HOSPITAL

QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

2021-2022

MEASUREMENT YEAR

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PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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PROGRAM OVERVIEW

Partnership HealthPlan of California (PHC) has value-based programs in the areas of primary care, hospital care, long-term care, community pharmacy, palliative care, perinatal care, specialty care and behavioral health. These value-based programs align with PHC's organizational mission to help our members and the communities we serve be healthy.

The Hospital Quality Improvement Program (Hospital QIP), established in 2012, offers substantial financial incentives for hospitals that meet performance targets for quality and operational efficiency. The measurement set was developed in collaboration with hospital representatives and includes measures in the following domains:

- Readmissions
- Advance Care Planning
- Clinical Quality: Obstetrics/Newborn/Pediatrics
- Patient Safety
- Operations/Efficiency
- Patient Experience

Measure Development

The Hospital QIP uses a set of comprehensive and clinically meaningful quality metrics to evaluate hospital performance across selected domains proven to have a strong impact on patient care. The measures and performance targets are developed in collaboration with providers and are aligned with nationally reported measures and data from trusted healthcare quality organizations, such as the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), and the Joint Commission. Annual program evaluation and open channels of communication between Hospital QIP and key hospital staff guide the measurement set development. This measurement set is intended to both inform and guide hospitals in their quality improvement efforts.

PARTICIPATION REQUIREMENTS

Hospitals with at least 50 licensed general acute beds report on the *Large Hospital Measurement Set*. Hospitals with fewer than 50 licensed, general acute beds report on the Small Hospital Measurement Set. Other requirements include:

a) Contracted Hospital

Hospital must have a PHC contract within the first three months of the measurement year (by October 1) to be eligible. Hospital must remain contracted through June 30, 2022, to be eligible for payment. Participation will require signing a contract amendment, as specified by the PHC Provider Contracting team, to participate in the 2021-2022 Hospital QIP. Hospitals that are invited to participate must be in Good Standing with state and federal regulators as of the month the payment is to be disbursed. In addition, PHC has the sole authority to further determine if a provider is in Good Standing based on the criteria set forth below:

1. Provider is open for services to PHC members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, PHC will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against PHC.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with PHC on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following PHC policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement or overbilling.
9. Provider is not conducting other activities adverse to the business interests of PHC.

PARTICIPATION REQUIREMENTS (continued)

b) HIE and EDIE Participation

Health Information Exchange (HIE) & Emergency Department Information Exchange (EDIE) **participation is a pre-requisite to joining the Hospital QIP.** Electronic HIE allows doctors, nurses, pharmacists, and other health care providers to appropriately access and securely share a patient's vital medical information electronically. HIE interface has been associated with not only an improvement in hospital admissions and overall quality of care, but also with other improved resource use: studies found statistically significant decreases in imaging and laboratory test ordering in EDs directly accessing HIE data. In one study population, HIE access was associated with an annual cost savings of $1.9 million for a hospital. Three different classes of HIE are available to hospitals, each with its own benefit for the patient and the health care delivery system:

1. Community HIE: Gathers data for patients from several community sources and integrates that data. Allows access to longitudinal patient information and search functionality for a specific data element without having to access and open a series of CCDA documents. Allows set up of alerts and notifications.

2. EDIE: Allows continuity of critical information on ED use across multiple states.

3. National HIE networks: Allows query of distant data sources, including national data (Social security, VA system).

Requirements apply to all hospitals and are as follows:

1. Hospitals with an existing community HIE interface will maintain ADT plus either an HL7 interface or a XDS interface with one of the following community HIEs:

    - Sac Valley Med Share
    - North Coast Health Information Network

2. ADT interface with EDIE (direct with CMT, or through another HIE).

3. Active link to one of the following national HIE networks (directly, or through another HIE):

    - CareQuality,
    - eHealth Exchange, or
    - Commonwell

PARTICIPATION REQUIREMENTS (continued)

Incentive Impact/Component Requirements:

- 100% of eligible dollars
  Community HIE interface with ADT plus HL7 or XDS; link to national network; and interface with EDIE available by June 30, 2022

- 90% of eligible dollars
  One or more of community HIE interface with ADT plus HL7 or XDS; link to national network; and interface with EDIE available not active on June 30, 2022, but all available by September 30, 2022

- 85% of eligible dollars
  Community HIE interface with ADT (but without HL7 or XDS interface); link to national network; and interface with EDIE available active by September 30, 2022.

- 75% of eligible dollars
  Two of three interfaces active by September 30, 2022.

- 50% of eligible dollars
  One of three interfaces completed by September 30, 2022.

- 0% of eligible dollars
  None of three interfaces completed by September 30, 2022.

This requirement will be satisfied upon hospital submission of Implementation Plan (available in Appendix I), and verification of participation by PHC with the vendor. By participating in the Hospital QIP, hospitals authorize vendors from community HIEs and Collective Medical Technologies to inform PHC of their participation status with the vendor:

Item	Completed by	When
Information Exchange Implementation or Maintenance	Hospitals	October 31, 2021
EDIE participation verification	PHC	August 31, 2022

PARTICIPATION REQUIREMENTS (continued)

c) Capitated Hospitals Only: Utilization Management Delegation

1. From July 1, 2021 to June 30, 2022, Hospitals must utilize Collective Plan (module of Collective Medical Technology's EDIE, for their capitated members to alert their internal Utilization Management team to out of network admissions.

2. Capitated hospitals must submit timely* and accurate delegation deliverables to Partnership HealthPlan according to deadlines outlined in your hospital's delegation agreement in order to receive the full Hospital QIP incentive payment. Deliverables include timely and accurate reporting of 1) Utilization Program Structure and 2) delegation reporting requirements indicated in Exhibit A of your hospital's delegation agreement. Impact of this requirement is as follows:

    - Timely submitting $\geq$ 90.0% of delegation reporting requirements results in 100% distribution of earned Hospital QIP incentive payment.
    - Timely submitting $\geq$ 75.0% and < 90.0% of delegation reporting requirements results in a 10% cut from the earned Hospital QIP incentive payment.
    - Timely submitting < 75.0% of delegation reporting requirements results in a 20% cut from the earned Hospital QIP incentive payment.

All reporting requirements and written Utilization Program Structure may be sent to DelegationOversight@partnershiphp.org.

*Timely reporting means the deliverables were submitted by the deadline noted in the agreement.

Performance Methodology

Participating hospitals are evaluated based on a point system, with points being awarded when performance meets or exceeds the threshold listed for each measure (outlined in specifications). Select measures present the opportunity for hospitals to earn partial points, with two distinct thresholds for full and partial points. Each hospital has the potential to earn a total of 100 points. If measures are not applicable (for example, maternity measures for a hospital with no maternity services), the points for the non-applicable measures are proportionately redistributed to the remaining measures.

Rounding Rules: The target thresholds are rounded to the nearest 10th decimal place.

Payment Methodology

The Hospital QIP incentives are separate and distinct from a hospital's usual reimbursement. Each hospital's potential earning pool is aside from their payment, and paid out at the end of the measurement year according to the number of points earned. The bonus funds are specific to each facility and will only be paid out to the extent points are awarded. Year-end payments will be mailed by October 31 following the measurement year.

Payment Dispute Policy

Hospital QIP participants will be provided a preliminary report that outlines final performance for all measures except Readmissions before final payment is distributed (see item 1 below). If during the Preliminary Report review period a provider does not inform PHC of a calculation or point attribution error that would result in potential under or over payment, the error may be corrected by PHC post-payment. This means PHC may recoup overpaid funds any time after payment is distributed. Aside from this, post-payment dispute of final data described below will not be considered:

1. **Data reported on the Year-End Preliminary Report**
   At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the final point earnings for all measures except Readmissions. Providers will be given one week, hereon referred to as the Preliminary Report review period, to review this report for performance discrepancies and calculation or point attribution errors. Beyond this Preliminary Report review period, disputes will not be considered.

2. **Hospital Designation**
   The Hospital QIP is comprised of two measurement sets: one for large hospitals, and one for small hospitals. The large hospital measurement set lists required measures for hospitals with at least 50 licensed, general acute (LGA) beds. The small hospital measurement set lists required measures for hospitals with less than 50 LGA beds. Each hospital's performance will be calculated based on which measurement set they fall under, with bed counts retrieved from the California Department of Public Health. Providers may confirm their designated hospital size with the QIP team at any point during the measurement year, and post-payment disputes regarding bed counts will not be considered.

3. **Thresholds**
   Measure thresholds can be reviewed in the Hospital QIP measurement specifications document throughout the measurement year. The Hospital QIP may consider adjusting thresholds mid-year based on provider feedback. However, post-payment disputes related to thresholds cannot be accommodated.

Should a provider have a concern that does not fall in any of the categories above (i.e. the score on your final report does not reflect what was in the Preliminary Report), a Payment Dispute Form must be requested and completed within 60 days of receiving the final statement. All conversations regarding the dispute will be documented and reviewed by PHC. All payment adjustments will require approval from PHC's Executive Team.

REPORTING TIMELINE

The Hospital QIP runs on an annual program period, beginning July 1 and ending June 30. While data reporting on most measures follows this timeline, exceptions are made in order to align with national reporting done by participants. Preliminary Reports for all measures are provided in September following the measurement year, and Final Reports are provided at the end of October following the measurement year. Please see the reporting summary below:

Table 2. 2021-2022 Large Hospital QIP Reporting Timeline for Performance Measurement Period of July 1, 2021 thru June 30, 2022

Measure/ Requirement	Hospital Reporting	PHC Reporting to Hospital *(outside of final reports)*	Max Points
HIE and EDIE Participation	Status due June 30, 2022 to PHC	N/A	N/A
Delegation Reporting	Refer to Delegation Agreement Exhibit A	N/A	N/A
Risk Adjusted Readmissions	No reporting necessary. PHC utilizes claims data to measure performance.	Interim Reporting Available Spring of 2022	20
Palliative Care Capacity	August 31, 2022 to PHC	N/A	10
Elective Delivery	Monthly reporting to CMQCC	N/A	5
Exclusive Breast Milk Feeding	Monthly reporting to CMQCC	N/A	5
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	Monthly reporting to CMQCC	N/A	5
Vaginal Birth After Cesarean	Monthly reporting to CMQCC	N/A	5
QI Capacity	Registration and attendance of *at least* one hospital staff at PHC's 2022 Hospital Quality Symposium	N/A	5
California Hospital Patient Safety (CHPSO)	Report to CHPSO	Interim Report: March 31, 2022	5

Substance Abuse Referral	No reporting necessary. PHC utilizes claims data to measure performance.	Interim Reporting Available Spring of 2022	10
Hepatitis B/ CAIR Utilization	**Maternity Hospitals:** No reporting necessary (PHC will access CAIR data) **Non Maternity Hospitals:** Submit CAIR report by August 31, 2022	N/A	10
Cal Hospital Compare-Patient Experience	No reporting necessary. PHC utilizes Cal Hospital Compare data to measure performance.	N/A	10
Health Equity	Part I: Project Plan, August 31, 2021 Part II: Summary of project, August 31, 2022	PHC will provide approval status of Part I, Project Plan Submission by September 15, 2021	5
Sexual Orientation/Gender Identity (SOGI) EHR	August 31, 2022 to PHC	N/A	5

2021-2022 LARGE HOSPITAL SUMMARY OF MEASURES

Table 3. Summary of Measures

Measure	Target/Points
Community HIE and EDIE Interface (*Required*)	
• All hospitals must complete or maintain Admission, Discharge, and Transfer (ADT) interface with a community HIE, a national HIE network, and EDIE interface as of the end of MY, and demonstrate use of this interface by the end of the measurement year, June 30, 2022.	All hospitals must complete Admission, Discharge, and Transfer (ADT) interface with a community HIE and EDIE interface by the end of MY. For capitated hospitals only: 3. Hospitals must use Collective Plan module of Collective Medical Technology's EDIE, to generate alerts for out of network inpatient admissions for their capitated members.
Risk Adjusted Readmission (20 points)	
• Risk Adjusted Readmissions for all hospitalized PHC patients	• Full Points = 20 points <1.0 Full Points • Partial Points = 10 points ≥1.0 - 1.2
Advance Care Planning (10 points)	
• Palliative Care Capacity	• Full Points = 10 points All of the following: – Part 1: Minimum of 10 patients – Part 2: >40% – Part 3: >40% • Partial Points = 5 points All of the following: – Part 1: Minimum of 5 patients – Part 2: >25% – Part 3: >25% Option for 50-99 bed hospitals: Inpatient palliative care capacity: at least two trained* Licensed Clinicians (RN, NP, or PA), and availability of video or in-person consultation with a Palliative Care Physician.

Clinical Quality: OB / Newborn / Pediatrics (20 points)	
For all maternity care measures, hospitals must timely* submit data to California Maternal Quality Care Collaborative (CMQCC). Hospitals must authorize PHC to receive data from CMQCC by completing the authorization form available on the Maternal Data Center. **For hospitals new to CMQCC**: Legal agreement executed by September 30. First data submission for months of July - October due by December 15, 2021. Timely data submission for each month after that, beginning in January of the Measurement Year. **For hospitals already participating in CMQCC**: 12 months of timely data submission for each month during the measurement year. *Per CMQCC, timely submissions are defined as those submitted within 45 to 60 days after the end of the month.	
• Rate of Elective Delivery Before 39 Weeks	• Full Points: ≤ 1.0% = 5 points • Partial Points: >1.0 – 2.0% = 2.5 points
• Exclusive Breast Milk Feeding Rate at Time of Discharge from Hospital for all Newborns	• Full Points: ≥ 75.0% = 5 points • Partial Points: 70.0% - < 75.0% = 2.5 points
• Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	• Full Points: < 21.7% = 5 points • Partial Points: ≥ 22.0% - 23.6% = 2.5 points
• Vaginal Birth After Cesarean (VBAC)	• Full Points: ≤ 5% = 5 points • No partial points available
Patient Safety (15 points)	
• California Hospital Patient Safety Organization (CHPSO) Participation	• Full Points = 5 points – Submit 100 events – Attend 4 Safe Table Forums • No partial points available
• Substance Use Disorder Referrals from Emergency Department	• Full Points: 10 PHC Members = 10 points • No partial points available
Operations/Efficiency (15 points)	
• Hepatitis B/ CAIR Utilization	Hospitals With Maternity Services: • Full Points: > 20% = 10 points • Partial Points: 10 - ≥ 20% = 5 points Hospitals Without Maternity Services: • Full Points: Ratio >1.20 = 10 points • Partial Points: Ratio 0.20 to 1.20 = 5 points

• QI Capacity	• Full points = 5 Attendance at PHC's 2022 Hospital Quality Symposium. • No partial points available
Patient Experience (20 Points)	
• Cal Hospital Compare-Patient Experience	• Full Points = 10 Patient Experience hospital composite score is greater than Average California Hospital score * 0.95 • No partial points available
• Health Equity	• Full points = 5 Submission of hospital plan (best practice) for addressing health equity and written project summary. • No partial points available
• Sexual Orientation and Gender Identity (SOGI) EHR	• Full points = 5 This measure is continuance of the SO/GI EHR Implementation plan submitted by hospitals in 2020-21. Providers will implement this plan on July 1, 2021, and complete all steps noted in the previously submitted implementation plan by the end of this measurement year. • No partial points available

2021-2022 MEASURE SET SPECIFICATIONS

Measure 1. *Risk Adjusted Readmissions*

A readmission occurs when a patient is discharged from a hospital and then admitted back into a hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d). Inclusion of this measure and benchmark determination is supported in alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768).

Measure Summary

For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays* (denominator)
- Observed Readmissions: Count of 30-Day readmissions (numerator)
- Expected Readmissions: Sum of adjusted readmission risk (numerator)
- Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year

Target

<1.0 Full Points

≥1.0 - 1.2 for Partial Points

Measurement Period

July 1, 2021 – June 30, 2022

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between July 1 and June 1 of the measurement by members age 18 to 64 years of age continuously enrolled for at least 90 days prior admission date and 30 days after admission date.

Numerator

Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 3 and June 30 of the measurement year by PHC members included in the denominator.

Calculation:

$$\text{Observed 30 Day Readmissions Rate} = \frac{\text{Observed 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$$

Note: Inpatient stays where the discharge date from the first setting and admission date to the second setting must be two or more days apart and considered distinct inpatient stays.

Expected 30-Day Readmission**:** An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

Calculation:

$$\text{Expected 30 Day Readmissions Rate} = \frac{\text{Expected 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$$

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

Exclusions

Exclusions for Numerator and Denominator:

- Discharges for death
- Pregnancy condition
- Perinatal condition
- Stays by members with 4 or more index admissions in the measurement year

Exclusions for Numerator:

- Planned admission using any of the following:
  - Chemotherapy
  - Rehabilitation
  - Organ Transplant
  - Planned procedure without a principal acute diagnosis

Reporting

No reporting by hospital to PHC is required. Note for capitated hospitals: the readmission rate used for this measure is based on all PHC adult members (ages 18-64) admitted to the hospital, whether they are capitated or not.

Measure 2. *Palliative Care Capacity*

Palliative care is specialized medical care for people with serious illness, focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for the patient and his/her family by identifying, assessing, and treating pain and other physical, psychosocial, and spiritual problems. Studies show that patients who receive palliative care have improved quality of life, feel more in control, are able to avoid risks associated with treatment and hospitalization, and have decreased costs with improved utilization of health care resources.[7-9]

Measure Requirements

Hospitals ≥100 beds will require Palliative Care Quality Collaborative (PCQC) participation:

Required to provide the following to PHC:

Part 1. Hospitals must submit a report summarizing the number of palliative care consults per month for the measurement year July 1, 2021 – June 30, 2022. Hospitals can send report including all consults in PCQC, not just PHC members.

Part 2. Rate of consults who have completed an Advance Care Directive:

- **Numerator**: Anyone with an Advance Directive status in PCQC at either the time of consult ***or*** the time of discharge.
- **Denominator:** Patients with a palliative care consult recorded in PCQC, discharged alive from July 1, 2021 – June 30, 2022.

Part 3. Rate of Consults who have a signed POLST:

- **Numerator**: Anyone with a POLST status on chart at either the time of consult ***or*** the time of discharge.
- **Denominator**: Patients with a palliative care consult recorded in PCQC, discharged alive from hospital from July 1, 2021 – June 30, 2022.

Hospitals 50-99 beds: Inpatient palliative care capacity: at least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician (option for hospitals with less than 100 beds).

Target

Thresholds for Full and Partial Points TBD.

Measurement Period

July 1, 2021 – June 30, 2022

Exclusions

No exclusions.

Reporting

Annual reporting, submit by August 31, 2022 to PHC at HQIP@partnershiphp.org.

Maternity Care Measures

Measures 3-6 Data Submission Instructions: Hospitals must submit timely* data to California Maternal Quality Care Collaborative. Hospitals must authorize PHC to receive data from CMQCC by completing the authorization form available on the Maternal Data Center.

For hospitals new to CMQCC: Legal agreement executed by September 30 of the HQIP Measurement Year. First data submission for months of July - October due to CMQCC by December 15, 2021. Timely data submission for each month after that, beginning in January of the Measurement Year.

For hospitals already participating in CMQCC: 12 months of timely data submission for each month during the measurement year.

*Per CMQCC, timely submissions are defined as those submitted within 45-60 days after the end of the month.

Measure 3. *Elective Delivery before 39 Weeks*

Elective delivery is defined as a non-medically indicated, scheduled cesarean section or induction of labor before the spontaneous onset of labor or rupture of membranes.[10] It has been found that compared to spontaneous labor, elective deliveries result in more cesarean births and longer maternal lengths of stay.[11] Repeated elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis, and hypoglycemia for the newborns.[12] The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) has consistently placed a standard requiring 39 completed weeks gestation prior to elective delivery, either vaginal or operative, for over 30 years.[13-15] Even with these standards in place, a 2007 survey of almost 20,000 births in HCA hospitals throughout the U.S. estimated that 1/3 of all babies delivered in the United States are electively delivered, with an estimated 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and can result in significant short term neonatal morbidity.[16]

Measure Summary

Percent of patients with newborn deliveries at ≥ 37 to < 39 weeks gestation completed, with an elective delivery within the Measurement Year.

Target

- Full Points: ≤ 1.0% = 5 points
- Partial Points: > 1.0% - 2.0% = 2.5 points

Target thresholds determined based on 2016-2017 Joint Commission Statewide Quality data and PHC Hospital QIP participant data.

Measurement Period

July 1, 2021 – June 30, 2022

Specifications

Joint Commission National Quality Care Measures Specifications v2018A used for this measure (Perinatal Care Measure PC-01).

For detailed specifications, follow this link:
https://manual.jointcommission.org/releases/TJC2018A/

Numerator: The number of patients in the denominator with an elective delivery.

Denominator: Patients delivering newborns at ≥ 37 and < 39 weeks of gestation during the measurement year.

Patient Population: All-hospital newborns, regardless of payer.

Exclusions

Exclusion list retrieved from v2018A Specifications Manual for Joint Commission National Quality Measures PC-01:

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation Appendix A, Table 11.07
- Patients delivering that are less than 8 years of age
- Patients delivering that are greater than or equal to 65 years of age
- Length of stay > 120 days
- Gestational Age < 37 or ≥ 39 weeks

For hospitals with a denominator of 50 patients or less, elective deliveries for a medical reason not listed under Joint Commission's PC-01 exclusions may be submitted for PHC's review and, if approved, be excluded from the denominator.

If the hospital does not have maternity services, this measure does not apply.

Reporting

Monthly Reporting. Hospitals will report directly to CMQCC, with all data uploaded by August 31, 2022.

Measure 4. *Exclusive Breast Milk Feeding Rate*

Exclusive breast milk feeding for the first 6 months of neonatal life has been a goal of the World Health Organization (WHO), and is currently a 2025 Global Target to improve maternal, infant, and young child nutrition. Other health organizations and initiatives such as the Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP), and American College of Obstetricians and Gynecologists (ACOG), Healthy People 2010, and the CDC have also been active in promoting this goal.[17-23]

Measure Summary

Exclusive breast milk feeding rate for all newborns during the newborn's entire hospitalization within the Measurement Year.

Target

- Full Points: ≥ 75.0% = 5 points
- Partial Points: 70.0% - < 75.0% = 2.5 points

Target thresholds determined based on 2016-2017 Joint Commission Statewide Quality and Hospital QIP participant data.

Measurement Period

July 1, 2021 – June 30, 2022

Specifications

Joint Commission National Quality Care Measures Specifications v2018A used for this measure (Perinatal Care Measure PC-05).

For detailed specifications, follow this link:
https://manual.jointcommission.org/releases/TJC2018A/

Numerator: The number of newborns in the denominator that were fed breast milk only since birth.

Denominator: Single term newborns discharged alive from the hospital during the measurement year.

Patient Population

All-hospital newborns, regardless of payer.

Exclusions

Exclusions retrieved from v2018A Specifications Manual for Joint Commission National Quality Measures, PC-05 specifications. Exclusions include:

- Newborns admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization
- ICD-10-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21
- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for parenteral nutrition as defined in Appendix A, Table 11.22

- Experienced death
- Length of Stay >120 days
- Patients transferred to another hospital
- Patients who are not term or with < 37 weeks gestation completed

If the hospital does not have maternity services, this measure does not apply.

Reporting

Monthly Reporting. Hospitals will report directly to CMQCC, with all data uploaded by August 31, 2022.

Measure 5. *Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Rate*

Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate is the proportion of live babies born at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions), via C-section birth. NTSV Rate is used to determine the percentage of cesarean deliveries among low-risk, first-time mothers. Studies show that narrowing variation and lowering the average C-section rate will lead to better quality care, improved health outcomes, and reduced costs.[24]

Measure Summary

Rate of Nulliparous, Term, Singleton, Vertex Cesarean births occurring at each HQIP hospital within the measurement period.

Target

Full Points: < 21.7% NTSV cesarean rate = 5 points

Partial Points: ≥ 22.0% - 23.6% NTSV rate = 2.5 points

Target thresholds determined considering the HealthyPeople2020 goal, and also statewide and HQIP participant averages calculated using Cal Hospital Compare data.

Measurement Period

July 1, 2021– June 30, 2022

Specifications

Joint Commission National Quality Care Measures Specifications v2018A used for this measure (Perinatal Care Measure PC-02).

For detailed specifications, follow this link:

https://manual.jointcommission.org/releases/TJC2018A/

Numerator: Patients with cesarean births.

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation.

Patient Population

All deliveries at the hospital with ICD-10-CM Principal Procedure Code or ICD-10-CM Other Procedure Codes for cesarean section as defined in Joint Commission National Quality Measures v2018A Appendix A, Table 11.06.

Exclusions

Exclusions retrieved from v2018A Specifications Manual for Joint Commission National Quality Measures, PC-02 specifications:

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09
- Patients delivering that are less than 8 years of age
- Patients delivering that are greater than or equal to 65 years of age
- Length of Stay >120 days
- Gestational Age < 37 weeks or unable to determine (UTD)

If the hospital does not have maternity services, this measure does not apply.

Reporting

Monthly Reporting. Hospitals will report directly to CMQCC, with all data uploaded by August 31, 2022.

Measure 6. *Vaginal Birth After Cesarean (VBAC)*

Vaginal Birth After Cesarean (VBAC) is used to describe a vaginal delivery of a child when the mother has delivered a baby through cesarean delivery in a previous pregnancy.

Measure Summary

For hospitals with ≥ 100 beds that offer maternity services: Percent of patients who had a previous cesarean delivery who deliver vaginally during the Measurement Year.

Target

Full Points: ≥ 5.0% VBAC Uncomplicated = 5 points

No Partial Points available for this measure. Target threshold developed in consideration of foundational objectives outlined in the Office of Disease Prevention and Health Promotion, HealthyPeople2020, along with statewide averages and existing HQIP participant performance published by Cal Hospital Compare.

Measurement Period

July 1, 2021 – June 30, 2022

Specifications

Numerator: Patients who deliver vaginally that have had a previous cesarean delivery.

Denominator: Patients with a previous cesarean birth.

Patient Population

All deliveries at the hospital with ICD-10 codes for cesarean section as defined in Specification Manual for Joint Commission National Quality Measures v2018A Appendix A, Table 11.06.

Exclusions

Exclusions include abnormal presentation, preterm, fetal death, multiple gestation, or procedure codes for breech delivery. As defined by AHRQ QI™ ICD-10-CM/PCS Specification v2019

If the hospital does not have maternity services, this measure does not apply.

Reporting

Monthly Reporting. Hospitals will report directly to CMQCC, with all data uploaded by August 31, 2022.

Measure 7. *CHPSO Patient Safety Organization Participation*

CHPSO is one of the first and largest patient safety organizations in the nation, and is a trusted leader in the analysis, dissemination, and archiving of patient safety data. CHPSO brings transparency and expertise to the area of patient safety, and offers access to the emerging best practices of hundreds of hospitals across the nation.

CHPSO provides members with a safe harbor. Reported medical errors and near misses become patient safety work product, protected from discovery. Members are able to collaborate freely in a privileged confidential environment.

Measure Summary

Participation in the California Hospital Patient Safety Organization. Membership is free for members of the California Hospital Association (CHA) and California's regional hospital associations. To see if your hospital is already a member of CHPSO, refer to the member listing.

- Participation in at least four "Safe Table Forums", either in-person or virtually, during the Measurement Year
- Submission of 100 patient safety events to CHPSO, for events occurring within the measurement year or the year prior
  - Please reference AHRQ's common reporting formats for information on the elements that may comprise a complete report: https://www.psoppc.org/psoppc_web/publicpages/commonFormatsV1.2.
  - You may also contact CHPSO to seek more information or examples of what may be considered a patient safety event.

Target

Full Points = 5 points. No partial points are available for this measure.

Measurement Period

July 1, 2021 – June 30, 2022

Reporting

Hospitals will report directly to CHPSO using their risk management reporting system. Please contact CHPSO at http://www.chpso.org/contact-0. No reporting by hospital to PHC is required. In order to receive credit for this measure, hospitals must grant CHPSO permission to share submission status updates with PHC by August 31, 2022.

Measure 8. *Substance Use Disorder Referrals*

Substance Abuse Referrals for Medication Assisted Treatment interventions present an opportunity to treat patients presenting in the hospital with opioid intoxication. Patients with substance use disorders are frequently hospitalized with complications from the condition, yet do not receive treatment for their underlying disease, which leaves patients at high risk of future overdose. Hospital visits can offer an opportunity to start effective medication treatment for addiction and connect patients to ongoing outpatient services.

Medication Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. [25, 26]

Specifications

To meet the measure criteria the following must be achieved:

- **Denominator:** Emergency Department or inpatient admissions of PHC Members with ICD10: F11.2x diagnosis code of opioid use disorder billed in any position on the claim.

- **Numerator:** Any subsequent prescription of buprenorphine ***or*** any subsequent office visit with a diagnosis of F11.2x

Buprenorphine Rx may include:	Buprenorphine, Buprenorphine HCl, Buprenorphine-naloxone, Suboxone, Zubsolv, Vivitrol, and/or Butrans

  "Subsequent" is defined as the period between 1 and 60 days post discharge after an inpatient stay, during the Measurement Year.

- **Data Collection:** PHC will use medical and Buprenorphine pharmacy claims data for the period 1-60 days post-discharge during the Measurement Year, as well as outpatient provider data to determine performance.

Target

Full points ≥ 10 PHC Members = 10 points. No partial points are available for this measure.

Measurement Period

July 1, 2021 – June 30, 2022

Exclusions

N/A

Reporting

PHC will access claims data to determine performance.

Measure 9. *Hepatitis B/CAIR Utilization*

Measure Summary

This measure is intended to help improve the interaction between PHC's contracted hospitals and the California Immunization Registry (CAIR). The CAIR system is accessed online to help providers track patient immunization records, reduce missed opportunities, and help fully immunize Californians of all ages. CAIR makes immunization records easily accessible, ensures accuracy, and improves efficiency. With a bi-directional interface, CAIR utilization can be automated through EHR integration.

Hospitals providing maternity services hold the valuable opportunity of optimizing their Hepatitis B birth dose practices. The U.S. Centers for Disease Control and Prevention (CDC) recommends all infants receive the first dose of Hepatitis B vaccine at Birth in the delivery room (called the "birth dose") or within 12 hours of life before they leave the hospital.[27]

Specifications

In order to demonstrate measure compliance, hospitals must be using the California Immunization Registry (CAIR) to record vaccines. PHC will use CAIR data uploaded during the Measurement Year to measure performance.

Specification for Hospitals Providing Maternity Services:

Numerator: Newborn Hepatitis B Vaccine entered in CAIR within first month of life

Denominator: Newborn births at the hospital between July 1, 2021 – June 30, 2022

Specification for Hospitals *Not* Providing Maternity Services:

Hospitals not providing maternity services, but administering TDaP and Tetanus, MMR, influenza, and Pneumococcal Conjugate (PCV13) vaccines in the hospital or ED.

Numerator: Number of vaccines recorded in CAIR from July 1, 2021 – June 30, 2022

Denominator: Number of Licensed acute inpatient beds (State OSHPD bed count)

Licensed acute bed utilization count may be submitted in the instance that bed utilization numbers differ from actual OSHPD bed count due to staffing or other clearly demonstrated reasons.

Target

Hospitals Providing Maternity Services:

- Full Points ≥ 20% = 10 Points
- Partial 10-20% = 5 Points

Hospitals *not* Providing Maternity Services:

- Full Points Ratio > 1.20 = 10 Points
- Partial Points Ratio 0.20 to 1.20 = 5 Points

Measurement Period

July 1, 2021 – June 30, 2022

Reporting

Hospitals Providing Maternity Services: None (PHC will access data)

Hospitals *not* Providing Maternity Services: Hospitals must submit CAIR report for all vaccines entered from July 1, 2021 – June 30, 2022 to PHC by August 31, 2022. Submissions can be sent by email to HQIP@partnershiphp.org.

Measure 10. *Quality Improvement (QI) Capacity*

Measure Summary

This measure is intended to introduce resources to all PHC network hospitals, particularly small and rural hospitals, to provide hospital administrators, physicians, and staff of all levels with tools, strategies, and inspiration for improving the quality of care provided to our members. Many of our hospitals are far from major cities or so small in size that it becomes difficult to facilitate training attendance. We offer this event with the desire to encourage PHC-contracted hospitals to send staff of all levels to an informative learning session.

Specifications

- CE/CME hours per person are available for attending this event
- Attendance at this event will be verified at the event by PHC
- The following are examples of potential quality topics that may be presented at this event:
  - Infection control or prevention
  - Outpatient care coordination
  - Opioid epidemic
  - Perinatal care services
  - Implicit bias
  - Emerging data resources

Target

Full Points = 5 points. No partial points are available for this measure.

Reporting

Hospital staff registration and attendance of the event will be documented for reporting by PHC.

Measure 11. *Cal Hospital Compare-Patient Experience*

Measure Summary

The terms, patient experience and patient satisfaction, are often used interchangeably, but they actually have different meanings. Patient satisfaction focuses on whether the patient's expectations about a health encounter were met. Patient experience, on the other hand, relates to what has or has not happened to a patient in an in-patient setting (such as clear or non-clear communication with a medical team).

Patient experience is an important component to creating a high quality hospital. There are many ways to gather information on patient experience. Ratings and data sources can be viewed on sources such as Cal Hospital Compare. The hospital data presented on Cal Hospital Compare is the result of a partnership among independent organizations dedicated to improving health care quality. Cal Hospital Compare includes hospital measures for clinical care, patient safety, and patient experience for all acute care hospitals in the state of California with publicly available information. (1)

Hospitals are scored based on patient experience results from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Survey questions are related to communication, responsiveness, care transition, pain management, discharge information, cleanliness, quietness as well as an overall rating of the hospital and if the patient would or would not recommend that hospital. This rating combines information about different aspects of patient experience to make it easier for consumers to compare hospitals.

Specifications

Hospital Patient Experience data collected on Cal Hospital Compare is measured as an aggregate score in comparison to the aggregate score of Patient Experience for all acute care hospitals in the state of California with publicly available information. (1)

Target

Full Points:
Hospital aggregate score is greater than average California hospital score * 0.95 = 5 points.

No partial points are available for this measure.

Measurement Period

July 1, 2021 – June 30, 2022

Reporting

No reporting by hospital required, PHC will collect Cal Hospital Compare scores to determine performance.

Measure 12. *Health Equity*

Measure Summary

To Partnership HealthPlan of California (PHC), Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. [30] PHC recognizes that a range of factors impact the holistic health of the diverse communities we serve. This includes safe housing and environment, educational and employment opportunities, freedom from discrimination, access to affordable and healthy food and access to comprehensive quality health care services. PHC promotes Health Equity through responsive, respectful and open processes involving our internal workforce, healthcare providers, community organizations, and our members. We are committed to create just and person-centered opportunities to attain the highest quality health and well- being for our members and the communities we serve.

Managing Health Equity in the healthcare environment is a major social challenge facing our nation. Every patient, regardless of socioeconomic status, race, gender, or other identifying traits, deserves a quality patient experience. With growing discussions about the importance of Health Equity, hospitals today have many opportunities to improve the patient experience through addressing health inequities and improving outcomes.[32]

Specifications

This two-part submission-based measure requests that hospitals submit a written project plan outlining a health equity project that will be implemented during the measurement year. Plans will be submitted in the beginning of the measurement year and reviewed for approval.

Project requirements include how best-practices apply to internal domains such as:

- Admissions
- Assessment
- Treatment
- Discharge
- Transfers

Completion and results of the project will be submitted after the close of the measurement year and reviewed for final scoring.

As an example, project plans may consider the suggestions below demonstrating five characteristics that health systems are successfully integrating Health Equity as a core strategy [34]. Additionally, projects should demonstrate how identified best-practices apply to internal domains such as: Admissions, Assessment, Treatment & Discharge and Transfers.

1. Make Health Equity a leader-driven priority (healthcare leaders must articulate, act on, and build the vision into all decisions).
2. Develop structures and processes that support equity (health systems must dedicate resources and establish a governance structure to oversee the Health Equity work).

3. Take specific actions that address Social Determinants of Health. Health systems must identify health disparities along with the needs of people who face disparities, then act to close the gaps. Some patient populations need additional support to achieve the same health outcomes as other patient populations (e.g., transportation to and from appointments, home visits, etc.).
4. Confront institutional racism within the organization (health systems must identify, address, and dismantle the structures, policies, and norms that perpetuate race-based advantage).
5. Partner with community organizations to better understand disparities with the community.

Target

Full Points: Submission, approval and completion of project plan = 5 points.

No partial points are available for this measure.

Measurement Period

July 1, 2021 – June 30, 2022

Reporting

Submit to HQIP@partnershiphp.org

- Proposed written project plan by August 31, 2021. Approval status will be announced by September 15, 2021.
- Written conclusion summarizing the results of the project by August 31, 2022.

Measure 12. *Sexual Orientation/Gender Identity (SOGI)*

Measure Summary

Both the Institute of Medicine and Joint Commission recommended the collection and documentation of patient sexual orientation and gender identity (SO/GI) in healthcare settings as this information is critical in providing patient-centered care for patients that identify as lesbian, gay, bisexual, transgender and/or queer (LGBTQ). [36]

Specifications

This measure embodies the implementation of previously submitted 2020-21 comprehensive implementation plans (over a 12-month period) to capture SO/GI information in a hospital's EHR or a screenshot of an existing SO/GI capture in an implemented EHR system. Demonstration of implemented plan will need to reflect efforts beginning July 1, 2021, with all steps completed by June 30, 2022.

Organizations can discuss options with their EHR vendor prior to starting the implementation process to see if the vendor has existing SO/GI customizations. In some cases, a vendor may have an updated version that includes SO/GI data fields such as:

- What is your legal name?
- What is your preferred name?
- What gender were you assigned at birth?
- What is your legal gender? (we will use gender on ID card)
- What is your gender identity?
- What pronouns do you use?

Sample implementation plan reference for 12-month period Appendix II

Screenshots should include the following criteria:

- Data on sexual orientation
- Preferred pronoun
- Dropdown options for the gender identity question.
- Best practice is for any transgender patient to identify their surgical transition status.

Target

Full Points: Plan completion by June 30, 2022 = 5 points.

No partial points are available for this measure.

Measurement Period

July 1, 2021 – June 30, 2022

Reporting

Hospitals will submit a written summary of the following: evidence of plan completion, such as a timeline of when plan was implemented, a summary of how components implemented, how the data capture now is being managed now, lessons learned and plans for next steps.

Submissions due by August 31, 2022 to HQIP@partnershiphp.org

APPENDICES

Appendix I: Information Exchange Implementation Plan

Partnership HealthPlan of California
Hospital Quality Improvement Program
4665 Business Center Drive, Fairfield, CA 94534
Tel (707) 420-7505 · Fax (707) 863-4316
HQIP@partnershiphp.org
http://www.partnershiphp.org/Providers/Quality

HIE Gateway Measure Status or Plan
Due June 30, 2022

To qualify for full incentive amount for the 2021-2022 Hospital QIP, newly participating hospitals must have a Community HIE interface with ADT plus HL7 or XDS; link to national network; and interface with EDIE available by June 30, 2022. Please complete the following to detail your plans for HIE implementation. *If you are already live with a community HIE and EDIE, please still complete this form to confirm your continued participation and detail any changes for 2021-22.*

Please complete and email this Implementation Plan to HQIP@partnershiphp.org.

Hospital: *(e.g. Lakeside Hospital)*	
Name of Community Health Information Exchange: 1. Community HIE interface with ADT plus either an HL7 interface or a XDS interface with one of the following community HIEs: ○ Sac Valley Med Share ○ North Coast Health Information Network ○	Community HIE: Types of interfaces, with dates of implementation/anticipated implementation: (final status will be confirmed with community HIE)
2. ADT interface with EDIE (direct with CMT, or through another HIE)	Date of EDIE go live: (final status will be confirmed with CMT)
3. Active link to one of the following national HIE network (directly or through another HIE) ○ CareQuality, ○ eHealth Exchange, or ○ Commonwell	Name of national network: Date national network interface active: (Final status will be confirmed with national network)
Please add any additional information: Onboarding budget approval, anticipated date of BAA completion, Network Participation Agreement, installation proposal details, etc.	

Appendix II: Sample Timeline for Implementing Sexual Orientation and Gender Identity (SO/GI) Data Collection in Healthcare Settings

Months 1 to 3	• Identify a team of internal change champions • Collect and read resources on SO/GI • Engage leadership • Plan implementation timeline • Begin continuous quality improvement process
Months 4 to 6	• Determine data collection systems • Modify electronic health record
Months 6 to 8	• Train staff • Make changes to policies and physical environment
Month 7	• Pilot SO/GI in 1 department/provider panel
Months 8 to 11	• Expand to more departments and monitor progress through data feedback reports
Month 12	• Conduct first data summary report
Ongoing	• Monitor data quality • Train new staff and re-train existing staff • Gather feedback from staff and make changes as needed

WORK CITED

1. Selke, Curt. "Using ADTs as a Starting Point for Valuable Insights into Accountable Care Delivery | Insights." Using ADTs as a Starting Point for Valuable Insights into Accountable Care Delivery. Accountable Care News, 10 Apr. 2013. Web. 24 May 2016. http://www.ihie.org/insights/using-adts-as-a-starting-point-for-valuable-insights-into-accountable-care-delivery.
2. Evidence Report/ Technology Assessment: Health Information Exchange. Rep. No. 220. Agency for Healthcare Research and Quality, Dec. 2015. Web. 24 May 2016. http://www.effectivehealthcare.ahrq.gov/ehc/products/572/2154/health-information-exchange-report-151201.pdf
3. "Plan All-Cause Readmissions." National Committee for Quality Assurance State of Health Care Quality Report 2015. October 21, 2015. May 11, 2016. http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/plan-readmissions.
4. Benbassat, Jochanan, and Mark Taragin. "Hospital Readmissions as a Measure of Quality of Health Care." Arch Intern Med Archives of Internal Medicine 160.8 (2000): 1074. Web. May 17, 2016.
5. Jackson, C., M. Shahsahebi, T. Wedlake, and C. A. Dubard. "Timeliness of Outpatient Follow-up: An Evidence-Based Approach for Planning After Hospital Discharge." The Annals of Family Medicine 13.2 (2015): 115-22. Web. May 17, 2016.
6. "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program." New England Journal of Medicine N Engl J Med 361.3 (2009): 311-12. Web. May 17, 2016.
7. Teno JM, Clarridge, BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004;291(1):88–93.
8. Emanuel EJ, Ash A, Yu W, et al. Managed care, hospice use, site of death, and medical expenditures in the last year of life. *Arch Intern Med*. 2002;162(15):1722–1728.
9. Bakitas M, Lyons KD, Hegel MT, et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial.*JAMA*. 2009;302(7):741–749.
10. Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age. March of Dimes, California Maternal Quality Care Collaborative, Maternal, Child and Adolescent Health Division; Center for Family Health. California Department of Public Health. https://www.cdph.ca.gov/programs/mcah/Documents/MCAH-EliminationOfNon-MedicallyIndicatedDeliveries.pdf

11. Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. J Reprod Med. 50(4):235-40.
12. Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. NEJM. 360:2, 111-120.
13. ACOG. American College of Obstetricians and Gynecologists: Assessment of Fetal Maturity Prior to Repeat Cesarean Delivery or Elective Induction of Labor. Committee on Obstetrics: Maternal and Fetal Medicine September, 1979(22).
14. ACOG. Clinical management guidelines for obstetrician-gynecologists. The American College of Obstetricians and Gynecologists Practice Bulletin Number 10 November, 1999.
15. ACOG. Clinical management guidelines for obstetricians-gynecologists: Induction of labor. American College of Obstetricians and Gynecologists Practice Bulletin Number 107 August, 2009.
16. Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version].Am J Obstet Gynecol. 200:156.e1-156.e4.
17. Centers for Disease Control and Prevention. (Aug 3, 2007). Breastfeeding trends and updated national health objectives for exclusive breastfeeding--United States birth years 2000-2004. MMWR - Morbidity & Mortality Weekly Report. 56(30):760-3.
18. Centers for Disease Control and Prevention. (2007). Division of Nutrition, Physical Activity and Obesity. Breastfeeding Report Card. Available at: http://www.cdc.gov/breastfeeding/data/report_card2.htm.
19. US Department of Health and Human Services. (2007). Healthy People 2010 Midcourse Review. Washington, DC: US Department of Health and Human Services. Available at: http://www.healthypeople.gov/data/midcourse.
20. American College of Obstetricians and Gynecologists. (Feb. 2007). Committee on Obstetric Practice and Committee on Health Care for Underserved Women. Breastfeeding: Maternal and Infant Aspects. ACOG Committee Opinion 361.
21. "Global Targets 2025." World Health Organization. N.p., n.d. Web. 24 May 2016. http://www.who.int/nutrition/global-target-2025/en/
22. Ip, S., Chung, M., Raman, G., et al. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. Rockville, MD: US Department of Health and Human Services. Available at: http://www.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf
23. American Academy of Pediatrics. (2005). Section on Breastfeeding. Policy Statement: Breastfeeding and the Use of Human Milk. Pediatrics.115:496 506.
24. Pacific Business Group on Health. (September 2014). Variation in NTSV C-Section Rates. Pacific Business Group on Health. Web.

http://www.leapfroggroup.org/media/file/PBGH_NTSV-C-Section-Variation-Report.pdf
25. Preventing Hospital-Associated Venous Thromboembolism. October 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/vtguide/index.html
26. Support for Hospital Opioid Use Treatment (SHOUT). June 24, 2019. https://www.projectshout.org/
27. Substance Abuse and Mental Health Services Administration (SAMHSA). June 24, 2019. https://www.samhsa.gov/medication-assisted-treatment
28. Center for Disease Control and Prevention (CDC). Hepatitis B and the Vaccine (Shot) to Prevent it. (June 24, 2019). https://www.cdc.gov/vaccines/parents/diseases/child/hepb.html
29. Agency for Healthcare Research and Quality. (n.d.). About CAHPS. What is patient experience? Retrieved January 16, 2020, from https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html
30. Cal Hospital Compare. (n.d.). Ratings and data sources. Retrieved January 16, 2020, from http://calhospitalcompare.org/about/ratings-data-sources/
31. Robert Wood Johnson Foundation. (n.d.). *What is health equity? And what differences does a definition make?* Retrieved February 10, 2020, from https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
32. Pellegrini, C.A. (2018, June 1). Bulletin of the American College of Surgeons. *Advancing health equity in hospitals.* Retrieved February 10, 2020, from https://bulletin.facs.org/2018/06/advancing-health-equity-in-hospitals/
33. *Advancing effective communication, cultural competence, and patient-and family-centered care: a roadmap for hospitals.* (n.d.). The Joint Commission. Retrieved February 11, 2020 from https://www.jointcommission.org/resources/patient-safety-topics/health-equity/#t=_Tab_Resources&sort=relevancy
34. Schoonover, H. (2018, March 8). Health Catalyst. *Health equity: why it matters and how to achieve it.* Retrieved February 11, 2020, from https://www.healthcatalyst.com/health-equity-why-it-matters-how-to-achieve-it
35. Grasso, C., McDowell, MJ, Goldhammer, H., Keuroghlian, AS. (2018, November 18). Journal of American Medical Informatics Association, Volume 26, Issue 1, January 2019, Pages 66-70. *Planning and implementing sexual orientation and gender identity data collection in electronic health records.* Retrieved February 20, 2020, from: https://academic.oup.com/jamia/article/26/1/66/5185589