



Hospital Quality Improvement Program (QIP)

2018-19 Measure Specifications for Small Hospitals (≤ 50 licensed general acute beds)

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Table of Contents

| | |
|---|-----------|
| <u>PROGRAM OVERVIEW</u> | 3 |
| Measure Development..... | 3 |
| <u>PARTICIPATION REQUIREMENTS:</u> | 3 |
| a) <u>Contracted Hospital</u> | 3 |
| b) <u>Information Exchange: Community HIE and EDIE</u> | 4 |
| c) <u>Capitated Hospital: Utilization Management Delegation</u> | 4 |
| <u>Performance Methodology</u> | 5 |
| <u>Payment Methodology</u> | 5 |
| <u>Payment Dispute Policy</u> | 6 |
| <u>Reporting Timeline</u> | 7 |
| <u>2018-2019 SUMMARY OF MEASURES</u> | 8 |
| <u>2018-2019 MEASURE SPECIFICATIONS</u> | 11 |
| READMISSIONS DOMAIN | 11 |
| <u>1) All-Cause 30-Day Adult Readmission Rate</u> | 11 |
| ADVANCE CARE PLANNING DOMAIN | 14 |
| <u>2) Palliative Care Capacity</u> | 14 |
| CLINICAL QUALITY DOMAIN: OB/NEWBORN/PEDIATRICS | 15 |
| <u>3) Elective Delivery before 39 Weeks</u> | 16 |
| <u>4) Exclusive Breast Milk Feeding Rate</u> | 18 |
| <u>5) Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Rate</u> | 20 |
| PATIENT SAFETY DOMAIN..... | 22 |
| <u>6) CHPSO Patient Safety Organization Participation</u> | 22 |
| OPERATIONS/EFFICIENCY DOMAIN | |
| <u>7) California Immunization Registry (CAIR) Utilization Measure</u> | 23 |
| <u>8) Quality Improvement Capacity</u> | 24 |
| <u>Appendix I: Information Exchange Implementation Form</u> | 25 |
| <u>Appendix II: Measure Submission Forms</u> | 26 |
| <u>Works Cited</u> | 33 |

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, and mental 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

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, 2019 to be eligible for payment. Participation will require signing a contract amendment by July 1, 2018 to participate in the 2018-2019 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. Good standing means that the hospital is open, solvent, and not under financial sanctions from the state of California or Centers for Medicare & Medicaid Services. If a hospital appeals a financial sanction and prevails, PHC will entertain a request to change the hospital status to good standing.

b) Community Health Information Exchange (HIE) and EDIE Participation

For the 2018-19 measurement year, HIE and EDIE participation is a pre-requisite to joining the Hospital QIP. Requirements apply to all hospitals, and are as follows:

- Hospitals will maintain Admission, Discharge, and Transfer (ADT) interface with a community HIE enduring the duration of the measurement year, ending June 30, 2019.
- Hospitals will complete or maintain EDIE interface by the end of the measurement year, June 30, 2019.

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 authorization 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 Plan | Hospitals | October 31, 2018 |
| ADT + EDIE participation verification | PHC | August 31, 2019 |

Community HIEs from whom attestation will be accepted: Redwood Mednet, Sac Valley Med Share, North Coast Health Information Network, and Marin County Health Information Exchange. PHC will verify hospitals' participation in community HIEs and EDIE at end of year.

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.²

c) Capitated Hospitals Only: Utilization Management Delegation

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. Please see below for various rounding examples and respective points for Readmissions (measure 1).

Table 1. Rounding Examples for Readmissions Target (Full Points: ≤13.0 % Partial Points: >13.0 % - 16.0 %)

| Raw Rate | Final Rate Rounding | Final Points |
|----------|---------------------|--------------|
| 16.05% | 16.1% | None |
| 16.04% | 16.0% | Partial |
| 13.05% | 13.1% | Partial |
| 13.04% | 13.0% | Full |

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 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 on October 31 following the measurement year. Please see the reporting summary below:

Table 2. 2018-2019 Small Hospital QIP Reporting Timeline

| Measure/ Requirement | Measurement Period | Hospital Reporting | PHC Reporting to Hospital (outside of preliminary and final reports) | Points |
|---|------------------------------|---|---|--------|
| HIE and EDIE Participation | July 1, 2018- June 30, 2019 | October 31, 2018 to PHC | N/A | N/A |
| Delegation Reporting | July 1, 2018- June 30, 2019 | Refer to Delegation Agreement Exhibit A | N/A | N/A |
| 1. Readmissions | July 1, 2018- June 30, 2019 | N/A | Interim Report : March 14, 2019 | 25 |
| 2. Palliative Care Capacity | July 1, 2018- June 30, 2019 | August 31, 2019 to PHC | N/A | 15 |
| 3. Elective Delivery | July 1, 2018- June 30, 2019 | Monthly reporting to CMQCC | N/A | 10 |
| 4. Exclusive Breast Milk Feeding | July 1, 2018- June 30, 2019 | Monthly reporting to CMQCC | N/A | 10 |
| 5. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate | July 1, 2018- June 30, 2019 | Monthly reporting to CMQCC | N/A | 10 |
| 6. California Hospital Patient Safety Organization (CHPSO) | July 1, 2018- June 30, 2019 | Report to CHPSO | Interim Report: January 8, 2019 | 10 |
| 7. California Immunization Registry (CAIR) Utilization | July 1, 2018 – June 30, 2019 | October 31, 2018 and August 31, 2019 to PHC | Interim Report: January 8, 2019 | 10 |
| 8. Quality Improvement (QI) Capacity | July 1, 2018- June 30, 2019 | August 31, 2019 to PHC | N/A | 10 |

2018-2019 Small Hospital Summary of Measures

Table 3. Summary of Measures

| Measure | Target/Points |
|---|--|
| Community HIE and EDIE Interface (<i>Required</i>) | |
| <ul style="list-style-type: none"> • Hospitals will complete and/or maintain Admission, Discharge, and Transfer (ADT) interface with a community HIE by the end of the measurement year, June 30, 2019. • Hospitals will complete and/or maintain EDIE interface by the end of the measurement year, June 30, 2019. | Submissions: <ul style="list-style-type: none"> • HIE and EDIE Interface Implementation plan, due October 31, 2018 |
| Readmissions (20 points) | |
| 1. All-Cause 30-day Adult Readmission Rate for all hospitalized PHC patients | <ul style="list-style-type: none"> • Full Points: $\leq 13.0\%$ = 25 points • Partial Points: $>13.0\%$ - 16.0% = 12.5 points |

| Advance Care Planning (10 points) | |
|---|--|
| <p>2. Palliative Care Capacity</p> | <p>Hospitals meeting one of two options will receive full points (15 points):</p> <ul style="list-style-type: none"> • Option for all hospitals: Dedicated inpatient palliative care team: one Physician Champion, and one trained* Licensed Clinical Social Worker or trained* Licensed Clinician (RN, NP, or PA), and availability of video or in-person consultation with a Palliative Care Physician) <i>OR</i> • Option for <100 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 <p>*Training must total 4 CE or CME hours. Training options include ELNEC, EPEC, or the CSU Institute for Palliative Care.</p> |
| Clinical Quality: OB/Newborn/Pediatrics (45 points) | |
| <p>For all maternity care measures, hospitals must timely* submit 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.</p> <p>For hospitals new to CMQCC: Legal agreement executed by September 30. First data submission for months of July - October due by December 15, 2018. Timely data submission for each month after that, starting in January.</p> <p>For hospitals already participating in CMQCC: 12 months of timely data submission for each month during the measurement year.</p> <p>*Per CMQCC, timely submissions are defined as those submitted within 45 to 60 days after the end of the month.</p> | |
| <p>3. Rate of Elective Delivery Before 39 Weeks</p> | <ul style="list-style-type: none"> • Full Points: $\leq 1.5\%$ = 10 points • Partial Points: $>1.5\%$ - 3.0% = 5 points |

| | |
|---|---|
| 4. Exclusive Breast Milk Feeding Rate at Time of Discharge from Hospital for all Newborns | <ul style="list-style-type: none"> • Full Points: $\geq 70.0\%$ = 10 points • Partial Points: $65.0\% - < 70.0\%$ = 5 points |
| 5. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate | <ul style="list-style-type: none"> • Full Points: $< 23.9\%$ NTSV Cesarean rate = 10 points • Partial Points: $\geq 23.9\% - 25.9\%$ = 5 points |
| Patient Safety (10 points) | |
| 6. California Hospital Patient Safety Organization (CHPSO) Participation | <p>Hospitals meeting both requirements will receive full points (10 points):</p> <ul style="list-style-type: none"> • Attend at least one Safe Table Forum, in-person or via phone, during the measurement year • Share 50 patient safety events across all categories (e.g. perinatal events, surgical events, etc.) |
| Operations/Efficiency (10 points) | |
| 7. CAIR Utilization | <p>Pay for Reporting first year. Hospitals will submit (10 points):</p> <ul style="list-style-type: none"> • CAIR ID (provided by CAIR) by October 31, 2018 • CAIR Policy by August 31, 2019 <p>Both components must be completed.</p> |
| 8. Quality Improvement (QI) Capacity | <p>Hospitals will make a two-part submission to help inform PHC of QI infrastructure at place (10 points):</p> <ul style="list-style-type: none"> • QI Training Summary • QI Project Summary |

2018-2019 Measure Set Specifications

Measure 1. All-Cause 30 Day Adult Readmission Rate

In healthcare, a “readmission” occurs when a patient is discharged from a hospital, and then admitted back into the hospital within a short period of time. Increased re-admissions are often associated with increased rates of complications and infections, and some studies even suggest that readmissions are commonly preventable. High rates of hospital readmissions not only indicate an opportunity for improving patient experience, safety, and quality of care, but they are also recognized by policymakers and providers as an opportunity to reduce overall healthcare system costs through quality improvement. As such, readmissions rates are prioritized by organizations such as the NCQA to help inform and guide health care providers in their quality efforts, and is a HEDIS® plan measure.^{3,4}

Measure Summary

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).

Target

- Full Points: ≤13.0% = 20 points
- Partial Points: >13.0% - 16.0% = 10 points

Measurement Period

July 1, 2018 – June 30, 2019.

Specifications

Numerator: The total number of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days of discharge.

Denominator: Total number of adult acute inpatient discharges from July 1- May 31 during the measurement year.

Definitions:

| | |
|-------------------------------|---|
| IHS | Index hospital stay. An acute inpatient stay with a discharge on or between July 1, 2018 and June 1, 2019. Exclude stays that meet the exclusion criteria in the denominator section. |
| Index Admission Date | The IHS admission date. |
| Index Discharge Date | The IHS discharge date. The index discharge date must occur on or between July 1, 2018 and June 1, 2019. |
| Index Readmission Stay | An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date. |
| Index Readmission Date | The admission date associated with the Index Readmission Stay. |

| Patient Population | |
|---------------------------|---|
| Coverage | <ul style="list-style-type: none"> - Medi-Cal only (with member status code NN, excludes medi-medis and anyone with second source of insurance) - Continuously enrolled with PHC 90 days prior to the index admission date, through 30 days after index admission date. |
| Ages | 18 years or older as of the Index Discharge Date |

| Exclusions |
|-------------------|
|-------------------|

- Hospital stays for the following reasons:
 - The member died during the stay
 - A principal diagnosis of pregnancy
 - A principal diagnosis of a condition originating in the perinatal period
- PHC members who have Medicare or a second source of insurance.
- Stays at long term care, intermediate care, sub-acute, rehabilitation, and behavioral health facilities.
- Discharges occurring in the last 30 days of the measurement period.
- Planned stays, based on discharge codes

| 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 members admitted to the hospital, whether they are capitated or not.

PHC will provide an interim report in April for the period of July – December, for participating hospitals to monitor performance.

| Methodology for extracting data at PHC |
|---|
|---|

Denominator: Start with eligible population, i.e. Medi-Cal only members who do not have Medicare or other source of insurance.

Step 1: Identify all acute inpatient stays in an acute facility with a discharge date on or between July 1, 2018 and May 31, 2019. Identify the discharge date for the stay.

Step 2: Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer’s discharge date as the Index Discharge Date for the entire stay.

Step 3: Exclude Hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 (Required Exclusions): Exclude hospital stays for the following reasons:

- The member died during the stay
- A principal diagnosis of pregnancy
- A principal diagnosis of a condition originating in the perinatal period

Step 5: Apply continuous enrollment at the health plan level, i.e. enrolled with PHC 90 days prior to the Index Admission Date, through 30 days after Index Admission Date.

Step 6: Assign each acute inpatient stay to the hospital where the discharge occurred

Numerator: At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1: Identify all acute inpatient stays with an admission date on or between July 2, 2018 and June 30, 2019.

Step 2: Acute-to-acute transfers: Keep the original admission date as the Index Admission Date for the entire stay, but use the transfer's discharge date as the Index Discharge Date for the entire stay.

Step 3: Exclude acute inpatient hospital admissions with a principal diagnosis of pregnancy or a principal diagnosis for a condition originating in the perinatal period.

Step 4: For each Index Hospital Stay, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting

No reporting by hospital to PHC is required. A final report will be provided to the hospital by October 31, 2019, only if the hospital does not meet the full or partial points target for the Readmissions measure.

Methodology for extracting data at PHC

Using claims and encounter data, PHC will identify all inpatient discharges from hospital for all members during the measurement period.

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

- Dedicated inpatient palliative care team: one Physician Champion, one trained* Licensed Clinical Social Worker or 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 all hospitals).
- OR
- 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).

*Training must total 4 CE or CME hours. Training options include [ELNEC](#), [EPEC](#), the [CSU Institute for Palliative Care](#), or other approved Palliative Care Training. Training valid for 4 years.

Target

Pay for reporting [Palliative Care Capacity Attestation Form](#), including the information listed under Measure Requirements above. 15 points. No partial points are available for this measure.

Measurement Period

July 1, 2018 – June 30, 2019.

Exclusions

No exclusions.

Reporting

Hospitals must submit an [attestation form](#) no later than August 31, 2019 via email at HQIP@partnershiphp.org or fax at 707-863-4316.

Measures 3-5: Data Submission Instructions

For the following maternity care measures, hospitals must timely* submit 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. First data submission for months of July - October due by December 15, 2018. Timely data submission for each month after that, starting in January.

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, where the delivery was elective.

Target

- Full Points: $\leq 1.5\%$ = 10 points
- Partial Points: $> 1.5\%$ - 3.0% = 5 points

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

Measurement Period

July 1, 2018 – June 30, 2019.

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 who had elective deliveries.

Denominator: Patients delivering newborns with ≥ 37 and < 39 weeks of gestation completed 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 as defined in [Appendix A, Table 11.07](#)
- Less than 8 years of age
- 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 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, 2019.

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.

Target

- Full Points: $\geq 70.0\%$ = 10 points
- Partial Points: $65.0\% - < 70.0\%$ = 5 points

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

Measurement Period

July 1, 2018 – June 30, 2019.

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:

- 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](#)

Small Hospital Measure Specifications- Clinical Quality Domain

- 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, 2019.

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: <23.9% NTSV cesarean rate = 10 points.

Partial Points: $\geq 23.9\%$ - 25.9% NTSV rate = 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, 2018– June 30, 2019.

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-9-CM Principal Procedure Code or ICD-9-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:

Small Hospital Measure Specifications- Clinical Quality Domain

- 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](#)
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Gestational Age < 37 weeks or 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, 2019.

Measure 6. 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](#).

Target

- Participation in at least one Safe Table Forum, either in-person or via telecommunications.
- Submission of 50 patient safety reports 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.

10 points. No partial points are available for this measure.

Measurement Period

July 1, 2018 – June 30, 2019.

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.

Measure 7. California Immunization Registry (CAIR) Utilization Measure

Measure Summary

This measure is intended to help improve the interaction between PHC's contracted hospitals and the [California Immunization Registry \(CAIR\)](#). In 2018, DHCS issued policy clarification stating that Medi-Cal Managed Care Plans are required to ensure that their contracted providers are utilizing CAIR. The California Immunization Registry is a secure, confidential, statewide computerized immunization information system for California residents. 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.

Specifications

- Pay for reporting first year. To earn points for this measure, two steps must be met:
 1. Provide CAIRID to PHC
 - Join CAIR by going to <http://cairweb.org/enroll-now/>
 - Once you are enrolled, email HQIP@partnershiphp.org your CAIRID
 2. Create a CAIR Utilization Policy for your hospital, and send to PHC. We recommend the following components be included:
 - Date policy is effective
 - Language indicating all vaccines administered in the hospital will be entered into CAIR, with some specification regarding how timely the data would need to be entered (or state if uni or bi-directional interface is in place, and if so, include go-live date)

Note: The process to join CAIR may take up to 2 months.

Target

Pay for Reporting both components:

- CAIR Utilization: Hospitals must provide CAIR ID, which authorizes PHC to retrieve utilization data from CAIR, by October 31st, 2018.
- CAIR Policy: Hospitals must provide a CAIR utilization policy by June 30, 2019.

10 points. No partial points are available for this measure.

Reporting

Hospitals must submit CAIR ID by October 31st, 2018 and and CAIR Policy by August 31, 2019 via email to HQIP@partnershiphp.org.

Measure 8. Quality Improvement (QI) Capacity

Measure Summary

This measure is intended to help PHC better understand the Quality Improvement activities and infrastructure in place at our contracted hospitals. We hope to do this by requesting I) a summary of a QI training attended, and II) a summary of a QI project taking place at your hospital (may be unrelated to training from Part I).

Specifications

- Part I: Summary of a QI training attended
 - At least 2 staff members participate in an **in-person**, PHC-approved program or training (min. 4 CE/CME hours per person) aimed at improving one aspect of hospital quality. If uncertain whether a training would qualify, providers may contact HQIP@partnershiphp.org for approval prior to the training. Training may be in any of the following quality areas, among others:
 - Infection control or prevention
 - Outpatient care coordination
 - Telemedicine services capability
 - Perinatal care services

- Part II: Summary of a QI Project
 - Summarize one QI project taking place at your hospital. May be unrelated to training from Part I.

Target

Pay for reporting summaries of [QI Training](#) and [QI Project](#). 10 points. No partial points are available for this measure.

Reporting

Submissions due no later than August 31, 2019 via email at HQIP@partnershiphp.org. Submissions must respond to all questions included in [submission templates](#).

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>



ADT + EDIE Implementation Plan Due October 31, 2018

To qualify for incentive for the 2018-2019 Hospital QIP, hospitals must go-live with ADT + EDIE by June 30, 2019. Please complete the following to detail your plans for ADT + EDIE 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 2018-19.*

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

| | |
|--|--|
| Hospital: (e.g. Lakeside Hospital) | |
| Name of Community Health Information Exchange: | |
| Go-live date for ADT and EDIE: (e.g. February 1, 2018) | |
| <i>Please add any additional information: Onboarding budget approval, anticipated date of BAA completion, Network Participation Agreement, installation proposal details, etc.</i> | |
| | |

Appendix II: Hospital QIP Submission Forms

The following submission forms and the required attachments are due by **August 31, 2019**, with exceptions noted below. Email all material to HQIP@partnershiphp.org or fax to (707) 863- 4316, Attention: Hospital QIP Project Coordinator. Should you have any questions, please email us at HQIP@partnershiphp.org

Please find the following forms in this appendix:

- **Measure 2. Palliative Care Capacity**
- **Measure 8. QI Capacity**

Measure 2. Hospital QIP Palliative Care Capacity Attestation

Hospitals in the Partnership HealthPlan of CA (PHC) provider network who provide Palliative Care services may qualify for a financial bonus under PHC's Hospital Quality Improvement Program (QIP). Hospitals may meet the Palliative Care Capacity measure by one of the following options:

- Dedicated inpatient palliative care team: one Physician Champion, one trained* Licensed Clinical Social Worker or one 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 all hospitals)

OR

- Inpatient palliative care capacity: at least 2 trained* Licensed Clinicians (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).

Hospitals with less than 20 general acute beds will be excluded from this measure. Palliative Care capacity must be established **between July 1, 2018 and June 30, 2019**. All submitted attestations are reviewed by PHC. Upon approval, the attestation will qualify for the incentive. Attestation forms should be submitted no later than **August 31, 2019** via email at HQIP@partnershiphp.org or fax at 707-863-4316.

Measure 2. Palliative Care Capacity

Option 1: Dedicated Palliative Care Team

In addition to the information below, also attach:

1. Agreement for availability of either video or in-person palliative care physician consultation, and include a report indicating total number of palliative care consultations between July 1, 2018 and June 30, 2019.
2. CE/CME certificates for trained clinicians.

Hospital Name: _____

Submitted By: _____ Date: _____

Please include name, title, responsibilities, and training information for team members below.

| Name | Title | Responsibilities | Date of training | Palliative Care FTEs |
|-------------|---------------------------|-------------------------|-------------------------|-----------------------------|
| | Physician Champion | | N/A | |
| | Clinician (RN, NP, or PA) | | | |
| | LCSW | | | |

Please include a brief description of how the team is selected, their reporting structure within the hospital, how often the team meets, number of patients served in 2018-19, and team goals/challenges addressed in 2018-19

Measure 2. Palliative Care Capacity

Option 2: Inpatient Palliative Care Capacity

In addition to the information below, also attach:

- 1. Agreement for availability of either video or in-person palliative care physician consultation, and include a report indicating total number of palliative care consultations between July 1, 2018 and June 30, 2019.
- 2. CE/CME certificates for trained clinicians.

Hospital Name: _____

Submitted By: _____ Date: _____

Please complete the following information for trained clinicians:

| Name | Title | Date of Palliative Care training |
|------|-------|----------------------------------|
| | | |
| | | |



Measure 8. QI Capacity Measure
Summary of a QI Training Attended
Due August 31, 2019

Hospital Name: _____

1. Training attended and date of training: _____

2. Training organization: _____

3. Area of focus (please check one):

- Infection Control or Prevention
- Outpatient Care Coordination
- Telemedicine Services Capability
- Perinatal Care Services
- Other: _____

4. Objective(s) of the training:

5. Name and title of participating employees and length of training per attendee

| Name | Title | Hours in training |
|------|-------|-------------------|
| | | |
| | | |
| | | |
| | | |

6. Improvement Plan

a. Based on the training, what area are you targeting for improvement?

b. What interventions are planned to make improvements in the area targeted?

c. Who is responsible for implementing this plan? What are their roles?

d. What is the implementation timeline?

e. What is your measurable goal (e.g. our Surgical Site Infection rate will decrease from X% to Y% by December 31, 2018)? Please provide your baseline data and the data source.

Submitted by _____ (Name & Title) **on** _____ (Date)

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