



Blue Cross Blue Shield of Michigan

2018 Hospital Pay-for-Performance Program

Peer Groups 1-4

November 2017



Table of Contents

Program Overview	3
What's New in 2018	3
Payment Methodology	4
Prequalifying Condition	5
Collaborative Quality Initiatives	6
Great Lakes Partners for Patients Hospital Improvement Innovation Network	7
CQI Performance Index	7
CQI Data Abstraction and Reporting Funding Support	8
Blue Cross-Supported	8
MHA-Sponsored	9
Payment Schedule	9
Hospital Cost Efficiency	9
Michigan Value Collaborative	10
2018 Measure Expectations	11
MVC Bonus Point	11
Timeline of the 2018 and 2019 MVC-based P4P Performance Measure	12
MVC Support for Hospitals	12
All-Cause Readmissions Domain	12
2018 P4P Readmission Rate Performance	13
Health Information Exchange	14
2018 Health Information Exchange Components	14
Performance Scoring Multiplier Methodology	16
Blue Cross-Sponsored Hospital CQI Programs	17
CQI Scoring Method	18
CQI Performance Index Scorecards	19
General Blue Cross CQI Participation Requirements	19
Hospital Cost Efficiency Calculations	21
Cost per case compared to Statewide Mean	21
Cost per case compared to a NHIPI-based Target Inflation Factor	22
Cost per case Expanded Measurement Period	22
Hospital MVC Calculations	24
Health Information Exchange Measures and Data Elements	26
Data Conformance Measures	26
ADT Conformance Thresholds and Performance Coding	27
Medication Reconciliation Measure No. 1b	29
Common Key Service	29
Exchange Statewide Lab Results	30
Hospital Improvement Innovation Network Scoring Index	31

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 2018, the program will pay hospitals, in aggregate, an additional 5 percent of statewide inpatient and outpatient operating payments – nearly \$190 million statewide.

The P4P program structure and measures are developed with input from hospitals via the Participating Hospital Agreement Incentive Committee. Hospital performance on most program measures is evaluated on a calendar-year basis and the P4P rate a hospital earns, based on its 2018 P4P program performance, will be applied to its inpatient and outpatient operating payments, effective July 1, 2019.

What's New in 2018

The 2018 P4P program year will closely follow the structure, performance measurement and incentive framework of the 2017 program year. The following table summarizes the 2018 P4P program structure:

2018 Program Components and Weights	
Prequalifying Condition	0%
Collaborative Quality Initiatives	40%
Hospital Cost Efficiency	10%
Michigan Value Collaborative	10%
All-Cause Readmissions Domain	30%
Health Information Exchange	10%

The amount of P4P incentive dedicated to readmission rate performance has increased to 30 percent of the program's overall incentive and the option to participate in alternative readmission measures has been retired. To support hospitals with the scoring increase, scoring methodology has been updated – a detailed explanation can be found in the All-Cause Readmission Domain section of the program guide.

Hospitals will continue to be eligible to have the opportunity to earn a fixed percent of the program's potential incentive for performance across MHA and CQI initiatives. The CQI domain will be capped at 40 percent, regardless of the number of participating initiatives. Hospitals eligible for and participating in more than ten CQIs will be scored using only the top 10 individual CQI performance scores, with preference given to Blue Cross-sponsored CQI programs.

All P4P participating hospitals must first meet a patient-safety prequalifying condition to be eligible to participate in and receive incentives for performance within the P4P program.

Similar to the 2017 program year, the MHA Keystone Center will no longer enroll hospitals into individual collaboratives. Instead, hospitals will have the opportunity to engage with the Great Lakes Partners for Patients Hospital Improvement Innovation Network, a two-year initiative sponsored by the Centers for Medicare & Medicaid Services, to address areas of patient harm and readmission reduction efforts. Hospital participation in the HIIN is **optional** in 2018 and will be weighted equivalent to **two** CQI programs – exact weights vary depending on total number of CQIs a hospital is participating in. Preference will continue to be given to Blue Cross-sponsored CQI programs for hospitals in 10 or more collaboratives.

With the re-introduction of the MVC program component, the Hospital Cost Efficiency and Health Information Exchange measures are each worth 10 percent of the program's potential incentive. Notable updates to the HIE component can be found in the HIE section of the program guide.

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 2018. P4P participating hospitals will also have the opportunity to request patient-level readmissions information to help assist readmission reduction efforts.

Payment Methodology

The 2018 P4P program maintains that the statewide *aggregate* P4P payout is equal to the full 5 percent value of the program. Although some hospitals will continue to earn a P4P rate less than 5 percent, some high-performing hospitals will earn P4P rates greater than 5 percent.¹

As introduced with the 2014 program year, the 2018 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.

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 the Blue Cross Participating Hospital Agreement, its payout is limited to 4 percent of its inpatient operating payment only. Non-model 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 via CEO attestation due by **March 31, 2019**.

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

1. Conduct regular patient safety walk-rounds 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

Collaborative Quality Initiatives

40%

As introduced in 2016, the 2018 P4P program will offer hospitals the opportunity to earn a fixed percent of the program’s potential incentive based upon its performance across Blue Cross-supported CQIs and MHA quality initiatives. The amount of incentive allocated to CQI performance (40 percent) will be equal for all hospitals regardless of the number of CQIs a hospital is eligible for.

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. Hospitals participating in fewer CQIs will have a greater portion of the program’s potential incentive allocated to performance on an individual initiative.

The below chart provides the potential program weight per CQI, depending on the number of initiatives chosen:

Number of Eligible/Participating CQIs	Overall Potential Incentive, CQI Domain	Potential Incentive per Blue Cross-sponsored 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%

In 2018, five of the Blue Cross-sponsored CQIs have been categorized as “required” CQIs (see Appendix B for a list of eligible CQIs). Similar to 2017, individual MHA Keystone collaboratives have been replaced by the Great Lakes Partners for Patients Hospital Improvement Innovation Network (see Page 7 for details).

If your hospital is eligible for participation in a “required” CQI and, at the time of enrollment, voluntarily elects not to participate, your hospital will forfeit the ability to earn the associated program weight and P4P incentive attributed to that CQI. This will only count against your hospital after it has been provided the opportunity to participate through an enrollment application process. If your hospital has not been recruited or is ineligible to participate in a “required” CQI, then it will not be penalized for non-participation. There will be no negative affect on its P4P score if a hospital is deemed ineligible, has not

been recruited for participation or has been recruited for and voluntarily elects not to participate in a “non-required” CQI.

Separate from P4P scoring, designation as a Blue Cross Blue Shield Association Blue Distinction Center will require participation in a related CQI program.²

To find out whether your hospital is eligible for a specific CQI and its potential affect on your hospital’s 2018 P4P score, contact the 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 2018, 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.

In 2018, hospital participation in the HIIN is **optional** and will be weighted equivalent to two CQI programs – exact weights vary depending on total number of CQIs a hospital is participating in. For hospitals participating in nine Blue Cross CQIs, the program weight assigned to the HIIN will be capped at 4 percent.

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. A HIIN Performance Index scorecard outlining measure requirements can be found in Appendix F.

Although enrollment in the HIIN closed on **Nov. 10, 2016**, hospitals that want to join for Blue Cross purposes may still do so. In addition, hospitals planning to participate in a HIIN other than the Great Lakes Partners for Patients may still be eligible for CQI points and should contact the MHA Keystone Center for more information at KeystoneP4P@mha.org.

CQI Performance Index

A hospital’s P4P score for each CQI is determined by its performance on specific measures related to that CQI. The measures and corresponding weights tied to each measure are referred to as the hospital’s CQI Performance Index scorecard. Each index consists of both performance and participation-based

² Designation as a Blue Cross Blue Shield Association Blue Distinction Center® requires participation in a related CQI. If your hospital is currently designated as a BDC and voluntarily elects not to participate in the corresponding CQI, it will lose its BDC status. A hospital’s BDC designation status will only come into question upon your hospital’s recruitment in the associated CQIs. Refer to appendix B for which CQIs are associated with BDC designation status.

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 2017. Our website is the following:

<http://www.Blue Cross.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 will provide participating hospitals with a mid-year scorecard to identify your performance progress as well as a final scorecard (distributed first quarter of the following year). Blue Cross is provided with a final aggregate score for each corresponding CQI that, will be used in your hospital's final P4P score calculations. An example of how the combined score is calculated is provided in Appendix B.

Specific questions regarding scoring 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 models for each CQI are developed by its respective coordinating center with review from 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.

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, 2018, to be eligible for this payment.

Hospitals in peer groups 1 and 2 aren't eligible for a 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 2018 CQI data abstraction funding as a lump-sum add-on to their Blue Cross interim payment, or BIP, during the second quarter of 2018. 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 officer, chief financial officer, and other stakeholders designated by the hospital will be notified via email when the payment is issued.

Hospital Cost Efficiency	10%
---------------------------------	------------

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 10 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 2018 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 \leq 25% of target	125%
Actual more than 25% but \leq 50% of target	90%
Actual more than 50% but \leq 75% of target	75%
Actual more than 75% but \leq 100% of target	62.5%
Actual more than 100% but \leq 125% of target	50%
Actual more than 125% but \leq 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 2018 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 non-acute 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 2018 program year (for P4P incentives beginning July 2019), the calculation will be made using cost data from 2015, 2016 and 2017, as follows:

- 2015 FYE costs and cases will be weighted at 15 percent
- 2016 FYE costs and cases will be weighted at 35 percent
- 2017 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. Established in 2013, 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 cost data to empower local quality improvement activities, many of which are tied to the quality initiatives in the Blue Cross CQIs. MVC data supplies condition-specific, price-standardized, and risk-adjusted 30- and 90-day total episode costs for Blue Cross PPO and Medicare fee-for-service claims. In the future, MVC reports will

include BCN and Medicaid claims data, but only Blue Cross PPO and Medicare fee-for-service data will be applied to the 2018 measure.

2018 Measure Expectations

In 2016, hospitals selected two service lines to be measured for performance in 2018 and 2019. However, before a hospital is eligible to earn points for the selected service lines, it must first meet the quality requirement, which stipulates its in-hospital mortality or related readmission rate for the selected service line is above the 10th percentile in the performance year.

Hospitals meeting the quality requirement can earn up to five points for reducing total episode costs 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 peer group, as shown in the following table:

Points Earned	Year-over-Year Improvement Baseline: Hospital service line total episode costs for the most recently available 12-month period	Absolute Achievement Baseline: MVC cohort group service line total episode costs for the most recently available 12-month period
1 Point	Baseline Mean	50 th Percentile
2 Points	Baseline Mean - (5% * Standard Deviation)	60 th Percentile
3 Points	Baseline Mean - (10% * Standard Deviation)	70 th Percentile
4 Points	Baseline Mean - (15% * Standard Deviation)	80 th Percentile
5 Points	Baseline Mean - (20% * Standard Deviation)	90 th Percentile

MVC Bonus Point

If a hospital doesn't earn full points for a service line, but its performance didn't decline from the baseline year, it may be eligible for a bonus point. The bonus point will be awarded if the aggregate episode cost of all hospitals selecting the same service line decreases by at least 5 percent. The purpose of the bonus point is to encourage hospitals to reduce costs through collaboration, rather than competition. However, the maximum points a hospital may receive for the MVC measure is 10, even if the hospital is eligible for the bonus point.

Refer to Appendix D for an example of the MVC score calculation. A detailed description of the 2018 and 2019 performance-based measure is also provided in the separate Background and Technical Document found on the bcbsm.com [P4P site](#).

Timeline of the 2018 and 2019 MVC-based P4P Performance Measure

The MVC performance measurement periods and associated analytic and incentive timelines are summarized in the following table:

	2018 P4P Program	2019 P4P Program
Baseline Period	CY 2015	CY 2016
Performance Period	CY 2017	CY 2018
Data Analysis/Claims Adjudication	CY 2018	CY 2019
Performance impacts incentives effective	July 1, 2019 through June 30, 2020	July 1, 2020 through June 30, 2021

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 and host semi-annual meetings to provide a venue for the sharing of best practices and additional insights.

All-Cause Readmissions Domain

30%

In 2018, 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.

Beginning in 2016, Blue Cross began a three-year transition to 30 percent readmission rate performance. The table below reflects the updated timeline of this transition:

	2016 P4P Program	2017 P4P Program	2018 P4P Program
Readmission Rate Performance	At least 10%	At least 15%	30%
Alternative Readmission Activities	Maximum 20%	Maximum 15%	0%
Baseline Period	CY 2015	CY 2016	CY 2017
Performance Period	CY 2016	CY 2017	CY 2018
Incentives Effective	7/1/2017	7/1/2018	7/1/2019

2018 P4P Readmission Rate Performance (30%)

To help promote hospital and physician collaboration across the care continuum and align measurement reporting and incentives with CMS requirements, the 2018 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.

2018 P4P readmissions performance is assessed using only Blue Cross commercial membership claims (PPO, POS and Traditional products for Michigan adult residents aged 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 2018 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 2017 baseline period and 2018 measurement period or **as each hospital's own confidence interval as compared to the Michigan P4P participating hospital statewide average**.

Readmission Scoring Methodology

New to the P4P 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 2018 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 vs. 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 2018CY 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

10%

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

Hospitals will earn a portion of their HIE points through continued data quality conformance standards for previously implemented use cases. The remaining points will be earned by participating in at least one new HIE use case through the MiHIN statewide service each new P4P program year.

2018 Health Information Exchange Components

Data Conformance – 5 Points	
Hospitals can earn up to five points for maintaining data quality standards for the ADT and Medication Reconciliation use cases. If a hospital isn't meeting data quality standards, it will be notified by Blue Cross and given 30 days to meet the standard. See Appendix E for specific conformance requirements.	
3 Points	<u>Measure 1a</u> : Maintain data quality conformance for specific aspects of ADT transmissions.
2 Points	<u>Measure 1b</u> : Maintain data quality conformance for specific aspects of discharge medication transmissions.
New Use Case – 5 points	
Hospitals can earn up to five points for implementing one new use case in 2018. See Appendix E for information on the specific implementation milestones and associated point allocations for each eligible use case.	
5 Points	Measure 2: Implement one of the new use cases from the following list: <ul style="list-style-type: none"> • Common Key Service • Exchange Statewide Lab Results

Hospitals will be given adequate notice to meet all conformance and use case expectations and due dates, and won't be penalized for delays caused by MiHIN's readiness to implement a specific activity.

As a reminder, the P4P incentive allocated to the HIE component is fixed at 10 percent of the overall program's incentive. Any unearned funds in the HIE component will be redistributed to hospitals using a normalized approach, providing a larger portion of unearned funds to higher performing hospitals.

Performance Scoring Multiplier Methodology

The below chart 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, \$2.6 million in this example, is then redistributed to hospitals via a scoring multiplier.

In years past, the total unearned incentive for the entire P4P program was distributed equally to all hospitals. However, the 2018 P4P uses a performance scoring multiplier introduced in 2014 that keeps unearned incentive dollars within each specific program measure and redistributes that amount to hospitals differentially, based on the normalized performance on each measure as compared to their peers. Additionally, the scoring measure takes into account the relative size of each hospital to ensure that the additional incentive received is proportionate to each hospital’s overall potential incentive.

Hospital Name	Collaborative Quality Initiatives (Fixed 40% of P4P Incentive)						
	Potential CQI Incentive (Fixed 40%)	CQI Performance	Earned CQI Incentive (Performance)	Unearned CQI Incentive	Normalized Performance	Additional CQI Incentive Earned	Total Earned CQI Incentive (\$, %*)
Hospital A	\$100,000	95%	\$95,000	\$5,000	0.8750	\$16,852	\$111,852 111.85%
Hospital B	\$250,000	80%	\$200,000	\$50,000	0.5000	\$24,074	\$224,074 89.63%
Hospital C	\$350,000	78.57%	\$275,000	\$75,000	0.4643	\$31,296	\$306,296 87.51%
Hospital D	\$500,000	100%	\$500,000	\$0	1.0000	\$96,296	\$596,296 119.26%
Hospital E	\$750,000	93.33%	\$700,000	\$50,000	0.8333	\$120,370	\$820,370 109.38%
Hospital F	\$800,000	91.25%	\$730,000	\$70,000	0.7813	\$120,370	\$850,370 106.30%
Hospital G	\$1,500,000	60%	\$900,000	\$600,000	0.0000	\$0	\$900,000 60%
Hospital H	\$2,250,000	88.89%	\$2,000,000	\$250,000	0.7222	\$312,963	\$2,312,963 102.80%
Hospital I	\$3,500,000	100%	\$3,500,000	\$0	1.0000	\$674,074	\$4,174,074 119.26%
Hospital J	\$10,000,000	85%	\$8,500,000	\$1,500,000	0.6250	\$1,203,704	\$9,703,704 97.04%
Total	\$20,000,000		\$17,400,000	\$2,600,000		\$2,600,000	\$20,000,000 100.00%

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.	No
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
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 that it has been recruited and is eligible for and the optional and the 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/ 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 2018 Pay-for-Performance Program guide in mid- to late-December 2017, 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 2018 P4P Program Guide.

General Blue Cross 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.

- Identification of "physician champions" at participating sites who can affect change, collaborate in generating data for enhanced knowledge and analysis of processes and outcomes of care
- Identification of 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:

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

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:

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

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:

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

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 \times 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:

$$\$103 \div \$240 = 43\%$$

Cost per case Expanded Measurement Period

In 2018, 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 2018 program year (P4P incentives effective July 2019 the calculation will be made using data from 2015, 2016 and 2017.
 - 2015 costs and cases will be weighted at 15 percent
 - 2016 costs and cases will be weighted at 35 percent
 - 2017 costs and cases will be weighted at 50 percent

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

$$\begin{array}{l} \text{2018 hospital} \\ \text{cost per case} = \end{array} \quad \frac{(0.15 \times 2015 \text{ costs}) + (0.35 \times 2016 \text{ costs}) + (0.50 \times 2017 \text{ costs})}{(0.15 \times 2015 \text{ cases}) + (0.35 \times 2016 \text{ cases}) + (0.50 \times 2017 \text{ cases})}$$

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 2018 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 2018 program year (P4P rate effective July 2019), the hospital-specific inflation targets will be calculated using the same rolling averages, as shown in the following formulas:

$$\begin{array}{l} \text{3-year weighted} \\ \text{target inflation} = \end{array} \frac{\begin{array}{l} (0.15 \times 2014 \text{ costs} \times 2014 \text{ NHIPI}) \\ + (0.35 \times 2015 \text{ costs} \times 2015 \text{ NHIPI}) \\ + (0.50 \times 2016 \text{ costs} \times 2016 \text{ NHIPI}) \end{array}}{(0.15 \times 2014 \text{ cases}) + (0.35 \times 2015 \text{ cases}) + (0.50 \times 2016 \text{ cases})}$$

Hospital MVC Calculations

Program years 2018 and 2019

The following is an illustration of how the scoring system will be applied for program year 2018 for a fictitious hospital (Hospital A) selecting joint replacement. All dollar amounts provided below are for illustrative purposes only.

In 2018, Hospital A meets the quality requirement by performing above the 10th percentile on the mortality and related readmission measure. Eligible service lines include (a minimum of 20 cases in the past 12 months of MVC data was required for service line eligibility):

Acute Myocardial Infarction	Joint Replacement (hip and knee episodes combined)
Congestive Heart Failure	
Pneumonia	Spine Surgery (labeled as “Other spine” on MVC registry)
Colectomy (non-cancer)	
Coronary Artery Bypass Graft	

Hospital A’s 30-day mean episode costs for joint replacement are outlined below:

Service line	Mean costs for baseline period	MVC Winsorized ⁴ Standard deviation based target for baseline period	Mean costs in 2018 performance period
Joint replacement	\$16,393	\$2,100	\$16,871

Hospital A’s 2018 cost *improvement* targets for joint replacement are calculated as follows (see Page 11 for the target cost reduction methodology):

2018 year over year improvement targets	Points
\$16,393	1
$\$16,393 - (0.05 \times \$2,100) = \$16,288$	2
$\$16,393 - (0.10 \times \$2,100) = \$16,183$	3
$\$16,393 - (0.15 \times \$2,100) = \$16,078$	4
$\$16,393 - (0.20 \times \$2,100) = \$15,973$	5

⁴ The utility of winsorization is to mitigate the effect of extreme outlier cases. Cases will be winsorized at the 99th percentile. For more information, please refer to the MVC Technical Document.

Because Hospital A’s mean episode cost for joint replacement in 2018 exceeds its baseline period targets, it doesn’t earn any points for year-over-year *improvement*. However, because Hospital A’s 2018 episode costs for joint replacement are well below its cohort’s average episode cost for joint replacement it’s eligible for *achievement* points.

	Mean costs for baseline period
Hospital A’s Cohort	\$19,202
Hospital A	\$16,871

2018 <i>achievement</i> targets	Points
\$19,202 (50th percentile)	1
\$18,883 (60th percentile)	2
\$18,378 (70th percentile)	3
\$17,502 (80th percentile)	4
\$16,792 (90th percentile)	5

Hospital A will earn 4 points for absolute *achievement* because its 2018 joint replacement costs are ranked between the 80th and 90th percentiles.

As stated on Page 11, a bonus point may be earned if all hospitals working on the same service line achieve a 5 percent 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 percent (data not shown). However, since Hospital A’s 2018 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.

For 2018, Hospital A will earn a total of 4 points for its joint replacement service line. Its 2018 pneumonia service line performance would be scored separately using the same methodology.

Health Information Exchange Measures and Data Elements

Data Conformance Measures

ADT Measure No. 1a

Maintain data quality conformance for specific aspects of ADT transmissions - 3 points

In 2018, the specific ADT quality conformance requirements are outlined in the tables below.

- Conformance will be scored using the red, yellow and green performance threshold levels established for each ADT data category.
 - A hospital is considered to be in full conformance with ADT data quality expectations if it maintains a green performance level *across all categories*.
 - A hospital is considered to be in partial conformance if it maintains a combination of green and yellow performance levels across all categories.
 - A hospital is considered to be out of conformance if it maintains a red performance level in one or more categories.
- If a hospital is notified by Blue Cross that it is not in full conformance, it must address the issue and regain conformance within 30 days of the notification.
- Hospital conformance will be scored on a quarterly basis with up to .75 point earned each quarter (1Q-4Q 2018).
 - A hospital will earn .75 point for each quarter in which it maintains full conformance, or regains full conformance within 30 days notification from Blue Cross.
 - A hospital will earn 0.25 point for each quarter in which it maintains partial conformance, or regains partial conformance within 30 days notification from Blue Cross.
 - A hospital will earn 0.00 points for each quarter in which it remains out of conformance within 30 days notification from Blue Cross.

ADT Conformance Thresholds and Performance Coding

The following tables list the data fields and performance thresholds required for all ADT notifications in 2018.

1. Complete Routing Data (population of fields)

Green	Yellow	Red
All 10 fields are populated at or above the relevant threshold	7 -9 fields are populated at or above the relevant threshold	Fewer than 7 fields are populated at or above the relevant threshold

Relevant Fields	Threshold
MSH-4: Sending Facility	≥95%
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%
PID-19: Patient SSN*	≥85%
PV1-19: Visit Number	≥95%
IN1-3: Insurance Company ID	≥90%
IN1-4: Insurance Company Name	≥90%
IN1-36: Policy Number	≥90%

*Social Security number for newborns and babies less than 6 months old can be coded using the hospital’s EMR’s default process. All others must have a valid Social Security number or be left blank.

ADT Conformance Thresholds and Performance Coding (continued)

2. Complete Mapping to Specified Value Sets*

Green	Yellow	Red
13 fields are mapped at or above the relevant threshold	7-12 fields are mapped at or above the relevant threshold	0-6 fields are mapped at or above the relevant threshold

Relevant Fields	Threshold
PID-8: Patient Sex	≥95% of populated messages
PID-10: Patient Race	≥95% of populated messages
PID-22: Ethnic Group	≥95% of populated messages
PV1-2: Patient Class	≥95% of populated messages
PV1-4: Admission Type	≥95% of populated messages
PV1-14: Admit Source	≥95% of populated messages
IN1-17: Insured’s Relationship to Patient	≥95% of populated messages
DG1-6: Diagnosis Type	≥95% of populated messages
IN1-3 & IN1-4: Insurance Company ID and Name	≥90% of populated messages
MSH-4: Sending Facility	≥95% of populated messages
PV1-10: Hospital Service	≥95% of populated messages
PV1-18: Patient Type	≥95% of populated messages
PV1-36: Discharge Disposition	≥95% of populated messages

*Fields must be populated at threshold and included in the mapping table.

3. Adherence to Coding Standards**

Green	Yellow	Red
Both coding groups have all fields at or above threshold	One of the coding groups has all fields at or above threshold	None of the coding groups has all fields at or above threshold

	Relevant Field	Threshold
Coding group 2	DG1-3.1: Diagnosis Code ID	≥95%
	DG1-3.2: Diagnosis Code Text	≥95%
	DG1-3.3: Diagnosis Code Name of Coding System	≥95%
Coding group 3	PV1-7: Attending Doctor ID	≥95%
	PV1-17 Admitting Doctor ID	≥95%

**Fields must be populated and populated correctly at 95 percent.

Medication Reconciliation Measure No. 1b**Maintain data quality conformance for specific aspects of Med Rec transmissions – 2 points**

In 2018, the focus for the Med Rec conformance measure is the discharge medication field included in each hospital's individual weekly conformance report.

- Conformance will be scored using the red, yellow and green performance threshold level of $\geq 85\%$ established for the discharge medication data category.
 - A hospital is considered to be in full conformance with MR data quality expectations if it maintains a green performance level.
 - A hospital is considered to be in partial conformance if it maintains a yellow performance level.
 - A hospital is considered to be out of conformance if it maintains a red performance level.
- If a hospital is notified by Blue Cross that it is not in full conformance, it must address the issue and regain conformance within 30 days of the notification.
- Hospital conformance will be scored on a quarterly basis with up to .50 points earned each quarter (1Q-4Q 2018).
 - A hospital will earn .50 point for each quarter in which it maintains full conformance, or regains full conformance within 30 days notification from Blue Cross.
 - A hospital will earn 0.15 point for each quarter in which it maintains partial conformance, or regains partial conformance within 30 days notification from Blue Cross.
 - A hospital will earn 0.00 points for each quarter in which it remains out of conformance within 30 days notification from Blue Cross.

Measure No. 2**Common Key Service**

The Common Key Service is a unique patient attribute generated by MiHIN to increase the patient match rate for information passing through the statewide service. MiHIN will also pass the Common Key to each patient's caregivers, who will store the information and attach it to subsequent transmissions for that patient.

In addition to improving the rate and accuracy of patient matches by MiHIN, providers can use the Common Key to securely connect patient data from outside sources to the correct medical record within their own systems. This will foster effective data sharing across multiple organizations with disparate systems and nomenclature and improve the efficiency and accuracy of data exchange for all users, including hospitals, physician offices and other caregivers.

The CKS activities and associated P4P points are outlined in the following table:

Common Key Service	P4P Points
The following activities pertain to the full implementation of the Common Key Service:	
<ul style="list-style-type: none"> Actively working with MiHIN to onboard 	2
<ul style="list-style-type: none"> Fully implement use case 	5 (Full points)

Exchange Statewide Lab Results

Doctors, labs and other health care professionals have a critical need to easily exchange and access clinical lab data to help with clinical decision support, trending analyses, population health management, medication management and numerous other care activities. Lab results need to be presented in a timely manner and in a format that is usable and actionable so the recipients can deliver efficient and effective patient care. Timely, efficient electronic exchange of statewide lab results can positively influence the quality, efficiency and cost of health care.

The Exchange Statewide Lab Results Use Case enables the secure, electronic transfer of clinical lab data among trusted data sharing organizations to achieve this exchange. The exchange of lab data among providers has also been targeted by the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology for Meaningful Use Stage 1 and 2 requirements.

The ESLR implementation activities and associated P4P points are outlined in the following table:

Exchange Statewide Lab Results	P4P Points
The following activities pertain to the full implementation of the Exchange Statewide Lab Results:	
Actively working with MiHIN to onboard	2
Fully implement use case	5 (Full points)



A Voluntary Collaborative to Improve Quality and Save Lives

**MHA Keystone Center / Great Lakes Partners for Patients
Hospital Improvement Innovation Network**

2018 Blue Cross Pay for Performance Program Requirements

Peer Groups 1 – 4

Table 1: Component	Weight	Scoring Frequency	Reporting Timeframe
Data submission: Outcome Measures <i>(Please see the Encyclopedia Of Measures)</i>	30%	Monthly	Jan. – Sept. 2018
Performance: Improvement on ADE - Opioids, C. diff, Falls and Sepsis measures <i>(individual improvement from HIIN baselines)</i>	40%	Once	Varies by measure <i>(see Table 3)</i>
Storyboard/Poster: Safety Across the Board - Improvement activity project	30%	Once	Due by August 1, 2018 <i>(To be displayed at an MHA conference in the fall of 2018)</i>

Table 2: Component Description	Available Points
Data Submission <ul style="list-style-type: none"> At least 90% of outcome data submitted across 9-month period 70 – 89% of all outcome data submitted across 9-month period Less than 70% of all outcome data submitted across 9-month period <i>(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)</i>	30 points 15 points 10 points
Performance on outcomes for C. Diff, Falls, Sepsis and Opioid Adverse Drug Events <i>(see Table 3 for additional detail)</i> <ul style="list-style-type: none"> Improvement from HIIN baseline on 4 of 4 measures Improvement from HIIN baseline on 3 of 4 measures Improvement from HIIN baseline on 2 of 4 measures Improvement from HIIN baseline on 1 of 4 measures 	50 points <i>(10 bonus*)</i> 45 points <i>(5 bonus*)</i> 40 points (Full points) 15 points
Storyboard/Poster <i>(see Table 4 for additional detail)</i> Safety Across the Board Improvement Activity Project <ul style="list-style-type: none"> Identify an area of opportunity within the HIIN scope of work based on your data Develop and implement a plan to drive improvement and share results Create a storyboard to display your improvement activity (Storyboards must follow the template elements to receive the full 30 points <i>(see template)</i>) 	30 points
Total Possible Points	100 points*

**If bonus points are received from the Performance measures component they can be used toward either the Data Submission component or the Storyboard component. A maximum of 100 points can be obtained.*

Table 3: Performance Measures	HIIN Baseline	Performance Period – Final Score
Clostridium difficile (C. diff): Hospital onset C. diff (KDS-HIIN-CDIFF-1) <i>Or</i> C. diff SIR (KDS-HIIN-CDIFF-2)	Calendar Year 2015	Jan. – Sept. 2018 Jan. – June 2018
Falls with Injury: All documented patient falls with an injury level of minor or greater (KDS-HIIN-Falls-1)	<i>Returning HEN 2.0 Hospitals:</i> Q1 2016 <i>New GLPP HIIN Hospitals:</i> Q4 2016	Jan. – Sept. 2018
Sepsis: Post-op Sepsis (KDS-HIIN-SEPSIS-1) <i>Or</i> Sepsis Mortality (KDS-HIIN-SEPSIS-2)	Q4 2015 – Q3 2016	Jan. – June 2018
Opioid Adverse Drug Events: Use of naloxone among inpatients receiving opioids (KDS-HIIN-ADE-4)	Q4 2016	Jan. – Sept. 2018

Hospitals will be scored on their own performance over time, and whether they are demonstrating improvement in rates from the designated (hospital-specific) baseline to the listed performance period. Baseline rates must be entered in order for performance measures to be scored. This aligns with how the MHA Keystone Center will track performance of hospitals in the HIIN for all measures. Hospitals that maintain rates in the top quartile among all participating hospitals will receive full points for improvement.

Table 4: Storyboard Improvement Activity
<p>Description/Questions to consider when developing your project:</p> <p>What are you doing to increase safety across the board?</p> <ul style="list-style-type: none"> • What type of harm are you trying to reduce and what is your improvement plan? • What are you doing to reduce your hospital's readmissions? • How are you trying to reduce health disparities in your community? • How are you engaging patients & families in your work? • How are you making your organization more highly reliable? • What activities are you doing to improve your hospital's culture?
<p>General Guidelines</p> <ul style="list-style-type: none"> • Improvement activity should have started within the GLPP HIIN contract (Sept 2016 – Sept 2018) • Storyboard must be submitted through the online template to receive the full 30 points. • Hospitals must individually submit their unique storyboards by August 1, 2018 for credit; system submissions will not be accepted. • MHA Keystone will display the storyboards electronically at the 2018 MHA Patient Safety & Quality Symposium on September 19, 2018 and the 2018 MHA Keystone Fall Workshop on October 23, 2018. • Attendance at either workshop is not required.

Along with the posters being displayed at the 2018 MHA Keystone Fall Workshop, several hospital teams will have an opportunity to present their storyboard during the workshop. Chosen hospitals will be provided 10-15 minutes to discuss their work and process with attendees.

General HIIN Participation Requirements:

- Participation in HIIN-wide quality improvement activities and/or site-specific or targeted activities (such as Improvement Action Networks (IANs), Regional learning sessions (RLS), Simulation events, Safe Tables, or Site Visits (Maximum requests = 4 per year) related to achieving the aims of the HIIN (20% reduction in all-cause harm and 12% reduction in preventable readmissions over a two-year period) is strongly encouraged, however attendance does not affect your P4P scores.