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# Hospital Performance Metrics Advisory Committee

May 20, 2016



# Agenda Overview

- Consent Agenda
- Updates
- Presentation: Healthy Families Oregon
- Public Testimony
- Opioid Measurement

# Consent Agenda

# Updates

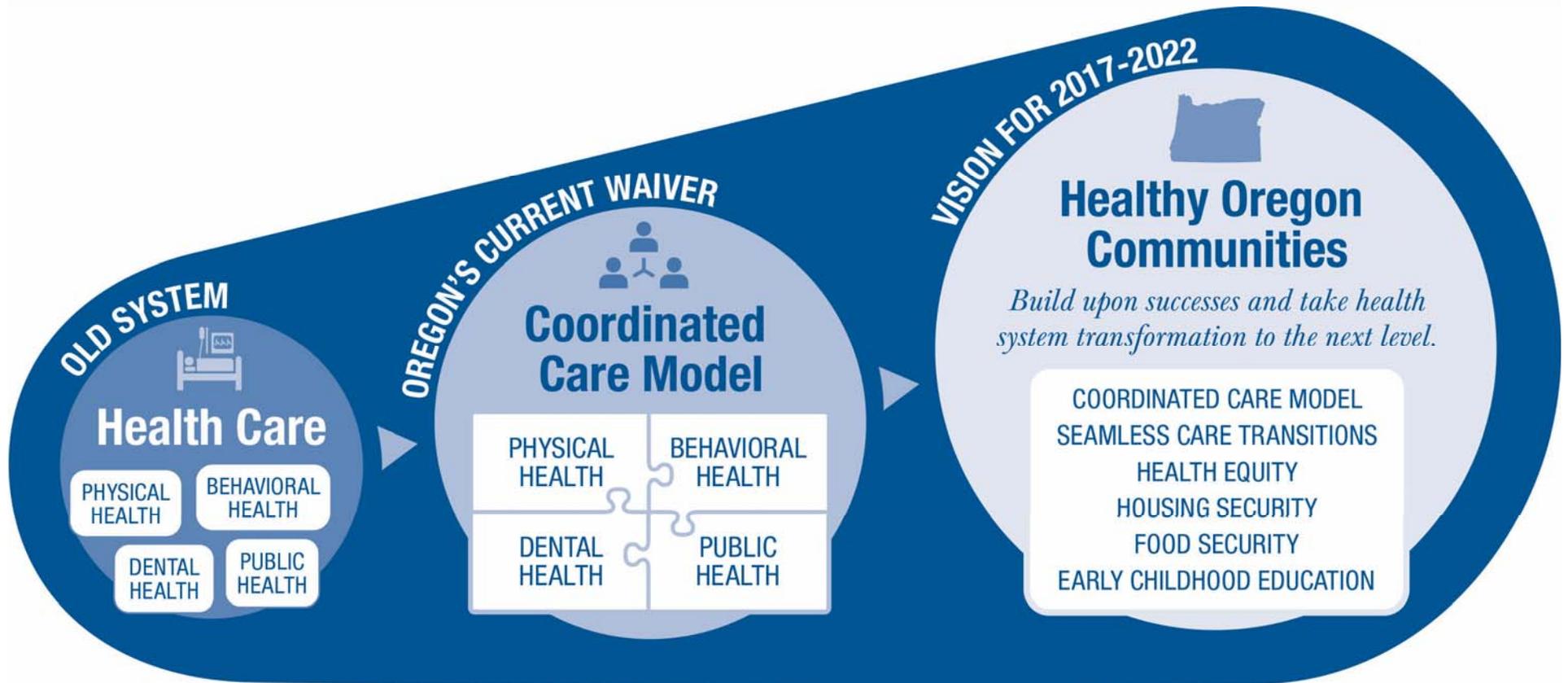
# Committee Nominations

- Applications being reviewed, pending confirmation from Speaker of the House and the President of the Senate.
- OHA hopes to notify applicants by mid-June.

## Year 2 Close Out

- OHA has completed its review of Year 2 data submissions.
- OHA sent summary reports to each hospital on May 12<sup>th</sup> for final hospital review prior to processing payments and populating the Year 2 public report. Hospitals had until May 19<sup>th</sup> for final comment.
- Year 2 report will be published in June.

# Waiver Renewal



# Waiver Renewal

- Draft waiver application posted online [www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx](http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx)
  - See Appendix III / C for Measurement Strategy
- OHA accepting public comment through June 1, 2016.

# CMS Update for Year 3

- CMS and OHA are currently reviewing the amended STCs to document the Year 3 extension of the program.
- *See handout for measures / benchmarks for Year 3. These are still pending final, written approval from CMS, but have been verbally agreed upon.*

**OPC Recommendation to  
Oregon Hospital Performance Metrics  
Advisory Committee**

**May 2016**

*Presented by*



# OPC Recommendation to HTPP

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- ▶ Use the OPC Steering Committee process to prioritize a limited set of measures for the HTPP Perinatal Domain
  - ▶ OPC bimonthly meetings occur to facilitate this work
- ▶ OPC to provide a formal recommendation to the HTPP
- ▶ OPC available to review & discuss proposal with the Oregon Hospital Performance Metrics Advisory Committee at future meetings



# MDC Clinical Quality Measures

<ul style="list-style-type: none"> <li>• 3rd &amp; 4th Degree Lacerations in Vaginal Deliveries-All</li> </ul>	<ul style="list-style-type: none"> <li>• Cesarean Section Rate-Nullip, Term, Singleton, Vertex (PC-02)</li> </ul>	<ul style="list-style-type: none"> <li>• Induction Rate</li> </ul>	<ul style="list-style-type: none"> <li>• Operative Vaginal Delivery</li> </ul>
<ul style="list-style-type: none"> <li>• 3rd &amp; 4th Degree Lacerations in Vaginal Deliveries-Instrument Assisted</li> </ul>	<ul style="list-style-type: none"> <li>• Cesarean Section Rate-Primary (Standard)</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal Length of Stay-Vaginal Deliveries</li> </ul>	<ul style="list-style-type: none"> <li>• Preeclampsia ICU Admissions</li> </ul>
<ul style="list-style-type: none"> <li>• 3rd &amp; 4th Degree Lacerations in Vaginal Deliveries-Non Instrument Assisted</li> </ul>	<ul style="list-style-type: none"> <li>• Cesarean Section Rate-Primary, Term, Singleton, Vertex</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal Blood Transfusion Rate</li> </ul>	<ul style="list-style-type: none"> <li>• Preeclampsia Total ICU Days</li> </ul>
<ul style="list-style-type: none"> <li>• 5 Minute APGAR &lt;7 Among All Deliveries &gt;39 weeks</li> </ul>	<ul style="list-style-type: none"> <li>• Cesarean Section Rate-Overall</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal ICU Admissions</li> </ul>	<ul style="list-style-type: none"> <li>• Severe Morbidity w/Pre-Eclampsia</li> </ul>
<ul style="list-style-type: none"> <li>• 5 Minute APGAR &lt;7 in Early Term Newborns</li> </ul>	<ul style="list-style-type: none"> <li>• Cesarean Section-Uncomplicated (Term, Singleton, Vertex)</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal Long Length of Stay-Cesarean Deliveries</li> </ul>	<ul style="list-style-type: none"> <li>• Timely Treatment for Severe HTN (HEN)</li> </ul>
<ul style="list-style-type: none"> <li>• Antenatal Steroids (PC-03)</li> </ul>	<ul style="list-style-type: none"> <li>• Elective Delivery &lt;39 Weeks (PC-01)</li> </ul>	<ul style="list-style-type: none"> <li>• Newborn Bilirubin Screening Prior to Discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Unexpected Newborn Complication</li> </ul>
<ul style="list-style-type: none"> <li>• Appropriate DVT Prophylaxis in Women Undergoing C-Section</li> </ul>	<ul style="list-style-type: none"> <li>• Episiotomy Rate</li> </ul>	<ul style="list-style-type: none"> <li>• NTSV No Labor</li> </ul>	<ul style="list-style-type: none"> <li>• Vaginal Birth After Cesarean (VBAC) Rate, All (AHRQ IQI 34)</li> </ul>
<ul style="list-style-type: none"> <li>• Birth Trauma Rate</li> </ul>	<ul style="list-style-type: none"> <li>• Exclusive Breastfeeding (PC-05)</li> </ul>	<ul style="list-style-type: none"> <li>• OB-Hemorrhage: Massive Transfusions (HEN, RM)</li> </ul>	<ul style="list-style-type: none"> <li>• Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated (AHRQ IQI 22)</li> </ul>
<ul style="list-style-type: none"> <li>• Cesarean Section Rate-Inductions in Full Term Multiparas</li> </ul>	<ul style="list-style-type: none"> <li>• Exclusive Breastfeeding (PC-05a)</li> </ul>	<ul style="list-style-type: none"> <li>• OB-Hemorrhage: Risk Assessment on Admission</li> </ul>	<ul style="list-style-type: none"> <li>• Very Low Birth Weight Infant (&lt; 1500 Grams) Not Delivered at Level III NICU</li> </ul>
<ul style="list-style-type: none"> <li>• Cesarean Section Rate-Inductions in Full Term Nulliparas</li> </ul>	<ul style="list-style-type: none"> <li>• Failed Induction</li> </ul>	<ul style="list-style-type: none"> <li>• OB-Hemorrhage: Total Transfusions (HEN, RM) per 1000</li> </ul>	

# MDC Data Quality Measures

- Apgar Score of 0
- Missing / Inconsistent Birth Weight (among <2500g)
- Missing 5 Minute Apgar in Newborn Clinical/Birth File
- Missing Birth Weight in Newborn Clinical Files
- Missing Delivery Provider in Maternal Clinical Files
- Missing Gestational Age in Maternal Clinical Files
- Missing Parity in Maternal Clinical Files
- Missing/Inconsistent Gestational Age (<37 weeks) in Newborn Discharge Records
- Missing / Inconsistent Birth Weight (among <2500g)
- ICU Admission Rate among Severe Morbidity Cases
- Unlinked Mothers

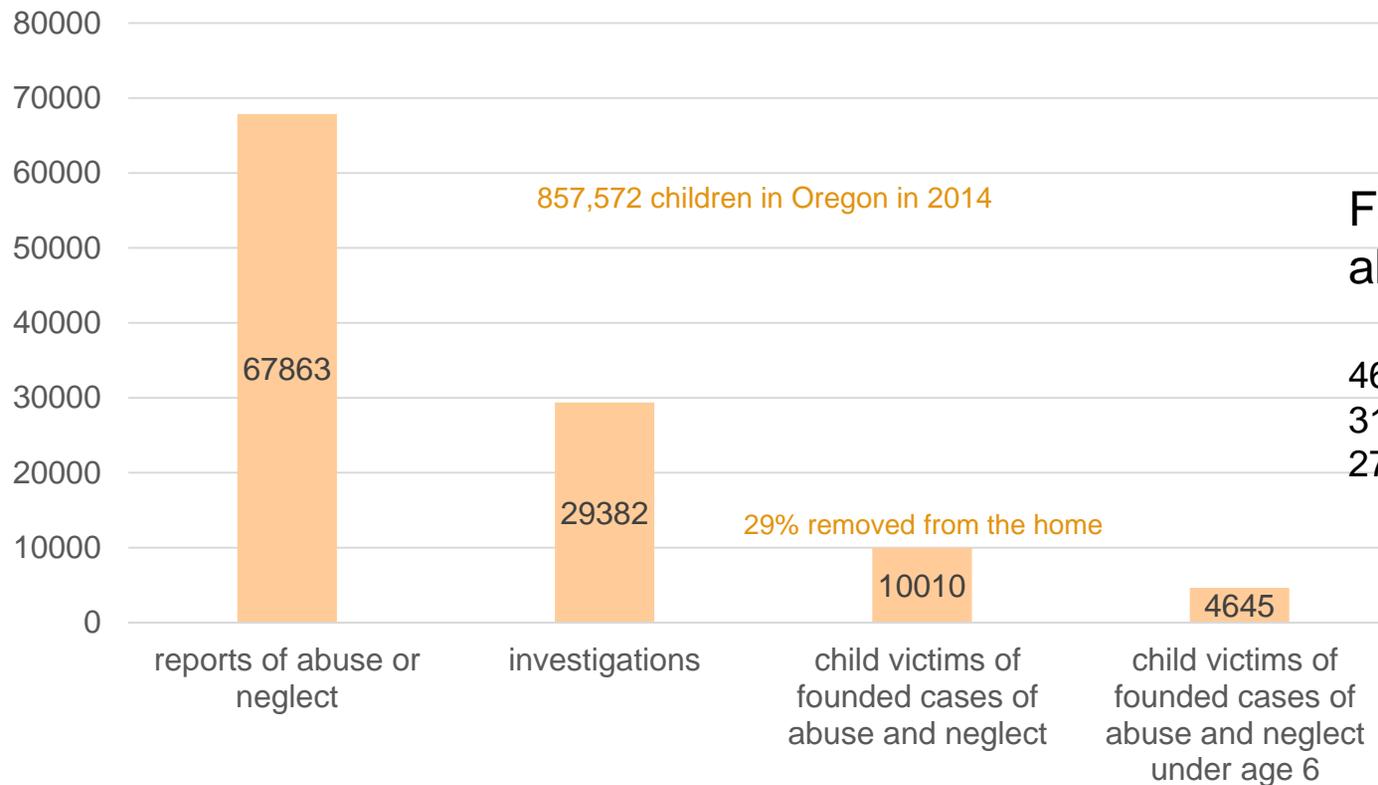
# What are “transformative” metrics for hospitals in perinatal care?

- Transform the way routine care is delivered to significantly improve outcomes
- Bring something on the radar that hasn't been there before to re-orient the care: disruptive innovation

# What is most likely to affect the health of mothers and infants long-term?

- Whether she had a C-section or a vaginal birth
- Whether the baby had a NICU stay or not
- Whether the infant breastfed or not
- Whether parents are supported in developing a healthy relationship with their child, preventing child abuse and neglect

# 2014 Child Welfare data



**Factors in child abuse and neglect:**

- 46% alcohol or drugs
- 31% domestic violence
- 27% criminal involvement

# Parenting support in Oregon

- Home visiting programs
  - Healthy Families Oregon
  - Cacocon
  - Babies First
- Parenting classes
- Behavioral health experts in primary care

# Hospitals are already involved in parenting support!

Healthy Families Oregon has screeners who come to the hospitals to screen women right after birth for eligibility in their program.

Oregon is moving to a statewide screening and referral system for all home visiting programs



**healthy  
families  
oregon®**



# Healthy Families America (HFA)

- The HFA model, developed in 1992 by Prevent Child Abuse America is based upon 12 Critical Elements derived from more than 30 years of research to ensure programs are effective in working with families.
- A nationally recognized, evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment.

# Healthy Families Oregon

- Eligibility Screening: Prenatally or within 14 days of birth
- Families enroll before newborn is 90 days old
- Enrolled Families:
  - Weekly Home visits for a minimum of 6 months
  - Home Visits last until child is 3 years old.
  - All Services are Voluntary



# Healthy Families Oregon



- Focus on Parent/Child relationship
  - Attachment & positing parent/child interactions
  - Infant Mental Health
  - Maternal Mental Health
  
- Connect families to:
  - Health Insurance & establishing a medical home
  - Encourage and discuss well-child visits & immunizations
  - How to access health benefits instead of using ER
  - Other community resources:
    - SNAP – food assistance
    - WIC
    - TANF
    - Energy/rental assistance, clothing, diapers, etc.

# Healthy Families Oregon

Characteristics of families served:

- 85% below FPL (compared to 15% statewide)
- 75% single parents (35% statewide)
- 70% report childhood history of abuse or neglect
- 44% have current substance abuse issues

Families who agree to participate have more risk factors (3.46) than those who decline (3.07).

Three or more risk factors result in a 16-fold increase in the likelihood of maltreatment.

# Outcomes 2013-14

## ■ Health

- 98% of children in HFO were connected a medical home
- 87% of children at age 2 were up-to-date on immunizations
- 80% had developmental screening

## ■ Abuse and neglect

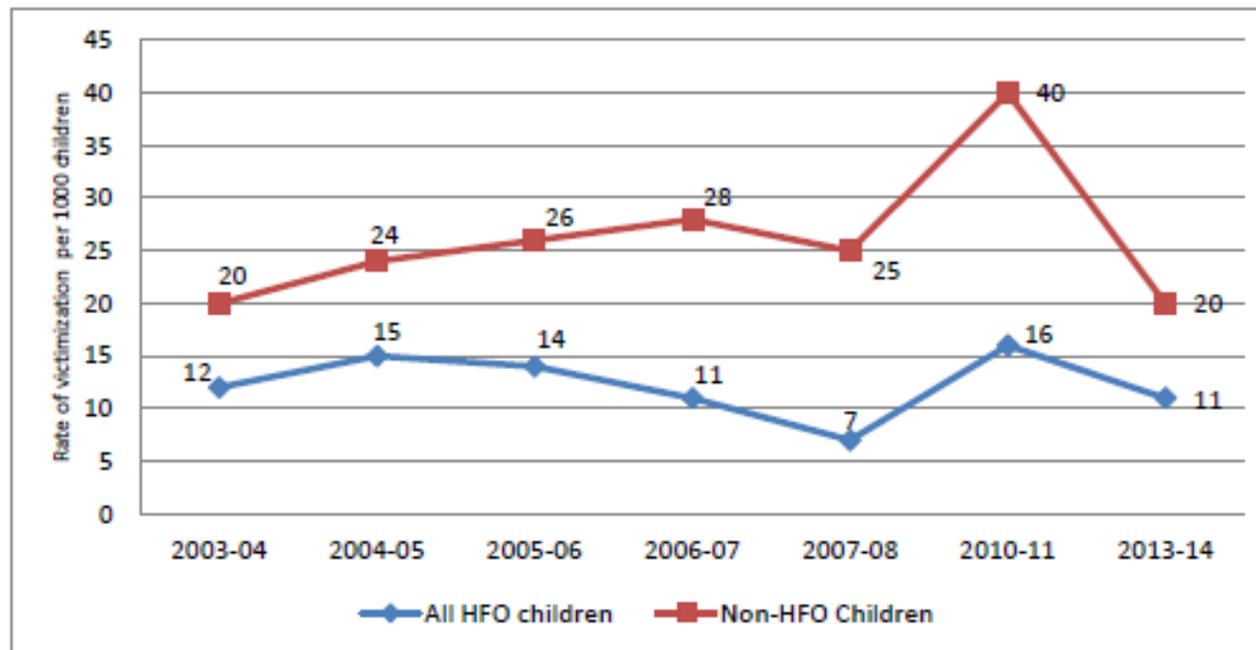
- 98.9% of children in HFO were free from Child Abuse or Neglect (CAN)

- HFO rate of CAN: 11 per 1,000
- Oregon rate of CAN: 20 per 1,000



# Healthy Families Oregon services effectively prevent maltreatment

Figure 1. Rate of Maltreatment for Healthy Families Oregon vs. Non-Healthy Families Oregon Children

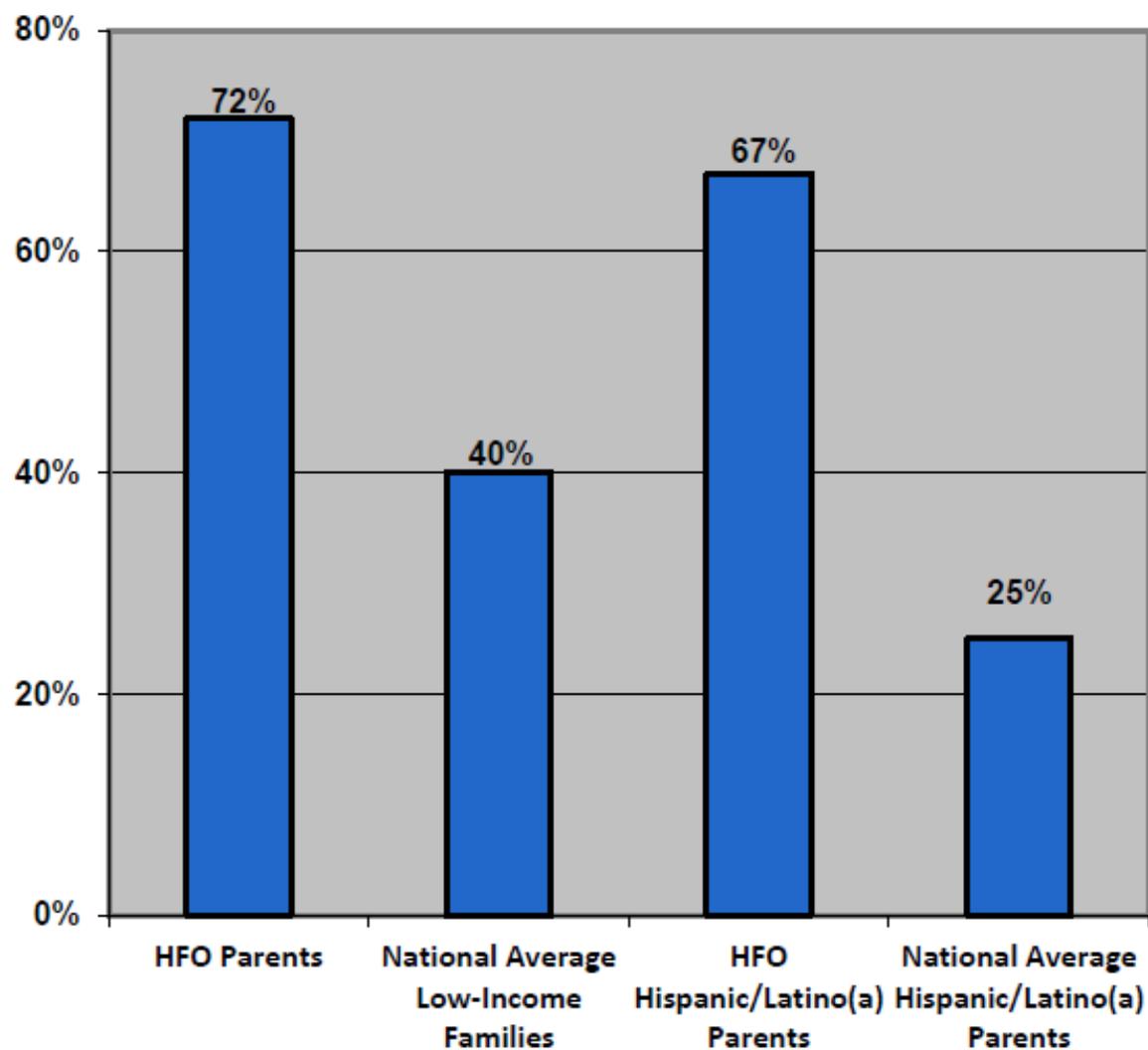


# Healthy Families reduces risk factors and supports school readiness

After at least 6 months in the program:

- 95% of parents report positive, supportive interactions with their children
- 75% report improved parenting skills
- 66% report a significant decrease in parenting-related stress

### Percentage of Parents Reading to Children 0-5 Daily\*



# Eligibility Screening

## ■ New Baby Questionnaire

- Depression
- Substance Abuse
- Previous Child Welfare involvement
- Or 2+ other risk factors

## ■ Prenatal or in Hospitals

- WIC, other community partners or clinics who see women prenatally
- Hospitals
- Screening takes roughly 15 minutes
- All families receive a “Welcome Baby Packet” of information re: caring for a newborn and contact information for local community resources

# How many families do we serve?

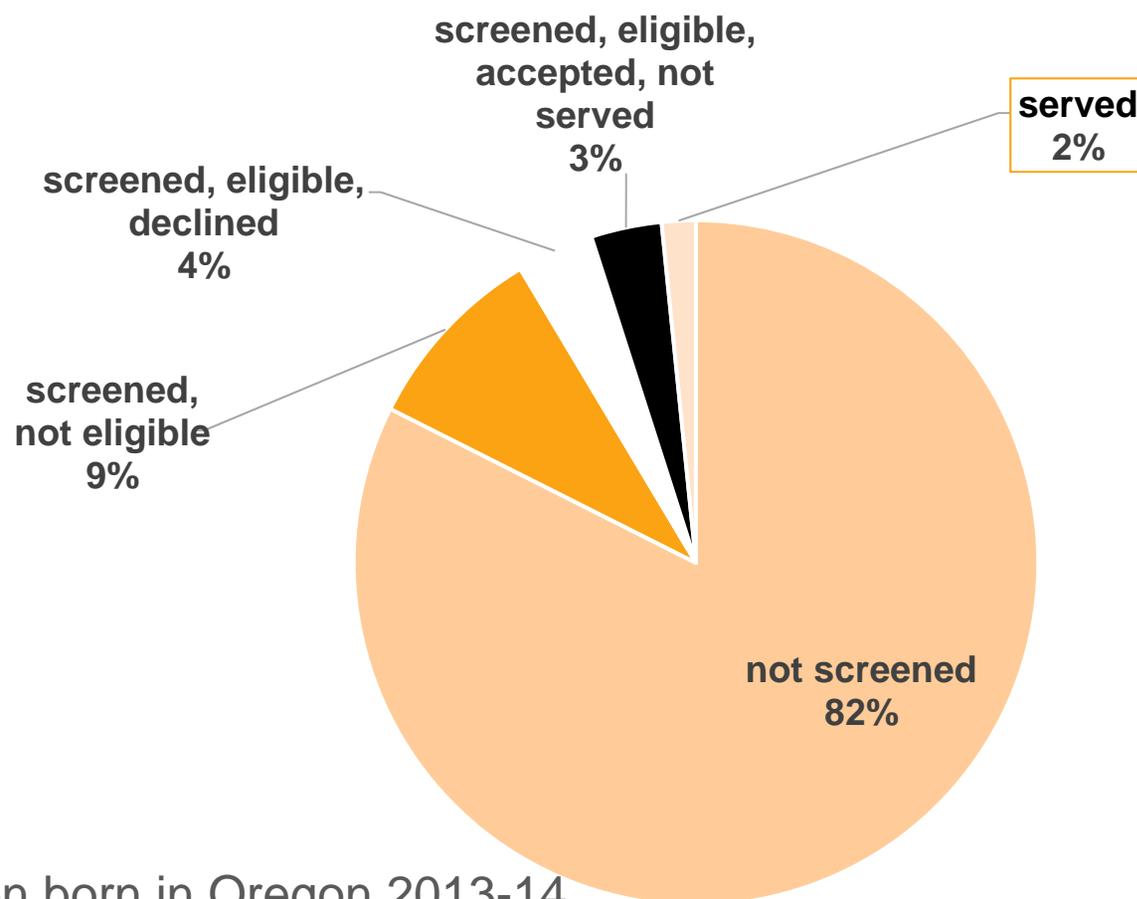
2013 – 2014:

- Total Oregon Births: 45,447
  - HFO screened 7,990 families for eligibility (17.5%)
  - 3,898 of these families were eligible for HFO services (52%)
  - 2,248 of these families wanted home visits (57%)
  - 730 (32% of eligible and interested families) enrolled in HFO services (new in 2013-14)



Total for 2013 – 14:  
2,436 families were served  
(new and enrolled in previous years)

# Not reaching enough children



Children born in Oregon 2013-14  
45,447

# Questions?



# CaCoon

- Public Health nurse home visitors
- Focus is on children with medical needs
  - Previously in the NICU
  - Medical condition requiring nursing care
  - Care coordination

Institute on Development & Disability  
Child Development & Rehabilitation Center

## CaCoon Program

Oregon Center for Children &  
Youth with Special Health Needs



# Babies First

- Public Health nurse home visitors
- See children up to age 5 with social risk factors
  - Parent with substance use
  - Homeless
  - Domestic violence

Babies First!



# Other types of parenting support

- More than half of families who are eligible for home visiting services decline them
- Some families prefer to get support in the clinic or community
- Parenting classes, playgroups, community outreach and education
- *211info* Family Services



# Mandate for a new screening system for home visiting programs

## Budget Note:

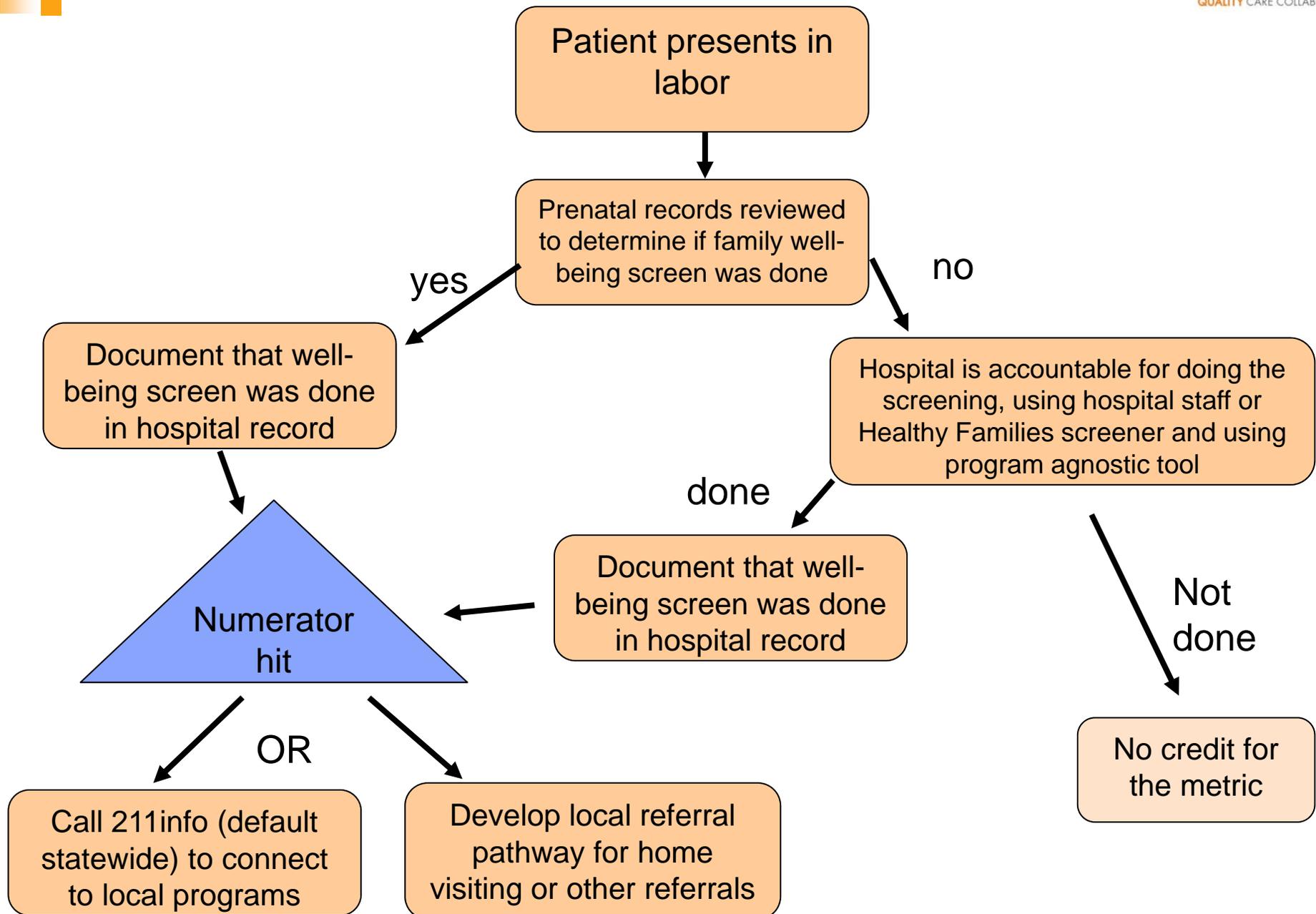
Given the expanded Healthy Families Oregon home visiting funding added to the Early Learning Division's budget, the Early Learning Division and the Oregon Health Authority are instructed to:

- Develop a set of outcome metrics connected to evidence of impact for consideration by the Early Learning Council and the Oregon Health Policy Board that any home based service that receives state dollars must meet in order to continue to receive state funds, effective July 1, 2016;
- Develop a plan and timeline for integrating the state's professional development system for early learning providers with the emerging professional development system for home visitors; and
- **Develop a common program agnostic screening tool** to identify potential parent/child risk factors and intake form for families who are eligible for home visiting services and require implementation by state funded home visiting programs by July 1, 2016.

## Metric proposal:

# Proportion of hospital births screened for eligibility for home visiting programs or other types of parenting support

- Would use new program-agnostic tool
- Current performance is 17-18%, sufficient room for improvement
- Hospitals could check if this screening was done prenatally (which is preferred)
- Any hospital staff (or Healthy Families screeners) could conduct the screening if it was not done prenatally
- Centralized default referral to 211 Family Info line, but each hospital or community could decide on a local referral number



## Proportion of hospital births screened for eligibility for home visiting programs or other types of parenting support

### Advantages of this metric

- Transformational
- Healthy Families is a national program (replicable)
- Babies First and CaCoon are effective Oregon models run by our public health departments
- Healthy Families and Babies First are supported by Oregon Legislature, and are available statewide in every community
- Aligns with CCO and Early Learning Hub investments and priorities
- Promotes cross sector engagement (clinical systems, public health, early learning, hospital to community)

## Proportion of hospital births screened for eligibility for home visiting programs or other types of parenting support

### Disadvantages of this metric

- Need to build data field for this in hospital EHR, although it would logically connect to Oregon Maternal Data Center and could be one of the routine prenatal data points of interest
- Need to build engagement of hospital teams
- Need mechanism to ensure that services are available with all the additional screening

# Problems we are trying to solve

- Early childhood health is core to lifelong health and success. We could do more to support parents in helping their children thrive.
- Hospitals can play a stronger role in the continuum of care for families

## How could hospitals ensure services are available to families who screen positive?

- Possible local investment in parenting support services
  
- Possible investment in 211info as a central referral system for the state
  
- Balancing metric:
  - Proportion of families referred to home visiting programs who want to receive services and are able to be served

# Other issues

- Training needed for tool (simple)
- Tool is actually a set of standardized questions that can be built into EHR or branded and combined with other questionnaires
- Need checkbox data point in hospital EHRs that translate to OMDC
- Screening strategy at the hospital
  - Internal staff
  - Healthy families staff (contract for additional support)
- Referral strategy
  - Communication about availability of programs
  - Hospitals can “build their own” or use 211info as default



# Questions?

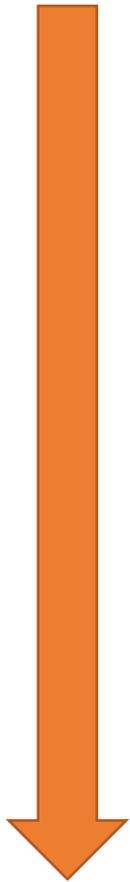


We'll be  
back  
soon...

# Public Testimony

# Measure Development: Opioid Prescribing in ED

# Recap



- Original presentation in December 2015
- Original proposed metric: % of patients discharged from the ED receiving > 6-10 pills.
- Committee interested in exploring measure.
- TAG raised concerns re: reporting challenges and establishing a threshold for # of pills.
- Additional TAG discussion and survey conducted re: reporting capabilities.
- Multiple alternate measures proposed.

# Proposed Measure Options (to date)

#	Measure	Source
1	% of patients discharged from the ED with >xx # of opioid pills	Committee proposal, Dec 2015
2	# of opioid Rx written per 1,000 ED visits	TAG discussion, Feb 2016
3	# of pills prescribed per 1,000 ED visits	Committee discussion, Feb 2016
4	MED prescribed per 1,000 ED visits	Committee discussion, Feb 2016
5	# of long-acting / extended release Rx per 1,000 ED visits	TAG discussion, May 2016

# Today's Goal

- Review measure development process to date.
- Review literature on opioid prescribing in EDs.
- Establish intent / problem statement for hospital metric to provide clear guidance for TAG to finalize measure specifications.

# Why is this an issue in Oregon?

- **Deaths in 2014**

- 154 Oregonians died (prescription opioids)
- Rate of opioid deaths declined 40% between 2006 and 2014

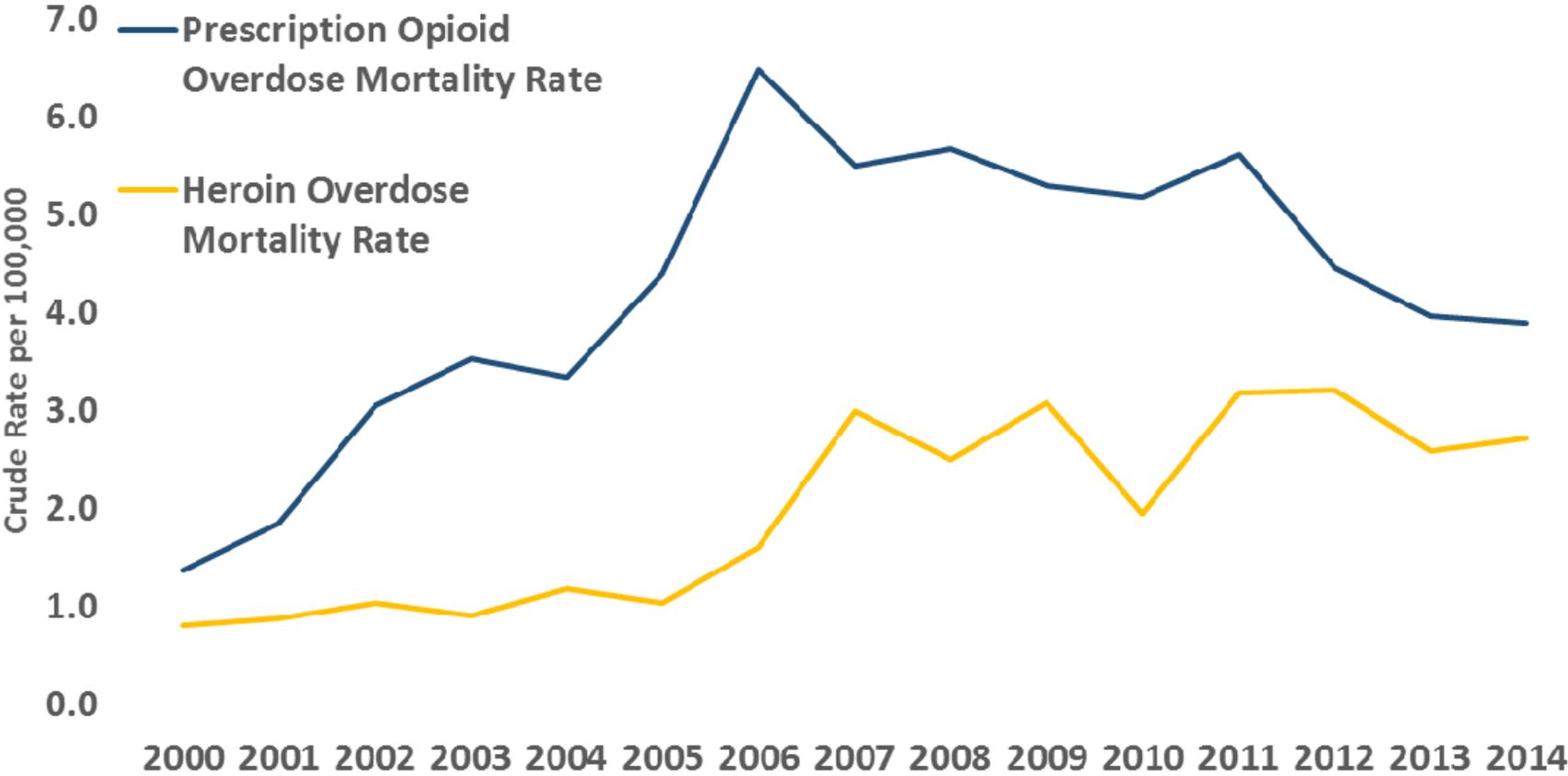
- **Hospitalizations in 2013**

- 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



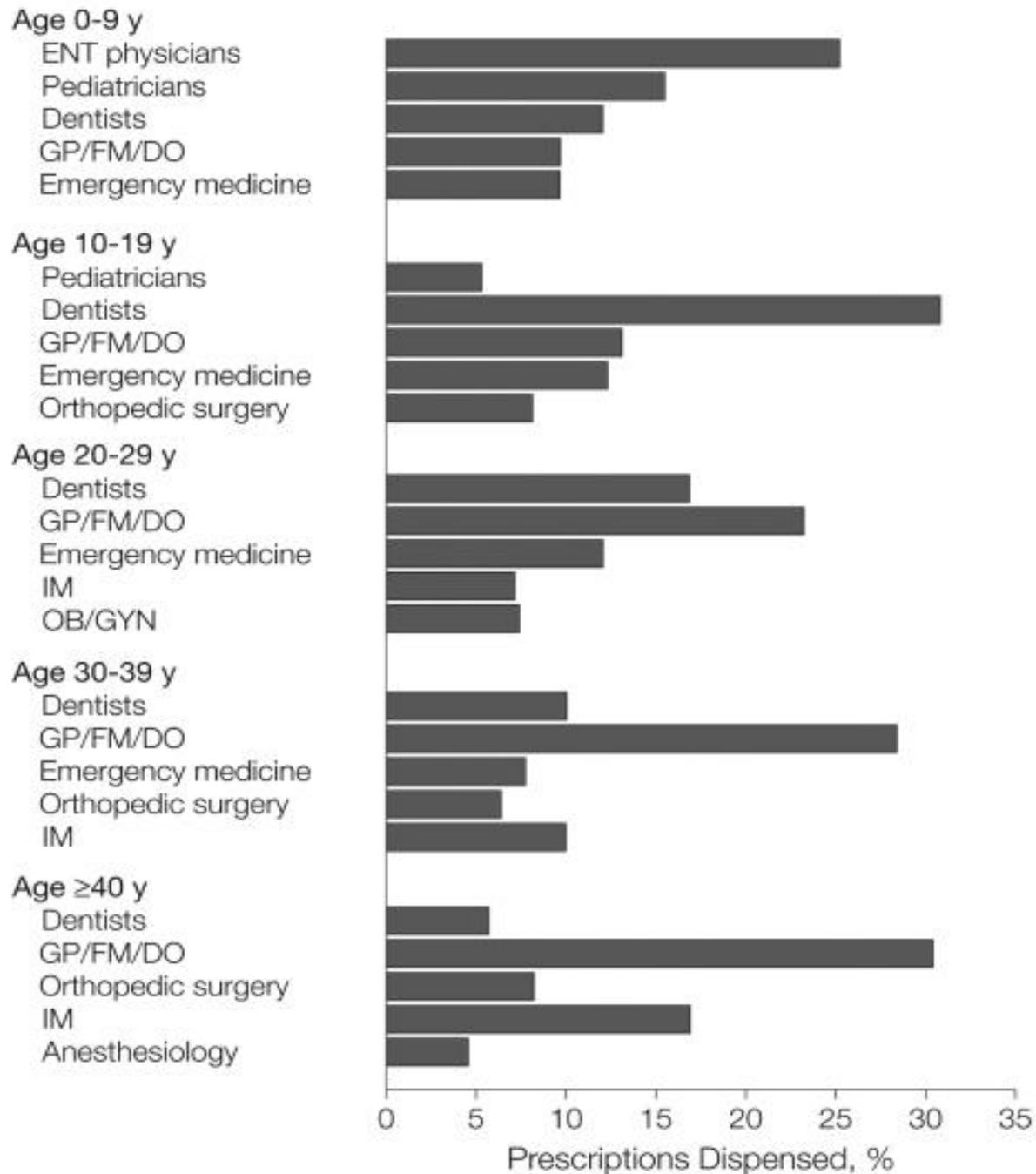
# Why is this an issue for hospitals?

- Percentage of national ED visits for adults where any opioid was prescribed: between 2001-2010 absolute increase of 10.2%.<sup>1</sup>
- 39% of all opioids prescribed, administered, or continued come from the ED.<sup>2</sup>
- ED providers are one of the top 5 prescribing specialties for patients less than 39 years old.<sup>3</sup>

1. Rising opioid prescribing in adult US emergency department visits 2001-2010. Academic Emergency Medicine, March 2014.

2. Medication therapy in ambulatory medical care, 2003-2004. National Center for Health Statistics. December, 2006.

3. Characteristics of opioid prescriptions in 2009. JAMA. April, 2011.



# What do we know about opioid prescribing in the ED nationally?

- 2012 study: 11.9% of all patients / 17.0% of discharged patients received opioid Rx.<sup>4</sup>
  - More than 99% were immediate release.
  - Mean # of pills: 16.6
  - Median # of pills: 15
- 2015 study: 26.7% of patients received opioid Rx.<sup>5</sup>
  - 63% prescribed 0-12 pills
  - 35% prescribed 13-30 pills
  - 1.9% prescribed >30 pills

4. Opioid prescribing in a cross section of US emergency departments. Annals of Emergency Medicine. Sept, 2015.

5. Opioid prescribing in the emergency department. Annals of Emergency Medicine. October, 2015.

# What else do we know?

- While EDs on average dispense 44% fewer pills / 17% lower MME than prescriptions from office visits<sup>6</sup>...
- Among opioid-naïve patients receiving prescriptions in the ED, 12% went on to recurrent use at 1 year<sup>7</sup>....
- And among individuals with at least one ED prescription for opioids, 10.3% had at least one indicator of misuse.<sup>8</sup>

6. Strength and dose of opioids prescribed from US emergency departments compared to office practices. *Annals of Emergency Medicine*. Oct., 2014.

7. Association of emergency department opioid initiation with recurrent opioid use. *Annals of Emergency Medicine*. May, 2015.

8. Opioid prescribing in emergency departments: the prevalence of potentially inappropriate prescribing and misuse. *Med Care*. August, 2013.

# Problem Statement

- Oregon needs to address its opioid epidemic.
- EDs are a major source of opioids coming into the community, primarily short-acting Rx.
- Hospitals have a role to play in reducing overall opioid use and misuse in their communities.
- Adopting an opioid prescribing metric for the HTPP can help focus attention and efforts.

# Strategies to reduce ED prescribing

- Adopt hard limit – no more than 30 pills / Rx
- Default to 10 pill Rx for opioids
- No refills of chronic opiates
- No prescribing in certain risk populations without clear indication (i.e., known diverters, drug seekers)
- No opioids for migraines, and other Dx that have proven evidence of harm > benefit
- No prescribing in people actively intoxicated, or with concerning UDS results (benzos, meth, etc)
- Preferential treatment of certain conditions with NSAIDs (e.g., renal colic, migraines, dental pain)

# CDC Guidelines

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

# Suggested Goal for the Metric

- Reduce overall opioid prescribing in the ED by
  - Reducing total number of pills in community
  - Reducing inappropriate opiate Rx
  - Reducing average number of pills per Rx
  - Reducing long-acting / extended release Rx

# Proposed Metric

- 1) Adopt short-acting opioid Rx metric for the first year.

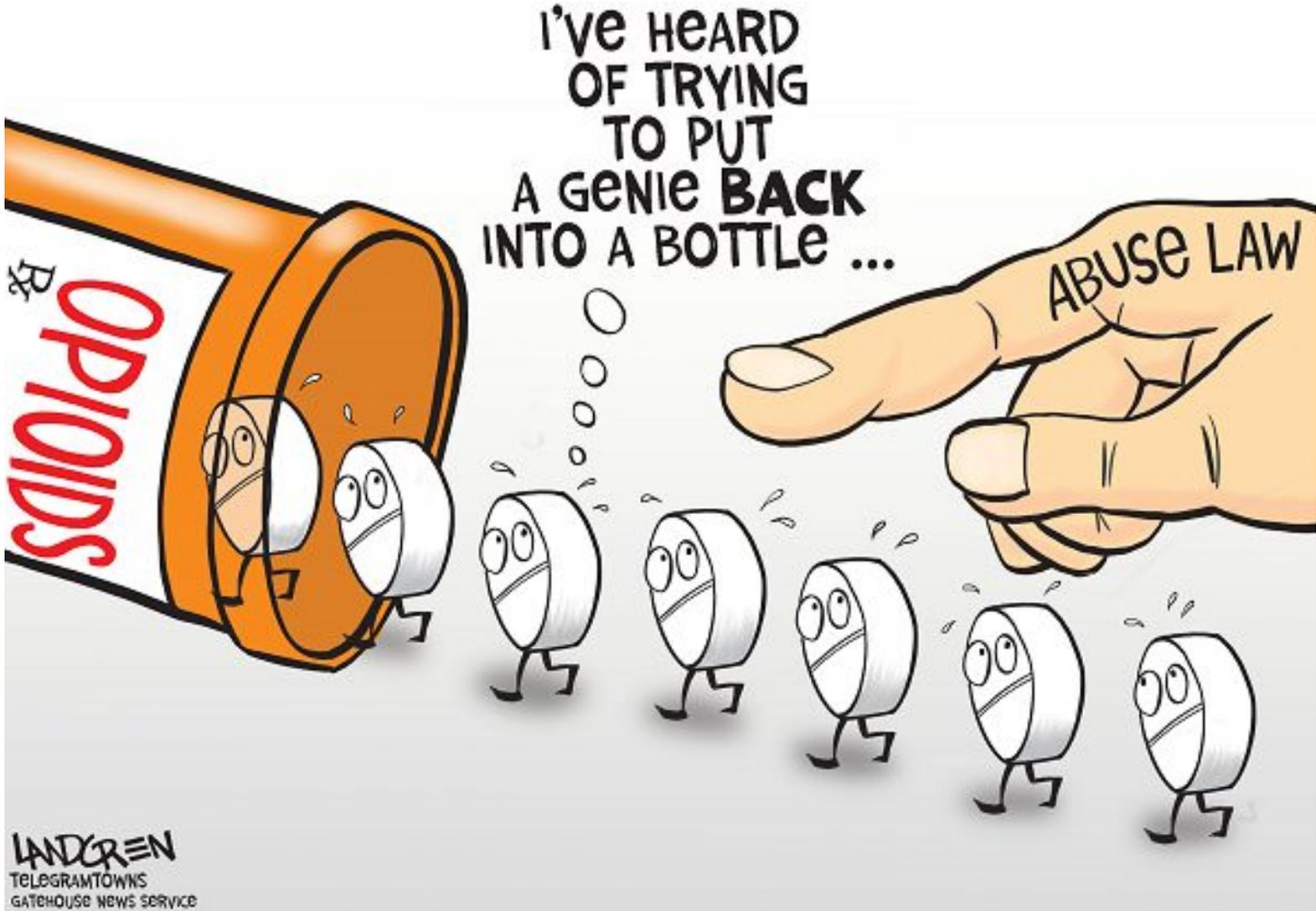
# of pills = no more than 30 per Rx, per OCEP guidelines  
*or*  
# of pills = no more than 6-10 per Rx, per Dec proposal.

Collect Oregon-specific data, then revisit standard for second year (year 5).

- 2) Also adopt report-only measure to address increased prescribing of opioids in EDs:

# of pills prescribed / 1,000 ED visits.

# Discussion



# Next Meeting

Propose cancelling June 17<sup>th</sup> meeting.

Next meeting: July 15<sup>th</sup> from 1:00 – 4:00 PM in Wilsonville