



Category 3 Progress Update

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1115 Transformation Waiver

- Category 3 Overview & Progress Update
- Overall Category 3 Success
- Success by Outcome
- Success by Project Area

Category 3 Overview

- Each DSRIP project must have at least one associated Category 3 outcome.
 - 2,111 active Category 3 selections
 - 251 standardized outcomes in use
 - \$805 Million P4P available in Category 3 in DY5
- Outcomes were selected by providers from a predefined menu developed with provider input and approved by CMS.
- Each outcome is related to a DSRIP project, but generally measures improvement at a level broader than the DSRIP project intervention.
- One DSRIP project can have more than one Category 3 outcome and providers may report the same outcome for multiple DSRIP projects.
- Most outcomes are Pay for Performance (P4P), some are Pay for Reporting (P4R). All P4P outcomes have achievement goals that must be met to earn payment.
- Providers can earn partial payment for achieving at least 25% of the goal for a given performance year.

Common Outcomes

- Outcomes include primary care, behavioral health, ED utilization, hospital readmissions, hospital infection rates, patient satisfaction, public health, quality of life measures, and others.
- Majority of outcomes are measured at a facility or system level. Roughly 10% are measured specific to a payer type.
- Most Common Outcomes:
 - IT-1.10: Diabetes: HbA1c >9% (25% of providers)
 - IT-1.7: Controlling High Blood Pressure (21% of providers)
 - IT-9.2: ED Visits for Ambulatory Care Sensitive Conditions (18% of providers)
 - IT-3.3: Risk Adjusted Congestive Heart Failure Readmission Rate (11% of Providers)

Category 3 Reporting Progress

- Baselines were reported in DY3, and are mostly six or twelve months of data set between the beginning of 2012 and the end of DY3, with the majority of outcomes using DY3 as their baseline measurement period.
- 88% of standard P4P outcomes have reported Performance Year 1 (PY1)
- 12% of P4P outcomes have reported Performance Year 2 (PY2)
- Performance will be reported for same outcomes through DY6

Analysis Considerations

- Numbers presented are preliminary
- Identical rates are reported for multiple projects/outcomes
- Comparability between projects
- Relationship between Category 1 or 2 project and Category 3
- Variety in measure selection and limited options for certain types of providers and projects
- Most P4P outcomes will report two years of performance under the current waiver. Some P4P outcomes (~10%) will report only one year of performance due to the timing of project approval and data collection. These outcomes are not included in PY1 analysis.
- Population Focused Priority Measures are not included at this time

Analysis Definitions

- **Success Rate:** Percent of P4P outcomes that earned payment for reporting at least 25% achievement of their goal, out of all P4P outcomes that reported.
- **Gap Closure:** Percent of gap closed in performance year between baseline and highest possible score.
- **Median Gap Closure:** Median percent of improvement between baseline and perfect for outcomes that have reported at least 25% achievement in a given reporting period.
- **High Achieving:** Percent of common outcomes with a gap closure above the median, out of all common outcomes that have reported at least 25% achievement of goal for a given reporting period.

Category 3 Success Rate

Provider Type	P4P Outcomes	P4P reporting PY1	Success Rate PY1	P4P Reporting PY2	Success Rate PY2
All Providers	1723	1376	81%	228	84%
Hospital	1115	900	79%	183	85%
Academic Health Science Center (AHSC)	212	172	76%	29	-
Community Mental Health Center (CMHC)	292	217	91%	8	-
Local Health Department (LHD)	103	86	90%	8	-

Outcome Domain		P4P Reporting PY1	PY1 Success Rate
1	Primary Care & Chronic Disease Management	395	83%
2	PPAs - Potentially Preventable Admissions	15	67%
3	PPRs - Potentially Preventable Readmissions	128	80%
4	PPCs, Healthcare Acquired Conditions, Patient Safety	45	87%
5	Cost of Care	12	67%
6	Patient Satisfaction	128	67%
7	Oral Health	24	92%
8	Perinatal Outcomes and Maternal Child Health	49	78%
9	Right Care, Right Setting	211	79%
10	Quality of Life/Functional Status	90	91%
11	Behavioral Health/Substance Abuse	81	88%
12	Primary Prevention	125	78%
13	Palliative Care	51	92%
14	Healthcare Workforce*	NA	NA
15	Infectious Disease Management	22	82%

**all outcomes in OD-14 are Pay for Reporting*

Selected Category 3 Outcomes

Standalone P4P outcomes with at least 10 P4P outcomes reporting PY1, excluding surveys and tools in ODs 6, 10, and 11

Outcome		P4P Reporting PY1	Success Rate	Median Gap Closure
IT-1.10	Diabetes Care: HbA1c Poor Control (>9.0%) (NQF 0059)	84	74%	17%
IT-1.7	Controlling High Blood Pressure (NQF 0018)	57	84%	11%
IT-9.2	ED Visits for Ambulatory Care Sensitive Conditions	47	66%	7%
IT-3.22	Risk Adjusted All-Cause 30-Day Readmissions	52	75%	10%
IT-3.3	Risk Adjusted CHF 30-Day Readmissions	35	77%	20%
IT-1.11	Diabetes Care: BP Control (<140/90mm Hg) (NQF 0061)	22	77%	13%
IT-9.1	Mental Health Admissions to Criminal Justice Setting	14	93%	47%
IT-1.18	Follow-Up After Hospitalization for Mental Illness (NQF 0576)	24	100%	12%
IT-9.2.a	ED Visits per 100,000	19	63%	3%
IT-9.4.e	ED Visits for Behavioral Health/Substance Abuse	18	72%	11%
IT-2.21	Ambulatory Care Sensitive Conditions Admissions Rate	15	67%	13%
IT-9.4.b	ED Visits for Diabetes	15	93%	16%
IT-4.10	Sepsis Bundle (NQF 0500)	10	90%	9%
IT-1.22	Asthma Percent of Opportunity Achieved	15	87%	25%
IT-3.5	Risk Adjusted Diabetes 30-Day Readmissions	14	79%	17%
IT-9.10	ED Throughput Measure Bundle (NQF 0495, 0496, 0497)	11	100%	10%
IT-8.19	Post-Partum Follow-Up and Care Coordination	11	91%	35%
IT-8.2	Percentage of Low Birth- Weight Births (NQF 1382)	11	82%	20%
IT-3.15	Risk Adjusted BH/Substance Abuse 30-Day Readmissions	10	100%	21%
IT-9.3	Pediatric ED Visits for ACSC	11	100%	33%

IT-1.10: Diabetes HbA1C >9% (NQF 0059)

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	106	43.92%		
PY1	87	35.88%	74%	17%
PY2	9	-	100%	23%

- Reported by Hospitals, AHCSs, CMHCs, and LHDs
- Most Common Project Areas:
 - 2.2 Expand Chronic Care Management Models
24 reported PY1, 88% success rate, 12% median gap closure
 - 1.1 Expand Primary Capacity
18 reported PY1, 56% success rate, 17% median gap closure
 - 2.1 Enhance Expand Medical Homes,
8 reported PY1, 100% success rate, 20% median gap closure
 - 1.3 Implement a Chronic Disease Registry
8 reported PY1, 88% success rate, 14% median gap closure

IT-1.7: Controlling High Blood Pressure (NQF 0018)

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	71	57.09%		
PY1	57	64.33%	84%	11%
PY2	7	-	100%	19%

- Reported by Hospitals, AHCSs, CMHCs, and LHDs
- Most Common Project Areas:
 - 1.1 Expand Primary Care Capacity
26 reported PY1, 81% success rate, 5% median gap closure
 - 2.15 Integrate Primary Care/Behavioral Health
11 reported PY1, 91% success rate, 42% median gap closure
 - 2.2 Expand Chronic Care Management Models
4 reported PY1, 100% success rate, 26% median gap closure
- CMHC providers have 92% success rate, and 24% median gap closure in PY1

IT-9.2: Reduce ED Visits for Ambulatory Care Sensitive Conditions

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	63	21.57%		
PY1	48	19.91%	66%	7%
PY2	11	25.00%	82%	12%

- Reported by Hospitals, AHCSs, CMHCs, and LHDs
- Most Common Project Areas:
 - 1.1 Expand Primary Care Capacity
17 reported PY1, 47% success rate, 4% median gap closure
 - 2.9 Patient Care Navigation
17 reported PY1, 71 % success rate, 8% median gap closure

IT-3.22: Risk Adjusted All-Cause Readmissions

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	56	1.0353		
PY1	52	0.9466	75%	10%
PY2	25	0.8953	88%	15%

- Reported by Hospitals only
- Most Common Project Areas:
 - 2.12 Care Transitions Programs
16 reported PY1, 50% success rate, 13% median gap closure
 - 1.1 Expand Primary Care Capacity
6 reported PY1, 83% success rate, 8% median gap closure
 - 1.3 Enhance Interpretation Services & Culturally Competent Care
3 reported PY1, 100% success rate, 11% median gap closure
 - 1.4 Chronic Disease Management Registry
4 reported PY1, 75% success rate, 8% median gap closure

IT-9.1: Criminal Justice Admissions

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	32	28.76%		
PY1	18	16.15%	93%	47%
PY2	0	-	-	-

- Reported by AHSCs, CMHCs, and LHDs
- Most Common Project Areas:
 - 2.13 Targeted Behavioral Health Intervention
9 reported PY1, 89% success rate, 47% median gap closure
 - 1.13 Behavioral Health Crisis Stabilization
4 reported PY1, 100% success rate, 20% median gap closure
- Measure developed for DSRIP by DSHS and requires data from local jails

IT-1.18: Follow-Up After Hospitalization for Mental Illness (NQF 0576)

Year	Reported	Rate Part	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	30	7 Day	45.55%		
		30 Day	54.22%		
PY1	24	7 Day	56.40%	100%	12%
		30 Day	63.96%	96%	13%
PY2	0		-	-	-

- Reported by Hospitals, AHCSs, CMHCs, and LHDs
- Most Common Project Areas:
 - 1.13 Behavioral Health Crisis Stabilization Services
4 reported PY1, 100%/75% success rate, 28%/23% median gap closure
 - 2.13 Targeted Behavioral Health Intervention
5 reported PY1, 100%/100% success rate, 10%/5% median gap closure
 - 1.4 Enhance Interpretation Services & Culturally Competent Care
4 reported PY1, 100%/100% Success Rate, 16%/19% median gap closure

IT-9.4.b: Reduce ED Visits for Diabetes

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	23	10.51%		
PY1	15	8.21%	93%	16%
PY2	2	-	-	-

- Reported by Hospitals & AHCSs
- Most Common Project Areas:
 - 2.9 Patient Care Navigation
8 reported PY1, 88% success rate, 12% median gap closure

IT-8.2: Percent of Low Birth-Weight Births (NQF 1382)

Year	Reported	Average Rate	Success Rate (P4P)	Median Gap Closure (P4P)
Baseline	14	8.33%		
PY1	12	6.79%	82%	20%
PY2	2	-	-	-

- Reported by Hospitals & LHDs
- Most Common Project Areas:
 - 1.9 Expand Specialty Care Capacity
5 reported PY1, 80% success rate, 13% median gap closure
 - 1.1 Expand Primary Care Capacity
3 reported PY1, 100% success rate, 25% median gap closure

Category 3 by Project Area

Project Area	Cat 1 or 2 Projects	P4P Reporting PY1	PY1 Success Rate	High Achieving
1.1: Expand Primary Care Capacity	221	265	73%	46%
1.7: Introduce/Enhance Telemedicine/Telehealth	47	40	78%	50%
1.9: Expand Specialty Care Capacity	133	118	78%	44%
1.12: Enhance Service Availability for Behavioral Health	77	57	89%	48%
1.13: Behavioral Health Crisis Stabilization Services	53	32	91%	41%
2.1: Enhance/Expand Medical Homes	40	55	89%	44%
2.2: Expand Chronic Care Management Models	76	85	85%	48%
2.6: Evidence-Based Health Promotion Programs	57	48	83%	58%
2.7: Evidence-Based Disease Prevention Programs	65	66	82%	44%
2.9: Patient Care Navigation	91	81	79%	42%
2.10: Use of Palliative Care Programs	28	54	91%	49%
2.11: Conduct Medication Management	30	31	90%	58%
2.12: Care Transitions Programs	59	49	65%	48%
2.13: Targeted Behavioral Health Intervention	115	50	92%	47%
2.15: Integrate Primary Care/Behavioral Health	53	44	93%	63%

1.1 Expand Primary Care Capacity

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
1.1 Expand Primary Care Capacity	265	73%	46%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-1.7 Controlling High Blood Pressure	26	81%	5%
IT-9.2 Reduce ED Visits for ACSC	17	47%	4%
IT-1.10 HbA1c Poor Control (>9.0%)	18	56%	17%
IT-12.1 Breast Cancer Screening	12	67%	19%

1.9 Expand Specialty Care Capacity

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
1.9 Expand Specialty Care Capacity	118	78%	49%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-1.1 Third Next Available Appointment	11	73%	26%
IT-1.10 Diabetes Care: HbA1c Control (>9%)	3	100%	9%
IT-1.22 Asthma Percent Opportunity Achieved	7	86%	28%
IT-3.3 Risk Adjusted CHF 30-Day Readmission Rate	5	80%	28%

2.1 Enhance/Expand Medical Homes

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
2.1 Enhance/Expand Medical Homes	55	89%	44%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-1.10 Diabetes Care: HbA1c Poor Control (>9%)	8	100%	20%
IT-1.13 Diabetes Care: Foot Exam	4	100%	52%
IT-1.20 Diabetes Care: LDL Screening	4	100%	51%
IT-1.12 Diabetes Care: Retinal Eye Exam	4	75%	24%

2.2 Expand Chronic Care Management Models

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
2.2 Expand Chronic Care Management Models	85	85%	48%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-1.10 Diabetes HbA1c Poor Control (>9%)	24	88%	12%
IT-3.3 Risk Adjusted CHF 30-Day Readmission	7	71%	28%
IT-1.11 Diabetes Care: BP Control (<140/90 mm Hg)	5	100%	10%
IT-1.13 Diabetes Care: Foot Exam	6	67%	29%

2.10 Use of Palliative Care Programs

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
2.10 Use of Palliative Care Programs	54	91%	49%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-13.5 Discussion of Spiritual/Religious/Existential Concerns	15	93%	55%
IT-13.2 Treatment Preferences	13	100%	40%
IT-13.1 Pain Assessment	7	100%	31%
IT-13.4 Proportion Admitted to ICU in Last 30 Days of Life	8	50%	21%
IT-13.6 Interdisciplinary Family Meeting within 5 days of Admission to the ICU	6	100%	12%
IT-13.3 More than One Emergency Room Visit in the Last 30 Days of Life	2	100%	28%

2.12 Care Transitions

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
2.12 Care Transitions	49	65%	48%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-3.22 Risk Adjusted All-Cause Readmissions	16	50%	13%
IT-3.3 Risk Adjusted CHF Readmissions	6	83%	17%
IT-9.2 Reduce ED Visits for ACSC	3	67%	7%

2.15 Integrate Primary and Behavioral Health Care Services

Project Area	P4P Outcomes Reported	PY1 Success Rate	High Achieving
2.15 Integrated Primary Care/Behavioral Health Care	44	93%	63%

Outcome	P4P Outcomes Reported	PY1 Success Rate	Median Gap Closure
IT-1.7 Controlling High Blood Pressure	11	91%	42%
IT-1.10 Diabetes Care: HbA1c Control (>9%)	4	75%	67%
IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression	4	100%	32%
IT-11.26.e.i PHQ-9	4	100%	14%

How HHSC & Providers Can Use Aggregate Category 3 Data

- One way to identify strong projects and project areas
- Facilitating sharing of best practices between providers
- Planning for DY6 and DY7 – DY10
- MCO Performance Improvement Projects & alignment with Medicaid Managed Care
- Informing statewide analysis

Additional Resources

- [Reported Category 3 Outcomes – All RHPs & DSRIP Tableau Dashboard](#)
- [Category 3 Measure Specifications](#)

“The goal is to reduce readmissions, but more than that, it’s driven by the desire to do the right thing for the patient”

*- Charlene Dawson, Director of Pharmacy,
Medical Center Hospital, RHP 14*