Hospital Quality Program
Evaluation & Scoring Methodology
December 20, 2013
DISCLAIMER

The following content represents the Evaluation and Scoring Approach Appendix of the 2014 Hospital Quality Program. The reader is advised to review the content in context of the Hospital Quality Program Policy Manual.
Introduction to the Hospital Quality Program (HQP)

Program Introduction:

The Hospital Quality Program (HQP) is BCBSNC’s third generation quality program for acute care hospitals to improve care outcomes. The HQP program will measure hospital performance using a standard set of quality measures in a collaborative manner with the hospital community.

What is Different?

The new program expands and standardizes the quality measurement set, and emphasizes the collaborative nature of hospital engagement going forward.

- **Focus** – value for the consumer/patient
- **Program design** – uses a scorecard, more holistic measurement categories, standardized measures, collaborative approach to improve care outcomes and aligns reimbursement increase to quality
- **Measurement approach** – more structured, transparent and comprehensive (absolute and relative to peers)
- **Hospital engagement** – ongoing, consultative, promotes peer-to-peer learning and knowledge sharing
Program Design Highlights

1. Aligns with the IHI’s (Institute for Healthcare Improvement) “Triple Aim” initiative, which pursues health system performance improvement along 3 dimensions of: improving the patient experience (including quality and satisfaction), improving health outcomes, and reducing the cost of care.

2. Developed and implemented in collaboration with the NC hospital community:
   • Guided by a Hospital Quality Advisory Group comprised of select hospital CMOs and hospital executives of Quality and Medical Affairs
   • Input and cooperation from the NC Quality Center and various individual NC hospitals

3. Introduces an updated Quality scorecard using a standard set of quality measures in an easy to understand format to be utilized in a consistent manner across hospitals.

4. Quality measurement categories:
   A. Leadership commitment to quality
   B. Improve health outcomes
   C. Lower costs
   D. Improve patient experience

5. Encourages hospitals to:
   • Improve or sustain high performance Year-over-Year
   • Achieve performance relative to peers
   • Share knowledge with peers
# 2014 Hospital Quality Program Measures

## A. Leadership Commitment to Quality

1. **Board or Executive-level Accountability for Quality**:
   - Examples of quality programs:
     - NCHA “Just Culture” or other Clinical Collaboratives
     - IHI “Getting Boards on Board”
     - AHA “Center for Governance Quality”
     - ACS-NSQIP
     - AHRQ Patient Safety Culture

2. **Commitment to Patient-Centered Care**: (if applicable)
   - PCMH/PCSP designation application
   - PCMH/PCSP designation achievement

## B. Improve Health Outcomes

1. **Outcome Measures**
   - 30-day risk-standardized mortality rates
     - Pneumonia
     - Acute Myocardial Infarction
     - Heart Failure
   - AHRQ Patient Safety Indicators
     - Death among surgical inpatients with serious treatable complications (PSI 04)

2. **Obstetrics Outcome Measures**:
   - Primary C-section Rate (for information only)
   - Elective Delivery Prior to 39 Wks Rate

3. **Infection Prevention Measures**:
   - CLABSI Rate
   - CAUTI Rate
   - SSI for Abdominal Hysterectomy Rate
   - SSI for Colon Surgery Rate

4. **Outpatient Measures**:
   - Select HEDIS Measures

## C. Lower Costs

1. All Cause 30-Day Unplanned Readmission Rate
2. All Cause 30-Day Observation Unit Readmission Rate (for information only)

## D. Improve Patient Experience

**HCAHPS Measures**:
- Ten HCAHPS measures displayed on Hospital Compare
Objective of Evaluating and Scoring Quality

Objective:

The objective of measuring and scoring hospital quality data is to help hospitals improve care quality by obtaining insight into performance and sharing information back with the individual hospital.
Approach to Evaluating and Scoring Quality

**Data Collection**
- Hospital quality results for the measurement period are collected and compiled.

**Data Analysis**
- When possible results for each quality measure are analyzed at two levels –
  1. Improving or sustaining performance over time, which includes achieving quality goals set at the beginning of the performance period.
  2. Monitoring performance relative to peers (such as statewide averages or peer percentile performance).

**Data Scoring**
- Results on each quality measure are assigned a score. Scoring is done based on absolute level of performance.
- Scores on the quality measures are aggregated at the four category levels in the scorecard – Leadership Commitment to Quality, Improve Outcomes, Lower Costs, and Improve Patient Experience.
- Pre-determined weights are applied to each Category Score to determine a Weighted Category score.
- Four Weighted Category scores are summed up to determine an overall quality score for the individual hospital for the measurement period.

**Data Reporting**
- Hospitals receive their data in an easy to understand format on a regular basis.
- BCBSNC to discuss the quality results and next steps with the HQP enrolled hospital.
Overall Scoring Notes:

Notable items:

1. Quality measures earn a score based on absolute performance. Relative performance to peers may be provided for information only. The scores earned on the quality measures sum up to a Quality Category Score.

2. Each Quality Category can earn up to 100 Points. Each of the 4 Quality Categories are assigned a weight as follows:
   A. Leadership commitment to quality – 10% weight
   B. Improve health outcomes – 60%
   C. Lower costs – 20%
   D. Improve patient experience – 10%

3. The Total Hospital Quality Score is a sum of the 4 Weighted Quality Category Scores.

4. A subset of quality measures are designated for information sharing only (by BCBSNC to hospitals or vice-versa) i.e. these measures will not be used for performance evaluation.

5. If a certain quality measure is not applicable to the hospital, the points for that particular measure will be redistributed to other quality measures within the same category.
A. Leadership Commitment to Quality

Description:
Hospital quality measurement category that demonstrates the commitment of hospital leadership to quality. Commitment to quality is demonstrated by active engagement in quality improvement, supporting and/or dedicating resources to national, state, local quality collaboratives and learning networks.

Requirement:
1. **Board/Executive-level commitment to quality** – Hospitals must demonstrate leadership commitment to quality. Commitment may be demonstrated by participating in at least one external quality program. Examples of programs:
   - NCQC Clinical Collaboratives or Learning Networks, e.g. “Just Culture”
   - IHI “Getting Boards on Board”
   - AHA “Center for Governance Quality”
   - ACS-NSQIP
   - AHRQ Patient Safety Culture

2. **Commitment to Patient-Centered Care** – Hospitals that own primary and specialty care clinics must participate in the Commitment to Patient-Centered Care program.

Scoring Menu:
Category earns a maximum of 100 Points.
Scorecard Weight Allocation – 10%.
Points Distribution –
1. **Board/Executive-level accountability for quality** – 50 Points
   A. Leadership External Program Participation – 50 Points

2. **Commitment to Patient-Centered Care** (if applicable) – 50 Points
   A. PCMH/PCSP Designation Application Submission – 25 Points
   B. PCMH/PCSP Designation Achievement – 25 Points
A. Leadership Commitment > 1. Leadership Program

1. Board/Executive-level Accountability –

A. External Program Participation (any 1): 50 Points

Program Examples:


• Participation in a NCHA Clinical Collaborative or Learning Network. More information at http://www.ncqualitycenter.org/engage-providers/collaboratives-learning-networks

• Other notable and recognized quality leadership programs (needs prior-approval)
External Program Participation Guidelines: *What constitutes “active participation”?*

1. Written notification for participation in the select program (email).

2. Fulfill the program enrollment, participation and curriculum requirements in spirit. Representative activities may include:
   - Attend program webinars, conferences, work sessions, etc.
   - Complete assignments, other curriculum deliverables.
   - Apply learning to set up a clinical program, or develop an action plan to, (as may be the case) at your hospital and provide a statement of compliance to program coordinator.
   - Collect, validate and submit relevant data to NCQC or other entity (e.g. CDC, NSQIP, etc) as required by the program.
   - Engage in performance improvement activity, e.g. meet regularly with quality staff and department heads to share learnings and best practices; review reports and address any issues, participate in program benchmarking, develop and implement the improvement plan, etc.
   - Present quality program activity/results to hospital leadership, internal/external forums, etc.
A. Leadership Commitment > 2. Patient-Centered Care

2. Commitment to Patient-Centered Care: 50 Points

<table>
<thead>
<tr>
<th>A. Apply for PCMH/PCSP Designation – 25 pts</th>
<th>B. Achieve PCMH/PCSP Designation – 25 pts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Incent and reward health systems that own practices to apply for PCMH or PCSP designation.</td>
<td>Incent and reward health systems that own practices to achieve PCMH or PCSP designation.</td>
</tr>
<tr>
<td><strong>Criteria:</strong> Apply for PCMH/PCSP designation for a set number of practices for the performance time period.</td>
<td>Achieve PCMH/PCSP designation for a set number of practices for the performance time period.</td>
</tr>
<tr>
<td><strong>Requirement:</strong></td>
<td>• Applicable hospitals to self report the PCMH designation and provide a copy of the NCQA or JCAHO confirmation for each practice</td>
</tr>
<tr>
<td>• Applicable hospitals to determine the number of practices planning to submit applications for the period</td>
<td>• Utilize available resources, e.g. <a href="http://www.ahecqualitysource.com/">http://www.ahecqualitysource.com/</a></td>
</tr>
<tr>
<td>• Hospital to self report the application submission and provide a copy of NCQA or JCAHO submission confirmation for each practice</td>
<td></td>
</tr>
<tr>
<td>• Utilize available resources, e.g. <a href="http://www.ahecqualitysource.com/">http://www.ahecqualitysource.com/</a></td>
<td></td>
</tr>
<tr>
<td><strong>Measurement:</strong></td>
<td>• Maximum 25 points</td>
</tr>
<tr>
<td>• Maximum 25 points</td>
<td>• Points awarded for PCMH/PCSP designation for the set number of practices for the performance time period.</td>
</tr>
<tr>
<td>• Points awarded for PCMH/PCSP application submission for the set number of practices for the performance time period.</td>
<td>• For entities that have a mix of practices applying for and achieving designation, a total maximum of 50 points will be available</td>
</tr>
</tbody>
</table>
B. Improve Health Outcomes

**Description:**
Hospital quality measurement category with a focus on improving care outcomes. Commitment to quality is demonstrated by the reporting of outcome data, sharing of knowledge/best practices, and implementing performance improvements.

**Requirement:**
Hospitals must report outcome measures under the following:
1. Care Outcomes
2. Obstetrics Outcomes
3. Infection Prevention Outcomes
4. Outpatient Measures: Select HEDIS Measures (if applicable)

Category earns a maximum of 100 Points
Allocated a 60% weight on the performance scorecard

**Measures Menu:**
Point distribution -
1. **Care Outcome Measures:** 20 Points
   A. Pneumonia 30-day risk-standardized mortality rate
   B. Acute Myocardial Infarction 30-day risk-standardized mortality rate
   C. Heart Failure 30-day risk-standardized mortality rate
   D. Mortality of surgical inpatients with serious treatable complications (AHRQ PSI-04)
2. **Obstetrics:** 20 Points
   A. Rate of Primary C-Sections (for information only)
   B. Rate of Elective Delivery prior to 39 Weeks
3. **Infection Prevention:** 30 Points
   A. Rate of CLABSI
   B. Rate of CAUTI
   C. Rate of SSI for Abdominal Hysterectomy
   D. Rate of SSI for Colon Surgery
4. **Outpatient (if applicable):** 30 Points
   A. Select HEDIS Measures
### B. Improve Health Outcomes > 1. Care Outcomes

#### 1. Care Outcome Measures: (20 Points)

**A. Pneumonia 30 Day Risk-Standardized Mortality Rate – 5 points**

**Description:**
30-Day Risk Adjusted Mortality Rate for Pneumonia – This measure estimates a hospital-level, risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients discharged from the hospital with a principal diagnosis of pneumonia. This is a CMS only measure.

**Calculation:**
- Numerator: ratio of the number of "predicted" deaths to the number of "expected" deaths, multiplied by the national unadjusted mortality rate. The "numerator" of the ratio component is the number of deaths within 30 days predicted on the basis of the hospital's performance with its observed case mix.
- Denominator: Number of admissions with a principal discharge diagnosis of pneumonia.
- For exclusions and details refer to CMS Hospital Compare.

**Requirement:**
- Measure is evaluated for performance
- CMS only measure.
- Data source: CMS Hospital Compare [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html) or self-reported by hospital if hospital chooses

**Measurement:**
- Maximum 5 points
- Points based on CMS Hospital Compare data at time of evaluation:
  - 0 points: Hospital’s rate = Worse than US National Rate
  - 3 points: Hospital’s rate = No different than the US National Rate
  - 5 points: Hospital’s rate = Better than the US National Rate
  - NA: Hospital did not have enough cases to reliably tell how well they are performing (Points will be equally redistributed to other measures in this category)
B. Improve Health Outcomes > 1. Care Outcomes

1. Care Outcome Measures: (20 Points)

B. Acute Myocardial Infarction 30-Day Risk-Standardized Mortality Rate – 5 points

Description: 30-Day Risk Adjusted Mortality Rate for acute myocardial infarction (AMI) – This measure estimates a hospital-level, risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients discharged from the hospital with a principal diagnosis of AMI. This is a CMS only measure.

Calculation: • Numerator: ratio of the number of "predicted" deaths to the number of "expected" deaths, multiplied by the national unadjusted mortality rate. The "numerator" of the ratio component is the number of deaths within 30 days predicted on the basis of the hospital's performance with its observed case mix.
• Denominator: Number of admissions with a principal discharge diagnosis of AMI.
• For exclusions and details refer to CMS Hospital Compare.

Requirement: • Measure is evaluated for performance
• CMS only measure.
• Data source: CMS Hospital Compare http://www.medicare.gov/hospitalcompare/search.html or self-reported by hospital if hospital chooses.

Measurement: • Maximum 5 points
• Points based on CMS Hospital Compare data at time of evaluation:
  • 0 points: Hospital’s rate = Worse than US National Rate
  • 3 points: Hospital’s rate = No different than the US National Rate
  • 5 points: Hospital’s rate = Better than the US National Rate
  • NA: Hospital did not have enough cases to reliably tell how well they are performing (Points will be equally redistributed to other measures in this category)
B. Improve Health Outcomes > 1. Care Outcomes

1. Care Outcome Measures: (20 Points)

C. Heart Failure 30-Day Risk-Standardized Mortality Rate – 5 points

Description: 30-Day Risk Adjusted Mortality Rate for heart failure (HF) – This measure estimates a hospital-level, risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients discharged from the hospital with a principal diagnosis of HF. This is a CMS only measure.

Calculation:

- Numerator: Number of deaths among cases meeting the inclusion and exclusion rules for the denominator.
- Denominator: All discharges, age 18 years and older, with a principal diagnosis code of heart failure (HF).
- For exclusions and details refer to CMS Hospital Compare.

Requirement:

- Measure is evaluated for performance
- CMS only measure.
- Data source: CMS Hospital Compare [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html) or self-reported by hospital if hospital chooses.

Measurement:

- Maximum 5 points
- Points based on CMS Hospital Compare data at time of evaluation:
  - 0 points: Hospital’s rate = Worse than US National Rate
  - 3 points: Hospital’s rate = No different than the US National Rate
  - 5 points: Hospital’s rate = Better than the US National Rate
  - NA: Hospital did not have enough cases to reliably tell how well they are performing (Points will be equally redistributed to other measures in this category)
B. Improve Health Outcomes > 1. Care Outcomes

1. Care Outcome Measures: (20 Points)

D. Mortality of Surgical Inpatients with Serious Treatable Complications (PSI 04) – 5 Points

**Description:**
Mortality of Surgical Inpatients with Serious Treatable Complications - This measure estimates a hospital-level mortality rate per 1,000 surgical discharges, among patients ages 18 through 89 years of age or obstetric patients with serious treatable complications. The measures are risk adjusted to account for differences in hospital patients’ characteristics.

**Calculation:**
- Numerator: Number of deaths among cases meeting the inclusion and exclusion rules for the denominator.
- Denominator: or MDC 14 (pregnancy, childbirth, and puerperium) defined by specific DRGs or MS-DRGs and an ICD-9-CM code for an operating room procedure, principal procedure within 2 days of admission or admission type of elective (ATYPE=3) with potential complications of care listed in Death among Surgical definition (e.g., pneumonia, DVT/PE, sepsis, shock/cardiac arrest, or GI hemorrhage/acute ulcer).
- For exclusions and details refer to CMS Hospital Compare.

**Requirement:**
- Measure is evaluated for performance
- CMS only measure.
- Data source: CMS Hospital Compare [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html) or self-reported by hospital if hospital chooses.

**Measurement:**
- Maximum 5 points
- Points based on CMS Hospital Compare data at time of evaluation:
  - 0 points: Hospital’s rate = Worse than US National Rate
  - 3 points: Hospital’s rate = No different than the US National Rate
  - 5 points: Hospital’s rate = Better than the US National Rate
  - NA: Hospital did not have enough cases to reliably tell how well they are performing (Points will be equally redistributed to other measures in this category)
## B. Improve Health Outcomes > 2. Obstetrics (OB)

### 2. Obstetrics Outcomes: (20 Points)

<table>
<thead>
<tr>
<th><strong>A. Rate of Primary C-Sections</strong></th>
<th><strong>B. Rate of Elective Delivery prior to 39Wk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Low risk Primary C-section rates – the measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section (NQF 471)</td>
<td>This measure assesses patients with elective vaginal deliveries or elective cesarean sections at $\geq 37$ and $&lt; 39$ weeks of gestation completed (NQF 469)</td>
</tr>
<tr>
<td><strong>Calculation:</strong></td>
<td></td>
</tr>
<tr>
<td>• Numerator: Patients with cesarean sections with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for cesarean section.</td>
<td>• Numerator: Patients with elective deliveries with ICD-9-CM Principal Procedure Code or codes for a) medical induction of labor, and/or b) cesarean section while not in active labor or experiencing spontaneous rupture of membranes.</td>
</tr>
<tr>
<td>• Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation.</td>
<td>• Denominator: Patients delivering newborns with $\geq 37$ and $&lt; 39$ weeks of gestation completed.</td>
</tr>
<tr>
<td><strong>Requirement:</strong></td>
<td></td>
</tr>
<tr>
<td>• Applies to hospitals with OB service</td>
<td>• Measure is evaluated for performance</td>
</tr>
<tr>
<td>• For information only; not evaluated</td>
<td>• Hospital to self-report to BCBSNC</td>
</tr>
<tr>
<td>• BCBSNC to report measure to Hospital</td>
<td>• BCBSNC patients only</td>
</tr>
<tr>
<td>• All Payer data</td>
<td>• Maximum 20 points</td>
</tr>
<tr>
<td><strong>Measurement:</strong></td>
<td><strong>Results to Plan:</strong></td>
</tr>
<tr>
<td>• Information only</td>
<td>• 0 points: If rate equal or greater than 10%</td>
</tr>
<tr>
<td></td>
<td>• 10 points: If rate is between 0 and 10%</td>
</tr>
<tr>
<td></td>
<td>• 20 points: If rate = 0</td>
</tr>
</tbody>
</table>
B. Improve Health Outcomes > 3. Infection Prevention

3. Infection Prevention: (30 Points)

<table>
<thead>
<tr>
<th>A. Rate of CLABSI – 8 points</th>
<th>B. Rate of CAUTI – 8 points</th>
</tr>
</thead>
</table>

**Description:** Measures the healthcare associated infection incidence in the form of the Rate of Device-associated Infections in the hospital ICU setting only (to be expanded to the hospital-wide setting in the future). ICU aggregate rates as reported to CDC NHSN. Measures include:
- Central line-associated bloodstream infection (CLABSI)
- Catheter-associated urinary tract infection (CAUTI)

**Calculation:**
- Aggregate rates as reported as Infection / Device Days X 1000.
- Aggregate rates as reported as Infection / Device Days X 1000.

**Requirement:**
- Measure is evaluated for performance
- CMS data only.
- Data source: CMS Hospital Compare [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html)
- Same as CLABSI

**Measurement:**
- Maximum 8 points each for CLABSI and CAUTI infection incidence rates
- Points based on CMS Hospital Compare data at time of evaluation:
  - 0 points: Hospital rate = Worse than U.S. National Benchmark
  - 4 points: Hospital rate = No different than U.S. National Benchmark
  - 8 points: Hospital rate = Better than the U.S. National Benchmark
  - NA: A comparison to similarly-sized hospitals was not conducted (Points will be equally redistributed to other measures in this category)
B. Improve Health Outcomes > 3. Infection Prevention

### 3. Infection Prevention: (30 Points)

| Description: | Rate of surgical site infections reported by the NC DHHS and CDC NHSN. Infection symptoms include: redness and pain around the area of surgery, drainage of cloudy fluid from the surgical wound, and fever. Covered procedures include:  
|              | • Abdominal Hysterectomy  
|              | • Colon Surgery |
| Calculation: | • Numerator: Patients who have had the surgical procedure followed by infection in the part of the body where the surgery took place.  
|              | • Denominator: All patients with the surgical procedure code. |
| Requirement: | • Measure is evaluated for performance  
|              | • All Payer data  
|              | • Data source: CMS Hospital Compare  
|              | [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html) or self-reported by hospital if hospital chooses |
| Measurement: | • Maximum 8 points each for Hysterectomy and Colon Surgery SSI infection rates  
|              | • Points based on CMS Hospital Compare data at time of evaluation:  
|              | • 0 points: Hospital rate = lower than similarly-sized hospitals  
|              | • 4 points: Hospital rate = No different than similarly-sized hospitals  
|              | • 8 points: Hospital rate = higher than similarly-sized hospitals  
|              | • NA: A comparison to similarly-sized hospitals was not conducted (Points will be equally redistributed to other measures in this category) |

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C. SSI Rate Abd. Hysterectomy – 7 points

D. SSI Rate Colon Surgery – 7 points
B. Improve Health Outcomes > 4. Outpatient

4. Outpatient Measures (If Applicable) : Select HEDIS measures (30 Points)

A. Select 5 HEDIS Measures - 6 points each, Total of 30 points possible

Description: The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). By focusing on key dimensions of care and service, HEDIS assists providers in streamlining comprehensive, quality care that generates better health outcomes.

Requirement: • Required for Hospitals that own Primary Care clinics (as applicable)
  • Identify the Primary Care Clinics for performance evaluation (Select approximately 25% of the practices in your network)
  • Identify the 5 HEDIS measures for performance evaluation (The 5 HEDIS measures will be applicable to all selected Primary care clinics)
  • Hospitals self-report HEDIS results along with supporting patient documentation using the approved scorecard and database format

Measurement: Maximum 6 points per HEDIS measure based on performance results**
  • 6 points: HEDIS measure performance = 90th percentile or greater
  • 4 points: HEDIS measure performance = 75th percentile or greater
  • 2 points: HEDIS measure performance = 50th percentile or greater
  • 0 points: HEDIS measure performance = less than 50th percentile

*See Appendix for the menu of HEDIS measures and format for reporting HEDIS results
** HEDIS measure results evaluated using NCQA Quality Compass tool for the South Atlantic Region
C. Lower Cost

Description:
Hospital quality measurement category with a focus on lowering the cost of care to the customer. The lowering of cost initiative aligns with the IHI objective of reducing the per-capita cost of health care and BCBSNC’s desire to enhance the value of the healthcare dollar for the paying customer (individuals and groups).

Requirement:
- Data Source - BCBSNC Claims data (Exclusions: Federal, Medicare, Blue Card Host and all ancillary products)
- **Readmission Rate** will be evaluated for performance;
- **Observation Unit Readmission** will be monitored but not used in the evaluation (information only)
  - Category earns a maximum of 100 Points;
  - Allocated a 20% weight on the performance scorecard

Measures Menu:
A. All Cause 30-Day Unplanned Readmission Rate (100 Points)
B. All Cause 30-Day Unplanned Readmission to Observation Unit (0 Points – information only)
## C. Lower Cost

### 1. Readmission Management: (100 Points)

<table>
<thead>
<tr>
<th>Description</th>
<th>A. Unplan. Readmission Rate – 100 points</th>
<th>B. Obs. Unit Readmission Rate – 0 points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
<td>All Cause 30-Day Unplanned Readmission Rate. Measure is used to assess the number of acute inpatient stays during the measurement period that were followed by an acute unplanned readmission for any diagnosis within 30 days.</td>
<td>This measure assesses the number of Observation Unit stays during the measurement period that were preceded by an acute inpatient discharge for any diagnosis within 30 days.</td>
</tr>
</tbody>
</table>
| **Calculation:** | • Numerator: Count of 30-Day Readmissions  
  • Denominator: Count of Index hospital stays | • Numerator: Count of Observation Unit Stays with previous inpatient admission within past 30 days.  
  • Denominator: Count of Index Hospital Stays. |
| **Requirement:** | • Measure is evaluated for performance  
  • BCBSNC only member data excluding: Federal, Medicare, Blue Card Host and all ancillary products  
  • Source: BCBSNC claims data | • Measure is for information only  
  • BCBSNC only member data  
  • Source: BCBSNC claims data |
| **Measurement:** | • Maximum 100 points  
  • Results to Plan (100 points):  
    • 0 point: met less than 50% of target  
    • 40 points: equal or >50% but <90% of target  
    • 80 points: equal or >90% but <100% of target  
    • 100 points: 100% of target | • For information only; not evaluated for performance |
D. Improve Patient Experience

Description: Hospital quality category with a focus on improving the inpatient experience of care as determined by select CMS HCAHPS measures.

Requirement: • All measures are mandatory; all measures will be evaluated for performance
• Date source: CMS Hospital Compare [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html)
• CMS data only
• Note - Category earns a maximum of 100 Points;
• Allocated a 10% weight on the performance scorecard

Measures Menu: • HCAHPS Measures: 100 Points
  • All ten HCAHPS measures displayed on Hospital Compare (10 points each)
1. HCAHPS Survey Results: (100 Points)

**All ten HCAHPS Measures - 10 Points each**

**Description:**
The HCAHPS survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. The public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care.

**Calculation:**
Determined by CMS.

**Requirement:**
- Measures will be evaluated for performance
- CMS data only
- Source: CMS Hospital Compare or self-reported by hospital
- [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html)

**Measurement:**
- Maximum 10 points each
- Results to Plan:
  - 10 Points: IF score improvement of 5% or more (relative to the prior period) OR if the score is 5% or higher than the NC average
  - 5 points: IF improvement is less than 5% OR if the score is at or above the NC average
  - 0 Points: IF no improvement OR the score is below the NC average.
APPENDIX

HOSPITAL QUALITY PROGRAM
EVALUATION & SCORING METHODOLOGY
## HEDIS Menu of Measures:

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>Abbreviation</th>
<th>HEDIS Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appropriate Testing for Children with Pharyngitis</td>
<td>CWP</td>
<td>The % of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).</td>
</tr>
<tr>
<td>2. Appropriate Treatment for Children with URI</td>
<td>URI</td>
<td>The % of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription</td>
</tr>
</tbody>
</table>
| 3. Follow-Up Children Prescribed ADHD Medication Maintenance Phase | ADD2 | The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported (Initiation Phase & Continuation & Maintenance).  
• Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. |
| 4. Persistence of Beta Blocker Treatment After a Heart Attack | PBH | The % of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge |
| 5. Cholesterol-LDL-C Screening for Patients with Cardiovascular Conditions | CMC1 | The % of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), (CABG) or (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had an LDL-C screening during the measurement year. |
| 6. Childhood Immunizations (Combination 2) | CIS2 | The % of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), two H influenza type B (Hib), three hepatitis B, one chicken pox (VZV) vaccines by their second birthday. |
# HEDIS Menu of Measures:

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>Abbreviation</th>
<th>HEDIS Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Pharmacotherapy Management of COPD Exacerbation-- Bronchodilator Total</td>
<td>PCE1</td>
<td>The % of COPD exacerbations for members 40 and older who had an acute IP discharge or ED visit on or between 1/1-11/30 of the measurement year and who were dispensed a bronchodilator within 30 days of the event. Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.</td>
</tr>
<tr>
<td>8. Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>SPR</td>
<td>The % of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.</td>
</tr>
<tr>
<td>9. Diabetes Care - HbA1c Testing</td>
<td>CDC1</td>
<td>The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing</td>
</tr>
<tr>
<td>10. Diabetes Care – Poor HbA1c Control</td>
<td>CDC2</td>
<td>The % of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td>11. Diabetes Care - LDL-C Screening</td>
<td>CDC 5</td>
<td>The % of members 18–75 years of age with diabetes (type 1 and type 2) who had Eye exam (retinal) performed</td>
</tr>
<tr>
<td>12. Diabetes Care - Nephropathy Monitoring</td>
<td>CDC 8</td>
<td>The % of members 18–75 years of age with diabetes (type 1 and type 2) who had Medical attention for nephropathy</td>
</tr>
<tr>
<td>13. Diabetes Care - Eye Exams</td>
<td>CDC 5</td>
<td>The % of members 18–75 years of age with diabetes (type 1 and type 2) who had Eye exam (retinal) performed</td>
</tr>
<tr>
<td>14. Controlling High Blood Pressure</td>
<td>CBP</td>
<td>The % of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year. Use the Hybrid Method for this measure.</td>
</tr>
</tbody>
</table>
# HEDIS Reporting Template

## Health System/Hospital Information
- **Name:**
- **NPI:**
- **Address:**
- **Performance Period:**
  - Year 1:
  - Year 2:

## Primary Care Practice Information
- **Name:**
- **NPI:**
- **Address:**

## Outpatient HEDIS Performance Measures - Hospital Self Reported

<table>
<thead>
<tr>
<th>HEDIS Abbrev.</th>
<th>Measure Name</th>
<th>Measure Description</th>
<th>Year End Results</th>
<th># patients receiving services **</th>
<th># eligible patients***</th>
<th>HQP Points</th>
<th>Year End Results</th>
<th># patients receiving services**</th>
<th># eligible patients***</th>
<th>HQP Points</th>
<th>Total HQP Points</th>
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<td><strong>Hospital/Health System attests to the accuracy of the information and submits completed member data base provided in Appendix A</strong></td>
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<td>*<strong>All Lines of BCBSNC business. Minimum of 30 eligible patients required for each chosen HEDIS measure</strong></td>
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</table>
Appendix A

Please complete the following template for patients you are reporting on the Hospital Quality Program - HEDIS Measure worksheet. You may also submit the data elements below as a reportable extract from your electronic health record system.

<table>
<thead>
<tr>
<th>Subscriber ID Number</th>
<th>First Name</th>
<th>Last Name</th>
<th>DOB</th>
<th>Member Address</th>
<th>Servicing Provider Name</th>
<th>Servicing Provider NPI</th>
<th>Date of Service</th>
<th>Measure</th>
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