



Healthcare Quality Reporting Program

**STEERING COMMITTEE**

01/10/11, 3-4:30pm  
 Department of Health, Room 401

**Goals/Objectives**

- Obtain Steering Committee approval and input regarding ongoing healthcare quality reporting

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

G Ted Almon	G Neal Galinko, MD, MS, FACP	G Donna Policastro, NP, RCN
G Virginia Burke, Esq.	G David Gifford, MD, MPH	G Louis Pugliese
G Cathy Cranston	G Linda McDonald, RN	G Sharon Pugsley, BSN
G Ron Cotugno, RN	G Jim Nyberg	G Gina Rocha, RN, MPH
G Arthur Frazzano, MD	G Rhoda E. Perry	G Corrine Russo, MSW

**Time Topic/Votes**

3:00pm **1. Welcome & Remarks**  
*David Gifford, MD, MPH, HEALTH*

3:10pm **2. Administrative Updates**  
*Samara Viner-Brown & Rosa Baier*

- 2011 meeting schedule
- Review action items from November:
  - Review public reporting websites and share ideas (Steering Committee)
  - Meet with the Webmaster and then share updates (Rosa/Sam)
  - Coordinate the dissemination of a hospital flu vaccination press release (Sam)
- Website edits
- Data updates:

Report (Oldest to Newest, by Setting)	Update Frequency	Last Updated
<b>Home Health</b>		
• Clinical quality measures from Medicare	Quarterly	Nov 2009
• Patient satisfaction	2 years	May 2008
<b>Hospital</b>		
• Clinical quality measures from Medicare	Quarterly	Dec 2010
• Hand hygiene processes	Annually	Feb 2010
• Surgical Care Infection Program (SCIP) Measures	Quarterly	Dec 2010
• Central-Line Associated Bloodstream Infections (CLABSI)	Quarterly	Dec 2010

Time	Topic/Notes
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Report (Oldest to Newest, by Setting)	Update Frequency	Last Updated
• Pressure ulcer incidence	Quarterly	Sept 2009
• Employee influenza vaccination rates	Annually	Oct 2010
• MRSA incidence	Quarterly	-
• C. difficile incidence	Quarterly	-
<b>Nursing Home</b>		
• Clinical quality measures from Medicare	Quarterly	Nov 2010
• Resident and family satisfaction	Annually	Jan 2010
• Employee influenza vaccination rates	Annually	-
<b>Physician</b>		
• HIT adoption	Annually	Mar 2010

3:45pm **3. Home Health Measures Subcommittee** (Chair: R. Baier)  
*Samara Viner-Brown, MS & Rosa Baier, MPH*

- Reporting:
  - Patient satisfaction surveys
- Next meeting: None scheduled

3:50pm **4. Hospital-Acquired Infections (HAI) Subcommittee** (Chairs: L. Mermel/S. Viner-Brown)  
*Samara Viner-Brown, MS & Rosa Baier, MPH*

- Reporting:
  - Flu vaccination
  - Hand hygiene
  - MRSA and C. difficile
- Hospital support:
  - National Healthcare Safety Network (NHSN) enrollment
- Next meeting: 12/27, 8-9am, Department of Administration

4:00pm **5. Hospital Measures Subcommittee** (Chair: S. Viner-Brown)  
*Samara Viner-Brown, MS & Rosa Baier, MPH*

- Pressure ulcer incidence
- Next meeting: None scheduled

4:10pm **6. Nursing Home Measures Subcommittee** (Chair: G. Patry)  
*Rosa Baier, MPH*

- Reporting:
  - Family/resident satisfaction surveys
  - Employee influenza vaccination
- Next meeting: 2/15, 3-4:30pm, RIHCA

Time	Topic/Notes
4:20pm	<b>7. Physician Measures Workgroup</b> <i>Rosa Baier, MPH</i> <ul style="list-style-type: none"><li>• 2011 Physician HIT Survey</li><li>• Next meeting: None scheduled</li></ul>
4:25pm	<b>8. Closing</b> <i>David Gifford, MD, MPH</i> <ul style="list-style-type: none"><li>• Open forum</li><li>• Next meeting: 3-4:30pm, 3/14</li></ul>



Healthcare Quality Reporting Program

**2011 STEERING COMMITTEE MEETING SCHEDULE**

Last Updated 1/06/11

Meetings are from 3-4:30pm on Mondays in alternating months.

Agendas will be sent at least one business day in advance of a meeting and minutes within 3 business days afterwards.

Location:

Room 401\*  
Department of Health  
One Capitol Hill  
Providence, RI 02908

\*Unless otherwise noted on the agenda

Meeting Dates:

Monday, January 10  
Monday, March 14  
Monday, May 16  
Monday, July 18  
Monday, September 19  
Monday, November 21

RSVP:

Ann Messier  
amessier@riqio.sdps.org

Please note:

Your RSVP helps us with meeting preparation, including preparing materials and ensuring appropriate representation for the agenda topics. If you're unable to attend, we encourage you to send a representative in your place.



## [Rhode Island news](#)

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# A campaign to vaccinate R.I. health-care workers

01:00 AM EST on Sunday, January 2, 2011

By Felice J. Freyer

Journal Medical Writer

In six of the seven years that Deborah Owens worked as a nurse at South County Hospital, she declined to get vaccinated against influenza — even though the vaccine was strongly recommended.

Owens doesn't like needles, and besides, she reasoned, she has a healthy, strong immune system. "I always took extra good care of myself in the winter," she explained.

Owens, 33, of Wakefield, gave a common reason for declining a flu shot, one offered by many other health-care workers — more than half of whom typically fail to get vaccinated. She doesn't get sick; she didn't think she needed it.

A person can have the flu for 24 hours without any symptoms, and during that time can transmit it to others. In hospitals, that can mean infecting vulnerable people with flu, which can be fatal in the elderly and sick. Increasingly, health-care officials are recognizing that unimmunized workers are a threat to patient safety. They also miss work from sickness in seasons when employees are most needed.

A few hospitals elsewhere in the country have mandated vaccination as a condition of employment, and the Providence-based Lifespan hospital group is weighing whether to do so. But in Rhode Island so far, flu-vaccination campaigns have focused on dispelling myths and bringing vaccine directly to the workers, to make it effortless for them.

South County's program also enlists workers who support vaccination to educate and encourage their peers. A nurse is available on every unit to vaccinate colleagues during their work day. It's been one of the state's most successful vaccination efforts, according to Health Department data from last year, which showed wide variation in vaccination rates.

South County's campaign worked for Owens, a charge nurse and clinical leader at the Wakefield hospital. This season, she got her shot. The hospital made it easy for her — she had to walk only "two steps away from the floor I work on." The injection didn't hurt. It didn't make her sick. And now, she intends to get it every year.

For Owens, the immediate impetus was her doctor's recommendation, because she was taking medication that weakened her immune system. But the educational messages from South County were also sinking in: despite being young and strong, she could still get sick. "You can't be too safe," Owens

said.

South County Hospital had the second-highest flu-vaccination rate in Rhode Island during the 2009-10 flu season, according to the Health Department, which compiled and publicized the information for the first time last fall. Among nurses, certified nursing assistants and doctors employed by the hospital, 82.5 percent at South County were vaccinated against seasonal flu. The best rate was at Newport Hospital, with 83.6 percent. The lowest vaccination rates were at Our Lady of Fatima Hospital in North Providence (46.7 percent) and Miriam Hospital in Providence (51.5 percent). The statewide average was 61.2 percent.

Last year's flu season was unusual, however. The H1N1 pandemic raised awareness and concerns, resulting in higher immunization rates. Nationwide, 62 percent of health-care workers had received their seasonal-flu vaccine by mid-January 2010, while previously the rate was only 44 percent.

Lee Ann Quinn, South County Hospital's manager of infection prevention and control, said her hospital started beefing up flu-vaccination efforts in 2007 and quickly brought the rate up. Quinn participated in Health Department-led research on why workers decline the flu vaccine.

A 2007 survey of 846 workers, as well as focus groups, identified concerns similar to those heard elsewhere in the country: People perceive influenza as a mild illness. They believe they have "natural immunity" to it or that hand-washing and other healthy habits can protect them adequately; in reality, anyone can get the flu and every year thousands die from it. They believe the vaccine is ineffective or that it can give them the flu — also false.

"It was very difficult to change their decision," Quinn said. "Even giving them factual information — they weren't ready to hear it."

The hospital focused on those most ready to listen — new nurses and new employees, as well as those who were "on the fence" about whether to get vaccinated. Many, like Deborah Owens, changed their attitude.

In its flu-vaccine effort, the Lifespan hospital group deploys an army of clinical managers who go floor to floor on all three shifts with a mobile flu wagon, says Donna Dube, director of employee and occupational health services.

Even though the same methods were used, the success rates varied among three Lifespan hospitals, with Rhode Island and Miriam vaccinating just over half, and Newport reaching four out of five.

Dube points out that many people get vaccinated elsewhere, and the hospitals cannot track that.

Additionally, the Health Department's data didn't include people who are not doctors, nurses or nursing assistants but who do have direct patient contact, such as diagnostic-imaging technicians. Big hospitals such as Rhode Island have a higher percentage of such workers. When all those with patient contact are counted, Dube said, the vaccination rate at Miriam was 72 percent, at Rhode Island 78 percent and at Newport, 93 percent in the 2009-10 season.

That still puts Newport Hospital in the lead. Nancy Costello, an employee health nurse at Newport, attributed the success to the hospital's size and intimacy. "Because we're a small community hospital, the word gets out pretty quickly," she said. "I know about 95 percent of the staff personally."

In the current season, the four Lifespan hospitals (including Bradley, which is not in the Health Department report) have vaccinated about 59 percent of workers, Dube said. Although the campaign is still going on, Dube does not expect to duplicate last year's unusually high numbers.

The one approach that has been shown to work best is requiring employees to be vaccinated. At the Virginia Mason Medical Center in Seattle, the first hospital to mandate flu shots for employees, 99 percent of its 5,000 employees were vaccinated last season. Three medical groups last year endorsed mandating flu vaccinations for all health-care workers, including the American Academy of Pediatrics, whose 2010 position paper states: "Mandatory influenza immunization for all health-care personnel is ethically justified, necessary and long overdue to ensure patient safety."

In the next few weeks, Lifespan will convene a task force to consider whether to require employees to be vaccinated. Dube, for one, is all for it. "Mandating flu vaccine makes a lot of sense," she said. "I personally believe flu vaccine is vital to patient safety."

[ffreyer@projo.com](mailto:ffreyer@projo.com)

## [Bali1228](#)

8:53 AM on January 3, 2011

I find it disturbing that a charge nurse needs to be educated on the efficacy of flu vaccine, we need to raise our education requirements for nurses to match that of other developed countries.....

 2 replies

**Name withheld**

### [Kimity5](#)

4:58 PM on January 4, 2011

Bali1228 - the problem is NOT the nurse's education (or lack thereof, as you seem to imply) but rather her knowledge of the potential side effects and the crap-shoot that is flu vaccination development. It is telling that so many RNs choose to decline the flu shot - it's risk/benefit ratio is not attractive. I'd be interested to see how many doctors and pharmacists also decline flu vaccination.

**Name withheld**

### [Kimity5](#)

5:01 PM on January 4, 2011

...and for the record, I am an RN, and I DO get the flu shot, but governments cannot legislate that choice. The flu shot is not comparable to childhood vaccines like measles, mumps, or rubella in its efficacy or its tolerability.

**Name withheld**

### [Doing It](#)

3:55 PM on January 2, 2011

If it is mandatory will the hospital cover the time lost for those that have reactions? If not what is the hospitals committment to its staff? This is going to be a tough decision by all parties. One more thing why is the proactive ProJo doing this story when we are well into the flu season?



Department of Health

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

December 21, 2010

Dear Hospital CEO,

As part of the Department of Health's (HEALTH's) ongoing efforts to encourage high-quality care, we want to share news related to measuring and improving hospital-acquired infections (HAIs) using the CDC's National Hospital Surveillance Network (NHSN). **I have previously communicated some of the following information, as has HARI, but want to remind you of upcoming deadlines that may require your staff's attention and also share attachments that you may find helpful for advance planning.**

There are three upcoming activities related to NHSN:

### 1. **Healthcare Quality Reports (C. difficile and MRSA)**

Key information: **Over the past two years, HEALTH's has begun releasing healthcare quality reports for HAI measures (e.g., SCIP, CLABSI, hand hygiene, and flu vaccination data). The next topics are C. difficile and MRSA.**

These topics were selected by the stakeholder group that guides the healthcare quality reporting program, which recommended that hospitals use the National Hospital Surveillance Network (NHSN) definitions and system to collect data.

Important dates: January 1, 2011 - MRSA CLABSI data submission to NHSN begins  
April 1, 2011 - C. difficile data submission to NHSN begins

Point of contact: Samara Viner-Brown, MS, Healthcare Quality Reporting Program  
[Samara-Viner-Brown@health.ri.gov](mailto:Samara-Viner-Brown@health.ri.gov) or 222-5122

### 2. **HAI Collaborative (C. difficile and MRSA)**

Key information: **HEALTH has CDC funding to provide hospitals with the training and technical assistance necessary for hospital staff to begin using the NHSN system to submit HAI data.**

In October 2010, in anticipation of the 2011 release of healthcare quality reports on C. difficile and MRSA, we launched a HAI Collaborative focused on improving care for these HAIs. Given the public reporting program's recommendation that hospitals use NHSN for these topics (above) and Medicare's requirement that hospitals enroll by January 1, 2011 (below), the Collaborative's initial focus has been on NHSN specifically.

Important dates: January 1, 2011 - MRSA data submission to NHSN begins  
April 1, 2011 - C. difficile data submission to NHSN begins

Point of contact: Maureen Marsella, RN, BSN, HAI Collaborative  
[mmarsella@riqio.sdps.org](mailto:mmarsella@riqio.sdps.org) or 528-3223

### **3. Mandated Medicare Reporting (CLABSI and CDI)**

Key information: **Medicare is mandating that hospitals begin submitting CLABSI data to NHSN.**

This information was included in Medicare's final rule, released in July 2010, and will affect hospital reimbursement beginning after one year of data collection (i.e., January 2012): Medicare will withhold 2% of funds if a hospital does not comply with the mandate.

Important dates: January 1, 2011 - CLABSI data submission to NHSN begins  
April 1, 2011 – CDI data submission to NHSN begins

Point of contact: Lauren Pond, RN, BSN, Medicare Beneficiary Protection Program  
[lpond@rigio.sdps.org](mailto:lpond@rigio.sdps.org) or 528-3204

As a result of these local and national activities related to NHSN, I am attaching two documents that may help hospitals with planning for NHSN enrollment and use:

### **1. NHSN Business Case**

The Wisconsin Department of Health Services created a business case to help hospitals understand and prepare for efforts to use NHSN for HAI surveillance and prevention. The business case provides context for CDC and Medicare efforts, as well as a detailed estimates of the NHSN system's staffing and training requirements. We have adapted and are sharing the business case with permission.

### **2. NHSN Business Case Executive Summary**

The Infection Control Prevention Southern New England (ICP SNE) group has significant representation on both the healthcare quality reporting program's HAI stakeholder group and the HAI Collaborative. The group created an Executive Summary to preface the business case, describing local activities and providing recommended actions for hospital executives.

Please use the contact information above with any questions and thank you, again, for your recognition of the importance of ensuring adequate Infection Control resources to curb HAIs.

Sincerely,



David Gifford, MD, MPH  
Director of HEALTH

*Attachments:* NHSN Business Case  
NHSN Business Case Executive Summary

*CC:* Infection Control Prevention Southern New England (ICP SNE) group  
HAI Subcommittee



**Infection Control Professionals of Southern New England (ICPSNE)**  
**NATIONAL HEALTHCARE SAFETY NETWORK (NHSN) BUSINESS CASE EXECUTIVE SUMMARY**  
**Issued December 15, 2010**

## **Background**

Healthcare-associated infections (HAIs) are a major threat to patient safety and are among the most common adverse events in healthcare. The Federal Government has implemented a strategic initiative to prevent HAIs across the nation, using 'Target Zero' bundles and reimbursement incentives and penalties.

## **Rhode Island Status**

- The Rhode Island Department of Health (HEALTH) and its public HAI Subcommittee have been working collaboratively to establish the metrics for HAI public reporting in Rhode Island. The Subcommittee has recommended two NHSN metrics, for *C. difficile* and MRSA.
- The Rhode Island HAI Collaborative, a HEALTH-funded initiative, meets regularly at Quality Partners of Rhode Island to facilitate the hospitals' transition to using NHSN for reporting infection data.
- Currently, hospitals in Rhode Island are preparing to use the NHSN program to report ICU central line-associated bloodstream infections (CLABSI). Hospitals that want to receive an additional 2.35% in Centers for Medicare & Medicaid Services (CMS) reimbursement should be certified, accepted, and ready to use the system by January 1, 2011. The penalty for not reporting to CMS is a loss of 0.35% reimbursement.
- Beginning FY2015, hospitals in the lowest performing quartile of Medicare Hospital-Acquired Condition (HACs) will get a 1% reduction in Medicare inpatient payments.
- Hospitals in Rhode Island need to prepare for automated data entry into NHSN for the next phase of CMS requirements regarding surgical site infection (SSI) reimbursement as of January 1, 2012. At least 3-4 months should be allowed for internal Information Technology Services to achieve the necessary links.

## **Executive Actions**

It is well documented that in states where NHSN has been used, they learned that additional resources were required in order to conduct the increased surveillance and to enter data. For example, in Pennsylvania, hospitals needed 1.5 times their original number of Infection Preventionist FTEs to utilize NHSN. This did not take into account the *C. difficile* infection NHSN module that Rhode Island will use soon.

The ICP SNE group, therefore, advises hospital executives to:

- Discuss the elements of their Infection Prevention and Control Program with the Infection Preventionists to agree upon a course of action.
- Prioritize their Information Technology Department to facilitate the transition to automated NHSN data entry.
- Discuss the plan to provide additional resources for NHSN data entry and report management.

# NATIONAL HEALTHCARE SAFETY NETWORK (NHSN) BUSINESS CASE<sup>1</sup>

Updated December 15, 2010

## Executive Background

Hospitals understand the value of preventing healthcare-associated infections (HAIs) and have created infection prevention and control programs to track, manage, reduce and eliminate them. Despite these efforts, HAIs remain a major cause of morbidity and mortality and excess medical cost in the United States. An estimated 5-10% of all hospital admissions are complicated by HAIs.

The Centers for Disease Control and Prevention (CDC) provide a set of surveillance definitions and a database called the National Healthcare Safety Network (NHSN) for collecting healthcare-associated infection surveillance data at no charge to hospitals. Efforts are underway at the CDC to strengthen and extend capacity for HAI surveillance and prevention by encouraging hospitals to use NHSN as their HAI infection surveillance data collection system.

The CDC's Division of Healthcare Quality Promotion is administering federal-state cooperative agreement programs, funded through a number of different grants, which are designed to improve surveillance and prevention efforts.<sup>2</sup>

State-specific and national-level HAI surveillance data are vital for quantifying the prevalence of HAIs, identifying prevention priorities, and evaluating the impact of prevention efforts. It is assumed that these definitions will need to be used in a standardized way by all hospitals in the U.S. at some point in the future. Currently, 22 of 30 states with mandatory HAI reporting require the use of the CDC NHSN system to compile information on these infections and are able to use the reporting function to track trends and compare against benchmarks. With the assistance now available from HEALTH, hospitals in the state have an opportunity to transition to the NHSN HAI surveillance system, which will allow them to report on HAI quality measures that may be required by the Centers for Medicare & Medicaid Services (CMS), the Joint Commission, and other government bodies now and in the future.

In addition to the reporting referenced above, NHSN provides:

- ✓ Free system with a more automated approach to surveillance
- ✓ Standardized surveillance with consistent case definitions
- ✓ Benchmarking (national, state, and local)
- ✓ Real-time analytics within system
- ✓ Local support for training and technical assistance
- ✓ Protocols for each module
- ✓ Detailed tables of instruction
- ✓ Data collection forms to help you collect what you need throughout your monthly surveillance
- ✓ Help functionality incorporated into system to provide case definition answers as you enter data

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<sup>1</sup> Adapted with permission from the Wisconsin Department of Health Services' NHSN Business Case, available at: <http://www.dhs.wisconsin.gov/communicable/HAI/PDFs/BusinessCaseNHSN.pdf>

<sup>2</sup> The CDC provided funds to Rhode Island that have allowed the Rhode Island Department of Health to offer hospitals support for training and technical assistance related to the use of NHSN for HAI data collection. Please contact Maureen Marsella at [mmarsella@rigio.sdps.org](mailto:mmarsella@rigio.sdps.org) or 401-528-3223 with questions about Rhode Island's NHSN support or the NHSN system.

## Project Description

The project is to implement the NHSN infection surveillance database as the method for compiling HAI surveillance data collected by infection preventionists (IPs) in hospitals. Compiled data will be used for measuring rates of HAIs in the hospital, tracking HAI trends, and making for risk-adjusted comparisons to national benchmarks.

## Business Need

There is a business need for hospitals to prepare for how they will demonstrate their performance on HAI quality measures. On March 23, 2010, President Obama signed HR 3590, the Patient Protection and Affordable Care Act, which includes several infection prevention provisions, such as:

- Hospital value-based purchasing program that includes certain HAIs as quality measures
- 1% payment penalty for hospitals in the top quartile for hospital-acquired condition rates
- A payment-bundling pilot program that includes HAI incidence and reducing hospital readmissions

In addition, the Final Rule for CMS's Reporting Hospital Quality Data Annual Payment Update (RHQDAPU) program for prospective payment system (PPS) hospitals (non-critical access), includes HAI-related quality measures for FY 2013 payment determinations. The rule was published in the Federal Register on July 30, 2010. Hospitals must use the NHSN infrastructure to report measures for central line-associated bloodstream infections and surgical site infections for use in their payment determination and for public reporting purposes.

Data collected in the NHSN system can serve multiple purposes:

- ✓ Enable hospital benchmarking against local and national peers for internal quality improvement
- ✓ Support statewide improvement and reporting initiatives
- ✓ Support current and upcoming Federal requirements

## Goal/Scope

The goal of the project is to collect infection surveillance data according to the standardized definitions and enter them into NHSN in order to monitor HAI incidence and prevalence data. Once data is entered, the system's reports will support infection control committees, physician peer review, and other quality management functions.

The data are primarily acquired through active surveillance, including microbiology report review and chart review by IPs in hospitals, and by direct observation of hospital practices; they cannot be obtained from coding.

## NHSN Components

Hospitals may select their level of participation from the following NHSN modules for collecting HAI surveillance data:

Topic	Module	Surveillance Data	Requirements
Patient safety	Device-associated module	<ul style="list-style-type: none"> <li>• Central line-associated bloodstream infection (CLABSI)</li> <li>• Central line insertion practices adherence (CLIP)</li> <li>• Ventilator-associated pneumonia (VAP)</li> <li>• Catheter-associated urinary tract infection (CAUTI)</li> <li>• Dialysis event (DE)</li> </ul>	<p>ICU CLABSIs: CMS mandate to receive 2.35% more reimbursement as of 1/1/2011</p> <p>MRSA ICU CLABSIs: HEALTH public reporting mandate as of 1/1/2011</p> <ul style="list-style-type: none"> <li>• CAUTI: CMS projection 2013</li> </ul>

Topic	Module	Surveillance Data	Requirements
	Procedure-associated module	<ul style="list-style-type: none"> <li>Surgical site infection (SSI)</li> <li>Post-procedure pneumonia (PPP)</li> </ul>	<ul style="list-style-type: none"> <li>SSI: CMS mandate for extra reimbursement as of 1/1/2012</li> </ul>
	Medication-associated module (currently being revised)	<ul style="list-style-type: none"> <li>Antimicrobial use and resistance options (AUR)</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
	MDRO/CDAC module	<ul style="list-style-type: none"> <li>Multidrug-resistant organisms/<i>C. difficile</i>-associated disease</li> <li>High-risk inpatient influenza vaccination</li> </ul>	<ul style="list-style-type: none"> <li>CDI: HEALTH public reporting mandate as of 4/1/11</li> </ul>
Healthcare personnel safety	n/a	<ul style="list-style-type: none"> <li>Staff influenza vaccination Blood and body fluids exposure</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
Biovigilance	n/a	<ul style="list-style-type: none"> <li>Hemovigilance</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

### Reporting Requirements for NHSN

- Submit a monthly reporting plan to inform CDC which modules, if any, will be reported that month
- Submit data for at least one module for at least six months each calendar year. **To meet CMS and RI public reporting laws, certain data must be submitted for 12 months each calendar year.**
- Complete an annual facility survey
- Follow the data collection protocols for selected modules exactly, reporting complete and timely data
- Agree to report outbreaks identified by the surveillance system to the state health department if contacted by CDC

### Resources and Commitment Required

Building the data collection systems for loading the appropriate information into this database can require an investment in vendor software interfaces, IT staff time and computer hardware, plus active data collection by trained IPs who will do the analysis and reporting. Data entry into NHSN can be done by administrative staff, but will require time for those staff members to complete required online training modules and enrollment into the system.

### Criteria for NHSN Use

- Be a bona fide healthcare facility in the United States
- Have email addresses for NHSN users and high-speed Internet access on the computers
- Be willing to follow the selected NHSN component protocols and report complete and accurate data in a timely manner
- Be willing to share such data with CDC
- Be able to provide written consent for participation in the NHSN by a member of the facility's chief executive leadership (e.g., Chief Executive Officer)

### Minimum System Requirements

- 1 GHz equivalent or greater Intel Pentium III processor
- 128 MB of RAM
- Windows 98
- Email account
- High-speed internet access (greater than 200 Kbs)
- 500 MB available disk space
- Microsoft Internet Explorer 6 or higher

### *Staffing Considerations*

Infection preventionists (IPs) trained in infection surveillance lead case finding efforts, train others who will help collect data (e.g., device days for CLABSI), act as local experts in NHSN definitions and surveillance methods, enter case information as needed, and run reports and analyze resulting NHSN data outputs. Most of these activities are part of any IP's surveillance responsibilities, but using NHSN **will increase** the time commitment. An article on infection control program structure in the *American Journal of Infection Control* (Stone et al, 2009) indicated that IPs spend about fifty percent of their time performing infection surveillance activities, based on a nationwide survey of NHSN users.

Administrative support staff can help with the entry of infection numerator and denominator information. The system is intuitive and data entry can be accomplished by someone other than a trained IP as staffing models allow. This frees the IP to be able to focus on infection surveillance, education and prevention activities.

IT support staff are a valuable resource for NHSN users, assisting in loading each user's digital certificate and creating backup copies, translating IP software needs with vendor application builders, and building custom reports to help with NHSN interfaces.

### *Training*

Staff training on NHSN surveillance methodology, definitions and data entry is provided free via a hybrid of CDC-archived webcasts and standalone slide sets that are available in real-time from any computer. Required courses include the majority of the available modules in order to give users a well-rounded understanding of the system. Estimated training time for completing all of the required modules is 10-14 hours.

Local resources to support NHSN are available through the CDC –NHSN Website including:

- A dedicated staff position
- Enrollment, training and technical assistance
- Teleconferences, and webinars

### *Data Entry*

We estimate between 5-15 minutes to enter each numerator, although this depends on the specific module being used, patient volume, the presence of a direct electronic interface, and how easily accessible the required data elements are within various hospital systems. The device-associated module denominators consist of daily collection of patient days and device days, with only the monthly total entered into the NHSN system. The procedure-associated module requires that every procedure performed during the particular month under surveillance (e.g., all hip arthroplasties) be entered, including more detailed operation information fields, which **will take more of a data entry time commitment.** If a report can be easily translated into an Excel standard file format, possibly with help from an IT staff member, the procedures for denominators can be imported quickly and easily. Most likely, the data entry cannot be done manually.

### *Data Output*

The NHSN system has a built-in data analysis tool package, allowing for real-time analytics using CDC's canned reports (rate tables, frequency tables, control charts, etc.). Once the data is entered into NHSN, any NHSN user can run reports, using CDC's set configurations or modifying them to include filters or custom results. To begin the process, an IP should be involved in evaluating which reports are most useful, but after that point, administrative staff who perform data entry could also be used to help run the reports and prepare them for meetings and presentations. The

data can also be exported into Excel, SAS, and Access if an in-house analyst would like to perform more in-depth analytics.

### **Note on Staffing Resources**

The national Association for Professionals in Infection Control and Epidemiology (APIC) recently developed an *IP Program Evaluation Tool* in a CD-Rom format to evaluate the resources needed to support a hospital infection prevention program. It was made available to APIC members in the spring 2010 edition of *The Prevention Strategist*.

### *Data Protection*

NHSN is a secure, internet-based surveillance system. CDC's confidentiality protections are summarized as follows: "The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not be disclosed or released without the consent of the individual, or the institution in accordance with Section 304, 306, and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d))."

Data Use and Confidentiality Agreements will protect data that is shared with states when conferring rights in NHSN. The agreement provides for hospital-level information contained in NHSN or other infection surveillance data systems to be shared with HEALTH for infection prevention purposes and if used for aggregate public reporting. A hospital participating in NHSN may confer rights to HEALTH to be used for hospital-specific public reporting. NHSN will not release the data without hospital agreement to states for public reporting purposes.

### **Business Impact**

According to NHSN users, advantages to participating in NHSN include:

- You have the backing of the CDC.
- Your rates can be risk stratified by infection type, hospital type, unit type, unit size and procedure type so comparisons are made "apples to apples" with other like hospitals around the country.
- Provides clear definitions with detailed surveillance instructions and applicable flowcharts to guide classification so you have evidence to show why you are classifying an infection an infection. These definitions can be shared with committees and providers who have questions about how surveillance is being done and whether certain cases meet criteria.
- It is much easier to identify a problem when you have national rates and a p-value for comparison.
- An infection rate that is statistically significant sends a clear message to physicians and hospital staff.

### *Quotes from Hospitals Participating in NHSN*

"The benefit of the system is the ability to have comparative data from other facilities which can be used to gauge facility progress."

"The ability to have risk-adjusted comparative rates has been very helpful for all stakeholders"

"The use of statistical analysis and comparative rates has been extremely useful in the identification of problems, evaluating actions and to demonstrate success of interventions."

### *Benefits According to CDC*

Data collected in NHSN are used for improving patient safety at the local and national levels. In aggregate, CDC analyzes and publishes surveillance data to estimate and characterize the national burden of healthcare-associated infections. At the local level, the data analysis features of NHSN that are available to participating facilities range from rate tables and graphs to statistical analysis that compares the healthcare facility's rates with national aggregate metrics.

### **Alternative Analysis**

Infection surveillance data collected in hospitals using the NHSN definitions can be uploaded to the NHSN database through various methods. Costs and risks associated with these alternatives include investment in vendor software that may or may not be supported in the future or have NHSN interfaces.

#### *Interfaces – Electronic Health Records and Commercial Infection Surveillance Software*

Design of electronic health records and commercial infection surveillance software applications can include data interfaces with the NHSN system (several have already been built) to allow data fields to be populated automatically.

In 2009, CDC released an HL7 implementation guide to specify a standard format for electronic submission of HAI data to the NHSN. Since that time, multiple vendors and institutions have begun using that format to submit HAI data directly to the CDC using this standard. At this time, only limited data can be submitted directly, including bloodstream infection events, procedures and denominator data, and SSI events. CDC is working to build additional capacity for accepting data for other modules. The vendors who participated in the 2007-2008 pilot activities for BSI and SSI reporting include MedMined™ from Cardinal Health, EpiQuest, ICPA (now BD Diagnostics), Premier, TheraDoc and Vecna Technologies.

Several of the proposed CMS Clinical Quality Measures for electronic submission by eligible hospitals (meaningful use certification requirements) can be captured in NHSN. These include:

- NQF 0140 – Ventilator-associated pneumonia for ICU and high-risk nursery patients
- NQF 0138 – Urinary catheter-associated infection for ICU patients
- NQF 0139 – Central line catheter-associated bloodstream infection rates for ICU and high-risk nursery patients

### **Note on Vendor Selection**

APIC developed an Infection Prevention and Control Surveillance Technology Assessment Tool (March 2007), which provides questions and items to consider when shopping for an infection surveillance software vendor. This tool is available on APIC's website at

[http://www.apic.org/AM/Template.cfm?Section=Search&section=Educational\\_Tools&template=/CM/ContentDisplay.cfm&ContentFileID=7816](http://www.apic.org/AM/Template.cfm?Section=Search&section=Educational_Tools&template=/CM/ContentDisplay.cfm&ContentFileID=7816)



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January 18, 2011

Dear Physician,

The Rhode Island Department of Health's (HEALTH's) 4th annual Physician Health Information Technology (HIT) Survey is now live. **This brief survey is required of all licensed physicians.** It asks about your use of electronic medical records (EMRs) and e-prescribing, and should take 10 minutes to complete.

**Please use the below link to complete the online survey by Monday, February 7, 2011, regardless of whether or not you currently use HIT. Please note that a lack of response will be treated (and reported) as if you do not use HIT, and may affect your eligibility to secure HIT-based incentives (see information below).**

<https://www.surveymonkey.com/s/HITSurvey2011> (note the "s" on https)

You also may receive an email link, if you have provided HEALTH with your email address, and can respond by clicking on the link you receive.

**HEALTH's legislatively-mandated public reporting program will publicly report the 2011 survey results for each individual physician.** Since 1998, the program has reported clinical outcomes and patient satisfaction data for home health agencies, hospitals, and nursing homes. In 2006, the state legislature expanded the program to include physicians. If you have questions about the public reporting program or this survey, please visit the Program's website ([www.health.ri.gov/chic/performance](http://www.health.ri.gov/chic/performance)) or review the attached Frequently Asked Questions (FAQ). If you still have a question, you can contact HEALTH at [HITSurvey@health.ri.gov](mailto:HITSurvey@health.ri.gov).

**Your responses may also determine your eligibility for the health plans' HIT-based incentives.** (If so, the health plans will contact you directly about their programs.) To minimize the data collection burden for you, HEALTH collaborates with Blue Cross & Blue Shield of Rhode Island, UnitedHealthCare of New England, Tufts Health Plan, the Department of Human Services, and other community partners to ensure that this single survey collects the majority of information needed to assess local HIT use.

Thank you for continuing to support high-quality healthcare in Rhode Island.

Sincerely,

A handwritten signature in black ink, appearing to read "David R. Gifford".

David R. Gifford, M.D., MPH  
Director, HEALTH

A handwritten signature in black ink, appearing to read "Samara Viner-Brown".

Samara (Sam) Viner-Brown, M.S.  
Center for Health Data and Analysis, HEALTH

*Encl.* Physician HIT Survey Frequently Asked Questions

## Physician HIT Survey Frequently Asked Questions (FAQ)

### BACKGROUND

#### 1. Why does the Department of Health (HEALTH) collect this information every year?

The state legislature mandated that HEALTH publicly report this information annually. Because your use of electronic medical records (EMRs) and e-prescribing changes over time, we ask you to update your responses.

#### 2. Why is this mandatory? What does “mandatory” mean?

The state legislature has mandated that HEALTH publicly report this information annually, so you are required to submit this information. If you do not, non-response is reported as non-use of HIT. This may affect your eligibility to secure HIT-based incentives from the health plans.

### ELIGIBILITY & COMPLETION

#### 3. Who is eligible to complete this survey?

The physicians who receive the survey are identified through HEALTH’s licensure database. The target population is 100% of physicians (MDs and DOs) with active RI licenses, who indicate that they are in active practice and provide direct patient care (or left these questions blank). Data are reported for those with RI, CT, or MA mailing addresses.

#### 4. I’m not a physician. Should I complete this survey?

No, the survey targets physicians (MDs and DOs). You should not need to complete it if you are not a physician.

#### 5. This doesn’t really apply to my specialty. Is it intended for me? Should I complete it?

The survey targets 100% of physicians, regardless of specialty. We have created pathways for office- and hospital-based physicians to tailor the questions to differing HIT usage—but realize that the questions may not be appropriate for all specialties. Please respond to the best of your ability. If you do not, non-response is reported as non-use of HIT.

#### 6. I’m retired. Why did I get this survey?

The physicians who receive the survey are identified through HEALTH’s licensure database. If you have retired since the database was last updated, you may be included. You can opt not to respond to the survey, knowing that your lack of response will be reported as non-use of HIT (which is likely accurate).

#### 7. I practice abroad or in a state other than Rhode Island. Why did I get this survey?

The physicians who receive the survey are identified through HEALTH’s licensure database. You will receive a survey notification if you have a RI license and indicated you are in active practice and provide direct patient care (or left these questions blank). Data are reported for physicians with mailing addresses in RI, CT, or MA. You can ignore the survey, but please note that non-response will be reported as non-use of HIT.

#### 8. Can my Office Manager complete the survey?

The survey asks very specific questions about how you use HIT and is best answered by you, instead of your Office Manager. It should take about 10 minutes to complete.

### TECHNICAL ASSISTANCE

#### 9. I didn’t get a copy of the survey. Can you send me one?

The survey is electronic, not on paper. You can access it via the link in the letter you received. This helps to save you time, since it incorporates skip patterns automatically based on your responses. If you cannot access a computer and do not use HIT, you can opt not to respond to the survey, knowing that your lack of response will be reported as non-use of HIT.

#### 10. Can I complete the survey on paper?

No, the survey is electronic. This helps to save you time, since it incorporates skip patterns automatically based on your responses. If you cannot access a computer and do not use HIT, you can opt not to respond to the survey, knowing that your lack of response will be reported as non-use of HIT.

#### 11. I tried to access the link, but I couldn’t get to the survey.

- If you are typing the URL into your Web browser, please make sure you include the “s” on “https.” If you are copying and pasting the URL, please make sure that the full URL is pasted into your browser.
- If you still have trouble, please contact HEALTH at [HITSurvey@health.ri.gov](mailto:HITSurvey@health.ri.gov). We will make every effort to respond to your inquiry within two (2) business days of receipt.

## Physician HIT Survey Frequently Asked Questions (FAQ)

### 12. I completed the survey. Can I get a confirmation?

No, at this time we are unable to generate confirmation emails. If you need confirmation of your survey completion, please print the thank you page (last page) from your Web browser.

### 13. I completed the survey, but I still got a reminder email. Were my responses saved?

SurveyMonkey tracks response/non-response using your email address (if you provided it to HEALTH). If you responded by typing in the survey URL, rather than clicking on the link emailed to you, you will receive a reminder regardless of your response. Your survey responses are saved.

## HIT-BASED INCENTIVES

### 14. I'm a PCP. How does this survey affect my Blue Cross & Blue Shield of Rhode Island (BCBSRI) fee increase?

HEALTH partners with BCBSRI to minimize the data collection burden for you, but does not determine BCBSRI's fee increase. Please contact BCBSRI directly with questions.

### 15. I'm a PCP. How does this survey affect my United Health Care (UHC) incentive payment?

HEALTH partners with UHC to minimize the data collection burden for you, but does not determine UHC's incentive payment. Please contact UHC directly with questions.

### 16. I'm a PCP. How does this survey affect my Tufts Health Plan ("Tufts") incentive payment?

HEALTH partners with Tufts to minimize the data collection burden for you, but does not determine Tufts' incentive payment. Please contact Tufts directly with questions.

### 17. Does this survey determine "Meaningful Use" for the Department of Human Services (DHS)?

DHS released the final rule for Meaningful Use in July 2010 and registration opened January 3, 2011. (Registration is available at <https://ehrincentives.cms.gov/hitech/login.action>.) The 2011 Physician HIT Survey will not assess Meaningful Use, though responses may guide state efforts to educate and support physicians implementing EMRs and applying for incentives.

## MEASUREMENT & REPORTING

### 18. What measures are publicly reported based on my responses?

We calculate five measures based on your responses, including use of: (1) "EMR components" (Y/N), (2) a "qualified" EMR (Y/N), (3) basic EMR functionalities (0-100 scale), (4) advanced EMR functionalities (0-100 scale), and (5) e-prescribing (Y/N). You can learn how these measures are calculated at [www.health.ri.gov/chic/performance/physician.php](http://www.health.ri.gov/chic/performance/physician.php).

### 19. How was the survey and its measures created?

HEALTH and Quality Partners of Rhode Island led the survey design in partnership with BCBSRI, UHC, and the Rhode Island Quality Institute, as well as input from physician stakeholder groups. These partnerships help ensure that the survey collects information to support a variety of state needs, while minimizing your data collection burden.

## COMMENTS

### 20. It's unfair of HEALTH to report HIT use, but not pay for me to adopt an EMR.

We recognize that there are many barriers to HIT adoption, and the survey provides you with an opportunity to help us understand your unique situation and barriers. This information is not publicly reported at the physician level.

### 21. I'd like to tell you about my positive/negative experiences with EMRs or e-prescribing.

We welcome your input. The survey provides you with an opportunity to share your thoughts. This information is not publicly reported at the physician level.

## ADDITIONAL QUESTIONS

### 22. I'd like more information. Where can I learn more?

Please visit the public reporting program's Web site at [www.health.ri.gov/chic/performance](http://www.health.ri.gov/chic/performance).

### 23. My question wasn't answered here. What should I do?

Please contact HEALTH at [HITSurvey@health.ri.gov](mailto:HITSurvey@health.ri.gov) with additional questions. We will make every effort to respond to your inquiry within two (2) business days of receipt.

## Proposed Edits for 2011 Physician HIT Survey

*New questions for the 2011 office-based survey instrument (not the hospital-based version):*

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

- <sub>1</sub> Yes, from Medicaid's EHR Incentive Program
  - <sub>2</sub> Yes, from Medicare's EHR Incentive Program
  - <sub>3</sub> Yes, but I haven't chosen between Medicare and Medicaid yet
  - <sub>4</sub> No, I don't plan to seek incentive payments (meaningful use reimbursement)
  - <sub>5</sub>
  - <sub>6</sub> Don't know
  - <sub>7</sub> Need more information
- [Add free text field to this answer option]

**2. With your EMR, do you plan to seek incentive payments, also called Meaningful Use reimbursements? (Choose one.)**

- <sub>1</sub> Yes, from Medicaid's EHR Incentive Program
  - <sub>2</sub> Yes, from Medicare's EHR Incentive Program
  - <sub>3</sub> Yes, but I haven't chosen between Medicare and Medicaid yet
  - <sub>4</sub> No, I don't plan to seek incentive payments (meaningful use reimbursement)
  - <sub>5</sub>
  - <sub>6</sub> Don't know
  - <sub>7</sub> Need more information
- [Add free text field to this answer option]

*If respondents intend to seek reimbursement (response choices 1-3, above), they will see the following two questions:*

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

- <sub>1</sub> 2011
- <sub>2</sub> 2012
- <sub>3</sub> After 2012

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

- <sub>1</sub> Implement drug-formulary checks
- <sub>2</sub> Incorporate clinical lab-test results into certified EMR technology as structured data
- <sub>3</sub> Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
- <sub>4</sub> Send reminders to patients per patient preference for preventive/follow-up care
- <sub>5</sub> Provide patients with timely electronic access to their health information (allow patients to view their health information online)

- <sub>6</sub> Use certified EMR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate
- <sub>7</sub> Perform medication reconciliation when receiving a patient from another provider or care setting
- <sub>8</sub> Provide a Summary of Care record for each transition of care or referral from another provider or care setting
- <sub>9</sub> Complete at least one electronic data submission to an immunization registry or Immunization Information System
- <sub>10</sub> Submit electronic syndromic surveillance data to public health agencies
- <sub>11</sub> Don't know

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

*Existing questions on both the office- and hospital-based survey instruments that reflect minor changes reflecting stakeholder input:*

- **If you do plan to implement an EMR, which EMR vendor are you considering (if any)?**  
*Respondents will be allowed to choose more than one vendor, rather than being forced to choose one.*
- **Is your EMR certified by the Office of the National Coordinator (ONC)? (This includes CCHIT and Drummond certification.) View the ONC's database of certified products [here](#).**  
*Certification is being broadened from CCHIT to ONC certification, which is new since 2010.*

*Existing questions on the office-based survey instrument (not the hospital-based version) that reflect the fact that the DEA approved electronic transmission of Schedule II-V drugs in June 2010:*

- **What percent of the time do you transmit prescriptions electronically to the pharmacy? (Exclude faxing.)**
  - <sub>1</sub> 0% → Skip to Question 27
  - <sub>2</sub> <30%
  - <sub>3</sub> 30%-60%
  - <sub>4</sub> >60%
- **Have you started to e-prescribe Schedule II-V drugs?** The DEA approved electronic transmission of Schedule II-V drugs in June 2010. Read more about e-prescribing controlled substances [here](#).
  - <sub>1</sub> No
  - <sub>2</sub> Yes
- **Do you transmit electronic prescriptions using an EMR?**
  - <sub>1</sub> No
  - <sub>2</sub> Yes → Skip to Question 28

- **Do you plan to transmit prescriptions using an EMR within the next 12 months?**

<sub>1</sub> No

<sub>2</sub> Yes