2024

HOSPITAL P4P

Pay for Performance (P4P) Program Technical Guide

IEHP
Inland Empire Health Plan

Contact: *QualityPrograms@iehp.org*

Published: December 27, 2023

TABLE OF CONTENTS

Program Overview

Program Measures

Core Measures

HQI Cares: Implementing BETA HEART® Program 42

Optimal Care Initiatives

Data Sharing

Risk-Based Measures

Appendix 1

Appendix 2

PROGRAM OVERVIEW

Inland Empire Health Plan (IEHP) is pleased to announce the seventh 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 2024 Hospital P4P will award financial incentives for 21 individual measures which fall under five 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
3. HQI: Patient Safety and Adverse Events Composite
4. HQI: Healthcare-Associated Infection Composite
5. Follow-Up Care for Mental Health & Substance Use Disorder ED – Seven Days
6. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio
7. Timely Postpartum Care
8. Maternal Morbidity Safety Bundle Implementation
9. Patient Experience: Percentile Achievement

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

10. HQI Cares: Participation Milestones
11. HQI Cares: Domain Validation

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

12. Hospital Quality Star Rating
13. Quality Improvement Activity: Patient Experience
14. Quality Improvement Activity: Clinical Variation Reduction
15. Quality Improvement Activity: Readmission Reduction
16. Quality Improvement Activity: Safety and Adverse Events
17. Cal Hospital Compare Opioid Honor Roll

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

18. Manifest MedEx Active Data Sharing

E. **Risk-Based Measures**

19. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate
20. Post Discharge Follow-Up Appointment Within Seven Days of Discharge
21. Covered CA (CCA) Adequate Network

☑ Participation Requirements

General:

- 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 and Covered California population at the beginning of the measurement year (2024).
- 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 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, 2024, and continue through the entire measurement year (2024).
    - Due to their unique structure, Critical Access Hospitals are offered an alternative and must provide either EMR access (as above) and/or remain in good standing with IEHP's Integrated Transitional Care team throughout the program year. This is defined as a Hospital engaging in discussions, meetings and performance improvement related to member care transitions as requested and appropriate based on member volume and need.
- For those measures that are evaluated on a quarterly basis, IEHP will re-evaluate performance for the entire measurement year, at the close of the 2024 reporting period.

Participation With/In Other Entity Reporting:

- 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 participate in the Cal Hospital Compare Opioid Self-Assessment by March 29, 2024. A link to additional details can be found here: Opioid Care Honor Roll (calhospitalcompare.org)

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

Data Submission:

- Hospitals must complete an update to their IEHP Hospital Profile as requested, approximately twice per year.
- Hospitals must submit their Inpatient, ED, and Ambulatory 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 must participate in disease-specific gap analysis and other strategic planning-related requests as requested by IEHP and relevant to hospital scope. This will be limited to no more than six requests throughout the calendar year.

** 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.*
Please reference table in Reporting Calendar portion of the guide for exact dates

☑ 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.

Incentive payments may be reduced or withheld as follows:

- (All Measures) 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.
- (Manifest MedEx) Late or incomplete data feeds will generally not be accepted. If a late data feed or replay 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 data feed or replay.

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

Definitions:

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. For purposes of the P4P program, Critical Access Hospital (CAH) designation is determined by Accreditation/Licensure. Hospitals must demonstrate qualification upon request by IEHP.

Financial Overview

The annual budget for the 2024 Hospital P4P Program is $80,800,000 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.

2024 HOSPITAL P4P PROGRAM	
Measure Name	**Financial Allocation**
Core Measures	**$28,250,000**
1. HQI: Hospital-Wide All-Cause Mortality	$3,000,000
2. HQI: Sepsis Mortality	$3,000,000
3. HQI: Patient Safety and Adverse Events Composite	$3,000,000
4. HQI: Healthcare-Associated Infection Composite	$3,000,000
5. Follow-Up Care for Mental Health & Substance Use Disorder ED-Seven Days	$3,000,000
6. Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	$6,000,000
7. Timely Postpartum Care	$3,000,000
8. Maternal Morbidity Safety Bundles Implementation	$1,250,000
9. Patient Experience: Percentile Achievement	$3,000,000
HQI Cares: Implementing BETA HEART® Program	**$11,730,000**
10. HQI Cares: Participation Milestones	$2,932,500
11. HQI Cares: Domain Validation	$8,797,500
Optimal Care Initiatives	**$34,820,000**
12. Hospital Quality Star Rating	$10,000,000
a. National Association for Healthcare Quality Workforce Accelerator® - $2,040,000	
b. Dexur Healthcare Quality Excellence Implementation - $3,400,000	
c. 2024 CMS Hospital Quality Star Rating - $4,560,000	
13. Quality Improvement Activity: Patient Experience	$3,400,000
14. Quality Improvement Activity: Clinical Variation Reduction	$6,800,000
15. Quality Improvement Activity: Readmission Reduction	$6,800,000
16. Quality Improvement Activity: Safety and Adverse Events	$6,800,000
17. Cal Hospital Compare Opioid Honor Roll	$1,020,000
Data Sharing	**$6,000,000**
18. Manifest MedEx Active Data Sharing	$6,000,000
Risk-Based Measures	
19. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery	*
20. Post-Discharge Follow-Up Within Seven Days of Discharge	*
21. Covered CA (CCA) Adequate Network	*
Total Budget	**$80,800,000**

*These measures are not eligible for payment. Hospitals not meeting measure milestones and/or targets as outlined in individual measure specifications will be subject to payment withhold.

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.

2024 MEASURE PERFORMANCE TARGETS			
Core Measures			
	Measure Name	**Data Source**	**2024 Performance Targets**
1	HQI: Hospital-Wide All-Cause Mortality	HQI*	1) Less than or equal to 1.012% ***OR*** 2) Reduce hospital baseline rate by 10%
2	HQI: Sepsis Mortality	HQI*	1) Less than or equal to 14.48% ***OR*** 2) Reduce hospital baseline rate by 10%
3	HQI: Patient Safety and Adverse Events Composite	HQI*	1) Less than or equal to 0.863 ***OR*** 2) Reduce hospital baseline rate by 10%
4	HQI: Healthcare – Associated Infection Composite	HQI*	1) Less than or equal to 0.57 ***OR*** 2) Reduce hospital baseline rate by 10%
5	Follow-Up Care for Mental Health & Substance Use Disorder ED-Seven Days	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 27.59% or above (75th percentile performance for IEHP network)
6	Plan All-Cause Readmission Observed-to-Expected (O/E) Ratio	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 0.8258 or below (75th percentile performance for IEHP network)
7	Timely Postpartum Care	IEHP Claims & Encounters	Tier 1: 10% improvement over hospital-specific baseline performance** Tier 2: 81.46% or above (75th percentile performance for IEHP network)
8	Maternal Morbidity Safety Bundle Implementation	Hospital	Fully implemented Maternal Morbidity Safety Bundles.
9	Patient Experience: Percentile Achievement	Hospital HCAHPS Survey Vendor	≥50th percentile performance in each recognized domain

2024 MEASURE PERFORMANCE TARGETS			
HQI Cares: Implementing BETA HEART® Program			
	Measure Name	**Data Source**	**2024 Performance Targets**
10	HQI Cares: Participation Milestones	HQI Cares Team	All conditions must be met: 1) Hospital must sign participation agreement 2) Hospital must complete the readiness assessment 3) New hospitals must complete the gap analysis 4) Hospital representative(s) must attend all three (3) workshops
11	HQI Cares: Domain Validation	HQI Cares Team	All conditions must be met: 1) Select domain for validation 2) Schedule validation of selected domain(s) with HQI Cares team 3) Participate in all aspects of domain validation process 4) Obtain validation
Optimal Care Initiatives			
12	Hospital Quality Star Rating	CMS	All conditions must be met as outlined in measure-specific section of the guide. This includes performance requirements for: 1) National Association for Healthcare Quality (NAHQ®) Workforce Accelerator 2) Dexur Healthcare Quality Excellence Implementation 3) 2024 CMS Hospital Quality Star Rating
13	Quality Improvement Activity: Patient Experience	Hospital	Establish a new quality improvement activity that focuses on improving patient experience, with a clearly outlined strategy to address performance improvement opportunities within one identified domain/question See measure details for milestones
14	Quality Improvement Activity: Clinical Variation Reduction	TJC	Obtain certification in selected area from The Joint Commission See measure details for milestones
15	Quality Improvement Activity: Readmission Reduction	Hospital	Establish quality improvement activities that focus on reducing preventable readmissions See measure details for milestones
16	Quality Improvement Activity: Safety and Adverse Events	Hospital	Establish quality improvement activities that focus on preventing serious, but potentially avoidable complications with an overall goal to lower the rate of safety and adverse events See measure details for milestones
17	Cal Hospital Compare Opioid Honor Roll	Hospital	Recognition as a member of the 2024 Opioid Care Honor Roll by achieving a select category listed in measure See measure details for milestones

2024 MEASURE PERFORMANCE TARGETS			
Data Sharing			
	Measure Name	**Data Source**	**2024 Performance Targets**
18	Manifest MedEx Active Data Sharing	Manifest MedEx	All conditions must be met: 1) Hospitals are actively sharing data elements with MX per quarter 2) Hospitals must submit all required P4P data elements for all hospital events throughout the entire measurement period
Risk-Based Measures			
19	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery	CMQCC	Less than or equal to 23.6%
20	Post-Discharge Follow-Up Within Seven Days of Discharge	IEHP	All conditions must be met: 1) Hospital-based personnel actively participate in the post-discharge appointment scheduling process for high-risk members Expected performance is >75%. 2) Hospital-based personnel actively communicate with the Plan when high-risk members are not able to be scheduled for post discharge follow-up timely
21	Covered CA (CCA) Adequate Network	IEHP	Hospitals must ensure that they have an adequate network that includes Anesthesiology, Diagnostic Radiology, and Pathology Providers.

CMS: Centers for Medicare and Medicaid Services
CMQCC: California Maternal Quality Care Collaborative
HQI: Hospital Quality Institute
TJC: The Joint Commission

*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 Calendar

The chart below summarizes the Hospital P4P Program reporting calendar. All items for any program year due between January 1, 2024, and January 31, 2025, are included.

Deliverables extending beyond January 31,2025 will be itemized in the 2025 Hospital Pay for Performance Technical Guide.

2024 REPORTING CALENDAR				
JANUARY 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Monday, January 1st	2023	Quality Improvement Activity: Patient Experience Milestone #2	N/A	Hospital to submit to IEHP
Thursday, January 25th	2023	HQI: Healthcare – Associated Infection Composite	November 2023	Hospital to submit to NHSN
Friday, January 26th	2024	HQI Cares: Readiness Assessment	N/A	Hospital to submit to HQI Cares Team
	2024	Dexur Healthcare Quality Excellence Implementation Milestone #1	N/A	Hospital to submit to IEHP
Wednesday, January 31st	2024	Hospital Profile Update 1 of 2 due (participation requirement)	N/A	Hospital to update Hospital Profile in IEHP's Provider Portal
	2022	End of Year Push/Bonus: QIA Quarterly Update	Q4 2023	Hospital to submit to IEHP
FEBRUARY 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Friday, February 2nd	2024	HQI Cares: Gap Analysis***	N/A	Hospital to schedule with HQI Cares Team
Thursday, February 8th	2024	HQI Cares Workshop	N/A	N/A
Friday, February 9th	2024	HQI Cares Workshop	N/A	N/A
	2024	National Association for Healthcare Quality (NAHQ®) Workforce Accelerator Milestone #3	N/A	Hospital to complete with IEHP

***Required only for hospitals new to HQI Cares

2024 REPORTING CALENDAR				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Sunday, February 25th	2023	HQI: Hospital-Wide All-Cause Mortality	Q4 2023	Hospital to submit Inpatient, ED, and Ambulatory data to HQI (HCAI data set / SIERA file)
	2023	HQI: Sepsis Mortality		
	2023	HQI: Patient Safety and Adverse Events Composite		
	2023	HQI: Hospital – Acquired Pressure Injuries	Q1 2023 - Q4 2023	
	2023	HQI: Healthcare – Associated Infection Composite	December 2023	Hospital to submit to NHSN
Wednesday, February 28th	2024	Quality Improvement Activity: Clinical Variation Reduction Milestone #1 and Milestone #2	N/A	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Readmission Reduction Milestone #1	N/A	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Safety and Adverse Events Milestone #1	N/A	Hospital to submit to IEHP
Thursday, February 29th	2024	Opioid Management Hospital Self-Assessment, Cal Honor Roll submission	N/A	Hospital to submit evidence of submission to IEHP
	2024	Dexur Healthcare Quality Excellence Implementation Milestone # 2	N/A	Hospital to submit to IEHP
	2024	Dexur Healthcare Quality Excellence Implementation Milestone # 3	N/A	Hospital to complete with CDC NHSN
MARCH 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Saturday, March 9th	2024	National Association for Healthcare Quality (NAHQ®) Milestone #3	N/A	Hospitals to complete with IEHP
Friday, March 15th	2023	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Q4 2023	CMQCC

2024 REPORTING CALENDAR				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Friday, March 15th	2023	Timely Postpartum Care	Q3 2023	IEHP Claims and Encounters
	2023	Follow-Up Care for Mental Health & Substance Use Disorder ED - 7 days	Q4 2023	IEHP Claims and Encounters
	2023	Post Discharge Follow-Up Within Seven Days of Discharge		IEHP Claims and Encounters
	2023	Plan All-Cause Readmission Observed to-Expected (O/E) Ratio		IEHP Claims and Encounters
	2023	Hospitalization for Potentially Preventable Complications		IEHP Claims and Encounters
Friday, March 29th	2024	Opioid Management Hospital Self-Assessment, Cal Honor Roll submission	N/A	Hospital to submit evidence of submission to IEHP
	2024	HQI: Healthcare – Associated Infection Composite	January 2024	Hospital to submit to NHSN
	2024	National Association for Healthcare Quality (NAHQ®) Workforce Accelerator Milestone #4	N/A	Hospital to submit to IEHP
	2023	Maternal Morbidity Safety Bundle Validation	N/A	Validation completed by IEHP
	2024	Dexur Healthcare Quality Excellence Implementation Milestone #4	N/A	Hospital to complete with Dexur
Sunday, March 31st	2023	Mainfest Medex Active Data Sharing	Q4 2023	Manifest Medex

APRIL 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Wednesday, April 10th	2024	National Association for Healthcare Quality (NAHQ®) Workforce Accelerator Milestone #5	N/A	Hospital to submit to IEHP

2024 REPORTING CALENDAR				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Monday, April 15th	2024	Quality Improvement Activity: Patient Experience Milestone #1	N/A	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Readmission Reduction Milestone #2 and Milestone #3	N/A	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Safety and Adverse Events Milestone #2 and Milestone #3	N/A	Hospital to submit to IEHP
Thursday, April 25th	2024	HQI Cares Workshop II	N/A	N/A
Friday, April 26th	2024	HQI Cares Workshop II	N/A	N/A
	2024	HQI: Healthcare – Associated Infection Composite	February 2024	Hospital to submit to NHSN
MAY 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Wednesday, May 15th	2024	Dexur Healthcare Quality Excellence Implementation Milestone # 5	N/A	Hospital to complete with vendor or Hospital to submit to Dexur
	2024	Quality Improvement Activity: Readmission Reduction Milestone #3	N/A	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Safety and Adverse Events Milestone #3	N/A	Hospital to submit to IEHP
Friday, May 31st	2024	HQI: Hospital-Wide All-Cause Mortality	Q1 2024	Hospital to submit Inpatient, ED, and Ambulatory data to HQI (HCAI data set / SIERA file)
	2024	HQI: Sepsis Mortality		
	2024	HQI: Patient Safety and Adverse Events Composite		
	2024	HQI: Healthcare – Associated Infection Composite	March 2024	Hospital to submit to NHSN
	2024	Dexur Healthcare Quality Excellence Implementation Milestone # 6 and Milestone #7	All Historic Data as requested Q1 2024	Hospital to ensure Inpatient, ED and Ambulatory data is submitted to Dexur

2024 REPORTING CALENDAR

JUNE 2024

Date	P4P Program Year	Measure	Measurement Period	Data Source
Saturday, June 15th	2023	Timely Postpartum Care	Q4 2023	IEHP Claims and Encounters
	2024	Plan All-Cause Readmission Observed to-Expected (O/E) Ratio	Q1 2024	IEHP Claims and Encounters
	2024	Follow-Up Care for Mental Health & Substance Use Disorder ED - 7 days		IEHP Claims and Encounters
	2024	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate		CMQCC
	2024	Post Discharge Follow-Up Within Seven Days of Discharge		IEHP Claims and Encounters
Friday, June 28th	2024	Hospital Profile Update 2 of 2 (Participation Requirement)	N/A	Hospital to update Hospital Profile in IEHP's Provider Portal
	2024	HQI: Healthcare – Associated Infection Composite	April 2024	Hospital to submit to NHSN
	2024	Quality Improvement Activity: Clinical Variation Reduction Milestone #3	Q2 2024	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Readmission Reduction Milestone #4	Q2 2024	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Safety and Adverse Events Milestone #4	Q2 2024	Hospital to submit to IEHP
Sunday, June 30th	2024	Manifest MedEx Active Data Sharing	Q1 2024	Manifest MedEx

JULY 2024

Date	P4P Program Year	Measure	Measurement Period	Data Source
Monday, July 15th	2024	Patient Experience: Percentile Achievement - OPTIONAL submission, please reference measure details	Q1 2024	Hospital to submit to IEHP
Friday, July 26th	2024	HQI: Healthcare – Associated Infection Composite	May 2024	Hospital to submit to NHSN

2024 REPORTING CALENDAR

AUGUST 2024

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, August 30th	2024	HQI: Hospital-Wide All-Cause Mortality	Q2 2024	Hospital to submit Inpatient, ED, and Ambulatory data to HQI (HCAI data set / SIERA file) Inpatient, ED and Ambulatory data due to Dexur
	2024	HQI: Sepsis Mortality		
	2024	HQI: Patient Safety and Adverse Events Composite		
	2024	HQI: Healthcare – Associated Infection Composite	June 2024	Hospital to submit to NHSN
	2024	Quality Improvement Activity: Patient Experience Milestone #2	Q1 2024 - Q2 2024	Hospital to submit to IEHP
	2024	Dexur Healthcare Quality Excellence Implementation Milestone #6 and Milestone #7	Q2 2024	Hospital to submit to Dexur

SEPTEMBER 2024

Date	P4P Program Year	Measure	Measurement Period	Data Source
Friday, September 6th	2024	HQI Cares Workshop III	N/A	N/A
Sunday, September 15th	2024	Timely Postpartum Care	Q1 2024	IEHP Claims and Encounters
Sunday, September 15th	2024	Plan All-Cause Readmission Observed to-Expected (O/E) Ratio	Q2 2024	IEHP Claims and Encounters
Sunday, September 15th	2024	Follow-Up Care for Mental Health & Substance Use Disorder ED - 7 days	Q2 2024	IEHP Claims and Encounters
	2024	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate		CMQCC
	2024	Post Discharge Follow-Up Within Seven Days of Discharge		IEHP Claims and Encounters
Friday, September 27th	2024	HQI: Healthcare – Associated Infection Composite	July 2024	Hospital to submit to NHSN

2024 REPORTING CALENDAR				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Monday, September 30th	2024	HQI Cares: Requests for Domain Validation	N/A	HQI Cares Team
	2024	Maternal Morbidity Safety Bundle Implementation	N/A	Hospital to submit to IEHP
	2024	National Association for Healthcare Quality (NAHQ®) Workforce Accelerator Milestone #6	N/A	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Clinical Variation Reduction Milestone #3 and Milestone #4	Q3 2024	Hospital to submit application to TJC
	2024	Quality Improvement Activity: Readmission Reduction Milestone #4	Q3 2024	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Safety and Adverse Event Milestone #4	Q3 2024	Hospital to submit to IEHP
	2024	Manifest MedEx Active Data Sharing	Q2 2024	Manifest MedEx
OCTOBER 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Tuesday, October 1st	2024	Patient Experience: Percentile Achievement - OPTIONAL submission, please reference measure details	Q2 2024	Hospital to submit to IEHP
Thursday, October 31st	2024	HQI: Healthcare – Associated Infection Composite	August 2024	Hospital to submit to NHSN
NOVEMBER 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Friday, November 15th	2024	Quality Improvement Activity: Patient Experience Milestone #3	Q3 2024	Hospital to submit to IEHP

2024 REPORTING CALENDAR				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Friday, November 29th	2024	HQI: Hospital-Wide All-Cause Mortality	Q3 2024	Hospital to submit Inpatient, ED, and Ambulatory data to HQI (HCAI data set / SIERA file) Inpatient, ED and Ambulatory data due to Dexur
	2024	HQI: Sepsis Mortality		
	2024	HQI: Patient Safety and Adverse Events Composite		
	2024	HQI: Healthcare – Associated Infection Composite	September 2024	Hospital to submit to NHSN
	2024	Dexur Healthcare Quality Excellence Implementation Milestone #6 and Milestone #7	Q3 2024	Hospital to submit to Dexur
DECEMBER 2024				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Sunday, December 15th	2024	Timely Postpartum Care	Q2 2024	IEHP Claims and Encounters
	2024	Plan All-Cause Readmission Observed to-Expected (O/E) Ratio	Q3 2024	IEHP Claims and Encounters
	2024	Follow-Up Care for Mental Health & Substance Use Disorder ED - 7 days		IEHP Claims and Encounters
	2024	Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate		CMQCC
	2024	Post Discharge Follow-Up Within Seven Days of Discharge		IEHP Claims and Encounters
	2024	Manifest MedEx Active Data Sharing		Manifest MedEx
Friday, December 27th	2024	HQI: Healthcare – Associated Infection Composite	October 2024	Hospital to submit to NHSN

2024 REPORTING CALENDAR				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Tuesday, December 31st	2024	HQI Cares Milestone #2	N/A	HQI Cares
	2024	National Association for Healthcare Quality (NAHQ®) Workforce Accelerator Milestone #7	N/A	Hospital to submit to IEHP
	2024	Dexur Healthcare Quality Excellence Implementation Milestone #8 and Milestone #9	N/A	IEHP to obtain from Dexur
	2024	Manifest MedEx Active Data Sharing	Q3 2024	Manifest MedEx
	2024	Quality Improvement Activity: Clinical Variation Reduction Milestone #3	Q4 2024	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Readmission Reduction Milestone #4	Q4 2024	Hospital to submit to IEHP
	2024	Quality Improvement Activity: Safety and Adverse Events Milestone #4	Q4 2024	Hospital to submit to IEHP
JANUARY 2025				
Date	**P4P Program Year**	**Measure**	**Measurement Period**	**Data Source**
Wednesday, January 15th	2024	Patient Experience: Percentile Achievement - OPTIONAL submission, please reference measure details	Q3 2024	Hospital to submit to IEHP
Friday, January 24th	2024	HQI: Healthcare – Associated Infection Composite	November 2024	Hospital to submit to NHSN

CMQCC: California Maternal Quality Care Collaborative
HQI: Hospital Quality Institute
TJC: The Joint Commission
NHSN: National Healthcare Safety Network

Supplemental Reporting Calendar:

In addition to the above reporting calendar, hospital teams who are responsible for the submission of NHSN data and/or SIERA data files may reference the supplemental reporting calendar below.

These deliverables are noted in the overarching reporting calendar above and have been listed separately here for ease of reference.

NHSN/SIERA DATA FILE DUE DATES		
Due Date:	**NHSN Data to CDC****	**SIERA Data Files to HQI***
	Accelerated Monthly Reporting Data Period	**Accelerated Quarterly Reporting Data Period**
January 25, 2024	November 2023	-
February 25, 2024	December 2023	Q4 2023
March 29, 2024	January 2024	-
April 26, 2024	February 2024	-
May 31, 2024	March 2024	Q1 2024
June 28, 2024	April 2024	-
July 26, 2024	May 2024	-
August 30, 2024	June 2024	Q2 2024
September 27, 2024	July 2024	-
October 31, 2024	August 2024	-
November 29, 2024	September 2024	Q3 2024
December 27, 2024	October 2024	-
January 24, 2025	November 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.*

Payment Schedule

The chart below summarizes the Hospital P4P Program payment schedule. There are a total of five payments beginning August 2024, extending through August 2025.

PAYMENT SCHEDULE					
Measure Name	Payout #1 **Aug. 2024**	Payout #2 **Nov. 2024**	Payout #3 **Feb. 2025**	Payout #4 **May 2025**	Payout #5 **Aug. 2025**
Core Measures					
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. Follow-Up Care for Mental Health & Substance Use Disorder ED – 7 Days	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
6. Plan All-Cause Readmission Observed- to-Expected (O/E) Ratio	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
7. Timely Postpartum Care		Quarter 1	Quarter 2	Quarter 3	Quarter 4
8. Maternal Morbidity Safety Bundle Implementation				All Bundles	
9. Patient Experience: Percentile Achievement		Quarters 1 & 2		Quarters 3 & 4	
HQI Cares: Implementing BETA HEART® Program					
10. HQI Cares: Participation Milestones	Reference HQI Cares: Implementing BETA HEART® Program measure details for reporting and payment schedule				
11. HQI Cares: Domain Validation					
Optimal Care Initiatives					
12. Hospital Quality Star Rating	Reference Hospital Quality Star Rating details for payment schedule				
13. Quality Improvement Activity: Patient Experience	Milestone 1	Milestone 2	Milestone 3		
14. Quality Improvement Activity: Clinical Variation Reduction	Milestone 1 & 2		Milestone 3 & 4	Milestone 5	

PAYMENT SCHEDULE					
Measure Name	Payout #1 **Aug. 2024**	Payout #2 **Nov. 2024**	Payout #3 **Feb. 2025**	Payout #4 **May 2025**	Payout #5 **Aug. 2025**
15. Quality Improvement Activity: Readmission Reduction	Milestone 1, 2 & 3		Milestone 4	Milestone 5	
16. Quality Improvement Activity: Safety and Adverse Events	Milestone 1, 2 & 3		Milestone 4	Milestone 5	
17. Cal Hospital Compare Opioid Honor Roll		2024 Honor Roll Result			
Data Sharing					
18. Manifest MedEx Active Data Sharing	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Risk-Based Measures					
19. Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery Rate	Quarter 1*	Quarter 2*	Quarter 3*	Quarter 4*	
20. Post Discharge Follow-Up Within Seven Days of Discharge	Quarter 1*	Quarter 2*	Quarter 3*	Quarter 4*	
21. Covered CA (CCA) Adequate Network	Quarter 1*	Quarter 2*	Quarter 3*	Quarter 4*	

*These measures are not eligible for payment. Hospitals not meeting measure milestones and/or targets as outlined in individual measure specifications will be subject to payment withhold.

2024 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 2024 = 3,000
Total IEHP Admissions for All Hospitals for Quarter 1 2024 = 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 Star Rating Payment Calculation:

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

Step 1: Determine the Hospital Encounter Index
[IEHP admissions per hospital % converted into the 4-tier patient encounter load weighting scale]

Step 2: Determine the Hospital Payment Factor
[Hospital Quality Star Rating x Hospital Encounter Index]

Step 3: Determine the Weighted Incentive Payout per eligible hospital
[(Hospital Payment Factor ÷ Sum of eligible Hospital Payment Factors) × Measure Incentive Pool]

2024 HOSPITAL P4P MEASURES

☑ 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 their 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 written at the time of or within 24 hours of admission 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, ED, and Ambulatory 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**
    - Do Not Resuscitate (DNR) order written at the time of or within 24 hours of admission (Do Not Resuscitate Order = Y) 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 condition that arises from the body's response to an infection. The infection can lead to injury of tissues and organs causing organ dysfunction (WHO, 2023). If sepsis is not recognized early and treated with rapid management it can have devastating outcomes including septic shock, multiple organ failure, and death. Nearly 49 million people are affected worldwide by sepsis and globally sepsis causes 11 million deaths (WHO, 2023).

The 2021 in-hospital case mortality rate for California sepsis cases was 19.0%, a 5.5-percentage point (or 40%) increase from the pre-COVID 2019 rate of 13.5%. Sepsis represents a substantial global health burden as well as in 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 does not need to 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, ED, and Ambulatory 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 *Septicemia Or Sepsis*)
- Organ dysfunction (code set *Organ Dysfunction*)

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 *Septicemia Or Sepsis*) **AND**
    - Diagnosis ICD-10 code (in any position) for *organ dysfunction* (code set *Organ Dysfunction*)
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

References:

World Health Organization (WHO). (2023). Sepsis. World Health Organization. https://www.who.int/health-topics/sepsis#tab=tab_1

☑ 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).

Per AHRQ, the Patient Safety Indicator 90 (PSI 90) is a composite measure that reflects the safety climate of a hospital by providing a marker of patient safety during the delivery of care. Higher rates of potentially preventable complications can be a direct reflection of the quality of care provided by the hospital to patients. Hospitals can work to reduce these significant complications by following best practices.

This PSI 90 measure includes all payors 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, ED, and Ambulatory 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 Quality Indicators

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

References:

Agency for Healthcare Research and Quality (AHRQ). (n.d.). Fact Sheet on Patient Safety Indicators. Toolkit for Using the AHRQ Quality Indicators How To Improve Hospital Quality and Safety. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/ systems/hospital/qitoolkit/combined/a1b_combo_psifactsheet.pdf

AHRQ PSI Technical Documentation, Version v2023, Agency for Healthcare Research and Quality, Rockville, MD. https://qualityindicators.ahrq.gov/measures/PSI_TechSpec.

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

Healthcare-associated infections (HAI) are infections that patients can acquire while receiving treatment for medical or surgical conditions. Risk factors for HAIs include invasive procedures, severity of illnesses, and deviation from known best practices. HAIs are associated with high morbidity and mortality rates, yet most HAIs are preventable (CDC, 2021).

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) is a staph infection that is a multiple-antibiotic-resistant bacterium. Infections can occur anywhere throughout the body including the integumentary system, urinary system, and/or circulatory system. These infections are difficult to treat and often lead to poor outcomes.

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

Centers for Disease Control and Prevention. (2015). Preventing Healthcare-associated Infections. Centers for Disease Control and Prevention. https://www.cdc.gov/hai/prevent/prevention.html

Centers for Disease Control and Prevention. (2021). Health Topics – Healthcare-associated Infections (HAI). Centers for Disease Control and Prevention. https://www.cdc.gov/policy/polaris/healthtopics/hai/index.html

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

The HEDIS® modified measure Follow-Up Care for Mental Health and 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 on 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: *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 (2024). 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 (2024)

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 expected readmissions is determined in two steps:

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: *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 on or between October 8, 2023 and October 7, 2024.

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-10-CM	Z01.411	Encounter for Gynecological Examination (general) (routine) With Abnormal Findings
Postpartum Care	ICD-10-CM	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-10-CM	Z01.42	Encounter for Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear
Postpartum Care	ICD-10-CM	Z30.430	Encounter for Insertion of Intrauterine Contraceptive Device
Postpartum Care	ICD-10-CM	Z39.1	Encounter for Care and Examination of Lactating Mother
Postpartum Care	ICD-10-CM	Z39.2	Encounter for Routine Postpartum Follow-up
Postpartum Care	HCPCS	Z1038*	Postpartum Follow-up Office Visit

*HCPCS Code Z1038 must be used in conjunction with one of the following per-visit delivery CPT codes: 59409, 59514, 59614, 59612, or 59620

☑ Measure Name: *Maternal Morbidity Safety Bundle Implementation*

There are approximately 5.5 million pregnancies each year in the United States (CDC, 2023). Maternal morbidity includes physical and psychological conditions resulting from or aggravated by pregnancy that may result in poor pregnancy outcomes (WHO, 2023).

Over the last two decades, the most severe complication, known as severe maternal morbidity (SMM), rose nearly 200% likely due to increases in maternal age, pre-existing comorbidities, and cesarean deliveries (CDC, 2021).

Starting in 2022, CMS has 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.

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, 2024.

Hospitals will be eligible for payment for each fully implemented Maternal Morbidity Safety Bundle; max of two bundles* per Hospital:

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

Exclusions:

Hospitals without a maternity service line are not eligible to participate in this P4P measure.

*Hospitals who participated in the 2023 HP4P Maternal Morbidity Safety Bundle Implementation are only eligible in 2024 for a newly implemented bundle(s). Bundles implemented as part of the 2023 HP4P guide will not count toward this measure.

Criteria:

To be considered fully implemented, all requirements must be met by September 30, 2024. Hospitals are encouraged to reference: The Joint Commission Standards for Maternal Safety, CMQCC's Maternal Quality Improvement Toolkits, complete a gap analysis, and maintain an evidence binder.

Validation of full implementation for each hospital selected bundle will be completed by IEHP's Hospital Relations Team utilizing the checklists in appendix 1.

Validation will occur between October 1, 2024, and March 29, 2025.

Bundles/Toolkits are based upon and adopted from The Joint Commission Standards for Maternal Safety and from CMQCC's Maternal Quality Improvement Toolkits.

References:

CDC, Centers for Disease Control and Prevention. (2023) Updated Methodology to Estimate Overall and Unintended Pregnancy Rates in the United States. Vital and Health Statistics, Series 2, Number 201. https://www.cdc.gov/nchs/data/series/sr_02/sr02-201.pdf

CDC, Centers for Disease Control and Prevention. (2021) National Hospital Care Survey Demonstration Projects: Severe Maternal Morbidity in Inpatient and Emergency Departments. https://www.cdc.gov/nchs/data/nhsr/nhsr166.pdf

CMS, Centers for Medicare & Medicaid Services. (2022, April 13). CMS Announces Key Actions to Reduce Maternal Mortality and Morbidity. https://www.cms.gov/newsroom/press-releases/cms-announces-key-actions-reduce-maternal-mortality-and-morbidity

WHO, World Health Organization. (2023). Maternal morbidity and well-being. Maternal Health Unit. https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/maternal-health/maternal-morbidity-and-well-being

NEW

☑ Measure Name: *Patient Experience: Percentile Achievement*

In 2023, IEHP began administering an abbreviated version of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to all members experiencing an inpatient hospital stay. Concurrently, many hospitals elected to participate in the 2023 Hospital P4P quality improvement activity (QIA) specific to Patient Experience. Results from the survey and QIA highlighted a need to continue to recognize and reward hospitals achieving outcomes-based improvements as a result of their performance improvement efforts in the following HCAHPS domains of focus:

- Communication with doctors
- Discharge information
- Care transition
- Overall rating of the hospital
- Likelihood to recommend the hospital

This measure compares the top-box score (%) for each domain against the 50th percentile scores as referenced in nationally published HCAHPS Percentiles Table (referenced below).

Methodology:

The top-box score is the most positive response to the survey questions. Percentiles allow IEHP to compare a hospital's "top-box" score relative to national rates for each of the survey domains.

Top box scores for each domain will be converted into percentile rankings utilizing the nationally published HCAHPS Percentile Table (referenced below)*. Hospitals will receive incentive for each domain achieving ≥50th percentile performance.

Numerator:

Numerator varies by survey domain as follows:

Communication with Doctors – The number of respondents selecting "Always" for all three questions that comprise the Communication with Doctors composite

- How often doctors treated you with courtesy and respect
- How often doctors listened carefully to you
- How often doctors explained things in a way you could understand

Discharge Information – The number of respondents selecting "Yes" for all two questions that comprise the Discharge Information composite

- Did staff communicate about the help they would need at home after they left the hospital
- Did patients receive written information about symptoms or health problems to look out for after they left the hospital

Care Transition – The number of respondents selecting "Strongly Agree" for all three questions that comprise the Care Transition composite.

- Staff took my preferences and those of my family or caregiver into account in deciding health care needs
- I had a good understanding of the things I was responsible for in managing my health
- I clearly understood the purpose for taking each of my medications

Overall Rating of Hospital – The number of respondents rating the hospital a '9' or '10'

Likelihood to Recommend – The number of respondents selecting "Definitely yes"

Denominator:

The total number of survey responses

Determining Percentile:

The outcome of the calculation of numerator divided by denominator is compared to the 50th Percentile top-box score from the HCAHPS Percentiles Table.

50th Percentile Performance Target:

TOP BOX SCORE					
Hospital Percentile	**Communication with Doctors**	**Discharge Information**	**Care Transition**	**Overall Rating**	**Likelihood to Recommend**
50th	79%	86%	50%	70%	69%

**Percentiles are based off surveys of patients discharged between January 2022 and December 2022*

*Understanding that percentile ratings can fluctuate, hospitals utilizing a survey vendor that accesses more concurrent percentile rating scales can proactively submit vendor-developed evidence of 50th percentile achievement by the dates listed below (approximately 30-45 days prior to the CMS public reporting deadline):

- Quarter 1: July 15, 2024
- Quarter 2: October 1, 2024
- Quarter 3: January 15, 2025
- Quarter 4: April 1, 2025

Hospitals that do not proactively submit evidence will be evaluated based upon the referenced table.

☑ 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 healthcare organizations in implementing a reliable and sustainable safety culture grounded in a philosophy of transparency. 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 an interactive, and collaborative process supporting the organization, its staff, and patients. Hospitals progress through five program domains, each an essential component of the culture of safety 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 implementation of 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 the actions needed to be taken, 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. For domain completion (validation) requirements, visit: https://hqinstitute.org/hqi-cares-introduces-beta-heart/, Program at a Glance, BETA HEART® Guideline. For most hospitals, completing a domain will require a significant investment of time and effort. The HQI Cares program team and faculty are available to provide multi-faceted support to participating hospitals throughout the implementation.

Performance Requirements Overview – All eligible hospitals

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 #	2024 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	DUE DATE
1	Participation Requirements	Sign Participation Agreement (new hospitals) or Participation Agreement Addendum (continuing hospitals).	11/30/2023
		Complete the readiness assessment: 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 link 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/departmental directors, managers, and educators • Patient and family advisors (if applicable) 3) Project Leader oversees completion of readiness assessments from a minimum of 20 leaders and staff. Critical access hospitals must have a minimum of 10 • Readiness assessments are completed via Survey Monkey by individuals selected by the Project Leader	1/26/2024
		Complete Gap Analysis*: Required only for new participating hospitals. 1) 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. 2) Project Leader partners with HQI Cares to schedule and hold gap analysis focus group sessions. 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: executive leadership, medical staff leadership, unit-level managers, front-line patient care staff and ancillary staff (dietary, engineering, biomed, etc.). Refer to Gap Analysis Guide for detailed guidance. 3) 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.	2/2/2024
		Workshop Attendance: Hospital representatives must attend all three workshops. 1) Critical access hospitals– Minimum of 2 attendees per workshop, per hospital. 2) All other hospitals – Minimum of 4 attendees per workshop, per hospital. Suggested participants (no longer required): an executive leader, a physician leader, a nursing leader, a risk manager and/or patient safety officer. 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). Max of 6 participants, per facility.	9/30/2024

MILESTONE #	2024 INCENTIVE MILESTONES	HOSPITAL REQUIREMENTS	DUE DATE
2	Validation in Selected Domain(s)	Once domain elements are complete hospitals may request validation for up to **two** domains. 1) Select domain for validation 2) Schedule validation of selected domain (s) with HQI Cares team. 3) Participate in all aspects of domain validation process (document review, interviews, observation.) Please refer to HQI Cares BETA HEART® Guidelines for domain validation criteria. 4) Obtain validation in selected domain(s). To be eligible for the P4P dollars associated with validation, validation must occur prior to 12/31/2024. **Participating hospitals will need to ensure that they allow ample time to coordinate validation planning and scheduling with the HQI Cares team. Requests for validation must be received by 9/30/2024.**	12/31/2024

Payment Methodology – All eligible hospitals:

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				
Milestone	**Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution***
1	Sign Participation Agreement	$43,125	Q4 2023	April 2024
	Complete Readiness Assessment Complete Gap Analysis*		Q1 2024	April 2024
	2024 Workshop Attendance***	$43,125	Q1-Q3 2024	November 2024
2	Obtain Validation in selected Domain**	$172,500	Q1- Q2 2024 Q3 - Q4 2024	August 2024 February 2025
	Obtain Validation in selected additional Domain**	$86,250	Q1- Q2 2024 Q3 - Q4 2024	August 2024 February 2025
Milestones Total		**$345,000**		

*Gap Analysis: Required only for hospitals that are new to HQI Cares: Implementing BETA HEART®.

**Payments will be issued in either August 2024, or February 2025 dependent on the quarter the hospital obtained validation for their selected domain(s).

***While workshops are incentivized separately, they are also a milestone for validation. Hospitals requesting validation must have met this milestone to be eligible.

☑ Measure Name: *Hospital Quality Star Rating*

IEHP is committed to helping hospitals ensure exceptional quality outcomes for patients. One way to evaluate the overall quality of care provided by a hospital is to assess their Centers for Medicare & Medicaid Services (CMS) Hospital Quality Star rating. IEHP has established a goal that ≥75% of IEHP network hospitals will have a rating of 3 stars or higher by 2026.

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 2023 star rating system are:

1. Mortality (7 measures) – examines death rates within 30 days of the date of hospital admission
2. Safety of Care (8 measures) – observes potentially preventable injury and complications during hospitalization
3. Readmission (11 measures) – monitors the return of patients following hospitalization
4. Patient Experience (8 measures) – observes the patient perspective on the hospital care received
5. Timely & Effective Care (13 measures) – assesses how often or quickly hospital care is provided

Methodology:

This measure consists of three components with multiple requirements within each:

1. National Association for Healthcare Quality (NAHQ®) Workforce Accelerator
2. Dexur Healthcare Quality Excellence Implementation
3. 2024 CMS Hospital Quality Star Rating

Performance Requirements Overview – All eligible hospitals

Hospitals must complete each milestone (as described under "Hospital Requirements" below), by the associated completion due date to qualify for the milestone incentive dollars. In addition, to qualify for any payment related to the 2024 CMS Hospital Quality Star Rating, hospitals must meet all milestones associated with NAHQ Workforce Accelerator and Dexur Healthcare Quality Excellence Implementation.

NAHQ® WORKFORCE ACCELERATOR			
Milestone #	**2024 Incentive Milestone**	**Hospital Requirements**	**Completion Due Date**
1	Sign and Submit Participation Agreement*	Participation Agreement signed by Hospital CEO and submitted to IEHP	11/19/2023
2	Complete the Professional Assessment	Minimum number of participants** complete the NAHQ Professional Assessment	12/18/2023
3	Review Professional Assessment results	All participants complete a formal review of Assessment results (individually) with a NAHQ and/or IEHP navigator	3/9/2024
4	Professional Development 1	All participants complete 8 hours of Healthcare Quality (HQ) Foundations content	3/29/2024
5	Develop an action/ training plan*	All participants develop and submit an action/ training plan for professional development to IEHP	4/10/2024
6	Attend 2024 NAHQ Next Conference	All participants submit evidence of completion of a minimum of 45 CPHQ education credits earned during the course of the Conference	9/30/2024
7	Professional Development 2	All participants leverage NAHQ Professional Membership to complete 52 hours of content from NAHQ's Domain Collections	12/31/2024

*Please reference supplemental submission templates provided by IEHP
**3 participants for all General Acute Care Hospitals; 2 participants for all Critical Access Hospitals

DEXUR HEALTHCARE QUALITY EXCELLENCE IMPLEMENTATION			
Milestone #	**2024 Incentive Milestone**	**Hospital Requirements**	**Completion Due Date**
1	Sign and Submit Participation Agreement*	Participation Agreement signed by Hospital CEO and submitted to IEHP	1/26/2024
2	Execute BAA	Execute a BAA with vendor to allow for data sharing	2/29/2024
3	HAI Data Access	Grant CDC NHSN Group Access to Dexur to allow for download of HAI data	2/29/2024
4	Onboarding Process	Hospital completion of program readiness requirements	3/29/2024
5	HCAHPS Data Access	Provide Access to Dexur via vendor portal, OR If vendor is unable to provide vendor portal access, Hospital will work with Vendor to share HCAHPS data to include Linear Mean Score If manual data exchange is required, monthly submission is required	5/15/2024** Monthly through 12/31/2024
6	Claims Data Access	Ensure all historic HCAI data (inpatient, ED, Ambulatory) is submitted to Dexur as required for complete data analysis and is available on an accelerated basis beginning with Quarter 1 2024 data	5/31/2024 8/29/2024 11/29/2024
7	Timely and Effective Care Data Access	All abstracted measures are shared with Dexur at least quarterly	5/31/2024 8/29/2024 11/29/2024
8	Ongoing Improvement Efforts	Hospital will remain in good standing with vendor as evidenced by quarterly vendor confirmation that hospital has worked with Dexur to: a) Develop simulations and determine best path to improve hospital-specific Star Ratings b) Determine goals at the measure level and input them into the Dexur system c) Input planned interventions (i.e., start date, root cause, corrective action plans, and other associated details) at the Measure level into the Dexur System	4/1/2024 - 12/31/2024
9	CMS Preview Report Sharing	All CMS Preview reports are shared with Dexur for purposes of reconciliation	12/31/2024

2024 CMS HOSPITAL QUALITY STAR RATING
No additional participation requirements are necessary. IEHP will leverage publicly released star ratings to determine eligibility for this portion of the measure.

*Please reference supplemental submission templates provided by IEHP

**Hospitals will have access to the Dexur platform beginning 4/1/2024 or once HCAHPS vendor integration is complete (whichever is sooner)

Payment Methodology – All eligible hospitals:

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

NAHQ® WORKFORCE ACCELERATOR PAYMENT SCHEDULE				
Milestone #	**2024 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Sign and Submit Participation Agreement	$10,000	Q4 2023	August 2024
2	Complete the Professional Assessment	$10,000	Q4 2023	August 2024
3	Review Professional Assessment results	$10,000	Q1 2024	August 2024
4	Develop an action/ training plan	$10,000	Q1 2024	August 2024
5	Attend 2024 NAHQ Next Conference	$10,000	Q3 2024	November 2024
6	Professional Development	$10,000	Q4 2024	February 2025
	Milestones Total	**$60,000**		

DEXUR PAYMENT SCHEDULE				
Milestone #	**2024 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Sign and Submit Participation Agreement	$5,000	Q1 2024	August 2024
2	Execute BAA	$5,000	Q1 2024	August 2024
3	HAI Data Access	$10,000	Q1 2024	August 2024
4	Onboarding Process	$10,000	Q1 2024	August 2024
5	HCAHPS Data Access	$10,000	Q2 2024	August 2024
6	Claims Data Access	$10,000	Q2 2024 Q3 2024 Q4 2024	February 2025
7	Timely and Effective Care Data Access	$10,000	Q2 2024 Q3 2024 Q4 2024	February 2025
8	Ongoing Improvement Efforts	$30,000	Q4 2024	February 2025
9	CMS Preview Report Sharing	$10,000	Q4 2024	February 2025
	Milestones Total	**$100,000**		

2024 CMS HOSPITAL QUALITY STAR RATING PAYMENT SCHEDULE
Eligibility for payment will be determined via the officially released 2024 CMS Hospital Quality Star Rating.
Hospitals will earn incentive for either achieving/maintaining a 3+ CMS Hospital Quality Star Rating OR improving their CMS Hospital Quality Star Rating when compared to the July 2023 release.

☑ Measure Name: *Quality Improvement Activity: 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. In 2023, IEHP began administering an experience survey to all Members upon hospital discharge. As of 2024, this survey was updated to focus on areas that reflect the most significant alignment between hospital and health plan priorities, including:

- Communication with doctors
- Discharge information
- Care transition
- Overall rating of the hospital
- Likelihood to recommend the hospital

This measure encourages hospital engagement in a new* Quality Improvement Activity (QIA) that focuses on improving patient experience, specifically targeting the bulleted priorities listed above.

***Hospitals participating in this QIA in program year 2023 must select a new domain/ question of focus for CY 2024.**

Performance Requirements Overview – All eligible hospitals

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

HOSPITAL REQUIREMENTS			
Milestone #	**2024 Incentive Milestone**	**Hospital Requirements**	**Completion Due Date**
1	Establish the Program*	1) Hospital to select one question or domain from bulleted options above that demonstrated a top box % reflective of <50th percentile for 4th quarter 2023 2) Hospitals to submit baseline data for 4th quarter 2023 3) Submit evidence of established performance improvement efforts	4/15/2024
2	Share Project Outcomes*	1) Hospitals will share Q1-Q2 outcomes	8/30/2024
3	Share Project Outcomes*	1) Hospitals will share Q3 outcomes	11/15/2024

*Please reference supplemental submission templates provided by IEHP

Payment Methodology:

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

QUALITY IMPROVEMENT ACTIVITY: PATIENT EXPERIENCE PAYMENT SCHEDULE				
Milestone #	**2024 Incentive Milestones**	**Incentive Per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish the program	$40,000	Q1 2024 (Data from Q4 2023)	August 2024
2	Share project outcomes	$30,000	Q1 - Q2 2024	November 2024
3	Share project outcomes	$30,000	Q3 2024	February 2025
	Milestones Total	**$100,000**		

NEW

☑ Measure Name: *Quality Improvement Activity: Clinical Variation Reduction*

Clinical variation reduction (CVR) is a process that identifies evidence-based practices/medicine for a specific diseases process and then leverages them to develop a clinical pathway to guide clinicians in providing and directing care. Standardized care that reduces variations improves quality outcomes, increases collaboration, and can improve the patient experience. Overall, CVR efforts can have great impact on hospitals and patients by reducing potentially preventable complications, readmissions, and unexpected outcomes (Ardoin & Malone, 2019).

IEHP has collaborated with The Joint Commission for utilization of their evidence-based certification standards as a means of establishing disease-specific program standards. Leveraging these standards will allow for the development of a robust quality-centric hospital network with as much reduction in variability as possible given the operational nuances and diversity within this network.

Goal:

Obtain certification in selected area from The Joint Commission.

Performance Requirements Overview – All eligible hospitals

Improvement activities should always consider differences in organizational structure, strategies, and culture. Therefore, to reduce clinical variations, hospitals may choose one certification to apply for from The Joint Commission*.

Available Certifications:

- Advanced Certification in Perinatal Care ***
- Advanced Heart Failure
- Chronic Obstructive Pulmonary Disease**
- Hospital-based Palliative Care**
- Inpatient Diabetes**
- Pneumonia**
- Sepsis**

* Hospitals must demonstrate to IEHP that there is a clinical need for selected certification. Please see appendix for additional details.
**Per The Joint Commission certification standards, hospital must be Accredited by The Joint Commission to participate in these certification programs.
***The Joint Commission requires that hospitals meet the following eligibility criteria prior to Advanced Certification in Perinatal Care:

- PC-02 NTSV Cesarean Delivery rate ≤ 30%.
- PC-06 Unexpected Complications in Term Newborns - Severe Rate < 50 complications per 1000 live births, or < 5%.

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

Hospital are not eligible for incentive dollars related to certifications that:

1. Are already in effect anytime in calendar year 2024, and/or
2. For which they have already formally applied for before 1/1/2024

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION			
Milestone #	**2024 Incentive Milestone**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current certification steering team*	Establish or demonstrate evidence of a current committee, workgroup, or task force that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader	2/28/2024
2	Participation*	1) Hospital to select one certification for completion 2) Hospitals to demonstrate that there is a clinical need for the certification a. Hospital to send IEHP data, as outlined in Appendix for the past 12 months (10/01/22-9/30/23) i. Data should not include PHI 3) Once certification is approved by IEHP, hospital will complete a participation agreement with IEHP outlining their intent to participate in this QIA and engage with The Joint Commission for the formal certification process**	2/28/2024
3	Quarterly Progress Updates	1) Submit Quarterly progress updates including progress toward certification and updated data outcomes	6/28/2024 9/30/2024 12/31/2024
4	Apply for certification	1) Hospitals will apply for certification of selected measure through The Joint Commission	9/30/2024
5	Obtain Certification	1) Hospitals will obtain certification from The Joint Commission in selected area	3/31/2025^

*Please reference supplemental submission templates provided by IEHP

** To engage with The Joint Commission, hospital may reach out to

Loren Salter
Director Hospital Certifications, The Joint Commission
LSalter@jointcommission.org

^Administrative delays outside of the control of the Hospital will not impact ability to earn incentive dollars for this milestone

Payment Methodology:

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

QUALITY IMPROVEMENT ACTIVITY: CLINICAL VARIATION REDUCTION PAYMENT SCHEDULE				
Milestone	**Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current Certification Steering Team	$80,000*	Q1 2024	August 2024
2	Participation			
3	Quarterly Progress Updates	$20,000	Q2 2024 Q3 2024 Q4 2024	February 2025
4	Apply for certification	$20,000	Q4 2024	February 2025
5	Obtain Certification	$80,000	Q1 2025	May 2025
	Milestones Total	**$200,000**		

*Dollars are issued in good faith, but will be withheld from future P4P incentive payments if certification is not obtained by 3/31/2025

References:

Ardoin MD, D., & Malone , J. (2019). Reducing clinical variation to drive success in value-based care (part 1). HFMA. https://www.hfma.org/operations-management/care-process-redesign/reducing-clinical-variation-to-drive-success-in-value-based-care0/

NEW

☑ Measure Name: *Quality Improvement Activity: Readmission Reduction*

IEHP is committed to ensuring that members successfully transition from one care setting to the next. One indicator of this successful transition is a low preventable readmission rate.

Readmission rates are included within the hospital's overall CMS star rating; comprising 22% of the total score (Centers for Medicare & Medicaid Services, n.d).

This measure encourages hospital engagement in Quality Improvement Activities (QIA) that focus on reducing preventable readmissions.

Performance Requirements Overview – All eligible hospitals

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

QUALITY IMPROVEMENT ACTIVITY: READMISSION REDUCTION			
Milestone #	**2024 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current Readmission Reduction Workgroup*	1) Establish or demonstrate evidence of a current committee, workgroup, or task force that at minimum includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader	2/28/2024
2	Identify key priority areas for improvement*	1) Hospital conducts an initial analysis of readmission rates including: a. Data from a minimum of 6 months (Jul-Dec 2023) b. Overall readmission rates c. Readmission rates for IEHP members d. At least two additional disease-specific readmission rates: i. Acute Myocardial Infarction (AMI) ii. Heart Failure iii. Chronic Obstructive Pulmonary Disease (COPD) iv. Pneumonia v. Stroke vi. Total Hip/Total Knee Arthroplasty (THA/THK)	4/15/2024

QUALITY IMPROVEMENT ACTIVITY: READMISSION REDUCTION			
3	Leverage analysis to implement performance improvement*	1) A total of three new readmission reduction strategies are implemented, with IEHP approval. Options may include, but are not limited to: a. Screen patients on admission using readmission risk assessment tools b. Implement teach-back methodology for disease-specific and medication education c. Facilitate interprofessional rounds d. Implement Meds to Bed Program** e. Develop a discharge specific hospital checklist f. Develop a patient discharge checklist g. Identify and implement performance improvement for two independent variables associated with missed follow-up appointments h. Schedule home visits prior to discharge for high-risk patients i. Implement post-discharge phone calls within 48 hours post discharge j. Develop procedure for continuity of care between hospital and outside clinician k. Establish a collaborative between hospital and health plan clinical and business intelligence teams to optimize interoperability and analytics that utilize care transition information (i.e. throughput, social determinants of health, discharge orders/instructions, etc.). l. Hospital-specific readmission reduction strategy***	4/15/2024 (Selection of priorities sent to IEHP for approval) 5/15/2024 (Initial implementation complete for each activity)
4	Demonstrate meeting and working of Readmission Reduction Workgroup*	1) Demonstrate evidence that group met at least monthly (April through December 2024) via Quarterly update a. Summary report includes, at minimum: i. Meeting Attendees ii. Summary of data reviewed (please do not include PHI) b. Update to PDSA cycle	6/28/2024 9/30/2024 12/31/2024
5	Demonstrate a reduction in preventable readmission rates	1) Demonstrate at least a 10% reduction in hospital readmissions from baseline (baseline period: 2Q2022-1Q2023) and/or achieve the state average readmission rate of California (state average retrieved from data period: 13.8%) Hospital performance period: Q2 2024 - Q4 2024	N/A - Data will be pulled from HQI following 4Q2024 data submission. (see accelerated reporting timelines)

*Please reference supplemental submission templates provided by IEHP.

**Hospitals who elected to participate in the 2022 HP4P QIA for Meds to Beds are encouraged to continue this program as one of their three initiatives. Hospitals desiring to newly select Meds to Beds as an initiative will select this as one of three total initiatives for purposes of measure participation.

***Hospital-specific readmission reduction strategy must be evidence-based and pre-approved by IEHP.

Payment Methodology:

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

QUALITY IMPROVEMENT ACTIVITY: READMISSION REDUCTION PAYMENT SCHEDULE				
Milestone #	**2024 Incentive Milestones**	**Incentive Per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current Readmission Reduction Workgroup	$100,000	Q1 2024 Q2 2024	August 2024
2	Identify key priority areas for improvement			
3	Leverage analysis to implement performance improvement			
4	Demonstrate meeting and working of Readmission Reduction Workgroup	$50,000	Q2 2024 Q3 2024 Q4 2024	February 2025
5	Demonstrate a reduction in preventable readmission rates	$50,000	Q4 2024	May 2025
	Milestones Total	**$200,000**		

References:

Centers for Medicare & Medicaid Services. (n.d) Overall Hospital Quality Star Rating. Hospitals - Overall hospital quality star rating | Provider Data Catalog. https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating

NEW

☑ Measure Name: *Quality Improvement Activity: Safety and Adverse Events*

IEHP is committed to ensuring that all patients receive safe, high-quality care. One indicator of this is the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) composite measure, commonly referred to as the AHRQ PSI 90 composite measure.

Safety and adverse events are included within the hospital's overall CMS star rating. The Patient Safety Indicator (PSI) composite falls into the domain of Safety of Care; accounting for a portion of the 22% allotted for the domain (Centers for Medicare & Medicaid Services, n.d).

This measure encourages hospital engagement in Quality Improvement Activities (QIAs) that focus on preventing these serious, but potentially avoidable complications with an overall goal to lower the rate of safety and adverse events.

Performance Requirements Overview – All eligible hospitals

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

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS			
Milestone #	**2024 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
1	Establish or provide evidence of a current Safety and Adverse Event Workgroup*	1) Establish or demonstrate evidence of a current committee, workgroup, or task force includes the following key representatives: a. Executive Sponsor (Senior/Executive Director or above) b. Physician champion (i.e., Hospitalist) c. Patient safety representative d. Quality representative e. Nurse leader	2/28/2024

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS			
Milestone #	**2024 Incentive Milestones**	**Hospital Requirements**	**Completion Due Date**
2	Identify key priority areas for improvement*	1) Hospital conducts an initial analysis of safety and adverse events including: a. Data from a minimum of 6 months (Jul-Dec 2023) b. Overall PSI rates c. AHRQ PSI specific measures i. PSI 03 - Pressure ulcer rate ii. PSI 06 - Iatrogenic pneumothorax rate iii. PSI 08 - In-hospital fall with hip fracture rate iv. PSI 09 - Postoperative hemorrhage or hematoma rate (bleeding or blood clots requiring a procedure after surgery) v. PSI 10 - Postoperative acute kidney injury requiring dialysis rate vi. PSI 11 - Postoperative respiratory failure rate (respiratory failure after surgery) vii. PSI 12 - Perioperative pulmonary embolism or deep vein thrombosis rate (blood clots in the lung or a large leg vein after surgery) viii. PSI 13 - Postoperative sepsis rate ix. PSI 14 - Postoperative wound dehiscence rate (a wound that splits open after surgery on the abdomen or pelvis) x. PSI 15 - Abdominopelvic accidental puncture or laceration rate (AHRQ, 2023)	4/15/2024
3	Leverage analysis to implement performance improvement*	1) Select three under-performing patient safety indicators for focused improvement a. These must be approved by IEHP	4/15/2024 (Selection of priorities sent to IEHP for approval) 5/15/2024 (Initial implementation complete for each activity)
4	Demonstrate meeting and working of current Safety and Adverse Event Workgroup*	1) Demonstrate evidence that group met at least monthly (April through December 2024) a. Summary report includes, at minimum: i. Meeting Attendees ii. Summary of data reviewed (please do not include PHI) b. Update to PDSA cycle	6/28/2024 9/30/2024 12/31/2024

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS			
5	Demonstrate a reduction in the rate of safety and adverse events*	1) Demonstrate at least a 10% reduction in selected patient safety indicators from baseline (baseline period: Q2 2022-Q1 2023) and/or achieve the state average Patient Safety Indicator Composite rate (state average retrieved from data period: 1.08) Hospital performance period: Q2 2024 - Q4 2024	N/A - Data will be pulled from HQI following Q4 2024 data submission. (see accelerated reporting timelines)

*Please reference supplemental submission templates provided by IEHP.

Payment Methodology:

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

QUALITY IMPROVEMENT ACTIVITY: SAFETY AND ADVERSE EVENTS PAYMENT SCHEDULE				
Milestone #	**2024 Incentive Milestones**	**Incentive per Hospital**	**Performance Period**	**P4P Payment Distribution**
1	Establish or provide evidence of a current patient safety and adverse event workgroup	$100,000	Q1 2024 Q2 2024	August 2024
2	Identify key priority areas for improvement			
3	Leverage analysis to implement performance improvement			
4	Demonstrate meeting and working of current patient safety and adverse event workgroup	$50,000	Q2 2024 Q3 2024 Q4 2024	February 2025
5	Demonstrate a reduction in the rate of safety and adverse events	$50,000	Q4 2024	May 2025
	Milestone Total	**$200,000**		

References:

Centers for Medicare & Medicaid Services. (n.d). Overall Hospital Quality Star Rating. Hospitals - Overall hospital quality star rating | Provider Data Catalog. https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating

AHRQ PSI Technical Documentation, Version v2023, Agency for Healthcare Research and Quality, Rockville, MD. https://qualityindicators.ahrq.gov/measures/PSI_TechSpec. Accessed December 22nd, 2023.

Note: AHRQ changed the name of PSI 09 in v2021 to "Postoperative Hemorrhage or Hematoma Rate" from "Perioperative Hemorrhage or Hematoma Rate" due to ICD-10-CM codes no longer allowing preoperative or intraoperative hemorrhage or hematoma.

.

NEW

☑ Measure Name: *Cal Hospital Compare Opioid Honor Roll*

The opioid epidemic is one of the most severe public health crises in US history. Over 21,000 people sought treatment for an opioid overdose in emergency rooms in 2021, and an additional 7,000 people died as a result from an overdose (CDPH, 2023).

To help combat the epidemic Cal Hospital Compare developed the California Opioid Care Honor Roll Program. This program was built to accelerate hospitals progress toward building systems that appropriately treat hospitalized patients with opioid use disorder and increase the overall knowledge of health care professionals for opioid safe practices (Cal Hospital Compare, 2023). The goal of the honor roll program is to increase access to appropriate treatment for hospitalized patients and reduce the death rate related to opioid disorder (Cal Hospital Compare, 2023).

Methodology:

As part of their participation in the 2024 IEHP P4P Program, hospitals submit Opioid Management Hospital Self-Assessment from Cal Hospital Compare Opioid Honor Roll.**

The Opioid Management Hospital Self-Assessment is used to assess hospital-specific performance in four select domains:

1. Safe & effective opioid use
2. Identifying and treating patients with Opioid Use Disorder
3. Harm reduction
4. Applying cross-cutting opioid management best practices

This assessment evaluates hospital performance during the period of April 2023 - March 2024. Please visit Opioid Care Honor Roll for more information regarding measure.

Goal:

Hospitals submit to Cal Hospital Compare the 2024 Opioid Management Hospital Self-Assessment. Based upon identified achievement, Hospital recognized as a member of the 2024 Opioid Care Honor Roll in one of the following categories:

1. Superior Performance
2. Excellent Progress
3. Most Improvement
4. Sustained Improvement

Payment Methodology:

Hospital partners will be eligible for P4P dollars if elements in tiers below are met.

PERFORMANCE INDICATOR			
Milestone #	**Hospital Requirement**	**Data Source**	**Completion Due Date**
1	As part of their participation in the 2024 IEHP HP4P Program, Hospitals will submit an Opioid Management Hospital Self-Assessment.	1. Hospitals will submit a self-assessment to Cal Hospital Compare 2. Hospitals will submit to IEHP confirmation of self-assessment completion	3/29/2024
2	Hospital recognized as a member of the 2024 Opioid Care Honor Roll in selected categories above.	1. 2024 Cal Hospital Compare Opioid Care Honor Roll results (IEHP to obtain results)	N/A

*Please submit confirmation to IEHP no later than 03/29/2024. Please email confirmation to: HospitalRelationsServiceTeam@iehp.org
**All information related to Cal Hospital Compare and California Opioid Care Honor Roll Program taken from source.

References:

Cal Hospital Compare. (2023, June). About the 2023 Opioid Care Honor Roll Program. https://calhospitalcompare.org/wp-content/uploads/2023/08/2023-Fact-Sheet-Opioid-Honor-Roll-Program-Final.pdf

California Department of Public Health. (2023, August). Welcome to the California Overdose Surveillance Dashboard. California Overdose Surveillance Dashboard. https://skylab.cdph.ca.gov/ODdash/?tab=Home

☑ 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 (calendar year 2024). Completeness of hospital data will be assessed monthly and quarterly 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. Compliance with this measure requires hospitals to 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*
HLF ORU/MDM 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***		
NEW/DISCOVERY: HL7 ORM order data feed with MX		
Physician Admit and Discharge orders		

* Chart notes include: History & Physical, 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).

Technical details for this measure's requirements can be found on the IEHP website at: https://www.providerservices.iehp.org/en/provider-central/provider-incentive-programs/pay-for-performance-program#hospital-P4P-program

IEHP ACTIVE DATA SHARING NEW REQUIREMENTS BY Q3 2024	
HL7 Field	**HL7 Field Description**
PV1-10/PV1-18	At least 1 required: bi-directional pass PV1-10 Hospital Service: BEH, NICU, NWB, OBS PV1-18: Patient Type
TXA-4.1/TX"A-6".1/TXA-7.1	At least 1 required: tri-directional pass TXA-4.1: Activity Date TXA-6.1: Origination Date TXA-7.1: Transcription Date
TXA-5.1/TX"A-9".1	At least 1 required: bi-directional pass TXA-5.1: Activity Provider TXA-9.1: Originator Provider
OBR-24	Physician Discharge Orders, or Other existing document code with discharge orders and needs
PID-11.7/ZZZZZ in Zip Code	At least 1 required: bi-directional pass PID-11.7: Address Type, or ZZZZZ in Zip Code (Homeless identification)
Discovery meetings will be required in 2024, at a minimum of once per quarter, to determine how to exchange and measure care transition related data points for consideration in future program. Examples: length of stay (i.e., expected length of stay, geometric mean LOS), discharge-related consults, barriers to discharge, post-discharge level of care needs.	

Due to the unique characteristics of critical access hospitals (CAH), the following adjustment is made to provide additional resources to support establishment and maintenance of the required data feeds for this measure:

- A maximum of $25,000 is available for the measurement year, distributed at the end of the measurement year.
- Incentives are awarded as follows:
  - $1,562.50 for each HIE feed (ADT, ORU/MDM, RDE, VXU) that
    - is newly established during the quarter, or
    - meets the quality threshold for the quarter

Acronym Dictionary:

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

RISK-BASED MEASURES: *The following section of the guide outlines measures for which there is no payment outlay, but for which hospitals are held accountable for measure performance via forfeiture of dollars earned from other measures.*

☑ 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, 2024.

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.

Risk-Based Payment Methodology:

Hospitals must achieve an NTSV Cesarean Delivery rate of ≤23.6% or forfeit 5% of total dollars earned during that measurement quarter.

- Measure will be assessed and payment reduced quarterly.
- To accommodate for volume variance, performance will also be assessed annually.

Hospitals who meet the target utilizing annualized outcomes are eligible for repayment of the withhold.

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

This measure captures the hospital's participation in the post discharge follow-up (PDFU) within seven days process. Specifically, the measure ensures that hospitals are scheduling appointments for high risk members, 18 years of age and older and that scheduled appointment is within seven days of hospital discharge.

Methodology:

To identify high-risk Members, IEHP employs the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx (MRx) model (CDPS+MRx), a combined diagnostic and pharmacy model, to identify high-, rising- and low-risk members. This is also referred to as the FAR tool. The system was developed by the University of California, San Diego, and has been adopted by the Department of Health Care Services (DHCS) of the State of California for use in it's rate setting methodology with Medi-Cal Managed Care Plans (MCPs).

CDPS+MRx uses clinical and pharmaceutical data from the prior 12 months to generate predictive risk scores for the next 12 months.

The CDPS+MRx system measures the morbidity burden of patient populations based on age, gender, and diagnostic markers.

For member stratification, IEHP uses the CDPS+MRx risk scores, along with other inputs including Social Determinants of Health (SDOH) indices, and other clinical indicators to further stratify members into high, rising, and low risk tiers.

Successful performance for this measure will be measured via two interconnected criteria. Both must be met.

Hospitals are encouraged to contact their assigned care manager or the IEHP Integrated Transitional Care Team for any non-hospital barriers to making a member a post discharge follow up appointment within seven days.

Criteria 1:

Hospitals will not experience a decrease in their baseline PDFU rate from CY 2023. Indirectly, this will ensure that post-discharge follow up appointments are being made as effectively as in previously calendar years for which there was upside financial incentive for this measure.
All acute and nonacute inpatient discharges during the measurement period for high-risk Members.

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
- Note: Licensed practical nurses, registered nurses and pharmacists are not considered PCPs or Specialists

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.

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. Members discharged to Hospice
2. Members discharged to a Skilled Nursing Facility
3. Members presenting for Delivery

Criteria 2:

Hospitals will make a post-discharge appointment within seven days for high-risk IEHP members prior to discharge.

Upon request, IEHP will provide hospitals with quarterly interim compliance reports within 30 days of the quarter close.
Hospitals wishing to dispute IEHP captured compliance must submit a report with the following details within 45 days of the quarter close:

- Member Name
- Member Date of Birth
- Date follow-up appointment was made
- Location of follow-up appointment (Provider, Clinic, etc.)
- Date/time of scheduled follow-up appointment

Denominator:

All acute and nonacute inpatient discharges during the measurement period for high-risk Members as defined in the denominator statement for Criteria 1.
*Members that cannot be contacted by IEHP post-discharge will be excluded from the denominator.

Risk-Based Payment Methodology:

Hospitals not maintaining baseline PDFU rates and/or 75% compliance with appointment scheduling as further detailed above will be subject to a 5% reduction of total P4P dollars earned within that measurement quarter.

CODES TO IDENTIFY FOLLOW-UP VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	92202	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	92203	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	92204	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	92205	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	92212	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	92213	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	92214	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	92215	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.
Office Visit	CPT	92241	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.

CODES TO IDENTIFY FOLLOW-UP VISITS:			
Service	**Code Type**	**Code**	**Code Description**
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.
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.
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.

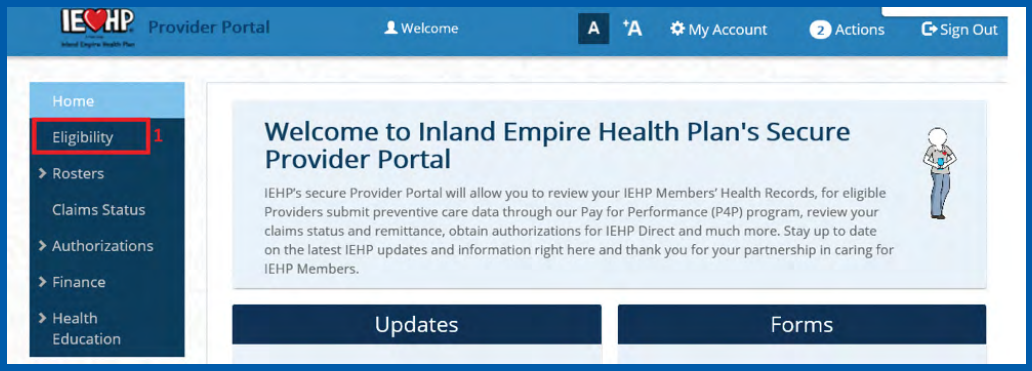
CODES TO IDENTIFY FOLLOW-UP VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk 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	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	CPT	T1015	Clinic visit/encounter, all-inclusive.
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.

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.

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:

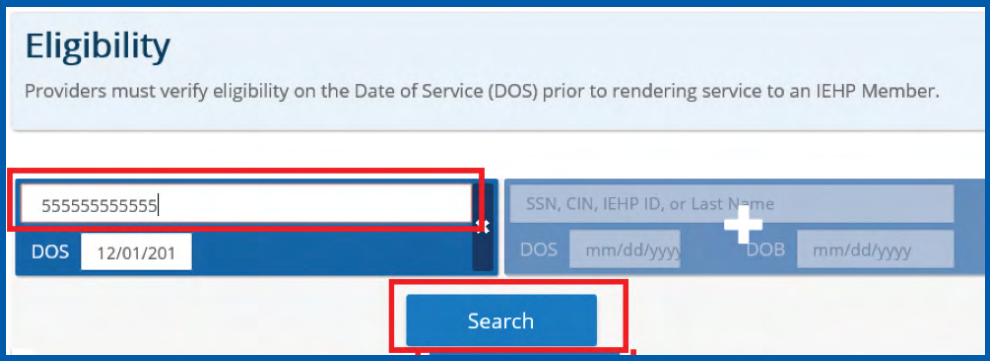
1

From the Home Screen, click on "Eligibility"



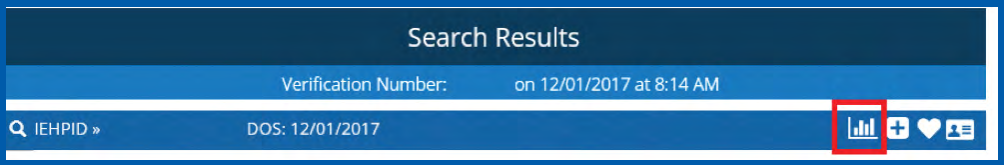
2

Enter the Member ID and Click "Search"



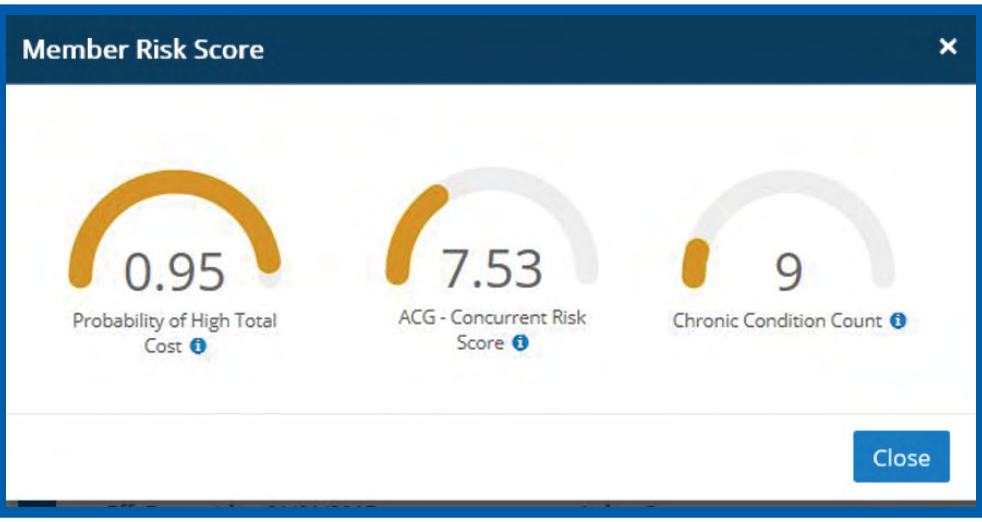
3

Click on the "Chart" icon



4

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



NEW

☑ Measure Name: *Covered CA (CCA) Adequate Network*

Inland Empire Health Plan (IEHP) would like to ensure IEHP contracted hospitals work collaboratively with both IEHP and their contracted specialty groups to ensure continuous network coverage for IEHP CCA Members. Hospitals are expected to provide support to ensure IEHP has established an adequate network including: Anesthesiology; Diagnostic Radiology; and Pathology.

Methodology:

Hospitals participating in the IEHP Covered CA line of business must ensure that they have an adequate network that includes Anesthesiology; Diagnostic Radiology; and Pathology Providers.

Risk-Based Payment Methodology:

Hospitals must establish an adequate network that includes Anesthesiology; Diagnostic Radiology; and Pathology or the hospital forfeits 5% of the total dollars earned within the measurement quarter.

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 written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.*				
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				

OBSTETRIC HEMORRHAGE:				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Criteria for when a team debrief is required immediately after a case of severe hemorrhage				
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. Drills include representation from each discipline identified in the hospitals hemorrhage response procedures. Hemorrhage drills include a team debrief.				
Review 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				

Bundle/Toolkit Elements 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 evidenced-based procedures for managing pregnant and postpartum patients with severe hypertension/ preeclampsia that includes the following: *The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, emergency department, anesthesiology, nursing, laboratory, and pharmacy.*				
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 to a 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 a 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 a 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				

Bundle/Toolkit Elements 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 in pregnancy				
Ensure methadone and buprenorphine dosages are not tapered in the immediate postpartum period				
Implement care pathways for peripartum and postpartum pain management for pregnant patients without opioid use disorder to minimize opioid use				
Utilize shared decision making to tailor post-procedure pain control				

MOTHER AND BABY SUBSTANCE EXPOSURE				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
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				
Identify community care resources for the mother and newborn				
Codevelop a multidisciplinary peripartum plan of care for pregnant women on medication assisted treatment and ensure a warm handoff to the hospital				

MOTHER AND BABY SUBSTANCE EXPOSURE				
Bundle/Toolkit Element	**Complete**	**Incomplete**	**N/A (as per hospital-specific gap analysis)**	**Comments**
Implement opioid use disorder discharge checklists for all hospital-based points of entry				
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				

Bundle/Toolkit Elements 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				

Bundle/Toolkit Elements are based upon and adopted from CMQCC's Maternal Sepsis Toolkit

APPENDIX 2: *The Joint Commission Certification Details*

Hospitals must demonstrate that there is a clinical need or clinical relevance to obtain certification in a selected area.

Hospitals interested in incentive to pursue a certification must provide relevant data to IEHP as outlined in the table below:

TJC CERTIFICATION SELECTION DATA ELEMENTS	
Available Certifications	**Hospitals to send IEHP data, as outlined below for the past 12 months 10/01/2022 - 09/30/2023. i. Data should be provided in monthly or quarterly aggregates ii. Please do not include any PHI**
Advanced Certification in Perinatal Care	Measures associated with The Joint Commission Perinatal Care Measure Set: PC-01: Elective Delivery PC-02: Cesarean Birth PC-05: Exclusive Breast Milk Feeding PC-06: Unexpected Complications in Term Newborns
Advanced Heart Failure	Measures associated with The Joint Commission Heart Failure Measure Set: ACHF-01: Beta-Blocker Therapy ACHF-02: Post-Discharge Appointment ACHF-03: Care Transition Record Transmitted ACHF-04: Discussion of Advance Directives/Advance Care Planning ACHF-05: Advance Directive Executed ACHF-06: Post-Discharge Evaluation for Heart Failure Patients
Chronic Obstructive Pulmonary Disease*	Readmission Rate** Mortality Rate**
Hospital-based Palliative Care*	N/A In lieu of data, hospitals must actively participate in Advance Care Planning data exchange with CareDirectives
Inpatient Diabetes*	Measures associated with the CMS electronic clinical quality measures (eCQMs): HH-01: Hospital Harm- Severe Hypoglycemia HH-02: Hospital Harm- Severe Hyperglycemia Hospital must have elected to submit and have access to eCQM data for both of these measures
Pneumonia*	Readmission Rate** Mortality Rate** Excess Days in Acute Care (CMS measure)
Sepsis*	Measure associated with The Joint Commission Inpatient Quality Measure: SEP-1 Sepsis Mortality Rate from HQI

These measures were selected as they align with mutual hospital-health plan priorities and are likely available within most hospital settings.

Depending on the certification selected, the hospital may also be required to collect/report data directly to The Joint Commission as part of the certification process. These data elements may or may not match those listed in the table above.

*Per The Joint Commission certification standards, hospital must be Accredited by The Joint Commission to participate in these certification programs
**Hospital can determine data definition and source, however, data must be disease-specific and must include both hospital-specific outcomes and state or national benchmark

IEHP
Inland Empire Health Plan
iehp.org

HOSPITAL RELATIONS SERVICE TEAM
hospitalrelationsserviceteam@iehp.org

Follow us: