Rhode Island Healthcare Quality Reporting Program

13th Annual Report to the General Assembly

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I. Executive Summary

Over the past 13 years, the Department of Health (HEALTH) and its public reporting contractor, Quality Partners of Rhode Island, have worked with healthcare providers and stakeholders to implement a healthcare quality public reporting system for all licensed healthcare facilities in the State. Initially, the Healthcare Quality Reporting Program focused on home health agencies, hospitals, and nursing homes, incrementally expanding from clinical outcome measures to satisfaction data.

In the previous fiscal year (FY 2010), Rhode Island began reporting hospital-acquired infections (HAI). This topic was added as a result of recent state legislation and continued during a FY 2010 state funding hiatus, thanks to a Centers for Disease Control and Prevention (CDC) HAI Planning grant (see p. 5). During FY 2011, the Program continued releasing recurring reports for all settings and added several new HAI topics. FY 2011 reporting activities and new data reports are summarized below:

Table 1: FY 2011 Reporting Activity, by Measure and Frequency

Setting	Care Outcomes		Structure Measures	Patient Satisfaction
	Process	Outcome		
Home Health		Quarterly		Bi-Annually†
Hospital	Quarterly*	Quarterly		Quarterly
Nursing Home		Quarterly		Annually
Physician			Annually	

*Includes two new reports (employee influenza vaccination and MRSA CLABSI rates) and one calculated using a different method (hospital-acquired pressure ulcers)
†Includes data collected using a new survey instrument, Home Health CAHPS (HH-CAHPS)

This Annual Report details the above reporting activities and describes goals for FY 2012 Program goals, which include:

- Updating the program website,
- Generating recurring reports,
- Completing a nursing home employee influenza vaccination reporting pilot, and
- Publishing the first hospital *C. Difficile* care outcomes report.

II. Program Overview

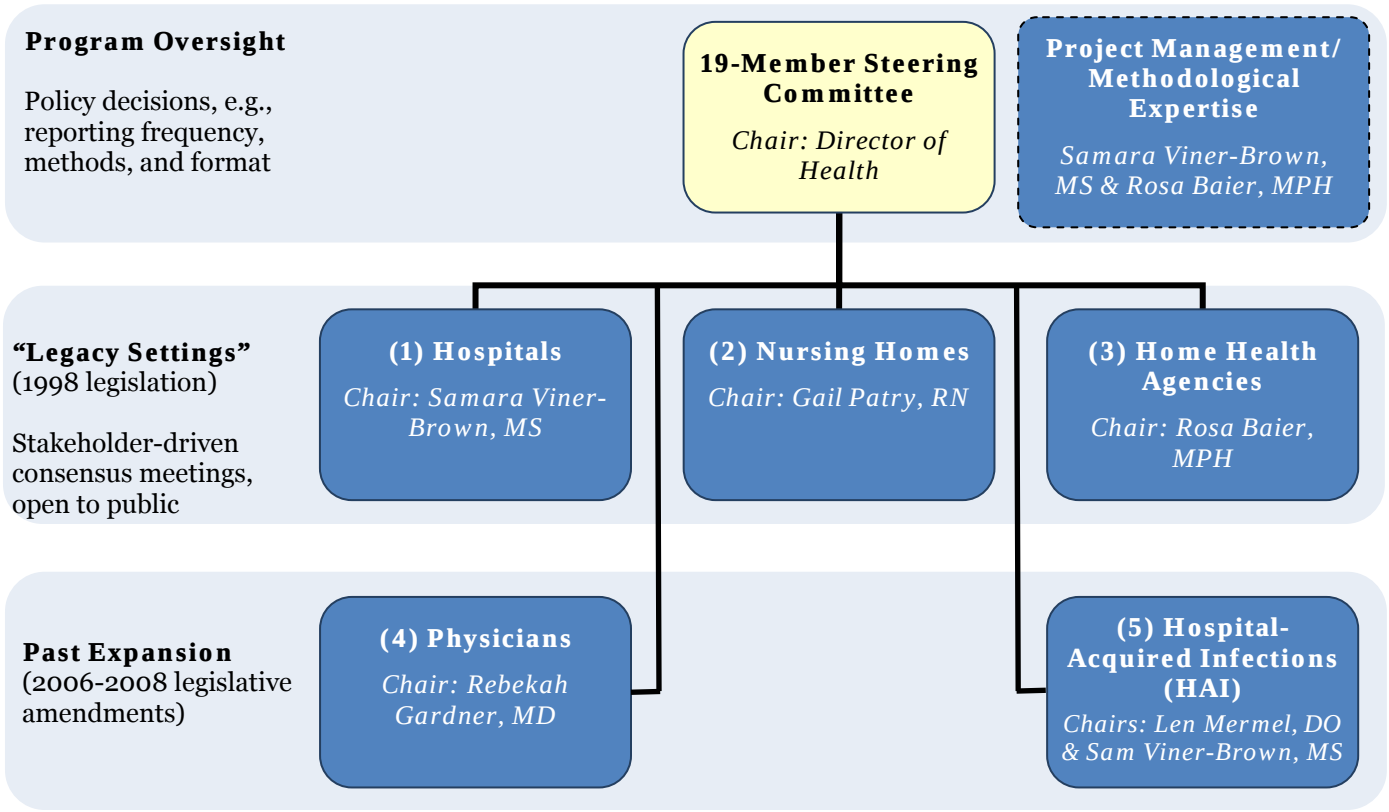
In 1998, the State of Rhode Island mandated that HEALTH develop a healthcare quality public reporting system for all licensed healthcare facilities.[1] Through the Healthcare Quality Reporting Program, the state required licensed healthcare facilities to publish clinical outcomes and patient satisfaction via HEALTH's website:

http://www.health.ri.gov/programs/healthcarequalityreporting/

Over the past 13 years, HEALTH and its public reporting contractor, Quality Partners of Rhode Island, have worked with healthcare providers and other stakeholders to report data for home health agencies, hospitals, nursing homes and physicians.

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] The Program did not add any new groups during FY 2011.

Figure 1: Program Organizational Structure



[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, 9 Sept 2010.

[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 2011 Reporting Activity

The FY 2011 work is described below. New reports and associated files are included as Appendices; recurring reports are available on HEALTH's Web site via the links included in each section below.

A. Home Health Agencies

Home health clinical outcomes are available at:

http://www.health.ri.gov/healthcare/providers/homehealthagencies/about/quality/

Care outcomes for Medicare-certified home health agencies are presented in a "diamond report" that is usually updated quarterly to reflect an annualized average. However, during FY 2011, Medicare ceased calculating home health quality measures during the transition to its new assessment tool, "OASIS C." Quarterly quality measure data will be available again in FY 2012.

The most recent care outcomes data are published on HEALTH's site in a report that includes 11 measures publicly reported by 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 (———).

In May 2008, Rhode Island was the first state in the nation to report home health **patient satisfaction**. After releasing the May 2008 report, the Home Health Subcommittee recommended that agencies report this information every two years. To align the survey period with Medicare's mandated implementation of HH-CAHPS for Medicare patients, the Subcommittee pushed that date back to Fall 2010. Data were collected for patients on service from September-December 2010. All agencies in the state are required to report on patient satisfaction, though vendor choice differs slightly depending on patient population [**Table 2**] and data are stratified based on their patient population, skilled Medicare or non-skilled patients [**Appendices A** and **B**].

Table 2: Reporting Requirements, by Certification Status

	Certification	
Patients	**Medicare**	**Non-Medicare**
Skilled Medicare	Must use HH-CAHPS, but can choose the vendor	*N/A*
Non-Skilled	Must use Press Ganey	Must use Press Ganey

The Home Health Subcommittee will resume meeting in FY 2012 to review the published report—released at the end of FY 2011—debrief on the satisfaction survey process, and make recommendations for future satisfaction reports.

[3] Centers for Medicare & Medicaid Services (CMS). Home Health Compare [Online]. Available: http://www.medicare.gov/HHCompare/, 9 Sept 2010.

B. Hospitals

The Program reported hospital clinical processes and staffing plans at:

http://www.health.ri.gov/hospitals/about/quality/index.php

Eleven hospital **care processes** are reported for acute care hospitals as bar graphs (process and prevalence measures), dichotomous Y/N measures (hand hygiene process measures) or diamonds (incidence measures). Most care processes are updated quarterly, although some are updated annually (i.e., hand hygiene processes). Two new reports were released in FY 2011 (employee influenza vaccination and MRSA CLABSI rates; **Appendices C-F**) and one calculated using a different method (hospital-acquired pressure ulcers; **Appendices G** and **H**). Using administrative data to calculate pressure ulcer incidence reduces the data collection burden for hospitals.

Where possible, data are obtained from existing data sources, such as Medicare[4] or the Hospital Discharge Data Set. The hospitals undertake primary data collection for four reports: Central line-associated bloodstream infections (CLABSI), hand hygiene, employee influenza vaccination and *C. difficile* infections. (The FY 2011 *C. difficile* data collection was a pilot, with a published report anticipated in FY 2012. With the addition of C. difficile reporting, the hospital care processes will include 12 measures.)

Incidence measures 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 a state or national benchmark, the hospital 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 (———).

During FY 2011, the HAI Subcommittee was funded by a CDC American Recovery and Reinvestment Act (ARRA) grant. This grant funded: continued HAI Subcommittee meetings; the naming of a State HAI Coordinator (Rosa Baier, MPH); the creation of a State HAI Plan; and the Subcommittee's selection of two Department of Health and Human Services (HHS) HAI priority topics, MRSA CLABSI and *C. difficile*.

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.

C. Nursing Homes

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

http://www.health.ri.gov/nursinghomes/about/quality/

Care outcomes for Medicare-certified nursing homes are presented in a "diamond report" that is that is usually updated quarterly. However, during FY 2011, Medicare ceased calculating nursing home quality measures during the transition to its new updated assessment tool, "Minimum Data Set 3.0." Quarterly quality measure data will be available again in FY 2012.

[4] *Ibid.*

The most recent care outcomes data are published on HEALTH's site in a report that includes 19 measures publicly reported by CMS for Medicare-certified nursing homes in Rhode Island.[5] 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 fifth year during FY 2011. This was the nursing homes' fourth annual data collection using the survey vendor My InnerView;[6] nursing homes used a company named Vital Research[7] for the pilot and first public round of data collection. The nursing homes collected data in October and November 2010. 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).

HEALTH's Division of Facilities Regulations continued 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. Facilities were required to provide written explanations of their survey populations to Facilities Regulations or risk receiving a state citation.

D. Physicians

The Program reported structural measures[8] for individual physicians at:

http://www.health.ri.gov/physicians/about/quality/

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:

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

The measures were developed during FY 2008. Since then, the Physician Workgroup has revised the survey to best meet stakeholders' needs for HIT-based incentive payments and longitudinal tracking of HIT adoption in the State.[9] For example, the FY 2011 survey includes questions

[5] Centers for Medicare & Medicaid Services (CMS). Home Health Compare [Online]. Available: http://www.medicare.gov/NHCompare/, 9 Sept 2010.

[6] My InnerView, Inc. [Online]. Available: http://www.myinnerview.com/, 9 Sept 2010.

[7] Vital Research, Inc. [Online]. Available: http://www.vitalresearch.com/, 9 Sept 2010.

[8] 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.

[9] 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.

about the use of stimulus funding for HIT/EMR planning and implementation. The updated instruments are included at the end of this report [**Appendix I**].

Between January and February 2011, Quality Partners disseminated the updated survey, including mailed notifications, email links and email reminders. HEALTH released the Summary and Physician Reports in March 2011.

IV. FY 2012 Program Goals

In FY 2012, 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	(Jun 2012)
	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)
	▪ Perform other tasks (e.g., media interviews)	(as requested)
Home Health	▪ Convene the Home Health Subcommittee	(as needed)
	▪ Chair the Subcommittee	(ongoing)
	▪ Generate reports and technical files:	
	o Quarterly clinical quality measures	(Jan/Apr/Jul/Oct)
	o Satisfaction data	(TBD)
	▪ 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(s)	(ongoing)
Hospital*	▪ Convene the Hospital Subcommittee	(as needed)
	▪ Collect data (e.g., HAI process measures submitted by hospitals)	(as needed)

Setting/Task	Description	(Frequency or Date)
Hospital (Cont'd)*	▪ Generate reports and technical files:	
	o Quarterly clinical quality measures	(Jan/Apr/Jul/Oct)
	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 Subcommittee	(Feb/Apr/Jun/Aug/Oct/Dec)
	▪ Satisfaction survey process:	
	o Co-host annual seminar (with trade associations)	(Jul/Aug)
	o Follow-up on vendor contracts	(Aug-Oct)
	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 2011)
	▪ 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)
Physician	▪ Convene the Physicians 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)
	o Create public-use data file	(Mar)
	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)

Setting/Task	Description	(Frequency or Date)
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 Website redesign	(as needed)

*HAI tasks are intentionally omitted, with the assumption that they will continue to be funded by the CDC ARRA grant, which funds work from October 2008 through December 2011.

NOTE: 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.

Notable goals for FY 2012 Program include:

- Updating the program website,
- Generating recurring reports,
- Completing a nursing home employee influenza vaccination reporting pilot, and
- Publishing the first hospital *C. Difficile* care outcomes report.

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[10]; 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."[11]

[10] Now called the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

[11] 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.

Current Steering Committee membership is detailed below:

Organization	Representative
1. Alliance for Better Long-Term Care	Diane Gallagher
2. Blue Cross & Blue Shield of Rhode Island	Debra McDonald, RN
3. The Claflin Company	Ted Almon
4. Department of Health	Michael Fine, MD
5. Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	Louis Pugliese
6. LeadingAge-RI	James Nyberg
7. Rhode Island Health Care Association	Virginia Burke, Esq.
8. Rhode Island Medical Society	Arthur Frazzano, MD
9. Rhode Island Partnership for Home Care	Cathy Cranston
10. Rhode Island State Nurses Association	Donna Policastro, NP, RCN
11. Hospital Association of Rhode Island	Jean Marie Rocha, RN, MPH
12. State Senate	Rhoda E. Perry
13. United Health Care of New England	Neal Galinko, MD, MS, FACP
14. United Nurses & Allied Professionals	Linda McDonald, RN

There are currently four 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, (3) the Department of Human Services, (4) the Department of Elderly Affairs, and (5) 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. Project leadership include:

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C. Budget

The Program's FY 2011 budget was as follows:

FY 2010 Expenditures	FY 2011 Expenditures
$84,209	$120,000

NOTE: The lower FY 2010 expenditure reflects the fact that the Program's funding was cut in January 2010, prompting a stop-work from January to June 2010. Funding was reinstated for FY 2011, beginning July 2010.

D. Public Information

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

http://www.health.ri.gov/programs/healthcarequalityreporting/

During FY 2011, the website was redesigned and significantly reorganized, with the goal of making it more user-friendly and accessible.

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 Healthcare Quality Reporting Program's activities for FY 2011 (July 1, 2010-June 30, 2011). During FY 2011, the Program continued releasing recurring reports for all settings, including home health satisfaction (last reported in 2007), added two new hospital topics (employee influenza vaccination and MRSA CLABSI), piloted a third hospital topic (*C. difficile*) and revised its website. In FY 2012, 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

Healthcare Quality Reporting Program

HOME HEALTH PATIENT SATISFACTION

Satisfaction Report, October-December 2010

Patients' satisfaction with their home health care is reported on the Department of Health's (HEALTH's) Web site. Patients took surveys and answered questions about their experience with home care. There were two different surveys, based on the kind of home health care patients received:

- **Skilled care paid for by Medicare**, such as nursing and therapy
- **Non-skilled care**, such as help with dressing, bathing and light cleaning

The agencies that provide *both* kinds of care are listed twice, so that information is included from patients receiving both kinds of care.

Each agency is awarded diamonds for a number of different categories, showing how different their performance is from the state average for each category:

——— Better than the Rhode Island average
—— About the same as the Rhode Island average
— Worse than the Rhode Island average

The diamond categories are different for skilled care paid for by Medicare and non-skilled care, because services for these patients are different.

You can learn more by reading the Methods document that goes with this report. This includes:

- The surveys for each kind of home health care (skilled care paid for by Medicare and non-skilled care)
- How the rates and diamonds are calculated
- How many people answered each survey
- Why this information is important

While the diamond report evaluates satisfaction, it is only one measure of quality and there are other ways for consumers to assess quality. You may want to contact an agency to ask questions, or speak with other patients who have received care from that agency. Agencies that provide similar care or services may have differences that can affect patients' experiences and may make one agency a better "fit." For example, some agencies may provide a lot of care for patients with multiple illnesses, whose care is more difficult. Remember to check other sources of information when choosing a home health agency.

With questions about an agency (performance, service area, etc.), please contact the agency directly. You can get contact information from the Department of Health by calling 401-222-2566.

The diamonds show you how agencies compare to one another

Table 1: Patient satisfaction with agencies providing **skilled care paid for by Medicare** (e.g., nursing and therapy)

Home Health Agency *(Alphabetical)*	Care of Patients	Communication between Providers and Patients	Specific Care Issues	Care from the Agency's Home Health Providers	Recommend this Agency to Friends or Family
1. Assisted Daily Living	—	—	—	—	–
2. Bayada Nurses	——	—	——	—	—
3. Capitol Home Care Network	——	–	–	—	—
4. Cathleen Naughton	——	—	—	—	—
5. Concord Home Health Services	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
6. Home Care Advantage	—	——	——	—	—
7. Interim Healthcare of RI	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
8. Life Care At Home of RI	——	——	——	——	—
9. Memorial Hospital Home Care	–	–	–	—	—
10. Roger Williams Home Care	——	——	—	——	—
11. Nursing Placement	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
12. St Jude Home Care	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
13. Tender Loving Care	——	——	——	—	—
14. Vital Care of RI	–	–	–	—	—
15. VNA of Care New England	——	——	——	——	—
16. VNA of RI	——	——	——	–	—
17. VNS Home Health Services	——	——	——	——	—
18. VNS of Greater RI	——	–	–	——	—
19. VNS of Newport & Bristol Counties	–	–	–	—	—

Some agencies were not required to submit these data:

Consistent Care, H & T Medicals, and Homefront Healthcare received a Federal exemption because they had too few Medicare patients during this time frame (October-December 2010). Independence Health Services is seeking a similar exemption.

Dependable Health Services had no patients during this time frame (October-December 2010) because the agency was new.

The diamonds show you how agencies compare to one another

Table 2: Patient satisfaction with agencies providing **non-skilled care** (e.g., help with dressing, bathing and light cleaning)

Home Health Agency *(Alphabetical)*	Arranging Home Care	Dealing with the Office	Nurses	Home Health Aides	Homemakers/ Companions	Therapists and Others	Likelihood to Recommend	Overall Quality
1. A Caring Experience	-	-	-	-	-	n/a	-	-
2. Access Healthcare	—	—	—	—	—	n/a	—	—
3. All About Homecare	——	——	—	——	——	n/a	——	——
4. Alternative Care Medical Services	-	-	-	-	-	n/a	-	-
5. Assisted Daily Living	—	—	—	—	—	n/a	—	—
6. Bayada Nurses	—	—	—	—	—	—	—	—
7. Bayside Nursing	-	-	-	-	-	-	-	-
8. Bright Star Health Care of Kent/ Washington Counties	-	-	-	-	-	n/a	-	-
9. Brightstar Healthcare	-	-	-	-	-	n/a	-	-
10. Cathleen Naughton	—	—	—	—	—	n/a	—	—
11. Child & Family Services of Newport	—	—	——	—	—	n/a	—	—
12. Community Care Nurses	—	—	—	—	—	n/a	—	—
13. Concord Home Health Services	—	—	-	—	-	n/a	—	—
14. Consistent Care	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
15. Cowesett Home Care	—	—	—	—	—	n/a	—	—
16. Family Friends Health Care	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
17. Gleason Medical Services	-	-	-	-	-	-	-	-
18. H & T Medicals	—	—	—	—	—	n/a	——	—
19. Health Care Connections Nursing Services	—	—	—	—	—	n/a	—	—
20. Health Care Services	—	—	—	—	—	n/a	—	—
21. Healthtouch	—	—	—	—	—	n/a	–	–
22. Home Care Advantage	—	—	—	——	—	n/a	——	——
23. Home Care Services of RI	—	——	—	—	—	n/a	——	——
24. Home Care Solutions	–	—	—	—	—	n/a	—	—
25. Homefront Health Care	—	—	—	—	—	n/a	—	—
26. Hope Nursing Home Care	—	—	—	—	—	n/a	—	—

Home Health Agency *(Alphabetical)*	Arranging Home Care	Dealing with the Office	Nurses	Home Health Aides	Homemakers/ Companions	Therapists and Others	Likelihood to Recommend	Overall Quality
27. Ideal Home Care Service	—	—	—	—	—	n/a	—	—
28. Independence Health Services	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
29. Jamestown Home Health	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*	*Did not survey*
30. Lifetime Medical Support Services	—	—	—	—	—	n/a	—	—
31. Mass Home Care of RI	—	—	-	—	-	n/a	-	—
32. Maxim Healthcare Services	-	-	-	-	-	n/a	-	-
33. Morning Star Homecare	—	—	—	—	—	n/a	—	—
34. New Care	—	-	-	-	-	n/a	-	—
35. Nursing Placement Inc	—	—	—	—	—	n/a	—	—
36. Ocean State Nursing Service	—	—	—	—	—	n/a	—	—
37. Phenix Home Care	—	—	—	—	—	n/a	—	—
38. Preferred Health Care Services	-	-	-	-	-	n/a	-	-
39. Senior Helpers	—	—	—	—	—	n/a	—	—
40. South County Quality Care	-	-	-	-	-	n/a	-	-
41. Specialty Home Care Services	—	—	—	—	—	n/a	—	—
42. St Jude Home Care	—	—	—	—	—	n/a	—	—
43. Summit Health Services	-	-	-	-	-	n/a	-	-
44. Visiting Angels	-	-	-	-	-	n/a	-	-
45. VNA Support Services	——	——	-	——	-	n/a	——	——
46. VNS of Newport & Bristol Counties	-	-	-	-	-	n/a	-	-

n/a Not applicable. Non-skilled patients do not typically receive these services.

\- Data withheld because fewer than 10 patients provided feedback.

Dependable Health Services had no patients during this time frame (October-December 2010) because the agency was new.

Healthcare Quality Reporting Program

Home Health Patient Satisfaction Methods

Prepared for:

Rhode Island Department of Health
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Prepared by:

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Report: June 2011
Data: October-December 2010

Department of Health

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June 30, 2011

Dear Rhode Island Home Health Agency Consumer,

Thank you for your interest in the 2010 Rhode Island Home Health Satisfaction Report. The information in this packet will help you understand the satisfaction survey results and where they come from.

Patients took surveys and answered questions about their experience with home care received between October and December 2010. There were two different surveys, based on the kind of home health care patients received:

- **Skilled care paid for by Medicare**, such as nursing and therapy
- **Non-skilled care**, such as help with dressing, bathing and light cleaning

The agencies that provide *both* kinds of care are listed twice, so that information is included from patients receiving both kinds of care.

Each agency is awarded diamonds that show how different their performance for a number of different categories is from the state average:

——— Better than expected
—— About the same as expected
— Worse than expected

These diamonds are explained in more detail on pages 3-4. This document also includes:

This report includes information about patient satisfaction. The Department of Health also releases information about the quality of home care paid for by Medicare. For more information, please visit the quality reporting program's Web site:
http://www.health.ri.gov/programs/healthcarequalityreporting/.

Sincerely,

Samara Viner-Brown

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

How Rhode Island Reports Home Health Satisfaction

As part of the public reporting program, Rhode Island's home health agencies collect information about patient satisfaction on a regular basis. Agencies first collected and released this information in 2007. The 2010 Home Health Satisfaction Report is the second round of public information about home health satisfaction. Agencies sign a contract with a survey company, and the survey company collects information from patients or family members.

How the Information is Collected

Patients took surveys and answered questions about their experience with home care received between October and December 2010. There were two different surveys, based on the kind of home health care patients received:

- Information about **skilled care paid for by Medicare** comes from the Home Health CAHPS survey. Medicare began requiring agencies to send this to patients in October 2010 and plans to release data in 2012. Agencies can choose any survey company to help them collect this information. In 2010, agencies chose: Deyta Systems, Fazzi, OCS, Strategic Healthcare Systems or Press Ganey.
- Information about **non-skilled care** comes from a survey company called Press Ganey, which has its own satisfaction survey.
- Agencies that provide **other skilled care** not paid for by Medicare are not required to survey these patients.

The agencies that provide *both* non-skilled care and skilled Medicare care are listed twice, so that information is included from patients receiving both kinds of care.

Each agency signed a contract with an outside survey company to collect information from the agency's patients. Medicare agencies can choose any Home Health CAHPS vendor. Agencies with non-skilled patients must sign a contract with Press Ganey.

Data collection took place in late 2010 and early 2011. Patients received a packet in the mail that included a cover letter, the satisfaction survey, and a pre-addressed, postage-paid return envelope to return the completed survey. Having patients send results directly to an outside survey company helps ensure that people share their true feelings.

Surveys went to patients receiving home care services between October and December 2010. After receiving the completed surveys, the survey companies looked at the results and provided confidential feedback reports to each individual agency. This occurred in Spring 2011.

Topics Included in the Surveys

Home health patients answer different questions, based on the kind of home health care they received. Their answers are grouped together as follows:

Information	What does this mean?
For patients receiving **skilled care paid for by Medicare**, such as nursing and therapy:	
1. Care of patients	Patients' perceptions of **the quality of care.** These questions look at whether home health providers were courteous, gentle, and easy to contact.

Information	What does this mean?
2. Communications between providers and patients	Patients' perceptions of **how easy it was to communicate with providers.** These questions look at whether home health providers helped patients understand their care and how easy it was to get questions answered.
3. Specific care issues	Patients' perceptions of **receiving enough information about medications and pain.** These questions look at whether home health providers talked about changes in medication and pain.
4. Care from the agency's home health providers	Patients' perceptions of **overall care.** This question asks patients to rate their home health providers from 0 (bad) to 10 (good).
5. Recommend this agency to friends or family	Whether patients **would recommend this agency to someone they know** if they needed home health care.
For patients receiving **non-skilled care**, such as help with dressing, bathing and light cleaning:	
1. Arranging home care	Patients' perceptions of **how easy it was to arrange home care.** These questions look at whether the initial plan of care or treatment met patients' needs, ease of scheduling visits, and making initial arrangements for care.
2. Dealing with the Office	Patients' perceptions of **how easy it was to deal with the agency's office.** These questions look at the person answering the office phone, how the office dealt with requests (e.g., schedule changes or new caregivers), and how calls were handled after hours.
3. Nurses	Patients' perceptions of their **interactions with the agency's nurses**. These questions look at the nurses' friendliness, concern for patients' comfort, and clinical skills.
4. Home health aides	Patients' perceptions of their **interactions with home health aides (non-nurses)** who provide personal care, such as bathing or dressing. These questions look at the aides' friendliness, concern for patients' privacy and comfort, and clinical skills.
5. Homemakers/ companions	Patients' perceptions of **the agency's homemakers/ companions,** who shop, cook, clean, or run errands for them. These questions look at how much attention the homemaker/companion paid to the patients' ideas about their homes, their helpfulness, and their respect for patients and patients' privacy. *Only patients receiving care from agencies that also provide non-skilled care are asked the questions in this category.*
6. Therapists and others (Other Professionals)	Patients' perceptions of **the agency's therapists and other professionals,** including occupational therapists, physical therapists, speech therapists, social workers, and dieticians. These questions look at their friendliness, concern for patients' comfort, and clinical skills.

Why do does the report include different information for patients receiving skilled care paid for by Medicare and patients receiving non-skilled care? This is mostly because services for these patients are different, so it makes sense to ask them different questions. It is also because the

information comes from difference sources. To compare agencies to one another, the data must come from the same questions. This is why agencies that provide skilled care paid for by Medicare are compared to one another, and agencies that provide non-skilled care are compared to one another.

Understanding the Report

For this report, 15 skilled Medicare and 42 non-skilled home health agencies collected patient satisfaction information. Each agency is awarded diamonds for each of the above topics to show how different their performance is from the state average in each category. For example:

The diamonds show you how agencies compare to one another

Table 1: Patient satisfaction with agencies providing **skilled care paid for by Medicare** (e.g., nursing and therapy)

Home Health Agency *(Alphabetical)*	Care of Patients	Communication between Providers and Patients	Specific Care Issues	Care from the Agency's Home Health Providers	Recommend this Agency to Friends or Family
1. Home health agency A	◆◆	◆◆◆	◆◆◆	◆◆	◆◆◆
2. Home health agency B	◆◆◆	◆◆	◆◆◆	◆◆◆	◆◆

What the Diamonds Mean

Each agency is awarded diamonds for a number of different categories, showing how different their performance is from the state average for each category:

——— Better than the Rhode Island average
—— About the same as the Rhode Island average
— Worse than the Rhode Island average

This helps you understand how the agency's performance for each category compares to other agencies in Rhode Island.

There are several reasons why an agency might not have *any* diamonds:

- A Medicare agency may receive a Federal exemption from completing the Home Health CAHPS survey, if the agency has too few Medicare patients.
- An agency may not have any patients during the survey time frame, if it was new and had not yet begun seeing patients.
- If 10 or fewer people provided responses for a category, there is not enough information to accurately judge patient satisfaction and these data are withheld.
- An agency may not have performed the survey, even though it is required.

How We Calculate the Diamonds

The diamonds help you understand how the average of the home health agency's responses compares to the performance of other similar agencies in Rhode Island:

1. One Diamond (—): One diamond is the **lowest category**. It means that the home health agency's score for this area of performance is worse than the Rhode Island average.
2. Two Diamonds (——): Two diamonds is the **middle category**. It means that the home

	health agency's score for this area of performance is similar to the Rhode Island average.
3. Three Diamonds (———):	Three diamonds is the **highest category**. It means that the home health agency's score for this area of performance is better than the Rhode Island average.

These categories are determined mathematically to ensure that the differences are meaningful. In detailed terms, this means that home health agencies with either one diamond (—) or three diamonds (———) have scores that are "statistically significantly different" from the Rhode Island average.

Statistical Details

The information in this section is for people who want statistical details about the diamond calculations:

The one- and three-diamond cut-points are the 25th and 75th percentile of all Rhode Island scores. To have one diamond (—) the score must fall below the state average and its margin of error, or "95% confidence interval," cannot include the Rhode Island average. To have three diamonds (———) the score must fall above state average and its margin of error, or "95% confidence interval," cannot include the Rhode Island average. If the 95% confidence interval includes the Rhode Island average, then the home health agency's score is not accurate enough to categorize it as better or worse than other agencies. The agency then has two diamonds for that score (——).

Choosing a Home Health Agency

While the diamond report evaluates satisfaction, it is only one measure of quality and there are other ways for consumers to assess quality. Consumers may want to visit or call an agency to ask questions, or speak with other patients who have received care from that agency. Agencies that provide similar care or services may have differences that can affect patients' experiences and may make one agency a better "fit" for a particular patient. For example, some agencies may provide a lot of care for patients with multiple illnesses, whose care is more difficult. Remember to check other sources of information when choosing a home health agency. Consider using these other sources of information, too:

- Recommendations from other home care providers, family, and friends
- Clinical information for Medicare agencies available through the Department of Health's public reporting program: http://www.health.ri.gov/programs/healthcarequalityreporting/
- Inspection reports available through the Department of Health: 401-222-2566

Together, this information can help you figure out which home health agency may be a good fit for you or your family member.

Which Home Health Agencies Participated in 2010

The table below shows which home health agencies participated in the 2010 Home Health Satisfaction Survey. Some agencies give both skilled care paid for by Medicare and non-skilled care—they should have surveyed both groups:

Home Health Agency *(Alphabetical)*	Non-Skilled Care		Skilled Care		
	Non-skilled	Surveyed?	Skilled, Paid for by Medicare	ONLY other skilled care	Surveyed?
1. Assisted Daily Living	√	√	√		√
2. A Caring Experience	√	√		√	*Not required*
3. Access Healthcare	√	√		√	*Not required*
4. All About Homecare	√	√		√	*Not required*
5. Alternative Care Medical Services	√	√		√	*Not required*
6. Bayada Nurses	√	√	√		√
7. Bayside Nursing	√	√		√	*Not required*
8. Bright Star Health Care of Kent/ Washington Counties	√	√		√	*Not required*
9. Brightstar Healthcare	√	√		√	*Not required*
10. Capitol Home Care Network		*Not required*	√		√
11. Cathleen Naughton	√	√	√		√
12. Child & Family Services of Newport	√	√			*Not required*
13. Community Care Nurses	√	√		√	*Not required*
14. Concord Home Health Services	√	√	√		**No**
15. Consistent Care	√	**No**	√		**Exception*
16. Cowesett Home Care	√	√			*Not required*
17. Dependable Health Services	√	**Exception*	√		**Exception*
18. Family Friends Health Care	√	**No**			*Not required*
19. Gleason Medical Services	√	√		√	*Not required*
20. H & T Medicals	√	√	√		**Exception*
21. Health Care Connections Nursing Services	√	√		√	*Not required*
22. Health Care Services	√	√			*Not required*
23. Healthtouch	√	√		√	*Not required*
24. Home Care Advantage	√	√	√		√
25. Home Care Services of RI	√	√		√	*Not required*
26. Home Care Solutions	√	√			*Not required*
27. Homefront Health Care	√	√	√		**Exception*
28. Hope Nursing Home Care	√	√		√	*Not required*

Home Health Agency *(Alphabetical)*	Non-Skilled Care		Skilled Care		
	Non-skilled	Surveyed?	Skilled, Paid for by Medicare	ONLY other skilled care	Surveyed?
29. Ideal Home Care Service	√	√			*Not required*
30. Independence Health Services	√	**No**	√		*Exception
31. Interim Healthcare of RI		*Not required*	√		**No**
32. Jamestown Home Health	√	**No**		√	*Not required*
33. Life Care At Home of RI		*Not required*	√		√
34. Lifetime Medical Support Services	√	√			*Not required*
35. Mass Home Care of RI	√	√			*Not required*
36. Maxim Healthcare Services	√	√		√	*Not required*
37. Memorial Hospital Home Care		*Not required*	√		√
38. Morning Star Homecare	√	√		√	*Not required*
39. New Care	√	√		√	*Not required*
40. Nursing Placement Inc	√	√	√		**No**
41. Ocean State Nursing Service	√	√		√	*Not required*
42. Phenix Home Care	√	√			*Not required*
43. Preferred Health Care Services	√	√			*Not required*
44. Roger Williams Home Care		*Not required*	√		√
45. Senior Helpers	√	√			*Not required*
46. South County Quality Care	√	√		√	*Not required*
47. Specialty Home Care Services	√	√			*Not required*
48. St. Jude Home Care	√	√	√		**No**
49. Summit Health Services	√	√		√	*Not required*
50. Tender Loving Care		*Not required*	√		√
51. Visiting Angels	√	√		√	*Not required*
52. Vital Care of RI		*Not required*	√		√
53. VNA of Care New England		*Not required*	√		√
54. VNA of RI		*Not required*	√		√
55. VNA Support Services	√	√		√	*Not required*
56. VNS Home Health Services		*Not required*	√		√
57. VNS of Greater RI		*Not required*	√		√
58. VNS of Newport & Bristol Counties	√	√	√		√

*Exceptions: Consistent Care, H & T Medicals, and Homefront Healthcare received Federal exemptions (did not have to survey) because they had too few Medicare patients during this time frame (October-December 2010). Independence Health Services is seeking a similar exemption. Dependable Health Services had no patients during this time frame (October-December 2010) because the agency was new.

Public Reporting in Rhode Island

In 1998, Rhode Island passed a law that requires the public release, or "public reporting," of information about the quality of care in all licensed healthcare facilities. This law includes releasing information about patient satisfaction and health processes and outcomes, like pain. Over the past 13 years, the state has reported information for home health agencies, hospitals, and nursing homes. This information helps people compare different healthcare providers—like home health agencies—and choose among them.

The Rhode Island public reporting program is located in the Department of Health and has a Home Health Subcommittee. The Subcommittee helps the program's larger Steering Committee decide what information to share about home health agencies and how to share it. The Home Health Subcommittee meetings are open to the public. Participants include local stakeholders—such as representatives of local agencies, government agencies, health insurers, and others interested in Rhode Island's agencies. Together, these people help to shape the state's home health public reporting efforts.

If you are interested in attending the Home Health Subcommittee meetings, please contact Sam Viner-Brown: 401-222-5122.

Home Health Agencies publicly reported patient satisfaction for the first time in 2007. Agencies collected this information once before, in 2006, to practice collecting the data and preview their results before the information was made public.

Outside Survey Companies

Having patients send results directly to the outside survey company helps ensure that people share their true feelings. For the 2010 report:

- Information about **skilled care paid for by Medicare** comes from the Home Health CAHPS survey. Medicare began requiring agencies to send this to patients in October 2010 and plans to release data in 2012. Agencies can choose any survey company to help them collect this information. In 2010, agencies chose: Deyta Systems, Fazzi, OCS, Strategic Healthcare Systems, or Press Ganey.
- Information about **non-skilled care** comes from a survey company called Press Ganey, which has its own satisfaction survey.

All survey companies use surveys designed by survey experts and tested their surveys to make sure they were easy for patients to understand and provided accurate, reliable information.

Health Care Quality Performance (HCQP) Program

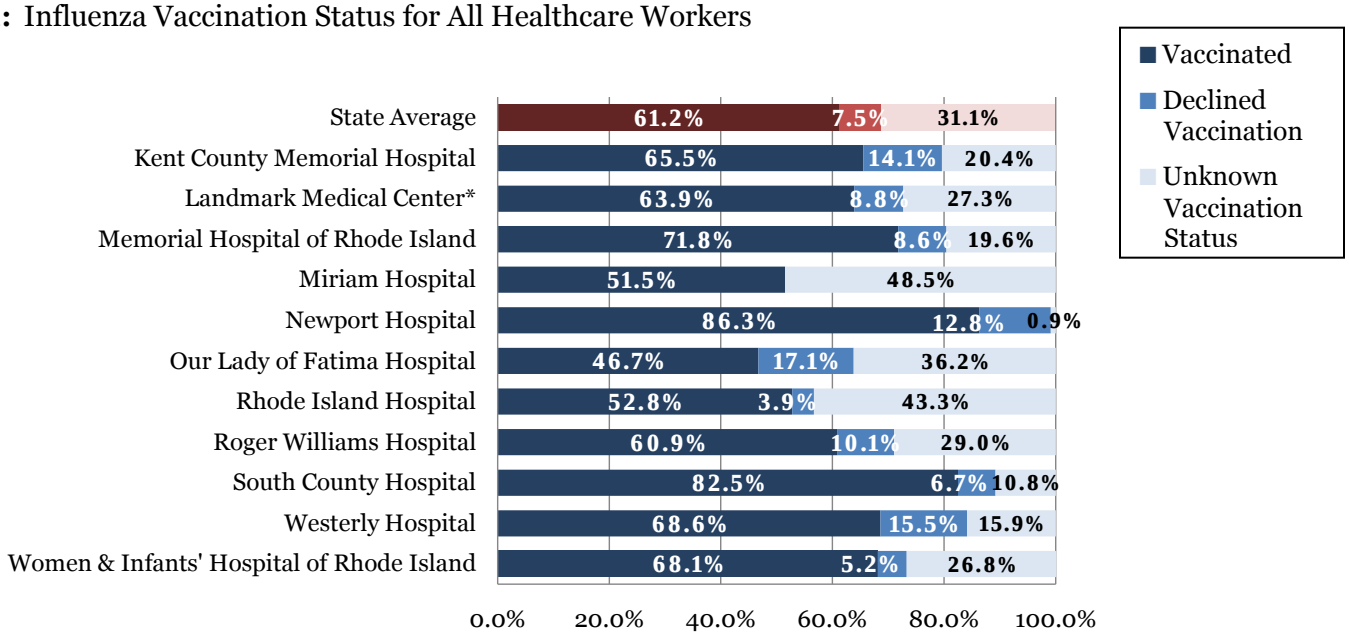
HOSPITAL EMPLOYEE INFLUENZA VACCINATION STATUS

Data Report
October 2009-March 2010

Information about hospital employee influenza vaccination is reported annually on the Department of Health's (HEALTH's) Web site as part of the quality reporting program. Vaccinating healthcare workers can prevent the spread of influenza, or flu, to hospital patients. You can learn more about the rates—including their data source and how they are calculated—by reading the Technical Page. With questions about a hospital's score, please contact the hospital directly. This information is updated each year in the Spring.

NOTE: In hospitals, some of the doctors who care for patients are hospital employees and some are not hospital employees, but have "privileges" to see their patients when they are hospitalized. The information below includes only doctors and other healthcare workers who are hospital employees.

Figure 1: Influenza Vaccination Status for All Healthcare Workers

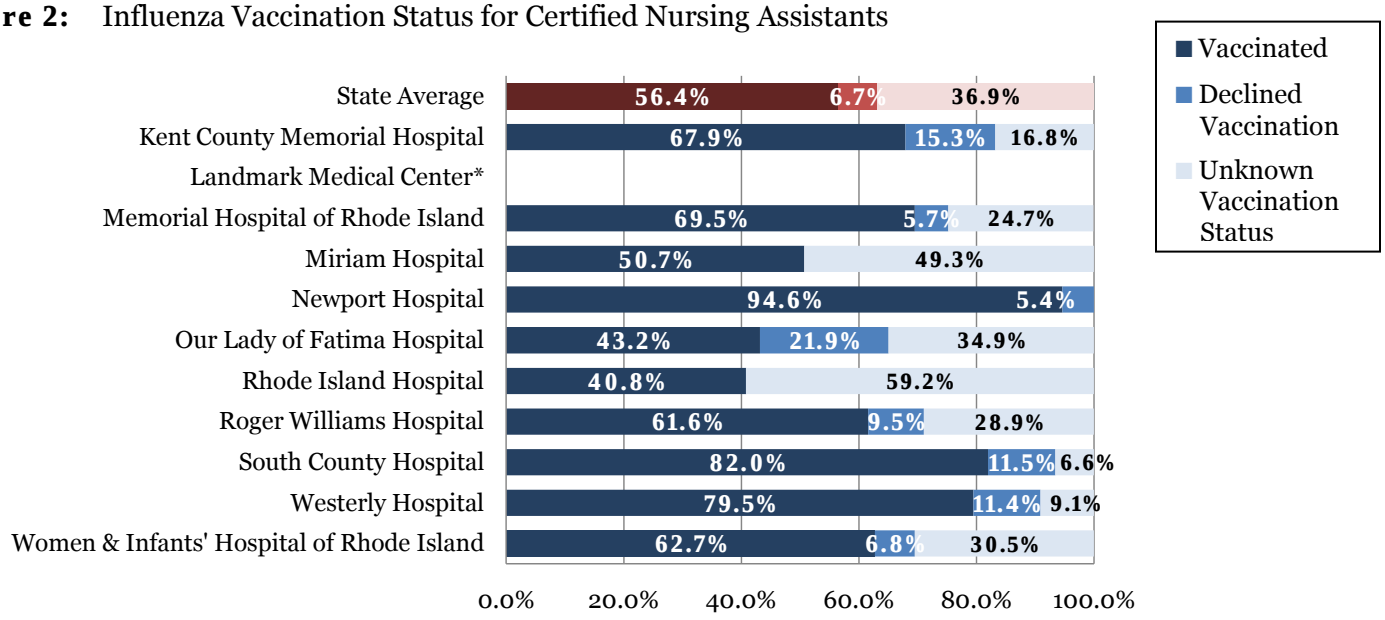


*** Hospital did not submit data**

Hospital Score
(% of All Healthcare Workers)

For % vaccinated, higher scores are better

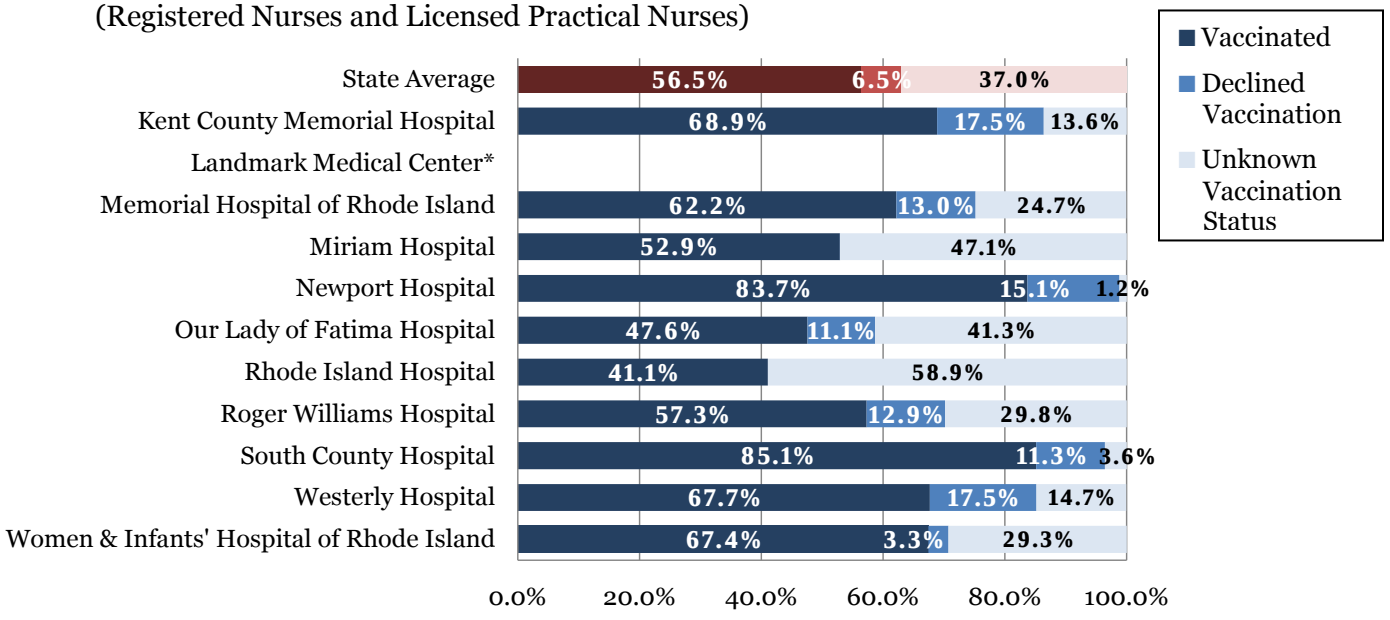
Figure 2: Influenza Vaccination Status for Certified Nursing Assistants



*** Hospital did not submit data**

Hospital Score
(% of Certified Nursing Assistants)
For % vaccinated, higher scores are better

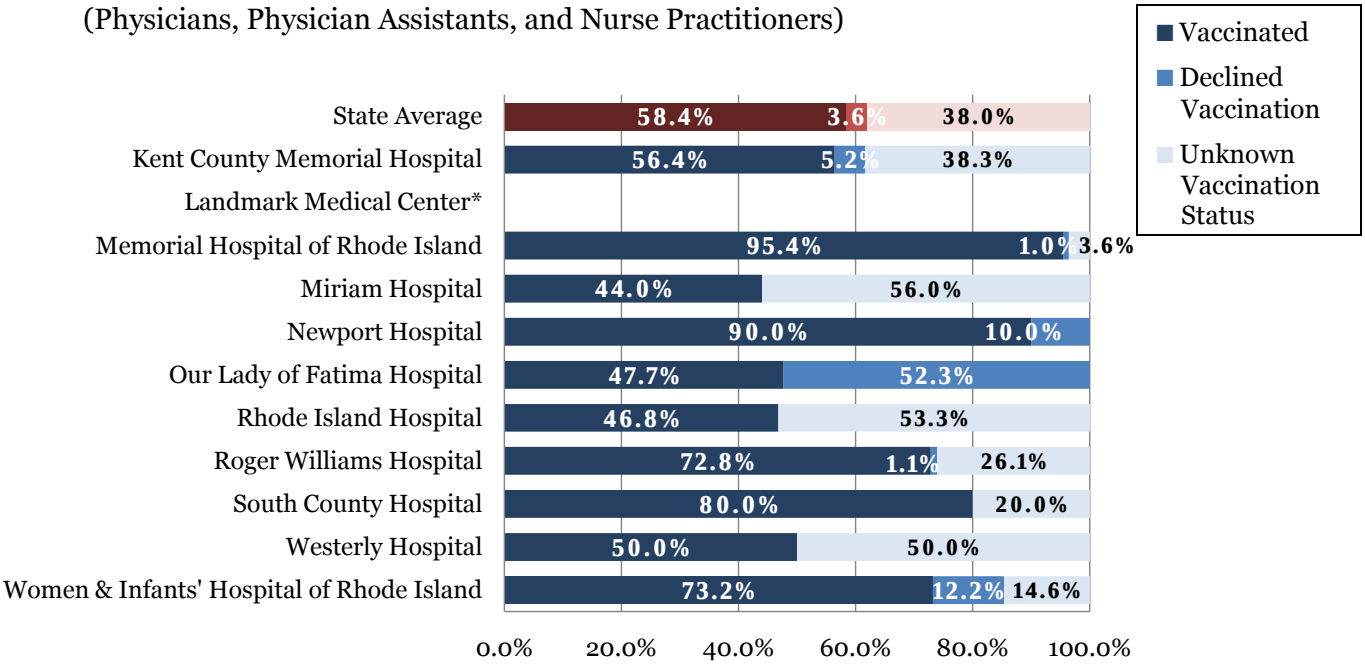
Figure 3: Influenza Vaccination Status for Nurses
(Registered Nurses and Licensed Practical Nurses)



*** Hospital did not submit data**

Hospital Score
(% of Nurses)
For % vaccinated, higher scores are better

Figure 4: Influenza Vaccination Status for Doctors and Other Practitioners (Physicians, Physician Assistants, and Nurse Practitioners)



*** Hospital did not submit data**

Hospital Score
(% of Doctors/Practitioners)

For % vaccinated, higher scores are better

Health Care Quality Performance (HCQP) Program

HOSPITAL EMPLOYEE INFLUENZA VACCINATION AND DECLINATION

Technical Page
October 2009-March 2010

Hospital employee influenza vaccination rates are reported annually on the Department of Health's (HEALTH's) Web site as part of the quality reporting program. The information on this page provides additional details about the influenza vaccination rates, including their data source, how they are calculated, and why influenza vaccination is important for hospital employees.

Measure Information

Measure	Why is this information important?
1. Influenza Vaccination Status for Hospital Healthcare Workers	Influenza, or the flu, can be very serious for hospital patients. Vaccinating healthcare workers is important because influenza spreads from person to person. Vaccination can prevent its spread from healthcare workers to patients. This measure looks at how often healthcare workers receive influenza vaccination during the influenza season (October-March). There are three percentages that total 100% altogether: 1. % vaccinated, 2. % who declined vaccination, and 3. % with unknown vaccination status. These categories are reported for all healthcare workers who are hospital employees, and then broken down for the four types of healthcare workers listed below. This information is updated annually in the Spring.

Data Source

In hospitals, some of the doctors who care for patients are hospital employees and some are not hospital employees, but have "privileges" to see their patients when they are hospitalized. Hospitals collect influenza vaccination data for the healthcare workers who are their employees during each influenza season (October-March) and submit that data to HEALTH each April. The information they collect includes:

1. Type of healthcare worker (e.g., doctor, nurse)
2. Who received influenza vaccination, either at the hospital where they are employed or somewhere else
3. Who did not receive influenza vaccination, either at the hospital where they are employed or anywhere else (and why they declined)
4. Whose vaccination status is unknown, either because the employee did not know or did not tell the hospital

HEALTH's public reports include overall influenza vaccination rates for all healthcare workers who are hospital employees, and then breaks down the information for four different types of hospital employees:

1. Certified Nursing Assistants (CNAs)
2. Nurses, including Licensed Practical Nurses (LPNs) and Registered Nurses (RNs)
3. Doctors and other practitioners, including Physician Assistants (PAs) and Nurse Practitioners (NPs)
4. Other employees, such as students

Measure Calculation

For each measure, the score includes all three of the following percents:

Measure/ Healthcare Worker Type	Numerator	Denominator*
Certified Nursing Assistants (CNAs) who are employees		
% vaccinated	# who declined influenza vaccination	Total # of CNAs
% who declined vaccination	# who received influenza vaccination	Total # of CNAs
% with unknown vaccination status	# with unknown vaccination status	Total # of CNAs
Nurses (LPNs and RNs) who are employees		
% vaccinated	# who declined influenza vaccination	Total # of nurses
% who declined vaccination	# who received influenza vaccination	Total # of nurses
% with unknown vaccination status	# with unknown vaccination status	Total # of nurses
Doctors/practitioners who are employees (Doctors and other Practitioners, such as Physician Assistants and Nurse Practitioners)		
% vaccinated	# who declined influenza vaccination	Total # of doctors/practitioners
% who declined vaccination	# who received influenza vaccination	Total # of doctors/practitioners
% with unknown vaccination status	# with unknown vaccination status	Total # of doctors/practitioners
Students/others who are employees		
% vaccinated	# who declined influenza vaccination	Total # of students/others
% who declined vaccination	# who received influenza vaccination	Total # of students/others
% with unknown vaccination status	# with unknown vaccination status	Total # of students/others
All healthcare workers who are employees		
% vaccinated	# who declined influenza vaccination	Total # of healthcare workers
% who declined vaccination	# who received influenza vaccination	Total # of healthcare workers
% with unknown vaccination status	# with unknown vaccination status	Total # of healthcare workers

*Limited to hospital employees; physicians with admitting privileges, for example, are excluded

For each healthcare worker type (e.g., CNAs), the three percents add up to 100%:

100% = (% vaccinated) + (% who declined vaccination) + (% whose vaccination status is unknown)

Hospitals' measure scores are compared to each other and to the state average.

Data Table, October 2009-March 2010

The data table below provides additional details which are not presented in the Data Report, including counts for the number of healthcare workers who received influenza vaccination, declined it, or whose vaccination status is unknown. These are the numbers used to calculate the percents included in the Data Report graphs.

Hospital (Alphabetical)	Healthcare Worker Type*															
	CNAs				Nurses (LPNs and RNs)				Doctors/Practitioners (including PAs and NPs)				All Health Care Workers*			
	Y	N	DK	T	Y	N	DK	T	Y	N	DK	T	Y	N	DK	Tot
	Count															
Kent County Memorial Hospital	89	20	22	131	547	139	108	794	184	17	125	326	820	176	255	1,251
Landmark Medical Center	-	-	-	-	-	-	-	-	-	-	-	-	799	110	341	1,250
Memorial Hospital	121	10	43	174	277	58	110	445	187	2	7	196	585	70	160	815
Miriam Hospital	73	0	71	144	397	0	353	750	55	0	70	125	525	0	494	1,019
Newport Hospital	53	3	0	56	205	37	3	245	45	5	0	50	303	45	3	351
Our Lady of Fatima Hospital	63	32	51	146	236	55	205	496	31	34	0	65	330	121	256	707
Rhode Island Hospital	202	0	293	495	821	0	1,179	2,000	561	0	639	1,200	1,584	118	1,300	3,002
Roger Williams Hospital	149	23	70	242	196	44	102	342	67	1	24	92	412	68	196	676
South County Hospital	50	7	4	61	143	19	6	168	128	0	32	160	321	26	42	389
Westerly Hospital	35	5	4	44	147	38	32	217	8	0	8	16	190	43	44	277
Women & Infants' Hospital	74	8	36	118	694	34	301	1,029	180	30	36	246	948	72	373	1,393
Total	909	108	594	1,611	3,663	424	2,399	6,486	1,446	89	941	2,476	6,817	849	3,464	11,130

Yes = Received influenza vaccination; No = Declined influenza vaccination; DK = Unknown vaccination status; T = Total
* Limited to hospital employees
- Hospital did not submit data

Healthcare Quality Reporting Program

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) BLOODSTREAM INFECTIONS

Care Outcomes Report, January-March 2011

MRSA bloodstream infections are reported on the Department of Health's (HEALTH's) Web site. Diamonds are assigned based on how different each hospital's performance is from other hospitals nationally:

——— Better than expected
—— About the same as expected
— Worse than expected

You can learn more about the MRSA bloodstream infections report by reading the Methods. It includes more information about the data and why this information is important. If you have questions about a hospital's performance, please contact that hospital directly by clicking on each hospital's name.

MRSA bloodstream infections may be preventable with proper care, but some hospitals may have higher rates even if they provide good care. For example:

- There may be more MRSA bloodstream infections in hospitals that care for more patients who have had antibiotics recently, come from nursing homes, or who have diabetes. Patients who are often in the hospital are also at greater risk.
- Some hospitals may have higher rates if they test more patients for infections. They may be more likely to find or diagnose infections.

MRSA bloodstream infections are caused by a kind of bacteria that can enter the body in many ways. Hospitals in Rhode Island report MRSA bloodstream infections that their intensive care patients get through their central lines (a kind of catheter, or medical tube). MRSA bloodstream infections are also called MRSA central line-associated bloodstream infections, or MRSA CLABSI.

The diamonds show you how hospitals compare to one another*

Table 1: MRSA Bloodstream Infections in Coronary Critical Care Units (CCUs)

Hospital ICU *(Alphabetical)*	Diamonds
Miriam Hospital	———
Rhode Island Hospital	———

Table 2: MRSA Bloodstream Infections in Medical Intensive Care Units (MICUs)

Hospital ICU	Diamonds
Rhode Island Hospital	———

*Statistical methods are described in the Methods (separate document).

The diamonds show you how hospitals compare to one another*

Table 3: MRSA Bloodstream Infections in Medical/Surgical Critical Care Units (ICUs) at Major Teaching Hospitals

Hospital ICU *(Alphabetical)*	Diamonds
Kent County Hospital	——
Memorial Hospital	——
Miriam Hospital	——
Providence Veteran's Affairs Medical Center	x
Roger Williams Medical Center	——

x This hospital did not report data for this unit.

Table 4: MRSA Bloodstream Infections in Medical/Surgical Critical Care Units (ICUs) at All Other (Non-Teaching) Hospitals

Hospital ICU *(Alphabetical)*	Diamonds
Landmark Medical Center	——
Newport Hospital	——
Our Lady of Fatima Hospital	——
South County Hospital	——
Westerly Hospital	——

Table 5: CLABSI Ratings among Pediatric Medical/Surgical Intensive Care Units (PICUs)

Hospital ICU	Diamonds
Rhode Island Hospital	——

Table 6: MRSA Bloodstream Infections in Surgical Intensive Care Units (SICUs)

Hospital ICU	Diamonds
Rhode Island Hospital	——

Table 7: MRSA Bloodstream Infections in Surgical Cardiothoracic Critical Care Units

Hospital ICU *(Alphabetical)*	Diamonds
Miriam Hospital CVTS**	——
Rhode Island Hospital CTIC[HH]	——

** CVTS: Cardiovascular Thoracic Surgical Care Unit

HH CTIC: Cardiovascular Thoracic Intensive Care Unit

*Statistical methods are described in the Methods (separate document).

The following units do not have a national comparison, so we cannot calculate diamonds. Because these units did not have any infections, their performance could not be any better and may be considered similar to receiving three diamonds:

1. Women & Infants Hospital:
   - Level III Neonatal Intensive Care Units (NICUs)

2. Rhode Island Hospital:
   - Neurosurgical Intensive Care Units (INCs)
   - Trauma Intensive Care Units (TICUs)

*Statistical methods are described in the Methods (separate document).

Healthcare Quality Reporting Program

METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) BLOODSTREAM INFECTIONS

Methods

MRSA bloodstream infections are reported on the Department of Health's (HEALTH's) Web site. The information on this page provides additional details about the results presented, including the data source, how hospital diamonds are calculated, and why this information is important.

MRSA bloodstream infections are caused by a kind of bacteria that can enter the body in many ways. Hospitals in Rhode Island report MRSA bloodstream infections that their intensive care patients get through their central lines (a kind of catheter, or medical tube). MRSA bloodstream infections are also called MRSA central line-associated bloodstream infections, or MRSA CLABSI.

Measure Information (adapted from the Centers for Disease Control and Prevention)

Topic	Why is this information important?
Methicillin-resistant Staphylococcus aureus (MRSA)	MRSA bacteria most commonly cause skin infections. MRSA is resistant to (cannot be treated with) certain antibiotics.
MRSA central line-associated bloodstream infections (MRSA CLABSI)	MRSA CLABSI are reasonably preventable with proper care, especially good hygiene.

Definitions

Word or Phrase	What does this mean?
Bloodstream infection	An infection caused by bacteria entering a patient's blood.
Central line	A special kind of medical tube ("IV") that connects directly to a patient's heart or a major blood vessel. It can be used to draw blood or give patients medicines or nutrition.
MRSA CLABSI	A type of bloodstream infection caused by MRSA bacteria that enter the blood through a central line. These infections are not related to another infection, such as a urinary tract infection, pneumonia, or wound infection. Any *S.aureus* infection that tests oxacillin-resistant.
Intensive Care Unit (ICU)	A hospital unit that cares for critically-ill patients.
Rate	A score that reflects new (hospital-acquired) infections over a period of time. For the MRSA infection rates, this timeframe is three months. *Lower* rates are better for MRSA.

Data Source

Hospitals in Rhode Island collect information about the MRSA CLABSI that their ICU patients get and share it with the Department of Health for reporting. Hospital rates are based on MRSA CLABSI. For MRSA CLABSI rates, *lower* numbers are better.

Measure Calculation

The information in this section is for people who want details about the data calculations. For each ICU, two numbers are calculated: (1) **MRSA CLABSI incidence**, and (2) a **Standardized Incidence Ratio** (SIR). Incidence is needed to calculate each hospital's SIR, and the diamonds presented in the public report are based on the SIR.

1. **MRSA CLABSI incidence** is calculated as follows:

$$Rate = \frac{(number\ of\ MRSA\ CLABSI)}{(number\ of\ central\ line\ days)}\ x\ 1{,}000$$

   The number of patients who develop a MRSA CLABSI is the **numerator**. The number of central line days (the number of days when patients could have developed an infection in the ICU) is the **denominator**. The **incidence rate** is the numerator divided by the denominator multiplied by 1,000. Each hospital's rate is compared to the rates of other hospitals nationally using SIRs.

2. Incidence rates are used to calculate **SIRs**, which are:

$$SIR = \frac{(observed\ cases)}{(expected\ cases)}$$

   The **observed cases** are the actual number of MRSA CLABSI (incidence rate numerator) and the **expected cases** are the number we expect to see if we applied the national average MRSA CLABSI incidence rate to each hospital's patient population (the incidence rate's denominator). *Lower* scores are better. An SIR score less than 1.0 means the incidence is better than expected.

For hospitals with SIRs calculated, each hospital's SIR is included in the public report and helps to determine its diamond category (see "Diamond Categories").

Diamond Categories

The diamond categories help you understand how each hospital's incidence compares to its expected incidence (or "expected cases," determined based on the national average):

— Worse than expected
—— About the same as expected
——— Better than expected

These categories are determined mathematically to ensure that the differences are meaningful. In detailed terms, this means that hospitals with either one diamond (—) or three diamonds (———) have MRSA incidence rates that are "statistically significantly different" from their expected rates.

Diamond Calculation

The information in this section is for people who want statistical details about the diamond calculations. The diamond categories are determined based on hospitals' SIRs (see "Measure Calculation"). An SIR less than 1.0 means the hospital's rate is lower (better) than expected; an SIR greater than 1.0 is higher (worse) than expected. The margin of error, or "90% confidence interval," determines whether each SIR is meaningfully different from 1.0. Diamonds are assigned as follows:

- One diamond (—): If the SIR falls above 1.0 (is worse than expected) AND its margin of error, or "90% confidence interval," does not include 1.0, then the hospital has one diamond.
- Two diamonds (——): If the 90% confidence interval for the SIR includes 1.0, then the hospital's score is not accurate enough to categorize it as better or worse than other hospitals (the national average). The hospital has two diamonds.

- Three diamonds (———): If the SIR falls below 1.0 (is better than expected) AND its margin of error, or "90% confidence interval," does not include 1.0, then the hospital has three diamonds. **Note**: The exception is when the hospital does not have any infections (where zero is the best performance). When this occurs, a hospital is automatically given three diamonds.

Data Table, January-March 2011

The data table below provides additional details which are not presented in the Data Report, including:

- Number of MRSA CLABSI
- Number of central line days
- MRSA rate per 1,000 central line days
- SIR, based on the national average[1]
- 90% CI range

Hospital (Alphabetical by ICU Type)	Number of MRSA CLABSI Infections	Number of Central-Line Days	MRSA CLABSI Rate per 1,000 Central Line Days	SIR	90% CI		Diamonds
					Lower Limit	Upper Limit	
Coronary Critical Care Units (CCUs)							
Miriam Hospital	0	165	0.00	0.00	-	-	—
Rhode Island Hospital	0	191	0.00	0.00	-	-	—
Medical Intensive Care Units (MICUs)							
Rhode Island Hospital	0	1,011	0.00	0.00	-	-	—
Medical/Surgical Critical Care Units (ICUs) at Major Teaching Hospitals							
Kent County Hospital	0	797	0.00	0.00	-	-	—
Memorial Hospital	0	468	0.00	0.00	-	-	—
Miriam Hospital	0	852	0.00	0.00	-	-	—
Providence Veteran's Affairs Medical Center	x	x	x	x	x	x	x
Roger Williams Medical Center	0	380	0.00	0.00	-	-	—
Medical/Surgical Critical Care Units (ICUs) at All Other (Non-Teaching) Hospitals							
Landmark Medical Center	0	654	0.00	0.00	-	-	—
Newport Hospital	0	194	0.00	0.00	-	-	—
Our Lady of Fatima Hospital	0	368	0.00	0.00	-	-	—
South County Hospital	0	436	0.00	0.00	-	-	—
Westerly Hospital	0	133	0.00	0.00	-	-	—

x This hospital did not report data for this unit.

[1] Burton DC, Edwards JR, Horan TC, Jernigan JA, Fridkin SK. Methicillin-resistant staphylococcus aureus central line-associated bloodstream infections in US intensive care units, 1997-2007. *JAMA.* 2009; 301(7):727-736.

Hospital (Alphabetical by ICU Type)	Number of MRSA CLABSI Infections	Number of Central-Line Days	MRSA CLABSI Rate per 1,000 Central Line Days	SIR	90% CI		Diamonds
					Lower Limit	Upper Limit	
Women & Infants Hospital's Level III Neonatal Intensive Care Units (NICU), by Birthweight							
<750 grams	0	191	0.00		n/a		n/a
751-1,000 grams	0	168	0.00		n/a		n/a
1,001-1,500 grams	0	217	0.00		n/a		n/a
1,501-2,500 grams	0	124	0.00		n/a		n/a
>2,500 grams	0	18	0.00		n/a		n/a
Umbilical Catheter-Associated Infections at Women & Infants Hospital's Level III NICU, by Birthweight							
<750 grams	0	105	0.00		n/a		n/a
751-1,000 grams	0	116	0.00		n/a		n/a
1,001-1,500 grams	0	152	0.00		n/a		n/a
1,501-2,500 grams	0	46	0.00		n/a		n/a
>2,500 grams	0	27	0.00		n/a		n/a
Neurosurgical Intensive Care Units (INCs)							
Rhode Island Hospital	0	530	0.00		n/a		n/a
Pediatric Medical/Surgical Intensive Care Units (PICUs)							
Rhode Island Hospital	0	322	0.00	0.00	-	-	——
Surgical Intensive Care Units (SICUs)							
Rhode Island Hospital	0	398	0.00	0.00	-	-	——
Surgical Cardiothoracic Critical Care Units							
Miriam Hospital CVTS	0	443	0.00	0.00	-	-	——
Rhode Island Hospital CTIC	0	483	0.00	0.00	-	-	——
Trauma Intensive Care Units (TICUs)							
Rhode Island Hospital	0	400	0.00		n/a		n/a

- Confidence intervals are not applicable when the SIR equals 0.000.
n/a There is no national comparison for this type of unit.

Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED PRESSURE ULCERS

Care Outcomes Report, January-December 2010

Hospital-acquired pressure ulcers (sometimes called pressure sores or bed sores) are reported on the Department of Health's (HEALTH's) Web site as part of the public reporting program's hospital reporting work. You can learn more about hospital-acquired pressure ulcers—including the data source, how the rates and diamonds are calculated, and why this information is important—by reading the Methods. With questions about a hospital's performance, please contact the hospital directly by clicking on its name.

The diamonds show you how hospitals compare to one another

Hospital *(Alphabetical)*	Diamonds*
Kent County Memorial Hospital	—
Landmark Medical Center	——
Memorial Hospital	—
Miriam Hospital	—
Newport Hospital	——
Our Lady of Fatima Hospital	——
Rhode Island Hospital	—
Roger Williams Medical Center	—
South County Hospital	——
Westerly Hospital	—
Women and Infants Hospital	——

* Diamonds are assigned based on how different each hospital's performance is from the state's average performance:

—— Better than expected
— About the same as expected
– Worse than expected

The statistical methods are described in the Methods.

Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED PRESSURE ULCERS

Methods

Hospital-acquired, or incident, pressure ulcers (sometimes called pressure sores or bed sores) are reported on the Department of Health's (HEALTH's) Web site as part of the public reporting program's hospital reporting work. The information on this page provides additional details about the information reported, including its data source, how scores and diamonds are calculated, and why it is important.

Measure Information (adapted from the Agency for Healthcare Research and Quality)

Measure	Why is this information important?
Pressure Ulcer Incidence	This measures hospital-acquired, or incident, pressure ulcers in patients aged 18 and older who were hospitalized for five days or more. Pressure ulcers, sometimes called bed sores or pressure sores, are skin wounds that can be painful, take a long time to heal, and cause other complications, such as skin and bone infections. There are several things that hospitals can do to prevent pressure ulcers, such as frequently changing the patient's position, ensuring proper nutrition, and using soft padding to reduce pressure on the skin. However, some patients may get pressure ulcers even when the hospital provides good preventive care. For the pressure ulcer SIR, which compares actual incidence to what is "expected," *lower* scores are better. A SIR score less than 1.0 means the incidence is better than expected.

Definitions (adapted from the Pressure Ulcer Advisory Panel)

Word or Phrase	What does this mean?
Pressure Ulcer	Pressure ulcers, sometimes called bed sores or pressure sores, are skin wounds that can be painful, take a long time to heal, and cause other complications, such as skin and bone infections. Pressure ulcers are "staged" I-IV according to their depth. Only Stage III, Stage IV, and unstageable pressure ulcers are included in the public report. There are several things that hospitals can do to prevent pressure ulcers, such as frequently changing the patient's position, ensuring proper nutrition, and using soft padding to reduce pressure on the skin. However, some patients may get pressure ulcers even when the hospital provides good preventive care.
Rate	A score that reflects new (hospital-acquired) pressure ulcers over a period of time; for pressure ulcer incidence, three months.
Stage III Pressure Ulcer	Stage III pressure ulcers are deep enough to go through the skin, and may expose the fat that is under the skin. However, bone, tendon, and muscle are not exposed.
Stage IV Pressure Ulcer	Stage IV pressure ulcers are deep enough to go through the skin and expose bone, tendon, or muscle.

Word or Phrase	What does this mean?
Unstageable Pressure Ulcer	Unstageable pressure ulcers are deep enough to go through the skin, but are covered by debris so it is not possible to determine whether or not bone, tendon, or muscle are exposed.
Present on admission	A pressure ulcer is already there when a patient enters the hospital; these do NOT count as new, hospital-acquired pressure ulcers and are not counted on this report.

Data Source

Rhode Island hospitals submit patient-level information to the Department of Health as part of the Hospital Discharge Data Set (HDDS). The HDDS includes patient information, including patients' diagnoses, how long they were hospitalized, and what care the hospital provided. The Department of Health uses these data to report hospital-acquired pressure ulcers. For pressure ulcers, *lower* numbers are better.

Measure Calculation

The information in this section is for people who want details about the data calculations. For each hospital, two numbers are calculated: (1) pressure ulcer incidence, and (2) a Standardized Incidence Ratio (SIR). Only the SIR is included in the public report, but incidence is needed to calculate each hospital's SIR.

1. **Pressure ulcer incidence** is calculated as follows:

$$Rate = \frac{(patients\ who\ develop\ a\ pressure\ ulcer)}{(number\ of\ patients\ aged\ 18\ years\ and\ older\ who\ were\ hospitalized\ 5+\ days)}$$

   The number of patients who develop an advanced pressure ulcer (Stage III, Stage IV, or their clinical equivalent among unstageable pressure ulcers) that is NOT present when patient is admitted is the **numerator**. The number of patients aged 18 years and older who were hospitalized five or more days is the **denominator**. The denominator also excludes some patients; these details are below, under "Measure Exclusions." The **incidence rate** is the numerator divided by the denominator multiplied by 1,000. Each hospital's rate is compared to the rates of other hospitals in Rhode Island using SIRs (below and p. 3).

2. Incidence rates are used to calculate **SIRs**, which are:

$$SIR = \frac{(observed\ cases)}{(expected\ cases)}$$

   The **observed cases** are the number of hospital-acquired pressure ulcers (incidence rate numerator) and the **expected cases** are the number we expect to see if the average Rhode Island pressure ulcer incidence rate is applied to each hospital's patient population (the incidence rate's denominator). *Lower* scores are better. A SIR score less than 1.0 means the incidence is better than expected.

Each hospital's SIR helps to determine its diamond category (see p. 3) and is included in this file (p. 4).

Measure Exclusions

The information in this section is for people, often clinicians, who want detailed information about which patients are excluded from the data. The incidence rate denominator excludes certain patients, such as those:

- Hospitalized fewer than five days
- Who already had a pressure ulcer when admitted to the hospital
- MDC 9 (Skin, Subcutaneous Tissue, and Breast)
- MDC 14 (pregnancy, childbirth, and puerperium)
- With any diagnosis of hemiplegia, paraplegia, or quadriplegia

- With ICD-9-CM code of spina bifida or anoxic brain damage
- With an ICD-9-CM procedure code for debridement or pedicle graft before or on the same day as the major operating room procedure (surgical cases only)

- Admitted from a long-term care facility (SID Admission Source=3)
- Transferred from an acute-care facility (SID Admission Source=2)

The number of patients who meet these criteria is listed on the public report.

Diamond Categories

The diamond categories help you understand how each hospital's incidence (SIR score) compares to its expected incidence (which is determined based on the average performance of Rhode Island hospitals):

— Worse than expected
—— About the same as expected
——— Better than expected

These categories are determined mathematically to ensure that the differences are meaningful. In detailed terms, this means that hospitals with either one diamond (—) or three diamonds (———) have pressure ulcer incidence rates that are "statistically significantly different" from their expected rates.

Diamond Calculation

The information in this section is for people who want statistical details about the diamond calculations. The diamond categories are determined based on hospitals' SIRs (see p. 2). An SIR less than 1.0 means the hospital's rate is lower (better) than expected; an SIR greater than 1.0 is higher (worse) than expected. The margin of error, or "90% confidence interval," determines whether each SIR is meaningfully different from 1.0. Diamonds are assigned as follows:

- One diamond (—): If the SIR falls above 1.0 (is worse than expected) AND its margin of error, or "90% confidence interval," does not include 1.0, then the hospital has one diamond.
- Two diamonds (——): If the 90% confidence interval for the score includes the Rhode Island average, then the hospital's score is not accurate enough to categorize it as better or worse than other hospitals. The hospital has two diamonds.
- Three diamonds (———): If the SIR falls below 1.0 (is better than expected) AND its margin of error, or "90% confidence interval," does not include 1.0, then the hospital has three diamonds. **Note**: The exception is when the hospital does not have any hospital-acquired pressure ulcers (where 0 is the best performance). When this occurs, a hospital is automatically given three diamonds.

Data Table, January-December 2010

The data table below provides additional details which are not presented in the Data Report, including:

- Number of hospital-acquired pressure ulcers
- Number of patients (who meet the eligibility criteria)
- Pressure ulcer rate per 1,000 patients
- SIR, based on the statewide benchmark
- 90% CI range

Hospital (Alphabetical by Name)	Number of Hospital-Acquired Pressure Ulcers	Number of Patients	Pressure Ulcer Rate per 1,000 Patients	SIR	90% CI		Diamonds
					Lower Limit	Upper Limit	
Kent County Memorial Hospital	3	4,653	0.64	1.519	0.410	3.923	—
Landmark Medical Center	0	2,860	0.00	0.000	-	-	——
Memorial Hospital	1	1,754	0.57	1.344	0.053	6.353	—
Miriam Hospital	3	4,259	0.70	1.660	0.448	4.286	—
Newport Hospital	0	1,497	0.00	0.000	-	-	——
Our Lady of Fatima Hospital	0	3,955	0.00	0.000	-	-	——
Rhode Island Hospital	8	9,799	0.82	1.924	0.957	3.471	—
Roger Williams Medical Center	2	2,000	1.00	2.357	0.407	7.405	—
South County Hospital	0	1,146	0.00	0.000	-	-	——
Westerly Hospital	1	1,073	0.93	2.196	0.087	10.385	—
Women and Infants Hospital	0	1,318	0.00	0.000	-	-	——
State Average			0.42				

- Confidence intervals are not applicable when the SIR equals 0.000; these facilities automatically receive three diamonds.
-- Not applicable

Last updated 1.06.11

Healthcare Quality Reporting Program

2011 PHYSICIAN HIT SURVEY: OFFICE-BASED VERSION

This short questionnaire asks about physicians' use of health information technology (HIT) and should take ~10 minutes to complete. The Rhode Island Department of Health (HEALTH) requires that all licensed physicians complete the Physician HIT Survey each year. For physicians using HIT, a lack of response is treated (and reported) as non-use HIT.

***Instructions**: Please answer the following questions based on your current practice. These questions ask about your use of HIT and may be most accurately answered by you, rather than your Office Manager or another staff member. Note that you will need your license number and Individual National Provider Identifier (NPI) to complete this survey.*

SECTION A: Physician and Practice Information

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

6. **Do you currently provide direct patient care services?**

☐1 No ➔ *If not providing direct patient care, stop the survey.*

☐2 Yes, and **my <u>primary</u> specialty is:**

☐1	Allergy & Immunology	☐11	Hematology/ Oncology	☐21	OB-GYN	☐31	Pulmonary/Critical Care
☐2	Anesthesiology	☐12	Hospitalist	☐22	Occupational Med.	☐32	Radiation Oncology
☐3	Cardiology	☐13	Infectious Disease	☐23	Ophthalmology	☐33	Radiology
☐4	Colorectal Surgery	☐14	Intensivist	☐24	Otolaryngology	☐34	Rheumatology
☐5	Dermatology	☐15	Internal Medicine (general)	☐25	Orthopaedic Surgery	☐35	Surgery (general and other)
☐6	Emergency Med.	☐16	Medicine/ Pediatrics	☐26	Pathology	☐36	Thoracic Surgery
☐7	Endocrinology	☐17	Nephrology	☐27	Pediatrics	☐37	Urology
☐8	Family Medicine	☐18	Neurology	☐28	Physical Med/Rehab.	☐38	Vascular Surgery
☐9	Gastroenterology	☐19	Neurosurgery	☐29	Plastic Surgery	☐39	Other: _____
☐10	Geriatrics	☐20	Nuclear Medicine	☐30	Psychiatry		

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

☐1 <10 hours ☐2 10-20 hours ☐3 >20 hours

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

_____

Practice name

_____

Practice Address *Box/Suite*

_____

City/Town *State* *ZIP Code*

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

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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

☐1 <5 clinicians ☐2 5-10 clinicians ☐3 10+ clinicians

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

☐1 0% ☐2 <30% ☐3 30-60% ☐4 >60% ☐5 Don't know

SECTION B: Electronic Medical Records (EMR) Status*

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

	Not a barrier	Minor barrier	Major barrier
Access to technical support	☐1	☐2	☐3
Availability of a computer in the appropriate location	☐1	☐2	☐3
Impact of computer on doctor-patient interaction	☐1	☐2	☐3
Lack of computer skills	☐1	☐2	☐3
Lack of interoperability (i.e., ability of different systems to communicate)	☐1	☐2	☐3
Privacy or security concerns	☐1	☐2	☐3
Start-up financial costs	☐1	☐2	☐3
Ongoing financial costs	☐1	☐2	☐3
Technical limitations of systems	☐1	☐2	☐3
Training and productivity impact	☐1	☐2	☐3

Other (*please specify*): _____

_____

13. **Does your <u>main</u> practice have EMR components?** *By 'EMR components,' we mean an integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.*

☐2 Yes ➔ *Skip to Question 19 on page 5*

☐1 No ➔ a. **Aside from your main practice, do ANY of your practice settings (hospital- or office-based) have EMR components?** *If more than one has EMR components, please choose the practice in which you provide the most direct patient care.*

- ☐1 No
- ☐2 Yes, a hospital practice ➔ *Stop and complete the Physician HIT Survey: Hospital-Based Version*
- ☐3 Yes, an office practice ➔ *Skip to Question 19 on page 5*
- ☐4 N/A – no other practices

SECTION C: Plans to Implement EMR

14. **Does your main practice or another practice <u>plan</u> to implement an EMR?**

☐1 No ➔ *If your main practice is not planning to implement an EMR, skip to Question 24 on page 7*

☐2 Yes, within 1 year

☐3 Yes, after 1 year

☐4 Don't know

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

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

☐1 No vendor identified	☐8 e-MD	☐15 Next Gen
☐2 Allscripts	☐9 Epic Systems	☐16 Polaris - EpiChart
☐3 Amazing Charts	☐10 GE Centricity	☐17 Practice Partner
☐4 Athena Heath	☐11 Greenway	☐18 Sage - Intergy EHR
☐5 Cerner - PowerChart	☐12 Lighthouse MD	☐19 SOAPware
☐6 CPRS/Vista (VA Hospital)	☐13 McKesson Provider Tech.	☐20 Other: (*please specify*)
☐7 eClinicalWorks	☐14 Misys	_____

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

☐1 Yes, from Medicaid's EHR Incentive Program
☐2 Yes, from Medicare's EHR Incentive Program
☐3 Yes, but I haven't chosen between Medicare and Medicaid yet

☐4 No, I don't plan to seek incentive payments
☐5 Don't know
☐6 Need more information

Skip to question 24 on page 7

*(Comments?)*_____
_____

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

☐1 2011
☐2 2012
☐3 After 2012

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

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

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

➔ *The following questions are for physicians using EMRs. If you don't have an EMR in either your main practice or another practice, skip to Question 24 on page 7.*

SECTION D: EMR Use

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

a. **What is your practice's EMR vendor?**

☐1	(Don't know)	☐8	e-MD	☐15	Next Gen
☐2	Allscripts	☐9	Epic Systems	☐16	Polaris - EpiChart
☐3	Amazing Charts	☐10	GE Centricity	☐17	Practice Partner
☐4	Athena Heath	☐11	Greenway	☐18	Sage - Intergy EHR
☐5	Cerner - PowerChart	☐12	Lighthouse MD	☐19	SOAPware
☐6	CPRS/Vista (VA Hospital)	☐13	McKesson Provider Tech.	☐20	Other: (*please specify*)
☐7	eClinicalWorks	☐14	Misys		_____

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

c. **Is your EMR certified by the Office of the National Coordinator (ONC)?** (This includes CCHIT, Drummond, and other certifications.) View the ONC's database of certified products here.

☐1 No ☐2 Yes ☐3 Don't Know

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

0% of patients	*Never*
<30% of patients	*Sometimes*
30-6% of patients	*Often*
>60% of patients	*Always*

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

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

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

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

☐1 Yes, from Medicaid's EHR Incentive Program
☐2 Yes, from Medicare's EHR Incentive Program
☐3 Yes, but I haven't chosen between Medicare and Medicaid yet

☐4 No, I don't plan to seek incentive payments
☐5 Don't know
☐6 Need more information

Skip to question 24

*(Comments?)*_____
_____

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

☐1 2011
☐2 2012
☐3 After 2012

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

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

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

SECTION C: Electronic Prescribing (e-Prescribing) Use

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

☐1 **0%** ➔ *Skip to Question 27*
☐2 **<30%**
☐3 **30%-60%**
☐4 **>60%**

25. **Have you started to e-prescribe Schedule II-V drugs?** The DEA approved electronic transmission of Schedule II-V medications in June 2010. Read more about e-prescribing controlled substances here.

    ☐1 No
    ☐2 Yes

26. **Do you transmit electronic prescriptions using an EMR?**

    ☐1 No
    ☐2 Yes ➔ *Skip to Question 28*

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

    ☐1 No
    ☐2 Yes

28. **Please provide any feedback about EMRs:** _____

    _____

    _____

29. **Please provide any feedback about e-prescribing.** _____

    _____

    _____

30. **Please use this space to provide additional comments:** _____

    _____

    _____

    _____

Thank you for taking the time to complete this survey.

Last Updated 1.06.11

Healthcare Quality Reporting Program

2011 PHYSICIAN HIT SURVEY: HOSPITAL-BASED VERSION

This short questionnaire asks about physicians' use of health information technology (HIT) and should take ~10 minutes to complete. The Rhode Island Department of Health (HEALTH) requires that all licensed physicians complete the Physician HIT Survey each year. For physicians using HIT, a lack of response is treated (and reported) as non-use HIT.

***Instructions**: Please answer the following questions based on your current practice. These questions ask about your use of HIT and may be most accurately answered by you, rather than your Office Manager or another staff member. Note that you will need your license number and Individual National Provider Identifier (NPI) to complete this survey.*

SECTION A: Physician and Practice Information

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

6. **Do you currently provide direct patient care services?**

□1 No ➔ *If not providing direct patient care, stop the survey.*
□2 Yes, and **my <u>primary</u> specialty is:**

☐1	Allergy & Immunology	☐11	Hematology/ Oncology	☐21	OB-GYN	☐31	Pulmonary/Critical Care
☐2	Anesthesiology	☐12	Hospitalist	☐22	Occupational Med.	☐32	Radiation Oncology
☐3	Cardiology	☐13	Infectious Disease	☐23	Ophthalmology	☐33	Radiology
☐4	Colorectal Surgery	☐14	Intensivist	☐24	Otolaryngology	☐34	Rheumatology
☐5	Dermatology	☐15	Internal Medicine (general)	☐25	Orthopaedic Surgery	☐35	Surgery (general and other)
☐6	Emergency Med.	☐16	Medicine/ Pediatrics	☐26	Pathology	☐36	Thoracic Surgery
☐7	Endocrinology	☐17	Nephrology	☐27	Pediatrics	☐37	Urology
☐8	Family Medicine	☐18	Neurology	☐28	Physical Med/Rehab.	☐38	Vascular Surgery
☐9	Gastroenterology	☐19	Neurosurgery	☐29	Plastic Surgery	☐39	Other: _____
☐10	Geriatrics	☐20	Nuclear Medicine	☐30	Psychiatry		

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

☐1 <10 hours ☐2 10-20 hours ☐3 >20 hours

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

_____ _____
Practice name *Hospital Name*

_____
Practice Address *Box/Suite*

_____
City/Town *State* *ZIP Code*

9. **Altogether, approximately how large is your practice?** *Please consider the physicians, nurse practitioners, and physician assistants with whom you work directly; not the overall size of the hospital.*

☐1 <5 clinicians ☐2 5-10 clinicians ☐3 10+ clinicians

10. **Approximately what percentage of your patient visits are funded by Medicaid?**

☐1 0% ☐2 <30% ☐3 30-60% ☐4 >60% ☐5 >60% ☐6 Don't know

SECTION B: Electronic Medical Records (EMR) Status*

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

	Not a barrier	Minor barrier	Major barrier
Access to technical support	☐1	☐2	☐3
Availability of a computer in the appropriate location	☐1	☐2	☐3
Impact of computer on doctor-patient interaction	☐1	☐2	☐3
Lack of computer skills	☐1	☐2	☐3
Lack of interoperability (i.e., ability of different systems to communicate)	☐1	☐2	☐3
Privacy or security concerns	☐1	☐2	☐3
Start-up financial costs	☐1	☐2	☐3
Ongoing financial costs	☐1	☐2	☐3
Technical limitations of systems	☐1	☐2	☐3
Training and productivity impact	☐1	☐2	☐3

Other (*please specify*): _____

_____

12. **Does your <u>main</u> hospital practice have EMR components?** *By 'EMR components,' we mean an integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.*

☐2 Yes ➔ *Skip to Question 18 on page 5*

☐1 No ➔ a. **Aside from your main practice, do ANY of your practice settings (hospital- or office-based) have EMR components?** *If more than one has EMR components, please choose the practice in which you provide the most direct patient care.*

☐1 No
☐2 Yes, a hospital practice ➔ *Skip to Question 18 on page 5*
☐3 Yes, an office practice ➔ *Stop and complete the Physician HIT Survey: Office-Based Version*
☐4 N/A – no other practices

SECTION C: Plans to Implement EMR

13. **Does your main practice or another practice <u>plan</u> to implement an EMR?**

☐1 No ➔ *If your practice is not planning to implement an EMR, skip to Question 23 on page 7*
☐2 Yes, within 1 year
☐3 Yes, after 1 year
☐4 Don't know

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

14. **If you do plan to implement an EMR, which EMR vendor are you considering (if any)?**

☐1 No vendor identified	☐8 e-MD	☐15 Next Gen
☐2 Allscripts	☐9 Epic Systems	☐16 Polaris - EpiChart
☐3 Amazing Charts	☐10 GE Centricity	☐17 Practice Partner
☐4 Athena Heath	☐11 Greenway	☐18 Sage - Intergy EHR
☐5 Cerner - PowerChart	☐12 Lighthouse MD	☐19 SOAPware
☐6 CPRS/Vista (VA Hospital)	☐13 McKesson Provider Tech.	☐20 Other: (*please specify*)
☐7 eClinicalWorks	☐14 Misys	_____

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

☐1 Yes, from Medicaid's EHR Incentive Program
☐2 Yes, from Medicare's EHR Incentive Program
☐3 Yes, but I haven't chosen between Medicare and Medicaid yet

☐4 No, I don't plan to seek incentive payments
☐5 Don't know
☐6 Need more information

Skip to question 23 on page 7

*(Comments?)*_____
_____

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

☐1 2011
☐2 2012
☐3 After 2012

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

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

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

➔ *The following questions are for physicians using EMRs. If you don't have an EMR in either your main practice or another practice, skip to Question 23 on page 7.*

SECTION D: EMR Use

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

a. **What is your hospital practice's EMR vendor?**

☐1	(Don't know)	☐8	e-MD	☐15	Next Gen
☐2	Allscripts	☐9	Epic Systems	☐16	Polaris - EpiChart
☐3	Amazing Charts	☐10	GE Centricity	☐17	Practice Partner
☐4	Athena Heath	☐11	Greenway	☐18	Sage - Intergy EHR
☐5	Cerner - PowerChart	☐12	Lighthouse MD	☐19	SOAPware
☐6	CPRS/Vista (VA Hospital)	☐13	McKesson Provider Tech.	☐20	Other: (*please specify*)
☐7	eClinicalWorks	☐14	Misys		_____

b. **In which year did your hospital practice install its EMR?** ___ ___ ___ ___

c. **Is your EMR certified by the Office of the National Coordinator (ONC)?** (This includes CCHIT, Drummond, and other certifications.) View the ONC's database of certified products here.

☐1 No ☐2 Yes ☐3 Don't Know

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

0% of patients	*Never*
<30% of patients	*Sometimes*
30-6% of patients	*Often*
>60% of patients	*Always*

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

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

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

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

☐1 Yes, from Medicaid's EHR Incentive Program
☐2 Yes, from Medicare's EHR Incentive Program
☐3 Yes, but I haven't chosen between Medicare and Medicaid yet

☐4 No, I don't plan to seek incentive payments
☐5 Don't know
☐6 Need more information
Skip to question 23

*(Comments?)*_____
_____

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

☐1 2011
☐2 2012
☐3 After 2012

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

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

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

SECTION C: Electronic Prescribing (e-Prescribing) Use

23. **What percent of the time do you transmit medication orders electronically to the pharmacy?** *(Exclude faxing.)*

☐1 0% ➔ *Skip to Question 25*
☐2 <30%
☐3 30%-60%
☐4 >60%

24. **Do you transmit these medication orders using an EMR?**

☐1 No
☐2 Yes ➔ *Skip to Question 26*

25. **Does your hospital plan to transmit medication orders using an EMR within the next 12 months?**

☐1 No
☐2 Yes

26. **Please provide any feedback about EMRs:**

_____

_____

27. **Please provide any feedback about e-prescribing.**

_____

_____

28. **Please use this space to provide additional comments:** _____

_____

_____

_____

Thank you for taking the time to complete this survey.