# Blue Cross Blue Shield of Michigan

## 2020 Hospital Pay-for-Performance Program

## Peer Groups 1 through 4

**September 2020**

VALUE Partnerships

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## Program overview

Blue Cross Blue Shield of Michigan's Hospital Pay-for-Performance program recognizes short-term acute-care hospitals in Peer Groups 1 through 4 for achievements and improvements in quality, cost efficiency and population-health management. In 2020, the program will pay hospitals, in aggregate, an additional 5% of statewide inpatient and outpatient operating payments — nearly $190 million statewide.

The P4P program structure and measures are developed with input from hospitals through the P4P Measurement Workgroup. Hospital performance on most program measures is evaluated on a calendar-year basis and the P4P rate a hospital earns, based on its 2020 P4P program performance, will be applied to its inpatient and outpatient operating payments, starting July 1, 2021.

To help hospitals better assess their performance across all program measures throughout the program year, Blue Cross will continue to provide hospitals with quarterly, **informational** P4P performance reports into 2020. P4P participating hospitals continue to also have the opportunity to request patient-level readmissions information to help assist readmission reduction efforts.

## What's new in 2020

The 2020 P4P program year will closely follow the structure, performance measurement and incentive framework of the 2019 program year. The following table summarizes the 2020 P4P program structure:

| **2020 program components and weights** | |
|---|---|
| Prequalifying condition | 0% |
| Collaborative Quality Initiatives | 40% |
| Hospital cost efficiency | 5% |
| Michigan Value Collaborative | 10% |
| All-cause readmissions domain | 30% |
| Health information exchange | 15% |

## Payment methodology

The 2020 P4P program maintains that the statewide **aggregate** P4P payout is equal to the full 5% value of the program. Although some hospitals will earn a P4P rate less than 5% , some high-performing hospitals will earn P4P rates greater than 5%.[1]

As introduced with the 2014 program year, the 2020 P4P program will continue to use the performance scoring multiplier concept to redistribute any remaining, unearned incentive dollars differentially within each program component. This allows the program to award a larger portion of unearned incentive to the highest-performing hospitals in each individual program domain.

New in 2020, hospitals who participate in all CQIs for which they have been recruited will be eligible for a fixed-dollar bonus paid from the unearned incentive dollars within the CQI component. All other remaining unearned dollars will be paid based on the multiplier concept. The below chart provides the potential bonus by hospital, depending on the number of CQIs in which they participate:

| Number of eligible or participating CQIs | Potential unearned dollar fixed bonus |
|---|---|
| 1-4 CQIs | $20,000 |
| 5-9 CQIs | $50,000 |
| 10 or more CQIs | $75,000 |

In order for hospitals to be eligible for any additional P4P multiplier dollars, they must meet **one** of the following criteria:

- CMS hospital star rating of at least 2
- Leapfrog hospital safety grade of at least a C

Appendix A provides a more detailed explanation of this performance scoring multiplier concept and a mock distribution of unearned incentive back to P4P participating hospitals.

[1]If a hospital's reimbursement arrangement doesn't comply with the formula established within Blue Cross' *Participating Hospital Agreement*, its payout is limited to 4% of its inpatient operating payment only. Nonmodel hospitals will also not be eligible to receive any unearned incentive.

## Prequalifying condition

All P4P participating hospitals must first meet a patient-safety prequalifying condition to be eligible to participate and receive incentives for performance within the P4P program. Hospital compliance with this prequalifying condition is determined by CEO attestation due by **March 31, 2021.**

To successfully meet this condition, hospitals must fully comply with the following three requirements:

1. Conduct regular patient WalkRounds with hospital leadership
2. Assess and improve patient safety performance by fully meeting one of the following options:
    - Complete and submit the National Quality Forum Safe Practices section of the *Leapfrog Hospital Survey* at least once every 18 months
    - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months
        - First established by The Joint Commission in 2002 to help accredited organizations target critical areas where safety can be improved
        - All Joint Commission-accredited health care organizations are surveyed for compliance with the requirements of the goals — or acceptable alternatives — as appropriate to the services the organization provides
        - Goals and requirements are re-evaluated each year and new NPSGs are announced in the year prior to their implementation
        - For more information, visit National Patient Safety Goals*
    - Review compliance with the Agency for Healthcare Research Patient Safety indicators at least once every 18 months
        - Set of indicators providing information on potential in-hospital complications and adverse events following surgeries, procedures and childbirth
        - Can be used to help hospitals identify potential adverse events that might need further study and provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record
        - For more information, download the Patient Safety Indicators Brochure*

- Participate in a federally qualified patient safety organization
    - Federally listed by the Agency for Healthcare Research and Quality
    - Provides a secure environment to assist health care providers collect, aggregate and analyze data to identify and reduce safety risks, learn from errors and prevent future harm
    - For more information, visit AHRQ PSO*

3. Ensure results of the patient safety assessment and improvement activities are shared with the hospital's governing body and incorporated into a board-approved, multidisciplinary patient safety plan that is regularly reviewed and updated.

*Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.

## Collaborative Quality Initiatives 40%

Hospitals can earn up to 40% of their P4P points based on performance across Blue Cross-supported CQIs and MHA quality initiatives.

### Individual CQI weights

The CQI component of the P4P is weighted equally for all hospitals, regardless of the number of CQIs a hospital participates in. Therefore, hospitals participating in fewer CQIs will have a greater portion of their incentive allocated to each initiative, while hospitals participating in a greater number of CQIs will have a smaller portion allocated to each initiative. Hospitals eligible for and participating in more than 10 CQIs will be scored using only the top 10 individual CQI performance scores, with preference given to Blue Cross-supported CQIs.

The following chart provides the weight per CQI based on the number of initiatives a hospital participates in:

| Number of CQIs | Overall potential incentive | Potential incentive per CQI |
|---|---|---|
| 1 | 40% | 40% |
| 2 | 40% | 20% |
| 3 | 40% | 13.33% |
| 4 | 40% | 10% |
| 5 | 40% | 8% |
| 6 | 40% | 6.67% |
| 7 | 40% | 5.71% |
| 8 | 40% | 5% |
| 9 | 40% | 4.44% |
| 10+ | 40% | 4% |

### Required CQIs

In 2020, seven of the Blue Cross-sponsored CQIs have been categorized as “required” (see Appendix B for a list of all CQIs). New to the list of required CQIs is the Hospital Medicine Safety Consortium, or HMS. This CQI has the goal of improving the quality of care for hospitalized medical patients who are at risk for adverse events.

If your hospital is recruited to participate in a "required" CQI, but declines to participate, your hospital will forfeit the points attributed to that CQI. If your hospital is not recruited to participate in a "required" CQI, it will not be penalized for nonparticipation.

To find out whether your hospital is eligible for a specific CQI and its potential effect on your hospital's 2020 P4P score, contact Blue Cross' CQI administration team at CQIPrograms@bcbsm.com.

### Great Lakes Partners for Patients Hospital Improvement Innovation Network

Beginning with the 2017 program year, the MHA, in partnership with the Illinois Health and Hospital Association and Wisconsin Hospital Association, combined Keystone collaborative efforts into a single, two-year long Hospital Improvement Innovation Network initiative, named Great Lakes Partners for Patients HIIN. In 2020, all targeted improvement work will occur under the Great Lakes Partners for Patients HIIN and as such, the MHA Keystone center will not be enrolling hospitals in individual collaboratives.

Hospital participation in the HIIN remains **optional** and will be weighted equivalent of up to two CQI programs — exact weights vary depending on total number of CQIs a hospital is participating in. For hospitals participating in nine of Blue Cross' CQIs, the program weight assigned to the HIIN will be capped at 4%.

The HIIN focuses on implementing person and family engagement practices, enhancing antimicrobial stewardship, building cultures of high reliability, reducing readmissions and addressing 11 types of inpatient harm. An HIIN performance index scorecard outlining measure requirements can be found in Appendix G.

While the HIIN is set to expire during the 2020 P4P program year, a replacement is expected to be developed during 2020. Therefore, the opportunity for hospitals to be scored on HIIN performance will remain, and scoring will be calculated as outlined in Appedix G.

### CQI performance index

A hospital's P4P score for each CQI is determined by its performance on specific measures related to that CQI. These measures and their corresponding weights are referred to as the hospital's CQI performance index. Each index consists of both performance and participation-based measures. Performance measures are related to quality and clinical process improvement and outcomes, such as reductions in morbidity or surgical complications. Participation measures are related to program participation and engagement, such as meeting attendance and timely data submission.

Each CQI's performance index is developed by the corresponding CQI coordinating center and discussed with participating hospital clinical champions and Blue Cross before they are finalized. The measures in each CQI index scorecard are reviewed annually and updated, if applicable, with increasing weight given to performance measures (versus participation measures) as programs become more established.

The most recent performance index scorecard for each CQI will be made available from the corresponding CQI coordinating center, as well as displayed on the Blue Cross website, by the end of December 2019. Our website is the following:

**https://www.bcbsm.com/providers/value-partnerships/hospital-pay-for-performance.html**

A hospital's score on each CQI performance index is determined by the corresponding coordinating center. Each coordinating center gives participating hospitals a mid-year scorecard to identify performance progress. A final scorecard is then distributed to hospitals in the first quarter of the following year. The coordinating center also gives Blue Cross a final aggregated score for each CQI to calculate P4P scores. The coordinating center does not share hospital performance on individual measures with Blue Cross.

An example of how a hospital's score is calculated is provided in Appendix B. Specific questions about index measures should be directed to the applicable CQI coordinating center.

## CQI data abstraction and reporting funding support

*Blue Cross supported*

Eligible hospitals participating in Blue Cross-supported CQIs may have the opportunity to receive annual funding support, **outside of the P4P**, for a portion of the costs they incur for data abstraction and reporting. These additional funds are designed to minimize potential cost barriers to participation, including abstracting medical record data, patient follow-up and reporting for Blue Cross, BCN, Medicare, Medicaid, uninsured and self-insured cases. The data abstraction funding model for each CQI is developed by its respective coordinating center with review by Blue Cross' CQI administration.

In return for these additional funds, hospitals are expected to comply with all participation expectations agreed to upon joining the initiative (refer to Appendix B). These expectations and your hospital's compliance are both determined by each CQI's coordinating center and Blue Cross. Specific participation expectations for each CQI are available from the associated coordinating center.

*MHA sponsored*

Hospitals in Peer Groups 3 and 4 who participate in the MHA HIIN initiative are eligible for a $20,000 participation payment from Blue Cross. This payment is intended to help smaller hospitals with the additional costs they incur to participate in the HIIN. Hospitals must be participating as of Jan. 1, 2020, to be eligible for this payment.

Hospitals in Peer Groups 1 and 2 aren't eligible for an MHA HIIN participation payment. However, any hospital that hasn't reached the 10 CQI scoring maximum may earn P4P credit for the HIIN initiative. Active participation in HIIN is determined by the MHA Keystone Center.

*Payment schedule*

Hospitals will receive their 2020 CQI data abstraction funding as a lump-sum add-on to their Blue Cross interim payment, or BIP, during the second quarter of 2020. If a hospital is not on the BIP system, it will be issued a check for the total amount. Hospital Pay-for-Performance administrators, chief executive officers, chief financial officers and other stakeholders designated by the hospital will be notified by email when the payment is issued.

## Hospital cost efficiency 5%

Blue Cross will continue to reward hospitals for a decrease in or more efficient management of hospitals' inpatient cost structure — lowering overall facility payments, thus furthering improvement in the overall population-based cost of care.

Hospitals will have the opportunity to earn 5 percent of their P4P incentive through performance on two hospital cost efficiency measures, each weighted at 50 percent:

1) Cost per case compared to statewide mean
2) Cost per case compared to target inflation factor — NHIPI

The 2020 program will continue to use similar scoring tiers from previous program years to measure both performance and improvement:

| **Cost per case compared to statewide mean** | **Score** |
|---|---|
| More than 0.5 standard deviation below | 125% |
| Within 0.5 standard deviation of statewide mean | 90% |
| Between 0.5 and 1.0 standard deviation above | 50% |
| More than 1.0 standard deviation above | 0% |
| **Cost per case compared to target inflation factor (NHIPI)** | **Score** |
| Actual ≤ 25% of target | 125% |
| Actual more than 25% but ≤ 50% of target | 90% |
| Actual more than 50% but ≤ 75% of target | 75% |
| Actual more than 75% but ≤ 100% of target | 62.5% |
| Actual more than 100% but ≤ 125% of target | 50% |
| Actual more than 125% but ≤ 175% of target | 37.5% |
| Actual more than 175% of target | 0% |

For example, a hospital scoring 90 percent on the statewide mean and 50 percent on the target inflation components will receive an overall hospital cost efficiency measure performance of **70 percent.**

As in years past, hospitals have the opportunity to earn more points than the total value for each measure, but its combined score is capped at 100 percent.

The 2020 P4P program measures hospital cost efficiency using each hospital's standardized cost per case. The cost per case value is based on hospital-specific margin files (full-cost model), excluding nonacute services, such as psychiatric, rehabilitation and substance abuse. The cost per case is also adjusted for a hospital's case mix index, graduate medical education, capital expenses and bad debt.

Similar to previous P4P program years, cost per case calculations are made using three years of cost data. For the 2020 program year (for P4P incentives beginning July 2021), the calculation will be made using cost data from 2017, 2018 and 2019, as follows:

- 2017 FYE costs and cases will be weighted at 15 percent
- 2018 FYE costs and cases will be weighted at 35 percent
- 2019 FYE costs and cases will be weighted at 50 percent

## Michigan Value Collaborative 10%

The Michigan Value Collaborative is a collaborative quality initiative funded by Blue Cross. MVC aims to help Michigan hospitals achieve the best possible patient outcomes at the lowest reasonable cost by using high-quality data and best practice sharing to drive collaborative quality improvement. MVC provides hospital leaders with claims-based utilization and episode payment data to empower local quality improvement activities, many of which are tied to the quality initiatives in Blue Cross' CQIs. MVC data supplies condition-specific, price-standardized, and risk-adjusted 30- and 90-day total episode payments for Blue Cross' PPO, Blue Cross' Medicare Advantage, Blue Care Network's HMO, BCN's Medicare Advantage and Medicare fee-for-service claims. In the future, MVC reports will also include Medicaid claims data, but as it stands, these will not be included in the 2020 measure.

### 2020 measure expectations

In an effort to continually improve the MVC component of Blue Cross' P4P program, a number of updates have been implemented and will take effect from program year 2020 onwards. These improvements include:

- Excluding episodes with inpatient transfers within the index admission
- Discontinuing acute myocardial infarction as a service line option, and replacing it with chronic obstructive pulmonary disease
- Reclassifying episodes of coronary artery bypass grafting previously in the AMI service line into the CABG service line
- Incorporating BCN commercial, BCN Medicare Advantage, and Blue Cross PPO Medicare Advantage episodes into the MVC P4P metric, which also includes Blue Cross PPO commercial and Medicare FFS episodes

In late 2019, hospitals were informed of these changes and asked to select two service lines to be measured for performance in 2020 and 2021. As before, in order for a hospital to be eligible to earn points for its selected service lines, it must first meet the quality requirement. This stipulates that its in-hospital mortality or related readmission rate for the selected service line is not statistically below the 10$^{th}$ percentile in the relevant performance year.

Hospitals meeting the quality requirement can earn up to five points for reducing total episode payments for each of its selected service lines. Improvement may be demonstrated by either year-over-year improvement within the hospital, or through absolute achievement compared to a cohort of their peers, as shown in the following table:

| Points earned | Year-over-year improvement<br>Baseline: hospital service line total episode payments for the most recently available 12-month period* | Absolute achievement<br>Baseline: MVC cohort group service line total episode payments for the most recently available 12-month period |
|---|---|---|
| 1 point | Baseline mean | 50th percentile |
| 2 points | Baseline mean — (5% $*\frac{A}{B}*C$) | 60th percentile |
| 3 points | Baseline mean — (10% $*\frac{A}{B}*C$) | 70th percentile |
| 4 points | Baseline mean — (15% $*\frac{A}{B}*C$) | 80th percentile |
| 5 points | Baseline mean — (20% $*\frac{A}{B}*C$) | 90th percentile |

*Hospital mean represented by A. MVC mean represented by B. MVC winsorized standard deviation represented by C.

### MVC bonus point

A hospital may be eligible for a bonus point if two conditions are met. First, a hospital's mean episode payment does not increase from the baseline year. Second, all hospitals choosing that service line within the same cohort decrease their aggregate average episode payment by 5 percent or greater. The purpose of the bonus point is to encourage hospitals to reduce payments through collaboration, rather than competition. Please note that the maximum points a hospital may receive for the MVC measure is 10, even if the hospital is eligible for the bonus point.

Please refer to Appendix E for an example of the MVC score calculation. A detailed description of the 2020 and 2021 performance-based measure will be shared with all hospitals in an updated version of the MVC technical document in early 2020.

### Timeline of the 2020 and 2021 MVC-based P4P performance measure

| | 2020 P4P program | 2021 P4P program |
|---|---|---|
| Baseline period | CY 2017 | CY 2018 |
| Performance period | CY 2019 | CY 2020 |
| Data analysis and claims adjudication | CY 2020 | CY 2021 |
| Performance impacts incentives effective | July 1, 2021 through June 30, 2022 | July 1, 2022 through June 30, 2023 |

## MVC support for hospitals

The MVC Coordinating Center hosts a series of virtual workgroups based on input from its hospital partners. The primary goal of these workgroups is to provide hospital leaders with a highly accessible platform to share best practices and challenges facing hospitals throughout the state of Michigan. The ideas and strategies outlined in these discussions also serve as a foundation and framework for collaborative learning and best practice sharing at MVC meetings.

The MVC Coordinating Center will also continue its work to improve the utility of the MVC data registry website, disseminate hospital-specific performance reports, offer custom reports as requested, facilitate regional networking dinners, undertake in-person hospital site visits, and host semi-annual meetings to provide a venue for the sharing of best practices and additional insights.

## All-cause readmissions domain 30%

In 2020, P4P participating hospitals will have the opportunity to earn 30 percent of their potential P4P incentive within the all-cause readmissions domain. Hospitals will earn incentives for demonstrating favorable year-over-year improvements in their own 30-day all-cause readmission rate.

### 2020 P4P readmission rate performance (30%)

To continue to promote hospital and physician collaboration across the care continuum and align measurement reporting and incentives with CMS requirements, the 2020 P4P program will continue to use the NQF-endorsed hospital-wide all-cause unplanned readmission measure (HWR; NQF 1789) developed by Yale University and CMS.

P4P readmissions performance is assessed using only Blue Cross commercial membership claims (PPO, POS and Traditional products for Michigan adult residents ages 18 to 64).

Due to the adaptation of this measure to a commercially insured population, this measure **won't be risk standardized** according to CMS methodology. Additionally, readmission data used within the P4P isn't adjusted for variations in patient mix, market or geography. Consequently, a hospital's all-cause readmissions performance and earned incentive will be measured as each hospital's own year-over-year improvement, across a 2019 baseline period and 2020 measurement period or **as each hospital's own confidence interval as compared to the Michigan P4P participating hospital statewide average**.

*Readmission scoring methodology*

Introduced in the 2018 program, confidence intervals are a range of values so defined that there is a specified probability that the value of the parameter lies within it. On hospital compare, CMS calculates hospital-specific confidence intervals for the majority of its measures and compares them against a national rate. Similarly, the 2020 P4P program will calculate hospital-specific confidence intervals and compare them against the **Michigan P4P participating hospital statewide average**.

The more favorable methodology (current method versus confidence intervals) will be used for a hospital if any of the following conditions are met:

- Hospital shows improved readmission rate, regardless if rates are above P4P statewide average.
- Hospital 2020CY readmission rate is less than the P4P statewide average.
- Hospital is considered low volume (<250 IP discharges).

**All other hospitals will continue to be scored based on the current year-over-year improvement method.**

**1. Year-over-year improvement (current method)**

| Year-over-year improvement (relative % change) | Points earned | Example baseline | Example performance |
|---|---|---|---|
| More favorable than -2.5% improvement | 100% | 10% | Less than 9.75% |
| Between +/-2.5% | 50% | 10% | 9.75% to 10.25% |
| Less favorable than +2.5% | 0% | 10% | Greater than 10.25% |

**2. Confidence intervals (new method)**

| Confidence interval | Points earned |
|---|---|
| Entire confidence interval is less than P4P statewide average | 100% |
| P4P statewide average falls within confidence interval | 50% |
| Entire confidence interval is greater than the P4P statewide average | 0% |

## Health information exchange 15%

The health information exchange component of the P4P program is designed to ensure caregivers have the data they need to effectively manage the care of their patients. The HIE component is focused on improving the quality of data transmitted through the Michigan Health Information Network's statewide service, expanding the types of data available through the service and developing capabilities that will help facilitate statewide data exchange going forward.

In its January *2018 Health Information Exchange Fact Sheet*, CMS states its expectation for HIE sender and receiver collaboration.[2] The intent is to promote data quality from the initiating provider so the receiving provider can incorporate the data into its patient-associated processes of care. If the receiver is unable to use the sender's data, then the receiver is unable to provide patients with appropriate and timely care. Blue Cross shares CMS' vision of promoting the transmission of quality data that can be effectively used by a patient's providers.

The 2020 HIE measures and associated points are summarized in the table below. There are two new measures in 2020:

- Measure 4: Transmit **all** ambulatory CCDA data. This includes all outpatient hospitals, visits as well as office visits for any physician sharing the hospital's EMR, whether employed or not employed.
- Measure 5: Participate in one or more HIE pilot projects.

Details on all the HIE measures can be found in Appendix F.

| Measure number | Measure description | Total points available | Points available by quarter | | | |
|---|---|---|---|---|---|---|
| | | | 1Q | 2Q | 3Q | 4Q |
| 1 | Maintain ADT data quality conformance | 2 | .50 | .50 | .50 | .50 |
| 2 | Receive, send and maintain common key service attribute | 2 | .50 | .50 | .50 | .50 |
| 3 | Maintain CCDA data conformance for inpatient, observation and ED visits | 4 | 1.0 | 1.0 | 1.0 | 1.0 |
| 4 | Transmit all ambulatory CCDA data | 4 | 0.0 | 0.0 | 0.0 | 4.0 |
| 5 | Participate in one or more HIE pilot projects | 3 | n/a | n/a | n/a | n/a |

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HealthInformationExchange_2017.pdf (Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.)

## Performance scoring multiplier methodology

The table below displays how the CQI incentive pool is calculated, based on actual CQI performance and the redistribution of unearned CQI dollars. In this example, the overall CQI incentive pool of $20 million is calculated based on the potential CQI incentive for each hospital, determined by individual CQI eligibility. The earned CQI incentive is then determined by multiplying each hospital's actual CQI performance by its potential CQI incentive amount. The unearned dollars resulting from less than 100 percent CQI performance, which is $2.6 million in this example, is then redistributed to hospitals by a scoring multiplier.

Beginning in 2020, before the unearned CQI incentive dollars are redistributed to hospitals, some of these unearned dollars will be used to give a bonus to hospitals that participate in *all* CQIs for which they have been recruited. This bonus is intended to recognize and reward hospitals for the additional work and resource commitment it takes to participate in all multiple CQI programs. The potential bonus amount for each hospital is based on the number of CQIs it is recruited to participate in, as follows:

| CQI Count | Bonus Amount |
|---|---|
| 1-4 CQIs | $20,000 |
| 5-9 CQIs | $50,000 |
| ≥10 CQIs | $75,000 |

If a hospital drops out of a CQI, it is no longer eligible for this bonus. Similarly, if a hospital is recruited to join a CQI, regardless of whether or not it is a required CQI, and chooses not to join, it will not receive the bonus.

| Hospital name | **Collaborative Quality Initiatives** (Fixed 40% of P4P incentive) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Potential CQI Incentive (fixed 40%) | CQI performance | Earned CQI incentive | CQI full-participation bonus | Unearned CQI incentive | Scoring Multiplier (hospital earned/ total earned) | Additional CQI incentive earned | Total earned CQI incentive ($, %*) | |
| Hospital A | $100,000 | 95% | $95,000 | | | 0.5% | $13,404 | $108,404 | 108.4% |
| Hospital B | $250,000 | 80% | $200,000 | | | 1.1% | $28,218 | $228,218 | 91.3% |
| Hospital C | $350,000 | 78.57% | $275,000 | $20,000 | | 1.6% | $38,800 | $333,800 | 95.4% |
| Hospital D | $500,000 | 100% | $500,000 | | | 2.9% | $70,546 | $570,546 | 114.1% |
| Hospital E | $750,000 | 93.33% | $700,000 | | | 4.0% | $98,764 | $798,764 | 106.5% |
| Hospital F | $800,000 | 91.25% | $730,000 | $50,000 | | 4.2% | $102,997 | $882,997 | 110.4% |
| Hospital G | $1,500,000 | 60% | $900,000 | | | 5.2% | $126,983 | $1,026,983 | 68.5% |
| Hospital H | $2,250,000 | 88.89% | $2,000,000 | | | 11.5% | $282,184 | $2,282,184 | 101.4% |
| Hospital I | $3,500,000 | 100% | $3,500,000 | | | 20.1% | $493,822 | $3,993,822 | 114.1% |
| Hospital J | $10,000,000 | 85% | $8,500,000 | $75,000 | | 48.9% | $1,199,282 | $9,774,282 | 97.7% |
| **Total** | **$20,000,000** | | **$17,400,000** | **$145,000** | **$2,455,000** | | **$2,455,000** | **$20,000,000** | **100.0%** |

## APPENDIX B

| Blue Cross-sponsored hospital CQI programs | | Required CQI |
|---|---|---|
| **CQI name** | **Description** | **Yes/No** |
| Michigan Cardiovascular Consortium, or BMC2 * | Improve the quality of care and reduce health care costs for patients undergoing percutaneous coronary interventions, vascular surgery and carotid interventions by reducing complications and focusing on the appropriate use. | Yes |
| Michigan Bariatric Surgery Consortium, or MBSC * | Innovate the science and practice of metabolic and bariatric surgery through comprehensive, lifelong, patient-centered obesity care. | Yes |
| Michigan Emergency Department Improvement Collaborative, or MEDIC | Advance the science and delivery of emergency care for adult and pediatric patients across a diversity of emergency department settings. | No |
| Michigan Society of Thoracic and Cardiovascular Surgeons, or MSTCVS, Quality Collaborative* | Improve the quality of care for patients who undergo cardiac surgery, general thoracic surgical procedures, transcatheter valve replacements and perfusion practices. | Yes |
| Michigan Surgical Quality Collaborative, or MSQC | Develop and implement practical approaches to better outcomes and lower costs for patients undergoing general surgery by focusing on reducing venous thromboembolism, surgical site infections and implementing enhanced recovery programs. | Yes |
| Michigan Trauma Quality Improvement Project, or MTQIP | Improve the quality of care administered to trauma patients, while reducing the costs associated with trauma care. | Yes |
| Hospital Medicine Safety, or HMS, Consortium | Improve the quality of care for hospitalized medical patients who are at risk for adverse events. | Yes |
| Michigan Radiation Oncology Quality Consortium, or MROQC | Improve the quality of the radiation treatment experience for patients with breast or lung cancer by identifying best practices in radiation therapy that minimize the side effects that patients may experience from radiation treatment. | No |
| Michigan Arthroplasty Registry Collaborative for Quality Improvement, or MARCQI* | Engage hospitals and physicians in quality improvement activities for patients undergoing hip and knee joint replacement surgery procedures. | No |
| Michigan Anticoagulation Quality Improvement Initiative, or MAQI2 | Improve the safety, quality of care and outcomes of patients requiring anticoagulation. | No |
| Michigan Spine Surgery Improvement Collaborative, or MSSIC* | Engages orthopedic surgeons and neurosurgeons with the aim of improving the quality of care of spine surgery, by improving patient care outcomes and increasing efficiency of treatment. | No |
| Anesthesiology Performance Improvement and Reporting Exchange, or ASPIRE | Integrate surgeon and anesthesiologist perspectives to assess variation in practice, identify best practices, and measure process adherence and patient outcomes to improve the quality of anesthesiology care. | No |
| Integrated Michigan Patient-centered Alliance on Care Transitions, or I-MPACT | Works with hospitals, providers, community service organizations, patients and families using standard practices and innovative processes to improve care transitions for patients. | No |
| OB Initiative (OBI) | Reduce cesarean deliveries for low-risk pregnancies. | Yes |
| MHA Sponsored Program | | |
| Great Lakes Partnership for Patients Hospital Improvement Innovation Network, or HIIN | Two-year, CMS-sponsored collaborative focused on implementing person and family engagement practices, enhancing antimicrobial stewardship, building cultures of high reliability, reducing readmissions and addressing 11 areas of patient harm. | No |

*Participation associated with maintenance of Blue Distinction Center designation status

## CQI scoring method

The tables in this appendix list the measures used to score hospital performance on each CQI. The measures within each index apply to a hospital only if it is eligible to participate in the corresponding CQI. Each CQI index is scored on a 100-point basis.

A hospital participating in multiple CQIs will have its index scores combined into one overall score. For example, assume the following:

Hospital A participates in two CQIs (for which it has been recruited and is eligible) and the optional MHA-sponsored HIIN initiative (weighted as two CQIs).

Its total CQI weight is 40 percent.

**Its individual CQI weight is 10 percent – 2 CQI Programs + HIIN weighed 2x**

Its performance on CQI No. 1 is 80 percent.

Its performance on CQI No. 2 is 90 percent.

Its performance on the MHA-sponsored HIIN is 100 percent.

Hospital A's overall CQI score is calculated as follows:

| | **Index score** | | **CQI weight** | | **Earned score or potential score** |
|---|---|---|---|---|---|
| CQI No. 1 | 80% | X | 10% | = | 8% |
| CQI No. 2 | 90% | X | 10% | = | 9% |
| HIIN | 100% | X | 20% | = | 20% |
| **Total CQI aggregate score** | **93%** | | **40%** | | **37%** |

In this example, Hospital A earned a total CQI score of 37 percent out of a potential 40 percent. Hospital A left on the table approximately 3 percent of its potential maximum incentive reward tied to CQIs.

See Appendix A for a more detailed breakdown of how unearned CQI incentive dollars are distributed to hospitals within the CQI incentive pool based on a comparative CQI performance.

## CQI performance index scorecards

The CQI performance index scorecards will be made available as a separate addendum to the 2020 Pay-for-Performance program guide in mid- to late-December 2019, as well as made available through each coordinating center.

All performance index measures and weights are established by the CQI coordinating centers. The weights and measures of a specific CQI index may be adjusted for newly participating hospitals. The coordinating center for each CQI will evaluate and score each hospital's performance index and submit the final aggregate score to Blue Cross.

The measurement period for each performance index measure is January through December, unless otherwise noted.

Specific questions and comments pertaining to the performance index measures should be directed to the respective CQI coordinating center. Contact information will be available in the performance index scorecard addendum to the 2020 P4P program guide.

### General CQI participation requirements

General expectations that Blue Cross has for CQI site participants and affiliated clinicians are listed below. Each CQI also has developed distinct expectations for participation, which are made available by the respective CQI coordinating centers.

- Identify "physician champions" at participating sites who can affect change, collaborate in generating data for enhanced knowledge and analysis of processes and outcomes of care
- Identify an administrative contact at participating sites
- Thoroughly and accurately collect comprehensive data (i.e., no consistent pattern of errors or omissions with regard to data elements) on patient cases, as specified by the coordinating center on all cases
- Submit data in a timely manner for entry into registry, in the format specified by the coordinating center
- Respond to queries from the coordinating center in a timely manner
- Cooperate with data quality audits conducted by the coordinating center
- Attend and participate in all collaborative meetings (either the physician champion, administrative project lead or an assigned designee who has the ability to impart QI within the organization)
- Participate in collaborative-wide QI activities or site-specific initiated QI activities related to the work of the CQI

- Demonstrate that comparative performance reports provided by the CQI are actively used in QI efforts
- Participate in inter-institutional QI activities (e.g., sharing best practices)
- Report on the effect of QI activities and provide examples of specific QI interventions to the coordinating center
- Obtain institutional approval for CQI data collection requirements, as specified by the coordinating center (i.e., Institutional Review Board approval)
- Maintain personnel to collect data
- Obtain signatures required for the site's data use agreement or business associate agreements, which are to be signed by the site's president or CEO or a site representative who holds sign-off authority for the hospital and in the case of the signed data use agreement, returned to the coordinating center
- Contribute data and information that could be used in academic publications

## Hospital cost-efficiency calculations

### Cost per case compared to statewide mean

One portion of each hospital's efficiency score is based on the number of standard deviations its cost per case is away from the statewide mean. This is also referred to as the hospital's "standard normal score" and is calculated as follows:

$$\text{Hospital standard Normal score} = \frac{\text{hospital cost per case — statewide average (mean) cost per case}}{\text{standard deviation of statewide average cost per case}}$$

The statewide average (mean) cost per case is calculated by totaling each hospital's cost per case and dividing by the number of hospitals participating in the P4P program:

$$\text{Statewide Average (mean)} = \sum (\text{hospital cost per case}) / \text{number of participating hospitals}$$

The standard deviation in the above calculation is defined as the square root of the average squared deviation from the mean, as shown in the following formula:

$$\text{Standard deviation} = \text{SQRT} \left( \sum (\text{hospital CPC - statewide average CPC})^2 / \text{number of hospitals} \right)$$

Applying this calculation to a single hypothetical hospital, assume the following:

- Hospital A's cost per case = $8,103
- Overall statewide average cost per case is $7,700
- Standard deviation of the statewide average cost per case is $1,000
- Standard normal score for this hospital is calculated as follows:

$$\text{Hospital A standard normal score} = \frac{(\$8{,}103 - \$7{,}700)}{\$1{,}000} = 0.403$$

Hospital A's standard normal score is between -0.5 and 0.5. Therefore, Hospital A earns a measure performance of 90 percent for this performance-based cost-efficiency component.

### Cost per case compared to a NHIPI-based target inflation factor

The remainder of each hospital's efficiency score is based on a comparison of the change in its cost per case to a target inflation amount, which is calculated using the National Hospital Input Price Index. For example:[3]

- Hospital A's cost per case at the beginning of the measurement period is $8,000
- The reported NHIPI for the same period is 3 percent
- Hospital A's target cost per case increase is calculated as follows: $8,000 x 0.03 = $240

This target increase is compared to its actual increase, as follows:

- Hospital A's actual cost per case at the end of the measurement period is $8,103. Therefore, its actual cost per case increase is:

$8,103 - $8,000 = $103

- Hospital A's actual cost per case increase is divided by its target cost per case increase:

$103 ÷ $240 = 43%

### Cost per case expanded measurement period

In 2020, the standardized inpatient cost per case is calculated using a three-year rolling average. This longer measurement period is designed to minimize the effect of short-term variations on hospital cost per case scores. At the same time, the average is weighted to more heavily emphasize recent performance, as follows:

- For the 2020 program year (P4P incentives effective July 2021 the calculation will be made using data from 2017, 2018 and 2019.
  - 2017 costs and cases will be weighted at 15 percent
  - 2018 costs and cases will be weighted at 35 percent
  - 2019 costs and cases will be weighted at 50 percent

Using these weights, each hospital's cost per case is calculated as follows:

$$\text{2020 hospital cost per case} = \frac{(0.15 \times \text{2017 costs}) + (0.35 \times \text{2018 costs}) + (0.50 \times \text{2019 costs})}{(0.15 \times \text{2017 cases}) + (0.35 \times \text{2018 cases}) + (0.50 \times \text{2019 cases})}$$

[3]For simplicity this example uses a measurement period of only one year. However, the cost per case measurement period is based on a three-year measurement period for the 2020 program, as described in a subsequent section of this appendix.

The weighted statewide mean cost per case for each measurement period will be calculated in the same manner. For the 2020 program year (P4P rate effective July 2021), the hospital-specific inflation targets will be calculated using the same rolling averages, as shown in the following formulas:

$$\text{3-year weighted target inflation} = \frac{\begin{array}{l}(0.15 \times \text{2016 costs} \times \text{2017 NHIPI}) \\ + (0.35 \times \text{2017 costs} \times \text{2018 NHIPI}) \\ + (0.50 \times \text{2018 costs} \times \text{2019 NHIPI})\end{array}}{(0.15 \times \text{2017 cases}) + (0.35 \times \text{2018 cases}) + (0.50 \times \text{2019 cases})}$$

## Hospital MVC calculations

**Program years 2020 and 2021**

The following is an illustration of how the scoring system will be applied for program year 2020 for a fictitious hospital (Hospital A) selecting joint replacement. All dollar amounts provided below are for illustrative purposes only.

In 2020, Hospital A meets the quality requirement by performing above the 10th percentile on the mortality and related readmission measure.

Hospital A's 30-day mean episode payments for joint replacement are outlined below:

| Service line | Mean payments for baseline period | Mean payments in 2020 performance period |
|---|---|---|
| Joint replacement | $16,393 | $16,871 |

Hospital A's 2020 improvement targets for joint replacement are shown below (see Page 12 for the target payment reduction methodology):

| 2020 year over year improvement targets | Points |
|---|---|
| $16,393 | 1 |
| $16,295 | 2 |
| $16,197 | 3 |
| $16,099 | 4 |
| $16,001 | 5 |

Because Hospital A's mean episode payment for joint replacement in 2020 exceeds its baseline period target, it doesn't earn any points for year-over-year **improvement**. However, because Hospital A's 2020-episode payment for joint replacement is well below its cohort's average episode payment for joint replacement, it's eligible for **achievement** points.

| Hospital A's rank | Hospitals in cohort | Hospital A's percentile |
|---|---|---|
| 3 | 20 | 85% |

Hospital A will earn 4 points for absolute achievement because it is ranked between the 80th and 90th percentile.

| **2020 *achievement* rankings** | **Percentiles** | **Points** |
|---|---|---|
| 10/20 | 50th percentile | 1 |
| 8/20 | 60th percentile | 2 |
| 6/20 | 70th percentile | 3 |
| 4/20 | 80th percentile | 4 |
| 2/20 | 90th percentile | 5 |

As stated on Page 12, a bonus point may be earned if all hospitals working on the same service line achieve a 5% or greater improvement in total episode costs and the hospital's own performance didn't decline from the baseline year. In this illustrative example, all hospitals in the state working on joint replacement reduced average episode costs by more than 5% (data not shown). However, since Hospital A's 2020 joint replacement costs were higher than its baseline costs, it would not be eligible to earn an additional bonus point as part of its **collaboration** goal.

| **Hospital A's improvement points** | **Hospital A's achievement points** | **Hospital A's bonus point** | **Total points for service line** |
|---|---|---|---|
| 0 | 4 | 0 | 4 |

For 2020, Hospital A will earn a total of 4 points for its joint replacement service line. Its 2020 pneumonia service line performance would be scored separately using the same methodology.

## Health Information Exchange measures

### HIE measures 1, 2 and 3: ADT, Common Key Service and Exchange CCDA

The Blue Cross conformance standards are designed to continually improve the data that flows through the Michigan Health Information Network, ensuring it is complete and actionable when it's received by the practitioners using the information. Data quality conformance requirements are focused on three MiHIN use cases: ADT, Common Key Service and Exchange CCDA. For each of measure:

- A hospital will be considered in conformance if all fields are populated at or above the relevant threshold.
- A hospital will be considered out of conformance if one or more fields is not populated at the relevant threshold.
    - If a hospital is notified by Blue Cross it is not in conformance, it must address the issue and regain conformance within 30 days of the notification.
    - A hospital will earn 0.00 points for each quarter in which it remains out of conformance following 30 days notification from Blue Cross.
- For mapped fields, updated mapping tables must be submitted to MiHIN when changes occur.

Conformance thresholds apply to all inpatient, observation and ED visits. Specific conformance thresholds for each measure are outlined in the tables below.

### Measure 1: ADT conformance thresholds – 2 points

Hospital will earn two points for maintaining ADT data conformance. The following table shows the required ADT data fields and performance thresholds. Please note the following:

- In 2020, messages must meet and maintain an overall conformance score of 95% across all three categories; complete routing, complete mapping and adherence to coding standards. This is a change from 2019, in which adherence to coding standards was scored separately from complete routing and complete mapping.
- The insurance fields, IN1-3 and IN1-4, which were removed from conformance in 2019, have been added back to the list of required fields for 2020. However, unlike previous years, these fields only need to be populated and will not be subject to mapping. Population of these fields enables MiHIN to better differentiate self-pay patients from insured patients.

| **Measure 1 – ADT conformance thresholds – 2 points** | |
|---|---|
| **Group A: complete routing – messages must be populated with all the following fields** | **Threshold** |
| PID-5.1: Patient Last Name | ≥95% |
| PID-5.2: Patient First Name | ≥95% |
| PID-7: Patient Date of Birth | ≥95% |
| PID-11.5: Patient Zip | ≥95% |
| PV1-19: Visit Number | ≥95% |
| PV1-37: Discharged to Location | ≥95% |
| PV1-44: Admit Date/Time | ≥95% |
| PV1-45: Discharge Date/Time | ≥95% |
| PID-29: Patient Death Date/Time | ≥95% |
| PID-30: Patient Death Indicator | ≥95% |
| IN1-3: Insurance Company ID | ≥95% |
| IN1-4: Insurance Company Name | ≥95% |
| **Group B: complete mapping – MiHIN mapping tables must be kept current for the following fields. *** | **Threshold** |
| MSH-4.1: Sending Facility- Hospital OID | ≥95% |
| PV1-36: Discharge Disposition | ≥95% |
| PID-8: Patient Gender | ≥95% |
| PID-10: Patient Race | ≥95% |
| PID-22: Ethnic Group | ≥95% |
| PV1-2: Patient Class (e.g., observation bed) | ≥95% |
| PV1-4: Admission Type | ≥95% |
| PV1-14: Admit Source | ≥95% |
| DG1-6: Diagnosis Type | ≥95% |
| PV1-10: Hospital Service | ≥95% |
| **Group C: adherence to coding standards — values must be sent using the standard indicated below *** | **Threshold** |
| PV1-7.1: Attending Doctor ID (NPI) | ≥95% |
| PV1-17.1: Admitting Doctor ID (NPI) | ≥95% |
| DG1-3.1: Diagnosis Code ID (ICD10) | ≥95% |
| DG1-3.2: Diagnosis Code Description | ≥95% |

*Group B and C fields are both scored on population of at least 95% on the messages and mapped or correctly formatted.

**Measure 2: Common Key Service conformance thresholds – 2 points**

Hospitals will earn two points for populating ADT messages with the CKS attribute. The following table shows the CKS data fields and performance thresholds required for all ADT transmissions in 2020.

| Measure 2 – common key: conformance thresholds – 2 points | |
|---|---|
| **Group A: complete routing – messages populated with all the following fields** | **Threshold – percent of ADT messages populated** |
| PID-3.1: Unique Identifier (Common Key) | Q1 – CKS implementation<br>Q2- at least 25%<br>Q3- at least 50%<br>Q4- greater than 50% |
| PID-3.5: Identifier Type (identifier tag) | |

**Measure 3: exchange CCDA (previously medication reconciliation use case) – 4 points**

Hospitals will earn four points for maintaining CCDA data conformance for all inpatient, observation and ED visits. The following table shows the required CCDA data fields and performance thresholds required in 2020.

- There are several fields at the bottom of the table that do not have conformance thresholds in 2020. However, hospitals are expected to transmit these fields so the information can be analyzed for potential future conformance development.
- CCDA messages should be sent within 24 hours of visit.

| Measure 3 – exchange CCDA: conformance thresholds – 4 points | |
|---|---|
| **CCDA – med rec relevant fields** | **Complete routing threshold** |
| **OID – object identifier** | **≥95%** |
| Visit ID | ≥95% |
| Patient Date of Birth | ≥95% |
| Patient Gender | ≥95% |
| Patient SSN – when available | Not scored |
| Patient First Name | ≥95% |
| Patient Last Name | ≥95% |
| Patient Address | ≥95% |
| Patient City | ≥95% |
| Patient Zip Code | ≥95% |
| Encounter Type | ≥95% |
| Attending Provider First Name | ≥95% |
| Attending Provider Last Name | ≥95% |
| Attending Provider NPI | ≥95% |
| Attending Provider Phone | ≥95% |

| | |
|---|---|
| Admission Medications Present | ≥95% |
| Discharge Medication Name | ≥75% |
| Discharge Medication Begin Date | ≥75% |
| Discharge Medication Dose Unit | ≥75% |
| Discharge Medication Dose Quantity | ≥75% |
| Discharge Medication Instructions | ≥75% |
| Discharge Medication Code (RxNorm or NDC) | ≥75% |
| Allergies | ≥95% |
| Active Problems Present | ≥95% |
| Chief Complaint | ≥95% |
| Visit Diagnosis Code (ICD10) | ≥95% |
| Visit Diagnosis Description | ≥95% |
| Vital Signs | ≥95% |
| Immunizations | ≥50% |
| Results/Laboratory | ≥95% |
| Discharge Medication End Date | TBD |
| Discharge Medication Status | TBD |
| Advanced Directives | Not Scored |
| Discharge Instructions | Not Scored |
| Functional Status | Not Scored |
| Plan of Care | Not Scored |
| Procedures | Not Scored |
| Progress Notes | Not Scored |
| Reason for Referral | Not Scored |
| Social History | Not Scored |
| Tests Ordered | Not Scored |

**Measure 4: transmit all ambulatory CCDA data – 4 points**

Hospitals will earn four points by transmitting all ambulatory CCDA data for all patients. This includes outpatient hospitals visits and office visits to physicians sharing the hospital's EMR, both employed and non-employed. Because this is a new measure, there are no conformance thresholds. Instead, hospitals will be scored only on whether they transmit the data. However, the data will be analyzed with the intent of developing conformance standards for future program years.

The points for this measure will be earned as follows if accomplished by 2020-year end:

- 1 point: Sign MiHIN Exchange CCDA agreement
- 3 points: Begin sending all ambulatory CCDA

**Measure 5: participate in one or more HIE pilot projects – 3 points**

Hospitals will earn three points by participating in selected pilot projects in collaboration with PGIP organizations. For example, some hospitals will be selected to participate in a PGIP pilot whereby a patient's physician uses ADT notifications to engage the hospital ED and avert unnecessary inpatient admissions.

Hospitals selected to participate in a pilot will be given clear expectations in writing at the time they are invited to participate. Hospitals that decline to participate or do not meet expectations for the pilot will forfeit points allocated to Measure 5. If a hospital is not selected to participate in a pilot, the three points for this measure will be reallocated to measures 1, 2 and 3, as follows:

- Measure 1 (ADT conformance) will be reweighted at 3 points, with 0.75 points earned in each quarter.
- Measure 2 (CKS conformance) will be reweighted at 3 points, with 0.75 points earned in each quarter.
- Measure 3 (CCDA conformance) will be reweighted at 5 points, with 1.25 points earned in each quarter.

## MHA Keystone Center / Great Lakes Partners for Patients (GLPP) Hospital Improvement Innovation Network (HIIN)

**2020** Blue Cross' Pay for Performance program requirements
**Peer Groups 1 through 4**

| Table 1: Component | Weight |
|---|---|
| **Data submission:** outcome measures *(see the HIIN Encyclopedia of Measures)*<br>• Jan. through March 2020 (three final months of the GLPP HIIN) | 15% |
| **Engagement**: attend a 2020 MHA Keystone event from the following:<br>• MHA Quality & Safety Workshop or post-conf. session: April 16 and 17, 2020, Marquette<br>• HMS/MHA Sepsis Symposium: April 29, 2020, tentatively in Ann Arbor<br>• Sepsis Simulation Train the Trainer event (September 2020 date TBD, tentatively in Kalamazoo) | 25% |
| **Process improvement:** Participation in one Improvement Sprint program<br>(Falls **or** readmissions)<br>• Submission of the Process Improvement Discovery Tool by January 21<br>• Submission of Desired Performance Statement in Behavioral Terms by February 18<br>• Participation in at least one implementation consultation call between Jan 22 and Mar 31 | 40% |
| **Outcomes**: Sepsis Mortality — risk-adjusted performance for 2020<br>• Improvement **or** O/E ratio less than or equal to 1 | 20% |

| Table 2: component breakdown | Available |
|---|---|
| **Data submission — January through March 2020**<br>• At least 90% of outcome data submitted across three-month period<br>• 70% – 89% of all outcome data submitted across three-month period<br>• Less than 70% of all outcome data submitted across three-month period<br>(Hospitals will only be scored for the submission of outcome data they are eligible to collect. Please reference the HIIN Encyclopedia of Measures for a complete list of the required measures) | **15 points**<br>10 points<br>5 points |
| **Engagement — attend one of the three listed events for credit**<br>• **April 16 and 17, 2020**, MHA Quality & Safety Workshop, Marquette *(*can attend April 16 workshop **or** a April 17 post-conference session*)*<br>• **April 29, 2020**, HMS/MHA Sepsis Symposium, tentatively in Ann Arbor<br>• **September 2020***,* Sepsis Simulation Train the Trainer event*,* tentatively in Kalamazoo<br>Registration will open early for all three events. Choose which event you wish to attend early, as there are registration limits on some events. (If you cannot send a representative to any of the three events listed, please discuss with the MHA Keystone team asap) | **25 points** |

| | |
|---|---|
| **Process improvement — engage in one of the two Improvement Sprints (Falls or readmissions)**<br>(Select the area your facility demonstrates needing improvement – see GLPP HIIN dashboard)<br>• Submission of the Process Improvement Discovery Tool by **January 21**<br>• Submission of Desired Performance Statement in Behavioral Terms by **February 18**<br>• Participation in one implementation consultation call between **January 22 and March 31**<br><br>An Improvement Sprint is a practical process for focused work and rapid implementation; a simple way to learn new skills, build or change habits, and amplify impact by applying concentrated effort to generate improvement over a short period of time. Improvement Sprints provide guidance in policy development, address drift and help organizations get back on track, provide technical and educational resources, and support implementation of best practices around a given topic. Participants have an opportunity to share across their cohort, which provides a strong platform for rapid adoption and sustainability of best practices.<br><br>The Improvement Sprint is a three-month process which will include submission of the Process Discovery Tool, three learning webinars (Jan., Feb. and March (not required for P4P points)), submission of the Desired Performance Statement and participation in implementation consultation with process improvement experts through consultation calls.<br><br>**Process Improvement Discovery Tool**<br>The Process Improvement Discovery Tool is an assessment meant to help hospitals provide safer patient care to identify process improvement opportunities. Hospitals can use the results to develop specific strategies to address gaps and identify resource needs. The tool is to be completed on five to 10 patient charts.<br><br>**Desired Performance Statement in Behavioral Terms**<br>This tool is part of the Implementation Science program and helps individuals think through their current state, their desired state, the gaps that are currently present and what behavior change is needed to attain the desired goal. This tool will help hospitals develop an action plan based on the identified gaps found in the Process Discovery Tool.<br><br>**Implementation consultation calls** can be scheduled by clicking **https://go.oncehub.com/MHAKeystone***<br><br>*(see Sprint guide on the MHA Member Forum for documents and further details)* | **40 points** |
| **Outcomes — Sepsis**<br>Sepsis mortality improvement — risk-adjusted performance (observed to expected)<br>Baseline period: Q1 2019 through Q3 2019<br>Performance period: Q1 2020 through Q3 2020<br><br>Full points received for<br>• Improvement from baseline **or** a score of O/E of </= 1 | **20 points** |
| **Total possible points** | **100 points** |

*Blue Cross Blue Shield of Michigan and Blue Care Network doesn't own or control this website.