BlueCross BlueShield of North Carolina

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Hospital Quality Program Manual

For Hospitals and Health Systems

2014

Table of contents

1. Purpose of Document

The purpose of this Policy document is to describe Blue Cross Blue Shield of North Carolina's (BCBSNC) Hospital Quality Program (HQP or the "program"). The policy provides an overview of the Program including goals, objectives, guidelines and a brief snapshot of the quality measures included in the program. For details on the assessment and scoring of quality measures, refer to the HQP Scoring Methodology document.

BCBSNC will periodically update this manual. The most up to date version will be available on the Provider Portal under Quality Programs.

2. Program Context

BCBSNC is committed to improving the quality of healthcare delivered to North Carolinians in partnership with consumers, hospitals, physicians, state officials and other stakeholders. As part of our commitment to care quality and creating value for our customers, BCBSNC has enhanced the Hospital Quality Program (HQP) for acute care hospitals to focus on improving quality outcomes in the inpatient and outpatient setting.

3. Program Introduction

The Hospital Quality Program (HQP) is BCBSNC's quality program for acute care hospitals to improve quality outcomes. The HQP program will measure hospital performance using a set of industry-standard quality measures in a collaborative manner with the hospital community. The program is designed to align with the Institute for Healthcare Improvement's "Triple Aim" initiative, which pursues health system performance improvement along three dimensions: improving the patient experience (including quality and satisfaction), improving health outcomes, and reducing the cost of care.

HQP Goals, Objectives and Guidelines:

The overall goal of the HQP program is to provide BCBSNC customers with the highest value for their hospital care (i.e. best care outcomes at an optimal cost). BCBSNC believes that progress towards this goal can be made by a focus on three tactical objectives, at this time:

1. Partnering with hospitals to improve care outcomes, reduce care costs, and improve the patient experience.
2. Promote the sharing and adoption of information and clinical best practices among hospitals.
3. Promote transparency into hospital performance.

HQP program design was conducted in alignment with the above goals and objectives, and guided by a set of operating principles listed below:

1. **Promote a culture of trust, collaboration and openness** – design and administer the HQP in partnership with the hospital community.

2. **Engage hospitals on an ongoing, consultative basis to help enhance their performance on quality** – share claims-based insights with the hospital and promote hospital peer-to-peer learning and knowledge sharing as part of HQP.
3. **Reward high performing hospitals** – provide financial incentives by aligning reimbursement to hospital performance on the HQP scorecard.
4. **Administer HQP in a consistent, simple and transparent manner** – select outcome measures that are tied to value, accepted as industry standard, and do not pose an undue reporting burden on hospitals.
5. **Promote insight and transparency into hospital performance** – in the future, work with the hospital community and others to share appropriate quality data with employers and consumers.

4. The Quality Scorecard

HQP attempts to standardize how hospital quality is measured and assessed using a scorecard concept. The HQP scorecard was inspired by the IHI Triple Aim initiative and includes a set of industry-standard quality measures organized around four categories as described below.

HQP Quality Categories:

A. **Leadership Commitment to Quality**. Hospital quality measurement category that demonstrates the commitment of hospital leadership to quality. Commitment to quality is demonstrated by active engagement in quality improvement internally, supporting and/or dedicating resources to national, state, local quality collaboratives and learning networks
B. **Improve Health Outcomes**. 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.
C. **Lower Care Cost**. Hospital quality measurement category with a focus on lowering the cost of care to the customer or patient. The lowering of cost initiative aligns with the IHI objective of reducing the per-capita cost of health care and BCBSNC's goal to enhance the value of the hospital care dollar for the paying customer (individuals and groups).
D. **Improve Patient Experience**. Hospital quality category with a focus on improving the inpatient and outpatient experience of care.

5. Quality Measures in the Scorecard

Quality Measures Selection:

The selection of quality measures for the scorecard was a two step process.

First, an initial set of applicable quality measures were identified under each of the four HQP quality categories. The identification of these measures was conducted under the HQP Design Guiding Principles enumerated above. The following attributes were considered – the measure should focus on care outcome where possible, the measure is tied to value, the measure is nationally accepted as industry standard, and does not present an undue reporting burden on the hospital or BCBSNC.

Second, the initial set of quality measures were then shared with the North Carolina Quality Center and representatives of the Hospital Quality Advisory Committee, a panel of 10-12 hospital Chief Medical or Quality Officers. The measurement set was updated based on hospital feedback. BCBSNC plans to work with the North Carolina Quality Center and other quality organizations on the administration of the "Leadership Commitment to Quality" component of the hospital scorecard.

The following graphic outlines the 2014 HQP quality measures. For additional details such as definitions, scope, data sources, measurement and scoring approach, etc. refer to the **HQP Scoring Methodology document**.

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

6. Quality Measurement

Hospital performance on the quality measures will be evaluated and analyzed for performance improvement. A subset of these measures will be designated for reporting-only (BCBSNC to hospital or vice-versa), i.e. will not be used for performance evaluation. BCBSNC will work collaboratively with individual hospitals to set appropriate targets for each measure and the expectations associated with reporting and evaluation of results. Unless otherwise indicated, hospital performance evaluation, analysis and reporting will focus at the hospital facility-level (i.e. not at the health system level).

Data Collection

Depending on the quality measure, the hospital specific data for the measures will be collected in one of three ways: self-reporting by the hospital, sourced from public sources (such as CMS' Hospital Compare website or the North Carolina Department of Public Health), or generated using BCBSNC claims data. The data collection will feed the determination of the"baseline" and "performance"targets and periods. BCBSNC will work with the individual hospitals to collect the most timely and representative quality data.

Data Analysis

The objective of analyzing hospital quality data is to obtain insight into hospital performance, both absolute and relative, and sharing the information with the individual hospital to help improve care quality. Hospital data on quality will be 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).

Hospital performance on each quality measure will be evaluated on the basis of their "actual"performance relative to the quality goal set at the beginning of the performance period. Based on their performance, hospitals will obtain a score for each quality measure, which will be aggregated at the quality category level. Pre-determined weights will be applied to each quality category score, and the weighted score of each quality category will be added to come up with an overall score on the hospital scorecard. An overview of the hospital scorecard and the four quality categories are described in the Quality Scorecard section above. For details on how each quality measure will be assessed and scored is available in the HQP Scoring Methodology document.

Data Review/Reporting

Hospitals enrolled in HQP will receive their quality performance data on a periodic basis. The hospital will have the opportunity to discuss the quality results with BCBSNC.

BCBSNC will make a good faith effort to focus on the accuracy of data collection, analysis and reporting. In the event of disagreement over the results, BCBSNC will, in the spirit of collaboration, work with the hospital to rectify any errors. For intractable situations BCBSNC and the hospital will determine a mutually acceptable reconciliation path for resolution.

Review of Quality Measures

Collaboration with the hospital community is key to achieving the shared goals of care quality. The quality measures on the scorecard will be periodically reviewed and amended by a Hospital Quality Advisory Group comprised of hospital Chief Medical Officers, Chief Quality Officers or their representative. In general, BCBSNC anticipates that the quality categories in the hospital scorecard will likely remain consistent but the quality measures will evolve over time.

7. Support

Hospitals enrolled in HQP will receive their quality performance data (e.g. Readmission data)on a periodic basis. It is envisioned that the reports will help hospitals gain insight into their individual performance and performance relative to peers. Hospital quality committees could use the report findings as an input for internal quality improvement initiatives, re-engineer workflows, improve education, etc. To foster knowledge sharing and peer-to-peer collaboration, BCBSNC plans to support one or more of the following activities:

a) Steer hospitals to Clinical Collaboratives or Learning Networks supported by national/statewide quality organizations.
b) Sponsor/co-sponsor a Hospital Quality Symposium for hospitals to participate and share successes in quality.
c) Facilitate one-to-one hospital conversations for quality improvement based on mutual agreement and understanding.

8. Payment Connection

In this era of "value-based"reimbursement, a significant and growing number of hospitals in the BCBSNC hospital network have a quality-based pay-for-performance component in their contracts. BCBSNC anticipates that hospital performance data from this program may be utilized as the quality input during hospital contract discussions and in the development of other BCBSNC quality programs, such as Network Tiering, in the future.

Hospital Quality Program Policy

Appendix

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Contents:

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1. Summary of the 2014 Hospital Quality Program Categories and Quality Measures

The following table summarizes the 2014 HQP quality measures. For additional details such as definitions, scope, data sources, measurement and scoring approach, etc. refer to the **HQP Scoring Methodology document**.

Note: In the event that a quality measure is not applicable to the hospital – the points will be redistributed to other measures in the same category. The selected quality measures are not to be customized however the quality targets will be custom set in joint discussions between BCBSNC and the hospital.

	Quality Measurement Categories	Quality Measure or Program	Points Allocated	Measure Scored?	Applicable Hospital	Data Source	Notes, Inclusions & Exclusions
A	**Leadership Commitment to Quality (100 Points; 10% Weight)**						
1	Board or executive-level commitment to quality). Demonstrated by participation in at least one external quality program at the state or national level.	Program Examples: • NCQC Collaboratives or Learning Networks, e.g. "Just Culture" • AHRQ Patient Safety Culture • IHI "Getting Boards on Board" • AHA "Center for Governance Quality" • ACS-NSQIP	50	Yes	All Hospitals	Hospital self reported with verification from NCQC or relevant organization	
2	Commitment to Patient-Centered Care: (if applicable)	A. Submit PCMH/PCSP designation application for set number of practices (25 points). B. Achieve PCMH/PCSP designation for set number of practices (25 points).	50	Yes	Hospitals that own Primary or Specialty Care clinics	Hospital self reported with NCQA verification	If not applicable Points distributed to A1

	Quality Measurement Categories	Quality Measure or Program	Points Allocated	Measure Scored?	Applicable Hospital	Data Source	Notes, Inclusions & Exclusions
B	**Improving Health Outcomes (100 Points; 60% Weight)**						
1	30 Day Risk-Standardized Mortality Rates: (Total 20 Points)	A. Pneumonia	5	Yes	All hospitals	CMS Hospital Compare (or successor) http://www.medicare.gov/hospitalcompare/search.html or self-reported if hospital chooses	CMS Data only
		B. Acute Myocardial Infarction	5	Yes	All hospitals	Same as above	CMS Data only
		C. Heart Failure	5	Yes	All hospitals	Same as above	CMS Data only
		D. AHRQ PSI 04 Composite (Mortality of surgical inpatients with serious treatable complications)	5	Yes	All hospitals	Same as above	CMS Data only
2	OB Outcomes: (20 Points)	A. Rate of Primary Low-Risk C-sections (NQF 471)	0	No	Hospitals with Obstetric service	BCBSNC to share the information with hospital	All Payer Data
		B. Rate of Elective Delivery prior to 39 Weeks	20	Yes	Hospitals With Obstetric Services	Hospital self reported with BCBSNC validation. Target value to be zero	BCBSNC Data only. All lines of business.

	Quality Measurement Categories	Quality Measure or Program	Points Allocated	Measure Scored?	Applicable Hospital	Data Source	Notes, Inclusions & Exclusions
3	Infection Prevention Programs: (30 points)	A. Device Associated Infection Rates - CLABSI	8	Yes	All hospitals	CMS Hospital Compare (or successor) http://www.medicare.gov/hospitalcompare/search.html or self-reported if hospital chooses	CMS Data only
		B. Device Associated Infection Rates - CAUTI	8	Yes	All hospitals	Same as above	All Payer data. All lines of business.
		C. Surgical Site Infections Rate for Abdominal Hysterectomy	7	Yes	All hospitals	Same as above	All Payer data. All lines of business.
		D. Surgical Site Infections Rate for Abdominal Colon Surgery	7	Yes	All hospitals	Same as above	All Payer data. All lines of business.
4	Outpatient measures (if applicable): (Total 30 points)	A. Select any 5 HEDIS measures from the menu provided and submit HEDIS reporting	6 each; 30 Total	Yes	Hospitals that own Primary Care clinics	Hospital self reported (Using template provided) with BCBSNC validation. Benchmark: NCQA Quality compass results across all LOB's for the South Atlantic region	BCBSNC Data only. Hospitals must submit supportive patient data for HEDIS results as per Appendix 5.
C	**Lower Costs (100 Points; 20% Weight)**						
1	Readmission Management	A. All Cause 30-Day Unplanned Readmission Rate	100	Yes	All hospitals	BCBSNC claims data	BCBSNC to share the information with hospital. BCBSNC Data only. LOB exclusions: Federal, Medicare, Blue Card Host and all ancillary

	Quality Measurement Categories	Quality Measure or Program	Points Allocated	Measure Scored?	Applicable Hospital	Data Source	Notes, Inclusions & Exclusions
							products.
		B. Observation Unit Admission Rate within 30-Days of Inpatient Discharge	0	No	All hospitals	BCBSNC claims data	Same as 1A.
D	**Improving the Patient/Consumer Experience (100 Points; 10% Weight)**						
1	HCAHPS Measures (Total 100 points)	All 10 HCAHPS Measures displayed on Hospital Compare	10 each; 100 Total	Yes	All hospitals	CMS Hospital Compare (or successor) http://www.medicare.gov/hospitalcompare/search.html	CMS Data only

2. HEDIS Menu for the Hospital Quality Program

HEDIS Measure	Abbreviation	HEDIS Measure Description
1. Appropriate Testing for Children with Pharyngitis	CWP	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).
2. Appropriate Treatment for Children with URI	URI	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.
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 Measure	Abbreviation	HEDIS Measure Description
7. Pharmacotherapy Management of COPD Exacerbation-- Bronchodilator Total	PCE1	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.
8. Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	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.
9. Diabetes Care - HbA1c Testing	CDC1	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing
10. Diabetes Care – Poor HbA1c Control	CDC2	The % of members 18–75 years of age with diabetes (type 1 and type 2) who .• HbA1c poor control (>9.0%)
11. Diabetes Care - LDL-C Screening	CDC 5	The % of members 18–75 years of age with diabetes (type 1 and type 2) who • Eye exam (retinal) performed
12. Diabetes Care - Nephropathy Monitoring	CDC 8	The % of members 18–75 years of age with diabetes (type 1 and type 2) who had Medical attention for nephropathy
13. Diabetes Care - Eye Exams	CDC 5	The % of members 18–75 years of age with diabetes (type 1 and type 2) who • Eye exam (retinal) performed

3. HEDIS Measure Reporting Guidelines for the Hospital Quality Program

Guidelines

- **Required for all Health Systems/Hospitals that own Primary Care clinics**
- **Applicable Hospitals must choose 5 HEDIS measures for evaluation from the inventory of HEDIS measures (Tab2)**
    - 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 to self-report HEDIS results in the Workbook provided, one practice per tab (more tabs can be added)**
    - Provide supportive patient documentation as per format in Appendix 5

- **HEDIS measure performance results will be evaluated and scored as follows:**

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

** HEDIS measure results evaluated using the NCQA Quality Compass tool for the South Atlantic Region*

4. HEDIS Results Reporting Template for the Hospital Quality Program

Health System/Hospital Information		Primary Care Practice Information	
Name:		**Name:**	
NPI:		**NPI:**	
Address:		**Address:**	
Performance Period:			
Year 1:		**Year 2:**	

Outpatient HEDIS Performance Measures - Hospital Self Reported												
	HEDIS Abbrev.	Measure Name	Measure Description	Year End Results	# patients receiving services *	# eligible patients**	HQP Points	Year End Results	# patients receiving services*	# eligible patients**	HQP Points
				Year 1				Year 2			
1											
2											
3											
4											
5											
				Total HQP Points				Total HQP Points			

*Hospital/Health System attests to the accuracy of the information and submits completed member data base provided in Appendix A

**All Lines of BCBSNC business. Minimum of 30 eligible patients required for each chosen HEDIS measure

5. HEDIS Patients Reporting Template for the Hospital Quality Program

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

Subscriber ID Number	First Name	Last Name	DOB	Member Address	Servicing Provider Name	Servicing Provider NPI	Date of Service

6. Glossary of Terms and Acronyms

ACA-NSQIP *– American College of Surgeons/ National Surgical Quality Improvement Program*

AHA*- American Hospital Association*

AHRQ *– Agency for Healthcare Research and Quality*

CAUTI –*Catheter-associated urinary tract infection*

CLABSI – *Central line-associated bloodstream infection*

HCAHPS *- Hospital Consumer Assessment of Healthcare Providers and Systems. The first national, standardized, publicly reported survey of patients' perspectives of hospital care.*

HEDIS *- 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).*

IHI *– Institute for Healthcare Improvement*

Medicare Stars *- Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.*

NCQA –*National Committee for Quality Assurance, a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality*

NCQC *– North Carolina Quality Center*

PCMH/PCSP *– National Center for Quality (NCQA) recognition for Patient Centered Medical Home and Patient Centered Specialty Practice*