

---

# Hospital Performance Metrics Advisory Committee

December 18, 2015



# Consent Agenda

# Public Testimony

# **Expert Testimony on Potential Measure: Opioid Measurement in Oregon**

**Katrina Hedberg, MD, OHA**

**Catherine Livingston, MD, OHA**

**Lisa Bui, MBA, OHA**

**David Labby, MD, Health Share**

---

# Oregon Opioid Overdose Prevention Initiative

Lisa Bui, MBA, Quality Improvement Director, OHA  
Katrina Hedberg, MD, MPH, Health Officer & State Epidemiologist, OHA  
David Labby, MD, PhD, Health Strategy Officer, Health Share of Oregon  
Cat Livingston, MD, MPH, HERC Associate Medical Director, OHA

December 18, 2015



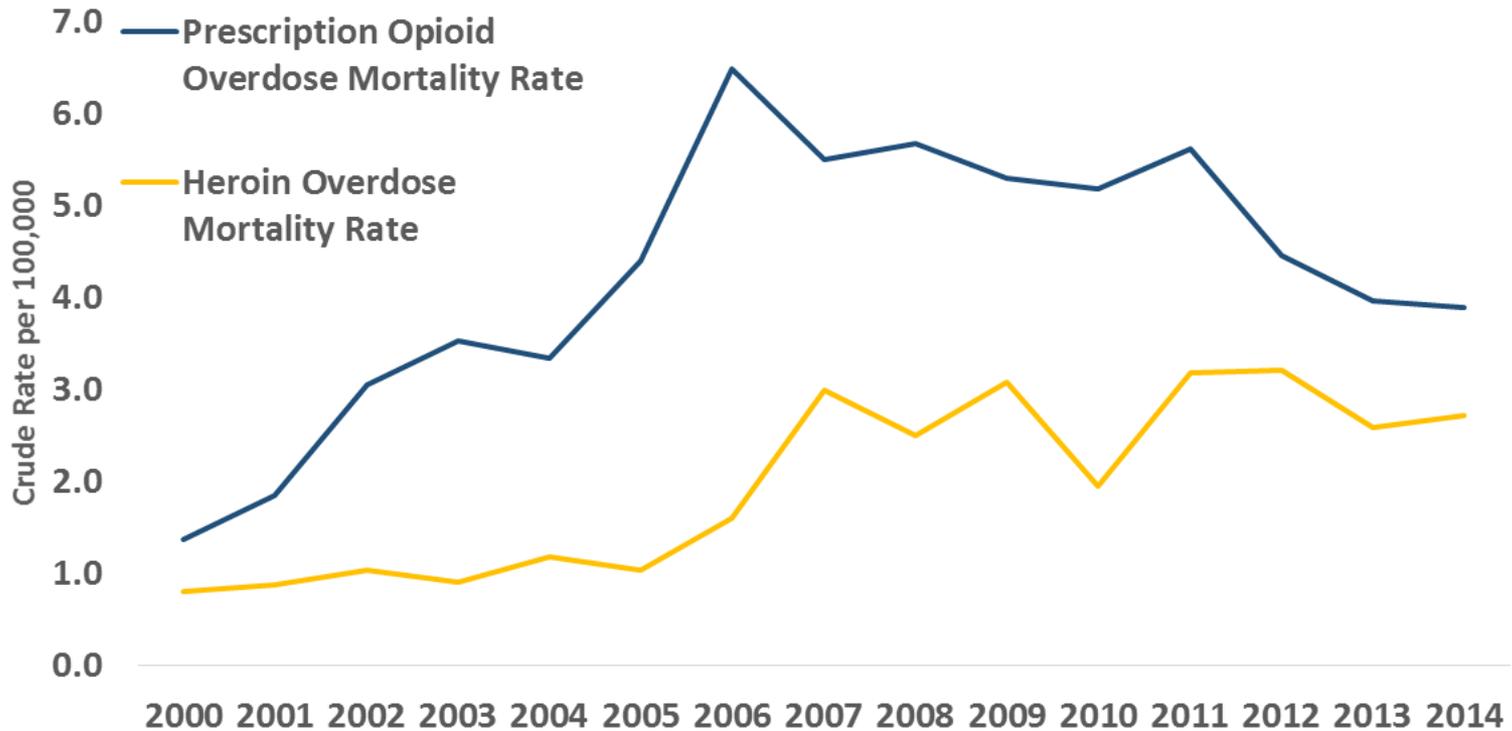
# Agenda

- Current Public Health strategies and the role of hospitals (Katrina)
- Community Efforts for reduction in Opioids (David)
- Statewide Performance Improvement Project (Lisa)
- Potential opioid metric for hospitals/emergency departments (Cat)
- Discussion (All)

# Oregon Prescription Opioids: The Problem

- **Deaths in 2014**
  - 154 Oregonians died (prescription opioids)
  - Rate of opioid deaths declined 40% between 2006 and 2014
- **Hospitalizations in 2013**
  - 330 Oregonians hospitalized
  - Cost of care was \$9.1 million
  - 4,300 hospitalized patients had opioid use disorder diagnosis
- **Misuse**
  - 212,000 Oregonians (5% of population) self-reported non-medical use of prescription pain relievers in 2012-13

## Annual Rates of Overdose Mortality, Prescription Opioids and Heroin, Oregon, 2000-2014



# Spectrum of Interventions

- Decrease amount of opioids prescribed
- Increase availability of naloxone rescue for overdoses
- Ensure availability of treatment of opioid misuse disorder
- Use data to target and evaluation interventions

# Role of Hospitals: Decrease Amount of Opioids Prescribed

- Implement Opioid Prescribing Guidelines for Pain Management
  - Acute, Cancer, End-of-life; versus Chronic
  - Emergency Departments; in-patient; primary care
- Use Prescription Drug Monitoring Program to Assess

# Role of Hospitals: Emergency Department Guidelines

- Single provider for all opioids
- No injections of opioids in ED; no replacements for lost opioids; no prescriptions for long-acting opioids
- Limit number of pills; no co-prescribing of opioids & benzos
- Check PDMP
- Coordinate with primary care
- Perform SBIRT; evaluation substance abuse hx

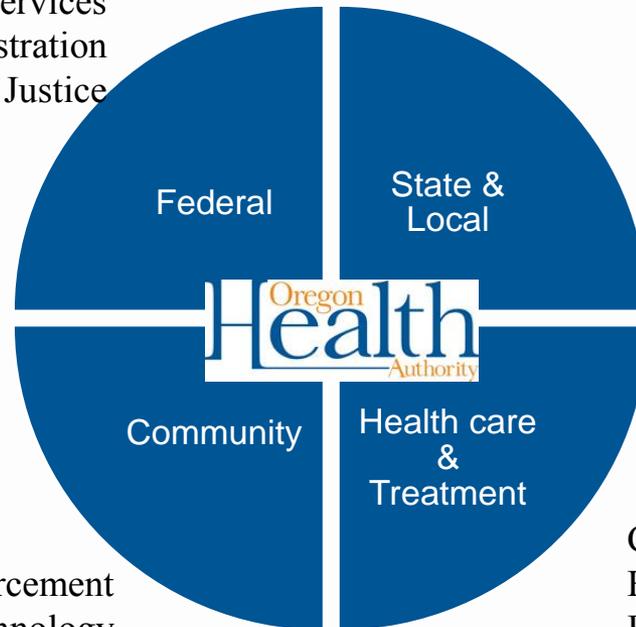
# Role of Hospitals: Naloxone Rescue & MAT

- Co-prescribe naloxone with opioids for at-risk patients
- Improve infrastructure for naloxone rescue by EMTs and law enforcement
- Link ED patients who have received naloxone for opioid overdose with Medication-Assisted Treatment (MAT) services

# Oregon Opioid Initiative Partnership

Centers for Disease Control & Prevention  
Substance Abuse & Mental Health Services  
Administration  
Department of Justice

State policy makers and statutes  
Oregon Health Leadership Council  
Health Systems  
Local public health departments



Public safety/ Law Enforcement  
OHSU & NW Addictions Technology  
Transfer Center  
OR Coalition for the Responsible Use of  
Meds  
Needle exchange programs

Coordinated Care Organizations  
Health systems  
Emergency Departments  
Pain management clinics  
Public & Private Opioid Use Disorder  
Treatment Programs

# OHA Opioid Initiative Activities

- Prescription Drug Monitoring Program
- CCO Performance Improvement Project: Tool kit for CCOs
- Opioid website with links to resources
- CDC grant funding for LHD and CCO partnerships in areas with high opioid overdose
- Support for statutory change to increase naloxone access
- Resources to increase MAT access
- Population data on opioid overdose, use, abuse

# Community Efforts for reduction in Opioids

# Statewide Performance Improvement Project (PIP)

- July 2015 – June 2017 Statewide PIP: Opioid Reduction
- CCOs are required to participate in the statewide PIP as negotiated in the CMS waiver
- OHA selected topic with broad CCO engagement
- Performance Metric: 120 MED, 90 MED
  - Percentage of OHP enrollees, aged 12 years and older, who have prescriptions for opioid pain relievers totaling  $\geq 120\text{mg}$ ,  $\geq 90\text{mg}$ , Morphine Equivalent Dosage (MED) on at least one day during the measurement period
  - # of Consecutive Days of MED (potential aggregate detail)
- CCO specific Aim and Project Interventions are being developed Q1 2016

# Hospital Metric Options

- **% of patients discharged with >XX opiate pills (e.g.10)**
- % of patients with a history of drug abuse/opiate addiction receiving opiates or benzodiazepines
- % of patients who receive controlled substances for which the OPDMP is reviewed
- % of patients receiving opiates acutely who are on chronic opiates (acute exacerbation of chronic pain)
- % of patients receiving a co-prescription for opiates and benzodiazepines

# Recommended Metric

## **% of patients discharged from the ED (or hospital) receiving >XX opiate pills (recommend 6-10)**

- Metric Methodology:
  - Numerator: The number of patients discharged from the ED (or hospital) on short acting opioids with no more than xx pills\* (e.g. a 3 day supply).
  - Denominator: The number of patients discharged from the ED (or hospital) on ANY opioid at ANY quantity.
- Benefit
  - EMR reporting
  - Aligns with goal of to reduce risk and pills in circulation
  - Aligns to community and CCO work towards opioid reduction
- Challenges
  - Rx must be prescribed in EMR (issues of paper rx, dispensed meds)
  - ED focus (versus adding in hospital discharge)

# Questions

Lisa Bui, MBA, Quality Improvement Director, OHA

[Lisa.t.Bui@state.or.us](mailto:Lisa.t.Bui@state.or.us)

Katrina Hedberg, MD, MPH, State Health Officer, OHA

[Katrina.Hedberg@state.or.us](mailto:Katrina.Hedberg@state.or.us)

David Labby, MD, PhD, Health Strategy Officer, Health Share of Oregon

[david@healthshareoregon.org](mailto:david@healthshareoregon.org)

Cat Livingston, MD, MPH, HERC Associate Medical Director, OHA

[Catherine.LIVINGSTON@state.or.us](mailto:Catherine.LIVINGSTON@state.or.us)

# **Expert Testimony on Potential Domain: Care Transitions**

**Divya Sharma, MD,  
Mosaic Medical, Central Oregon Independent  
Practice Association**



# Transitions of care

## the outpatient perspective

Divya Sharma, MD, MS.

Regional Med Director Bend, Mosaic Medical; Medical Director, Central Oregon IPA

*Transition of care focus in this presentation will address specifically bidirectional outpatient to inpatient transition*

# Why is This Important?

- Same reasons as previously stated from the hospital side:
  - Patient Safety
  - Decreased waste/lower cost
  - Greater member experience and greater Provider experience

# Safety Concerns

- Medication errors are frequent during transition
  - Medicines do not get accurately reconciled when patient is first admitted (info often relied on what the patient provides)
  - Doses of some chronic medications get changed but patient and PCP are unaware at discharge

# Increased Cost/Poor Member Experience

- Frequent duplication of tests – e.g. imaging
- Admitting provider is unaware of patient's advance care goals and orders inappropriate tests
- Lack of appropriate follow up results in avoidable ER visits or readmissions

# Member and PCP experience

- Members often need help sorting through complex information after a hospital stay.
  - The more their outpatient team can provide assistance, the better.
- PCP is able to maximize time with patient in an efficient way if all discharge information easily available

# Barriers to good transitions

- Different Electronic Medical Records (EMRs) between outpatient and inpatient clinics – one can't view the other
- Even if able to view other EMRs (e.g. through Epic CareEverywhere or via a view only portal), med reconciliation process is very time consuming, confusing, and difficult for PCP to complete in a busy practice without significant ancillary support

# Barriers to good transitions cont.

- Direct communication between inpatient provider and PCP does not happen consistently
- Significant reliance on patients to provide information, but most have low health literacy
- Valuable info regarding socioeconomic barriers impacting health are not recorded in EMRs. Inpatient provider does not have access to this information.
  - May result in poor discharge planning
- PCP is often unaware that patient admitted to the hospital
  - Not able to provide valuable care goal information to inpatient provider if appropriate

# Possible Metrics

- Step wise approach important
- Pharmacy/Med reconciliation: This is most useful since this is likely the most frequent error
  - Potential process measure: Develop a Continuity of Care Document (CCD) showing the most accurate medication list and patient problem list
    - Year 1: CCD created and workflow developed to review/update document every time patient is seen by a PCP or a hospitalist
      - Challenge – Ease of accessibility from a centralized source. There is a wide variation in level of HIE development in regions. Tools such as PreManage may have this capability. CCOs could be incentivized to provide such a tool to their service areas
    - Year 2: Demonstrate use of CCD

# Possible Metrics cont.

- PCPCH certification has already required clinics to develop the following transition of care workflows:
  - Process for requesting hospital admission
  - Process and performance expectations for communication at the time of hospital admission
  - Process for sharing of patient medical records at the time of hospital admission
  - Process and performance expectations for communication at the time of hospital discharge
  - Process and performance expectations for scheduling after-hospital *follow up appointments*

# Possible Metrics cont.

- *A process metric pushing one of these PCPCH measures may be established:*
  - *Process for sharing of patient medical records at the time of hospital admission*
    - *Potential metric: Develop a tracking and reporting system showing presence of last PCP visit note with updated med list and problem list into the inpatient EMR within 24 hours of admission*
  - *Process and performance expectations for communication at the time of hospital discharge*
    - *Potential metric: Develop a tracking and reporting system demonstrating presence of discharge summary in patient's PCP clinic chart within 24 hours of discharge.*

Other important transitions of care worth considering at some later time

- Transitions of patients from independent to assisted living facilities
- Transition of post-surgical patients from hospital to skilled nursing facilities and then to either assisted living facilities or their independent homes

**BREAK**

# Year 3 Program Structure

- Oregon Perinatal Collaborative Update from Diane Waldo, OAHHS
- See information sent to CMS in packet

### Current Structure – Years 1 & 2

Focus Area	Domains	Measures
Hospital focus	1. Readmissions	1. Hospital-wide all-cause readmission
	2. Medication Safety	2. Hypoglycemia in inpatients receiving insulin 3. Excessive anticoagulation with Warfarin 4. Adverse drug events due to opioids
	3. Patient Experience	5. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Staff always explained medicines (NQF 0166) 6. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Staff gave patient discharge information (NQF 0166)
	4. Healthcare-Associated Infections	7. Central Line-Associated Bloodstream Infection (CLABSI) in all tracked units (adapted from NQF 0139) 8. Catheter Associated Urinary Tract Infection (CAUTI) in all tracked units (adapted from NQF 0754)
Hospital-CCO collaboration focus	5. Sharing ED Visit Information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits (two-part measure)
	6. Behavioral Health	10. Follow-up after hospitalization for mental illness (adapted from NQF 0576) 11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the emergency department (two-part measure)

### Potential New Structure (all community focused)

Domains	Measures
<b>NEW:</b> <b>1. Fostering Effective Care Transitions</b>	1. Hospital-wide all-cause readmission 2. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Staff always explained medicines (NQF 0166) 3. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Staff gave patient discharge information (NQF 0166)
2. Improving Patient Safety	4. Central Line-Associated Bloodstream Infection (CLABSI) in all tracked units (adapted from NQF 0139) 5. Catheter Associated Urinary Tract Infection (CAUTI) in all tracked units (adapted from NQF 0754) 6. Hypoglycemia in inpatients receiving insulin 7. Excessive anticoagulation with Warfarin 8. Adverse drug events due to opioids 9. <b>POTENTIAL NEW: C-Difficile (replace 4 or 5)</b>
3. Reducing Avoidable ED visits	10. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits (two-part measure)
4. Coordinating Behavioral Health and Substance Use Interventions	11. Follow-up after hospitalization for mental illness (adapted from NQF 0576) 12. SBIRT in the emergency department (two-part measure) 13. <b>POTENTIAL NEW: Reducing opioid use</b>
<b>NEW:</b> <b>5. Improving Maternal health</b>	14. <b>POTENTIAL NEW: Reducing C-sections (work with Oregon Perinatal Collaborative)</b>

# Group Discussion of CMS Feedback, Testimony and Next Steps

# Wrap-up

**Next meeting – January 22, 2016**