
Hospital Performance Metrics Advisory Committee

November 20, 2015



Consent Agenda

Public Testimony

Where Do We Go From Here?

Proposed new domains – areas for further exploration from 10/23 meeting

No.	Proposed Domain Name
1	Transitions of Care**
2	Community Health Needs Assessment, Education, and Outreach
3	Patient- and Family-Focused Care**
4	Disparities Reduction
5	Youth
6	Women and Children – Perinatal Care**
7	Efficiency** (move to bundled payments)
8	Drop all current domains – use new framework
9	Medication side (pharmacy and safety improvements)

Potential Domain Expert Testimony: Perinatal Care

Duncan Neilson, MD, Legacy Health

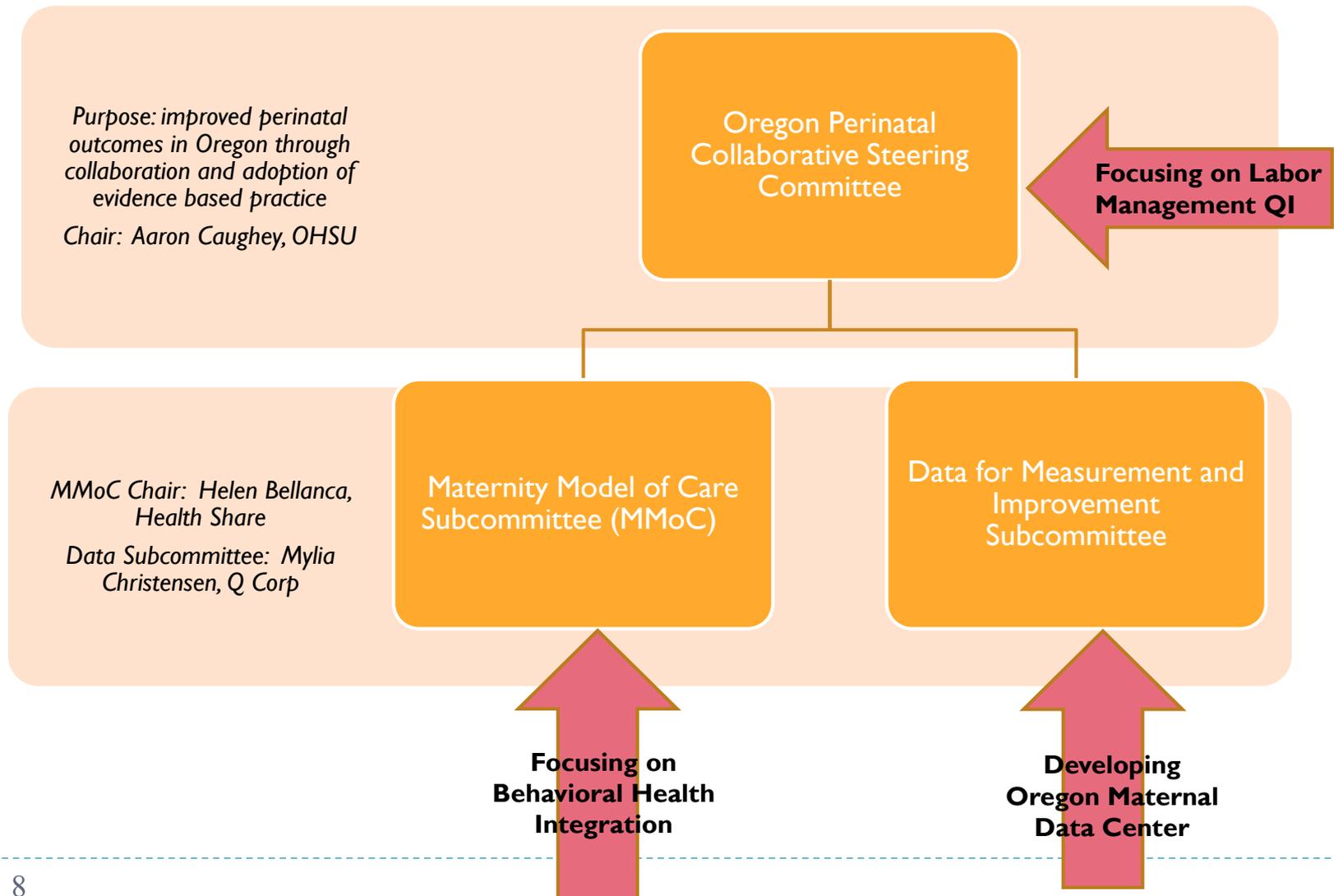
Liz Whitworth, MPH, Q-Corp

**OPC Presentation to Oregon Hospital
Performance Metrics Advisory Committee
November 20, 2015**

Presented by



OPC: Coordinated Efforts to Improve Maternity Care



OPC Steering Committee Member Organizations

Good Samaritan Regional Medical
Center

Health Share of Oregon

Kaiser Permanente

Legacy Health

March of Dimes (convener)

Oregon Association of Hospitals &
Health Systems (OAHHS)

Oregon Health Authority

Oregon Health & Science University
(OHSU)

Providence Health & Services

Q Corp

Tuality Healthcare

Virginia Garcia

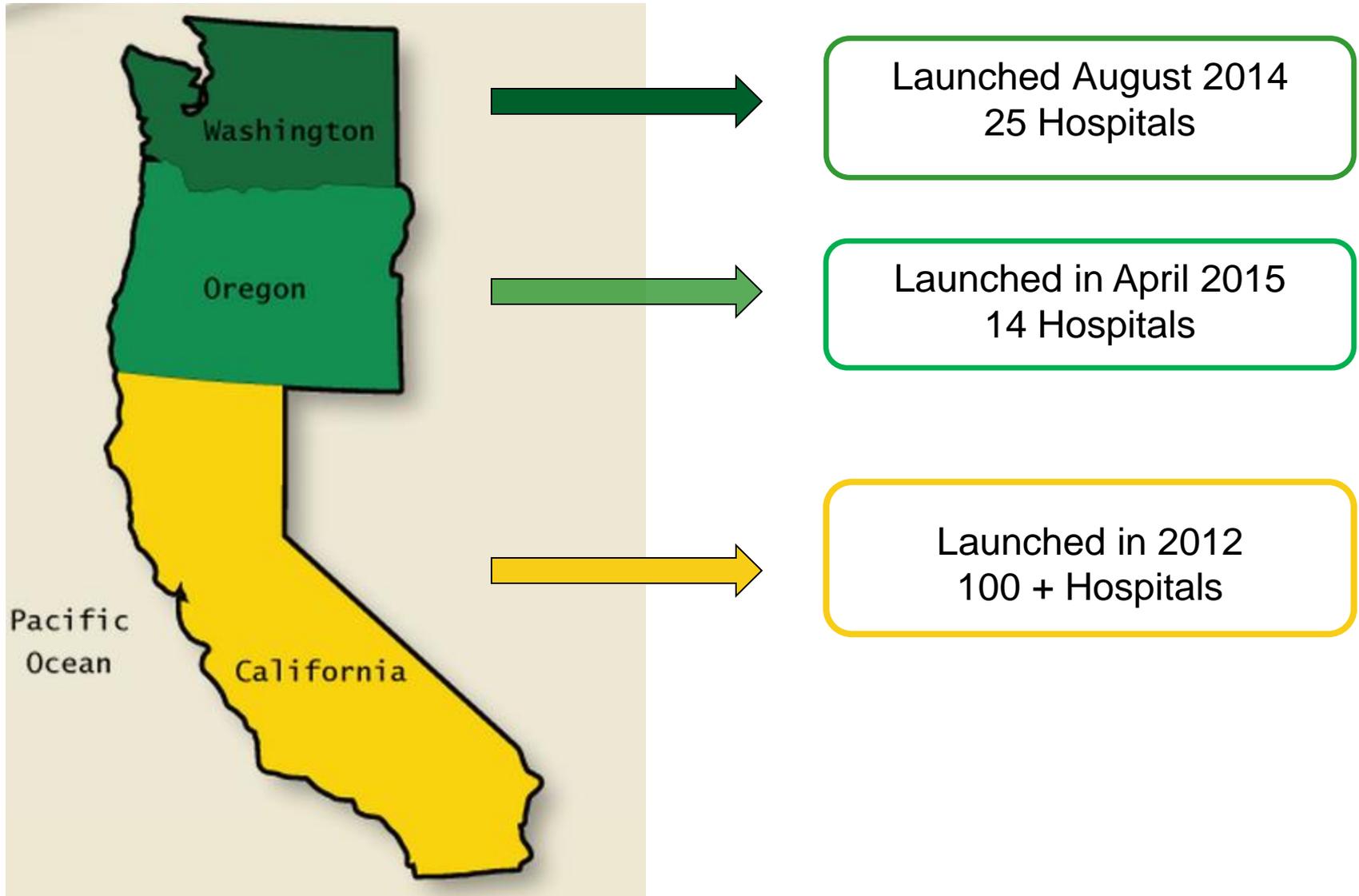
*And growing...Over 125 individuals attended the Oct 30, 2015
OPC Perinatal Summit.*





The CMQCC Maternal Data Center (CMDc)

The MDC Hospital Tool: Used in 3 States



What is the Oregon Maternal Data Center (OMDC)?

- **Collaborative effort** of March of Dimes, Oregon Perinatal Collaborative, Q Corp and other sponsors (*TBD*)
- **Web-based tool** to generate performance metrics, reports and other information on maternity care services and outcomes
- **Built off California Maternal Quality Care Collaborative (CMQCC) tool** developed by Dr. Elliott Main and colleagues at Stanford University
- Designed to be **low-burden, low-cost, high value** tool
- **Links hospital discharge data to birth certificate data** to generate drill-down information for use by hospital clinicians, managers, and administrators
- **Patient-level data is fully secure** and visible only to authorized hospital staff
- **Can incorporate other data sets of use to other audiences**— maternity care providers, health systems, purchasers, consumers and policymakers
- **CMQCC tool in use in California, Oregon and Washington**

OPC Data Subcommittee 2013-2015

The image shows a screenshot of a web browser displaying the Oregon Maternal Data Center website. The browser's address bar shows the URL <https://oregonmaternaldatacenter.org>. The page features a sign-in form with fields for 'Login*' and 'Password*', a green 'Sign in' button, and a link for 'Forgot your password?'. Below the form are links for 'Contact Us' and 'Copyright 2015, CMQCC'. The Oregon Health Care Quality Corporation logo is prominently displayed, along with a statement: 'The Oregon Maternal Data Center is a collaboration between Q Corp, the March of Dimes and the Oregon Perinatal Collaborative.' Surrounding the central content are eight orange ovals, each containing a statistic related to the OPC Data Subcommittee's activities from 2013 to 2015.

Over 12 stakeholder organizations involved

Over 150 perinatal measures reviewed & prioritized

20 hospital & stakeholder meetings

14 early adopter hospitals enrolled in OMDC

17 OPC Data Committee meetings

10 OPC Steering & MMoC meetings

5 OMDC webinars

Over 60 individuals involved

Over \$400K invested by all parties



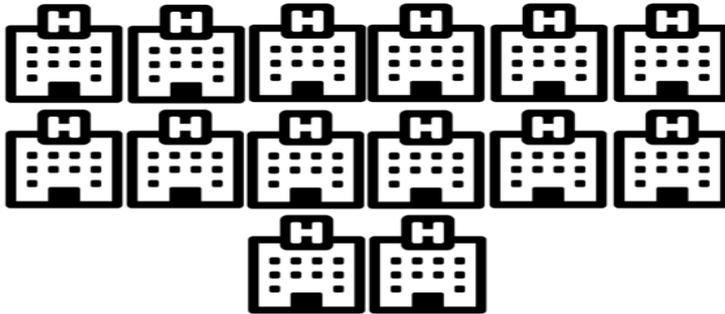


To measure and improve maternity care, Q Corp and other sponsors launched the

Oregon Maternal Data Center (OMDC)

which currently houses data from

14 of Oregon's 52 hospitals



and includes

41.7%
(19,167) 
of the births in the state

Hospitals Enrolled in the OMDC

1. Kaiser Sunnyside Medical Center
2. Kaiser Westside Medical Center
3. Legacy Good Samaritan Medical Center
4. Legacy Meridian Park Medical Center
5. Legacy Emanuel Medical Center
6. Legacy Mount Hood Medical Center
7. Providence St Vincent Medical Center
8. Providence Portland Medical Center
9. Providence Newberg Medical Center
10. Providence Seaside Hospital*
11. Providence Hood River Memorial Hospital*
12. Providence Medford Medical Center
13. Providence Willamette Falls Medical Center
14. Tuality Healthcare—Hillsboro

Hospitals in process

15. OHSU Hospital
16. Good Samaritan Regional Medical Center
17. Samaritan Albany General Hospital
18. Samaritan Lebanon Community Hospital*
19. Samaritan North Lincoln Hospital*
20. Samaritan Pacific Communities Hospital*

* Denotes Critical Access Hospital (CAH)



MDC Clinical Quality Measures

• 3rd & 4th Degree Lacerations in Vaginal Deliveries-All	• Cesarean Section Rate-Nullip, Term, Singleton, Vertex (PC-02)	• Induction Rate	• Operative Vaginal Delivery
• 3rd & 4th Degree Lacerations in Vaginal Deliveries-Instrument Assisted	• Cesarean Section Rate-Primary (Standard)	• Maternal Length of Stay-Vaginal Deliveries	• Preeclampsia ICU Admissions
• 3rd & 4th Degree Lacerations in Vaginal Deliveries-Non Instrument Assisted	• Cesarean Section Rate-Primary, Term, Singleton, Vertex	• Maternal Blood Transfusion Rate	• Preeclampsia Total ICU Days
• 5 Minute APGAR <7 Among All Deliveries >39 weeks	• Cesarean Section Rate-Overall	• Maternal ICU Admissions	• Severe Morbidity w/Pre-Eclampsia
• 5 Minute APGAR <7 in Early Term Newborns	• Cesarean Section-Uncomplicated (Term, Singleton, Vertex)	• Maternal Long Length of Stay-Cesarean Deliveries	• Timely Treatment for Severe HTN (HEN)
• Antenatal Steroids (PC-03)	• Elective Delivery <39 Weeks (PC-01)	• Newborn Bilirubin Screening Prior to Discharge	• Unexpected Newborn Complication
• Appropriate DVT Prophylaxis in Women Undergoing C-Section	• Episiotomy Rate	• NTSV No Labor	• Vaginal Birth After Cesarean (VBAC) Rate, All (AHRQ IQI 34)
• Birth Trauma Rate	• Exclusive Breastfeeding (PC-05)	• OB-Hemorrhage: Massive Transfusions (HEN, RM)	• Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated (AHRQ IQI 22)
• Cesarean Section Rate-Inductions in Full Term Multiparas	• Exclusive Breastfeeding (PC-05a)	• OB-Hemorrhage: Risk Assessment on Admission	• Very Low Birth Weight Infant (< 1500 Grams) Not Delivered at Level III NICU
• Cesarean Section Rate-Inductions in Full Term Nulliparas	• Failed Induction	• OB-Hemorrhage: Total Transfusions (HEN, RM) per 1000	

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

OPC Recommendation to HTPP

- ▶ 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



Thank you!

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Potential Domain Expert Testimony: Care Transitions

Honora Englander, MD, OHSU

Devan Kansagara, MD, MCR, OHSU & VA

Oregon's Hospital Performance Metrics Advisory Committee

Honora Englander, MD, OHSU

Devan Kansagara, MD, MCR, OHSU, VA

November 20, 2015

The Care Transitions Innovation (C-Train) for Socioeconomically Disadvantaged Adults: Results of a Cluster Randomized Controlled Trial

Honora Englander, MD^{1,2}, Leann Michaels, BS³, Benjamin Chan, MS⁴, and Devan Kansagara, MD, MCR^{1,5}

- Multicomponent transitional care intervention targeting socioeconomically vulnerable adults
 - Transitional nursing, social work care including home visits for highest risk
 - Inpatient pharmacy consultation
 - Reinforced linkage to primary care medical home
- No change in ED, readmission rates
- Improved care quality (CTM-3)
- Improved rates of primary care follow up
- Fewer deaths (small study, needs further study)

Readmissions are complicated

- The contributors to readmission risk and pathways to readmission are numerous
- Risk models fail to predict readmission

Kansagara, Englander, JAMA, 2011

- The interventions that reduce readmissions are complex and multifaceted
 - And, even then, many interventions have not reduced readmissions

Kansagara, Englander, JHM, 2015

Leppin, JAMA IM, 2014

Reasons to Improve Care Transitions

- Cost (readmissions)
- Patient experience/quality
- Safety

Patient experience

- Patients/caregivers feel unprepared and confused by hospital to home transition
 - This was a major impetus for the development of the Care Transitions Intervention
- Four main areas of concern:
 - Self-managing illness
 - Asserting preference
 - Accessing health professionals
 - Information transfer
 - Medication confusion

Safety

- Adverse events are common after discharge
 - Usually adverse drug event
- Medical errors are common after discharge
 - Half of all discharged patients are exposed to medical errors in medication continuity, test follow-up or diagnostic work-up

Kripalani S, J Hosp Med, 2007

Forster AJ, Ann Intern Med, 2003

Rennke, Ann Intern Med, 2013

Policy Implications

- Many potential steps in the care transition that could degrade quality if not sufficiently addressed
 - focusing on just one unlikely to yield big changes
- To address this, we developed a detailed transitional care map that systems can use to identify gaps, target improvements
- Measures can be framed in context of this map

Figure 2. Components of an Ideal Care Transition

Setting	Primary care	Hospitalization			Home	Outpatient follow up
		Admission	Hospital Stay	Discharge		
Core Processes	Advanced care planning	Psychosocial needs assessment with process to enlist social and community supports			Reassessment of signs/ symptoms - Follow up call - Home visit for high risk patients	Timely ambulatory follow up
		Readmission risk assessment				
		Anticipatory discharge planning and care coordination - Arrange post-DC services (ie SNF, home health, transportation) - Patient has a clear point of contact across settings				
			Patient/ Caregiver education with focus on: - Self-management including red flags/ warning signs - Medication changes - Follow up			
		Proactive communication - hospital team engages primary care	Communication with hospital and ambulatory providers regarding key issues (i.e. end of life decisions, opioid pain management)	DC summary completed and transmitted Written patient-level transition record		Outstanding test follow through
	Admission medication reconciliation		Discharge medication reconciliation		PCP med list updated	
Key team members	Patient/ caregivers					
	PCP ←	Hospital MD			→	PCP
		Hospital RNs, social workers, PT/OT, inpatient pharmacists			home health, physical/ occupational therapy	Outpatient pharmacists
		←				Ambulatory RNs
	Transitions coaches, peers					→

Adapted from Kansagara et al, VA-ESP; 2014

Metrics

Patient experience:

- Measurable with the Care Transitions Measure
 - Explicitly incorporated patient viewpoint
 - Meant to capture the broad scope of care transitions
- Originally developed as a 15-item measure
 - Lower scores were associated with higher rates of subsequent ED/hospital use

Care Transitions Measure (CTM-3)

1. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left
2. I had a good understanding of the things I was responsible for in managing my health
3. I clearly understood the purpose for taking each of my medications

CTM-3

- 3-item version explained 88% of the variance and has same ability to detect group differences (Parry, Med Care, 2008)
- Subsequent studies have found that it may not discriminate well those with higher subsequent ED/hospital use
- Range of possible scores is wide, but the range of observed scores is relatively narrow
- Incorporated into HCAHPS in 2013

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Safety: Medication reconciliation

Direct measurement vs. checkbox approach

- NQF # 2456
 - Assesses the quality of the med rec process by identifying errors in admit and DC medication orders
- Meaningful use completion of med rec
 - Assesses electronic health record checkbox
 - However, check box measures may not reflect actual improvements in care

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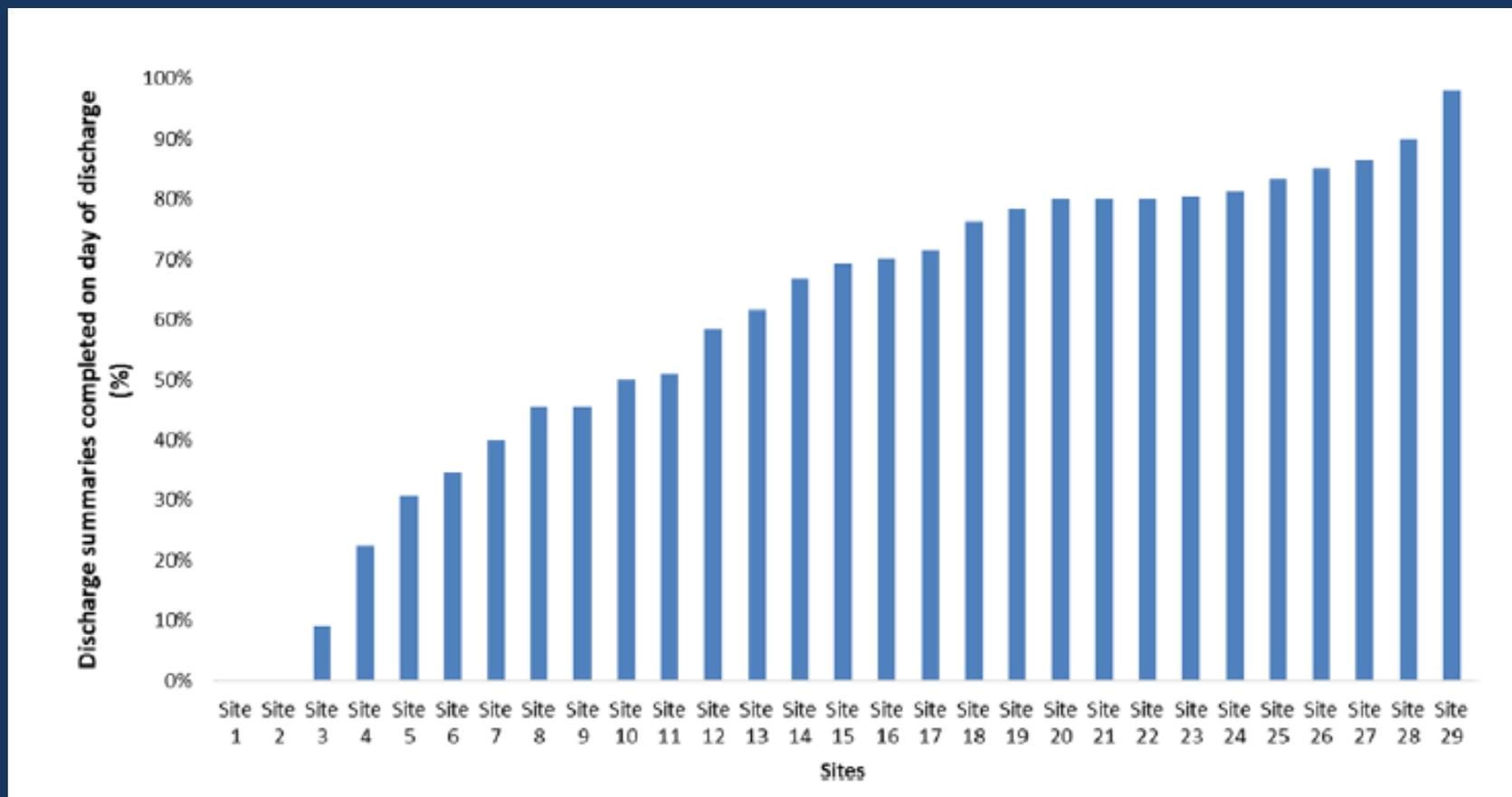
Safety: DC summaries

- Test follow-up
 - Difficult to measure
- Discharge summaries
 - Substantial hospital-level variation in timeliness, transmission, and content of DC summaries
 - Hospital characteristics (ie teaching status, urban location, US region, bed size) were not significant predictors of DC summary quality
 - DC summaries are a key mechanism in addressing gaps in test follow-up

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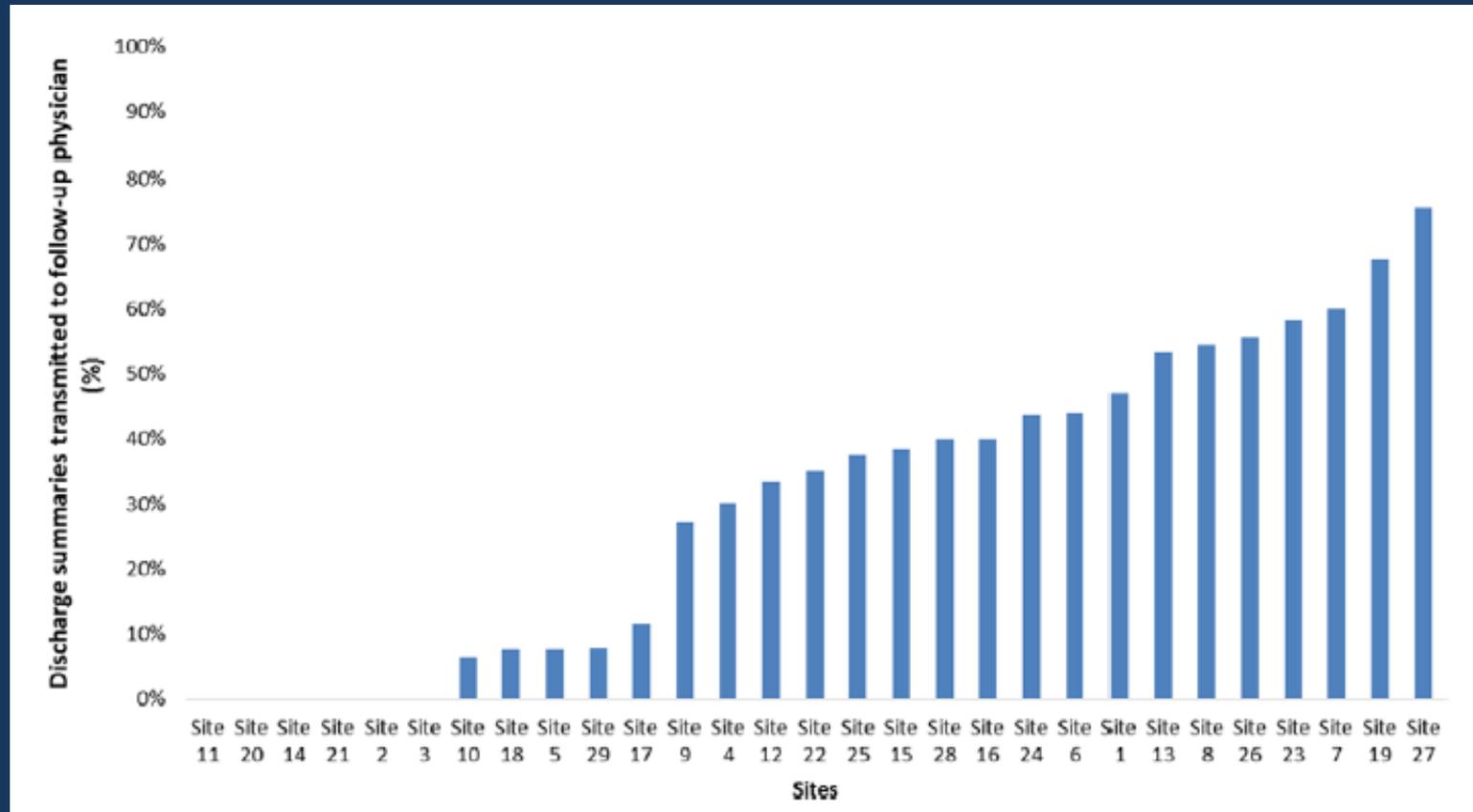
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	Transitions coaches, peers					→

% DC Summaries completed on day of discharge by site, by hospital



*restricted to hospitals w ≥ 10 DC summaries

% DC summaries transmitted to follow-up physician, by site



*restricted to hospitals w ≥ 10 DC summaries

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	Transitions coaches, peers →					

Quality and safety: Follow-up

- Conceptually, the need for some form of reassessment and opportunity to re-educate after discharge seems important and has been part of many successful transitional care interventions
- Early follow-up associated with lower readmission rates in CHF patients, but the effect is relatively small

Follow-up metrics

- NTOCC proposes several measures
 - # (target) patients that had a follow-up visit within an appropriate time period following discharge
 - # patients that had a follow-up phone call within an appropriate time period and a scheduled physician office visit
- In practice, routine and universal in-person visits may not be necessary, may be infeasible, and may not be patient-centered (esp rural patients)
- Data on effectiveness and best practices for post-discharge phone calls are lacking

Measure	Type	Pros	Cons	Questions
Discharge summaries completed in 24hrs	Process	Mechanism for improving other medical errors (lab f/u etc); opportunity for improvement; relevant; attainable; should be easy to measure; reasonable accountability	Stakeholder buy-in; perhaps this fruit is too low-hanging	Should this be completed AND delivered within 24 hours? Will too strict a time frame result in lower quality summaries? At some point, sampling to assess quality of content may be necessary
Meaningful use med rec	Process	Relevant (conceptually); consistent with existing national measure; attainable	Unclear if will lead to meaningful change; potential for gaming high	

Measure	Type	Pros	Cons	Questions
Follow-up appointment	Process	Relevant (to an extent); Potential for driving broader systems change;	Accountability unclear (hospital or medical home?); attainability; relevance (if too broadly applied)	Implementation issues very important; potential for unintended consequences
CTM-3	Outcome	Relevant (to patients); consistent with existing national metric; feasible to measure	Mixed evidence re: ceiling effect; relevance to utilization measures unclear;	May be useful to identify low-performing hospitals. ? diminishing returns in distinguishing higher performing hospitals

Thank you



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BREAK

Updates and Debriefing

- CMS negotiations for Year 3 (CY 2016)
- Behavioral Health Learning Session, 30 October

Potential Domain

Disparities Reduction: Lessons from Other States

Disparities Reduction Work in Hospitals

- Expecting Success: Excellence in Cardiac Care (RWJF national program)
- Massachusetts Hospital Pay for Performance Program
- Disparities Solutions Center - Massachusetts General Hospital
- National Quality Forum (NQF) Healthcare Disparities and Cultural Competency Project

Expanding Success: Excellence in Cardiac Care (RWJF program)

- Aimed to improve overall cardiac care while reducing racial, ethnic, and language (REAL) disparities
- Institutionalized collection of self-reported REAL data to use in quality improvement efforts
- All hospitals increased proportion of patients receiving all core measures of care for heart attack and heart failure within the first year ... but, didn't fare better than comparison hospitals

Expanding Success: Excellence in Cardiac Care (RWJF program), cont.

- However, collecting the data allowed hospitals to identify disparities they didn't know they had
- Lessons learned informed RWJF **Aligning Forces for Quality** initiative (cross-system, not limited to hospitals or focused solely on disparities)
 - Four OR hospitals that participated in improving language services component showed improvement in screening patients for their preferred spoken language for health care
 - Three OR hospitals demonstrated improvement in ensuring limited English-proficient patients had a qualified interpreter at initial assessment and discharge, with one hospital demonstrating a 65 percent improvement over the duration of the program (<http://q-corp.org/news/oregon-hospitals-improve-care-patients-part-national-program-quality-and-safety>)

MA Hospital Pay for Reporting Program

- In 2006, MA set aside a portion of their hospital P4P funds specifically for measures aimed at reducing racial and ethnic disparities in hospital care for Medicaid patients
- Per state mandate, hospitals were already tracking and reporting patients' race & ethnicity in a standard manner

MA Hospital Pay for Reporting Program

- Selected five clinical conditions to stratify by race/ethnicity; because of small n's developed aggregated 'opportunity score' across all measures for each racial/ethnic group
- Challenges
 - Small n's (led to need for aggregated 'opportunity score')
 - Concentration of minority patients in 10 hospitals throughout state (therefore, not necessarily efficient way to address disparities)
 - Metrics used didn't find evidence of widespread disparities in care statewide

'Analysis Raises Question on Whether Pay-for Performance In Medicaid Can Efficiently Reduce Racial and Ethnic Disparities', Health Affairs, 30, no.6 (2011): 1165-1175

Other Hospital Disparities Metrics Resources

- Disparities Solutions Center - Massachusetts General Hospital
 - Dedicated to eliminating racial and ethnic disparities in healthcare
 - Tools include a guide on disparities and quality measurement strategies, and guides for hospitals to use in creating equity reports

Other Hospital Disparities Metrics Resources (cont)

- National Quality Forum (NQF) Healthcare Disparities and Cultural Competency Project
 - Endorsed 12 *new* measures for accountability and quality improvement in area of disparities and cultural competency
 - Identified 60 *disparities sensitive measures* among existing NQF endorsed measures (some under consideration by Committee)
 - When selecting specific measures under other domains, Committee could prioritize those included on this list

Summing Up - Disparities Reduction in Hospitals

- Considerations
 - Ensuring hospitals are collecting REAL data
 - Ensuring standardization of data collection
 - Small n's across each racial / ethnic group
 - Not all disparities statistics are equal
 - Could stratify key quality measures by REAL and/or gender
 - Could select measures identified as disparities sensitive, even if not able to stratify in short-term

Group Discussion of Testimony and Next Steps

see work plan in materials

Wrap-up

Next meeting – December 18, 2015