Draft of 2018 HQIP Proposed Measure

March 28, 2017

Submitted to: Hospital Provider Fee Oversight and Advisory Board

COLORADO
Department of Health Care Policy & Financing

Contents

I. Regional Care Collaborative Organization and Behavioral Health Organization Engagement (mandatory for all hospitals)

Hospitals must meet criteria #1 and #2 below and report on #3; these three elements (1-3) are required but are not scored. Hospitals will be scored on the number of engaged elements under #4a - 4e **and** under #5a - 5e.

1. For patients associated with the hospital's Regional Care Collaborative Organization (RCCO), notify that RCCO of ED visit within 24 hours of the ED visit and include chief complaint/reason for visit (RCCO name and contact information is on Medicaid's eligibility verification notice).
2. For patients associated with the hospital's RCCO, notify that RCCO of inpatient hospitalization admission and include chief complaint/reason for visit (RCCO name and contact information is on Medicaid's eligibility verification notice).

Providers will be required to summarize how they achieved these goals via a narrative of up to 2 paragraphs; the narrative will not be scored.

AND

3. Provide information about your hospital's current systems for collaboration with your Regional Care Collaborative Organization/Behavioral Health Organization to address substance use disorder in order to decrease ED visits and IP admissions; this is not a scored element.

AND At least one of the following:

4. Elements related to Physical Health
    a. Joint efforts to improve population health
    b. Care coordination collaboration (e.g., sharing of care transition plan)
    c. Case management collaboration (e.g., conversations between case managers, RCCO case manager invited to case conferences, etc.)
    d. Collaboration on high utilizers to decrease ED visits and IP admissions
    e. Participation in RCCO level advisory committee meetings or similar meetings.

Providers will choose all that apply and will provide a brief summary that justifies how the hospital met the elements. The narrative of up to 2 paragraphs will not be scored.

AND at least one of the following:

5. Elements related to Mental Health
    a. Collaboration with Behavioral Health Organization (BHO) on psych high utilizers to decrease ED visits and IP admissions
    b. Case management collaboration (e.g., conversations between case managers, BHO case manager invited to case conferences, etc.)
    c. Joint effort with BHO to increase training of staff related to mental health issues (e.g., Mental Health 1st Aid, Trauma Informed Care, Zero Suicide, etc.)
    d. Notification to BHO of ED patient suicide attempt/ideation
    e. Follow-up with BHO/patient within 24 hours of suicide attempt.
    f. Participation in BHO level advisory committee meetings or similar meetings.

Providers will choose all that apply and will provide a brief summary that justifies how the hospital met the elements. The narrative of up to 2 paragraphs will not be scored.

Hospitals will be required to inform HCPF of the criteria they intend to undertake throughout 2018. A random check of participation will be verified with the Regional Accountable Entity.

II. Culture of Safety/Patient Safety (mandatory for all hospitals)

1. **Culture of Safety:** This measure is designed to promote a culture of safety in hospitals. Definitions, criteria and reporting requirements for each of these activities is provided below.
    a. Patient and Family Advisory Council
    b. Leadership Safety Rounds or Daily Leadership Safety Huddles/Briefings
    c. Patient Safety Survey

d. Daily Unit Safety Briefings/Huddles

2. **Patient Safety:** This measure is designed to promote patient safety in hospitals. Definitions, criteria and reporting requirements for each of these activities is provided below.

   a. Hospital Acquired Clostridium Difficile Infections
   b. Adverse Event Reporting:
   c. Falls with Injury

A. Culture of Safety Elements Details:

1. **Patient and Family Advisory Council (PFAC):** an established council with both hospital staff and members who are former patients or family members of former patients.

   Measure Criteria:

   - The council must meet at least four (4) times in calendar year 2018. Note that planning meetings for PFAC do not count.
   - At least three (3) council members must be former patients or family members of former patients.
   - The purpose of the council should be to provide advice and guidance regarding patient safety and/or patient experience issues identified by council members.
   - There should be demonstration by the organization that such advice and guidance was taken into consideration in the planning and improvement of patient care experience and outcomes.

2. **Patient Safety and Hospital Leadership:** ONE of the following is conducted on a regular basis:

   a. Leadership Safety Rounds. These are planned visits to the appropriate hospital departments by hospital executive(s) or senior leaders for the purpose of demonstrating leadership's commitment to a strong patient safety program and identifying and responding to patient safety concerns identified by hospital staff. A senior leader is defined as someone at a Division Director level or higher.

OR

b. Daily Leadership Safety Huddles/Briefings. These are short, daily meetings attended by a hospital executive or senior leader in which representatives from all departments gather to report on potential clinical safety concerns for the day. A senior leader is defined as someone at a Division Director level or higher.

Measure Criteria:

- Leadership Safety Rounds should be attended weekly by a hospital executive or senior leader. Hospital executives or senior leaders will round on at least 50% of the hospital departments during a year.
- Daily Leadership Safety Huddles/Briefings are conducted with the appropriate personnel seven days per week. A hospital executive or senior leader (or designee on weekends) will attend the meeting. A senior leader is defined as someone at a Division Director level or higher.

3. **Patient Safety Survey:** completion of a survey that gathers data regarding hospital staffs' perceptions of the organization's safety culture and demonstration of actions taken by the hospital to address issues identified by survey responses.

   One of the following is required:

   a. For hospitals new to conducting Patient Safety Survey: A validated Patient Safety Survey (such as AHRQ's) conducted in the first quarter of 2018, AND a project plan to improve the poorest scores is developed in the second quarter of 2018, AND that project plan is implemented in the second half of 2018.

   OR

   b. For hospitals who have previously conducted a Patient Safety Survey: a validated Patient Safety Survey (such as AHRQ's) conducted in the last 24 months, AND a project plan to improve poorest scores was developed and is implemented throughout 2018.

Measure Criteria:

- Survey must include at least ten questions related to a safety culture and can be combined with another survey of hospital staff.
- Safety culture questions must be from a survey tool that has been tested for validity and reliability.
- Survey questions can be part of another survey tool as long as it meets the above criteria.
- Safety culture survey has been administered within the past 24 months.
- Actions taken in response to the survey should address those survey questions that demonstrated the poorest scores on the survey.

4. **Daily Unit Safety Briefings/Huddles:** These are short meetings held in nursing units and in clinical departments to identify possible patient safety issues or concerns.

   Measure Criteria:

   - Meetings should be held daily.
   - Meetings should be led by unit or department leader or designee.
   - All available department/unit staff should be present.

B. Patient Safety Elements Details:

1. **Hospital Acquired Clostridium Difficile**. Hospitals must submit data for this measure to National Healthcare Safety Network (NHSN); this allows for risk adjusting and calculation of an SIR rate. NHSN rates are then used in the Colorado Department of Public Health and Environment's *Healthcare Associated Infections in Colorado* annual report. HCPF will pull hospital data from that report. Hospitals that do not submit C-DIFF data to NHSN cannot be scored on this measure.

2. **Adverse Event Reporting** Hospital describes system for reporting on and responding to Adverse Events.

   Measure Criteria:

   - Must allow anonymous reporting.

- Reports should be received from a broad range of personnel.
- Summaries of reported events must be disseminated in a timely fashion.
- A structured mechanism must be in place for reviewing reports and developing action plans.

3. **Falls with Injury**

The *Falls with Injury* measure is based on the definition provided by the National Quality Forum (NQF) for the number of documented patient falls with an injury level of moderate or greater on eligible unit types during the measurement period (the NQF measure also includes minor falls, which this HQIP measure does not). Measure specifics can be found on the NQF website (measure ID: 0202). Hospitals will be required to submit data from calendar year 2017 to HCPF (all patients regardless of payer).

A patient injury fall is an unplanned descent to the floor with injury (moderate or greater) to the patient, and occurs on an eligible reporting nursing unit. Include falls when a patient lands on a surface where you would not expect to find a patient. Unassisted and assisted falls are to be included whether they result from physiological reasons (e.g., fainting) or environmental reasons (slippery floor). Also report patients that roll off of a low bed onto a mat as a fall.

Hospitals will report four data points:

a. Number of Moderate Injury Falls: resulted in suturing, application of steri-strips/skin glue, splinting, or muscle/joint strain.
b. Number of Major Injury Falls: resulted in surgery, casting, traction, required consultation for neurological or internal injury or patients with coagulopathy who receive blood products as a result of a fall.
c. Number of Falls Resulting in Death: the patient died as a result of injuries sustained from the fall (not from physiological events causing the fall).
d. Total number of inpatient days for applicable units during calendar year 2017 (including observation patients on applicable units). To calculate Total Patient Days, refer to the NQF measure specification

section: Patient Days Reporting Methods. (Note: hospitals will not multiply by 1000.)

Included in the measure: inpatients, short-stay patients, observation patients, and same-day surgery patients who receive care on eligible inpatient units for all or part of a day: adult critical care, step-down, medical, surgical, medical-surgical combined, critical access and adult rehabilitation inpatient units; patients of any age on an eligible reporting unit are included in the patient-day count.

Excluded from the measure: visitors, students, staff members, falls on other units not eligible for reporting, falls by patients from an eligible reporting unit when the patient was not on unit at the time of fall (e.g., patient falls in radiology department); other unit types (e.g., pediatric, psychiatric, obstetrical, etc.).

The nursing unit area includes the hallway, patient room and patient bathroom. A therapy room (e.g., physical therapy gym), even though physically located on the nursing unit, is not considered part of the unit.

C. Documentation for Culture of Safety and Patient Safety Elements:

Documentation should give a high-level picture of *Culture of Safety* and *Patient Safety* for the time period January 2018 through December 2018. We are interested in what is being done and the results/effect on patient care. It is important that all criteria below is addressed in the summary.

Culture of Safety:

1. **Patient and Family Advisory Council**. A short summary (1-2 paragraphs) that includes the following elements: the number of meetings to be held from January 2018 to December 2018, one or two of the major discussion topics from meetings held, and any actions planned or implemented as a result of the discussion.
2. **Patient Safety and Hospital Leadership**. A short summary (1-2 paragraphs) of some of the issues identified and addressed during these meetings/discussions.

3. **Patient Safety Survey**. A short summary (1-2 paragraphs) of survey findings as relates to the lowest scores, what is planned for 2018 as a result of the survey and the number of staff completing the survey.

4. **Daily Unit Safety Briefings/Huddles**. A short summary (1-2 paragraphs) of some of the issues identified and the number and description of the units on which briefings are conducted.

Patient Safety:

1. **Hospital Acquired Clostridium Difficile**. Hospitals must submit data for this measure to NHSN; this allows for risk adjusting and calculation of an SIR rate. NHSN rates are then used in the Colorado Department of Public Health and Environment's *Facility Infections* annual report. HCPF will pull hospital data from that report. Hospitals that do not submit C-DIFF data to NHSN cannot be scored on this measure.

2. **Adverse Event Reporting**. A short summary (1-2 paragraphs) describing the Adverse Reporting system, some of the issues identified and addressed as a result of adverse event reporting.

3. **Falls with Injury**. Hospitals will report four data points: number of Moderate Injury Falls, number of Major Injury Falls, Falls Resulting in Death, total number of inpatient days for applicable units during calendar year 2017. To calculate Total Patient Days, refer to the NQF measure specification section: Patient Days Reporting Methods. (Note: hospitals will not multiply by 1000.)

III. Discharge Planning

A. Advanced Care Planning

The *Advance Care Planning* measure is based on the definition provided by the National Quality Forum (NQF) for the number of patients 65 years of age or older who have an advanced care plan documented or who did not wish to provide an advance care plan. Measure specifics can be found on the NQF website (measure ID: 0326). Hospitals will be required to submit data from calendar year 2017 to HCPF (all patients, regardless of payer).

Hospitals will also summarize process for discussing/initiating advanced care planning when a patient does not have an ACP or when their ACP is not available to the hospital. This short summary (up to 2 paragraphs) will not be scored.

Random sampling is allowed. Sampling Guidelines will be provided.

B. Care Transition Activities

Identify activities in which your hospital is engaged from January 1, 2017 through December 31, 2017. Scoring is based upon number of engaged activities.

- Assigned staff conducts post-discharge phone call or post-discharge home visit
- Assign care management responsibilities for high-risk (hospital defined) patients in ED or IP.
- Assigned staff discusses transitions to acute-care services with patient and family prior to transition to foster understanding about next steps and to discuss any concerns.
- Coordinate medications across transitions from hospital to post-acute care services.
- Maintain an inventory of community resources available to patients.
- Engage local health coalitions to identify resources in areas where resources are scarce.
- Develop a medication action plan for high-risk patients.
- Develop policies and training to address patient health literacy issues.
- Other care transition activities.

Providers will choose all that apply and will provide a brief summary that justifies how the hospital met the elements. If you selected "Other," please describe in detail. This short summary (up to 2 paragraphs) will not be scored.

IV. Cesarean Section

The *Cesarean Section* measure uses the Joint Commission calculation and sampling for PC-02a in the perinatal care measure set. This measure counts the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section during calendar year 2017 (all patients, regardless of payer). Minimum sample size of 30 is required.

Measure criteria:

- To be eligible for a score on the hospital's 2017 Cesarean Section data, the hospital will be required to describe their process for notifying physicians of their respective Cesarean Section rates and how they compare to other physicians' rates and the hospital average.
- The hospital has discretion over how to format the report and disclosures for statistical significance.
- Hospitals will be required to include a blank example of the report that is provided to physicians for this purpose.

V. Breastfeeding Practices

All hospitals will be required to submit PC-05 data (#1). Hospitals can then choose one activity: #2, #3 or #4.

1. Hospitals will submit calendar year 2017 data for The Joint Commission (TJC) PC-05, Exclusive Breast Milk Feeding measure (all patients, regardless of payer). Points will be given for reporting and will not be based upon the hospital's PC-05 rate.

AND ONE OF THE FOLLOWING

2. Written breastfeeding polices for hospitals not officially on the pathway to Baby-Friendly designation. Must implement five (5) of *The Ten Steps to Successful Breastfeeding* by April 1, 2018. Must also provide a copy of the policy and a statement as to how staff is trained on the policy:
   a. Help mothers initiate breastfeeding within one hour of birth.

b. Give infants no food or drink other than breast milk unless medically indicated.
c. Practice rooming in – allow mothers and infants to remain together 24 hours a day.
d. Give no pacifiers or artificial nipples to breastfeeding infants.
e. Breastfeeding support telephone number provided before discharge.

OR

3. *4-D Pathway* to Baby-Friendly Designation. Hospitals must move from one of the following *4-D Pathway* phases to the next during the time period of January 1, 2017 and April 1, 2018.
   a. From Discovery Phase to Development Phase
   b. From Development Phase to Dissemination Phase
   c. Dissemination Phase to Designation Phase

OR

4. Baby-Friendly Designation: hospitals officially receiving or maintaining Baby-Friendly designation at some point between January 1, 2017 and April 1, 2018.

VI. Tobacco (TOB) and Substance Use (SUB) Screening and Follow-Up

The *Tobacco Screening and Follow-Up* measure is based on the Joint Commission definitions for the number of patients 18 years of age or older who were screened for tobacco use and, if positive, referred to or refused evidence based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge (TOB-01 and TOB-03, Screening for Tobacco Use and Tobacco Use Treatment Provided or Offered). Hospitals will be required to submit data from calendar year 2017 to HCPF (all Medicaid patients, 18+). Random sampling is allowed (see sampling guidelines below). Rates for TOB-01 and TOB-03 must be submitted; however, only TOB-03 (follow-up) will be scored.

AND

The *Alcohol Screening and Follow-Up* measure is based on the Joint Commission definitions for the number of hospitalized patients 18 years of age or older who were screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use and, if positive, referred to or refused evidence based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge (SUB-01 and SUB-03, Alcohol use Screening and Alcohol and Other Drug use Disorder Treatment Provided or Offered at Discharge).. Hospitals will be required to submit data from calendar year 2017 to HCPF (all Medicaid patients, 18+). Random sampling is allowed (see sampling guidelines below). Rates for SUB-01 and SUB-03 must be submitted; however, only SUB-03 (follow-up) will be scored.

VII. ED Process Measure

Summarize your hospital's policy and practice related to non-opioid alternatives to pain management in the ED. This short narrative of up to two (2) paragraphs will not be scored.

AND at least one of the following interventions, which must be effective during the period January 1, 2018 through December 31, 2018.

1. All discharged ED patients are given information about local primary care clinics if they have no PCP.
2. All discharged ED patients are provided information about available nurse advice lines.
3. ED policies or guidelines that state providers will not provide replacement prescriptions for opioids that are lost, destroyed or stolen are in effect by January 1, 2018. Hospital will be required to submit a copy of this policy/guideline.
4. ED policies or guidelines are in place indicating no long acting opioids are prescribed in the ED are in effect by January 1, 2018. Hospital will be required to submit a copy of this policy/guideline.

5. Provide Training to ED staff on issues such as: Trauma Informed Care, Mental Health 1st Aid, and Zero Suicide. Training provided is at the hospital's discretion.

VIII. HCAHPS

This measure is based on the question on the HCAHPS survey showing the percentage of patients who gave the hospital a rating of a "9" or "10" on a scale from 0 (lowest) to 10 (highest). Data from this measure will be taken from the most current data on Hospital Compare in order to provide a patient-mix adjustment.

IX. 30 Day All-Cause Readmissions, CMS methodology

The *30 Day All Cause Readmission calculation* is defined by the Centers for Medicare and Medicaid Services (CMS) and counts Medicaid clients with readmissions during calendar year 2017. Hospitals do not need to submit data for this measure. Patients must be continuously enrolled in Medicaid for at least 365 days prior to the discharge date to be included in this measure; therefore, the numerators, denominators and subsequent readmission rates will be lower than a hospital calculates with its own data. Minimum sample size of 30 is required.

X. Maintenance Measures

MM #1: PE/DVT (no points). Hospitals do not need to submit data for this measure. The data source for this measure is the Colorado Hospital Report Card.

MM #2: CLABSI (no points). Hospitals do not need to submit data for this measure. The data source for this measure is the NHSN data submitted to the Colorado Department of Public Health and Environment and obtained in the annual *Health Care Associated Infections Report in Colorado*.

MM #3 Early Elective Deliveries (no points). This measure uses the TJC calculation and sampling for PC-01 in the perinatal care measure set.