Cal Healthcare Compare Board of Directors Meeting

TUESDAY, JUNE 21, 2022

10:00AM PT

Cal Healthcare Compare
Board of Directors Meeting Agenda
Tuesday, June 21, 2022, 10:00am – 1:00pm PST
Virtual Meeting

Participant Dial In 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
10:00 - 10:15 *15 min.*	Welcome and call to order - Introductions & new to the Board - Announcements - Approval of past meeting summary - Consent Agenda	- **Ken Stuart** Board Chair - **Bruce Spurlock** Executive Director Cal Healthcare Compare
10:15 –10:45 *30 min.*	Cal Healthcare Compare Operations - Board composition – size, diversity, & advisory positions - 2023 data use fees - Financials - CMS measure suppression	- **Bruce Spurlock** Cal Healthcare Compare
10:45 - 11:30 45 min.	Cal Long Term Care Compare - Overview - Review of Domains o Staffing Domains o Quality of Facility Domain - Federal and State Violations - Complaints - Penalties and Fines	- **Alex Stack** Director, Cal Healthcare Compare - **Deb Bakerjian** Clinical Professor, UC Davis Health
11:30 –12:55 85 min.	Cal Hospital Compare - 2021 opioid care honor roll results & next steps o How to recognize "most improved?" - HPI updates o Refresher o HPI 2.0 vs 3.0 data o Website demo - Social needs index workgroup o Recap workgroup discussions o Recommendations, next steps, BOD approval - Health equity landscape: HCAI activities - 2022 network analysis results - Impact of COVID-19 on quality	- **Alex Stack** Director, Cal Healthcare Compare - **Mahil Senathirajah** Senior Director IBM Consulting - **Chris Krawczyk** HCAI
12:55 – close	Adjourn – Next meeting: Tuesday, September 13, 2022 at 10:00am PT	- **Ken Stuart** Board Chair

Cal Healthcare Compare
Board of Directors Meeting Summary
Thursday, March 17, 2022, 10:00am PST

Attendees: Gretchen Alkema Ash Amarnath, Debra Bakerjian, Richele Benevent, Kristen Bettega, Tracy Fisk, Staci Gillespie, Terry Hill, David Hopkins, Libby Hoy, Chris Krawczyk, Helen Macfie, Joan Maxwell, Dominique Ritley, Patrick Romano, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Kristof Stremikis, Ken Stuart, Kevin Worth

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting was called to order at 10:00am PST. • The minutes from the meeting on December 1, 2021 were moved, motioned, seconded and approved as written.
General Updates	• Helen Macfie will officially retire from Memorial Care in June 2022. • A new "parent" website for Cal Healthcare Compare will launch in March and provide links to both CHC and CLTCC. • The Cal Long Term Care Compare went live on January 26th. CHC is planning communication via targeted outreach to stakeholders and other networks, requesting organizations to promote the new site. A formal press release will be published in February. • CHC solicited TAC & BOD support with submitting advocacy letters to the Senate Budget Committee, requesting funding to expand the CLTCC website to include non nursing home providers. Will include reference to California's Master Plan for Aging in the letter template. • It was recommended to recruit a new BOD member that has • The open application period for the 2021 Opioid Care Honor Roll will close on March 31, 2022.
Cal Hospital Compare	IBM Watson provided a high-level overview of the Social Needs Index work. IBM reran all analytics and updated the mapping tool. The Public Health Alliance of Southern California will launch HPI 3.0 in late March. HCAI's regulation packet will be circulated for public comments on March 25th. Determining action on the needs assessment is a collaborative effort with the community. Having access to physicians in certain hospitals can be a complex issue. The findings from the re-hospitalization chart are profoundly valuable from a Medi-Care perspective. A social needs index workgroup will convene for three meetings in April and May to discuss how hospitals can validate and use the Healthy Places Index (HPI). TAC and BOD members are invited to participate. Results of the 2021 Patient Safety Honor Roll will be announced in March 2022. Participating health plans will receive the honor roll and poor performance reports.

Cal Long Term Care Compare	The CLTCC website will be updated in May 2022 and include two new CMS staffing measures. UC Davis presented a detailed overview of the quality of facility domain - fines and citations measure. The LTAC did not have a strong opinion to defer from reporting a 3-year weighted data for all measures by scope and severity. CHC has the capability of displaying 1 year and 3 year trends on the website. The LTAC and BOD were supportive of being transparent with the data without overwhelming the consumer. It is important to display this data as an at glance and deeper dive. The vast majority of consumers are those making a referral to a nursing home. What are the levers that can be pulled to change the nursing home industry? There is a diminished local level of control with many nursing homes. How can we take a multi-pronged approach to drive improvement? Libby with PFCC partners shared that access to information indicated safety and quality to consumers. Consumers were interested in seeing how nursing homes improved their care (i.e. staffing rates, patient experience reports). On-line tools like FindHelp (Aunt Bertha rebranded) would also be interesting to look at. Are there avenues to obtain different data points that make a difference to consumers? The LTAC explored different ideas and titles for recognizing a nursing home honor roll based on staffing quality. The title "Honor Roll" will be substituted for a new name. Further discussion to follow at the next BOD meeting.
Next Meeting/Meeting Adjournment	• Next meeting: Tuesday, June 21st from 10:00am to 2:00pm PST. • The meeting formally adjourned at 1:33pm PST
Executive Session	• An executive session convened immediately following the adjournment of the Board meeting.

Proposed Agenda

- Welcome and Call to Order
- Consent Agenda
- Operations
- Cal Long Term Care Compare
- Cal Hospital Compare
- Wrap Up

Welcome & Introductions

Welcome New Board Member - Rachel Brodie

Rachel Brodie leads multi-stakeholder initiatives to advance healthcare quality and put performance information to use for payment and decision-making. She leads several measurement collaboratives, including one for statewide patient-reported experience, and fielded a new telehealth experience survey that measures disparities in care and enables quality improvement. She also leads a national initiative to demonstrate the feasibility and impact of collecting and using outcome measures to support value-based contracting and payment and develop methods to address barriers to collecting patient-reported outcomes (PROs). Rachel managed the California Joint Replacement Registry which reported results of hip and knee replacement surgeries, including PROs. She has served on several technical committees for CMS, NQF, AHRQ, CQMC, ASCO and IHA. She received a BA from Princeton University.

Announcements

- Effective **July 1, 2022,** Cal Hospital Compare will transition from IBM Watson to American Institutes for Research (AIR) to provide data analytics

- Thank you to IBM Watson for your dedication and contributions to the HTAC and Board of Directors!

Consent Agenda

General Updates

2022 Patient Safety Honor Roll Results & Poor Performers Report

2022 Maternity Honor Roll Results

Formal Announcement for All Honor Rolls

General Updates

--Bi-annual website refresh scheduled for July 2022

--Better Staffing Recognition (BSR) will be delayed until next refresh in December/January

--The request for budget support for $1M funding to expand the CLTCC website has passed through the assembly budget and is pending approval from the CA Governor.

- CLTCC is continuing with targeted email outreach and virtual presentations to CA community organizations, hospitals, ombudsman services and other networks.
  - Let's continue to promote Cal Healthcare Compare's LinkedIn page by sharing with fellow stakeholders, colleagues, and other connections!

General Updates

--Website refresh scheduled for July 2022 and will include CY 2021 maternity data

--Honor roll announcements are updated on the website and reports distributed to subscribing health plans:

- 2021 Opioid Care Honor Roll
- 2022 Patient Safety Honor Roll
- 2022 Maternity Care Honor Roll

Patient Safety Honor Roll & Patient Safety Poor Performers Report

323 hospitals were considered

86 hospitals were identified as high patient safety performers

- 18 hospitals met Tier 1 criteria
- 68 hospitals met Tier 2 criteria
- 57 hospitals also received recognition on the 2020 honor roll
- 29 hospitals are new to this year's honor roll

71 hospitals were identified as poor performers

- 11 Tier 1 hospitals
- 60 Tier 2 hospitals
- 24 additional hospitals were recognized on the 2022 report in comparison to the 2021 report
- All 24 additional hospitals were Tier 2 category

2022 Maternity Care Honor Roll

- 211 hospitals were considered using CY2021 data
- 108 hospitals (51%) achieved honor roll status meeting the revised 23.6% threshold
- 32 of the 108 hospitals achieved honor roll status for the past six years

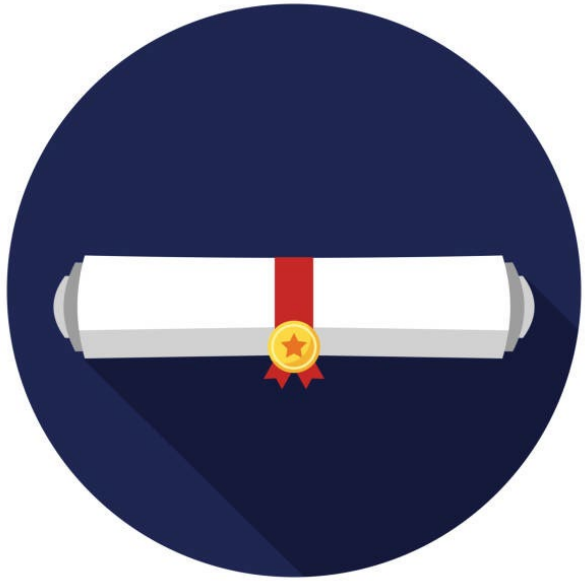
Honor Rolls

Stay tuned for a formal release announcing the new honor roll recipients in summer 2022!

2022 Patient Safety Honor Roll

2022 Maternity Honor Roll

2021 Opioid Care Honor Roll



Operations

Board History

Steering Committee (2005)

- 30+ representatives
- Inclusivity to create "one version of the truth"
- Large hospital representation
- Decision making was slow and cumbersome
- Supported by CHCF Grant

1st BOD (2009)

- Formal BOD for new corp.
- 4 consumers
- 5 hospitals
- 4 purchasers
- 4 health plans
- ACNL
- Multiple ex-officio members
- Improvement in some processes but consensus was slow
- Self-sufficient funding

2nd (2013) & 3rd BOD (2021)

- 3 consumers
- 2 hospitals
- 2 purchasers
- 2 health plans
- + Kaiser
- + Executive Director
- Ex-officio members only state agencies
- Added 2 LTC representatives in 2021
- BOD attendance across representative groups is not consistent

4th BOD

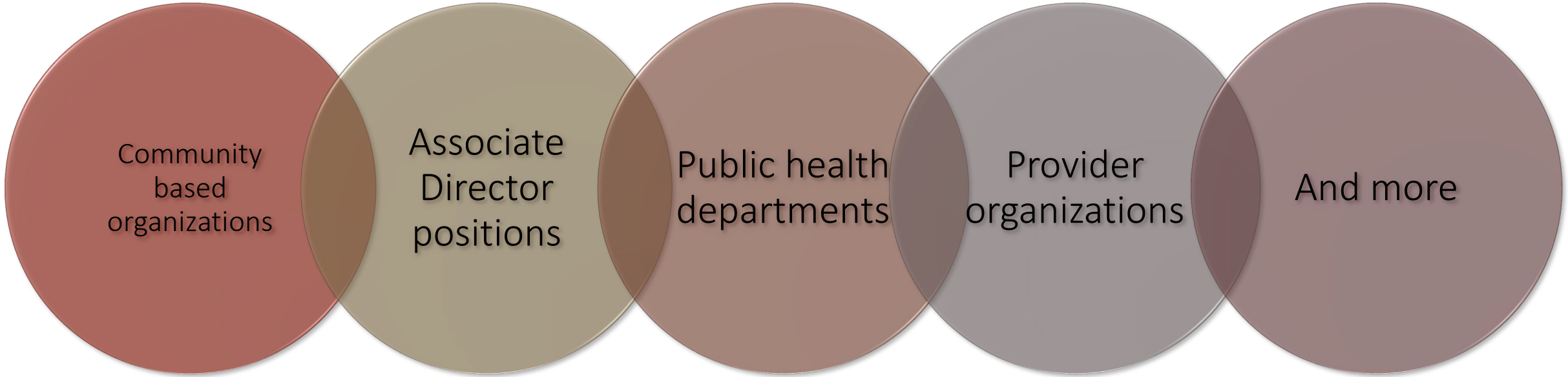
- Proposal to
  - expand BOD size
  - include new role of associate director

Why alter BOD Composition?

- Add new diverse perspectives
- Easier to get quorum
- Decisions have impact on new stakeholders
- Evolution of public reporting

Board Composition

Potential Additional Representation:



2023 Data Use Fees

- BOD to discuss at the September 2022 meeting
- Updated data use fees with consider:
  - Possible Department of Aging Funding for the expansion of the Cal Long Term Care Compare website ($1M)
  - Planned business development for health equity activities
  - Additional data services e.g., HPI base package, nursing home information, etc.
  - Interest and ability of plans to pay annual fee

CMS proposes to suppress rates of **preventable complications from surgery**

THE LEAPFROG GROUP
Giant Leaps for Patient Safety

Health Care Choices and why they matter | About Our Ratings and reports | Hospital Survey and materials | ASC Survey and materials | News, Events and impact | Who We Are and our mission

We Need Your Help - Don't Let CMS Suppress the Data on 25,000 Deaths a Year in Hospitals

May 26, 2022

CMS, the federal agency that runs Medicare, proposes to suppress data on some of the most dangerous medical and surgical complications that happen in hospitals. These dangerous complications, such as sepsis, kidney harm, deep bedsores, and lung collapse, are largely preventable yet kill 25,000 people a year and harm 94,000. The rates of harm for these medical and surgical complications are reported by hospital as part of a measure called CMS Patient Safety and

Spread the Word:

Click to Tweet

CMS proposes to suppress data on some of the most dangerous medical and surgical complications happening in

Cal Long Term Care Compare

Overview: July Website Refresh

- **Refresh Data for Quality of Care (QOC) Domain (COVID-19 Vaccines)**

- **Updating Data for Staffing Domain**
  - COVID-19 vaccination rates & scores for staff (booster + vaccine composite*)
  - Add Weekend staffing hours
  - Update HPRD to 0.xx to improve specificity

- **Nursing Home Recognition Initiative: Staffing**
  - Scoring: PDPM data challenges

- **Adding Quality of Facility Domain** New
  - Counts citations, deficiencies, complaints
  - Dollars in federal and state penalties

QOC: COVID-19 Vaccines*

- Recommend reporting a combined, weighted rate of *residents* vaccinated **and** boosted
- Recommend reporting a combined, weighted rate and score *staff* vaccinated **and** boosted
  - Pros: including booster is important as it conveys better protection, one rate (with partial credit for completing primary series) reduces cognitive burden and complexity
  - Cons: new type of measure, not reported elsewhere (see below)

Provider Name	# resident	# vaccinated residents	% vaccinated residents	# boosted resider	% Boosted resider	# staff	# vaccinated staff	Vaccinated staff	# boosted staff	% boosted staff	Percentage of Current Healthcare
REDLANDS HEALTHCARE CENTER	69	59	85.507	40	67.797	138	122	88.406	107	87.705	87.705
COUNTRY MANOR HEALTHCARE	85	76	89.412	70	92.105	123	123	100	122	99.187	99.187
EUREKA REHABILITATION & WELLNE	72	62	86.111	51	82.258	96	89	92.708	83	93.258	93.258
EDGEMOOR HOSPITAL			95.679		94.839			99.747		97.716	

*Also applies to Staffing Domain

Does the Board agree to reporting a combined COVID-19 vaccine measure for staff?

What about reporting for residents?

Staffing Domain

Methodology for CMS Staffing 5-Star Rating

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

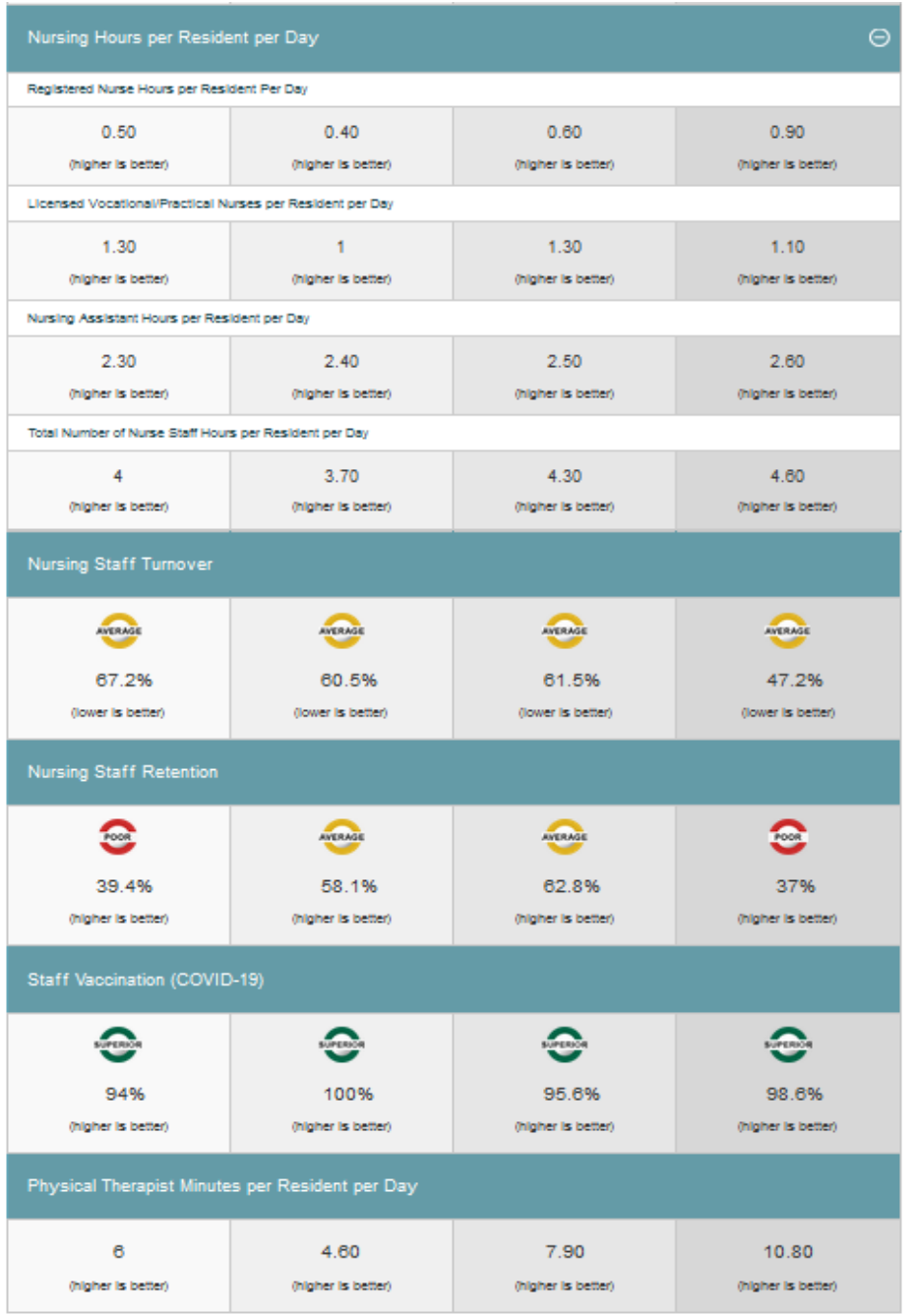
Staffing and Rating (updated April 2019)

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.

Staffing Domain

- Currently, we are reporting:
  - Nursing staff turnover, with scoring into categories
  - Nursing staff retention, with scoring into categories
  - Staff vaccination, with scoring into categories
  - Nursing hrs per resident-day (RN, LVN, NA, total), without scoring
  - PT minutes per resident-day, without scoring
- Update the Hours Per Resident Day (HRPD) to second decimal
- Add two new CMS staff weekend measures
  1. total number of nurse staff hours per resident-day, and
  2. total number of RN hours per resident day
- Potentially update STAFF COVID-19 vaccination rate (as above)



Nursing Hours per Resident per Day			
Registered Nurse Hours per Resident Per Day			
0.50 (higher is better)	0.40 (higher is better)	0.60 (higher is better)	0.90 (higher is better)
Licensed Vocational/Practical Nurses per Resident per Day			
1.30 (higher is better)	1 (higher is better)	1.30 (higher is better)	1.10 (higher is better)
Nursing Assistant Hours per Resident per Day			
2.30 (higher is better)	2.40 (higher is better)	2.50 (higher is better)	2.60 (higher is better)
Total Number of Nurse Staff Hours per Resident per Day			
4 (higher is better)	3.70 (higher is better)	4.30 (higher is better)	4.60 (higher is better)
Nursing Staff Turnover			
AVERAGE 67.2% (lower is better)	AVERAGE 60.5% (lower is better)	AVERAGE 61.5% (lower is better)	AVERAGE 47.2% (lower is better)
Nursing Staff Retention			
POOR 39.4% (higher is better)	AVERAGE 58.1% (higher is better)	AVERAGE 62.8% (higher is better)	POOR 37% (higher is better)
Staff Vaccination (COVID-19)			
SUPERIOR 94% (higher is better)	SUPERIOR 100% (higher is better)	SUPERIOR 95.6% (higher is better)	SUPERIOR 98.6% (higher is better)
Physical Therapist Minutes per Resident per Day			
6 (higher is better)	4.60 (higher is better)	7.90 (higher is better)	10.80 (higher is better)

Staffing Domain

- ISSUE: Staffing requirements vary by type of NH
  - Subacute units require higher staffing
  - Hospital-based units require higher staffing
- PROPOSE: Separate staffing HPRD by type of facility
  - Report the NH HPRD and the CA average for that type facility

Nursing Home "Recognition": Staffing

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

Challenge: Pursuing CMS **P**atient **D**riven **P**ayment **M**odel (SNF case mix data)

Case mix data is necessary to accurately report appropriate staff levels for the level and type of care required for residents.

- Short term resident data obtained by FOIA request to CMS
- Conversations with CMS, HCAI, CDPH, DHCS, Tosh law firm

Metric initially agreed on by LTAC: Staffing + Retention (with possible inclusion of Weekend Hours depending on results of analyses with full data set)

PROPOSE to defer scoring of staffing until next refresh
This will also DEFER the "RECOGNITION" (Honor Roll)

Tentative release date for *Appropriate Staffing Recognition Program* is late-Oct—mid-Nov.

Staffing Domain

Does the Board agree with reporting the new HPRD-weekend staffing rates?

Does the Board concur with scoring subacute, behavioral health, and distinct part NHs separately?

Quality of Facility Domain

Quality of Facility Domain

Federal and State Inspection Violations:

Report **total** counts of events (open and closed) for each primary category over last 3 years for:

- federal deficiencies (11 subcategories)
- state citations (7 subcategories)
- substantiated complaints (7 subcategories)

Fines:

Report total combined ($) for pending and closed events over last 3 years for federal & state penalties

Data Sources: federal annual inspection surveys, state inspection surveys, & state complaints (resident/individual and facility-reported incidents)

Federal and State Violations

ANALYSIS

Scoring Overall Quality of Facility Measures

Federal deficiency measure only or state-federal composite?

- CMS standard surveys (deficiencies), with points tallied using CMS approach (next slide)
- State health inspections (citations), with points tallied using Harrington's mapping to CMS approach

NOTE: State inspections usually, but don't always overlap with federal inspections; types of infractions are also similar, but not perfectly aligned between state and federal criteria.

Challenge: Accommodating mismatched data years (pre/post COVID) state and federal inspection cycles.

(*Also considered using infection control surveys, administered to all SNFs in 2020, but data are arguably old at this point and changes were likely made [ECHO trainings well attended])

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

CMS Standard Inspection Survey Cycles by Year

*CMS surveys are supposed to occur every 12 months, but COVID prevented surveys at many NHs for several years.

To align with the state data, NHs need to have all 3 surveys after July 1, 2018. **Only 313 facilities meet that criterion** (through the 4/1/22 data processing date).

Proposed solution: Use only Cycle 1 and Cycle 2 surveys to best balance reliability and validity

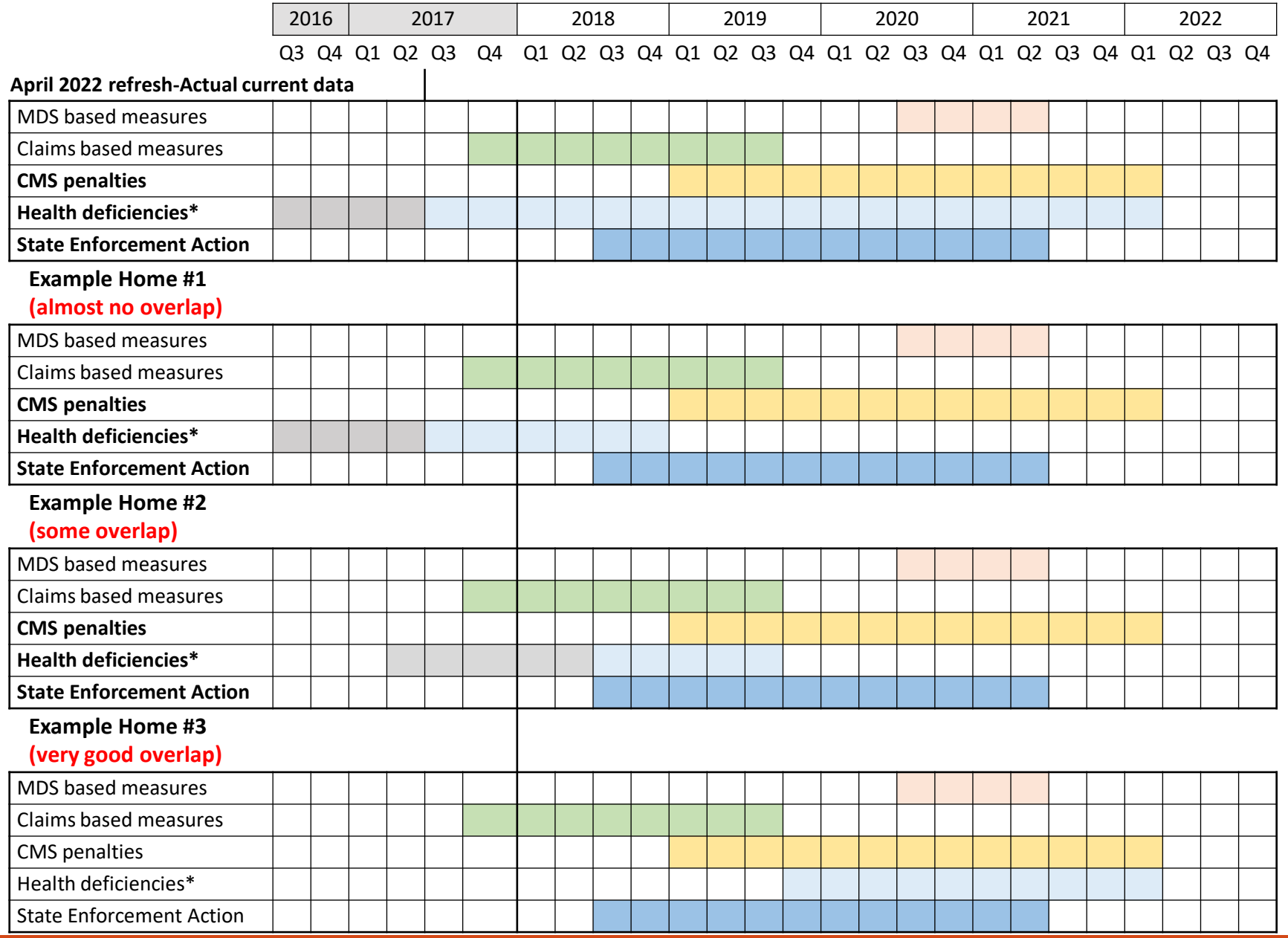
Year of inspection	Cycle 1 (most recent)	Cycle 2	Cycle 3 (oldest)	Grand Total
2016			23	23
2017		10	554	564
2018	3	585	512	1100
2019	593	484	76	1153
2020	129	85		214
2021	380	4		384
2022	72			72
Grand Total	1177	1168	1165	3510

CMS Penalties denoted by **GOLD** cells

CMS deficiency data denoted by **LIGHT BLUE** cells (2 cycles)

State Enforcement **Dark Blue** Cells

Cycle 3 (oldest data) denoted by **GREY** cells



Results of 2-Cycle Analyses

FEDERAL SCORE BY INSPECTION YEAR (raw values per CMS point scheme)

Analysis Variable : Federal Inspection Score Using Cycle 1 and Cycle 2

Year	N	10th Pctl	25th Pctl	Median	75th Pctl	90th Pctl	Mean	Std Dev
2016	24	20	48	62	86	122	68.8	40.5
2017	655	16	32	60	88	136	71.8	65.3
2018	1118	20	36	64	100	164	88.2	103.6
2019	1157	20	40	68	112	200	99.3	128.2
2020	214	28	48	72	116	222	108.5	113.0
2021	346	36	64	92	156	260	131.9	130.6

REGRESSION ANALYSIS (with facility fixed effects)

Parameter	Estimate	Standard Error	t Value	Pr > |t|
Intercept	101.29	72.70	1.39	0.16
Inspection Year 2017	31.01	24.47	1.27	0.21
Inspection Year 2018	39.59	24.33	1.63	0.10
Inspection Year 2019	45.19	24.30	1.86	0.06
Inspection Year 2020	51.29	25.57	2.01	0.05
Inspection Year 2021	49.24	25.07	1.96	0.05

ICC of Scores

Compares shared variation in groups

Cycle 1-Cycle 2= 0.31
Cycle 2- Cycle 3= 0.19
Cycle 1- Cycle 3= 0.22

Conclusion

Adjusted analysis shows increased inspection difficulty between 2017-2021

Table 1 Frequency of State citation class

NOTE about half of facilities have 0 citations, 75% with <20 points, state-federal correlation r=0.36-0.40

Class_Initial	Freq	Percent	Cumulative Frequency	Cumulative Percent
B	1134	64.51	1592	90.56
A	425	24.18	425	24.18
AA	33	1.88	458	26.05
BR	2	0.11	1594	90.67
NHPPD	144	8.19	1738	98.86
WF	19	1.08	1757	99.94
WO	1	0.06	1758	100
Frequency Missing = 502				

BR = Breach
NHPPD= Not meeting minimal Staffing of 3.2 hprd
WF=Willful Material Falsification
WO= Willful Material Omission

Fiscal Year of Citation	Frequency	Percent	Cumulative Frequency	Cumulative Percent
2007-08	1	0.06	1	0.06
2008-09	2	0.11	3	0.17
2009-10	3	0.17	6	0.34
2010-11	4	0.23	10	0.57
2011-12	16	0.91	26	1.48
2012-13	3	0.17	29	1.65
2013-14	13	0.74	42	2.39
2014-15	4	0.23	46	2.62
2015-16	20	1.14	66	3.75
2016-17	60	3.41	126	7.17
2017-18	46	2.62	172	9.78
2018-19	633	36.01	805	45.79
2019-20	491	27.93	1296	73.72
2020-21	462	26.28	1758	100

State-Federal Combo Metric Slightly Stronger than Fed Only (but r=0.90-0.91, 51% of facilities have 0 state point)

Table 1A The performance categories of State-Federal Violations Score for 1,178 facilities

	Performance Category											
	1 (0-10th Percentile, Superior)		2 (10th-25th Percentile, Above Average)		3 (25th-75th Percentile, Average)		4 (75th-90th Percentile, Below Average)		5 (>90th Percentile, Poor)		Not rated	
	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%
Measure												
Total_Score Fed-State	86	7.3	206	17.49	631	53.57	144	12.22	103	8.74	8	0.68

Table 2A The performance categories of Federal Violations Only for 1,178 facilities

	Performance Category											
	1 (0-10th Percentile, Superior)		2 (10th-25th Percentile, Above Average)		3 (25th-75th Percentile, Average)		4 (75th-90th Percentile, Below Average)		5 (>90th Percentile, Poor)		Not rated	
	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%	Number of Facilities	%
Measure												
Total_Score Fed Only	92	7.81	187	15.87	646	54.84	129	10.95	116	9.85	8	0.68

Options for Violations Reporting

Does the Board agree:

1. **Reporting federal deficiencies and state citations separately, with drill-down for category, severity, and scope details?**
2. **Using Cycle 1 and 2 data (dropping Cycle 3 data)**
3. **Using combined state-federal surveys for scoring survey-based quality?**

Complaints

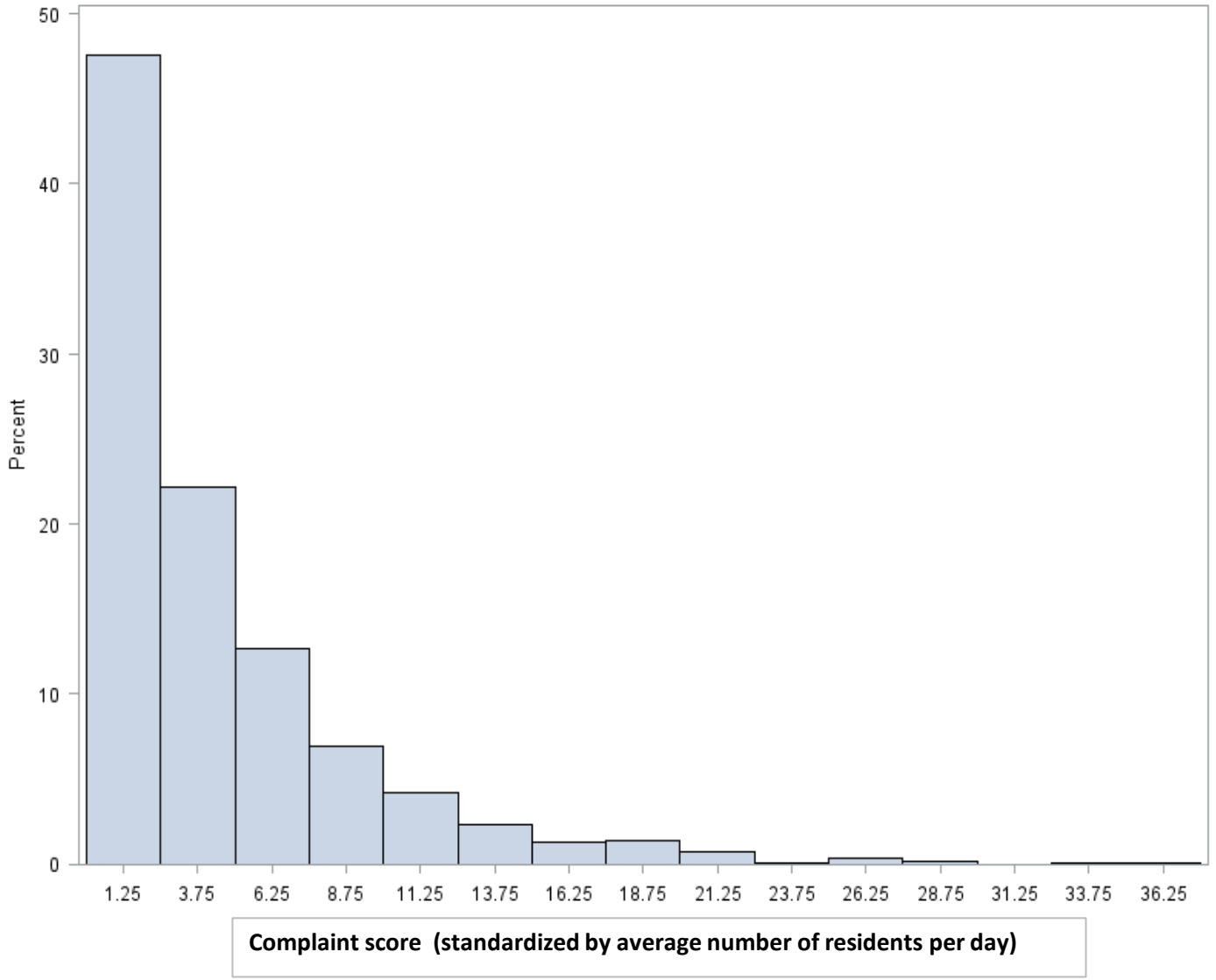
ANALYSIS

Abuse Complaints

- Definition: abuse is identified as having received a deficiency of any of these tags:
  - F600 (Protect each resident from all types of abuse, such as physical, mental, sexual abuse, physical punishment, and neglect by anybody);
  - F602 (Protect each resident from the wrongful use of the resident's belongings or money);
  - F603 (Protect each resident from separation from other residents, his/her room, or confinement to his/her room);
  - F223 (Protect each resident from all abuse, physical punishment, and involuntary separation from others);
  - F224 (Protect each resident from mistreatment, neglect, and misappropriation of personal property).

Complaints

- Distribution of complaint scores
- ~30% of NHs have no complaints



Abuse Complaints

- Abuse citations receive at least an extra 20 points and G level citation
- We propose using an Abuse Icon on the site
  - Drop the Abuse icon if no abuse for 12 months
  - Limit any NH with an Abuse icon to 3 stars
  - NHs with Abuse citations could not be on the honor roll

Complaints

Does the Board recommend:

1. **Using an Abuse Icon on the site?**
   a. **Dropping the Abuse icon if no abuse for 12 months?**
   b. **Limiting any NH with an Abuse icon to 3 stars once we implement the CLTCC composite Star Rating?**
   c. **Excluding NHs with Abuse citations from the Staffing Recognition Initiative ?**

Penalties and Fines

ANALYSIS

Options for Penalties and Fines

- **Does the Board recommend reporting:**
  - Total Number of State Fines
  - Total Number of Federal Penalties
  - Total State Fines ($)
  - Total Federal Penalties ($)
  - Total Fines $ (state and federal)
  - Other?

Conclusions

Other July Additions to Website

- Add Technical Notes document
- Include supporting information for “?” buttons for all new entries in Staffing and Quality of Facility Domain

Further Summer Work

- Obtain PDPM data to enable scoring for staffing, long-term quality of care measures, and staffing recognition initiative
- Analyze data for Nursing Home Recognition Initiative:
  - Present results of various inclusion criteria (guardrails)
  - Present results of different cut points
- Prep trend analyses for LTAC and Board Summer/Fall presentations (challenges include 63% of facilities with inspection data from before 2020).

Cal Hospital Compare

Opioid Care Honor Roll

2021 PERFORMANCE

2021 Results

105 hospitals submitted their application!

Recognition Categories

Superior performance – hospital scores at least 27 points

Excellent progress – hospital scores between 21 and 26 points

Participant – hospital scores between 0 and 20 points

Most improved – hospital shows significant improvement from 2020 to 2021

Quick stats

Category	# of hospitals	
	2021	2020
Submissions	101	91
Repeaters	69	46
New to the program	33	45
Attrition	22	14
CA BRIDGE sites	84	37

Results

Superior Performance	• 41 hospitals
Excellent Progress	• 32 hospitals
Program Participant	• 29 hospitals

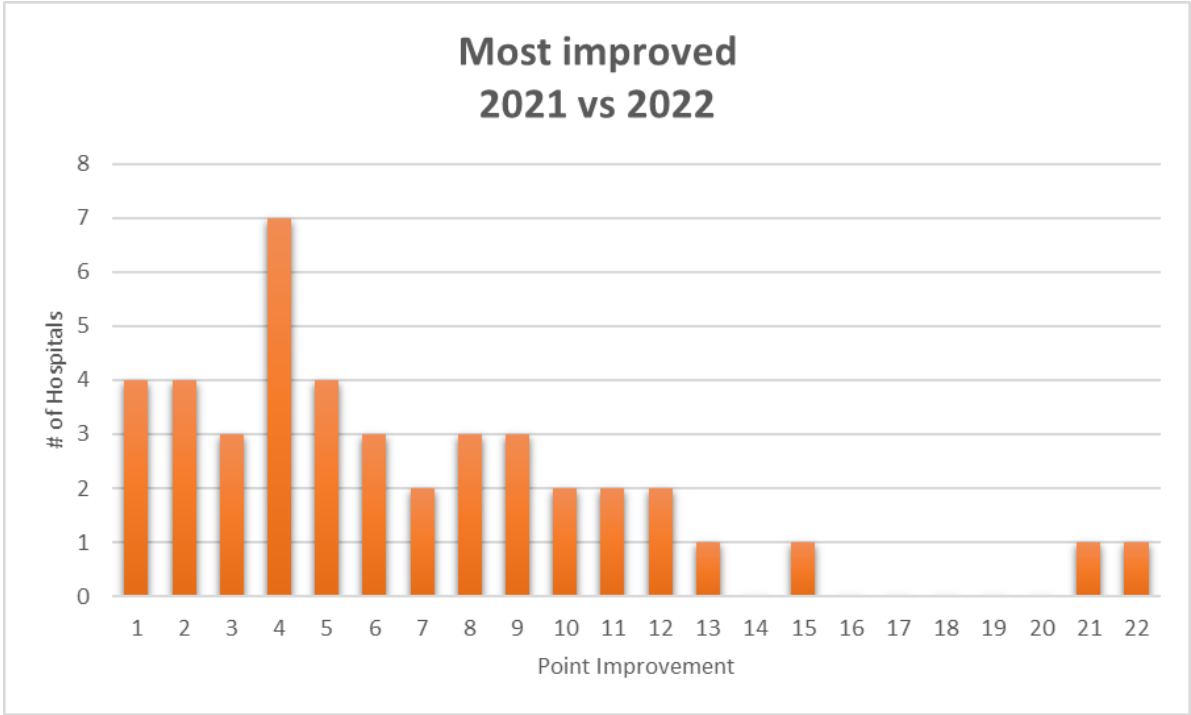
Most improved…

Considerations

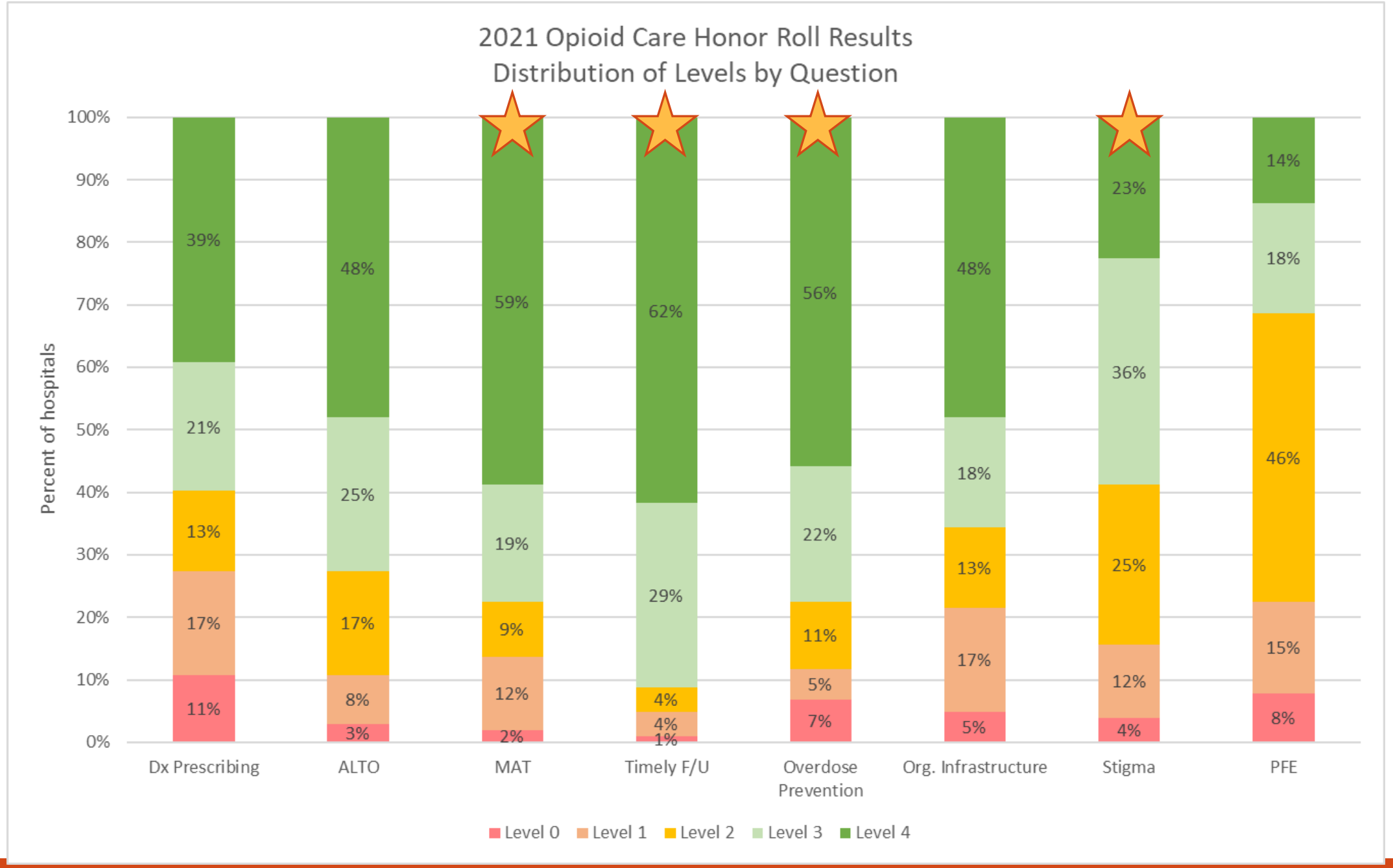
- n = 69 hospitals
- 21 hospitals scored worse; inter-rater reliability
- 5 hospitals had no change
- 43 hospitals showed improvement

Point Breakdown

- Min: 1 point
- Max: 22 points
- **Average: 7 points**



Note: Minimal changes between 2021 and 2020 self-assessment tool

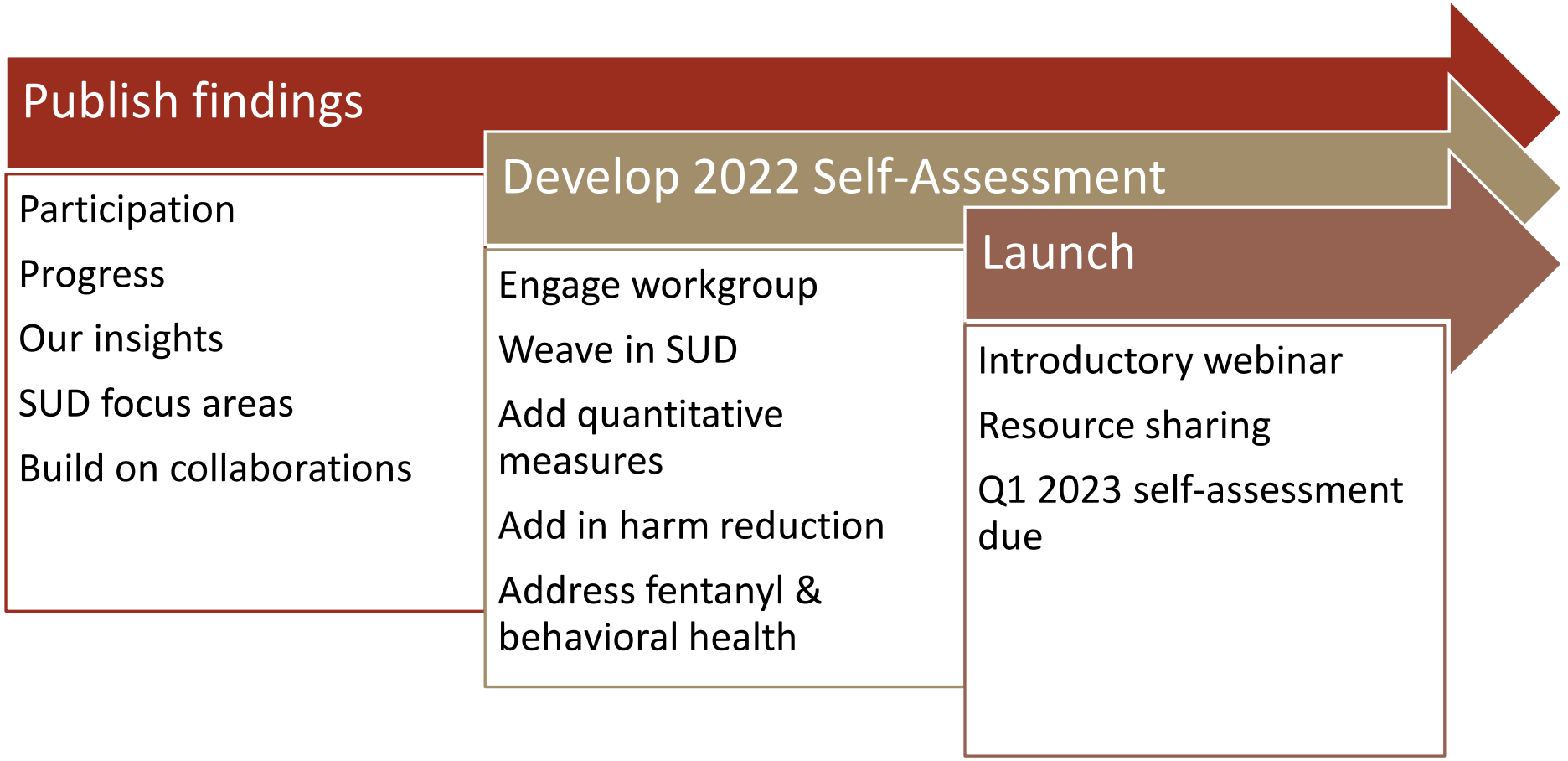

2021 Opioid Care Honor Roll Results
Distribution of Levels by Question
Percent of hospitals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
39%
21%
13%
17%
11%
48%
25%
17%
8%
3%
59%
19%
9%
12%
2%
62%
29%
4%
4%
1%
56%
22%
11%
5%
7%
48%
18%
13%
17%
5%
23%
36%
25%
12%
4%
14%
18%
46%
15%
8%
Dx Prescribing
ALTO
MAT
Timely F/U
Overdose Prevention
Org. Infrastructure
Stigma
PFE
Level 0
Level 1
Level 2
Level 3
Level 4

How should we recognize those showing the “most” improvement?

All	Set threshold	Set distributions (25%-50%)
• All 43 hospitals with an improved score • 43 hospitals represents 42% of all participating hospitals	• Avg. 7 points • 18 hospitals • 41% of most improved hospitals • 18% of all participating hospital	• ~25% - 11 hospitals, ≥ 10 points • ~33% - 16 hospitals, ≥ 8 points • **~50% - 25 hospitals, ≥ 5 points**

Recommend ~50% Balance recognizing participation with improvement

Next steps


Publish findings
Participation
Progress
Our insights
SUD focus areas
Build on collaborations
Develop 2022 Self-Assessment
Engage workgroup
Weave in SUD
Add quantitative measures
Add in harm reduction
Address fentanyl & behavioral health
Launch
Introductory webinar
Resource sharing
Q1 2023 self-assessment due

Healthy Places Index

A QUICK REFRESHER

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

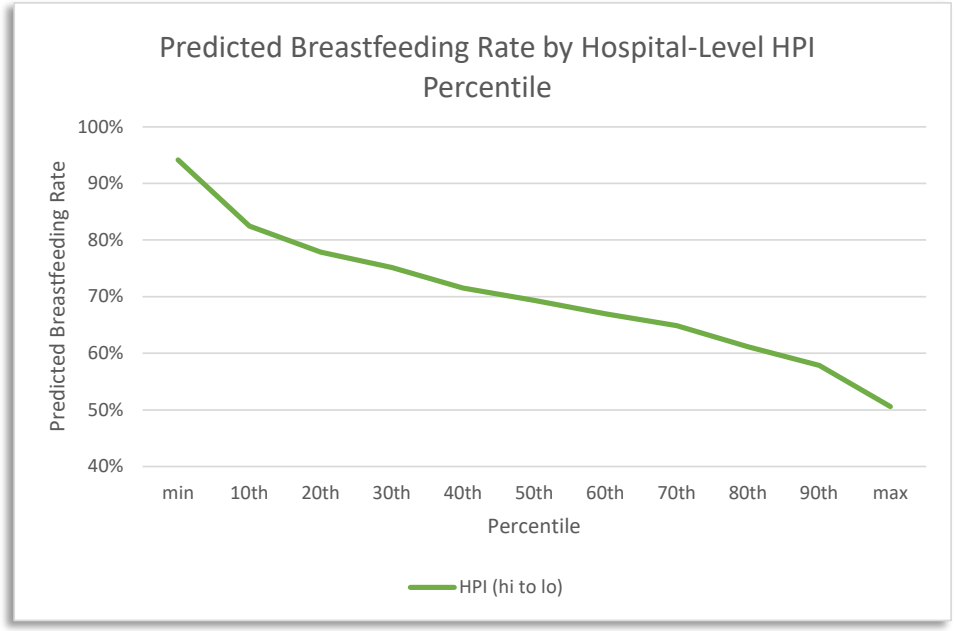
- Five hospitals account for 50% of admissions from high social need zip code 90059

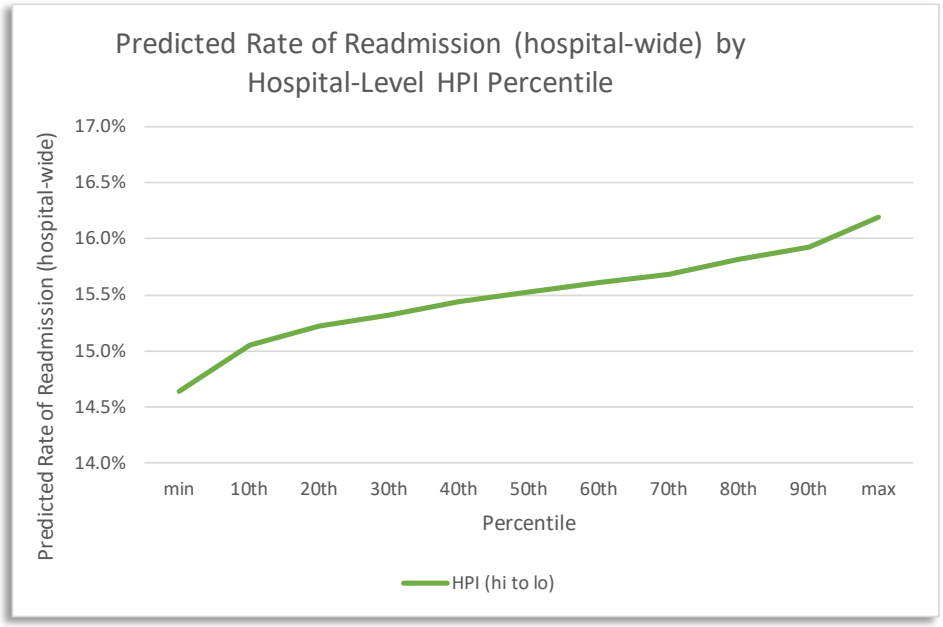
Proportion of Admissions from High Needs Zip Code by Hospital

						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

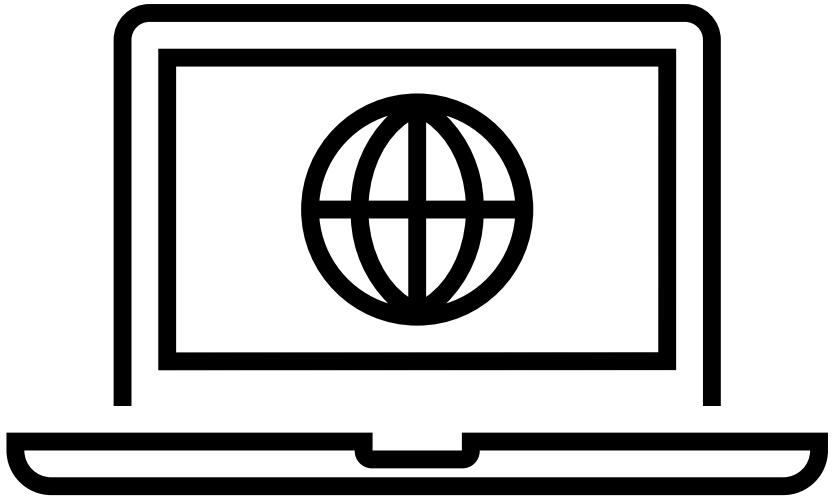
- Measures **MOST CLOSELY correlated**: breastfeeding, readmissions, patient experience, surgery volume
- Measures **LEAST correlated**: HAIs, patient safety
- Opportunity to focus SDOH investment on structures and processes related to measures most correlated to social need?
  - E.g., supporting CBOs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





Website Demo

- Interactive website
- Designed for hospitals and community-based organizations
- Allows users to drill into HPI domains by zip code, and patient population
- Opportunity to layer in additional data
- Information can be put behind a paywall



Update to Healthy Places 3.0

In April 2022, Public Health Alliance of Southern California Updated the Healthy Places Index

Key Changes:

- Update of data sources to most currently available
  - American Community Survey (half of indicators) updated to 2015 – 2019
- Of 25 indicators:
  - Three indicators retired: Two parent family, alcohol availability, access to healthy food (based on feedback from users and lack of association with Life Expectancy at Birth (LEB))
  - Per capita income substituted for household income
  - Supermarkets added to retail density indicator
  - New indicator: participation in 2020 census
- Domain weights recalculated (based on LEB)
- Impact: Overall, little change due to methodology changes. Changes mostly due to updated data.
- HPI website added numerous data layers, including race/ethnicity (https://www.healthyplacesindex.org/), and additional functionality

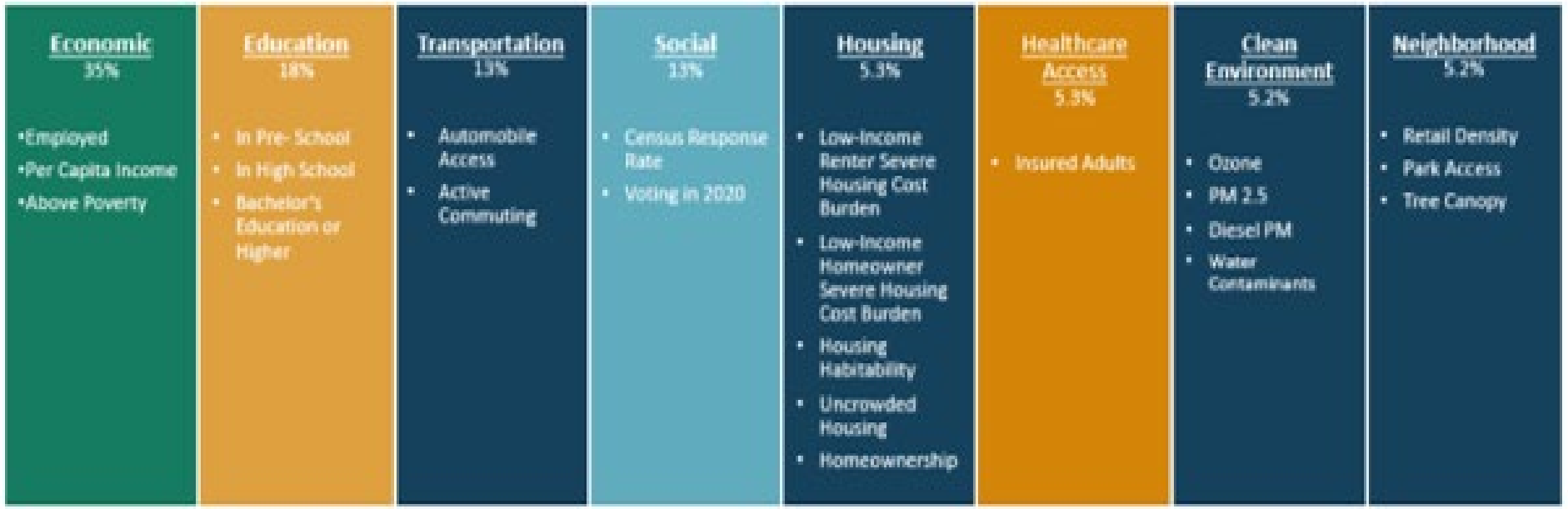


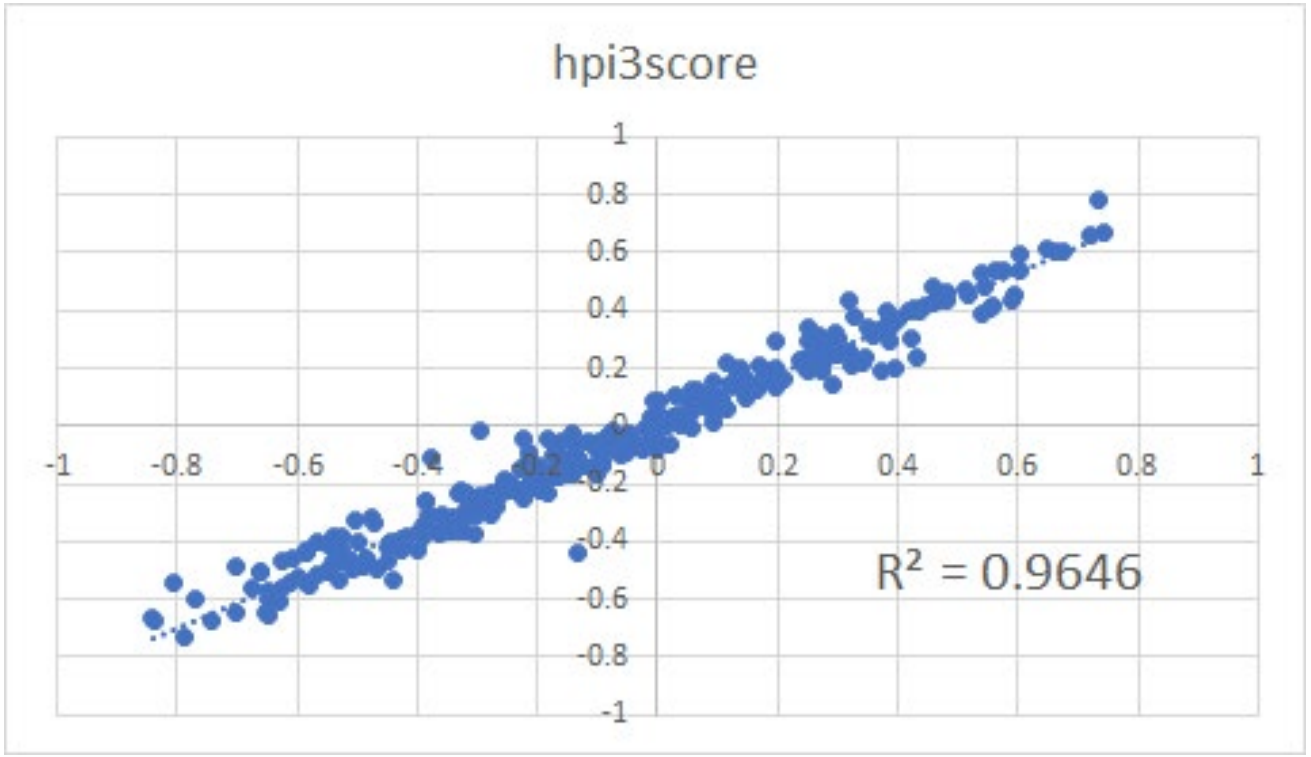
Figure 3. Health Places Index Policy Action Areas (Domains), Weights, and Individual Indicators

…Update to Healthy Places 3.0

…Update to Healthy Places 3.0

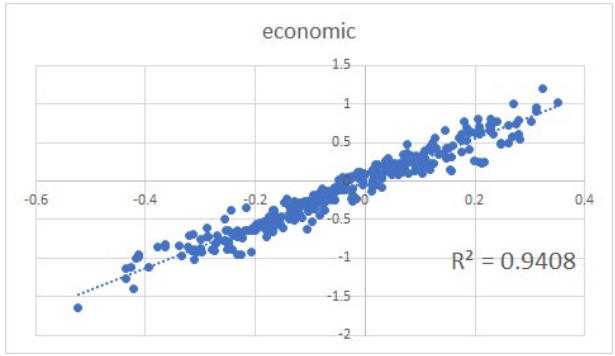
- IBM obtained new data, reran all analytics and created new version of interactive mapping tool
- Overall Findings:
  - Little change in correlation between hospital-level HPI and quality measures
  - No change in “collaboration” findings since same 2019 HCAI patient origin data was used
  - Modest change in hospital-level HPI and rankings (due principally to updated data)

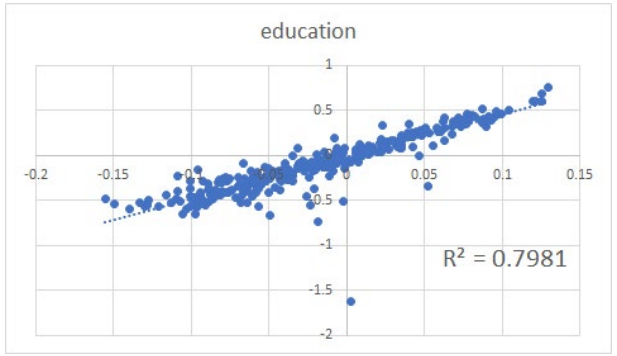
Hospital HPI: Correlation between HPI 2.0 and 3.0 Versions (Overall Score)

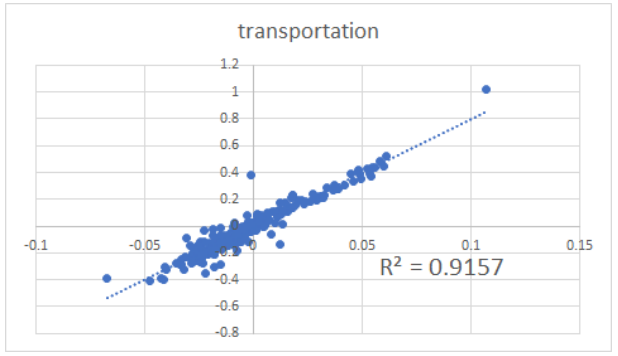


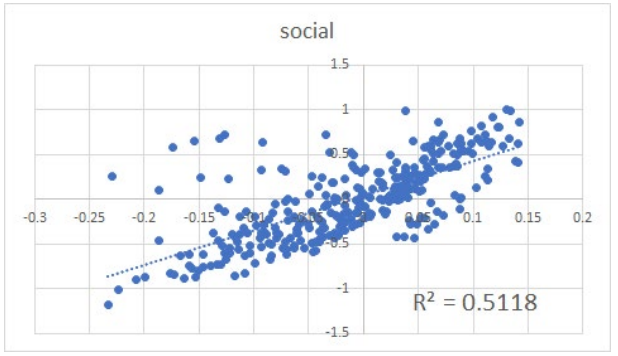
High correlation between HPI 2.0 and 3.0 consistent with limited changes to methodology

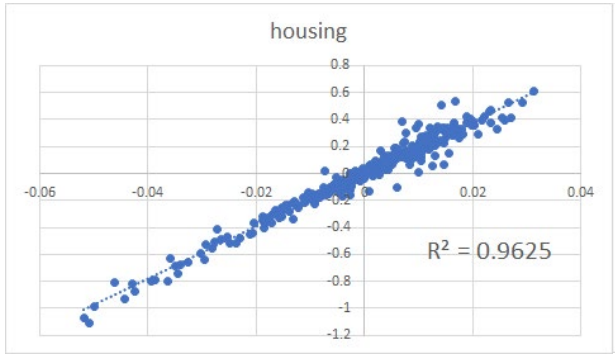
Hospital HPI: Domain Correlations between HPI 2.0 and 3.0 Versions

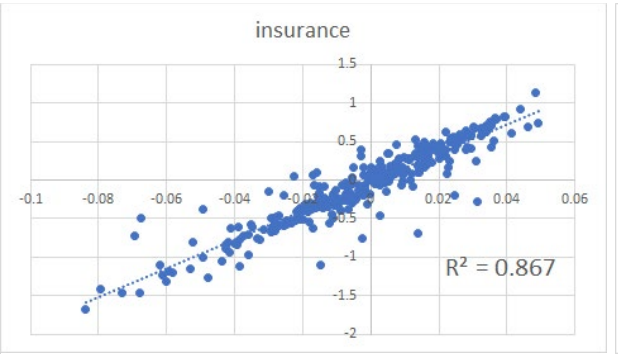


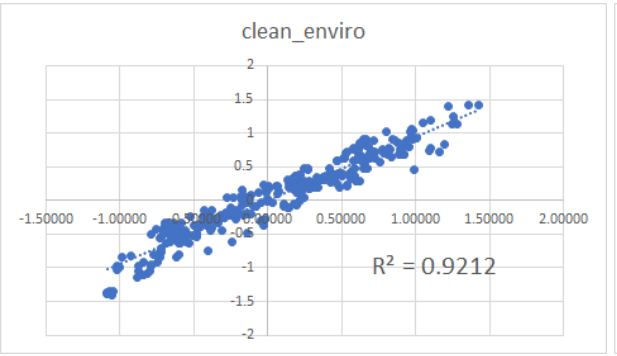


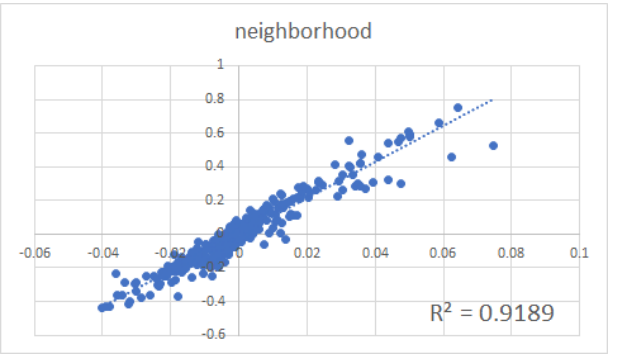












Low correlation in Social Domain expected given deletion of one indicator (two parent household) and addition of census participation indicator

HPI 3.0 and 2.0: Correlation with Quality Measures

Top 10 Measures

Higher is better for all except "SSI – Cardiac"

Measure	Domain	Correlation with HPI 3.0	Correlation with HPI 2.0
Breastfeeding Rate (CDPH)	Mother & Baby	0.57	0.57
Patients who reported that their doctors always communicated well	Patient Experience	0.45	0.47
Would recommend hospital	Patient Experience	0.45	0.46
Primary and Revision Hip Surgery Volume	Hip and Knee	0.34	0.33
Esophageal Resection - Number of Cases	Other Surgery	0.32	0.33
Surgical Site Infections - Cardiac	SSI Cardiovascular/Thoracic	0.28	0.28
Patients who reported that their nurses always communicated well.	Patient Experience	0.27	0.30
Primary and Revision Knee Surgery Volume	Other Conditions	0.27	0.27

Little change in correlations between HPI 2.0 and HPI 3.0

Bottom 10 Measures

Lower is better for all except "understood care"

Measure	Domain	Correlation with HPI 3.0	Correlation with HPI 2.0
Pneumonia Potentially Preventable Readmissions	Lung Conditions	-0.15	-0.16
Rate of readmission after hip/knee surgery	Hip and Knee	-0.15	-0.17
Percentage of patients who left the emergency department before being seen	Emergency Department (ED) Care	-0.18	-0.19
Death after Serious Treatable Complication	Patient Safety	-0.19	-0.20
Heart Attack Death Rate	Heart Conditions	-0.20	-0.19
Episiotomy Rate	Mother & Baby	-0.20	-0.19
Patients who reported they understood their care when they left the hospital	Patient Experience	-0.28	-0.30
Rate of readmission after discharge from hospital (hospital-wide)	Re-hospitalizations	-0.31	-0.32
Heart Failure Potentially Preventable Readmissions	Heart Conditions	-0.34	-0.36
Abdominal Aortic Aneurysm Repair - Mortality Rate	Other Surgery	-0.38	-0.39

Social needs consistently associated with poorer performance

HPI 3.0 and 2.0: Change in Hospital Rank

Based on HPI 3.0: Top 10 hospitals with highest social need

Total hospitals ranked: 312

Hospital	HPI 3.0 Rank	HPI 3.0 Score	HPI 2.0 Rank	HPI 2.0 Score	Change In Rank	County
Delano Regional Medical Center	1	-0.84	4	-0.67	-3	Kern
Kern Valley Healthcare District	2	-0.84	2	-0.68	0	Kern
Sierra View Medical Center	3	-0.81	15	-0.54	-12	Tulare
Martin Luther King, Jr. Community Hospital	4	-0.79	1	-0.73	3	Los Angeles
Kern Medical	5	-0.77	9	-0.60	-4	Kern
Community and Mission Hospital of Huntington Park - Slauson	6	-0.74	3	-0.67	3	Los Angeles
Barstow Community Hospital	7	-0.70	27	-0.49	-20	San Bernardino
California Hospital Medical Center	8	-0.70	6	-0.65	2	Los Angeles
Adventist Health Reedley	9	-0.68	13	-0.56	-4	Fresno
Good Samaritan Hospital - Bakersfield	10	-0.66	23	-0.50	-13	Kern

Modest changes in rank – principally due to updated data

Central Valley, Los Angeles, Inland Empire

…HPI 3.0 and 2.0: Change in Hospital Rank

Based on HPI 3.0: Top 10 hospitals with lowest social need

Total hospitals ranked: 312

Hospital	HPI 3.0 Rank	HPI 3.0 Score	HPI 2.0 Rank	HPI 2.0 Score	Change In Rank	County
California Pacific Medical Center - Van Ness Campus	303	0.59	294	0.44	9	San Francisco
Kaiser Permanente San Francisco Medical Center	304	0.59	296	0.46	8	San Francisco
Stanford Health Care – ValleyCare	305	0.60	306	0.59	-1	Alameda
Kaiser Permanente Redwood City Medical Center	306	0.60	304	0.54	2	San Mateo
El Camino Hospital	307	0.65	309	0.62	-2	Santa Clara
Kaiser Permanente San Rafael Medical Center	308	0.66	307	0.61	1	Marin
Mills-Peninsula Medical Center	309	0.67	308	0.61	1	San Mateo
Marin General Hospital	310	0.72	310	0.66	0	Marin
San Ramon Regional Medical Center	311	0.74	312	0.78	-1	Contra Costa
Sequoia Hospital	312	0.74	311	0.67	1	San Mateo

Very little change in rank

Bay Area

Social Needs Index Workgroup

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, learning 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

Recap of 3 Workgroups

Refining the role of the hospital	Data sensemaking support	Stratifying the data	Learning from and leveraging early adopters
Reporting timeline/roadmap	Identifying drivers to lead change	Determining if we are a data distributor, convenor or collaborator	Considering a health equity honor roll or other distinction

Reporting Timeline

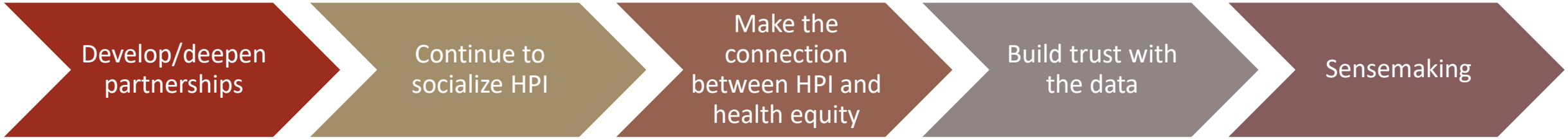
Create & distribute reports to stakeholders

- **Audience**: hospitals & community-based organizations
- **Goal**: support targeted quality improvement
- **Needs**: tools to interpret the data, combine with their own data and guidance on how to best utilize the data with community members

Report data publicly

- **Audience**: consumers, public health departments, policymakers, news outlets
- **Goal**: engage consumers, influence organizational strategy, and policy efforts
- **Outlets:** website, honor roll reports
- **Needs**: trust with the data, ensured accuracy

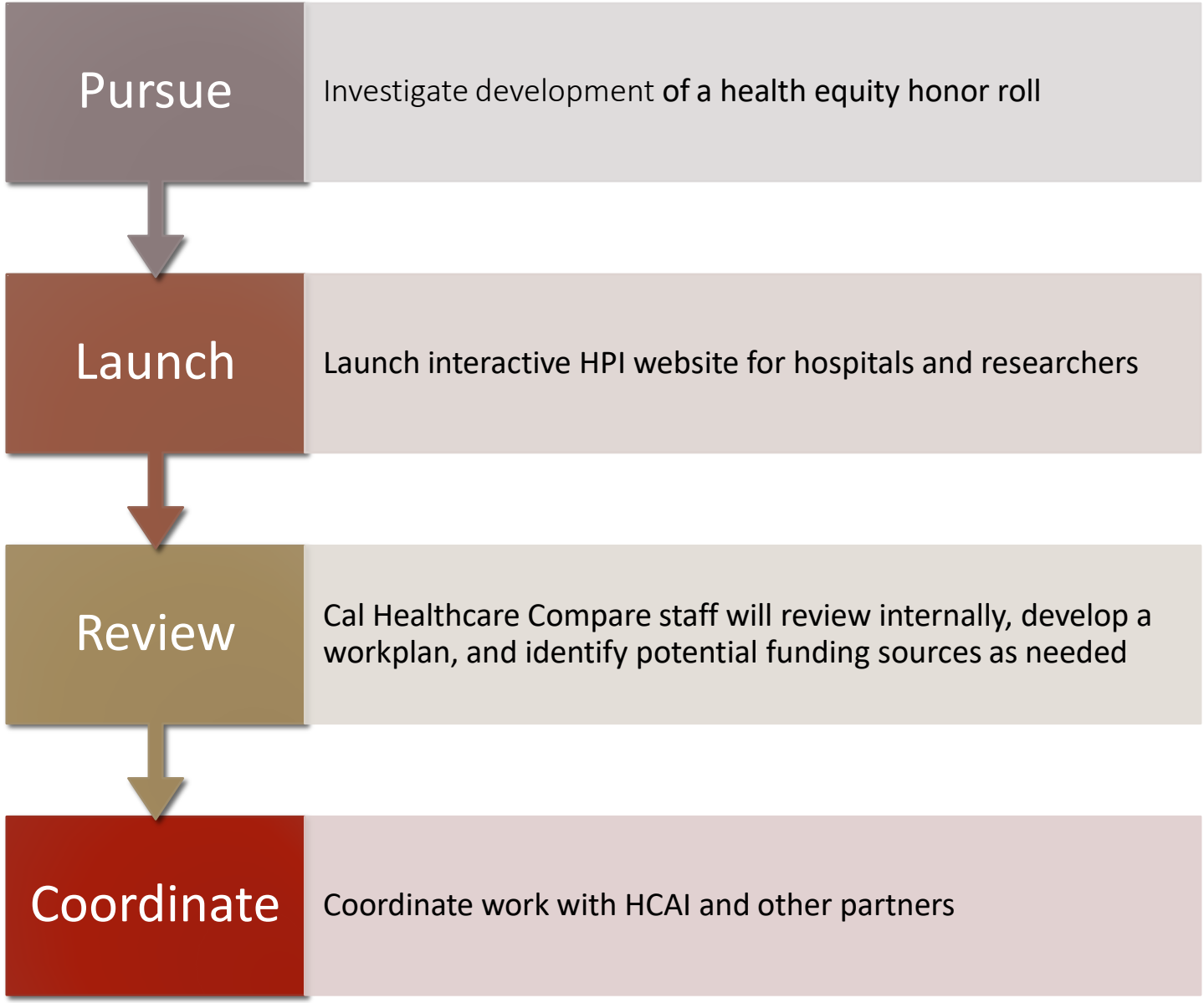
Immediate Next Steps



Advancing Health Equity

- The workgroup collectively favored the idea of “advancing” health equity over “recognizing” specific hospitals
  - Recommend Cal Hospital Compare serve in the role of convener; educate on equity, available data, and surface what hospitals can do
  - Spotlight hospitals who meet certain improvement criteria and celebrate success without excluding the work of others
  - Initially focus on process or structural measures of improvement
  - Consider an application process for hospitals interested in joining the “innovation hub”
  - Through this process we can introduce how data can be used to identify social needs in the community and the importance of getting community feedback

Next Steps


Pursue
Investigate development of a health equity honor roll
Launch
Launch interactive HPI website for hospitals and researchers
Review
Cal Healthcare Compare staff will review internally, develop a workplan, and identify potential funding sources as needed
Coordinate
Coordinate work with HCAI and other partners

Board Discussion & Feedback

- What are your thoughts on the role of Cal Hospital Compare in advancing health equity?

- What else should we consider as we plan to share and spread Healthy Places Index information?

- **Request BOD approval** for the development of a business plan for the HPI Mapping tool and to pursue workgroup recommendations?

Health Equity Landscape

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION UPDATE

Covered CA Network Analysis

WITH HEALTHY PLACES INDEX INFORMATION

Data Analysis Description

IBM Watson Health retrieved the most recent data for CMQCC NTSV C-Section and CMS HAI data :

- NTSV C-Section (7/1/2020 to 6/30/2021)
- CLABSI (10/1/2019 to 3/31/2021)
- CAUTI (10/1/2019 to 3/31/2021)
- MRSA (10/1/2019 to 3/31/2021)
- C. Diff (10/1/2019 to 3/31/2021)
- SSI :Colon (10/1/2019 to 3/31/2021)
- Sepsis (7/1/2020 to 3/31/2021)
- Hospital-Wide Readmissions (7/1/2017 to 12/1/2019)

We linked the hospital-level data to the Covered CA network information provided in February 2020

We then generated plan-network-region level rates as:

- Weighted averages (weighted by measure denominator): reflects care received by the population served by the network

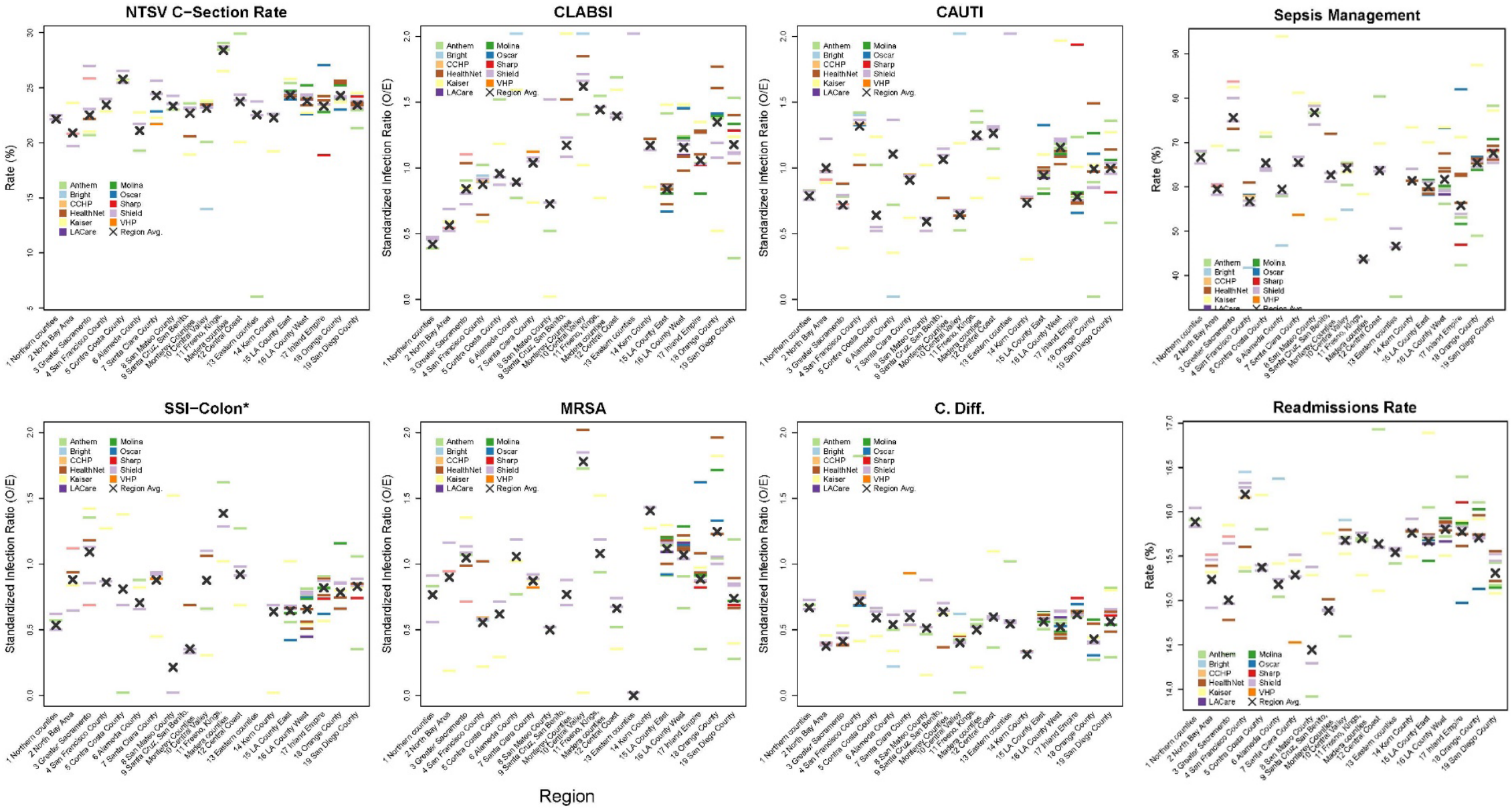
Selected results included in this slide deck based on weighted averages

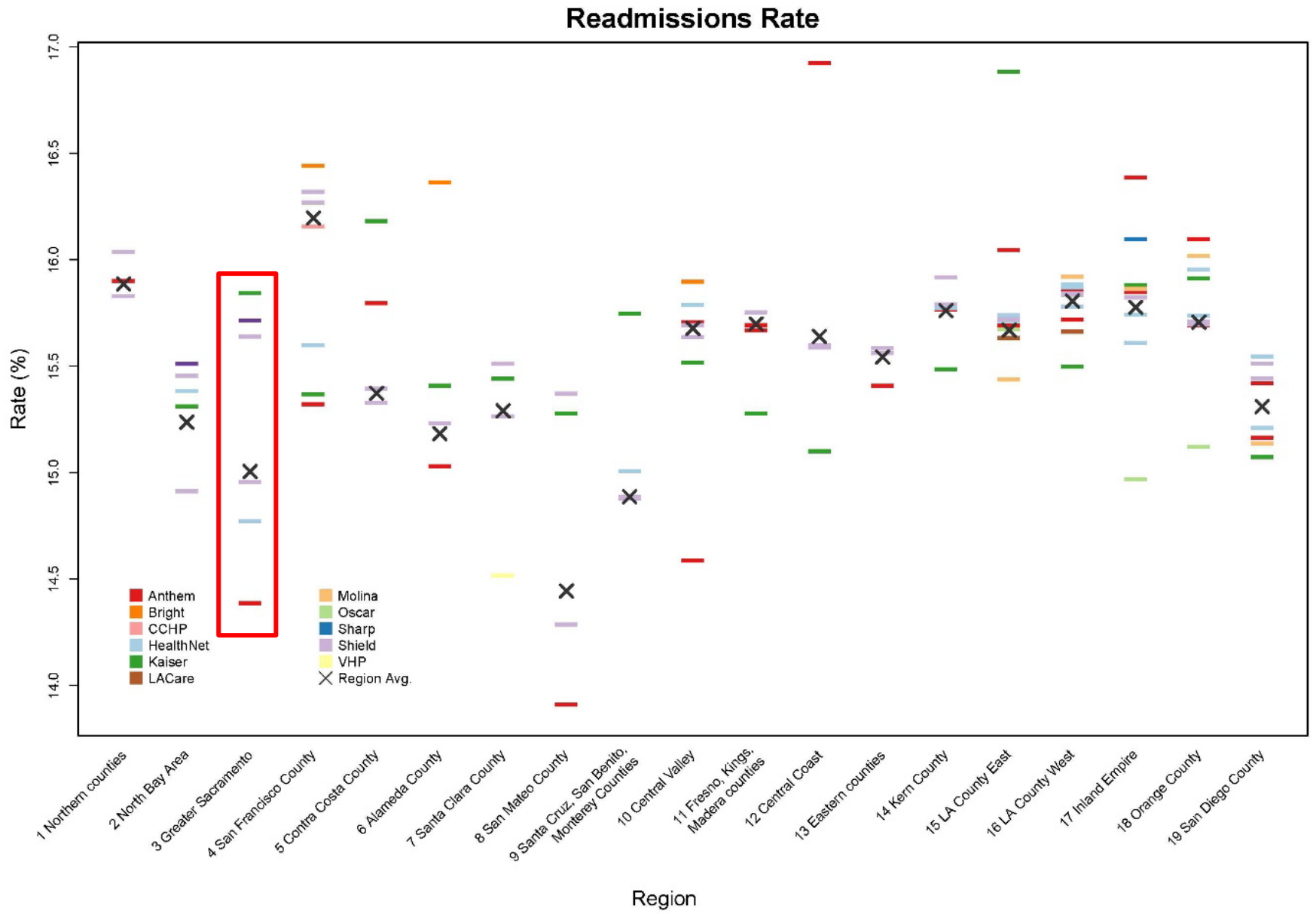
Region Map


California Rating & Plan Regions
Color Coded by County
PRICING REGION
1 Northern counties
2 North Bay Area
3 Greater Sacramento
4 San Francisco County
5 Contra Costa County
6 Alameda County
7 Santa Clara County
8 San Mateo County
9 Santa Cruz, San Benito, Monterey counties
10 Central Valley
11 Fresno, Kings, Madera counties
12 Central Coast
13 Eastern counties
14 Kern County
15 Los Angeles County East
16 Los Angeles County West
17 Inland Empire
18 Orange County
19 San Diego County
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Lake
Colusa
Sutter
Yuba
Nevada
Placer
Sonoma
Napa
Yolo
Sacra-mento
El Dorado
Alpine
Amador
Calaveras
Tuolumne
Marin
Solano
San Joaquin
Contra Costa
Alameda
San Francisco
San Mateo
Santa Clara
Santa Cruz
Stanislaus
Mariposa
Merced
Madera
Fresno
Inyo
Mono
San Benito
Monterey
Kings
Tulare
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial

Network Summary

Region	Number of Unique Plans	Number of Networks				
		HMO	PPO	EPO	HSP	Total
Across All Regions	**11**	**39**	**71**	**6**	**25**	**141**
Northern counties	2	1	1	0	1	3
North Bay Area	5	2	3	0	1	6
Greater Sacramento	5	1	3	0	2	6
San Francisco County	7	3	4	0	1	8
Contra Costa County	5	2	3	0	1	6
Alameda County	4	1	3	0	1	5
Santa Clara County	7	3	4	0	1	8
San Mateo County	6	3	3	0	1	7
Santa Cruz, San Benito, Monterey Counties	4	2	2	0	1	5
Central Valley	5	2	4	0	1	7
Fresno, Kings, Madera counties	3	1	3	0	1	5
Central Coast	3	1	3	0	1	5
Eastern counties	3	1	3	0	1	5
Kern County	4	2	3	1	1	7
LA County East	7	3	6	1	2	12
LA County West	7	3	6	1	2	12
Inland Empire	7	3	6	1	2	12
Orange County	6	3	5	1	2	11
San Diego County	6	2	6	1	2	11


NTSV C−Section Rate
Rate (%)
CLABSI
Standardized Infection Ratio (O/E)
CAUTI
Standardized Infection Ratio (O/E)
Sepsis Management
Rate (%)
SSI−Colon*
Standardized Infection Ratio (O/E)
MRSA
Standardized Infection Ratio (O/E)
C. Diff.
Standardized Infection Ratio (O/E)
Readmissions Rate
Rate (%)
Anthem
Bright
CCHP
HealthNet
Kaiser
LACare
Molina
Oscar
Sharp
Shield
VHP
Region Avg.
1 Northern counties
2 North Bay Area
3 Greater Sacramento
4 San Francisco County
5 Contra Costa County
6 Alameda County
7 Santa Clara County
8 San Mateo County
9 Santa Cruz, San Benito,
Monterey Counties
10 Central Valley
11 Fresno, Kings,
Madera counties
12 Central Coast
13 Eastern counties
14 Kern County
15 LA County East
16 LA County West
17 Inland Empire
18 Orange County
19 San Diego County
Region


Readmissions Rate
Rate (%)
17.0
16.5
16.0
15.5
15.0
14.5
14.0
Anthem
Bright
CCHP
HealthNet
Kaiser
LACare
Molina
Oscar
Sharp
Shield
VHP
Region Avg.
1 Northern counties
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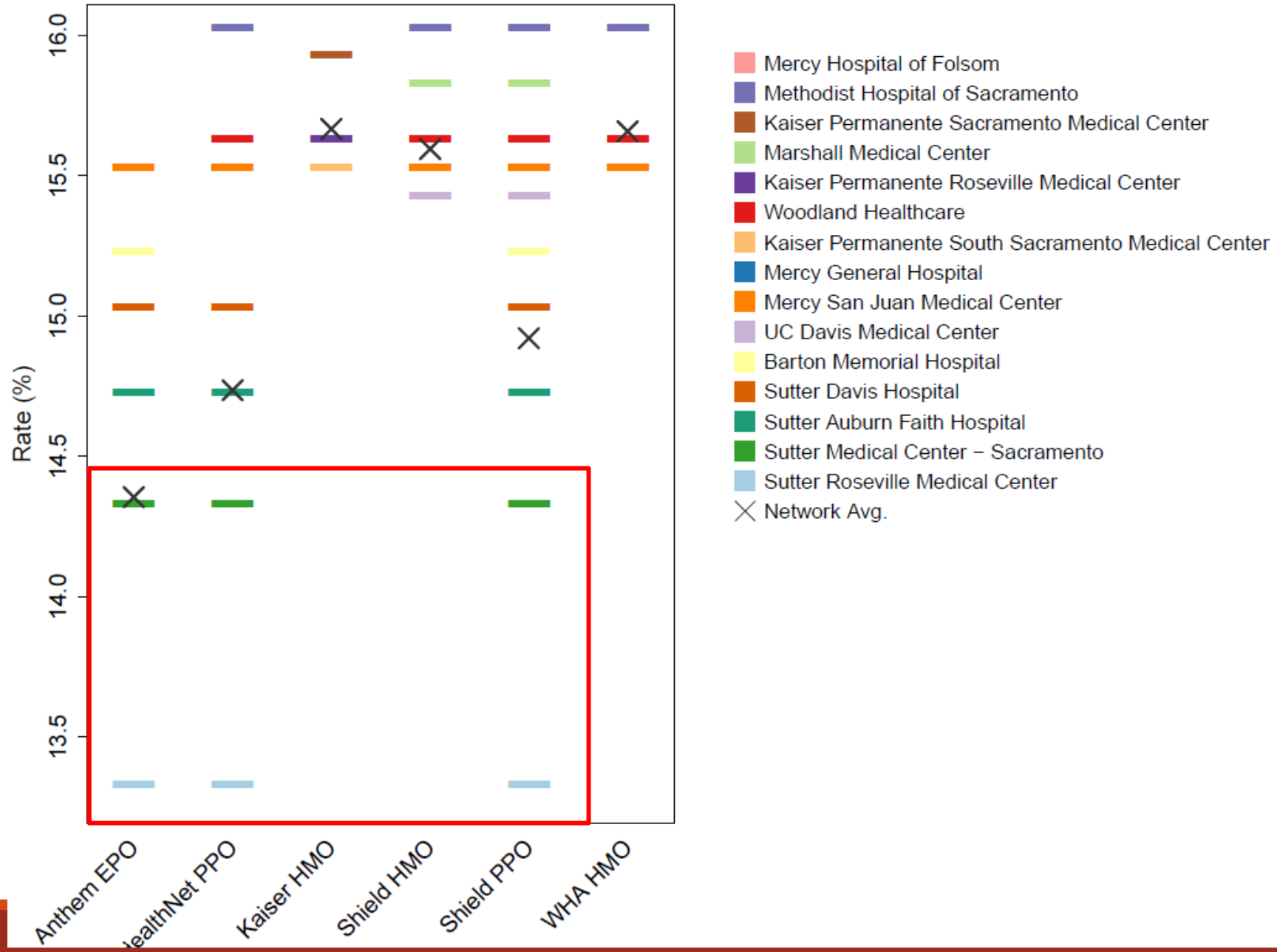
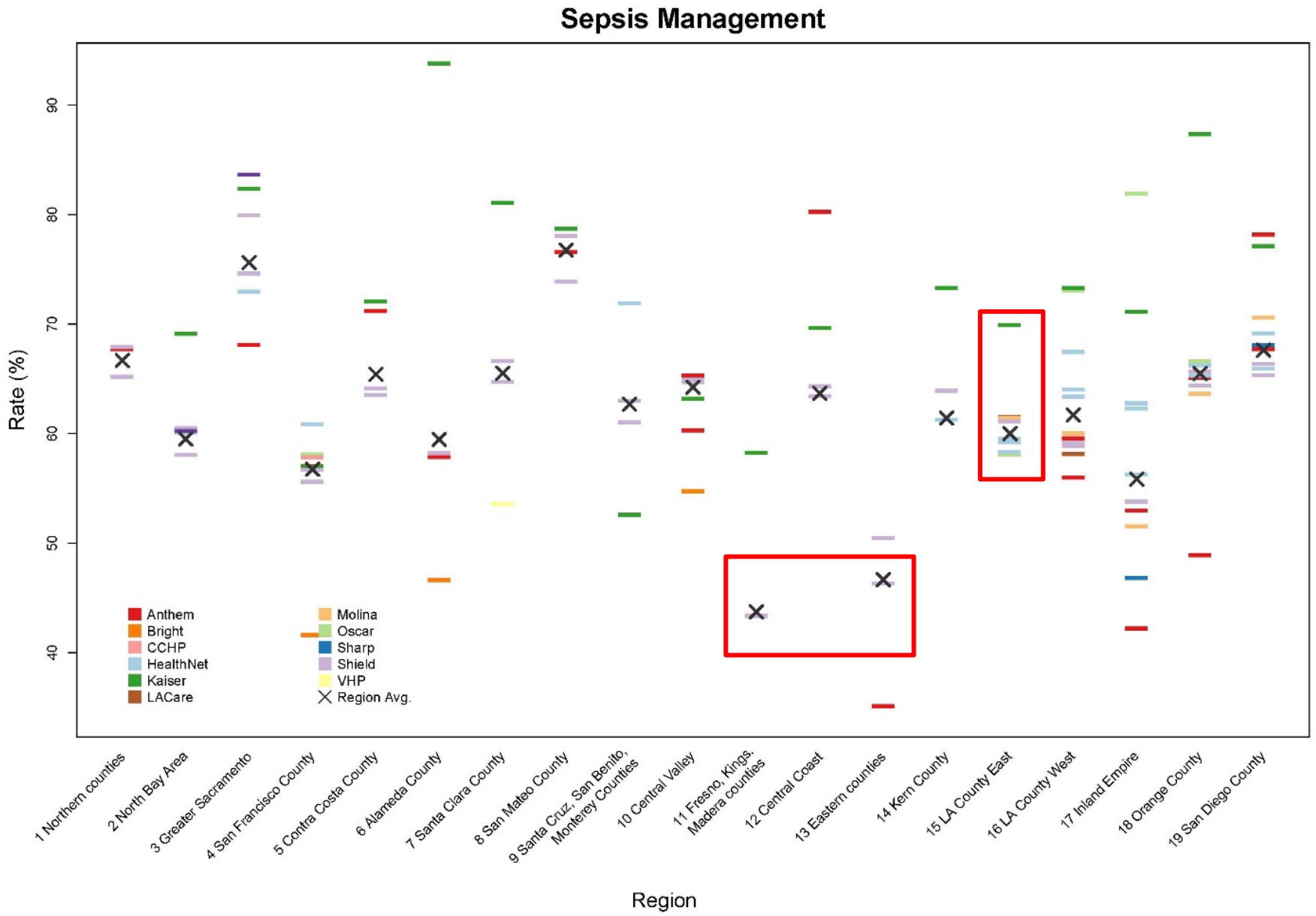
11 Fresno, Kings, Madera counties
12 Central Coast
13 Eastern counties
14 Kern County
15 LA County East
16 LA County West
17 Inland Empire
18 Orange County
19 San Diego County
Region

Hospital Readmissions Rate by Networks Serving Greater Sacramento (Region 3)




Sepsis Management
Rate (%)
90
80
70
60
50
40
Anthem
Bright
CCHP
HealthNet
Kaiser
LACare
Molina
Oscar
Sharp
Shield
VHP
Region Avg.
1 Northern counties
2 North Bay Area
3 Greater Sacramento
4 San Francisco County
5 Contra Costa County
6 Alameda County
7 Santa Clara County
8 San Mateo County
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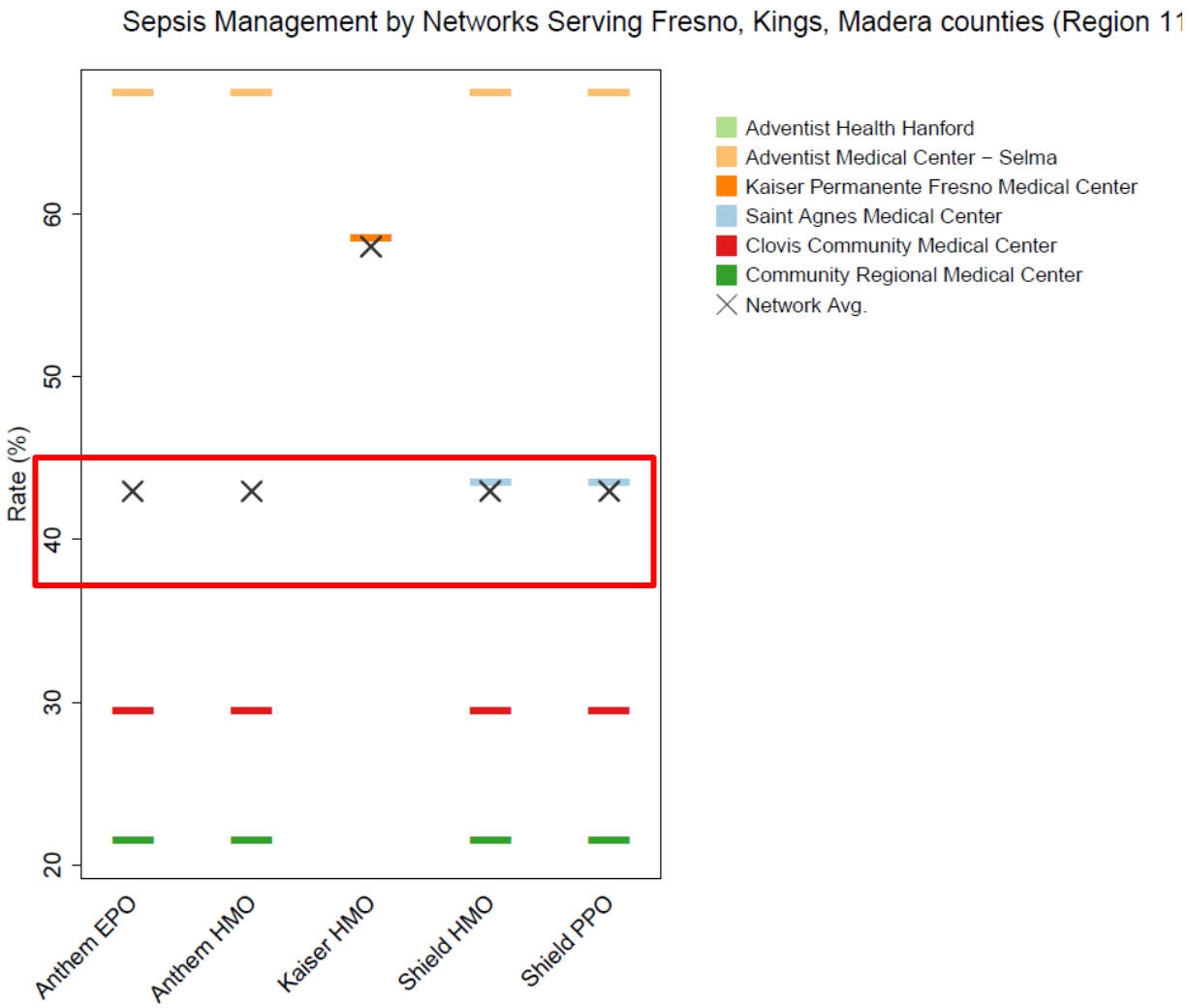
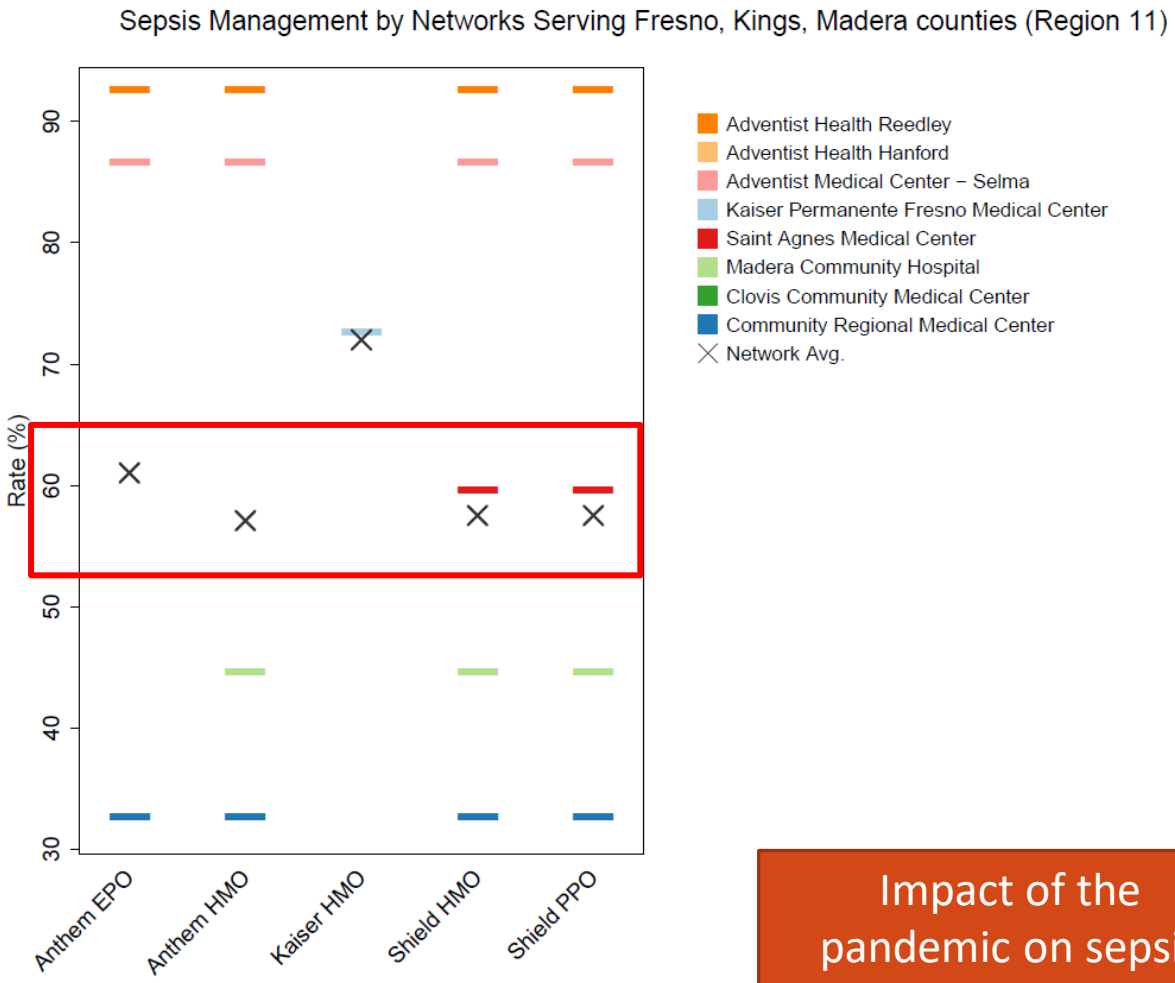
15 LA County East
16 LA County West
17 Inland Empire
18 Orange County
19 San Diego County
Region



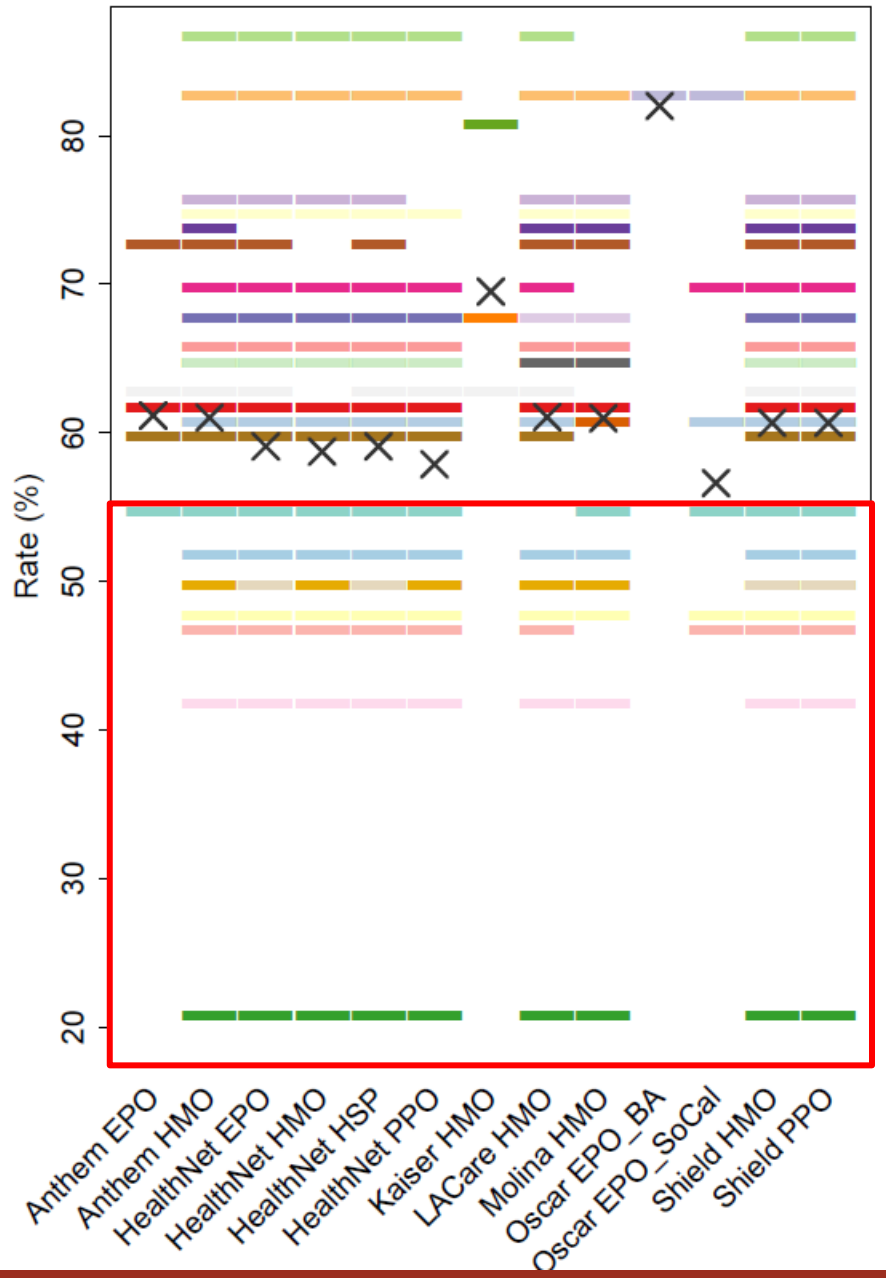
2022 Network Analysis



2021 Network Analysis

Impact of the pandemic on sepsis management in more rural/underserved communities?

Sepsis Management by Networks Serving LA County East (Region 15)



- Glendale Memorial Hospital and Health Center
- Providence Little Company of Mary Medical Center San Pedro
- San Dimas Community Hospital
- Kaiser Permanente South Bay Medical Center
- Beverly Hospital
- San Gabriel Valley Medical Center
- College Medical Center
- Adventist Health Glendale
- Providence Saint Joseph Medical Center
- Kaiser Permanente Baldwin Park Medical Center
- Monterey Park Hospital
- USC Verdugo Hills Hospital
- Whittier Hospital Medical Center
- Greater El Monte Community Hospital
- Pomona Valley Hospital Medical Center
- St. Mary Medical Center Long Beach
- Antelope Valley Hospital
- Garfield Medical Center
- Citrus Valley Medical Center – Inter-Community Campus
- Emanate Health Queen of the Valley Hospital
- Palmdale Regional Medical Center
- Lakewood Regional Medical Center
- MemorialCare Long Beach Medical Center
- Alhambra Hospital Medical Center
- PIH Health Hospital – Whittier
- Foothill Presbyterian Hospital
- Huntington Hospital
- Coast Plaza Doctors Hospital
- Methodist Hospital of Southern California
- Network Avg.

Opportunity to collaborate across plans to drive improvement in key hospitals?

Impact

All Regions

Measure		Cost per Excess Infection	Region-Level Excess Cost	Mortality per Excess Infection	Region-Level Excess Mortality
HAI_1	CLABSI	$48,108	$11,297,334	0.15	35
HAI_2	CAUTI	$13,793	$5,023,438	0.036	13
HAI_3	SSI Colon	$28,219	$6,031,422	0.026	6
HAI_6	C. Diff	$17,260	$14,498,650	0.044	37
		Total (All Regions)	$36,850,845		91

Region 15 – LA County East

Measure		Cost per Excess Infection	Region-Level Excess Cost	Mortality per Excess Infection	Region-Level Excess Mortality
HAI_3	SSI Colon	$28,219	$509,187	0.026	0.469
HAI_6	C. Diff	$17,260	$1,263,106	0.044	3.220
		Total (LA County East)	$1,772,292	0.070	4

COVID-19 Impact on Quality

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

Measurement Periods During Pandemic

Measures	Domain	Source	From Date	To Date
Sepsis Management	Patient Safety	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported that their room and bathroom were always clean.	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported that their nurses always communicated well.	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported that their doctors always communicated well	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported that they always received help as soon as they wanted	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported that staff always explained about medicines before giving it to them	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Information and education	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported they understood their care when they left the hospital	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Patients who reported that the area around their room was always quiet at night.	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Would recommend hospital	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Summary Star Rating	Patient Experience	CMS Hospital Compare	7/1/2020	12/31/2020
Certified Nurse Midwife Delivery Rate	Maternity	CMQCC	7/1/2020	6/30/2021
NTSV C-Section Rate	Maternity	CMQCC	7/1/2020	6/30/2021
Episiotomy Rate	Maternity	CMQCC	7/1/2020	6/30/2021
VBAC Rate	Maternity	CMQCC	7/1/2020	6/30/2021
VBAC Routinely Available	Maternity	CMQCC	7/1/2020	6/30/2021
Surgical Site Infections (19 measures)	HAI	CDPH	7/1/2020	12/31/2020
VRE Infection	HAI	CDPH	7/1/2020	12/31/2020
CLABSI	HAI	CMS Hospital Compare	7/1/2019	12/31/2020
CAUTI	HAI	CMS Hospital Compare	7/1/2019	12/31/2020
SSI Colon	HAI	CMS Hospital Compare	7/1/2019	12/31/2020
MRSA	HAI	CMS Hospital Compare	7/1/2019	12/31/2020
C. Diff	HAI	CMS Hospital Compare	7/1/2019	12/31/2020
Average time patients spent in the emergency department before being sent home	Emergency Department (ED) Care	CMS Hospital Compare	7/1/2020	12/31/2020
Percentage of ED patients with stroke symptoms who received brain scan results in 30 minutes	Emergency Department (ED) Care	CMS Hospital Compare	7/1/2020	12/31/2020
Cancer Surgery Volume (11 measures)	Cancer Surgery Volumes	HCAI	1/1/2020	12/31/2020

Analyses conducted for measures highlighted in **red**

Breast cancer surgery volume examined

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	Cancer Surgery	Quartile	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	Prostate	1	115	9	-92%	02 - Golden Empire
2	Ronald Reagan UCLA Medical Center	Prostate	1	88	21	-76%	11 - Los Angeles
3	Kaiser Permanente South Sacramento Medical Center	Prostate	1	89	28	-69%	02 - Golden Empire
4	Adventist Health Bakersfield	Prostate	1	40	14	-65%	09 - Central
5	MemorialCare Saddleback Medical Center	Prostate	1	50	18	-64%	13 - Orange
6	Cedars-Sinai Medical Center	Prostate	1	71	26	-63%	11 - Los Angeles
7	Kaiser Permanente Santa Clara Medical Center	Prostate	1	125	49	-61%	07 - Santa Clara
8	UCSF Medical Center - Mt. Zion	Prostate	1	262	105	-60%	04 - West Bay
9	UCSF Medical Center - Moffitt/Long	Prostate	1	262	105	-60%	04 - West Bay
10	Kaiser Permanente Fontana Medical Center	Prostate	1	155	80	-48%	12 - Inland Counties
11	Kaiser Permanente Ontario Vineyard Medical Center	Prostate	1	155	80	-48%	12 - Inland Counties
12	John Muir Medical Center - Concord Campus	Prostate	1	41	22	-46%	05 - East Bay
13	Kaiser Permanente Los Angeles Medical Center	Prostate	1	72	42	-42%	11 - Los Angeles
14	Kaiser Permanente West Los Angeles Medical Center	Prostate	1	76	45	-41%	11 - Los Angeles
15	Providence Holy Cross Medical Center	Prostate	1	42	26	-38%	11 - Los Angeles

- Hospitals in both Northern and Southern CA

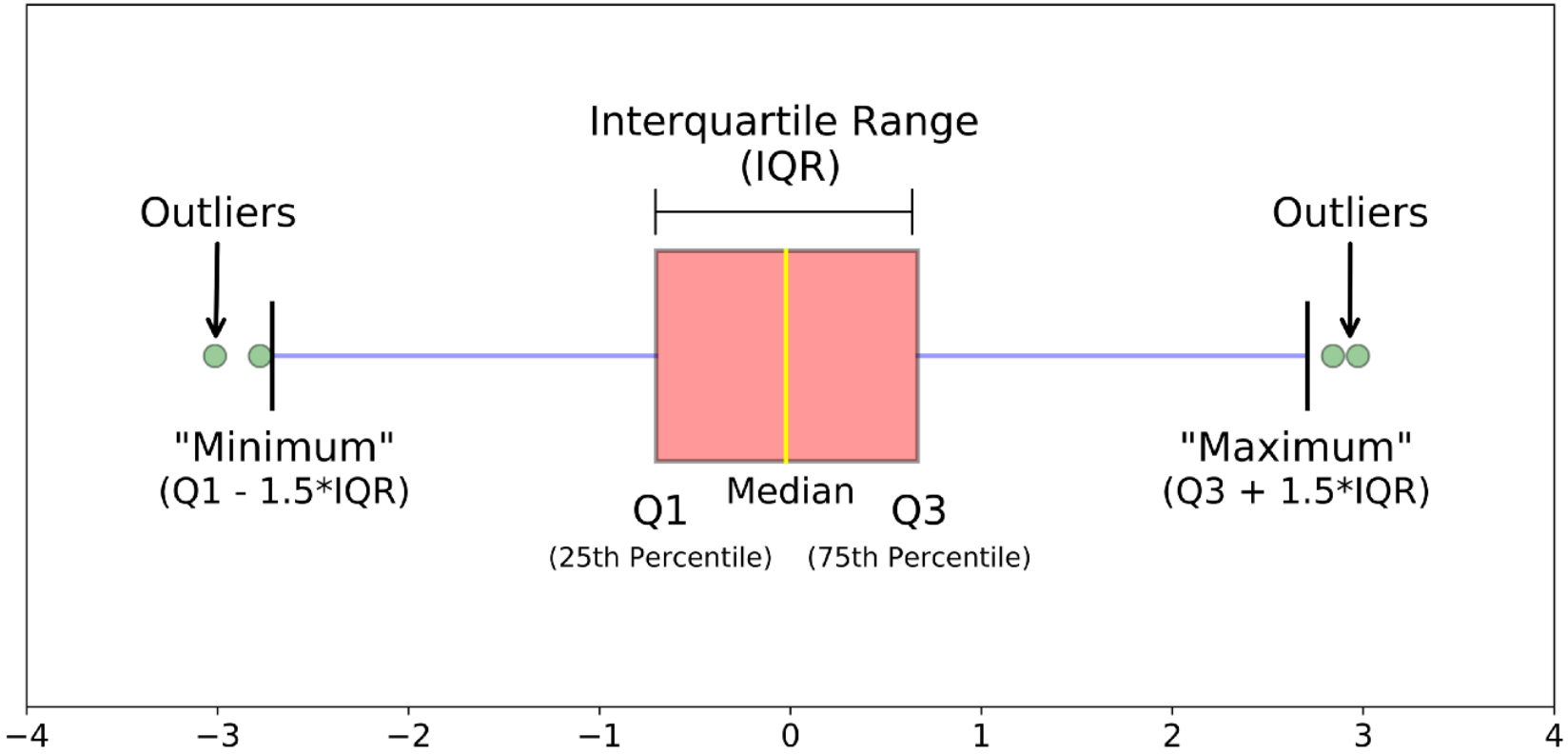
Breast Cancer Surgery Volume

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

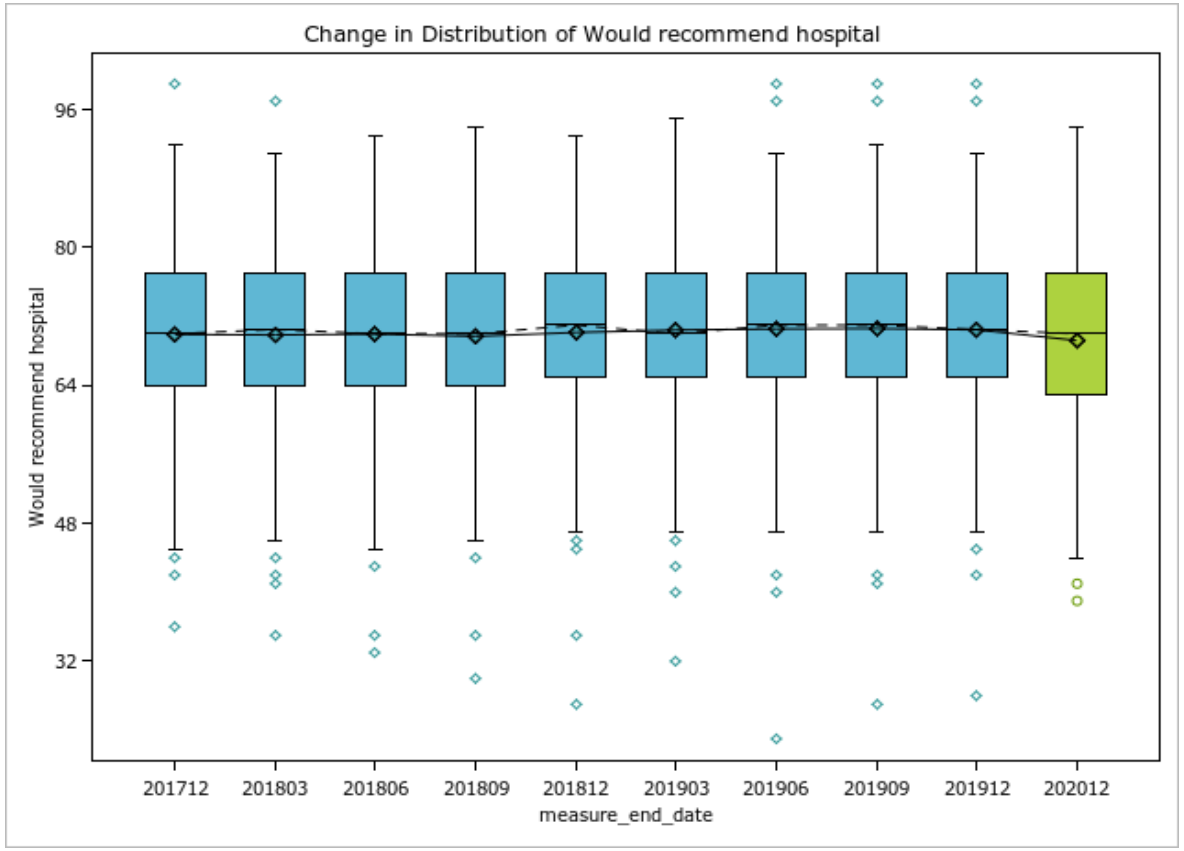
Rank	Hospital Name	Cancer Surgery	Quartile	Number of Surgeries CY 2019	Number of Surgeries CY 2020	Percent Change (CY 2019 to CY 2020)	Hospital Market Area
1	St. Joseph Hospital, Orange	Breast	1	323	153	-53%	13 - Orange
2	Providence Tarzana Medical Center	Breast	1	186	111	-40%	11 - Los Angeles
3	Antelope Valley Hospital	Breast	1	181	120	-34%	11 - Los Angeles
4	Good Samaritan Hospital - San Jose	Breast	1	177	125	-29%	07 - Santa Clara
5	PIH Health Hospital - Whittier	Breast	1	190	137	-28%	11 - Los Angeles
6	Kaiser Permanente Santa Clara Medical Center	Breast	1	425	307	-28%	07 - Santa Clara
7	Kaiser Permanente San Francisco Medical Center	Breast	1	223	164	-26%	04 - West Bay
8	Kaiser Permanente Vallejo Medical Center	Breast	1	324	241	-26%	03 - North Bay
9	Cedars-Sinai Medical Center	Breast	1	813	608	-25%	11 - Los Angeles
10	Community Memorial Hospital	Breast	1	200	151	-25%	10 - Santa Barbara/Ventura
11	Adventist Health Bakersfield	Breast	1	193	147	-24%	09 - Central
12	Kaiser Permanente Walnut Creek Medical Center	Breast	1	462	355	-23%	05 - East Bay
13	Hollywood Presbyterian Medical Center	Breast	1	183	141	-23%	11 - Los Angeles
14	Mills-Peninsula Medical Center	Breast	1	258	199	-23%	04 - West Bay
15	UC San Diego Health - LA Jolla, Jacobs Medical Center and Sulpizio Cardiovascular Center	Breast	1	497	386	-22%	14 - San Diego/Imperial

- Hospitals in both Northern and Southern CA

Box Plot Explanation



“Would Recommend Hospital”

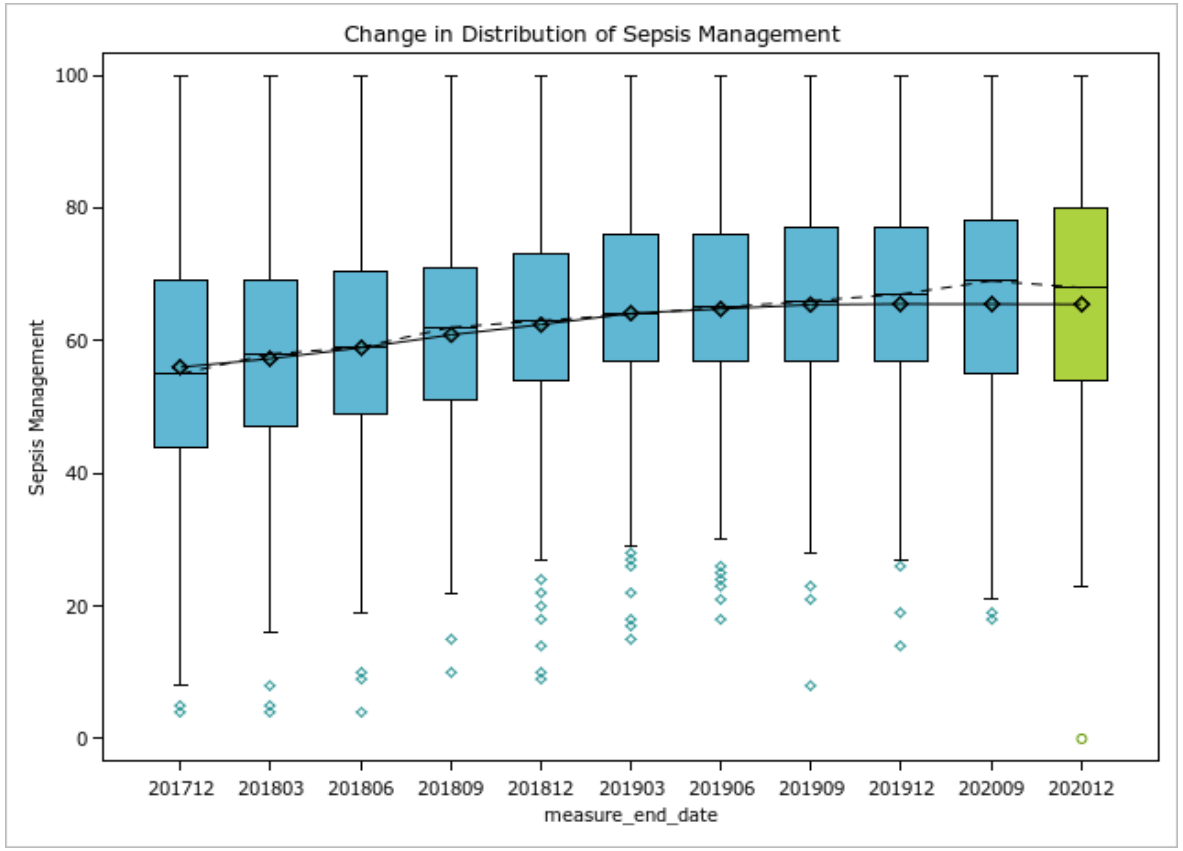


“Would Recommend Hospital” – One Pandemic Measurement Period: 7/1/20 – 12/31/20

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

Sepsis Management



Two overlapping cycles of pandemic-affected rates are available:

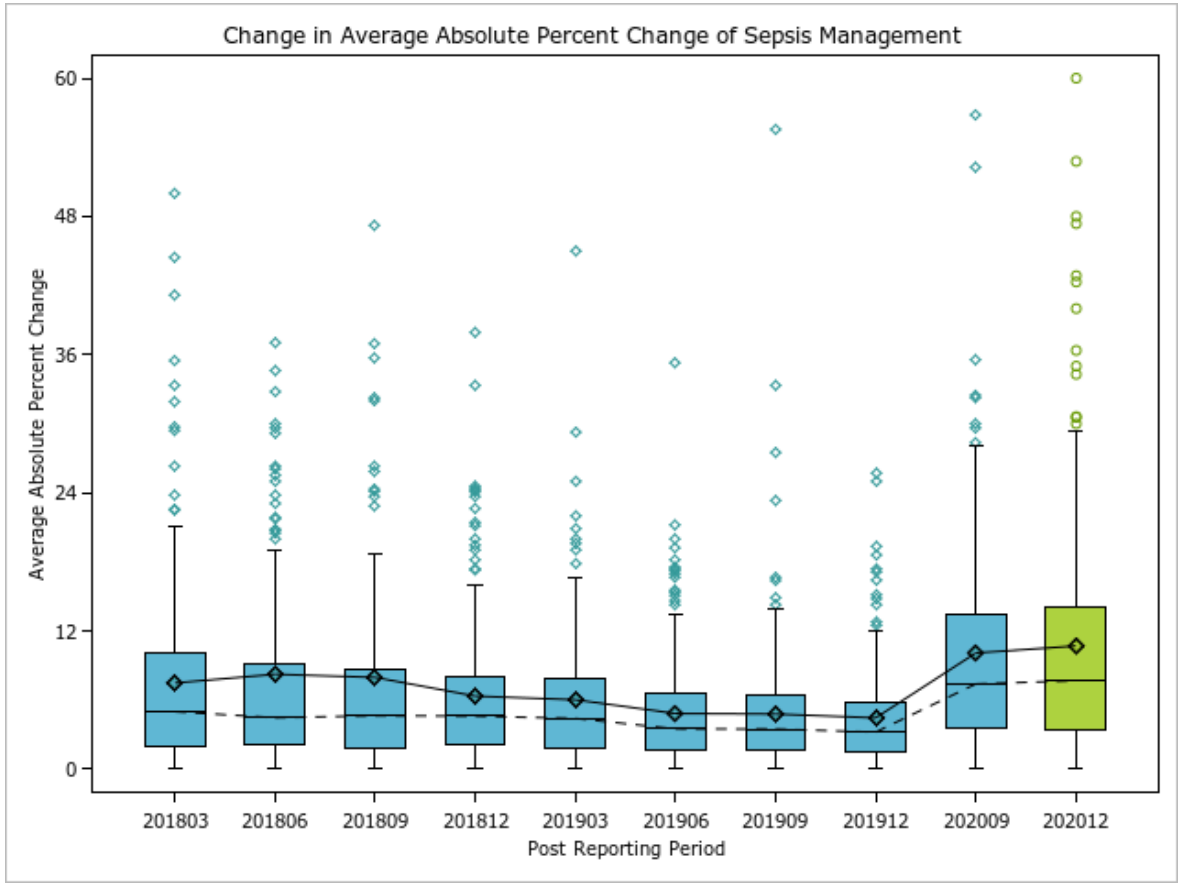
1) 10/1/2019 to 9/30/20
2) 7/1/2020 to 12/31/20

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

Absolute Changes in Rates

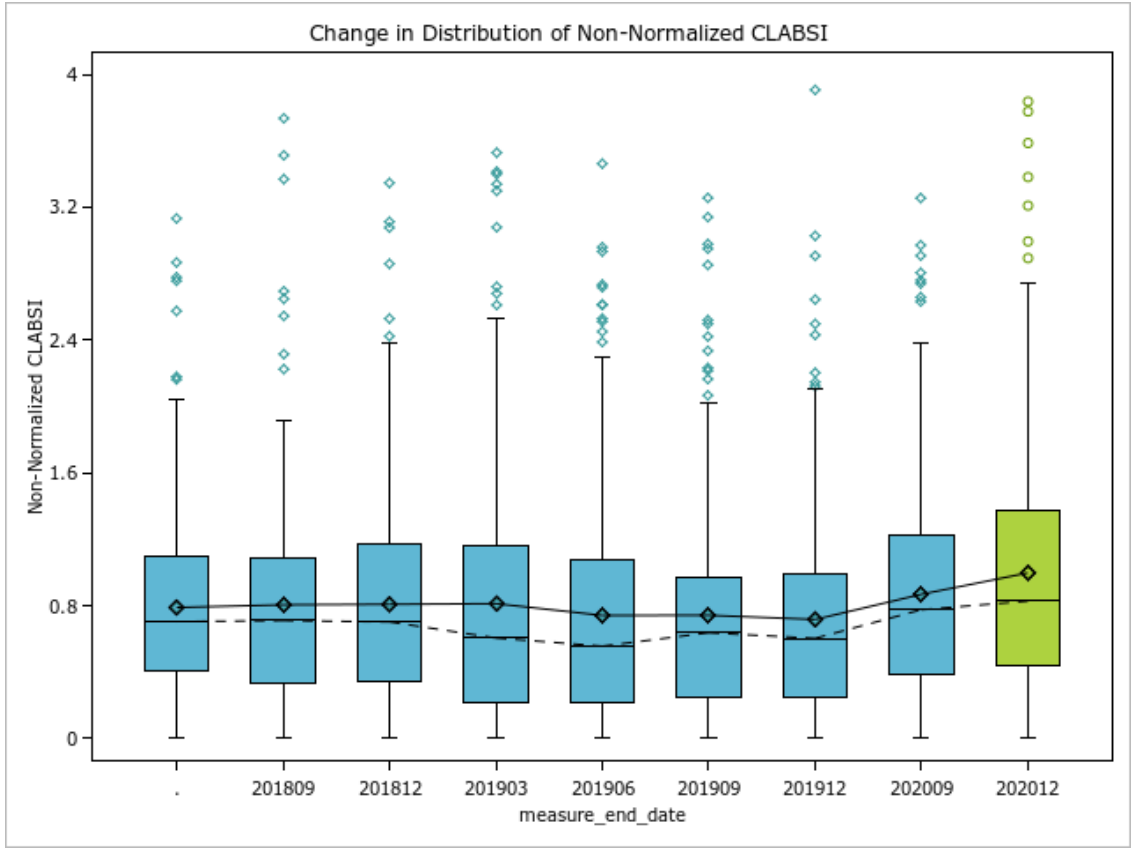


- Graphic shows the distribution of the absolute change in hospital rates from prior period to current period
- Much greater instability in rates prompted by pandemic

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

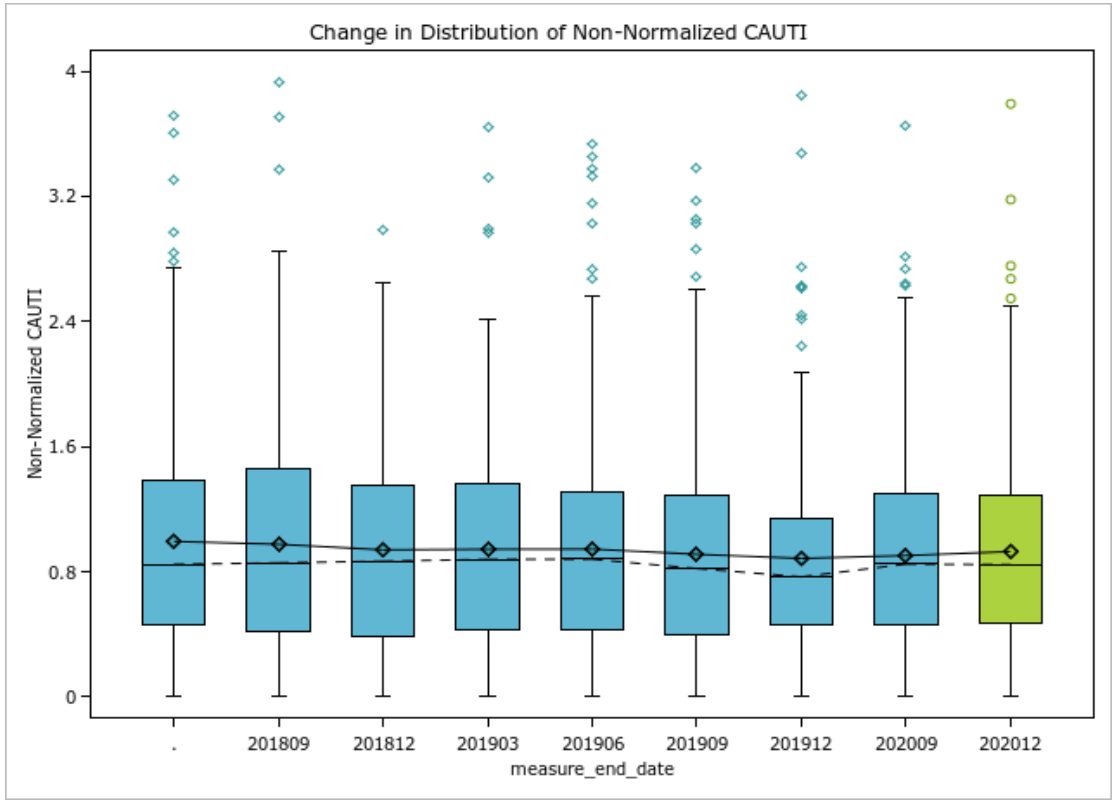
CLABSI



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

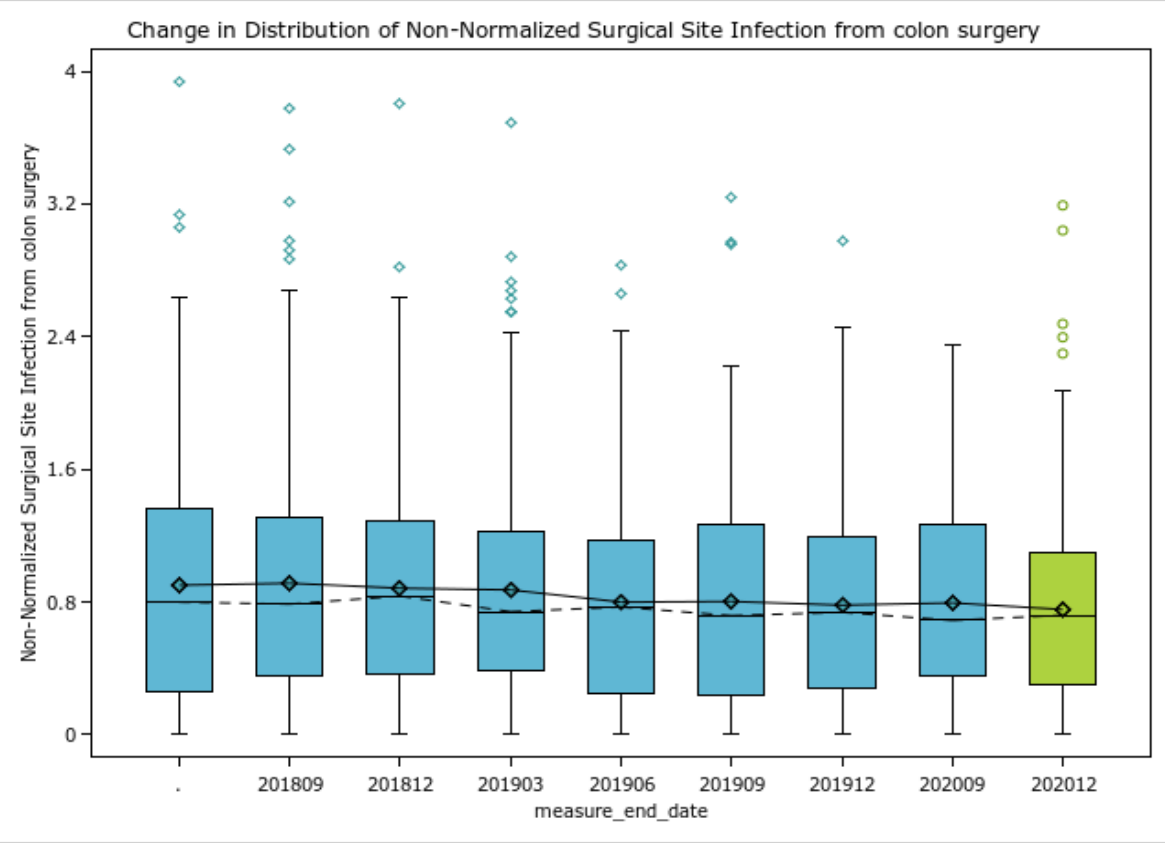
CAUTI



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

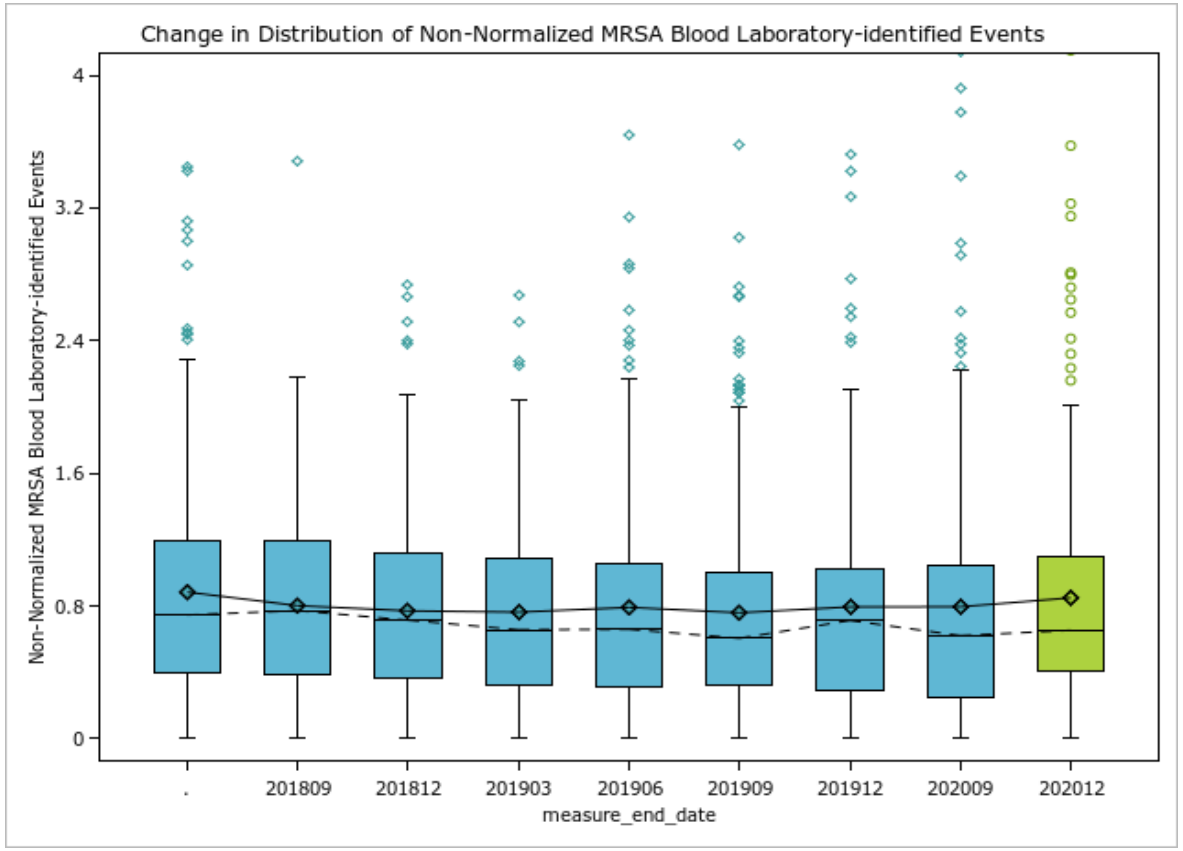
SSI Colon Surgery



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

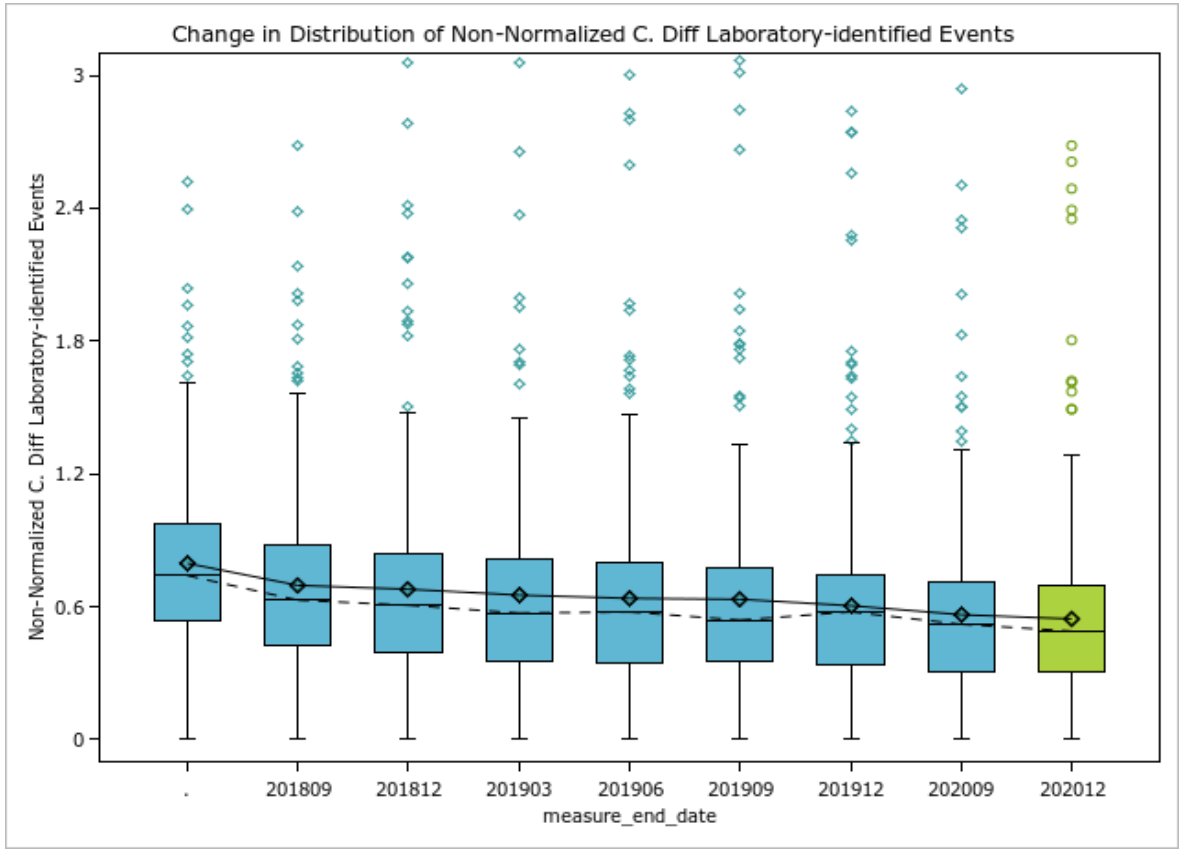
MRSA



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)

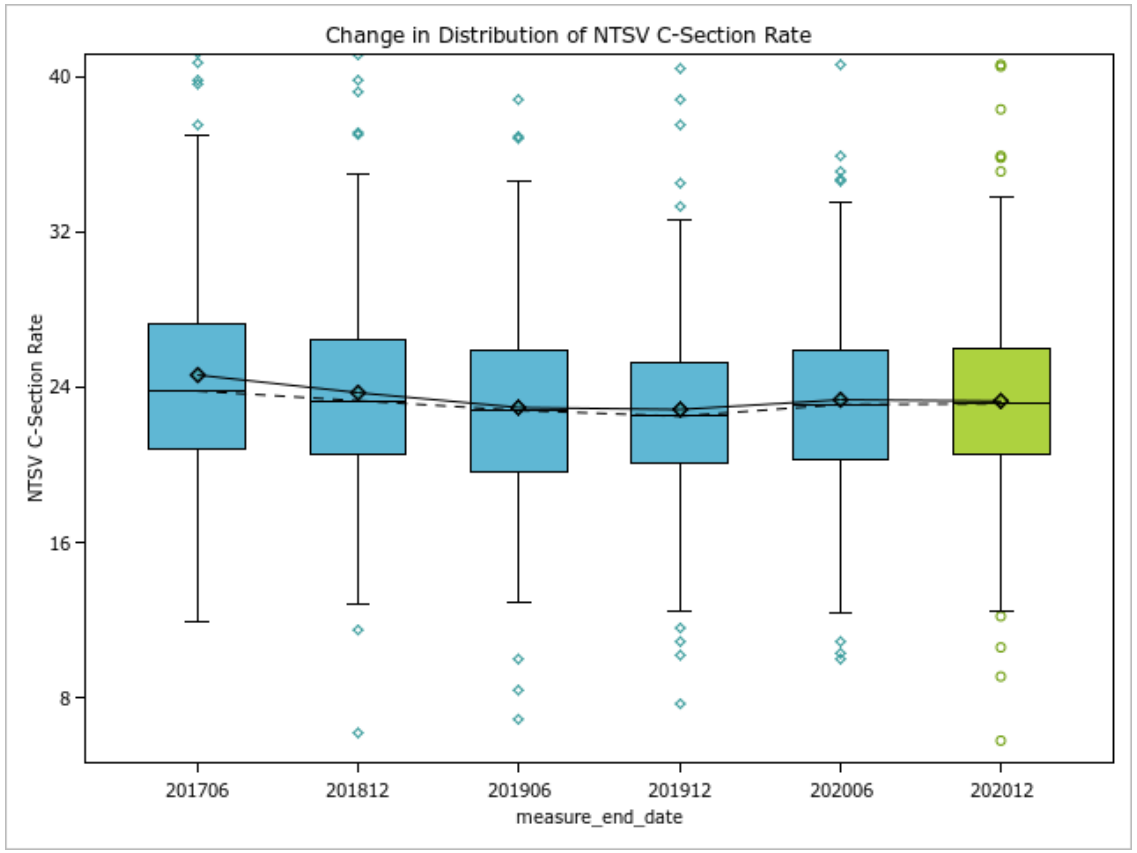
C. Diff



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

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

- Very little change in either median and average performance or standard deviation
- Implies little impact from pandemic

Wrap Up

2022 Cal Healthcare Compare BOD Schedule

(all times are Pacific Time Zone)

Tuesday, September 13	**10:00am to 12:30pm – TBD**
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 Long Term Care Compare 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 = 3 hrs In person = 4 hrs			Mar 17 virtual			Jun 21 virtual			Sep 13 tbd			Dec 13 tbd

Thank you!

Appendix

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)*	

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