General

Q. One of our hospitals just recently came on board with Epic. Many of the PfP variables that are part of the HTPP will not be available to pull baseline data on for timeframes prior to June 2014. How will that affect their performance? Will another baseline period be allowed for the variables that are only available from June forward?

The document Baseline Year Data Submission Guidance, found on the OHA HTPP website, here http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx, outlines what data are required for baseline year data submission. A brief summary is also included below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Option</th>
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<tr>
<td>FUH Readmissions</td>
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<td>HCAHPS – explain meds</td>
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<td>SBIRT Hypoglycemia with insulin</td>
<td>See tiered options below</td>
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<td>Anticoagulation with Warfarin</td>
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Use the following logic to determine the appropriate baseline data to submit for year one reporting:

1. Full year of data adhering to HTPP measure specifications if available. This should be reported directly into the OAHHS reporting platform.
2. If data covering the entire baseline year and which adhere to HTPP measure specifications are not available, but the hospital has partial year data for baseline period (i.e., because didn’t begin tracking until mid-year, etc.):
   a. If partial year data for the baseline period are in EHR or easily extractable via chart review or another method:
      i. The hospital must submit all data available for the baseline year from the point it began tracking with adherence to HTPP specifications (though must be a minimum of 30 consecutive days). This must not be a sample – all records

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must be reported. This should be reported directly into the OAHHS reporting platform.

ii. If fewer than 30 consecutive days of data are available the hospital will need to submit data from the performance year as below.

b. If partial year data for the baseline period are not in the EHR or otherwise easily extractable via chart review or another method:

i. Randomized sampling is allowed at the 90% confidence level with a 5% margin of error. The required sample sizes will be provided in the document. The population size and reason behind difficulty extracting data must be recorded when reporting the data. The sample used must be a random sample covering the entire period during which the hospital was tracking the measure with adherence to HTPP measure specifications. **Note sampling is only allowed if extracting all tracked data places undue hardship on the hospital.**

3. If the hospital does not have a minimum of 30 consecutive days of data from the baseline period which adhere to the HTPP measure specifications, data from the first quarter part of the performance year (October 1, 2014 – January 15, 2015) will be used to calculate a baseline. In such cases the hospital will receive credit for submitting data from Year 1 so long as at least 30 consecutive days of data from the first quarter part of the performance year are entered into the OAHHS reporting platform by **January 23, 2015 December 31, 2014.** This will allow OAHHS time to review and calculate the rate prior to submission to OHA on February 28, 2015.

a. Note that this option is only available if the hospital does not have at least 30 consecutive data from the baseline year (Year 1) which adhere to HTPP measure specifications.

b. The OAHHS reporting platform will include a place in which hospitals can indicate that they must use data from quarter 1 of the performance year for their baseline data submission. OAHHS will then calculate the rates as appropriate.

c. Hospitals which must utilize this option must indicate why data are not available for the baseline year (Year 1) in the space provided in the OAHHS reporting platform.

**Q. For the ADE and SBIRT measures, if sampling is allowed, do you have the sample size methodology available?**

Yes, the sample size methodology is in the document called Baseline Year Data Submission Guidance, found on the OHA HTPP website, here [http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx).

**Q. Will there be a report writing/specification manual developed for this program?**

Measure specifications and other documents regarding the HTPP are available at: [http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx). OAHHS/Apprise is developing a web-based reporting platform for data submission and review.

**Q. What is the minimum submission requirement to receive the floor payment? Are hospitals still required to submit data on one measure per domain to receive the floor payment?**

The floor payment is no longer going to be calculated by domain. To receive the floor payment, a hospital must achieve 75% of the measures for areas in which it operates. For example, if a hospital does
not have an emergency department (ED), neither the measure related to drug and alcohol abuse in the ED (SBIRT) nor the measure related to sharing of ED visit information with primary care providers will be included in the calculation of whether it achieved 75% of the measures for the floor payment eligibility calculation. However, all hospitals are eligible for payment for achieving the individual follow-up after hospitalization for the mental illness measure. For example, a hospital without an acute psychiatric ward would still be eligible for payment for achieving the follow-up after hospitalization for mental illness measure. In such instances, OHA will use an attribution methodology in which Coordinated Care Organization (CCO) performance will be attributed to the hospital (the measure specification sheet has details on the attribution methodology and can be found here: http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx). This is to foster hospital-CCO collaboration.

Q. What is the methodology regarding maintaining performance if a hospital's current performance is at the 90th percentile?

If the measure's benchmark is also the 90th percentile, then the hospital has met the benchmark. The hospital will need to keep the measure at or above the benchmark to receive performance funds. If the benchmark is at the 95th percentile, for example, then the MN method would be applied to determine a performance improvement target.

Q. Can you give a brief overview of the Minnesota method?

The Minnesota Department of Health’s Quality Incentive Payment System (“Minnesota method” or “basic formula”) is used to calculate improvement targets, similar to that used in the Oregon CCO incentive program. This method requires at least a 10 percent reduction in the gap between the baseline and the benchmark to qualify for incentive payments.

Stated as a formula,

\[
\text{State Benchmark} - \text{Hospital Baseline} = x \\
\frac{x}{10} = \text{Hospital Baseline} + [x] = \text{Improvement Target}
\]

Please refer to Hospital Improvement Target Brief on the OHA HTPP website (http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx) for further details.

Q. For the MN method in determining improvement, can you explain the 1%, 2%, and 3% floor?

In some cases, depending on the difference between the state benchmark and the hospital baseline, the Minnesota method calculation may result in very small improvement targets. OHA has established a “floor” or a minimum level of required improvement before a hospital would meet the improvement target and be awarded the quality pool funds associated with that measure. The floor ranges from one to three percentage points, depending on the measure. OHA has created a document that explains the improvement targets and includes concrete examples (see Hospital Improvement Target Brief here: http://www.oregon.gov/oha/HospitalData/Hospital%20Improvement%20Target%20Brief.pdf).

Updated 3 December 2014. New additions in red type.
Q. For the metrics that are being supplied by Apprise (Readmissions) and the OHA calculation for Follow-up after Hospitalization, will the baseline and ongoing measurement during the performance period be regularly communicated to hospitals?

Yes. Apprise will download the data for the readmissions baseline period, and regularly calculate and post to the reporting platform. This will allow all hospitals to see all of their data for the measures and also allow for hospitals to express any concerns right away.

OHA will also work with hospitals on the follow-up after hospitalization for mental illness measure. This will involve working with hospitals to validate the hospital discharge data that OHA will pull. OHA will also provide hospitals with quarterly progress reports on this measure. Details on this process are included in the timeline here: http://www.oregon.gov/oha/HospitalData/Timeline%20-Detailed%20Table.pdf.

Q. Where can I find the results of the HTPP survey re: baseline data?

The survey results are on the OAHHS website: (requires login) http://www.oahhs.org/hospital-transformation-performance-program

Q. Can you provide information on how soon we will be able to report quality data for the baseline year?

The reporting platform is a web-enabled tool that will allow hospitals to submit data for both the baseline year as well as the performance year. It is scheduled to be available for data submission approximately mid-November 2014 on the OAHHS website.

Q. When the reporting/data collection platform (site) has gone live, what is the expectation for reporting? Is it monthly, quarterly, etc.?

OHA is required to provide quarterly progress reports to the Centers for Medicare & Medicaid Services (CMS). Therefore, the OAHHS reporting platform is set up for monthly data reporting (though hospitals can enter data at any time). Therefore, we would like hospitals to enter as much data in the platform as possible each month. However, the data in the quarterly reports to CMS will be considered preliminary. Also, note that the incentive calculations are based on the entire 12 months of data.

Q. We're anxious to report data before Dec 31 to ensure ability to book the receivable by then for accounting purposes.

The first payments will not be made until April 2015, so you will not have an exact amount of payment before then. OHA will send hospitals notification of finalized rates and payment amounts for the baseline year by April 17, 2015. Any decision that a hospital makes about when to book and the amount is entirely up to the hospital.

Q. This program seems duplicative with the CMS Value Based Purchasing program. What do you hope to gain with this program that is not already being achieved with VBP?

The Value Based Purchasing program is a Medicare specific program, involving penalties and incentives for hospitals. Hospital Transformation Performance Program (HTPP) is a voluntary incentive program

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with no penalties and is aimed at helping DRG hospitals work with CCOs to achieve health care transformation.

**Q. Will the Benchmark specifications address the impact of poorer performance in the Performance Period from the Benchmark Period due to measurement variation? I am concerned that we will not be comparing like-like measures.**

To ensure comparison of like measures, we are using the same measure specification for both the baseline year and the performance year.

**Q. What about acute units on the hospital premises that are exempt or excluded from the DRG payment system? We exclude the units’ data in our inpatient hospital reporting. These units have a separate tax ID/CCN numbers. We bill for their services under a special Medicare number, not our normal Medicare number. For example, is Geriatric Psych Unit, included in the denominators? It seems the Geriatric Psych Unit affects the following measures: Readmissions; Medication Safety – ADE’s; Patient Experience; and Healthcare Associated Infections.**

If such units are included as part of net revenues reported and taxed under the provider tax system, they should be included in HTPP wherever possible and appropriate given individual measure specifications.

**Q. How do I access a copy of the kickoff webinar slides?**

A copy of the slides is available at both OHA and the OAHHS websites (see [http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx)).

**Q. Please explain sampling vs. full data review for each of the measures.**

There may be some measures that hospitals are not tracking for the baseline period. Therefore, you may need to sample the patient population instead of doing a full year of retrospective review of data to see how your hospital is performing. The guidelines for sampling will be posted on the OHA website in early November, 2014.

**Q. Some orientation might be helpful with regard to the measures.**

Two webinars providing more details on the measures have already been held: There was one on SBIRT on Tuesday, Oct. 21 and one introducing all of the measures was held on Tuesday, Oct 28. All webinars are recorded and posted on both the OHA and OAHHS websites.

**Q. Are you anticipating putting more definitive definitions on the website today (7 October 2014), or are the ones out on the website final?**

We consider the measure specifications on the OHA website as definitive. Any updates/clarifications to the specifications are highlighted and noted in the measure specification sheets on the OHA website. All changes are tracked so they can be easily identified.

**Q. Can we be certain that the measures and the specifications in this webcast (7 October 2014) are the final CMS approved allowing us to complete our plans for compliance?**

Updated 3 December 2014. New additions in red type.
Yes, these are the final measures. If we need to add clarifications, we will add them to the measure specifications and dates of changes to the specifications will be included on the document for version control. The benchmarks listed are subject to a review and may be adjusted if the baseline data show that an adjustment is warranted. Also, the benchmarks for measures that are aligned with CCO measures, like the follow-up to mental health hospitalization and SBIRT, could change if the CCO benchmarks change. This review and adjustment of benchmarks is a requirement of CMS for the program. However, CMS has signed and approved the measures so this is part of the official CMS waiver for Oregon.

Q. Does the calculation of days and discharges include fee for service Medicaid and managed Medicaid or both? Also what about out of state Medicaid?

The calculation includes both fee-for-service and managed care. It also includes newborns. It excludes all non-Oregon hospitals.

**Readmissions**

Q. Will the readmissions measure be an aggregate of the individual readmission rates for each condition or will this need to be reported on a per condition basis?

Readmissions will be an aggregate rate using the same methodology of Oregon’s Partnership for Patients program.

Q. Do the readmissions include psych diagnosis in the metric?

Yes, the hospital-wide all cause readmission include all diagnoses, including psych diagnoses.

Q. If a hospital has a separate psych unit with a separate CMS Certification Number (CCN), are readmissions on those patients tracked? Or are readmissions only being tracked for acute inpatients (IPs)?

No, we are not tracking readmission in separate CCNs, only readmissions in acute IPs. The measure is based off of the mandatory inpatient discharge data – anything reported there is included in this measure.

**Medication Safety**

Q. What does 'tracked during the month' mean? If a patient is admitted one month but discharged another month, in what month is the patient counted?

Patients should be counted in the month in which they are discharged. But do remember that OHA will aggregate these data across the entire year (the monthly counts are only so hospitals, OHA, and OAHHS can monitor progress on an ongoing basis).

Q. For the anticoagulation measure you indicated the tracked month is based on the earliest dose of
warfarin. Does similar logic apply to the Narcan and Hypoglycemia measures? That is, put patient in the month of the earliest event.

The patient should be counted once per admission (in which Warfarin, Insulin, or Opioid is administered). However, if the patient is again admitted (even in the same month) the count begins again. The denominator for these measures is a distinct count of admissions per patient in which one of these drugs is administered (i.e., a patient is counted once per admission). The numerator is also a distinct count per admission per patient (after a patient receives one of these medications): For each measure, a patient is counted in the numerator once if he or she is given that drug at any point in that admission and subsequently exceeds the threshold (>6 for Warfarin; plasma glucose concentration of 50 mg per dl or less for insulin; and administration of narcan for opioids).

For example, say a patient is admitted from June 1-20 and receives Warfarin three times, and during this admission has an INR > 6 two times after the Warfarin was administered. For the month of June she would be counted once in the denominator (because she received Warfarin during this admission), and only once in the numerator (because the elevated INR is only counted once per admission).

Say she is again admitted from August 28 – September 5 and receives Warfarin once, but her INR never exceeds the threshold. In this case, she is again counted in the denominator for September (since she received Warfarin during this admission and was discharged in September), but is not counted in the numerator (as her INR stayed at a safe level).

However, over the course of the measurement year this patient would be counted twice in the denominator (as she received Warfarin in two separate admissions), and only once in the numerator (as in only one admission did her INR exceed the threshold). The aggregated counts over the measurement year are used in assessing whether the hospital achieves the benchmark or improvement target (and receives the incentive payment).

Q. Will Hypoglycemia in inpatients receiving insulin exclude all oral agents and ED patients who are hypoglycemic present on admission/arrival?

Yes, this measure excludes both oral agents and ED patients.

Q. For Hypoglycemia in inpatients receiving insulin, will all hospitals use the same insulin prep product list?

No, all hospitals will not use the same insulin prep product list.

Q. What is the interval between the administration of insulin and hypoglycemia?

The episode of hypoglycemia in inpatients receiving insulin should be within the expected duration of the insulin given. For example, if a patient receives a dose of rapid acting insulin, you may expect to see a hypoglycemia event within 3-5 hours. If a patient receives intermediate-acting insulin, you may see a hypoglycemia event within the 18-24 hour duration of the medication. There is no hard and fast rule on when hypoglycemia events may occur after a dose of insulin; be sure to examine what else is going on with the patient, including nutrition, stress, and activity.

Updated 3 December 2014. New additions in red type.
Q. For excessive anticoagulation in inpatients administered Warfarin, what is the threshold cutoff and why was this chosen?

The threshold is set at 6, which was decided in Oregon’s Partnership for Patients Program.

Q. For the excessive anticoagulation in inpatients administered Warfarin, please clarify that the INR is greater than 6, not greater/equal to 6, so only count INRs 6.1 or greater? Also, do we only count INRs via lab./ phlebotomy, or do we have to capture point of care? INRs?

That is correct. We only count INRs greater than 6.0. Any INR greater than 6.0 at any point of care would be included.

Q. For the Warfarin measure, does each elevated INR get counted as 1 patient or 1 episode?

The denominator for this measure is a distinct count of admissions per patient in which Warfarin is administered (i.e., a patient is counted once per admission in which Warfarin is administered). The numerator is also a distinct count per admission per patient (after a patient receives Warfarin): A patient is counted in the numerator once if he or she receives Warfarin at any point in that admission and subsequently his/her INR is greater than 6.

For example, say a patient is admitted from June 1-20 and receives Warfarin three times, and during this admission has an INR > 6 two times after the Warfarin was administered. For the month of June she would be counted once in the denominator (because she received Warfarin during this admission), and only once in the numerator (because the elevated INR is only counted once per admission).

Say she is again admitted from August 28 – September 5 and receives Warfarin once, but her INR never exceeds the threshold. In this case, she is again counted in the denominator for September (since she received Warfarin during this admission and was discharged in September), but is not counted in the numerator (as her INR stayed at a safe level).

However, over the course of the measurement year this patient would be counted twice in the denominator (as she received Warfarin in two separate admissions), and only once in the numerator (as in only one admission did her INR exceed the threshold). The aggregated counts over the measurement year are used in assessing whether the hospital achieves the benchmark or improvement target (and receives the incentive payment).

Q. Will/could the OR and WA criteria for reporting be identical? e.g. blood glucose, INR, etc. as well as inclusion and exclusion criteria?

No, the HTPP program measures are based on what CMS has approved. The medication safety measures are modeled after the Oregon Partnership for Patients program, and therefore, may vary somewhat from models from other networks.

Q. For excessive anticoagulation in inpatients administered Warfarin, will ED be included?

ED is excluded for this measure. We are only asking for inpatients. See the measure specification sheet on OHA’s website for detailed information.

Updated 3 December 2014. New additions in red type.
Q. What are the exclusions for the measure adverse drug events due to opioids?

ED patients are excluded from this measure as well as those patients who receive naloxone for treatment of nausea and pruritus. Detailed measure specifications are available here: http://www.oregon.gov/oha/HospitalData/Adverse%20Drug%20Events%20due%20to%20Opioids.pdf.

Q. Do your exclusions for ED patients mean to exclude the time admitted patients spend in the ED prior to Admission? For example, patient receives opioids and Narcan while in ED, but that visit subsequently turns into an inpatient admission.

The 'clock', does not start until the hospital administers an opioid and the patient is an inpatient admission. However, this measure excludes opioids administered to patients while they are in the ED. The ‘clock’ doesn’t start until the patient is admitted. If a person is given an opioid in the ED and is then admitted, that opioid administration is not counted in the denominator. If they are again given an opioid once admitted, however, they should be counted – because the hospital administered an opioid once they were admitted.

Q. Does adverse drug events due to opioids include all routes (i.e. PO, IV, PCA)?

Yes. It includes all routes.

HCAHPS

Q. Can you explain why the benchmark is set at the 90th percentile in the nation?

We looked at the number of hospitals that met the benchmark. If we go below the 90th percentile, many hospitals already met the benchmark, and CMS was unwilling to approve the measure. Even at the 90th percentile, two Oregon hospitals already met the benchmark. However, for this measure, there is an improvement target. Hospitals are eligible for payment if they meet either the benchmark or the improvement target.

CLABSI

Q. If the only consistent tracked unit is ICU across hospitals, will this be sufficient to qualify for the measure?

No, for the performance year, hospitals will need to expand CLABSI data reporting beyond ICUs in order to qualify for incentive funding. According to the measure specifications, tracked units are defined as adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards. This expansion from ICU to all tracked units is the same measure that the Oregon Health Authority will require from Oregon hospitals for the Healthcare Acquired Infections reporting program beginning in January 2015.
Q. NHSN changes for 2015 for CLABSI do not require units mapped as other than med/surgical, such as orthopedic ward, telemetry ward, step-down unit. For HTPP, will these units need to be included in surveillance?

All these are considered as med/surgical or combined so that is how they would be referenced in the surveillance.

Q. Will there be information regarding the method for submitting the baseline period CLABSI and CAUTI data to the Apprise system?

In terms of baseline period reporting, OHA has released a document, Baseline Year Data Submission Guidance, outlining the sequence of tiered options that is acceptable for data reporting for Year 1. It has methods for submitting the baseline period for all measures, including CLABSI and CAUTI and can be found on the OHA HTPP website, here: http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx.

CAUTI

Q. If the only consistent tracked unit is ICU across hospitals; will this be sufficient to qualify for the measure?

No, for the performance year, hospitals will need to expand CLABSI and CAUTI data reporting beyond ICUs in order to qualify for incentive funding. This expansion from ICU to all tracked units is the same as what the Oregon Health Authority will require from Oregon hospitals under the Healthcare Acquired Infections reporting program starting in January 2015.

Q. NHSN does not allow the option of following UTIs in the NICU units.

Hospitals are not required to report UTIs for NICUs for the HTPP program. Hospitals are required to report all tracked units as defined or accepted by NHSN. NICU CAUTIs are accepted in NHSN; however, the NICU CAUTI data are not used in calculating hospital CAUTI reports.

Q. To qualify for baseline submission, would we have to retrospectively review house-wide CLABSI/CAUTI for submission in February 2015?

In the inventory, we noted that a number of hospitals do not have data, or may have incomplete data for the baseline year. In those cases, there are a variety of ways hospitals will need to address data submission for these measures. OHA will have guidance posted in early November 2015 that will address data sampling.

Sharing of ED visit information

Q. Is the EDIE measure a self-reported attestation?

Updated 3 December 2014. New additions in red type.
No, this is not self-reported attestation. The denominator will come from EDIE (patients with at least 5 visits in the last 12 months). For the numerator (outreach to primary care providers), please see response to question below.

**Q. Our EDs are enabled to share information with other EDs, but what if the primary care provider is not set up to accept this information? Will that be considered a failure on the part of the health system?**

All communication pushes to primary care providers will be captured in EDIE (via the direct link to some primary care providers, or via the tick box that hospitals can use should they contact primary care via some other method – email, phone, fax, EHR, etc.). Hospitals may indeed contact hospitals outside EDIE (and should be able to document this should OHA request it), but then need to note that the contact occurred.

**Q. With the EDIE measure, what happens if the patient does not have a primary care physician?**

We have learned that it is not technically possible to exclude those without a primary care physician in the baseline year. Since the measure specifications for the baseline (year 1) and performance year (year 2) must be consistent, patients without a primary care physician **will** be included in the denominator for this measure. However, OHA will take this issue into account when setting the benchmark.

**Q. For the EDIE measure, is there a time frame when the notification to the primary care provider has to occur?**

The notification to the primary care provider must occur within 72 hours of the visit to the Emergency Department.

**Follow up after hospitalization for mental illness**

**Q. This does not measure the hospitals' efforts to get the appointments made within 7 days and educate the patient on follow up. This only measures whether the patient decided to go to the appointment.**

Correct. This measure only counts the actual follow up visits that occur. The expectation is that hospitals and CCOs will coordinate to ensure appointments are arranged and patients receive follow-up visits.

**Q. What about patients who refuse all follow up?**

The measure does not have a mechanism to exclude patients who refuse follow-up. Refusals cannot be tracked through administrative (claims/encounter) data.

**Q. What about patients transferred to CATC, and other places? Who is responsible to arrange the follow up?**

There are a variety of exclusions for patients who are directly transferred or readmitted to other facilities because the readmission or transfer may prevent the follow up visit from taking place. The
exclusion depends on whether the transfer or readmission is to an acute or non-acute facility and whether the patient has a mental health principal diagnosis. Residential substance abuse facilities are considered non-acute care, so if the patient has a principal mental diagnosis, they would be excluded. See the measure specification sheet for the full details on these exclusions.

Q. What about patients readmitted here or elsewhere before appointments so they don’t keep their scheduled follow up appointment?

See above. Discharges followed by readmission or direct transfer to an acute or non-acute facility for mental health principal diagnoses are excluded. Discharges in which a patient is transferred directly or readmitted within 30 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis is also excluded.

Q. We have patients and adults who are hospitalized at our facility that does not provide Inpatient mental health treatment and we are not able to transfer them due to beds not being available within the state. Will there be stratification between treatment in a non-mental health facility VS those that do provide MH services?

We are not stratifying those in non-mental health facilities versus those that do provide mental health services. All hospitals, even those without any mental health discharges, are eligible for this measure. But what performance is attributed to them depends. If there are no discharges from a hospital that is part of a system, the hospital-system rate will be attributed to that individual hospital. OHA is taking a tiered approach to attribution: (1) Use individual hospital rate; (2) Use system rate if individual hospital rate is unavailable and hospital is part of a system; and, (3) Use statewide CCO rate if neither individual nor system rates are available. Additional details on the tiered approach to attribution are available in the measure specification sheet.

Q. As follow up to questions re MH patients in a non-MH facility. These are Outpatient observation patients. Do you only track inpatients?

Only inpatients are included in this measure.

SBIRT

Q. Are Behavioral Health Reports being submitted differently to OAHHS than the other domains?

Follow-up after hospitalization for mental illness will be calculated by OHA using already submitted claims data. OHA will work directly with hospitals to validate these data, and will provide quarterly progress reports to hospitals during the performance year of the program (year 2). However, the SBIRT measure will be submitted by hospitals. Hospitals will need to track screening and brief intervention in the ED in order to report this to OAHHS. OAHHS will then report this to OHA on behalf of hospitals.

Q. Which patients that present in the ED would need to receive the SBIRT screening, all or those with certain conditions? Is this for Medicaid only?

With a few exclusions (e.g., those with emergent issues), all patients age 12+ in the ED would need to receive SBIRT screening, regardless of payer. See the measure specification sheet for details.

Updated 3 December 2014. New additions in red type.
Q. Is this for every patient age 12 or older seen in the ED whether admitted to Observation or Inpatient for either Medical or Behavioral Health, or does this pertain only to an ED visit in which the patient is discharged from the ED? If it pertains only to the patients seen in the ED and not admitted, are there exclusions such as Transfer to another facility; Leaving AMA; Refusal of the screening; Expiring in ED?

This measure pertains to everyone age 12+ seen in the ED (with some exclusions that are outlined in the measure specification sheet, which can be found on OHA’s HTPP website, here: http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx). Those who are seen in the ED and who are subsequently admitted (i.e., not discharged from the ED) are included in the measure (the hospital should screen these patients, and if appropriate, provide a brief screen).

Q. The process our ED currently employs for screening alcohol and drug misuse is to ask patients if they have any problems with drugs or alcohol and then mark yes or no on their Clinical Service Record. If the patient says yes, our staff provides them with a list of community resources. We do not currently screen adolescents. What we currently do – is that sufficient to report for year 1 data submission? If not, are we allowed to submit data for year 2 once we’ve adapted our ED processes to include everything required by this measure?

The screening tools used must be from the approved OHA list (a link to the list of approved tools is included in the measure specifications). However, since the measure specifications were not available during the baseline year of the program (year 1), hospitals may not have been tracking SBIRT in the ED, or using approved tools, etc. In such instances hospitals will be able to submit data from the first quarter of the performance year (year 2). These data will serve two purposes: (a) in such instances this will count as the hospital’s year 1 submission, meaning the hospital will be eligible for payment for the baseline year (year 1); (b) it will be used to set that hospital’s improvement target for year 2.

Details on baseline year data submission options were will be posted on the OHA website in early November. There are many options to allow hospitals to successfully submit data that will count as the baseline submission for the program. If, however, a hospital does not choose to submit data that count towards year 1, it can still submit data to count towards year 2 only. However, in such instances OHA will not be able to calculate an improvement target for the hospital. This means the hospital must hit the benchmark in order to receive payment for year 2 (normally a hospital would receive payment for achieving either the improvement target or the benchmark).

Q. Regarding SBIRT - is this all ED patients (discharged and admitted)? Does it matter when the screen is done (triage, prior to discharge/admit)? What documentation is required for the brief intervention?

Please refer to measure specification, and as well as the slides and recording of the SBIRT-specific webinar (held on Tuesday, October 21, 2014).

Q. The data specification for alcohol & drug misuse screening, the Joint Commission specification is about inpatients. This measure is just for the ER? Is the intent that everyone uses the same screening tool? Where can I find these tools?

That is correct. This measure, unlike the Joint Commission, is just in the Emergency Department. Our focus with this measure is to give homage to the importance of screenings that occur in the Emergency Department.
Q. If they are screened at a primary care clinic, do they have to be screened again at the ED?

Yes. Patients in the ED may have been screened for SBIRT in their primary care clinic. This would count for CCOs’ SBIRT incentive metric. However, for HTPP, the screening must occur in the ED (the screening in the primary care clinic does not count towards the hospital measure). Therefore, the patient may have more than one screening.

Q. How often do we do this screening in the ED?

Anyone seen in the ED aged 12+ should be screened at least once per year (year as defined by the program, October – September). If a patient is in the ED in January and is screened, but appears in the ED again in February, the patient does not need to be screened a second time in order for the hospital to receive credit for the measure (though OHA would encourage a second screening as good clinical practice).

Q. For the SBIRT measure, do we have to do the brief screen on everyone and then do the full screen if they answer positive to the brief screen?

Any screening counts in the numerator (i.e., if you use the brief screen and the person screens positive, you do not have to do a longer screen in order to count it in the numerator – the brief screen can be counted). However, we would encourage best practice, which would be a longer screen (and brief intervention) for those who initially screen positive.

In addition, the measure requires that hospitals report the rate at which they provide brief interventions for those who screen positive from any tool. Though there isn’t a benchmark that must be met on this measure, hospitals are required to report the rate in order to be eligible for a payment.

Q. Can any of you reaffirm that the 12% benchmark for SBIRT in the ED is referring to the percent of patients who actually screened positive on the brief screen? Or, is the 12% referring to the percent of patients who were screened, regardless of whether or not they screened positive?

The second sentence above is true. The 12% benchmark refers to the proportion of patients who were screened – regardless of whether or not they screened positive. However, any patient who screens positive should be offered a brief intervention. Hospitals must report both rates (1. proportion of patients who are screened, and 2. Of those who screened positive, the proportion who were offered a brief intervention). However, only the former (proportion screened) is subject to the 12% benchmark (the brief intervention rate must be reported, but there is no benchmark that must be met).

Q. Are Behavioral Health Reports being submitted differently to OAHHS than the other domains?

Follow-up after hospitalization for mental illness will be calculated by OHA using claims data (these data have already been submitted; hospitals do not need to resubmit data for this measure). OHA will work directly with hospitals to validate these data, and will provide quarterly progress reports to hospitals during the performance year of the program (year 2).

Updated 3 December 2014. New additions in red type.
However, the SBIRT measure will be collected and submitted by hospitals. Hospitals will need to track screening and brief intervention in the ED in order to report this to OAHHS on its reporting platform. OAHHS will then report this to OHA on behalf of hospitals.

Version Control

Additional questions and answers were added to this document on 3 December 2015, and the timeline for the baseline reporting options was clarified.