2019 Hospital Quality Incentive Payment (HQIP) Program

May 1, 2019

COLORADO
Colorado Healthcare Affordability & Sustainability Enterprise

Contents

I. Overview of the HQIP Program

The Hospital Quality Incentive Payment (HQIP) Program is offered by the Colorado Health Care Affordability and Sustainability Enterprise (CHASE), a government-owned business that operates within the Department of Health Care Policy and Financing (the Department) for the purpose of charging and collecting the healthcare affordability and sustainability fee to obtain federal matching funds to provide business services to hospitals by improving the quality of health care for Health First Colorado members. The HQIP Program provides incentive payments to hospitals for improving health care and patient outcomes

A. Program Authority

On May 20, 2017 the governor signed Senate Bill 17-267, Concerning the Sustainability of Rural Colorado into Law. This action replaced the Colorado Health Care Affordability Act at Section 25.5-4-402.3, C.R.S. effective June 20, 2017 and created the CHASE at Section 25.5-4-402.4, C.R.S. effective July 1, 2017.

The thirteen-member Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board including five hospital members; one statewide hospital organization member; one health insurance organization or carrier member; one health care industry member; two consumers; one health insurance member; and two Department members, provide oversight of the CHASE. The CHASE Board is tasked with, among other responsibilities, recommending reforms to hospital reimbursement and quality incentive payments to increase accountability, performance, and reporting.

The CHASE Board also has an appointed subcommittee comprised of staff from hospitals, the Colorado Hospital Association and the Department to provide recommendations on the Hospital Quality Incentive Payment (HQIP). The major tasks of the subcommittee include:

- Recommend performance measures that form the basis of the incentive payment.
- Recommend how payments should be made.
- Communicate with hospitals.
- Develop and recommend measures specifications.

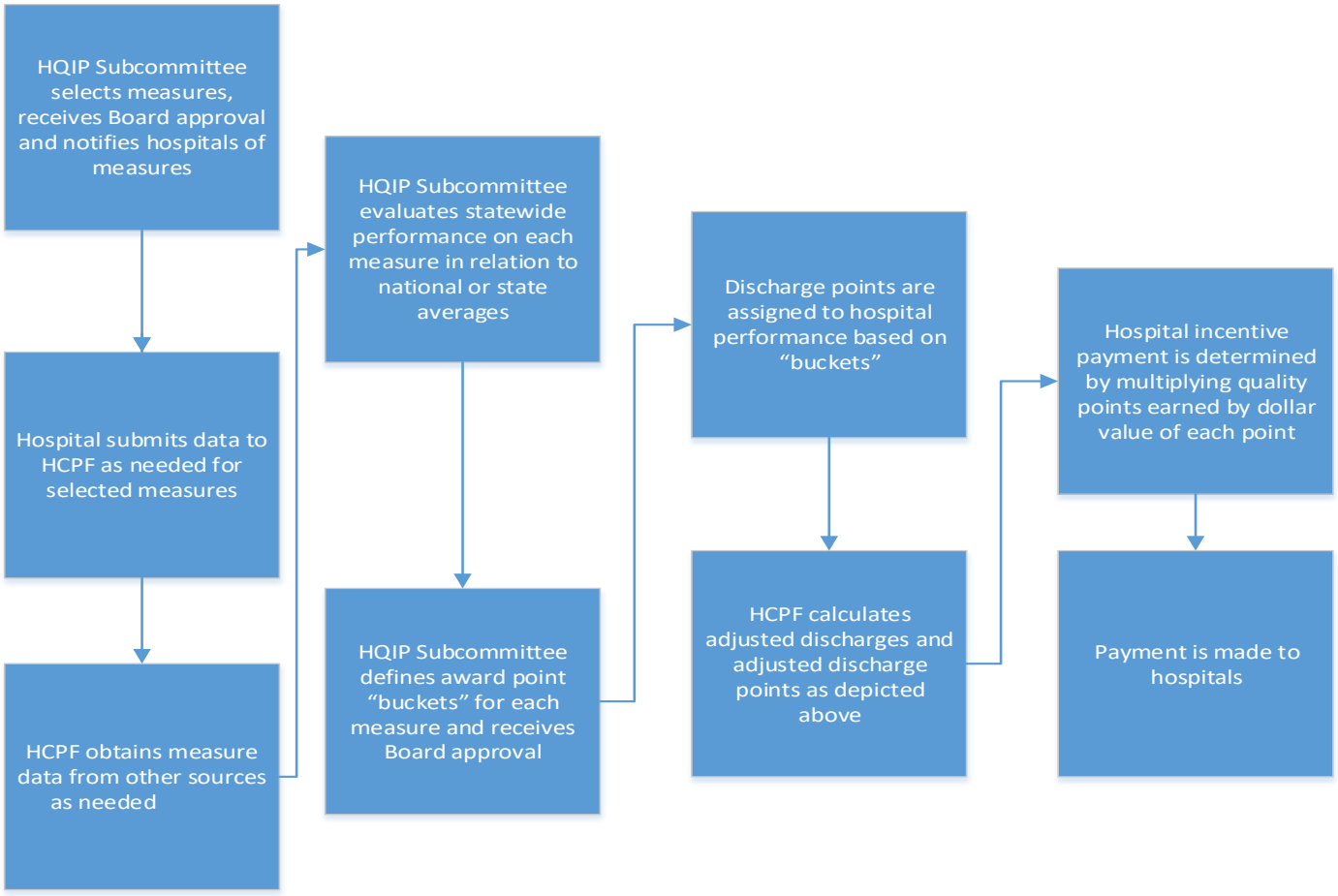
The subcommittee recommends performance measures and scoring to the CHASE Board. The incentive payments are calculated based on measures and scoring recommended by the CHASE Board. The Medical Services Board (MSB) promulgates rules and CMS approves the State Plan. The Medical Services Board and the Centers for Medicare and Medicaid Services (CMS) must then approve the payments. Incentive payments are made once all approvals have been obtained. Hospital participation in the HQIP program is voluntary.

B. 2019 HQIP Subcommittee and CHASE Board

The HQIP Subcommittee is comprised of staff from hospitals, one statewide hospital organization member, and the Department. The HQIP Advisory Group provides technical assistance and feedback on the HQIP measures; the CHASE Board is comprised of staff whose work relates to data and quality at varied Colorado hospitals.

C. Annual HQIP Process

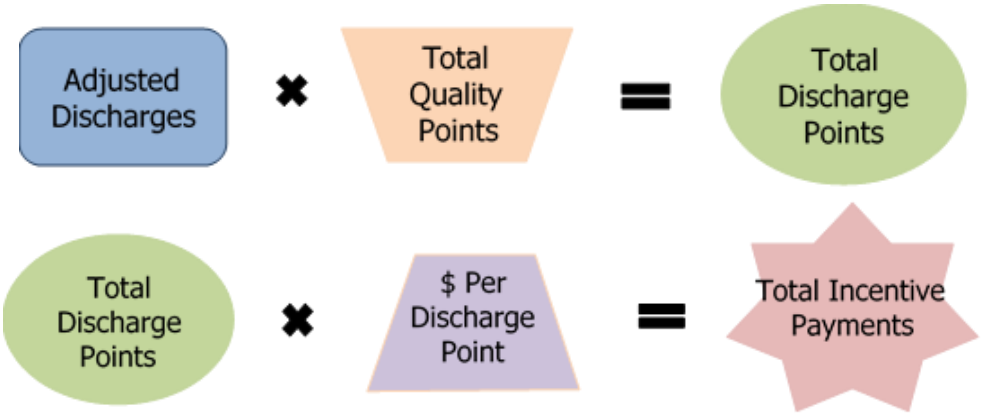
The annual HQIP process is depicted by the following flowchart.



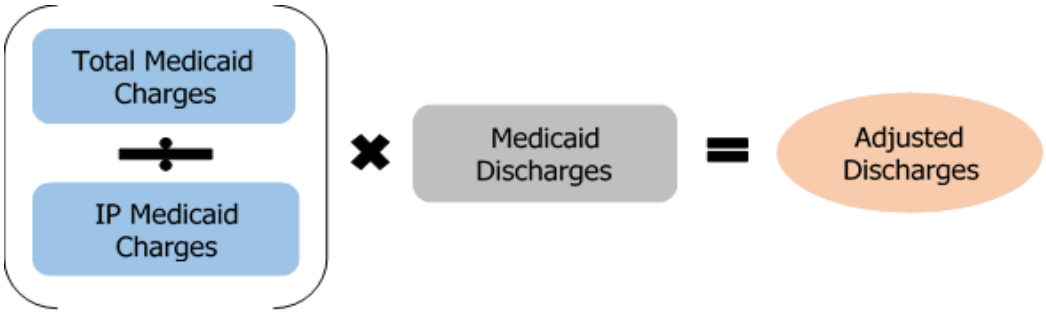
D. Incentive Payment Calculation

The HQIP incentive payments are based on each hospital's performance on the measures recommended by the HQIP Subcommittee and the CHASE Board. Data to assess performance is obtained from a variety of sources: hospitals report to the Department on selected measures and data is obtained from Medicaid claims data, Hospital Compare, and other sources for other measures. The incentive payment calculation is displayed below.

Annual adjusted discharges are multiplied by the total quality points earned by a hospital to determine total discharge points. Total discharge points are then multiplied by the dollars per discharge point to arrive at the total incentive payment.



Adjusted discharges are calculated by dividing the total Medicaid charges by inpatient Medicaid charges. This quotient is multiplied by total inpatient Medicaid discharges to arrive at Adjusted Discharges. This calculation is done to derive a metric that represents total inpatient and outpatient volume combined.



E. Dollars per Discharge Point

A hospital's performance level determines the quality points earned. The Dollars ($) per Discharge Point (above) is dependent on the total quality points earned by a hospital. The higher the total quality points, the more money each discharge point is worth.

F. HQIP Timeline

	2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Performance Period	Jan - Dec											
Data Collection						May						
Scoring							Jun - Aug					
On-Site Reviews							Aug					
Payment Calculations							Aug - Sep					
Payment Period								Oct - Sep				

II. 2019 Measures

Measures for the 2019 HQIP program are listed below. Hospitals will be requested to complete all six measure groups. Measures with an asterisk (*) denote new measures for the 2019 HQIP.

A. 2019 Measure Groups

1. Maternal Health and Perinatal Care Group

Measure	Measure Basis	Source	Measurement Period
Exclusive Breast Feeding (PC-05)	The Joint Commission (TJC)/CMS	Hospital Reported	January 1, 2018 to December 31, 2018
Cesarean Section (PC-02)	The Joint Commission /CMS	Hospital Reported	January 1, 2018 to December 31, 2018
Perinatal Depression and Anxiety*	Council on Patient Safety in Women's Health Care	Hospital Reported	In place by April 30, 2019
Maternal Emergencies*	National Partnership for Maternal Safety	Hospital Reported	In place by April 30, 2019
Reproductive Life/Family Planning*	Department of Health Care Finance/US Office of Population Affairs	Department/Hospital Reported	In place by April 30, 2019

2. Patient Safety Group

Measure	Measure Basis	Source	Measurement Period
Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	Department/Hospital Reported	January 1, 2018 to December 31, 2018
Adverse Event	HQIP	Hospital Reported	January 1, 2018 to December 31, 2018
Falls with Injury	American Nurses Association	Hospital Reported	January 1, 2018 to December 31, 2018
Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection

3. Patient Experience Group

Measure	Measure Basis	Source	Measurement Period
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)*	AHRQ/ Hospital Compare	Department	January 1, 2018 to December 31, 2018
Advance Care Plan	National Committee for Quality Assurance (NCQA)	Hospital Reported	January 1, 2018 to December 31, 2018

4. Regional Accountable Entity (RAE) Engagement

Measure	Measure Basis	Source	Measurement Period
Regional Accountable Entity (RAE) Engagement	CO Regional Accountable Entity (RAE)	Department	January 1, 2019 to December 31, 2019

5. Substance Abuse Group

Measure	Measure Basis	Source	Measurement Period
Substance Use Disorder Composite*	American Medical Association (AMA)	Hospital Reported	January 1, 2018 to December 31, 2018
ALTO* (Alternatives to Opioids)	Colorado Hospital Association (CHA)	Hospital Reported	In place by October1, 2019

6. Addressing Cost of Care Group

Measure	Measure Basis	Source	Measurement Period
Hospital Index*	Prometheus	Department	State Fiscal Year 2017-18

B. 2019 Maintenance Measures

1. Pulmonary Embolism /Deep Vein Thrombosis (PE/DTV)

Measure Steward	Data Source	Measurement Period
AHRQ	CHA Hospital Report Card	January 1, 2018 to December 31, 2018

2. Central Line Associated Blood Stream Infections (CLABSI)

Measure Steward	Data Source	Measurement Period
CDC	Colorado Department of Public Health and Environment (CDPHE)	August 1, 2018 to July 31, 2018

3. Early Elective Deliveries

Measure Steward	Data Source	Measurement Period
The Joint Commission	CMS	January 1, 2018 to December 31, 2018

C. Changes from the Prior Year

- Hospitals will be requested to complete all six measure groups.
- RAE Engagement and Addressing the Cost of Care are new measure groups
- 11 new measures have been added while eight have been retired
- Outcomes measures are prioritized where possible, and Department reported measures are used

D. New Measures

- Perinatal Depression and Anxiety
- Maternal Emergencies
- Reproductive Life/Family Planning
- RAE Engagement
- Emergency Department Utilization for Mental Health
- Emergency Department Utilization for Substance Use Disorder
- HCAHPS
- Substance Use Disorder Composite
- ALTO-Alternatives to Opioids
- Hospital Index

E. Retired Measures

- Regional Care Collaborative Organization Engagement
- Behavioral Health Organization Engagement
- Culture of Safety
- Care Transitions
- Tobacco Screening and Follow-Up
- Substance Use Screening and Follow-Up
- Emergency Department Process Measure
- 30 Day All-Cause Readmissions

F. 2019 Measure Details

Measures for the 2019 HQIP program are listed below. Hospitals will be requested to complete all six measure groups.

1. Maternal Health and Perinatal Care

a. Breast Feeding

This measure is based on activities from January 1, 2018 to December 31, 2018 and is for all patients regardless of insurance coverage.

All hospitals will be required to report The Joint Commission (TJC) PC-05 data (NQF #0480) (#1). Hospitals can then choose one activity: #2, #3 or #4. There is no minimum denominator for this measure.

1. Hospitals will submit calendar year 2018 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. Sampling is allowed. There is no minimum denominator for this measure.

AND ONE OF THE FOLLOWING

2. Written breastfeeding policies for hospitals not officially on the pathway to Baby-Friendly designation. Must implement all five (5) of The Ten Steps to Successful Breastfeeding by December 31, 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, 2018 and December 31, 2018

    a) From Discovery Phase to Development Phase

    b) From Development Phase to Dissemination Phase

    c) Dissemination Phase to Designation Phase

Hospitals that completed activity #3 during the 2018 HQIP program year and reported a phase change occurring between January 1 to April 1, 2018 must show subsequent move from one phase to the next within the 12 months succeeding the initial change. No points will be awarded for a transition that was already rewarded in the 2018 HQIP program year

OR

4. Baby-Friendly Designation: hospitals officially receiving or maintaining Baby-Friendly designation at some point between January 1, 2018 and December 31, 2018.

Scoring

- Points earned for reporting PC-05 data (all or nothing)
- Highest number of points will be awarded to hospitals with Baby-Friendly Designation, and second-tier of points for those on the Pathway. The lowest tier of points will be awarded for hospitals that submit written breastfeeding policies but are not on the Pathway. Documentation will also be required to verify Pathway transition and Baby-Friendly Designation

b. Cesarean Section

This measure is based on calendar year 2018 and is for all patients regardless of insurance status.

The Cesarean Section measure is based on the Joint Commission calculation and sampling for PC-02 in the perinatal care measure set. This measure counts the number of qualified births (nulliparous women with a term, singleton baby in a vertex position) delivered by cesarean section. Sampling is allowed. Minimum denominator of 30 is required for this measure.

Measure Criteria

In order to receive a score for the hospital's Cesarean Section rate, 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. This should be communicated to physicians through a regular report as well as through regular executive and team meetings (or equivalent). The report must be uploaded and must include at a minimum:

- Physician's Cesarean Section rate.
- The individual rates (not aggregated) of other physicians' Cesarean Section rates so as to provide a peer-to-peer comparison.
- The hospital's average Cesarean Section rate

The hospital has discretion over how to format the report and disclosures for statistical significance.

Hospitals will be required to upload a blank example of the report that is provided to physicians for this purpose.

Scoring

- Hospitals that meet the criteria outlined will be eligible to earn points.
- Points will be assigned based on relative performance with hospitals performing worse than minimum standard of 23.9% (Healthy People 2020) receiving no points and the remaining divided into terciles.

c. Perinatal Depression and Anxiety

This measure must be in place by in place by April 30, 2019 and is for all patients regardless of insurance status.

The Perinatal Depression and Anxiety measure is based on the Council on Patient Safety in Women's Health Care Perinatal Depression and Anxiety. The measure has been revised to better suit the nature of care delivery in hospital environments. The measure is modeled after 4 "Rs": Readiness, Recognition and Prevention, Response, Reporting/Systems Learning.

1. Readiness-Clinical Care Setting:
    - Provide documentation on the mental health screening tools used in the facility for screening during pregnancy/immediate postpartum period as well as any education materials and plans provided to clinicians and support staff on use of the identified screening tools and response protocol.
    - Identify the individual who is responsible for driving adoption of the identified screening tools and response protocol.
2. Recognition and Prevention-Every Woman:
    - Describe the process where the hospital obtains individual and family mental health history (including past and current medications) at intake and how it is reviewed and update as needed.
    - Document the validated mental health screening provided at the hospital during patient encounters during pregnancy/immediate postpartum period.
3. Response-Every Case:
    - Submit documentation on the facility's stage-based response protocol for a positive mental health screen.
    - Submit documentation on the emergency referral protocol for women with suicidal/homicidal ideation or psychosis.

4. Reporting/Systems Learning-Clinical Care Setting:
    - Describe the policies and processes by which the hospital incorporates information about patient mental health into how it plans care.
    - Report the number of patients screened, the number of positive screens and the number of positive screens that resulted in a documented action or follow up plan.

Measure Criteria

Hospitals should report the requested information and documentation that addresses each of the four "Rs" (1-4) in the measure.

Scoring

- To be scored, hospitals must submit complete information on at least two of four "Rs" (1-4)
- Scoring will be tiered with points earned for completion of two, three, or four "Rs" (1-4).

d. Maternal Emergencies and Preparedness

This measure must be in place by April 30, 2019 and is for all patients regardless of insurance status.

This measure is based on the National Partnership for Maternal Safety Consensus Bundle on Severe Hypertension During Pregnancy and the Postpartum Period.

Hospitals will report on the structure and process measures below through attestation, narratives that describe processes and provide supporting evidence. The Department will calculate the outcome measures based on claims data. The Department will evaluate the structure and process measures based on the Council on Patient Safety in Women's Health Care Severe Hypertension in Pregnancy 4 "Rs". (Readiness, Recognition and Prevention, Response, Reporting/Systems Learning).

Structure Measures:

1. Does the facility have a severe hypertension or preeclampsia policy and procedure updated within the past 3 years that provides a standard approach for measuring blood pressure, treatment of severe hypertension or preeclampsia, administration of magnesium sulfate, and treatment of magnesium sulfate overdose?

2. Have any of the severe hypertension and preeclampsia processes (i.e. order sets, tracking tools) been incorporated into the facility's electronic health record?
3. Has the facility developed obstetric-specific resources and protocols to support patients, families, and staff through major obstetric complications?
4. Has the facility established a system to perform regular formal debriefs and system-level reviews on all cases of severe maternal morbidity or major obstetric complications?

Process Measures

1. How many drills on maternal safety topics were performed in the facility during the past quarter or year?
2. What proportion of maternity care providers and nurses have completed a bundle or unit protocol– specific education program on severe hypertension and preeclampsia within the past 2 years?
3. How many women with sustained severe hypertension received treatment according to protocol within 1 hour of detection?

Outcome Measure:

Denominator

All women during their birth admission (excluding those with ectopic pregnancies and miscarriages) with one of the following diagnosis codes:

- Gestational hypertension
- Severe preeclampsia
- HELLP syndrome
- Eclampsia
- Preeclampsia superimposed on pre-existing hypertension
- Chronic hypertension

Numerator

Among those patients counted in the denominator, cases with any Severe Maternal Morbidity code as detailed on the Alliance for Innovation on Maternal Health website: www.safehealthcareforeverywoman.org/aim-data

Compliance on the structure and process measures would be based on the 4 "Rs" criteria from the Council on Patient Safety in Women's Health Care Severe Hypertension in Pregnancy which is listed below:

Readiness - Every Unit:

1. Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
2. Unit education on protocols, unit-based drills (with post-drill debriefs)
3. Process for timely triage and evaluation of pregnant and postpartum women with hypertension including Emergency Department (ED) and outpatient areas
4. Rapid access to medications used for severe hypertension/eclampsia:
5. Medications should be stocked and immediately available on Labor & Delivery (L&D) and in other areas where patients may be treated. Include brief guide for administration and dosage.
6. System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

Recognition and Prevention – Every Patient:

1. Standard protocol for measurement and assessment of Blood Pressure (BP) and urine protein for all pregnant and postpartum women
2. Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
3. Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

Response – Every case of severe hypertension/preeclampsia:

1. Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
    a) Severe hypertension
    b) Eclampsia, seizure prophylaxis, and magnesium over-dosage
    c) Postpartum presentation of severe hypertension/preeclampsia
2. Minimum requirements for protocol

a) Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes

b) After the second elevated reading, treatment should be initiated ASAP, preferably within 60 minutes of verification

c) Includes onset and duration of magnesium sulfate therapy

d) Includes escalation measures for those unresponsive to standard treatment

e) Describes manner and verification of follow-up within 7 to 14 days postpartum

f) Describe postpartum patient education for women with preeclampsia

Reporting/Systems Learning – Every Unit:

1. Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
2. Multidisciplinary review of all severe hypertension/eclampsia cases admitted to Intensive Care Unit (ICU) for systems issues
3. Monitor outcomes and process metrics

Measure Criteria

Structure Measures will be evaluated through a combination of attestation and uploading of evidence or documentation. In order to receive points for structure measures, hospitals must answer structure measure 1 regarding hypertension or preeclampsia policy, and two of three remaining structure measures (2,3,4).

For each structure measure, hospitals are advised to use the following crosswalk as guidance to determine the relevant "R's" and their associated subcomponents in which documents and narratives submitted must address in order to fully satisfy the requirements for this measure.

Relevant "Rs"

Structure Measure	Readiness	Recognition and Prevention	Response	Reporting
1 (Required)	1,3,6	1,2,3	1(a-c), 2(a-g)	N/A
2	1,3,6	1,2	2(a-g)	N/A
3	1,3,4,5,6	1,2,3	1(a-c), 2(a-g)	N/A
4	N/A	N/A	N/A	1,2,3

Process measures must be reported, and points can be earned by reporting data for all three process measures 1,2, and 3.

Outcome measures will be calculated by the Department using claims data.

Scoring

In order to receive full points, hospitals must answer Structure measure 1 and two of the three remaining measures (2,3,4) as well as all Process measures. Structure and Process Measures are each scored on an all-or-nothing basis.

e. Reproductive Life/Family Planning

This measure must be in place by in place by April 30, 2019 and is for all patients regardless of insurance status.

The proposed measure is a process measure where hospitals will attest that they have a program in place that offers counseling about all forms of postpartum contraception in a context that allows informed decision making. Immediate postpartum long-acting reversible contraception (LARC) should be offered as an effective option for postpartum contraception. The immediate postpartum period can be a particularly favorable time for discussion and initiation of contraceptive methods, including LARC.

If a hospital does not offer contraception counseling for religious or other reasons, it should attest that there is a program in place that offers counseling on reproductive life/family planning and describe how they communicate what family planning services are available.

Measure criteria:

The Department will calculate LARC insertion rates using the following claims-based measure: NQF #2902 Contraceptive Care - Postpartum (U.S. Office of Population Affairs)

Among women ages 15 through 44 who had a live birth, the percentage that is provided:

- A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) method of contraception within 3 days of delivery.
- A long-acting reversible method of contraception (LARC) within 3 days of delivery.

Scoring

- Pay for reporting, hospitals will attest that they have program in place that offers counseling about all forms of postpartum contraception or that they offer counseling on reproductive life/family planning. Hospitals are required to upload evidence or descriptions of their processes or policies.
- Points will be earned on an all or nothing basis.

2. Patient Safety

These measures are mandatory for all hospitals is based on calendar year 2018 and is for all patients regardless of insurance status.

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

1. Hospital Acquired Clostridium Difficile Infections
2. Adverse Event Reporting
3. Falls with Injury
4. Culture of Safety Survey

a. Hospital Acquired Clostridium Difficile (C. Diff) Infections

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. The Department will pull hospital data from that report. Hospitals that do not submit C. Diff data to NHSN will receive a zero for this element.

b. Adverse Event Reporting

1. Must allow anonymous reporting.
2. Reports should be received from a broad range of personnel.
3. Summaries of reported events must be disseminated in a timely fashion.
4. A structured mechanism must be in place for reviewing reports and developing action plans.

c. Falls with Injury

Hospitals will report four data points:

1. Number of Moderate Injury Falls: resulted in suturing, application of steri-strips/skin glue, splinting, or muscle/joint strain.
2. 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.
3. 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).
4. Total number of inpatient days for applicable units during calendar year 2018 (including observation patients on applicable units). To calculate Total Patient Days, refer to the NQF measure specification section: Patient Days Reporting Methods. Please note that hospitals will not multiply by 1000.

Included in the measure:

- Inpatients
- Short-stay patients
- Observation patients
- 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 in 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.

d. Culture of Safety Survey

To receive points, hospitals will attest to using the AHRQ survey OR provide the following:

- A copy of the survey instrument
- A copy of the key findings of the survey highlighting areas where performance is low, and improvements can be made.
- A copy of the plan to address the low performing areas identified above

Measure Criteria

- Survey must include at least ten questions related to a safety culture.
- Culture of Safety 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.
- Culture of Safety survey has been administered within the 24 months prior to data collection.
- Actions taken in response to the survey should address those survey questions that demonstrated the poorest scores on the survey.

Scoring

- For Hospital Acquired Clostridium Difficile infections points will be earned based on hospital performance over self, with points earned for maintaining the same rate or improving.
- Adverse Event Reporting and Culture of Safety Survey are pay for reporting; points will be earned on an all or nothing basis.
- Falls with Injury points earned based on quartile ranking; the top quartile will receive maximum points, the second and third quartiles will receive lower tier of points, and the lowest quartile will receive no point.

3. Patient Experience

This element is based on calendar year 2018 and is for all patients regardless of insurance status.

a. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The Department will collect data for three HCAHPS composites from Hospital Compare:

1. Composite 5: Communication About Medicines (questions 16, 17)
2. Composite 6: Discharge Information (questions 19, 20)
3. Complex 7: Care transition (questions 23, 24, 25)

b. Advanced Care Planning (ACP)

The Advance Care Planning measure is based on the definition provided by the National Quality Forum (NQF) for the number of patients, regardless of payer, 65 years of age or older who have an advanced care plan documented in the medical record or who did not wish to provide an advance care plan. Measure specifics can be found on the NQF website (measure ID: 0326). Note that this measure includes initial hospital observation care services, inpatient services and critical care services (refer to NQF measure #0326 for CPT codes). Hospitals will be required to submit data from calendar year 2018 to the Department. Sampling is allowed. There is no minimum denominator for this measure.

Hospitals are also required to summarize their 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.

Scoring

- Each HCAPHS Composite measure will be evaluated independently using a ranking method. Points will be earned based on quartile tiering; the top quartile will receive maximum points, the second and third quartiles will receive lower tier of points, and the lowest quartile will receive no point.
- Advanced Care Planning will be scored by setting a performance threshold and then awarding points based on rank. Only those above the performance threshold earn points.

4. Regional Accountable Entity (RAE) Engagement

This measure is mandatory for all hospitals, based on calendar year 2019 activities, for Medicaid patients.

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 - #5f.

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

   Providers will be required to summarize how they achieved these goals (1 and 2) via a narrative of up to two paragraphs; the narrative will not be scored.

   AND

3. Provide information about your hospital's current systems for collaboration with your RAE to address substance use disorder in order to decrease ED visits and IP admissions; this 1-2 paragraph narrative is not a scored element.

   AND

4. At least <u>three</u> of the following scored elements related to Physical Health:
   a) Joint efforts to improve population health. This refers to the health outcomes of a group of individuals. These groups are often geographic populations such as communities but can also be other groups such as ethnic groups, disabled persons, prisoners, or any other defined group.
   b) Care coordination collaboration (e.g., sharing of care transition plan).
   c) Case management collaboration (e.g., conversations between case managers, RAE case manager invited to case conferences, etc.).
   d) Collaboration on high utilizers to decrease emergency department visits and inpatient admissions.

e) Participation in RAE level advisory committee meetings or similar meetings.

Providers will be required to summarize how they achieved these goals (1 and 2) via a narrative of up to two paragraphs; the narrative will not be scored

5. At least two of the following scored elements related to Mental Health:
   a) Collaboration with the RAE on psychiatric high utilizers to decrease ED visits and IP admissions.
   b) Case management collaboration (e.g., conversations between case managers, RAE behavioral health case manager invited to case conferences, etc.).
   c) Joint effort with RAE to increase training of staff related to mental health issues (e.g., Mental Health 1st Aid, Trauma Informed Care, Zero Suicide, etc.).
   d) Attestation that there is a process/policy in place (and use of process as needed) for notification to RAE of ED patient suicide attempt/ideation.
   e) Attestation of a process/policy in place (and use of process as needed) for follow-up with RAE/patient within 24 hours of suicide attempt.
   f) Participation in RAE level behavioral health 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 for both physical health and behavioral health engagement with the RAE throughout 2019. A random check of participation will be verified with the RAE

Scoring

Scoring will be tiered based on the number of engaged elements under Physical Health and Mental Health categories. Providers should choose all that apply and provide a brief summary that justifies how the hospital met the elements.

5. Substance Use

This element is based on calendar year 2018 and is for all patients regardless of insurance status.

a. Using Alternatives to Opioids (ALTOs) in Hospital Emergency Departments (ED)

This program was developed by the Colorado Hospital Association and the Colorado Chapter of the American College of Emergency Physicians. There was support among the members of the Subcommittee for the adoption of this measure.

- Hospitals should attest that before or during October 2019 that they are implementing the pre-launch checklist found in the "Using Alternatives to Opioids (ALTOs) in Hospital Emergency Departments"
- Hospitals should attest that they have appointed an ATLO champion and an IT and Data Support Champion and submit those people's names and contact information. (see the following link: www.cha.com/wp-content/uploads/2018/01/CHA-Opioid-Checklist.pdf)
- Hospitals should commence collecting data for baseline measurement of opioid use and alternatives to opioid use and implement systems ready to report the data specified below to the state beginning October 2019:
  - ✓ Opioids Used
    - Numerator: Total administration of opioids (converted into Morphine Equivalent Units)
    - Denominator: Total number of treated pain visits per 1,000 ED visits.
    - The following medications are to be included in this measure: methadone, hydromorphone, meperidine, oxycodone, hydrocodone, codeine, buprenorphine, morphine, fentanyl, fentanyl nasal spray and tramadol.
  - ✓ ALTOs Used
    - Numerator: Total administration of ALTOs.
    - Denominator: Total number of treated pain visits per 1,000 ED visits.
    - ALTOs include the following medications: acetaminophen, ibuprofen, lidocaine, haloperidol, ketamine, ketorolac and dicyclomine.
- These results should be reported at the aggregate level. The results should also be stratified by the following conditions: diagnostic groups including headache, low back pain/lumbago, kidney stones, long bone fractures, abdominal pain and malignant neoplasm.

Data specifications and training materials for the Colorado ALTO project can be found at www.cha.com/pharmacist-and-it-data-training-materials

b. Tobacco and Substance Use

In order to receive points for this measure, hospitals must report on one of the following:

1. The Substance Use Screening and Intervention Composite (National Quality Forum - NQF# 2597). The tool focuses on the percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results.

OR

2. As an alternative, a measure for tobacco and substance use screening requires hospitals to report their screening rates, provide documentation on how and where they document follow up plans in the medical record, and describe the interventions they provide and examples of follow up plans and any resources that patients are referred to.

Scoring

This is a pay for reporting measure based on the Using Alternatives to Opioids (ALTOs) in Hospital Emergency Departments program. Hospitals will have to attest to the steps they are taking to implement these guidelines and submit supporting evidence or documentation.

Hospitals must report on one of the following measures:

1. For those reporting on Substance Use Screening and Intervention Composite (National Quality Forum - NQF# 2597) the submission of data (including numerators and denominators) is required. Documentation as to the screening tools being used should also be provided.

OR

2. Those reporting using the alternative method screening are required to submit screening rates (including numerator and denominator), information about the screening tools, documentation on how and where they document follow up plans in the medical record, descriptions of the interventions they provide, and examples of follow up plans and any resources that patients are referred to.

6. Addressing Cost of Care

Hospital Index is calculated using Altarum's PROMETHEUS Analytics® tool. PROMETHEUS Analytics is a transparent and proprietary model for bundled payment valuation.

- The Prometheus tool is an episode of care grouper that allows us to measure risk in ways outside of the traditional utilization and unit cost metrics.
- Prometheus splits episode service costs into Typical and Potentially Avoidable Complications (PAC) from which we are able to calculate PAC rates. Higher PAC rates can indicate lower quality while lower PAC rates can be an indicator of higher quality.
- Prometheus identifies 97 different episodes of which 24 procedural episodes are used to calculate this index. Episodes have been defined and refined by expert clinicians assembled in Clinical Working Groups.

In order to receive points for this measure, hospitals must provide an assessment of the overall PROMETHEUS'/Hospital Index results that demonstrates an in-depth understanding of the data. This includes providing data from the following tabs:

- Attending Providers Tab
  - ✓ Identify the episode description with the highest unsplit PAC cost
    - Provide: the PAC cost, PAC %, and the episode count for the episode Description
  - ✓ Identify the attending provider with the highest unsplit PAC cost
    - Provide the member count for the attending provider in 1A's episode
- Rendering Provider Tab
  - ✓ Identify the category of service with the highest split PAC %
    - Provide: the PAC cost, PAC % and member count for that category of service
    - Provide the episode description with the highest unsplit PAC %
  - ✓ Identify the rendering provider with the highest split PAC % in the category of service.
- Service Tabs
  - ✓ Under Emergency Department Visit service, provide: the unsplit PAC cost, unsplit PAC %, episode count, and member count.
  - ✓ Provide the episode description with the highest unsplit PAC cost
    - Provide the episode count and % of total episode volume

        - Provide the member count and % of total member volume
- Members Tab
    - ✓ Identify eligibility type with the highest split Total Cost
        - Provide: the total cost, and the episode description with the highest split total cost
    - ✓ For members with disabilities with the highest unsplit PAC costs, provide the episode description and age of that member.

Additionally, providers will be asked to provide a narrative regarding how the tool will be useful to approaching lowering PAC costs.

Scoring

Hospitals must complete all data fields. Scoring will be conducted on an all-or-nothing basis.

G. Maintenance Measures

Maintenance Measures are those measures that are important to quality of care and patient safety but have little room for improvement over current statewide performance levels. The HQIP Subcommittee will continue to review the statewide rates to be sure that gains are maintained. No points are assigned for 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 will be obtained from the annual Health Care Associated Infections Report in Colorado report.

MM #3 Early Elective Deliveries (no points). Hospitals do not need to submit data for perinatal care measure set. The data source for this measure is Hospital Compare.

III. Measure Resources

A. Internet Resources

Cesarean Section

The Joint Commission, PC-02 Cesarean Section

Breastfeeding Practices

The Joint Commission: PC-05, Exclusive Breast Milk Feeding

Baby Friendly USA

CDPHE Breastfeeding Essentials

CDPHE Colorado Baby Friendly Hospital Collaborative is offered through the Colorado Department of Public Health and Environment, supports participating hospitals to improve breastfeeding rates and practices by providing training, resources and opportunities to improve policies and processes that impact breastfeeding outcomes, and ultimately help hospitals achieve Baby-Friendly designation.

Perinatal Depression and Anxiety

Maternal Emergencies and Preparedness

Reproductive Life/Family Planning

LARC

Patient Safety

The Joint Commission Patient Safety Information

AHRQ - Voluntary Patient Safety Event Reporting (Incident Reporting)

Patient Safety Survey from AHRQ: the Colorado Hospital Association provides access to the Patient Safety Survey via an online tool for hospital use. Survey results are calculated and provided to the hospital for analysis and planning.

Falls - NQF website (Falls, measure ID: 0202)

HCAHPS

HCAHPS on Hospital Compare

Discharge Planning

ACP - NQF website (ACP, measure ID: 0326)

ACP - Colorado MOST Form

Substance Use

Substance Use - Screening and Intervention Composite

Addressing Cost of Care

Risk Standardized PAC Rates

B. Sampling

Hospitals that use The Joint Commission (TJC) sampling for a measure can report the data as sampled for TJC.

Hospitals that are not TJC accredited may sample using the methodology below, which is based on TJC sampling requirements

For those measures that are not submitted to TJC, hospitals can use the methodology below, regardless of TJC submission for other measures (e.g., Advanced Care Planning—NQF 0326).

Sample Size Requirements

Hospitals can use sampling to report HQIP measures. The size of the sample depends on the number of cases that qualify for a measure. Hospitals need to use the next highest whole number when determining their required sample size. The sample must be a random sample (e.g., every third record, every fifth record, etc.), taken from the entire 12 months of the year and cannot exclude cases based on physician, other provider type or unit. Hospitals can choose to use simple random sampling or systematic random sampling

Hospitals selecting sample cases must include at least the minimum required sample size. The sample size table below shows the number of cases needed to obtain the required sample size. A hospital may choose to use a larger sample size than is required.

Hospitals selecting sample cases for a measure must ensure that the annual patient population and annual sample size for each measure sampled meet the following conditions:

Annual Sample Size

Annual number of patients meeting measure denominator	Minimum required sample size "n"
>=1551	311
391-1551	20% of discharges in denominator
78-390	78
0-77	No sampling, 100% of the patient population is required

Examples

- A hospital's number of patients meeting the criteria for advanced care planning is 77 patients for the year. Using the above table, no sampling is allowed – 100% of the cases should be reviewed.
- A hospital's number of patients meeting the criteria for advanced care planning is 401 patients for the year. Using the above table, the required sample size is 80 cases (401 x .20 = 80) for the year.