Readmissions Domain Overview

In 2017, P4P-participating hospitals will have the opportunity to earn 30% of their potential incentive within the All-Cause Readmissions domain. Hospitals will earn incentives for demonstrating year-over-year improvements in their own 30-day all-cause readmission rate as well as through participation in additional hospital-specific activities focused on readmissions.

Hospital-specific Readmission Activities (Maximum 15%)

To help hospitals prepare for the transition toward increasing emphasis on readmissions performance, BCBSM has provided hospitals the opportunity to engage in additional readmissions-related initiatives intended to help support year-over-year improvements in their own readmission rates. Participation in up to two additional initiatives will fall under the all-cause readmissions domain and P4P incentive will be allocated toward meeting expectations within each initiatives.

<table>
<thead>
<tr>
<th>2017 P4P Readmission Domain (30% of Program’s Incentive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Rate Performance</td>
</tr>
<tr>
<td>Hospital-specific activity focused on readmissions (Choose Two)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Contact: P4Phospital@bcbsm.com
Alternative Readmission Activity Descriptions

The below readmission alternatives serve as a conduit for promoting statewide collaboration focused on reducing avoidable readmissions:

**Option 1: Designation of champion(s) responsible for readmission reduction efforts and attendance at readmission summit-like event**

Hospitals electing to choose option 1 as an alternative measure will designate a readmission champion within their site who is responsible for leading readmission reduction efforts. This individual should also have the authority to implement new initiatives or change processes to improve readmission performance at their facilities or health systems.

As part of this option, Champions are required to attend one of the following events throughout 2017:

- MHA Keystone Improvement Action Network Meetings: 2/7, 8/10, 8/24
- MPRO Readmission Summit: 6/1
- MVC Meeting: 11/3

Beyond the attendance requirement at one of the above events, readmission champions will have the responsibility to submit a detailed plan outlining the changes or process improvements made using key learnings and takeaways from summit presentations. While the plan is open-ended, proposals should directly lend themselves to describing how the hospital plans to build infrastructure in 2017 to support improvement in its readmission rate performance in future P4P program years.

**Option 2: Participate in the MHA Keystone and The Joint Commission Center for Transforming Healthcare Senior Leadership High Reliability Organization (HRO) Program**

The MHA Keystone Center, through its patient safety and quality improvement efforts, has entered a new partnership with the Center for Transforming Healthcare to assist Michigan hospitals in becoming highly reliable organizations (HROs). HROs have a strong safety culture that allows them to anticipate the unexpected and contain errors so they do not become larger or continuous issues. HROs are not error free, but they are resilient and able to respond to and learn from errors to prevent their reoccurrence.

Performance would be demonstrated through the development of an annual action plan based on the hospital’s Oro 2.0™ assessment and subsequent submission to the MHA Keystone Center. Following participation in the Oro 2.0™ assessment, hospital leadership teams create an action plan that is based on areas that demonstrate opportunity for improvement in moving the hospital on the HRO journey. The annual plan is to be submitted to the MHA Keystone Center, by March 31, 2017, to allow for identification of opportunities to support the hospital in their HRO journey. More information on HROs and the Oro™2.0 High Reliability Organizational Assessment can be found here. Questions about completing the assessment through the MHA Keystone Center initiative can be directed to Gary Roth, DO, Chief Medical Officer at the MHA.

The four remaining alternative readmission measures (options 3-6) are focused on hospital-specific activities and processes focused on making improvements to positively affect readmission rates. The criteria used to evaluate hospital submissions for these hospital-specific activities is solely based on completeness – with hospitals...
receiving full-credit for submitting plans addressing each of the elements listed in the “Template for hospital-specific Alternative Readmission Activity” included in this document. However, hospitals that approach these alternative readmission activities objectively position themselves to perform more favorably on the readmission performance measure as it represents a greater portion of the P4P incentive in future program years. Hospitals selecting more than one of the below options are required to submit separate proposals for each alternative readmission activity chosen. These proposals will be due after the program year ends with the standard CEO Attestation form in the first quarter of 2018.

**Option 3: Developing a post-acute network strategy**

Hospitals electing to choose option 3 as an alternative measure should focus their efforts on actively identifying high quality post-acute care for their patients and effectively transitioning patients to the appropriate level of care after leaving the hospital. The development of a post-acute network strategy is intentionally non-prescriptive, but BCBSM has several programs already in place – such as the Skilled Nursing Facility Pay-for-Performance (SNF P4P) program – that could serve in partnership with an acute care provider’s efforts to meet this measure’s requirements.

**Option 4: Collaboration plan with local social service agencies to better understand and address patients’ social determinants of care**

Hospitals electing to choose option 4 as a readmission alternative measure should actively build relationships with local community leaders to better understand the social determinants of the community’s population, allowing hospitals to pinpoint key areas for reducing readmission risk.

Social determinants of health – such as access to social and economic opportunities – have an effect a wide range of health outcomes and are therefore play a key role in readmission rates. This thinking is in line with CMS’ recent Accountable Health Communities Model, a pilot assessing social determinants of Medicare and Medicaid beneficiaries with the hope of directing them to community-based services while improving the quality and affordability of care.

**Option 5: Establish process to identify potentially preventable readmissions**

Hospitals electing to choose option 5 as an alternative readmission measure will benefit from creating a comprehensive plan that develops a strategy for identifying potentially preventable readmissions and using that data to drive process improvements that prevent similar readmissions in the future. As the populations served across hospitals are unique, it is within each hospital’s discretion to determine the best course of action for preventing these readmissions.

**Option 6: Develop process to use PG 1-4 P4P Health Information Exchange (HIE) activities meaningfully for the purposes of improving care transitions and readmission reduction**

To leverage the efforts hospitals have been making in advancing Health Information Exchange (HIE) activities across the state within the P4P since 2014, hospitals have the opportunity to use this data to effectively manage the care of their patient population through improved care transitions and medication reconciliation. Hospitals choosing option 6 should outline how HIE information has been incorporated into daily care processes so caregivers can act upon the information to improve patient transitions.

Contact: P4Phospital@bcbsm.com
### Option chosen for hospital-specific activity (check one per individual template):

| Option 1: Champion plan to implement learnings from statewide readmission summit |
| Option 3: Development of a post-acute network strategy |
| Option 4: Collaboration plan with local social service agencies to better understand and address patients’ social determinants of care |
| Option 5: Establish process to identify potentially preventable readmissions |
| Option 6: Develop process to use PG 1-4 P4P Health Information Exchange (HIE) activities meaningfully for the purposes of improving care transitions and readmission reduction |

### High-level narrative describing plan or intervention, including (but not limited to) the below elements:
* Please feel free to use additional space or alternative format, if desired

1. Activity purpose, priorities and goals

2. Descriptions of internal roles and responsibilities
3. Process for external stakeholder engagement, if applicable

4. Core measures and measurement processes:
   a. Baseline readmission measurement
   b. Targeted performance goal
   c. Populations and/or service lines affected
   d. Expected milestone dates and/or completion date

5. Communication and evaluation plan