HOSPITAL QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

Large Hospitals are ≥ 50 licensed, general acute (LGA) beds

Small Hospitals are < 50 licensed, general acute (LGA) beds

2024-2025
MEASUREMENT YEAR

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Published: July 2024

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PROGRAM OVERVIEW

Partnership HealthPlan of California (Partnership) has value-based programs in the areas of primary care, hospital care, long-term care, palliative care, perinatal care, specialty care and behavioral health. These value-based programs align with Partnership'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 hospital representatives 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 stakeholders guide measurement set development annually. 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

In general, to be eligible, a hospital must have a Partnership contract by October 1 of the measurement year, (which runs from July 1 – June 30). Hospital must remain contracted through June 30 of the measurement year to be eligible for payment. Participation will require signing a contract amendment, as specified by the Partnership Provider Contracting team, to participate in the 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, Partnership has the sole authority to further determine if a provider is in Good Standing based on the criteria set forth below (for the purpose of QI program continuity, "provider" is substituted here for "hospital"):

1. Provider is open for services to Partnership 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, Partnership will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against Partnership.
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 Partnership on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following Partnership 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 averse to the business interests of Partnership.

PARTICIPATION REQUIREMENTS (continued)

b) HIE and EDIE Participation

Health Information Exchange (HIE) & Emergency Department Information Exchange (EDIE) implementation and maintenance is a pre-requisite to participating in 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 Emergency Departments (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 Consolidated Clinical Document Architecture (CCDA) documents. Allows set up of alerts and notifications.

2. EDIE: Allows continuity of critical information on Emergency Department (ED) use across multiple states.

3. National HIE networks: Allows query of distant data sources, including national data (Social Security, VA system).[1]

Requirements for all hospitals are as follows:

1. Hospitals will maintain an HIE interface with a community HIE, to include an ADT and XDSb interface or a HL7 lab, radiology interface or with one of the following community HIEs:

    - Sac Valley Med Share (SVMS)
    - North Coast Health Information Network (NCHIN)

    Regardless of the mechanism of the exchange, the data elements of this interface must meet USCDI Level 1. We recommend striving towards meeting Level 2, as this is likely a future standard: https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#level-1

2. Admission, Discharge and Transfer (ADT)1 interface with PointClickCare's EDIE module (either directly with PointClickCare 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

Incentive Impact/Component Requirements:

- 100% of eligible dollars
  Community HIE interface with ADT plus HL7 or XDS with USCDI stage 1data; link to national network; and interface with EDIE available by June 30, 2025

- 90% of eligible dollars
  Community HIE interface with ADT plus HL7 or XDS with USCDI stage 1 data; link to national network; and interface with EDIE available not active on June 30, 2025, but all available by August 31, 2025

- 85% of eligible dollars
  Community HIE interface with ADT (but without HL7 or XDS interface or without all elements of USCDI stage 1 data); link to national network; and interface with EDIE available active by August 31, 2025

- 75% of eligible dollars
  Two of three interfaces active by August 31, 2025

- 50% of eligible dollars
  One of three interfaces completed by August 31, 2025

- 0% of eligible dollars
  None of three interfaces completed by August 31, 2025

This requirement will be satisfied upon hospital submission of Summary of HIE systems (available in Appendix I), and verification of participation by Partnership with the vendor. By participating in the Hospital QIP, hospitals authorize vendors from community HIEs and PointClickCare to inform Partnership of their participation status with the vendor:

Item	Completed By	When
Information Exchange Implementation or Maintenance	Hospitals	October 31, 2024
EDIE participation verification via HQIP: New and continuing hospitals must email verification to Partnership via the HQIP inbox: hqip@partnershiphp.org	Partnership	August 31, 2025

PARTICIPATION REQUIREMENTS (continued)

c) ***Capitated Hospitals Only***: Utilization Management Delegation

1. From July 1, 2024 to June 30, 2025, Hospitals must utilize the PointClickCare module of PointClickCare's EDIE, for their capitated members to alert their internal Utilization Management team to out-of-network admissions.
    - PointClickCare utilization must remain regular and consistent throughout the measurement year.
    - PointClickCare will report usage data to Partnership HealthPlan confirming routing (month-by-month) utilization of the PointClickCare EDIE module via responsiveness to previously established alerts.

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 UM delegation agreement.

    Impact of this requirement for Capitated hospitals is as follows:

    - Timely submitting **≥ 90.0%** of delegation reporting requirements results in **100%** distribution of earned Hospital QIP incentive payment.
    - Timely submitting **≥ 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.

Performance Methodology

Participating hospitals are evaluated based on a points system, with points being awarded when performance meets or exceeds the threshold listed for each measure (outlined in the 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 100% of their allocated 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 (i.e. the nearest 0.1%).

Payment Methodology

The Hospital QIP incentives payments are separate and distinct from a hospital's usual reimbursement for services provided to Partnership members. Hospital QIP earnings are determined at the end of the measurement year according to the number of program points earned. QIP payments will be mailed by November 30th, following the measurement year. The potential incentive payment amount for Hospitals with less than 25 Licensed, General Acute (LGA) beds is fixed at a maximum of $25,000.

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 Partnership of a calculation or point attribution error that would result in potential under or over payment, the error may be appealed post-payment for up to 30-days after payment distribution. However, Partnership maintains the right to recoup overpaid funds any time after payment is distributed. Aside from this, post-payment disputes of final data, as described below, will not be considered for an appeal:

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**
   This Hospital QIP Measurement Set correlates the measure targets and reporting requirements to the different hospital size designations of Large and Small and may at times include the two subsets of X-Large and Very Small hospitals. The Large Hospitals measure set applies to hospitals with at least 50 licensed, general acute (LGA) beds, including the X-Large hospital subset with greater than 100 LGA beds. The Small Hospital measure set applies to hospitals with 49 or less LGA beds, but also includes the smaller subset of "Very Small hospitals" with less than 25 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 will not be considered.

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 30 days of receiving the final statement. All conversations regarding the dispute will be documented and reviewed by Partnership. All payment adjustments will require approval from Partnership's Executive Team.

REPORTING TIMELINE

The Hospital QIP runs on an annual program period, beginning July 1st and ending June 30th. 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 close of the measurement year. Please see the reporting summary below:

Table 2. 2024-2025 Hospital QIP Reporting Timeline for Performance Measurement Period of July 1, 2024 thru June 30, 2025
Measures 4-8 apply only to hospitals with maternity services

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

9. Increasing Screening Mammogram Capacity	Attestation/Report if hosting a mobile mammography clinic. No other reporting.	Provide the baseline rates for the year	Large & Small	10
10. California Hospital Patient Safety (CHPSO)	Report to CHPSO	N/A	Large & Small	Large: 5 Small: 5
11. Substance Use Referral	No reporting necessary. Partnership utilizes claims data to measure performance.	Interim Reporting Available in the Spring	Large & Small	10
12. QI Capacity	Registration and attendance of Partnership's *2024 Hospital Quality Symposium* or other approved training.	N/A	Large & Small	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	Large & Small	5
14. Cal Hospital Compare Patient Experience	Partnership receives report with calculated scores from the Hospital Quality Institute after August 31, 2025	N/A	Large & Small	5
15. Health Equity	Submission of HE Plan due to Partnership August 31, 2025	N/A	Large & Small	5

2024-2025 LARGE & SMALL HOSPITAL SUMMARY OF MEASURES

Table 3. Summary of Measures

Measure	Target/Points
Community HIE and EDIE Interface (*Required*)	
All hospitals must complete or maintain an interface with a community HIE, a national HIE network, and EDIE interface by the end of measurement year (MY), **and** demonstrate use of this interface by the end of June 30, 2025	All hospitals must complete defined interfaces by the end of MY. Demonstrated use templates: Appendix I & Appendix II For capitated hospitals **only**: 1. Hospitals must use PointClickCare EDIE module to generate alerts for out of network inpatient admissions for their capitated members. 2. PointClickCare utilization must remain regular and consistent throughout measurement year
Risk Adjusted Readmission Domain (20 points)	
Measure 1: Risk Adjusted Readmissions for all hospitalized Partnership patients	**Large & X-Large Hospitals Only** **Full Points** = 10 points: RAR is <1.0 **Partial Points** = 5 points: RAR is ≥1.0 - 1.2
Measure 2: 7-day Clinical Follow-up Visits	**Large Hospitals:** **Full Points: 10 points: ≥ 35%** of members with a follow-up visit within 7 days of hospital discharge. **Partial Points: 5 points: 30 – 34.9%** of patients with a follow-up visit within 7 days of hospital discharge. **Small Hospitals:** **Full Points: 20 points: ≥ 35%** of members with a follow-up visit within 7 days of hospital discharge. **Partial Points: 10 points: 30% - 34.9%** of patients with a follow-up visit within 7 days of hospital discharge.
Advanced Care Planning (Large Hospitals: 10 points / Small Hospitals: 5 points) ****Very Small Hospitals are excluded from this measure****	
Measure 3: Palliative Care Capacity	**X-Large Hospitals > 100 Beds: Quality Measure Reporting** **Full credit (10 points) - All of the following:** Part 1: Minimum of 10 patients Part 2: ≥ 40% of patients with completed AD or signed POLST Part 3: Palliative Care Team Attestation Form

	Partial credit (5 points)- All of the following: Part 1: 5-9 patients Part 2: ≥ 40% of patients with completed AD or signed POLST Part 3: Palliative Care Team Attestation Form **Large Hospitals 50-99 Beds:** 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. **Small Hospitals 25-49 Beds (Excluding Very Small Hospitals < 25 beds):** Hospitals meeting one of two options will receive full points: • Option for small 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) *Training must total 4 CE or CME hours per staff. Training options include ELNEC, EPEC, or the CSU Institute for Palliative Care.
Clinical Quality: OB / Newborn / Pediatrics (35 points)	
For all maternity care measures, hospitals must timely* submit data to California Maternal Quality Care Collaborative (CMQCC). Hospitals must authorize Partnership 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 30th. First data submission for months of July - October due by December 15, 2024. 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.	

Measure 4: Rate of Elective Delivery Before 39 Weeks	• **Full Points**: ≤ 1.0% = 5 points • **Partial Points**: >1.0 – 2.0% = 2.5 points
Measure 5: 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
Measure 6: Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	• **Full Points**: < 22.0% • **Large Hospitals**: 5 points **Small Hospitals**: 10 points • **Partial Points:** ≥ 22.0% - 23.9% **Large Hospitals**: 2.5 points **Small Hospitals**: 5 points
Measure 7: Vaginal Birth After Cesarean (VBAC)	**Only hospitals >100 beds eligible.** • Full Points: ≥ 5% = 5 points • No partial points available
Measure 8: Expanding Delivery Privileges	**Full Points** = 5 points • No partial points available.
Measure 9: Increasing Screening Mammogram Capacity	**Full Points** = 10 points for 10% capacity increase over last year • No partial points available
Patient Safety (15 points)	**Only Full Points awarded for the measure**
California Hospital Patient Safety Organization (CHPSO) Participation	• **Large Hospitals:** 5 points – Submit 100 events – Attend 4 Safe Table Forums • **Small:** 5 Points – Submit 10-25 events – Attend 1 Safe Table Forum
Substance Use Disorder Referrals from Emergency Department	**Option 1:** All: Proof of full time, dedicated Substance Use Navigator position = 10 points **Option 2:** **Large & X-Large Hospitals with ≥ 50 LGA beds**: Full points ≥ 10 Partnership Members and 40% of Partnership Members received prescription or office visit = 10 points. **Small Hospitals with 25 - 49 LGA beds:** Full Points ≥ 5 Partnership Members = 10 points. **Very Small Hospitals:** ≥ 3 Partnership Members = 10 points**.**

Operations/Efficiency (15 points)	
Quality Improvement (QI) Capacity	**Only Full Points awarded for measure.** • 5 points awarded for attendance at Partnership's 2024 Hospital Quality Symposium or other approved training
Hospital Quality Improvement (HQI) Platform	**Full Points = 5 points** **New HQI participants: All of the following:** • **Part 1**: Proof of successful enrollment in HQI Platform as evidenced by a signed data sharing agreement with HQI • **Part 2:** At least one (1) submission of data into HQI platform by 12/30/2024. • **Part 3:** Continued monthly submission of discharge data from January 2025 through June 2025. **Existing HQI participants**: • For hospitals with existing data sharing agreement, full points are awarded for maintaining *continued* timely data submissions *monthly* for the measurement year. • Partial Points are available for hospitals who have a data share agreement with HQI but have not submitted monthly data. **Partial Points = 2.5 points** • **Part 1**: Proof of successful enrollment in HQI platform as evidenced by a signed data sharing agreement with HQI • **Part 2**: At least one (1) submission of data into HQI platform by 12/30/2024.
Patient Experience (15 Points)	**Only Full Points awarded for the measure**
Cal Hospital Compare-Patient Experience	**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.
Health Equity	**Full points** = 5 points earned for approved Health Equity Report or for proof of Joint Commission Health Equity Accreditation. Submission of HE Report or accreditation due to Partnership **August 31, 2025**

2024-2025 MEASURE SET SPECIFICATIONS

Measure 1. *Risk Adjusted Readmissions*

This measure is required for Large & X-Large hospitals only.

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).[2-5]

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 Only

<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 Partnership 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 Partnership is required. Note for capitated hospitals: the readmission rate used for this measure is based on all Partnership adult members (ages 18-64) admitted to the hospital, whether they are capitated or not.

Measure 2. *7- Day Follow-up Clinical Visits*

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.

Target

Large Hospitals:

Full Points: 10 points: ≥ 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: ≥ 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.

Measurement Period

July 1, 2024 – June 30, 2025

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 & Perinatal conditions, SNF transfers, Out-Patient in Bed

Measure 3. *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.[6-8]

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 Partnership.

Required to provide the following to Partnership:

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 Partnership 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

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

Part 1: Minimum of 10 patient consults per month
Part 2: ≥ 40% of patients with a completed AD or signed POLST
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 patient consults per month
Part 2: ≥ 40% of patients with a completed AD or signed POLST
Part 3: Pay for reporting Palliative Care Capacity Attestation Form, Appendix II including the information listed under Measure Requirements above.

Measure Requirements for Large Hospitals with 50-99 Beds

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).

Large Hospital Target

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

Large Hospital Full points = 10 points. No partial points are available for this measure.

Measure Requirements for Hospitals with Small <50 Beds

Hospitals <50 beds: 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).

*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.

Small Hospital Target

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

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

Measurement Period

July 1, 2024 – June 30, 2025

Exclusions

Hospitals with < 25 general acute beds are excluded from this measure.

Reporting

- Hospitals ≥ 100 beds: PCQC Annual reporting or other report alternative, and submit attestation form no later than **August 31, 2025** via email at HQIP@partnershiphp.org or fax to Partnership 707-863-4316.
- Hospitals 50-99 beds: Submit attestation form no later than **August 31, 2025** via email at HQIP@partnershiphp.org or fax to Partnership: 707-863-4316.
- Hospitals <50 beds: Hospitals must submit an attestation form no later than **August 31, 2025** via email at HQIP@partnershiphp.org or fax at 707-863-4316.

- *Palliative Care providers who are certified by the appropriate organization may submit the certification and date of certification. See Appendix (X) for a list of acceptable certifications. Staff who do not have Palliative Care Certification must submit documentation of training as listed in Appendix under Palliative Care Certifications. Training must total 4 CE or CME hours every two years. Training options include ELNEC, EPEC, the CSU Institute for Palliative Care, or other approved Palliative Care Training.

A Special Note for Measures 4-8: Maternity Care Measures

Measures 4-8 only apply to those hospitals providing maternity services**.**

Early Elective Delivery, Exclusive Breast Milk Feeding, and Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate measure apply to maternity hospitals regardless of hospital size.

The Vaginal Birth After Caesarian measure only applies to X-Large hospitals.

Since Very Small hospitals do not provide maternity services, these measures are not applicable to them.

Measures 4-7 Data Submission Instructions: Hospitals must submit timely* data to California Maternal Quality Care Collaborative (CMQCC). Hospitals must authorize Partnership 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, 2024. 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.[9-15]

Measure 4. *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.[9] It has been found that compared to spontaneous labor, elective deliveries result in more cesarean births and longer maternal lengths of stay.[10] 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.[11] 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.[12-14] 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.[15]

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 Partnership Hospital QIP participant data.

Measurement Period

July 1, 2024 – June 30, 2025

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 Partnership'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, 2025.**

Measure 5. *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.[16-22]

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, 2024 – June 30, 2025

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, 2025.**

Measure 6. *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.[23]

Measure Summary

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

Target

Large Hospitals

Full Points: < 22.0% NTSV cesarean rate = 5 points

Partial Points: ≥ 22.0% - 23.9% NTSV rate = 2.5 points

Small Hospitals

Full Points: < 22.0% NTSV cesarean rate = 10 points

Partial Points: ≥ 22.0% - 23.9% 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, 2024– June 30, 2025

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, 2025.**

Measure 7. *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, 2024 – June 30, 2025

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, 2025.**

Measure 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 the hospitals and the family practitioners. 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.

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 Partnership no later than August 31, 2025.

Measure 9. *Increasing Screening Mammogram Capacity*

Measure Summary

According to the CDC, "Cancer is the second leading cause of death in the United States, and breast cancer is one of the most commonly diagnosed cancers in women. The risk of breast cancer increases with age. About 83% of breast cancer diagnoses each year are among women aged 50 or older."[24]

Increasing the access to mammograms is a powerful tool to help screen more women for breast cancer. Catching cancers early is crucial to successful treatment of the disease. This measure encourages hospitals to increase access to mammography outside of normal business hours and/or through mobile mammography clinics.

Specifications

Hospitals can be incentivized by increasing access/capacity to mammogram screening by increasing breast cancer screening access/capacity for Partnership 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 Partnership 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

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

Exclusions

Breast Magnetic Resonance Images (MRIs) do not count toward the targets.

Measure 10. *CHPSO Patient Safety Organization Participation*

California Hospital Patient Safety Organization (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. Please reference AHRQ's common reporting formats for information on the elements that may comprise a complete report. You may also contact CHPSO via email at info@hqinstitute.org to seek more information or examples of what may be considered a patient safety event.

Large Hospitals:

- Participation in at least four (4) "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

Small Hospitals:

- Participation in at least one (1) "Safe Table Forum", either in-person or virtually, during the Measurement Year
- Submission of 10 - 25 patient safety events to CHPSO, for events occurring within the measurement year or the year prior

Target

***Large Hospitals*: Full Points = 5 points**. No partial points are available for this measure.

***Small Hospitals*: Full Points = 5 points**. No partial points are available for this measure.

Measurement Period

July 1, 2024 – June 30, 2025

Reporting

Hospitals will report directly to CHPSO using their risk management reporting system. Please contact CHPSO/HQI via email at info@hqinstitute.org for more information. No reporting by hospital to Partnership is required. In order to receive credit for this measure, hospitals must grant CHPSO/HQI permission to share submission status updates with Partnership by **August 31, 2025**.

Measure 11. *Substance Use Disorder Referrals*

Substance Use Disorder 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:

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 Partnership Members with ICD10: F11.1x 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.x

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 ED or inpatient stay, during the Measurement Year.

- **Data Collection:** Partnership 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

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 Partnership Members and 40% of Partnership Members received prescription or office visit = 10 points.

Small Hospitals with 25 - 50 LGA beds: Full Points ≥ 5 Partnership Members = 10 points.
Very Small Hospitals with < 25 beds: Full Points ≥ 3 Partnership Members = 10 points.

No partial points are available for this measure

Measurement Period

July 1, 2024 – June 30, 2025

Exclusions

N/A

Reporting

Partnership will access claims data to determine performance.

Measure 12. *Quality Improvement (QI) Capacity*

Measure Summary

This measure is intended to introduce resources to all Partnership 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.

Partnership offers the *Hospital Quality Symposium* with the intent to encourage Partnership contracted hospitals to send staff of all levels to an informative learning session (One (1) representative per entity site location). Full credit is also available for attending the national meeting of the Institute for HealthCare Improvement.

Specifications

- CE/CME hours per person are available for attending this event
- Attendance at this event will be verified at the event by Partnership
- The following are examples of potential quality topics that may be presented at this event:
  - Health Equity
  - Infection control or prevention
  - Outpatient care coordination
  - Opioid epidemic
  - Perinatal care services
  - Emerging data resources
  - Ways to reduce readmissions
  - Addressing Workforce Challenges

Target

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

Reporting

Hospital staff registration and attendance of the event in its entirety will be documented for reporting by Partnership. If IHI attendance is used, submission of proof of attendance documentation.

Measure 13. Hospital Quality Improvement Platform

The Hospital Quality Improvement platform is supported by the Hospital Quality Institute (HQI). The HQI provides coordination and support for improvement and measures supporting patient safety and quality improvement activities. This measure is designed to encourage hospitals to submit data into the HQI Platform and allow Partnership access to view hospital-specific results.

Participation in this platform will allow Partnership the visibility to see hospital-specific measure performance for network hospitals using validated hospital quality measures. Hospitals who sign up are encouraged to continue submitting data into the platform for the remainder of the year in order to achieve full points in this measure. In order to participate in this measure, hospitals must sign a data sharing agreement with HQI to share summary data for scoring.

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 (Partnership 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 sing up with HQII, 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. Partnership 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.

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.

Measure 14. *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 for creating a high quality hospital. There are many ways to gather information on patient experience. Ratings and data sources can be viewed on resources 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. [27]

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 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. [28]

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 Partnership necessary. Partnership 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.

Measure 15. *Health Equity*

Measure Summary

Partnership 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 Partnership, 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.[29-32]

Specifications

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

Measure 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. Provide data measuring the effect of this intervention or pilot
6. Summarize lessons learned from this intervention/pilot and plans for the future.

Measurement Period

July 1, 2024 – June 30, 2025

Target

Full Points: 5 Points for approved Health Equity Report or proof of Joint Commission Health Equity Accreditation. There are no partial points available for this measure.

Reporting

All reports must be submitted Partnership no later than August 31, 2025.
(See the Resource section of the Appendices for an example of a report)

Proof of Joint Commission Health Equity Accreditation can be submitted in place of the Health Equity Report to earn full points for the measure.

APPENDICES

Appendix I: Information Exchange Verification – New Hospitals

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, 2024

To qualify for full incentive amount for the 2024-2025 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, 2025. 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 2024-25.*

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: Information Exchange Verification – Continuing Hospitals

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
Due June 30, 2025

Hospital Name:

Name and Title of Employee Completing Form **Today's Date**

To qualify for full incentive amount for the 2024-2025 Hospital QIP, hospitals continuing in the HQIP, must verify continued use of a Community HIE interface with ADT plus HL7 or XDS; and their link to national network and interface with EDIE.

Please confirm your continued participation and detail any changes for 2024-2025 by completing this form and emailing it to HQIP@partnershiphp.org.

Please confirm your continued use of HIE and EDIE by answering the following questions:

1. Name of Community HIE:
    a. Date(s) of Implementation:
2. Date of EDIE go live:
3. Name of active link to either CareQuality, eHealth Exchange, or Commonwell
4. National network interface activation date:

If needed, please add any additional information that clarifies any of the above information:

Appendix III: Palliative Care Capacity

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

Measure 3. Hospital QIP Palliative Care Capacity Attestation
****NOTE****: Very Small hospitals with less than 25 general acute beds will be excluded from this measure.

Hospitals in the Partnership HealthPlan of CA (Partnership) provider network who provide Palliative Care services may qualify for a financial bonus under Partnership'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).

Palliative Care capacity must be established **between July 1, 2024 and June 30, 2025**. All submitted attestations are reviewed by Partnership. Upon approval, the attestation will qualify for the incentive. Attestation forms should be submitted no later than **August 31, 2025** via email at HQIP@partnershiphp.org or fax at 707-863-4316.

Measure 2. Palliative Care Capacity Continued

☐ **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, 2024 and June 30, 2025.
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 (MD, DO, 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 2024-25, and team goals/challenges addressed in 2024-25

Measure 3. Palliative Care Capacity Continued

☐ **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, 2024 and June 30, 2025.
2. CE/CME certificates for trained clinicians.

Hospital Name:

_____

Submitted By: _____ Date: _____

Please complete the following information for Palliative Care clinicians:

Certified Provider Staff:

Name	Title	Certification Organization	Certification Date

Non-Certified Provider Staff:

Name	License	Course Provider	Course	Education Hours

Palliative Care Certifications for PHC Hospital QIP Program:

Physician:

- Board certification in Hospice and Palliative Care by the American Academy of Hospice and Palliative Care

Nurse Practitioner:

- Advanced Certified Hospice and Palliative Nurse (ACHPN) certification from the Hospice and Palliative Care Credentialing Center (HPCC)
- Advanced Practice RN Certificate in Palliative Care from CSU Shirley Haynes Institute for Palliative Care

Nurse:

- Certified Hospice and Palliative Care Nurse (CHPN) by Hospice and Palliative Care Credentialing Center (HPCC)
- RN Certificate in Palliative Care from CSU Shirley Haynes Institute for Palliative Care

Social Workers:

- Advanced Palliative Hospice Social Worker – Certified by Hospice and Palliative Care Credentialing Center (HPCC)
- Certification by National Association of Social Workers (NASW), the National Hospice and Palliative Care Organization (NHPCO), or the Social Work Hospice and Palliative Network (SWHPN)
- Advanced Practice Palliative Care Certificate for Social Workers from CSU Shirley Haynes Institute for Palliative Care

Spiritual Care:

- Certificate in Palliative Care by Board of Chaplaincy (BCCI), Association of Professional Chaplains (APC) or National Association of Catholic Chaplains (NACC)

Non-Certified Team Members:

For providers who do not have certification by a specialty board or hospice/palliative care organization, the provider must provider a list of courses in palliative care.

Requirements:

- Minimum or four hours of palliative care medical education every four years.
- Documentation must include:
    - Course provider
    - Course name
    - Date of course
    - Number of education hours

Resource: Health Equity Report Example

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.

Our Community Hospital collects data from hospital inpatients who identify as unhoused.

2. Present data analysis and any drill-down and roll-up analysis done to characterize the scope and drivers of the inequity.

On admission, patients are asked for identification of their current residence to determine housing status. Unhoused patients are identified and prior to discharge from the hospital, the primary nurse and the discharge planner assist with addressing gaps by offering supportive services prior to discharge. In 2023, 114 inpatients were identified as unhoused. Year to date in 2024, 78 inpatients have been identified as unhoused when screened. Our Hospital works closely with a county coalition, which reserves two men's beds in their Men's Transitional Housing unit for our Hospital to send our unsheltered men who need further medical care or Home Health. Home Health must have an address for a patient to admit them to service. Going to the medical bed in facility also allows patients to keep dressing dry, have a place to store medications and have access to food and clean water. The coalition also has many other resources available such as a day center, transitional housing and emergency housing.

3. A discussion of hypothesized drivers for the inequity.

When the 2023 Point-in-Time survey was released it found that there were 304 people in our County experiencing unsheltered or sheltered homelessness in 2023. This was an increase from 2021 where there were 267 people and from 2019 where there were 288. The 35-44 age group had the largest population of homeless. Several drivers exist as potential causes of homelessness and housing insecurity.

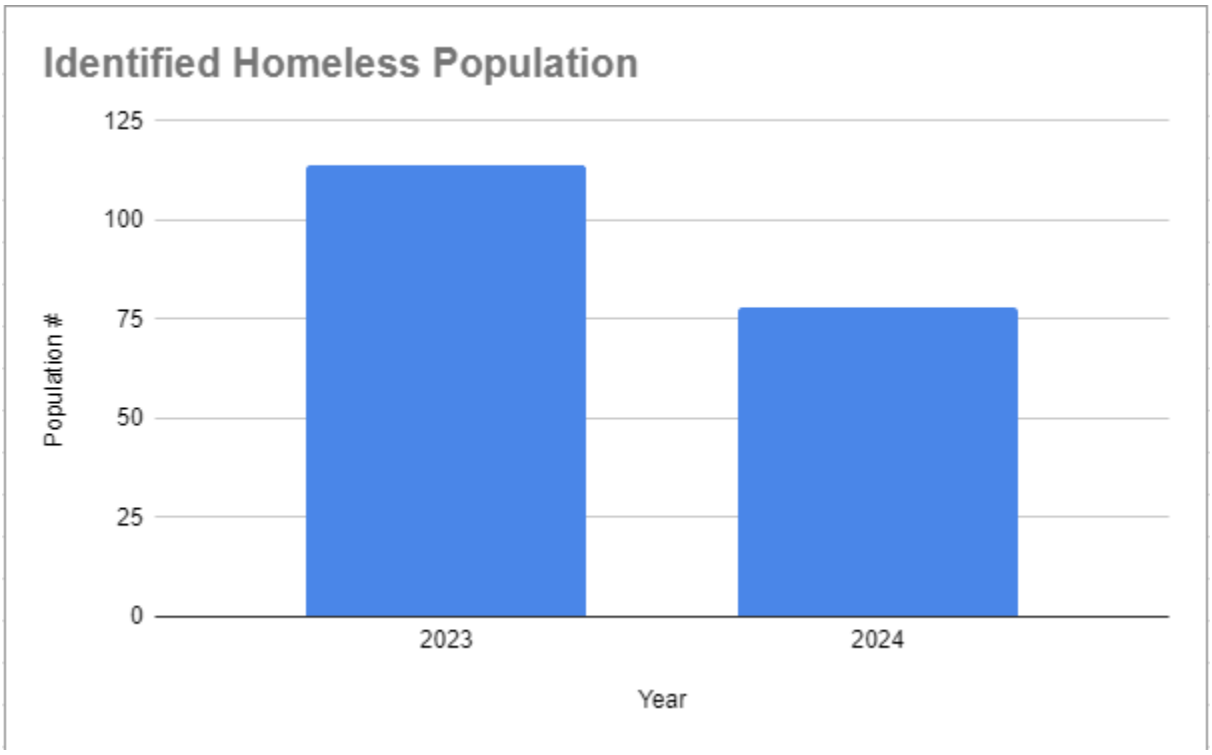
Across California, the high cost of housing as well as the stagnation of wages could be having an effect. As a rural area, our County has limited community resources to assist with housing. 58 percent of people surveyed reported one or more medical issues, which include mental health, substance use, chronic health conditions and other health issues as a contributing factor to their homelessness (Point-in-Time survey, Daily News). Another challenge is that our Hospital Community is very close to Interstate 5 and there can be unhoused individuals traveling through the area who may seek medical care.

4. Describe an intervention plan or pilot designed to address the inequity.

Our Hospital does address the high risk needs for unhoused patients. A multidisciplinary team consisting of nursing, providers and Care Coordination work together to prepare unhoused patients to return to the community by connecting them with community resources, treatment, shelter (if available) and other supportive services. The intent is to provide a safe discharge to our patients. In addition, we always try to have a follow up appointment for our patients. Many of our homeless patients do not have a Primary Medical Doctor, so we work with our clinics to

have them seen at least one time after discharge to help prevent readmissions and to provide a continuity of care.

5. Provide data measuring the effect of this intervention or pilot



6. Summarize lessons learned from this intervention/pilot and plans for the future.

There are significant opportunities to increase community resources available to assist with housing insecurity. Consistency with screening and identification of these patients is critical to discharging patients safely back into the community with the resources they need. Plans for the future include continued monitoring, evaluation of the data and also working with local government agencies and community groups to improve resources available to unhoused populations.

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