maryland
health services
cost review commission

Performance Measurement Workgroup

March 21, 2023

HSCRC Quality Team

PMWG Members

Carrie	Adams	Meritus	Lily	Mitchell	CareFirst
Ryan	Anderson	MedStar - MD Primary Care Program	Jonathan	Patrick	MedStar Health
Kelly	Arthur	Qlarant QIO	Elinor	Petrocelli	Mercy Medical Center
Ed	Beranek	Johns Hopkins Health System	Mindy	Pierce	Primary Care Coalition of Montgomery County
Barbara	Brocato	Barbara Marx Brocato & Associates	Tricia	Roddy	Maryland Department of Health
Zahid	Butt	Medisolv Inc.	Farzaneh L.	Sabi	Kaiser Mid-Atlantic Permanente Medical Group
Tim	Chizmar	MIEMSS	Nitza	Santiago	Lifebridge Health
Linda	Costa	University of Maryland School of Nursing	Dale	Schumacher	MedChi, Maryland State Medical Society
Ted	Delbridge	MIEMSS	Jodi	Segal	Johns Hopkins University
Lori	Doyle	Community Behavioral Health Association of Maryland	Madeleine "Maddy"	Shea	Health Management Associates
Laura	Goodman	MD Medicaid	Brian	Sims	Maryland Hospital Association
Toby	Gordon	Johns Hopkins Carey Business School	Mike	Sokolow	University of Maryland Medical Systems
Theressa	Lee	Maryland Health Care Commission	Geetika "Geeta"	Sood	JHU SOM,Division of Infectious Diseases.
Staci	Lofton	Families USA	April	Taylor	Johns Hopkins Health System
Patsy	Mcneil	Adventist Health	Bruce	VanDerver	Maryland Physicians Care
Stephen	Michaels	MedStar Southern Maryland Hospital	Jamie	White	Frederick Health

Workgroup Ground Rules

- Be prepared: please read materials before the meeting
- Be brief
- Share the floor: please monitor your contributions to make sure others have an opportunity to engage in the discussion
- No interruptions (except for the time-keeper)
- Stay on topic
- Questions are welcome
- Respect deadlines for written comments

REMINDER: These workgroup meetings are recorded.

Timeline of Deliverables (See PMWG Workplan document)

Month	Commission Meetings	CMMI	HSCRC/Other
October 2022	Draft QBR		
November	Final QBR Draft MHAC Hospital Population Health Policy Discussion		RY2023 Revenue Adjustments
December	Final MHAC	Annual report including Year 3 SIHIS Update	
January 2023	RRIP Policy Extension PAU Measurement Report on Avoidable ED Hospital Population Health Policy Discussion		
February			
March/April			Internal TCOC Model Expansion Recommendations
May	Draft PAU Savings RY 2024 report (in Draft Update Factor Policy)		RY 2024 Revenue Adjustments
June	Final PAU Savings RY 2024 report (in Final Update Factor Policy)	Exemption Request	

Meeting Agenda

- Potentially Avoidable Emergency Department Utilization
- Quality and Population Health: Model Progression Plan
  - Hospital Accountability for Population Health
  - Statewide Population Health
  - Hospital Quality Programs
  - Health Equity
- HCAHPS Improvement Approach
- Diabetes Screening Update
- Sexual Orientation and Gender Identity (SOGI) Data Collection

Potentially avoidable emergency department utilization

Recap of last meeting

Continued discussion for a potentially avoidable emergency department utilization policy

New focus on Multi-Visit Patients (MVPs), a better descriptive term compared to frequent flier and more actionable than low acuity visits

The biggest questions left are:

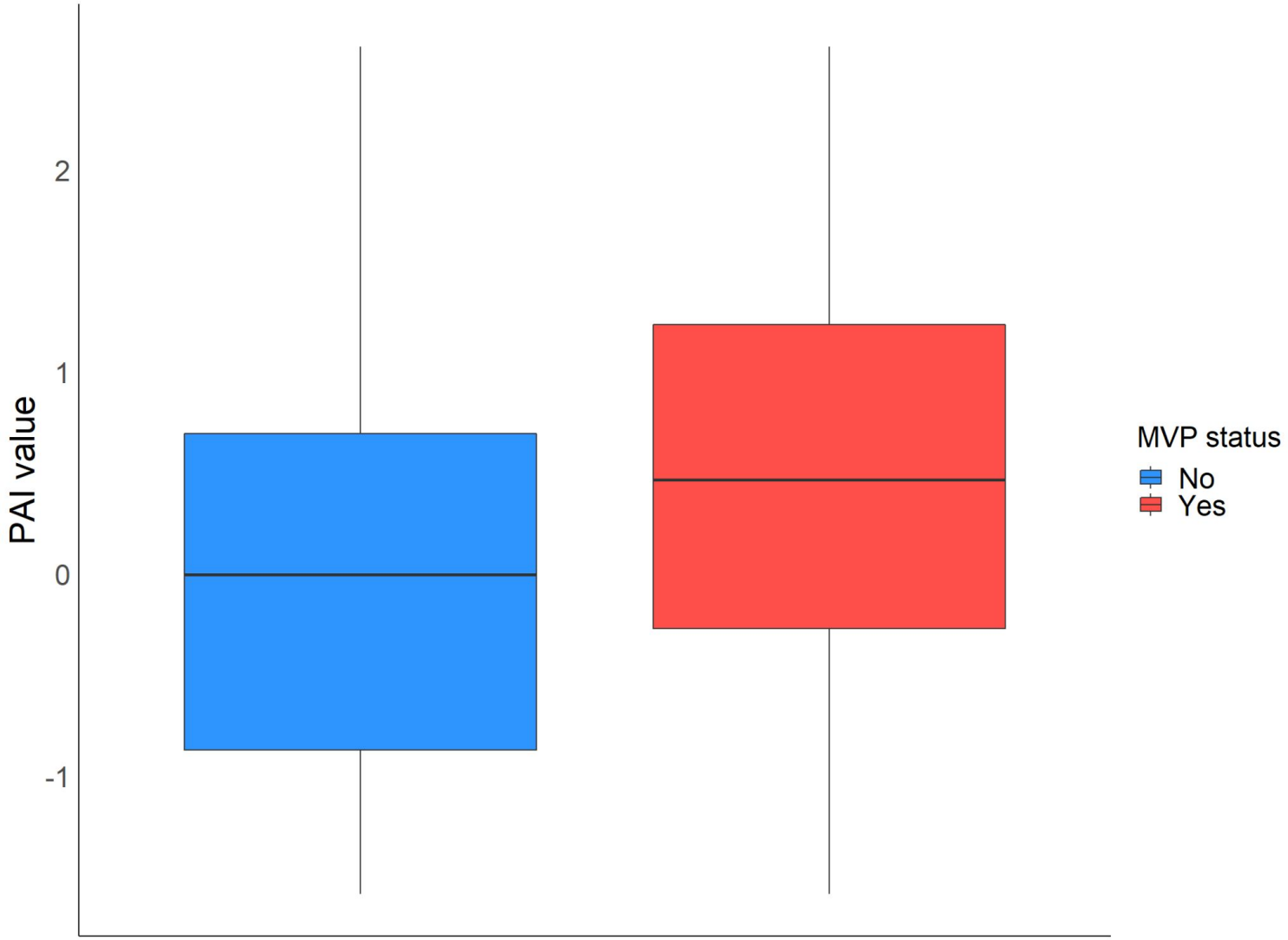
- What is the measurement for this policy?
  - Attainment vs. improvement discussion
  - Future incentive structure must reflect elected approach

Analytic questions

Questions asked by the group at prior meeting

- Relationship between PAI and MVPs
- Principal diagnosis for MVPs
- Day of week analysis
- Percent arriving by ambulance
- Frequency and type of behavioral health items
- Consistency across systems and time

MVPs by PAI

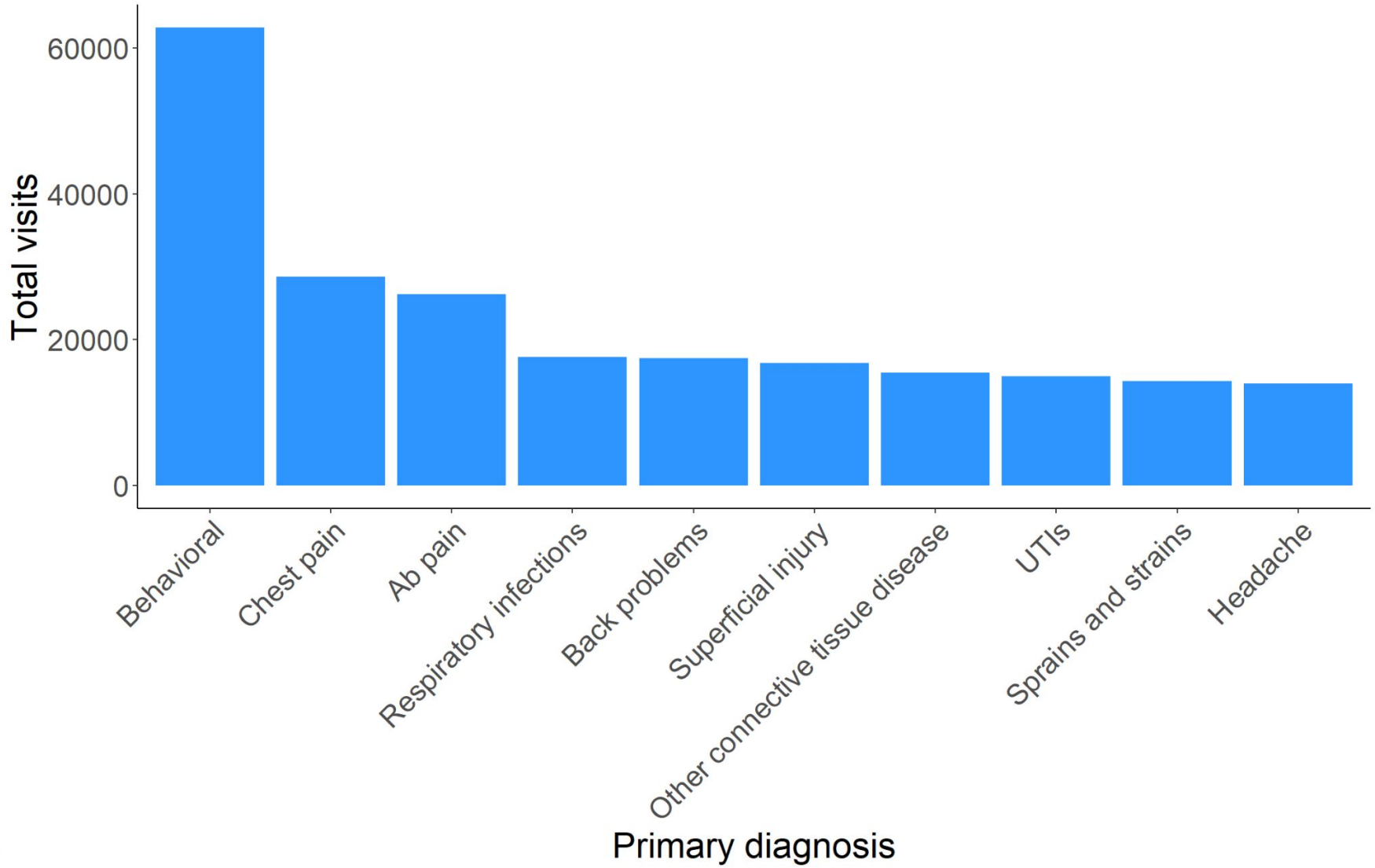


MVPs have a higher PAI value by 0.5

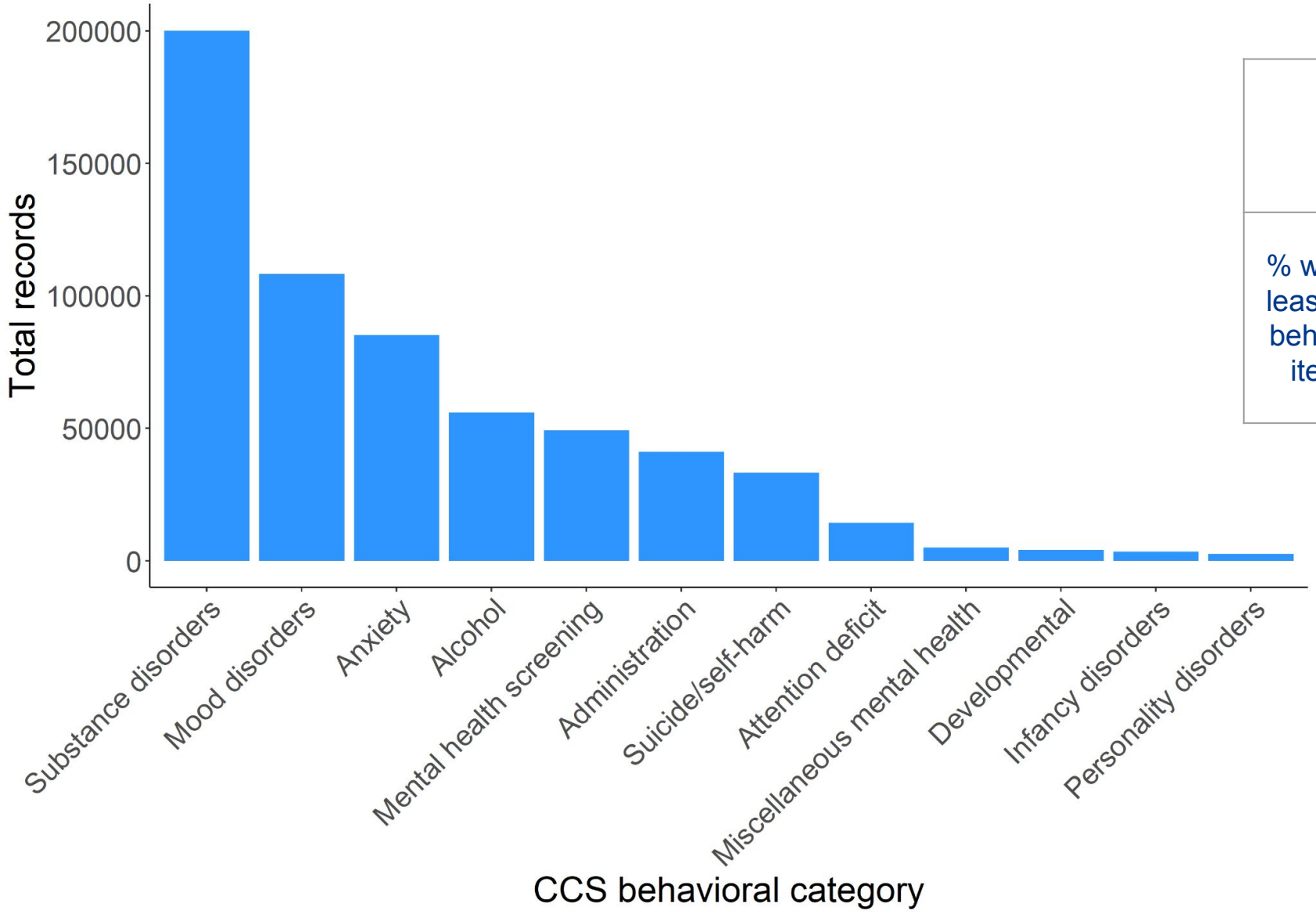
MVP Visits by Day of Week and EMS status

	Non MVPs	MVP
Weekday %	73	74
Weekend %	27	26
Arrival by EMS %	24	29
Arrival from nursing home %	2	3

MVP Visits by primary diagnosis for ED all sources in 2019



Any behavioral health diagnosis for MVPs across all 2019 ED



	Non MVP	MVP
% with at least one behavior items	29	67

Consistency Across Systems and Time

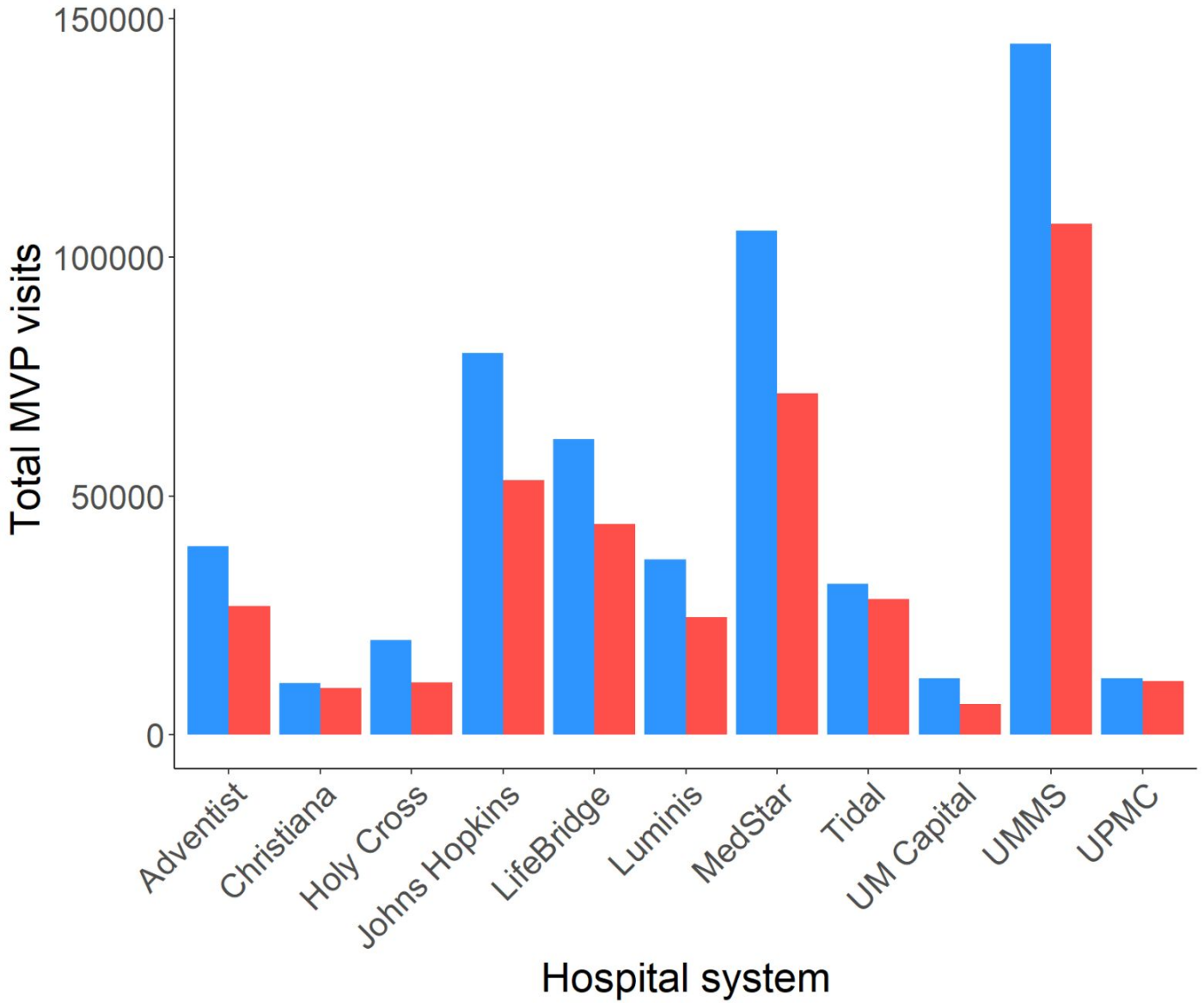
Additional analyses indicate the MVP population is consistent over time, less consistent by region, more consistent in between the third and fourth visit, and fairly consistent in terms of unique patients

- In 2019, 45% of MVP's visits were at the same ER and over 75% were at two or fewer ER's; this remained true in 2018, the numbers are 47% and 79% respectively
  - In 2019, Baltimore City and Northern DC suburbs had statistics similar to the statewide average; MVPs in other areas of the State had less facility hopping.
- The 3rd and 4th visits occur at different hospitals ~33% of the time and different systems ~27% of the time.
  - This compares favorably to all visits where 45% were at the same ER.
- Of the unique MVPs in 2019, 32% of them were also MVPs in 2018

By Region

Region	% of MVPs who visit one hospital	% of MVPs who visit two hospitals
Baltimore Area	44	76
Eastern Shore	75	98
Northern DC Sub.	40	92
Southern MD	64	93
Western MD	97	99

Total MVP visits by system and non-system requirements



On average, hospitals systems see 72% of MVP visits created in their system

Measure Definitions: Option A

- Numerator: # of **PATIENTS visiting ED** who have >= 4 visits at any hospital in calendar year
- Denominator: # of patients visiting ED
- Strengths: Focus on patients rather than visits
- Limitations
  - Not responsive to progress in reducing visit count for heaviest users
  - Hospitals may not have clarity on who is in numerator/in need of intervention if visits occur outside system

Measure Definitions: Option B

- Numerator: # of **ED VISITS** at a given hospital by patients who have >= 4 visits at any hospital in calendar year
- Denominator: # of ED visits at a given hospital
- Strengths
  - Responsive to reductions in visit count for heaviest users
  - Encourages hospitals to work together to reduce utilization
- Limitations
  - Hospitals may not have clarity at the time of service on who is in numerator if visits occur at other hospitals

Measure Definitions: Option C

- Numerator: # of **ED VISITS** at a given hospital by patients who have >= 4 visits in calendar year **within system**
- Denominator: # of ED visits at hospital
- Strengths
  - Responsive to reductions in visit count for heaviest users
  - Clarity on who's in numerator
- Limitations
  - Measure may have significantly less impact

Additional Measure Details

- Monitoring only for CY23
  - Hospital reports for monitoring will include summary level by hospital report and case level details on a monthly/quarterly basis
- Likely to be improvement only for initial payment policy implementation
- May be able to work with CRISP to build tool that provides better cross-hospital visibility on patients headed toward MVP status
- That will happen as measure moves into payment policy
- Explicitly define all charge codes related to ED use

Staff Recommendation and Discussion

- Staff recommends Option B for monitoring period
  - Represents most significant impact
  - Recognizes progress across range of MVP utilization
  - Concerns about hospital accountability (numerator visibility issue) can be potentially addressed by improvement-only approach
- Suggestions on other approaches for structuring measure?
- Next steps
  - Begin monitoring
  - Build out CRISP reporting
  - Evaluate and discuss transition into payment policy

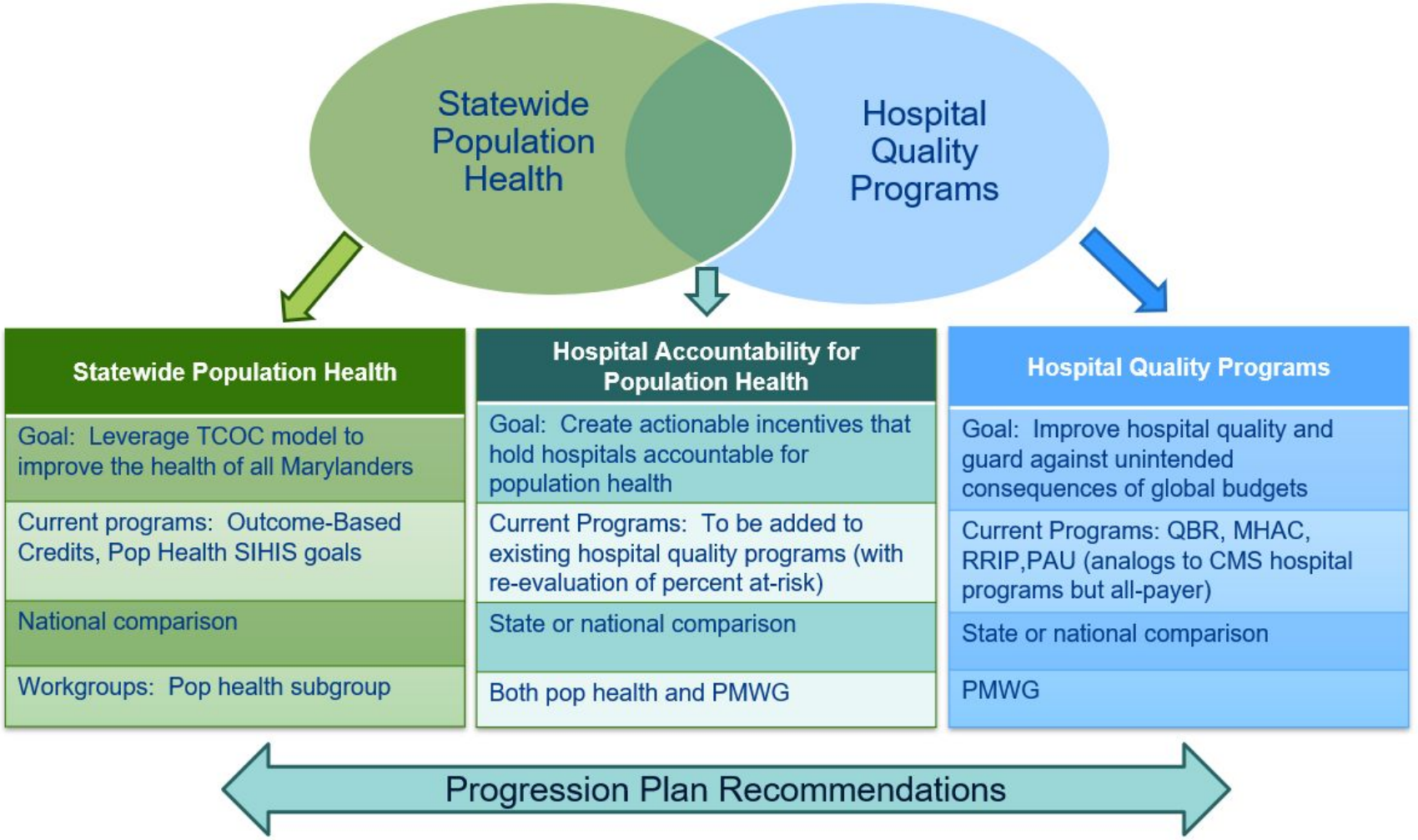
Hospital Quality and Population Health Progression Plan Strategy Development

Future Model Planning: Hospital Quality and Population Health

Task: April report for HSCRC leadership outlining strategic plan for future model

- Convene workgroup members to discuss model evolution and outline 3-5 year plan for future of Quality programs
  - Population health metrics
  - Digital measures: electronic Clinical Quality measures (eCQMs)/hybrid measures
  - Additional disparity metrics
  - Expansion of hospital focus, e.g., patient-reported outcome measures, climate change
  - Consider providers and other care settings
  - Revise policy approach (e.g., service lines, unified policy per MedPAC Hospital Value Incentive Program (HVIP))

Intersection of Hospital Quality and Population Health



Today's Discussion:

1. Hospital Quality Programs
2. Health Equity
3. Statewide Population Health
4. Hospital accountability for Population Health

Stakeholder Input

- Received 4 submissions
  - Feedback types: measure suggestions, technical adjustments, guiding principles, policy

- Feedback still expected from several stakeholders; input still welcome.
  - Any subject area not covered in today's meeting will be discussed at next month's meeting.

- Despite potentially impacting performance measurement, input on MPA attribution methodology and market shift/deregulation concerns are not dealt with by quality team
  - Concerns about MPA attribution can be brought up with TCOC workgroup
  - Concerns about MS/dereg can be brought up at payment models

Progression Plan: Hospital Quality

Hospital Quality Program Updates (MedPAC, Universal Foundation, CMMI, HSCRC)

RY23/CY21 and Prior	RY24/CY 22	RY 25/CY 23	RY 26/CY 24	RY27/CY25	RY 28/CY26	New TCOC Model
-Use absolute performance standards**	-Develop 30-day all condition mortality measure***	-Engage stakeholders in digital measures WG****	-Develop new targets for RRIP*	-Assess safety measure portfolio (PPCs, PSI, NHSN)	-Model and develop monitoring reports for streamlined quality program	**Implement Enhanced Hospital Quality Program/s**
-Use prospective targets**	-Begin state collection of digital measures/ eCQMs***	-Add perinatal eCQMs****	-Include ED wait times in payment policy*	-Evaluate QBR domains and measures	-Reassess revenue at-risk across quality programs	
-Use all-condition measures**		-Collaborate with MHA and on HCAHPS improvement***	-Consider adding perinatal or other eCQMs in payment policy*	-Assess risk-adjustment across programs		
-Distribute rewards based on a continuous scale of points**		-Implement TFU Medicaid***	-Develop infrastructure for PROMs*			
		-Implement 30 day mortality, TFU Beh Hlth, EDAC Monitoring Reports****				
		-Consider plan for all-payer patient reported outcome measures (PROMs)*				
		-Develop progression plan recommendations*				
		Consider options for streamlining Hospital quality programs*** Imbed payment incentives for Equity in Hospital Quality Programs***				

Quality Incentives:
Patient Centeredness through Service Line Approach

	Ways to measure and report quality	Hospital Service Line Examples: Medical	Surgical	Obstetrics	Behavioral Health	Emergency Department
Quality Domains	Safety					
	Patient Experience					
	Mortality					
	High Quality primary care/chronic disease management					
	Care Coordination					
	Other?					

Should measures be reported by quality domain?

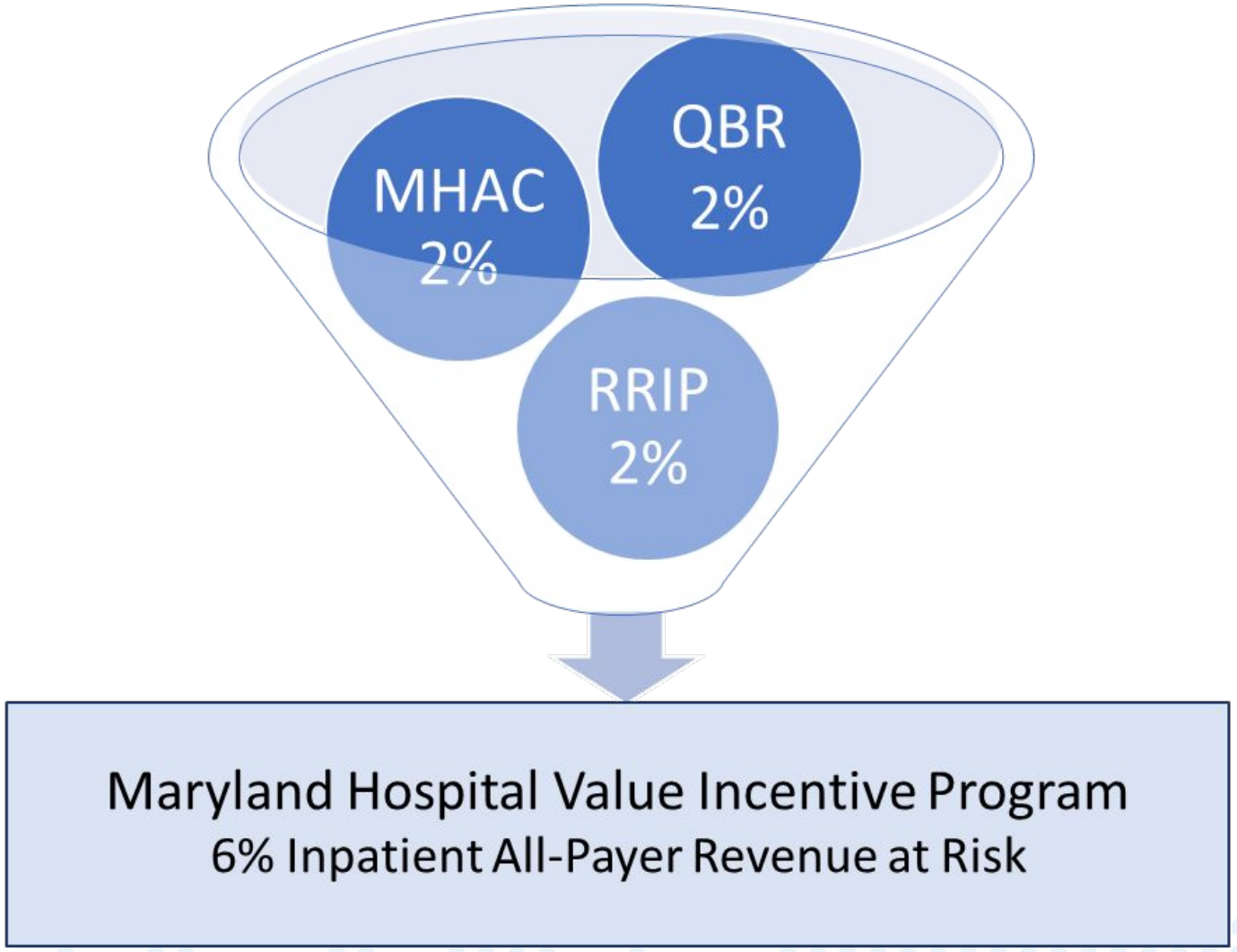
Should revenue adjustments be applied to quality domains?

Should measures be reported by service lines?
Should revenue adjustments be applied to service lines?
Determine granularity of service lines (e.g., CMS hybrid mortality measure has 15)

Additional questions:

- What is meaningful for clinicians? Patients?
- Improvement vs. attainment for payment?
- Report improvement?
- Roll service lines into hospital level metric
  - Risk adjustment at service line level?

Streamlined Programs and Revenue At-Risk



Additional Revenue At-Risk under:

- Potentially Avoidable Utilization Adjustment
- Readmission Disparity Gap reward
- Quality adjustment in MPA

Patient-Reported Outcomes: THA/TKA

PRO = Patient-reported outcome
PROM = Patient-reported outcome measure
PRO-PM = Patient-reported performance measure

- Provides timely information on patient health status, function, and symptoms over time that can be used to improve patient-centered care and inform clinical decision making.
  - THA/TKAs are important, effective procedures on a broad population and the outcomes such as pain and mobility can be valid and reliable way.

Should Maryland require hospitals to submit PROMs on an all-payer basis?

Table 1: Voluntary and Mandatory Reporting Data Periods and Data Submission Deadlines

Data Periods		2025 Voluntary Reporting	2026 Voluntary Reporting	2027 Mandatory Reporting (FY 2028 payment determination)
Preoperative PRO Data	Data collection period	October 3, 2022- June 30, 2023	April 2, 2023-June 30, 2024	April 2, 2024-June 30, 2025
	Data submission deadline	**October 2, 2023**	**September 30, 2024**	**September 30, 2025**
THA/TKA Procedures Performed		January 1, 2023- June 30, 2023	July 1, 2023-June 30, 2024	July 1, 2024-June 30, 2025
Postoperative PRO Data	Data collection period	October 28, 2023 - August 28, 2024	April 26, 2024- August 29, 2025	April 27, 2025- August 29, 2026
	Data submission deadline	**September 30, 2024**	**September 30, 2025**	**September 30, 2026**

Next Steps

- Meeting in April
  - Review draft progression plan recommendations and timeline

Progression Plan: Health Equity

Health Equity Measurement Timeline

<table>
<tr><th>RY23/CY21</th><th>RY25/CY23</th><th>RY26/CY24</th><th>RY27/CY25</th><th>RY28/CY26</th><th>Post- TCOC Model</th></tr>
<tr><td rowspan="2">RRIP Disparity Gap measure</td><td rowspan="2">Assess application of existing PAI measure on additional HE measures

Medicaid TFU in QBR Program

Workgroup to improve SDoH Data Collection and Documentation</td><td>TFU Disparity Measure in QBR Payment Program</td><td></td><td rowspan="2">Continuation of RRIP, TFU, and Avoidable Admissions Disparity Measures, and consider HCAHPS</td><td rowspan="2">Aggregated Health Equity Monitoring and Pay-for-Performance Program???</td></tr>
<tr><td colspan="2">Avoidable Admissions Disparity Measure in PAU Payment Program</td></tr>
</table>

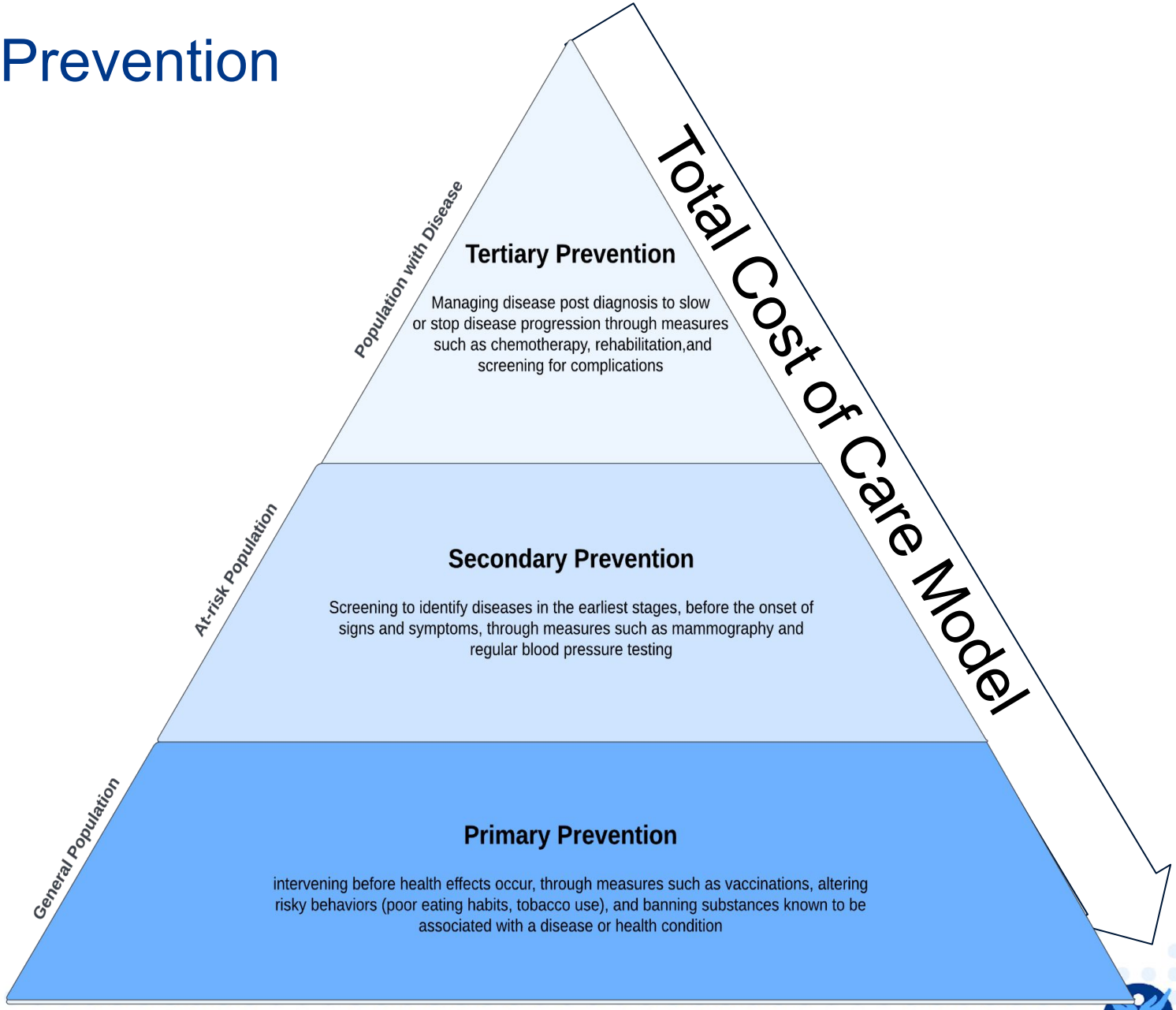
- Staff will modify the RRIP PAI methodology for the TFU and Avoidable Admissions measures
  - Which social factors are of interest, measure specific or same for all?
- These measures (RRIP, TFU, and Avoidable Admissions) are being prioritized due to their drastic disparities and their indication of issues with access to outpatient services

Potential Health Equity Recommendations

- Adopt an equity in all policies approach for hospital quality and population health accountability
- Collect additional data on socio-demographics/hospital process measures, stratify all quality and population health measures, and develop payment programs to address identified disparities.
  - Staff currently working to improve collection of SOGI data
  - Improvements need to be made with the collection of SDoH data

Progression Plan: Hospital Accountability in Population Health

Levels of Prevention



https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

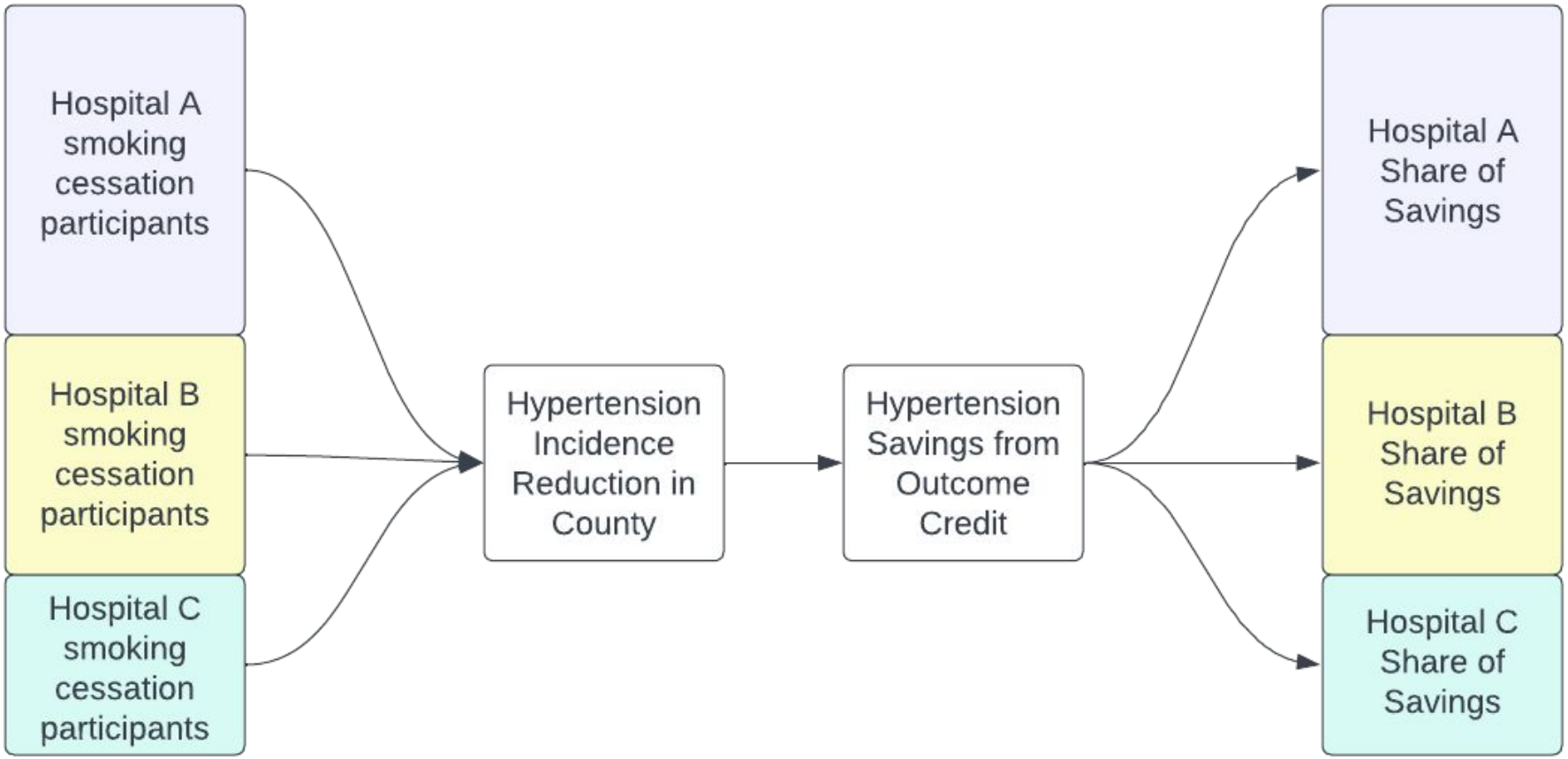
Key Work Streams for Pop Health in Remaining Model Years

- Focus on hospital accountability for primary and secondary prevention
  - Key question: How to attribute population health outcomes to hospitals?
- Identify data sources for pop health work
  - Timely
  - Sub-state estimates
  - Visibility on incidence, prevalence and screening
  - Provide counterfactuals outside of Maryland
- Develop new measures for monitoring first, followed by payment

Attribution: One Approach

- Focus pop health accountability on outcome credit areas
  - Maximize focus on disease areas that align with larger state goals, i.e., SIHIS
  - Enhance return on investment
- Measure hospital performance using process measures
  - Measures focus on evidence-based primary prevention interventions that should drive better performance in outcome credit areas
  - One or two interventions per credit area
  - Provides hospitals with direct control over results, eliminates attribution issues
- Scale rewards based on county performance on incidence, hospital performance on process measure
  - Allocate incentive payments related to disease incidence based on hospital performance measures

Attribution/Reward Example



Additional Notes

- This is one way to address the complex challenges around attribution and performance measurement
- We are open to others, as long as they focus on primary prevention related to diabetes, OUD, hypertension
- Strengths: Straightforward attribution, encourages hospitals to focus work on a small portfolio of proven interventions
- Limitations: Prescriptive as far as permitted interventions, poses data/measurement challenges for incidence

Population Health Data Sources

	Survey data	**All-payer claims**
Strengths	● Nationwide ● Representative sample ● Includes people not under care	● Maryland only ● Large sample
Limitations	● Lagged ● Small sample ● Limited value for sub-state analysis	● Lagged ● Missing key populations ○ Outside MD ○ Not under care ○ Federal employees

Potential Solutions

- Require providers to submit claims to HSCRC as well as payer
  - Provides limited information on each encounter
  - Close to 100% of encounters
  - Significant administrative burden
- Obtain measure info from MDPCP participants
  - Potentially deeper information from EHR systems
  - Smaller population but still large and broad-based
- Both approaches would likely require access to Medicare/Medicaid and privately compiled commercial claims data for national comparisons

Staff Recommendation

- Explore claims route
  - How does this work with HMOs?
  - What would administrative burden look like?
  - What are legislative/regulatory processes to secure data access?
- Suggestions on this approach?
- Other possibilities?

Progression Plan: Statewide Population Health

Statewide Population Health

- Statewide Integrated Health Improvement Strategy
  - What should this look like in the future?
    - Expansion?
    - More holistic, e.g., life expectancy?
  - Are there things the state should try to link with SIHIS success?
- Statewide population health should measure and consider impact on equity
- Outcomes Based Credits
  - Does PMWG recommend that HSCRC staff advocate for continuing and potentially expanding OBCs under future model?
  - Should OBC amount be more directly tied to hospital payments?

Population Health Progression Timeline

RY25/CY23	RY26/CY24	RY27/CY25	RY28/CY26
Evaluate A1c screening, avoidable ED measure performance Submit opioid and HTN outcome credit methodologies Update diabetes credit methodology to address added test volume, measurement challenges Evaluate need for EMS handoff incentive	Transition A1c, avoidable ED measures into payment policy Evaluate need for additional secondary prevention measures Identify data requirements for developing hospital accountability measures on primary prevention	Implement additional secondary prevention measures Bring enhanced pop health data online Develop & monitor primary prevention hospital accountability measures Evaluate need for pop health equity measures Consider stand-alone pop health payment policy	Move primary prevention hospital accountability measures into payment policy Evaluate state population health progress and update focus for SIHIS/outcome credits/hospital accountability based on disease burden estimates

Diabetes Screening Update

Background

- CMMI asked staff to develop one or more measures to enhance hospital accountability for population health progress
- After series of subgroup meetings, staff recommended monitoring diabetes screening for ED patients
- JHHS/MedStar recommended focusing measure on inpatients due to concerns about ED throughput, followup
- Staff have been working with CRISP to develop monitoring process for IP diabetes screening prevalence

Monitoring update

- CRISP is evaluating use of hospital lab feeds to track increases in IP A1c screening
- Initial indication is that this will be feasible and valid
- HSCRC expects to receive data beginning in April
- Staff will work with CRISP to develop dashboard reporting
- Hospitals should confirm accuracy of A1c reporting in LOINC feeds to CRISP

Measure Definition

- Numerator: # of inpatients with a CRISP A1c record with admit date <= service date <= discharge date
- Denominator: # of inpatient discharges patient in monitoring period
- Exclusions
  - <35 years old
  - Died in hospital
  - Transferred
  - AMA

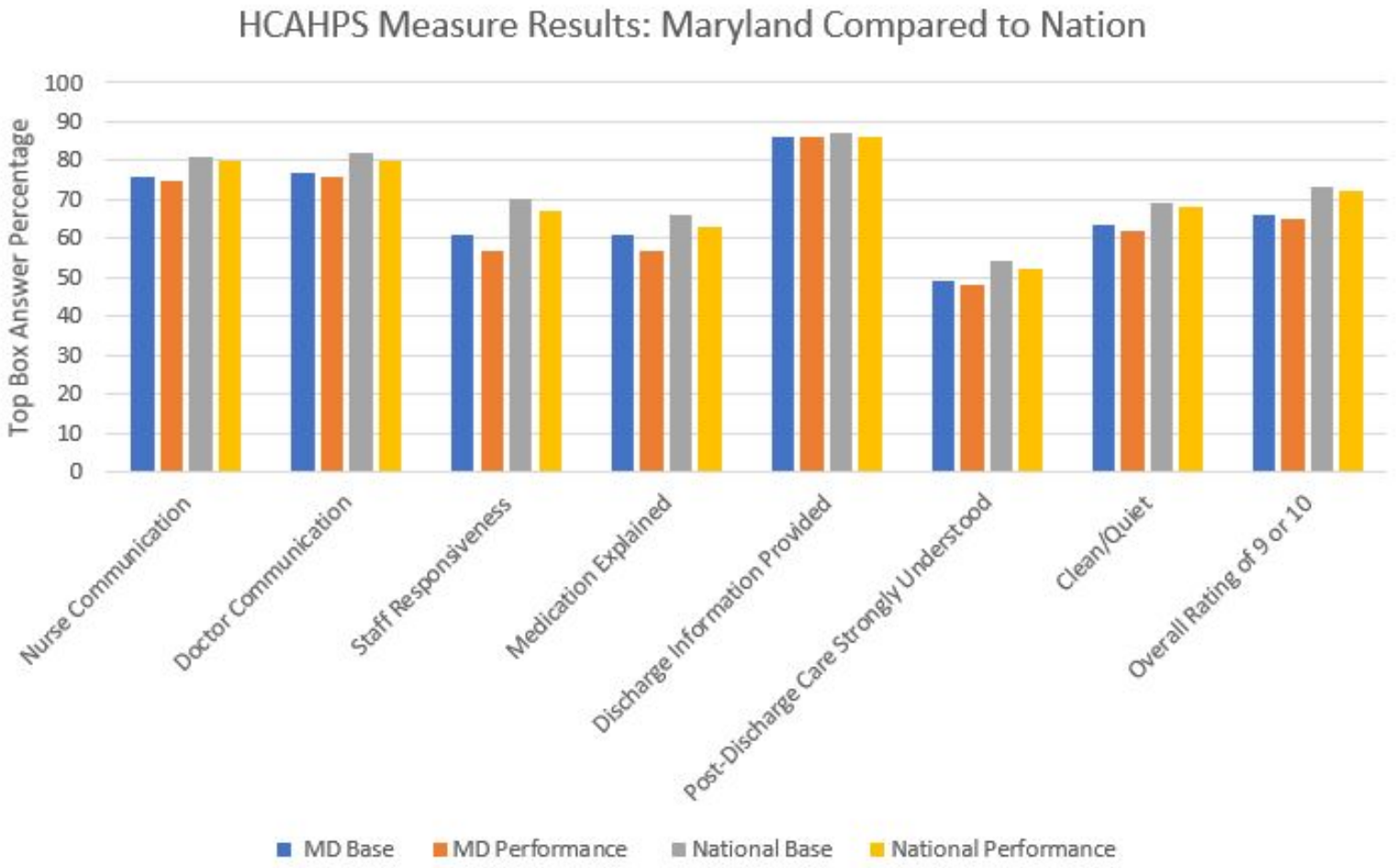
Additional Details

- Confirmed with AG's office that screening does not constitute research. No IRB approval required
- Policy is monitoring only for CY23
- Likely to focus on improvement only for near term
- Staff will work with CRISP to build out
  - Dashboard reporting
  - Analytics on follow-up for out-of-range A1c values
  - Tracking of additional exclusions (pt refused test, clinically inappropriate)
- Hospitals: collaborate on EPIC/Cerner standing test order

HCAHPS Improvement Approach

Maryland Performs Below the National Average on HCAHPS

HCAHPS Top Box Results: Maryland Compared to the Nation, CY 2019 vs 10/1/20-9/30/21



Maryland Efforts to Improve Performance on HCAHPS:

- Hospital incentive has been increased to twice that of hospitals outside of Maryland since 2027
- In 2018, MHA initiated a Patient Experience Mentoring Program that identified hospitals whose patient satisfaction scores exceeded the Nation average, and improved over time.
- In 2019, MHA conducted a Patient Experience learning Conference
- This year, HSCRC has committed to:
  - Identifying hospital HCAHPS leaders
  - Learning from patient-level HCAHPS results
  - Asking hospitals to adopt best practices

MHCC Patient Level Data Analysis Results

Maryland HCAHPS Exploratory Data

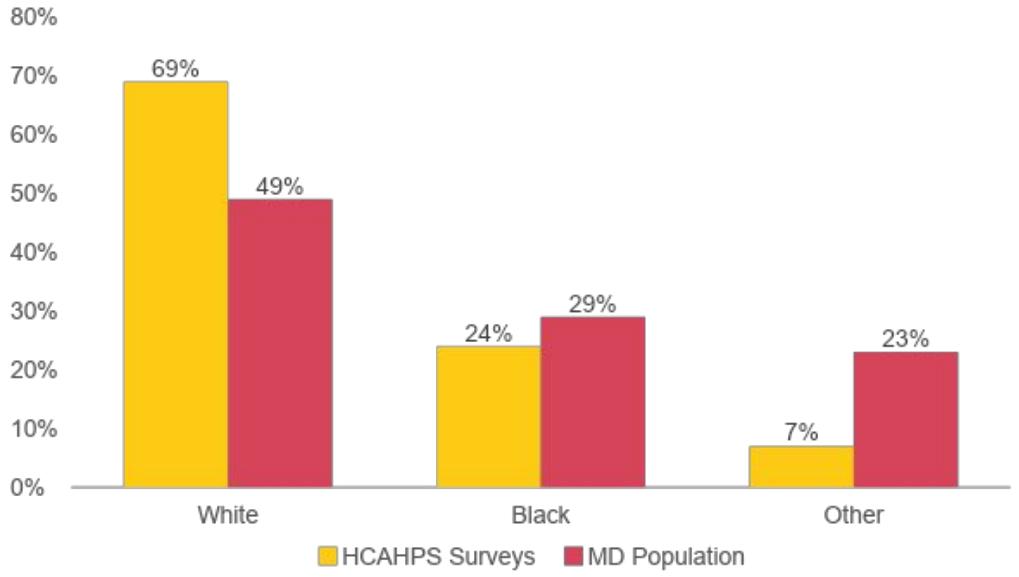
PERFORMANCE MEASUREMENT WORKGROUP MEETING

MARCH 2023

Background

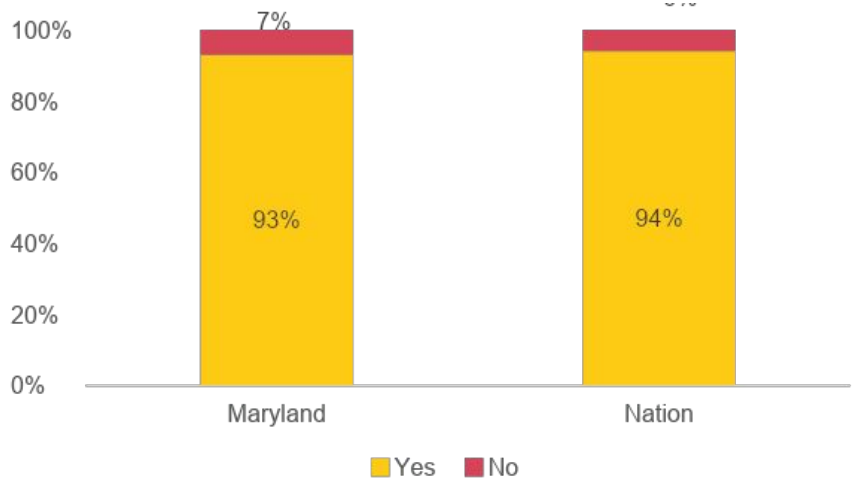
- MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
  - Joint memo with HSCRC
- Allows for more detailed analysis into race, ethnicity, service line, etc.
  - More timely
- More targeted approaches for quality improvement (e.g., populations, domains, etc)

- Q3 2021 – Q2 2022 (33,134 surveys)
- MD population data from 2020 Census



Would Recommend

- Collapsed Scores
- Denominator – 33,134
  - No = *Definitely No/Probably No - 2,263 (7%)*
  - Yes = *Definitely Yes/Probably Yes* - 30,871 (93%)



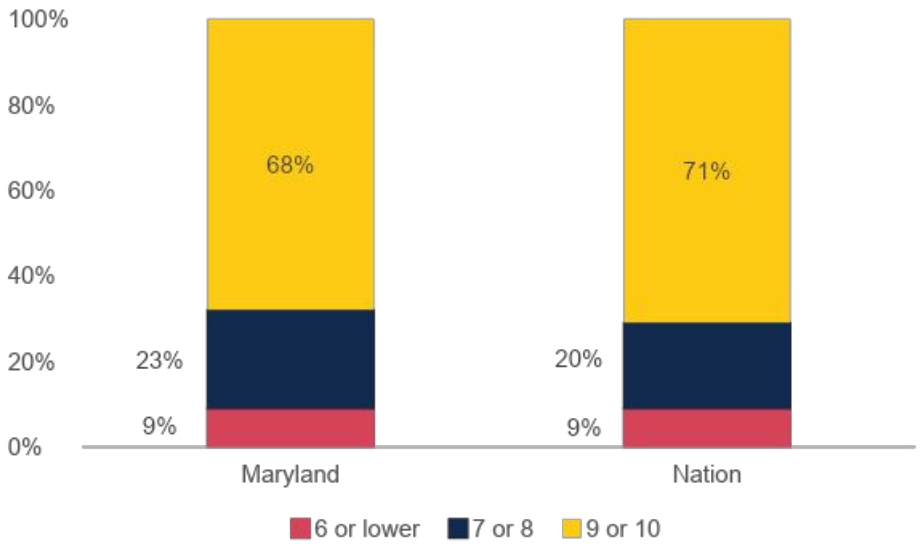
National data: Q2 2021-Q1 2022

- Chi-square test shows marginal differences in Recommendation (Yes/No) between races in MD data
  - More blacks report “No” than expected

	Yes (93%)	No (7%)
White	70%	67%
Black	24%	27%
Other	7%	7%

Overall Rating

- Collapsed Ratings 1-10
- Denominator – 33,134
  - 6 or lower – 3,121 (9%)
  - 7 or 8 – 7,458 (23%)
  - 9 or 10 – 22,555 (68%)



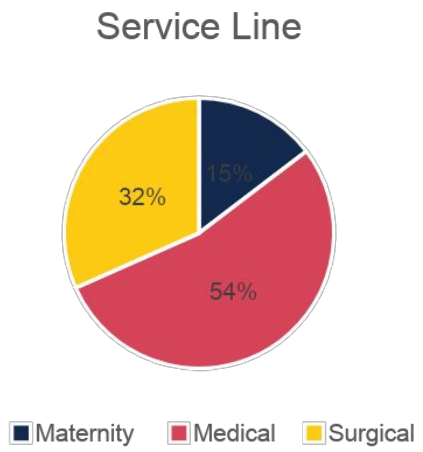
National data: Q2 2021-Q1 2022

- Chi-square test shows marginal differences in Overall Rating between races
  - Fewer white, more black in the 6 or lower category

	6 or lower (9%)	7 or 8 (23%)	9 or 10 (68%)
White	67%	70%	70%
Black	26%	23%	24%
Other	7%	7%	6%

Service Lines

- Denominator – 32,520
  - Maternity – 4,760 (15%)
  - Medical – 17,475 (54%)
  - Surgical – 10,285 (32%)



- Black & Other is higher in the maternity service line than medical and surgical

	Maternity (15%)	Medical (54%)	Surgical (32%)
White	56%	69%	75%
Black	31%	25%	20%
Other	14%	5%	5%

Maternity Service Line – Black Women

- Denominator – 4,760
  - Black – 1,456 (31%)
  - Other – 3,304 (69%)
- Significant differences between black and other races
  - Would Recommend – Significantly more “No” reported by black women than expected
  - Overall Rating – Significantly more “6 or lower” reported by black women than expected

Would Recommend		
	Yes (96%)	No (4%)
Black	30%	49%
Other	70%	51%

Overall Rating			
	6 or lower (7%)	7 or 8 (24%)	9 or 10 (70%)
Black	47%	32%	28%
Other	53%	68%	72%

Qlarant/American Institutes for Research (AIR) Patient Family Engagement Work to Improve HCAHPS

Patient & Family Engagement: An Effort to Improve HCAHPS

(Hospital Consumer Assessment of Healthcare Providers and Systems)

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The IPRO QIN-QIO: Who We Are

IPRO

New York, New Jersey, Ohio

Healthcentric Advisors

Maine, New Hampshire, Vermont,
Massachusetts, Connecticut, Rhode Island

Qlarant

Maryland, Delaware, District of Columbia

The IPRO QIN-QIO Region

Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

What Is Person and Family Engagement and Why Does it Matter?

https://vimeo.com/656629216

This 10-minute presentation provides a basic overview and definition of person and family engagement, or PFE, and explains what partnership might look like in the hospital setting. The presentation outlines the benefits of PFE to improve care and shows how hospital staff can invite patients and families to become partners with them in direct care or in general hospital improvement. A list of resources is shared at the end of the presentation.

Partnership for Patients: Patient and Family Engagement in Hospital Care | American Institutes for Research (air.org)

How Can Person and Family Engagement Practices Help Reduce All-Cause Harms in Hospitals?

https://vimeo.com/683002031

This 14-minute presentation expands on engaging patients and families to be partners and focuses on using PFE as a quality improvement strategy that can assist in reducing all-cause harms (e.g., falls, pressure injuries, infections) in the hospital. The presentation introduces the five PFE Best Practices required by the Centers for Medicare & Medicaid Services for hospitals enrolled in the Hospital Quality Improvement Contract (HQIC). It explains how these best practices can be implemented and applied to improve patient safety at the hospital. A list of resources is shared at the end of the presentation.

All Cause Harm Resource Tool:

HCAHPS Performance Scores

- Cleanliness and Quietness of Hospital Environment
- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Communication About Medicines
- Discharge Information
- Patients who “ Strongly Agree” they understood their care when they left the hospital
- Overall Rating of this Hospital

Person and Family Engagement

The Five Implementation Guides for Hospital

- PFE 1: Preadmission Planning Checklist
- PFE 2: Discharge Planning Checklist
- PFE 3: Shift Change Huddles and bedside reporting
- PFE 4:Designated PFE Leader
- PFE 5: PFAC or representatives on hospital committees

Person and Family Engagement Implementation Guides for Hospitals:
https://hqic-library.ipro.org/2021/12/20/person-and-family-engagement-implementation-guides-for-hospitals/

Shared Resources

The AHRQ Guide to Patient and Family Engagement

- **Become a Patient and Family Advisor: Working Together to Help Improve Our Hospital**: Brochure that provides information on who patient and family advisors are, how they help the hospital, and who can become an advisor (Tool 3)
- **Patient and Family Advisor Information Session**: PowerPoint presentation that gives information on who patient and family advisors are, what they do, and how they help the hospital and provides tips from other advisors (Tool 5)
- **Working With Patient and Family Advisors**: PowerPoint presentation of a two-part training for clinicians and staff. Part 1, Introduction and Overview, discusses who patient and family advisors are, the benefits of working with them, and opportunities for doing so. Part 2, Building Effective Partnerships, helps clinicians and hospital staff develop partnership skills (Tool 11)
- **Working With Patient and Family Advisors on Short-Term Projects**: Handout for the clinician and staff training session that contains suggestions for ways to incorporate advisors on short-term projects along with a form to request advisor participation (Tool 13)

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Patient and Family Engagement

Teams

- Quality Committee
- Unit team meetings
- Patient advisor peers
- Discharge Planning Team

Objectives

- Interdisciplinary discussions on quality metrics.
- Create team alignment around goals.
- Utilize patient advisors as liaisons to discuss HCAHPS categories.

Thank You!

Let us know how the IPRO QIN-QIO can best support your efforts…

Kelly Arthur
arthurk@Qlarant.com
Direct: (443) 746-4455

Janet Jones
jonesj3@Qlarant.com
Direct: 443.746.4496

HCAHPS Improvement Discussion

- Updates from MHA
- Additional stakeholder input and discussion

CY 2023 Sexual Orientation and Gender Identity Data Collection (SOGI) Survey Results

Impetus for SOGI Data Collection

- Members of the LGBTQIA+ community experience health disparities and require care and services tailored to their unique needs
- The lack of data collection regarding SOGI makes it challenging to provide appropriate health services
- The systematic collection and analysis of SOGI data are essential to ensuring the surveillance, delivery, and evaluation of high-quality, patient-centered care
- In 2019, the HSCRC conducted a survey regarding data collection practices but the COVID-19 pandemic stymied progress with assisting and training hospitals with the collection of SOGI data

Hospital Responses

- 19 responses for 52 hospitals
- Gender Identity (GI): A patient's current internal sense of being man, woman, neither, or both.
  - Male/Man
  - Female/Woman
  - Female to Male -or- Male to Female Transgender
  - Genderqueer
- Sexual Orientation (SO): A patient's identity with regard to romantic and/or sexual attraction.
  - Straight/Heterosexual
  - Lesbian, Gay, or Homosexual
  - Bisexual

Gender Identity Field Options

- All hospitals collect “Male/Man” and “Female/Woman”
- 27 hospitals collect “Female To Male (FTM) Transgender” and “Male To Female (MTF) Transgender”
  - Increase from 17 hospitals in 2019
- 24 hospitals collect “Genderqueer”
  - Increase from 12 hospitals in 2019
- 25 hospitals collect “Sex at Birth”
  - No change in # of hospitals from 2019
- 44 hospitals allow patients to decline to answer their GI
  - Increase from 29 hospitals in 2019

Sexual Orientation Fields Options

- 30 hospitals collect
  - “Straight or Heterosexual”
  - “Lesbian, Gay, or Homosexual”
  - “Bisexual”
  - Increase from 18 hospitals in 2019
- 26 hospitals collect “Something Else”
  - Increase from 18 hospitals in 2019
- 23 hospital collect “Don’t Know”
  - Increase from 17 hospitals in 2019
- 28 hospitals allow patients to decline to answer their SO
  - Increase from 19 hospitals in 2019

Collection Methods & Data Usage

How do Hospitals Collect SOGI Data:

- 46 hospitals collect SOGI verbally
- 15 via paper form
- 32 electronically

How do Hospitals Use SOGI Data:

- 6 hospitals use SOGI data to assess quality assurance/improvement
- 4 hospitals use SOGI data to reduce health disparities
- 2 hospitals use SOGI data for monitoring
- 10 hospitals use SOGI data to assess patient safety
- 28 hospitals use SOGI data for record keeping

Barriers to Collection

- EHR vendors are not currently set up for collection of all options presented in the survey
- Lack of universal data collection processes (especially for minors)
- Lack of clinical pertinence could violate patient rights/privacy
- Staff discomfort in asking
- Patients' refusal to answer and how to deal with moral objectifications

Next Steps

- 1-2 virtual meetings in April – May 2023
- Stakeholder workgroup to draft recommendations
  - Codes and definitions
  - Timeline for implementation and training
- Training/Staff Education
- Addition of new variables

THANK YOU!

Next Meeting: Wednesday, April 19th, 2023

Appendix

Acute Care Hospital Survey Results

- 10 responses received for 28 hospitals
- All acute care hospitals explicitly prioritize health equity in their missions and goals
- 23 hospitals have a particular definition for health equity
- 25 have a designated health equity individual/team
- 25 have specific goals for achieving health equity, but all have plans to further develop specific health equity goals
  - 4 hospitals have incentives tied to goals
- Analyzed outcomes data to understand the health disparities
  - 12 hospitals have analyzed for the surrounding community
  - 25 have analyzed for their patients
- 28 hospitals are committed to recruiting and supporting multilingual employees that are fluent in languages most spoken by patient population

Health Equity Survey Results cont'd

- All hospitals have training and education to support the workforce in culturally appropriate practices and policies
- 22 require implicit bias training for all staff members
- 28 have items related to HE in their CHNA implementation strategy; all plan to include health equity in CHNA in future
- 18 hospitals do not screen for SDoH during IP admissions; 21 don't during obs stays or ED visits
- 9 document SDoH indicators on EMR; 2 using z-codes; 1 doesn't document at all