Rhode Island Health Care Quality Performance (HCQP) Program

11th Annual Report to the General Assembly

R.I.G.L. 23-17.17-5, Fiscal Year 2008

David R. Gifford, MD, MPH, Director
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

www.health.ri.gov/chic/performance/index.php

July 2009

Table of Contents

I. Executive Summary 2

II. Program Overview 3

III. FY 2009 Reporting Activity 4

- A. Home Health Agencies 4
- B. Hospitals 4
- C. Nursing Homes 6
- D. Physicians 6

IV. FY 2010 Program Goals 7

V. Project Management 9

- A. Steering Committee Membership 9
- B. Project Staffing 10
- C. Budget 10
- D. Public Information 11

VI. Summary 11

Appendices

Appendix A: Pressure Ulcer Admission Assessment: Measure Information Form
Appendix B: Daily Pressure Ulcer Reassessment: Measure Information Form
Appendix C: Pressure Ulcer Process Measures: Data Report
Appendix D: Pressure Ulcer Process Measures: Technical Page
Appendix E: Surgical Care Infection Program (SCIP) Measures: Data Report
Appendix F: Surgical Care Infection Program (SCIP) Measures: Technical Page
Appendix G: 2009 Physician HIT Survey Measures
Appendix H: 2009 Physician HIT Survey Summary Report

Addendum

Hospital-Acquired Infections Reporting

I. Executive Summary

Over the past 11 years, the Department of Health (HEALTH) has worked with healthcare providers and other stakeholders to implement a healthcare quality public reporting system for all licensed healthcare facilities in the State. Initially, the Health Care Quality Performance (HCQP) Program reported data for home health agencies, hospitals, and nursing homes. Notably, during FY 2009, Rhode Island was the first state in the nation to report individual-level measures of health information technology adoption for all licensed physicians. The Program also expanded to include hospital-acquired infections, as a result of recent legislation, and hospital pressure ulcer care processes. FY 2009 reporting activities and new data reports are summarized below [**Tables 1** and **2**].

Table 1: FY 2009 Reporting Activity, by Measure and Frequency

Setting	Clinical Quality Measures		Structure Measures	Patient Satisfaction
	Process	Outcome		
Home Health		Q		n/a
Hospital	Q+			Q
Nursing Home		Q		A
Physician			A+	

n/a Reported every 2 years, but not during FY 2009
A Annually
Q Quarterly
\+ Some or all new data reported in FY 2009

Table 2: Data Reports Newly-Added During FY 2009

Setting	Category	Measures
Hospital	Pressure ulcers	• Percent of patients receiving pressure ulcer admission assessment • Percent of patients receiving daily pressure ulcer reassessment
	Hospital-Acquired Infections (HAIs)	• Percent of surgery patients given antibiotics within one hour prior to surgery • Percent of surgery patients given the right kind of antibiotics before surgery • Percent of surgery patients who stop receiving antibiotics within 24 hours of surgery
Physician	Physician HIT Adoption	• Physicians with EMRs • Physicians with 'qualified' EMRs • Basic EMR functionality use • Advanced EMR functionality use • Physicians who are e-prescribing

HIT Health Information Technology
EMR Electronic Medical Record

This Annual Report details the above reporting activities, and also describes the FY 2010 Program goals, which include recurring reports and expanding the Program to include: (1) hospital-acquired, or incident, pressure ulcers, and (2) additional hospital-acquired infection (HAI) measures, such as employee influenza vaccination levels, central line-associated bloodstream infections (CLABSI) rates, and hand hygiene processes.

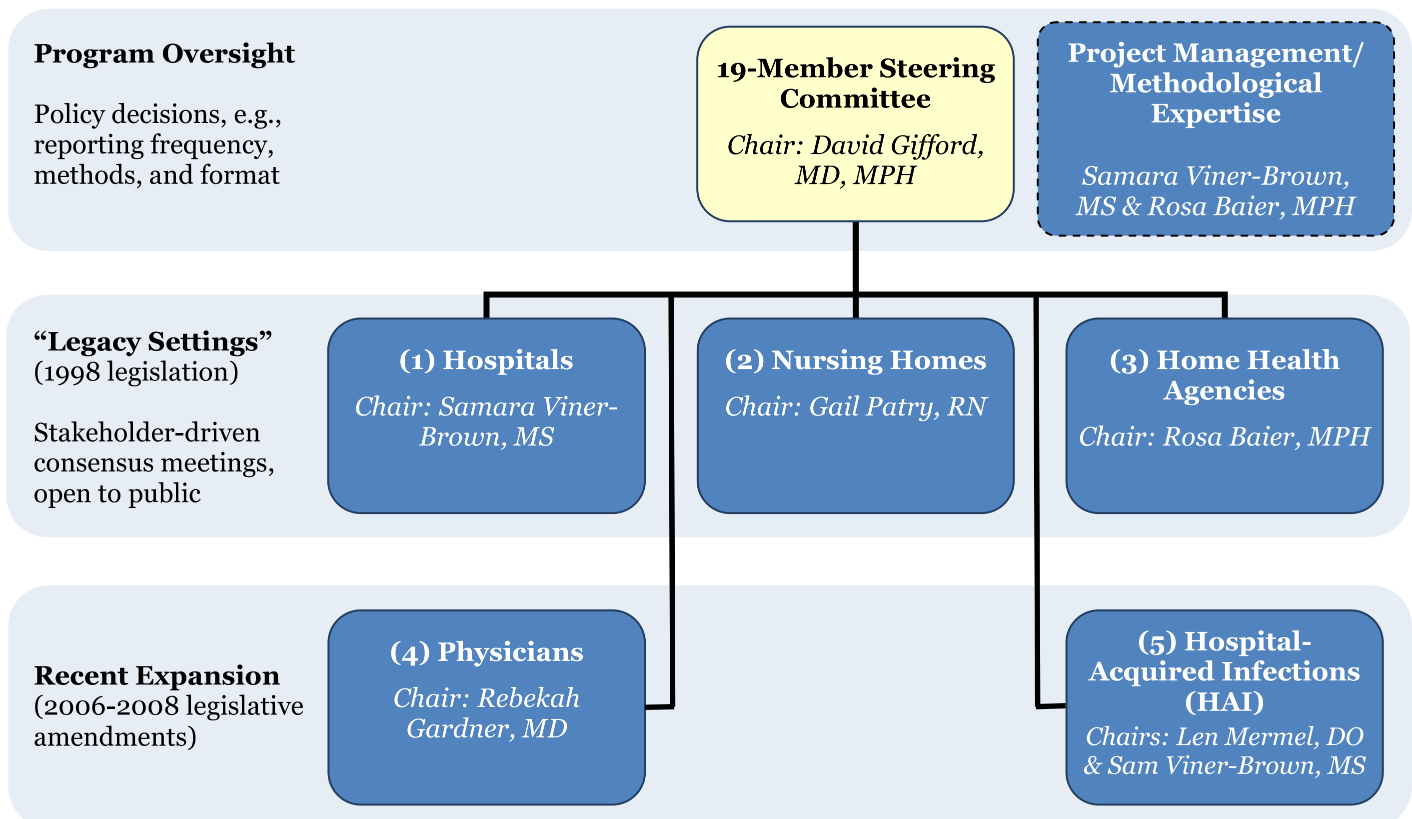
II. Program Overview

In 1998, the State of Rhode Island mandated that HEALTH develop a healthcare quality public reporting system for all licensed healthcare facilities.[1] With the Health Care Quality Performance (HCQP) Program, licensed healthcare facilities were required to report clinical outcomes and patient satisfaction through HEALTH's website:

http://www.health.ri.gov/chic/performance

Over the past 11 years, HEALTH has worked with healthcare providers and other stakeholders to report data for home health agencies, hospitals, and nursing homes.

The Program is governed by a 19-member Steering Committee Chaired by the Director of HEALTH and managed by HEALTH and its contractor, Quality Partners of Rhode Island. Each setting has a public stakeholder group that vets proposed measure(s) and provides recommendations on the measures, process, and report format to the Steering Committee [**Figure 1**]. In response to legislative amendments, the Program added two new stakeholder groups in FY 2008 and FY 2009: The Physician Measures Workgroup and Hospital-Acquired Infections (HAI) Subcommittee.[2]



[1] Chapter 23-17.17, Health Care Quality Program, Index of Sections [Online]. Available: http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.17/INDEX.HTM, 02 Sept 2008.

[2] Although related to the Hospital Subcommittee, since both Subcommittees focus on hospital-related reporting, the HAI Subcommittee has legislatively-mandated composition and a narrow focus on HAI-related measures.

III. FY 2009 Reporting Activity

The FY 2009 work is described below. New reports and associated files are included as Appendices to this Report; recurring reports are available on HEALTH's Web site via the links included in each section.

A. Home Health Agencies

The Program reported home health clinical outcomes at:

http://www.health.ri.gov/chic/performance/homehealth/index.php

The **clinical outcomes** for Medicare-certified home health agencies are presented in a "diamond report" that is updated quarterly to reflect an annualized average. The report includes 11 measures publicly reported by the Centers for Medicare & Medicaid Services (CMS) for Medicare-certified home health agencies in Rhode Island.[3] Agencies' clinical measure scores are classified into three categories (below average, average, above average) based on the proximity of their score to the national average. If the score's 90% confidence interval overlaps the national average, the agency is categorized as average (◆◆) for that measure; if the confidence interval does not overlap the national average, the agency is classified as below average (◆) or above average (◆◆◆).

Notably, in May 2008, Rhode Island was the first state in the nation to report home health **patient satisfaction**. However, agencies did not collect or report patient satisfaction during FY 2009. After releasing the May 2008 report, the Home Health Subcommittee recommended that agencies report this information every two years. The next data collection period is scheduled for Fall 2009, at which time CMS's Home Health CAHPS (HH CAHPS) instrument should be finalized and ready for local deployment. If Medicare-certified agencies choose to use HH CAHPS to collect satisfaction data using a standardized instrument, this may affect the Program's requirement that these agencies contract with Press Ganey Associates[4] (the 2007 vendor) to collect data going forward. The HH CAHPS requirement may also result in the Subcommittee recommending increased reporting frequency and other process changes.

Because the clinical outcome reports are routine updates and no new patient satisfaction work is scheduled until Fall 2009, the Home Health Subcommittee was largely dormant during FY 2009. The Program sent periodic updates and plans to reconvene the group as soon as additional information is available about HH CAHPS deployment.

B. Hospitals

The Program reported hospital clinical processes and staffing plans at:

http://www.health.ri.gov/chic/performance/hospitals.php

The routine, long-standing **clinical processes** for Medicare-certified hospitals are presented in a bar graph format that is updated quarterly. The report includes three measures publicly

[3] Centers for Medicare & Medicaid Services (CMS). Home Health Compare [Online]. Available: http://www.medicare.gov/HHCompare/, 2 Sept 2008.

[4] Press Ganey Associates [Online]. Available: https://www.pressganey.com/, 2 Sept 2008.

reported by CMS for Medicare-certified Rhode Island hospitals.[5] Hospitals' clinical measure scores are presented as percentages and compared to state and national averages.

In addition to the three measures previously reported, several new clinical processes (or "nurse sensitive measures") were reported by each hospital-related Subcommittee in FY 2009:

1. The Hospital Subcommittee's measures reflect Rhode Island hospitals' pressure ulcer prevention care for two processes [**Appendices A** and **B**]:

   - Percent of patients receiving pressure ulcer admission assessment
   - Percent of patients receiving daily pressure ulcer reassessment

   These measures are adapted from the Institute for Healthcare Improvement's (IHI's) *5 Million Lives* campaign.[6] The hospitals first used IHI's infrastructure to pilot data collection for these measures between October 2007 and July 2008, and then collected data for a public report between October 2008 and April 2009. The Program released the Pressure Ulcer Process Measure Data Report and Technical Page [**Appendices C** and **D**] in May 2009, using the same bar graph format as the clinical outcomes (described above).[7]

2. The HAI Subcommittee's measures reflect Rhode Island hospitals' care for three Surgical Care Infection Program (SCIP) measures publicly reported by CMS for Medicare-certified Rhode Island hospitals[8]:

   - Percent of surgery patients given antibiotics within one hour prior to surgery
   - Percent of surgery patients given the right kind of antibiotics before surgery
   - Percent of surgery patients who stop receiving antibiotics within 24 hours of surgery

   These three measures are the first HAI-related reporting effort, and the Program expects to follow them in quick succession with three additional types of measures (see FY 2010 Goals, p. 7). The Program released the SCIP Data Report and Technical Page [**Appendices E** and **F**] in June 2009, using the same bar graph format as the clinical outcomes (described above).

The HAI Subcommittee (new during FY 2009) and work to date are described in the **HAI Addendum** to this report. At the end of FY 2009, HEALTH was in the process of creating a press release with additional details about both the pressure ulcer and HAI process measures. When complete, this press release will be posted to HEALTH's Web site.

Additionally, **staffing plans** for each of Rhode Island's hospitals are submitted annually to HEALTH and posted on the Program's website. These prospective reports indicate how each hospital will staff their units based on estimates of the future census for each unit.

---

[5] Centers for Medicare & Medicaid Services (CMS). Hospital Compare [Online]. Available: http://www.hospitalcompare.hhs.gov/Hospital/, 2 Sept 2008.

[6] Institute for Healthcare Improvement (IHI). 5 Million Lives campaign [Online]. Available: http://www.ihi.org/IHI/Programs/Campaign/, 2 Sept 2008.

[7] The May 2009 report is a one-time report that will be succeeded by hospital-acquired, or incident, pressure ulcer reporting during FY 2010 (see FY 2010 Goals, p. X).

[8] Centers for Medicare & Medicaid Services (CMS). Hospital Compare [Online]. Available: http://www.hospitalcompare.hhs.gov/Hospital/, 2 Sept 2008.

C. Nursing Homes

The Program reported nursing home clinical outcomes and resident and family satisfaction at:

http://www.health.ri.gov/chic/performance/nursinghome.php

The **clinical outcomes** for Medicare-certified nursing homes are presented in a "diamond report" that is updated quarterly. The report includes 19 measures publicly reported by CMS for Medicare-certified nursing homes in Rhode Island.[9] Nursing homes' clinical measure scores are classified into three categories (bottom 25%, middle 50%, top 25%) based on the state's 25th and 75th percentile cut-points. If the score's 50% Confidence Interval overlaps the 25th or 75th percentile, the nursing home is categorized in the middle 50% (◆◆) for that measure; if the Confidence Interval does not overlap the 25th or 75th percentile, the nursing home is classified as the bottom 25% (◆; worst) or top 25% (◆◆◆; best).

Rhode Island's nursing homes collected and reported **resident and family satisfaction** data for the third time during FY 2009. This was nursing homes' second annual data collection using the survey vendor My InnerView;[10] for the pilot and first public round of data collection, nursing homes used a company named Vital Research.[11] The nursing homes collected data in October and November 2008. The surveys reflected four satisfaction domains and were sent to all cognitively intact long-stay (100+ days) residents and all long-stay residents' family members (regardless of their relative's cognitive status). The data were classified into three categories (bottom 25%, middle 50%, top 25%) using the same classification strategy as for the clinical measures (see above).

The nursing homes' satisfaction data reports were released in February 2009. HEALTH's press release provides additional details about the results:

http://www.ri.gov/press/view.php?id=8198

The press release highlights the fact that Rhode Island nursing homes, on average, continued to outperform nursing homes nationwide that used the same survey during the survey year. At FY 2009's end, HEALTH's Division of Facilities Regulations was continuing to follow-up with nursing homes that surveyed fewer than expected residents or family members and/or did not survey one of those two groups. State citations are possible during FY 2010.

D. Physicians

The Program reported structural measures[12] for individual physicians at:

http://www.health.ri.gov/chic/performance/physician.php

The **structural measures** reflect physicians' performance on five measures developed by the Physician Workgroup in partnership with Blue Cross & Blue Shield of Rhode Island, the Rhode Island Quality Institute, and UnitedHealthCare of New England:

---

[9] Centers for Medicare & Medicaid Services (CMS). Home Health Compare [Online]. Available: http://www.medicare.gov/NHCompare/, 2 Sept 2008.

[10] My InnerView, Inc. [Online]. Available: http://www.myinnerview.com/, 2 Sept 2008.

[11] Vital Research, Inc. [Online]. Available: http://www.vitalresearch.com/, 2 Sept 2008.

[12] Some of the physician measures may also be considered process measures, since they evaluate physicians' use of HIT (vs. its presence in their practices or hospitals). However, since this use is tied to a structural component of physician practice – presence of EMRs and e-prescribing – and not linked to specific clinical outcomes, the measures are classified as structural measures.

- Physicians with EMRs
- Physicians with 'qualified' EMRs
- Basic EMR functionality use
- Advanced EMR functionality use
- Physicians who are e-prescribing

The measures were first developed during FY 2008. In FY 2009, the Physician Workgroup reconvened and revised the measures (1) based on validation work and (2) to best meet stakeholders' needs for HIT-based incentive payments and longitudinal tracking of HIT adoption in the State.[13] The updated measures are included here [**Appendix G**].

Between January and May 2009, Quality Partners:

- Disseminated the survey, including mailed notifications, email links, and email reminders;
- Created summary [Appendix H] and physician-level [not included] reports; and
- Created a public-use data file for stakeholder analyses.

HEALTH released the Summary and Physician Reports in March 2009. HEALTH's press release provides additional details about the reports:

http://www.ri.gov/press/view.php?id=8198

IV. FY 2010 Program Goals

In FY 2010, which began July 1, 2009, the Program anticipates activities that include the following:

Setting/Task	Description	(Frequency or Date)
General Contract Support	▪ Provide analytic and methodological support and leadership	(ongoing)
	▪ Develop and maintain stakeholder relationships and consensus	(ongoing)
	▪ Conduct research:	
	o Environmental scans	(as needed)
	o Measure development and validation efforts	(ongoing)
	o Relevant clinical literature and best practices	(ongoing)
	▪ Perform contract oversight (fiscal and managerial)	(ongoing)
	▪ Write Program documents:	
	o Annual Report	(Jul 2009)
	o Press releases	(as needed)
	▪ Maintain committee member contact lists	(as needed)
	▪ Post information on state's Open Meetings site:	
	o Committee agendas	(2 days prior)
	o Committee minutes	(5 days after)
	▪ Attend Center for Health Data and Analysis meetings	(monthly)
	▪ Present Program information to internal/external audiences	(as requested)

[13] Several key partners use these data: Blue Cross & Blue Shield of Rhode Island, to determine their primary care physician fee increase; the Rhode Island Quality Institute, to monitor Rhode Island's HIT adoption longitudinally; and UnitedHealthCare of New England, to merge with practice-level data and determine practice HIT incentive payments.

Setting/Task	Description	(Frequency or Date)
	▪ Perform other tasks (e.g., media interviews)	(as requested)
Home Health	▪ Convene the Home Health Measures Subcommittee	(as needed)
	▪ Chair the Subcommittee	(ongoing)
	▪ Generate reports and technical files:	
	o Quarterly clinical quality measures	(Jan/Apr/Jul/Oct)
	o Bi-annual satisfaction data	(Dec 2010)
	▪ Communicate regularly with stakeholders	(as needed)
	▪ Respond to home health agency and trade association inquiries:	
	o General questions	(as needed)
	o Technical assistance (e.g., survey completion, data interpretation)	(as needed)
	o Programmatic questions (e.g., legislative mandate, requirements)	(as needed)
	▪ Serve as liaison with satisfaction vendor	(ongoing)
	▪ Serve on CMS's Home Health CAHPS Technical Expert Panel	(ongoing)
Hospital	▪ Convene the Subcommittees:	
	o Hospital Measures	(as needed)
	o Hospital-Acquired Infections (HAIs)	(as needed)
	▪ Collect data (e.g., HAI process measures submitted by hospitals)	(as needed)
	▪ Generate reports and technical files:	
	o Quarterly clinical quality measures	(Jan/Apr/Jul/Oct)
	o Quarterly HAI measures	
	o Quarterly pressure ulcer incidence	(TBD)
	▪ Communicate regularly with stakeholders	(as needed)
	▪ Respond to hospital and trade association inquiries:	
	o General questions	(as needed)
	o Technical assistance (e.g., survey completion, data interpretation)	(as needed)
	o Programmatic questions (e.g., legislative mandate, requirements)	(as needed)
Nursing Home	▪ Convene the Nursing Home Measures Subcommittee	(Feb/Apr/Jun/Aug/Oct/Dec)
	▪ Satisfaction survey process:	
	o Co-host annual seminar (with trade associations)	(Jul/Aug 2010)
	o Follow-up on vendor contracts	(Aug-Oct 2010)
	o Assist HEALTH with follow-up on provider non-compliance	(as needed)
	▪ Generate reports and technical files:	
	o Quarterly clinical quality measures	(Jan/Apr/Jul/Oct)
	o Annual satisfaction data	(Dec 2010)
	▪ Communicate regularly with stakeholders	(as needed)
	▪ Respond to nursing home and trade association inquiries:	
	o General questions	(as needed)
	o Technical assistance (e.g., data interpretation)	(as needed)
	o Programmatic questions (e.g., legislative mandate, requirements)	(as needed)
	▪ Serve as liaison with satisfaction vendor	(ongoing)

Setting/Task	Description	(Frequency or Date)
Physician	▪ Convene the Physicians Measures Workgroup	(as needed)
	▪ Re-administer the Physician HIT Survey	(Jan 2010)
	▪ Perform survey analysis:	
	o Validate reporting measures	(as needed)
	o Create public report	(Feb 2010)
	o Create public-use data file	(Mar 2010)
	o Generate ad hoc data analysis for stakeholder partners	(as requested)
	▪ Meet with key collaborators:	
	o Blue Cross & Blue Shield of Rhode Island	(ongoing)
	o UnitedHealthCare of New England	(ongoing)
	o Rhode Island Quality Institute	(ongoing)
	▪ Communicate regularly with stakeholders	(as needed)
	▪ Respond to physician inquiries:	
	o General questions	(as needed)
	o Technical assistance (e.g., survey completion, data interpretation)	(as needed)
	o Programmatic questions (e.g., legislative mandate, requirements)	(as needed)
Steering Committee	▪ Coordinate the Committee's meetings, presentations	(Jan/Mar/May/Jul/Sep/Nov)
	▪ Communicate regularly with stakeholders	(as needed)
	▪ Respond to Committee Members' inquiries:	
	o General questions	(as needed)
	o Technical assistance (e.g., data interpretation)	(as needed)
	o Programmatic questions (e.g., legislative mandate, requirements)	(as needed)
Website	▪ Post data reports	(as needed)
	▪ Update Website content	(as needed)
	▪ Collaborate with HEALTH on overall Web site redesign	(as needed)

NOTES: As with previous years, Program leadership will work with the Steering Committee and the Director of HEALTH to prioritize the above activities within the Program's available resources (e.g., staff time, budget) and ensure that they align with local healthcare priorities.

V. Project Management

Figure 1 (page 3) presents the Program's Organizational Structure, including the Steering Committee and Subcommittees and the project management. Further details about the Steering Committee and project management are below, along with financial information.

A. Steering Committee Membership

The 19-member Steering Committee is legislatively mandated to include:

> "…one member of the house of representatives, to be appointed by the speaker; one member of the senate, to be appointed by the president of the senate; the director or director's designee of the department of human services; the director or the director's designee of the department of mental health, retardation, and hospitals; the director or the director's designee of the department of elderly affairs; and thirteen (13) members to be appointed by the director of the department of health to include persons representing Rhode Island licensed hospitals and

other licensed facilities/providers, the medical and nursing professions, the business community, organized labor, consumers, and health insurers and health plans and other parties committed to health care quality."[14]

Current Steering Committee membership is detailed below:

Organization	Representative
1. Alliance for Better Long-Term Care	Donna Lonschein, RN
2. Blue Cross & Blue Shield of Rhode Island	Sharon Pugsley, BSN
3. The Claflin Company	Ted Almon
4. Department of Elderly Affairs	Corinne Russo, MSW
5. Department of Human Services	Sharon Reinere
6. Department of Health	David Gifford, MD, MPH
7. Department of Mental Health, Retardation, and Hospitals	Louis Pugliese
8. Rhode Island Association of Facilities & Services for the Aging	James Nyberg
9. Rhode Island Health Care Association	Virginia Burke, Esq.
10. Rhode Island Medical Society	Arthur Frazzano, MD
11. Rhode Island Partnership for Home Care	Alan Tavares
12. Rhode Island State Nurses Association	Donna Policastro, NP, RCN
13. Hospital Association of Rhode Island	Jean Marie Rocha, RN, MPH
14. State Senate	Rhoda E. Perry
15. United Health Care of New England	Neal Galinko, MD, MS, FACP
16. United Nurses & Allied Professionals	Linda McDonald, RN

There are currently three vacant seats on the Steering Committee that should be filled by: (1) the Rhode Island Health Center Association, (2) the Rhode Island House of Representatives, and (3) a designee of the Director's choice. The Program is working to fill these seats.

B. Project Staffing

The Program is part of HEALTH's Center for Health Data and Analysis and is run through a contract with Quality Partners of Rhode Island. HCQP project leadership include:

Samara Viner-Brown, MS
Chief
Center for Health Data and Analysis
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908
Samara.Viner-Brown@health.ri.gov
(401) 222-5935

Rosa Baier, MPH
HCQP Project Director
Quality Partners of Rhode Island
235 Promenade Street
Suite 500, Box 18
Providence, RI 02908
rbaier@riqio.sdps.org
(401) 528-3205

C. Budget

The Program's FY 2009 budget was as follows:

[14] Chapter 23-17.17, Health Care Quality Program, Index of Sections [Online]. Available: http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.17/INDEX.HTM, 02 Sept 2008.

FY 2008 Expenditures	FY 2009 Expenditures
$152,471	**$116,000**

D. Public Information

The HCQP Program public reports, referenced above, are posted online at the Program's website:

www.health.ri.gov/chic/performance

All Steering Committee and Subcommittee meetings are open to the public, and Steering Committee minutes are posted on the Rhode Island Secretary of State's open meetings website:

www.sec.state.ri.us/pubinfo/openmeetings

Anyone interested in receiving email notices of upcoming meetings should contact Program staff to subscribe to email distribution lists for the Steering Committee and/or Subcommittees.

VI. Summary

This Annual Report describes the FY 2009 activities for the HCQP Program. In FY 2009, the Program continued reporting key clinical quality measures for the home health, hospital, and nursing home settings, and began reporting hospital-acquired infections and measures of physician HIT adoption. In FY 2010, the Program expects to sustain and continue to expand these efforts, by prioritizing Program activities based on state focus topics and Steering Committee direction, within the constraints of the budget.

Appendices

Health Care Quality Performance (HCQP) Program

PERCENT OF PATIENTS RECEIVING PRESSURE ULCER ADMISSION ASSESSMENT

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

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

Measure

Intervention(s): Prevent Pressure Ulcers

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

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

Goal: 100%

Calculation Details

Numerator Definition: The number of patients for whom:

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

Numerator Exclusions: Same as denominator exclusions

Denominator Definition: All patients on the unit during data collection

Denominator Exclusions:

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

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

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

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

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

Collection Strategy

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

Sampling Plan

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

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

Exclusions: Patients in the following categories:
- Comfort measure only (CMO)
- Emergency Department (ED) only
- Hospice
- Observation only
- Obstetrics-Gynecology
- Palliative care status
- Pediatrics
- Psychiatric

Health Care Quality Performance (HCQP) Program

PERCENT OF PATIENTS RECEIVING DAILY PRESSURE ULCER RISK REASSESSMENT

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

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

Measure

Intervention(s):	Prevent Pressure Ulcers
Definition:	The percentage of patientsfor whom a pressure ulcer risk reassessment (using the Braden Scale) was documented as performed daily or with greater frequency (or for whom an appropriate contraindication was documented.
Goal:	100%

Calculation Details

Numerator Definition:	The number of patients for whom: - A pressure ulcer risk reassessment (using the Braden Scale) was documented as performed daily or with greater frequency; or - An appropriate contraindication was documented.
Numerator Exclusions:	Same as denominator exclusions
Denominator Definition:	All patients on the unit during data collection
Denominator Exclusions:	- Patients admitted less than 48 hours prior to data collection - Patients not on the unit during data collection - Patients that fall into one of the sampling exclusion categories (p. 2)
Measurement Period:	One day of the hospital's choice per quarter, during a week identified by the Department of Health

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

Definition of Terms:

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

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

Collection Strategy

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

Sampling Plan

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

Inclusions:

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

Exclusions: Patients in the following categories:

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

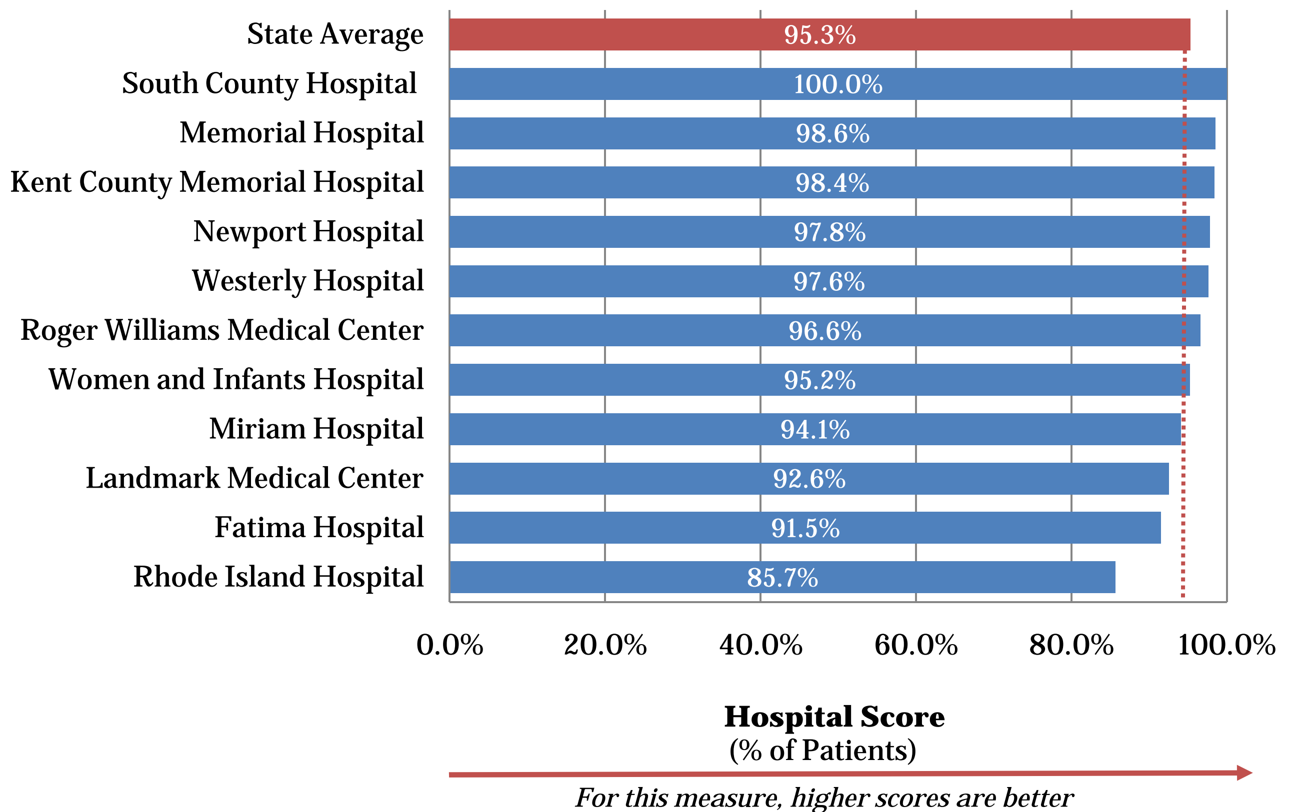
Health Care Quality Performance (HCQP) Program

PRESSURE ULCER PROCESS MEASURES

Data Report

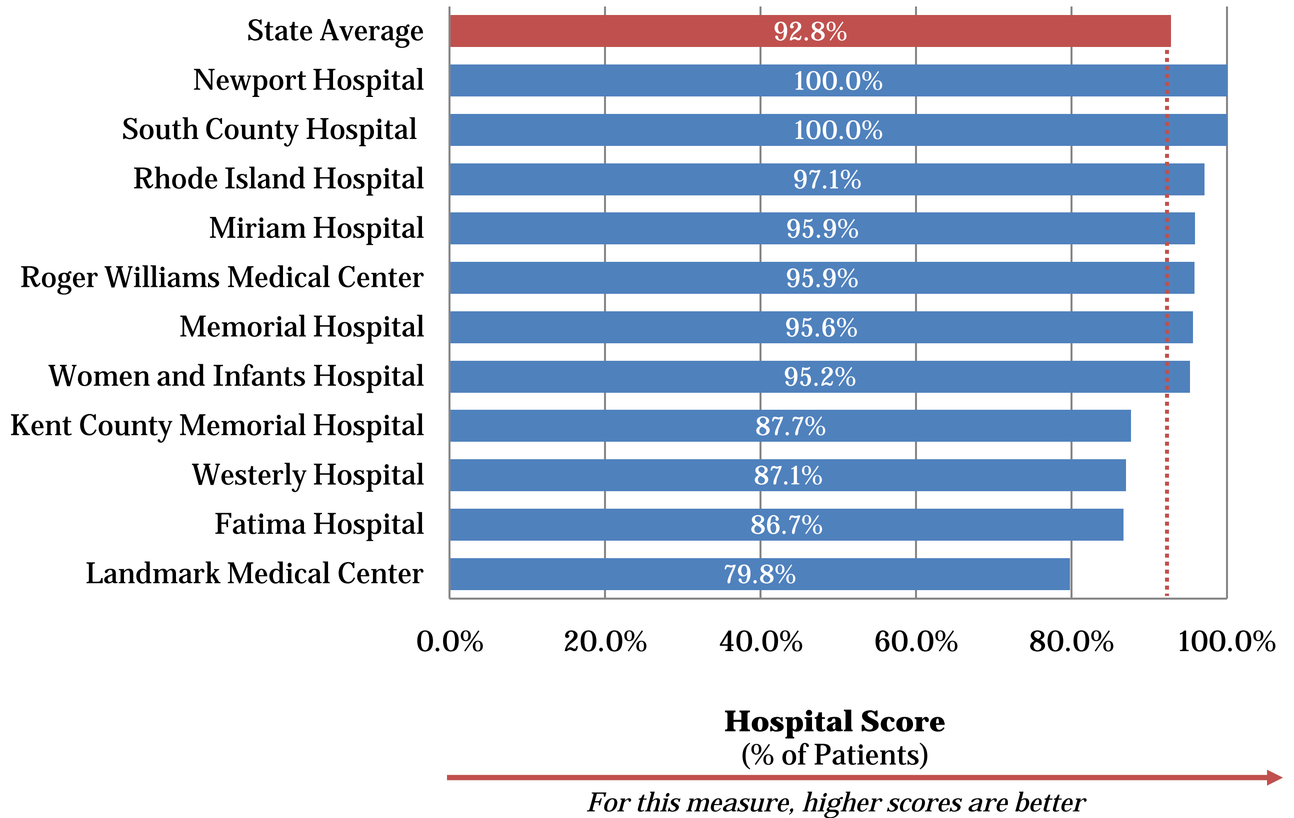
The pressure ulcer process measure data report is a one-time report[1] being released on the Department of Health's (HEALTH's) Web site as part of the HCQP Program's Hospital work. You can learn more about the measures—including their data source and why each is important—by reading the Technical Page.

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



[1] After reporting information about these care processes one time (in May 2009), the Program will report information about pressure ulcers that patients get during their hospital stays.

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



Health Care Quality Performance (HCQP) Program

PRESSURE ULCER PROCESS MEASURES

Technical Page

Pressure ulcers (also called "bed sores") are skin wounds caused by pressure from lying or sitting in one position too long.[1] The pressure ulcer process measures are a one-time report[2] being released on the Department of Health's (HEALTH's) Web site as part of the HCQP Program's Hospital work. The information on this page provides details about the measures, including their data source and why each is important.

Data Source

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

1. Percent of patients receiving pressure ulcer admission assessment
2. Percent of patients receiving daily pressure ulcer risk reassessment

} *Higher is better*

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

Measure Calculation

For each measure, the score is calculated as follows:

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

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

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

Measure Information (adapted from the Institute for Healthcare Improvement)

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

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

[2] After reporting process measures once, the Program will report data about pressure ulcers newly-acquired during patients' hospital stays.

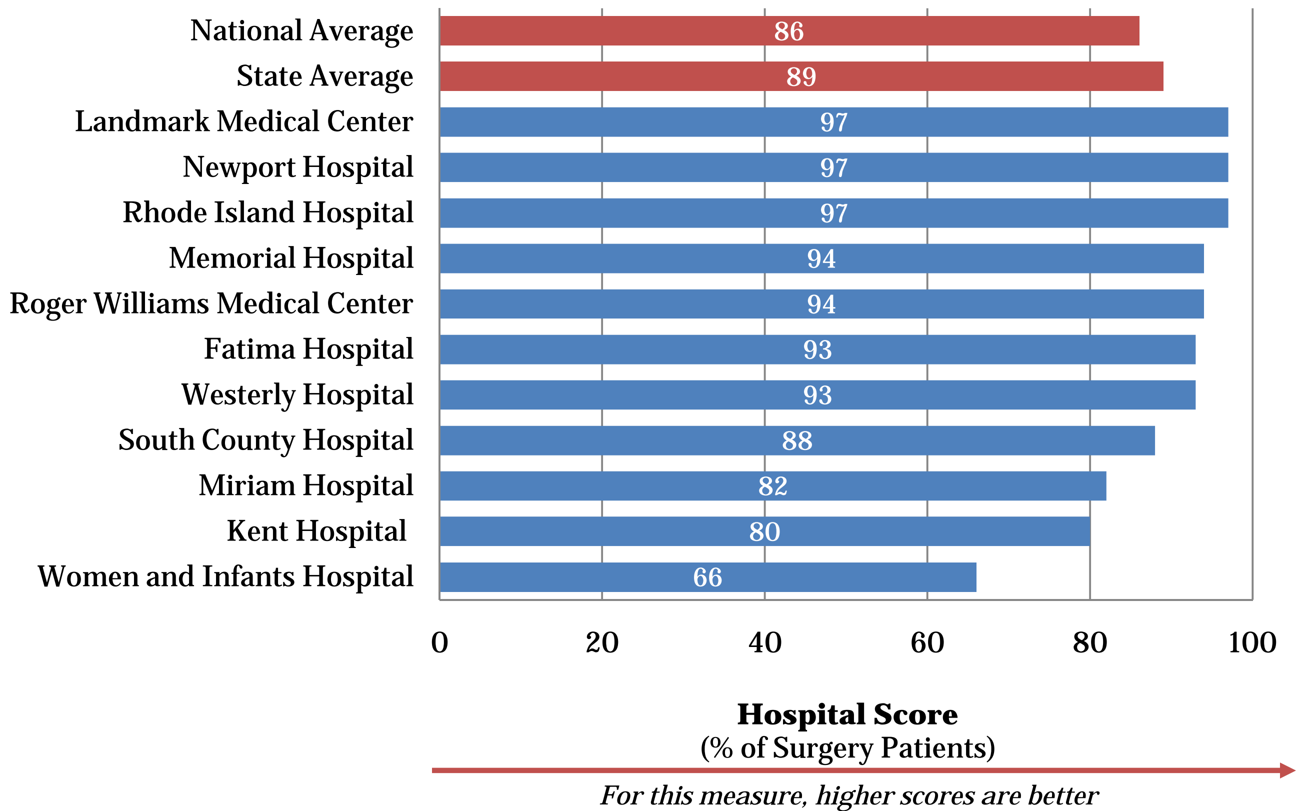
Health Care Quality Performance (HCQP) Program

SURGICAL CARE IMPROVEMENT PROJECT (SCIP) MEASURES

Data Report
July 2007-June 2008

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

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



Hospital Score
(% of Surgery Patients)

For this measure, higher scores are better

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

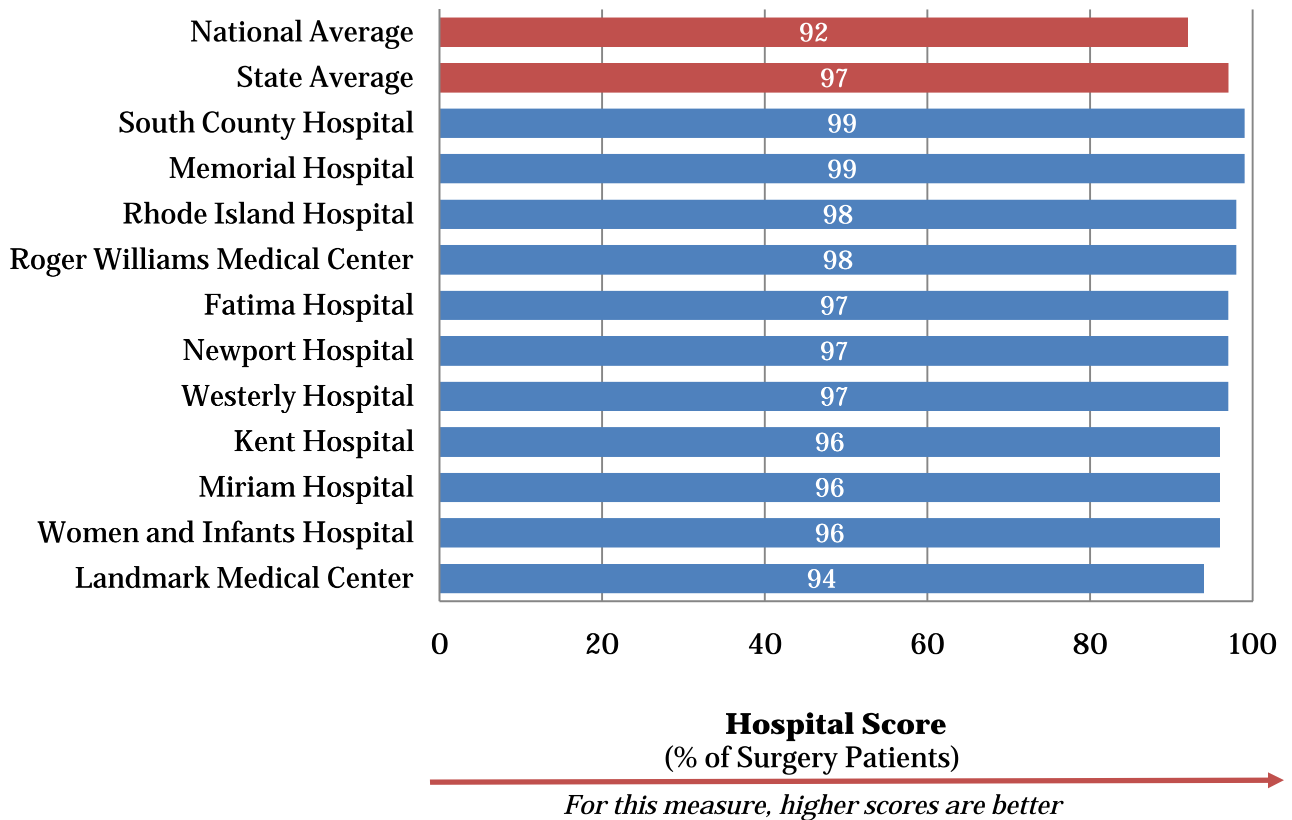
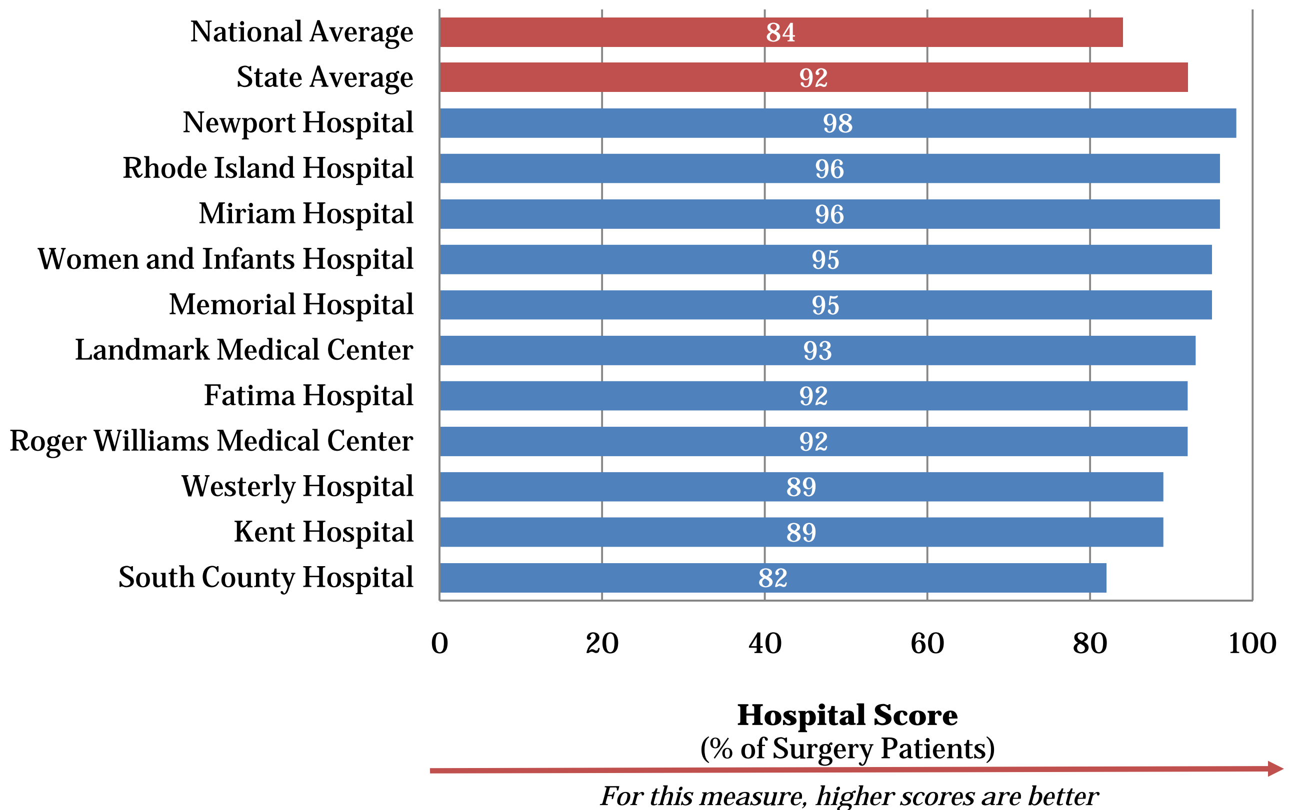


Figure 3: Percent of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)



Health Care Quality Performance (HCQP) Program

SURGICAL CARE IMPROVEMENT PROJECT (SCIP) MEASURES

Technical Page

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

Data Source

HEALTH's public reports include three measures that deal with surgical infections. They come from Medicare's Hospital Compare:

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

} *Higher is better*

Measure Calculation

For each measure, the score is calculated as follows:

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

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

Measure Information (adapted from Medicare)

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

Health Care Quality Performance (HCQP) Program

2009 PHYSICIAN HIT SURVEY MEASURES

The following health information technology (HIT) measures are derived from the Department of Health's annual Physician HIT Survey. Beginning with the February 2009 Physician Report, these measures will be publicly reported annually at the physician level. These data were also collected in 2008 as part of a confidential pilot; the 2008 data were published in aggregate only.

Measure 1: Physicians with EMRs

Summary: Percent yes

Physician: Yes/No

Numerator: Physicians who indicate that they have "EMR components" in their main practice OR another practice

Denominator: All physicians with Rhode Island licenses who are in active practice, have a mailing address in Rhode Island, Connecticut, or Massachusetts (includes survey non-respondents)

Note: Physicians ineligible for the measure (e.g., are not in active practice) are indicated by N/A.

Definition(s): EMR Components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

Measure 2: Physicians with 'qualified' EMRs

Summary: Percent yes

Physician: Yes/No

Numerator: Physicians who indicate that they have an EMR with all of the following:

- One or more **clinical documentation functionalities** (electronic visit notes, electronic lists of each patient's medications, electronic problem lists, AND/OR patient clinical summaries for referral purposes), AND
- One or more **reporting functionalities** (clinical quality measures, patients out of compliance with clinical guidelines, AND/OR patients with a condition, characteristic, or risk factor), AND
- One or more **results management functionalities** (lab test results via electronic interface, scanned paper lab test results, radiology test results via electronic interface, AND/OR scanned paper radiology test results), AND
- One or more **decision support functionalities** (drug interaction warnings AND/OR prompts to providers at the point of care), AND
- The **ability to e-prescribe** (i.e., transmit prescriptions electronically to the pharmacy), AND
- **Certification Commission on Health Information Technology (CCHIT) certification** (see "Qualified EMR" definition, below).

Denominator: All physicians with Rhode Island licenses who are in active practice, have a mailing address in Rhode Island, Connecticut, or Massachusetts (includes survey non-respondents)

Exceptions: Certain hospital-based practitioners (i.e., anesthesiologists, emergency department physicians, hospitalists, intensivists, pathologists, and radiologists) are excluded from the reporting functionality requirement and all hospital-based physicians have an altered e-prescribing functionality requirement (i.e., medication order entry counts as e-prescribing).

Note: Physicians ineligible for the measure (e.g., are not in active practice) are indicated by N/A.

Definition(s): Qualified EMR:

- 2008: An EMR that meets all of the above criteria for functionality, EXCLUDING CCHIT certification.
- 2009: An EMR that meets all of the above criteria for functionality AND is CCHIT-certified.

Measure 3: Basic EMR functionality use[i]

Summary: 0-100 scale

Physician: 0-100 scale

Calculation: Equal weight to each of the following 6 functionalities that physicians report, with scores proportional to the frequency of use:

- **Clinical documentation functionalities**:
  - Electronic visit notes
  - Electronic lists of each patient's medications
  - Electronic problem lists
  - Patient clinical summaries for referral purposes
- **Results management functionalities:**
  - Lab test results via electronic interface AND/OR scanned paper lab test results
  - Radiology test results via electronic interface AND/OR scanned paper radiology test results

Population: All physicians with Rhode Island licenses who are in active practice and have a practice address in Rhode Island, Connecticut, or Massachusetts who report who indicate that they have "EMR components" (limited to survey respondents)

Note: Physicians ineligible for the measure (e.g., are not in active practice) or without EMRs are indicated by N/A. Non-respondents are included in among those without EMRs.

Definition(s): Basic EMR functionality: The clinical documentation and results management functionalities within the EMR.

EMR Components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

Benchmark: Aggregate percent of physicians who meet both of the below RIQI-defined thresholds for use:

- Use of one or more **clinical documentation functionalities** (electronic visit notes, electronic lists of each patient's medications, electronic problem lists, AND/OR patient clinical summaries for referral purposes) at least 60% of the time, AND
- Use of one or more **results management functionalities** (lab test results via electronic interface, scanned paper lab test results, radiology test results via electronic interface, AND/OR scanned paper radiology test results) at least 60% of the time.

Measure 4:	**Advanced EMR functionality use**

Summary: 0-100 scale

Physician: 0-100 scale

Calculation: Equal weight to each of the following 10 functionalities that physicians report, with scores proportional to the frequency of use:

- **Decision support functionalities**:
  - Drug interaction warnings
  - Letters or other reminders directed at patients regarding indicated or overdue care
  - Prompts to providers at the point of care
- **External communication functionalities:**
  - Electronic referrals
  - Secure emailing with providers outside the physician's office
- **Order management functionalities**:
  - Laboratory order entry
  - Radiology order entry
- **Reporting functionalities**:
  - Clinical quality measures
  - Patients out of compliance with clinical guidelines
  - Patients with a condition, characteristic, or risk factor

Population: All physicians with Rhode Island licenses who are in active practice and have a practice address in Rhode Island, Connecticut, or Massachusetts who report who indicate that they have "EMR components" (limited to survey respondents).

Exceptions: Certain hospital-based practitioners (i.e., anesthesiologists, emergency department physicians, hospitalists, intensivists, pathologists, and radiologists) are excluded from the decision support, reporting, and e-prescribing functionalities requirements.

Note: Physicians ineligible for the measure (e.g., are not in active practice) or without EMRs are indicated by N/A. Non-respondents are included in among those without EMRs.

Definition(s): Advanced EMR functionality: The decision support, external communication, order management, and reporting functionalities within the EMR.

EMR Components: An integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

Benchmark: Aggregate percent of physicians who meet both of the below RIQI-defined thresholds for use:

- Use of one or more **reporting functionalities** (clinical quality measures, patients out of compliance with clinical guidelines, AND/OR patients with a condition, characteristic, or risk factor) at least 60% of the time, AND
- Use of one or more **decision support functionalities** (drug interaction warnings AND/OR prompts to providers at the point of care) at any frequency greater than 0%.

Measure 5:	**Physicians who are e-prescribing**
Aggregate:	Percent yes
Physician:	Yes/No
Numerator:	Physicians who indicate that they transmit their prescriptions or medication orders electronically to the pharmacy with any frequency greater than 0%.
Denominator:	All physicians with Rhode Island licenses who are in active practice, have a mailing address in Rhode Island, Connecticut, or Massachusetts (includes survey non-respondents).
Definition(s):	e-prescribing: Transmitting prescriptions or medication orders electronically to the pharmacy. Transmitting prescriptions electronically: Prescriptions may be transmitted within physicians' EMRs or externally, but cannot be transmitted via fax.
Note:	Office-based practitioners are required to transmit prescriptions electronically; hospital-based practitioners are required to transmit medication orders electronically.
Benchmark:	Percent of physicians who meet the below RIQI-defined thresholds for use: ▪ Use of an **EMR to e-prescribe** at least 60% of the time.[*]

[*] NOTE: The benchmark is limited ONLY to e-prescribing using an EMR, whereas the measure includes physicians who e-prescribe using software outside their EMR.

Health Care Quality Performance (HCQP) Program

2009 PHYSICIAN HIT SURVEY SUMMARY REPORT

In early 2009, the Rhode Island Department of Health (HEALTH) administered the Physician HIT Survey to 3,248 physicians licensed in Rhode Island, in active practice, and located in Rhode Island, Connecticut, or Massachusetts. The response rate was 58.1% (n=1,888). Results for these 1,888 respondents and all 3,248 physicians (including 1,360 non-respondents) are below.

Table: 2009 Physician HIT Survey Summary Results

Measure[1]	Survey Respondents (N=1,888)		All Physicians[2] (N=3,248)	
	Population	Score	Population	Score
1: Physicians with EMRs, n (%)[3]	1,888	1,277 (67.6%)	3,248	1,277 (39.3%)
2: Physicians with 'qualified' EMRs[4]	1,888	236 (12.5%)	3,248	236 (7.3%)
3: Basic EMR functionality use, mean[5]	1,277	63.6	--	--
4: Advanced EMR functionality use, mean[6]	1,277	44.1	--	--
5: Physicians who are e-prescribing, n (%)	1,888	777 (41.2%)	3,248	777 (23.9%)

CCHIT: Certification Commission on Health Information Technology certification
EMR: Electronic Medical Record, sometimes called an Electronic Health Record or EHR.
-- Same as survey respondents' population and scores, since non-respondents are not applicable for this measure.

HEALTH worked with stakeholders to create benchmarks for Measures 3, 4, and 5:[7]

- Among the 1,277 physicians who report using EMR components:
  - 731 (57.6%) are using all **basic functionalities** at least 60% of the time, and
  - 577 (45.2%) are using all **advanced functionalities** at least 60% of the time.
- Among all 1,888 respondents, 426 (22.6%) are **e-prescribing** at least 60% of the time and through an EMR.

The 2009 Physician HIT Survey is the second administration of this required annual survey, but the first to publicly report physician-level data (see the Physician Report). The 2008 Physician HIT Survey was a pilot effort and was reported in aggregate form only.

For more information, visit the public reporting program's Web site: www.health.ri.gov/chic/performance

---

[1] See the Measure Specifications for definitions of these measures.
[2] Includes the 1,459 non-respondents as not using HIT, or having responses of "No" for Measures 1, 2, and 5 and "N/A" for Measure 3 and 4. Because non-respondents are included, the All Physician measures reflect conservative estimates (underestimates) of HIT use.
[3] EMR: operationalized as "EMR components," or integrated electronic clinical information systems that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.
[4] Qualified EMRs: EMRs with specific clinical documentation, reporting, results management, decision support, and e-prescribing functionalities AND CCHIT certification. If CCHIT certification is excluded, 429 physicians qualify (22.7% of respondents; 13.2% of all physicians).
[5] Basic EMR functionality: Clinical documentation and results management functionalities. Scores range from 0-100 based on use of indicated functionalities.
[6] Advanced EMR functionality: Decision support, external communication, order management, and reporting functionalities. Scores range from 0-100 based on use of indicated functionalities.
[7] See the Measure Specifications for definitions of these benchmarks.

Health Care Quality Performance (HCQP) Program

HOSPITAL-ACQUIRED INFECTIONS REPORTING

FY 2009 Annual Report Addendum

With an 11-year-old, legislatively-mandated public reporting program, Rhode Island is a recognized national leader in healthcare quality reporting. Rhode Island has served as a resource for other states, like Maryland, beginning similar reporting programs and also served as a pilot site for Medicare reporting efforts, such as the Nursing Home Quality Initiative.[1] Together with local expertise coordinating collaborative quality improvement initiatives, the Rhode Island Health Care Quality Performance (HCQP) Program provides the existing institutional knowledge and infrastructure to efficiently and effectively expand hospital-acquired infection (HAI) prevention, reporting, and surveillance efforts.

HCQP Program

Since the 1998 legislative mandate to the Department of Health, the Department and its contractor, Quality Partners of Rhode Island, have collaborated with healthcare providers and other stakeholders to publish:

- Clinical quality measures and patient satisfaction scores for home health agencies, hospitals, and nursing homes; and
- Structural measures of health information technology (HIT) adoption for individual physicians [**Table 1**, below].

Table 1: HCQP Program Measures, by Healthcare Setting

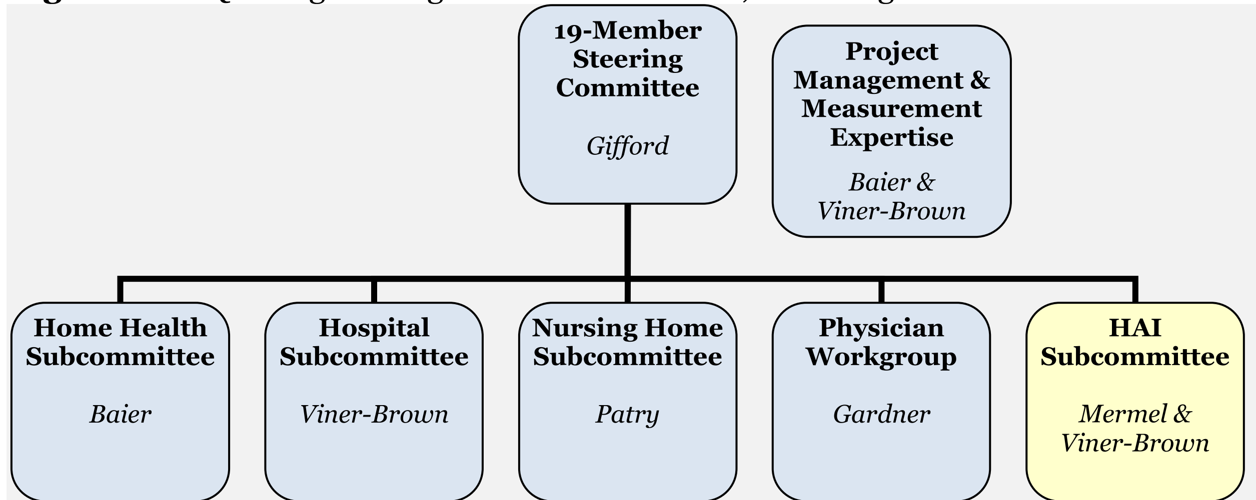
	Clinical Quality Measures		Structure Measures	Patient Satisfaction
Setting	Process	Outcome		
Home Health		✓		✓
Hospital	✓			✓
Nursing Home		✓		✓
Physician			✓	

The Program is governed by a 19-member Steering Committee, which oversees the work of five setting-specific Subcommittees and is chaired by David Gifford, MD, MPH, Director of the Department of Health [**Figure 1**, p. 2]. Each Subcommittee is chaired by a subject matter expert (or experts) and is open to the public, with meeting notices posted publicly, and includes healthcare providers and other stakeholders interested in

[1] American Health Quality Association (AHQA). Federal Nursing Home Quality Initiative: Success in Six-State Test Sets Stage For Nov. 12 National Launch [Online]. Available: http://www.ahqa.org/pub/media/159_678_3920.cfm, Accessed 9 Jun 2009.

helping to shape the content and format of the Program's reports.

Figure 1: HCQP Program Organizational Structure, Including Committees and Chairs



Using their measurement and consensus-building expertise, HCQP Program staff have:

- Provided consultation and guidance to select and report valid and reliable measures, where available, and develop meaningful measures, when none exist;
- Identified and implemented reporting formats that enable healthcare consumers to compare healthcare providers' performance on key measures; and
- Provided technical assistance to help healthcare providers collect data, when necessary, and incorporate results into their internal quality improvement efforts.

The Program's reports are published on the Department's Web site.[2]

HAI Reporting

Most recently, Rhode Island's 2008 "Hospital Infection Disclosure Act" expanded the Program to include HAI reporting.[3] HAIs refer to incident hospital infections, [4] resulting from infectious agents or toxins, and are considered largely preventable with the delivery of high-quality care and implementation of effective, consistent infection control practices, such as hand hygiene. [5] HAIs are widely recognized for their significant, adverse toll on patients' outcomes and satisfaction, as well as the financial burden they impose on the healthcare system. [6] It is estimated that 5-10% of all hospital

[2] Health Care Quality Performance (HCQP) Program [Online]. Available: www.health.ri.gov/chic/performance, 9 Jun 2009.
[3] Rhode Island State Senate. An act relating to health and safety – monitoring the occurrence of hospital-acquired infections in healthcare facilities [Online]. Jan 2008. Available: http://www.rilin.state.ri.us/billtext08/senatetext08/s2382a.pdf, 9 Jun 2009.
[4] Although *healthcare*-related infections in all settings of care, Rhode Island's Program and associated legislation focus specifically on *hospital*-acquired infections.
[5] Department of Health and Human Services. HHS action plan to prevent healthcare-associated infections [Online]. Jan 2009. Available: www.hhs.gov/ophs/initiatives/hai, 9 Jun 2009.
[6] Department of Health and Human Services. HHS action plan to prevent healthcare-associated infections [Online]. Jan 2009. Available: www.hhs.gov/ophs/initiatives/hai, 9 Jun 2009.

patients contract HAIs, resulting in approximately 100,000 deaths each year.[7]

The "Hospital Infection Disclosure Act" was developed in response to local consumer and media interest in HAIs, as well as the healthcare community's desire to increase related transparency and accountability.[8] Originally introduced to the Rhode Island Senate on behalf of a healthcare consumer whose spouse died as a result of a HAI,[9] the 2008 bill was authored by the Hospital Association of Rhode Island with input from healthcare consumers and the Department of Health. The act amended the public reporting program's original 1998 legislation and details the Department's responsibilities for reporting HAIs.

Subsequently, Rhode Island's focus on HAIs was echoed nationally by the Department of Health and Human Services' (HHS's) January 2009, "HHS Action Plan to Prevent Healthcare-Associated Infections."[10] HHS's action plan further details the prevalence and severity of HAIs, articulates the importance of monitoring and preventing them, and includes recommendations regarding prevention goals and related reporting.

HAI Subcommittee

Following the 2008 legislative amendment, the Program formed a HAI Subcommittee reflecting the composition outlined in the legislation:

> "Membership shall include representatives from public and private hospitals, infection control professionals, director care nursing staff, physicians, epidemiologists with expertise in HAIs, academic researchers, consumer organizations, health insurers, HMOs, organized labor, and purchasers of health insurance, such as employers. The [Subcommittee] shall have a majority of members representing the infection control community."

As a result of this direction, the HAI Subcommittee [**Figure 1**, p. 2] was formed in October 2008, separate from the Hospital Subcommittee. Although both Subcommittees focus on reporting measures for the hospital setting [**Table 1**, p. 1], the Hospital Subcommittee's hospital representation includes quality improvement specialists; the HAI Subcommittee's, largely infection control practitioners (ICPs). The HAI Subcommittee is also the only Subcommittee to have designated voting members [**Table 2**, below], although non-voting stakeholders are encouraged to attend meetings and actively participate.

Table 2: HAI Subcommittee Membership

Name	Organization
1. Utpala Bandy, MD, MPH	Department of Health

[7] Patients' bath basins increase risk for hospital-acquired infections [Online]. 29 Jan 2009. Available: http://www.reuters.com/article/pressRelease/idUS163860+29-Jan-2009+PRN20090129, 7 Jun 2009.
[8] Rhode Island Department of Health. Hospital surveys and incident events reporting [Online]. Available. http://www.health.ri.gov/hsr/facilities/hospitals/hospitals2001.pdf, 9 Jun 2009.
[9] Rhode Island State Senate. Available: Senate passes bill requiring better tracking of hospital-acquired infections [Online]. 18 May 2005. Available: http://www.rilin.state.ri.us/news/pr1.asp?prid=2239, 9 Jun 2009.
[10] Department of Health and Human Services. HHS action plan to prevent healthcare-associated infections [Online]. Jan 2009. Available: www.hhs.gov/ophs/initiatives/hai, 9 Jun 2009.

Name	Organization
2. Margaret Cornell, MS, RN	Quality Partners
3. Robert Crausman, MD, MMS	Department of Health
4. Marlene Fishman, MPH, CIC	St. Joseph Hospital
5. Julie Jefferson, RN, MPH, CIC	Rhode Island Hospital
6. Diane Kitson-Clark, RN, MSN, CIC	Women and Infants Hospital
7. Andrew Komensky, RN	Memorial Hospital
8. Pat Mastors	Consumer HAI Initiative
9. Leonard Mermel, DO, ScM (Co-Chair)	Rhode Island Hospital
10. Kathleen O'Connell, RN	Kent Hospital
11. Harold Picken, MD	Blue Cross Blue Shield of Rhode Island
12. Lee Ann Quinn, RN, BS, CIC	South County Hospital
13. Janet Robinson, RN, MEd, CIC	East Side Clinical Laboratory
14. Nancy Vallande, MSM, MT, CIC	Miriam Hospital
15. Aurora Pop-Vicas, MD	Memorial Hospital
16. Samara Viner-Brown, MS (Co-Chair)	Department of Health
17. Gloria Williams, MS	AARP

The HAI Subcommittee is Co-Chaired by Leonard Mermel, DO, a nationally-recognized infectious disease expert, and Samara Viner-Brown, MS, Chief of the Department of Health's Center for Health Data and Analysis. (Ms. Viner-Brown additionally oversees the HCQP Program.) The Subcommittee meets regularly; on average, every 2-3 weeks. Following the Program's successful model, it uses a consensus-based process to:

- Identify and obtain buy-in for proposed topics and associated measures;
- Obtain data (preferably via secondary data collection); and
- Generate public reports.

The Department of Health and Quality Partners facilitate this process and provide expert guidance.

HAI Public Reports

The "Hospital Infection Disclosure Act" proposed HAI topics for the HAI Subcommittee to consider reporting, and mandated that the Program begin reporting HAI data annually by October 2010. Recognizing both the public's desire for timely information and the complexity of prioritizing HAI measures, the Subcommittee decided to implement a "tiered" reporting structure, where the initial public reports focus on data that are readily available or easy to collect [**Table 3**, below], and future reports expand to include more complicated, resource-intensive measures. This approach enables Rhode Island to begin publicly reporting HAI-related measures well in advance of the legislatively-mandated October 2010 deadline. The first public reports are scheduled for June 2009 release.

Table 3: 2009 HAI Reporting Measures

Category	Measure	Data Source	Report (Data Period)
Surgical Care Infection Program (SCIP)	• % of surgery patients given antibiotics within one hour prior to surgery • % of surgery patients given the right kind of antibiotics before surgery • % of surgery patients who stop receiving antibiotics within 24 hours of surgery	Medicare's Hospital Compare	June 2009 (July 2007-June 2008)
Infections	• Central line associated bloodstream infections (CLABSI)	Rhode Island ICU Collaborative	June 2009 (Q1 2009)
Influenza vaccination	• % of hospital employees receiving influenza vaccination	Department of Health	July 2009 (October 2008-May 2009)
Infection control	• Hand hygiene process measures (to be defined)	Primary Data Collection	TBD

After selecting a topic area, the Subcommittee operationalizes the measures to ensure standard definitions and best enable meaningful cross-facility comparison of scores. Wherever possible, these definitions are drawn from national standards. For example, the CLABSI measure definition is based on National Healthcare Safety Network (NSHN) definitions. Beginning in January 2009, Rhode Island ICU Collaborative participants (all adult ICUs in the state) began using the NHSN definitions; as a result, the CLABSI reporting will begin with Quarter 1 (January-March), 2009 data.[11]

Future HAI Reporting

As outlined above, the Department of Health plans to expand over time to include additional HAI-related measures; topics under discussion at the HAI Subcommittee currently include outcome measures related to methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile (c-diff), and other prevalent HAIs. As with all of the public reporting program's reporting efforts, the HAI Subcommittee's work will be prioritized within the Program's needs and available resources. With a relatively constant budget, and an ever-expanding scope of work, the Program seeks to streamline existing reports while focusing resources on adding new measures. Additional resources will help the Program realize and expand its reporting goals, while implementing associated surveillance and prevention activities.

[11] Currently, three Rhode Island hospitals are submitting data (or will shortly) to NHSN: Rhode Island Hospital, Fatima Hospital, and Roger Williams Medical Center. As hospitals begin using NHSN, this may be an additional avenue for HAI reporting.