



2024-2025 Hospital QIP Kick-off Webinar

Presented by Partnership HealthPlan of California

Date: July 11, 2024

Time: 1 - 2:30 p.m.



Speaker:
Troy Foster
Program Manager,
Hospital Quality Incentive Program (HQIP)



Webinar Instructions

- This webinar will be recorded.
- All attendees have been muted to eliminate any possible noise/ interference/distraction.
- Please take a moment and open your chat box by clicking the chat icon found at the bottom right-hand corner of your screen and as shown in **Figure 1**.
- If you have any questions, please type your questions into the chat box, and they will be answered throughout the presentation.
- Be sure to select “Everyone” when sending a message.

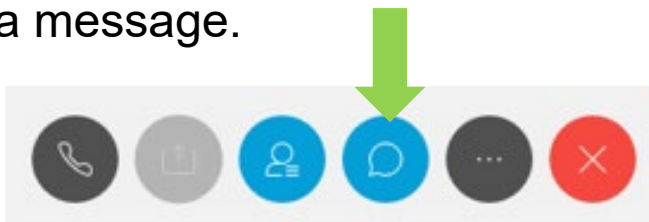
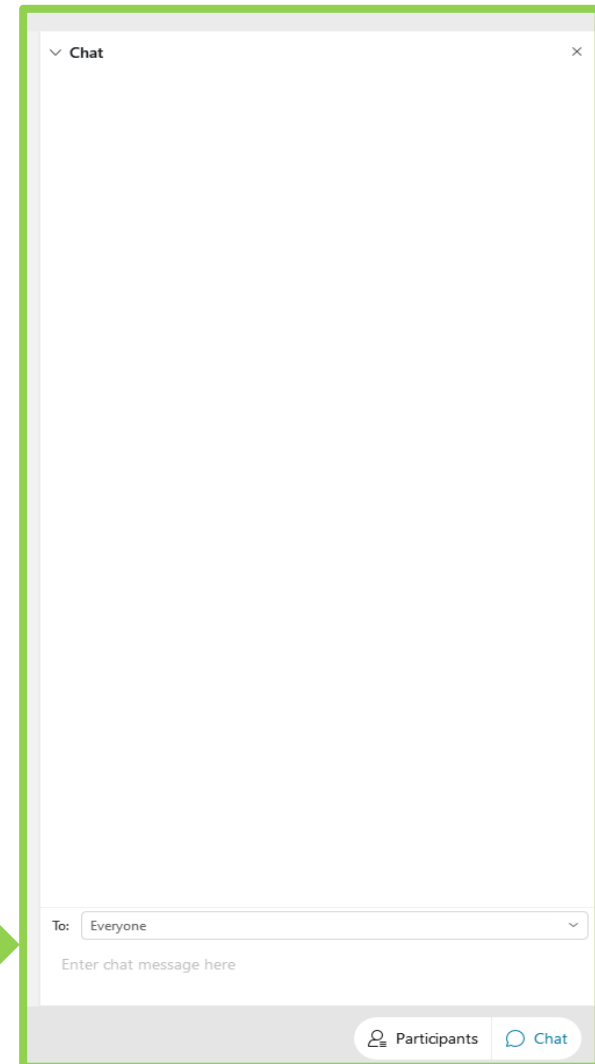


Figure 1



Objectives

1

PHC and Hospital QIP Background

2

2023-24 Close-out Timeline

3

Review of the 2024-25 HQIP Measures

4

Q&A

About Us



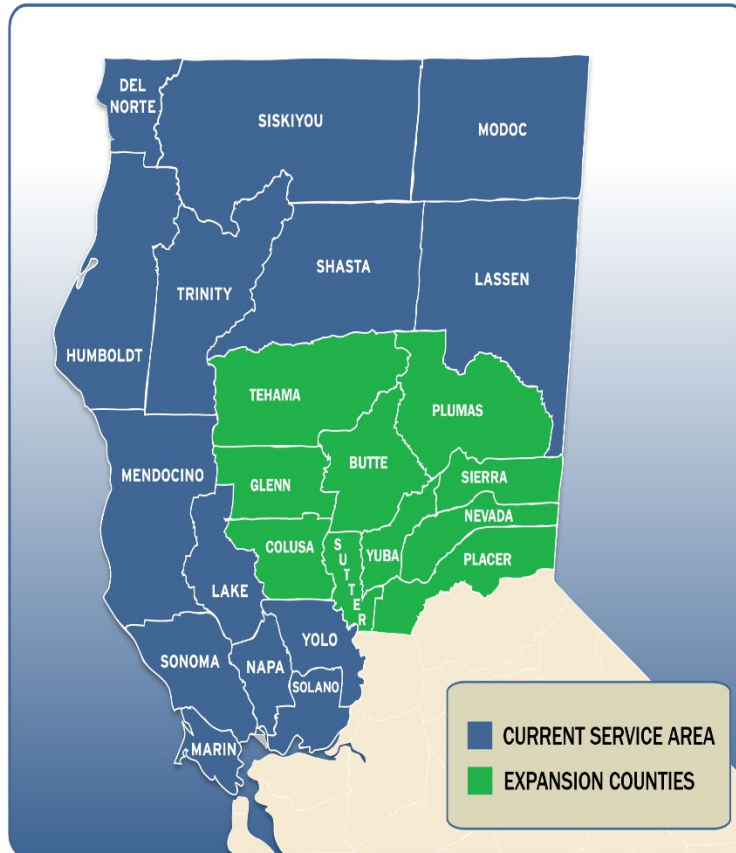
Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

County Expansion



- Partnership has expanded into 10 new counties in 2024!
- Six new hospitals began their participation in the HQIP on January 1, 2024.
- Partnership Reorganized its regions into 6 areas:
- Northwest: Del Norte, Humboldt, Mendocino, Lake
- Northern: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity
- Central: Butte, Colusa, Glenn, Sutter, Yuba
- Eastern: Nevada, Placer, Plumas, Sierra
- Southeast: Napa, Solano, Yolo
- Southwest: Marin, Sonoma

Hospital Quality Improvement Program

- Pay-for-performance program **supporting hospitals** serving PHC members **to improve quality and health outcomes.**
- Substantial Financial Incentives: approximately **\$10.8** million awarded among **25 hospitals in the 2022-23** measurement year
- Six domains: Readmissions, Advance Care Planning, Clinical Quality (OB / Newborn / Pediatrics), Patient Safety, Patient Experience, and Operations and Efficiency



Guiding Principles

1. Where possible, pay for outcomes instead of processes
2. Actionable measures
3. Feasible data collection
4. Collaboration with providers in measure development
5. Simplicity in the number of measures
6. Representation of different domains of care
7. Align measures that are meaningful
8. Stable measures



Hospital QIP

Timeline and Reporting





2023-24 Hospital QIP Close-Out Timeline

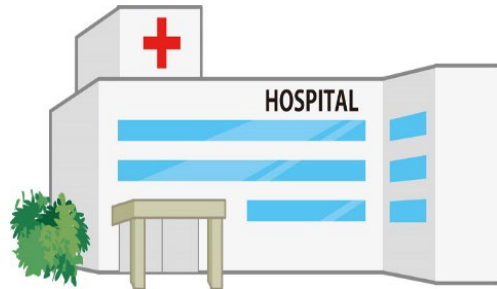


2024-25 Hospital QIP

2024-25 Measures

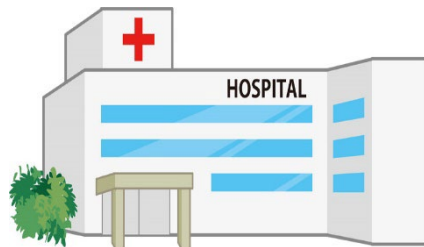


Hospital Size



X-Large Hospitals

≥ 100 licensed general acute beds



Large Hospitals

≥ 50 licensed general acute beds



Small Hospitals

< 50 licensed general acute beds



Very Small Hospitals

< 25 licensed general acute beds



2024-25 HQIP Reporting Timeline

Measure/ Requirement	Hospital Reporting	PHC Reporting to Hospital (outside of final reports)	Hospital Size	Max Points
HIE and EDIE Participation	Status due June 30, 2025 to PHC	N/A	N/A	N/A
Delegation Reporting	Refer to Delegation Agreement Exhibit A	N/A	Capitated Hospitals only	N/A
1. Risk Adjusted Readmissions	No reporting necessary. PHC utilizes claims data to measure performance.	Interim Reporting Available Spring of 2024	Large	10
2. 7-day Clinical Follow-up Visit	No Reporting. PHC utilizes claims data to measure performance	N/A	Large & Small	10 20
3. Palliative Care Capacity	August 31, 2025 to PHC	N/A	Small & Large	Large: 10 Small: 5
4. Elective Delivery	Monthly reporting to CMQCC	N/A	Small & Large with Maternity	5
5. Exclusive Breast Milk Feeding	Monthly reporting to CMQCC	N/A	Small & Large with Maternity	5
6. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	Monthly reporting to CMQCC	N/A	Small & Large with Maternity	Large: 5 Small: 10
7. Vaginal Birth After Cesarean	Monthly reporting to CMQCC	N/A	X-Large Only with Maternity	5
8. Expanding Delivery Privileges	By laws & policy and procedures due August 31, 2025	N/A	Small & Large	5



Measure/ Requirement	Hospital Reporting	PHC Reporting to Hospital (outside of final reports)	Hospital Size	Max Points
9. Increased Capacity for Breast Cancer Screening	Attestation/Report if hosting a mobile mammography clinic. No other reporting.	Provide the baseline rates for the year	Small & Large	10
10. California Hospital Patient Safety (CHPSO)	Report to CHPSO	N/A	Small & Large	Large: 5 Small: 5
11. Substance Use Referral	No reporting necessary. PHC utilizes claims data to measure performance.	Interim Reporting Available Spring of 2024	Small & Large	10
12. QI Capacity	Registration and attendance of PHCs 2024 Hospital Quality Symposium or other approved training.	N/A	Small & Large	5
13. Hospital Quality Improvement Platform	Part I: Verification of participation in HQI Platform by 12/30/24 Part II: Timely, consistent data submissions through June 30, 2025	N/A	Small & Large	5
14. Cal Hospital Compare Patient Experience	PHC receives report with calculated scores from the Hospital Quality Institute after August 31, 2025	N/A	Small & Large	5
15. Health Equity	Submission of HE Plan due to PHC August 31, 2025	N/A	Small & Large	5

HIE + EDIE Participation Requirement

Health Information Exchange (HIE) & Emergency Department Information Exchange (EDIE) implementation and maintenance is a pre-requisite to participating in the Hospital QIP. To have the potential to earn 100% of your hospital's HQIP incentive dollars, all the items below must be met.

- **Admissions, Discharge, Transfer (ADT)**
plus HL7 or XDS interface with either:
 - Sac Valley Med Share*
 - North Coast Health Information Network*
- **ADT interface with EDIE**
- **Link to one of the following national HIE networks:**
 - CareQuality,*
 - eHealth Exchange, or*
 - Commonwell*

Capitated Hospitals: Utilization Management Delegation

Capitated Hospitals also have the additional requirements below that impact the percent amount of HQIP incentive dollars they can earn.

- **Capitated Hospital**

From July 1, 2024 to June 30, 2025, Hospitals must utilize **PointClickCare's EDIE** for their capitated members to alert their internal utilization Management team to out of network admissions.

- PointClickCare will report usage data to Partnership HealthPlan confirming routing (month-by-month) utilization of the Collective Plan module via responsiveness to previously established alerts

- **Delegation Reporting**

In order to receive the full Hospital QIP incentive payment capitated hospitals must submit timely and accurate delegation deliverables to Partnership HealthPlan according to deadlines outlined in your hospital's Utilization Management Delegation Agreement.

Payment Impact

Impact of this requirement for Capitated hospitals 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.

1. Risk Adjusted Readmissions

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

Large & X-Large Hospitals

<1.0 Full Points = 10 Points

≥1.0 - 1.2 for Partial Points = 5 Points

Measurement Period

July 1, 2024 – June 30, 2025

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between July 1st and June 1st of the measurement year 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 3rd and June 30th of the measurement year by PHC members included in the denominator.

1. Risk Adjusted Readmissions (Large Hospitals)

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 1 and June 1 of the measurement year by PHC members included in the denominator.

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

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

Final Measure Calculation:

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

2. 7-day Follow Up Clinical Visit

Goal: Ensure that a follow-up visit with the member's primary care provider, a hospital based provider, or a specialist provider occurs within one week after discharge from the hospital to help reduce readmissions to the hospital. While this can be a struggle, a good strategy is to have a clear and detailed discharge summary appropriately communicated to the follow-up provider at the time of discharge.

Measure Summary

For assigned members 18 to 64 years of age, the percentage of acute inpatient and observation stays for which the member received follow-up within 7 calendar days of discharge. The date of discharge is day zero. Follow-up visits may include in person, telephone, and telehealth visits done at the hospital or outpatient setting. Clinical visits by a qualified medical professional include those with a patient's primary care provider, other specialist, mental health professional, PA, NP, RN, CNM, or a hospitalist/hospital based clinician in a hospital discharge visit. Visits with a case manager (non-RN) would not count towards the numerator for this measure.

2. 7-day Follow Up Clinical Visit

Target

Large Hospitals:

Full Points: 10 points: $\geq 35\%$ of members with a follow-up visit within 7 calendar days of hospital discharge.

Partial Points: 5 points: 30 – 34.9% of patients with a follow-up visit within 7 calendar days of hospital discharge.

Small Hospitals:

Full Points: 20 points: $\geq 35\%$ of members with a follow-up visit within 7 calendar days of hospital discharge.

Partial Points: 10 points: 30 – 34.9% of patients with a follow-up visit within 7 calendar days of hospital discharge.

Denominator

The number of acute inpatient and observation visits on or between July 1st and June 30th of the measurement year 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

The number of members' age 18 to 64 years of age continuously enrolled for at least 90-days prior admission date and 30 days after admission date who had a follow-up visit within 7 calendar days of hospital discharge.

Exclusions

- Discharges for death
- Pregnancy condition
- Perinatal condition
- Transfer to SNFs
- Out Patient in Bed

3. Palliative Care Capacity Measure Requirements

Measure Requirements for X-Large Hospitals with ≥ 100 beds

Hospitals ≥ 100 beds are encouraged to join Palliative Care Quality Collaborative (PCQC) and use it to submit data to PHC.

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, 2024 – June 30, 2025. Hospitals using PCQC can send a report including all consults in PCQC, not just PHC members. For hospitals not participating in PCQC, these entities must submit data from an alternative reporting method to be determined by the hospital.
- Part 2.** Rate of consults who have completed an Advance Care Directive or have a signed POLST to be included in the report described in Part 1:
- **Numerator:** Anyone with an Advance Directive or POLST status in PCQC or inpatient EMR and on the palliative care service at either the time of consult *or* the time of discharge.
 - **Denominator:** Patients with a palliative care consult recorded in PCQC or in the inpatient EMR and on the palliative care service, discharged alive from July 1, 2024 – June 30, 2025.
- Part 3.** Submit Attestation form [Appendix II](#) showing 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

X-Large Hospital Target

X-Large Hospital Target

Full credit: All of the following: (10 points)

Part 1: Minimum of 10 patients

Part 2: $\geq 40\%$

Part 3: Pay for reporting Palliative Care Capacity Attestation Form, [Appendix II](#) including the information listed under Measure Requirements above.

Partial credit: All of the following: (5 points)

Part 1: 5-9 patients

Part 2: $\geq 40\%$

Part 3: Pay for reporting Palliative Care Capacity Attestation Form, [Appendix II](#) including the information listed under Measure Requirements above.

3. Palliative Care Capacity (Excludes Very Small Hospitals)

Large Hospitals with 50-99 Beds:

Palliative Care Teams with 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

Small Hospitals < 50 beds:

Palliative Care Team with one Physician Champion or availability of consultation, with trained clinical staff as defined by specification

Target for both Large and Small Hospitals:

Pay for reporting Palliative Care Capacity Attestation Form including the information listed under Measure Requirements.

Large Hospital Full points = 10 points.

Small Hospitals Full points = 5 points

*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.

Maternity Measures

(Large and Small Maternity Hospitals)

Data Submission Instructions

Hospitals must submit timely* 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: due September 30
- First data submission for July - October: due December 15. Timely data submission after that, starting 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.

4. Elective Delivery before 39 weeks (Large and Small Maternity Hospitals)

Description:

Percent of patients with newborn deliveries at ≥ 37 to < 39 weeks gestation completed, where the delivery was elective within the measurement year.

Numerator: The number of patients in the denominator who had elective deliveries.

Denominator: Patients delivering newborns at ≥ 37 to < 39 weeks gestation.

Target:

- Full Points: $\leq 1.0\%$ = 5 points
- Partial Points: $> 1.0\% - 2.0\%$ = 2.5 points

5. Exclusive Breast Milk Feeding Rate (Large and Small Maternity Hospitals)

Description:

Exclusive breast milk feeding rate for all newborns during the newborn's entire hospitalization within the measurement year

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

Target:

- Full Points: $\geq 75.0\%$ = 5 points
- Partial Points: $70.0\% - < 75.0\%$ = 2.5 points

6. NTSV C Section Rate (Large and Small Maternity Hospitals)

Description:

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

Numerator: Patients with cesarean births.

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

Large Hospital Target:

- Full Points: $< 22\%$ = 5 points
- Partial Points: $\geq 22.0\% - 23.9\%$ NTSV rate = 2.5 points

Small Hospital Target:

- Full Points: $< 22.0\%$ = 10 points
- Partial Points: $> 22\% - 23.9\%$ = 5 points

7. Vaginal Birth After Cesarean (VBAC – X-Large Hospitals Only)

Description:

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.

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

Denominator: Patients with a previous cesarean birth.

Target:

Full Points: $\geq 5.0\%$ VBAC Uncomplicated = 5 points

8. Expanding Delivery Privileges

Measure Summary

This measure is intended to increase the number of family physicians and midwives who are allowed to perform deliveries in the hospitals, which also respects the preferences of women in the community for midwifery care to be performed not just in the home. Increasing the number of family physicians performing deliveries should result in a greater continuity of care between family practitioners and the hospitals. This expansion of the clinicians available for labor and delivery services may help reduce the on-call frequency, and/or responsibility for clinicians on call for hospital these services. Obstetrical privileges for Family Physicians may also serve as an attractor for qualified Family Physicians for areas with primary care shortages.

Specifications

This measure will be implemented over multiple years, starting with the 2024-25 measurement year. In future years, hospitals will be required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity.

8. Expanding Delivery Privileges

Measure Requirements

Hospitals' medical staff bylaws will allow qualified family physicians and midwives to perform deliveries in the hospitals without requiring direct supervision by an obstetrician. In future years, we anticipate a second phase of this measure to include evidence that family physicians and midwives are granted privileges and evidence of clinical activity.

Hospitals with existing family physicians / midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

Measurement Period

July 1, 2024 – June 30, 2025

Target

Full Points: 5 Points

Evidence* that approved Bylaws and Policies are in place by June 30, 2025.

Reporting

*Evidence may include written policy, procedure and bylaws along with board minutes showing approval of bylaws and policy and procedure respective to the measure requirements above. Alternatively, a list of family physicians and midwives with current privileges to attend childbirth may be submitted. All documentation must be submitted to PHC no later than August 31, 2025.

9. Increasing Mammography Screening Capacity

Specifications

Hospitals can be incentivized by increasing access/capacity to mammogram screening by increasing breast cancer screening access/capacity for PHC members by at least 5 to 10%. Each hospital's baseline rate will be calculated from services provided during the previous measurement year in which the hospital participated in the HQIP, i.e. July 1, 2023-June 30, 2024 or January 1, 2024 – June 30, 2024 for those hospitals who joined the HQIP in January 2024. Future year baselines will be determined by the regular measurement year timeframe of July 1 through June 30th of each measurement year.

Measure Requirements

Large Hospitals and Small Hospitals with access to mammography:

Full Points = 10 Points: Increase access/capacity for breast cancer diagnostics and screening by 10% over previous year's baseline.

Partial Points = 5 Points: Increase access/capacity for breast cancer diagnostics and screening by 5-9.9% over previous year's baseline.

Very Small Hospitals without on-site access to mammography:

Full Points = 10 Points: Host at least 1 mobile mammography clinic during measurement year with at least 25 exams conducted with priority given to PHC members. Mammography may be hosted at the hospital or another location such as a Primary Care Provider (PCP) site if collaborating clinic with a PCP.

Reporting

PHC will utilize claims data to determine the percentage of capacity increase each year.

10. CHPSO Participation

Description

Active participation in the California Hospital Patient Safety Organization (CHPSO) via data submission and participation in Safe Table Forums.

Specifications

Small Hospitals (<50 beds):

- Participation in at least 1 Safe Table Forum
- Submission of 10-25 patient safety events to CHPSO
- **Full Points = 10 Points**

Large Hospitals (>50 beds):

- Participation in at least 4 Safe Table Forums
- Submission of 100 patient safety events to CHPSO
- **Full Points = 5 Points**

Reporting: Hospitals report directly to CHPSO. No reporting by hospital to PHC.

11. Substance Use Disorder Referrals

Specifications

To meet the measure criteria, the following must be achieved:

Option 1:

- Hospitals of all sizes can earn full credit for the measure by providing proof of a dedicated full-time substance use navigator for SUD referrals (i.e., Bridge Program Model). Hospitals' proof of dedicated full-time Substance Use Navigator consists of job description, and sample of weekly work schedule.

Option 2:

- 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.

11. Substance Use Disorder Referrals

Target

Option 1: All Hospital Sizes: Proof of full time, dedicated navigator position = 10 points

Option 2:

Large & X-Large Hospitals with ≥ 50 LGA beds: Full points ≥ 10 PHC Members and 40% of PHC Members received prescription or office visit = 10 points.

Small Hospitals with 25 - 50 LGA beds: Full Points ≥ 5 PHC Members = 10 points.

Very Small Hospitals with less than 25 beds:

Full Points ≥ 3 PHC Members = 10 points.

No partial points are available for this measure

12. Quality Improvement Capacity

Description

This measure is intended to introduce resources to all PHC network 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

- Full points for attending the Hospital Quality Symposium in August 2024
- CE/CME hours per person are available for attending this event. Attendance is verified at the event by PHC.

[Redding Area Registration Link](#)

August 5, 2024, 8:30 am – 4:00 pm
Registration and Networking Breakfast starts at 8:30

Gaia Hotel & Spa Redding, Ascend Hotel
Collection
4125 Riverside Place, Anderson, CA, 96007

[Fairfield Registration Link](#)

August 7, 2024, 8:30 am – 4:00 pm
Registration and Networking Breakfast starts at 8:30

Partnership HealthPlan of California
4605 Business Center Dr, Fairfield, CA 94534

2024 Hospital Quality Symposium Agenda

SYMPOSIUM AGENDA | 8:30 a.m. to 4:00 p.m. (Topics & times are subject to adjustment)

8:30 – 9:00	Registration and Networking Breakfast
9:00 – 9:15	Welcome and Introductions: <i>Robert Moore, MD, MPH, MBA – Chief Medical Officer, Partnership</i>
9:15 – 10:15	Keynote Session: Battling Buprenorphine Stigma in the ED: <i>Arianna Campbell, MPH, PA-C, Principal Investigator, Bridge</i>
10:15 – 11:15	Training the Next Generation of Nurses: <i>Christi Myers, MSN, RN, PHN Director of Nursing & Allied Health at Lassen College, Moderators - Mark Netherda, MD & David Lavine – Partnership</i>
11:15 – 12:15	Leading your Hospital on the Equity Journey: Meeting local needs as you align with new CMS quality reporting requirements. <i>Robert Moore, MD, MPH, MBA, Chief Medical Officer & Mohamed Jalloh, Pharm. D., BCPS, Health Equity Director – Partnership</i>
12:15 – 1:00	Lunch Break
1:00 – 2:00	CalAIM Progress for Acute Care Settings: Innovative Models and Early Outcomes <i>Katherine Barresi, RN, BSN, PHN, NE-BC, CCN, Chief Health Services Officer – Partnership</i>
2:00 – 3:00	Decoding the Chaos: Sepsis Incidence, Mortality, Readmission and Missed Opportunities <i>Scott Masten, PhD, Vice President, Measurement Science & Performance Analytics & Kamali Jones, MSN, RN, PHN, AG-ACCNS – Hospital Quality Institute</i>
3:00 – 4:00	Providing Compassionate Care to patients with Mental Health Struggles: <i>Valerie <u>Greggi</u>, BSN, RN, CMSRN</i>
4:00 – 4:15	Closing Remarks & Survey: <i>Mark Netherda, MD, Medical Director for Quality – Partnership</i>

13. Hospital Quality Improvement Platform

Measure Summary

Participation in the Hospital Quality Improvement Platform and timely, complete data submissions. The HQI Platform is available to all California Hospital Association members at no additional charge. This measure is broken into three (3) parts;

1. Participation in HQI Platform (verified by December 31, 2024), including NHSN rights conferral (PHC will assess hospital usage June 30, 2025) **and**,
2. One (1) submission of data into the HQI platform by December 31, 2024 **and**,
3. Timely, complete and consistent submission of discharge data into HQI Platform

Target

Full Points = 5 points: Hospitals maintain data sharing agreement with HQI for prior measurement year or successfully sign up with HQI, confer NHSN rights, submit all discharge data due to HCAI into the Hospital Quality Improvement Platform by December 31, 2024, and continue to submit all discharge data into the platform for the remainder of the measurement year. PHC assesses timely data submission at the end of the measurement year. |

Partial Points = 2.5 points: Hospitals maintain data share agreement with HQI from prior measurement year or successfully sign up with HQI, confer NHSN rights, and submit all discharge data due to HCAI into the Hospital Quality Improvement Platform by December 31, 2024.

13. HQI Platform

Measurement Period

Part 1 & 2: July 1, 2024 – December 31, 2024

Part 3: January 1, 2025 – June 30, 2025

Reporting

All reporting happens through the HQI platform.

To begin participation in the HQI platform: visit <https://hqinstitute.org/the-hospital-quality-improvement-platform/>, complete the Business Associate and Participation Agreements in the “[Join the Program](#)” section, and retrieve [upload instructions](#).

14. Cal Hospital Compare

Specifications

Hospital Patient Experience data 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. [29](#)

Numerator = The total numerical value of the hospital's Patient Experience Scores.

Denominator = The total numerical value of the State's Patient Experience Scores.

Target

Full Points: 5 Points:

Hospital aggregate score is greater than average California hospital score * 1.00/100%

Partial Points: 2.5 points:

Hospital aggregate score is greater than average California hospital score 95-.99 / 95-99%

Measurement Period

July 1, 2024 – June 30, 2025

Reporting

* No reporting to PHC necessary. PHC will collect data that hospitals submit to Cal Hospital Compare from the CMS Data File and compare aggregate score to the average California hospital score.

15. Health Equity

Description: Partnership HealthPlan of California (PHC) is actively engaged in Health Equity (HE) initiatives that bring about equitable awareness and result driven change within the 24 counties we serve and we highly encourage provider organizations to join our efforts. At PHC, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to healthcare.

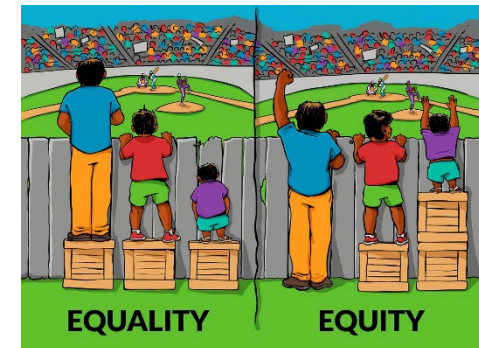
Target

Submission of an HE report based on identifying health inequities as outlined in measure requirements on next slide.

Due Date: Report due by August 31, 2025

Full Points = 5 Points

No Partial Points



Health Equity Submission Requirements

Submission shall demonstrate:

1. Using hospital data to identify at least one outcome inequity or service inequity of interest to the hospital. Any category of inequity for which the hospital has data, is acceptable. This may include: ethnicity, sex, sexual orientation, gender identity, language, residence, disability.
2. Present data analysis and any drill-down and roll-up analysis done to characterize the scope and drivers of the inequity.
3. A discussion of hypothesized drivers for the inequity.
4. Describe an intervention plan or pilot designed to address the inequity.
5. Provider data measuring the effect of this intervention or pilot
6. Summarize lessons learned from this intervention/pilot and plans for the future.



Contact Us

Contact Information

Troy Foster

Program Manager II, Hospital Quality Incentive Program

Partnership HealthPlan of California

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E-mail: HQIP@partnershiphp.org

Our website: www.partnershiphp.org

HQIP Website: <http://www.partnershiphp.org/Providers/Quality/Pages/Hospital-QIP.aspx>



The End

Thank you for joining us today!

