2023

HOSPITAL P4P

Pay for Performance (P4P) Program Technical Guide

IEHP
Inland Empire Health Plan

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PROGRAM OVERVIEW

Inland Empire Health Plan (IEHP) is pleased to announce the sixth year of the Hospital Pay For Performance (P4P) Program for IEHP Medi-Cal contracted hospitals servicing Riverside and San Bernardino counties. This program underlines IEHP's commitment and support to our partners by providing financial rewards to hospitals that meet quality performance targets and demonstrate high-quality care to IEHP Members.

The 2023 Hospital P4P will award financial incentives for 16 individual measures which fall under four main categories:

A. **Core Measures** feature clinical and transition of care quality indicators that highlight a hospital's commitment to excellence in patient outcomes.

1. HQI: Hospital-Wide All-Cause Mortality
2. HQI: Sepsis Mortality
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12. Hospitalization for Potentially Preventable Complications

B. **HQI Cares: Implementing BETA HEART** promotes a reliable and sustainable safety culture to support patient healing and clinician well-being.

13. Cohort Two, First Year and Cohort One, Second Year

C. **Optimal Care Initiatives** demonstrate a hospital's partnership in IEHP's strategic journey to excellence in providing optimal hospital care.

14. Hospital Quality Rating
15. Quality Improvement Activity: Patient Experience

D. **Data Sharing** promotes increased visibility and monitoring of key performance indicators, patient outcomes and clinical excellence.

16. Manifest MedEx Active Data Sharing

Participation Requirements

- Hospitals located within Riverside and San Bernardino counties or other identified areas with emerging needs for IEHP Members must have an active IEHP contract for the Medi-Cal population at the beginning of the measurement year (2023).
- Hospitals must provide Electronic Medical Record (EMR) access to IEHP for Members with IEHP as the primary or secondary payor. This access facilitates treatment, payment and operational processes, including but not limited to care coordination, utilization management (preauthorization, concurrent and retrospective review), and quality review. Access must be provided to IEHP by January 31, 2023, and continue through the entire measurement year (2023).
- Hospitals must be in good standing with IEHP throughout the program year. This is defined as a Provider currently contracted with Plan for the delivery of services, not pursuing any litigation or arbitration or has a pending claim pursuant to the California Government Tort Claim Act (Cal. Gov. Code §§ 810, et. seq.), which is unresolved filed against Plan at the time of program application or at the time additional funds may be payable and has demonstrated the intent, in Plan's sole determination, to continue to work together with Plan on addressing community and Member issues. Additionally, at the direction of the CEO or their designee, Plan may determine that a Provider is not in good standing based on relevant quality, payment, or other business concerns.
- Hospitals with Maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting, submit data timely as per CMQCC standards and have a signed CMQCC authorization release to share hospital-level results with IEHP. Hospitals without Maternity service lines are not eligible to receive incentive dollars for measures specific to this population.
- Hospitals must actively participate in the Hospital Quality Institute (HQI) Platform reporting and provide the necessary access and/or reporting to HQI to be eligible to receive incentive dollars for the HQI-affiliated P4P measures.
- Hospitals must submit their inpatient data to the Department of Health Care Access and Information (HCAI) on an accelerated quarterly* basis in an editable file report to be eligible to receive incentive dollars for the HQI-affiliated P4P measures.
- Hospitals must report their data on healthcare-associated infection measures to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) on an accelerated monthly** basis to be eligible to receive incentive dollars for the HQI-affiliated P4P measures.
- Hospitals that have a signed and approved Intent to Participate in the 2022 Hospital P4P Year End Push Quality Improvement Activities (QIA) and have received incentive payments must continue to meet quarterly reporting and other QIA program requirements that extend into 2023-2024.

** Quarterly reporting is effective 60 days (eight weeks) after the close of the measurement quarter.*
*** Monthly reporting is effective 60 days (eight weeks) after the close of the measurement month.*

☑ Program Terms and Conditions

- The Hospital must be in good standing with IEHP.
- Participation in the Hospital P4P Program, as well as acceptance of incentive payments, does not modify or supersede any terms or conditions of any agreement between IEHP and Providers, whether that agreement is entered before or after to the date of this communication.
- There is no guarantee of future funding for, or payment under, any IEHP Provider incentive program. The Hospital P4P Program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at IEHP's sole discretion.
- Criteria for calculating incentive payments are subject to change at any time, with or without notice, at IEHP's sole discretion.
- In consideration of IEHP's offering of the Hospital P4P Program, participants agree to fully and forever release and discharge IEHP from all claims, demands, causes of action, and suits, of any nature, relating to or arising from the offering by IEHP of the Hospital P4P Program.
- The determination of IEHP regarding performance scoring and payments under the Hospital P4P Program is final. If a potential discrepancy in performance scoring is identified, the responsibility will be on the Provider to demonstrate measure compliance.
- As a condition of receiving payment under the Hospital P4P Program, Providers must be credentialed and contracted with IEHP.
- Validation: P4P data is subject to retrospective validation and must pass all quality assurance checks. Recoupment of incentive payments may occur if the retrospective review of submitted claims fails medical record validation.
- Late or incomplete submissions: Late or incomplete submissions will generally not be accepted. If a late submission or resubmission is approved due to extenuating circumstances, hospitals may be penalized via a percent reduction in available/earned dollars. The specific percent reduction will be shared with the hospital at the time of approval for late submission or resubmission.

NOTE: If you disagree with your hospital's quarterly performance report, you may submit a request for dispute research by submitting dispute inquires to QualityPrograms@iehp.org. All disputes for research must be submitted within 90 days of the distributed quarterly performance report.

Financial Overview

The annual budget for the 2023 Hospital P4P Program is $79,000,000 in total possible payouts to qualifying hospitals that meet quality performance targets. The table below summarizes the Hospital P4P Program budget for the year and by dollars available per measure.

2023 HOSPITAL P4P PROGRAM	
Measure Name	**Financial Allocation**
Core Measures	**$52,000,000**
1. HQI: Hospital-Wide All-Cause Mortality - NEW	$5,000,000
2. HQI: Sepsis Mortality	$5,000,000
3. HQI: Patient Safety and Adverse Events Composite - NEW	$5,000,000
4. HQI: Healthcare-Associated Infection Composite	$5,000,000
5. HQI: Hospital-Acquired Pressure Injuries	$3,000,000
6. Maternal Morbidity Safety Bundle Implementation - NEW	$3,000,000
7. NTSV Cesarean Delivery Rate	$3,000,000
8. Timely Postpartum Care	$3,000,000
9. Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days	$3,000,000
10. Post Discharge Follow-Up Within Seven Days of Discharge	$6,000,000
11. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	$6,000,000
12. Hospitalization for Potentially Preventable Complications - NEW	$5,000,000
HQI Cares: Implementing Beta HEART	**$11,000,000**
13. HQI Cares: Implementing BETA HEART - Year 1, Cohort 2 HQI Cares: Implementing BETA HEART - Year 2, Cohort 1	$2,740,000 $8,260,000
Optimal Care Initiatives	**$10,000,000**
14. Hospital Quality Rating - NEW	$10,000,000
15. Quality Improvement Activity: Patient Experience – NEW (Baseline Year)	Baseline Year
Data Sharing	**$6,000,000**
16. Manifest MedEx Active Data Sharing	$6,000,000
Total Budget	**$79,000,000**

Performance Targets

The chart below summarizes the Hospital P4P Program measures and the performance goals.

For measures with two-tier performance goals, 50 percent of the available measure dollars are rewarded for reaching Tier 1 level performance, and 100 percent are rewarded for Tier 2 level performance, unless otherwise specified. For measures with only one performance goal, 100 percent of the available measure dollars are rewarded for meeting the goal.

2023 MEASURE PERFORMANCE GOALS			
Core Measures			
	Measure Name	**Data Source**	**2023 Performance Goals**
1	HQI: Hospital-Wide All-Cause Mortality	HQI*	1) Less than or equal to 1.1% ***OR*** 2) Reduce hospital baseline rate by 10%
2	HQI: Sepsis Mortality	HQI*	1) Less than or equal to 17.4% ***OR*** 2) Reduce hospital baseline rate by 10%
3	HQI: Patient Safety and Adverse Events Composite	HQI*	1) Less than or equal to 0.896 ***OR*** 2) Reduce hospital baseline rate by 10%
4	HQI: Healthcare – Associated Infection Composite	HQI*	1) Less than or equal to 0.63 ***OR*** 2) Reduce hospital baseline rate by 10%
5	HQI: Hospital – Acquired Pressure Injuries	HQI*	1) Less than or equal to 0.29% ***OR*** 2) Reduce hospital baseline rate by 10%
6	Maternal Morbidity Safety Bundle Implementation	Hospital	Fully Implemented Maternal Morbidity Safety Bundles Hospitals are eligible to receive P4P dollars for up to four implemented bundles.
7	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	CMQCC*	Less than or equal to 23.6%
8	Timely Postpartum Care	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 79.88% or above *(75th percentile performance for IEHP network)*
9	Follow-Up Care for Mental Health & Substance Use Disorder ED – 7 Days	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 32.60% or higher *(33rd percentile performance)*
10	Post Discharge Follow-Up Within Seven Days of Discharge	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 54.12% or above *(75th percentile performance for IEHP network)*
11	Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 0.7977 or below *(75th percentile performance for IEHP network)*

2023 MEASURE PERFORMANCE GOALS			
12	Hospitalization for Potentially Preventable Complications	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 0.3735 or below *(75th percentile performance)*
HQI Cares: Implementing BETA Heart Program			
13	Cohort 2, 1st Year Cohort 1, 2nd Year	HQI*	**<u>Cohort 2, 1st Year</u>** All conditions must be met: 1) Hospital must sign participation agreement 2) Hospital must complete the onboarding process 3) Hospital must form a HQI Cares Core Team (steering committee) 4) Hospital must develop an action plan to define what will be accomplished to advance the work on HQI Cares 5) Hospital must complete the communication skills assessment 6) Hospital senior leaders must attend all three (3) workshops in 2023 7) Hospital must implement 2023 action plan 8) Hospital must develop 2024 action plan **<u>Cohort 1, 2nd Year</u>** All conditions must be met: 1) Hospital must sign and submit the 2023 participation agreement addendum 2) Hospital must have a developed 2023 action plan 3) Hospital must complete the annual readiness assessment 4) Hospital must provide evidence of live meetings with frontline staff 5) Hospital must develop a HQI Cares dashboard 6) Hospital must share their developed HQI Cares dashboard with the HQI Cares Program Team 7) Hospital senior leaders must attend all three (3) workshops in 2023 8) Hospital must participate in domain-specific regional training 9) Hospital must implement 2023 action plan 10) Hospital must develop 2024 action plan
Optimal Care Initiatives			
14	Hospital Quality Star Rating	CMS*	1) Achieved 3-star or above in calendar year 2023 ***OR*** 2) Improved star rating from prior year
15	Quality Improvement Activity: Patient Experience	Hospital	Establish a quality improvement activity that focuses on improving patient experience, with a clearly outlined strategy to address findings or feedback from the IEHP survey

2023 MEASURE PERFORMANCE GOALS			
Data Sharing			
16	Manifest MedEx Active Data Sharing	Manifest MedEx	All conditions must be met: 1) Hospital must have a current PA in place with MX per quarter 2) Hospitals are actively sharing data elements with MX per quarter 3) Hospitals consistently submitting all required P4P data elements for all hospital events throughout the entire measurement period

* CMQCC: California Maternal Quality Care Collaborative
* CMS: Centers for Medicare and Medicaid Services
* HQI: Hospital Quality Institute
** The hospital is assigned a Tier 1 goal at the 50th percentile for the IEHP network if minimum denominator requirements for the baseline period are not met.

REPORTING & PAYMENT SCHEDULE					
Measure Name	**2023 Measurement Period** Data Due Dates				
1. HQI: Hospital-Wide All-Cause Mortality		Quarters 1* & 2*		Quarters 3* & 4*	
2. HQI: Sepsis Mortality		Quarters 1* & 2*		Quarters 3* & 4*	
3. HQI: Patient Safety and Adverse Events Composite		Quarters 1* & 2*		Quarters 3* & 4*	
4. HQI: Healthcare – Associated Infection Composite		Quarters 1** & 2**		Quarters 3** & 4**	
5. HQI: Hospital – Acquired Pressure Injuries				Quarters 1 to 4	
6. Maternal Morbidity Safety Bundle Implementation		Evidence of bundle implementation due September 30, 2023		Validation to be completed by IEHP before Mar. 31, 2024	
7. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Quarter 1 Data due June 15, 2023	Quarter 2 Data due Sept. 15, 2023	Quarter 3 Data due Dec. 15, 2023	Quarter 4 Data due Mar. 15, 2024	
8. Timely Postpartum Care		Quarter 1 Data due Sept. 15, 2023	Quarter 2 Data due Dec. 15, 2023	Quarter 3 Data due Mar. 15, 2024	Quarter 4 Data due June 15, 2024
9. Follow-Up Care for Mental Health & Substance Use Disorder ED – 7 Days	Quarter 1 Data due June 15, 2023	Quarter 2 Data due Sept. 15, 2023	Quarter 3 Data due Dec. 15, 2023	Quarter 4 Data due Mar. 15, 2024	

REPORTING & PAYMENT SCHEDULE					
Measure Name	**2023 Measurement Period** Data Due Dates				
10. Post Discharge Follow-Up Within Seven Days of Discharge	Quarter 1 Data due June 15, 2023	Quarter 2 Data due Sept. 15, 2023	Quarter 3 Data due Dec. 15, 2023	Quarter 4 Data due Mar. 15, 2024	
11. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	Quarter 1 Data due June 15, 2023	Quarter 2 Data due Sept. 15, 2023	Quarter 3 Data due Dec. 15, 2023	Quarter 4 Data due Mar. 15, 2024	
12. Hospitalization for Potentially Preventable Complications	Quarter 1 Data due June 15, 2023	Quarter 2 Data due Sept. 15, 2023	Quarter 3 Data due Dec. 15, 2023	Quarter 4 Data due Mar. 15, 2024	
13. HQI Cares: Implementing BETA Heart Program – Cohort 2, 1st Year and Cohort 1, 2nd Year	Reference HQI Cares: Implementing BETA Heart Program measure details for reporting and payment schedule				
14. Hospital Quality Rating		2023 CMS Star Rating Result			
15. Quality Improvement Activity: Patient Experience		Quarter 2 Data due July 1, 2023		Quarter 4 Data due Jan 1, 2024	
16. Manifest MedEx Active Data Sharing[1]	Quarter 1 Data due June 15, 2023	Quarter 2 Data due Sept. 15, 2023	Quarter 3 Data due Dec. 15, 2023	Quarter 4 Data due Mar. 15, 2024	
Payment Distribution	Payout #1 **July 2023**	Payout #2 **Oct. 2023**	Payout #3 **Jan. 2024**	Payout #4 **April 2024**	Payout #5 **July 2024**

* Accelerated reporting requirement- Quarterly reporting is effectively 60 days (8 weeks) after the close of the measurement quarter.

- 1Q2023 due May 26, 2023
- 2Q2023 due August 25, 2023
- 3Q2023 due November 25, 2023
- 4Q2023 due February 25, 2024

** Accelerated reporting requirement- Monthly reporting is effectively 60 days (8 weeks) after the close of the measurement month.

- January 2023 due March 28, 2023
- February 2023 due April 25, 2023
- March 2023 due May 26, 2023
- April 2023 due June 25, 2023
- May 2023 due July 26, 2023
- June 2023 due August 25, 2023
- July 2023 due September 25, 2023
- August 2023 due October 26, 2023
- September 2023 due November 25, 2023
- October 2023 due December 26, 2023
- November 2023 due January 25, 2024
- December 2023 due February 25, 2024

[1] Additional incentive pool available for Critical Access Hospitals (CAHs). Please see the Manifest MedEx Active Data Sharing measure description for additional incentive details.

2023 Hospital P4P Payment Calculation:

Incentive amounts for each measure are determined annually and may be set as follows:

- A flat rate,
- A pool amount divided among qualifying hospitals,
- Based on IEHP Member admissions, or
- Weighted based on additional factors

Payments based on IEHP Member admissions are calculated as follows:

Step 1: Determine the Percentage of Total Admissions per Hospital
[Total IEHP Admissions for Hospital in the Quarter] ÷
[Total IEHP Admissions for All Eligible Hospitals in the Quarter]
= Percentage of Total Admissions

Step 2: Determine the Amount of P4P Dollars Available per Hospital
[Percentage of Total Admissions] X [Total Quarterly P4P Dollars Available]
= Total P4P Dollars Available per Hospital Per Quarter

EXAMPLE: *Hospital X*

Step 1: Determine the Percentage of Total Admissions per Hospital
IEHP Admissions for Hospital X for Quarter 1 2023 = 3,000
Total IEHP Admissions for All Hospitals for Quarter 1 2023 = 16,000
3,000 ÷ 16,000 = 0.1875

Step 2: Determine the Amount of P4P Dollars Available per Hospital
0.1875 X $6,000,000 = $1,125,000 Available for Hospital X for All Measures per Quarter

Hospital Quality Rating Payment Calculation:

Payments for the Hospital Quality Rating are determined based on the following formula:

Step 1: Determine the Hospital Payment Factor
[Hospital Quality Rating × IEHP admission percentage per hospital × 100]

Step 2: Determine the Weighted Incentive Payout per eligible hospital
[Hospital Payment Factor ÷ Sum of eligible hospital payment factors] ×
[Measure Incentive Pool]

HQI Cares Implementing BETA Heart Program Methodology:

Payments for the HQI Cares: Implementing BETA Heart Program is based on achieving specific milestones.

2023 HOSPITAL P4P MEASURES

NEW

☑ Measure Name: *HQI: Hospital-Wide All-Cause Mortality*

Although uncommon, mortality is a significant outcome that is meaningful to patients and Providers. Most patients admitted to the hospital have survival as a primary goal. All-Cause mortality is used to track in-hospital deaths without requiring a specific cause of mortality. It allows for measuring a hospital's broader performance and meaningfully captures performance for smaller volume hospitals. While mortality rates are never expected to be zero, studies have shown mortality within 30 days of hospital admission to be related to the quality of care and that high and variable mortality rates indicate an opportunity for improvement.

Some patients are excluded from the calculation based on diagnoses of certain conditions associated with factors that make mortality less likely to be influenced by the quality of care provided. Patients under hospice or palliative care or who have a do not resuscitate (DNR) order are excluded.

Methodology:

Hospitals must actively participate in the Hospital Quality Institute's Hospital Quality Improvement Platform (HQIP).

Inpatient encounters from the following data sources are included in this measure:

- **AB2876** - historical discharge data sets made by HCAI for inpatient discharges, emergency department visits and ambulatory surgery visits.
- **System of Integrated Electronic Reporting and Auditing (SIERA) files** - required files uploaded periodically by hospitals to the Department of Health Care Access and Information (HCAI).

To qualify for the P4P Program, hospitals must follow an accelerated quarterly reporting schedule for inpatient discharge data; data must be reported eight weeks after the quarter's close. However, the rates used to determine compliance with P4P Program measure targets are reviewed after the HCAI published deadlines.

Code Source:

HQI adapted this measure from the methodology outlined in the Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure, however, only in-hospital deaths during a single admission are tracked (rather than 30-day follow-up from admission), and the risk-standardization methodology is not performed.

Denominator:

Acute-care inpatient discharges, excluding patients for whom survival was not the primary goal (hospice, palliative care and DNR patients).

Numerator:

Acute-care inpatient discharges, excluding patients for whom survival was not the primary goal (hospice, palliative care and DNR patients), who *expired* in the hospital.

Inclusion/Exclusion Criteria:

1. Calculate the denominator by identifying and *excluding* all inpatient discharges with a:
    - Type of care other than *acute care (Type of Care not equal to 1)* **OR**
    - Diagnosis ICD-10 code (in any position) indicating *palliative care* (code Z51.5) **OR**
    - Diagnosis ICD-10 code (in any position) indicating *do not resuscitate* (code Z66) **OR**
    - Source of admission indicating hospice *(Source of Admission Point of Origin = F)*
2. Calculate the numerator by identifying the discharges remaining after #1 *with* a discharge disposition indicating the patient expired *(Disposition = 20)*

Rate Calculation:

(Numerator ÷ Denominator) × 100

☑ Measure Name: *HQI: Sepsis Mortality*

Sepsis is a life-threatening organ dysfunction caused by a dysregulated host response to infection. If not recognized early and managed promptly, it can lead to septic shock, multiple organ failure and death. The 2020 in-hospital case mortality rate for California sepsis cases was 19.5%, a 6-percentage point (or 44%) increase from the 2019 rate of 13.5%. Sepsis represents a substantial global health burden as well as California. Sepsis is a contributing diagnosis in over 50% of all in-hospital deaths each year in California.

This is a measure of the in-hospital acute care sepsis case mortality rate (%) based on the modified Dombrovskiy Method for sepsis case identification, as used in the Hospital Quality Institute's (HQI) Hospital Quality Improvement Platform (HQIP). Sepsis and septic shock are proxy-diagnosed per the Third International Consensus Definitions for Sepsis and Septic Shock (SEP-3) based on combinations of diagnosis codes at discharge. This is an all-cause mortality measure, so sepsis need not be the cause of death for identified cases.

Methodology:

Hospitals must actively participate in the Hospital Quality Institute's Hospital Quality Improvement Platform (HQIP).

Inpatient encounters from the following data sources are included in this measure:

- **AB2876** - historical discharge data sets made by HCAI for inpatient discharges, emergency department visits and ambulatory surgery visits.
- **System of Integrated Electronic Reporting and Auditing (SIERA) files** - required files uploaded periodically by hospitals to the Department of Health Care Access and Information (HCAI).

To qualify for the P4P Program, hospitals must follow an accelerated quarterly reporting schedule for inpatient discharge data; data must be reported eight weeks after the quarter's close. However, the rates used to determine compliance with P4P Program measure targets are reviewed after the HCAI published deadlines.

Code Source:

The ICD-10-CM Coding for IEHP In-Hospital Sepsis Case Mortality provides the ICD codes used for this measure, sourced from the HCAI California Inpatient Severe Sepsis for:

- Septicemia or sepsis (code set *SepticemiaOrSepsis*)
- Organ dysfunction (code set *OrganDysfunction*)

HQIP Code Set:

Review the complete codeset used for this measure.

Denominator:

Acute-care inpatient discharges with a sepsis diagnosis, as defined by the SEP-3 proxy sepsis case definition.

Numerator:

Acute-care inpatient discharges with sepsis diagnosis, as defined by the SEP-3 proxy sepsis case definition, which *expired* in the hospital.

Inclusion/Exclusion Criteria:

1. Calculate the *initial* denominator by identifying and *including* all inpatient discharges with a:
    - Diagnosis ICD-10 code (in any position) for *septicemia* or *sepsis* (code set *SepticemiaOrSepsis*) **AND**
    - Diagnosis ICD-10 code (in any position) for *organ dysfunction* (code set *OrganDysfunction*)
2. Calculate the *final* denominator by identifying and *excluding* from #1 discharges with a type of care other than *acute care* (*Type of Care not equal to 1*)
3. Calculate the numerator by identifying the discharges remaining after #2 *with* a discharge disposition indicating the patient *expired* (*Disposition = 20*)

Rate Calculation:

(Numerator ÷ Denominator) × 100

NEW

☑ Measure Name: *HQI: Patient Safety and Adverse Events Composite*

The patient safety and adverse events composite is based on the code set by the Agency for Healthcare Research and Quality (AHRQ), as used in the Hospital Quality Institute's (HQI) Hospital Quality Improvement Platform (HQIP).

The Patient Safety Indicator 90 (PSI 90) composite measure reflects the safety climate of a hospital by providing a marker of patient safety during the delivery of care. Higher rates of these serious, but potentially preventable complications may signify poorer quality hospital care. Hospitals can reduce the chance of these serious complications by following safe practices. This is a PSI 90 measure with all payors included rather than the federal/Medicare population only.

Methodology:

Hospitals must actively participate in the Hospital Quality Institute's Hospital Quality Improvement Platform (HQIP). Inpatient encounters from the following data sources are included in this measure:

- **AB2876** - historical discharge data sets made by HCAI for inpatient discharges, emergency department visits and ambulatory surgery visits.
- **System of Integrated Electronic Reporting and Auditing (SIERA) files** - required files uploaded periodically by hospitals to the Department of Health Care Access and Information (HCAI).

To qualify for the P4P Program, hospitals must follow an accelerated quarterly reporting schedule for inpatient discharge data; data must be reported eight weeks after the quarter's close. However, the rates used to determine compliance with P4P Program measure targets are reviewed after the HCAI published deadlines.

HQIP Code Set:

The Quality Indicator User Guide: PSI Composite Measures provides AHRQ's methodology and steps to calculate the composite.

Inclusion/Exclusion Criteria:

These vary for each PSI, as detailed in AHRQ's component https://qualityindicators.ahrq.gov/measures/PSI_TechSpecPSI Technical Specifications.

Calculation:

The PSI 90 Composite is the weighted average of the observed-to-expected ratios for the following component PSIs among all inpatient encounters:

- PSI 03 - Pressure Ulcer Rate
- PSI 06 - Iatrogenic Pneumothorax Rate
- PSI 08 - In-Hospital Fall with Hip Fracture Rate
- PSI 09 - Postoperative Hemorrhage or Hematoma Rate
- PSI 10 - Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 - Postoperative Respiratory Failure Rate
- PSI 12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13 - Postoperative Sepsis Rate
- PSI 14 - Postoperative Wound Dehiscence Rate
- PSI 15 - Abdominopelvic Accidental Puncture or Laceration Rate

☑ Measure Name: *HQI: Healthcare-Associated Infection Composite*

Healthcare-associated infections (HAI) are infections that patients get while receiving treatment for medical or surgical conditions. Most HAIs are preventable, yet each year they are associated with significant mortality and morbidity. HAIs can include the following:

- Central line-associated bloodstream infections (CLABSIs) occur when microorganisms enter the bloodstream through the central line. They result in thousands of deaths annually and billions of dollars in added health care costs.
- Catheter-associated urinary tract infections (CAUTIs) occur when microorganisms enter the urinary tract and cause infection under conditions when an indwelling catheter has been in place for >2 days. They are associated with increased morbidity and mortality, health care costs and lengths of stay.
- *Clostridioides difficile* infections (CDIs) occur when this bacterium colonizes the large intestine after antibiotic use. They are a significant source of morbidity and result in thousands of deaths annually, particularly among persons 65 and older.
- Methicillin-resistant *Staphylococcus* aureus (MRSA) staph infections occur when this multiple-antibiotic-resistant bacterium infects a person in an acute setting. They are difficult to treat and often involved in deaths due to HAI.

This measure is a composite HAI standardized infection ratio (SIR) combined across CLABSI, CAUTI, CDI and MRSA staph infections reported by hospitals to the National Healthcare Safety Network. A composite HAI measure was chosen to provide larger sample sizes and more reliable estimates of the SIRs, allowing hospitals with low inpatient volumes the chance to participate. This composite HAI measure emphasizes that all infections given to patients are equally important to avoid and promotes quality improvement across a spectrum of HAI types.

Methodology

This measure uses the monthly infection data submitted by the hospital to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) Secure Access Management Services (SAMS) Partner Portal. Hospitals must join the HQI NHSN group and submit complete infection data to NHSN so it can be imported into the HQIP by the due dates.

To qualify for the P4P Program, hospitals are required to follow an accelerated monthly reporting schedule; data must be reported 8 weeks after the close of the measurement month. However, the rates used to determine compliance with P4P Program measure targets are reviewed after the NHSN published deadlines.

Denominator:
The predicted number of infections summed across CLABSI, CAUTI, CDI and MRSA during the measurement timeframe.

Numerator:
The observed number of infections summed across CLABSI, CAUTI, CDI and MRSA during the measurement timeframe.

Calculation:
Composite SIR = Numerator ÷ Denominator

References
Dowd B, Karmarker M, Swenson T, et al. Emergency department utilization as a measure of physician performance. Am J Med Qual 2014;29(2):135-43. http://ajm.sagepub.com/content/29/2/135.long. Accessed December 10, 2021.

Enard KR, Ganelin DM. Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. J Healthc Manag 2013;58(6);412-28. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142498/. Accessed December 10, 2021.

☑ Measure Name: *HQI: Hospital-Acquired Pressure Injuries*

Hospital-acquired pressure injuries result in significant patient harm, including pain, expensive treatments, increased length of institutional stay and, in some cases, premature mortality. Each year more than 2.5 million patients suffer from pressure injuries, and roughly 60,000 patients die from complications. Patients with a hospital-acquired pressure injury are 1.3 times more likely to be readmitted.

This is a measure of the rate (%) of hospital-acquired pressure injuries of any stage (including unspecified, unstageable and deep tissue damage) among acute care discharges with stays of three or more days who were not obstetric, severe burn or exfoliative skin disorder cases, as reported in the Hospital Quality Improvement Platform (HQIP).

Methodology:

Hospitals must actively participate in the Hospital Quality Institute's HQIP. Inpatient encounters from the following data sources are included in this measure:

- **AB2876** - historical discharge data sets made by HCAI for inpatient discharges, emergency department visits, and ambulatory surgery visits
- **System of Integrated Electronic Reporting and Auditing (SIERA) files** - required files uploaded periodically by hospitals to the Department of Health Care Access and Information (HCAI).

To qualify for the P4P Program, hospitals must follow an accelerated quarterly reporting schedule for inpatient discharge data; data must be reported eight weeks after the quarter's close. However, the rates used to determine compliance with P4P Program measure targets are reviewed after the HCAI published deadlines.

Code Source:

The ICD-10-CM Coding for IEHP Hospital-Acquired Pressure Injuries contains the codes used for Hospital-Acquired Pressure Injuries originally sourced from AHRQ PSI 03 for:

- Severe burns (code set *SevereBurns_Excl*)
- Exfoliative skin disorder (code set *ExfoliativeSkin_Excl*)
- Hospital-acquired pressure injury (code set *PressureInjuryDx*)

HQIP Code Set:

- Review the complete codeset used for this measure.

Denominator:
Acute-care inpatient discharges with a length of stay of three days or longer (excluding obstetric cases, severe burns and exfoliative skin disorders) during the measurement timeframe.

Numerator:
Acute-care inpatient discharges with a length of stay of three days or longer (excluding obstetric cases, severe burns and exfoliative skin disorders) with any not present on admission stage hospital-acquired pressure injuries during the measurement timeframe.

Inclusion/Exclusion Criteria:
1. Calculate the denominator by identifying and *excluding* all inpatient discharges with a:
    - Type of care other than *acute care (Type of Care not equal to 1)* **OR**
    - Diagnosis code (in any position) for *severe burn* (code set *SevereBurns_Excl*) **OR**
    - Diagnosis code (in any position) for an exfoliative skin disorder (code set *ExfoliativeSkin_Excl*) **OR**
    - Major Diagnostic Category (MDC) of *Pregnancy, childbirth and puerperium (MDC = 14)* **OR**
    - Length of stay (LOS) *less than three days (LOS < 3)*
2. Calculate the numerator by categorizing as hospital-acquired pressure injury cases the inpatient discharges remaining after #1 with a diagnosis code (in any position) for *any stage pressure injury* (code set *PressureInjuryDx*) **WITH** an associated present on admission (POA) code indicating that the pressure injury was *not present on admission (POA not equal to Y)*

Calculation:
(Numerator ÷ Denominator) × 100

Note:
Please note the requirements for hospitals to report hospital-acquired pressure injuries to IEHP and the Department of Health Care Services (DHCS):

- Inland Empire Health Plan Policy: https://www.iehp.org/en/providers/provider-manuals?target=2022manuals
    - MC-13D: "Reporting Requirements Related to Provider Preventable Conditions"
- DHCS Plan Letters: https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx
    - All Plan Letter (APL) 17-009: "Reporting Requirements Related to Provider Preventable Conditions"

NEW

☑ Measure Name: *Maternal Morbidity Safety Bundle Implementation*

There are approximately 6 million pregnancies each year in the United States. The low volume of in-hospital maternal deaths makes the study of individual factors challenging. Maternal morbidity includes physical and psychological conditions resulting from or aggravated by pregnancy that may result in poor pregnancy outcomes, including death. The most severe complications, known as severe maternal morbidity (SMM), affect more than 50,000 women annually and has been rising steadily likely due to increases in maternal age, pre-pregnancy obesity, pre-existing chronic medical conditions, and cesarean delivery (CDC, Reproductive Health, 2022).

In May 2022, CMS required hospitals to attest to the Hospital Inpatient Quality Reporting (IQR) Program's Maternal Morbidity Structural Measure as a first step in capturing hospitals' commitments to the quality and safety of maternity care they provide. Hospitals who meet this measure have indicated that they

1. Participate in a statewide and/or national perinatal quality improvement collaborative program aimed at improving maternal outcomes, and
2. Have implemented patient safety practices or bundles related to maternal morbidity. Initial results for a hospital's "Birthing Friendly" designation will be released in fall 2023 (CMS, Key Actions to Reduce Maternal Mortality and Morbidity, 2022).

This measure validates the information provided by hospitals as part of their IQR submission, verifies which maternal morbidity safety bundles have been fully implemented and encourages hospitals to engage in active work to expand safety practices.

Methodology:

Hospitals with maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting and have a signed CMQCC authorization release in place to share hospital-level results with IEHP by February 15, 2023.

Hospitals with no maternity service line are not eligible to participate in this P4P measure.

Hospitals will be eligible for payment for each fully implemented Maternal Quality Bundle, including:

- Obstetric Hemorrhage
- Hypertensive Disorders of Pregnancy
- Mother and Baby Substance Exposure
- Maternal Sepsis

Inclusion/Exclusion Criteria:

To be considered fully implemented, all requirements listed below must be met by September 30, 2023. Hospitals are encouraged to reference CMQCC's Maternal Quality Improvement Toolkits, complete a gap analysis, and maintain an evidence binder. Validation of full implementation of each bundle will be completed by IEHP's Hospital Relations Team utilizing the checklists in appendix 1. Validation will occur between October 1, 2023, and March 31, 2024.

Requirements are based upon and adopted from The Joint Commission Standards for Maternal Safety.

NEW

☑ Measure Name: *Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate*

The California Maternal Quality Care Collaborative (CMQCC) calculates a standardized measure that assesses the rate of Cesarean births, focusing on the all-important first birth. This measure is known as the Nulliparous Term Singleton Vertex (NTSV) Cesarean Birth Rate. It identifies the proportion of live babies born at or beyond 37 weeks of gestation to women in their first pregnancy, which are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions) via Cesarean birth. The United States Department of Health and Human Services, in its Healthy People 2020 project, simplified the name for non-obstetric audiences to "Low-Risk Cesarean Birth Among First-Time Pregnant Women." This is somewhat imprecise, as some higher-risk patients remain in the denominator but have very little impact.

The Joint Commission subsequently adopted this metric in 2010 and now requires all hospitals with more than 300 births to report their results as part of the Perinatal Core Measure Set. The metric has also been adopted by the Leapfrog Group and the Centers for Medicare and Medicaid Services. Several states also require hospital reporting as part of their Medicaid quality initiatives. The NTSV Cesarean Birth measure was re-endorsed as one of the National Quality Forum's (NQF) Perinatal and Reproductive Health measures in 2016, and the Joint Commission is now the steward of the measure.

Methodology:

Hospitals with maternity service lines must actively participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center Reporting and have a signed CMQCC authorization release in place to share hospital-level results with IEHP by February 15, 2023.

Hospitals with no maternity service line are not eligible to receive the quarterly dollars for the submission to the CMQCC Maternal Data Center.

All hospitals participating in the IEHP Hospital P4P Program must report their rates according to the CMQCC reporting guidelines and timeframes, and authorize CMQCC to give IEHP access to the reported rates. IEHP will receive hospital-specific rates from CMQCC according to the reporting timeline noted in the "Payment Methodology Section."

A lower rate in this measure indicates better performance.

☑ Measure Name: *Timely Postpartum Care*

The Healthcare Effectiveness Data and Information Set (HEDIS®) modified measure called Timely Postpartum Care is utilized to determine the percentage of live birth deliveries that had an outpatient postpartum visit on or between 7 and 84 days after delivery.

The eligible population in this measure meets all the following criteria:

- Continuous IEHP enrollment 43 days prior to delivery through 60 days after delivery.
- No allowable gaps in IEHP enrollment.

Numerator:

Members in the denominator who had a postpartum visit on or between 7 and 84 days after delivery.

Denominator:

Members who delivered a live birth during the measurement year (2023).

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

*This does not apply to Critical Access Hospitals (CAHs).

Note: Medi-Medi Members are excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Postpartum Care	CPT	57170	Diaphragm Or Cervical Cap Fitting With Instructions
Postpartum Care	CPT	58300	Insertion Of Intrauterine Device (IUD)
Postpartum Care	CPT	59430	Postpartum Care Only (separate procedure)
Postpartum Care	CPT	0503F	Postpartum Care Visit
Postpartum Care	CPT	99501	Home Visit For Postnatal Assessment And Follow-up Care
Postpartum Care	HCPCS	G0101	Cervical Or Vaginal Cancer Screening; Pelvic And Clinical Breast Examination
Postpartum Care	ICD 10CM	Z01.411	Encounter For Gynecological Examination (general) (routine) With Abnormal Findings
Postpartum Care	ICD 10CM	Z01.419	Encounter For Gynecological Examination (general) (routine) Without Abnormal Findings

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Postpartum Care	ICD 10CM	Z01.42	Encounter For Cervical Smear To Confirm Findings Of Recent Normal Smear Following Initial Abnormal Smear
Postpartum Care	ICD 10CM	Z30.430	Encounter For Insertion Of Intrauterine Contraceptive Device
Postpartum Care	ICD 10CM	Z39.1	Encounter For Care And Examination Of Lactating Mother
Postpartum Care	ICD 10CM	Z39.2	Encounter For Routine Postpartum Follow-up
Postpartum Care	HCPCS	Z1038	Postpartum Follow-Up Office Visit

☑ Measure Name: *Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days*

The HEDIS® modified measure Follow-Up Care for Mental Health or Substance Use Disorder Emergency Department-Seven Days is utilized to determine the percentage of emergency department (ED) visits for Members ages 6 years and older who had a principal diagnosis of a substance use disorder, any diagnosis of a drug overdose, mental illness or intentional self-harm, and had a follow-up visit with a Provider within seven days.

Below is a list of practitioner types/visits that count towards this measure:

- PCP
- MD or DO specializing in psychiatry
- Licensed psychologist
- Certified clinical social worker
- RN certified as a psychiatric nurse
- Licensed or certified professional counselor with a master's degree or doctoral degree in marital and family therapy
- PA certified to practice psychiatry
- Certified Community Mental Health Center/Clinic

Refer to the Mental Health Diagnosis List and the Substance Use Disorder Diagnosis section at the bottom of the IEHP P4P Program website. These lists include diagnoses for substance use disorder, drug overdose, mental illness or intentional self-harm.

Numerator:

Members in the denominator who had an in-person or telemedicine follow-up visit within seven days of discharge from the ED with a practitioner who is addressing the substance use or mental illness disorder.

Denominator:

Members ages 6 years and older who had a discharge from an ED with a principal diagnosis of a substance use disorder, any diagnosis of a drug overdose, mental illness or intentional self-harm.

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

*This does not apply to Critical Access Hospitals (CAHs).

Note: Medi-Medi Members are excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Measure Name: *Post Discharge Follow-Up Within Seven Days of Discharge*

This measure captures the number of discharges during the measurement period for High-Risk Medi-Cal Members, 18 years of age and older, with a follow-up outpatient visit within seven days of discharge.

Below is a list of practitioner types that count towards this measure:

- Primary Care Provider
- Physician or nonphysician (who offers primary care or speciality care medical services)
- Nurse Practitioner
- Physician Assistant
- Certified Nurse Midwife
- Speciality Care Providers (if the Provider offers ongoing care to the Member)

Methodology:

To identify high-risk Members, IEHP employs the Johns Hopkins ACG System, which uses data from the prior 12 months to generate predictive risk scores for the next 12 months. The ACG System measures the morbidity burden of patient populations based on disease patterns, age and gender. A key strength of the ACG System is its ability to capture the interrelationships between co-occurring morbidities, which are the hallmark of the chronically ill populations that pose the greatest demands for health care resources. The essence of the ACG system is the clinical and statistical algorithms by which billions of potential disease combinations are distilled down to a fixed number of health status categories. IEHP uses the ACG System to harness the power of the ambulatory and inpatient diagnostic information as well as pharmaceutical information to risk-stratify the entire IEHP membership.

For high-risk Member stratification, IEHP uses the ACG predictive marker "Probability of High Total Cost." This marker predicts the probability of a Member being in the top 5 percent of the total high cost for IEHP in the next 12 months. Because of the robust algorithms used by the ACG System, individuals with short acute episodic utilization of the health care system are not part of the top 5 percent of the total high-cost population. The top 5 percent of the total high-cost population includes individuals with multiple chronic conditions and comorbidities who often require extensive health care system utilization. They demonstrate the need for timely post-discharge follow-up with a Primary Care Provider. For this measure, IEHP considers high-risk Members to have a probability score of ≥ 0.5 for being in the top 5 percent of the total cost.

Numerator:

High-risk Members who had a follow-up visit with a practitioner within seven days of discharge. A practitioner for this measure is defined as a Primary Care Provider or Specialty Care Provider. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care or specialty care medical services. Licensed practical nurses and registered nurses are not considered PCPs or Specialists. Specialty Care Providers are included as qualifying Practitioners if the Provider offers ongoing care to the Member. Clinical pharmacists are not considered "practitioners" for this measure.

Denominator:

All acute and nonacute inpatient discharges during the measurement period for high-risk Members.

IEHP utilizes the HEDIS® modified measure denominator specifications for Transition of Care (TRC) to determine the initial denominator. Once these Members and discharges have been identified, the denominator is further refined to only include those Members who meet the high-risk criteria of a Probability of High Total Cost value of ≥ 0.5 on the date of admission.

To be eligible for this measure, IEHP Members must be enrolled with IEHP on the date of discharge through 30 days after discharge (31 total days).

Minimum Denominator Requirement*:

The denominator must be 10 or above for this measure.

*This does not apply to Critical Access Hospitals (CAHs).

Notes:

- Only the last discharge is counted if the discharge is followed by a readmission within seven days of the initial discharge.
- Urgent Care visits are not accepted for this Post Discharge Follow-Up measure.
- Medi-Medi Members are also excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

The following are excluded from the measure:

1. Hospice
2. Skilled Nursing Facility
3. Deliveries

CODES TO IDENTIFY FOLLOW-UP VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
Office Visit	CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

CODES TO IDENTIFY FOLLOW-UP VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99241	Office consultation for a new or established patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99242	Office consultation for a new or established patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99243	Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99244	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99245	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years.
Office Visit	CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older.
Office Visit	CPT	99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.
Office Visit	CPT	99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years.
Office Visit	CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older.
Office Visit	CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
Office Visit	CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
Office Visit	CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
Office Visit	CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
Office Visit	CPT	99411	Preventive Medicine Counseling And/or Risk Factor Reduction Intervention(s) Provided To Individuals In A Group Setting (separate Procedure); Approximately 30 Minutes
Office Visit	CPT	99412	Preventive Medicine Counseling And/or Risk Factor Reduction Intervention(s) Provided To Individuals In A Group Setting (separate Procedure); Approximately 60 Minutes
Office Visit	CPT	99429	Unlisted Preventive Medicine Service
Office Visit	CPT	99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of high complexity during the service period face-to-face visit, within seven calendar days of discharge.
Office Visit	HCPCS	G0402	Initial Preventive Physical Examination; Face-to-face Visit, Services Limited To New Beneficiary During The First 12 Months Of Medicare Enrollment (g0402)
Office Visit	HCPCS	G0438	Annual Wellness Visit; Includes A Personalized Prevention Plan Of Service (pps), Initial Visit (g0438)
Office Visit	HCPCS	G0439	Annual Wellness Visit, Includes A Personalized Prevention Plan Of Service (pps), Subsequent Visit (g0439)
Office Visit	HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	HCPCS	T1015	Clinic visit/encounter, all-inclusive.

CODES TO IDENTIFY TELEPHONE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Telephone Visit	CPT	98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
Telephone Visit	CPT	99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	CPT	98969	Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network
Online Assessment	CPT	98970	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	98971	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	98972	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
Online Assessment	CPT	98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
Online Assessment	CPT	98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	CPT	99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
Online Assessment	CPT	99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
Online Assessment	CPT	99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
Online Assessment	CPT	99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network
Online Assessment	CPT	99457	Remote physiologic monitoring treatment management services, clinical staff/ physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
Online Assessment	CPT	99458	Remote physiologic monitoring treatment management services, clinical staff/ physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	HCPCS	G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
Online Assessment	HCPCS	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
Online Assessment	HCPCS	G2061	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
Online Assessment	HCPCS	G2062	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
Online Assessment	HCPCS	G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes
Online Assessment	HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
Online Assessment	HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

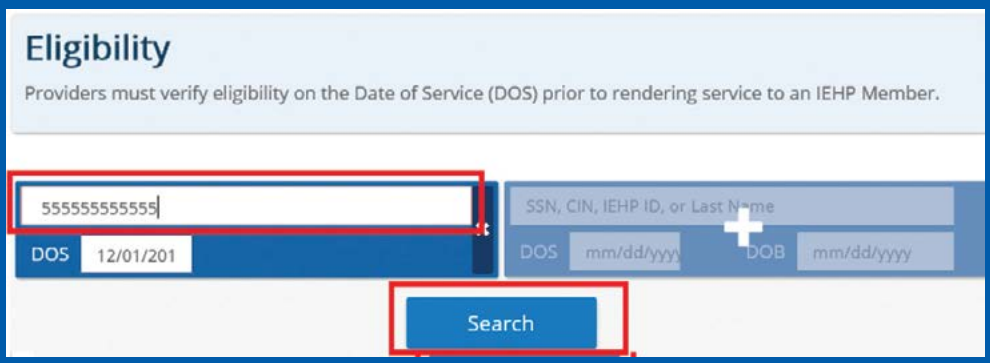
To view an IEHP Member's current "Probability of High Total Cost" Risk Score, hospitals can log in to the secure IEHP Provider Portal and follow these steps:

1

From the Home Screen, click on "Eligibility"

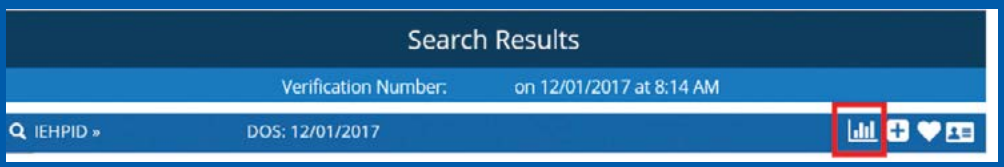
2

Enter the Member ID and Click "Search"



3

Click on the "Chart" icon



4

View Member Risk Score: "Probability of High Total Cost"

☑ Measure Name: *Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio*

This measure captures the number of acute inpatient stays during the measurement period that is followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of acute readmission for IEHP Members 18-64 years old. Acute inpatient stays include any observation days that exceed one day.

Methodology:

The HEDIS® modified measure called "Plan All-Cause Readmissions" (PCR) is utilized to determine the 30-day readmission rate for IEHP Hospitals. Data are reported in the following categories:

1) Count of Index Hospital Stays (IHS) (Denominator)
2) Count of Observed 30-Day Readmissions (Numerator)
3) Count of Expected 30-Day Readmissions
4) Observed-to-Expected Ratio

The Observed-to-Expected Ratio (O/E Ratio) is the final measure used to determine hospital performance.

Count of Index Hospital Stays (IHS):

Count of all acute inpatient discharges on or between January 1 and December 31 of the measurement year (2023). The index stay must occur at the hospital being measured.

The following are excluded from the Index Hospital Stay:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Member died during the stay
- Non-Acute inpatient stays
- Hospice care
- Same-day discharges. Observation stays will be excluded if the observation stay meets the same-day discharge criteria. Same-day discharge criteria is defined as having the same admit and discharge date.
- Outliers: Members with four or more index hospital stays between January 1 and December 31 of the measurement year (2023)

Count of Observed 30-Day Readmissions:

Count all acute readmissions for any diagnosis within 30 days of the Index Discharge Date. The readmission can occur at any hospital, including a hospital separate from the hospital being measured.

The following are excluded from the Count of Observed 30-Day Readmissions:

- Principal diagnosis of pregnancy
- Principal diagnosis of a condition originating in the perinatal period
- Nonacute inpatient stays
- Principal diagnosis of maintenance chemotherapy
- Principal diagnosis of rehabilitation
- Organ transplant
- Potentially planned procedures without a principal acute diagnosis

Count of Expected 30-Day Readmissions:

The count of expected readmissions is determined in two steps:

1) Calculate the Estimated Readmission Risk for each IHS by summing the following risk adjustment weights:
    - Age/gender
    - Surgeries
    - Discharge clinical condition
    - Comorbidities
2) Sum the Estimated Readmission Risk for all IHS in the reporting period

Observed 30-Day Readmissions Rate:

The count of Observed 30-Day Readmissions divided by the count of Index Hospital Stays.

Expected 30-Day Readmissions Rate:

The count of Expected 30-Day Readmissions divided by the count of Index Hospital Stays.

Observed-to-Expected Ratio:

The Rate of Observed 30-Day Readmissions divided by the Rate of Expected 30-Day Readmissions.

To be eligible for this measure, Members must be enrolled with IEHP 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date. No gap is allowed during the 30 days following the Index Discharge Date.

Minimum Denominator Requirement*:

The count of Index Hospital Stays must be 20 or greater for this measure to be eligible for payment.

**This does not apply to Critical Access Hospitals (CAHs).*

Notes:

- All hospital claims received by IEHP are included in the calculation of this measure regardless of payment decision (i.e., all payment statuses are counted, including denied status claims).
- Medi-Medi Members are excluded from this measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).

☑ Measure Name: *Hospitalization for Potentially Preventable Complications*

Methodology:

The HEDIS® measure called Hospitalization for Potentially Preventable Complications is utilized to determine the percentage of discharges, for Members 67 years of age and older, for ambulatory care sensitive conditions (ACSC) per 1,000 Members and the risk-adjusted ratio of observed-to-expected discharges for ACSC, by chronic and acute conditions.

Observed Events:

Count of all chronic ACSC acute inpatient and observation stay discharges during the measurement year (2023):

1) Identify the count of chronic ACSC acute inpatient and observation stay discharges
2) Calculate the total number of ACSC acute inpatient and observation stay discharges

Count of all acute ACSC acute inpatient and observation stay discharges during the measurement year (2023):

1) Identify the count of acute ACSC acute inpatient and observation stay discharges
2) Calculate the total number of ACSC acute inpatient and observation stay discharges

Risk Adjustment Determination and Calculation of Expected Events:

Calculate the expected events using risk-adjusted outcomes and predetermined risk weights. Prediction of the count of discharges each Member might have during the measurement year (2023) is based on the following:

- Age
- Gender
- Presence or absence of comorbid condition

Observed Events:

The count of observed discharges divided by the count of nonoutlier Members in the eligible population, multiplied by 1,000 for each age group, gender group and total counts for each ACSC category (including the Total ACSC category).

Expected Events:

The count of expected discharges divided by the count of nonoutlier Members in the eligible population, multiplied by 1,000 for each age group, gender group and total counts for each ACSC category (including Total ACSC category).

Observed-to-Expected Ratio:

The count of observed discharges divided by the count of expected discharges for each age group, gender group and total counts for each ACSC category (including Total ACSC category).

To be eligible for this measure, Members must be enrolled with IEHP during the measurement year (2023) and the prior year (2022) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment period.

Minimum Denominator Requirement*:

The count of inpatient and observed stay discharges must be 20 or greater for this measure to be eligible for payment.

**This does not apply to Critical Access Hospitals (CAHs).*

Notes:

- All hospital claims received by IEHP are included in the calculation of this measure regardless of payment decision (i.e., all payments statuses are counted, including denied status claims).
- Medi-Medi Members are excluded from the measure. Medi-Medi Members are defined as Members who have Medi-Cal with IEHP and Medicare with another Plan or with Fee for Service (FFS).
- Denominator defined by Members who are assigned to the hospital.

The following are excluded from the measure:

- Hospice
- Chronic ACSC Outlier: Members with three or more inpatient or observation stay ACSCs in the measurement year (2023)
- Acute ACSC Outlier: Members with three or more inpatient or observation stay ACSCs in the measurement year (2023)
- Nonacute inpatient stays

Definitions:

Ambulatory Care Sensitive Condition (ACSC)

An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions include:

- Chronic ACSC:
  - Diabetes short-term complications
  - Diabetes long-term complications
  - Uncontrolled diabetes
  - Lower-extremity amputation among patients with diabetes
  - COPD

- Asthma
- Hypertension
- Heart failure

- Acute ACSC:
  - Bacterial pneumonia
  - Urinary tract infection
  - Cellulitis
  - Pressure ulcer

☑ Measure Name: *HQI Cares: Implementing BETA Heart Program*

HQI Cares: Implementing BETA HEART®, (healing, empathy, accountability, resolution, and trust) (in further text "HQI Cares") is a coordinated effort designed to guide health care organizations in implementing a reliable and sustainable safety culture grounded in a transparency philosophy. The goals of the program are to develop an empathic and clinically appropriate process that supports the healing of the patient and clinician after an adverse event; ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust in all clinicians and patients.

HQI Cares is a multi-year, interactive, collaborative process supporting the organization, its staff and patients. Hospitals progress through five program domains, each an essential component of the safety culture and transparency:

1. **Safety Culture:** Administering a scientifically validated, psychometrically sound safety culture survey to measure staff perceptions of safety and engagement, as well as sharing and debriefing results. The Culture domain includes the implementation of a Just Culture of accountability.
2. **Rapid Event Response and Analysis:** A formalized process for early identification of adverse events and rapid response to them. This includes applying cognitive interviewing tactics to collect information. The event analysis process integrates human factors science, systems analysis, and the principles of Just Culture. Organizations learn to differentiate between strong and weak performance improvement action items and apply strong actions that result in improved systems.

3. **Communication and Transparency:** The organization commits to honest and transparent communication with patients and family members harmed during care or after an adverse event. Participating organizational leaders, physicians and staff will take a communication assessment, identify, and designate a Communication Consult or Resource team and develop processes for ensuring empathic and transparent communication with patients and families that begins early and continues through the course of the event review. Findings from the event review and actions taken are shared with patients and families.
4. **Care for the Caregiver:** Development and implement an organizational proactive peer support program that ensures emotional support for members of the health care team involved in or impacted by an adverse event.
5. **Early Resolution:** A process for resolution when harm is deemed a result of inappropriate care or medical error. Resolution may include financial or non-financial means and is dependent upon the impact of the event and that which will help, to the best of the organization's ability, to make the patient/family whole.

The five domains are introduced through distinct workshops attended by participating hospital teams. The order and timeframe for the implementation of domains will vary by organization. After the workshops, the HQI Cares program team and faculty provide multi-faceted support to participating hospitals throughout the implementation.

There are currently two hospital cohorts enrolled in HQI Cares under the auspices of IEHP's Hospital P4P Program:

- Cohort One consists of 24 hospitals that started HQI Cares in 2022. These hospitals are continuing their participation in 2023.
- Cohort Two consists of 8 hospitals that are starting HQI Cares in 2023. Note: For HQI Cares, the P4P Program Year 2023 commenced on August 26, 2022, the due date for the first milestone.

Performance requirements are presented separately for each hospital cohort.

Performance Requirements Overview – Cohort Two (First year of program):

Hospitals must complete each milestone (as described under "Hospital Requirements" below) by the associated completion due date to qualify for the milestone incentive dollars.

MILESTONE #	2022 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE
1	Sign and submit the Participation Agreement	Participation Agreement signed by Hospital CEO and submitted to HQI Cares by the due date.	08/26/2022
2	Complete the Onboarding Process, including Readiness Assessment and Gap Analysis	1) Hospital identifies HQI Cares Project Leader in the Hospital who will be the key contact for HQI Cares Program Team (HQI Cares). 2) Project Leader distributes Readiness Assessment to key leaders and staff in the organization, including: • Executive leadership team • Medical staff – select leaders, attending physicians and resident physicians (if residency program) • Vice Presidents for clinical services • Safety, Risk Management, Quality, Legal and Ethics personnel • Unit/department directors, managers and educators • Patient and family advisors (if applicable) 3) Project Leader collects and collates completed Readiness Assessments from a minimum of ten leaders and staff. Project Leader submits one comprehensive Readiness Assessment to HQI Cares, which reflects perspectives from multiple individuals. 4) Project Leader sends to HQI Cares the organizational policies and procedures as defined in the Gap Analysis Guide. These must be received at least two weeks before the scheduled focus group sessions. 5) Project Leader partners with HQI Cares to schedule and hold gap analysis focus groups session. The exact number and composition of the focus groups are to be determined in collaboration between the Hospital and HQI Cares. The following roles must be included (at a minimum): executive leadership, medical staff leadership, unit-level managers, front-line patient care staff and ancillary staff (dietary, engineering, bio-med, etc.). Refer to Gap Analysis Guide for detailed recommendations. 6) Project Leader ensures that a meeting is scheduled and held between the Hospital's executive leadership team and HQI Cares to deliver and discuss an executive leader report on the results of the gap analysis and the recommended next steps.	11/30/2022
3	Form a Hospital-Based HQI Cares Steering Team	1) Project Leader submits to HQI Cares the list of names, titles and contact information of a hospital-based HQI Cares Steering Team (Steering Team). 2) The Steering Team must be comprised of the following individuals (at a minimum): the HQI Cares Project Leader, an executive sponsor, a medical staff leader, a nursing leader, and a patient safety leader. Additional leaders and staff may be added to the Steering Team as needed.	3/31/2023
4	Develop an Action Plan to define what the hospital plans to accomplish by the end of 2023 to advance the work on HQI Cares	1) The Steering Team meets with HQI Cares to discuss the gap analysis findings and recommendations and determine priorities and actions for 2023. 2) The Steering Team produces an Action Plan for 2023 and secures its approval by the hospital's executive team and HQI Cares. 3) The Action Plan must be informed and responsive to recommendations identified in the Gap Analysis Report.	6/30/2023

MILESTONE #	2022 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE
5	Complete the Communication Skills Assessment with all Workshop Two participants before Workshop Two (April 26-27, 2023)	1) All participants of Workshop Two have completed and submitted a Communication Skills Assessment by April 17, 2022. 2) Additional physicians and staff are welcome to complete the Assessment and receive results.	6/30/2023
6	A specified team of senior hospital leaders attends all three workshops in 2023 (4-6 attendees)	1) A team of senior leaders has attended each of the three workshops. 2) Participants are to include, at a minimum: an executive leader, a physician leader, a nursing leader, and a risk manager and/or patient safety officer. 3) Additional staff can attend and may include those with key roles in implementing domain-specific strategies addressed at each workshop (e.g., designated peer supporters, culture survey administration leads, communication resource team members, and others).	12/31/2023
7	Implement a 2023 Action Plan	1) Project Leader provides regular reports on the progress of the work to the Steering Team. 2) Steering Team or its designee meets with HQI Cares quarterly to review progress on the Action Plan activities for 2023. 3) By the end of Q4, the Steering Team submits a final report to HQI Cares showing evidence of implementation of the Action Plan.	12/31/2023
8	Develop a 2024 Action Plan	1) The Steering Team, in collaboration with HQI Cares, reviews key documents and activities to date. 2) The Steering Team meets with HQI Cares to discuss next steps and priorities for 2024. 3) The Steering Team produces an Action Plan for 2024 and secures its approval by the Hospital's executive team and HQI Cares. 4) The Steering Team shares the approved Action Plan for 2024 with HQI Cares.	12/31/2023

Payment Methodology – Cohort Two (First year of program):

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

BETA HEART PAYMENT SCHEDULE - YEAR ONE, COHORT TWO				
Milestone	**Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution***
1	Sign Participation Agreement	$17,000	Q4 2022	See 2022 Program Guide
2	Complete the Onboarding Process	$69,000	Q4 2022	See 2022 Program Guide
3	Form a Hospital-Based HQI Cares Core Team (Steering Committee)	$35,000	Q1 2023	October 2023
4	Develop a 2023 Action Plan	$17,500	Q2 2023	October 2023
5	Complete the Communication Skills Assessment	$17,500	Q2 2023	October 2023
6	2023 Workshop Attendance	$69,000	Q4 2023	April 2024
7	Implement 2023 Action Plan	$103,000	Q4 2023	April 2024
8	Develop 2024 Action Plan	$17,000	Q4 2023	April 2024
	Milestones Total	**$345,000**		

*Payment milestones are for activities that occurred within the performance period.

Performance Requirements Overview – Cohort One (Second year of program):

Hospitals must complete each milestone (as described under "Hospital Requirements" below) by the associated completion due date to qualify for the milestone incentive dollars.

MILESTONE #	2023 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE
1	Sign and submit Participation Agreement Addendum 2023	Participation Agreement Addendum signed by Hospital CEO and submitted to HQI Cares by the due date.	10/07/2022
2	Develop a 2023 Action Plan	1) Review HQI Cares Guideline and meet with HQI Cares Program Team to ensure an understanding of domain completion criteria 2) Decide on one to two domain(s) to focus on in 2023 3) Develop an Action Plan for implementing the selected domain(s) through the year: a. Follow the HQI Cares Action Plan Template b. Stay consistent with HQI Cares Guideline and domain criteria c. Include implementation steps and due dates 4) Secure approval of the Action Plan by the hospital's executive team 5) Submit the Action Plan to HQI Cares Program Team 6) Submit a current list of Steering Team members with contact information to HQI Cares Program Team *Note: Not separately payable as this milestone meets 2022 Milestone #8 ("Develop Action Plan 2023")*	12/31/2022
3	Complete the annual Readiness Assessment	Critical access hospitals must obtain a minimum of 10 and all other hospitals a minimum of 20 assessments. Exceptions may be granted by IEHP upon request.	01/31/2023
4	Utilize culture data, gap analysis input and/or information gained through interactive discussions with the front-line staff to develop a foundation of trust that will support implementation of HQI Cares	Provide evidence of live meeting(s) with front-line staff discussing one or more of the following: • Findings and recommendations of HQI Cares Gap Analysis • Actions implemented as a result of Culture Survey debriefs • Actions implemented as a result of Leadership Rounding related to HQI Cares Meeting(s) must include at least 10% of an organization's front-line staff. Provide sign-in sheet(s), or other proof of meeting completion and attendees.	03/31/2023
5	Develop HQI Cares Dashboard	1) Review HQI Cares Guideline and consult with HQI Cares Program Team to select appropriate metrics that are consistent with domain criteria 2) Include both process and outcome measures in the dashboard 3) Construct the dashboard and prepare for tracking as of 4/1/23	03/31/2023
6	Provide initial HQI Cares Dashboard data to internal stakeholders and the HQI Cares Program Team	1) Track metrics quarterly working in collaboration with HQI Cares Program Team to ensure reporting elements are captured 2) Provide evidence of the process for communicating dashboard data internally in the organization 3) Share initial dashboard data with HQI Cares Program Team	09/30/2023

MILESTONE #	2023 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	COMPLETION DUE DATE
7	Senior hospital leaders attend all three workshops in 2023	1) Each workshop is attended by a minimum of an executive leader, a physician leader, a nursing leader, and a patient safety, risk management or quality leader. Exceptions must be approved by IEHP and could take the form of an alternative assignment as determined by HQI Cares Program Team 2) Additional staff can attend, such as those with key roles in the domain implementation (up to six attendees in total) 3) New team members must attend both introductory and intermediate tracks; continuing participants are welcome to attend both tracks but can chose to attend intermediate tracks only 4) First-time Workshop Two participants must complete Communication Skills Assessment before April 17, 2023	12/31/2023
8	Participate in domain-specific regional training	Hospital staff members and providers participate in domain-specific regional training aimed at expanding the learnings from the workshops and facilitating the implementation of the domain(s) in focus. The minimum number of trainees must be determined in consultation with HQI Cares Program Team.	12/31/2023
9	Implement 2023 Action Plan	1) Implement Action Steps on time per the 2023 Action Plan 2) Meet with HQI Cares Program Team quarterly to review implementation progress and adjust approaches if/as needed 3) Submit a final report showing evidence of Action Plan implementation using the HQI Cares Action Plan Template	12/31/2023
10	Develop 2024 Action Plan	1) Meet with HQI Cares Program team to discuss the next steps and priorities for 2024 2) Produce an Action Plan for 2024 following the HQI Cares Action Plan Template 3) Secure the plan's approval by HQI Cares Program Team and the hospital's executive team	12/31/2023

Payment Methodology – Cohort One (Second year of program):

The following table describes the payment amounts available for hospitals to earn for achieving each milestone along with the associated P4P payment cycle dates.

BETA HEART PAYMENT SCHEDULE - YEAR TWO, COHORT ONE				
Milestone	**Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution***
1	Sign and submit Participation Agreement Addendum 2023	$17,250	Q4 2022	April 2023
2	Develop a 2023 Action Plan	*N/A: Payable as Milestone 8 in 2022*	*N/A: Payable as Milestone 8 in 2022*	*N/A: Payable as Milestone 8 in 2022*
3	Complete the annual Readiness Assessment	$17,250	Q1 2023	April 2023
4	Utilize culture data, gap analysis input and/or information gained through interactive discussions with the front-line staff to develop a foundation of trust that will support implementation of HQI Cares	$51,750	Q1 2023	July 2023
5	Develop HQI Cares Dashboard	$34,500	Q1 2023	July 2023
6	Provide initial HQI Cares Dashboard data to internal stakeholders and the HQI Cares Program Team	$51,750	Q3 2023	January 2024
7	Senior hospital leaders attend all three workshops in 2023	$34,500	Q4 2023	April 2024
8	Participate in domain-specific regional training	$34,500	Q4 2023	April 2024
9	Implement 2023 Action Plan	$86,250	Q4 2023	April 2024
10	Develop 2024 Action Plan	$17,250	Q4 2023	April 2024
	Milestones Total	**$345,000**		

*Payment milestones are for activities that occurred within the performance period.

NEW ☑ Measure Name: *Hospital Quality Star Rating*

IEHP is on a journey towards achieving the strategic priority of Optimal Care for all Members and has established a goal that ≥75% of IEHP network hospitals will have a Centers for Medicare & Medicaid Services (CMS) Hospital Quality Star rating of 3 or higher by 2026. IEHP is committed to helping hospitals achieve this goal by enhancing collaboration throughout the continuum of care and offering incentives to support the journey, including enhanced reporting for greater visibility into hospital quality and increased insight into challenges faced by hospitals in securing optimal patient outcomes.

The Hospital Quality Star Rating is a trusted, robust, validated methodology designed by the Center for Outcomes Research and Evaluation (CORE) project team in collaboration with CMS. This rating system was launched in July 2015 and since its inception has been modified into a statistically sound, comprehensive evaluation tool to summarize hospital performance that patients and consumers can easily interpret. Hospital quality outcomes and results are categorized into five major areas. These measure groups for the July 2022 star rating system are:

I. **Mortality** (7 measures) – examines death rates in the 30 days following hospitalization
II. **Safety of Care** (8 measures) – observes potentially preventable injury and complications during hospitalization
III. **Readmission** (11 measures) – monitors the return of patients following hospitalization
IV. **Patient Experience** (8 measures) – observes the patient perspective on the hospital care received
V. **Timely & Effective Care** (12 measures) – assesses how often or quickly hospital care is provided

Methodology:

Hospitals receive a composite score through the weighted combination of individual measure results associated with their measure groups. However, only hospitals that have a minimum of three (3) measures within three (3) measure groups, with at least one (1) of those measure groups being Mortality or Safety of Care, are eligible to receive a quality star rating. Hospitals are assigned to peer clusters based on the number of their measure groups attaining the required measure reporting threshold minimum, then a clustering algorithm (k-means) is applied to categorize a hospital composite score on a 1 to 5 rating scale to derive the Hospital Quality Star Rating.

Eligibility for payment will be determined via the officially released 2023 CMS Hospital Quality Star Rating.

NEW ☑ Measure Name: *Patient Experience*

IEHP is focused on ensuring Members discharged from Network Hospitals receive care and services that reflect cultural humility, respect and human-centered hospital care that aligns with our Mission, Vision and Values. Beginning in 2023, IEHP will administer a new Patient Experience survey for all Members upon discharge. This survey will focus on areas that hospitals are also interested and invested in gaining positive marks:

1. Overall Rating of the Hospital
2. Care from Nurses
3. Care from Doctors
4. Discharge Information
5. Transitions of Care

This measure encourages hospital engagement in Quality Improvement Activities (QIA) that focus on improving patient experience, specifically targeting the priorities mentioned above.

Goal:

1. Establish a quality improvement activity that directly addresses patient experience. This will contain a clearly outlined strategy to address performance improvement opportunities within one or more of the patient experience domains listed above.
2. Establish and share with IEHP the project or work plan, key performance indicators, and project outcomes:
    a. Email these documents to: HospitalRelationsServiceTeam@iehp.org
    b. By the following due dates:
    July 1, 2023: Establish the program
    January 1, 2024: Share project outcomes

☑ Manifest MedEx Active Data Sharing

Manifest MedEx (MX) supports Health Information Exchange (HIE) connectivity across California and currently includes over 30 hospitals, medical groups, IPAs and Physician practices in the Inland Empire. Manifest MX works closely with a local partner, Inland Empire Health Information Organization (IEHIO) which represents 36 hospitals and most of the Physicians in the area who participate in organized Physician groups and IPAs (2,400 unduplicated Physicians). The remaining Physicians are largely in solo practices. Manifest MX also includes many other health care organizations, such as Federally Qualified Health Centers (FQHCs) and multi-specialty clinics.

Performance Requirements:

Hospitals must demonstrate active data sharing with Manifest MX by submitting all data types listed below throughout the measurement period (i.e., quarter). Completeness of hospital data will be assessed throughout the quarter to ensure data sharing is in place throughout the entire measurement period.

This data sharing requirement aims to leverage new technology to support care transition processes between hospitals and Providers. To be compliant with this measure, it is expected that hospitals report all discharges and admissions (including emergency room, acute and subacute stays) to Manifest MX for all message types noted in the following table during the entire measurement period.

MX DATA CONTRIBUTION FOR HOSPITALS:		
HL7 ADT data feed that complies with MX data sharing guidelines in production		
Admissions Data	*Discharge Data*	*Diagnosis Data*
HL7 ORU data feed that complies with MX data sharing guidelines in production		
Lab Orders	*Lab Results*	*Lab Documents*
Pathology Documents	*Radiology Documents*	*Chart Notes**
HL7 RDE data feed that complies with MX data sharing guidelines in production		
Prescription Medications/Orders		*Medication Information (including SIG)*
Delivery Route		*Status*
HL7 VXU data feed that complies with MX data sharing guidelines in production		
*Immunization Data***		

* Chart notes include: discharge summary, consults, progress notes, surgical notes and procedure notes. These notes can be provided by HL7 Medical Document Management (MDM).

** Immunization data submitted to MX is separate from immunization reporting to California Immunization Registry (CAIR2)

New requirements have been added to the MX Active Data Sharing measure. Please see below. Details of the MX requirements can be found on the IEHP website at: https://www.iehp.org/en/providers/p4p-prop56-gemt#P4PHospital.

2023 MX ACTIVE DATA SHARING – NEW REQUIREMENTS:	
HL7 Field	**HL7 Field Description**
PV1-37	Discharge to Location
PV1-10	Hospital Services: BEH, NICU, NWB, OBS
OBR-3.1	LOINC Codes
IN1-4 and IN1-36	Insurance Information
TXA-4.1 / TXA-7.1	Transcription Date/Time
TXA-8	Edit Date/Time
OBX-11	Result Status
TXA-6	Origination Time
RXE-1.1	Quantity
Note: There will be discovery discussions in 2023 to understand where **ED/IP physician orders** are entered.	

Hospitals must have a **current participation agreement (PA) in place with MX**. The executed PA using MX's post-merger PA structure must be in place at the beginning of each quarter in order to qualify for the quarterly payment.

Due to the unique characteristics of the critical access hospitals, the following adjustment is made to ensure adequate funding for this measure:

- Manifest MedEx Active Data Sharing
- A $25,000 incentive is available for Critical Access Hospitals (CAHs) who meet the Manifest MedEx Active Data Sharing measure within any quarter of the 2023 performance year (quarter 1- 4).

Definitions:

Current Participation Agreement (PA)
Participant has executed a PA with MX using MX's post-merger PA structure

Critical Access Hospital (CAH)
CAHs are specially designated hospitals located in rural areas. These may be more than 35 miles from the nearest hospital or more than 15 miles in areas with mountainous terrain or only secondary roads or designated by the State as a "necessary provider" of health care services to residents in the area. These facilities maintain no more than 25 inpatient beds that can be used for inpatient or swing-bed (skilled nursing facility level care), maintain an average length of stay of 96 hours or less for inpatients, and provide emergency services 24 hours a day, 7 days a week. Hospice agencies may contract with critical access hospitals to provide inpatient hospice care, included in the 25-bed maximum. Critical access hospitals may also operate a psychiatric and/or rehabilitation distinct part unit of up to 10 beds each.

Acronym Dictionary:
ADT: Admission, discharge, transfer message
HL7: Health level 7 standards development organization
MDM: Medical Document Management
ORU: Observation result message
PA: Participation Agreement
RDE: Pharmacy/treatment encoded order message
VXU: Immunization data

APPENDIX 1: *Maternal Morbidity Safety Bundle Implementation - Checklist*

OBSTETRIC HEMORRHAGE :				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and on admission to postpartum.				
Develop written evidenced-based procedures for managing pregnant and postpartum patients who experience maternal hemorrhage that includes the following:				
The use of an evidence-based tool that includes an algorithm for identification and treatment of hemorrhage				
The use of an evidence-based set of emergency response medications that are immediately available on the obstetric unit				
Required response team members and their roles in the event of severe hemorrhage				
How the response team and procedures are activated				
Blood bank plan and response for emergency release of blood products and how to initiate the hospital's massive transfusion procedures				
Guidance on when to consult additional experts and consider transfer to a higher level of care				
Guidance on how to communicate with patients and families during and after the event				
Criteria for when a team debrief is required immediately after a case of severe hemorrhage				

OBSTETRIC HEMORRHAGE :				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Each obstetric unit has a standardized, secured and dedicated hemorrhage supply kit that must be stocked per the hospital's defined process and, at a minimum contains:				
Emergency hemorrhage supplies as determined by the hospital				
The hospital's approved procedures for severe hemorrhage response				
Provide role-specific education to all staff and providers who treat pregnant/postpartum patients about the hospital's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years.				
Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Hemorrhage drills include a team debrief.				
Review severe hemorrhage cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event.				
Provide printed education to patients (and their families including the designated support person whenever possible). At a minimum, education includes:				
Signs and symptoms of postpartum hemorrhage during hospitalization that alert the patient to seek immediate care				
Signs and symptoms of postpartum hemorrhage after discharge that alert the patient to seek immediate care				

Requirements are based upon and adopted from The Joint Commission Standards for Maternal Safety.

HYPERTENSIVE DISORDERS OF PREGNANCY:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Develop written evidence-based procedures for measuring and remeasuring blood pressure. These procedures include criteria that identify patients with severely elevated blood pressure.				
Develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes the following:				
The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit				
The use of seizure prophylaxis				
Guidance on when to consult additional experts and consider transfer toa higher level of care				
Guidance on when to use continuous fetal monitoring				
Guidance on when to consider emergent delivery				
Criteria for when a team debrief is required				
Provide role-specific education to all staff and providers who treat pregnant/postpartum patients about the hospital's evidence-based hypertensive disorders of pregnancy procedure. At minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years. **Note: Education should be provided to staff and providers in the emergency department as this is often where patients with symptoms of severe hypertension present for care after delivery.*				

HYPERTENSIVE DISORDERS OF PREGNANCY:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/ preeclampsia drills include a team debrief.				
Review severe hypertension/ preeclampsia causes that meet criteria established by the hospital to evaluate the effectiveness of care, treatment and services provided to the patient during the event.				
Provide printed education to patients and their families, including the designated support person whenever possible. At minimum, education includes:				
Signs and symptoms of severe hypertension/preeclampsia during hospitalization that alert the patient to seek immediate care				
Signs and symptoms of severe hypertension/preeclampsia after discharge that alert the patient to seek immediate care				
When and why to schedule a post-discharge follow-up appointment				

Requirements are based upon and adopted from The Joint Commission Standards for Maternal Safety.

MOTHER AND BABY SUBSTANCE EXPOSURE:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Use validated verbal screening and assessment tools to evaluate all pregnant women for substance use disorders				
Once substance use is identified, perform a brief intervention and referral to appropriate treatment (SBIRT)				
Develop policies surrounding and take steps to educate caregivers about maternal urine toxicology and the role of explicit/implicit bias in decision making				
Create a prenatal checklist for care of women with opioid use disorder				
Identify substance-exposed newborns				
Implement selective newborn biological toxicology testing				
Implement trauma-informed care to optimize patient engagement				
Understand and implement the principles of motivational interviewing				
Encourage breastfeeding for women with opioid use disorder				
Initiate medication assisted treatment in the prenatal setting				
Implement an inpatient treatment protocol for pregnant women with opioid use disorder				
Implement evidence-based anesthesia practices in the peripartum period for opioid use disorder pregnancy				
Ensure methadone and buprenorphine dosages are not tapered in the immediate postpartum period				
Implement care pathways for peripartum pain management of pregnant patients without opioid use disorder to minimize opioid use				

MOTHER AND BABY SUBSTANCE EXPOSURE:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Utilize shared decision making to tailor post-procedure pain control				
Implement a non-pharmacologic bundle of care for neonatal abstinence syndrome for medical staff and parents to follow				
Develop guidelines for inpatient monitoring of newborns managed with a non-pharmacologic bundle of care				
Consider parental rooming-in with the newborn when safety of mother and newborn can be ensured				
Prioritize measurement of functional impairment as a basis for initiation and escalation of pharmacologic treatment				
If pharmacotherapy is indicated, consider a trial of morphine every 3 hours PRN as an initial strategy for the treatment of neonatal abstinence syndrome instead of scheduled dosing or more long-acting pharmacotherapy options				
Consider methadone as first line pharmacotherapy for the treatment of neonatal abstinence syndrome following evaluation of its benefits/ risks				
Consider clonidine instead of phenobarbital as a potential second line/adjunctive therapy for neonatal abstinence syndrome				
Develop guidelines for inpatient monitoring of newborns receiving morphine, clonidine, or methadone pharmacotherapy prior to discharge				
Establish a pharmacotherapy weaning protocol				
Implement opioid use disorder discharge checklists				

MOTHER AND BABY SUBSTANCE EXPOSURE:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Continue to establish a therapeutic relationship with parents/caregivers once the infant has been born and empower parents to be involved with the care of their newborn				
Develop a dyad-centered plan of safe care				
Implement a warm handoff strategy to follow at time of discharge				
Ensure linkage to home visitation program or other in-home supports are in place				
Ensure referral and linkage to other necessary services/resources at discharge				
Communicate directly with the outpatient primary care provider prior to the newborn leaving the hospital to review the hospital course and discuss follow up				
Provide staff and provider education on opioid use disorder				
Educate patients and families about opioid use disorder				
Educate pregnant women about opioid use disorder in pregnancy and the hospital experience				
Provide health care providers with stigma education/resources				
Educate pregnant women and families about neonatal abstinence syndrome and the newborn hospital experience				
Educate clinical providers and staff about neonatal abstinence syndrome				

Requirements are based upon and adopted from CMQCC's Mother & Baby Substance Exposure Toolkit

MATERNAL SEPSIS:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Implement a two-step approach for the diagnosis of sepsis during pregnancy and postpartum				
Establish protocols or policies to ensure careful individual consideration of elevated lactic acid levels during labor				
Establish protocols or policies to ensure timely recognition and action of sepsis/septic shock				
Establish protocols or policies to address reassessment and response/ lack of response to intervention				
Establish protocols or policies to ensure communication of sepsis status during bedside care and handoff				
Aim for antibiotic administration within one hour of sepsis recognition and actively monitor current performance/ implement performance improvement activities as appropriate				
Establish criteria for ensuring appropriate initial choice of antibiotics				
Establish protocols or policies to ensure assessment for timely source control (such as surgical/ percutaneous draining) using the least invasive approach possible				
Establish protocols or policies outlining the individualized timing of delivery in a patient who is septic				
Perform a risk assessment and/ or establish protocols or policies referencing the hospital's stance on avoidance of neuraxial procedures in patients with clinical signs/ symptoms consistent with sepsis/ septic shock				

MATERNAL SEPSIS:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Provide every woman and at least one support person with discharge instructions regarding the dangers of sepsis				
Establish protocols or policies for the proactive prevention of sepsis (i.e., frequent handwashing)				
Establish a process to ensure that follow-up contact is made 3-4 days after discharge for all perinatal women who have had sepsis.				

Requirements are based upon and adopted from CMQCC's Maternal Sepsis Toolkit

END OF THE YEAR ACTIVITY: *Overview*

One new measure is being introduced in a year-end push to encourage Hospitals to implement rapid improvements during the remainder of the 2023 performance year. The following measure is included in this year-end push:

- Advance Care Planning (ACP)

This year-end push has been added to the 2023 Hospital P4P Program to prepare participating Hospitals for Advance Care Planning metrics that will be added to the 2024 Hospital P4P Program. The 2024 Advance Care Planning measure will be a continuation of this end of the year Advance Care Planning Activity.

Eligibility and Participation

To be eligible for the end of the year activity incentive, Hospitals must be eligible to participate in the 2023 Hospital P4P Program and did not elect to participate in implementation and integration of ACP workflows as part of the 2022 Hospital P4P Program.

Financial Overview – End of the Year Activity

Additional financial incentive is available for meeting goals in the below measure for the 2023 Quarter 4 performance period.

FINANCIAL ALLOCATION - ADVANCE CARE PLANNING (4TH QUARTER EFFORTS)	
Measure Name	**Incentive Dollars**
Advance Care Planning	$200,000
Total 4th Quarter Advance Care Planning Budget	**$200,000**

Payment Distribution

Hospitals that meet the milestones, shown in the Advance Care Planning measure description, will receive payment for this end of the year push metric in the Hospital P4P payment distributed January 2024.

Measure Name: Advance Care Planning

Advance Care Planning (ACP), one of the 32 elective measures in the Quality Incentive Pool (QIP), is a high value service that promotes timely end-of-life discussions between health care providers, patients, families, and caregivers.

This incentive encourages hospitals to begin the work required to achieve bidirectional integration between hospital electronic medical records (EMR) and the Advance Directive Information Exchange (ADiE). ADiE is a centralized, cloud-based ACP registry that collects paper-based documents such as Advance Directives, Physician Orders for Life-Sustaining Treatment (POLST) forms, Durable Power of Attorney for Healthcare, and Pre-Hospital Do Not Resuscitate (DNR). Care Directives, an IEHP partner, will work with hospitals and provide the technology for sustainable and automated sharing of ACP records across the care continuum. Full implementation and integration of ACP workflows, with additional P4P incentives, are targeted in 2024.

For hospitals that did not elect to participate in implementation and integration of ACP workflows as part of the 2022 Hospital P4P Program, a final P4P incentive will be awarded as follows:

Option 1: Full integration

A flat rate of $50,000 will be awarded to each hospital

To be eligible, hospitals must achieve all of the following milestones:

MILESTONE #	INCENTIVE MILESTONE	COMPLETION DATE
1	Sign the Participation Agreement.	9/15/23
2	Phase 1 Queries: Participating hospitals set up an integration with ADiE to facilitiate automation of registry query each time a patient is registered within the hospital's Electronic Health Record (EHR) system.	10/31/23
3	Phase 2 ACP Document Ingestion: Participating hospitals would design and implement a workflow within their EHR system, to ingest pateints' ACP documents shared by ADiE (ACP Registry). Workflow design must support clinician access to ACP documents within the EHR record.	11/30/23
4	Phase 3 ACP Documentation Submission: Participating hospitals set up an integration ADiE (ACP Registry), so that their EHR system or document management system automatically submits periodic (e.g. daily) ACP document drops to ADiE's ACP form processing system.	12/31/23

Option 2: Faxed ACP Document Capabilities

A flat rate of $20,000 will be awarded to each hospital

To be eligible, hospitals much achieve all of the following milestones:

MILESTONE #	INCENTIVE MILESTONE	COMPLETION DATE
1	Sign the particiption agreement.	9/15/23
2	Phase 1: Digitized faxing is operational as evidenced by the receipt of at least one ACP document.	10/15/23
3	Phase 2: Hospital logs into the Care Directives portal to query for existing ACP documents and files matching documents to the patient's chart for at least one patient.	11/1/23
4	Phase 3: Hospital submits a process map/algorithm outlining how ACP documents will be routinely identified, captured and submitted (template and details provided by IEHP).	12/31/23

NOTES

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