

Oregon Hospital Performance Metrics Advisory Committee

Meeting Minutes

June 26, 2015

1:00 pm – 4:00 pm

ITEM

Welcome and consent agenda

Committee members present: Manny Berman, Steve Gordon (Chair; phone), Doug Koekkoek, Jeff Luck, Janet O'Hollaren, Pam Steinke (phone), Ken House (phone)

Not attending: Maggie Bennington Davis

OHA staff: Lori Coyner, Sara Kleinschmit, Milena Malone, Pam Naylor

OAHHS staff: Barbara Wade, Elyssa Tran, Diane Waldo

Sara Kleinschmit welcomed members and guests. Chair Steve Gordon was absent the first hour of the meeting; Doug Koekkoek facilitated. The May 29 meeting minutes were approved.

Public Testimony

None was provided.

Finalize year 2 decisions

Follow-up after hospitalization for mental illness (local allocation)

At its May 29 meeting, the Committee recommended that hospitals that are not part of a system and have fewer than 10 mental health discharges should be allocated their local CCO rate, where "local" is defined as the CCO(s) in which the hospital is a participating member. Today, staff provided a list of these hospitals' contracting arrangements with CCOs. Several hospitals contract with more than one CCO; staff would like the Committee's recommendation on whether to 1) pool the rate for all contracted CCOs or 2) use the rate for the single CCO in the local geographic region only. The Committee noted that their recommendation to use the hospitals' local CCO was based upon the principle that this is where a hospital has the most direct control, and the policy would thus encourage coordination upon discharge. In consistency with this principle, the Committee recommended that hospitals that (a) have fewer than 10 discharges, (b) are not part of a system, and (c) that contract with more than one CCO will select the CCO with which they work most closely. The hospital will be allocated the chosen CCO's rate for the follow-up after hospitalization for mental illness measure.

Hospital-wide all-cause readmissions

At its May 29 meeting, the Committee decided it would like to change the improvement target floor for this measure, and requested staff provide additional information to inform its final recommendation. Information was provided today showing the number of readmissions that would need to be prevented if the Year 2 improvement target floor was set at: 1 percentage point [this is currently the measure specification]; 0.5 percentage point, and 3 percent floors. Discussion included:

- Any of these options would still be extremely challenging for high-acuity hospitals to meet; a Potentially Preventable Readmissions (PPR) measure or other risk adjusted measure would be preferable.

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- The Committee can discuss changing the measure to PPR beginning in Year 3 of the program; however, Year 2 should remain the same for consistency with baseline.
- The difficulties with the all-cause measure are compounded by the fact that it is worth a large proportion of the quality pool (18.75%) since it is the only measure within its domain.
 - Perhaps the allocation methodology can be changed in future years so that this measure does not carry such weight. There is a risk of rewarding hospitals substantially based on random variation rather than real improvement.

The Committee recommended **1) changing the Year 2 benchmark to the 90th percentile for DRG hospitals only (versus all hospitals) and 2) improvement target floor to 3 percent.** *Staff were also tasked with producing a table indicating improvement target values based on these specifications for the Committee to review.*

Year 3

CMS negotiations and potential program structure changes

Lori Coyner reminded the Committee that the Hospital Transformation Performance Program was initially established and approved as a two-year program by the state legislature and Centers for Medicare and Medicaid Services (CMS). During the current state session, the Legislature extended the program four additional years. OHA intends to negotiate Year 3 of the program with CMS as part of larger waiver amendments this summer, and to negotiate Years 4-6 as part of Oregon's next 1115 waiver demonstration (the current waiver expires in 2017). CMS has approved six Delivery System Reform Incentive Payment (DSRIP) programs as elements of other states' 1115 waivers. CMS will be looking toward these DSRIP programs—which are generally more extensive and stringent than Oregon's current HTPP—during our waiver negotiations. CMS will also want closer coordination with CCOs. OHA initially sought to limit changes to the program in Year 3. However, initial feedback from CMS on our Year 3 proposal means that OHA must propose a program structure that bridges the current program with CMS expectations. Staff ideas for potential changes in year 3 include instituting a challenge pool; changing benchmarks where appropriate; retiring measures that do not foster continuous improvement; and/or including additional hospital-CCO coordination measures. Today, staff is seeking Committee guidance on the overall program design moving forward. Discussion and ideas included:

- In addition to a core set of required measures, the Committee could create a "menu" of measures from which hospitals can choose. This would help solve the problem of certain hospitals being unable to actively participate in some measures due to hospital structure (e.g., follow-up after hospitalization for mental illness). Hospitals could also be required to meet a certain percentage of measures in order to receive 100% of their distribution.

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- The Committee was supportive of exploring a “menu” option.
- Staff will provide a program design proposal at the July 10 meeting.
- Hospitals could choose some measures *together with* their local CCO. This would foster hospital-CCO collaboration while also allowing for local control
- Transition of care meaningful use measure would be an excellent opportunity to promote synergy with CCOs. However, Committee members recalled receiving pushback from CMS on meaningful use earlier based on the idea of "double dipping."
 - *Staff will review meaningful use (clinical quality) measures and provide any appropriate options at the July 10 meeting.*
- Committee members were generally supportive of a challenge pool.
- The Committee prefers to keep the total number of measures low to ensure focused quality improvement efforts.

Benchmarking options

Healthcare-associated infections (CLABSI and CAUTI):

- Hospitals' primary strategy to reduce CLABSIs is to reduce the total number of central lines and days used. This will shrink the denominator, which could result in the rate *increasing*, even when the absolute number of infections decreases.
- The Committee recommends, as general policy, moving away from measures that include device days and would rather use measures that account for acuity and are risk-adjusted.
- CLABSI and CAUTI are areas where hospitals are already making enormous improvements. Sepsis and C Diff, however, are significant problems and might be better measures for this domain.
- Generally, measures ought to serve a large number of patients rather than a few.

Staff will:

1. *Provide numerators and denominators for CLABSI and CAUTI at the next meeting.*
2. *Identify the CDC direct target*
3. *Provide information on CDiff and Sepsis metrics, which could replace CLABSI and CAUTI in the future.*

Medication safety:

Staff recommended retiring all three measures in the medication safety domain (Hypoglycemia in inpatients receiving insulin, Excessive anticoagulation due to Warfarin, and Adverse drug events due to opioids) due to very high performance in the baseline year, and replacing them with different measures. Committee discussion included:

- These medications have high utilization and adverse events are catastrophic; these are high-impact measures.
 - On the other hand, adverse events are very rare.
- The goal for these measures is really zero.

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- Polypharmacy and falls are both significant problems, especially among elderly patients.
- Medication reconciliation (NQF 2456) could be a good measure in this domain. However, it is difficult to measure. Perhaps this measure could be phased in with pay-for-reporting initially.

At the July 10 meeting, staff will provide

1) Additional options for this domain from the HEDIS list; and

2) Additional information on Medication reconciliation specifications.

Patient experience domain (HCAHPS measures):

The Committee recommends no change in year 3.

Readmissions:

Staff recommended switching to a Potentially Preventable Readmissions measures in year 3. Committee members expressed uncertainty on their earlier benchmark and improvement target recommendation and reiterated their desire for a risk-adjusted measure.

Massachusetts uses a risk-adjusted measure based on Medicare methodology. Staff will provide additional information on the Massachusetts methodology at the July 10 meeting.

Follow-up after hospitalization for mental illness:

The Committee recommends no changes to this measure in year 3. This measure could go on a "menu" if that option is used.

Emergency department information exchange:

This measure was a big lift for hospitals to implement and staff does not recommend any changes. Baseline rates are currently being re-run. There was discussion of how this measure will fit with PreManage, which provides real-time hospital alerts for non-hospital users such as health plans and providers. PreManage allows users to upload care guideline information into EDIE, providing a bi-directional communication point between hospital and outpatient settings. Therefore, there is potential for redundancy in future years. Staff will 1) provide more information the PreManage Program and 2) provide progress report data at the July 10 meeting. The Committee will wait to make a recommendation.

SBIRT in the ED:

The Committee recommends no change for year 3. Due to the developmental nature of this measure and differing stages of implementation, baseline rates were varied. When available the Committee would like to see more months of data to inform future benchmarking.

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Potential additional measures and domains

Maternal and child health domain:

The Committee considered measures from the Joint Commission Perinatal Care Core Measure Set. Discussion included:

- Whether any new measures could be pay-for-reporting to begin with.
- This Committee had originally recommended Early Elective Delivery as an HTPP measure, but CMS did not approve.
- Hospitals are only required to report these measures if they have more than 1,100 births and three DRG hospitals do not provide OB services. These measures may thus be well-suited to a "menu" option.
- Q-Corp is piloting a program to gather these data in the Maternal Data Center.
- General approval of a maternal and child health domain.

Staff will provide additional information on 1) measure specifications, 2) Q-Corps Maternal Data Center and 3) baseline data (where available) at the July 10 meeting.

Oral health:

The Committee was generally wary of this domain due to lack of actionable intervention related to oral health. However, a number of emergency department visits are for oral health reasons, especially among patients in their twenties. Staff will share an article with more information on this topic. Committee members discussed a potential follow-up/notification measures (e.g. follow-up with CCO or primary care provider after dental ED visits). Staff will provide data on follow-up rates as soon as data are available.

PQI 92: Prevention Quality Chronic Composite

Discussion included:

- Concern that hospitals cannot impact this measure. However, it would encourage collaboration with primary care / CCOs. Interest in knowing variation across the state (staff will provide data at July 10 meeting).
- Could create a measure of "two or more admissions per year for ambulatory care issues." Multiple admissions would indicate that the hospital did not take adequate care and/or did not coordinate with primary care after the admission. This could also be a CCO measure. Staff will explore the feasibility of such a measure and report back.

Opioid

Committee was generally supportive of an opioid misuse measure, and suggested "percent of patients who are admitted with 120 MED of morphine and getting, e.g. a) pain consultation or b) pain care plan (etc.). There was also discussion of an opioid measure being developed by David Labby. Staff will explore feasibility of the 120 MED measure and consult with David Labby about presenting his proposal to the committee.

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Year 3 - update on payment weighting and floor amount

Elyssa Tran (Apprise Health Insights) informed the Committee that the Provider Tax Advisory Committee is scheduled to meet Tuesday June 30 and will look at the payment methodology for Year 3 at that time.

Amended bylaws

At the May 29 meeting, the Committee approved bylaws which 1) establish a Co-Chair / "Chair-elect" position which would serve as Co-Chair for the first 12 months and Chair in the second 12 month AND 2) allow the Chair to be re-elected indefinitely. However, these two clauses are incompatible with one another. **The Committee elected to remove language about the Co-Chair also being Chair-Elect.**

Next Steps and Wrap Up

Next meeting is scheduled Friday July 10, 2015 from 1-4 pm in Wilsonville. Staff will communicate with Committee members about whether this meeting should be held in Portland instead.