

## **Oregon Hospital Performance Metrics Advisory Committee**

### **February 7 meeting notes**

*Due to inclement weather, the meeting was held by webinar and conference call*

All documents referenced here can be found at: <http://www.oregon.gov/oha/Pages/http.aspx>

#### **Members present:**

Steve Gordon, MD (Chair)- PeaceHealth  
Manny Berman – Tuality Healthcare  
Bob Dannenhoffer, MD – Umpqua Health Alliance  
Phil Greenhill, MD – Western Oregon Advanced Health  
Doug Koekkoek, MD – Providence Health & Services  
David Labby, MD – Health Share  
Pam Steinke – St. Charles Health System

#### **Presenters and staff:**

Lori Coyner - OHA  
Tina Edlund - OHA  
Milena Malone - OHA  
Elyssa Tran – Apprise  
Diane Waldo – OAHHS  
Mark Whitaker – OHA

**Audience members:** Sarah Bartellman; Lisa Taylor; Joell Archibald; Jeff Fritsche; Gretchen Morley; Cindi McElhaney; David Roher; Leslie Clement

#### **Summary:**

##### ***Item: Welcome and Introductions***

***Presenter: Steve Gordon, Chair***

Dr. Gordon called a quorum and outlined the purpose of the committee, which is to identify three to five performance standards for hospitals that are designed to meet the Triple Aim: to advance health system transformation, reduce hospital costs, and improve patient safety.

Members introduced themselves and stated briefly what they hope to contribute to the committee.

##### ***Item: Background and Committee Charter***

***Presenter: Tina Edlund, OHA***

Tina explained that payment for outcomes is an important part of Oregon's Health System Transformation. This group is establishing incentives for hospital outcomes. House Bill 2216 guides OHA to distribute fifty percent of dollars based on data submission and the remainder based on performance standards, which are to be identified by this committee. This is part of a waiver application that is before CMS right now. CMS will need to approve the recommendations of this group; they are a stakeholder at the table.

Chosen metrics should not be brand new, but rather should align with the goals of Health Systems Transformation and with Coordinated Care Organizations. This committee will recommend metrics, and OHA

will focus on payment methodology. Committee's recommendation will go before CMS. If CMS has input or feedback, an additional meeting may be convened.

**Question:** Why is the committee constrained to recommend so few (3-5) metrics?

**Answer:** That number is in the statute; staff does not have insight into the development of the bill. However, since the program is limited to only two years, it is important to consider that the chosen performance standards should be something hospitals can move the needle on in a short amount of time. The pool is further limited since the metrics are expected to be consistent with existing standards. There is an overarching goal to keep the work simple.

**Item: Background on Coordinated Care Organization Quality Pool**

**Presenter: Lori Coyner, OHA**

Lori presented the [COO Quality Pool Presentation](#) to provide background on CCO Quality Pool Methodology and to help the committee understand the established program with which they are attempting to align the hospital metrics.

Key elements:

1. CCO'S have multiple opportunities to meet standards and receive funding
2. All the money is paid out
3. There are formulas for computing the funds paid (not every CCO is eligible for the same amount)
4. Incentive payments are "new and additional" money

**Item: Base Payment Methodology**

**Presenter: Elyssa Tran, Apprise**

Elyssa presented slides 1-8 of [Funding Allocation Methodology](#) to provide background on payment methodology that has already been established for the Hospital Transformation Performance Program.

**Question:** Regarding process, is this methodology a *proposed* methodology that would be included in the plan submitted to CMS for approval?

**Answer:** Yes. Similarly to this committee, it is possible that CMS will return with further questions or recommendations. Dr. Dannenhoffer also added that CMS was unsatisfied with two measures proposed by the Metrics and Scoring Committee.

**Question:** What is the timeline/deadline for CMS approval?

**Answer:** While there is no specific deadline, the sooner the committee makes recommendations, the sooner OHA can begin working with CMS.

**Question:** A ballpark range of how much money is play would be helpful so that hospitals know how much money to invest in meeting the measures. The more money that is involved, the greater risk hospitals will be willing to take to truly transform.

**Answer:** Elyssa explained that when Apprise worked with DMAP on the waiver amendment, it was determined that the assessment of the 1 percent (which is based on net patient revenue) was about \$75-80 million. When the state used that money to draw down the 1 percent federal equivalent value, the estimate was about \$133 million.

**Item: Potential Hospital Performance Measures**

**Presenter: Diane Waldo, OAHHS**

Dr. Gordon, Committee Chair, explained that while the previous two presentations were for background, the discussion will now turn to measures and targets themselves.

Diane presented slides 9-16 of [Funding Allocation Methodology](#) to provide suggestions for Hospital Performance Potential Measures.

**Item: Discussion of Performance Measures**

**Presenter: Dr. Steve Gordon, Chair**

Dr. Gordon, Committee Chair, asked the committee to discuss whether the three potential measures strongly recommended by the Work Group (Early Elective Deliveries; Preventable Readmissions; and Meaningful Use) hold promise for the group:

**1. Early Elective Deliveries**

Description/definition: Patients with elective vaginal or elective C/S at greater than or equal to 37 and less than 39 weeks completed gestation (Joint Commission definition)

- Alignment with CCO (one of 17 CCO measures)
- Important patient safety effort
- Cost savings

There was strong consensus among the committee in support of this measure. Discussion included:

- Key issue is whether or not there is a process in the OB unit so that requested elective deliveries must meet medical criteria.
- Given that this is a short term initiative, choosing this measure would help solidify work that has already been done
- However, it would also be nice to choose something more aspirational that pushes the envelope further.
- A lot of work has been done in recent years to measure and collect data related to this measure.
- Most tertiary facilities that have NICUs have seen NICU revenue and volumes drop because of these measures. We should be rewarding hospitals for doing work that improves quality but takes revenue away.
- This measure has very important consequences.
- When the Metrics and Scoring Committee was choosing measures, the pool was \$40 million divided between 17 measures, so each measure was essentially worth \$2-3 million. These measures are worth much more: about \$40 million *each*. So the question is, is this measure worth \$40 million? (yes)
- The issue is not whether viable units like NICUs should continue operation, but rather whether resources are being used appropriately.
- Concern whether measures are quality indicated on the delivery of care. If measures are meant to meet Triple Aim, which one produces cost efficiency? Concern = resource containment.
- This measure does moderate cost of care because there are fewer newborn complications.
- This measure also helps meet the Triple Aim because of education to the community.

## 2. Preventable Readmissions

Description/definition: Reducing preventable readmissions has value as an indicator of quality; may reflect poor coordination of services and transitions of care at discharge or in the immediate post discharge period. Potentially preventable readmissions (PPR) as calculated by Apprise Health Insights, using 3M software.

There was strong consensus among the committee in support of this measure, but concern about benchmark/target methodology. Discussion included:

- This is a different readmission measure than the CCOs. CCOs used “Plan All Cause” Readmissions (rather than “Preventable”) and it’s not one of the 17 Incentive Measures.
- More detail about the methodology behind this measure would be helpful
  - Diane explained that several states use the 3M software and have found it to be reliable. The software filters and produces a report of each hospital’s top 25 DRGs of those patients being readmitted. This information helps hospitals focus on the conditions that see readmission and make focused process improvements.
- The measure is for 30 days
- At a high level, a readmission prevention measure seems valuable and consistent
- Great measure to meet Triple Aim
- Reducing readmissions is a function of both hospitals and primary care, and should therefore create incentive to create more integrated care across the hospital outpatient continuum.
- Supports efforts to move patients away from hospitals and into primary care
- Worth \$40 million.
- 3M Software/PPR has advantage of tracking admissions to other hospitals. Disadvantage = software is proprietary. Not consistent with CCO metric or CMS Value Based Purchasing Metrics. CMS will likely move toward hospital-wide readmission metric. However since this is a limited duration program, that may not be important. From a pragmatic standpoint, this is probably the best metric in the readmission category.
- Elyssa explained 3M makes the software available for free to the state
- With previous methodologies, this metric was manipulated and gamed by hospitals. However if hospitals are satisfied with the new methodology, it’s a great measure.
- Tremendous advantage that new methodology tracks between hospitals
- Could Apprise Health Insights provide the data so that hospitals don’t need do additional tracking? (yes)
- If the committee chooses a measure that does not have CMS programmatic alignment, will there be problems with benchmarking? Does this measure have any opportunity for benchmarking or target setting?
  - Answer: there are not national benchmarks for this data. The calculation is based on hospital inpatient discharge data. Apprise could find, for example, a state average to use for target setting). It’s possible to calculate an improvement target, but not a national benchmark.
- The committee should acknowledge areas where Oregon hospitals collectively outperform national standards.
- Does OHA have concerns about how CMS would view this proposal?

- Answer: while the concept of readmission is strong, it would be necessary to provide strong methodology for improvement targets and/or benchmarks. The lack of benchmark is a legitimate concern.
- Target should not be too aspirational. Most initiatives that reduce readmissions are complex and time consuming. Since this is a short-term program, an improvement target may suffice.

**Action:** OHA and Apprise staff will discuss options and provide background on national benchmarks at a later meeting.

### 3. Meaningful Use and adoption of Electronic Health Records

The committee had a mixed reception to this measure.

- Have there been instances of providers experiencing a pre-payment audit? (Answer: no)
- CCOs have done well in a short time on this measure, partly because baseline year was 2011 and first measure was 2013
- To what extent are hospitals currently meeting this metric? Have any hospitals done this; would it be a great stretch or are we already halfway there?
  - Answer: most recent review found that approximately two-thirds of the 28 DRG hospitals have achieved Meaningful Use (both attested and payment received) and the rest are in process).
- Is it known whether hospitals have met Stage 1 or Stage 2? A possible target would be to increase stage (i.e. if a hospital is at Stage 1, they need to get to Stage 2).
- This measure is poor choice because it's already being accomplished by the hospitals and is part of CMS incentive payments. Not aspirational or transformative.
- This measure is a good choice because it is key to coordinating care. Current meaningful use payments don't come close to covering cost, so more incentive is reasonable. Concern that hospitals will reach Stage 1 but falter at Stage 2 because they can't afford the investment.
- Are there measures that would better meet the Triple Aim, rather than just repeating incentive payments?
- Reaching Meaningful Use Level 2 will likely be difficult for DRG hospitals.

The committee also discussed other potential measures as recommended by the work group: Falls with Injury; and Catheter-Associated Urinary Tract Infection (CAUTI) –

#### **Falls with Injury**

Patient safety issues: addresses inpatient falls and categorizes minor or major; e.g. scraped knee versus fractured hip.

The committee strongly and unanimously rejected this measure and agreed that it is neither innovative nor transformative, and is easily manipulated. However, patient safety is important, and it was suggested that the state's Patient Safety Commission make a recommendation for the committee to consider.

## **Catheter-Associated Urinary Tract Infection (CAUTI)**

Again, the committee agreed that this measure is neither innovative nor transformative. Further discussion included:

- Does this measure meet the Triple Aim? It helps reduce cost, but not to the same degree as (for example) unnecessary emergency department use.
- Suggestion = Central Line Infection. A bundle would be much more evidence-based and realistic than CAUTI.
- Measure might not accurately capture improvements.
- Page 5 of the [meeting packet](#) lists additional healthcare associated infections and other preexisting measures that the committee might like to consider

The committee expressed interest in an Emergency Department Utilization measure and discussed the Emergency Department Information Exchange (EDIE). New Jersey has a hospital performance based program that was approved by CMS and includes some ED measures; OHA staff will include information in the next meeting packet. ED Utilization is a CCO Incentive Measure.

### ***Item: Public Testimony***

***Presenter: Dr. Steve Gordon, Chair***

The phone lines were opened for public testimony; there was none.

### ***Follow Up and Next Steps:***

Other suggestions for potential measures to discuss:

- Breast feeding
- Mental health (for example follow up after discharge)
- Any other measures recommended by the OAHHS work group

If committee members have any other recommendations, please email [mark.whitaker@state.or.us](mailto:mark.whitaker@state.or.us)

Information on these potential measures will be presented at the next meeting. In addition, staff will complete background research and provide information on:

- Patient Safety
- Potential Emergency Department process measures
- Benchmarks options and baseline numbers for Early Elective Delivery and Preventable Readmissions
- Meaningful Use

***\*\*Meeting Adjourned\*\****