NEW YORK STATE | Department of Health

VBP QIP Facility Plan Guidance Document:

Addendum for Rural Health and Critical Access Hospitals

Updated as of 3/6/17

VBP QIP Facility Plans

Facility Plans should reflect a distressed facility's overall approach to improve quality and outcomes in a way that aligns with New York State (NYS') Payment Reform as a means to achieve long-term sustainability. Through the development of these plans, facilities will not only have an opportunity to assess the factors contributing to their current state, but will also have an opportunity to develop plans to address those factors. The development of reporting and performance metrics is essential to this process. As a performance based program, starting in Demonstration Year (DY) 3 (April 1, 2017- March 31, 2018) the reporting and accountability metrics set forth in the Facility Plans will be the driver of payment for the remainder of the VBP QIP.

Purpose of this Document

This document is an addendum to the main VBP QIP Facility Plan Guidance document and is intended solely for **facilities with less than 100 licensed medical/surgical beds**. Facilities currently meeting this criteria participating in the VBP QIP include:

- Aurelia Osborn Fox Memorial
- Bon Secours Community
- Lewis County General
- Orleans Community
- Rome Memorial
- St. James Mercy
- Wyoming County Community

The amendments to the VBP QIP measure selection and reporting process have been made in consideration of the unique role and responsibilities rural and community access hospitals have to the communities they serve, and the pivotal role each has in supporting the NYS Delivery System Reform Incentive Payment (DSRIP). **All guidance contained in the main VBP QIP Facility Plan Guidance document, other than the measure selection and reporting described in this document, applies to providers with less than 100 licensed medical/surgical beds**.

Updated Facility Plans for all facilities participating in VBP QIP are expected to be in place by April 1, 2017 (start of DY3).

As stated in the main Facility Plan Guidance document, the Department of Health (DOH) has made recommendations that VBP QIP participants should consider and potentially adopt in their effort to create a structured transformation; however, the final authority to adopt the recommendations made in this document is left to the discretion of the VBPQIP- paired MCO.

P4P Measure Selection

Recommended Quality Measures

Each Rural and Critical Access VBP QIP Facility Plan is expected to contain six (6) quality measures for pay for performance (P4P) evaluation. While it is recommended that ***facilities (in consultation with their paired PPS) be given the ability to choose the measures which the facility is assessed, the facility's paired-MCO must agree to the measures***

***selected for the Facility Plan*.** *Once selected, the facility will be assessed on its performance on these quality measures for the remainder of the VBP QIP, barring corporate restructuring/reorganization*. DOH advises that Facility Plans contain no more than six measures as there should be a focus on improving in targeted areas. DOH, in collaboration with the Office of Quality and Patient Safety (OQPS) and Office of Rural Health, have researched quality measures that would be appropriate to implement at a Rural or Critical Access facility level. Figure 2 provides a menu of quality measures based on the guidelines below.

1. Nationally recognized measures (e.g. AHRQ, CMS, CDC, NDNI, NHSN, NQF, NCQA)[1]
2. Avoidable hospital use measures
3. Measures tracking Hospital Acquired Infections

Measures highlighted in yellow were added to the menu *only* for RH and CA facilities.

Figure 2: VBP QIP Recommended P4P Measure Menu for Rural and CAH

#	Measure Name	Data Steward	Focus Area/Domain
1	Acute MI Mortality (IQI #15)	AHRQ	Mortality
2	Stroke Mortality (IQI #17)	AHRQ	Mortality
3	Pneumonia Mortality (IQI #20)	AHRQ	Mortality
4	CAUTI Rate per 10,000 Patient Days (Population Rate)	NHSN	Hospital Acquired Conditions
5	CLABSI per 10,000 Patient Days (Population Rate)	NHSN	Hospital Acquired Conditions
6	CDI Healthcare Facility - Onset Incidence Rate per 10,000 Patient Days	NHSN	Hospital Acquired Conditions
7	Falls with Injury	NDNQI	Hospital Acquired Conditions
8	3-Hour Sepsis Bundle	NYSDOH	Hospital Acquired Conditions
9	Episiotomy Rate	Pediatric Measure Center of Excellence	Maternity
10	Primary C-Section (IQI #33)	AHRQ	Maternity
11	Avoidable ED Use	3M	Utilization
12	Avoidable Admissions	3M	Utilization
13	Pressure Ulcer Rate, Stage III or IV	NQF	Hospital Acquired Conditions
14	**Fibrinolytic Therapy Received with 30 minutes of ED Arrival (OP-2)**	**CMS**	**Timely and Effective Care**
15	**Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3)**	**CMS**	**Timely and Effective Care**
16	**Median Time to ECG (OP-5)**	**CMS**	**Timely and Effective Care**
17	**EDTC Emergency Department Transfer Communication (All or None)**	**NQF/ Stratis Health**	**Transitions of Care**

[1] Spelling of abbreviations: NQF: National Quality Forum; NCQA: National Committee for Quality Assurance; AHRQ: Agency for Healthcare Research and Quality; CMS: Centers for Medicare & Medicaid Services; CDC: Centers for Disease Control and Prevention; NDNI: The National Database of Nursing Quality Indicators.

Quality Measure Alternatives (Maximum of 2 allowed)

As an alternative, facilities may choose up to 2 quality measures not included in Figure 2 of this document as long as the measures selected follow criteria similar to the OQPS measure selection logic above. Alternative measures should be nationally recognized with a publicly available methodology and standardized reporting requirements to allow for valid comparison. Facilities can look across their organization to find meaningful areas of improvement and possibly look to report on measures they do not normally report on.

If alternate measures are chosen, the facility is required to not only document the reasons for using alternatives measures, but also state how data will be collected and reported to its paired MCO. As with all measures in the Facility Plan, the facility's paired-MCO has to review and accept an approach using alternate measures. Recommended criteria for alternate measure selection include:

1. Other nationally recognized measures not included in Figure 2 of this document.
2. Measures similar to nationally recognized measures that are currently in use at the facility as part of existing quality improvement efforts. Some examples fitting this description may include measures with facility-defined specifications related to:
    a) Length of stay
    b) Hospital acquired infections
3. Facility should need to show improvement in the measure.

PPS/Facility Partnership in Measure Selection

VBP QIP facilities and their paired PPS are expected to collaboratively select the six P4P quality measures. A facility's selected measures should align with the PPS' DSRIP goals and the paired PPS should also provide support (non-financial) and guidance to the participating facility. By the facility and PPS aligning measures, the PPS can help the facility identify areas of improvement that will not only help the facility meet its VBP QIP metrics, but also help the PPS meet its DSRIP metrics. The facility will not only benefit by focusing on a specific set of actions to perform well in both the VBP QIP and DSRIP programs, but the facility will also benefit from guidance and help the PPS can share in aligned areas.

Refer to page 8 (figure 3a) in the main Facility Guidance document for a visual on the menu selection process and recommendation on selecting the six P4P quality measures.

P4P Measures with Denominators Under 15

For VBP QIP facilities with less than 100 licensed medical/surgical beds, the denominator for VBP QIP P4P measures will be set at 15 events per reporting period.

- If a facility selects a measure where the denominator is under 15 events for a given reporting period, that measure's performance cannot count as achieved for the reporting period. Hence, the facility's P4P performance for the period would then be based on the 5 other valid measures with the facility needing to achieve four (4) out of five (5) remaining valid measures to ensure it earns the full allowable payment for that period.
    - If multiple denominators are invalid during the same reporting period, more valid measures will need to be achieved for a facility to earn full payment for the period. Performance for at least 4 measures will need to

be achieved in a reporting period for the facility to earn full payment for that period.

- If 3 or more measures have invalid denominators during a reporting period, the facility will earn up to the amount of achieved valid measures. Since less than 4 valid measures can be achieved, unearned P4P dollars will be available through the AIT.

- The facility could also not earn performance for a measure where the rolling annual denominator was less than 15 in the following/next quarter, because there would not be a most recent valid rolling annual quarter with which to measure success. Therefore, the measure would be reported to the MCO and recorded so that the valid quarterly measurement could be used as a baseline to assess the performance on the measure in the following quarter. Hence, for a reporting period following a period where a facility was not able to report valid performance, the facility's P4P performance for the period would then be based on the other measures with valid denominators with the facility needing to achieve 4 of remaining measures with valid denominators to ensure it earns the full allowable payment for that period.

- If a facility's measure denominator is invalid for two or more periods during a baseline measurement or performance measurement period, the measure will be deemed invalid and will not be considered for AIT, meaning that the facility will need to achieve other measures with valid AIT baselines and performance measurements to receive AIT awards.

Figure 3b of this document (below) illustrates a scenario where multiple measures' denominators fall below 15 throughout a demonstration year.

In DY4 Q1, this facility has three (3) measures where denominators were less than 15. Since the facility is required to achieve four (4) out of six (6) measures to receive 100% of the quarterly award amount, the facility could only receive a maximum of 75% of the quarterly award amount in DY4 Q1 if it achieves three (3) out of the three (3) remaining measures.

Although the six (6) measures have denominators of at least 15, the three (3) measures that were invalid in the prior quarter are still invalid because there is no baseline from the prior quarter to compare the current quarter against. Since the facility is required to achieve four (4) out of six (6) measures to receive 100% of the quarterly award amount, the facility could only receive a maximum of 75% of the quarterly award amount in DY4 Q1 if it achieves three (3) out of the three (3) remaining measures.

All six (6) measures have valid denominators in DY4 Q3. The three (3) measures that were originally invalid in DY4 Q1 had denominators are now valid in DY4 Q3 because they have denominators above 15 and a baseline from the previous quarter. The facility needs to achieve at least four (4) out of six (6) measures to receive 100% of the DY4 Q3 award amount.

In DY4 Q4, the denominator for Measure 6 falls below 15 again. Therefore, the denominator is deemed invalid for DY4 Q4 and the facility is required to achieve four (4) out of five (5) valid measures to receive 100% of the DY4 Q4 award amount.

Figure 3a: Example of P4P Measures with Denominators Less Than 15

Quarterly Improvement Target Achievement

Measure	DY4 Q1				DY4 Q2			
	Denom.	Denom Valid?	Measure Valid?	Needed Achievement	Denom.	Denom Valid?	Measure Valid?	Needed Achievement
Measure 1	12	No		3/3*	16	Yes		3/3*
Measure 2	18	Yes	✓		22	Yes	✓	
Measure 3	10	No			16	Yes		
Measure 4	22	Yes	✓		20	Yes	✓	
Measure 5	25	Yes	✓		33	Yes	✓	
Measure 6	9	No			16	Yes		
	3 measures are invalid due to denominators less than 15. Since the Facility is required to achieve 4 out of 6 measures to receive 100% of the quarterly award amount, the Facility could only receive a maximum of 75% of the quarterly award amount in DY4 Q1 if it achieves 3 out of 3 of the remaining measures.				Although the 6 measures have denominators of at least 15, the 3 measures that were invalid last quarter are still invalid because there is no baseline from the prior quarter to measure the current quarter against. Since the Facility is required to achieve 4 out of 6 measures to receive 100% of the quarterly award amount, the Facility could only receive a maximum of 75% of the quarterly award amount in DY4 Q2 if it achieves 3 out of 3 of the remaining measures.			

* Facilities are required to achieve at least 4 measures to receive 100% of awards. Since the Facility only has 3 valid measures, the maximum amount it can receive is 75% of the award for achieving 3 out of 3 measures.

Quarterly Improvement Target Achievement

Measure	DY4 Q3				DY4 Q4			
	Denom.	Denom Valid?	Measure Valid?	Needed Achievement	Denom.	Denom Valid?	Measure Valid?	Needed Achievement
Measure 1	17	Yes	✓	4/6	16	Yes	✓	4/5
Measure 2	21	Yes	✓		20	Yes	✓	
Measure 3	17	Yes	✓		20	Yes	✓	
Measure 4	25	Yes	✓		22	Yes	✓	
Measure 5	32	Yes	✓		31	Yes	✓	
Measure 6	16	Yes	✓		13	No		
	All 6 measures have valid denominators. The 3 measures that were originally invalid in DY4 Q1 because of low denominators are now valid because they have denominators above 15 and a baseline from the previous quarter. Facility needs to achieve at least 4 out of 6 measures to receive 100% of the DY4 Q3 award amount.				Measure 6 becomes invalid again due to a denominator less than 15. The Facility is required to achieve 4 out of 5 valid measures to receive 100% of the DY4 Q4 award amount.			

The facility has the opportunity to earn the previously unearned P4P funds that it missed in DY4 Q1 and DY4 Q2 if it meets its AIT. Since the denominators for Measures 1 and 3 only fell below 15 for one (1) quarter, they are still valid to evaluate for performance for AIT. Conversely, since the denominator for Measure 6 fell below 15 for more than one (1) quarter in DY4, this measure is deemed invalid when evaluating AIT. Therefore, the facility would need to achieve performance in four (4) of the five (5) remaining measures to meet its AIT.

Annual Improvement Target Achievement

Measure	Valid for DY4 AIT?	Measure Valid?	Needed Achievement/ Valid Measures
Measure 1	Yes	✓	Facility has the opportunity to earn back unearned funds from DY4 Q1 and Q2. Since Measure 6 had two or more instances of denominators under 15 during the year, the measure is invalid for AIT. Therefore, the facility needs to achieve at least 4 out of the 5 remaining measures to receive 100% of the remaining funds.
Measure 2	Yes	✓	
Measure 3	Yes	✓	
Measure 4	Yes	✓	
Measure 5	Yes	✓	
Measure 6	No		

For guidance on P4P measure reporting, refer to page 11 in the main Facility Guidance document.

Annual Improvement Target (AIT) [DY 4 & DY5 Only]

For DY4 & DY5[8], an Annual Improvement Target (AIT) will be calculated by the facility and reviewed by its paired MCO to confirm improvement over the course of a four quarter "measurement period" compared to a "baseline period." DOH recognizes that due to updating process flows to achieve better performance, facilities may see temporary declines in performance metrics, potentially leading to missed quarterly achievement on a P4P quality measure. Facilities will have an opportunity to earn P4P dollars in DY4 and DY5 that may have been missed in quarterly performance periods due to these short-term variations in performance by calculating an AIT and reviewing its paired MCO to confirm improvement over the course of a four quarter measurement period.

For alternate measures, the facility is responsible for the calculation. The facility must use NYS data for comparison in the second requirement of each DY. If this data is not available, the facility can use a national average for the measure. The facility must use the most recent published reports at May 1, 2017 for DY4 and May 1, 2018 for DY5. The MCO is responsible for confirming the sources for alternate measures.

Figure 7 of this document (below) outlines the 11 P4P measures for **facilities with less than 100 licensed medical/surgical beds**, including the units and data source of the NYS results. OQPS will provide the data for comparison for the measures below. The mean included in the table below is the most recent published data for the measures for illustrative purposes only.

[8] An Annual Improvement Target will not be paid in DY3 because there is only one quarter where payment is based on actual performance (DY3 Q4). Payment in DY3 Q3 is based on reporting on quality measures that will be used as a baseline.

OQPS will release the NYS mean results for DY4 in June 2017. Mean data will be pulled based on the most recent data available as of May 1, 2017.

Figure 7: P4P Measure Data Source and Units for AIT

#	Measure Name	Data Steward	Focus Area/Domain	Measure Definitions	Units	Data Source	Period	Rate, Mean (15+ or more Disch) for Illustration Only
1	Acute MI Mortality (IQI #15)	AHRQ	Mortality	In-hospital deaths per 1,000 hospital discharges with acute myocardial infarction (AMI) as a principal diagnosis for patients ages 18 years and older. Excludes obstetric discharges and transfers to another hospital.	Rate per 1000 Discharges	NYSDOH (SPARCS)	2014	84.26
2	Stroke Mortality (IQI #17)	AHRQ	Mortality	In-hospital deaths per 1,000 hospital discharges with acute stroke as a principal diagnosis for patients ages 18 years and older. Includes metrics for discharges grouped by type of stroke. Excludes obstetric discharges and transfers to another hospital.	Rate per 1000 Discharges	NYSDOH (SPARCS)	2014	90.3
3	Pneumonia Mortality (IQI #20)	AHRQ	Mortality	In-hospital deaths per 1,000 hospital discharges with pneumonia as a principal diagnosis for patients 18 years and older.	Rate per 1000 Discharges	NYSDOH (SPARCS)	2014	40.19
4	CAUTI Rate per 10,000 Patient Days (Population Rate)	NHSN	Hospital Acquired Conditions	Catheter-associated urinary tract infections (CAUTI)	CAUTI Rate per 10,000 Device Days	CMS	2015	12.77
5	CLABSI per 10,000 Patient Days (Population Rate)	NHSN	Hospital Acquired Conditions	Central line-associated bloodstream infections (CLABSI)	CLABSI Rate per 10,000 Device Days	CMS	2015	9.93
6	CDI Healthcare Facility - Onset Incidence Rate	NHSN	Hospital Acquired Conditions	Clostridium difficile (C diff) Laboratory-identified Events	CDI Rate per 10,000 Patient Days	CMS	2015	5.99

#	Measure Name	Data Steward	Focus Area/Domain	Measure Definitions	Units	Data Source	Period	Rate, Mean (15+ or more Disch) for Illustration Only
	per 10,000 Patient Days							
7	Falls with Injury	NDNQI	Hospital Acquired Conditions	Acute Patient Fall Rate	Falls per 1,000 Patient Days	CMS	2013	0.52
8	3-Hour Sepsis Bundle	NYSDOH	Hospital Acquired Conditions	The percentage of adult patients with sepsis treated in the emergency room with the hospital's sepsis protocol who received all the recommended early treatments in the 3-hour early management bundle within three (3) hours of their arrival	Percent Compliance	NYSDOH		TBD*
9	Episiotomy Rate	Pediatric Measure Center of Excellence	Maternity	Patients who underwent an episiotomy	Per 100 Vaginal Deliveries	NYSDOH	2014	15.87
10	Primary C-Section (IQI #33)	AHRQ	Maternity	First-time Cesarean deliveries without a hysterotomy procedure per 1,000 deliveries. Excludes deliveries with complications (abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or breech procedure).	Rate per 1000 Deliveries	NYSDOH (SPARCS)	2014	189.1
11	Avoidable ED Use	3M	Utilization	Potentially Avoidable ED Use	Rate per 100 Discharges	NYSDOH (SPARCS)	2014	72.23

#	Measure Name	Data Steward	Focus Area/Domain	Measure Definitions	Units	Data Source	Period	Rate, Mean (15+ or more Disch) for Illustration Only
12	Avoidable Admissions	3M	Utilization	Potentially Avoidable Admissions	Rate per 100 Admissions	NYSDOH (SPARCS)	2014	23.97
16	Pressure Ulcer Rate, Stage III or IV	National Quality Forum	Hospital Acquired Conditions	Stage III or IV pressure ulcers or unstageable (secondary diagnosis) per 1,000 discharges among surgical or medical patients ages 18 years and older	Rate per 1,000 discharges among surgical or medical patients ages 18 years and older	NYSDOH (SPARCS), PSI #03	2014	0.73
13	**Fibrinolytic Therapy Received with 30 minutes of ED Arrival (OP-2)**	**CMS**	**Timely and Effective Care**	**Outpatients with Chest Pain or Possible Heart Attack Who Got Drugs to Break Up Blood Clots Within 30 Minutes of Arrival (OP-2)**	**Percent Compliance**	**CMS**	**2016**	**78**
14	**Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3)**	**CMS**	**Timely and Effective Care**	**Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital**	**Minutes**	**CMS**	**2016**	**71.88**
15	**Median Time to ECG (OP-5)**	**CMS**	**Timely and Effective Care**	**Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG**	**Minutes**	**CMS**	**2016**	**10.2**

#	Measure Name	Data Steward	Focus Area/Domain	Measure Definitions	Units	Data Source	Period	Rate, Mean (15+ or more Disch) for Illustration Only
17	EDTC Emergency Department Transfer Communication (All or None)	NQF/ Stratis Health	Transitions of Care	Patients who are transferred from an ED to another healthcare facility have all necessary communication with the receiving facility within 60 minutes of discharge	Rate per 100 transfers	Stroudwater		TBD**

* This column's data is for illustration purposes only. Updated SPARCS and CMS data will be available and used to establish the mean NYS result (applicable to the DY4 AIT payment) by June 30, 2017 – before the start of the DY4 Measurement Period.

**This benchmark is currently unavailable and data will be released in the near future.

Refer to page 17 of the main Facility Guidance document for an explanation of achieved measures. Refer to page 19 and figure 8a of the main Facility Guidance document for information regarding the AIT performance period and payment timeline.