Nursing Home	*** Unable to Submit Data ***				
Pawtucket Skilled Nursing and Rehabilitation Center	*** Unable to Submit Data ***				
Pine Grove Health Center	*** Unable to Submit Data ***				
Rhode Island Veterans Home	59.8	64.7	100.0	67.6	64.5
Riverview Healthcare Community	*** Unable to Submit Data ***				
Roberts Health Centre Inc.	*** Unable to Submit Data ***				
Saint Elizabeth Home	70.4	66.7	N/A	66.2	68.0
Saint Elizabeth Manor	63.6	57.8	50.0	81.3	67.2
Scalabrini Villa	72.1	67.4	100.0	84.6	75.2
Scallop Shell Nursing & Rehabilitation Center	66.7	84.6	N/A	75.9	74.6
Scandinavian Home	68.9	77.8	100.0	57.9	68.7
Shady Acres, Inc.	*** Unable to Submit Data ***				
Silver Creek Manor	81.5	75.0	37.5	68.4	72.7
South County Nursing and Subacute Center	74.5	73.3	100.0	N/A	77.0
South Kingstown Nursing and Rehabilitation Center	74.6	86.4	N/A	93.3	82.0
St. Antoine Residence	*** Unable to Submit Data ***				
St. Clare Home	*** Unable to Submit Data ***				
Steere House Nursing and Rehabilitation Center	*** Unable to Submit Data ***				
Summit Commons Skilled Nursing and Rehab Center	85.5	88.9	N/A	92.6	87.8
Sunny View Nursing Home	*** Unable to Submit Data ***				
Tockwotton Home	*** Unable to Submit Data ***				
Trinity Health & Rehabilitation Center	75.8	64.5	0.0	95.7	69.1
Village House	*** Unable to Submit Data ***				
Warren Skilled Nursing and Rehabilitation	*** Unable to Submit Data ***				
Waterview Villa Skilled Nursing & Rehabilitation Ctr.	61.0	48.1	100.0	N/A	58.2
West Shore Health Center	*** Unable to Submit Data ***				
West View Health Care Center	*** Unable to Submit Data ***				

N/A = Nursing home does not have this kind of healthcare worker

Nursing Home (alphabetical)	Healthcare Worker Type				
	CNAs	Nurses	Doctors / Practitioners	Other Employees	All Healthcare Workers
	% Vaccinated				
Westerly Health Center	80.3	70.6	N/A	52.2	69.2
Westerly Nursing Home	71.7	88.9	100.0	34.6	65.3
Woodpecker Hill Health Center	*** Unable to Submit Data ***				
Woonsocket Health Centre	*** Unable to Submit Data ***				
Average for All Nursing Homes	57.8	60.5	46.7	64.3	60.0

N/A = Nursing home does not have this kind of healthcare worker



Last updated 2.23.12

Healthcare Quality Reporting Program

2012 PHYSICIAN HIT SURVEY: OFFICE-BASED VERSION

This short questionnaire asks about physicians' use of health information technology (HIT) and should take 10-15 minutes to complete. **The Rhode Island Department of Health (HEALTH) requires that all licensed physicians complete the Physician HIT Survey each year.** For physicians using HIT, please note that a lack of response will be treated (and reported) as if you do not use HIT.

This is the 5th annual administration of this survey. HEALTH's Health Care Quality Performance (HCQP) Program publicly reports [results for each individual physician](#) each year. These data may also determine your eligibility for the health plans' HIT-based fee increases/incentives and help the Department of Human Services plan for stimulus incentives. If you have questions about this survey, [read the Frequently Asked Questions \(FAQ\)](#). Contact the health plans directly with any questions about their HIT-based fee increases/incentives or stimulus funds.

INSTRUCTIONS: These questions ask about your use of HIT and may be most accurately answered by you, rather than your Office Manager or another staff member. Note that you will need your license number and [Individual National Provider Identifier \(NPI\)](#) to complete this survey.

SECTION A: Physician and Practice Information

1. **What is your name?** _____
Last name First name Middle Initial Degree(s)
2. **What is your email address?** _____
3. **Are you licensed as a physician in Rhode Island?**
 - ₁ No, and I am not licensed in any other state(s) → *If not a licensed physician, stop the survey.*
 - ₂ No, but I am licensed in another state(s)
 - ₃ Yes, and **my license information is:**
 - a. **Rhode Island medical license number:** _____
 - b. **License type:** ₁ MD ₂ DO ₃ Neither → *If not a physician, stop the survey.*
4. **Are you licensed in either of these states adjacent to Rhode Island? (Check all that apply.)**
 - ₁ Connecticut
 - ₂ Massachusetts
 - ₃ Neither of these states adjacent to Rhode Island. → *If not licensed in RI, CT or MA, stop the survey.*
5. **What is your individual [National Provider Identifier \(NPI\)](#)?** _____
(If retired, please enter N/A.)

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6. Do you currently provide direct patient care services?

- _1 No → *If not providing direct patient care, stop the survey.*
- _2 Yes, and my **primary specialty** is:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> _1 Allergy & Immunology | <input type="checkbox"/> _11 Hematology/Oncology | <input type="checkbox"/> _21 OB-GYN | <input type="checkbox"/> _31 Pulmonary/Critical Care |
| <input type="checkbox"/> _2 Anesthesiology | <input type="checkbox"/> _12 Hospitalist | <input type="checkbox"/> _22 Occupational Med. | <input type="checkbox"/> _32 Radiation Oncology |
| <input type="checkbox"/> _3 Cardiology | <input type="checkbox"/> _13 Infectious Disease | <input type="checkbox"/> _23 Ophthalmology | <input type="checkbox"/> _33 Radiology |
| <input type="checkbox"/> _4 Colorectal Surgery | <input type="checkbox"/> _14 Intensivist | <input type="checkbox"/> _24 Otolaryngology | <input type="checkbox"/> _34 Rheumatology |
| <input type="checkbox"/> _5 Dermatology | <input type="checkbox"/> _15 Internal Medicine (general) | <input type="checkbox"/> _25 Orthopaedic Surgery | <input type="checkbox"/> _35 Surgery (general and other) |
| <input type="checkbox"/> _6 Emergency Med. | <input type="checkbox"/> _16 Medicine/Pediatrics | <input type="checkbox"/> _26 Pathology | <input type="checkbox"/> _36 Thoracic Surgery |
| <input type="checkbox"/> _7 Endocrinology | <input type="checkbox"/> _17 Nephrology | <input type="checkbox"/> _27 Pediatrics | <input type="checkbox"/> _37 Urology |
| <input type="checkbox"/> _8 Family Medicine | <input type="checkbox"/> _18 Neurology | <input type="checkbox"/> _28 Physical Med/Rehab. | <input type="checkbox"/> _38 Vascular Surgery |
| <input type="checkbox"/> _9 Gastroenterology | <input type="checkbox"/> _19 Neurosurgery | <input type="checkbox"/> _29 Plastic Surgery | <input type="checkbox"/> _39 Other: _____ |
| <input type="checkbox"/> _10 Geriatrics | <input type="checkbox"/> _20 Nuclear Medicine | <input type="checkbox"/> _30 Psychiatry | |

7. How many hours per week do you spend in direct patient care?

- _1 <10 hours
- _2 10-20 hours
- _3 >20 hours

8. What is your **main practice's** name and mailing address? *By 'main practice,' we mean the practice where you spend the majority of the time you provide direct patient care.*

Practice name

Practice Address

Box/Suite

City/Town

State

ZIP Code

9. What is your **practice's** organizational **National Provider Identifier (NPI)**?

10. **Altogether, approximately how large is your practice?** *Please consider physicians, nurse practitioners, and physician assistants.*

- _1 <5 clinicians
- _2 5-10 clinicians
- _3 >10 clinicians

11. **Approximately what percent of your patient visits are funded by Medicaid?**

- _1 0%
- _2 <30%
- _3 30-60%
- _4 >60%
- _5 Don't know

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SECTION B: Electronic Health Records (EMR) Status*

12. Whether or not you use an EMR, please indicate the extent to which you consider each of the following to be a barrier to EMR use.

	Not a barrier	Minor barrier	Major barrier
Access to technical support	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Availability of a computer in the appropriate location	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Impact of computer on doctor-patient interaction	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Lack of computer skills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Lack of interoperability (i.e., ability of different systems to communicate)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Privacy or security concerns	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Start-up financial costs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Ongoing financial costs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Technical limitations of systems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Training and productivity impact	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Other (please specify): _____			

13. Does your **main** practice have EMR components? By ‘EMR components,’ we mean an integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc. (This is also known as an electronic health record or EHR.)

- ₂ Yes → Skip to Question 22 on page 5
- ₁ No → a. Aside from your main practice, do ANY of your practice settings (hospital- or office-based) have EMR components? If more than one has EMR components, please choose the practice in which you provide the most direct patient care.
 - ₁ No
 - ₂ Yes, a hospital practice → Stop and complete the Physician HIT Survey: Hospital-Based Version
 - ₃ Yes, an office practice → Skip to Question 22 on page 5
 - ₄ N/A – no other practices

SECTION C: Plans to Implement EMR

14. Does your main practice **plan** to implement an EMR?

- ₁ No → If your main practice is not planning to implement an EMR, skip to Question 30 on page 9
- ₂ Yes, within 1 year
- ₃ Yes, after 1 year
- ₄ Don’t know

* EHR questions adapted with permission from: (1) Simon et al. Physicians and electronic health records: A statewide survey. *Arch Intern Med* 2007; 167: 507-512; and (2) Simon et al. Correlates of electronic health record adoption in office practices: A statewide survey. *J Am Med Assoc* 2007; 14: 110-117.

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15. If you do plan to implement an EMR, which EMR vendors are you considering (if any)?

- | | | |
|--|--|---|
| <input type="checkbox"/> _1 No vendor identified | <input type="checkbox"/> _9 Epic Systems | <input type="checkbox"/> _17 Practice Partner |
| <input type="checkbox"/> _2 Allscripts | <input type="checkbox"/> _10 GE Centricity | <input type="checkbox"/> _18 Sage - Intergy EMR |
| <input type="checkbox"/> _3 Amazing Charts | <input type="checkbox"/> _11 Greenway | <input type="checkbox"/> _19 SOAPware |
| <input type="checkbox"/> _4 Athena Heath | <input type="checkbox"/> _12 Ingenix- Caretracker | <input type="checkbox"/> _20 SuccessEHS |
| <input type="checkbox"/> _5 Cerner - PowerChart | <input type="checkbox"/> _13 McKesson Provider Tech. | <input type="checkbox"/> _21 Other: <i>(please specify)</i> |
| <input type="checkbox"/> _6 CPRS/Vista (VA Hospital) | <input type="checkbox"/> _14 Misys | |
| <input type="checkbox"/> _7 eClinicalWorks | <input type="checkbox"/> _15 Next Gen | |
| <input type="checkbox"/> _8 e-MD | <input type="checkbox"/> _16 Polaris - EpiChart | |

16. If you plan to implement an EMR, do you plan to seek incentive payments, also called Meaningful Use reimbursements? (Choose one.)

- _1 Yes, from Medicaid's EHR Incentive Program
 - _2 Yes, from Medicare's EHR Incentive Program
 - _3 Yes, but I haven't chosen between Medicare and Medicaid yet
 - _4 No, I don't plan to seek incentive payments
 - _5 Don't know
- } *Skip to question 19
on page 5*

17. When do you plan to request your first Medicare or Medicaid incentive payment?

- _1 2012
- _2 2013
- _3 After 2013

18. In pursuing Meaningful Use, you must choose five criteria from the following "menu set." Which five criteria are you currently planning to choose from the menu set?

- _1 Implement drug-formulary checks
- _2 Incorporate clinical lab-test results into certified EMR technology as structured data
- _3 Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
- _4 Send reminders to patients per patient preference for preventive/follow-up care
- _5 Provide patients with timely electronic access to their health information (allow patients to view their health information online)
- _6 Use certified EMR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate
- _7 Perform medication reconciliation when receiving a patient from another provider or care setting
- _8 Provide a Summary of Care record for each transition of care or referral from another provider or care setting
- _9 Complete at least one electronic data submission to an immunization registry or Immunization Information System (HEALTH is only able to accept childhood immunizations at this time)
- _10 Submit electronic syndromic surveillance data to public health agencies (when HEALTH is ready to accept these data)

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₁₁ Don't know

Note: You must include one of the last two objectives (9 & 10) to receive Meaningful Use incentive payments.

19. Do you plan to apply for EMR incentive funds in 2012 from any commercial insurers (e.g. Blue Cross & Blue Shield of Rhode Island, UnitedHealthcare of New England, and Tufts Health Pan)?

- Yes
 No

20. Are you currently reporting into the incentive-based Physician Quality Reporting System (PQRS)?

- Yes, and plan to continue in 2012
 Yes, but plan to discontinue in 2012 -> If you are not planning to report into PQRS, skip to Question 22
 No, but plan to start in 2012
 No, and have no plans to start -> If you are not planning to report into PQRS, skip to Question 22

21. How are you planning to report for PQRS in 2012?

- Claims-method
 Registry-method
 EMR Method
 Don't Know

-> The following questions are for physicians using EMRs, in your main practice or another practice. If you don't have an EMR in either your main practice or another practice, skip to Question 30 on page 9.

SECTION D: EMR Use

22. Please provide the following information about the EMR you use. If your main practice has an EMR, answer these questions based on your main practice. If your main practice does not have an EMR, answer them based on the practice with an EMR in which you spend the most time providing direct patient care.

a. What is your practice's EMR vendor?

- _1 Don't know
_2 Allscripts
_3 Amazing Charts
_4 Athena Heath
_5 Cerner - PowerChart
_6 CPRS/Vista (VA Hospital)
_7 eClinicalWorks
_8 e-MD
_9 Epic Systems
_10 GE Centricity
_11 Greenway
_12 Ingenix - Caretracker
_13 McKesson Provider Tech.
_14 Misys
_15 Next Gen
_16 Polaris - EpiChart
_17 Practice Partner
_18 Sage - Intergy EMR
_19 SOAPware
_20 SuccessEHS
_21 Other: (please specify)

b. In which year did your practice install its EMR? _____

c. Is your EMR certified by the Office of the National Coordinator (ONC)? (Only ONC-certified products are eligible for Meaningful Use incentives. View the ONC's database of certified products here.)

- _1 No
_2 Yes
_3 Don't Know

-> For the following questions, please indicate the percent of patients with whom you use these EMR functions when the functions are applicable. It may be helpful to think of the percents as follows:

- 0% of patients Never
<30% of patients Sometimes

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30-60% of patients *Often*
>60% of patients *Always*

23. Please indicate the percent of patients with whom you use the following functions:

Clinical Documentation	Don't Have	0%	<30%	30%-60%	>60%
• Write electronic visit notes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• View electronic lists of each patient's medications	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• View electronic problem lists	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Generate patient clinical summaries for referral purposes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Demographics	Don't Have	0%	<30%	30%-60%	>60%
• Patient demographics (e.g., address, date of birth, gender)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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Decision Support	Don't Have	0%	<30%	30%-60%	>60%
• Drug interaction warnings at the point of prescribing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Letters or other patient reminders regarding indicated or overdue care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Prompts at the point of care, regarding recommended care specific to the patient	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Interoperability	Don't Have	0%	<30%	30%-60%	>60%
• Electronic referrals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Clinical messaging (secure emailing with providers outside your office via your EMR)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Order Management	Don't Have	0%	<30%	30%-60%	>60%
• Laboratory order entry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Radiology order entry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Reporting	Don't Have	0%	<30%	30%-60%	>60%
• Clinical quality measures (e.g., % of diabetics with a hemoglobin A1c test)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Patients out of compliance with clinical guidelines (e.g., women over age 50 without a recent mammogram)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Patients with a condition, characteristic, or risk factor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Results Management	Don't Have	0%	<30%	30%-60%	>60%
• Laboratory test results directly from lab via electronic interface	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Scanned paper laboratory test reports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Radiology test results directly from facility via electronic interface	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
• Scanned paper radiology test reports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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24. With your EMR, do you plan to seek or have you already sought or accepted incentive payments, also called Meaningful Use reimbursements? (Choose one.)

- ₁ Yes, from Medicaid’s EHR Incentive Program
 - ₂ Yes, from Medicare’s EHR Incentive Program
 - ₃ Yes, but I haven’t chosen between Medicare and Medicaid yet
 - ₄ No, I don’t plan to seek incentive payments
 - ₅ Don’t know
- } *Skip to question 30*

25. When will you (or did you) request or when did you request your first Medicare or Medicaid incentive payment?

- ₁ 2011
- ₂ 2012
- ₃ 2013
- ₃ After 2013

26. In pursuing Meaningful Use, you must choose five criteria from the following “menu set.” Which five criteria did you choose or are you planning to choose from the meaningful use menu set?

- ₁ Implement drug-formulary checks
- ₂ Incorporate clinical lab-test results into certified EMR technology as structured data
- ₃ Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
- ₄ Send reminders to patients per patient preference for preventive/follow-up care
- ₅ Provide patients with timely electronic access to their health information (allow patients to view their health information online)
- ₆ Use certified EMR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate
- ₇ Perform medication reconciliation when receiving a patient from another provider or care setting
- ₈ Provide a Summary of Care record for each transition of care or referral from another provider or care setting
- ₉ Complete at least one electronic data submission to an immunization registry or Immunization Information System (HEALTH is only able to accept childhood immunizations at this time)
- ₁₀ Submit electronic syndromic surveillance data to public health agencies (when HEALTH is ready to accept these data)
- ₁₁ Don’t know

**Note: You must include one of the last two objectives (9 & 10) to receive Meaningful Use incentive payments.*

27. Did you apply or are you planning to apply for EMR incentive funds from any commercial insurers (e.g. Blue Cross & Blue Shield of Rhode Island, UnitedHealthcare of New England, and Tufts Health Pan)?

- Yes
- No

28. Are you currently reporting or do you plan to report into the incentive-based Physician Quality Reporting System (PQRS)?

- Yes, and plan to continue in 2012
- Yes, but plan to discontinue in 2012 → *If you are not planning to report into PQRS, skip to Question 30*
- No, but plan to start in 2012
- No, and have no plans to start → *If you are not planning to report into PQRS, skip to Question 30*

29. How are you planning to report for PQRS in 2012?

- Claims-method
- Registry-method
- EMR Method
- Don't Know

SECTION E: Electronic Prescribing (e-Prescribing) Use

30. What percent of the time do you transmit prescriptions electronically to the pharmacy? (Exclude faxing.)

- ₁ N/A – I do not prescribe medications → *Skip to Question 32*
- ₂ 0% → *Skip to Question 32*
- ₂ <30%
- ₃ 30%-60%
- ₄ >60%

Health Care Quality Performance (HCQP) Program
2012 PHYSICIAN HIT SURVEY: OFFICE-BASED VERSION

31. Do you transmit these electronic prescriptions using an EMR?

- ₁ No
- ₂ Yes

32. Have you heard of Rhode Island's statewide Health Information Exchange called [currentcare](#)?

- ₁ No
- ₂ Sounds familiar, but I do not know much about it
- ₃ Yes, and I would encourage patients to enroll
- ₄ Yes, but I would not encourage patients to enroll

Please provide any comments on [currentcare](#): _____

33. Please provide any feedback about e-prescribing: *(Although e-prescribing of controlled substances [i.e., Schedule II-V medications] is now allowed by the DEA, the state regulations and the software changes needed by physicians, pharmacies, and e-prescribing intermediaries to operationalize this are not in place in most states, including Rhode Island. We know this is frustrating for many of you, and we are working to make e-prescribing of controlled substances available in Rhode Island as soon as possible.)*

34. Please provide any feedback about EMRs: _____

35. Please use this space to provide additional comments: _____

Thank you for taking the time to complete this survey.



Steering Committee: HCQP Program Updates

Samara Viner-Brown, MS, HEALTH

Rosa Baier, MPH, Healthcentric Advisors

November 26, 2012



Agenda

- Welcome & introductions
- Action items
- New/updated data reports
- State consumer websites
- Home health satisfaction reporting
- Physician HIT Survey planning
- Open forum



Welcome & introductions

- Roll call
- New member
 - Deidre Gifford, MD, MPH, Executive Office of Health and Human Services (EOHHS)
- Vacant seats
 - Rhode Island Medical Society
 - Rhode Island Partnership for Home Care



Action items

- Distribute the meaningful use and certified EMR reports (Margaret)
- Research Medicaid home health satisfaction data (Rosa)
- Research any home health or nursing home quality measurement data shared with the Integrated Care Initiative's quality measurement group (Rosa)
- Share the Medicaid nursing home data with PCPAC (Dr. Fine/Rosa)
- Write an advisory letter summarizing the CDI recommendations (Sam/Rosa)



Data reports

- New/updated
 - Nursing home healthcare worker (HCW) flu vaccination (Nov)
- Upcoming
 - Hospital *C. Difficile* Infections (Nov)
 - Home Health HCW flu vaccination (pilot; ASAP)
 - Hospital MRSA CLABSI (Dec)
 - Nursing home resident and family satisfaction (Dec/Jan)
 - Hospital hand hygiene (Feb/Mar)
 - Physician HIT adoption (Apr/May)



New report: Nursing home healthcare worker influenza vaccination (Nov)



Healthcare Quality Reporting Program
NURSING HOME EMPLOYEE INFLUENZA VACCINATION STATUS
 Care Outcomes Report, 2011-2012

Information about nursing home employee influenza vaccination is reported annually on the Department of Health's (HEALTHY's) Web site as part of the public reporting program. Vaccinating healthcare workers can prevent the spread of influenza, or flu, to nursing home residents. You can learn more about the rates—including their data source and how they are calculated—by reading the Methods. With questions about a nursing home's score, please contact the nursing home directly.

NOTE: In nursing homes, some of the doctors who care for patients are nursing home employees and some are not nursing home employees, but have "privileges" to see their patients when they are staying at a nursing home. The information below includes only doctors and other healthcare workers who are nursing home employees.

Figure 1: Top 10 Nursing Homes for Healthcare Workers - Employees Influenza Vaccination

Rank	Nursing Home	Healthcare Worker Type					All Healthcare Workers
		CNAs	Nurses	Doctors / Practitioners	Other Employees	% Vaccinated	
1.	Summit Commons Skilled Nursing and Rehab Center	85.5	88.0	N/A	92.6	87.8	
2.	Elmwood Health Center	68.8	80.0	100.0	88.0	82.2	
3.	South Kingstown Nursing and Rehabilitation Center	74.6	86.4	N/A	93.3	82.0	
4.	Grand Islander	64.3	88.0	N/A	85.0	78.0	
5.	Chestnut Terrace Nursing and Rehabilitation Center	66.7	81.3	N/A	94.4	77.6	
6.	South County Nursing and Subacute Center	74.5	73.3	100.0	N/A	77.0	
7.	Scalaberna Villa	72.1	67.4	100.0	84.6	75.2	
8.	Scallop Shell Nursing & Rehabilitation Center	66.7	84.6	N/A	75.0	74.6	
9.	Golden Crest Nursing Centre	73.7	83.3	50.0	72.2	73.7	
10.	Elmhurst Extended Care	72.0	73.7	N/A	75.8	73.4	

N/A = Nursing home does not have this kind of healthcare worker

Last updated: 11/07/12

1

Center for Health Data and Analysis

Overall rates:

- CNAs - 57.8%
- Nurses - 60.5%
- Doctors/practitioners - 46.7%
- Other employees - 64.3%
- All workers - 60.0%

Trends:

- 2010-2011 season: 56.7%
- 2011-2012 season: 60.0%
- **+3.3%**



New report: Nursing home healthcare worker (HCW) flu vaccination (Nov)



Healthcare Quality Reporting Program
NURSING HOME EMPLOYEE INFLUENZA VACCINATION STATUS
 Care Outcomes Report, 2011-2012

Information about nursing home employee influenza vaccination is reported annually on the Department of Health's (HEALTHY's) Web site as part of the public reporting program. Vaccinating healthcare workers can prevent the spread of influenza, or flu, to nursing home residents. You can learn more about the rates—including their data source and how they are calculated—by reading the Methods. With questions about a nursing home's score, please contact the nursing home directly.

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		% Vaccinated				
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3.	South Kingstown Nursing and Rehabilitation Center	74.6	86.4	N/A	93.3	82.0
4.	Grand Islander	64.3	88.0	N/A	85.0	78.0
5.	Chestnut Terrace Nursing and Rehabilitation Center	66.7	81.3	N/A	94.4	77.6
6.	South County Nursing and Subacute Center	74.5	73.3	100.0	N/A	77.0
7.	Scalaberna Villa	72.1	67.4	100.0	84.6	75.2
8.	Scallop Shell Nursing & Rehabilitation Center	66.7	84.6	N/A	75.0	74.6
9.	Golden Crest Nursing Centre	73.7	83.3	50.0	72.2	73.7
10.	Elmhurst Extended Care	72.0	73.7	N/A	75.8	73.4

N/A = Nursing home does not have this kind of healthcare worker

Last updated: 11/07/12

1

Center for Health Data and Analysis

36 of 85 facilities submitted data

Overall rates:

- CNAs - 57.8%
- Nurses - 60.5%
- Doctors/practitioners - 46.7%
- Other employees - 64.3%
- All workers - 60.0%

Trends :

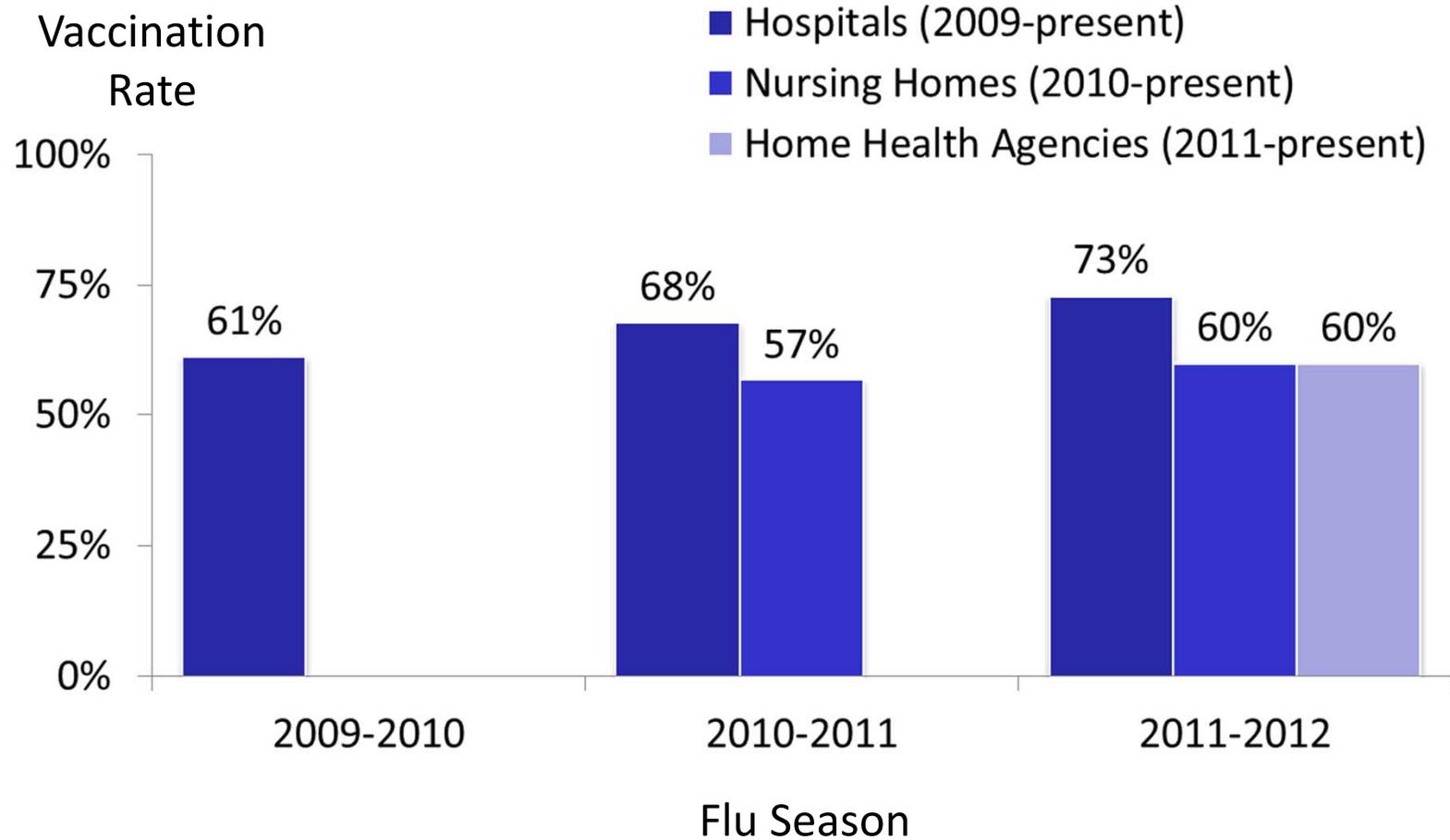
- 2010-2011 season: 56.7%
- 2011-2012 season: 60.0%
- **+3.3%**

Upcoming/pilot report: Home health HCW flu vaccination (Nov)



- Feedback report (no published data)
- 17 of 73 agencies submitted data
- Overall rates:
 - CNAs - 57.8%
 - Nurses - 60.5%
 - Doctors/practitioners - 46.7%
 - Other employees - 64.3%
 - All workers - 60.0%

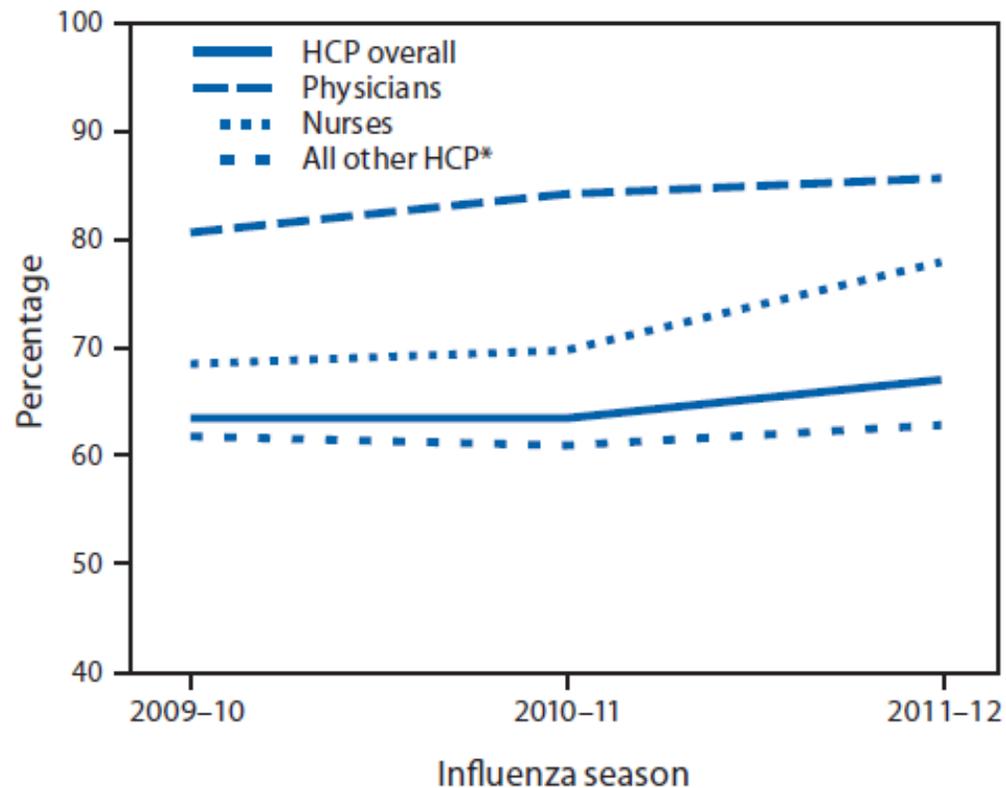
Hospital HCW vaccination status, by setting





MMWR: Influenza vaccination coverage among health-care personnel — 2011–12

FIGURE 1. Percentage of health-care personnel (HCP) who received influenza vaccination, by occupation — Internet panel surveys, United States, 2009–10, 2010–11, and 2011–12 influenza seasons

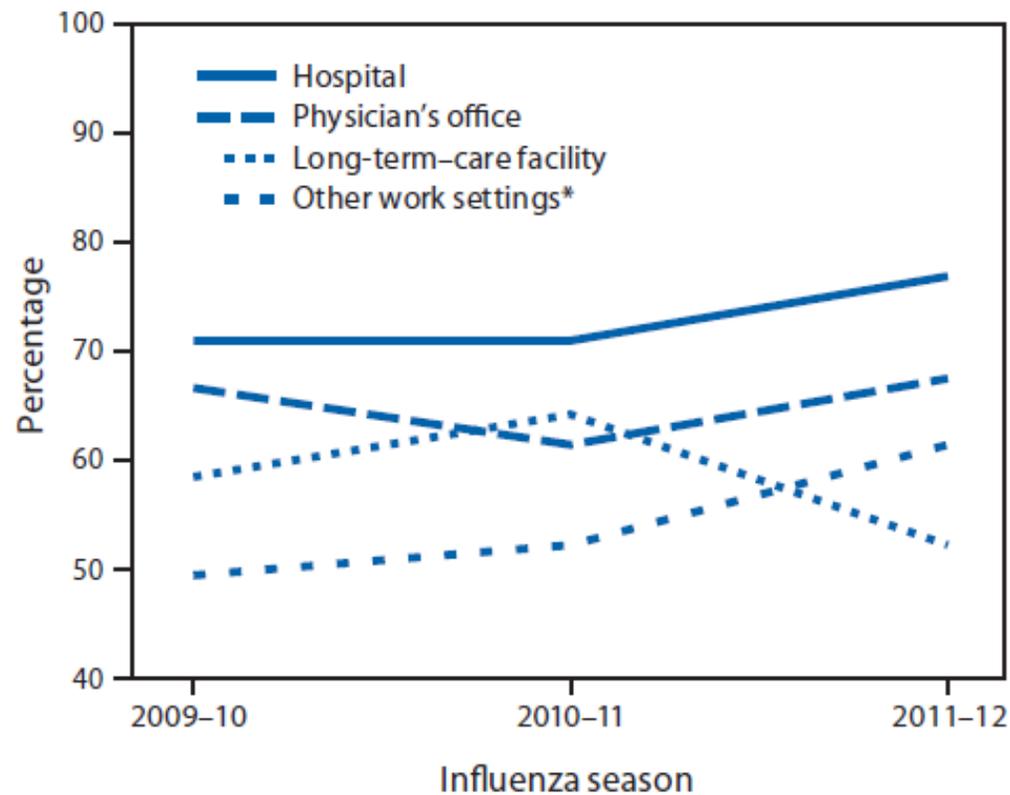


Source: Influenza Vaccination Coverage Among Health-Care Personnel — 2011–12 Influenza Season, United States. MMWR 28 Sept 2012; 61 (38).



MMWR: Influenza vaccination coverage among health-care personnel — 2011–12

FIGURE 2. Percentage of health-care personnel (HCP) who received influenza vaccination, by work setting — Internet panel surveys, United States, 2009–10, 2010–11, and 2011–12 influenza seasons



Source: Influenza Vaccination Coverage Among Health-Care Personnel — 2011–12 Influenza Season, United States. MMWR 28 Sept 2012; 61 (38).

Upcoming/updated report: Hospital MRSA CLABSI (Dec)



New Subcommittee recommendations:

- Report at the hospital level (instead of ICU)
- Use 95% CI (instead of 90%)



State consumer websites

- Two primary questions:
 - How can we make our website consumer friendly?
 - How should we align with the concurrent development of state consumer websites?

State consumer websites: Our public reporting program website



A screenshot of a Windows Internet Explorer browser window displaying the Healthcare Quality Reporting Program website. The browser's address bar shows the URL "http://www.health.ri.gov/programs/healthcarequalityreporting/index.php". The website header includes the "RI.gov" logo, the text "State of Rhode Island Department of Health", and navigation links for "R.I. Government Agencies", "Privacy Policy", and "Search RI.gov". A search bar is also present. The main content area is titled "Healthcare Quality Reporting Program" and includes a "Mission" section with a paragraph and a "What we do" section with a bulleted list. A left sidebar contains a navigation menu with items like "Home", "News", "Data", "Topics & Programs", "Licensing", "Birth, Death, & Marriage", "Publications", "Find +", "Information For +", and "Laws & Regulations +". A right sidebar contains sections for "Publications" (with links to "Annual Report" and "FAQ's about Data Collection and Reporting") and "Legal Authority" (with a link to "Healthcare Quality Reporting Program").

State consumer websites: Find a physician tool



The screenshot shows a web browser window displaying the "Find a Doctor" tool on the Rhode Island Department of Health website. The browser's address bar shows the URL <http://www.health.ri.gov/find/physicians/>. The website header includes the RI.gov logo and navigation links for "R.I. Government Agencies", "Privacy Policy", and a search bar. The main content area is titled "Find a Doctor in Rhode Island" and provides instructions for searching by last name and city/town. It includes two input fields: "Last Name" and "City/Town/Village", followed by a "Get Results" button. Below the form is a table with columns for "Last Name", "First Name", "Specialty", "City", and "State". A left-hand navigation menu lists various website sections like Home, News, Data, Topics & Programs, Licensing, Birth, Death, & Marriage, Publications, Find, Information For, and Laws & Regulations.

Find a Doctor: Rhode Island Department of Health - Windows Internet Explorer

http://www.health.ri.gov/find/physicians/

Find a Doctor: Rhode Island ...

File Edit View Favorites Tools Help

Journal - Author Name Esti... Suggested Sites Home - PMC - NCBI

RI.gov R.I. Government Agencies | Privacy Policy | Search RI.gov: [] Go

State of Rhode Island
Department of Health

Directions | Contact us | About Us | Español | Français | Português Search: [] Go

Home > Find > Doctors

Find a Doctor in Rhode Island

This provides a list of currently active physicians licensed by the Rhode Island Department of Health. Filter your search by physician last name, and/or, the city/town of where the physicians practices.

Last Name
[]

If you are not sure of spelling, enter only as many letters as you know. Please DO NOT include any punctuation marks in the licensee's name (e.g. hyphens, apostrophes).

City/Town/Village
[]

Get Results

To sort results, click on column heading. For additional physician details, click on the row.

Last Name	First Name	Specialty	City	State
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State consumer websites: Concurrent efforts

- Multiple concurrent efforts:
 - OHIC - Health insurance exchange
 - OHHS - All-payer claims database (APCD)
 - OHHS - Integrated Care Initiative
 - Others?
- Discussion:
 - What role should this program play?
 - Should we align or integrate efforts? How?
 - What conversations need to occur?

Home health satisfaction reporting: Home Health CAHPS



- Continued discussion:
 - Which populations should be required to conduct satisfaction surveys? With what frequency?

<u>Population</u>	<u>Current Requirement</u>	<u>Subcommittee Recommendation</u>
Medicare, skilled patients	HH CAHPS	Link to HH Compare
Skilled, commercial patients	Do not survey	Do not survey
Non-skilled patients	Press Ganey	Stop reporting
Skilled, Medicaid patients	(none)	(none)

Home health satisfaction reporting: Home Health CAHPS



- Required by Medicare; ongoing
- For patients receiving skilled care paid for by Medicare, such as nursing and therapy:
 - Care of patients
 - Communications between providers and patients
 - Specific care issues
 - Care from the agency's home health providers
 - Recommend this agency to friends or family

Home health satisfaction reporting: Press Ganey survey instrument



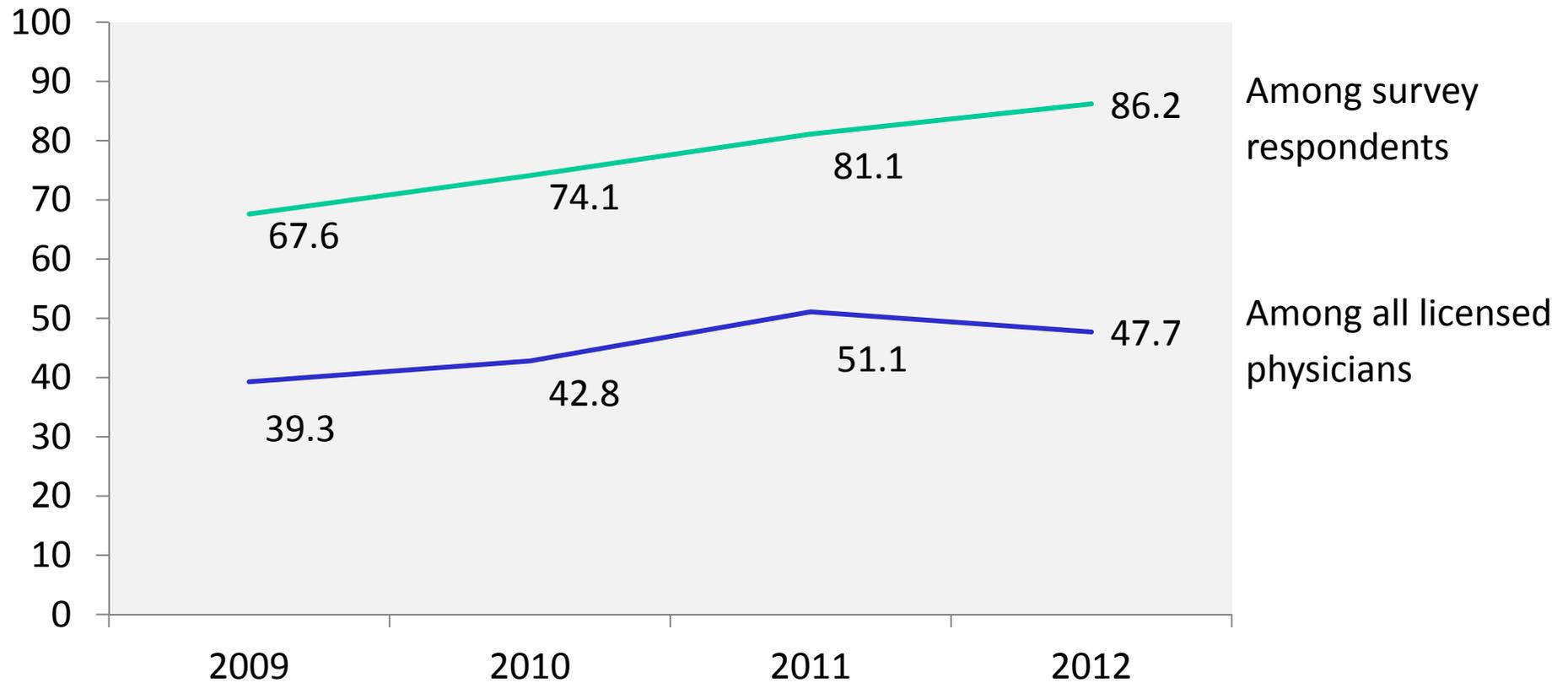
- Required by state; last done in 2010
- For patients receiving non-skilled care, such as help with dressing, bathing and light cleaning:
 - Arranging home care
 - Dealing with the Office
 - Nurses
 - Home health aides
 - Homemakers/ companions
 - Therapists and others (Other Professionals)

Home health satisfaction reporting: Home Health CAHPS

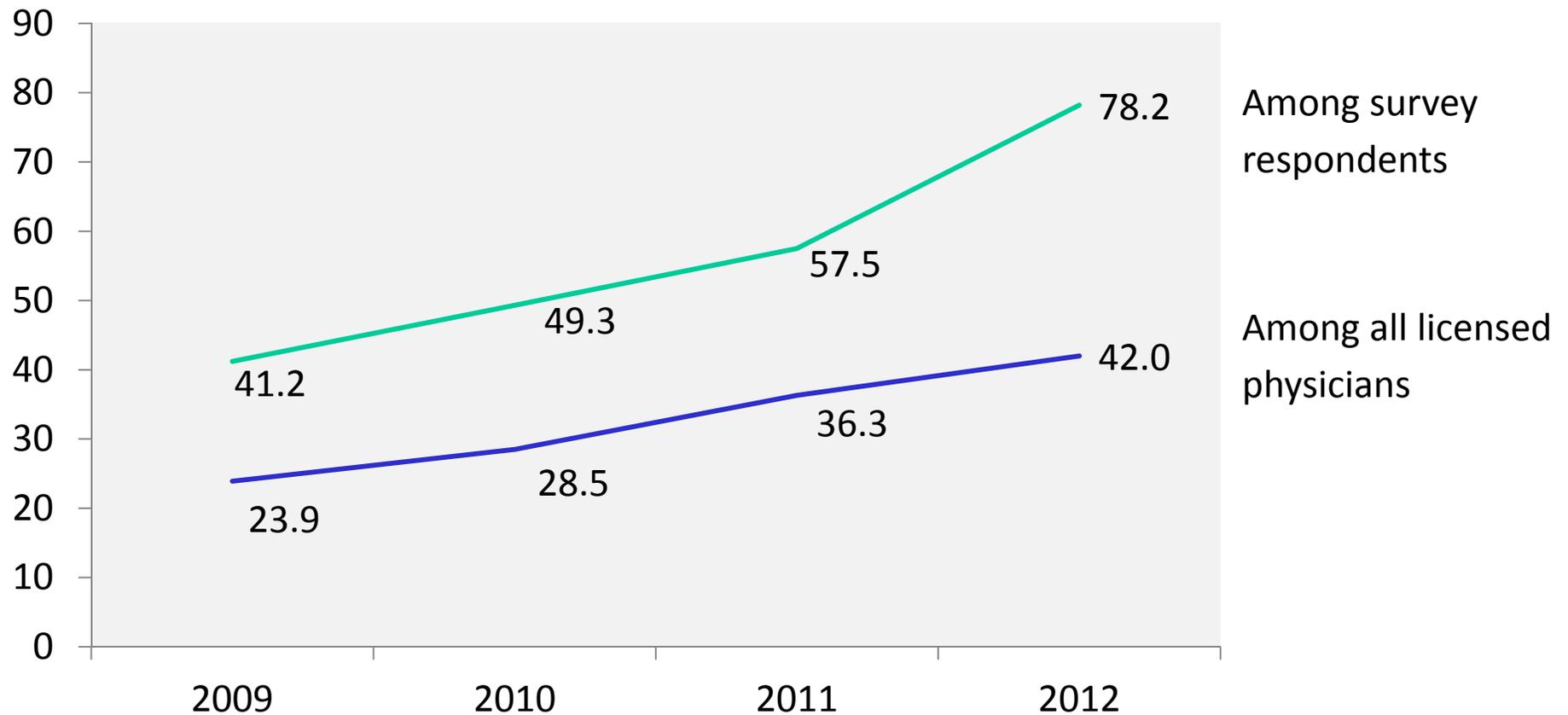


- Discussion:
 - Which populations should be required to conduct satisfaction surveys? With what frequency?

Physician HIT Survey planning: % of physicians with EMRs, 2009-2012



Physician HIT Survey planning: % of physicians e-prescribing, 2009-2012



Physician HIT Survey planning: Stakeholder outreach



- BCBSRI
- EOHHS
- HEALTH
- Medicaid
- Rhode Island Quality Institute
- Tufts
- United



Samara Viner-Brown, MS

Chief

Center for Health Data & Analysis

401.222.5935

Samara.Viner-Brown@health.ri.gov

www.health.ri.gov

Rosa Baier, MPH

Senior Scientist

Healthcentric Advisors

401.528.3205

rbaier@riqio.sdps.org

www.healthcentricadvisors.org

Influenza Vaccination Coverage Among Health-Care Personnel — 2011–12 Influenza Season, United States

Influenza vaccination of health-care personnel (HCP) is recommended by the Advisory Committee on Immunization Practices (ACIP) (1). Vaccination of HCP can reduce morbidity and mortality from influenza and its potentially serious consequences among HCP, their family members, and their patients (1–3). To provide timely estimates of influenza vaccination coverage and related data among HCP for the 2011–12 influenza season, CDC conducted an Internet panel survey with 2,348 HCP during April 2–20, 2012. This report summarizes the results of that survey, which found that, overall, 66.9% of HCP reported having had an influenza vaccination for the 2011–12 season. By occupation, vaccination coverage was 85.6% among physicians, 77.9% among nurses, and 62.8% among all other HCP participating in the survey. Vaccination coverage was 76.9% among HCP working in hospitals, 67.7% among those in physician offices, and 52.4% among those in long-term care facilities (LTCFs). Among HCP working in hospitals that required influenza vaccination, coverage was 95.2%; among HCP in hospitals not requiring vaccination, coverage was 68.2%. Widespread implementation of comprehensive HCP influenza vaccination strategies is needed, particularly among those who are not physicians or nurses and who work in LTCFs, to increase HCP vaccination coverage and minimize the risk for medical-care-acquired influenza illnesses.

For the Internet panel survey, two source populations were recruited through e-mails and pop-up invitations. Clinical professionals (e.g., physicians, nurses, and other health professionals [dentists, nurse practitioners, and physician's assistants]) were recruited from the current membership roster of Medscape, a web portal managed by WebMD Professional Services. Other HCP such as assistants, aides, administrators, clerical support workers, janitors, food service workers, and housekeepers were recruited for a health survey from SurveySpot, a general population Internet panel operated by Survey Sampling International that provides its members with

online survey opportunities in exchange for nominal cash and rewards.* Among the 2,518 HCP who completed the screening questions and entered the two panel survey sites, 2,348 (93.2%) completed the survey.† Of those, 1,724 (73.4%) were clinical professionals, and 624 (26.6%) were other HCP.

Survey categories included demographics, occupation type, work setting, self-reported influenza vaccination, reasons for nonvaccination during the current influenza season, and employer vaccination policies. Based on their responses to the questionnaire, HCP from both Internet sources were divided into three groups for this analysis: physicians, nurses, and all other HCP with occupations listed on the screening questionnaire. Sampling weights were calculated based on each occupation type by age, sex, race/ethnicity, medical-care setting, and census region to be more representative of the U.S. population of HCP. Because opt-in Internet panel surveys are not random

* Additional information available at <http://www.surveysampling.com>.

† A survey response rate requires specification of the denominator at each stage of sampling. During recruitment of an online opt-in survey sample, such as the Internet panel used for this report, these numbers are not available; therefore, the response rate cannot be calculated. Instead, the survey completion rate is provided.

INSIDE

- 758 Influenza Vaccination Coverage Among Pregnant Women — 2011–12 Influenza Season, United States
- 764 Influenza A (H3N2) Variant Virus-Related Hospitalizations — Ohio, 2012
- 768 Postvaccination Serologic Testing Results for Infants Aged ≤24 Months Exposed to Hepatitis B Virus at Birth — United States, 2008–2011
- 772 Announcements
- 773 QuickStats

Continuing Education examination available at http://www.cdc.gov/mmwr/cme/conted_info.html#weekly.



samples, statistical measures such as computation of confidence intervals and tests of differences cannot be performed.[§]

By occupation, influenza vaccination was most common among physicians (85.6%), followed by nurses (77.9%), and other HCP (62.8%) (Table). Vaccination coverage was 76.9% among HCP working in hospitals, 67.7% among those in physician offices, and 52.4% among those in long-term care facilities (LTCFs). By occupation and work setting, influenza vaccination was most common among physicians who worked in hospitals (86.7%) and lowest among other HCP who worked in LTCFs (50.2%) (Table). Among HCP working in hospitals that required influenza vaccination, coverage was 95.2%; among HCP in hospitals not requiring vaccination, coverage was 68.2%.

Coverage among HCP aged ≥60 years (75.7%) was higher than coverage for other age groups. Among racial/ethnic groups, coverage did not differ more than 5 percentage points. Vaccination coverage was higher among HCP with vaccination available at no cost on multiple days at their worksite (78.4%), compared with those not offered vaccination at no cost (48.4%). Overall, 496 (21.1%) of participating HCP reported being required to be vaccinated by their employers. Influenza vaccination was more common among those who reported that their employers promoted influenza vaccination

(75.8%), compared with those whose employers did not promote influenza vaccination (55.8%) (Table).

Overall, 33.1% of HCP reported not receiving influenza vaccination. The three most common answers to a question asking for the main reason a participant did not get vaccinated for influenza were 1) a belief that they did not need it (28.1%), followed by 2) concern about vaccination effectiveness (26.4%) and 3) concern about side effects (25.1%).

Reported by

*Sarah W. Ball, ScD, Deborah K. Walker, EdD, Sara M.A. Donahue, DrPH, David Izrael, MS, Abt Associates Inc., Cambridge Massachusetts. Jun Zhang, MD, Gary L. Euler, DrPH, Stacie M. Greby, DVM, Megan C. Lindley, MPH, Samuel B. Graitcer, MD, Carolyn Bridges, MD, Walter W. Williams, MD, James A. Singleton, PhD, Immunization Svcs Div, National Center for Immunization and Respiratory Diseases; Taranisia F. MacCannell, PhD, Div of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Infectious Diseases, CDC. **Corresponding contributors:** Gary Euler, geuler@cdc.gov, 404-639-8742; Jun Zhang, jzhang5@cdc.gov, 404-718-4867.*

Editorial Note

The overall HCP influenza vaccination coverage estimate from this Internet panel survey for the 2011–12 season was 66.9%, compared with previous CDC Internet panel estimates, from

[§]Additional information available at http://www.aapor.org/opt_in_surveys_and_margin_of_error1.htm.

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TABLE. Percentage of health-care personnel (HCP)* who received Influenza vaccination, by selected characteristics — Internet panel surveys, United States, 2011–12 influenza season

Characteristic	Unweighted no. of participants in sample	% vaccinated [†]	Percentage point change from 2010–11 survey
Overall	2,348	66.9	3.4
Occupation by work setting			
Physician	418	85.6	1.4
Hospital	247	86.7	5.4
Physician office	311	86.2	0.0
Long-term care facility	— [§]	— [§]	— [§]
Other work setting [¶]	— [§]	— [§]	— [§]
Nurse	373	77.9	8.1
Hospital	252	78.1	2.7
Physician office	91	75.6	1.4
Long-term care facility	54	72.2	— [§]
Other work setting [¶]	— [§]	— [§]	— [§]
All other HCP**	1,557	62.8	1.8
Hospital	688	75.5	6.5
Physician office	345	62.1	7.5
Long-term care facility	375	50.2	-16.7
Other work setting [¶]	261	58.4	6.3
Work setting			
Hospital	1,187	76.9	5.8
Physician office	747	67.7	6.2
Long-term care facility	455	52.4	-12.0
Other work setting [¶]	277	61.5	9.1
Age group (yrs)			
18–29	228	63.9	7.5
30–44	690	68.8	11.0
45–59	962	63.8	-5.2
≥60	332	75.7	1.5
Race/Ethnicity			
White, non-Hispanic	1,427	66.4	-0.2
Black, non-Hispanic	344	65.5	4.4
Hispanic	334	70.3	12.7
Other or multiple race, non-Hispanic ^{††}	243	69.0	19.4
Vaccination available at no cost			
More than 1 day	1,355	78.4	3.6
1 day	297	67.7	15.6
None	682	48.4	6.7

two surveys with varying methods, of 63.5% for the 2010–11 season (4) and 63.4% for the 2009–10 season (5) (Figure 1). Earlier estimates of influenza vaccination coverage levels in HCP based on the National Health Interview Survey (NHIS) were 10% in 1989, 38% in 2002 (6), and 49% in 2008 (7). In the Internet panel surveys for the three most recent influenza seasons, vaccination coverage was highest among physicians and nurses and lowest among all other HCP. From the 2009–10 season to the 2011–12 season, coverage increased among physicians from 80.5% to 85.6%, and among nurses from 68.5% to 77.9%. Coverage among all other HCP was similar from 2009–10 through 2011–12 in the Internet panel surveys.

For certain categories, vaccination coverage among HCP differed from 2010–11 to 2011–12, according to the Internet

TABLE. (Continued) Percentage of health-care personnel (HCP)* who received Influenza vaccination, by selected characteristics — Internet panel surveys, United States, 2011–12 influenza season

Characteristic	Unweighted no. of participants in sample	% vaccinated [†]	Percentage point change from 2010–11 survey
Required by employer to be vaccinated			
Yes	496	93.7	-4.4
Hospital	362	95.2	-2.9
Non-hospital	134	91.3	-6.7
No	1,829	59.7	1.4
Hospital	818	68.2	4.7
Nonhospital	1,011	55.0	-0.4
Employer promotion ^{§§}	390	75.8	11.1
Hospital	253	75.3	13.4
Nonhospital	134	76.3	8.4
No requirement or promotion	1,450	55.8	-1.3
Hospital	561	65.9	1.7
Nonhospital	865	51.5	-1.6

Source: CDC. Influenza vaccination coverage among health-care personnel—United States, 2010–11 influenza season. MMWR 2011;60:1073–7.

* Persons who worked in a medical-care setting or whose work involved hands-on care of patients.

[†] Weighted estimate. Sampling weights were calculated based on each occupation type by age, sex, race/ethnicity, medical-care setting, and census region to be more representative of the U.S. population of HCP.

[§] Estimate suppressed because sample size was <30.

[¶] Included dental offices, pharmacies, nonhospital laboratories, medical-related schools, emergency medical technician sites, and home medical-care sites.

** Includes dentists, nurse practitioners or physician's assistants, allied health professionals, technicians or technologists, assistants or aides, administrative support staff members or managers, and nonclinical support staff members (e.g., food service workers, housekeeping staff members, maintenance staff members, janitors, and laundry workers).

^{††} American Indian, Alaska Native, Asian, and Native Hawaiian or other Pacific Islander.

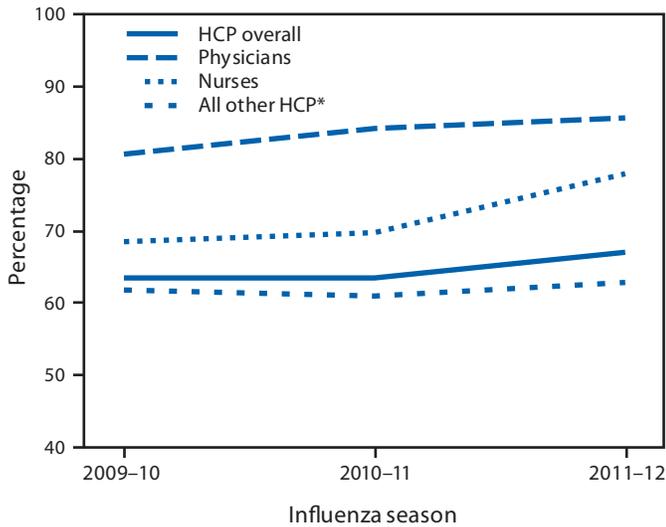
^{§§} Employer promoted influenza vaccination among employees through public recognition of vaccinated persons; financial incentives or rewards to persons; incentives or reminders/invitations, and special events.

panel surveys. Coverage in physician's office settings increased from 61.5% during the 2010–11 season to 67.7% during the 2011–12 season, and coverage in hospitals increased from 71.1% to 76.9% (4). Among LTCFs, influenza vaccination coverage was lower in 2011–12 (52.4%), compared with 2010–11 (64.4%). The 2011–12 coverage in work settings other than hospitals, physician's offices, and LTCFs was higher (61.5%) than in 2010–11 (52.4%) (4) (Figure 2).

For the 2011–12 influenza season, vaccination coverage among physicians (85.6%) neared the *Healthy People 2020* target of 90% (8). Among HCP work settings, hospitals were associated with the highest coverage, whereas coverage was lowest among HCP other than physicians and nurses working in LTCFs. Increased vaccination coverage was associated with employer vaccination requirements, employer promotion of HCP vaccination, and vaccination offered at no cost for multiple days.

These results indicate that targeted intervention and promotion programs developed for HCP groups other than physicians

FIGURE 1. Percentage of health-care personnel (HCP) who received influenza vaccination, by occupation — Internet panel surveys, United States, 2009–10, 2010–11, and 2011–12 influenza seasons

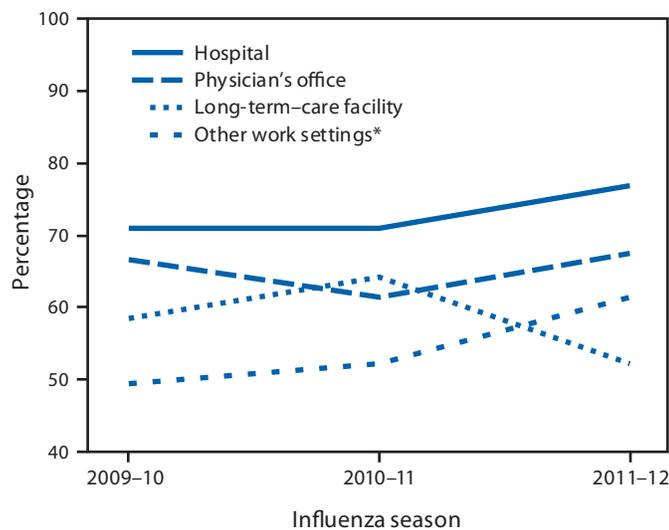


Sources: CDC. Interim results: influenza A (H1N1) 2009 monovalent and seasonal influenza vaccination coverage among health-care personnel—United States, August 2009–January 2010. *MMWR* 2010;59:357–62.

CDC. Influenza vaccination coverage among health-care personnel—United States, 2010–11 influenza season. *MMWR* 2011;60:1073–7.

* Includes dentists, nurse practitioners or physician’s assistants, allied health professionals, technicians or technologists, assistants or aides, administrative support staff members or managers, and nonclinical support staff members (e.g., food service workers, housekeeping staff members, maintenance staff members, janitors, and laundry workers).

FIGURE 2. Percentage of health-care personnel (HCP) who received influenza vaccination, by work setting — Internet panel surveys, United States, 2009–10, 2010–11, and 2011–12 influenza seasons



Sources: CDC. Interim results: influenza A (H1N1) 2009 monovalent and seasonal influenza vaccination coverage among health-care personnel—United States, August 2009–January 2010. *MMWR* 2010;59:357–62.

CDC. Influenza vaccination coverage among health-care personnel—United States, 2010–11 influenza season. *MMWR* 2011;60:1073–7.

* Includes dental offices, pharmacies, nonhospital laboratories, medical-related schools, emergency medical technician sites, and home medical-care sites.

What is already known on this topic?

To help reduce influenza-related morbidity and mortality that occurs in medical-care settings, the Advisory Committee on Immunization Practices recommends annual influenza vaccination for all health-care personnel (HCP). Estimates of overall HCP vaccination coverage were 63.4% and 63.5% from Internet panel surveys, and 57.5% and 55.8% from the National Health Interview Survey for the 2009–10 and 2010–11 seasons, respectively.

What is added by this report?

For the 2011–12 season, overall influenza vaccination coverage among HCP was 66.9%. By occupation and work setting, coverage was highest among physicians (86.7%) and nurses (78.1%) who worked in hospitals and lowest (50.2%) among other HCP who worked in long-term care facilities (LTCFs).

What are the implications for public health practice?

A comprehensive intervention strategy that includes targeted education, promotion to encourage vaccination, easy access to vaccine at no cost on multiple days, and routine monitoring can increase HCP influenza vaccination coverage. Beginning in January 2013, the Centers for Medicare & Medicaid Services (CMS) will require acute care hospitals to report HCP influenza vaccination levels as part of the Hospital Inpatient Quality Reporting Program. Targeted intervention and promotion programs developed specifically for HCP who are not physicians or nurses, and particularly for those who work in LTCFs, might be important components in improving overall HCP vaccination coverage.

and nurses, and especially for those who work in LTCFs, might be important components in improving overall HCP vaccination coverage. Raising vaccination coverage of HCP working in LTCFs is especially important given that LTCF residents are at increased risk for serious influenza complications and that HCP vaccination might reduce the risk for death among LTCF residents (2,3). To increase vaccination coverage for HCP, each medical-care facility should develop a comprehensive intervention strategy that includes education and promotion to encourage vaccination and easy access to vaccine at no cost. Educational programs should include emphasis on vaccination effectiveness and its safety, knowledge of influenza transmission, and the benefits of HCP vaccination for staff, patients, and family.

The findings in this report are subject to at least five limitations. First, the sample was not selected randomly from the approximately 18 million HCP in the United States. The sample consisted of a much smaller group of several thousand volunteer HCP (a nonprobability sample) who had already enrolled in Medscape or SurveySpot. Second, all results are based on self-report and are not verified by employment or medical records. Third, the definition of HCP used in this Internet panel survey might vary from definitions used in other surveys of vaccination coverage. Fourth, occupation categories

could not always be separated because of small sample sizes and questionnaire design or other limitations. Finally, the 2011–12 estimates might not be directly comparable to those made for previous influenza seasons using Internet survey panels and NHIS, because different methods of recruitment were used each year. Compared with the population-based estimates of NHIS, influenza vaccination among HCP from the Internet panel surveys differed (63.4% versus 57.5%) for 2009–10 (5). A similar difference (63.5% versus 55.8%) was observed for 2010–11 (4) (CDC, unpublished data, 2012).

A comprehensive intervention strategy that includes targeted education, promotion to encourage vaccination, and easy access to vaccination at no cost on multiple days can increase HCP vaccination coverage (1). Targeting undervaccinated HCP groups and regularly monitoring vaccination coverage are activities needed to stimulate increases in HCP influenza vaccination. CDC's National Healthcare Safety Network (NHSN), a longitudinal surveillance system, has introduced a module for reporting HCP influenza vaccination at the hospital level, based on the HCP influenza vaccination measure endorsed by the National Quality Forum (9). Beginning in January 2013, the Centers for Medicare & Medicaid Services will require acute care hospitals that they reimburse to report HCP influenza vaccination levels as part of the Hospital Inpatient Quality Reporting Program.[¶] CDC will continue to use Internet panel surveys to monitor self-reported HCP vaccination coverage and reasons for nonvaccination across multiple occupation categories and work settings.

[¶]Additional information available at <http://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html>.

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