Cal Healthcare Compare Board of Directors Meeting

THURSDAY, MARCH 17, 2022

11:00AM PT

Proposed Agenda

- Welcome and Call to Order
- General Updates
- Cal Hospital Compare
- Cal Long Term Care Compare
- Business Plan & Formative Evaluation
- Wrap Up

Cal Healthcare Compare
Board of Directors Meeting Agenda
Thursday, March 17, 2022, 11:00am – 1:30pm PT

Webinar Information
Webinar link: https://zoom.us/j/4437895416 | Phone: 1-669-900-6833
Access code: Code: 443 789 5416 | Passcode: **cyno#**

Time	Agenda Item	Presenters
11:00-11:05 *5 min.*	Welcome and call to order - Approval of past meeting summary - General Updates o CLTCC website relaunch announcement	- **Ken Stuart** Board Chair
11:05-11:50 *45 min.*	Cal Hospital Compare - Website refresh - Patient Safety Honor Roll - Social Needs Index - Impact of COVID-19 pandemic	- **Mahil Senathirajah** Senior Director IBM Watson
11:50-12:35 *45 min.*	Cal Long Term Care Compare - Accomplishments to date - May '22 Data Update - Potential Additions to Website - Quality of Facility Domain - Nursing Home Honor Roll	- **Deb Bakerjian** Clinical Professor, UC Davis Health Co-PI CQC
12:35 –1:20 *45 min.*	Executive Session - Financial report - Results/Discussion of Formative Evaluation - Data vendor proposals for Cal Hospital Compare	- **Bruce Spurlock** Executive Director - **Alex Stack** Director
1:20– close	Adjourn – Next meeting: Tuesday, June 21st – The California Endowment, Oakland – 2022 Meeting Cadence	- **Ken Stuart** Board Chair

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Cal Hospital Compare & Cal Quality Care
Board of Directors Meeting Summary
Wednesday, December 1, 2021, 10:00am PT

Attendees: Gretchen Alkema Ash Amarnath, Debra Bakerjian, Richele Benevent, Kristen Bettega, Gordon Blasco, Jamie Chan, Tracy Fisk, Terry Hill, David Hopkins, Libby Hoy, Chris Krawczyk, Julia Logan, Helen Macfie, Joan Maxwell, Gary Pickens, Dominique Ritley, Patrick Romano, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Kristof Stremikis, Kevin Worth

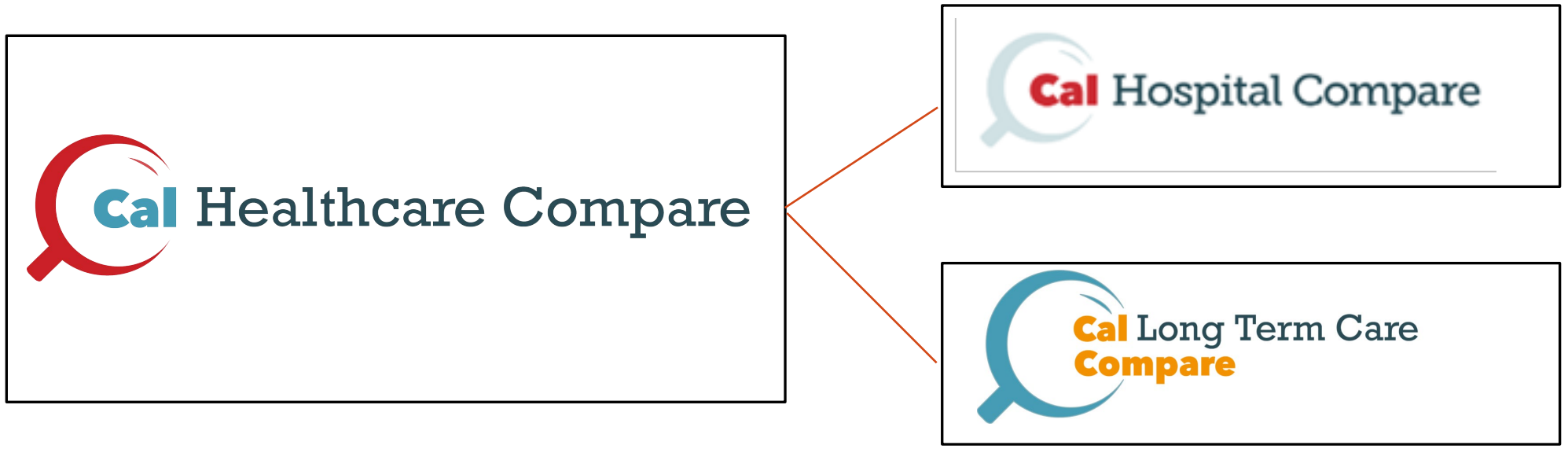
Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting was called to order at 10:00am. • The minutes from the meeting on October 29th were moved, motioned, seconded and approved as written.
Cal Hospital Compare	Goal - develop and evaluate the use of a hospital level index of social need to inform SDOH strategy & partnerships at the hospital, local, and state levels. Source options include HPI, SVI, and ADI – pros and cons of each. The more granular we can get the better – but census tract level information is harder to come by vs zip code. IBM Watson Health provided and interactive demonstration of the mapping tool using HPI data. Hospitals and others could utilize this tool to understand where their patients are coming from and what social needs those patients might have (e.g., economic, transportation, social, pollution, healthcare, etc.) Discussed the potential of collaborating between hospitals to address high need zip codes and those dual enrolled. Limitations do exist. Data likely does not include homeless populations and patient's with an international address, but directional data is extremely helpful. Measures are most impacted by social need: breastfeeding, readmissions, patient experience surgery volume. Least impacted: HAIs, patient safety. Next steps are to identify what to do with this information and obtain feedback from hospitals on how we can make it more usable for them.
Cal Quality Care	UC Davis explained in detail the proposed measures that will be published on the CQC website when reinstated in December. Reviewed domains of care/measures that will be included in the December website relaunch, other measures will be folded into the May data refresh. The "At-A-Glance" page on the website is new and will provide a quick quality/facility overview. Discussed how we can make the long term stay measures more relevant and focused on autonomy and choice vs infections, etc. in a declining population. Given the controversy around COVID-19 vaccination data and limitation, BOD recommended that we do not score, but provide % and/or trend data, for resident COVID vaccination rates particularly as NHs cannot require

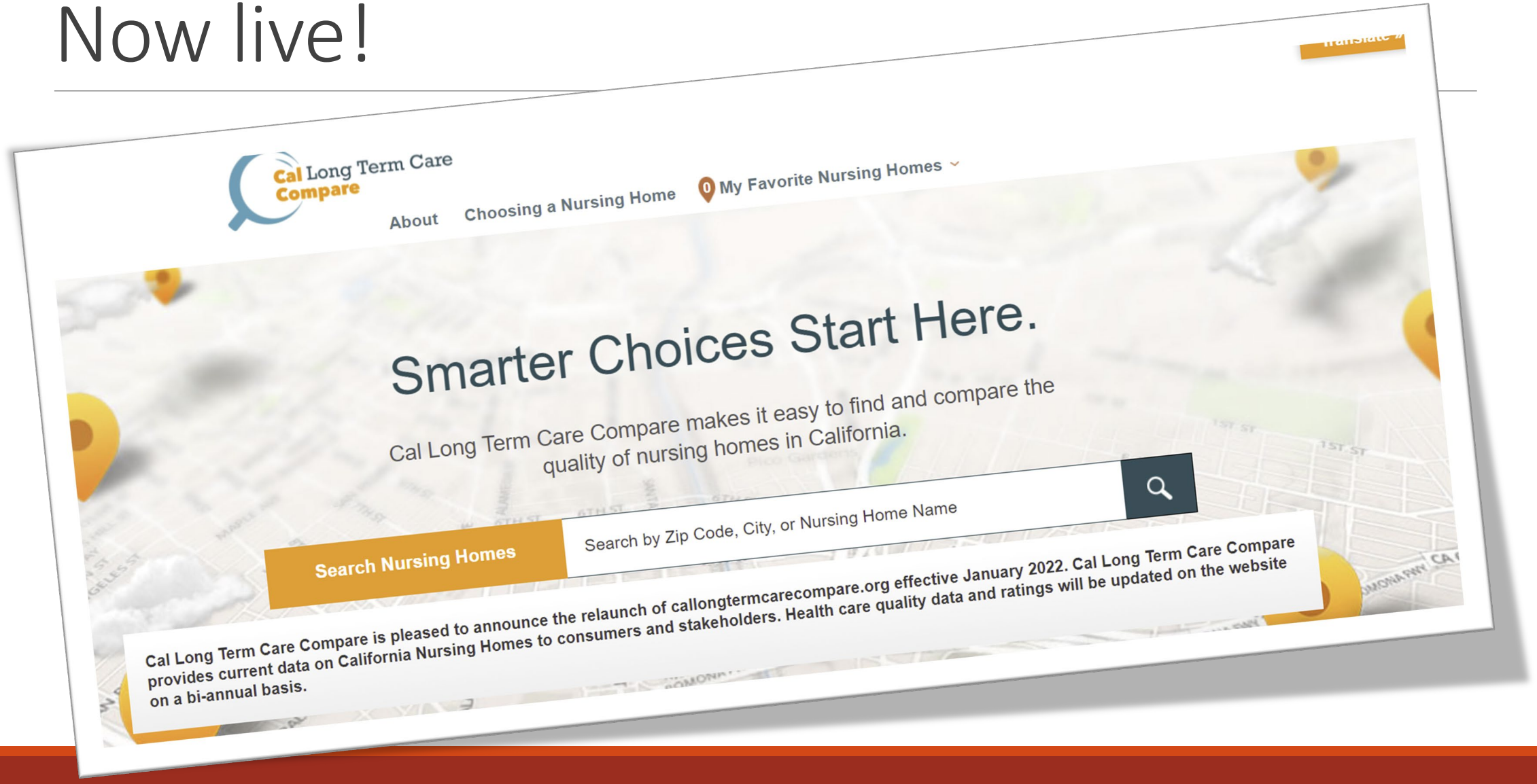
	residents be vaccinated. However, it is appropriate to score employee COVID-19 vaccination rates using the CQC methodology. "Successful discharge to home" here is defined by a lack of subsequent claims for return to SNF or hospital (or death). There was a concern about palliative/hospice care with long stay residents acknowledging that the patient may not leave the facility. Are there measures in place to address this?
Business Plan & Financials	• The current financial reports and preliminary budget were motioned, seconded and accepted by the Board.
Formative Evaluation	• The BOD is encouraged to consider development opportunities and strategic goals for the coming year and provide any feedback to Alex Stack. • The formative evaluation was deferred for further discussion at the next BOD meeting on March 17, 2022.
Next Meeting/Meeting Adjournment	• Next meeting: Thursday, March 17, 2022, virtually via Zoom. The meeting formally adjourned at 12:33pm PST.

General Updates

Rebranding

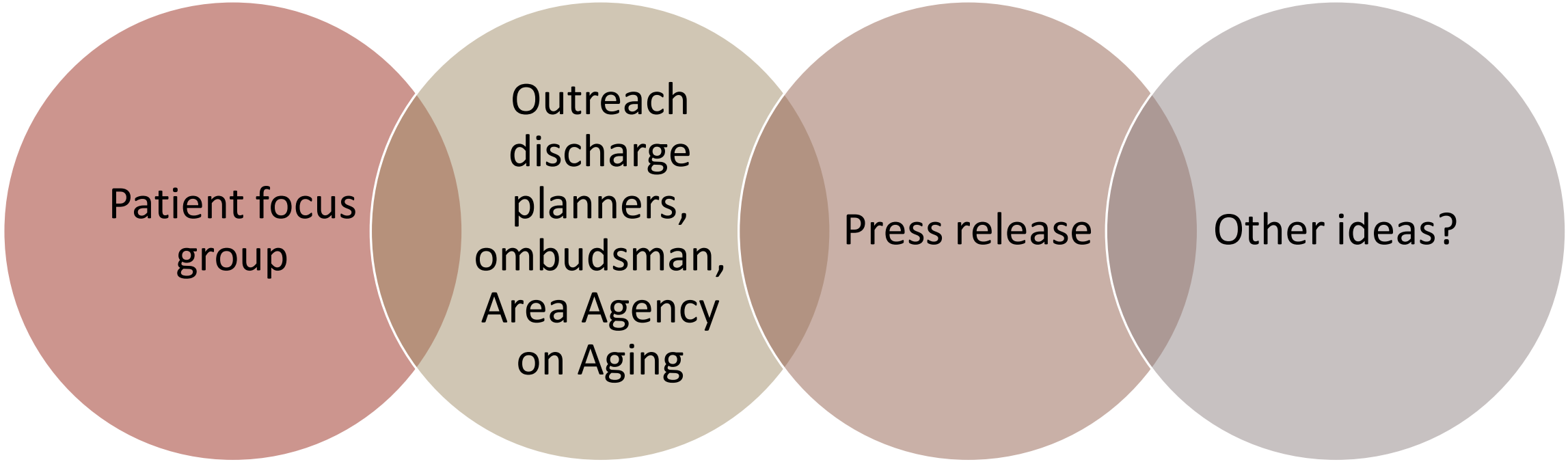

Cal Healthcare Compare
Cal Hospital Compare
Cal Long Term Care Compare

Now live!


Cal Long Term Care Compare
About
Choosing a Nursing Home
My Favorite Nursing Homes
Smarter Choices Start Here.
Cal Long Term Care Compare makes it easy to find and compare the quality of nursing homes in California.
Search Nursing Homes
Search by Zip Code, City, or Nursing Home Name
Cal Long Term Care Compare is pleased to announce the relaunch of callongtermcarecompare.org effective January 2022. Cal Long Term Care Compare provides current data on California Nursing Homes to consumers and stakeholders. Health care quality data and ratings will be updated on the website on a bi-annual basis.

Let’s spread the word

In the works


Patient focus group
Outreach discharge planners, ombudsman, Area Agency on Aging
Press release
Other ideas?

Help us expand our scope

Goal: Secure start-up funding to add non-nursing home long term care providers to the website.

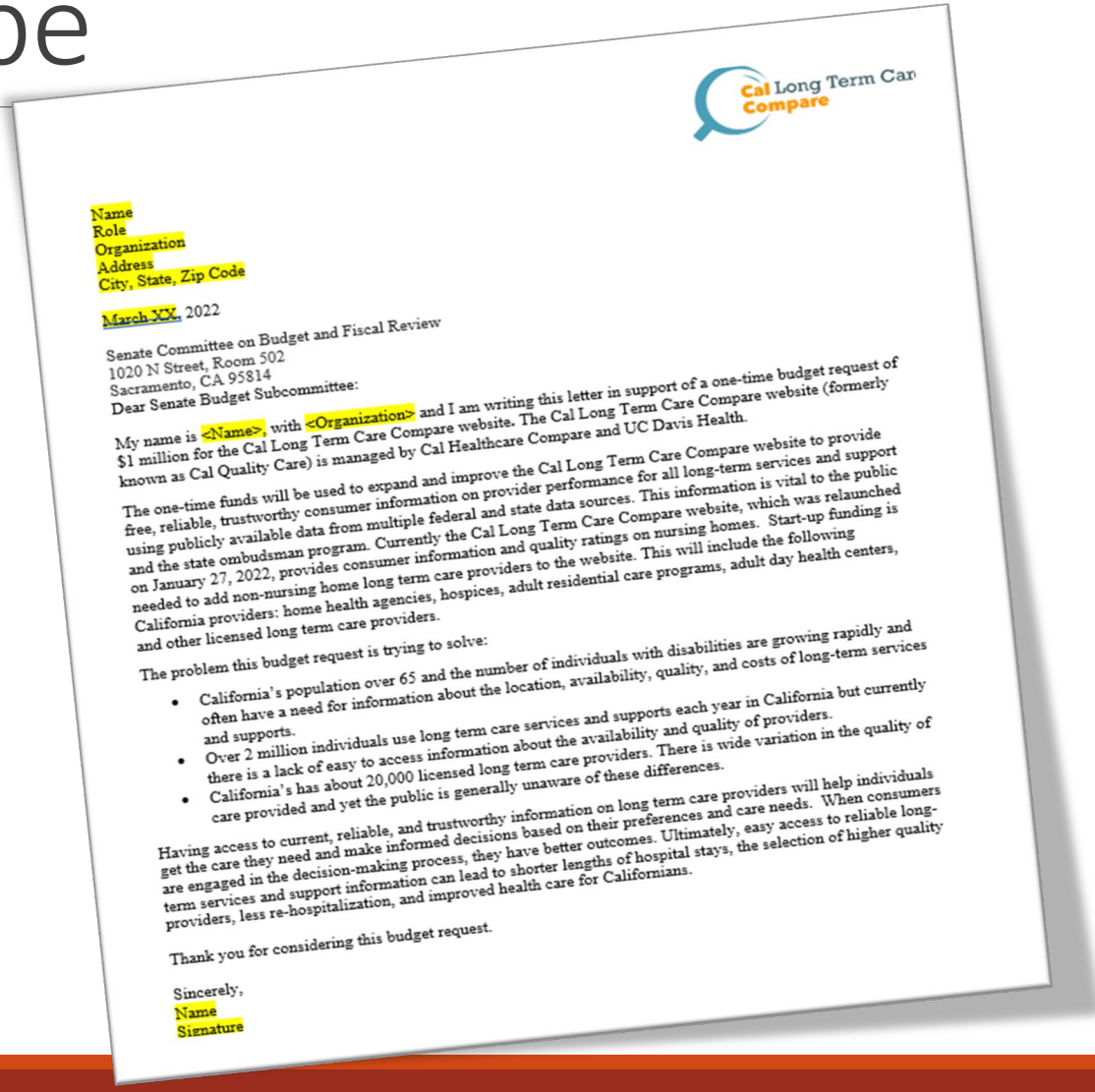
- This will include home health agencies, hospices, adult residential care programs, adult day health centers, and other licensed long term care providers.

Budget request: $1 million

How: Submit letter to Senate Budget Committee

Email: SBUD.Committee@sen.ca.gov

CC: Renita.Polk@sen.ca.gov



Cal Long Term Care Compare

Name
Role
Organization
Address
City, State, Zip Code

March XX, 2022

Senate Committee on Budget and Fiscal Review
1020 N Street, Room 502
Sacramento, CA 95814
Dear Senate Budget Subcommittee:

My name is <Name>, with <Organization> and I am writing this letter in support of a one-time budget request of $1 million for the Cal Long Term Care Compare website. The Cal Long Term Care Compare website (formerly known as Cal Quality Care) is managed by Cal Healthcare Compare and UC Davis Health.

The one-time funds will be used to expand and improve the Cal Long Term Care Compare website to provide free, reliable, trustworthy consumer information on provider performance for all long-term services and support using publicly available data from multiple federal and state data sources. This information is vital to the public and the state ombudsman program. Currently the Cal Long Term Care Compare website, which was relaunched on January 27, 2022, provides consumer information and quality ratings on nursing homes. Start-up funding is needed to add non-nursing home long term care providers to the website. This will include the following California providers: home health agencies, hospices, adult residential care programs, adult day health centers, and other licensed long term care providers.

The problem this budget request is trying to solve:

- California's population over 65 and the number of individuals with disabilities are growing rapidly and often have a need for information about the location, availability, quality, and costs of long-term services and supports.
- Over 2 million individuals use long term care services and supports each year in California but currently there is a lack of easy to access information about the availability and quality of providers.
- California's has about 20,000 licensed long term care providers. There is wide variation in the quality of care provided and yet the public is generally unaware of these differences.

Having access to current, reliable, and trustworthy information on long term care providers will help individuals get the care they need and make informed decisions based on their preferences and care needs. When consumers are engaged in the decision-making process, they have better outcomes. Ultimately, easy access to reliable long-term services and support information can lead to shorter lengths of hospital stays, the selection of higher quality providers, less re-hospitalization, and improved health care for Californians.

Thank you for considering this budget request.

Sincerely,
Name
Signature

Promote the 2021 Opioid Care Honor Roll!

Superior Performance

- Hospital scores at least **27 points** (≥75th%ile)

Excellent progress

- Hospital scores **between 21 and 26 points** (≥50th%ile and ≤74th%ile)

Most Improved

- TBD

Apply by March 31, 2022!!

2022 Reporting Timeline

Appendix

Cal Long Term Care Compare | Cal Hospital Compare

2022 Cal Healthcare Compare Data Reporting Timeline

Report	Expected Deliverable Date	Measures	Source	Measurement Period
Hospital Patient Safety Honor Roll and **Poor Performer Report**	Mar 2022	Healthcare Associated Infections *(CLABSI, CAUTI, SSI Colon Surgery, MRSA, CDI)*	CMS Hospital Compare	7/1/2019 – 12/31/2020* **Measurement period is longer than normal (18 months vs 1 year) and shifted due to COVID-19.*
		AHRQ PSI 90	CMS Hospital Compare	7/1/2018 –12/31/2019
		Sepsis Management	CMS Hospital Compare	7/1/2020 –12/31/2020
		Patient Experience *(RN communication, MD communication, Help received when wanted, Staff explained medication, Patients understood their care when they left the hospital)*	CMS Hospital Compare	7/1/2020 –12/31/2020
		Hospital Letter Grade	Leapfrog Hospital Safety Grades	Fall 2020, Spring 2021, Fall 2021
Hospital Maternity Honor Roll	July 2022	NTSV C-Section Rate *Starting with the 2022 Maternity Honor Roll, the NTSV C-section rate threshold for honor roll hospitals will be adjusted from 23.9% to 23.6% to align with the Healthy People 2030 goals*	California Maternal Quality Care Collaborative	CY 2021
Hospital Opioid Care Honor Roll	Summer 2023	• Safe & Effective Opioid Use • Identification & Treatment • Overdose Prevention • Cross Cutting Opioid Management Best Practices	Opioid Management Hospital Self-Assessment	CY 2022
Nursing Home Honor Roll	Dec 2022	• Exact measures and methodology to be determined	TBD	TBD

Cal Hospital Compare

Website Data Refresh

- **Maternity Data Updated -** July 2020 to June 2021 performance data – 209 hospitals reporting, 13 not reporting.
- **Retired Measures**
  - Abdominal SSI
  - Spinal refusion
  - CABG Death Rate – No Valve
  - Esophageal resection – death rate/number of cases
  - Craniotomy Death Rate
  - Time before ECG conducted

Development of Hospital Social Needs Index

Summary of Progress

- Met with Public Health Alliance of Southern California (PHASC) – creators of HPI
  - Supportive of approach
  - Provided a non-public data set that "cleans up" some zip codes (e.g., with prisons where "employment" not applicable)
- IBM reran all analytics and updated the mapping tool
- IBM switched to using 2019 patient origin data to avoid potential impact of COVID
- **Impact of changes:** No changes to the following key findings
  - Range of hospital HPI scores across and within market areas
  - Opportunities for collaboration
  - Correlation between quality measures and social needs
  - Did change the ranking of hospitals by social need slightly

…Summary of Progress

Meetings Held With	Feedback
Martin Luther King CEO (Elaine Batchelor)	Engaged discussion of approach and implications, role of hospital
HealthNet and LA Care	Potential follow up regarding opportunities for collaboration
Hospital Quality Institute (Robert Imhoff, Scott Masten)	Potential to provide useful tools to stakeholders who wish to address social needs. Future presentation/validation to HQI Equity Committee?
Covered California Presentation	Follow up mtg planned to explore potential uses
Met with California Breastfeeding Coalition	Discussed using this information to compare high and low breastfeeding facilities in zip codes with low HPI. They also suggested “supplementation” as an additional measure to assess breastfeeding in the hospital setting.
Met with Memorial Care Long Beach	Engaged discussion. Interested in access to mapping tool. Potential use in CNA.

No major red flags, encouragement to continue

High-Level Review of SNI Work

Background:	Hospitals are addressing the social needs of their patient population in various ways
Methodology:	Create a standardized, comparative hospital-level social needs index that integrates patient origin information with a geographic social need index (using publicly available data)
Goals:	1) Quantify differences in the social needs of populations served by hospitals
	2) Identify areas of potential collaboration
	3) Assess the impact of social needs on quality
	4) Identify hospitals with high social need and high-quality performance
Potential Impact:	Approach may help hospitals better understand their patient populations and focus social need investment to maximize its impact

California Healthy Places Index

- Developed by Public Health Alliance of Southern California
- 25 component measures, 8 domains, multiple data sources
- Domain weighting based on prediction of Life Expectancy at Birth

ECONOMIC 0.32	EDUCATION 0.19	HEALTHCARE 0.05	HOUSING 0.05	NEIGHBOR-HOOD 0.08	CLEAN ENVIRONMENT 0.05	SOCIAL 0.10	TRANSPOR-TATION 0.16
• Poverty • Employment • Income	• Pre-school enrollment • High school enrollment • Bachelors attainment	• Insured adults	Severe cost burden low-income: • renters • owners • Homeownership • Kitchen and plumbing • Crowding	• Retail jobs • Supermarket access • Parks • Tree canopy • Alcohol establishments	• Diesel PM • Ozone • PM2.5 • Drinking Water	• Two Parent Household • Voting	• Healthy Commuting • Automobile access

Figure 1. Health Places Index Policy Action Areas (Domains), Weights, and Individual Indicators

Hospital-Level SNI Ranking

Hospitals with Highest Social Need

- Calculated hospital Social Needs Index (SNI) by weighting zip-code-level HPI by proportion of hospital admissions from zip code

All hospitals (except Adventist Clear Lake) in Los Angeles, Central Valley or Inland Empire

Hospital Name	Hospital-Level HPI	Hospital-Level HPI Rank	Hospital Market Area	Percent Admission - Black	Percent Admissions - Hispanic	Admissions	Percent Days - Medicaid
Martin Luther King, Jr. Community Hospital	**-0.73**	**1**	11 - Los Angeles	27%	31%	9,334	81%
Kern Valley Healthcare District	**-0.68**	**2**	09 - Central	0%	5%	454	90%
Community and Mission Hospital of Huntington Park - Slauson	**-0.67**	**3**	11 - Los Angeles	12%	82%	3,450	58%
Delano Regional Medical Center	**-0.67**	**4**	09 - Central	2%	78%	2,821	54%
Adventist Health Clear Lake	**-0.66**	**5**	01 - Northern California	4%	13%	1,501	36%
California Hospital Medical Center	**-0.65**	**6**	11 - Los Angeles	29%	59%	19,382	77%
Community Regional Medical Center	**-0.65**	**7**	09 - Central	9%	48%	40,298	55%
Community Hospital of San Bernardino	**-0.61**	**8**	12 - Inland Counties	20%	56%	12,324	79%
Kern Medical	**-0.60**	**9**	09 - Central	9%	64%	11,046	76%
East Los Angeles Doctors Hospital	**-0.60**	**10**	11 - Los Angeles	8%	83%	3,920	80%

- MLK serves urban, Black and Hispanic population
- Adventist Clear Lake serves rural, White population - small
- Both have very high social needs

Hospital-Level HPI Ranking

Hospitals with Lowest Social Need

All hospitals in Bay area

Hospital Name	Hospital-Level HPI	Hospital-Level HPI Rank	Hospital Market Area	Percent Admission - Black	Percent Admissions - Hispanic	Admissions	Percent Days - Medicaid
Novato Community Hospital	**0.54**	**303**	04 - West Bay	3%	10%	2,113	16%
Kaiser Permanente Redwood City Medical Center	**0.54**	**304**	04 - West Bay	5%	19%	10,387	4%
Kaiser Permanente Walnut Creek Medical Center	**0.54**	**305**	05 - East Bay	5%	12%	14,287	3%
Stanford Health Care – ValleyCare	**0.59**	**306**	05 - East Bay	4%	12%	8,289	14%
Kaiser Permanente San Rafael Medical Center	**0.61**	**307**	04 - West Bay	3%	6%	3,723	2%
Mills-Peninsula Medical Center	**0.61**	**308**	04 - West Bay	3%	15%	14,136	14%
El Camino Hospital	**0.62**	**309**	07 - Santa Clara	2%	10%	23,919	10%
Marin General Hospital	**0.66**	**310**	04 - West Bay	4%	19%	9,085	28%
Sequoia Hospital	**0.67**	**311**	04 - West Bay	2%	8%	6,644	5%
San Ramon Regional Medical Center	**0.78**	**312**	05 - East Bay	3%	5%	4,985	9%

- 312 hospitals included – vast majority acute general

Opportunities for Collaboration

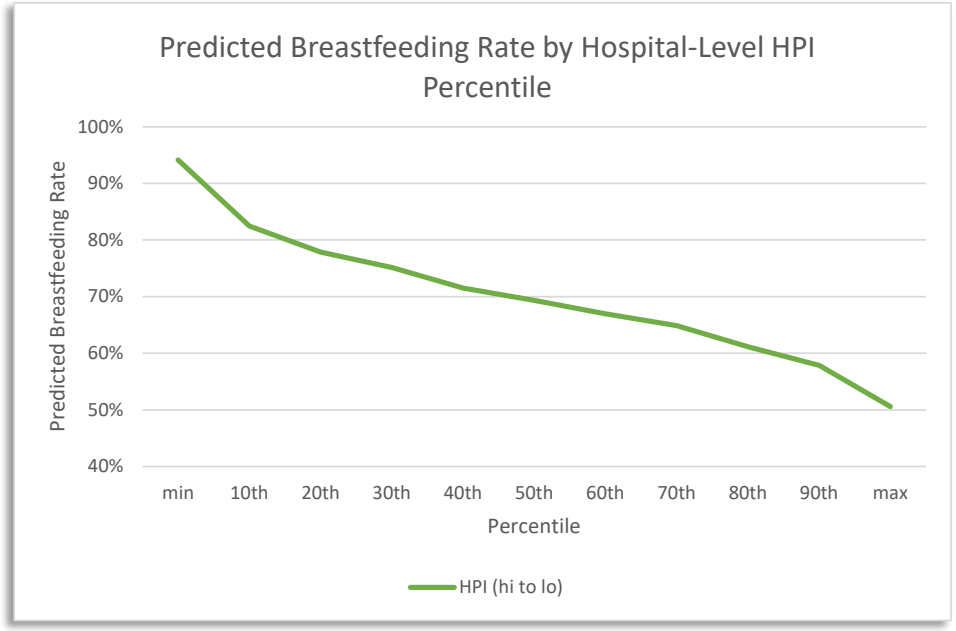
- Five hospitals account for 50% of admissions from high social need zip code 90059

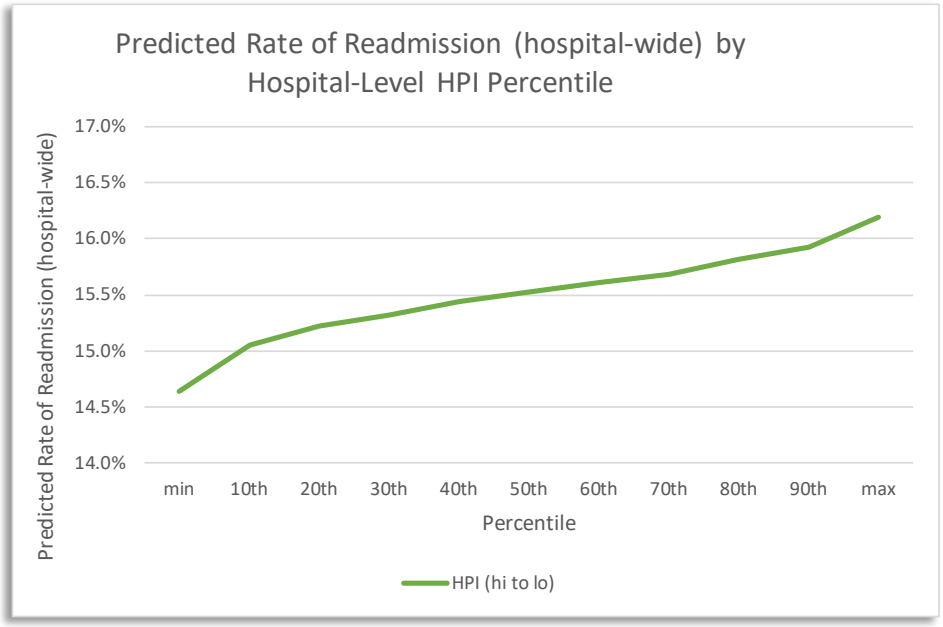
Proportion of Admissions from High Needs Zip Code by Hospital

						Hospital Characteristics				
PO Name	HPI of Zip Code	Hospital Name	Hospital HPI	Number of Admissions from Zip Code	Percent of Total Number of Admissons from Zip Code	System Size	Dispropor-tionate Share Hospital (DSH)?	Percent Days - Medicaid	Percent Admission - Black	Percent Admissions - Hispanic
Los Angeles	-0.952	Martin Luther King, Jr. Community Hospital	-0.73	1,191	20%	0	1	81%	27%	31%
Los Angeles	-0.952	St. Francis Medical Center	-0.57	929	16%	2	1	56%	20%	69%
Los Angeles	-0.952	Harbor - UCLA Medical Center	-0.35	323	6%	3	1	54%	19%	56%
Los Angeles	-0.952	California Hospital Medical Center	-0.65	261	4%	29	1	77%	29%	59%
Los Angeles	-0.952	Kaiser Permanente Downey Medical Center	-0.26	234	4%	28	0	10%	14%	61%
Los Angeles	-0.952	MemorialCare Miller Children's and Women's Hospital	-0.27	233	4%	0	1	0%	0%	0%
Los Angeles	-0.952	Memorial Hospital of Gardena	-0.47	184	3%	4	1	73%	45%	35%
Los Angeles	-0.952	Adventist Health White Memorial	-0.54	152	3%	11	1	56%	5%	81%
Los Angeles	-0.952	LAC+USC Medical Center	-0.48	151	3%	3	1	62%	11%	67%
Los Angeles	-0.952	Kaiser Permanente South Bay Medical Center	-0.14	123	2%	28	0	7%	27%	34%
Los Angeles	-0.952	Mission Community Hospital - Panorama Campus	-0.24	116	2%	1	1	49%	15%	35%
Los Angeles	-0.952	Providence Little Company of Mary Medical Center Torrance	0.04	101	2%	17	0	18%	14%	29%
Los Angeles	-0.952	Centinela Hospital Medical Center	-0.49	92	2%	14	0	40%	64%	23%
Los Angeles	-0.952	Los Angeles Community Hospital at Los Angeles	-0.40	90	2%	3	1	74%	24%	43%
Los Angeles	-0.952	MemorialCare Long Beach Medical Center	-0.14	88	1%	4	0	28%	17%	31%
Los Angeles	-0.952	Torrance Memorial Medical Center	0.16	78	1%	3	0	7%	10%	23%
Los Angeles	-0.952	Cedars-Sinai Medical Center	0.09	69	1%	3	0	13%	14%	14%
Los Angeles	-0.952	St. Mary Medical Center Long Beach	-0.37	60	1%	29	1	51%	14%	42%

Social Needs and Hospital Quality

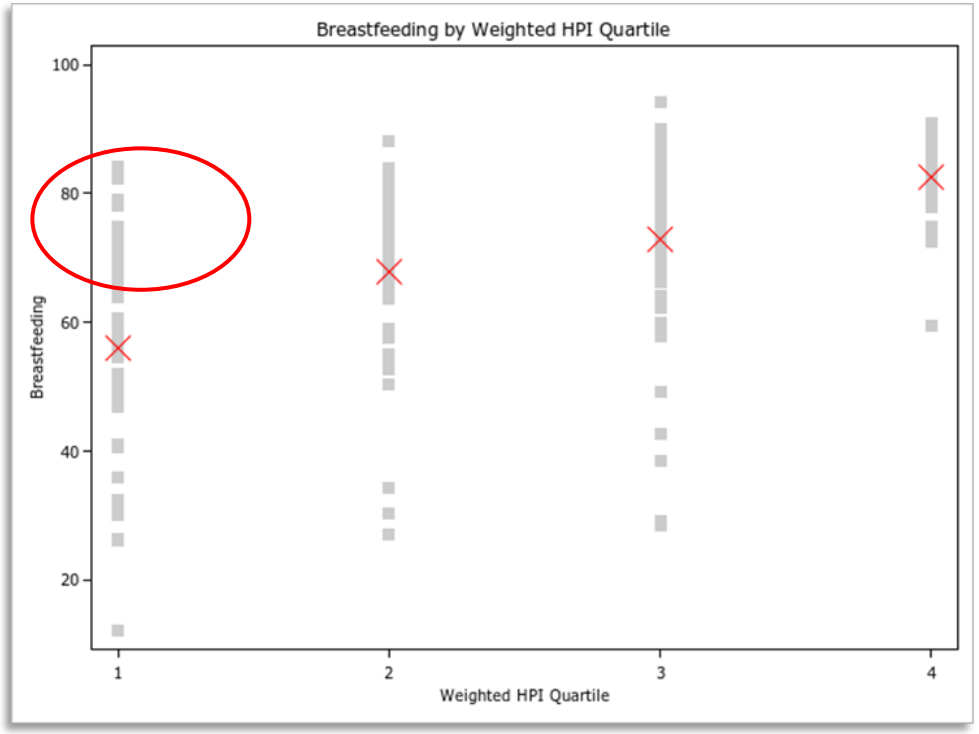
- Measures **MOST CLOSELY correlated**: breastfeeding, readmissions, patient experience, surgery volume
- Measures **LEAST correlated**: HAIs, patient safety
- Opportunity to focus SDOH investment on structures and processes related to measures most correlated to social need?
  - E.g., supporting CBOs that address breastfeeding within high social need areas





Possible Best Practices

High Breastfeeding Rates and High Social Needs



Highest Performing Hospitals within Lowest Quartile of Hospital-Level HPI (highest social need)

Hospital Name	Hospital-Level HPI	HPI Rank	Breastfeeding Rate
Arrowhead Regional Medical Center	-0.46	39	84%
Riverside University Health Systems	-0.43	45	84%
Kaiser Permanente Fresno Medical Center	-0.35	69	82%
Kaiser Permanente Moreno Valley Medical Center	-0.36	64	79%
Community Regional Medical Center	-0.65	7	78%
San Joaquin General Hospital	-0.40	53	75%
Sutter Coast Hospital	-0.39	55	73%
Kern Medical	-0.60	9	72%
Antelope Valley Hospital	-0.41	48	71%
Adventist Health Clear Lake	-0.66	5	70%
Clovis Community Medical Center	-0.35	67	70%
Desert Valley Hospital	-0.51	21	69%
Martin Luther King, Jr. Community Hospital	-0.73	1	68%
LAC+USC Medical Center	-0.48	32	67%
Saint Agnes Medical Center	-0.47	35	66%

Are there lessons to be learned from these hospitals?

Potential Use of Hospital SNI

- Polling Questions for HTAC:
  - How should a social needs index be used in CalHospitalCompare?
    1. **Public: Simple reporting of hospital's social need index (relative to other hospitals)**
    2. **Public: Stratified reporting of performance for highly correlated measures**
    3. **Internal: Analytic reports to stakeholders to help drive targeted performance improvement**
    4. **Internal: Analytic reports to stakeholders to help drive targeted reduction in disparities**

Potential Use of Hospital SNI, cont…

- Essential Next Step
  - Review/validation with a representative group of California hospitals
- Additional approach: Risk adjustment of measures based on social needs index – staff recommends holding due to complexity and level of effort
- See Appendix A for pros/cons of approaches
- TAC Brainstorming – other next steps?
  - **CHC Workgroup(s)**
  - **Creation of a voluntary collaborative to use data to address social need impact on a specific measure (e.g., Breastfeeding, Readmissions)**
  - **Other thoughts?**

Workgroup Framework

Goal

- Explore how Cal Hospital Compare can validate and use the social needs index
- For example, but not limited to, develop an interactive website, analytic reports to stakeholders to support targeted improvement, collaborative, etc.

Projected deliverables

- Prioritize options for further development
- Develop use case for hospitals
- For one project map out the who, what, when where, how, and what's in it for me

Timeline:

- 3 meetings, 75 min each
- Week of April 4, April 25 + May 10 TAC meeting

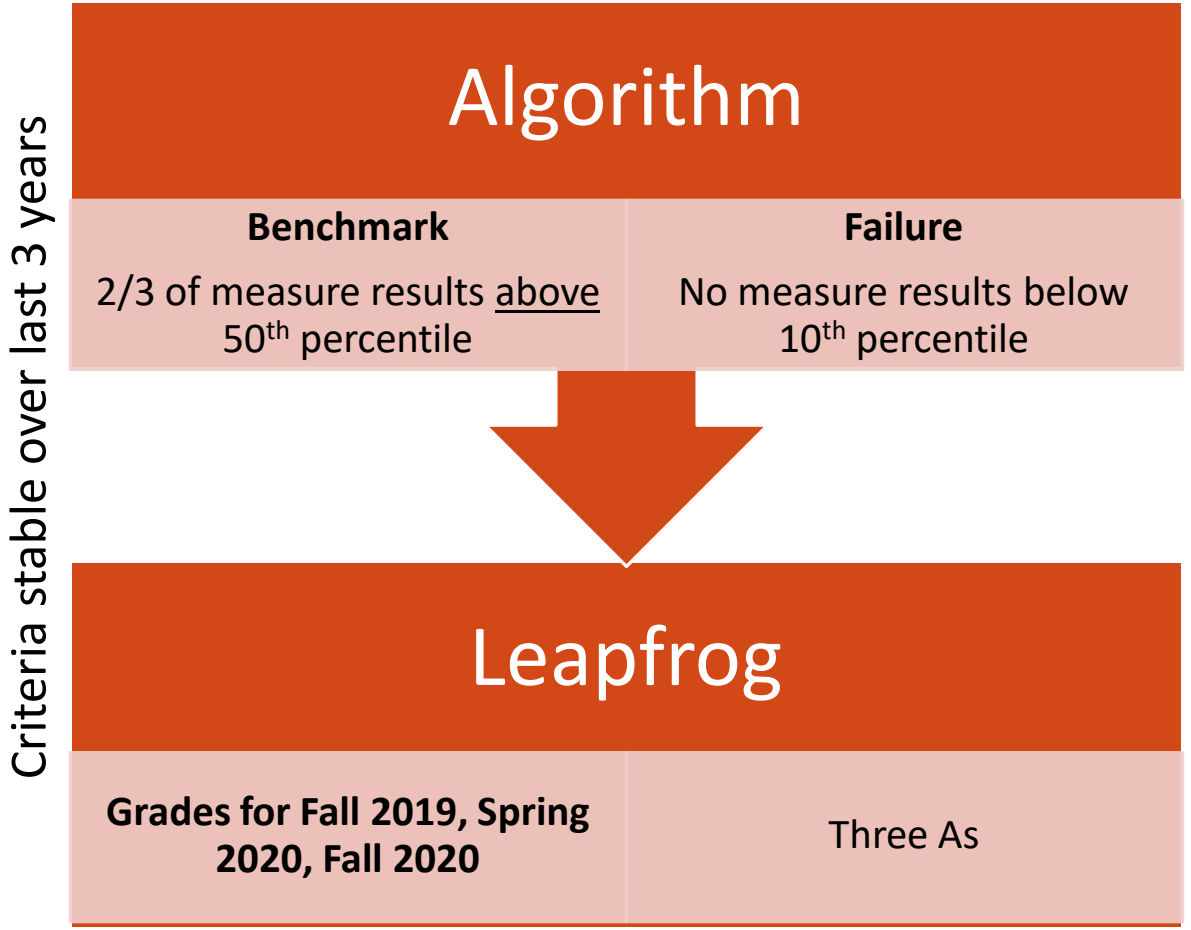
Patient Safety Honor Roll

Overview

- IBM Watson Health calculated Patient Safety Honor Roll (PSHR) and Patient Safety Poor Performers Report (PSPPR) based on:
    1. CMS Hospital Compare data released in fall of 2021 and
    2. Leapfrog data released in December 2021
- Results showed PSHR and PSPPR relatively stable despite impact of COVID – results presented in this slide deck
- CMS released updated data in late January 2022
- Proposed Next Steps:
    - IBM to rerun reports using most current CMS data
    - Project team to review results
    - Project team will bring any issues to TAC via email and convene ad hoc group if necessary

Honor Roll Criteria

- Tier 1: Met Algorithmic **and** Leapfrog Criteria
- Tier 2: Met Algorithmic **or** Leapfrog Criteria



PSHR Summary of Changes

2021 Version = January 2022 CMS Hospital Compare

2021 Version

Total CalHospitalCompare Hospitals = 323

Scenario	Eligible Hospitals			Algorithmic	Leap Frog	Tier 1 (AND)	Tier 2 (OR)
	Algorithmic	Leap Frog	Both				
2	293	236	229	43	61	18	86 (68)

2020 Version

Total CalHospitalCompare Hospitals = 329

Scenario	Eligible Hospitals			Algorithmic	Leap Frog	Tier 1 (AND)	Tier 2 (OR)
	Algorithmic	Leap Frog	Both				
2	305	233	229	36	54	17	73 (56)

2019 Version

Total CalHospitalCompare Hospitals = 326

Scenario	Eligible Hospitals			Algorithmic	Leap Frog	Tier 1 (AND)	Tier 2 (OR)
	Algorithmic	Leap Frog	Both				
2	301	242	242	45	49	17	77 (60)

- Note: Number of Tier 2 Hospitals excludes those meeting Tier 1 criteria

…PSHR Summary of Changes: Current vs Q1 2021

Stability:

Switching Tiers:
Joining Tier 2:

Only 5 hospitals joined/left Tier 1 that were not in Tier 2
20 hospitals joined Tier 1 from Tier 2 and vice versa
More hospitals joining/leaving Tier 2

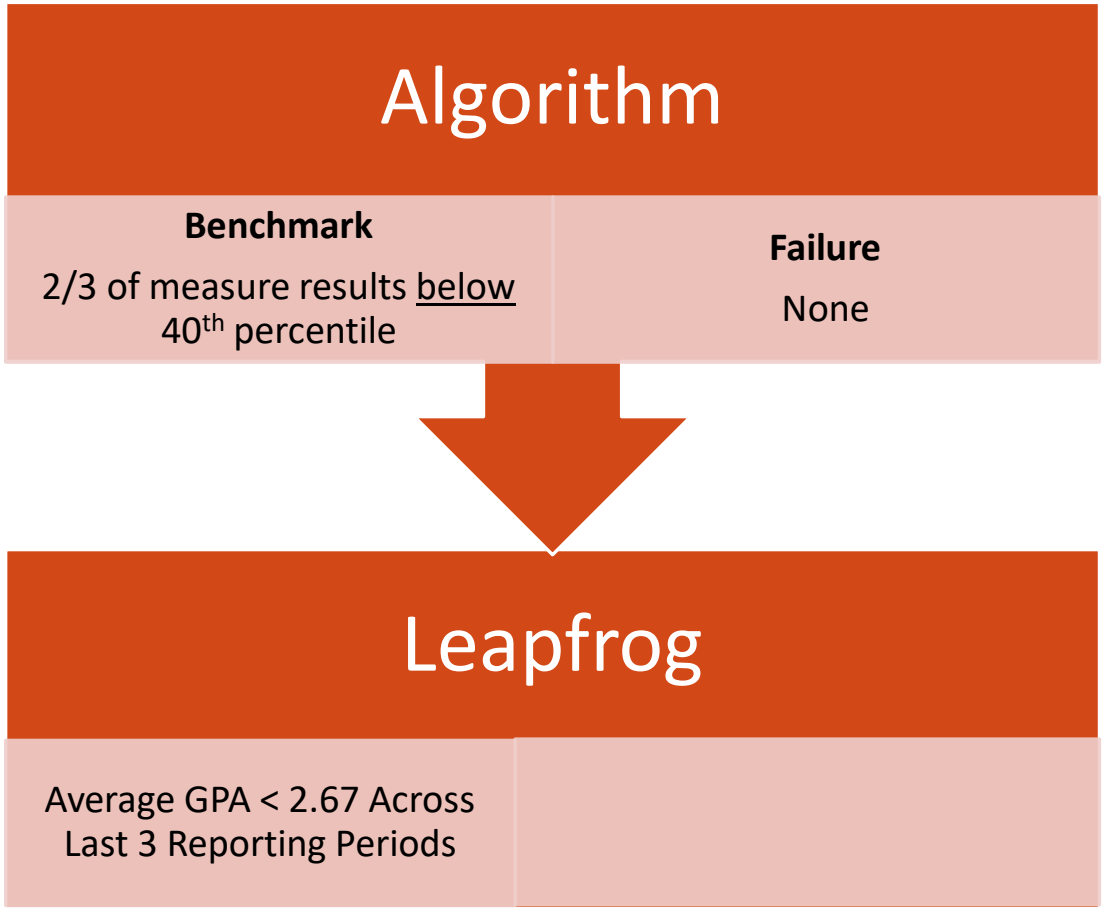
No Change	256
No Honor Roll in 2022 (Tier 1 in 2021)	2
No Honor Roll in 2022 (Tier 2 in 2021)	14
Tier 1 in 2022 (Tier 2 in 2021)	10
Tier 1 in 2022 (no Honor Roll in 2021)	3
Tier 2 in 2022 (Tier 1 in 2021)	10
Tier 2 in 2022 (no Honor Roll in 2021)	26

✓ PSHR stable across time periods

Patient Safety Poor Performers Report

Poor Performer Criteria

- Tier 1: Met Algorithmic **and** Leapfrog Criteria
- Tier 2: Met Algorithmic **or** Leapfrog Criteria



PSPPR Summary of Changes

2022 Version = January 2022 CMS Hospital Compare

2022 Version

Total CalHospitalCompare Hospitals = 323

Eligible Hospitals		Algorithmic	Leap Frog	Tier 1 (AND)	Tier 2 (OR)	DisHonor Roll Criteria (for hospitals meeting Minimum Measures)
Algorithmic	Leap Frog					
293	236	56	26	11	71	Algorithmic:At least 2/3 of measure results below 40th percentile. Leapfrog: Average GPA < 2.67

2021 Version

Total CalHospitalCompare Hospitals = 329

Eligible Hospitals		Algorithmic	Leap Frog	Tier 1 (AND)	Tier 2 (OR)	DisHonor Roll Criteria (for hospitals meeting Minimum Measures)
Algorithmic	Leap Frog					
305	233	57	29	13	73	Algorithmic:At least 2/3 of measure results below 40th percentile. Leapfrog: Average GPA < 2.67

…PSPPR Summary of Changes: 2022 vs 2021

Stability: Only 7 hospitals joined/left Tier 1 that were not in Tier 2

Switching Tiers: 29 hospitals joined Tier 1 from Tier 2 and vice versa

Joining Tier 2: More hospitals joining/leaving Tier 2

No Change	265
No PSPPR in 2022 (Tier 1 in 2021)	3
No PSPPR in 2022 (Tier 2 in 2021)	22
Tier 1 in 2022 (Tier 2 in 2021)	5
Tier 1 in 2022 (no PSPPR in 2021)	4
Tier 2 in 2022 (Tier 1 in 2021)	24
Tier 2 in 2022 (no PSPPR in 2021)	14

✓ PSHR stable across time periods

Measures & The Pandemic

Impact of Pandemic on Measure Performance

- **Goal:** Examine changes in 1) aggregate hospital performance 2) individual hospital performance
- **Approach:** In comparison to historical performance, examine
    1. Changes in median, distribution (box plots)
    2. Hospital-specific changes in rates in comparison to historical patterns
- **Note:** for HAIs, CHC normalizes rates which obscures changes over time. Therefore, analysis examines unnormalized rates

Summary of Pandemic Impacts

Selected Measures Examined

Cancer Surgery – large decrease in prostate surgeries, decrease in breast cancer surgeries

Sepsis and "Would Recommend Hospital" – some hospitals had relatively large decreases

NTSV C-Section – slowing in rate of decrease

HAIs

- Mixed results
- CLABSI had marked increases (consistent with CDC results)
- Other HAIs had lesser change

Cancer Surgery Volume – Statewide Decrease

State-wide Number of Cancer Surgeries					
	Measurement Year				
Surgery	CY 2017	CY 2018	CY 2019	CY 2020	Change CY 2019 to CY 2020
Prostate	7,648	6,194	5,874	4,194	-29%
Breast	29,184	30,868	31,635	27,795	-12%
Liver	1,613	1,775	1,593	1,430	-10%
Colon	7,876	8,185	7,796	7,088	-9%
Stomach	978	1,061	1,104	1,005	-9%
Lung	3,324	3,416	3,457	3,175	-8%
Rectal	3,397	3,577	3,623	3,370	-7%
Brain	3,359	3,757	3,799	3,637	-4%

Prostate Cancer Surgery Volume

- Largest decreases among hospitals in the top quartile of prostate cancer surgery volume in 2019

Rank	Hospital Name	Number of Surgeries CY 2019	Number of Surgeries CY 2020	Percent Change (CY 2019 to CY 2020)	Hospital Market Area
1	Sutter Medical Center - Sacramento	115	9	-92%	02 - Golden Empire
2	Ronald Reagan UCLA Medical Center	88	21	-76%	11 - Los Angeles
3	Kaiser Permanente South Sacramento Medical Center	89	28	-69%	02 - Golden Empire
4	Adventist Health Bakersfield	40	14	-65%	09 - Central
5	MemorialCare Saddleback Medical Center	50	18	-64%	13 - Orange
6	Cedars-Sinai Medical Center	71	26	-63%	11 - Los Angeles
7	Kaiser Permanente Santa Clara Medical Center	125	49	-61%	07 - Santa Clara
8	UCSF Medical Center - Mt. Zion	262	105	-60%	04 - West Bay
9	Kaiser Permanente Fontana Medical Center	155	80	-48%	12 - Inland Counties
10	John Muir Medical Center - Concord Campus	41	22	-46%	05 - East Bay

- Hospitals in both Northern and Southern CA

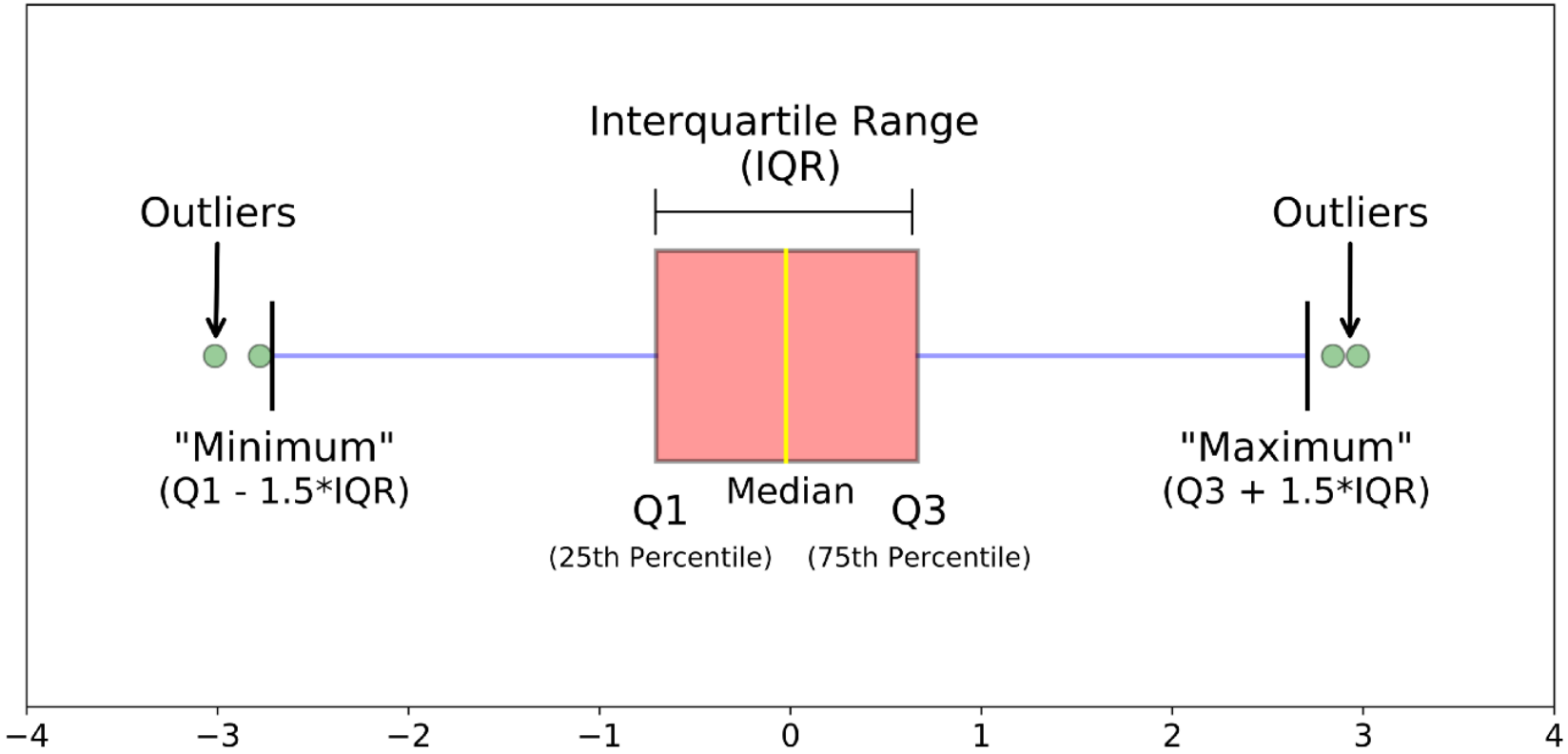
Breast Cancer Surgery Volume

- Largest decreases among hospitals in the top quartile of breast cancer surgery volume in 2019

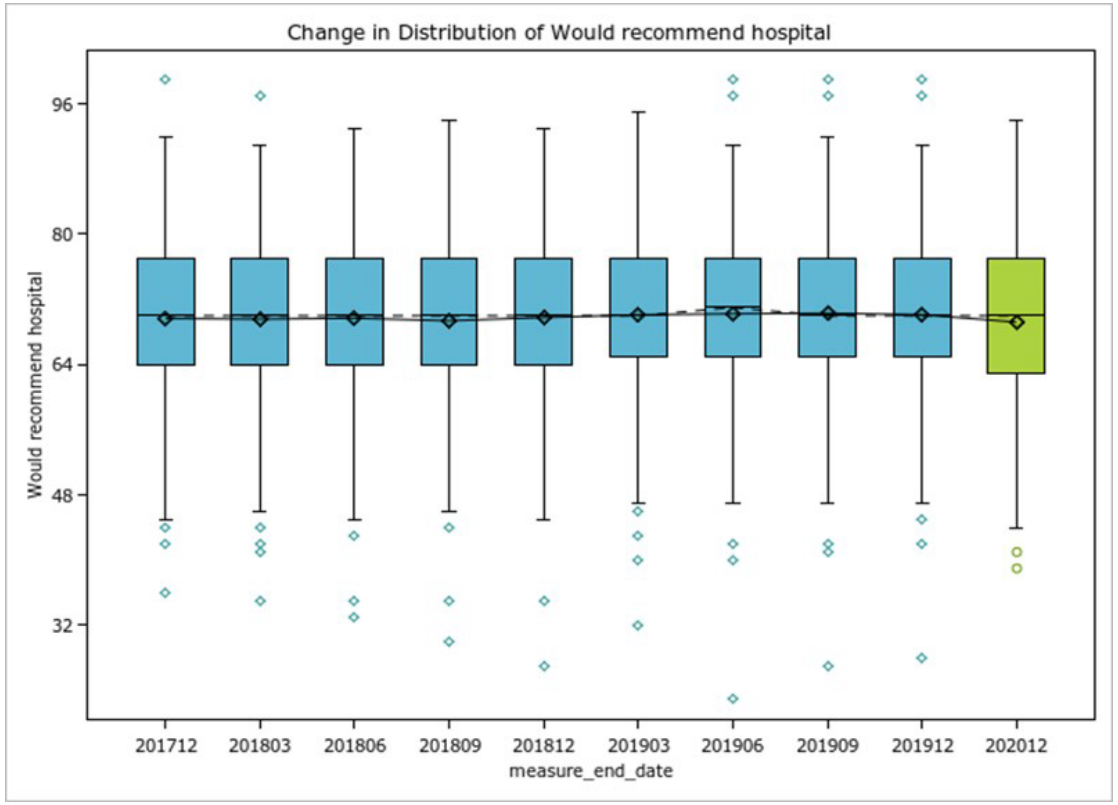
Rank	Hospital Name	Number of Surgeries CY 2019	Number of Surgeries CY 2020	Percent Change (CY 2019 to CY 2020)	Hospital Market Area
1	St. Joseph Hospital, Orange	323	153	-53%	13 - Orange
2	Providence Tarzana Medical Center	186	111	-40%	11 - Los Angeles
3	Antelope Valley Hospital	181	120	-34%	11 - Los Angeles
4	Good Samaritan Hospital - San Jose	177	125	-29%	07 - Santa Clara
5	PIH Health Hospital - Whittier	190	137	-28%	11 - Los Angeles
6	Kaiser Permanente Santa Clara Medical Center	425	307	-28%	07 - Santa Clara
7	Kaiser Permanente San Francisco Medical Center	223	164	-26%	04 - West Bay
8	Kaiser Permanente Vallejo Medical Center	324	241	-26%	03 - North Bay
9	Cedars-Sinai Medical Center	813	608	-25%	11 - Los Angeles
10	Community Memorial Hospital	200	151	-25%	10 - Santa Barbara/Ventura

- Hospitals in both Northern and Southern CA

Box Plot Explanation



“Would Recommend Hospital”



“Would Recommend Hospital” – One Pandemic Measurement Period: 7/1/20 – 12/31/20

Measurement Period End Date	N	Median	Mean	Std Dev
12/31/2017	302	70.0	69.9	10.1
03/31/2018	302	70.5	69.9	10.1
06/30/2018	301	70.0	70.0	9.9
09/30/2018	304	70.0	69.7	9.9
12/31/2018	323	71.0	70.1	10.0
03/31/2019	323	70.0	70.4	9.7
06/30/2019	318	71.0	70.6	9.9
09/30/2019	317	71.0	70.6	9.9
12/31/2019	318	70.5	70.5	9.9
12/31/2020	299	70.0	69.2	10.6

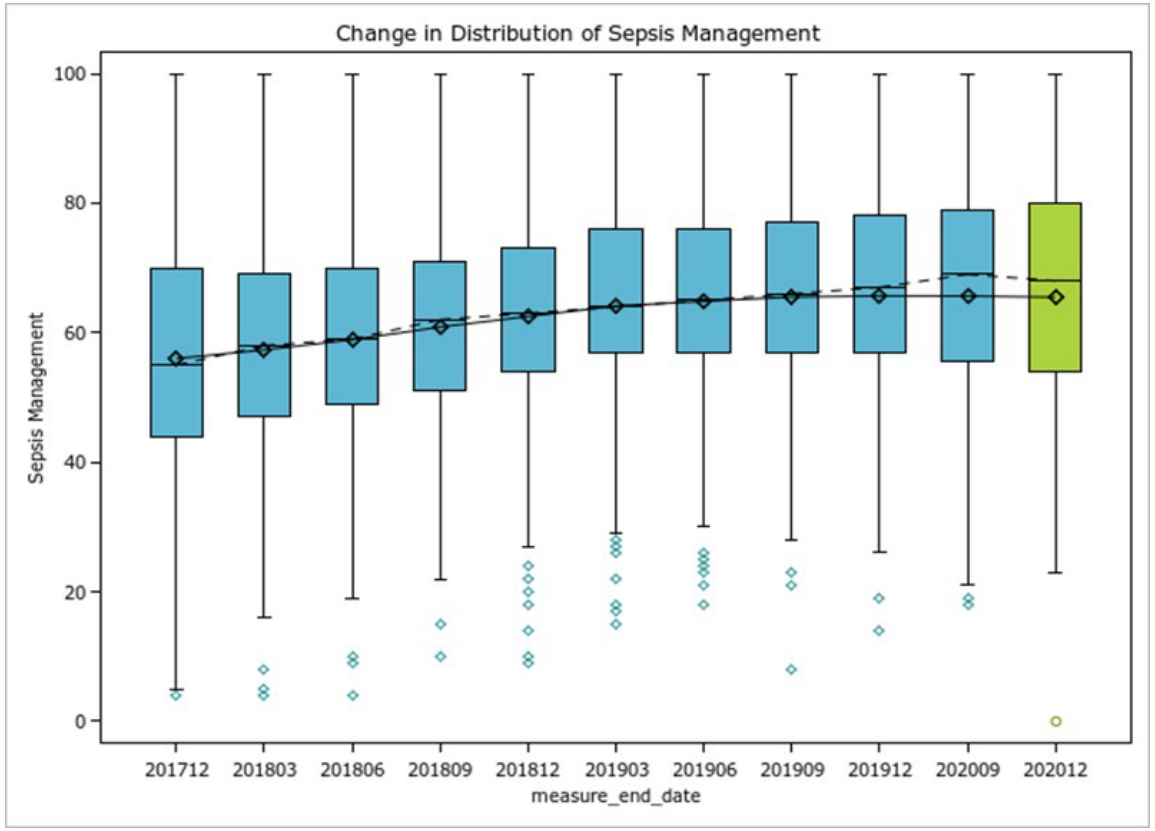
- ✓ Very stable measure historically
- ✓ Little change in median but decrease in average driven by large decreases among some hospitals

“Would Recommend Hospital” – Largest Decreases

	Hospital Name	Rate - Dec 2019	Rate - Dec 2020	Percentage Point Chage	Hospital Market Area
1	St. Francis Medical Center	56	41	-15	11 - Los Angeles
2	Good Samaritan Hospital - Bakersfield	63	49	-14	09 - Central
3	JFK Memorial Hospital	61	47	-14	12 - Inland Counties
4	Oak Valley District Hospital	77	63	-14	06 - North San Joaquin
5	East Los Angeles Doctors Hospital	63	50	-13	11 - Los Angeles
6	Sherman Oaks Hospital and Health Center	65	52	-13	11 - Los Angeles
7	Corona Regional Medical Center	64	51	-13	12 - Inland Counties
8	La Palma Intercommunity Hospital	67	55	-12	13 - Orange
9	San Gorgonio Memorial Hospital	69	57	-12	12 - Inland Counties
10	PIH Good Samaritan Hospital-Los Angeles	71	60	-11	11 - Los Angeles

All in Southern California and Central Valley

Sepsis Management



Two overlapping cycles of pandemic-affected rates are available:

1) 10/1/2019 to 9/30/20
2) 7/1/2020 to 12/31/20

Second period incorporates some of Delta wave

Measurement Period End Date	N	Median	Mean	Std Dev
12/31/2017	277	55.0	56.0	18.6
03/31/2018	276	58.0	57.3	17.8
06/30/2018	276	59.0	58.9	17.0
09/30/2018	278	62.0	60.9	15.9
12/31/2018	298	63.0	62.4	15.8
03/31/2019	297	64.0	64.1	15.3
06/30/2019	291	65.0	64.8	15.2
09/30/2019	290	66.0	65.4	15.5
12/31/2019	287	67.0	65.5	15.5
09/30/2020	279	69.0	65.5	16.6
12/31/2020	277	68.0	65.5	17.2

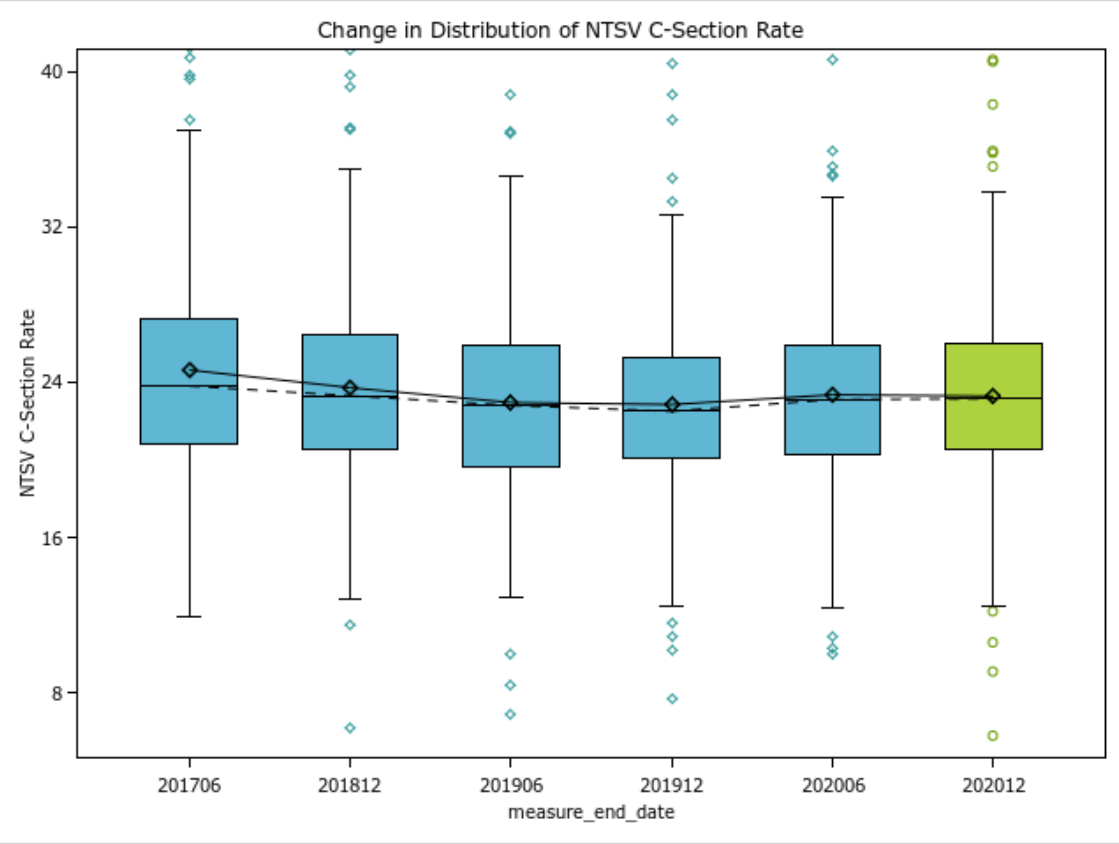
✓ Little change in aggregate performance but widening of distribution driven by some hospitals with lower rates

Sepsis Management – Largest Decreases

	Hospital Name	Rate - Dec 2019	Rate - Dec 2020	Percentage Point Difference	Hospital Market Area
1	California Pacific Medical Center - Davies Campus	79	42	-37	04 - West Bay
2	Alhambra Hospital Medical Center	72	48	-24	11 - Los Angeles
3	Community Hospital of San Bernardino	80	56	-24	12 - Inland Counties
4	AHMC Anaheim Regional Medical Center	62	39	-23	13 - Orange
5	Sutter Auburn Faith Hospital	89	66	-23	02 - Golden Empire
6	Adventist Health Hanford	86	64	-22	09 - Central
7	Saint Agnes Medical Center	59	38	-21	09 - Central
8	Bakersfield Memorial Hospital	77	56	-21	09 - Central
9	Temecula Valley Hospital	61	40	-21	12 - Inland Counties
10	Seton Medical Center	81	60	-21	04 - West Bay

Predominantly Southern California and Central Valley

NTSV C-Section



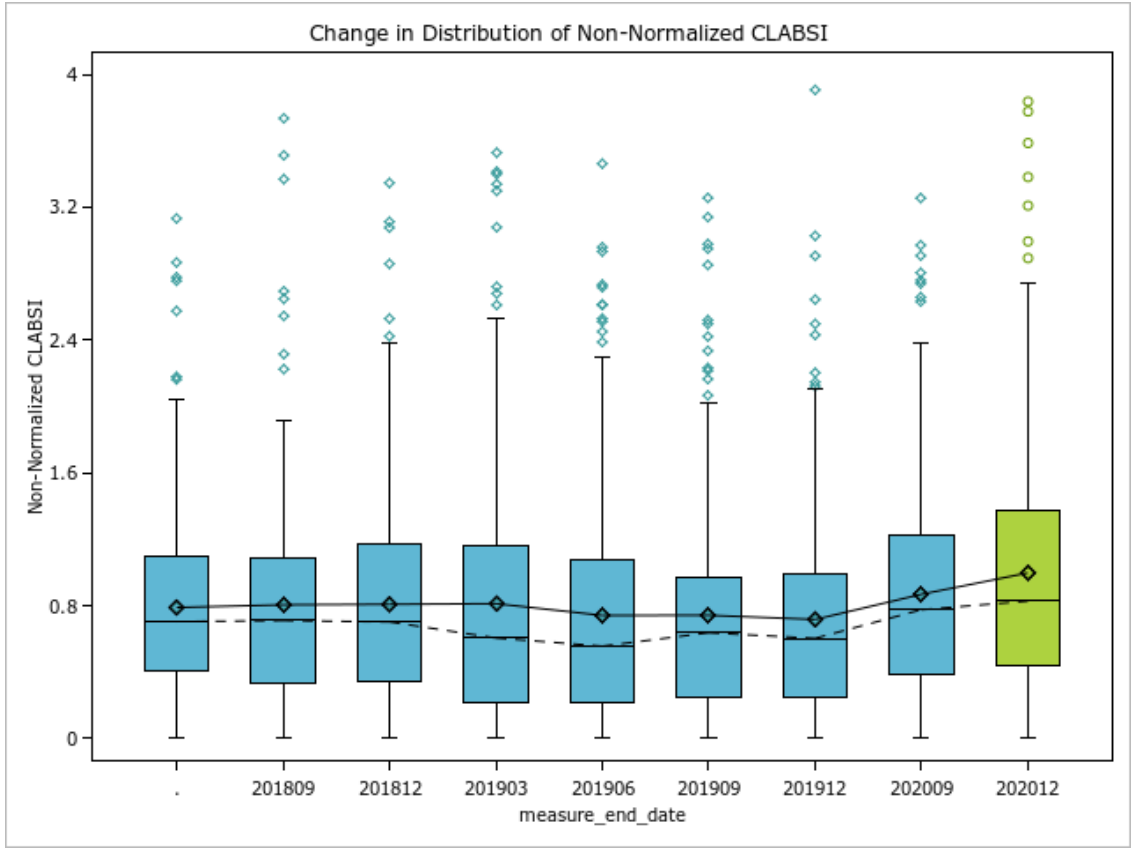
Measurement Period End Date	N	Median	Mean	Std Dev
06/30/2017	239	23.8	24.6	6.3
12/31/2018	239	23.3	23.7	5.9
06/30/2019	233	22.8	22.9	5.0
12/31/2019	229	22.5	22.8	5.1
06/30/2020	222	23.1	23.3	5.1
12/31/2020	218	23.2	23.3	5.2

- Slowing in decrease during pandemic

HAIs – General Notes

- For HAIs, two overlapping cycles of pandemic-affected rates are available:
  1. 4/1/2019 to 9/30/20
  2. 7/1/2019 to 12/31/20
- Second period incorporates some of Delta wave.
- Note: overlapping measurement periods reduces magnitude of changes between reporting cycles

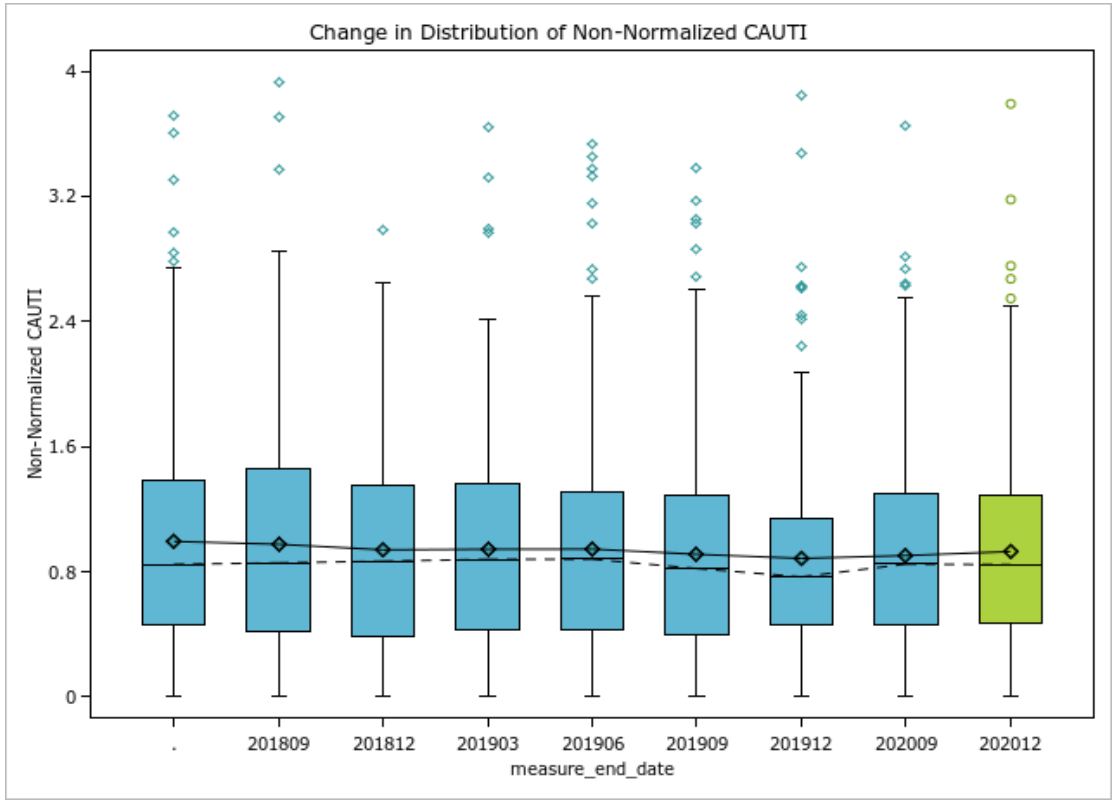
CLABSI



Measurement Period End Date	N	Median	Mean	Std Dev
09/30/2018	227	0.71	0.81	0.70
12/31/2018	244	0.70	0.81	0.71
03/31/2019	242	0.61	0.81	0.82
06/30/2019	245	0.56	0.74	0.71
09/30/2019	242	0.64	0.74	0.68
12/31/2019	240	0.60	0.72	0.65
09/30/2020	236	0.78	0.87	0.72
12/31/2020	241	0.83	1.00	0.92

- Increase in CLABSI rates and widening of distribution during the two pandemic periods
- Driven by larger increases in rates for some hospitals

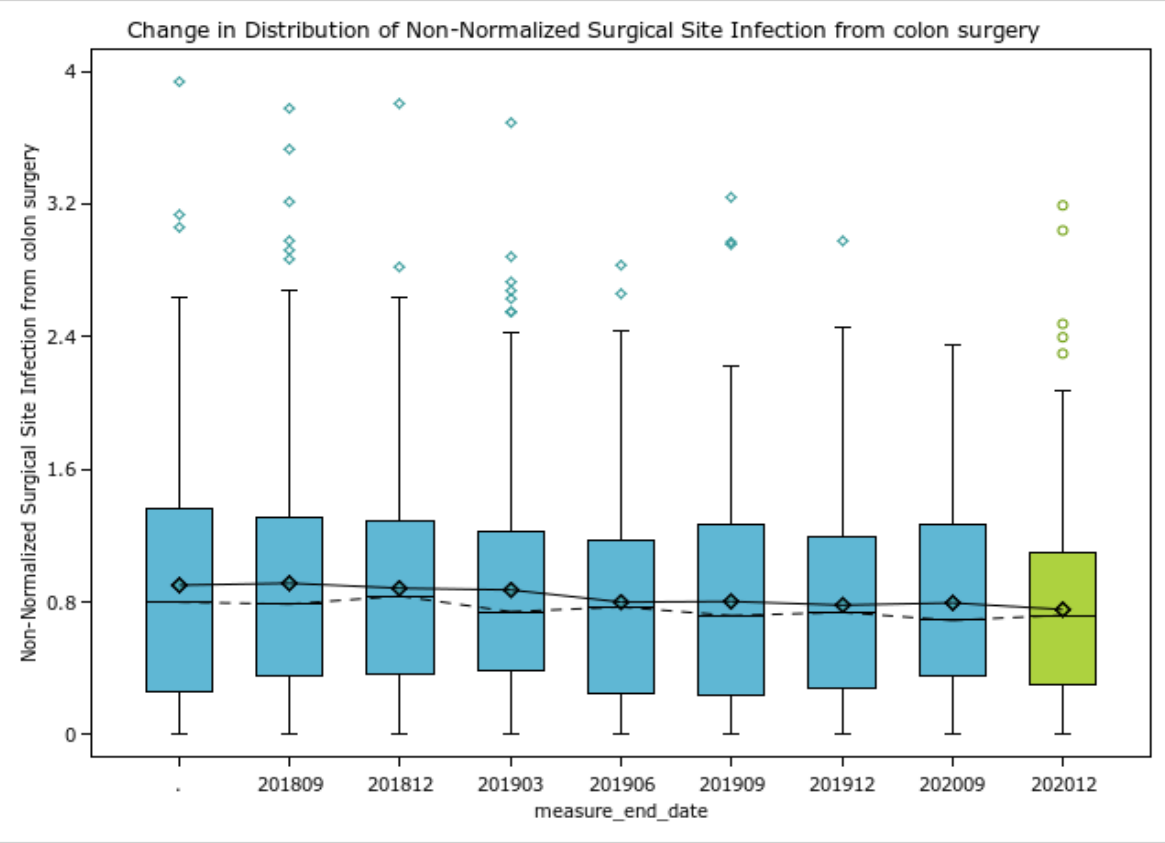
CAUTI



Measurement Period End Date	N	Median	Mean	Std Dev
09/30/2018	246	0.86	0.98	0.75
12/31/2018	268	0.87	0.94	0.70
03/31/2019	266	0.88	0.94	0.70
06/30/2019	260	0.88	0.95	0.70
09/30/2019	255	0.82	0.91	0.69
12/31/2019	258	0.77	0.89	0.66
09/30/2020	259	0.85	0.90	0.66
12/31/2020	261	0.85	0.93	0.71

- Increase in CAUTI rates, although less than CLABSI
- Relatively little change in width of distribution

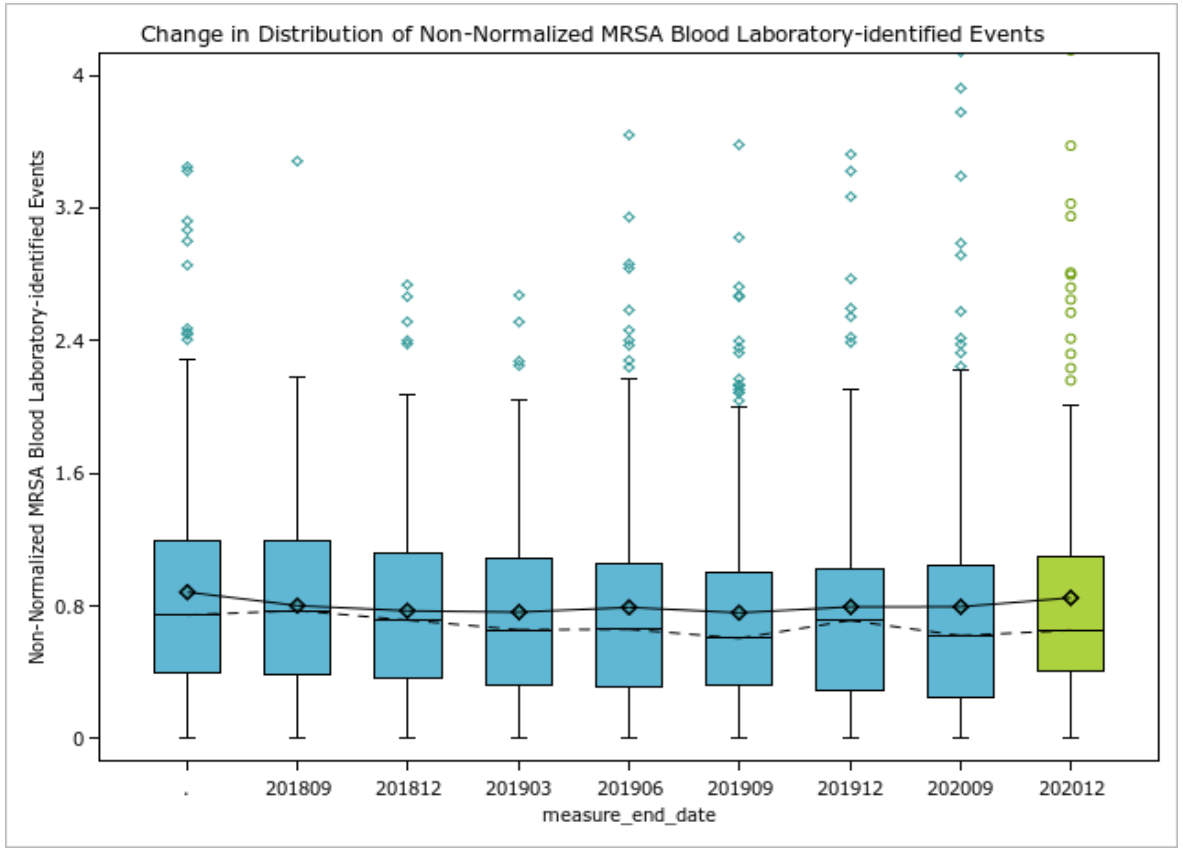
SSI Colon Surgery



Measurement Period End Date	N	Median	Mean	Std Dev
09/30/2018	190	0.79	0.91	0.75
12/31/2018	208	0.84	0.88	0.67
03/31/2019	210	0.74	0.87	0.72
06/30/2019	211	0.77	0.80	0.63
09/30/2019	206	0.72	0.80	0.67
12/31/2019	204	0.74	0.78	0.62
09/30/2020	204	0.69	0.79	0.59
12/31/2020	200	0.72	0.76	0.60

- Little change in rates or distribution in comparison to historical performance

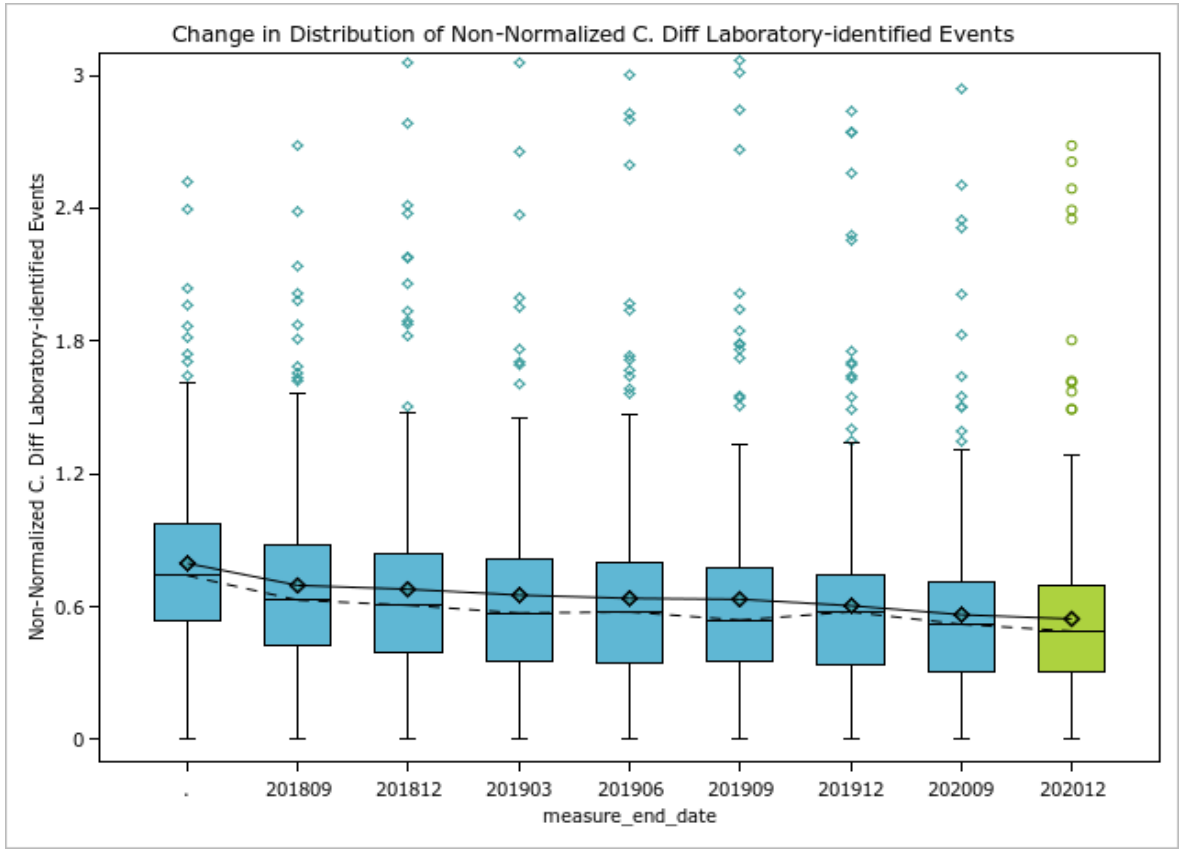
MRSA



Measurement Period End Date	N	Median	Mean	Std Dev
09/30/2018	182	0.77	0.80	0.60
12/31/2018	205	0.72	0.77	0.63
03/31/2019	205	0.66	0.76	0.66
06/30/2019	209	0.66	0.79	0.71
09/30/2019	206	0.61	0.76	0.69
12/31/2019	205	0.71	0.80	0.73
09/30/2020	201	0.62	0.80	0.83
12/31/2020	198	0.65	0.85	0.80

- Little change in median but widening of distribution (especially in first pandemic period)

C. Diff



Measurement Period End Date	N	Median	Mean	Std Dev
09/30/2018	284	0.63	0.70	0.46
12/31/2018	306	0.61	0.68	0.50
03/31/2019	304	0.57	0.65	0.53
06/30/2019	304	0.58	0.64	0.47
09/30/2019	300	0.54	0.63	0.50
12/31/2019	298	0.58	0.60	0.44
09/30/2020	293	0.52	0.56	0.40
12/31/2020	290	0.49	0.55	0.41

- Decrease in median. Little change in distribution

Cal Long Term Care Compare

CLTCC Agenda

- Accomplishments to date
- May ‘22 Data Update
- Potential Additions to Website
- Quality of Facility Domain
- Nursing Home Honor Roll

CLTCC Accomplishments To Date

Current Website Domains and Measures/Variables

- At-A-Glance (summary highlighting 21 categories)
- Facility Description (8 categories)
- Staffing (8 measures)
- Quality of Care (36 measures)

May ‘22 Update

Data Refresh for Existing Measures

- Data for website measures will be updated

- Reviewing changes in CMS measures (new/retired) and will add updates as required (e.g., weekend staffing, "up to date" COVID-19 vaccine)
  - Two new CMS staff weekend measures"
    - total number of nurse staff hours per resident day on the weekend and
    - total number of RN hours per resident day on the weekend.

- Pursuing denominator data from CMS for scoring long stay metrics

- Pursuing case mix data from CMS (FOIA)

May ’22 Update and Decision Points

Additional Measures

- Quality of Facility Domain
  - Citations/Deficiencies
  - Fines ($)
  - Display options

- Honor Roll Possibilities
  - Naming convention
  - Staffing turnover/retention
  - LS and SS composite

Quality of Facility Domain

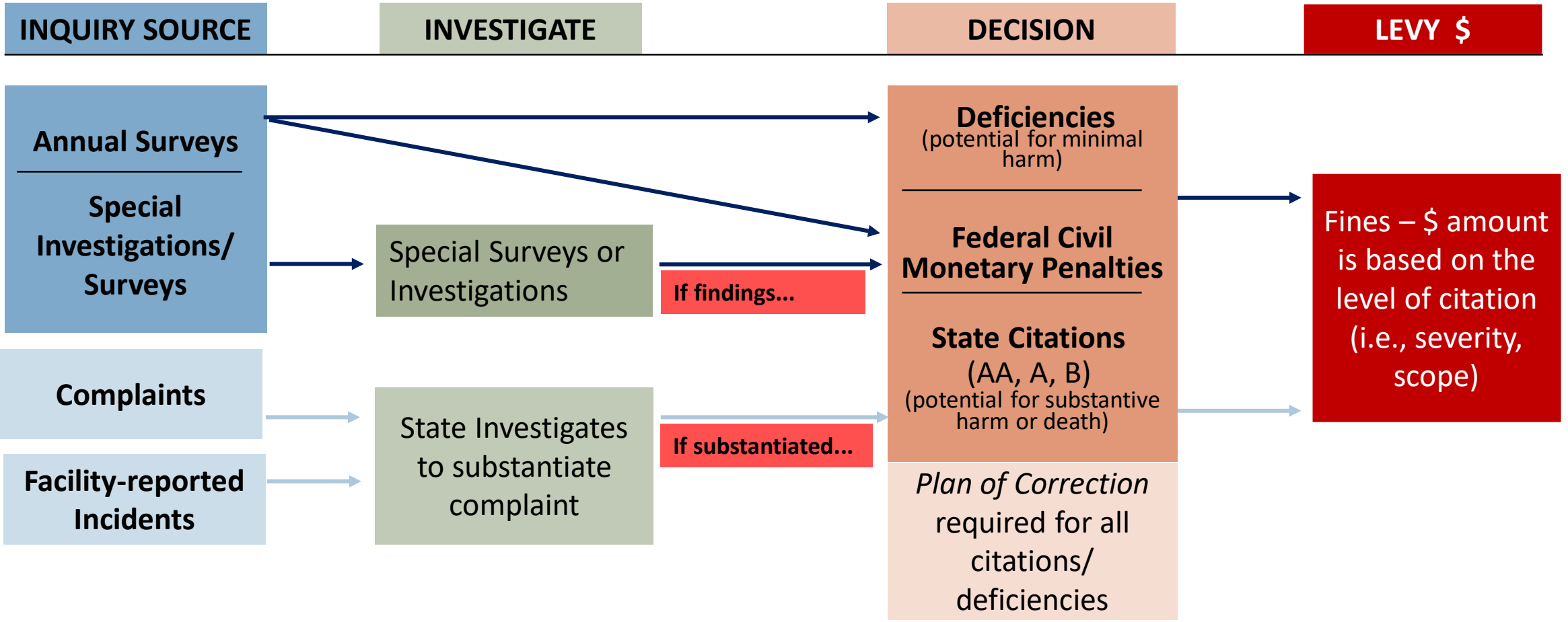
Health Citations and Deficiencies

- Scope and Severity
- Data Sources
  - Annual Surveys
  - Complaints
  - Facility-reported Incidents

Penalties and Fines ($)

- State
- Federal

DEFICIENCIES & CITATIONS



Quality of Facility: 10 Metrics for Discussion

Measure Deficiencies/Citations:	Staff Recommends	Staff Does Not Recommend	Notes
Quality of Care	✓		Failure to care for medical conditions and nursing needs appropriately and on a timely basis
Abuse [Mistreatment]	✓		Failure to prevent verbal, sexual, physical and mental abuse, the use of physical restraints, corporal punishment, or involuntary seclusion.
Resident Assessment	✓		Failure to properly assess each resident's care needs, and failure to develop, follow, and evaluate a care plan for each resident.
Resident Rights	✓		Failure to respect, recognize, and uphold the rights of residents
Environment	✓		Failure to maintain the resident environment in a manner that protects the health and safety of its residents, personnel, and the public
Nutrition	✓		Failure to meet each resident's nutritional needs and special dietary requirements or to properly prepare, serve, and store meals.

These metrics are CMS reported; understandable, meaningful, modifiable.

Quality of Facility: 10 Metrics for Discussion

Measure Deficiencies/Citations:	Staff Recommends	Staff Does Not Recommend	Notes
Pharmacy	✓		Failure to comply with pharmacy procedures for properly dispensing and storing medications. These standards are designed to make sure residents get the right medication at the right time.
Administration	✓		Failure to provide adequate administration and management. By law, a facility must be run in an efficient and effective manner that enables it to use its resources to attain and maintain the highest level of physical, mental and psychosocial well-being for each resident.
Life Safety	✓		Failure to create and maintain a safe environment for residents, and meet state and federal building inspection and fire codes were not met.
Total	✓		Total number of deficiencies/citations

These metrics are CMS reported; understandable, meaningful, modifiable.

Citations, Complaints, Deficiencies

- **Citations:** Citations are issued by the CDPH during the annual survey, complaint investigations, or special incident investigations for violations of state or federal laws (Class AA, A, B)
- **Complaints:** Complaints are primarily consumer complaints filed with CDPH, but this number does not include complaints filed solely with the Ombudsman program.
- **Deficiencies:** Deficiencies are usually federal violations issued by CDPH during annual inspection or in response to an investigation (self-reported or complaint)

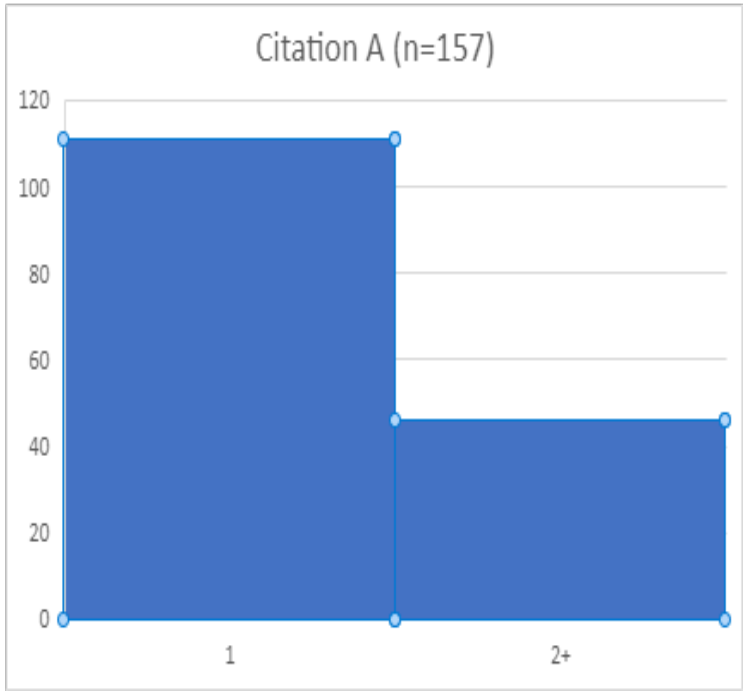
CITATION LEVELS

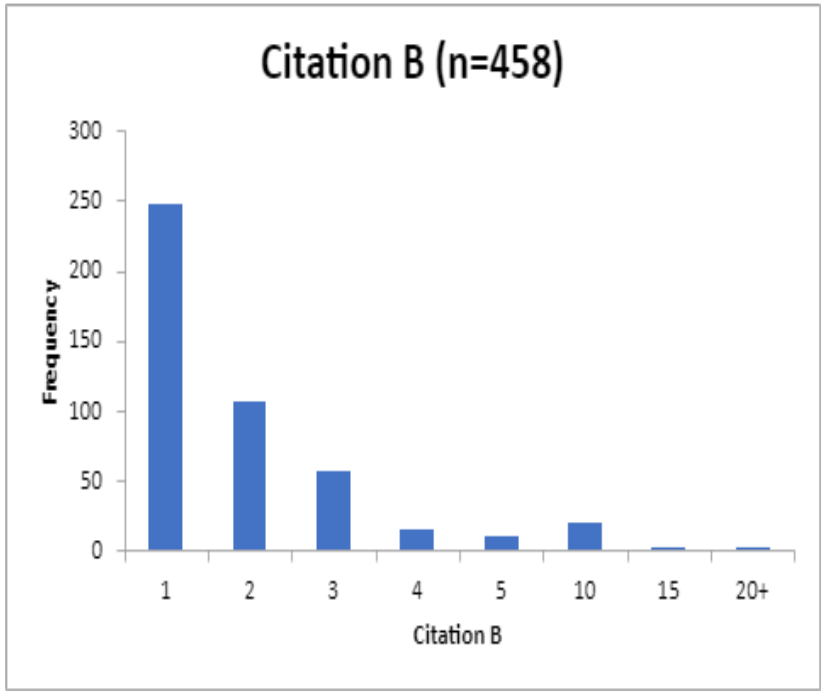
Class "B" . The violation at the time of occurrence has a **direct or immediate relationship to patient health, safety or security.** This includes emotional and financial elements, or in the case of a patient's rights violation which produces a situation likely to cause significant humiliation, indignity, anxiety or other emotional trauma, but is not serious enough to be a Class "A".

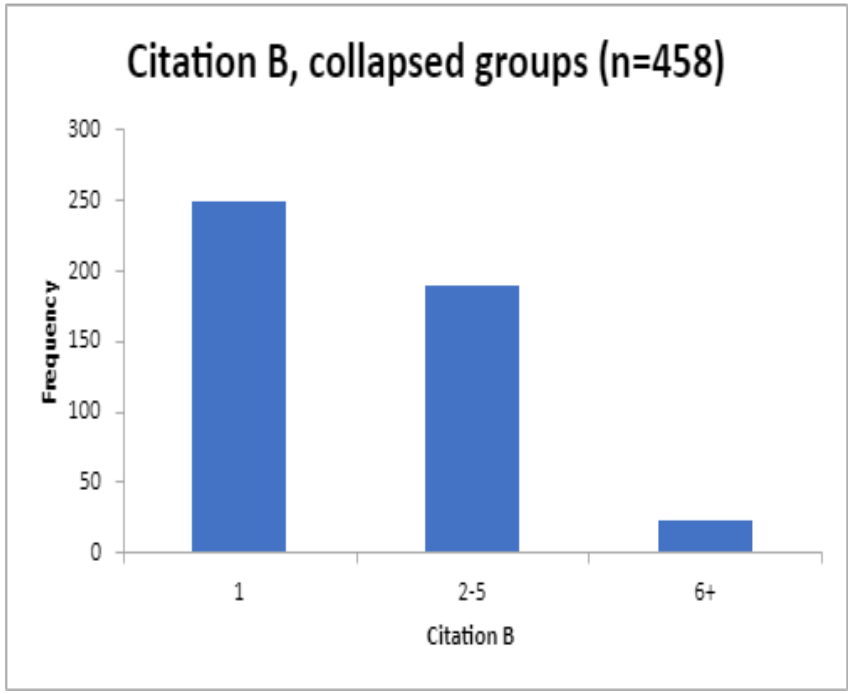
Class "A" . The violation at the time of occurrence **presents an imminent danger to the patient of the facility or a substantial probability that death or serious physical harm would result** therefrom. Examples of "serious physical harm" would be part of the body permanently removed, rendered functionally useless, substantially reduced in capacity temporarily or permanently, and/or part of the internal function of the body inhibited in its normal performance to such a degree as to temporarily or permanently cause a reduction in physical or mental capacity, or to shorten life.

Class "AA". The violation **meets the definition of a Class "A" AND was a direct proximate cause of patient harm and/or death** resulting from an occurrence the nature of which the regulation violated was designed to prevent.

Distribution of Citations

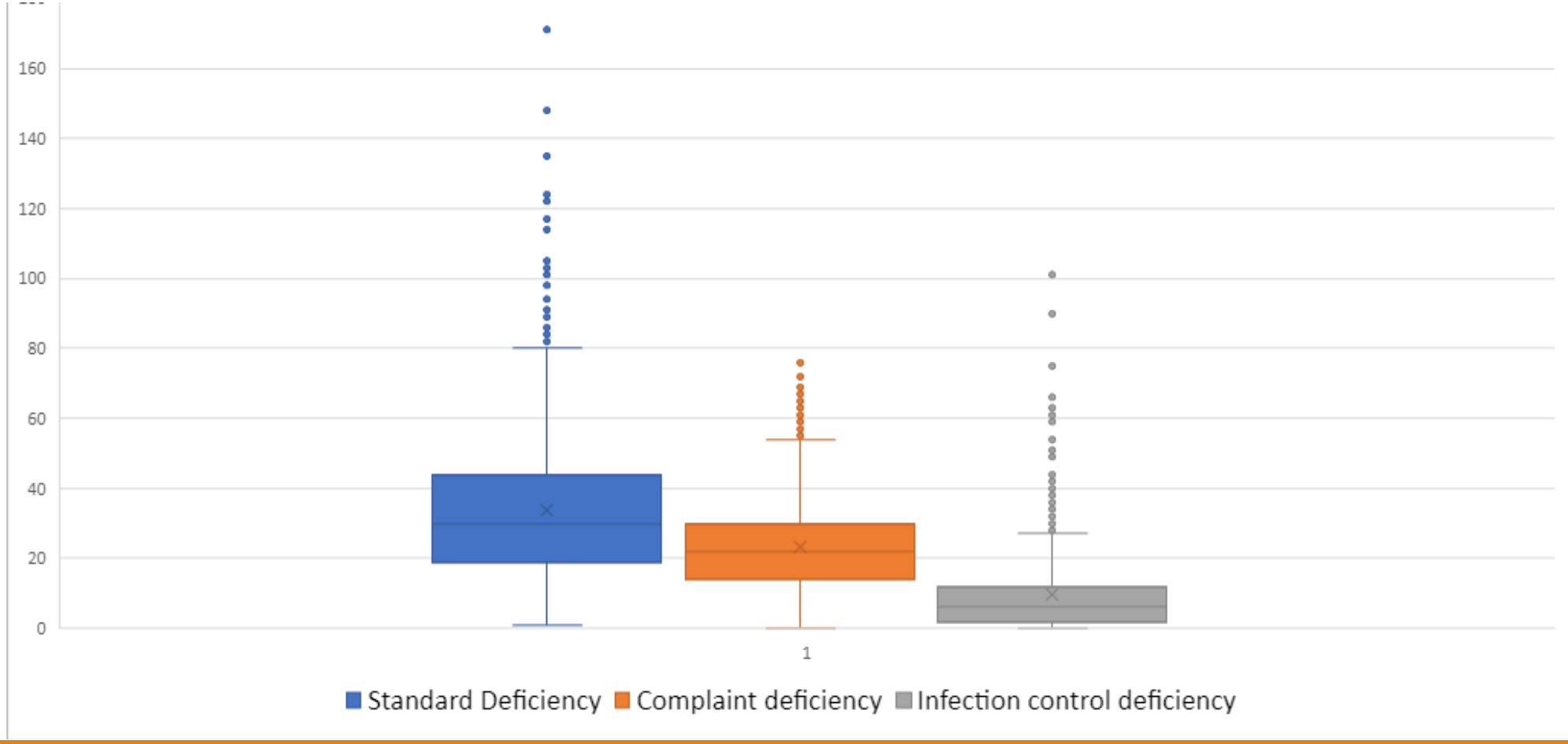






16 facilities had one AA citation each for this reporting period.

CMS Health Deficiencies



Quality of Facility: Severity and Scope of Violations

Measure	Staff Recommends	Staff Does Not Recommend	Notes
Deficiency Severity			**These categories add to 100%, which may cause confusion**
Death or Serious Injury	✓		Immediate jeopardy or serious harm to resident health and safety, or death occurred
Actual Harm	✓		Actual harm that is not immediate jeopardy
Minimal Discomfort	✓		No actual harm with potential for more than minimal harm that is not immediate jeopardy
No Harm, with the Potential for Minimal Harm	✓		No actual harm with potential for minimal harm
Deficiency Scope			**These categories add to 100%, which may cause confusion**
Widespread	✓		deficiencies are pervasive in the facility and/or represent systemic failure affecting facility population
Pattern	✓		more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice
Isolated	✓		one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.

These metrics are CMS reported; understandable, meaningful, modifiable.

CMS Health Inspection scores

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	**J** 50 points* (75 points)	**K** 100 points* (125 points)	**L** 150 points* (175 points)
Actual harm that is not immediate jeopardy	**G** 20 points	**H** 35 points (40 points)	**I** 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** 4 points	**E** 8 points	**F** 16 points (20 points)
No actual harm with potential for minimal harm	**A** 0 point	**B** 0 points	**C** 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.

Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care. See the Electronic Code of Federal Regulations (https://www.ecfr.gov/cgi-bin/text-idx?SID=9c4d022241818fef427dc79565aba4b5&mc=true&node=pt42.5.488&rgn=div5#se42.5.488_1301) for a definition of substandard quality of care.

* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a 'G-level" deficiency (i.e., 20 points) are assigned.

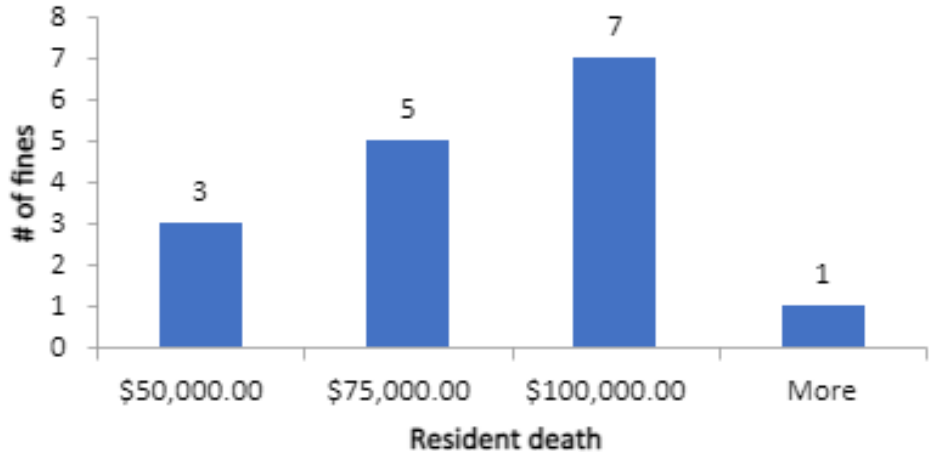
Source: Centers for Medicare & Medicaid Services

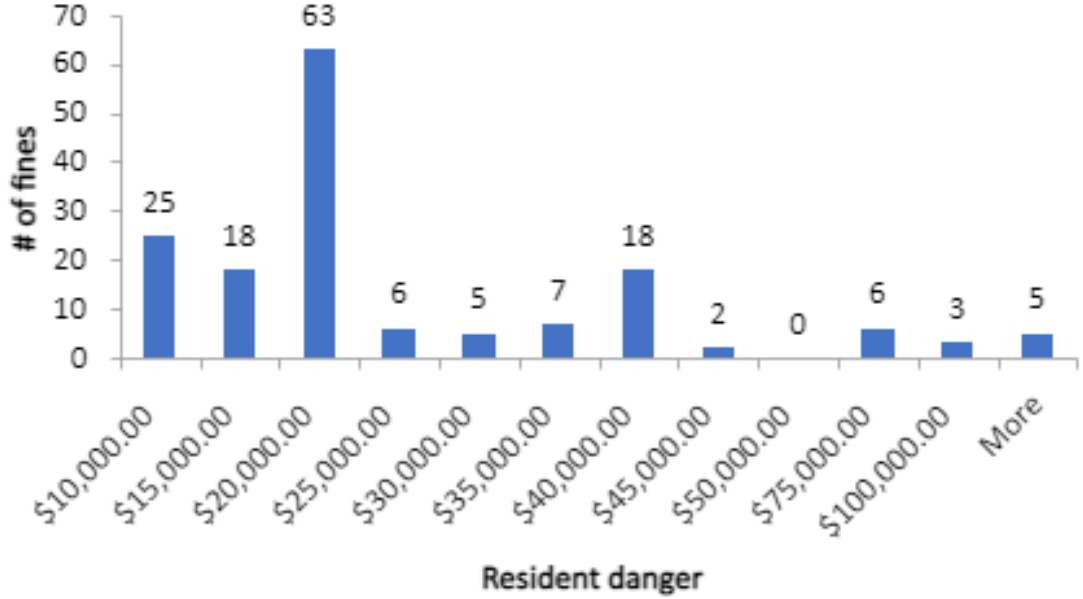
Quality of Facility: Penalties and Fines

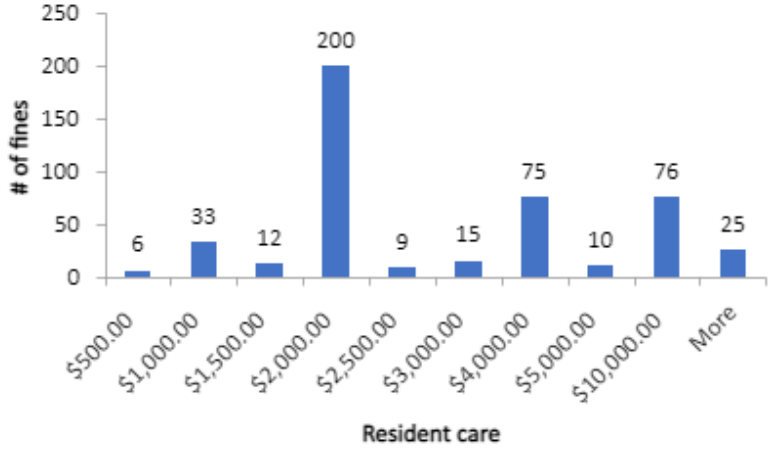
These metrics are unique CA-specific measures; understandable, meaningful, modifiable.

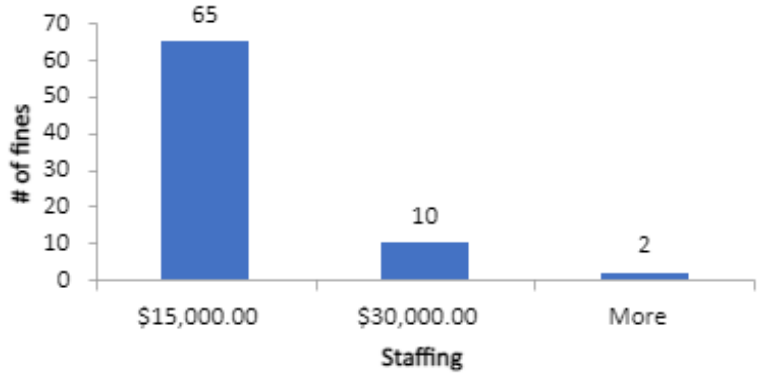
Measure **Facility Enforcement Actions Penalties and Fines**	Staff Recommends	Staff Does Not Recommend	Notes
State Violations and Fines: Resident Death ($)	✓		The Class AA citation is the most serious. A resident has died in such a way that the CDPH decided that the facility was responsible. The fines range from $25,000 to $100,000.
State Violations and Fines: Resident Danger ($)	✓		The Class A citation is issued when a resident is in immediate danger of death or serious bodily harm. The fines range from $2,000 to $20,000.
State Violations and Fines: Resident Care ($)	✓		The Class B citation is issued when a violation presents a direct or immediate risk to the resident's health, safety, or security. This can include emotional and financial elements. The fines range from $100 to $1,000.
State Violations and Fines: Staffing ($)	✓		Failure to provide each resident a minimum of 3.2 hours of skilled nursing care/day. Citation carries fines of $15,000 for failure to meet the requirement for 5-49% of the audited days; $30,000 for failure to meet the requirement for >49% of the audited days.
State Violations and Fines: Improper Disclosure ($)	✓		Unlawful or unauthorized access to, use, or disclosure of, a resident's medical information is not reported to the affected resident or the resident's representative, and/or to CDPH OR health record violations.
Total State Fines ($)	✓		Total dollar amount in state fines.
Federal Penalties and Fines			Total # of penalties and fines
Total Federal Fines ($)	✓		Fines are imposed once per deficiency or each day until the nursing home corrects the deficiency.
Denials of Payment for New Admission	✓		The government stops Medicare or Medicaid payments to the nursing home for new residents until the facility corrects the deficiency.

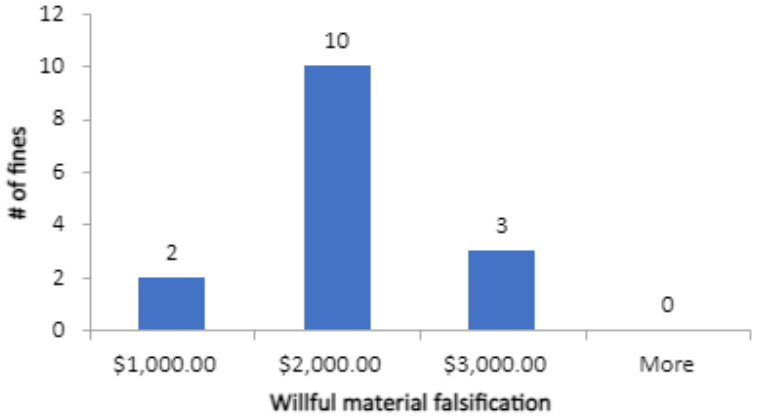
Fines Frequencies











CLOSED State Enforcement Actions 2016-2021 (n=573 Facilities)

	Original penalty **amount issued**	Final penalty **amount due**	Amount **collected** (Final minus Offset)	% collected of initial fine
Minimum	100	100	0	0%
Maximum	95,000	310,900	287,800	420%
Mean	14,278	14,664	11,958	82%

- NHs get a 35% reduction in penalty if paid within 30 days
- Appeals suspend the payment due until appeal is resolved – amount can be reduced or the enforcement action cancelled
- Between reduced and full penalties – avg 82% collected

Quality of Facility: Metrics for Discussion

Measure **Complaints (5-year total)**	Staff Recommends	Staff Does Not Recommend	Notes
Quality of Care	✓		• A complaint is a formal grievance against a facility that is filed with an ombudsman or the California Licensing and Certification (L&C) Program. • It is filed when someone has an objection to treatment or safety. • Complaints are grouped into eight categories. • After complaints are investigated by L&C, they are deemed either substantiated (if the inspector found the claim to be true), or unsubstantiated (if there was no proof to support the complaint). • If a complaint is substantiated, a deficiency or citation may be given to the facility.
Staffing	✓		
Abuse [Mistreatment]	✓		
Resident Rights	✓		
Environment	✓		
Nutrition	✓		
Administration	✓		
Total	✓		

Unique CA-specific measure; understandable, meaningful, modifiable.

LTAC Feedback About Quality of Facility Domain

Goal: 1) Motivate improvements in care (industry) and 2) provide simple, meaningful data for informed consumer decision making.

- Report total # of events (deficiencies, citations, complaints)
- Report total $ fines (plus total $ fines under appeal)
- Concern about reporting timeframe
  - 3 years?
  - Most recent year?

FUTURE WORK?

- Report 3-year weighted data for all measures by scope and severity

Nursing Home Honor Roll

? Staffing
? Short Stay Mobility
? Long Stay Functional Status

Methodology for CMS 5-Star Rating for Staffing

The CMS 5-star rating for staffing is based on two quarterly, case-mix adjusted measures:

- Total nursing hours per resident day (RN + LPN + nurse aide hours)
- RN hours per resident day

Table 4
Staffing and Rating (updated April 2019)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		< 3.108	3.108 - 3.579	3.580 - 4.037	4.038 - 4.407	≥4.408
1	< 0.317	★	★	★★	★★	★★★
2	0.317 - 0.507	★★	★★	★★	★★★	★★★
3	0.508 - 0.730	★★	★★★	★★★	★★★	★★★★
4	0.731 - 1.048	★★★	★★★	★★★★	★★★★	★★★★
5	≥1.049	★★★	★★★★	★★★★	★★★★★	★★★★★

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

HOLD: Update on CA Case-Mix Data from CMS FOIA

CLTCC Staffing Measures Available

- Nursing Hours per Resident per Day
  - Registered Nurse
  - Licensed Vocational/Practical Nurse
  - Nursing Assistants
  - Total
- Weekend Nursing Hours
  - Registered Nurse
  - Total Nurse
- Staff Turnover
- Staff Retention
- Staff COVID-19 Vaccination

Honor Roll Ideas

Measure	Description	Pros	Cons
Staffing (3 options)	Staffing levels as revised based on new case-mix	Research shows higher staffing levels highly correlated with better health outcomes	Not necessarily specific to interest (choosing care for long vs. short stay)
Turnover	Staff leaving	Turnover is found to negatively impact quality measures	Difficult to quantify how many positions turned over vs several staff turning over in same positions, which may be less negative impact
Retention + Turnover	# staff leaving & staff retained	Provides both the staff leaving but balanced by staff retained	May confuse the public between the two numbers
Retention + Turnover + Weekend	Staff leaving & staff retained & weekend staffing	Comprehensive reporting	May confuse the public with too many elements to understand

Examples of minimal qualifying criteria:

1. Minimum overall CMS star rating
2. Below threshold for citations or penalties in specific time period
3. Minimum staff vaccination rate (COVID-19)
4. Minimum percent of short stay residents meeting/exceeding ability to move at discharge
5. Maximum Percentage of long-stay residents who got an antianxiety or hypnotic medication

Honor Roll Ideas

Measure	Description	Pros	Cons
Long Stay Functional Status Composite	1. Percentage of Long-Stay Residents Whose Ability to Move Independently Worsened 2. Percentage of Long-Stay Residents Whose Need for Help with Activities of Daily Living Increased	Specific to choosing long stay Important goal for facilities to focus on	Dependent upon receiving denominator data from CMS These measure appear to be dropped in upcoming MDS reporting

Examples of minimal qualifying criteria:

1. Minimum staffing hours
2. Minimum overall CMS star rating
3. Below threshold for citations or penalties in specific time period

Honor Roll Ideas

Measure	Description	Pros	Cons
Short Stay Mobility Status Composite	1. Percentage of Short-Stay Residents Who Improved in Their Ability to Move Around on Their Own 2. Percentage of Residents Who Are At or Above an Expected Ability to Move Around at Discharge 3. Percentage of Residents Who Are At or Above an Expected Ability to Care for Themselves at Discharge	Focuses on key goal for those looking for short stay--gets at rehabilitation indirectly	Some of these measures may also be dropped Numbers can be "gamed" because NHs set a low goal that is easy for resident to achieve

Examples of minimal qualifying criteria:

1. Minimum staffing hours
2. Minimum overall CMS star rating
3. Below threshold for citations or penalties in specific time period

LTAC Feedback about Honor Roll

Goal: Motivate industry improvements in care without misleading consumers about quality of care at a facility.

1. Are there other measures you would like to see analyzed?
2. Which measures do you recommend for minimum qualifying criteria? Minimum scores?
3. Is there a minimum number/percent (10%?) of nursing homes that should make the Honor Roll?

Naming Convention

Alternative ideas suggested to replace "Honor Roll"

- Badge
- Certificate
- Award
- Accommodation

2022 Measures

Summer 2022

Update Data and Measures in Current Domains

- At-A-Glance
- Quality of Care Domain
- Staffing Domain

Additional Domain

- Quality of Facility Domain – MAY BE ABLE TO SCORE ADDITIONAL MEASURES

Future Work in 2022

Fall-Winter 2022

- **Nursing Home Honor Roll**
- **Cost and Finance Domain**
  - Medicare Days of Care
  - Benefits/Hour (all employees)
  - Nursing Wages/Hour
    - Directors of nursing/supervisors
    - Licensed Nurses (RN/LVN)
    - Nursing Assistants
- **Review Alternative Measure Sources**
- **Update Scoring with Case Mix (as available)**

Recognizing High Performing Facilities…

Ace in…

Best in…

Winning teams

Honor club

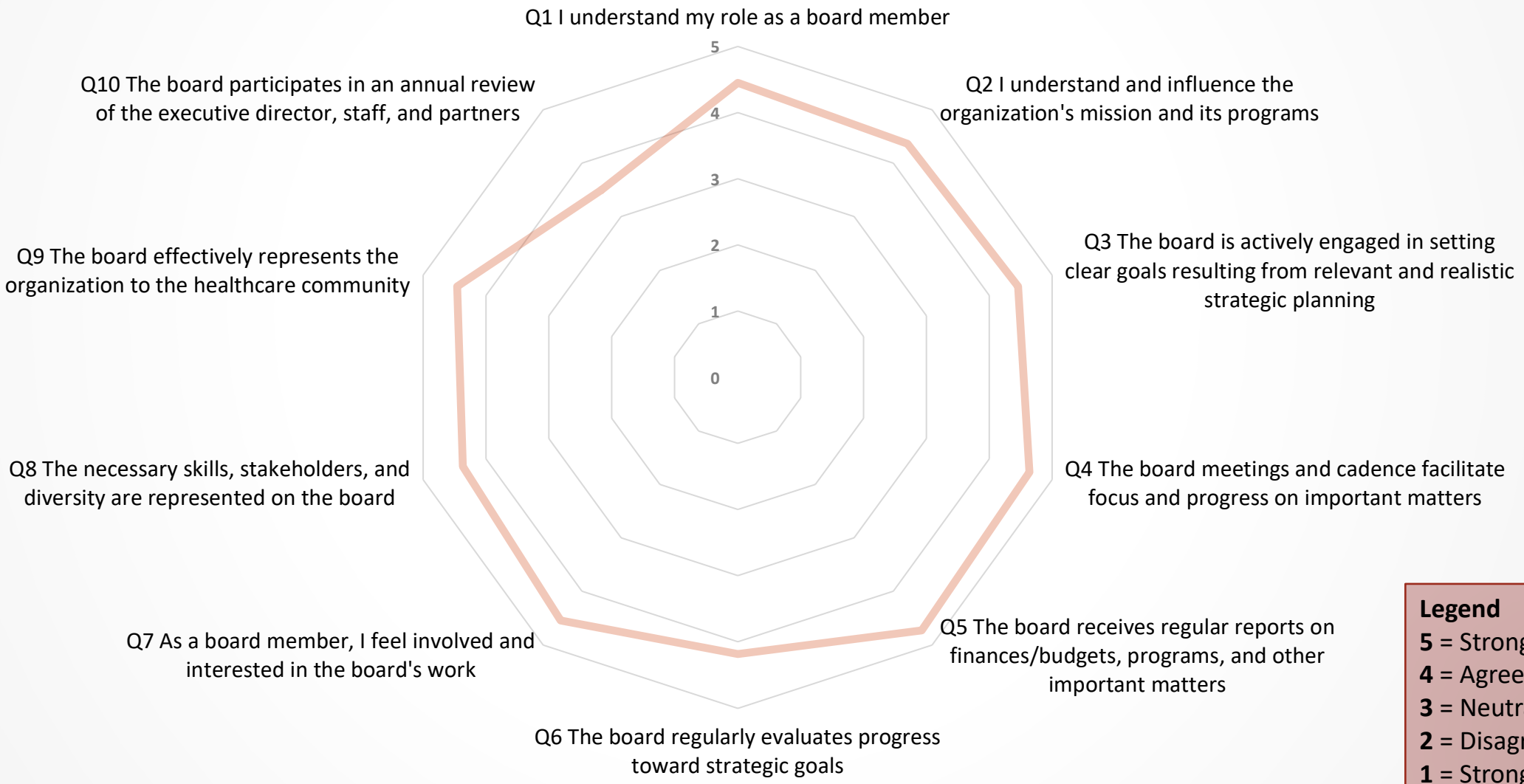
High “5” facilities

Leaderboard award

Formative Evaluation

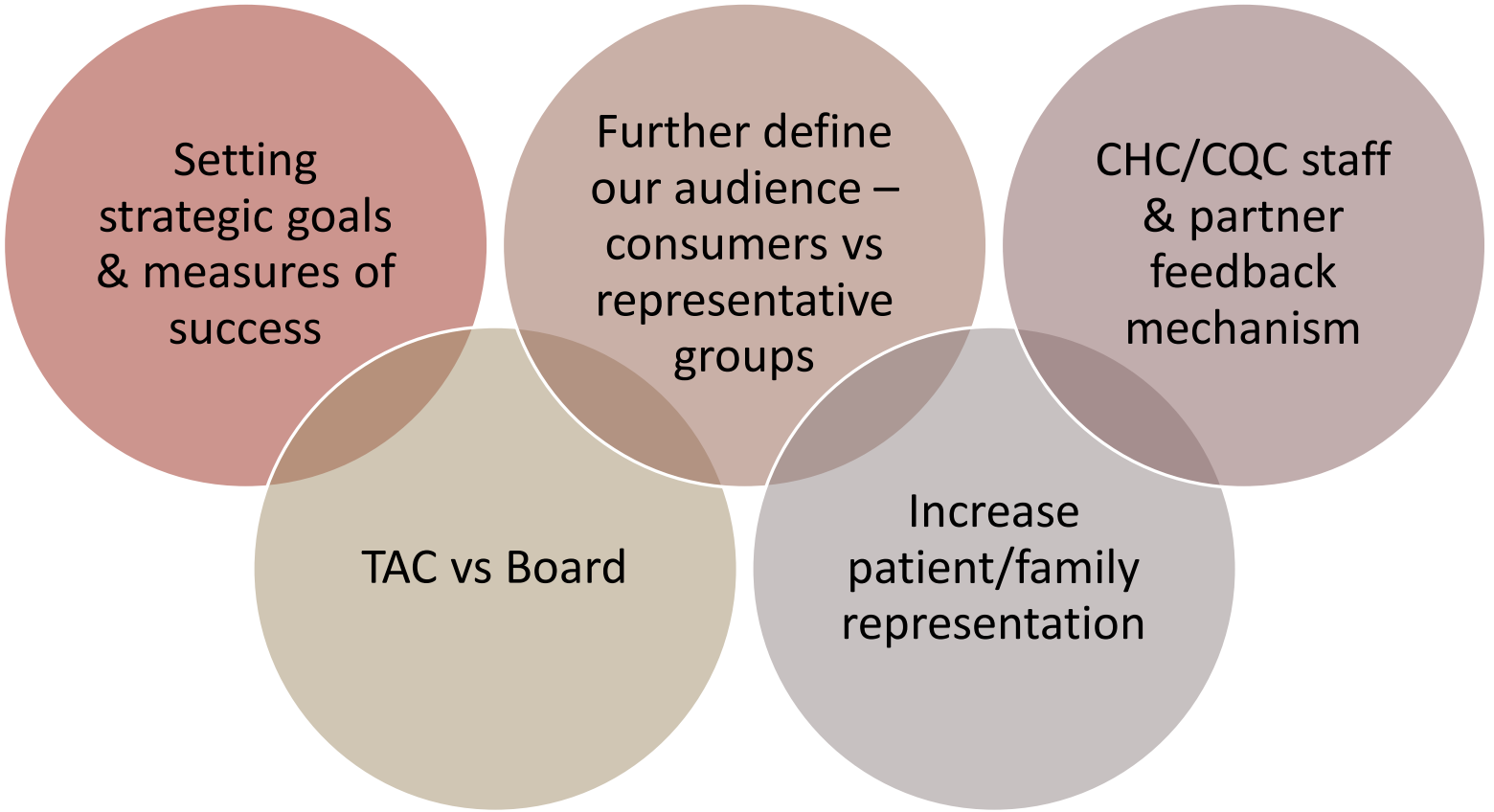
BUSINESS PLAN

BOD Formative Evaluation Results by Question
Average Score (11 respondents)



Legend
5 = Strongly agree
4 = Agree
3 = Neutral
2 = Disagree
1 = Strongly disagree

2022 BOD development opportunities



Data Vendor Proposals

FOR CAL HOSPITAL COMPARE

Wrap Up

2022 Cal Healthcare Compare BOD Schedule

(all times are Pacific Time Zone)

Tuesday, June 21	**11:00am to 2:00pm – Oakland**
Tuesday, September 13	11:00am to 2:00pm – virtual
Tuesday, December 13	10:00am to 1:00pm – tbd

2022 Meeting Cadence (Quarterly)

Meeting	CY 2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Cal Quality Care Technical Advisory Committee (2 hrs)		Feb 24		Apr 14			Jul 20			Oct 12		
Cal Hospital Compare Technical Advisory Committee (2 hrs)		Feb 15			May 10			Aug 16			Nov 15	
Board of Directors Virtual =2.5 hrs In person = 4 hrs			Mar 17 virtual			Jun 21 In person			Sep 13 virtual			Dec 13 virtual

Thank you!

2021 OPIOID MANAGEMENT HOSPITAL SELF-ASSESSMENT

Background: For more than a decade, Cal Hospital Compare (CHC) has been providing Californians with objective hospital performance ratings. CHC is a non-profit organization that is governed by a multi-stakeholder board, with representatives from hospitals, purchasers, consumer groups, and health plans. CHC uses an open and collaborative process to aggregate multiple sources of public data, and to establish relevant measures and scoring.

To address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths, CHC publishes an annual Opioid Care Honor Roll to support continued quality improvement and recognize hospitals for their contributions fighting the epidemic. CHC uses the *Opioid Management Hospital Self-Assessment* to assess performance and progress across the following 4 domains of care:

1. Safe & effective opioid use
2. Identifying and treating patients with Opioid Use Disorder
3. Overdose prevention
4. Applying cross-cutting opioid management best practices

Instructions: For each measure, please read through the measure description then select the level that best describes your hospital's work in that area. Please note that the levels build on each other e.g., to achieve a Level 3 score your hospital must have also implemented the strategies outlined in Levels 1 and 2. Similarly, if your hospital has addressed some of the components outlined in Level 4 but not Level 3 then your hospital may fall into the Level 3 or even the Level 2 category. CHC recommends each hospital convene a multi-stakeholder team to complete the *Opioid Management Hospital Self-Assessment* to ensure accuracy and completeness. To reduce variability in results year over year, CHC recommends hospitals follow a similar process each year.

Special note: For hospitals at any level of performance, we invite you to share detail on measures that you are currently reporting on. This will help us to understand and align future iterations of the *Opioid Management Hospital Self-Assessment* with the work that you are already doing. Providing this information is optional but highly encouraged.

For more information on the Opioid Care Honor Roll Program, register for upcoming events, and access tactical resources to support your quality improvement journey check out the Cal Hospital Compare website here.

Performance period: CY 2021

Assessment period: Jan 1, 2022 – Mar 31, 2022

Stay tuned for information on how to submit your Opioid Management Hospital Self-Assessment results!

Questions? Contact Alex Stack, Director, Programs & Strategic Initiatives via email at astack@cynosurehealth.org

Safe & Effective Opioid Use						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**

Appropriate Opioid Discharge Prescribing Guidelines
 	
Develop and implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new starts in opioid naïve patients and for patients on opioids to manage chronic pain. Possible exemptions: end of life, cancer care, sickle cell, and palliative care patients.
 	
Service line prescribing guidelines should address the following:
• Opioid use history (e.g., naïve versus tolerant)
• Pain history
• Behavioral health conditions
• Current medications
• Provider, patients, and family set expectations regarding pain management
• Limit benzodiazepine and opioid co-prescribing
• For opioid naïve patients:
  ○ Limit initial prescription (e.g., <5 days)
  ○ Use immediate release vs. long acting
• For patients on opioids for chronic pain:
  ○ For acute pain, prescribe short acting opioids sparingly
  ○ Avoid providing opioid prescriptions for patients receiving medications from another provider
	Developed and implemented evidence-based opioid discharge prescribing guidelines in **1 service line**, the Emergency Department OR 1 Inpatient Unit (e.g., Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented evidence-based opioid discharge prescribing guidelines across **2 service lines**, the Emergency Department AND 1 Inpatient Unit (e.g., Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented **hospital wide** opioid discharge prescribing guidelines	Developed and implemented evidence-based opioid discharge prescribing **guidelines for surgical patients in at least one surgical specialty** as part of an Enhanced Recovery After Surgery (ERAS) program	Your hospital is actively **measuring and developing strategies to improve** appropriate opioid prescribing at discharge
					
					Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)	

Safe & Effective Opioid Use						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Alternatives to Opioids for Pain Management Use an evidence based, multi-modal, non-opioid approach to analgesia for patients with acute and chronic pain. Guidelines should address the following: • Utilize non-opioid approaches as first line therapy for pain while recognizing it is not the solution to all pain • Provide pharmacologic alternatives (e.g., NSAIDs, Tylenol, Toradol, Lidocaine patches, muscle relaxant medication, Ketamine, medications for neuropathic pain, nerve blocks, etc.) • Offer non-pharmacologic alternatives (e.g., TENS, comfort pack, heating pad, visit from spiritual care, physical therapy, virtual reality pain management, acupuncture, chiropractic medicine, guided relaxation, music therapy, aromatherapy, etc.) • Provide care guidelines for common acute diagnoses e.g., pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation (ALTO Protocol) • Opioid use history (e.g., naïve versus tolerant) • Patient and family engagement (e.g., discuss realistic pain management goals, addiction potential, and other evidence-based pain management strategies that could be used in the hospital or at home)	Your hospital **does not** have a standardized approach to providing alternatives to opioids for pain management	Developed and implemented a non-opioid analgesic multi-modal pain management in the **Emergency Department OR 1 Inpatient Unit** (e.g., Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented a non-opioid analgesic multi-modal pain management guideline in the **Emergency Department AND 1 Inpatient Unit** (e.g., Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital offers at least at least **1 non-pharmacologic alternative** for pain management	Developed **supportive pathways** that promote a team-based care approach to identifying opioid alternatives (e.g., integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, etc.) **Aligned standard order sets** with non-opioid analgesic, multi-modal pain management program (e.g., changes to EHR order sets, set order favorites by provider, etc.)	Your hospital is actively **measuring and developing strategies to improve** use of opioid alternatives for pain management *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Identification and Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**

Medication Assisted Treatment (MAT)
 	
Provide MAT for patients identified as having Opioid Use Disorder (OUD), or in withdrawal, and continue MAT for patients in active treatment.
 	
Components of a MAT program should include:
• Identifying patients eligible for MAT, on MAT, and/or in opioid withdrawal
• Treatment is accessible in the emergency department and in all other hospital departments
• Treatment is provided rapidly (same day) and efficiently in response to patient needs
• Human interactions that build trust are integral to treatment
 	
*Suggested guidelines for how to universally offer MAT to all patients:
• Do <u>not</u> screen patients for OUD
• Do <u>not</u> ask patients if they are interested in MAT services
  ○ May be time consuming for providers and stigmatizing for patients
• <u>Do</u> promote MAT services using signage in waiting and exam rooms, badge flare, and patient forms
• During the exam, providers routinely let patients know that their site offers MAT
  ○ So that patients can choose to disclose whether and when they need support
	Methadone and buprenorphine on hospital **formulary**	MAT is offered, initiated, and continued for those already on MAT in at least **1 service line** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)
		
		Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT
			MAT is offered, initiated, and continued for those already on MAT in at least **2 service lines** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	MAT is **universally offered*** to all patients presenting to the hospital
				
				One or more **hospital staff** has the time and skills to **engage with patients** on a human level, motivating them to engage in treatment (e.g., a hospital employee embedded within either an emergency department or an inpatient setting to help patients begin and remain in addiction treatment – commonly known as a Substance Use Navigator, Case Manager, Social Worker, Patient Liaison, Chaplain, etc.)
					Your hospital is actively **measuring and developing strategies to improve** access to MAT
					
					Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)	

Identification & Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Timely follow up care Hospital coordinates follow up care for patients initiating MAT within 72 hours either in the hospital or outpatient setting. Hospital based providers and practitioners must have a X-waiver to prescribe buprenorphine at discharge under the Drug Addiction Treatment Act of 2000 (DATA 2000). As of 2021 for providers treating ≤30 patients the X-waiver education requirement is waived. If hospital does not have X-waivered providers: • Providers may provide a loading dose for long effect, provide follow up care in the ED that is in alignment with the DEA Three Day Rule or connect patient to X-waivered community provider for immediate follow care If hospital has X-waivered providers: • Prescribe sufficient buprenorphine until patient's follow up appointment with community provider within 24 to 72 hours *Practitioners= MDs, physician extenders, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives (see SUPPORT Act for details)	Hospital **identifies X-waivered providers** within the hospital and/or within the community Provides list of **community-based resources** for follow up care to patients, family, caregivers, and friends (e.g., primary care, outpatient clinics, outpatient treatment programs, telehealth treatment providers, etc.)	Hospital provides support to **practitioners* in the ED and IP units to obtain X-waiver** (e.g., provides education on changes to x-waiver education requirement, supports application process, education on how to use buprenorphine, hospital's process for providing MAT, etc.) Hospital is actively **building relationships and coordinating with post-acute services to support care transitions**	Hospital has an agreement in place with **at least one community provider to provide timely follow up care**	**Actively refer** MAT and OUD patients to a community provider for ongoing treatment (e.g., primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, etc.)	Your hospital is actively **measuring and developing strategies to improve** patient access to timely follow up care *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Overdose prevention						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Naloxone education and distribution program Provide naloxone prescriptions and education to all patients, families, caregivers, and friends discharged with an opioid prescription and/or at risk of overdose. *Staff include MD, PA, NP, Pharmacist, RN, LVN, Health Coach, Substance Use Navigator, Clinical Social Worker, Research Staff, Emergency Department Technician, Clerk, Medical Assistant, Security Guard, etc. trained to distribute naloxone and provide education on how to use it	Hospital **does not engage in overdose prevention** strategies	**Identify overdose prevention resources within hospital, health system, and community** (e.g., training programs, community access points, low/no-cost options, community pharmacies with naloxone on hand, community coalitions, California Naloxone Distribution Program, etc.)	**Standard workflow** for MDs and physician extenders in place for providing naloxone prescription at discharge for patients with a long-term opioid prescription and/or at risk of overdose; discharge prescriptions sent to patient's pharmacy of choice (e.g., naloxone incorporated into a standard order set for appropriate opioid prescriptions, and/or referral to low or no cost distribution centers, etc.)	**Standing order** in place allowing approved staff* to educate and distribute naloxone in hand to all patients, caregivers, at no cost while in the hospital setting under the California Naloxone Distribution Program; this should be an ED led process in collaboration with pharmacy (see CA BRIDGE Guide to Naloxone Distribution for details)	Your hospital is actively **measuring and developing strategies to improve** access to naloxone *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Organizational Infrastructure Opioid stewardship is a strategic priority with multi-stakeholder buy in and programmatic support to drive continued/sustained improvements in appropriate opioid use (e.g., executive leadership, Pharmacy, Emergency Department, Inpatient Units, General Surgery, Information Technology, etc.)	Opioid stewardship is **not a quality improvement priority**	**Multi-stakeholder team** identified opioid stewardship as a strategic priority and set improvement goals in one or more of the following areas: safe and effective opioid use, identifying and treating patients with OUD, overdose prevention, applying cross-cutting opioid management best practices (e.g., opioid stewardship committee, medication safety committee, a dedicated quality improvement team, subcommittee of the Board, etc.) **Executive sponsor/project champion identified**	**Communicated program, purpose, goal, progress to goal to appropriate staff** (e.g., a dashboard, all staff meeting, annual competencies, etc.) Opioid stewardship is included in **strategic plan** **Hospital/health system leadership plays an active role** in reviewing data, advising and/or designing initiatives to address gaps	Hospital participates in **local opioid coalition**	Your hospital is actively **measuring and developing strategies** that support opioid stewardship as an organizational priority *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance misuse. Hospital actively addresses stigma through the education and promotion of the medical model of addiction, trauma informed care, harm reduction principles including, motivational interviewing across all departments to facilitate disease recognition and the use of non-stigmatizing language/behaviors (e.g., words matter).	Hospital **does not address stigma with** physicians and staff	Provides passive, **general education** on hospital opioid prescribing guidelines in **at least 2 service lines**, identification, and treatment, and overdose prevention to appropriate providers and staff (e.g., M&M, lunch and learns, flyers/brochures, CME requirements, RN annual competencies, etc.)	Provides **point of care decision making support** (e.g., MME flag for providers, automatic pharmacy review for long-term opioid prescription, auto prescribe naloxone with any opioid prescription, reminder to check CURES, flag concurrent opioid and benzo prescribing, etc.)	Trains appropriate providers and staff on, some combination of, the **medical model of addiction, harm reduction principles, motivational interviewing and how to provide trauma informed care** to normalize opioid use disorder and treatment (e.g., M&M, lunch and learns, CME requirements, RN annual competencies, etc.) **Regularly assesses stigma** among providers and staff (e.g., audit of existing materials for stigmatizing language - internal documentation, forms, brochures, signs, annual survey, focus groups, focused leader rounding, etc.)	Your hospital is actively **measuring and developing strategies** to addresses physician and staff stigma towards OUD patients *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Patient and family engagement **Actively engage** patients, families, and friends in appropriately using opioids for pain management (opioid prescribing, treatment, and overdose prevention via naloxone, hospital quality improvement initiatives, etc.)	**Patients and families are not actively** engaged in OUD prevention, treatment, and/or quality improvement initiatives	Provides general education to **all patients, families, and friends in at least 2 service lines** (e.g., ED, Burn Care, General Medicine, Behavioral Health, OB, Cardiology, Surgery, etc.) regarding opioid risk, alternatives, and overdose prevention (e.g., posters about preventing or responding to an overdose, brochures/fact sheets on opioid risk and alternative pain management strategies, general information on hospital care strategies on website or portal, etc.)	Provides **focused education** to opioid naïve and opioid tolerant patients via conversations with care providers (e.g., MAT options, opioid risk and alternatives, naloxone use, etc.) Patients are part of a **shared decision-making process** for acute and/or chronic pain management (e.g., develop a pain management plan pre-surgery, set pain expectations, risk associated with opioid use, etc.)	Provides opportunities for **patients and families to engage** in hospital wide opioid management activities (Patient Family Advisory Council, peer navigator, program design, etc.)	Your hospital is actively **measuring and developing strategies** to improve patient and family engagement *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Addressing Substance Use Disorder *(OPTIONAL: Progress in this domain does not count toward the 2021 Opioid Care Honor Roll)*						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**
Many patients misuse more than one drug. Cal Hospital Compare is considering whether and how to address substance use disorder as part of the Opioid Care Honor Roll program in subsequent years. If applicable, please select the substance that you would most like us to address and select the level that best describes your hospital's work in that area. • Alcohol • CNS depressants (e.g., barbiturates, benzodiazepines, etc.) • Illicit fentanyl • Heroin • Methamphetamine • Marijuana/synthetic cannabinoids • Tobacco/nicotine • Other	**No standardized process** to identify patients misusing selected substance	**Standardized process in place** to identify patients misusing selected substance in the ED and on admission (e.g., Alcohol Use Disorders Identification Test, Brief Screener for Alcohol, Tobacco, and other Drugs, NIDA single question screener, Screening to Brief Intervention, etc.) Process to **manage withdrawal** in the hospital setting for selected substance, if applicable (e.g., alcohol withdrawal protocol in place)	**Medications required for treatment on formulary, if applicable** (e.g., naltrexone bupropion, nicotine replacement therapies, etc.) **If primary treatment medications are not on formulary**, other treatment options are made available (e.g., topiramate, baclofen, gabapentin, etc.)	Treatment is offered and initiated in at least **1 service line** (ED or inpatient)	**Actively refer** patients to a community provider for ongoing treatment (e.g., residential treatment facility, outpatient clinic, telehealth, etc.) Provide **culturally competent care** (e.g., translation services, translated materials, etc.)	

Open ended responses:

Briefly describe the steps your hospital has taken to improve opioid stewardship across the 4 domains assessed in the 2021 Opioid Management Hospital Self-Assessment.

What would you like to learn more about in 2022 that would help you to close a gap in your work?

What else do you want us to know?

2021 Opioid Management Hospital Self-Assessment Results

Measures	Score
Safe & effective opioid use	
Appropriate opioid discharge prescribing guidelines	
Alternatives to opioids for pain management	
Identification & treatment	
Medication Assisted Treatment (MAT)	
Timely follow-up care	
Overdose prevention	
Naloxone education and distribution program	
Cross cutting opioid management best practices	
Organizational infrastructure	
Address stigma with physicians and staff	
Patient and family engagement	
Addressing substance use disorder (OPTIONAL: Progress in this domain does not count toward the 2021 Opioid Care Honor Roll)	*NA*
"Hon-rolled" a friend *Share the Opioid Care Honor Roll opportunity with another hospital that did not participate in 2020. If they apply for the 2021 Opioid Care Honor Roll you both get 1 additional point.*	Provide hospital name(s)
Total score *(out of 32 points)*	