Recommendations to the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board

This document contains recommendations from the Hospital Transformation Program (HTP) Community Advisory Council (CAC) that was established by the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board to provide community feedback on hospital quality incentive programs funded by the hospital provider fee. These recommendations apply to both the Hospital Transformation Program (HTP) measure set and the Hospital Quality Incentive Program's (HQIP) proposed measures for 2022.

CAC Priority Area 1: Data disaggregation by race, ethnicity, and primary language

Recommendation 1.1: Prioritize improvements to the Department's race and ethnicity data

The utility of the race and ethnicity data that HCPF pulls from application data can and should be improved. Even though Medicaid applicants are not required to respond to race and ethnicity questions in the application, we understand that the large majority of applicants do respond. HCPF staff has explained that only 6 percent of applicants do not answer the questions.

The main problem with the data is how certain responses are captured. Specifically, if an applicant marks more than one race option as they are allowed to do, the applicant will be identified as "multiple races" in the data. Additional information about which specific races the individual selected is not captured. This is a system functionality issue that hides a significant amount of valuable race data. To give a sense of the magnitude of the problem, HCPF staff has indicated that 100,000 Medicaid eligibles are identified as white/Caucasian, while 158,000 are identified as "multiple races."

We recommend that the Department prioritize system changes that will provide specific race and ethnicity information about every person who responds to the race and ethnicity questions on the Medicaid application. If possible, system changes should be implemented before HTP is launched.

Recommendation 1.2: Report on all claims-based measures

We understand that HCPF will work to disaggregate HTP data by race, ethnicity, and primary language for those quality measures that are based on Medicaid claims. We appreciate that commitment. However, out of the 31 HTP measures, only 3 are required statewide measures. This means that the amount of disaggregated data we would get from the program may be extremely limited. In addition, none of the HQIP measures appear to be based on claims data.

We recommend that all 7 HTP measures that are based on claims data be mandatory in order to maximize the data reported under the program that can be disaggregated based on race, ethnicity, and primary language. Alternatively, we recommend that HCPF release (in accordance with Recommendation 1.3 below) disaggregated performance data for each

hospital on all claims-based measures, regardless of whether hospitals choose to be paid for performance on the measure.

Recommendation 1.3: Produce a consumer-friendly hospital quality report card and equity report card based on HTP and HQIP data

Consumers deserve to know how their hospitals are performing on HTP and HQIP measures. Moreover, since payment is not tied to reducing inequities, the transparency of disaggregated performance data is critical - that's where the incentive to improve will come from.

In order to have transparency, reporting on hospital measures must be accessible - which is difficult to accomplish. Studies have shown that 1) as the number of quality factors to consider increase, peoples' ability to use that information to inform their choices decreases; 2) consumers often do not understand the meaning or import of many of the indicators included in comparative reports, and thus do not know how to make trade-offs or differentially weight factors; and 3) processing lots of information and making trade-offs among quality indicators involves difficult cognitive tasks. These issues are discussed further in this article, which provides this example of a consumer-friendly hospital performance report -

FIGURE 2 : Example hospital performance report

Community Hospitals	Surgery	Non-Surgery	Hip/Knee	Cardiac	Maternity
Hospital A	⊕	⊕	⊕	○	⊕
Hospital B	⊕	⊕	⊕	⊕	○
Hospital C	⊕	⊕	⊕	○	○
Hospital D	⊕	⊕	⊕	○	○
Hospital E	⊕	⊕	⊕	○	○
Hospital F	⊕	⊕	⊕	○	○
Hospital G	⊕	⊕	⊕	⊕	⊖
Hospital H	⊕	⊕	○	○	—
Hospital I	⊕	⊕	⊕	○	⊖
Hospital J	⊕	⊕	⊕	⊖	○
Hospital K	○	⊕	⊕	○	—
Hospital L	⊕	○	○	○	—

⊕ Fewer mistakes, complications and deaths than expected
○ Average number of mistakes, complications and deaths
⊖ More mistakes, complications and deaths than expected

Adapted from QualityCounts™, a service of the Employer Health Care Alliance. http://www.qualitycounts.org/report_interactive.htm

We recommend that HCPF create and use public facing reporting formats (e.g. a hospital

performance report and an equitable hospital care report) that will help consumers digest and comprehend the information derived from the HTP and HQIP and that, in plain language, states the risks associated with poor performance on each HTP and HQIP measure. HCPF should partner with the CAC in the development of these reporting formats.

Recommendation 1.4: Require hospitals to include in their HTP application their plans for improving their ability to report disaggregated HTP performance data

We understand that hospitals may not have the systems in place to disaggregate their HTP performance data based on race, ethnicity, and primary language. However, this needs to change.

We recommend that HCPF require hospitals to explain in their HTP applications how they plan to improve collection of race, ethnicity, and primary language data from their patients.

CAC Priority Area 2: Maternal and perinatal health equity

Recommendation 2.1: Add the AIM measure of severe maternal morbidity to HTP of HQIP and make it a required measure

Colorado is now an AIM state and the top measure for each AIM patient safety bundle is identical – a measure of severe maternal morbidity (copied below).

O1: Severe Maternal Morbidity	**Denominator:** All mothers during their birth admission, excluding ectopics and miscarriages **Numerator:** Among the denominator, all cases with any SMM code	HDD File (ICD-9/ICD-10)	Quarterly (if available), otherwise annual	●State Agency ●Designated Data Coordinating Body/Hospital System	*see **AIM SMM Codes List*** *The SMM Outcome Measures will also be calculated on an annual basis by major Race/Ethnicity: **NH white, NH black, Hispanic, NH AI/AN, NH API (Asian-Pacific Islander) (NH=Non-Hispanic)** Each state will determine which race groups to report, but the first 3 are required.*

The measure is aligned with quality improvement initiatives in the state. Furthermore, its inclusion in the HTP might encourage hospitals to engage with AIM, which would provide support for their quality improvement efforts through the CPCQC.

We recommend including this measure in the HTP and making it a required measure at birthing hospitals across the state. A CAC member previously requested inclusion of this measure but we have not received a substantive response to the request.

Recommendation 2.2: Make screening and referral for prenatal depression and anxiety required for all birthing hospitals and align the measure with NCQA

We support the inclusion of the HTP measure on screening and referral for perinatal and postpartum depression and anxiety, and notification of positive screens to the RAE. However, we recommend two modifications related to the measure. First, because pregnancy-related depression and anxiety is the most common complication of pregnancy, this measure should be a statewide required measure at all birthing hospitals. Second, we request that the Department align the specifications of this measure to those established by the National Committee for Quality Assurance for the Healthcare Effectiveness Data and Information Set (HEDIS) to every extent possible. This recommendation was made in a December 13 letter joined by multiple CAC members, but we are not aware of a response on this specific request.

Recommendation 2.3: Engage in a stakeholder process around the HQIP Maternity measures.

The Department should take time to engage maternity care providers of color around the HQIP maternal and perinatal quality measures. Cesarean rates are rarely a priority for stakeholders who've had experience with the maternity care system, and further, evidence suggests that higher cesarean rates are associated with lower morbidity levels for both cesarean and vaginal births, and community members care deeply about morbidity rates. The Health Affairs article linked above states, "Interestingly, we found that hospitals with higher cesarean delivery rates had lower complication rates for women having either a vaginal or a cesarean delivery, compared to hospitals with lower cesarean rates." Community members also dislike using rates of exclusive breastfeeding as a quality measure for several reasons. First, there are stories of new moms being denied needed supplemental food for their hungry babies in hospitals. Second, evidence does not suggest that early supplementation reduces long-term breastfeeding success. Lastly, structural barriers experienced by people of color, including lack of access to lactation consultants, double electric pumps, and paid time off mean that they often struggle to breastfeed exclusively. Instead, the focus should be on inclusive breastfeeding, or infant feeding that involves some ongoing feeding of breast milk.

We recommend delaying finalization of the 2022 HQIP measures and using a future CAC meeting to engage maternity care providers of color on the maternity and perinatal measures used in HQIP and their impact on people of color.

CAC Priority Area 3: Patient experience equity

Recommendation 3.1: Disaggregate patient experience data by race, ethnicity, primary language, and disability status

As summarized by the Agency for Healthcare Research and Quality: "A positive patient experience is an important goal in its own right. Moreover, substantial evidence points to a positive association between various aspects of patient experience, such as good

communication between providers and patients, and several important health care processes and outcomes. These processes and outcomes include patient adherence to medical advice, better clinical outcomes, improved patient safety practices, and lower utilization of unnecessary health care services."

We appreciate that patient experience is a focus on HQIP. However, in order to achieve health care equity, we need to understand how hospitals are performing on patient experience for different racial, ethnic, and primary language groups. Disaggregation of patient experience data based on disability status is also critical from an equity perspective.

We recommend that all patient experience data be disaggregated based on race, ethnicity, primary language, and disability status. Further, we recommend that the disaggregated data be publicly reported, in line with Recommendation 1.3 above, to the extent protected health information is not compromised.