Healthcare Quality Reporting Program

STEERING COMMITTEE

09/23/13, 3-4:30pm
Department of Health, Room 401

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

Voting Members		
✓ Ted Almon (rep)	✓ Michael Fine, MD (*Chair*)	☐ Nicholas Oliver, MPA, CAE
☐ David Ashley, MD	☐ Neal Galinko, MD, MS, FACP	✓ Paula Parker, LCSW
☐ Rep. David Bennett	☐ Diane Gallagher	☐ Donna Policastro, NP, RCN
☐ Virginia Burke, Esq.	☐ Deidre Gifford, MD, MPH	☐ Louis Pugliese
✓ Tracey Cohen, MD	✓ Linda McDonald, RN	✓ Gina Rocha, RN, MPH
☐ Bradley Collins, MD	✓ Jim Nyberg	

Agenda

3:00pm **Open Meeting**
Michael Fine, MD, Chair

- Dr. Fine and Sam opened the meeting, welcoming attendees and reviewing the agenda.
- Rosa quickly reviewed the previous meeting's action items, all of which were complete or pending, and indicated that details would be included with the minutes:

  - **Suggest state senate representatives to Dr. Fine** (All) – Complete

    Ted provided a suggestion, which Sam shared with Dr. Fine.

  - **Invite state senate representative** (Dr. Fine/Sam) – Pending

    Sam provided Dr. Fine with a draft letter for the invitation.

  - **Provide orientation to new Steering Committee members** (Sam/Rosa) – Complete

    Sam, Rosa and Emily met with Tracey Cohen and Brad Collins to provide orientation to the program and the committee's role.

  - **Share the All-Payor Claims Database rules and regulations** (Rosa) – Complete

    Rosa included a link with the July meeting minutes:
    sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7305.pdf

  - **Submit the Annual Report to David Heckman at HEALTH** (Sam/Rosa) – Complete

    Sam and Rosa officially submitted the Annual Report to David Heckman, to complete the annual legislative requirement.

  - **Submit an Advisory Letter to Dr. Fine** (Sam/Rosa) – Complete

    Sam and Rosa submitted a letter to Dr. Fine summarizing the committee's

recommended guidelines; a copy was provided with today's agenda.

- **Examine impact of reporting on provider performance** (Sam/Rosa/Emily) – Complete

  Sam, Rosa and Emily looked at definitions for 'impact,' ranging from access to the information (web statistics) to its use for decision making and improvement in quality outcomes and patient satisfaction. Some of easily measurable concepts are included in today's slides to help drive discussion of FY 2014 priorities.

- **Share Facilities Regulations' nursing home "report"** (Rosa/Emily) – Complete

  Rosa and Emily included the updated Facilities Regulations report with the July meeting minutes; a copy was included with today's agenda and handouts. This replaces the 5-year-old version in use by hospital case managers.

- **Provide any Web developer suggestions to Rosa and Emily** (All) – Complete

  The AHRQ grant's vendor selection process is complete; Rosa and Emily provided an update in today's Open Forum (see below).

- **Provide the program's URL with the minutes** (Emily) – Complete

  Emily included a link with the July meeting minutes:
  health.ri.gov/programs/healthcarequalityreporting

- **Obtain Web tracking data from Sally** (Emily) – Complete

  Emily and Sally met to review the web statistics, which are included as a measure of 'impact' (use of the website) in today's slides.

3:10pm **Discussion: Strategic Planning**
Rosa Baier, MPH, Facilitator
Samara Viner-Brown, MS, Facilitator

- Sam and Rosa provided the group with a copy of the 7/23 Advisory Letter, along with slides showing the breakdown of FY 2013 and current reports by setting. They then asked committee members to make recommendations regarding FY 2014 activities and priorities for each setting, focusing on:

  1) **Legislative requirements**: What does the legislation require us to do?
  2) **Funding requirements**: Where do we need to focus to meet funding requirements? How do we want to prioritize within the two funding streams, state and CDC?
  3) **Advisory letter guidelines**: How do we want to implement the guidelines? What activities do we modify or implement?

- The group reviewed current activities for each setting (home health agencies, hospitals, nursing homes and physicians) and discussed web statistics and suggestions or considerations for each setting. Emily explained that the web statistics were for the past year (12 months). For example, we need to scale HAI efforts to the CDC funding; may want to address case manager needs for nursing home reports; and could consider expanding reporting themes to include disparities or other topics.

- Overall discussion themes included:

  - Program Funding

    Gina asked about the total funding available, including the $80K in grant funding

awarded to Healthcentric Advisors for web development. Overall, there is $58K in state funds; $74k in CDC funds (restricted to HAI efforts); and $80K in AHRQ funds (restricted to the home health web application). Emily explained that the AHRQ funds are a portion of the larger grant to study the use of public reports when patients choose a home health agency.

Rosa provided a breakdown of FY 2013 funding (see slides) and emphasized the fact that the majority of the state funds went to the HIT Survey (~62%) and to the nursing home satisfaction survey (~25%). To add new topics, one or both of these efforts would need to be modified or eliminated. The committee agreed that looking for additional funding sources for the program is a priority.

Gina also commented that funding is for program administration; this is an unfunded mandate for providers, making it important to leverage existing data sources and to weigh the value of additional reports against the burden for providers. Linda agreed and suggested looking for additional data sources as a way to lower the financial burden of primary data collection.

Paula asked if HealthSource RI, Rhode Island's health information exchange, might have available funding. Dr. Fine responded that funding would not be immediately available, especially since reaching meaningful participation could take a few years. Gina added that this may not be a good funding source, as the program priorities do not align. The program's focus is comparative reporting of healthcare providers, while HealthSource RI focuses on health plans.

- <u>"All-inclusive" consumer-friendly report</u>

  There are two settings where the Subcommittees have discussed "all-inclusive" reports (i.e., including all available primary and secondary data in a single report). Such reports may be more consumer-centric, since they would allow consumers to view and compare all of the information at once. This is a step in the direction of our vision for interactive, consumer-driven reports.

  For **hospitals**, the all-inclusive report would be a way to scale efforts to the CDC funding (since the majority of measures are HAI measures) without adding additional data collection burden to the hospitals. Emily provided the committee with a mock-up of measure this report might contain.

  For **nursing homes**, the all-inclusive report would: (1) address the case managers' need (discussed in July) for a report that includes all facilities in a single document (to support "patient choice" laws) and (2) help to eliminate old information from Facilities Regulations that is circulating in the environment (see handouts).

  Jim also asked how putting all of the measures in one report would work, since the measures are collected and updated at different times. The report would contain the most recent information for each measure, and be updated whenever a measure was updated. Information about the measure specifications and timeframes would be included in the Methods report.

  Gina questioned whether reports limited to Rhode Island are the right next step, since the state is moving towards a regional market. The group agreed, although Dr. Fine and Tracy pointed out the legislation is limited to what HEALTH can regulate/control (i.e., Rhode Island providers).

- <u>Health disparities</u>

Each of the setting-specific slides (see handouts) included web statistics and suggestions or considerations for each setting. For hospitals, suggestions included reporting hospital readmissions and disparities.

Gina suggested addressing emerging areas, such as disparities or population health outcomes. Dr. Fine responded that hospitals may not be able to do anything about disparities or population level health (is it fair to hold them accountable for these outcomes?) and said that a better approach would be a population-based primary care system.

Dr. Fine suggested using the Institute of Medicine report about treatment equality to identify possible measures. Gina responded that it might be difficult to identify consistent measures; for example, the Joint Commission requirements for interpretative services do not require hospitals to have the same policy.

Dr. Fine also brought up the idea of overall hospital rankings, citing methodology used by the United Health Foundation. Paula asked how to compare hospitals with different case mixes and capabilities. Jim commented that it is hard to measure overall quality, and that the 5-star method used by CMS is not effective because one bad inspection (or a series of minor problems) can ruin a facility's score for years.

Dr. Fine commented that funding could be used for a feasibility study to explore the measurement problems and recommend measurement strategies.

- Flu vaccination reporting

  In 2012-2013, the program expanded healthcare worker (HCW) flu vaccination reporting from hospitals and nursing homes to home health agencies. This was possible because of the CDC (HAI specific) funding, but data submission rates remain low for nursing homes and home health agencies.

  Tracy mentioned that the low data submission rates and self-reported nature of the data are limitations. Gina asked if there were fees or citations for agencies that did not comply. Rosa explained that public reporting of non-compliance often increases rates, but that the program also refers violations to Facilities Regulation for citations. Jim suggested involving the trade associations in publicizing the reports (including the lists of those who failed to submit data).

- Recommendations included:
  - Continuing existing state-funded reports (HIT and nursing home satisfaction)
  - Endorsing the Subcommittees' ongoing work to refine the all-inclusive report
  - Seeking additional funding sources for new efforts, e.g., hospital disparities
  - Reviewing methods to rank providers and measure treatment equality
  - Working with the trade associations on HCW flu vaccination data submission

3:20pm **Program Updates & Discussion**
Rosa Baier, MPH, Facilitator
Samara Viner-Brown, MS, Facilitator

- New reports

  Since July, the program has issued employee influenza vaccination reports for home health agencies, hospitals and nursing homes. Summary data are included in today's slides and the dates for these reports have been updated on the Steering Committee Data Updates file (see handout).

- Nursing home satisfaction survey

  The Nursing Home Subcommittee recommended moving forward with this year's resident and family satisfaction survey. The program mailed and faxed notices to all facilities, and the vendor (My Innerview) is in the process of obtaining contracts and mailing lists for all facilities. Emily and Ann are helping to follow-up to ensure that all facilities meet the deadlines and provide sufficient numbers of names for the surveys.

- Home Health Subcommittee meeting (10/2)

  Program staff scheduled a Home Health Subcommittee meeting to update the committee on the AHRQ grant (see Open Forum, below) and afford members an opportunity to weigh in on primary data needed from the agencies (insurance accepted, service area, services available, languages spoken, etc.).

  This committee has not convened since recommending that satisfaction surveys cease, so it is an opportune time to bring the group back together and answer any questions they have about public reporting (e.g., the AHRQ grant, the flu vaccination report).

- HIT Survey

  Rosa provided an update on the HIT Survey. In FY 2013, the survey took 62% of the state budget. To expand the program's ability to meet stakeholder needs, Medicaid is putting in a 90/10 matching funds request, asking for $50,000 in Medicaid funds and a $5,600K match from the program's state funding. Sam and Rosa will keep the group posted on the outcome of this request.

  Rosa asked the group to formally weigh in regarding data sharing policies. Currently, decisions about when to share datasets are guided by the following questions:

  - What does the survey say about confidentiality?
  - What does the survey disclose about potential use?
  - Will analyses be at the physician or aggregate level?
  - Will data be used to contact physicians?

  After discussion, the committee recommended codifying the above parameters into guidelines and adding a requirement for a signed data use agreement (DUA) for anyone receiving physician-level data files.

4:15pm **Other Business/Announcements**
Michael Fine, MD, Chair

- AHRQ Public Reporting Grant

  Rosa and Emily provided an update on the AHRQ grant. Qualitative findings were presented in July and are also summarized in a two-page handout designed to provide feedback to the hospital case managers.

  In partnership with HEALTH's webmasters, we have now selected a web vendor (RDW/iFactory) and are poised to begin work on the web application. One of the primary objectives for the grant was to provide resources to the program to expand the website's capabilities and use, beginning with home health. We are partnering with the HEALTH webmasters to ensure the web application is aligned with HEALTH's overall website goals and can be scalable for other purposes, too.

- All-Payor Claims Database (APCD)

  Gina asked when the APCD will be available. Sam and Rosa answered that it was supposed to be available 10/1, since it is linked to the health insurance exchange timeline, but it will now not be available until 2014. Rosa offered to invite Kim Paul from the Office of the Health Insurance Commissioner to present and provide more details.

- **Action items:**

  - Invite state senate representative (Dr. Fine/Sam)
  - Provide July Advisory Letter to the committee with the minutes (Rosa/Emily)
  - Submit an Advisory Letter to Dr. Fine (Sam/Rosa)
  - Share flu reports with the home health and nursing home trade associations (Rosa)
  - Develop DUA for the HIT Survey (Rebekah/Rosa/Emily)
  - Invite Kim Paull to speak about the APCD (Rosa)

- **Next meeting**: 11/25/13

Steering Committee: HCQP Program Updates

Samara Viner-Brown, MS, HEALTH
Rosa Baier, MPH, Healthcentric Advisors

September 23, 2013

Agenda

- Welcome & meeting objectives
- Action items
- Strategic Planning
  - 7/23 Advisory Letter
  - Additional information from action items
- Program updates/discussion, including HIT Survey dataset sharing policies
- Open forum

Action Items

Strategic Planning

- Submit an Advisory Letter to Dr. Fine
- Examine impact of reporting
- Obtain Web tracking data
- Share Facilities Regulations' nursing home "report“

All complete / included in today’s discussion

Action Items

Membership

- Suggest state senate representatives to Dr. Fine
- Invite state senate representative
- Provide orientation to new Steering Committee members
  - Tracey Cohen, MD, BCBSRI
  - Bradley Collins, MD, Rhode Island Medical Society

All complete or pending (invitation)

Action Items

Administrative

- Share the All-Payor Claims Database rules and regulations
- Submit the Annual Report to David Heckman at HEALTH
- Provide any Web developer suggestions to Rosa and Emily
- Provide the program's URL with the minutes

All complete

Discussion: Strategic Planning

- What guidance did the committee provide in July?
- How do we implement those guidelines in FY 2014?
- What activities do we modify or implement?

Advisory Letter Guidelines for FY 2014

- **#1: Continue to use the Steering Committee's 4/16/12 reporting guidelines to direct current priorities and future direction**

- *4/16/12 reporting guidelines:*
  1. *Sustain all current activities*
  2. *Expand reporting to align with local and national priorities*
  3. *If activities must be streamlined due to funding, retain primary data collection efforts and eliminate clinical reports*
  4. *Seek grant funding for both operations and research*
  5. *Improve consumer awareness and use of the reports*
  6. *Improve the content and format of the reports*
  7. *Improve the program's website and branding*
  8. *Expand committee members' roles and responsibilities*

Implementation of the Guidelines in FY 2013

- An emphasis on primary data collection
- Updated website content
- Healthcentric Advisors' research grant
  - Providing information about consumers' wants and needs
  - Funding website infrastructure ($80K)

Additional Advisory Letter Guideline for FY 2014

- **#2: Periodically reevaluate activities and priorities, to maximize alignment with concurrent initiatives and impact on consumer choice**

- Places additional emphasis on guidelines #2 and #5-7
- Involves add audit and feedback to monitor program activities and incorporate changes, when needed

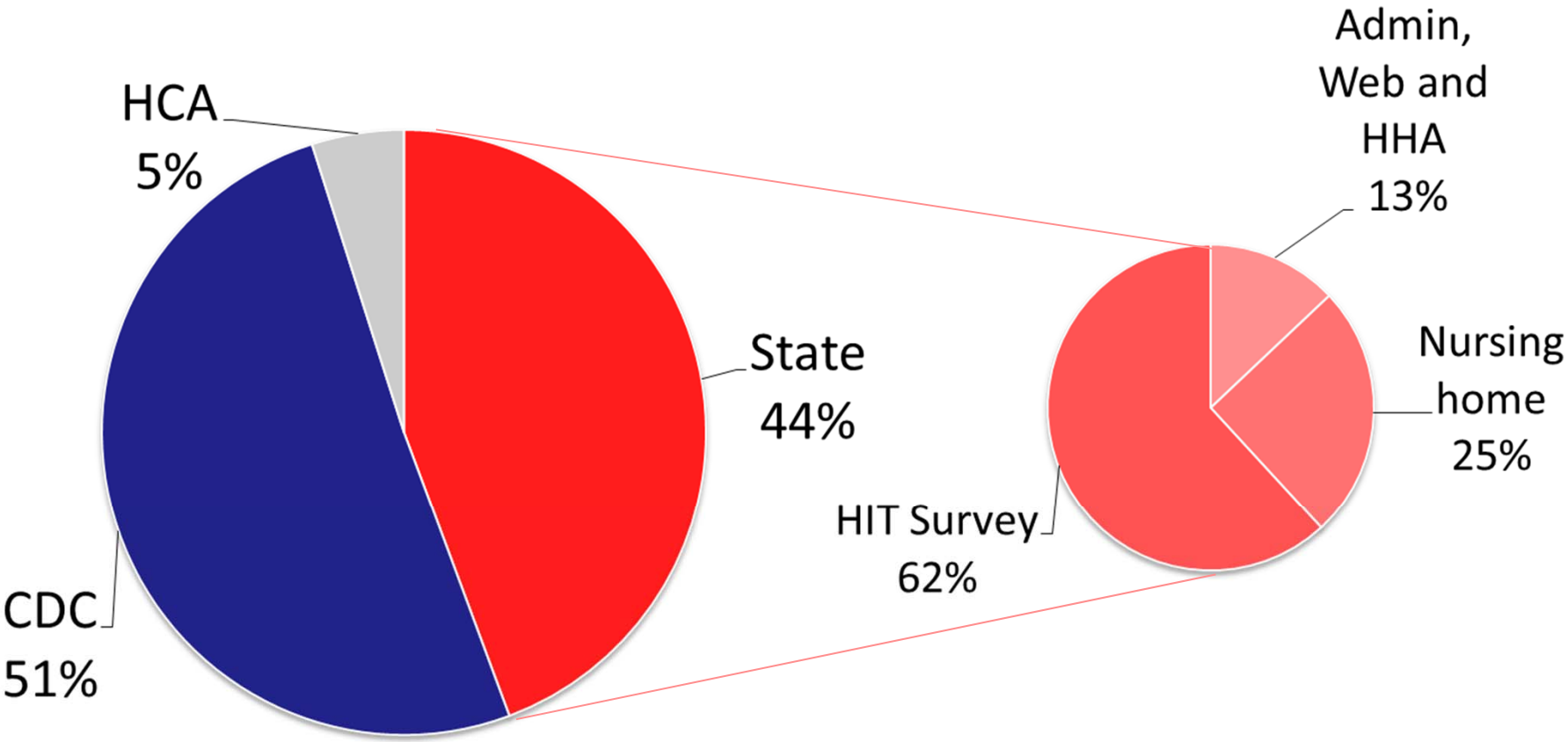
Activities & Reports for FY 2014

Discussion based on (1) legislative requirements, (2) funding requirements, (3) advisory letter guidelines

Legislative requirements:

- *Comparative ratings to inform patient choice*
- *Clinical quality measures*
- *Patient satisfaction*
- *Hospitals and other providers*
- *Physicians (2006 amendment)*
- *Healthcare-acquired infections (2008 amendment)*

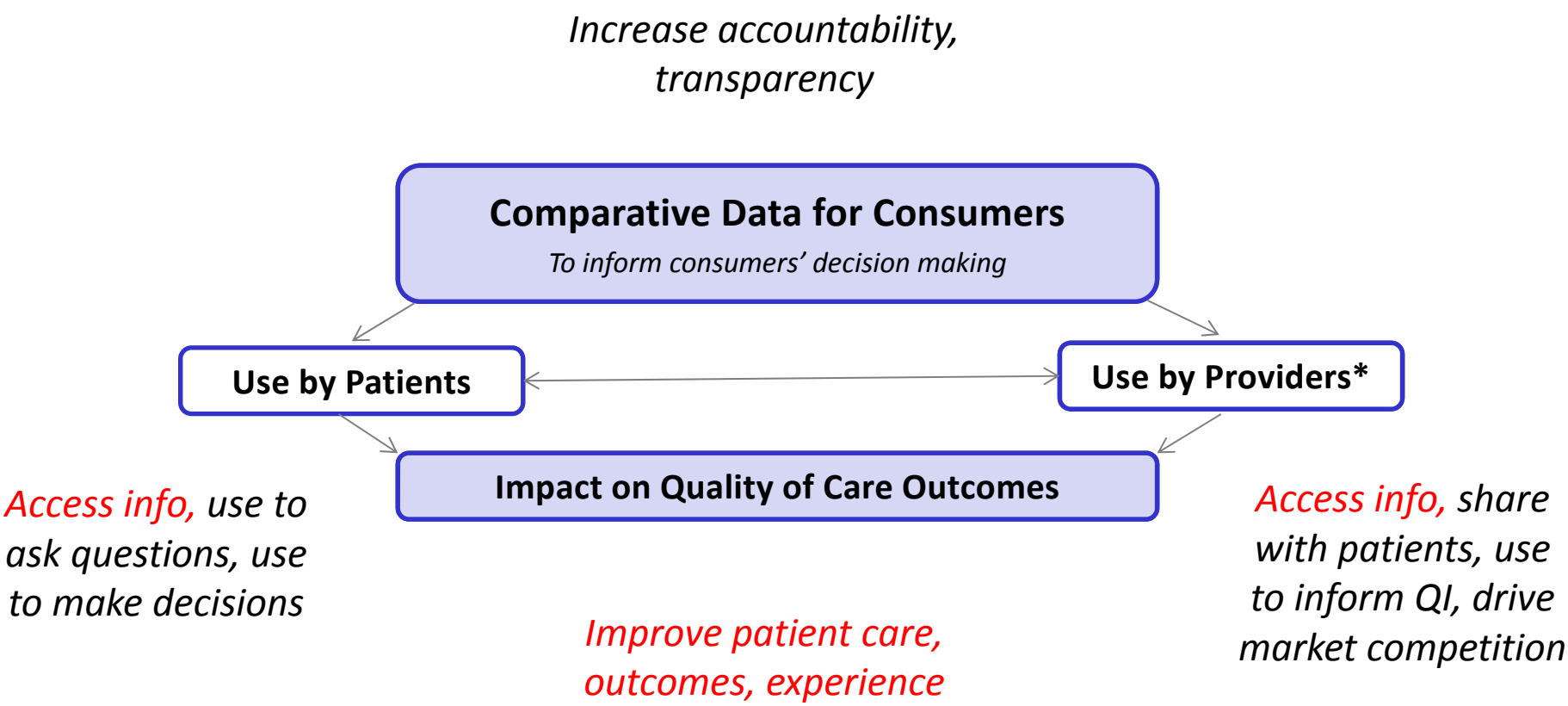
Distribution of Activities in FY 2013



Reports, by Setting and Funding

Setting	Eliminated	Current Reports	
		State $	CDC $
Hospital	*Clinical quality measure graphs, patient satisfaction, SCIP, CLABSI, C. difficile*	--	Hand hygiene, employee influenza vaccination, MRSA CLABSI
Nursing home	*Clinical quality measure diamonds*	Resident and family satisfaction	Employee influenza vaccination
Home health	*Clinical quality measure diamonds, patient satisfaction*	--	Employee influenza vaccination
Licensed independent practitioners	--	HIT adoption	--

What is 'Impact'?



Hospital Reporting

Setting	Eliminated	Current Reports	
		State $	CDC $
Hospital	*Clinical quality measure graphs, patient satisfaction, SCIP, CLABSI, C. difficile*	--	Hand hygiene, employee influenza vaccination, MRSA CLABSI

Web statistics: 1,179 unique page views (+450); 1 min on page

Discussion considerations:

- Need to scale HAI efforts to CDC funding
- Subcommittee requests to minimize data collection burden on hospitals
- Subcommittee endorsement of 'all inclusive' report
- Possible new topics: readmission; disparities; overtreatment; worksite wellness and nutrition programs

Nursing Home Reporting

Setting	Eliminated	Current Reports	
		State $	CDC $
Nursing home	*Clinical quality measure diamonds*	Resident and family satisfaction	Employee influenza vaccination

Web statistics: 4,162 unique page views (+1,500); 2 min on page

Resident satisfaction: 93% in 2012 (+1% since 2009)
Family satisfaction: 91% in 2012 (-1% since 2009)
Vaccination: 50 facilities reporting in 2012/2013 (+14 since 2010/2011)

Discussion considerations:

- Facilities Regulations reports in circulation at hospitals
- Case managers' needs
- Subcommittee recommendation for 'all inclusive' report

Home Health Reporting

Setting	Eliminated	Current Reports	
		State $	CDC $
Home health	*Clinical quality measure diamonds, patient satisfaction*	--	Employee influenza vaccination

Web statistics: 591 unique page views (+250); ~1 min on page

Vaccination: 23 agencies reporting in 2012/2013 (+6 since 2011/2012)

Discussion considerations:

- Potential Medicaid needs for satisfaction data

Licensed Independent Practitioner Reporting (Physician, APRN, PA)

Setting	Eliminated	Current Reports	
		State $	CDC $
Licensed independent practitioners	--	HIT adoption	--

Web statistics: 2,311 unique page views (+75); 1 min on page

Physician EMR adoption:	88%	(+25% since 2008)
Physician Basic EMR use:	79 / 100	(+28 since 2008)
Physician Advanced EMR use:	58 / 100	(+35 since 2008)
Physician e-Prescribing adoption:	80%	(+43% since 2008)

Discussion considerations:

- Address multiple stakeholders' needs
- Minimize data collection burden for physicians

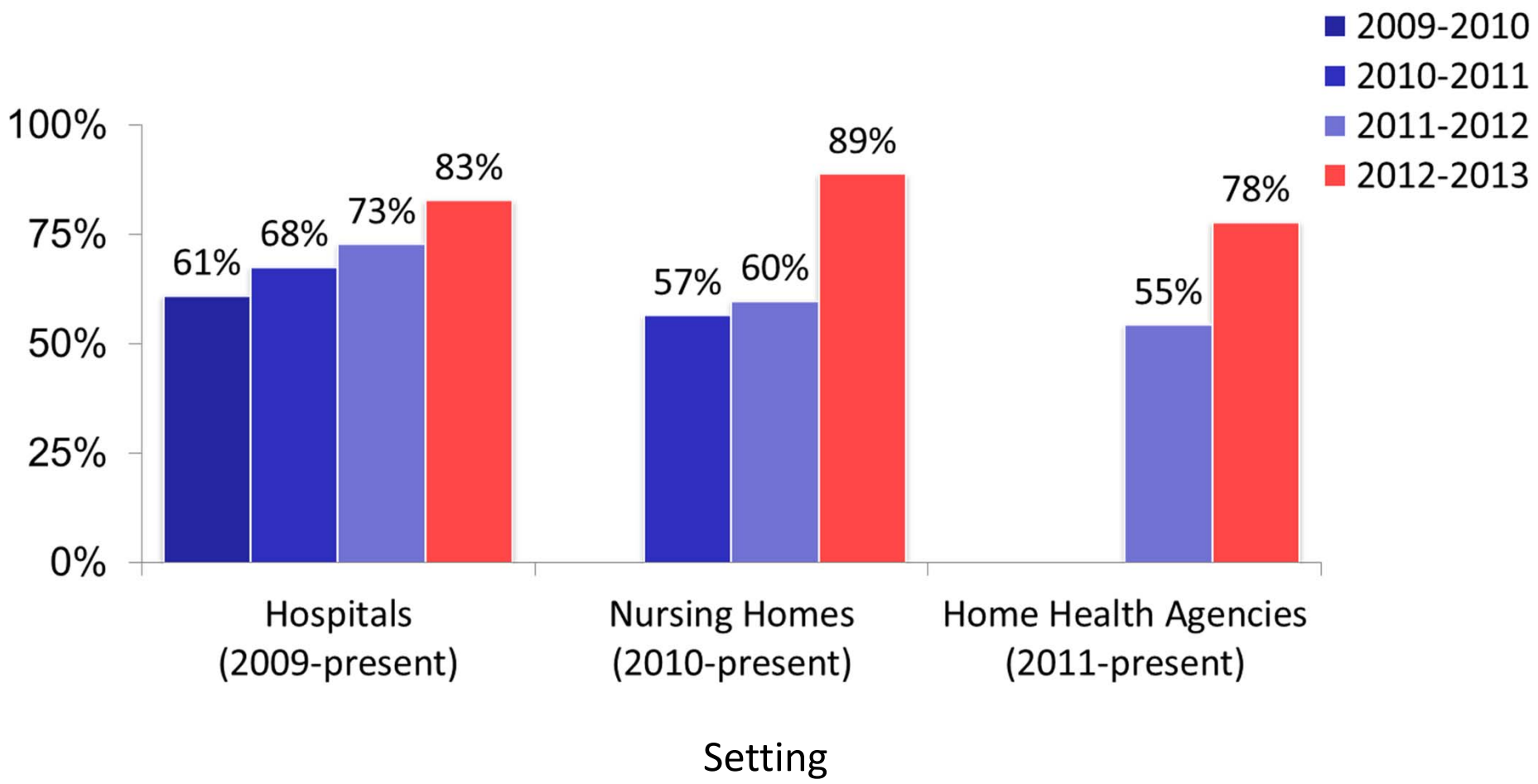
Program Updates/Discussion

- HIT Survey:
  - Medicaid 90/10 matching funds
  - Dataset sharing policies; currently based on:
    - What does the survey say about confidentiality?
    - What does the survey disclose about potential use?
    - Will analyses be at the physician or aggregate level?
    - Will data be used to contact physicians?
  - Discussion of program policy

Program Updates/Discussion

- Updated reports
- 2013 nursing home satisfaction survey process
  - Deadlines
  - Audit process
- Home Health Subcommittee

Updated Report: HCW Flu Vaccination, By Setting (2009-present)



Open Forum

- AHRQ public reporting grant
- Others?

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Healthcare Quality Reporting Program

STEERING COMMITTEE DATA UPDATES

09/23/13

Data Updates (Reports, Oldest to Newest by Setting)	Update Frequency	Last Updated	Comments
Home Health			
• Clinical quality measures from Medicare	Quarterly	Nov 2009	Now links to Home Health Compare
• Patient satisfaction	2 years	June 2011	Discontinued at agencies' request
• Employee influenza vaccination rates	Annually	Sept 2013	
Hospital			
• Clinical quality measures from Medicare	Quarterly	May 2011	Now links to Hospital Compare
• Hand hygiene processes	Annually	March 2013	
• Surgical Care Infection Program (SCIP) Measures	Quarterly	May 2012	Now links to Hospital Compare
• Central-Line Associated Bloodstream Infections (CLABSI)	Quarterly	Sept 2012	Now links to Hospital Compare
• Pressure ulcer incidence	Quarterly	Sept 2009	Now links to Hospital Compare
• Employee influenza vaccination rates	Annually	Sept 2013	
• MRSA CLABSI incidence	Quarterly	March 2013	New one will be coming out by the first week in October
• *C. Difficile* incidence	Once	Nov 2012	Will be reported by Hospital Compare in Jan 2014 (tentatively)
Nursing Home			
• Clinical quality measures from Medicare	Quarterly	Feb 2011	Now links to Nursing Home Compare
• Resident and family satisfaction	Annually	Feb 2013	
• Employee influenza vaccination rates	Annually	Sept 2013	
Licensed Independent Practitioners (Physicians, APRNs, PAs)			
• HIT adoption	Annually	Mar 2013	

SURVEY PERFORMANCE TOOL FOR RHODE ISLAND NURSING HOMES

Sheet1 | Gadget1

88% is Top Score

NURSING HOME	TOWN	SURVEY DATES	ADMIN	NURSING	RES. RIGHTS	FOOD	ENVIRON.	TOTAL(88)
SILVER CREEK MANOR	BRISTOL	4/28/06 5/21/07	25	22	15	8	14	84
OVERLOOK NURSING HOME	BURRILLVILLE	6/14/07 3/7/08	26	22	18	8	14	88
PINE GROVE HEALTH CENTER	BURRILLVILLE	5/10/07 7/3/08	24	21	18	8	14	85
BAYBERRY COMMONS	BURRILLVILLE	10/17/06 11/9/07	21	20	18	8	13	80
THE MANSION	CENTRAL FALLS	4/27/06 6/7/07	25	22	18	8	13	86
HARRIS HEALTH CARE CENTER	CENTRAL FALLS	8/9/07 8/8/08	24	22	18	8	14	86
HAVEN HEALTH CENTER OF COVENTRY	COVENTRY	8/2/06 11/30/07	22	22	17	8	14	83
WOODPECKER HILL	COVENTRY	9/13/06 10/4/07	26	22	18	8	14	88
RIVERVIEW HEALTHCARE COMMUNITY	COVENTRY	2/9/07 2/25/08	26	21	18	8	14	87
ALPINE NURSING HOME	COVENTRY	4/6/07 3/7/08	25	22	17	8	14	86
SCANDINAVIAN HOME	CRANSTON	3/15/07 5/7/08	25	22	18	8	14	87
CRA/MAR MEADOWS	CRANSTON	9/14/06 12/7/07	24	22	18	8	14	86
CEDAR CREST NURSING CENTER	CRANSTON	1/9/07 2/1/08	23	22	18	8	14	85
GRANDVIEW CENTER	CUMBERLAND	11/10/06 12/17/07	25	22	18	8	14	87
MOUNT ST. RITA HEALTH CENTRE	CUMBERLAND	12/14/06 1/29/08	26	22	16	8	14	86
ST ELIZABETH MANOR	EAST BAY BRISTOL	8/23/07 8/25/08	23	22	18	8	14	85
ST. ELIZABETH HOME	EAST GREENWICH	5/11/07 4/11/08	26	22	18	8	14	88
HARRIS HEALTH CENTER	EAST PROVIDENCE	02/06/07 11/19/07	26	22	18	8	14	88
EASTGATE NURSING								

Office of Facilities Regulation
Centers for Medicare Medicaid Services
Nursing Home 5-Star Rating

Provider Number	Provider Name	Overall	Health Inspection	MDS Quality Measures	Staffing	RN Staffing	Survey Score
415004	WESTERLY NURSING HOME INC	*****	*****	*****	****	*****	0.00
415012	BRIARCLIFFE MANOR	*****	*****	*****	****	****	0.00
415040	FOREST FARM HEALTH CARE CENTER	*****	*****	*****	****	*****	0.00
415073	JEANNE JUGAN RESIDENCE	*****	*****	****	*****	*****	0.00
415085	MOUNT ST RITA HEALTH CENTRE	*****	*****	****	*****	*****	0.00
415104	ROBERTS HEALTH CENTRE	*****	*****	**	****	*****	0.00
415024	HALLWORTH HOUSE	*****	****	*****	*****	*****	2.00
415113	TOCKWOTTON ON THE WATERFRONT	*****	*****	*****	*****	*****	2.00
415014	GRACE BARKER NURSING CENTER	*****	****	*****	***	***	2.67
415096	BETHANY HOME OF RHODE ISLAND	*****	****	****	*****	*****	2.67
415023	SUNNY VIEW NURSING HOME	*****	****	*****	****	*****	3.33
415045	OVERLOOK NURSING	*****	****	*****	****	*****	4.00
415084	ELMHURST EXTENDED CARE FACILITY	*****	****	*****	****	****	4.67
415061	BRENTWOOD NURSING HOME	*****	****	*****	***	****	5.33
415060	AVALON NURSING HOME	*****	****	*****	****	*****	6.00
415034	GRAND ISLANDER CENTER	*****	****	*****	****	*****	6.67
415108	HARRIS HEALTH CARE CENTER-NORTH	*****	***	*****	****	*****	9.33
415066	CRA-MAR MEADOWS	*****	***	*****	****	*****	10.00
415068	WARREN SKILLED NURSING	*****	***	*****	****	*****	11.33
415111	ST CLARE HOME	*****	***	*****	****	*****	13.33

RESEARCH BRIEF

September 20, 2013

BACKGROUND

In Fall 2012, Healthcentric Advisors and Brown University received a grant to create a Rhode Island Department of Health web application to help patients make informed decisions about home health care.

Because they routinely help patients choose agencies, we interviewed hospital case managers in early 2013. We wanted to understand case managers' (1) experiences with helping patients choose agencies and (2) needs and workflow, so that the web application is helpful for both patients and discharge planning.

We also conducted focus group discussions with home health consumers (i.e., patients and family members with home health experience). Key findings from both case manager interviews and consumer focus groups are below. These findings are based on consensus among the researchers about themes identified.

CASE MANAGER FINDINGS

We interviewed 28 hospital case managers at five Rhode Island Hospitals.

At a Glance: Case Manager Requirements

Key requirements for case managers include (but are not limited to):

- Ability to search for agencies based on various criteria, such as services, agency name or service area
- Printer-friendly options, including an option for grey-scale printing and the ability to display all agencies
- Ensuring that inclusion or exclusion criteria are on printed materials
- Up-to-date information that shows the date updated

Logistics

Case managers report rarely, if ever, having access to computers in patients' rooms or on the floors. They rely heavily on pre-printed materials or past experience; therefore, they may not be able to customize a report to a patient's needs.

Most case managers provide patients with a list that includes all agencies and basic agency information (e.g., agency name, address and phone number). The list may include insurance, but rarely lists services and does not include patient outcomes or satisfaction.

Case managers frequently direct patients to web-based resources, although this occurs more often for nursing homes than home health agencies. They recognize that online information may not be up-to-date, and that patients may not have time to research agencies prior to discharge; often, agency choice must be made in minutes or hours.

Some departments maintain lists with information about insurances accepted, services provided, languages spoken, etc., by agency. These lists take time and resources; they would value up-to-date, centrally-maintained information.

Patient Choice

Medicare and Social Security laws (as well as some hospital bylaws or policies) require providers to ensure that patients have the ability to choose freely among all Medicare providers ("patient choice"). However, case managers report that patients rarely have a preference, unless they have previously received services or recognize an agency name. They often ask for a recommendation. While patient choice prohibits case managers from making a *recommendation*, they can *inform* the patient's choice. However, most do not have information to inform choices. Some case managers choose agencies at random if patients do not express a preference.

To fully comply with patient choice, case managers want materials to list all facilities in the state or all facilities that meet patients' needs (insurance, services, service area, etc.). They also prefer that any inclusion or exclusion criteria (search terms) be listed on printed materials, so that it is clear they have not omitted an agency from patient choice.

Quality of Care

Most case managers indicate that they do not believe quality of care varies substantially between agencies, although they also say they would not necessarily know if a patient had a poor experience or outcome after hospital discharge. Few are aware that Medicare publishes information about home health agencies on Home Health Compare, which is similar to Hospital Compare and Nursing Home Compare, or that the state publishes information.

CONSUMER FINDINGS

We conducted two focus group discussions with 13 patients and family members with home health experience.

At a Glance: Consumer Requirements

Key requirements for consumers include (but are not limited to):

- Information about services, insurance, quality and satisfaction
- Inclusion of data from multiple sources as a "one-stop shop" for information about an agency
- Information written at no higher than a sixth-grade reading level, with key terms defined in layperson's terminology
- User-friendly and simple navigation, with a limited number of choices presented at one time
- Accessibility to the sight-impaired and users on mobile devices

Logistics

Consumers may have low literacy, low health literacy or low computer literacy. If hospitalized, they often have only a few minutes or hours to choose an agency. They may not be feeling well and may feel overwhelmed or stressed. These feelings may affect their ability to assimilate information.

Patients are also unlikely to have access to a hospital computer, although they or their family members may have their own computers, tablets or smart phones. Ensuring that information is accessible to the sight-impaired is also important.

Consumers want easy ways to determine whether an agency will accept their insurance, what is covered, and how much a service (such as non-skilled care) will cost. They also want details about what the agency will do and when.

Quality of Care

Consumers express concern about quality, which they define largely related to experience and satisfaction, not clinical outcomes. However, when presented with a list of options for clinical quality measures, they want to see all of these measures, too. They are also interested in other patients' experience ratings, and in any deficiencies or licensure issues.

NEXT STEPS

The case manager interviews and consumer focus groups were the first phase of a three-phase study.

The second phase (beginning in Fall 2013) involves developing a web application that meets the above needs. Case managers who participated in interviews will have an opportunity to review the tool before it is final.

The third phase (beginning in Summer 2014) involves enrolling patients in a study where they receive either the usual information (a handout listing agencies) or a printout from the new web application. This will be done by research staff and will not affect the regular discharge process. We will then examine patients' choices and post-discharge outcomes and satisfaction to evaluate the impact of the new application.

The web application will be available on the Department of Health's website in Fall 2015, when the study is complete.

Please contact Rosa Baier with any questions or for more information: rbaier@healthcentricadvisors.org or 528-3205.

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Vacant seats (2):
Rhode Island Medical Society
State Senate

Rhode Island Healthcare Quality Reporting Program Steering Committee

September 16, 2013

Michael Fine, MD, Director
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 providing recommendations regarding the program's FY 2014 priorities.

These recommendations are based on the Steering Committee's 7/22/13 discussion. They are intended to provide program staff with guidelines to inform the program's priorities and direction. They also reflect the program's legislative mandate to publish comparative ratings, including clinical quality measures and patient satisfaction, for hospitals and other providers. The goal is to provide information that consumers can use to choose among providers.

First, we recommend that the program continue to use the Steering Committee's 4/16/12 reporting guidelines to direct current priorities and future direction.

The guidelines resulted from structured interviews conducted with committee members in April 2012 and are as follows:

1. Sustain all current activities;
2. Expand reporting to align with local and national priorities;
3. If activities must be streamlined due to funding, retain primary data collection efforts and eliminate clinical quality measure reports;
4. Seek grant funding for both operations and research;
5. Improve consumer awareness and use of the reports;
6. Improve the content and format of the reports;
7. Improve the program's website and branding; and
8. Expand committee members' roles and responsibilities.

(These eight recommendations are detailed in our 4/18/12 advisory letter.)

Due to limited state funding, it was not – and is not – possible to sustain all activities from prior years (#1). The remaining guidelines informed FY 2013 activities, including: an emphasis on primary data collection (hospital, nursing home and physician office settings); updated website content; and Healthcentric Advisors' research grant, which is both providing information about consumers' wants and needs and also funding website infrastructure.

For #3 ("retain primary data collection efforts and eliminate clinical quality measure reports"), committee members suggested periodically reevaluating existing reports, for example to reaffirm or change past decisions to sustain (e.g., nursing home satisfaction) or eliminate topics (e.g., clinical quality measure reports).

Second, we recommend adding a 9th guideline for the committee to "periodically reevaluate activities and priorities," to maximize alignment with concurrent initiatives and impact on consumer choice.

This recommendation places additional emphasis on guidelines #2 and #5-7, above, which center on alignment with concurrent initiatives and activities (#2) and the program's goals to publish information that addresses consumers' needs, is readily accessible, and is used (#5-7). It also adds the use of audit and feedback – a core quality improvement principle – to monitor program activities and incorporate changes, when needed.

For #2 ("Expand reporting to align with local and national priorities"), committee members suggested leveraging emerging data sources, such as the All-Payor Claims Database (APCD) and supporting care transitions efforts by reporting hospital readmission. There may be other opportunities to inform other concurrent priorities and work, but – given the operating budget – the program will need to weigh the opportunity cost of adding a new task against the risk of dropping a current activity or report.

It is important to emphasize that any expanded efforts under #2 should align with the program's legislative mandate and goal: the mandate specifies comparative ratings, including clinical quality measures and patient satisfaction, for hospitals and other providers, and the goal is to provide information that consumers can use to choose among providers. Some topics may be of interest, but not aligned with one or both of these requirements.

For #5-7 ("Improve consumer awareness and use of the reports; improve the content and format of the reports; and improve the program's website and branding"), committee members suggested monitoring web statistics and seeking ways to obtain feedback from target audiences, including patients, families and providers, where possible.

On behalf of the committee, we suggest that you endorse these recommendations regarding the program's FY 2014 priorities. Thank you for your consideration.

Sincerely,

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

Rosa Baier, MPH
Facilitator, Steering Committee
Chair, Home Health Subcommittee
Program Director, Healthcare Quality Performing Program

CC: Steering Committee Members

Virginia M. Burke: Misstep stands to cost R.I. millions

September 23, 2013 01:00 AM

BY VIRGINIA M. BURKE

Rhode Island's recent announcement that it has launched an "Integrated Care Initiative" to provide health coverage to the state's elderly attracted little attention. Even the frail elders who will be most affected by this program probably missed the press release. But they, and the taxpayers who will fund the program, need to be aware that the state is about to make a misstep costing millions of dollars.

AdChoices

By way of background, the Integrated Care Initiative was established to meld the health coverage provided to residents who are eligible for both the Medicare and Medicaid programs. These so-called dual eligibles are the frailest and sickest among our elderly. Their dual eligibility typically arises when, because of stroke, dementia or other chronic condition, they develop the need for long-term care supports and services.

Since Medicare won't cover those services, the people affected must pay for them out of pocket. When their financial resources (and family caregivers) are finally exhausted, they turn to Medicaid. The "dual eligible" population thus has routine medical and hospital care covered by Medicare, and long-term care services covered by Medicaid.

But the Medicare and Medicaid programs don't mesh well, and are difficult for the elderly to navigate. The Integrated Care Initiative will eventually combine the two forms of coverage into a single benefit plan, which will then be turned over to a commercial health plan or plans to operate. The contracted health plan(s) will be paid a monthly fee for each enrolled person, to cover all his or her health care. This approach motivates the health plan(s) to keep people healthy, and avoid unnecessary tests and treatments.

Thus, a "duals integration" program is designed to control costs, enhance quality and be easier for people to understand. Makes sense, right?

But en route to this goal, our state is about to launch a halfway step that makes no sense whatsoever. During "Phase I" of the Integrated Care Initiative, the state will take Medicaid-only long-term care services, and turn them over to a health plan, in return for a monthly fee for each person enrolled. The monthly fee consists of an amount intended to pay for the enrollee's care, plus an 8 percent add-on as an administrative fee. The total administrative spending could reach $40 million in the first year.

Eventually, "Phase II" should bring Medicare-covered services into the picture, at which point there will probably be opportunities for savings and quality improvement. But Medicare involvement requires obtaining the approval of the federal government, which is not a sure thing, and cannot happen until 2015, at the very earliest.

Why is the state doing this? It's not as though Rhode Island has millions of spare dollars lying around.

The contracted health plan, Neighborhood Health Plan of Rhode Island (NHPRI), will not be able to "integrate" or "manage" much of anything. Dual-eligible people will continue to receive their physician and hospital care, as well as prescription drug coverage, through Medicare. NHPRI will have no control over the use or quality of those services. What's more, although NHPRI is one of the best Medicaid HMOs in the country, it has absolutely no experience with management of the long-stay nursing-facility population.

This might be okay if the state were going to save a corresponding $40 million in expenses, by transferring full administrative responsibility to NHPRI. But the federal authorities with jurisdiction over Medicaid require that the state continue to operate its existing Medicaid program. Integrated Care Initiative staff, when specifically asked, responded that no administrative savings to the state are anticipated.

In the case of nursing-facility care, NHPRI could be paid as much as $27 million to administer the nursing-home benefit for some 5,400 residents. (The total amount depends on whether any of them opt out of the program.) Will these residents receive any added value in return?

With all due respect to NHPRI, there is a steep learning curve for long-term care delivery. Moreover, when the 8 percent administrative fee is deducted, the remaining monthly fee is less than the state is paying today to cover that care. Where

will it get the funding to do anything more? What services will be cut to make up the shortfall? Will NHPRI be doing anything more than processing and paying the bills?

This extraordinary expenditure is being made during the same fiscal year that $7 million was cut from the funding allocated for patient care in nursing homes. Incredibly, the administrative fees will be paid out of money allocated by the state legislature for long-term care services to Rhode Island's elderly. (The General Assembly provided no funding for NHPRI's administrative expenses.)

Many Medicaid-covered residents in nursing homes have begun receiving letters informing them that they have been enrolled in the NHPRI plan. The letters advise that they have the option to "opt out" of the plan, but that they might like the "new services" to be offered by the plan. (No new services are identified.) The recipients are not informed that funding for the new plan will be taken out of money allocated for their care. Even worse, the opportunity to "opt out" is not likely to be meaningful for this population, who are challenged with vision, hearing and cognitive impairments.

It's not too late for the state to put a stop to this incomprehensible plan. NHPRI is scheduled to take over Medicaid-covered long-term care services in November. Whatever the benefit to those getting long-term care in the community, there are no discernible benefits to our state's nursing-home population.

Governor Chafee, please carve the nursing-home population out of this project until it becomes a true dual-integration plan, and save the state, and our most vulnerable elderly, millions in fees that could be used for their care.

Virginia M. Burke is the president and chief executive officer of the Rhode Island Health Care Association.

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