



**COLORADO**

Colorado Healthcare Affordability  
& Sustainability Enterprise

# 2019 Hospital Quality Incentive Payment (HQIP) Program

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November 20, 2019

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.  
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# 2019 Hospital Quality Incentive Payment (HQIP) Program

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## Overview of the HQIP Program

The Hospital Quality Incentive Payment (HQIP) Program is administered by the Colorado Department of Health Care Policy and Financing (HCPF)(the Department), and is offered by the Colorado Health Care Affordability and Sustainability Enterprise (CHASE), a government-owned business that operates within 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

### 1. 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 13-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 HCPF members, provide oversight of the CHASE and the Hospital Provider Fee and Supplemental Payment Program. 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 (HCPF) to provide recommendations on the Hospital Quality Incentive Payment (HQIP). The major tasks of the subcommittee include:

1. Recommend performance measures that form the basis of the incentive payment.
2. Recommend how payments should be made.
3. Communicate with hospitals.
4. 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 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.

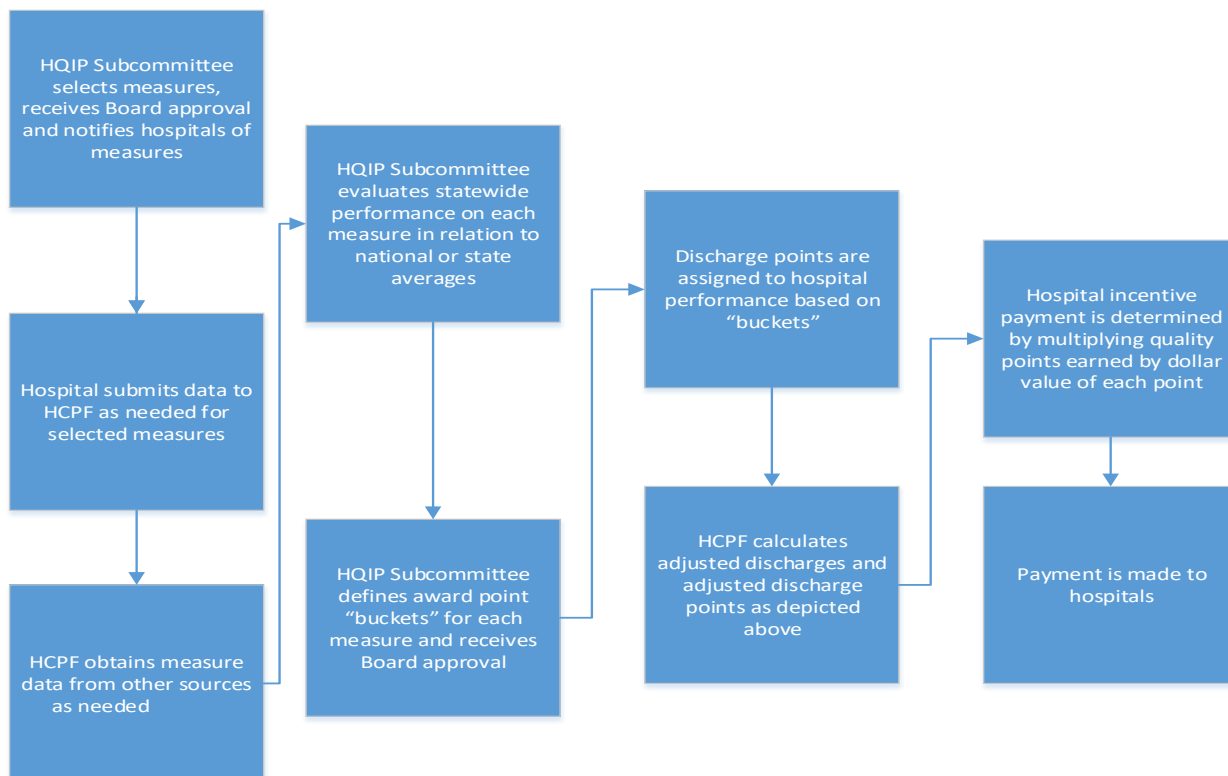


## 2. 2019 HQIP Subcommittee and CHASE Board

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.

## 3. Annual HQIP Process

The annual HQIP process is depicted by the following flowchart.

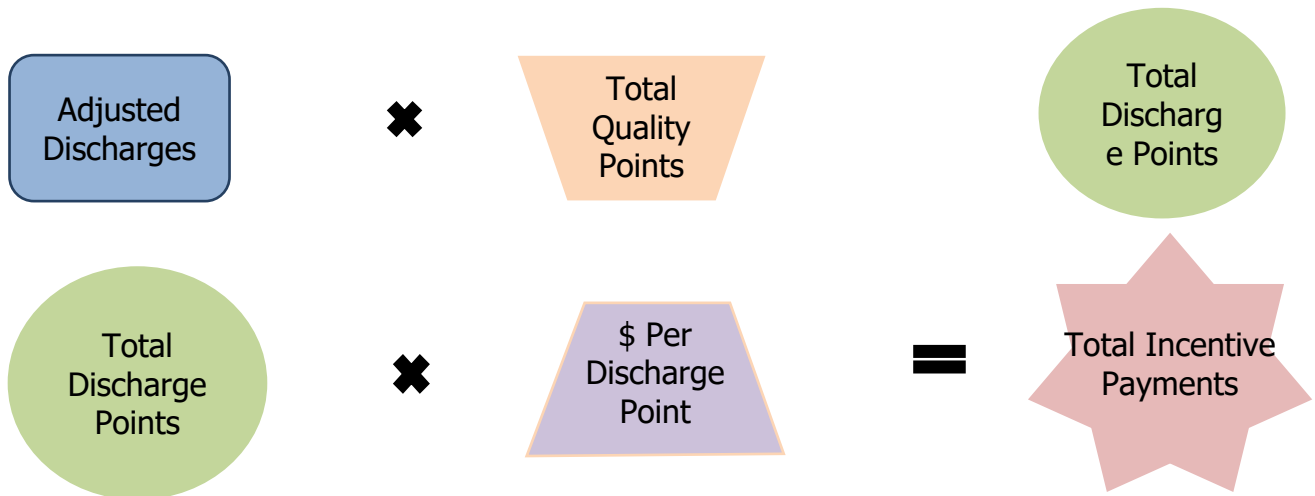


## 4. Incentive Payment Calculation

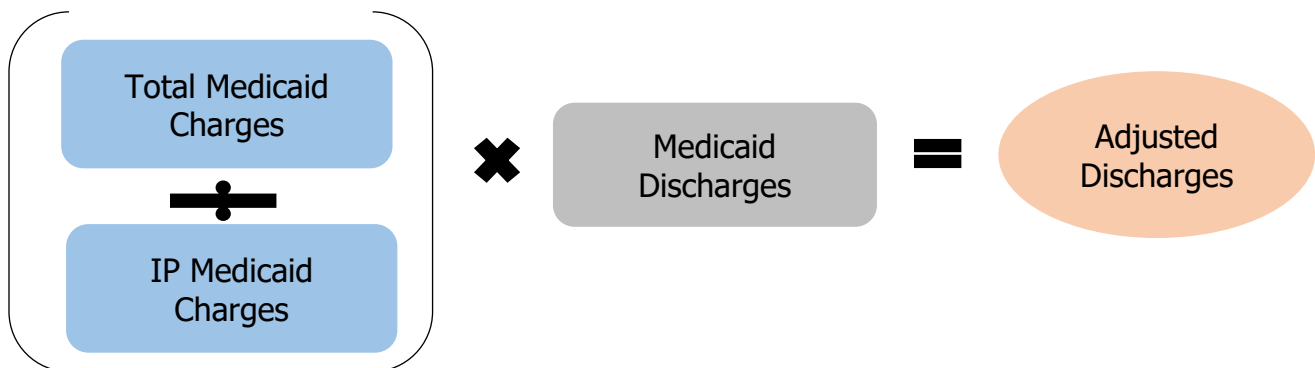
The HQIP incentive payments are based on each hospital's performance on the measures recommended by the HQIP Subcommittee and the CHASE Board. Data to assess performance is obtained from a variety of sources: hospitals report to the Department on selected measures and data is obtained from Medicaid claims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



### Dollars per Discharge Point

A hospital's performance level determines the quality points earned. The \$ 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.

## 5. 2019 Measures

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

2019 Measure Group	Measure	Measure Basis	Source	Measurement Period
1. Maternal Health and Perinatal Care	Exclusive Breast Feeding (PC-05)	The Joint Commission (TJC) /CMS	Hospital Reported	1/1/2018 – 12/31/2018
	Cesarean Section (PC-02)	The Joint Commission /CMS	Hospital Reported	1/1/2018 – 12/31/2018
	Perinatal Depression and Anxiety*	Council on Patient Safety in Women's Health Care	Hospital Reported	In place by 4/30/2019
	Maternal Emergencies*	National Partnership for Maternal Safety	Hospital Reported	In place by 4/30/2019
	Reproductive Life/Family Planning*	Department of Health Care Finance/US Office of Population Affairs	HCPF/ Hospital Report	In place by 4/30/2019
2. Patient Safety	Clostridium difficile (C. Diff)	Center for Disease Control (CDC)	HCPF/Hospital Report	1/1/2018 – 12/31/2018
	Adverse Event	HQIP	Hospital Reported	1/1/2018 – 12/31/2018
	Falls with Injury	American Nurses Association	Hospital Reported	1/1/2018 – 12/31/2018
	Culture of Safety Survey	Agency for Healthcare Research and Quality (AHRQ)	Hospital Reported	Within the 24 months prior to data collection
3. Patient Experience	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)*	AHRQ/ Hospital Compare	HCPF	1/1/2018 – 12/31/2018
	Advance Care Plan	National Committee for Quality Assurance (NCQA)	Hospital Reported	1/1/2018 – 12/31/2018
4. Behavioral Health	Follow-Up after Hospitalization for	CO Regional Accountable Entity (RAE)	HCPF	1/1/2018 – 12/31/2018



2019 Measure Group	Measure	Measure Basis	Source	Measurement Period
	Mental Illness 7 Days*			
	Follow-Up after Hospitalization for Mental Illness 30 Days*	CO Regional Accountable Entity (RAE)	HCPF	1/1/2018 – 12/31/2018
	Emergency Department Utilization for Mental Health*	CO Regional Accountable Entity (RAE)	HCPF	1/1/2018 – 12/31/2018
	Emergency Department Utilization Substance Use Disorder*	CO Regional Accountable Entity (RAE)	HCPF	1/1/2018 – 12/31/2018
5. Substance Use	Substance Use Disorder Composite*	American Medical Association (AMA)	Hospital Reported	1/1/2018 – 12/31/2018
	ALTO* (Alternatives to Opioids)	Colorado Hospital Association (CHA)	Hospital Reported	In place by 10/1/2019
6. Addressing Cost of Care	Hospital Index*	Prometheus	HCPF	State FY 2017/2018

2019 Maintenance Measures	Measure Steward	Data Source	Measurement Period
<b>1. Pulmonary Embolism /Deep Vein Thrombosis (PE/DTV)</b>	AHRQ	CHA Hospital Report Card	January 1, 2018 – December 31, 2018
<b>2. Central Line Associated Blood Stream Infections (CLABSI)</b>	CDC	Colorado Department of Public Health and Environment (CDPHE)	August 1, 2018 – July 31, 2018
<b>3. Early Elective Deliveries</b>	The Joint Commission	CMS	January 1, 2018 – December 31, 2018

## 6. Changes from the Prior Year

For HQIP 2019, hospitals will be requested to complete all six measure groups.

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Other changes of note:

- New areas added are: Behavioral Health and Addressing the Cost of Care
- 11 new measures added; eight retired
- Whenever possible, outcomes measures are prioritized and the Department reported measures are used

New Measures	
Perinatal Depression and Anxiety	Emergency Department Utilization for Substance Use Disorder
Maternal Emergencies	HCAHPS
Reproductive Life/Family Planning	Substance Use Disorder Composite
Follow-Up after Hospitalization for Mental Illness 7 Days	ALTO – Alternatives to Opioids
Follow-Up after Hospitalization for Mental Illness 30 Days	Hospital Index
Emergency Department Utilization for Mental Health	

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

HQIP Timeline

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			



## 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 – 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

Note: Hospitals that completed activity #2 during the 2018 HQIP program year and reported a phase change occurring between January 1 – 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**

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:

1. Physician's Cesarean Section rate.
2. The individual rates (not aggregated) of other physicians' Cesarean Section rates so as to provide a peer-to-peer comparison.
3. 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:

- 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?

- B. Have any of the severe hypertension and preeclampsia processes (i.e. order sets, tracking tools) been incorporated into the facility's electronic health record?
- C. Has the facility developed obstetric-specific resources and protocols to support patients, families, and staff through major obstetric complications?
- D. 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

- A. How many drills on maternal safety topics were performed in the facility during the past quarter or year?
- B. 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?
- C. 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: [https://safehealthcareforeverywoman.org/wp-content/uploads/2017/09/AIM-SMM-Codes-List\\_Latest.xlsx](https://safehealthcareforeverywoman.org/wp-content/uploads/2017/09/AIM-SMM-Codes-List_Latest.xlsx))

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 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 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:
  - i. Severe hypertension
  - ii. Eclampsia, seizure prophylaxis, and magnesium over-dosage
  - iii. Postpartum presentation of severe hypertension/preeclampsia
2. Minimum requirements for protocol
  - i. Notification of physician or primary care provider if systolic BP  $\geq$  160 or diastolic BP  $\geq$  110 for two measurements within 15 minutes
  - ii. After the second elevated reading, treatment should be initiated ASAP
  - iii. (preferably within 60 minutes of verification)



- iv. Includes onset and duration of magnesium sulfate therapy
- v. Includes escalation measures for those unresponsive to standard treatment
- vi. Describes manner and verification of follow-up within 7 to 14 days postpartum
- vii. 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 A regarding hypertension or preeclampsia policy, and two of three remaining structure measures (B,C,D).

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.

Structure Measure	Relevant "Rs"			
	Readiness	Recognition and Prevention	Response	Reporting
<b>A</b> (required)	1, 3, 6	1, 2, 3	1 (i-iii), 2 (i-vii)	N/A
<b>B</b>	1, 3, 6	1, 2	2 (i-vii)	N/A
<b>C</b>	1,3,4,5,6	1,2,3	1 (i-iii), 2 (i-vii)	N/A
<b>D</b>	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 A, B, and C.

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





## Scoring

- In order to receive full points, hospitals must answer Structure measure A and two of the three remaining measures (B,C,D) 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)

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

1. A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 days of delivery.
2. 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. HCPF will pull hospital data from that report. Hospitals that do not submit *C. Diff* data to NHSN will receive a "0" 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. (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 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**

1. Survey must include at least ten questions related to a safety culture.
2. Culture of Safety questions must be from a survey tool that has been tested for validity and reliability.
3. Survey questions can be part of another survey tool as long as it meets the above criteria.
4. Culture of Safety survey has been administered within the 24 months prior to data collection.
5. 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:

- Composite 5: Communication About Medicines (questions 16, 17)
- Composite 6: Discharge Information (questions 19, 20)
- 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 HCPF. Sampling is allowed. There is no minimum denominator for this measure.

\*\*Hospitals will also 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 HCAHPS 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. Behavioral Health

This element is based on calendar year 2018 and is for Medicaid patients only.

- Follow-up appointments within 7 days after hospital discharge for a mental health condition
- Follow-up appointments within 30 days after hospital discharge for a mental health condition
- Emergency Department Utilization for mental health condition
- Emergency Department Utilization for substance use condition

Each behavioral health measure will be evaluated independently using a ranking method.

##### **A. Follow-up Appointments Within 7 days After Hospital Discharge for a Mental Health Condition and Follow-up Appointments Within 30 days After Hospital Discharge for a Mental Health Condition**

###### Description

The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Rates are reported for each measure: one for follow-up within 7 days and one for follow-up within 30 days.

###### Numerator

Total number of discharges with an outpatient service (see table below) within 7 and 30 days (the 30 days includes the 7-day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See codes in table below for follow-up visit codes allowed.



Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Member included in the denominator	1		and	
Mental health (outpatient) follow-up visit with a mental health provider	1	<b>Codes to Identify Mental Health Visits HCPCS</b>		Within 7/30 days of the discharge
		G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2014- H2018, H2022, M0064, S9480, S9485	or	
		<b>CPT</b>		
		98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350	or	
		<b>CPT</b>		
		90791, 90792, 90832, 90834, 90837, 90839, Indic, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	and/or	
<b>UB Revenue Codes</b>		Within 7/30 days of the discharge		
<i>The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Mental Health diagnosis code.</i>				
0900, 0914, 0915	Or			

\*For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure.

#### Denominator

The population based on discharges during the specified fiscal year July 1 through June 30 (can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30-day follow-up information.



Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Member discharge from an inpatient hospital episode for a primary covered mental health diagnosis.	1	<b>UB Revenue Code</b>		
		100-219 or 0100-0219	or	
		45x or 045x	or	

## Notes:

- The denominator for this measure is based on ED visits, not members. If a member has more than one ED visit all visits are included in the denominator
- However, if a member has more than one ED visit in a 30-day period only the last ED visit will be included in the denominator
- If a member's time in the ED is greater than 24 hours and they are not admitted, the 'end date' (when they are released from the ED) is to be used for subsequent calculations, rather than the 'start date'.



## Population Exclusions

Members with a non-acute care discharge will be excluded from the denominator based on the chart below.

Codes To Identify Non-Acute Care				
Condition Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation Rehabilitation		0118, 0128, 0138, 0148, 0158	18x, 28x	
Respite		655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	H0017- H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB Revenue or type of bill codes for billing (e.g. ICF, SNF)				

The following are exclusions from the denominator:

If the discharge is followed by readmission or direct transfer to an emergency department for a primary diagnosis of mental health- within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.

Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission. These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.





## B. Emergency Department Utilization for Mental Health Condition

### Description:

Number of emergency room visits for a covered mental health diagnosis per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure, include only paid encounters.

Each behavioral health measure will be evaluated independently using a ranking method.

### Numerator:

ED visits that don't result in an inpatient admission within 24 hours of the day of the ED visit.

Numerator Codes: ED visit codes include CPT 99281-99285 and revenue code 045x

### Denominator:

Total number of Members during the specified fiscal year (12-month period).

### Measure Reference:

Part of HCPF's performance measures; Numerator will be calculated from BHO/RAE encounter claims data.

Covered Mental Health ICD-10 Diagnosis Codes	
Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F60.0	F63.9
F68.10	F69
F90.0	F99
R45.1	R45.2
R45.5	R45.82

## C. Emergency Department Utilization for Substance Use Condition

### Description:

Number of emergency room visits for a covered substance use diagnosis per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this



measure, include only paid encounters. Age for this indicator is determined on date of service.

Each behavioral health measure will be evaluated independently using a ranking method.

**Numerator:**

ED visits that don't result in an inpatient admission within 24 hours of the day of the ED visit.

Numerator codes: ED visit codes include CPT 99281-99285 and revenue code 045x

**Denominator:**

Total number of Members during the specified fiscal year (12-month period).

**Measure Reference:**

Part of HCPF's performance measures; Numerator will be calculated from BHO/RAE encounter claims data.

Covered Substance Use Disorder ICD-10 Diagnosis Codes	
Start Value	End Value
<b>F10.10</b>	<b>F10.26</b>
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

**Scoring**

- Each 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.



## 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: <https://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 to ready to report the data specified below to the state beginning October 2019:
- Opioid 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 the following link: <https://cha.com/wp-content/uploads/2018/07/Colorado-ALTO-Project-Data-Toolkit.pdf>

## **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**

- Pay for reporting: for using Alternatives to Opioids (ALTOs) in Hospital Emergency Departments. 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:

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***

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

This element is based on calendar year 2018 and is for Medicaid patients only.

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.
- The 24 distinct procedural episodes used in the index are:
  - Bariatric Surgery
  - Breast Biopsy
  - Coronary artery bypass grafting
  - (CABG) &/Or Valve Procedures
  - Cataract Surgery
  - Colonoscopy
  - Colorectal Resection
  - Coronary Angioplasty
  - Cesarean-Section
  - Gall Bladder Surgery
  - Hip Replacement and Hip Revision
  - Hysterectomy
  - Knee Arthroscopy
  - Knee Replacement & Knee Revision



- Lumbar Laminectomy
  - Lumbar Spine Fusion
  - Lung Resection
  - Mastectomy
  - Pacemaker/Defibrillator
  - Prostatectomy
  - Shoulder Replacement
  - Tonsillectomy
  - Transurethral resection prostate
  - Upper Gastrointestinal (GI) Endoscopy
  - Vaginal Delivery
- Using these procedural episodes, the Hospital Index calculates a relative factor for each facility reflecting the level of PAC dollars that existed in the study period (claims incurred in SFY14, SFY15, and SFY16 time periods (36 months)), and this will be used as benchmark data moving forward. SFY17 and SFY18 data will be used for additional trending and as the measurement period.
  - Lower hospital index indicates lower PAC cost relative to the total episode cost; lower score can be interpreted as better quality and cost effectiveness

### **Hospital Index - Methodology**

- Weighted average of PAC % with episode weights across all episodes generates the Hospital Index.
- An Index of 100 indicates PAC rates at the statewide average, below 100 represents PAC cost relative to total episode cost lower than the statewide average, while above 100 means greater than the statewide average
- Lower hospital index indicates lower PAC cost relative to the total episode cost; lower score can be interpreted as better quality and cost effectiveness
- The methodology normalizes for credibility, accounting for low utilization in specific episodes for each hospital
- Hospitals can be compared to themselves over time by tracking their Hospital Index through successive years to measure improvement and can be compared to benchmark targets



- Further information regarding calculation of Risk-Standardized PAC Rates can be found at: <http://prometheusanalytics.net/deeper-dive/risk-standardized-pac-rates-rspr>

The Hospital Index can also be a valuable tool for hospitals as the detail behind the Hospital Index allows facilities to drill down into their episode specific performance.

- Detailed summaries will be provided to each hospital allowing for deeper dives into the output
- Hospital Index will identify intervention targets as well as areas that are currently operating at an above average level of cost effectiveness

Hospitals will be able to review output to better understand inner operations at the physician level and evaluate drivers of PAC levels

### Scoring

- Hospitals with a Hospital Index score below the statewide average earn points based on rank with the top tier earning more than the lower tier. Those hospitals performing below the statewide average can earn a lower level of points based on improvement. Potentially stratified by hospital peer groups.

## 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.

## Measure Resources

### 1. Internet Resources

#### Cesarean Section

[The Joint Commission, PC-02 Cesarean Section](#)

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



## Breastfeeding Practices

[The Joint Commission: PC-05, Exclusive Breast Milk Feeding](#)

[Baby Friendly USA](#)

[CDPHE Breastfeeding Essentials](#)

[CDPHE Colorado Baby Friendly Hospital Collaborative](#): 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](#) Note that 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)

## Patient Experience

### 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](#)

## 2. 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



Annual number of patients meeting measure denominator	Minimum Required Sample Size "n"
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 ( $401 \times .20 = 80$ ) for the year.

