

Hospital Performance Metrics Advisory Committee

May 29, 2015

Consent Agenda

Public Testimony

Recap of May 1st Meeting Decisions

- No changes to benchmarks for medication safety domain measures
- No change to readmissions benchmark recommended, but requested additional information for discussion
- No changes to benchmarks for HCAHPS measures, but did recommend benchmark for Shriners Hospital for Children HCAHPS discharge metric; need improvement target floor recommendation
- Recommended benchmarks for CLABSI and CAUTI; need improvement target floor recommendations
- No change to follow-up after hospitalization for mental illness measure benchmark, but requested additional information and options for allocation methodology
- Requested additional information and benchmarking options for SBIRT measure
- Did not review EDIE-based measure due to time

Improvement Target Floors

HCAHPS, Discharge Information Benchmark Discussion – Shriner’s

Baseline: 55.2%

| | 50 th percentile | 75 th percentile | 90 th percentile |
|---------------------------------|-----------------------------|-----------------------------|-----------------------------|
| Small PG Database Peer Group | 90.4 | 91.9 | 93.0 |
| All PG Database Peer Group | 90.2 | 91.5 | 92.7 |
| Shriner’s Facilities Peer Group | 90.9 | 93.6 | 96.0 |

*Percentile source: Press Ganey Inpatient Pediatric Report for Shriner’s, 2/1/2014 – 7/31/2014

Recommendation for Improvement Target Floor:

- **Two (2) percentage point floor (consistent with floor for other hospitals)**

CAUTI Benchmark Discussion

| Option | Benchmark | Source |
|--------|-------------------------------|---|
| 1 | 0.48 (per 1000 catheter days) | 2010 NHSN Data Summary Report 50 th percentile (from <i>Partnership for Patients PEC: Hospital List Scoring Criteria and HEN-wide Performance Benchmarks</i> , CMS, April 2014) |
| 2 | 0.44 (per 1000 catheter days) | 75 th percentile from HTPP baseline |
| 3 | 1.13 (per 1000 catheter days) | 50 th percentile from HTPP baseline |

Recommendation for Improvement Target Floor:

- **Three (3) percent floor (percent, not percentage point)**

CLABSI Benchmark Discussion

| Option | Benchmark | Source |
|--------|------------------------------|---|
| 1 | 0.18 (per 1,000 device days) | 2010 NHSN Data Summary Report 50 th percentile (from <i>Partnership for Patients PEC: Hospital List Scoring Criteria and HEN-wide Performance Benchmarks</i> , CMS, April 2014) |
| 2 | (0.00 per 1000 device days) | 90 th / 75 th / 50 th percentiles from HTPP baseline |
| 3 | (0.66 per 1000 device days) | 25 th percentile from HTPP baseline |

Recommendation for Improvement Target Floor:

- **Three (3) percent floor (percent, not percentage point)**

Review Baseline Performance on Individual Measures (continued from May 1)

**Lori Coyner, OHA
Director of Health Analytics**

Sharing Emergency Department Visit Information Domain

Statewide EDIE Strategy

Susan Kirchoff and Sharon Meieran, MD, OHLC

- 55 hospitals (95%) are sending and receiving ED notifications
- ED physicians are very positive about the value of EDIE
- EDIE Committees have developed focused priorities to reduce ED utilization, particularly among high utilizers. Top priorities include:
 - Adoption of a standard care guideline template
 - Implementation of strategies to promote adoption of MU care guidelines
- Care guidelines and consistent PCP notification were key to Washington state's success in reducing unnecessary ED utilization
- A workgroup of stakeholders and experts will develop coordinated strategies and implementation plan for care guidelines
- The HTPP EDIE measure support continued focus on these efforts

Introduction to the Emergency Department Information (EDIE) Exchange System Measure

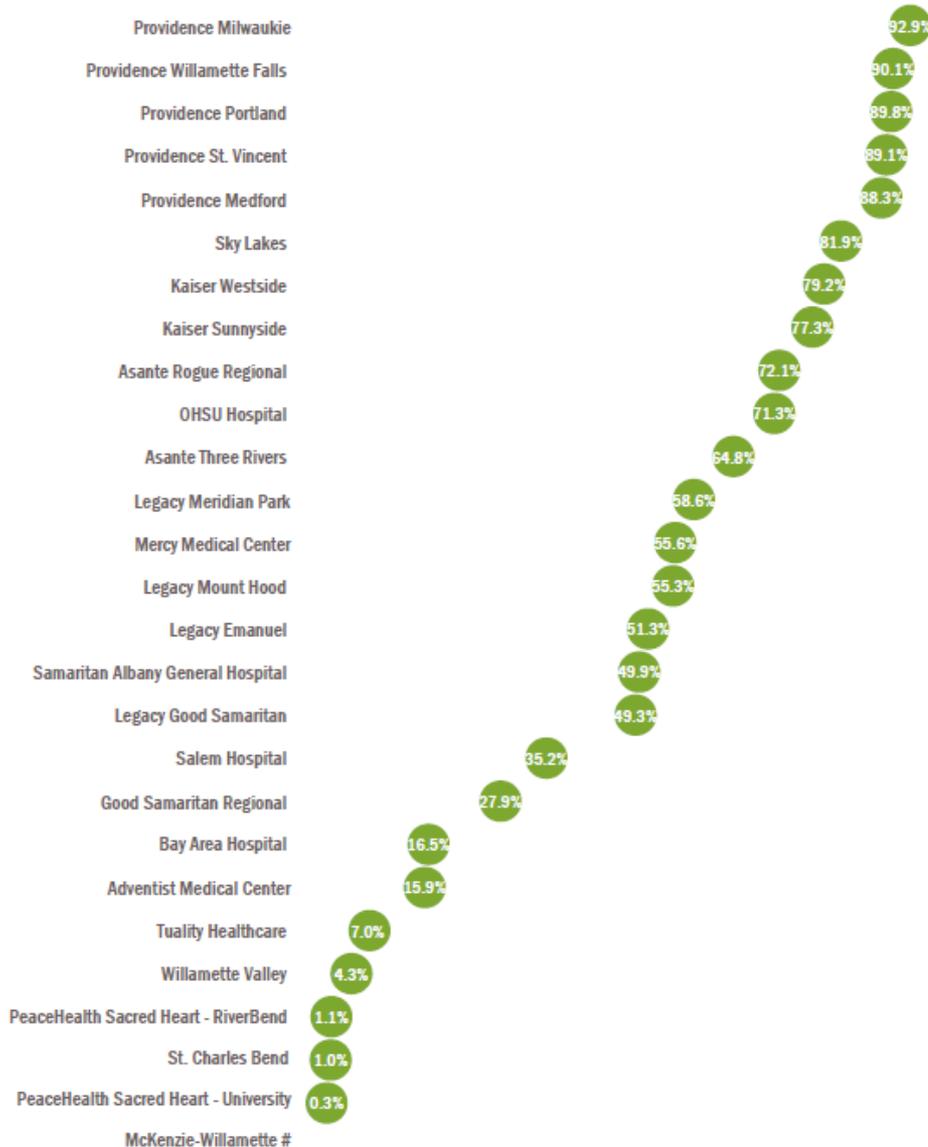
Two-part measure:

1. Outreach notifications to primary care providers for high utilizers
2. Care guideline completion rate
 - Care guideline rates are not tied to a benchmark in the second year of the program, and are not included in the baseline year report

The baseline data are developmental as this is a new measurement effort for hospitals

EDIE: Primary care provider notification

Percentage of times hospitals notified a patient's primary care provider when a frequent user of the emergency department was seen in the **baseline year***



Statewide rate: N/A

Performance range: 0.3% - 92.9%

Data source: Emergency Department Information Exchange

Benchmark: N/A

Benchmark source: N/A

* 13 Ingers Hospital for Children does not have an emergency department and cannot participate in this measure.
Did not submit data.

EDIE Benchmark Discussion

| Option | Benchmark |
|--------|--|
| 1 | Average of individual hospital rates: 51% |
| 2 | 25 th percentile from baseline: 19.4% |
| 3 | 50 th percentile from baseline: 55.5% |
| 4 | 75 th percentile from baseline: 78.7% |
| 5 | 90 th percentile from baseline: 89.5% |

Recommendation:

- 75th percentile from baseline – 78.7% (option 4)
- Improvement target using basic formula with a floor

Revisiting the Behavioral Health Domain

Follow-up after hospitalization for mental illness (allocation)

Percentage of patients hospitalized for mental illness who received follow-up care within seven days of discharge in the **baseline year**

Magenta dots indicates hospital received system rate.



Statewide rate: N/A

Performance range: 62.7% - 81.2%

Data source: Administrative (billing) claims

Benchmark: 70%

Benchmark source: 2013 national Medicaid 90th percentile (aligns with CCO incentive measure benchmark)

Received statewide CCO rate

Follow-up after hospitalization for mental illness (allocating local CCO)

Percentage of patients hospitalized for mental illness who received follow-up care within seven days of discharge in the **baseline year**
 Grey dots indicate local CCO rate.



Statewide rate: N/A
 Performance range: 62.7% - 81.2%
 Data source: Administrative (billing) claims
 Benchmark: 70%
 Benchmark source: 2013 national Medicaid 90th percentile (aligns with CCO incentive measure benchmark)

Follow-up after Hospitalization for Mental Illness Allocation Options

Recommendation:

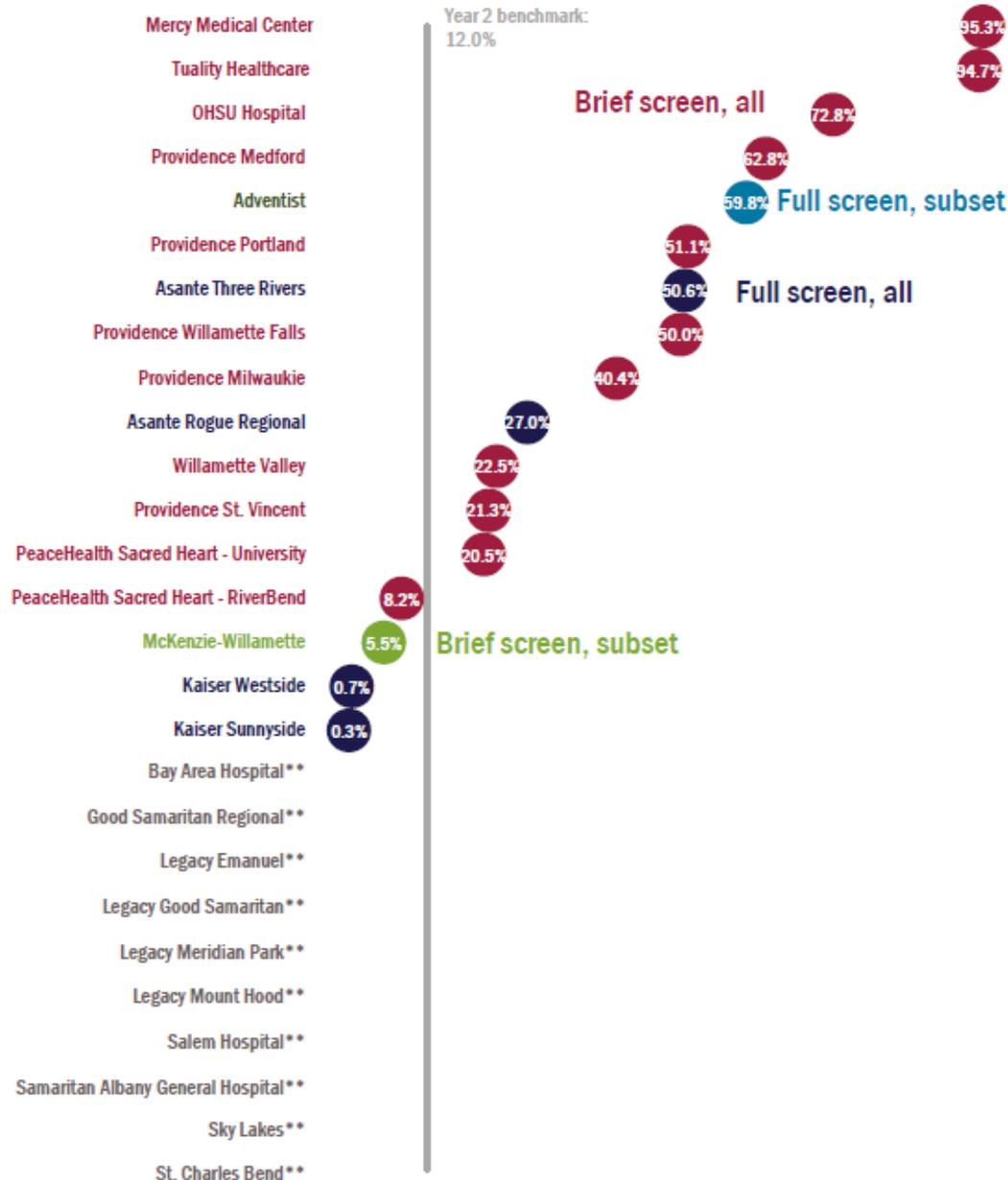
- Require a minimum of 10 discharges from the hospital in order to use the individual hospital rate. If < 10 discharges:

| Option | Description |
|------------------------|--|
| 1) Current method | Use system rate if in a system with more than one DRG hospital; if not in a system, use statewide CCO rate |
| 2) Limit participation | Only allow hospitals with 10+ discharges to participate in measure |
| 3) Local CCO rate | Use system rate if in a system with more than one DRG hospital; if not in a system, use local CCO rate (shown in previous slide) |
| 4) Basic floor for all | Give <i>all</i> hospitals a basic floor payment on this measure. Those with 10 discharges would then compete for the rest of the funds allocated for this measure by achieving their improvement target or benchmark |

Reminder: SBIRT Benchmark and Data Mismatch

- As this is a new process for hospitals, hospitals can receive numerator credit for the brief screen (unlike the CCOs; the numerator for the CCO screening rate is the full screen)
- Some hospitals had not yet implemented broader screening and instead reported data only for at-risk populations
- The 12% benchmark, aligned with that for the CCOs, is specifically tied to **full screens**
- The data show that some hospitals reported the brief screening rate, while others reported the full screening rate

SBIRT in the ED



Statewide rate: N/A

Performance range: 0.3% - 95.3%

Data source: Self-reported by hospitals: tracked internally through Electronic Health Records, chart abstractions, or other manual process

Benchmark: 12.0%

Benchmark source: 2015 SBIRT COO incentive measure benchmark

SBIRT Benchmark: Staff Recommendation

- Allow hospitals to report **either** the brief screening rate **or** full screening rate
- Establish separate benchmarks for the brief screening rate and the full screening rate
- Tie payment to achievement of **either** benchmark
- Those who targeted only special populations are expected to expand in the second year of the program and will be held to the benchmark for either the brief or full screening rate (whichever is reported)

SBIRT Brief Screen Benchmark Discussion

| Option | Benchmark | Source |
|--------|-----------|---|
| 1 | 94.7% | 90 th percentile from HTPP baseline (those reporting brief screen only); 2 of 11 already achieving |
| 2 | 67.8% | 75 th percentile from HTPP baseline (those reporting brief screen only); 3 of 11 already achieving |
| 3 | 50.0% | 50 th percentile from HTPP baseline (those reporting brief screen only); 5 of 11 already achieving |

Recommendation:

- 75th percentile from HTPP baseline - 67.8% (option 2)
- Improvement target using basic formula with a 3 percentage point floor

SBIRT Full Screen Benchmark Discussion

| Option | Benchmark | Source |
|--------|-----------|---|
| 1 | 12.0% | CCO SBIRT measure benchmark (currently included in HTPP measure specifications); 2 of 4 already achieving |
| 2 | 15.0% | CCO benchmark methodology applied to hospital data; 2 of 4 already achieving |

Recommendation:

- CCO SBIRT benchmark (12%)
- Improvement target using basic formula with a 3 percentage point floor

Revisiting the All-Cause Readmissions Measure

- The Committee was concerned that hospitals with higher needs patients and with particular units (neo-natal intensive care, rehabilitation, and psychiatric) may be at a disadvantage because of a greater likelihood of readmission
- In some hospitals, patients transferred from the psychiatric ward may be counted as a readmission
- The Committee asked for clarification on the improvement targets and the impact of the differing units on readmissions rates

All-cause Readmissions with Improvement Target

Results in the **baseline year** versus year 2 improvement target.



* **Bolded hospitals** have one or more of the following units:

- Psych
- Rehab
- NICU

Statewide rate: **10.9%**

Performance range: 4.9% - 17.5% (lower is better)

Data source: Oregon Association of Hospitals and Health Systems

Benchmark: **6.1%** (lower is better)

Benchmark source: State 90th percentile for all hospital types (not limited to DRG hospitals)

Readmissions

PPR RAW versus PPR ADJUSTED with rankings



← Lower is better

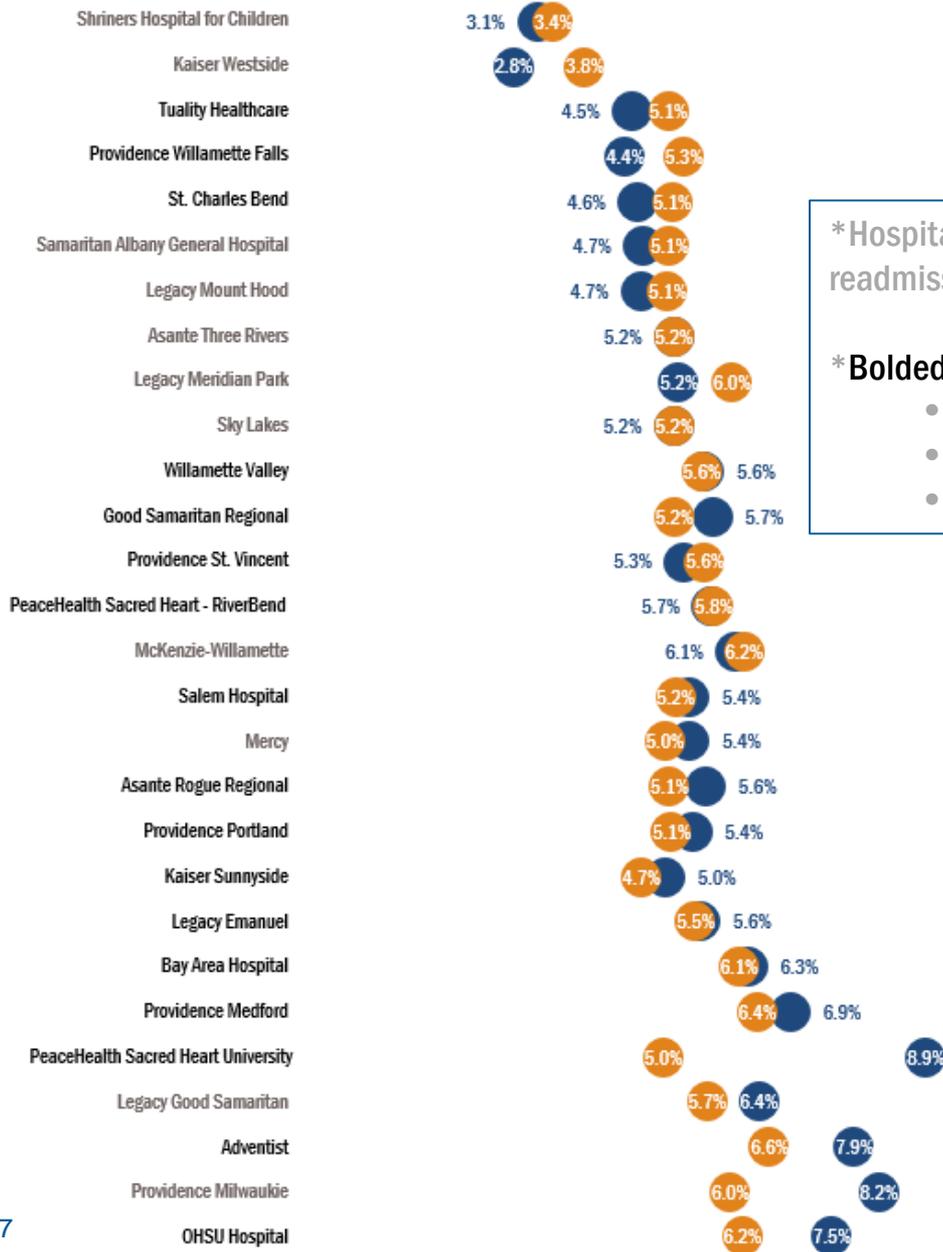
*Hospitals are ordered based on performance on the all-cause readmissions measure

***Bolded hospitals** have one or more of the following units:

- Psych
- Rehab
- NICU

Readmissions

PPR RAW versus PPR ADJUSTED with values



* Hospitals are ordered based on performance on the all-cause readmissions measure

* **Bolded hospitals** have one or more of the following units:

- Psych
- Rehab
- NICU

Readmissions Discussion

| Option | Description |
|--------|---|
| 1) | Continue with all-cause measure |
| 2) | Change to potentially preventable readmissions measure -would need to recalculate baseline |

Recommendation:

- Keep all-cause measure for Year 2 for stability with baseline year; consider changing to Potentially Preventable Readmissions measure in years 3+

Review Work Plan and Meeting Schedule

Key Dates

- **July 31, 2015:** Date by which OHA plans to formally submit amendment for Year 3 to CMS
- **October 1, 2015:** First day of Year 3 (if approved by CMS and continue with current schedule)
- **June 30, 2016:** Date on which the initial CMS approval of first two years of HTPP ends
- **June 2017:** End of current Oregon's current Medicaid waiver

Additional Support: Establishing a Technical Advisory Group (TAG)

- Purpose is to identify solutions and make recommendations to OHA and Committee in two broad areas:
 - Specifics around measurement (coding, technical specifications, address feedback from hospitals)
 - Data collection
- Helps ensure measures are consistent with and support hospital operations and processes

Bylaws Adoption and Vice-Chair Election

Year 3 of Program

Recapping Legislation and CMS Negotiations

- HB 2395 of 2015 Oregon Legislature extends HTPP four additional years, to September 30, 2019
- HB 2395 reduces the amount of the hospital assessment revenue available for HTPP from a full percentage point to 0.5 percent
- The Oregon legislature's extension of HTPP is beyond the current Medicaid 1115 waiver (which ends in June 2017)
- OHA will work with CMS on a one-year extension of HTPP through June 2017, and negotiate the additional years of HTPP as part of larger waiver negotiations
- OHA will seek to limit substantive changes to HTPP until Year 4
- OHA will request permission to change the measurement period from the federal fiscal year to calendar year, in alignment with the CCO incentive measure program

Year 3 Timeline and Measurement Period

- The timeline below shows the shift from federal fiscal year (current HTPP measurement period) to calendar year

| | CY 2014 | | | | CY 2015 | | | | CY 2016 | | | | CY 2017 | | | | CY 2018 | | | | CY 2019 | | | | CY 2020 | | | |
|-----------------------------|-----------------------|----|----------|----|--|----|----------|----|----------|----|----------|----|----------|----|------|----|---------|----|----|----|---------|----|----|----|---------|----|----|----|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| CURRENT WAIVER | | | DY 3 | | DY 4 | | DY 5 | | | | | | | | | | | | | | | | | | | | | |
| NEW WAIVER | | | | | | | | | | | | | DY 1 | | DY 2 | | DY 3 | | | | | | | | | | | |
| STATE FISCAL YEAR | | | SFY 2015 | | SFY 2016 | | SFY 2017 | | SFY 2018 | | SFY 2019 | | SFY 2020 | | | | | | | | | | | | | | | |
| FEDERAL FISCAL YEAR | FFY 2014 | | FFY 2015 | | FFY 2016 | | FFY 2017 | | FFY 2018 | | FFY 2019 | | FFY 2020 | | | | | | | | | | | | | | | |
| LEGISLATIVE APPROVAL | HTPP initial approval | | | | New HTPP approval (through Sep. 2019) | | | | | | | | | | | | | | | | | | | | | | | |
| CURRENT HTPP | YR 1 *began 10/13 | | YR 2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| PREFERRED HTPP, NEW | | | | | YR 3 : transitional 15 mth measurement** | | YR 4 | | YR 5 | | YR 6 | | | | | | | | | | | | | | | | | |

Potential Additional Measures: Current List

| Focus Area | Domains | Measures | Share of Available Funds |
|------------------------------------|-------------------------------------|--|--------------------------|
| Hospital focus | 1. Healthcare Associated Infections | 1. CLABSI in all tracked units (modified NQF 0139) | 9.38% |
| | | 2. CAUTI in all tracked units (modified NQF 0754) | 9.38% |
| | 2. Medication Safety | 3. Hypoglycemia in inpatients receiving insulin | 6.25% |
| | | 4. Excessive anticoagulation with Warfarin | 6.25% |
| | | 5. Adverse drug events due to opioids | 6.25% |
| | 3. Patient Experience | 6. HCAHPS, Staff always explained medicines (NQF 0166) | 9.38% |
| | | 7. HCAHPS, Staff gave patient discharge information (NQF 0166) | 9.38% |
| | 4. Readmissions | 8. Hospital-wide all-cause readmission | 18.75% |
| Hospital – CCO collaboration focus | 5. Behavioral Health | 9. Follow-up after hospitalization for mental illness (modified NQF 0576) | 6.25% |
| | | 10. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department | 6.25% |
| | 6. Sharing ED Visit Information | 11. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits | 12.50% |

Potential Additional Measures: Brainstorming Session

- The committee will need to recommend potential additional domains / measures for Year 3; those where hospitals and CCOs impact each other will likely be a CMS focus
- Per HB 2395, the metrics must be “consistent with state and national quality standards”
- Measures and domains previously mentioned:
 - Maternal health
 - Opioid-related deaths
 - Other areas the Committee would like staff to explore?

Additional Considerations - Floor Amount

- In Year 1 and 2, floor amount equals \$500,000 per year
- Based off of a quality pool capped at \$150 million per year (9.33% of quality pool)
- Hospitals are eligible for the floor payment by achieving 75% of the measure for which they are eligible

The Committee needs to recommend whether the floor amount for Year 3 should be adjusted as the hospital quality pool will be smaller

Additional Considerations - Payment Weights

- In Year 1 and 2 the amount of money individual hospitals receive for achieving a measure is based on hospital size, defined as the hospital's share of Medicaid discharges and patient days
- This was the recommendation of a work group convened by OAHHS

The Committee will need to decide if this should continue in Year 3 and beyond

Next steps and wrap-up

- Next meeting scheduled for June 26, 2015 from 1pm – 4pm at the Wilsonville Training Center