Report to the General Assembly: Rhode Island Healthcare Quality Reporting Program

MAY 2017
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Executive Summary

In the past 18 years, the Rhode Island Department of Health (RIDOH) and its public reporting contractor, Healthcentric Advisors, have worked with healthcare providers and stakeholders to implement a healthcare quality public reporting system for all licensed healthcare facilities and licensed independent practitioners (LIPs) in the state. Initially, the Healthcare Quality Reporting Program (HQRP) focused on hospitals, then incrementally expanded to include home health agencies, nursing homes, and physicians; and from clinical outcome measures to satisfaction (home health agencies, hospitals, and nursing homes) and structural measures (LIPs). HQRP also has funding from the Centers for Disease Control and Prevention (CDC) to address healthcare-acquired infections (HAI), antimicrobial resistance, (AR) and antimicrobial stewardship (AMS). Expanded funding from CDC allowed HQRP to increase activities related to this topics, primarily in the acute-care hospital and long-term care settings.

During fiscal year 2016, HQRP, for the fourth consecutive year, received less than 50% of historical state funding. As a result, it was unable to restart the home health, hospital, and nursing home clinical measure reports calculated using Medicare quality measures, which were discontinued during fiscal year 2013 due to lack of funds.

HQRP continued to prioritize primary data collection efforts that support concurrent state policies and priorities. Primary data included hospital hand hygiene practices, nursing home satisfaction, infection control practices in acute-care hospitals and long-term care facilities, and healthcare worker influenza vaccination reporting for hospitals and nursing homes to home health agencies. In order to reduce survey burden on providers, the Health Information Technology (HIT) survey was transitioned from an annual survey to a biennial survey, with administration during odd years. During even years, HQRP will perform additional analysis and stakeholder outreach related to the results.

Fiscal year 2016 reporting activities are summarized as follows:

Table 1: Fiscal year 2016 Reporting Activity, by Type of Measure and Provider

Provider	Care Outcomes		Structure Measures	Patient Satisfaction
	Process	Outcome		
Home Health	Annually (new)	(ceased) †		(ceased)†
Hospital	Annually	Quarterly*		Quarterly
Nursing Home	Annually (new)	Monthly		Annually
LIPs			Biennially	

†Medicare now reports data for Medicare-certified agencies using Home Health Consumer Assessment of Healthcare Providers and Systems (HH-CAHPS). This data will be included in the new Home Health Agency web application (currently in development).

This report details reporting activities and describes fiscal year 2017 HQRP goals, including leveraging ongoing results from a Healthcentric Advisors Agency for Healthcare Research and Quality (AHRQ) grant to improve the usability of the website, increase consumers' use of the information published, and increase program activities related to infection prevention and antimicrobial stewardship.

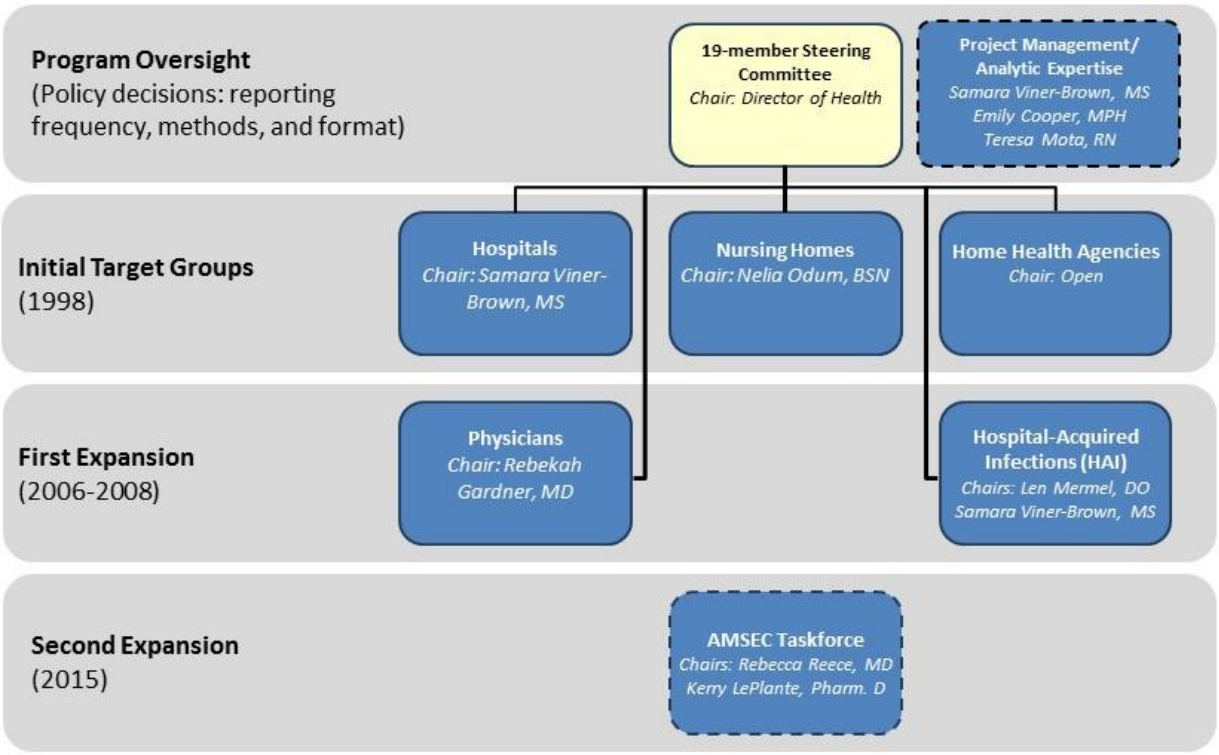
Program Overview

In 1998, the State of Rhode Island mandated that RIDOH develop a healthcare quality public reporting system for all licensed healthcare facilities.[1] Through HQRP, the state required licensed healthcare facilities to publish clinical outcomes and patient satisfaction on RIDOH's website:http://www.health.ri.gov/programs/healthcarequalityreporting/

In the past 18 years, RIDOH and its public reporting contractor, Healthcentric Advisors, have worked with healthcare providers and other stakeholders to report data for home health agencies, hospitals, nursing homes and physicians.

HQRP is governed by a 19-member Steering Committee, chaired by the Director of RIDOH and managed by RIDOH and Healthcentric Advisors. 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. Program Organizational Structure



In response to legislative amendments, HQRP added two new stakeholder groups in fiscal year 2008 and fiscal year 2009: the Physician Measures Workgroup and the HAI Subcommittee.[2]

[1] Chapter 23-17.17, Health Care Quality Program, Index of Sections [Online]. Available: http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.17/INDEX.HTM, 03 Apr 2013.

[2] Although related to the Hospital Subcommittee, since both Subcommittees focus on hospital-related reporting, the HAI Subcommittee has a legislatively-mandated composition and a narrow focus on HAI-related measures. Some of the HAI activities are also funded by a separate CDC grant.

HQRP did not add any new groups during fiscal year 2013 or fiscal year 2014, but the Physician Workgroup adapted the HIT Survey for advanced practice registered nurses (APRN) and physician assistants (PA). In fiscal year 2015, the Antimicrobial and Environmental Cleaning Task Force (AMSEC) was created to decrease HAI rates in Rhode Island. AMSEC does not fall under the oversight of the Steering Committee, but works collaboratively with HQRP.

Fiscal Year 2016 Reporting Activity

Recurring reports are available on RIDOH's website via the links included in each section below.

Home Health Agencies
Links to Medicare information about home health agency care outcomes and patient satisfaction are available on HQRP's website (http://www.health.ri.gov/healthcare/providers/homehealthagencies/about/quality/).
Due to budget constraints, HQRP ceased updating the care outcome reports calculated using Medicare quality measures during fiscal year 2013 and was unable to restore them in either fiscal year 2014 or 2015. In place of the care outcomes report, HQRP's website includes a link to Medicare's *Home Health Compare*. HQRP no longer publishes the comparative reports intended to help consumers interpret the Medicare data and inform consumer choice, per the legislation.

Previously, Medicare data were 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 with the national average, the agency was categorized as average (♦♦) for that measure; if the confidence interval did not overlap the national average, the agency was classified as below average (♦) or above average (♦♦♦). This was intended to translate the Medicare data into comparative ratings that inform consumer choice.

Medicare now provides star ratings for home health quality measures. The star rating is a composite of nine quality measures. The measure is reported on a five-star scale. Agencies that receive one or two stars have a lower quality rating than the average rating across other agencies. Agencies that receive three stars have a quality rating similar to the average across other agencies. Agencies that receive four or five stars have a quality rating higher than the average across other agencies.

HQRP also ceased reporting home health patient satisfaction during fiscal year 2013, due to a new Medicare requirement regarding home health CAHPS (HH-CAHPS). In place of the satisfaction report, HQRP's website includes a link to Medicare's *Home Health Compare*, which includes HH-CAHPS data.

After releasing the nation's first home health satisfaction report in early 2009 (reflecting fall 2008 data), HQRP began requiring agencies to contract with Press Ganey, a survey vendor, to collect and report these data every two years. Data were collected in fall 2010 and were scheduled for fall 2012. In the interim, however, Medicare began reporting patient satisfaction data for Medicare-certified agencies using the HH-CAHPS survey instrument. This means that the home health satisfaction data are now limited to Medicare skilled patients. Although HQRP determined there was value in surveying all home health patients regardless of payor and service provided, the survey process is resource-intensive for both HQRP and for home health agencies, who were required to contract with Press Ganey. As a result, the current policy recommendation limits home health satisfaction reporting to the HH-CAHPS data. This policy may be revisited and expanded to other payors or patient populations, as state priorities change.

HQRP currently reports data for home health agency healthcare workers' influenza vaccination. These data are collected by RIDOH's Immunization Program and shared with HQRP.

Information about home health agencies is also collected through a primary data survey. This survey was done in cooperation with RIDOH's Division of Policy, Information, and Communication. Information collected during this survey will be combined with available quality and satisfaction data and employee flu vaccination data and will be included in the home health web search tool. This tool is scheduled to be publically available in the spring of 2017.

Hospitals

Reports and links to Medicare information about hospital care outcomes and patient satisfaction are available on HQRP's website (http://www.health.ri.gov/hospitals/about/quality/index.php). Due to budget constraints, HQRP ceased updating the care outcome reports calculated using Medicare quality measures. In place of the care outcomes report, HQRP's website includes a link to Medicare's *Hospital Compare*. HQRP no longer publishes the comparative reports intended to help consumers interpret the Medicare data and inform consumer choice, per the legislation. Previously, the Medicare data for acute-care hospitals were reported as bar graphs (process and prevalence measures). HQRP also continues to link to satisfaction data on Medicare's *Hospital Compare*.

A separate CDC grant enabled HQRP to sustain HAI reporting during fiscal year 2016. This grant funded continued HAI Subcommittee meetings; a Rhode Island HAI Coordinator; and the Subcommittee's work to create reports on two Department of Health and Human Services (HHS) HAI priority topics. The HAI grant also enabled HQRP to sustain efforts to report hand hygiene process measures (annually) and healthcare worker employee influenza vaccination (annually).

HQRP continued to publish the *Hospital Summary Report*, which combines data from multiple sources, to create a single, consumer-centric comparative report. This report is updated quarterly to reflect the most current data available from our data sources.

Methicillin-resistant Staphylococcus aureus Central Line-Associated Bloodstream Infections (MRSA CLABSI) were classified into three categories (below average, average, above average) based on the proximity of their score to a benchmark (national Intensive Care Unit means). If the score's 90% confidence interval overlaps a 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 (♦♦♦). These ratings are intended to translate the data into comparative ratings that inform consumer choice.

In fiscal year 2016 all acute-care hospitals were asked to complete a hand hygiene agreement. This agreement outlines RIDOH's expectations for the elements to be included in hospitals' hand hygiene programs and requires hospitals to submit information about citations received related to hand hygiene. This information is publicly reported and takes the place of the previously published hand hygiene process measures report. The *Sample Hand Hygiene Agreement* is posted on the HQRP web page at http://www.health.ri.gov/programs/detail.php?pgm_id=137.

Additional funding from the CDC through the Epidemiology and Laboratory Capacity (ELC) Ebola Supplemental Grant was available in fiscal year 2016. This grant helped to fund HAI reporting activities and additional infection prevention antimicrobial stewardship work.

Nursing Homes
Links to Medicare information about nursing home care outcomes and reports about resident and family satisfaction are available on HQRP's website (http://www.health.ri.gov/nursinghomes/about/quality/).

Due to budget constraints, HQRP ceased updating the care outcomes reports calculated using Medicare quality measures during fiscal year 2013. In place of the care outcomes report, HQRP's website includes a link to Medicare's *Nursing Home Compare*. HQRP no longer publishes the comparative reports intended to help consumers interpret the Medicare data and inform consumer choice, per the legislation.

Previously, the Medicare data were 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). This was intended to translate the Medicare data into comparative ratings that inform consumer choice.

HQRP continues to publish the *Nursing Home Summary Report*, combining data from multiple sources to create a single, consumer-centric comparative report. This report, which is updated monthly, is sent directly to hospital case managers to assist them in discharge planning. This report fills a need for current and applicable nursing home information in a printer-friendly and consumer-friendly format. This report includes primary data collected from all Rhode Island nursing homes about their capacity and capabilities.

Rhode Island's nursing homes collected and reported resident and family satisfaction data for the 10th year during fiscal year 2016. This was the nursing homes' eighth annual data collection using the survey vendor *My InnerView*;[3] nursing homes used vendor Vital Research[4] for the pilot and first public round of data collection. The nursing homes collected data in October and November 2015. 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). In fiscal year 2016, Rhode Island used the survey company's new survey instrument that focuses on patient-centered care. The survey also included three questions developed, and currently under review, by American Health Care Association (AHCA). These questions are referred to as COREQ questions.

HQRP did not issue any citations or warnings in fiscal year 2016. In previous years, state citations have been recommended for facilities that failed to survey one or both of the two groups, and warnings have been recommended for facilities that failed to meet a 50% benchmark for the number of surveys HQRP would expect the facility to distribute. The 50% benchmark is based on bed size, occupancy, long-term care population, and resident cognitive status and it averages 16-17% of a facility's total bed size.

[3] My InnerView, Inc. [Online]. Available: http://www.myinnerview.com/, 03 Apr 2013.
[4] Vital Research, Inc. [Online]. Available: http://www.vitalresearch.com/, 03 Apr 2013.

Licensed Independent Practitioners

In order to reduce survey burden on providers, the HIT survey was transitioned from an annual survey to a biennial survey, and it was decided that the HIT survey would be administered in odd years so it would not conflict with the physician licensure renewal process. This will also ensure that the HIT survey continues to align with the legislatively mandated healthcare inventory surveys[5]. This alignment supports interoffice coordination within RIDOH, provides the opportunity to combine data elements from the two surveys to create a more comprehensive data set, and reduces duplication of data collection across the two instruments. During even years, HQRP will perform additional analysis and stakeholder outreach related to the previous year's survey results.

The original structural measures were developed in partnership with Blue Cross & Blue Shield of Rhode Island, the Rhode Island Quality Institute, and UnitedHealthCare of New England during fiscal year 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.[6] In fiscal year 2015, the survey was updated to improve understanding of how providers use HIT to interact with patients. The questions are being used to create a new measure, level of electronic health record (EHR) use for patient engagement. HQRP has also combined the items used to determine basic EHR functionality use and advanced EHR functionality use into a single level of EHR functionality use. The measures that were reported for fiscal year 2015 were:

- Providers with EHRs;
- Level of EHR functionality use;
- Level of EHR use for patient engagement; and
- Providers who are e-prescribing.

The initial results from the fiscal year 2015 survey were made available in November 2015. HQRP reported structural measures[7] for individual providers at http://www.health.ri.gov/publications/bytopic.php?parm=Medical%20Records#Healthcare%20Providers.

During fiscal year 2016, HQRP performed additional analysis on the fiscal year 2015 survey data. HQRP staff met with the Physician Workgroup to identify priorities for additional analysis, dissemination of results, and stakeholder engagement. Additional analysis focused on HIT use by psychiatrists as compared to non-psychiatrists; a crosswalk of Rhode Island's data with other national and state-based data; and expansion of previous analysis to stratify by particular physician or practice characteristics. HQRP expanded its initial analysis of e-prescribing, meaningful use attestation, population health management, patient engagement, and physicians without EHRs. These reports were further stratified by whether a physician provides primary care services; whether a physician provides care at a Federally Qualified Health Center

[5] For the FISCAL YEAR2015 survey, the program worked with the office of Primary Care and Rural Health and the Division of Policy, Information and Communications to combine the physician survey with the department's annual Primary Care Survey and with a new legislatively mandated healthcare inventory survey. This included working with the office of Primary Care and Rural Health to develop a cohesive communication strategy and shifting the survey period's timing for Primary Care Physicians to ensure that the data was collected in time for the office of Primary Care and Rural Health's federal reporting deadlines.

[6] 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; Tufts Health Plan, to assess physician HIT incentives; and UnitedHealthCare of New England, to merge with practice-level data and determine practice HIT incentive payments.

[7] 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 EHRs and e-prescribing) and not linked to specific clinical outcomes, the measures are classified as structural measures.

(FQHC); whether a physician provides care at a small practice (less than nine clinicians) or a large practice (10 or more clinicians); and physician age (younger than 45, 45-59, or older than 59). These additional and expanded analyses will help the state and other organizations that are developing training or technical assistance programs related to HIT use better target and design those programs. The additional and expanded analyses are available online at http://health.ri.gov/publications/annualreports/HealthInformationTechnologyExpandedPhysicanSummary.pdf

AHRQ Public Reporting Grant

During fiscal year 2013, Healthcentric Advisors, HQRP's public reporting contractor, was awarded an AHRQ grant for public reporting. Information about *Building the Science of Public Reporting* grant program is available at http://www.ahrq.gov/legacy/qual/value/sciencepubreport.htm.

The grant includes three phases:

1. Collect qualitative feedback about the type of information that home health patients/families and hospital case managers would find helpful when choosing a home health agency.
2. Create a new, consumer-centric home health report.
3. Randomize hospitalized patients to receive the new or old report and assess the impact of the new report on their home health agency choices and post-discharge outcomes.

RIDOH is a grant partner and HQRP will be able to leverage results to improve its website and reporting. The grant will fund development of a web-based tool for the consumer-centric report, providing infrastructure that HQRP can incorporate into the existing website and expand to other settings.

The first two phases of the grant are complete. The third phase of the grant was scheduled to conclude in the beginning of fiscal year 2016; however, due to unforeseen challenges in meeting recruitment targets, Phase III has been extended. The grant is now scheduled to conclude in the beginning of fiscal year 2017.

Antimicrobial Stewardship and Environmental Cleaning Taskforce (AMSEC)

In response to high rates of HAIs in Rhode Island, specifically clostridium-difficile infection (CDI), RIDOH established AMSEC. AMSEC works with HQRP. The HQRP and AMSEC jointly developed and administered two antimicrobial stewardship surveys during fiscal year 2015, one to hospitals and a second to nursing homes. HQRP intended to use CDC's ELC Ebola Supplemental funding to administer the survey annually and to expand the survey to home health agencies; however, the CDC developed and required the use of an Infection Control and Response (ICAR) assessment tool as part of the ELC Ebola Supplemental funding. It was determined that ICAR would be used instead of the previously administered antimicrobial stewardship survey. All acute-care hospitals and long-term care facilities were asked to complete the ICAR as a self-assessment. In fiscal year 2016, HQRP performed onsite assessments using the ICAR tool at three acute-care hospitals. There are plans to perform onsite assessments at 15 skilled nursing facilities in fiscal year 2017. All data collected through these tools are blinded and reported in aggregate only. The data will be used to determine future state priorities to and to direct future state activities.

The ICAR instruments for acute-care hospitals and long-term care are available on line at https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

Expanded Funding for Healthcare-Associated Infections and Antimicrobial Stewardship

HQRP activities in fiscal year 2016 included those funded by the CDS's fiscal year 2015 ELC grant. The funding supported activities managed by the Program from August 1, 2015-July 31, 2016.

A key aspect of HQRP is to work with RIDOH and other partners to secure additional funding to support either the activities of HQRP, the objectives of HQRP, or related objectives within RIDOH. HQRP staff worked with RIDOH's Center for Acute Infectious Diseases Epidemiology (CAIDE) to re-apply for CDC's ELC grant funding. Applications for two of the available sections of this grant were submitted by HQRP to CAIDE in May 2016 for inclusion in RIDOH's application. As part of these applications, HQRP applied to CDC for a significantly higher funding amount with the goal of increasing state activities in support of HAI prevention and expansion of AMS. The funding period for this grant is August 1, 2016 to July 31, 2017. Activities funded under this grant will be administered by HQRP between RIDOH's fiscal year 2017 and fiscal year 2018 and will be more fully addressed in future annual reports.

Fiscal Year 2017 Program Goals

In fiscal year 2017, HQRP anticipates the following activities:

Setting/Task	Description	Frequency
General Contract Support	▪ Provide analytic and methodological support and leadership	▪ Ongoing
	▪ Develop and maintain stakeholder relationships and consensus	▪ Ongoing
	▪ Conduct research	
	○ Environmental scans	▪ As needed
	○ Measure development and validation efforts	▪ Ongoing
	○ Relevant clinical literature and best practices	▪ Ongoing
	▪ Perform contract oversight (fiscal and managerial)	▪ Ongoing
	▪ Write HQRP documents:	
	○ Annual report	▪ September 2017
	○ Press releases	▪ As needed
	▪ Maintain committee member contact lists	▪ As needed
	▪ Post information on state's Open Meetings site	
	○ Committee agendas	▪ Two says prior
	○ Committee minutes	▪ Five days post
	▪ Attend Center for Health Data and Analysis meetings	▪ Monthly
	▪ Present HQRP information to internal/external audiences	▪ As requested
	▪ Perform other tasks (media interviews)	▪ As requested
Home Health	▪ Convene the Home Health subcommittee	▪ As needed
	▪ Chair the Subcommittee	▪ Ongoing
	▪ Generate reports and technical files	
	○ Quarterly clinical quality measures*	▪ Jan/Apr/Jul/Oct
	▪ Update and maintain web-based reporting tool**	
	○ Perform primary data collection	▪ July 2016
	○ Update quality and satisfaction measures (automated)	▪ Quarterly
	▪ Communicate regularly with stakeholders	▪ As needed
	▪ Respond to home health agency and trade association inquiries:	
	○ General questions	▪ As needed
	○ Technical assistance (survey completion, data interpretation)	▪ As needed
	○ Programmatic questions (legislative mandate, requirements)	▪ As needed

Setting/Task	Description	Frequency
Hospital	▪ Convene the Hospital Subcommittee ▪ Convene HAI Subcommittee ▪ Collect data (HAI process measures submitted by hospitals) ▪ Generate reports and technical files ○ Summary Report ○ Hand Hygiene Report ○ MRSA CLABSI White Paper ▪ Communicate regularly with stakeholders ▪ Respond to hospital and trade association inquiries ○ General questions ○ Technical assistance (survey completion, data interpretation) ▪ Programmatic questions (legislative mandate, requirements)	▪ As needed ▪ Feb/Apr/Jun/Aug/ Oct/Dec ▪ As needed ▪ Quarterly ▪ March 2017 ▪ Quarterly ▪ As needed ▪ As needed ▪ As needed ▪ As needed
Nursing Home	▪ Convene the Nursing Home Subcommittee ▪ Satisfaction survey process ○ Follow-up on vendor contracts ○ Assist RIDOH with follow-up on provider non-compliance ▪ Generate reports and technical files ○ Annual satisfaction data ○ Summary report ▪ Communicate regularly with stakeholders ▪ Respond to nursing home and trade association inquiries ○ General questions ○ Technical assistance (data interpretation) ○ Programmatic questions (legislative mandate, requirements) ▪ Serve as liaison with satisfaction vendor	▪ Feb/Apr/Jun/Aug/ Oct/Dec ▪ Aug-Oct ▪ As needed ▪ December 2016 ▪ Monthly ▪ As needed ▪ As needed ▪ As needed ▪ As needed ▪ Ongoing

Setting/Task	Description	Frequency
Physician, APRN, and PA	▪ Convene the Physician Workgroup ▪ Re-administer the HIT survey ▪ Perform survey analysis ○ Validate reporting measures ○ Create public report ○ Create public-use data file ○ Generate ad hoc data analysis for stakeholder partners ▪ Meet with key collaborators ○ Blue Cross & Blue Shield of Rhode Island ○ UnitedHealthCare of New England ○ Rhode Island Quality Institute ○ Tufts Health Plan ▪ Communicate regularly with stakeholders ▪ Respond to physician inquiries ○ General questions ○ Technical assistance (survey completion, data interpretation)	▪ As needed ▪ 2017 ▪ As needed ▪ TBD ▪ TBD ▪ As requested ▪ Ongoing ▪ Ongoing ▪ Ongoing ▪ Ongoing ▪ As needed ▪ As needed ▪ As needed
Steering Committee	▪ Coordinate the Committee's meetings, presentations ▪ Communicate regularly with stakeholders ▪ Respond to Committee members' inquiries ○ General questions ○ Technical assistance (e.g., data interpretation) ○ Programmatic questions (e.g., legislative mandate, requirements)	▪ Jan/Mar/May/Jul/ Sep/Nov ▪ As needed ▪ As needed ▪ As needed ▪ As needed
Website	▪ Post data reports ▪ Update website content ▪ Collaborate with RIDOH on overall website redesign	▪ As needed ▪ As needed ▪ As needed

**These reports are being transitioned to the home health web-based reporting tool. The data are still publicly available through* Home Health Compare.

***Tasks related to the Home Health web-based reporting tool are currently funded by the AHRQ grant. They will be funded by HQRP once the tool is made publically available (anticipated fiscal year 2017).*

NOTE: As with previous years, Program leadership will work with the Steering Committee and the Director of RIDOH 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.

Project Management

Figure 1 (page 3) presents HQRP's organizational structure, including program management, Steering Committee, and the subcommittees. Further details, including financial information are below.

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[8]; 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."*[9]

Organization	Representative
1. Office of the State Long Term Care Ombudsman	Judith Shaw, RN
2. Blue Cross & Blue Shield of Rhode Island	Elizabeth James, RN
3. The Claflin Company	Ted Almon
4. Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	Louis Pugliese
5. Director of Health's designee	David Ashley, MD
6. Division of Elderly Affairs	Paula Parker, LCSW
7. LeadingAge-RI	James Nyberg
8. Rhode Island House of Representatives	Rep. David Bennett
9. Rhode Island Health Care Association	Virginia Burke, Esq.
10. Rhode Island Medical Society	Bradley Collins, MD
11. Rhode Island Partnership for Home Care	Nicholas Oliver, MPA, CAE
12. Rhode Island State Nurses Association	Donna Policastro, NP, RCN
13. Hospital Association of Rhode Island	Jean Marie Rocha, RN, MPH
14. UnitedHealth Care of New England	Neal Galinko, MD, MS, FACP
15. United Nurses & Allied Professionals	Linda McDonald, RN

There are currently four vacant seats:

- A representative from the Rhode Island Health Center Association
- A representative from the State Senate
- A representative from RIDOH
- A representative from the Department of Human Services.

HQRP is working to fill these seats. All Steering Committee members are asked to designate an alternate so that the Steering Committee meetings maintain the representation outlined in HQRP's legislative mandate and have a quorum for any votes.

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8 Now called the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

9 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.

Project Staffing
HQRP is part of RIDOH's Center for Health Data and Analysis and is run by a contract with Healthcentric Advisors. Project leadership includes:

- Samara Viner-Brown, MS; Chief, RIDOH Center for Health Data and Analysis; samara.vinerbrown@health.ri.gov
- Emily Cooper, MPH; Program Coordinator, Healthcentric Advisors; ecooper@healthcentricadvisors.org
- Teresa M. Mota, BSN, RN; Program Administrator, Healthcentric Advisors; tmota@healthcentricadvisors.org

Public Information
The public reports referenced above, are posted on HQRP's website (http://www.health.ri.gov/programs/healthcarequalityreporting/).

All Steering Committee and Subcommittee meetings are open to the public, and all meeting agendas and minutes are posted on the Rhode Island Secretary of State's open meetings website (www.sec.state.ri.us/pubinfo/openmeetings).

Summary

This Report describes the HQRP's activities for the time period of July 1, 2015-June 30, 2016. During fiscal year 2016, HQRP received approximately 44% of historical state funding, prompting program staff to continue its hiatus on updating the home health, hospital, and nursing home clinical measure reports calculated using Medicare quality measures and to maintain its priority of collecting primary data. Primary data collection included recurring reports for hospital HAIs, nursing homes, home health agencies, and physicians and the expansion of employee influenza vaccination reporting from hospitals to home health agencies and nursing homes. As part of the CDC's ICAR program, HQRP collected self-reported information about current infection prevention practices from acute-care hospitals and long-term care facilities using the ICAR assessment tool. HQRP also performed onsite assessments at three acute-care hospitals using the ICAR tool and continued to publish two summary reports, *Nursing Home Summary Report* and *Hospital Summary Report*.