



Division of
**Health Care
Finance & Administration**

Health Care
Innovation Initiative

A large, light gray graphic consisting of a circle containing three five-pointed stars arranged in a triangular pattern.

Executive Summary

**Inpatient Urinary Tract Infection Episode
Corresponds with DBR and Configuration file V1.1**

Updated: January 11, 2017

OVERVIEW OF AN INPATIENT URINARY TRACT INFECTION (UTI) EPISODE

The inpatient urinary tract infection (UTI) episode revolves around patients who are diagnosed with a UTI in an observation or inpatient setting. The trigger event is an observation stay or inpatient admission where the primary diagnosis is UTI. In addition, a trigger event can be an observation stay or inpatient admission where the primary diagnosis is septicemia and a secondary diagnosis is UTI. All related care – such as imaging and testing, evaluation and management, and medications – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the facility where the inpatient UTI was ultimately treated. The inpatient UTI episode begins on the day of the triggering visit with a triggering diagnosis and ends 30 days after discharge.

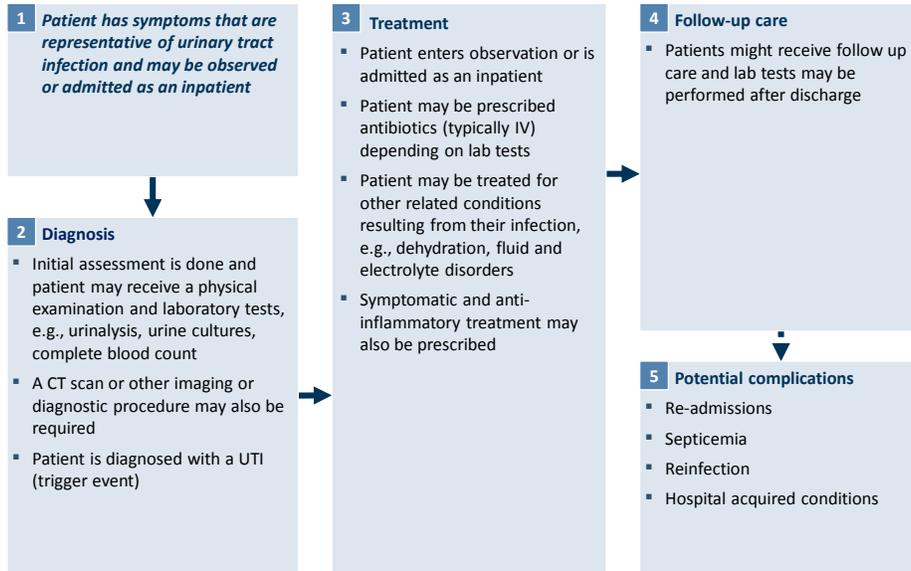
CAPTURING SOURCES OF VALUE

Providers have multiple opportunities during an inpatient UTI episode to improve the quality and cost of care. Example sources of value include the effective use of imaging and testing, and the appropriate length and setting of care (observation or inpatient). Additionally, providers should select the most appropriate initial antibiotic based on culture results when indicated. Providers can also facilitate care coordination after discharge to influence the patients' behavior and compliance to avoid repeat infections, readmissions, and other complications.

To learn more about the episode's design, please reference the following documents on our website at www.tn.gov/hcfa/topic/episodes-of-care:

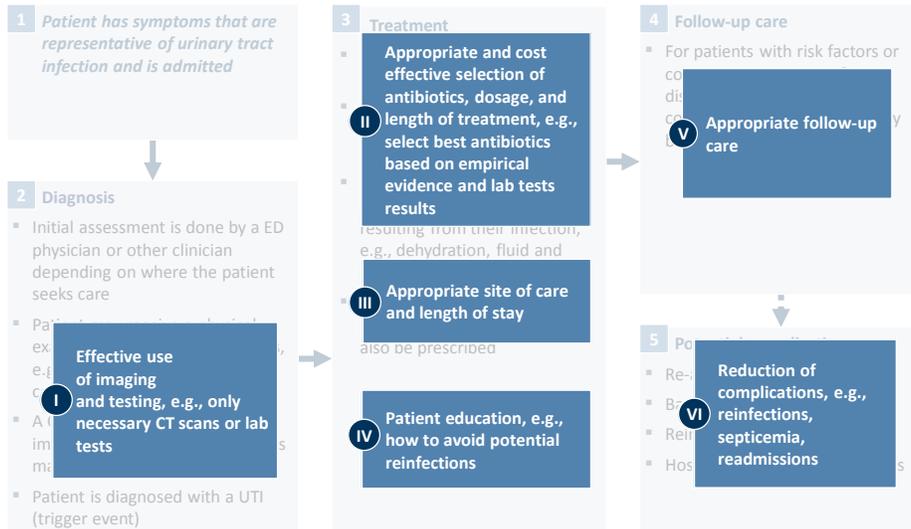
- *Detailed Business Requirements: Complete technical description of the episode*
<http://www.tn.gov/assets/entities/hcfa/attachments/DBRUTIInpatient.pdf>
- *Configuration File: Complete list of codes used to implement the episode*
<http://www.tn.gov/assets/entities/hcfa/attachments/ConfieUTIInpatient.xlsx>

Illustrative Patient Journey



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Potential Sources of Value



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ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the inpatient UTI episode, the quarterback is the facility where the inpatient UTI was treated. The contracting entity of the facility will be used to identify the quarterback.

MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Inclusion of only the cost of services and medications that are related to the inpatient UTI in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The inpatient UTI episode has no pre-trigger window. During the trigger window, all services and all medications are included. The post-trigger window includes care for specific complications, specific evaluation and management visits, specific imaging and testing, specific medications, and specific surgical and medical procedures.

Some exclusions apply to any type of episode, i.e., are not specific to an inpatient UTI episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Other examples of exclusion criteria specific to the inpatient UTI episode include a patient who has end stage renal disease (ESRD) or an organ transplant. These patients have significantly different clinical courses that cannot be risk adjusted. Furthermore, there may be

some factors with a low prevalence that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of inpatient UTI episodes with factors likely to be impacted by risk adjustment include those patients with a history of diseases of bladder or urethra, diseases of kidneys and ureters, or liver diseases. Over time, a payer may adjust risk factors based on new data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metric linked to gain sharing for the inpatient UTI episode is:

- **Follow-up care within the post-trigger window:** Percent of valid episodes where the patient receives relevant follow-up care within the post-trigger window (higher rate indicative of better performance).

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Follow-up care within the first seven days of post-trigger window:** Percent of valid episodes where the patient receives relevant follow-up care within the first seven days of the post-trigger window (higher rate indicative of better performance).
- **Emergency department visit within the post-trigger window:** Percent of valid episodes with a relevant ED visit within the post-trigger window (lower rate indicative of better performance).

- **Admission within the post-trigger window:** Percent of valid episodes with a relevant admission or observation care within the post-trigger window (lower rate indicative of better performance).
- **Follow-up visit versus emergency department visit:** Percent of valid episodes with the first visit being a relevant follow-up visit within the post-trigger window, for valid episodes that had any post-trigger window visits (higher rate indicative of better performance)
- **Pseudomembranous colitis within the post-trigger window:** Percent of valid episodes with pseudomembranous colitis occurring within the post-trigger window (lower rate indicative of better performance).

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.