

Oregon Health Authority Hospital Transformation Performance Improvement Program (HTPP) Improvement Targets

The Hospital Transformation Performance Program (HTPP) is a two year program. In the first year, Oregon’s hospitals will be awarded funds for submitting baseline data that meets OHA approval. In the second year of the program, hospital performance will be measured against a specified benchmark for each of the 11 incentive measures¹. Hospitals that do not meet the benchmark for a given measure will be assessed against their improvement from their own baseline target (“improvement target”). If hospitals meet either the benchmark or their improvement target on a given measure, they will be awarded the quality pool funds associated with that measure.

The benchmarks and improvement targets were developed by the Hospital Performance Metrics Advisory Committee, OHA, and CMS as a way to measure progress towards the state’s health system transformation goals. Improvement targets for the second year of the program (October 1, 2014 – September 30, 2015) for each of the hospital incentive measures are documented below in Appendix A.

Improvement Target Calculations

The improvement targets are based on the Minnesota Department of Health’s Quality Incentive Payment System (“Minnesota method” or “basic formula”).² This method requires at least a 10 percent reduction in the gap between the baseline and the benchmark to qualify for incentive payments.

Or, stated as a formula:

$$\frac{[\text{State Benchmark}] - [\text{Hospital Baseline}]}{10} = x \quad [\text{Hospital Baseline}] + [x] = \text{Improvement Target}$$

For example: a hospital’s baseline for the follow-up after hospitalization for mental illness measure may be 30 percent. Say the HTPP benchmark is 68.8 percent.

$$\frac{[68.8] - [30.0]}{10} = 3.88 \quad 30 + 3.88 = 33.9$$

¹ Benchmarks and improvement targets for each of the 11 hospital incentive measures are documented in the measure specification sheets online at: <http://www.oregon.gov/oha/Pages/Hospital-Baseline-Data.aspx>

² Additional details about this methodology are available online at: <http://www.health.state.mn.us/healthreform/measurement/QIPReport051012final.pdf>



The hospital must reduce the gap between its baseline and the benchmark by 10 percent; therefore, the hospital must improve its rate on the follow-up after hospitalization for mental illness measure by 3.88 percentage points, resulting in an improvement target of 33.9 percent.

The hospital must meet either the benchmark of 68.8 percent or the improvement target of 33.9 percent to be awarded quality pool funds for this measure.

Examples of Improvement Target with Floor Calculations

In some cases, depending on the difference between the state benchmark and the hospital baseline, the Minnesota method may result in very small improvements that may not represent statistically significant change.

For example: A hospital’s baseline for the follow up after hospitalization for mental illness measure may be 64 percent. If Oregon’s benchmark for this measure is 68.8 percent:

$$\frac{[68.8] - [64.0]}{10} = 0.5 \qquad 64.0 + 0.5 = 64.5$$

Where the Minnesota method results in small improvement targets, OHA has established a “floor” or a minimum level of required improvement before a hospital would meet the improvement target and be awarded the quality pool funds associated with that measure. The floor ranges from one to three percentage points, depending on the measure.

For measures where a floor has been established, if the improvement target calculation for a hospital results in an improvement target that is less than the floor, the floor takes precedence and is applied instead of the improvement target calculation.

For example, the follow-up after hospitalization for mental illness measure used above has a 3 percentage point floor. As the improvement target calculation results in only a 0.5 percentage point increase in the rate, the 3 percentage point floor is used instead.

| <i>Initial calculation</i> | <i>Improvement target</i> | <i>New improvement target with floor applied.</i> |
|------------------------------------|---------------------------|---|
| $\frac{[68.8] - [64.0]}{10} = 0.5$ | $64.0 + 0.5 = 64.5$ | $64.0 + 3.0 = 67.0$ |

However, if a second hospital’s baseline was only 20 percent on this measure, its improvement target would be greater than the 3 percentage point floor, and the floor would not be applied. Its improvement target would remain the initial calculation.



| <i>Initial calculation</i> | <i>Improvement target</i> | <i>New improvement target with floor applied.</i> |
|------------------------------------|---------------------------|---|
| $\frac{[68.8] - [20.0]}{10} = 4.9$ | $20 + 4.9 = 24.9$ | Not applicable. No floor applied. |

In some instances, the improvement target with floor calculation for a measure could equal the benchmark. For example, with the HCAHPS discharge measure, Oregon’s benchmark is the 90th national percentile, which in April 2014 was 90.0 percent. There is a two percentage point floor for the improvement target. If a hospital’s baseline was 87.8:

| <i>Initial calculation</i> | <i>Improvement target</i> | <i>New improvement target with floor applied</i> |
|------------------------------------|---------------------------|--|
| $\frac{[90.0] - [88.0]}{10} = 0.2$ | $88.0 + 0.2 = 88.2$ | $88.0 + 2 = 90.0$ (equal to benchmark) |

In this case, the hospital must reach the same rate (via the benchmark or the improvement target calculation) to be awarded the quality pool funds for that measure.

And finally, in some instances, the improvement target calculation for a measure could exceed the established benchmark. In this case, the hospital does not have an improvement target and must meet the benchmark to be awarded the quality pool funds for that measure.

For example, with the HCAHPS discharge measure, the state benchmark is set at the 90th national percentile, which in April 2014 was 90.0 percent. The improvement target for this measure has a two percentage point floor. Several hospitals have baselines ranging from 88 - 89 percent. Using the formula:

| <i>Initial calculation</i> | <i>Improvement target</i> | <i>New improvement target with floor applied.</i> |
|------------------------------------|---------------------------|---|
| $\frac{[90.0] - [89.0]}{10} = 0.1$ | $89.0 + 0.1 = 89.1$ | $89.0 + 2 = 91.0$ |

The calculated improvement target (91.0 percent) is higher than the established benchmark (90.0 percent). The hospital does not have an improvement target and must meet the benchmark of 90.0 percent to be awarded the quality pool funds for this measure. It does not need to meet the calculated improvement target when the improvement target is higher than the benchmark to qualify.

Appendix A: Existing Improvement Targets

See pages 1-3 above for a description of the basic formula and percentage point floors for the improvement target calculations.

| Hospital Incentive Measures | Improvement Target for Performance Year (2014-2015) | Benchmark |
|--|---|---|
| Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the ED: 1. Screening rate and 2. Brief intervention rate | Brief- and full-screen: Basic formula with 3 percentage point floor – tied to screening rate only (brief intervention rate must be reported, but no improvement target) | Brief Screen: 67.8% (75 th percentile from HTPP baseline) Full Screen: 12% (alignment with CCO full screen benchmark for 2015) Brief intervention rate must be reported, but is not benchmarked. |
| Follow-up after hospitalization for mental illness (modified NQF 0576) | Basic formula with 3 percentage point floor | 70.0% <i>Alignment with CCO benchmark: 70.0% is the 2014 National Medicaid 90th percentile and is the 2015 CCO benchmark.</i> |
| Hospital-Wide All-Cause Readmissions | Basic formula with 3 percent floor | 8.0% <i>State 90th percentile for DRG hospitals during baseline year</i> |
| Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure) | Basic formula with 1 percentage point floor | 7% or below |
| Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure) | Basic formula with 1 percentage point floor | 5% or below |
| Adverse Drug Events due to opioids (Institute for Safe Medication Practices measure) | Basic formula with 1 percentage point floor | 5% or below |
| HCAHPS, Staff always explained medicines (NQF 0166) | Basic formula with 2 percentage point floor | 72% <i>National 90th percentile (which was 72% as of April 2014)</i> |
| HCAHPS, Staff gave patient discharge information (NQF 0166) | Basic formula with 2 percentage point floor | 90% <i>National 90th percentile (which was 90% as of April 2014)</i> |



| Hospital Incentive Measures | Improvement Target for Performance Year (2014-2015) | Benchmark |
|--|---|---|
| CLABSI in all tracked units (modified NQF 0139) | Basic formula with 3 percent floor | 0.18 per 1000 device days (2010 NHSN Data Summary Report 50 th percentile) |
| CAUTI in all tracked units (modified NQF 0754) | Basic formula with 3 percent floor | 1.13 per 1000 catheter days (50 th percentile from HTPP baseline) |
| Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits: 1. Number of outreach notifications to primary care providers; 2. Number of care guidelines created | Basic formula with 3 percentage point floor – tied to outreach notifications only (must report on care guidelines created, but no improvement target) | 78.6% - 75 th percentile from HTPP baseline – tied to outreach notifications only (number of care guidelines created must be reported, but is not benchmarked) |

Version Control

- 30 July 2015: This briefing was updated to note the absolute Year 2 benchmark for the EDIE measure.
- This briefing was updated on 1 July 2015 to include the final Year 2 benchmarks from the Hospital Performance Metrics Advisory Committee meetings on 29 May 2015 and 26 June 2015.

