Hospital Transformation Performance Program (HTPP)

Measure Specifications Webinar

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Welcome Remarks

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Today’s webinar is devoted to going through each measure, including the specifications and benchmarks.

Note detailed measure specifications and a table summarizing the measure specifications and benchmarks are available here: [http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx)
Overview

The purpose of this measure is to address health care-associated infections.

A catheter is a tube inserted into a patient’s bladder through the urethra and left in place to collect urine. If not inserted correctly, kept clean, or left in place too long, germs can enter the body and cause serious infection (“catheter-associated urinary tract infection” or CAUTI).

This measure is modified from NQF 0754 and includes all tracked units.
CAUTI in all tracked units

Equation

\[
\text{Catheter-associated urinary tract infections} \div \text{Total number of urinary catheter days for all patients that have an indwelling urinary catheter in all tracked units} \times 1000
\]

Numerator and denominators should include all patients in tracked units with an indwelling urinary catheter.
CAUTI in all tracked units

Benchmark
Benchmark will be determined after review of baseline data since this measure is being expanded to include all units of a hospital (nationally, it is limited to intensive care units).

Improvement from Baseline Target:
Minnesota method with TBD floor
CAUTI in all tracked units

Reporting mechanism:

• Hospitals report these data to the CDC/National Healthcare Safety Network (CDC/NHSN)
• Hospitals confer rights to OAHHS to access NHSN data
• OAHHS will gather these data and report to OHA
Overview

The purpose of this measure is to address health care-associated infections.

A central line is a tube inserted into a large vein of a patient’s neck or chest to provide medical treatment. If not inserted correctly, kept clean, or left in place too long, germs can enter the body and cause serious infection (“central line-associated bloodstream infection” or CLABSI).

This measure is modified from NQF 0139
CLABSI in all tracked units

Equation

\[
\frac{\text{Total number of observed CLABSI in all tracked units}}{\text{Total number of central line days in all tracked units}} \times 1000
\]

Exclusions:
1. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are excluded as central lines
2. Peripheral intravenous lines are excluded from this measure
CLABSI in all tracked units

Benchmark
Benchmark will be determined after review of baseline data since this measure is being expanded to include all units of a hospital (nationally, it is limited to intensive care units).

Improvement from Baseline Target:
Minnesota method with TBD floor
CLABSI in all tracked units

Reporting mechanism:

- Hospitals report these data to the CDC/National Healthcare Safety Network (CDC/NHSN)
- Hospitals confer rights to OAHHS to access NHSN data
- OAHHS will gather these data and report to OHA
HCAHPS: Staff gave patient discharge information

Overview

The goal of this measure is to improve the quality of internal customer service.

The measure is based on a survey that asks patients whether hospital staff had discussed the help they would need at home, and whether they were given written information about symptoms or health problems to watch for during their recovery.

The specifications are unmodified NQF 0166
HCAHPS: Staff gave patient discharge information

Equation

Based on questions 19 and 20 of the HCAHPS questionnaire:

**Question 19:** During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

**Question 20:** During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

\[ \frac{\text{Number of patients who responded “yes” to both questions}}{\text{Number of patients with valid responses to both questions}} = \]
HCAHPS: Staff gave patient discharge information

Benchmark
90% (National 90th percentile, April 2014)

Improvement from Baseline Target:
Minnesota method with 2 percentage point floor
HCAHPS: Staff gave patient discharge information

Reporting mechanism:

• Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, self-administered by hospitals (sometimes through a vendor)

• OAHHS will collect responses from the hospitals and report to OHA.
HCAHPS: Staff always explained medicines

Overview

The goal of this measure is to improve the quality of internal customer service.

The measure is based on a survey that asks patients who were given a medicine that they had not taken before how often staff explained the medicine.

The specifications are unmodified NQF 0166
HCAHPS: Staff always explained medicines

Equation

Based on questions 16 and 17 of the HCAHPS questionnaire:

**Question 16:** Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

**Question 17:** Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

\[
\frac{\text{Number of patients who responded “always” to both questions}}{\text{Number of patients with valid responses to both questions}} = \text{HCAHPS: Staff always explained medicines}
\]
HCAHPS: Staff always explained medicines

Benchmark
72% (National 90th percentile, April 2014)

Improvement from Baseline Target:
Minnesota method with 2 percentage point floor
HCAHPS: Staff always explained medicines

Reporting mechanism:

• Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, self-administered by hospitals (sometimes through a vendor)

• OAHHS will collect responses from the hospitals and report to OHA.
Adverse Drug Events due to Opioids

Overview

The purpose of this measure is to increase medication safety.

Naloxone is an antidote for opiate overdose. For this reason, this measure uses naloxone administration to identify patients who have experienced an adverse drug event due to an opioid.

This is an Institute for Safe Medication Practices measure. Additional information on surveillance of adverse drug events can be found here: http://www.health.gov/hai/ade.asp#final.
Adverse Drug Events due to Opioids

Equation

Number of patients treated with opioids who also received naloxone

= Number of patients who received an opioid agent during tracked month

Exclusions:
1. ED patients
2. Patients who received naloxone for nausea and/or pruritus.
Adverse Drug Events due to Opioids

Benchmark
5% or below

Improvement from Baseline Target:
Minnesota method with 1 percentage point floor
Adverse Drug Events due to Opioids

Reporting mechanism:

• Reported by hospitals to OAHHS as part of the PfP program
• Hospitals will track these data internally (through EHR, chart abstractions, or another manual process)
• OAHHS will collect these data from DRG hospitals via its online reporting tool and report to OHA
Hypoglycemia in inpatients receiving insulin

Overview

The purpose of this measure is to increase medication safety. This is a measure of hypoglycemia in inpatients receiving insulin.

American Society of Health System Pharmacists (ASHP) Safe Use of Insulin measure.

Additional information on surveillance of adverse drug events can be found here: [http://www.health.gov/hai/ade.asp#final](http://www.health.gov/hai/ade.asp#final).
Hypoglycemia in inpatients receiving insulin

Equation

Plasma glucose concentration of 50 mg per dl or less = Inpatients on insulin who experience hypoglycemia during the month

Therefore, one patient with multiple low blood sugars during the same hospitalization is only counted once
Hypoglycemia in inpatients receiving insulin

Benchmark
7% or below

Improvement from Baseline Target:
Minnesota method with 1 percentage point floor
Hypoglycemia in inpatients receiving insulin

Reporting mechanism:

• Hospitals will track these data internally (through EHR, chart abstractions, or another manual process)

• OAHHS will collect these data from DRG hospitals via its online reporting tool and report to OHA
Excessive anticoagulation with Warfarin

Overview

The purpose of this measure is to increase medication safety. This measure is the proportion of inpatients who had excessive anticoagulation with warfarin.

This is an Institute for Safe Medication Practices measure.

Additional information on surveillance of adverse drug events can be found here: [http://www.health.gov/hai/ade.asp#final](http://www.health.gov/hai/ade.asp#final).
Excessive anticoagulation with Warfarin

Equation

Hospitals are to report only those elevated INRs that occur after the first dose of warfarin given by the hospital.

A patient with multiple INRs above the threshold during an admission is counted only once.

\[ \text{Inpatients (admitted patients) experiencing excessive anticoagulation with warfarin during the tracked month} \]

\[ = \text{Inpatients (admitted patients) receiving warfarin anticoagulation therapy during the tracked month} \]

Excluding ED patients
Excessive anticoagulation with Warfarin

Benchmark
5% or below

Improvement from Baseline Target:
Minnesota method with 1 percentage point floor
Excessive anticoagulation with Warfarin

Reporting mechanism:

- Hospitals will track these data internally (through EHR, chart abstractions, or another manual process)
- OAHHS will collect these data from DRG hospitals via its online reporting tool and report to OHA
Hospital-Wide All-Cause Readmissions

Overview

A significant proportion of hospital readmissions are among those who were only recently discharged. This can be costly, and is often avoidable. This metric therefore measures all inpatients (of all ages) who were readmitted within 30 days for any reason.

This measure is part of Oregon’s Partnership for Patients initiative.
Hospital-Wide All-Cause Readmissions

Equation

\[
\text{Number of readmissions by patients of all ages} = \frac{\text{Inpatient admission to any acute care facility which occurs within 30 days of the discharge date}}{\text{Total inpatient discharges (for patients of all ages)}}
\]

**Numerator exclusions:**
1. Those not readmitted as an acute care inpatient.
2. Readmission of any patient more than 30 days since previous hospital admission.

**Denominator exclusion:**
- Patients who have been discharged or transferred to another short-term hospital
Hospital-Wide All-Cause Readmissions

**Benchmark**
State 90th percentile for all hospital types (not limited to DRG hospitals). Specific benchmark to be confirmed once baseline data for Year One are submitted.

**Improvement from Baseline Target:**
Minnesota method with 1 percentage point floor
Reporting mechanism:

Oregon hospitals are currently required to report inpatient discharges on a quarterly basis – to COMPDATA (now) and INFOH (starting Q4 2014)

OAHHS pulls data from COMPDATA/INFOH to determine both numerator and denominator and calculate rates.

OAHHS reviews with hospitals and then reports numerator, denominator, and rate for hospitals to OHA.
Emergency Department Information Exchange (EDIE)

Overview

The goal of this measure is to ensure appropriate care is delivered in the most appropriate, most cost-effective setting.

This measure encourages hospitals and primary care providers to improve coordination and make use of health information technology to reduce unnecessary emergency department (ED) visits among high utilizers.

This measure was developed by OHA in collaboration with OAHHS.
Emergency Department Information Exchange (EDIE)

Equation

The measure has two parts:

1. Rate of outreach notifications to primary care providers
2. Care guideline completion rate

Only Part 1, Rate of outreach, has a benchmark:

\[
\text{Rate of outreach} = \frac{\text{Number of outreach notifications sent to primary care providers within the period under review}}{\text{Number of patient with five or more visits to any ED Oregon in the last year who are seen by the facility in the month}}
\]

Number of outreach notifications sent to primary care providers within the period under review

Number of patient with five or more visits to any ED Oregon in the last year who are seen by the facility in the month
Equation (cont.)

Part 2, Care guideline completion rate:

\[
\frac{\text{Number of care guidelines completed by the facility within the month}}{\text{Number of patients without a care guideline with five or more visits to an ED in Oregon in the last year who are seen by the facility in the month}}
\]

- Note this is cumulative (the numerator and denominators will grow in each month). This allows hospitals to continue creating care guidelines over the course of the performance period.
- However, once a care guideline is created for a patient, any subsequent ED visits are not counted in the denominator.
Emergency Department Information Exchange (EDIE)

Benchmark (tied to outreach notifications)
Benchmark will be determined after review of baseline data and is tied to the outreach notification rate only.

Improvement from Baseline Target (tied to outreach notifications):
TBD.
Emergency Department Information Exchange (EDIE)

Reporting mechanism:

- Hospitals enter notifications to primary care and outreach notifications in EDIE
- OAHHS accesses the data via EDIE
- OAHHS then submits the data to OHA

NOTE: All notifications to primary care 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 add the info to the EDIE system.
SBIRT in the ED

Overview

Research shows that the ED can be an effective place to screen and refer patients for substance use services.

This measure will help inform the statewide quality improvement focus area of integrating behavioral and physical health.

This measure was developed by OHA in collaboration with OAHHS.
SBIRT in the ED

Equation

The measure has two parts:

1. Screening rate
2. Brief intervention rate

Only Part 1, Screening rate, has a benchmark:

\[ \text{Screening rate} = \frac{\text{Patients in the ED age 12+ screened for alcohol and other substance use using an age-appropriate, validated instrument}}{\text{All emergency department patients age 12+}} \]

NOTE: Patients with multiple visits to the ED in the measurement year need only be screened once for the hospital to receive credit.
SBIRT in the ED

Equation (cont.)

Part 2, Brief intervention rate:

\[
\frac{\text{ED patients age 12+ who received a brief intervention}}{\text{ED patients age 12+ who screen positive for unhealthy alcohol or drug use}}
\]
SBIRT in the ED

Benchmark
12%

- Screening rate only; brief intervention rate is a reporting requirement, but there is no benchmark which must be achieved.
- This benchmark is aligned with the benchmark for the CCO SBIRT measure.

Improvement from Baseline Target:
Minnesota method with 3 percentage point floor.
SBIRT in the ED

Reporting mechanism:

- Hospitals will track these data internally (through EHR, chart abstractions, or another manual process)
- OAHHS will collect these data from DRG hospitals via its online reporting tool and report to OHA
Follow-up after hospitalization for mental illness

Overview

This goal of this measure is to improve coordination between hospitals and Coordinated Care Organizations (CCOs) to facilitate appropriate follow-up care for those hospitalized with mental illness.

Follow-up after hospitalization for mental illness is associated with lower rates of re-hospitalization, and with greater likelihood that gains made during hospitalization are retained.

This measure is limited to Medicaid members enrolled in a CCO.
Follow-up after hospitalization for mental illness

Patients receiving follow-up within seven days of discharge for a mental illness

= 

Discharges from acute inpatient settings for members age 6+ who were hospitalized for treatment of selected mental health disorders.

OHA will validate denominator with hospitals.

Hospital systems will have the option to report individual hospital level during validation period.

Detailed timeline is available on the program webpage: http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx
Follow-up after hospitalization for mental illness

Benchmark
Alignment with CCO benchmark
• Will change with any amendments to CCO benchmark
• 2014 CCO benchmark is \textbf{68.8\%} (2013 National Medicaid 90th percentile)

Improvement from Baseline Target:
Minnesota method with 3 percentage point floor
(Alignment with CCO benchmark)
Follow-up after hospitalization for mental illness

Reporting mechanism:

- Unlike the other measures, this measure is calculated by OHA. OHA will calculate rates for this measure through encounters/claims, and will validate the denominator (discharges) with hospitals.
- OHA will pull discharges from administrative data and send denominator information to hospitals for validation.
  - Some hospitals which are part of a larger system are not listed individually in OHA’s data; instead, just the system is recorded. As part of the validation process, such hospitals will have the option to indicate which individual hospital owns the discharge during validation period.
- Hospitals respond to OHA with any requested changes to denominator
- OHA then calculates the rate and shares with hospitals on a quarterly basis
- This process will be completed on a quarterly basis so that hospitals can track progress on this measure. A detailed timeline for this progress reporting is available on the HTPP webpage: http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx
Questions?

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