

Oregon Hospital Transformation Performance Program: Year 3 Measures & Benchmarks

In Year 3 (October 1, 2015 – September 30, 2016), hospitals will receive payment for submitting data to OHA and achieving the benchmark or improvement target¹. Unless otherwise noted, all Year 3 improvement targets will be calculated using the Minnesota Method with a floor, and will compare Year 3 performance with Year 2 performance. Please note improvement target calculations *could* be higher than the percentage point floor listed below, depending on the gap between the hospital’s Year 2 performance and the Year 3 benchmark.

Measures	Measure Calculation		Benchmarks and Improvement Targets		
	Numerator	Denominator	Improvement Target ²	Year 2 Benchmark	Year 3 Benchmark
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the emergency department (ED)	Measure set broken out as follows: 1. Alcohol and Other Drug Use Screening in the ED – Patients in ED age 12+ screened for alcohol and other substance use using an age-appropriate, validated instrument. Hospitals can submit <i>either</i> patients receiving the brief screen or the full screen (separate benchmarks apply)	Measure set out down as follows: 1. Alcohol and Substance Use Screening in the ED – All ED patients age 12+.	1. (a) Brief Screen: MN method with a 3 percentage point floor 1. (b) Full Screen: MN method with a 3 percentage point floor	1.(a) Brief Screen: 57.0% (75th percentile HTPP Year 1 for brief screens) 1.(b) Full Screen: 12.0% (alignment with CCO full screen benchmark)	1. (a) Brief Screen: 83.5% (90th percentile HTPP Year 2 brief screens) 1. (b) Full Screen: 71.3% (90th percentile HTPP Year 2 full screens)

¹ Hospitals can earn quality pool payments for achieving the benchmark, or making considerable improvement toward the benchmark. To measure improvement, an individual improvement target has been calculated for each hospital, which requires at least a 10 percent reduction in the gap between baseline and the benchmark. This methodology was adopted from Minnesota Community Measurement and is referred to as the “MN method”. Additional details at <http://www.oregon.gov/oha/analytics/HospitalData/Hospital%20Improvement%20Target%20Brief%20%28updated%2030%20July%202015%29.p df>.

² For year 2, improvement targets were calculated from baseline year; in year 3, improvement targets are calculated based on year 2 performance unless otherwise noted.

Measures	Measure Calculation		Benchmarks and Improvement Targets		
	Numerator	Denominator	Improvement Target ²	Year 2 Benchmark	Year 3 Benchmark
	2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who received a brief intervention.	2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who screen positive for unhealthy alcohol or drug use on full screen.	2. N/A - reporting only (no target)	2. N/A – reporting only (no benchmark)	2. N/A – reporting only (no benchmark)
Follow-up after hospitalization for mental illness (modified NQF 0576)	Number of discharges for Medicaid members enrolled in a CCO at hospital of interest: <ul style="list-style-type: none"> • Age 6+ • Hospitalized for treatment of selected mental health disorders • With an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of discharges 	Number of discharges from acute inpatient settings (including acute care psychiatric facilities) at hospital of interest for Medicaid members enrolled in a CCO: <ul style="list-style-type: none"> • Age 6+ • Who were hospitalized for treatment of selected mental health disorders 	MN method with 3 percentage point floor	70.0% (National Medicaid 90th percentile, alignment with CCO benchmark)	TBD (90th percentile HTPP Year 2)
All-cause readmissions	Number of readmissions, defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date.	Number of all inpatient discharges (for patients of all ages)	MN method with a 3% floor	8.0% (state 90th percentile for DRG hospitals) <i>Lower is better</i>	8.4% (90th percentile HTPP Year 2) <i>Lower is better</i>
Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure)	Number of inpatients with hypoglycemia (blood glucose of 50mg per dl or less)	Number of inpatients receiving insulin during the tracked time period	MN method with 1 percentage point floor	7% or below <i>Lower is better</i>	5% or below <i>Lower is better</i>

Measures	Measure Calculation		Benchmarks and Improvement Targets		
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Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure)	Number of patients experiencing excessive anticoagulation (INR > 6)	Number of inpatients receiving warfarin anticoagulation therapy during tracked period	MN method with 1 percentage point floor	5% or below <i>Lower is better</i>	3% or below <i>Lower is better</i>
Adverse Drug Events due to opioids (Institute for Safe Medication Practices measure)	Number of patients treated with opioids who also received naloxone	Number of patients who received an opioid agent during tracked period	MN method with 1 percentage point floor	5% or below <i>Lower is better</i>	3% or below <i>Lower is better</i>
HCAHPS, Staff always explained medicines (NQF 0166)	Number of patients answering 'always' to Q16 and Q17, using CMS composite methodology: Q16: Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Q17: Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?	The equation used is per CMS guidelines, and is the (1) rate for each individual question comprising the composite, and then (2) the average of these rates	MN method with 2 percentage point floor	72.0% (National 90th percentile, April 2014)	73.0% (National 90th percentile, April 2015)

Measures	Measure Calculation		Benchmarks and Improvement Targets		
	Numerator	Denominator	Improvement Target ²	Year 2 Benchmark	Year 3 Benchmark
HCAHPS, Staff gave patient discharge information (NQF 0166) ³	Number of patients answering 'Y' to Q19 and Q20, using CMS composite methodology: Q19: 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? Q20: 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?	The equation used is per CMS guidelines, and is the (1) rate for each individual question comprising the composite, and then (2) the average of these rates	MN method with 2 percentage point floor <i>Shriners : MN method with 2 percentage point floor</i>	90.0% (National 90th percentile, April 2014) <i>Shriners: 92.7% (90th percentile, all PG Database Peer Group, 2/1/2014 – 7/31/2014)</i>	91.0% (National 90th percentile, April 2015) <i>Shriners: 92.6% (90th percentile, all PG Database Peer Group, 2/1/2015 – 1/31/2016)</i>
CLABSI in all tracked units (modified NQF 0139)	Total number of CLABSI in all tracked units as defined by Oregon Public Health Reporting	Total number of central line days in all tracked units as required by Oregon Public Health Reporting	MN method with 3% floor	0.18 per 1000 device days (2010 NHSN Data Summary Report 50th percentile from Partnership for Patients Scoring Criteria for CMS, 2014)	N/A –improvement target only ⁴

³ Shriners' Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriners' performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey, and a separate benchmark has therefore been established for Shriners. The Press Ganey survey does not have a question about staff explaining medications, so Shriners' is not eligible for the HCAHPS staff explaining medication measure.

⁴ Since there is no benchmark with which to calculate an improvement target using the Minnesota Method, hospitals that had a zero numerator for CLABSI or CAUTI in Year 2 qualify for payment in Year 3 based upon raw number of infections, rather than a rate. To qualify for Year 3 payment, hospitals with a zero numerator in Year 2 will qualify for payment in Year 3 so long as they have no more than one infection in the measurement period.

Measures	Measure Calculation		Benchmarks and Improvement Targets		
	Numerator	Denominator	Improvement Target ²	Year 2 Benchmark	Year 3 Benchmark
CAUTI in all tracked units (modified NQF 0754)	Total number of healthcare-associated CAUTIs in all tracked as defined by Oregon Public Health Reporting	Total number of catheter days for all patients that have an indwelling urinary catheter in all tracked units as required by Oregon Public Health Reporting	MN method with 3% floor	1.02 per 1000 catheter days (50th percentile from HTPP Year 1)	N/A – improvement target only ⁴
Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits (EDIE)	<p>1. Number of outreach notifications to primary care providers for patients with 5+ ED visits in past 12 months</p> <p>2. Number of care guidelines completed for patients with 5+ ED visits in past 12 months who did not previously have a care guideline</p>	<p>1. Number of patients with five+ ED visits in the past 12 months</p> <p>2. Number of patients without a care guideline with five+ ED visits in the past 12 months</p>	<p>1. MN method with 3 percentage point floor</p> <p>2. N/A – reporting only</p>	<p>1. 77.4% (75th percentile from HTPP Year 1)</p> <p>2. N/A – reporting only</p>	<p>1. 84.4% (90th percentile from HTPP Year 1)</p> <p>2. N/A – reporting only</p>