

**OREGON HOSPITAL  
TRANSFORMATION  
PERFORMANCE PROGRAM (HTPP)  
Baseline Year Report**

Measurement period:  
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# Table of Contents

Executive summary.....	1
Background.....	2
Measures and domains.....	3
DRG Hospitals. ....	4
Quality pool distribution.....	5
<b>Measures:</b>	
CAUTI in all tracked units.....	8
CLABSI in all tracked units.....	10
Adverse drug events due to opioids.....	12
Excessive anticoagulation with Warfarin.....	14
Hypoglycemia in inpatients receiving insulin.....	16
HCAHPS: Staff always explained medicines.....	18
HCAHPS: Staff gave patient discharge information.....	20
Hospital-wide all-cause readmissions.....	22
Follow-up after hospitalization for mental illness.....	24
SBIRT: Screening for alcohol and drug misuse in the ED.....	26
EDIE: Outreach notification to primary care providers.....	28
OHA contacts and online information.....	31

# Executive Summary

The first Hospital Transformation Performance Program report lays out how hospitals are doing on key quality health metrics. These metrics indicate how well hospitals are advancing health system transformation by improving quality of care, reducing costs, and improving patient safety.

Eleven outcome and quality measures covering six domains were developed through a transparent process by the Hospital 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. The first year of **baseline** data, included in this report, spans from October 2013 through September 2014.

For the first year, a total of \$150 million in funds from a quality pool are being awarded based on **baseline** data submitted for the 11 measures. A two-phase distribution method determines amounts awarded. In the first phase, all participating hospitals are eligible for a \$500,000 "floor" payment if they achieve at least 75 percent of the measures for which they are eligible. All hospitals achieved this, resulting in \$14 million in payments to hospitals from phase one. In the second phase, the \$136 million in remaining funds went to a pool that is distributed on a measure-by-measure basis. This initial report shows that overall, hospitals succeeded in reporting most or all of the data required for payment.

Overall, hospitals were successful in reporting the measures required for payment in the first year. All hospitals successfully submitted data for 8 of the 11 measures.

The **baseline** data shows progress toward achieving key metrics and will help further discussions about benchmarks. While the benchmark doesn't apply toward payments until the second year, this report shows:

- Hospitals are doing well in the area of increased medication safety.
  - Adverse drug events due to opioids: all hospitals achieved the benchmark.
  - Excessive anticoagulation with Warfarin: 27 of the 28 hospitals achieved the benchmark.
  - Hypoglycemia in inpatients receiving insulin: 25 of the 28 hospitals achieved the benchmark.
- Follow-up after hospitalization for mental illness, a hospital / coordinated care organization (CCO) coordination-focused measure: 15 of the 28 hospitals achieved the benchmark.

This report tells us where Oregon's hospitals are today on key measures and advances the vision of a healthy Oregon. This report adds increased transparency and accountability to the health care system as Oregon sees continued progress toward the triple aim of better health, better care and lower costs.

# Background

In 2013, Oregon's House Bill 2216 directed the Oregon Health Authority to establish an incentive metric program for diagnosis-related group (DRG) hospitals. These metrics show how well hospitals are advancing health system transformation, reducing costs, and improving patient safety. The program is called the Hospital Transformation Performance Program (HTPP). HTPP is approved through OHA's 1115 Medicaid waiver agreement with the Centers for Medicare and Medicaid Services (CMS).

## Metrics

Eleven outcome and quality measures covering six domains were developed by the Hospital Metrics Advisory Committee for October 2013 – September 2014 (baseline year) and October 2014–September 2015 (performance year). The six domains and 11 measures are captured in two overarching focus areas:

1) hospital-focused and 2) hospital / coordinated care organization (CCO) coordination-focused. The hospital-CCO coordination-focused domains support greater collaboration and alignment of the work that hospitals and CCOs are doing to further health system transformation.

## Incentive Payments

In order to qualify for incentive payments in the first year of the program (**baseline** year), hospitals must submit data which adhere to the program measure specifications and data submission guidance from OHA (available at [www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx)). 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** performance for each of the 11 measures.

## Benchmarks

Benchmarks for the second year of the program were established prior to the availability of baseline data for some measures. Benchmarks for all measures will be finalized in spring and summer 2015.

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

### 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.

# Measures and Domains

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

# DRG Hospitals

<b>Hospital name</b>	<b>Location</b>
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

# Quality Pool Distribution

## Baseline Quality Pool

In this first year of the HTPP, Oregon's DRG hospitals may qualify for a quality pool payment by submitting **baseline** data that follow the official HTPP measure specifications and data submission guidance published by OHA (available at [www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx)).

These data are for the period October 1, 2013 - September 30, 2014, and provide a **baseline** for future performance. In subsequent years, hospitals will have to achieve benchmarks or improvement targets to receive a quality pool payment.

The program is funded by the Hospital Provider Assessment Program, as authorized by the Oregon Legislature. The **baseline** year quality pool is \$150 million; all funds are distributed in the **baseline** 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 One 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. To achieve a measure in the **baseline** year a hospital must have submitted data in accordance with measure specifications.

**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	28
		Floor payment per hospital	<u>x \$500,000</u>
		<b>Total floor payment</b>	<b>= \$14,000,000</b>

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

Step 2	{	Total in quality pool	\$150,000,000
		Subtract total floor payment	<u>- \$14,000,000</u>
		<b>Amount remaining for payment on individual measures</b>	<b>= \$136,000,000</b>

# Quality Pool Distribution

## Quality Pool: Phase Two Distribution

The remaining funds are allocated to hospitals based on their performance on the individual measures (in the **baseline** year, this means the successful submission of data).

**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 by the amount remaining in the pool after Phase One. This is the "base amount."

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

Measure	Measure weight	Total amount available for measure	Number of hospitals qualifying for baseline payment
CAUTI in all tracked units	9.38%	\$12,750,000	28
CLABSI in all tracked units	9.38%	\$12,750,000	28
Adverse drug events due to opioids	6.25%	\$8,500,000	28
Excessive anticoagulation with Warfarin	6.25%	\$8,500,000	28
Hypoglycemia in inpatients receiving insulin	6.25%	\$8,500,000	28
HCAHPS: Staff always explained medicines #	9.38%	\$12,750,000	27
HCAHPS: Staff gave patient discharge information #	9.38%	\$12,750,000	28
Hospital-wide all-cause readmissions	18.75%	\$25,500,000	28
Follow-up after hospitalization for mental illness	6.25%	\$8,500,000	28
SBIRT: Screening for alcohol and other substance misuse in the ED *	6.25%	\$8,500,000	17
EDIE: Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits *	12.50%	\$17,000,000	26
<b>Total</b>	<b>100.00%</b>	<b>\$136,000,000</b>	

# As a children's hospital, Shriners Hospital for Children fields the Press Ganey Inpatient Pediatric Survey, rather than HCAHPS. Shriners is still eligible for payment on the "HCAHPS: Staff gave patient discharge information" measures, but in the second year of the program Shriners' performance will be assessed using data from a similar question included in the Press Ganey Inpatient Pediatric Survey. The Press Ganey survey does not include a question analogous to the HCAHPS question on staff explaining new medications, so Shriners Hospital for Children is not eligible for payment on that measure.

\* Shriners Hospital for Children does not have an emergency department (ED), so it cannot participate in the two ED-based measures (SBIRT and notification to primary care [EDIE]). Shriners is therefore ineligible for payment on these measures.

# Quality Pool Distribution by Hospital

Hospital	Total measures possible	Number of measures met	Phase One payment earned	Phase Two payment earned	Total dollar amount earned
Adventist Medical Center	11	11	\$500,000	\$6,834,107	\$7,334,107
Asante Rogue Regional	11	11	\$500,000	\$6,268,746	\$6,768,746
Asante Three Rivers	11	11	\$500,000	\$3,316,085	\$3,816,085
Bay Area Hospital	11	10	\$500,000	\$2,344,858	\$2,844,858
Good Samaritan Regional	11	10	\$500,000	\$2,674,786	\$3,174,786
Kaiser Sunnyside	11	11	\$500,000	\$1,347,770	\$1,847,770
Kaiser Westside	11	11	\$500,000	\$63,280	\$563,280
Legacy Emanuel	11	10	\$500,000	\$13,669,906	\$14,169,906
Legacy Good Samaritan	11	10	\$500,000	\$3,246,433	\$3,746,433
Legacy Meridian Park	11	10	\$500,000	\$1,121,733	\$1,621,733
Legacy Mount Hood	11	10	\$500,000	\$2,786,298	\$3,286,298
McKenzie-Willamette	11	10	\$500,000	\$2,086,184	\$2,586,184
Mercy Medical Center	11	11	\$500,000	\$3,390,811	\$3,890,811
OHSU Hospital	11	11	\$500,000	\$21,894,906	\$22,394,906
PeaceHealth Sacred Heart - RiverBend	11	11	\$500,000	\$12,520,746	\$13,020,746
PeaceHealth Sacred Heart - University	11	11	\$500,000	\$1,926,574	\$2,426,574
Providence Medford	11	11	\$500,000	\$2,566,728	\$3,066,728
Providence Milwaukie	11	11	\$500,000	\$1,549,488	\$2,049,488
Providence Portland	11	11	\$500,000	\$12,108,786	\$12,608,786
Providence St. Vincent	11	11	\$500,000	\$10,455,994	\$10,955,994
Providence Willamette Falls	11	11	\$500,000	\$2,002,868	\$2,502,868
Salem Hospital	11	10	\$500,000	\$7,508,444	\$8,008,444
Samaritan Albany General Hospital	11	10	\$500,000	\$1,770,612	\$2,270,612
Shriners Hospital for Children	8	8	\$500,000	\$335,155	\$835,155
Sky Lakes	11	10	\$500,000	\$2,466,838	\$2,966,838
St. Charles Bend	11	10	\$500,000	\$5,586,898	\$6,086,898
Tuality Healthcare	11	11	\$500,000	\$2,516,202	\$3,016,202
Willamette Valley	11	11	\$500,000	\$1,638,763	\$2,138,763
<b>TOTAL</b>			<b>\$14,000,000</b>	<b>\$136,000,000</b>	<b>\$150,000,000</b>

# Catheter-associated urinary tract infections (CAUTI) in all tracked units



## Domain: Health care-associated infections

### Catheter-associated urinary tract infections (CAUTI) in all tracked units

**Measure description:** 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.*

**Purpose:** This measure is part of the domain that addresses infections patients can get while receiving medical treatment in a health care facility. A catheter is a drainage tube inserted into a patient's bladder through the urethra to collect urine. Germs can enter the body and cause serious infections in the urinary tract if the catheter is not inserted correctly, not kept clean, or left in place too long.

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.

### Baseline Year: October 2013 – September 2014 data

#### All hospitals successfully submitted baseline data for this measure.

Aggregated across all reporting hospitals, the baseline statewide DRG hospital CAUTI rate was 1.56 per 1,000 catheter days. Four hospitals (Bay Area, Providence Milwaukie, Shriners Hospital for Children, and Sky Lakes) did not have any CAUTIs during the baseline period. Among hospitals experiencing at least one CAUTI, the CAUTI rate per 1,000 catheter days ranged from 0.29 to 3.24. A benchmark for the second year of the program has not yet been established for this measure; a benchmark will be identified after a review of the baseline data.

Statewide rate: **1.56** per 1,000 catheter days

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

Benchmark: **TBD** (lower is better)

Benchmark source: N/A

# Catheter-associated urinary tract infections (CAUTI) in all tracked units

Rate of urinary tract infections for patients who had a catheter while in the hospital in the **baseline year** (Rates reported per 1,000 catheter days)



# Central line-associated bloodstream infections (CLABSI) in all tracked units



## Domain: Health care-associated infections

### Central line-associated bloodstream infections (CLABSI) in all tracked units

**Measure description:** 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. *A lower score for this measure is better.*

**Purpose:** This 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 (CLABSI).

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.

### Baseline Year: October 2013 – September 2014 data

#### All hospitals successfully submitted baseline data for this measure.

Aggregated across all reporting hospitals, the baseline statewide DRG hospital CLABSI rate was 0.80. Among individual hospitals experiencing at least one CLABSI, the rate per 1,000 central line days ranged from 0.30 to 2.07. Nine hospitals did not have any central line infections (CLABSIs) during the baseline period. A benchmark for the second year of the program has not yet been established for this measure; a benchmark will be identified after a review of the baseline data.

Statewide rate: **0.80** per 1,000 central line days

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

Benchmark: **TBD** (lower is better)

Benchmark source: N/A

# Central line-associated bloodstream infections (CLABSI) in all tracked units

Rate of bloodstream infections for patients who had a central line while in the hospital in the **baseline year** (Rates reported per 1,000 central line days)



# Adverse drug events due to opioids



## Domain: Medication safety

### Adverse drug events due to opioids

**Measure description:** Percentage of times a patient receiving an opioid agent also received Naloxone, an antidote for opiate overdose. *A lower score for this measure is better.*

**Purpose:** This measure is part of the medication safety domain, which aims to increase medication safety and avoid adverse drug events. Adverse drug events are injuries resulting from medication use, including physical or mental harm, and loss of function. Naloxone is an antidote for opiate overdose that reverses opioid intoxication. For this reason, this measure uses Naloxone administration to identify patients who may have experienced an adverse drug event due to an opioid.

### Baseline Year: October 2013 – September 2014 data

**All hospitals successfully submitted data for this measure.**

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 baseline year, with baseline year performance ranging from 0.1 percent to 0.8 percent. Aggregated across all reporting hospitals, the statewide DRG hospital baseline rate was 0.5 percent. Continued monitoring is important to ensure the rate remains low.

**Statewide rate: 0.5%**

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

**Benchmark: 5.0% (lower is better)**

**Benchmark source:** Hospital Transformation Performance Program consensus

# Adverse drug events due to opioids

Percentage of times in the **baseline year** when an opioid given to a patient in the hospital resulted in the need for Naloxone, an antidote for opioid overdose



# Excessive anticoagulation due to Warfarin



## Domain: Medication safety

### Excessive anticoagulation with Warfarin

**Measure description:** Percentage of times inpatients receiving Warfarin anticoagulation therapy experienced excessive anticoagulation. *A lower score for this measure is better.*

**Purpose:** 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, and loss of function. Warfarin helps prevent clots from forming in the blood. If not carefully monitored, it can result in bleeding because the blood does not clot appropriately (excessive anticoagulation).

### Baseline Year: October 2013 – September 2014 data

**All hospitals successfully submitted baseline data for this measure.**

Aggregated across all reporting hospitals, the statewide DRG hospital baseline for this measure was 1.5 percent. All but one hospital has already 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 5.9 percent (lower scores are better). The benchmark for the second year of the program is 5.0 percent or lower.

Statewide rate: **1.5%**

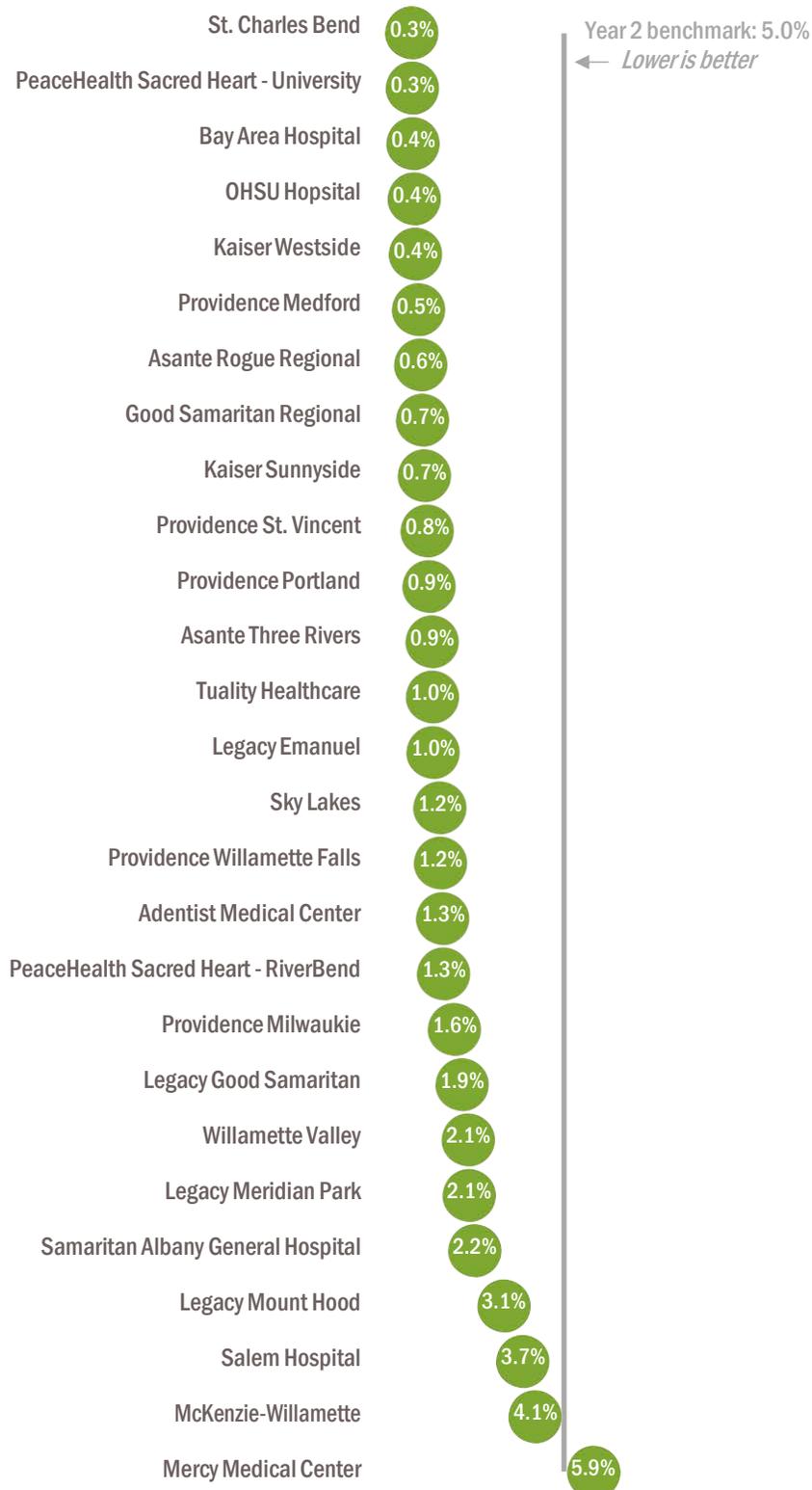
Data source: Self-reported by hospitals (tracked internally through electronic health records, chart abstractions, or other manual process)

Benchmark: **5.0%** (lower is better)

Benchmark source: Hospital Transformation performance program consensus

# Excessive anticoagulation due to Warfarin

Percentage of times in which Warfarin given to a patient during an admission in the **baseline year** resulted in excessive anticoagulation\*



\*Shriners Hospital for Children had no qualifying denominator events for this measure.

# Hypoglycemia in inpatients receiving insulin



## Domain: Medication safety

### Hypoglycemia in inpatients receiving insulin

**Measure description:** Percentage of times an inpatient receiving insulin experienced hypoglycemia. *A lower score is better.*

**Purpose:** This measure is part of the domain aiming to increase medication safety and avoid adverse drug events. Adverse drug events are 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.

### Baseline Year: October 2013 – September 2014 data

#### All hospitals successfully submitted data for this measure.

Aggregated across all reporting hospitals, the baseline statewide DRG hospital rate is 3.9 percent. All but three hospitals are already meeting the benchmark.

Performance among the individual hospitals administering insulin ranged from 0.4 percent to 10.5 percent (lower is better). The benchmark for the second year of the program is 7.0 percent or below.

Statewide rate: **3.9%**

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

Benchmark: **7.0%** (lower is better)

Benchmark source: Hospital Transformation Performance Program consensus

# Hypoglycemia in inpatients receiving insulin

Percentage of times when insulin given to a patient during an admission in the **baseline year** resulted in hypoglycemia\*



\*Shriners Hospital for Children had no qualifying denominator events for this measure.

# HCAHPS: Staff always explained medicines



## Domain: Patient experience

### HCAHPS: Staff always explained medicines

**Measure description:** Percentage of patients who said hospital staff always told them (1) what their medication was for and (2) possible medication side effects, in a way the patient understood.

**Purpose:** To support improvements in internal customer service and quality-related activities, this measure uses survey data to measure patients' perspectives on their hospital care experiences. 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.

### Baseline Year: October 2013 – September 2014 data

**All 27 hospitals eligible for this measure successfully submitted baseline data.**

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.

The benchmark is the national 90th percentile, which is 72.0 percent. Aggregated across all reporting hospitals, the baseline statewide DRG hospital performance was 63.6 percent.

Among individual hospitals, baseline performance ranged from 44.8 percent to 73.0 percent, with Legacy Mount Hood Medical Center already achieving the benchmark set for the second year of the program.

Statewide rate: **63.6%**

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

Benchmark: **72.0%**

Benchmark source: National 90th percentile

# HCAHPS: Staff always explained medicines

Percentage of patients reporting that hospital staff always explained new medications before administering them in the **baseline year**\*



*\*\*Shriners Hospital for Children uses the Press Ganey Inpatient Pediatric Survey rather than HCAHPS. Since there is not an analogous question on the Press Ganey survey, Shriners Hospital for Children cannot participate in this measure.*

# HCAHPS: Staff provided discharge information



## Domain: Patient experience

### HCAHPS: Staff gave patient discharge information

**Measure description:** 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 out for after the patient left the hospital.

**Purpose:** To support improvements in internal customer service and quality-related activities, this measure uses survey data to measure patients' perspectives on their hospital care experiences. 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."

### Baseline Year: October 2013 – September 2014 data

#### All hospitals successfully submitted baseline data for this measure.

Aggregated across all reporting hospitals\*, baseline statewide DRG hospital performance was 88.8 percent. Across all DRG hospitals, performance ranged from 73.2 percent to 93.2 percent. A total of nine hospitals have already achieved the benchmark set for the second year of the program (90.0 percent). The benchmark is the national 90th percentile.

Statewide rate: **88.8%**

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

Benchmark: **90.0%**

Benchmark source: National 90th percentile

\* Note that the Child HCAHPS survey is under development. Shriners Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriners performance on this measure will therefore be assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey. A benchmark for Shriners Hospital for Children is TBD.

# HCAHPS: Staff provided discharge information

Percentage of patients reporting that hospital staff provided discharge information in the **baseline year\***



\*Shriners Hospital for Children's baseline performance on the discharge instructions question on the Press Ganey Pediatric Inpatient Survey was 55.2%. Shriners' benchmark TBD.

# Hospital-wide all-cause readmissions



## Domain: Readmissions

### Hospital-wide all-cause readmissions

**Measure description:** Percentage of patients of all ages who had a hospital stay and were readmitted for any reason within 30 days of discharge. *A lower score for this measure is better.*

**Purpose:** Some patients who leave the hospital are admitted again shortly thereafter. These costly and burdensome "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. This metric therefore measures all inpatients (of all ages) who were readmitted within 30 days for any reason.

### Baseline Year: October 2013 – September 2014 data

**All 28 hospitals successfully submitted data for this measure.**

Aggregated across all reporting hospitals, the statewide DRG hospital rate is 10.9 percent.

For individual hospitals, rates ranged from 4.9 percent to 17.5 percent (lower scores are better). One hospital (Shriners Hospital for Children) met the benchmark. The benchmark for this measure is the statewide 90th percentile across all hospital types, which is 6.1 percent.

**Statewide rate: 10.9%**

**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)**

# Hospital-wide all-cause readmissions

Percentage of patients who had a hospital stay in the **baseline year** and were readmitted for any reason within 30 days of discharge



# Follow-up after hospitalization for mental illness



## Domain: Behavioral health

### Follow-up after hospitalization for mental illness

**Measure description:** 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.

**Purpose:** Research shows that follow-up care helps keep patients from returning to the hospital, providing an important opportunity to reduce health care costs and improve health. This measure supports coordination between hospitals and Oregon's coordinated care organizations 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.

### Baseline Year: October 2013 – September 2014 data

**All 28 hospitals successfully submitted data for this measure.**

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 the CCO statewide rate. This applied to 14 hospitals in the baseline year. This allows all hospitals to participate in the measure and facilitates further hospital-CCO coordination.

The benchmark for the performance year of the program (70.0 percent) is aligned with the analogous CCO incentive measure, which is based upon the 2013 national Medicaid 90th percentile. Fifteen hospitals are already performing better than the benchmark, with baseline performance ranging from 62.7 percent to 81.2 percent.

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

**Statewide rate: N/A**

**Data source: Administrative (billing) claims**

**Benchmark: 70.0%**

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

# Follow-up after hospitalization for mental illness

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



# SBIRT: Screening in the ED for alcohol and other substance misuse



Domain: behavioral health

## SBIRT in the emergency department: Screening

**Measure description:** This measure tracks screening, brief intervention, and referral to treatment (SBIRT) in the emergency department (ED).

**Purpose:** Research shows that the ED can be an effective place to screen and refer patients for substance use services. 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 SBIRT incentive measure focused on the use of SBIRT in primary care settings.

## Baseline Year: October 2013 – September 2014 data

Of the 27 eligible hospitals, 17 successfully submitted baseline data for this measure.

This is a new measurement effort for hospitals; therefore, the data are developmental. Because hospitals were in different phases of implementing and tracking the SBIRT process in their EDs, hospitals submitted data from varying timeframes and sampling methods.

Among the 17 hospitals reporting data, 13 achieved the benchmark, with baseline performance ranging from 0.3 percent to 95.3 percent. The benchmark for the second year of the program (12.0 percent) is aligned with the analogous 2015 CCO incentive measure.

Some hospitals chose to begin implementation of the SBIRT process by focusing on specific populations, while working to expand SBIRT over the second year of the program. Others focused less on specific populations, and more on getting the process into their electronic health records. Combined, these factors resulted in a wide range of performance.

The high rate of screening among some hospitals may be due to implementing brief screening among all patients.

Due to differences in screening and data capture, no statewide baseline is presented.

*Note: The percent of patients who screen positive and receive a brief intervention is also being tracked. However, the brief intervention rate isn't reported here as the data are developmental and this part of the measure isn't tied to a benchmark in the second year of the program.*

Statewide rate: N/A

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

Benchmark: 12.0%

Benchmark source: 2015 SBIRT CCO incentive measure benchmark

# SBIRT: Screening for alcohol and other substance misuse in the ED

Percentage of patients screened for alcohol and drug misuse in the emergency department in the **baseline year\***



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

# EDIE: Outreach notification to primary care providers



## Sharing emergency department visit information domain

### Outreach notifications to primary care providers

**Measure description:** This measure is the percentage of times hospitals notified a patient's primary care provider when a frequent user of the emergency department (ED) was seen in the ED. A patient is considered a frequent ED user if they visit the ED five or more times in 12 months. It uses the Emergency Department Information Exchange (EDIE) system as a data source. EDIE allows EDs to identify in real time patients who visit the ED five or more times in a 12-month period so care can be better coordinated and patients can be directed to the right care setting.

**Purpose:** Patients may visit the ED for conditions that could be better treated in a more appropriate, less costly setting. This measure was created to support coordination between hospitals and Oregon's coordinated care organizations (CCOs) and 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.

### Baseline Year: October 2013 – September 2014 data

#### All but one hospital successfully submitted baseline data for this measure.

This is a new measurement effort for hospitals; therefore, the data are developmental in nature. Because hospitals were in different phases of implementing the EDIE system, they submitted data from different timeframes. For these reasons, no statewide baseline is measured.

Performance among reporting hospitals ranged from 0.3 percent to 92.9 percent. This wide range in notification to primary care providers may be due to the large variation in the hospitals' stage of implementation of EDIE. A benchmark for the second year of the program has not yet been established for this measure; it will be identified after a review of the baseline data.

Statewide rate: N/A

Data source: Emergency Department Information Exchange.

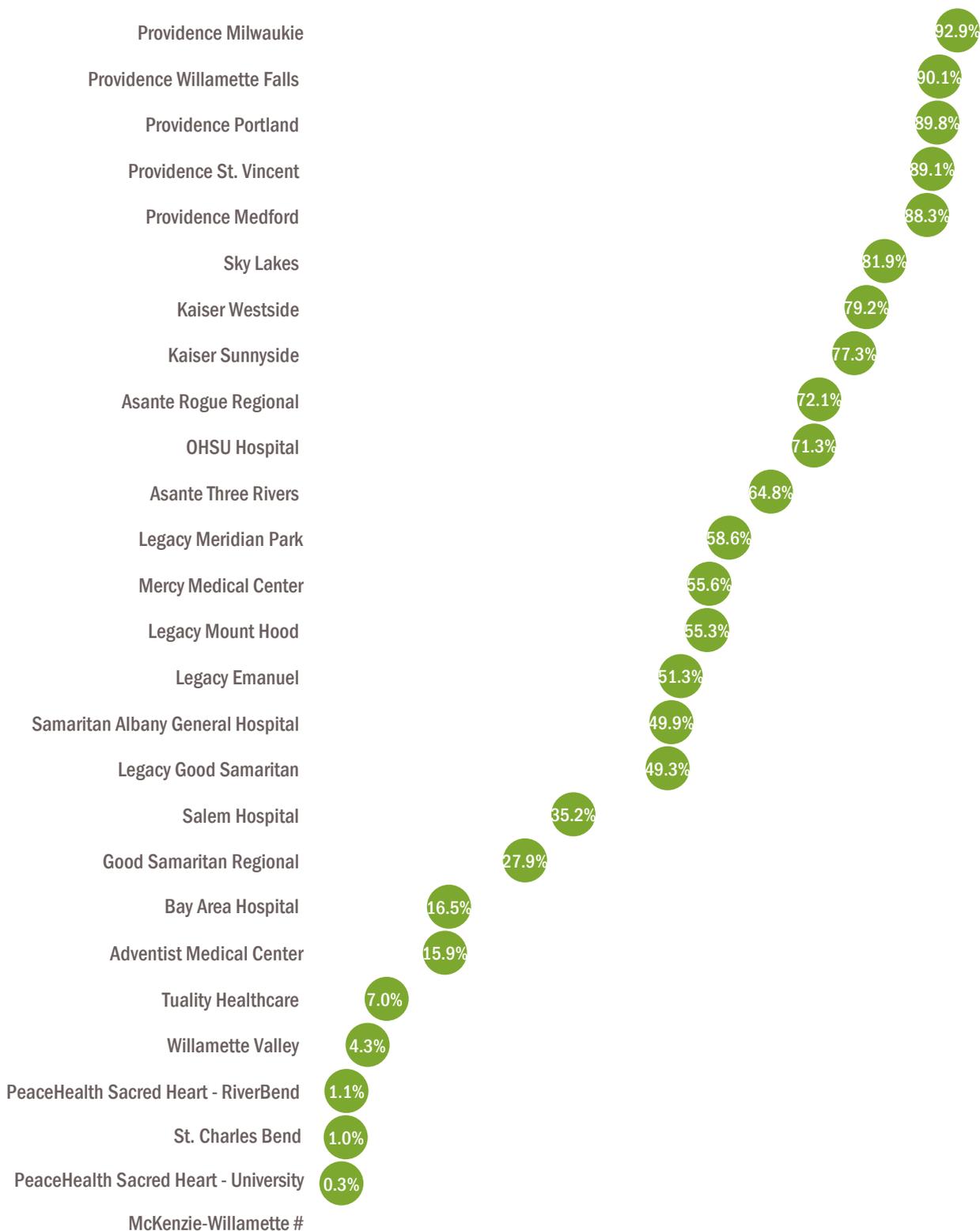
Benchmark: N/A

Benchmark source: N/A

*Note: The number of care guidelines completed for frequent ED users is also being tracked as part of this measure. This rate isn't reported here as the data are developmental and only the outreach notification rate will have a benchmark in the second year of the program.*

# EDIE 1: Outreach notification to primary care providers

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**\*



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

## OHA contacts and online information

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

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**For more information about technical specifications for measures, visit:**

[www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx](http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx)

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