

**OREGON HOSPITAL
TRANSFORMATION
PERFORMANCE PROGRAM (HTPP)
Year 2 Performance Report**

Measurement period:
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Executive summary

As the Oregon Health Authority continues to prioritize and move health system transformation forward, the second Hospital Transformation Performance Program (HTPP) report details how hospitals are doing on key quality metrics. The 11 outcome metrics included in this report, covering six domains, were developed through a transparent process by the Hospital Performance Metrics Advisory Committee, Oregon Association for Hospitals and Healthcare Systems (OAHHS), and the Oregon Health Authority (OHA) in coordination with the Centers for Medicare and Medicaid Services (CMS). These metrics indicate how well hospitals are advancing health system transformation by improving quality of care, reducing costs, and improving patient safety. The report provides data for the second year of the program, October 2014 through September 2015, compared to the baseline year (October 2013 through September 2014).

For the second year, a total of \$150 million in funds from a quality pool are being awarded based on performance data submitted for the 11 measures. A two-phase distribution method determines awards:

- In Phase 1, all participating hospitals are eligible for a \$500,000 “floor” payment if they achieve the benchmark or demonstrate improvement over their own baseline (“improvement target”) for at least 75 percent of the measures for which they are eligible. For most hospitals this equates to meeting 9 out of the 11 measures. Only 3 hospitals met this standard, resulting in \$1.5 million in payments from Phase 1.
- In Phase 2, a hospital receives quality pool funds based on the number of measures for which it achieves an absolute benchmark or improvement target.

Hospitals demonstrated progress toward achieving the metrics. Key findings include:

- Hospitals are doing very well in the area of increased medication safety.
 - Adverse drug events due to opioids: all hospitals achieved the benchmark.
 - Excessive anticoagulation with Warfarin: all hospitals achieved the benchmark.
 - Hypoglycemia in inpatients receiving insulin: 26 of 28 hospitals achieved the benchmark.
- Hospitals also did well in the area of hospital/coordinated care organization (CCO) coordination.
 - Follow-up after hospitalization for mental illness: 23 of 28 hospitals met the benchmark.
 - Emergency Department Information Exchange (EDIE): 24 of 28 hospitals met the benchmark or improvement target.
 - Screening, brief intervention, and referral to treatment (SBIRT) in the emergency department: 22 of 28 hospitals met the benchmark or improvement target.

Key areas needing improvement include readmissions, central-line associated bloodstream infection rates, and patient experience measures reported through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

The report provides insight into how Oregon’s hospitals are performing today on key measures. The report also adds increased transparency of and accountability to the health care system as Oregon demonstrates continued progress toward the Triple Aim of better health, better care, and lower costs for all Oregonians.

Background

Context: In 2013, Oregon's House Bill 2216 directed the Oregon Health Authority to establish an incentive metric program for diagnosis-related group (DRG) hospitals. In 2014, Oregon's Hospital Transformation Performance Program (HTPP) was established. In 2015, the first year's program data were reported. In June 2016, pay-for-performance payments will be made for the second year of the program.

Policy: HTPP is approved through OHA's 1115 Medicaid waiver agreement with the Centers for Medicare and Medicaid Services (CMS). The program issues incentive payments to DRG hospitals for quality improvement efforts as determined by the hospital incentive measures. Oregon's vision for achieving the Triple Aim of better health, better care, and lower costs means that all aspects of the delivery system must coordinate their transformation efforts. The program is an integral aspect of Oregon's health system transformation.

Metrics: Eleven outcome and quality measures covering six domains were developed by the Hospital Metrics Advisory Committee for both the baseline year and performance year ("Year 2"). The six domains and 11 measures are captured in two overarching focus areas: 1) hospital-focused and 2) hospital / coordinated care organization coordination-focused. The hospital-CCO coordination-focused domains support greater collaboration and alignment of the work hospitals and CCOs are doing to further health system transformation.

Measurement: The benchmarks and improvement targets were developed by the Hospital Performance Metrics Advisory Committee, OHA, and CMS as a way to measure progress toward the state's health system transformation goals. In the performance year, hospital performance is measured against a specified benchmark for each of the 11 incentive measures. Hospitals that do not meet the benchmark for a given measure will be assessed against their improvement target. Their target represents reasonable improvement compared to their baseline performance. Benchmarks for the second year of the program were established prior to the availability of baseline data for some measures.

Payments: Hospitals must achieve benchmarks or improvement targets in order to qualify for payment in the second year of the program. This report includes the baseline and second year performance for each of the 11 measures. The incentive payments for the second year total \$150 million.

Funding: Funding for HTPP comes from the Hospital Provider Assessment Program authorized by the Oregon Legislature. Oregon's DRG hospitals pay the provider assessment.

Committee: Additional information about the Hospital Metrics Advisory Committee is available online at: www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx.

Measures and domains

<i>Focus area</i>	<i>Domains</i>	<i>Measures</i>
Hospital focus	Healthcare-associated infections 	<ol style="list-style-type: none"> 1. Catheter-Associated Urinary Tract Infection (CAUTI) in all tracked units (adapted from NQF 0754) 2. Central Line-Associated Bloodstream Infection (CLABSI) in all tracked units (adapted from NQF 0139)
	Medication safety 	<ol style="list-style-type: none"> 3. Adverse drug events due to opioids 4. Excessive anticoagulation with warfarin 5. Hypoglycemia in inpatients receiving insulin
	Patient experience 	<ol style="list-style-type: none"> 6. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey: Staff always explained medicines (NQF 0166) 7. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey: Staff gave patient discharge information (NQF 0166)
	Readmissions 	<ol style="list-style-type: none"> 8. Hospital-wide all-cause readmission
Hospital-CCO collaboration focus	Behavioral health 	<ol style="list-style-type: none"> 9. Follow-up after hospitalization for mental illness (adapted from NQF 0576) 10. Screening for alcohol misuse, brief intervention, and referral to treatment (SBIRT) in the emergency department (ED) (two-part measure)
	Sharing ED visit information 	<ol style="list-style-type: none"> 11. Emergency Department Information Exchange (EDIE) - Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits (two-part measure)

DRG hospitals

Hospital name	Location
Adventist Medical Center	Portland
Asante Rogue Regional Medical Center	Medford
Asante Three Rivers Medical Center	Grants Pass
Bay Area Hospital	Coos Bay
Good Samaritan Regional Medical Center	Corvallis
Kaiser Sunnyside Medical Center	Portland
Kaiser Westside Medical Center	Hillsboro
Legacy Emanuel Medical Center	Portland
Legacy Good Samaritan Medical Center	Portland
Legacy Meridian Park Medical Center	Tualatin
Legacy Mount Hood Medical Center	Gresham
McKenzie-Willamette Medical Center	Springfield
Mercy Medical Center	Roseburg
OHSU Hospital	Portland
PeaceHealth Sacred Heart Medical Center at RiverBend	Springfield
PeaceHealth Sacred Heart Medical Center University District	Eugene
Providence Medford Medical Center	Medford
Providence Milwaukie Hospital	Milwaukie
Providence Portland Medical Center	Portland
Providence St. Vincent Medical Center	Portland
Providence Willamette Falls Medical Center	Oregon City
Salem Hospital	Salem
Samaritan Albany General Hospital	Albany
Shriners Hospital for Children	Portland
Sky Lakes Medical Center	Klamath Falls
St. Charles Bend Medical Center	Bend
Tuality Healthcare	Hillsboro
Willamette Valley Medical Center	McMinnville

What is a DRG hospital? DRG (diagnosis-related group) hospitals are larger hospitals that receive payments on a prospective basis. Rather than paying the hospital exactly what it spent caring for a patient (e.g. every dose of medicine, bandage, and room fee), Medicaid pays a fixed amount based on the patient's DRG or diagnosis. Oregon's DRG hospitals pay the provider assessment, which funds HTPP.

Quality pool distribution

Performance year quality pool

In the second year of the HTPP, Oregon's DRG hospitals qualify for quality pool payment by demonstrating improvement over their baseline performance on the 11 incentive measures. In the baseline year, hospitals received payment for submitting data according to OHA guidance; however in the second year of the program, hospitals are paid for performance.

Funding for the program comes from the Hospital Provider Assessment Program authorized by the Oregon Legislature. This performance year quality pool is \$150 million; all funds are distributed in this performance year. The amount of funds each hospital is eligible to receive is based on the number of measures submitted and hospital size. Hospital size is determined by the proportion of total Medicaid discharges and inpatient days (50 percent based on discharges and 50 percent based on inpatient days). The methodology for distribution occurs in two phases, described below:

Quality pool: Phase 1 distribution:

All participating hospitals are eligible for a \$500,000 floor payment by achieving at least 75 percent of the measures for which they are eligible. Achieving a measure in the performance year means the hospital met the benchmark or improvement target.

Step 1: OHA determines the number of hospitals qualifying for the floor payment and multiplies that number by \$500,000.

Step 1	{	Number of hospitals earning floor payment	3
		Floor payment per hospital	<u>x \$500,000</u>
		Total floor payment	= \$1,500,000

Step 2: The total floor payment is then subtracted from the quality pool, with the remainder to be allocated in Phase 2.

Step 2	{	Total in quality pool	\$150,000,000
		Subtract floor payment	<u>- \$1,500,000</u>
		Amount remaining for payment on individual measures	= \$148,500,000

Quality pool distribution

Quality pool: Phase 2 distribution

The fund remaining after Phase 1 (floor payment distribution) are allocated to hospitals based upon their performance on the individual measures.

Step 1: Determine the number of hospitals achieving each measure.

Step 2: Calculate total amount each measure is worth by multiplying each individual measure's weight (outlined in table below) by the amount remaining in the pool after Phase 1. This is the 'base amount'.

Step 3: Allocate base amount to hospitals who have achieved the measure according to relative hospital size (50 percent Medicaid discharges and 50 percent Medicaid days).

Measure	Measures weight	Total amount available for measure (base amount)	Number of hospitals qualifying for payment
CAUTI in all tracked units	9.38%	\$13,921,875	22
CLABSI in all tracked units	9.38%	\$13,921,875	9
Adverse drug events due to opioids	6.25%	\$9,281,250	28
Excessive anticoagulation with Warfarin	6.25%	\$9,281,250	28
Hypoglycemia in inpatients receiving insulin	6.25%	\$9,281,250	26
HCAHPS: Staff always explained medicines*	9.38%	\$13,921,875	6
HCAHPS: Staff gave patient discharge information	9.38%	\$13,921,875	11
Hospital-wide all-cause readmissions	18.75%	\$27,843,750	6
Follow-up after hospitalization for mental illness	6.25%	\$9,281,250	23
SBIRT: Screening for alcohol and other substance misuse in the ED*	6.25%	\$9,281,250	22
EDIE: Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits*	12.50%	\$18,562,500	24
Total	100.00%	\$148,500,000	

*As a children's hospital, Shriners Hospital for Children fields the Press Ganey Inpatient Pediatric Survey, rather than HCAHPS. The Press Ganey survey does not include a question analogous to the HCAHPS question on staff explaining new medications, so Shriners is not eligible for payment on this measure. Similarly, Shriners does not have an emergency department (ED), so it is ineligible for payment on the two ED-based measures: SBIRT and EDIE.

Quality pool distribution by hospital

Hospital	Total Medicaid discharges *	Number of measures met **	Phase 1 payment earned	Phase 2 payment earned	Total dollar amount earned
Adventist	2,959	10	\$500,000	\$21,848,818	\$22,348,818
Asante Rogue Regional	2,548	6	\$0	\$3,182,101	\$3,182,101
Asante Three Rivers	1,743	8	\$0	\$3,558,612	\$3,558,612
Bay Area Hospital	1,235	7	\$0	\$1,644,740	\$1,644,740
Good Samaritan Regional	1,368	9	\$500,000	\$8,745,218	\$9,245,218
Kaiser Sunnyside	625	5	\$0	\$582,691	\$582,691
Kaiser Westside	30	8	\$0	\$166,111	\$166,111
Legacy Emanuel	5,641	7	\$0	\$10,849,549	\$10,849,549
Legacy Good Samaritan	1,385	8	\$0	\$3,042,635	\$3,042,635
Legacy Meridian Park	611	8	\$0	\$1,327,708	\$1,327,708
Legacy Mount Hood	1,584	7	\$0	\$1,953,871	\$1,953,871
McKenzie-Willamette	1,152	7	\$0	\$3,507,095	\$3,507,095
Mercy	1,738	7	\$0	\$2,159,594	\$2,159,594
OHSU Hospital	8,024	8	\$0	\$18,631,079	\$18,631,079
PeaceHealth Sacred Heart - RiverBend	5,395	6	\$0	\$10,598,245	\$10,598,245
PeaceHealth Sacred Heart - University	531	7	\$0	\$2,728,082	\$2,728,082
Providence Medford	1,203	7	\$0	\$1,635,377	\$1,635,377
Providence Milwaukie	828	6	\$0	\$869,925	\$869,925
Providence Portland	4,875	7	\$0	\$12,636,697	\$12,636,697
Providence St. Vincent	4,326	7	\$0	\$6,665,237	\$6,665,237
Providence Willamette Falls	1,087	8	\$0	\$5,207,162	\$5,207,162
Salem Hospital	3,817	7	\$0	\$6,373,034	\$6,373,034
Samaritan Albany General Hospital	1,020	7	\$0	\$1,959,740	\$1,959,740
Shriners Hospital for Children	203	8	\$500,000	\$1,417,536	\$1,917,536
Sky Lakes	1,332	7	\$0	\$7,464,029	\$7,464,029
St. Charles Bend	2,679	7	\$0	\$5,836,486	\$5,836,486
Tuality Healthcare	1,269	8	\$0	\$2,149,195	\$2,149,195
Willamette Valley	848	8	\$0	\$1,759,434	\$1,759,434
TOTAL	60,056		\$1,500,000	\$148,500,000	\$150,000,000

*October 2011 through September 2012

**Of 11 measures possible (with the exception of Shriners Hospital for Children, which is only eligible for 8 measures)

Performance overview

<ul style="list-style-type: none"> ■ Hospital achieved BENCHMARK in Year 2 ■ Hospital achieved IMPROVEMENT TARGET * Top performing hospital in each measure + Tied top performers 	CAUTI	CLABSI	Opioids	Warfarin	Hypoglycemia	HCAHPS: Medicines	HCAHPS: Discharge	Readmissions	Follow-up after hosp.	SBIRT in the ED	EDIE
Adventist	■		■	■	■	■	■	■	■	■	■
Asante Rogue Regional			■	■	■				■	■	*
Asante Three Rivers	■	+	■	■	■				*	■	■
Bay Area Hospital	■		■	■	■				■	■	■
Good Samaritan Regional	■		■	■	■	■		■	■	■	■
Kaiser Sunnyside			■	■	■				■	■	■
Kaiser Westside	+		+	■	■		■	■	■	■	■
Legacy Emanuel			■	■	■		■		■	■	■
Legacy Good Samaritan	■		■	■	■		■		■	■	■
Legacy Meridian Park	■	■	■	■	■				■	■	■
Legacy Mount Hood	■		■	■	■				■	■	■
McKenzie-Willamette	■	+	■	■		*	■		■	■	■
Mercy	■		■	■	■		■		■	■	■
OHSU Hospital	■		■	■	*		■		■	■	■
PeaceHealth Sacred Heart - RiverBend	■	■	■	■	■				■	■	■
PeaceHealth Sacred Heart - University		+	+	■	■	■	■		■	■	■
Providence Medford	+		■	■	■				■	■	■
Providence Milwaukie	■		■	■	■				■	■	■
Providence Portland	■		■	■	■	■			■	■	■
Providence St. Vincent	■		■	■	■				■	■	■
Providence Willamette Falls	+		■	■	■		■	■	■	■	■
Salem Hospital			■	■	■		■		■	■	■
Samaritan Albany General Hospital	+	+	■	■	■				■	■	■
Shriners Hospital for Children	+	+	■	■	■	n/a	■	*	■	n/a	n/a
Sky Lakes			■	■	■	■		■	■	■	■
St. Charles Bend		■	■	■	■				■	■	■
Tuality Healthcare	■		■	*	■		*		■	*	■
Willamette Valley	+	+	■	■	■				■	■	■

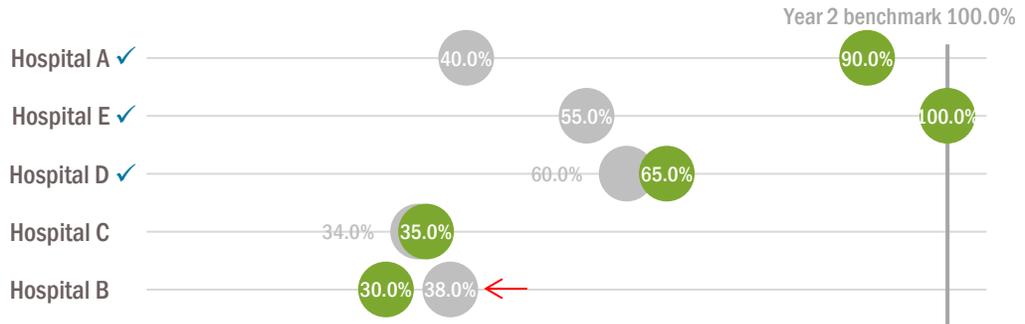
How to read these graphs

[Number of hospitals achieving] benchmark or improvement target in Year 2.

Grey dots represent baseline

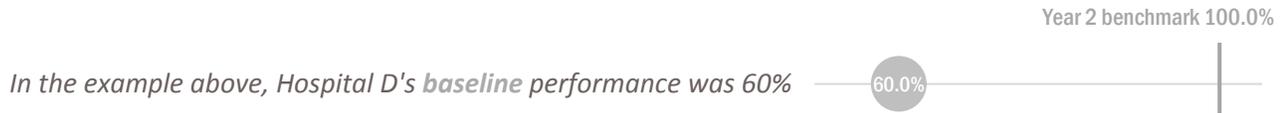
✓ Indicates hospital met benchmark or improvement target

Hospitals are sorted by amount of change between baseline and Year 2. That is, the hospital with the **most improvement** in Year 2 is listed first.



Arrows highlight negative change (away from the benchmark).

Benchmarks are selected by the Hospital Performance Metrics Advisory Committee. Hospitals can earn quality pool payment for a) achieving the benchmark or b) making considerable *improvement toward* the benchmark. To measure improvement, each hospital has an individual “improvement target” which requires at least a 10 percent reduction in the gap between baseline and the benchmark.



The gap between Hospital D's baseline and the benchmark is 40%

$$100\% - 60\% = 40\%$$

Ten percent of that gap is 4%

$$4\%$$

Hospital D must improve by 4 percentage points in Year 2 to meet its improvement target.

$$(60\% + 4\% = \text{improvement target})$$

Hospital D's performance in **Year 2** is 65%. **They have met their improvement target ✓ and will earn incentive payment.**



Note that in most cases, the Committee will establish an “improvement target floor,” meaning that an improvement target cannot be less than X% above baseline. In the example above, if the floor was 6 percentage points, Hospital A would need to earn at least [baseline + 6% =] 66% in Year 2 to earn incentive payment.

Catheter-associated urinary tract infections (CAUTI)



Domain: Health care-associated infections

Description

The measure is part of the domain aimed at addressing health care-associated infections, which are infections patients can get while receiving medical treatment in a healthcare facility. A catheter is a drainage tube inserted into a patient's bladder through the urethra and is 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 infections in the urinary tract. This is called a catheter-associated urinary tract infection, or CAUTI.

The measure is the rate of patients with catheter-associated urinary tract infections (CAUTI) per 1,000 urinary catheter days in all tracked units (all tracked units as defined or accepted by the National Health Safety Network). A lower score for this measure is better.

Note: The HTPP measure is an unadjusted CAUTI rate across all tracked units and is not limited to intensive care units. Some other reports, including the state's Healthcare Acquired Infections report, include the Standardized Infection Ratio (SIR). The SIR is a risk-adjusted rate that calculates the ratio of observed to expected CAUTIs.

Performance year: April 2015 – September 2015*

Statewide rate: 0.99 per 1,000 catheter days

Benchmark: 1.02 per 1,000 catheter days (lower is better)

Number of hospitals achieving measure: 22 of 28 eligible

Most improved: Legacy Mount Hood Medical Center



Aggregated across all reporting hospitals, the statewide DRG hospital CAUTI rate was 0.99 per 1,000 catheter days. Twenty-two out of 28 hospitals met the benchmark or improvement target. Six hospitals reported zero infections. Among hospitals reporting at least one CAUTI, the rate ranged from 0.26 to 2.03 per 1,000 catheter days. The majority of hospitals moved in the positive direction on this measure.

**The baseline and performance periods for this measure are different than rest of the HTPP. Due to significant changes to the specifications made by the Centers for Disease Control and Prevention (CDC) in CY 2015, results could not straddle 2014-2015. Thus, the baseline period for this measure covers January to March 2015, and the performance period covers April to September 2015.*

Data source: Self-reported by hospitals to Centers for Disease Control and Prevention (CDC) / National Health Safety Network (NHSN)

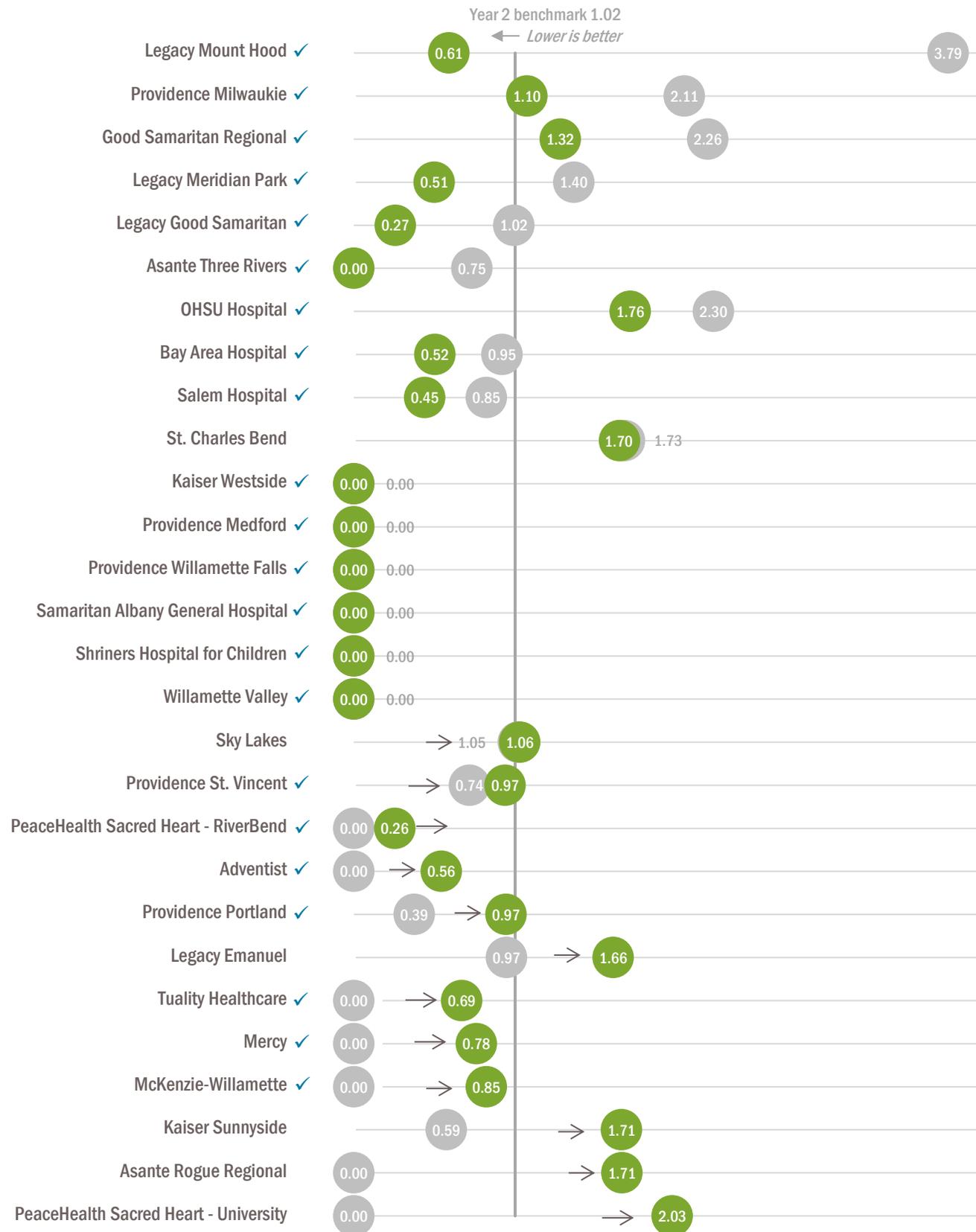
Benchmark source: 50th percentile from HTPP baseline (excluding hospitals with zero CAUTI events during the baseline period)

Catheter-associated urinary tract infections (CAUTI)

Twenty-two hospitals achieved benchmark or improvement target in Year 2.

Grey dots represent baseline. Rates are reported per 1,000 catheter days.

✓ Indicates hospital met benchmark or improvement target.



Central line-associated bloodstream infections (CLABSI)



Domain: Health care-associated infections

Description

The measure is part of the domain that addresses infections patients can get while receiving medical treatment in a health care facility. 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 or kept clean, germs can enter the body and cause serious infections in the blood.

This measure is the central line-associated bloodstream infection (CLABSI) rate in patients who had a central line within the 48-hour period before the development of a bloodstream infection that is not related to an infection at another site. The rate is reported per 1,000 central line days. A lower score for this measure is better.

Note: The HTPP measure is an unadjusted CLABSI rate across all tracked units in the hospital (all tracked units as defined or accepted by the National Health Safety Network; it is not limited to intensive care units). Some other reports, including the state's Healthcare Acquired Infections report, include the Standardized Infection Ratio (SIR). The SIR is a risk-adjusted rate that calculates the ratio of observed to expected CLABSIs.

Performance year: October 2014 – September 2015

Statewide rate: 0.89 per 1,000 central line days

Benchmark: 0.18 per 1,000 central line days (lower is better)

Number of hospitals achieving measure: 9 of 28 eligible

Most improved: McKenzie-Willamette Medical Center



Aggregated across all reporting hospitals, the statewide DRG hospital CLABSI rate was 0.89 per 1,000 central line days. Nine out of 28 hospitals met the benchmark or improvement target. Six hospitals reported zero infections. Among hospitals reporting at least one CLABSI, the rate ranged from 0.20 to 1.95 per 1,000 catheter days. McKenzie-Willamette Medical Center led all hospitals in improvement by dropping to zero down from their baseline of 2.07.

Data source: Self-reported by hospitals to Centers for Disease Control and Prevention (CDC) / National Health Safety Network (NHSN)

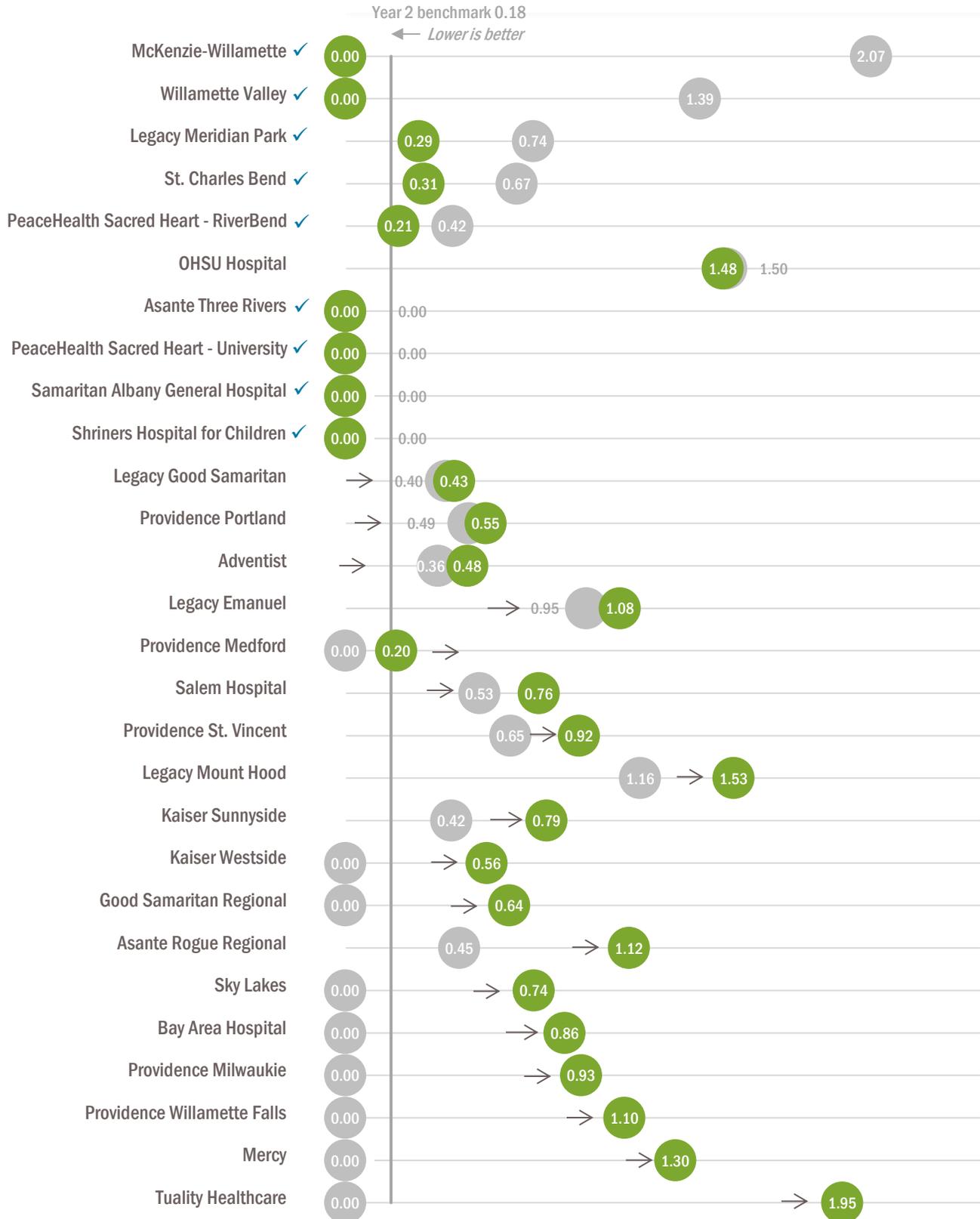
Benchmark source: 2010 NHSN Data Summary Report 50th percentile

Central line-associated bloodstream infections (CLABSI)

Nine hospitals achieved benchmark or improvement target in Year 2.

Grey dots represent baseline. Rates are reported per 1,000 catheter days.

✓ Indicates hospital met benchmark or improvement target.



Adverse drug events due to opioids



Domain: Medication safety

Description

The measure is part of the medication safety domain, which aims to increase medication safety and avoid adverse drug events. Adverse drug events or ADEs are injuries resulting from medication use, including physical or mental harm, and loss of function.

The measure is defined as the percentage of times a patient receiving an opioid agent also received naloxone, an antidote for opiate overdose that reverses opioid intoxication. The measure uses naloxone administration to identify patients who may have experienced an adverse drug event due to an opioid. A lower score for this measure is better.

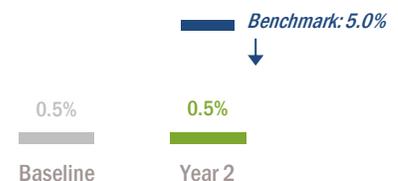
Performance year: October 2014 – September 2015

Statewide rate: 0.5%

Benchmark: 5.0% (lower is better)

Number of hospitals achieving measure: 28 of 28 eligible

Most improved: Salem Hospital



The benchmark that must be achieved in the second year of the program is 5.0 percent or lower. All hospitals achieved this benchmark in the performance year, with performance ranging from 0.1 percent to 1.2 percent. Aggregated across all reporting hospitals, the statewide DRG hospital performance rate was 0.5 percent. Continued monitoring is important to ensure the rate remains low.

Data source: Self-reported by hospitals (tracked internally through electronic health records, chart abstraction, or other manual process)

Benchmark source: Hospital Transformation Performance Program consensus

Adverse drug events due to opioids

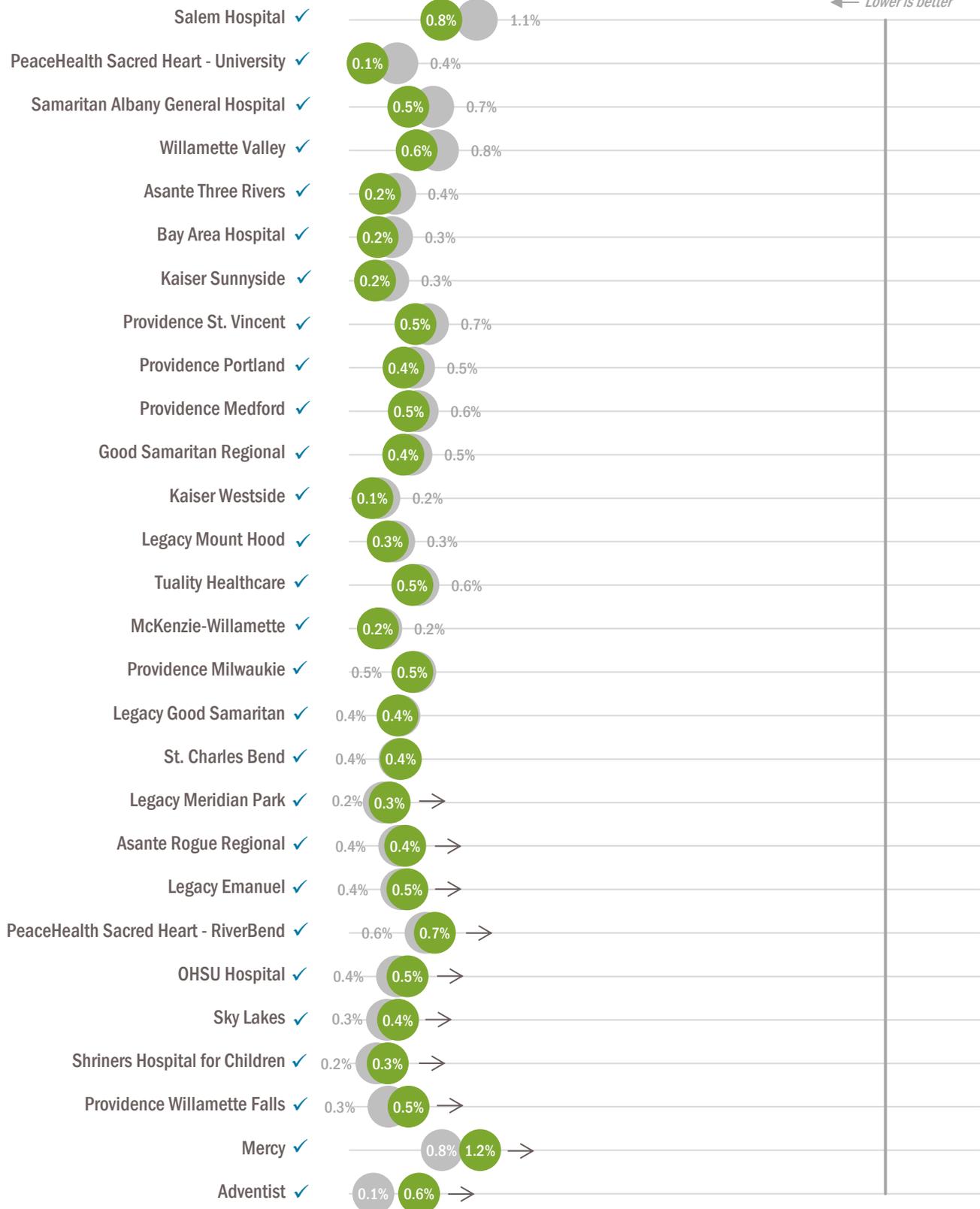
All hospitals achieved the benchmark in **Year 2**.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.

Year 2 benchmark 5.0%

← Lower is better



Excessive anticoagulation with Warfarin



Domain: Medication safety

Description

The measure is part of the domain aiming to increase medication safety and avoid adverse drug events. Adverse drug events are defined as any injuries resulting from medication use, including physical or mental harm, and loss of function. Warfarin is a type of blood thinner used to prevent blood clots. Incorrect dosage can cause too much thinning (excessive anticoagulation) which increases the risk of bleeding.

The measure is defined as the percentage of times patients receiving Warfarin anticoagulation therapy experienced excessive anticoagulation. A lower score for this measure is better.

Performance Year: October 2014 – September 2015

Statewide rate: 1.3%

Benchmark: 5.0% (lower is better)

Number of hospitals achieving measure: 28 of 28 eligible

Most improved: Mercy Medical Center



Aggregated across all reporting hospitals, the statewide DRG hospital performance was 1.3 percent. All hospitals achieved the benchmark, with the percentage of patients receiving Warfarin anticoagulation therapy who experienced excessive anticoagulation during the baseline year ranging from 0.3 percent to 4.3 percent (lower scores are better). The benchmark for the second year of the program is 5.0 percent or lower.

Data source: Self-reported by hospitals (tracked internally through electronic health records, chart abstraction, of other manual process)

Benchmark source: Hospital Transformation Performance Program consensus

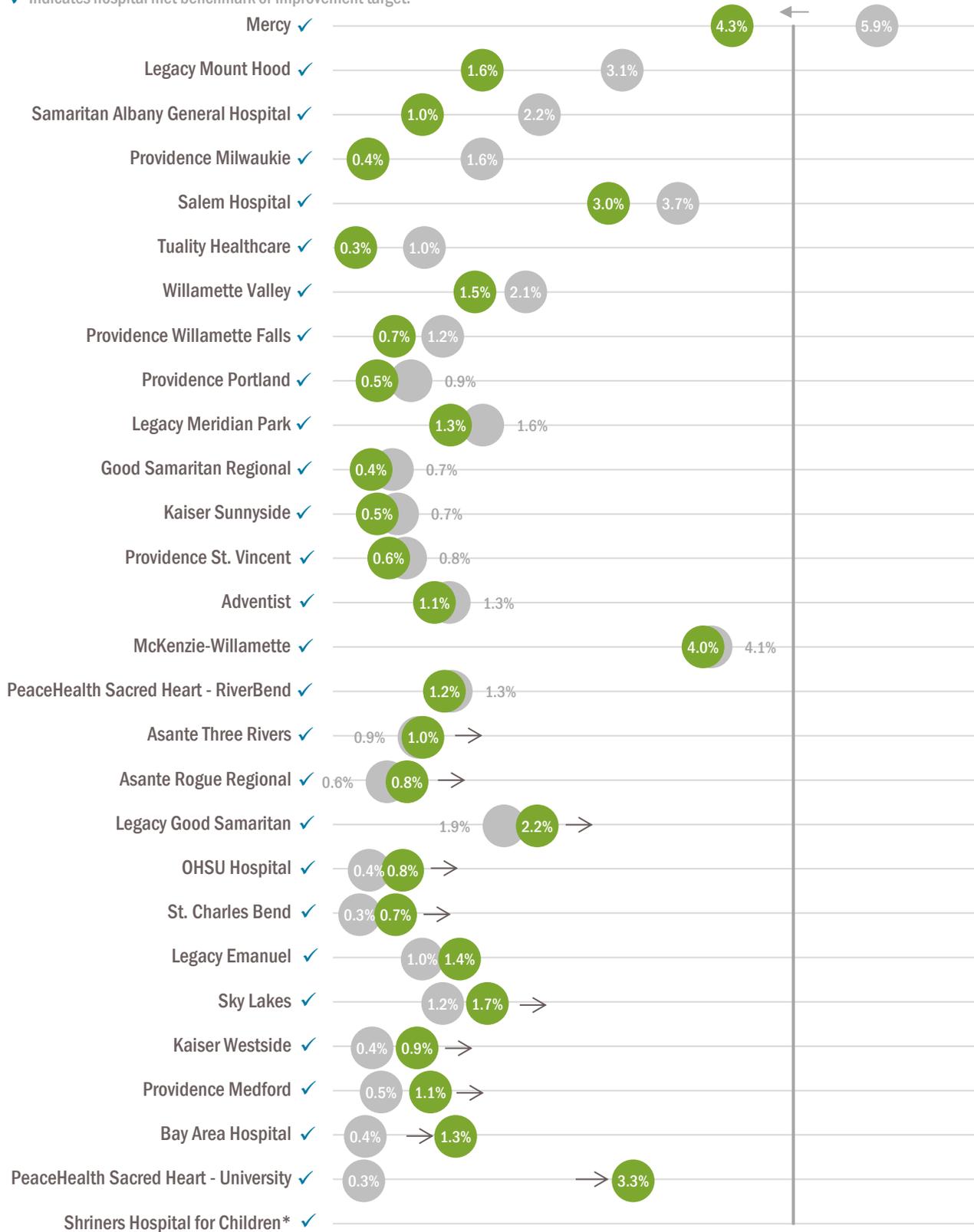
Excessive anticoagulation with Warfarin

All hospitals achieved the benchmark in Year 2.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.

Year 2 benchmark 5.0% (Lower is better)



*Shriners had zero qualifying denominator events for this measure.

Hypoglycemia in inpatients receiving insulin



Domain: Medication safety

Description

This measure is part of the domain aiming to increase medication safety and avoid adverse drug events. Adverse drug events are defined as any injuries resulting from medication use, including physical or mental harm, or loss of function. Insulin is an important component of diabetes care. If dosage is incorrect or the patient is not carefully monitored, hypoglycemia (low blood sugar) may occur.

The measure is defined as the percentage of inpatients receiving insulin who had experienced hypoglycemia. A lower score is better.

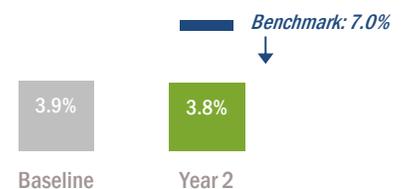
Performance year: October 2014 – September 2015

Statewide rate: 3.8%

Benchmark: 7.0% (lower is better)

Number of hospitals achieving measure: 26 of 28 eligible

Most improved: PeaceHealth Sacred Heart - University District



Aggregated across all reporting hospitals, the statewide DRG hospital performance rate is 3.8 percent. All but two hospitals met the benchmark, an improvement from last year where all but three hospitals met the benchmark. Performance among the individual hospitals administering insulin ranged from 0.0 percent to 8.2 percent (lower is better). The benchmark for the performance year is 7.0 percent or below.

Data source: Self-reported by hospitals (tracked internally through electronic health records, chart abstraction, or other manual process)

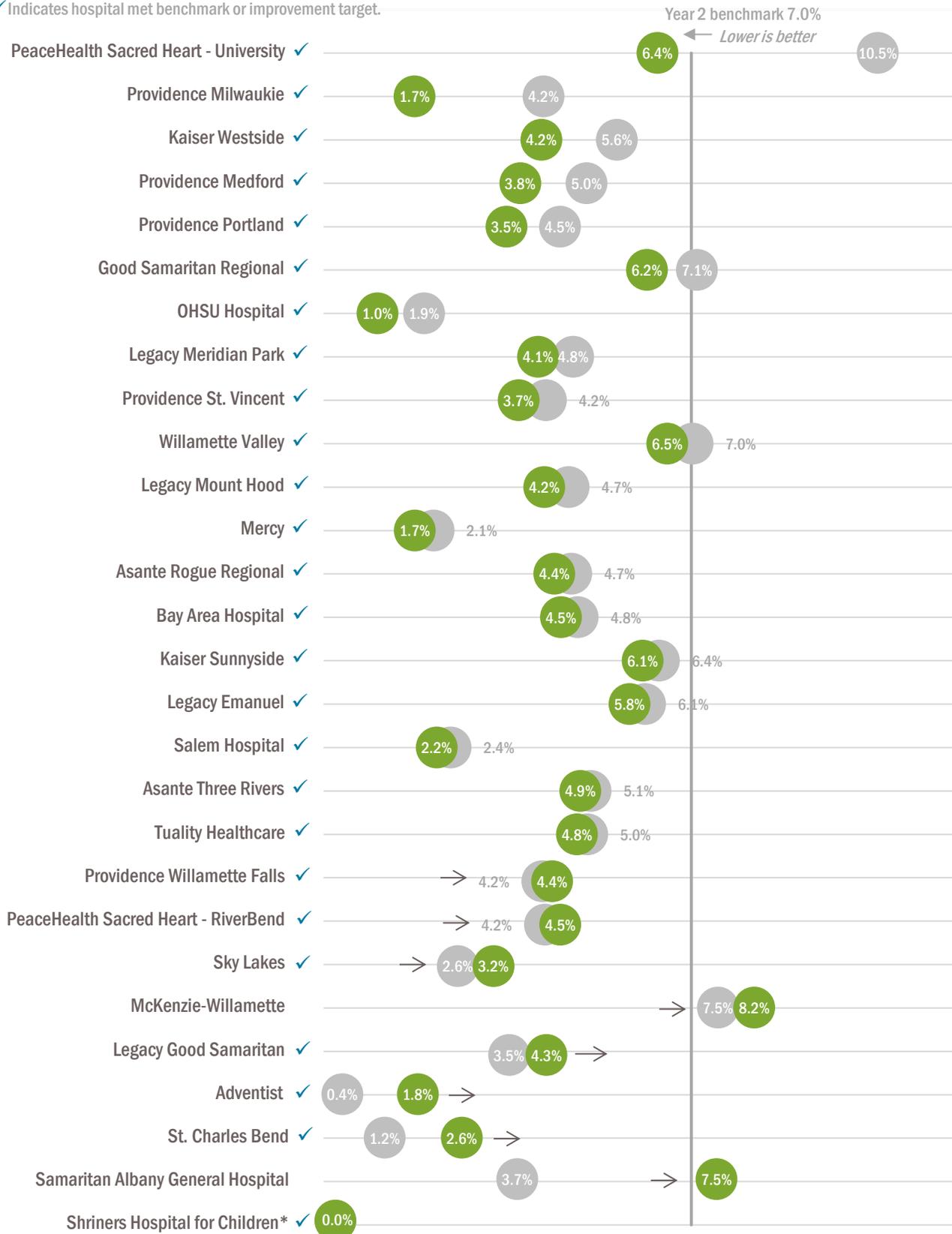
Benchmark source: Hospital Transformation Performance Program consensus

Hypoglycemia in inpatients receiving insulin

Twenty-six hospitals achieved the benchmark in **Year 2**.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.



*Shriners had zero qualifying denominator events for this measure.

HCAHPS: Staff always explained medicines



Domain: Patient experience

Description

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asks patients who were given a medicine that they had not taken before how often staff explained the medicine (on a scale of never, sometimes, usually, or always). “Explained” means that hospital staff told the patient what the medicine was for and what side effects it might have before they gave it to the patient. To support improvements in internal customer services and quality-related activities, the measure uses survey data to measure patients' perspectives on their hospital care experiences.

The measure is defined as the percentage of patients who said hospital staff always told them, in a way they understood (1) what their medication was for and (2) possible medication side effects.

Performance year: October 2014 – September 2015

Statewide rate: 64.0%

Benchmark: 72.0%

Number of hospitals achieving measure: 6 of 27 eligible

Most improved: PeaceHealth Sacred Heart - University District



Aggregated across all reporting hospitals, the statewide DRG hospital performance was 64.0 percent. Among individual hospitals, performance year rates ranged from 51.3 percent to 70.0 percent, with PeaceHealth Sacred Heart – University performing the best. The benchmark is the national 90th percentile, which is 72.0 percent.

Shriners Hospital for Children is ineligible for this measure as it does not field the HCAHPS survey, and its patient satisfaction survey does not have a similar question about explaining medications.

Data source: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

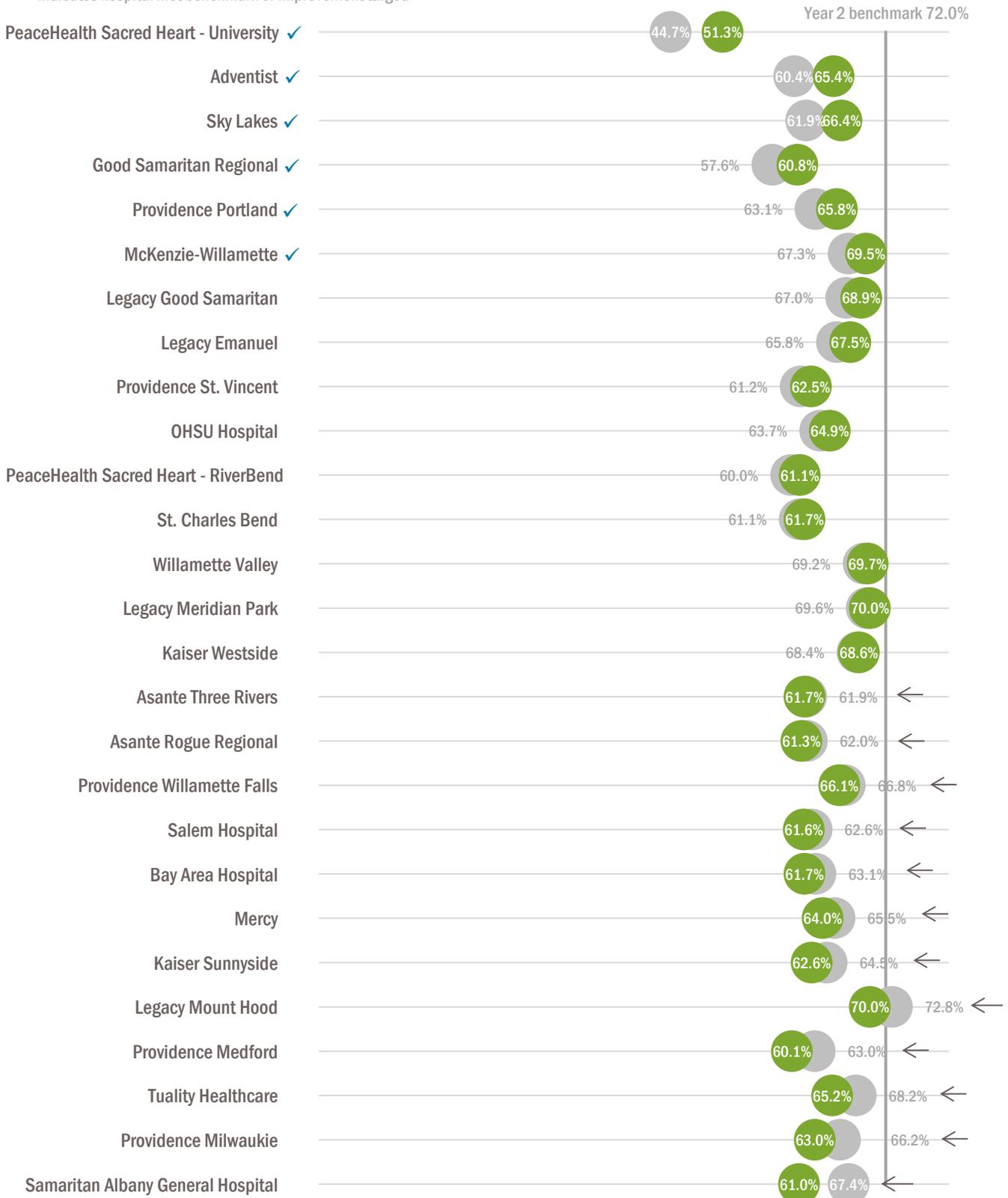
Benchmark source: National 90th percentile

HCAHPS: Staff always explained medicines

Six hospitals achieved their improvement target in Year 2.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.



Note: Shriners Hospital for Children uses the Press Ganey Inpatient Survey rather than HCAHPS. Since there is no analogous question on the Press Ganey Survey, Shriners cannot participate in this measure.

HCAHPS: Staff gave patient discharge information



Domain: Patient experience

Description

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asks patients whether hospital staff 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. Response options are 'Yes' or 'No'. To support improvements in internal customer services and quality-related activities, the measure uses survey data to measure patients' perspectives on their hospital care experiences.

The measure is defined as the percentage of patients who said hospital staff (1) talked about whether the patient would have the help needed when they left the hospital and (2) provided information in writing about what symptoms or health problems to look for after the patient left the hospital.

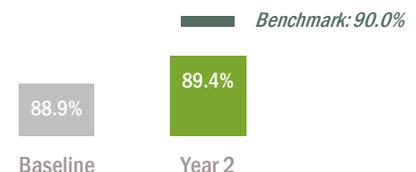
Performance Year: October 2014 – September 2015

Statewide rate: 89.4%

Benchmark: 90.0%

Number of hospitals achieving measure: 11 of 28 eligible

Most improved: PeaceHealth Sacred Heart - University District



Aggregated across all reporting hospitals,* statewide DRG hospital performance was 89.4 percent. Across all DRG hospitals, performance ranged from 82.2 percent to 92.7 percent. A total of 11 hospitals achieved the benchmark or improvement target for the performance year. The Year 2 benchmark is 90.0 percent.

Data source: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

Benchmark source: National 90th percentile

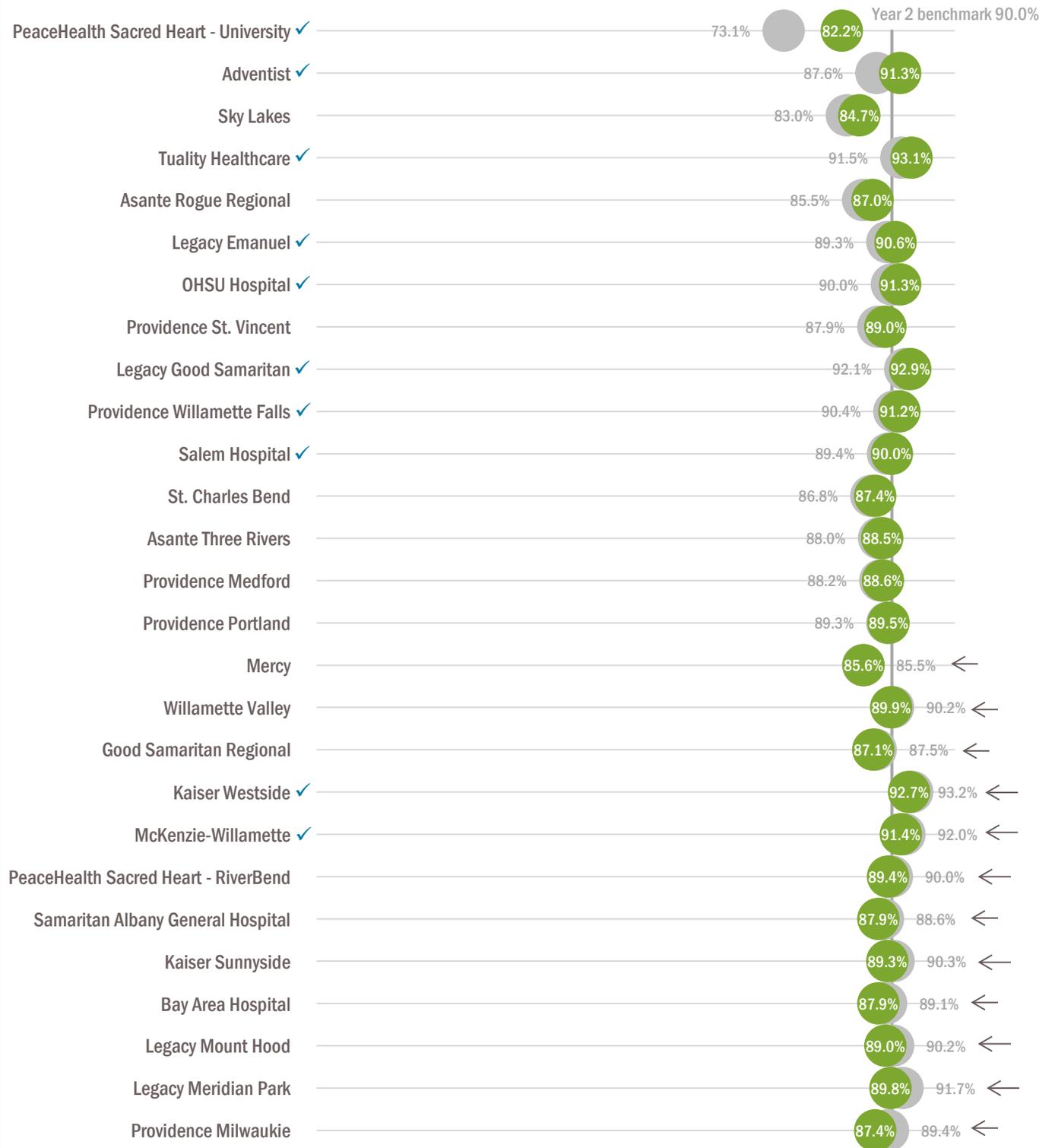
* Shriners Hospital for Children is unable to field an HCAHPS survey, and instead uses the Press Ganey Inpatient Pediatric Survey. Thus, the benchmark for Shriners is the 90th percentile of all Press Ganey Database Peer Group (92.7%)

HCAHPS: Staff gave patient discharge information

Eleven hospitals achieved benchmark or improvement target in Year 2.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.



Shriners Hospital for Children's performance is based on discharge instructions questions on the Press Ganey Inpatient Survey.



Hospital-wide all-cause readmissions



Domain: Readmissions

Description

Some patients who leave the hospital are admitted again shortly thereafter. Readmissions are often avoidable. Reducing the preventable problems that send patients back to the hospital is the best way to keep patients at home and healthy.

The measure is the percentage of patients (all ages) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score is better.

Performance year: October 2014 – September 2015

Statewide rate: 11.3%

Benchmark: 8.0% (lower is better)

Number of hospitals achieving measure: 6 of 28 eligible

Most improved: OHSU Hospital



Aggregated across all reporting hospitals, the statewide DRG hospital rate for the performance year is 11.3 percent. For individual hospitals, rates ranged from 4.7 percent to 16.7 percent (lower scores are better).

The benchmark for this measure is 8.0 percent. Three hospitals met the benchmark and three met their improvement targets. OHSU Hospital exhibited the greatest improvement relative to the baseline year.

Data source: Oregon Association of Hospitals and Health Systems (OAHHS)

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

Hospital-wide all-cause readmissions

Six hospitals met benchmark or improvement target in Year 2.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.



Follow-up after hospitalization for mental illness



Domain: Behavioral health

Description

The measure supports coordination between hospitals and Oregon's Coordinated Care Organizations (CCOs) in facilitating appropriate follow-up care for Medicaid members hospitalized with mental illness. This measure aligns the work of hospitals and CCOs, as it is also a CCO incentive measure.

The measure is defined as the percentage of Medicaid patients (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from the hospital for mental illness.

Performance year: October 2014 – September 2015

Statewide rate: N/A

Benchmark: 70.0%

Number of hospitals achieving measure: 23 of 28 eligible

Most improved: Asante Three Rivers Medical Center

Twenty-three out of 28 hospitals met the benchmark on follow-up after hospitalization for mental illness. Nearly all hospitals reported rates between 70.0 percent and 95.8 percent. Asante Three Rivers led all hospitals in improvement by rising from their baseline of 68.8 percent to 95.8 percent.

Note: Hospitals with fewer than 10 mental health discharges in the measurement period are allocated either their hospital system rate (for hospitals in systems with more than one DRG hospital) or their local CCO's rate. This allows all hospitals to participate in the measure and facilitates further hospital-CCO coordination.

Data source: Medicaid administrative (billing) claims

Benchmark source: 2014 national Medicaid 90th percentile (aligns with CCO incentive measure benchmark)

Due to performance attribution method used, a statewide rate is not available.

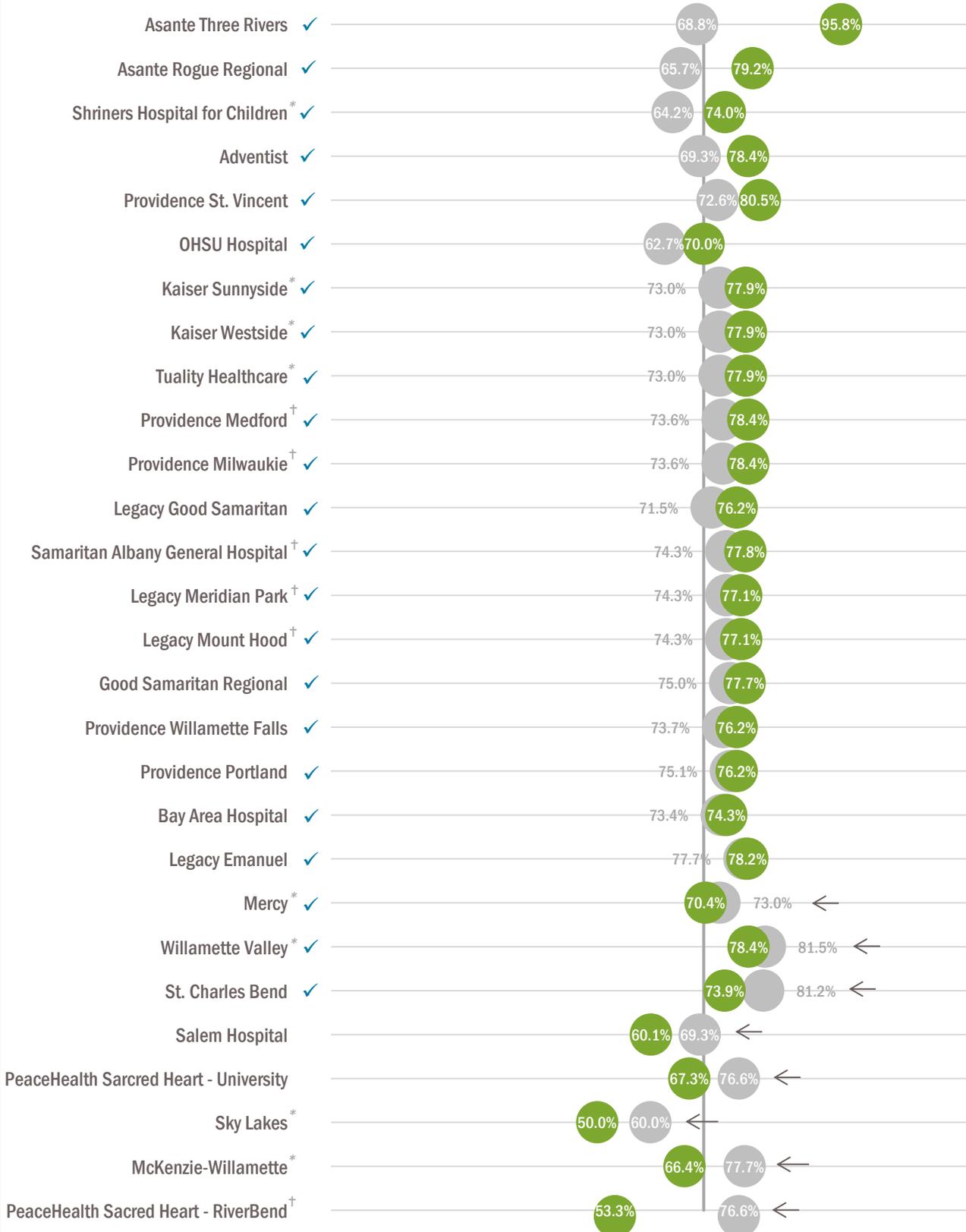
Follow-up after hospitalization for mental illness

Twenty-three hospitals achieved benchmark in **Year 2**.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.

Year 2 benchmark: 70.0%



* Hospital had fewer than 10 mental health discharges and is attributed local CCO rate.

† Hospital had fewer than 10 mental health discharges and is attributed system rate.

SBIRT in the emergency department



Domain: Behavioral health

Description

This measure supports the statewide quality improvement focus area of integrating behavioral and physical health, and also aligns the work of hospitals and CCOs, which have an incentive measure focused on the use of screening for alcohol and drug misuse in primary care settings.

The measure tracks screening, brief intervention, and referral to treatment (SBIRT) in the emergency department. Hospitals can report one of two rates: percent of patients who receive a brief screening, or percent of patients who receive a full screening.

The percent of patients who screen positive on the second screening and receive a brief intervention is also being tracked. The brief intervention rate is not reported here because this part of the measure is not tied to a benchmark for the second year of the program.

Performance year: October 2014 – September 2015

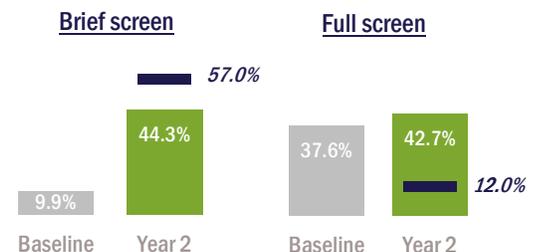
Statewide rate: brief screen=44.3%, full screen=42.7%

Benchmark: brief screen=57.0%, full screen=12.0%

Number of hospitals achieving measure: 22 of 27 eligible

Most improved brief screen: Willamette Valley Medical Center

Most improved full screen: Adventist Medical Center



Of the 27 eligible hospitals, 22 successfully met either the benchmark or improvement target for this measure. The benchmark for the brief screen is 57.0 percent and 12.0 percent for the full screen.

Willamette Valley Hospital improved to 47.6 percent from a baseline of 22.5 percent, and Adventist improved from 59.8 percent to 71.1 percent. Only three hospitals' performance diminished in comparison to their baseline performance.

Data source: Self-reported by hospitals (tracked internally through electronic health records, chart abstraction, or other manual process) **Benchmark source:** Brief screening -- 75th percentile from HTPP baseline; Full screen -- alignment with CCO benchmark

SBIRT in the emergency department

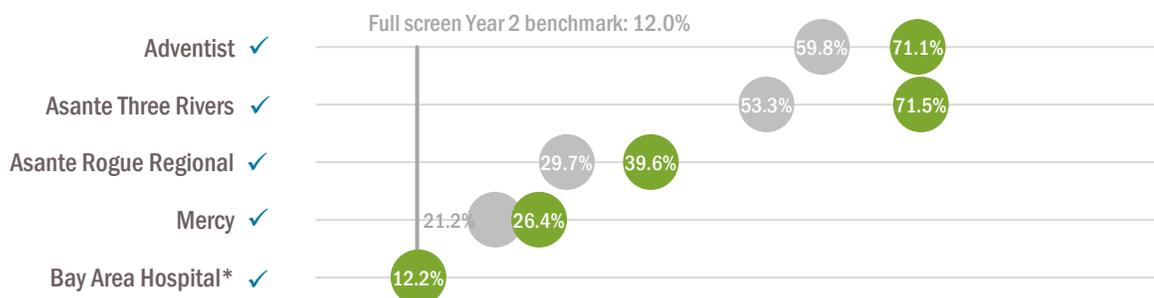
Twenty-two hospitals met benchmark or improvement target in **Year 2**.

✓ Indicates hospital met benchmark or improvement target. Grey dots represent baseline.

Brief screen



Full screen



* Hospital did not submit baseline data.

Note: Shriners Hospital for Children does not have an emergency department and cannot participate in this measure.

EDIE: Emergency department information exchange



Domain: Sharing emergency department visit information

Description

This measure was created to support more coordination between hospitals and Oregon's coordinated care organizations to promote care in the right setting. It encourages hospitals and primary care providers to make use of health information technology to reduce unnecessary ED visits among high utilizers.

The Emergency Department Information Exchange (EDIE) system allows EDs to identify in real-time patients who visit the ED more than five times in a 12 month period so care can be better coordinated and patients can be directed to the right care setting.

This measure is the percentage of times hospitals notified a patient's primary care provider when a frequent user of the ED was seen in the ED. A patient is considered a frequent user of the emergency department if they visit the ED five or more times in 12 months.

It is the first part of the two-part measure using EDIE. The second part looks at the number of care guidelines completed for frequent ED users. These data are not reported as the second part of the measure is not tied to a benchmark for the second year of the program.

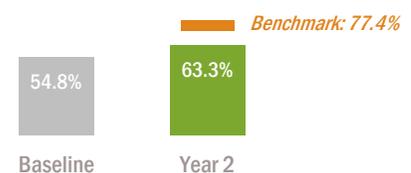
Performance year: October 2014 – September 2015

Statewide rate: 63.3%

Benchmark: 77.4%

Number of hospitals achieving measure: 24 of 27 eligible

Most improved: St. Charles Bend Medical Center



Aggregated across all reporting hospitals, the statewide DRG hospital EDIE rate was 63.3 percent. The benchmark is 77.4 percent. Ten hospitals met the benchmark in the performance year with rates ranging from 82.0 percent to 94.9 percent. St. Charles Bend showed the greatest improvement from the baseline year moving from 0.0 percent to 65.5 percent. The range in performance may be due to the large variation in the hospitals' stage of EDIE implementation.

Data source: Emergency Department Information Exchange

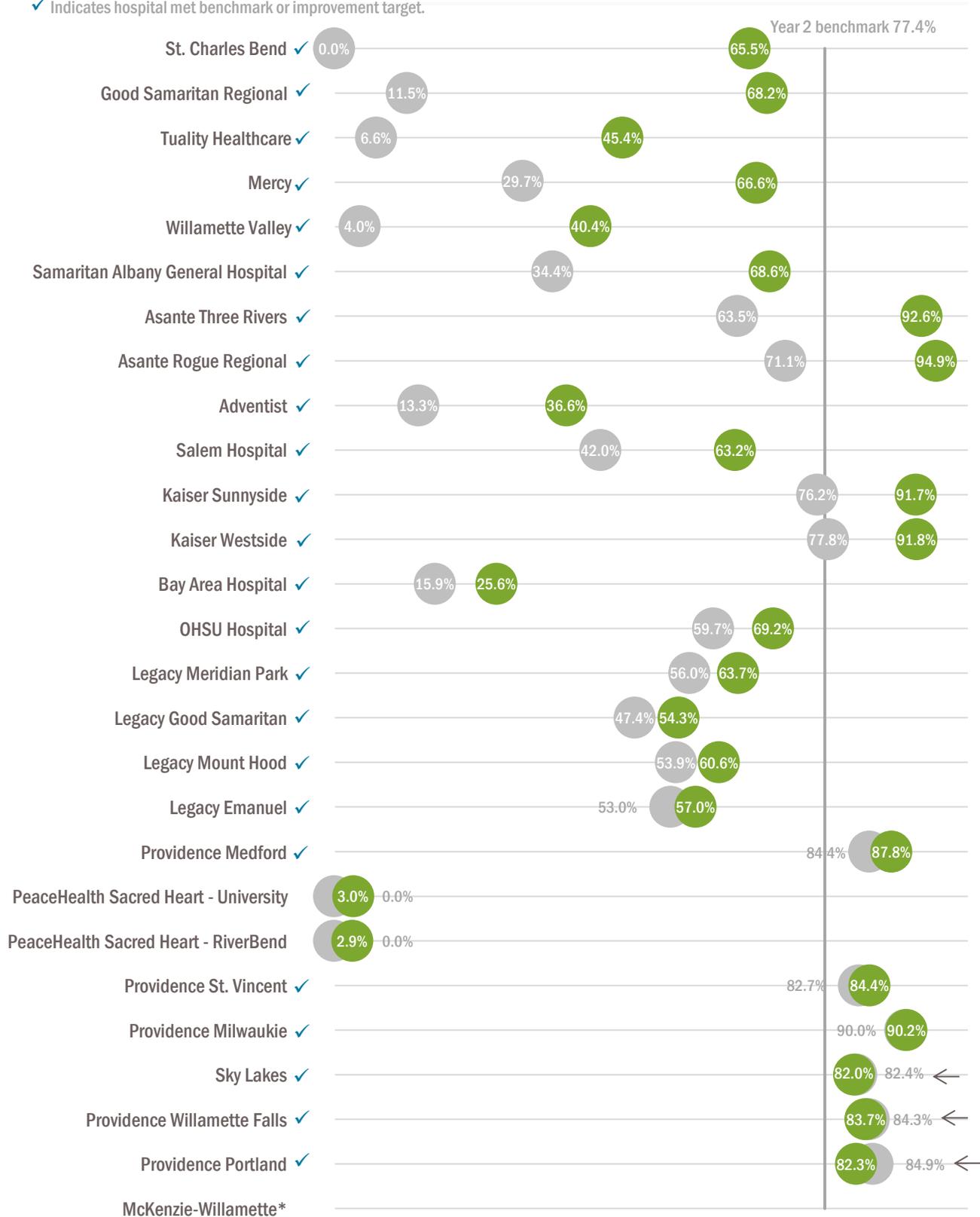
Benchmark source: 75th percentile from HTPP baseline

EDIE: Emergency department information exchange

Twenty-four hospitals met benchmark or improvement target in Year 2.

Grey dots represent baseline.

✓ Indicates hospital met benchmark or improvement target.



*Hospital did not submit data for this measure.

Note: Shriners Hospital for Children does not have an emergency department and cannot participate in this measure.

OHA Contacts and Online Information

For questions about the Hospital Transformation Performance Program, please contact:

Jon Collins, PhD, Director of Health Analytics Oregon Health Authority

Email: jon.c.collins@state.or.us

For more information about the measures and technical specifications, please visit:

www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx.

Version Control

June 30, 2016

The benchmark label on the CLABSI statewide bar graph (page 12) was corrected to read 0.18. It was previously incorrectly labeled 0.83.

All benchmark references for Excessive anticoagulation with warfarin (pages 16-17) were corrected to read 5.0%. The benchmark was previously incorrectly listed as 7.0%.



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