Cal Healthcare Compare Board of Directors Meeting

TUESDAY, FEBRUARY 7, 2023

12:00PM PT

Proposed Agenda

- Welcome, Announcements & Introductions
- Cal Healthcare Care Updates & Operations
- Cal Hospital Compare
- Cal Long Term Care Compare
- Wrap Up

Cal Healthcare Compare
Board of Directors Meeting Agenda
Tuesday, February 7, 2023, 12:00pm 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
12:00 - 12:15 *15 min.*	Welcome and call to order - Announcements - Introductions o New board members - Approval of past meeting minutes - General Updates	- **Ken Stuart** Board Chair, Cal Healthcare Compare - **Bruce Spurlock** Executive Director, Cal Healthcare Compare

12:15 – 12:30
15 min.
	Cal Healthcare Compare Operations
	- Hospital Community Healthy Places Index
	  o Website Launch
	  o Marketing Plan
	- BOD Executive Committee
	- Financials
		- **Alex Stack**
		- Director, Cal Healthcare Compare
		- **Bruce Spurlock**
		Executive Director

12:30 – 1:00
30 min.
	Cal Hospital Compare
	- Measure Review – TAC Recommendations & BOD Feedback
	  o CMS Measures
	  o Psychiatric and Children's Measures
	- Covered CA Analysis Demo
		- **Jack Jordan**
		Principal Researcher AIR

1:00 – 1:30
30 min.
	Cal Long Term Care Compare
	- Summary of SNF Website Refresh Measures
	  o COVID Vaccine
	- Website Expansion
	- External Accreditation/Awards Discussion
	  o LTAC feedback
	- 2023 SNF Recognition Update
		- **Deb Bakerjian**
		Clinical Professor, UC Davis Health

1:30 to close	Adjourn – Next meeting: Wed. April 26, 2023 at 10am PT, at the California Endowment, Oakland	- **Ken Stuart** Board Chair

Announcements

Introductions

Updates & Operations

CAL HEALTHCARE COMPARE

2023 Opioid Care Honor Roll

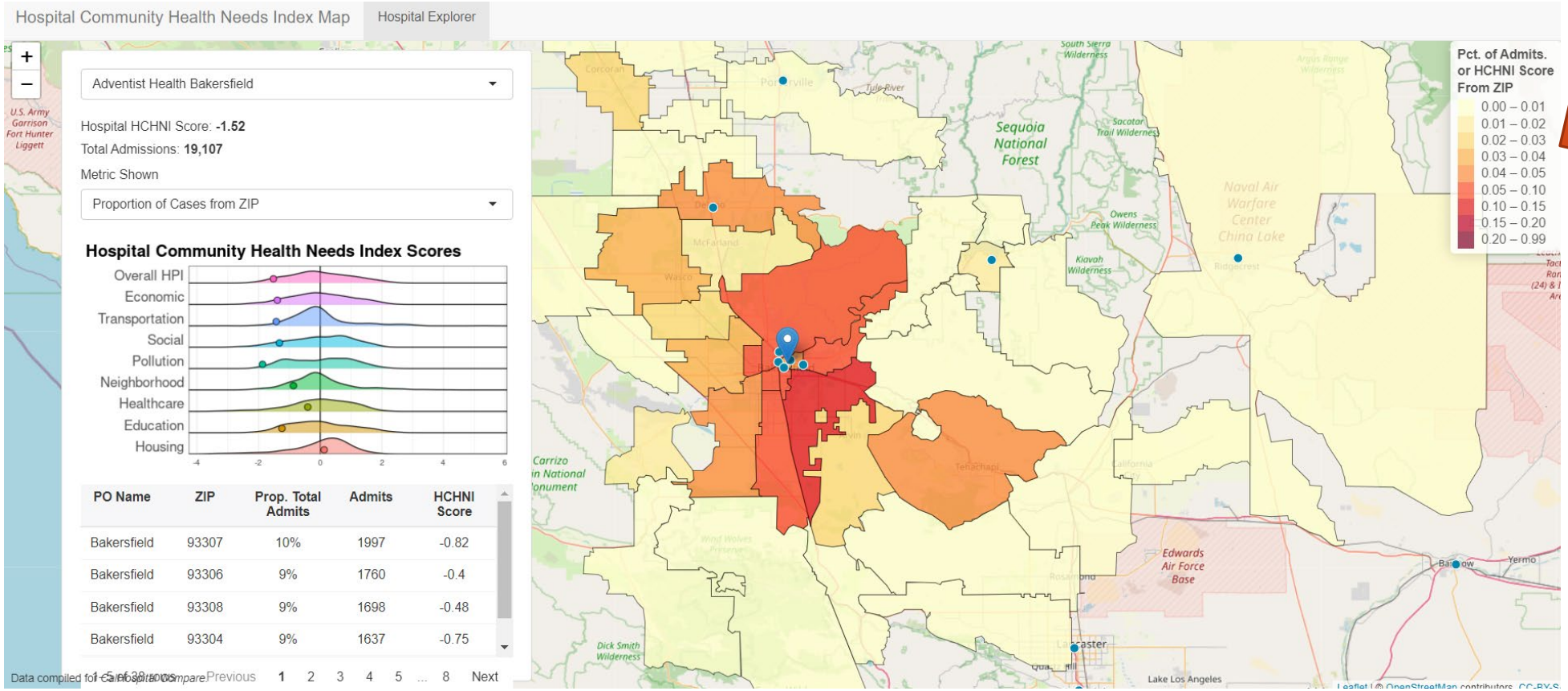
Apply Now!

The self-assessment application period is open until **March 31, 2023**.

Open office hours will be held **February 8th** and **March 8th**

Link to the Opioid Management Hospital Self Assessment and e-form to submit responses can be found on the website Programs page

Hospital Community Health Needs Index



Now Live!

Executive Committee of the Board

Executive Committee of the Board – Part I

Purpose

- Meet and act on time sensitive issues
- Advisory on all other issues

Meeting Frequency

- Twice annually for general check-in
- Ad hoc for time sensitive issues

Executive Committee of the Board – Part II

Membership

- Executive Director
- Board Chair
- At least three members but no more than five
- Target different perspectives
- Appointed by Chair in consultation with Executive Director

Accountability

- Notify Board as soon as practicable of decisions and actions
- Discuss decisions and actions at subsequent Board meeting

Cal Hospital Compare

Psychiatric and Children's Measures

Inpatient Psychiatric Facility Reporting (IPFQR)

Scope

- CMS Pay-for-reporting program
  - Not all hospitals have Psychiatric care units to be eligible
  - California has 55 Acute Care facilities submitting data and 39 Psychiatric facilities

Categories of Measures

- Measures on restraint use and seclusion
- Alcohol and tobacco screening and treatment offered
- Timely and complete record transfer
- Staff immunization
- **Follow up after hospitalization for mental illness**

Transition to electronic Clinical Quality Measures (eCQM)

- CMS is attempting to migrate as many measures as possible to eCQM formats
- Many measures replace existing measures but change in how they are transmitted but are very similar (Breastfeeding, ED time to discharge)
- Other measures utilize clinical documentation of labs, medication orders, etc.
- Many challenges with consistency across EMRs and local implementation hamper robustness of measures

Hospital Inpatient Quality Reporting Program

CY 2022 (FY 2024) Available eCQMs

For calendar year (CY) 2022 reporting (fiscal year [FY] 2024 payment determination), hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare Promoting Interoperability Program are required to successfully submit data for the mandatory **Safe Use of Opioids – Concurrent Prescribing** electronic clinical quality measure (eCQM) and three (3) other available eCQMs from the table below, for each of the three self-selected quarters. **Each self-selected quarter must contain at least three (3) self-selected eCQMs,** plus the mandatory Safe Use of Opioids-Concurrent Prescribing eCQM. The eCQMs must be the same eCQMs across quarters in a given reporting year.

Hospitals can use any combination of Quality Reporting Document Architecture (QRDA) Category I files, zero denominator declarations, and/or case threshold exemptions to reflect its total inpatient population. The data must be reported using Health Information Technology (Health IT) certified by the Office of the National Coordinator for Health IT (ONC) to the existing 2015 Edition certification criteria, the 2015 Edition Cures Update criteria, or a combination of both.*

The eCQM reporting deadline is **Tuesday, February 28, 2023, 11:59 p.m. Pacific Time**. For additional information, please visit the QualityNet eCQMs Overview page and the eCQI Resource Center eCQM page.

Mandatory *(CMS506v4)* **Safe Use of Opioids – Concurrent Prescribing** Safe Use of Opioids-Concurrent Prescribing is mandatory beginning with the FY 2024 payment determination.	
ED-2 *(CMS111v10)* Admit Decision Time to ED Departure Time for Admitted Patients	**PC-05** *(CMS9v10)* Exclusive Breast Milk Feeding
STK-02 *(CMS104v10)* Discharged on Antithrombotic Therapy	**STK-03** *(CMS71v11)* Anticoagulation Therapy for Atrial Fibrillation/Flutter
STK-05 *(CMS72v10)* Antithrombotic Therapy By the End of Hospital Day 2	**STK-06** *(CMS105v10)* Discharged on Statin Medication
VTE-1 *(CMS108v10)* Venous Thromboembolism Prophylaxis	**VTE-2** *(CMS190v10)* Intensive Care Unit Venous Thromboembolism Prophylaxis

ED = Emergency Department PC = Perinatal Care STK = Stroke VTE = Venous Thromboembolism

*CY 2022 is the final year to use the 2015 Edition certification criteria in the Hospital IQR and Medicare Promoting Interoperability Programs.

May 2022

Other Measures not in Use by Cal Hospital Compare

Excess Days in Acute Care – Attempts to use Emergency room visits and observation encounters in 30 days after admission for specific conditions

- + picks up broader challenges than readmission
- - Complicated to explain and SDOH drivers may be dominant

Medicare spending per Beneficiary – FFS and VA patients.

- + Helps capture some aspects of efficiency (Rehab use, excess referrals etc.)
- - Rapid move to Medicare Advantage programs my make the population inconsistent over time

Healthcare Workers Vaccination Rate

- Flu and COVID data exist
- COVID data are very inconsistent
- Very charged political topic

Cal Long Term Care Compare

Summary of SNF Refresh Measures

New SNF Measures for 2/23 refresh

1. **NH administrator turnover measure**
   - Rate (unscored)
2. **Resident-centered councils**
   - Resident council (required): Yes/No
   - Family council (optional): Yes/No
3. **Safety Inspections**
   - Date of most recent fire safety inspection: Date
   - Total number of fire safety and emergency preparedness citations: Number
4. **Percent of short-stay residents with NH-acquired infection requiring hospitalization**
   - Rate
   - Score (Poor/Average/Superior)

Summary of Scored Measure Results
February 2023 Refresh

Measure Name	Number of SNFs					
	Poor	Below Average	Average	Above Average	Superior	Missing
1. Rate of successful return to home and community from SNF	44	129	491	113	57	342
2. Percentage of SNF residents whose medications were reviewed and who received follow-up care when medication issues were identified*	76	96	585	278		141
3. Change in residents' ability to move around	24	59	781	82	17	213
4. Percentage of residents who are at or above an expected ability to care for themselves at discharge	77	146	509	160	71	213
5. Percentage of residents who are at or above an expected ability to move around at discharge	78	135	531	145	74	213
6. Percentage of residents with pressure ulcers/pressure injuries that are new or worsened*	51	144	657	183		141

***4 scoring categories**: poor, below average, average, superior **^3 scoring categories**: poor, average, superior

Summary of Scored Measure Results
February 2023 Refresh

Measure Name	Number of SNFs					
	Poor	Below Average	Average	Above Average	Superior	Missing
7. Percentage of infections patients got during their SNF stay that resulted in hospitalization^	34		894	31		217
8. Nursing turnover	83	164	533	132	93	0
9. Nursing retention	66	186	531	135	87	0
10. Combined Federal and State Health Inspections	112	141	638	198	78	36
11. Substantiated complaints from last three years*	109	149	610	300		35
12. Weighted staff COVID-19 vaccination + booster*						

***4 scoring categories**: poor, below average, average, superior **^3 scoring categories**: poor, average, superior

COVID-19 Vaccination Update

Q4 2022 (Sept 26 – Dec 25, 2022) Reporting dates:

Individuals are considered ***up to date*** with their COVID-19 vaccines for the purpose of NHSN surveillance if they meet (1) of the following criteria:

A. Received an updated (bivalent)* booster dose, **OR**
B. Received their last booster dose less than 2 months ago, **OR**
C. Completed their primary series less than 2 months ago

Board Decision:

Does the Board support the LTAC recommendation to report the Up-To-Date COVID-19 booster data (as defined in the Q4 2022 updated definition) with quarterly updates?

2023 SNF Ongoing Analyses

- **Continue investigation of Recognition Program Options**:
  - ✓ Better Staffing is problematic due to data access barriers.
  - ✓ *Alternative 1*: exploring mobility measures
  - ✓ *Alternative 2*: a mix of high impact measures
- **Correlation analyses:**
  - ✓ Rates of SNF staffing and Healthcare Associated Infections to inform the Staff turnover/retention measure:
  - ✓ Explore PBJ categories and explain differences between CDPH data source and PBJ
- **External Recognition program**: research AHCA Quality Awards and their correlation to staffing and 5-star program

Website Expansion

HOME HEALTH AND HOSPICE PROVIDERS

CLTCC Website: Expansion Schedule

	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Skilled Nursing Facilities	Feb.		July		Feb.		July	
Home Health Agencies‡			June/July	Nov/Dec		May		Nov.
Hospice Agencies‡			June/July	Nov/Dec		May		Nov.
Adult Residential Care Programs‡				Nov/Dec				Nov.
Adult Day Health Centers				Nov/Dec				Nov.
Other Licensed LTC Providers					TBD			

‡The first round of reporting will occur June/July 2023 followed thereafter by a May-November refresh cadence.

CLTCC Website Expansion: Hospice Indicators (n=3075)

Proposed Hospice Webpage Domains	Measure
Provider Service Description (3)	Treated conditions (list percent of pt w/ condition)
	Locations of care provided
	Level of care provided (up to 4 levels of care)
Family Caregiver Experience (9)	Summary rating (5 stars if participating in Medicare/Medicaid)
	8 CAHPS survey questions (communication, respect, help for pain, etc)
Hospice Quality of Care (3)	1) Patients assessed for 7 quality measures at the beginning of hospice care
(*no CMS summary rating)	2) Percentage of patients who received visits from a registered nurse or medical social worker on at least 2 of the final 3 days of their life
	3) Hospice Care Index score (0-10)
Other	Address, ownership type, owner, avg daily census, Medicare certification date, served at least one dual eligible pt, at least one pt in Medicare Advantage (y/n)
Website will also include tips on choosing a hospice provider and other consumer education tools.	

Overview of Hospice Care In CA

Facility type	
Hospice Agencies	3061
Hospice facility	14
Grand Total	3075

Ownership type	
Missing	8
For profit	2931
Not for profit	134
Government	2
Total	3075

Accreditation	
No accreditation	1350
ACHC	618
CHAP	175
JC	932
Grand Total	3075

Licensed/Certified	
Certified only	4
Licensed and certified	1639
Licensed only	1430
Not licensed/not certified	2
Grand Total	3075

Location of care %	Max	Average
Assisted_Living	100	18.38
Home	100	75.17
Inpatient_Hospice	9	0.05
Inpatient_Hospital	6	0.04
Nursing_Facility	86	2.52
other_locations	41	0.39
Skilled_Nursing	63	4.17

Primary diagnosis	Max	Average
% Patients with Cancer	70	22.77
% Patients with Heart disease	94	17.96
% Patients with Dementia	66	26.29
% Patients with Other Conditions	36	1.80
% Patients with Respiratory disease	33	2.97
% Patients with Stroke	47	9.08

Level of care	
Provided Routine Home Care and other levels of care	589
Provided Routine Home Care only	12
Missing/Not available	1148

Family Caregiver Experience (CAHPS) Analysis:
84% of providers are missing data (and not reported)

CLTCC Website Expansion: Home Health Indicators (n=3163)

Proposed Home Health Webpage Domains	Measure
Provider Service Description	Services offered (6 types Y/N)
Patient Survey (6 measures)	Summary rating
	5 measures (plus survey response rate/# completed surveys)
Home Health Quality of Care (16 quality + 1 financial measure)	Summary rating
Managing daily activities	4 measures
Treating symptoms	2 measures
Preventing Harm	6 measures
Preventing unplanned hospital care	4 measures
Payment and value of care	How much Medicare spends on an episode of care at this agency, compared to Medicare spending across all agencies nationally (e.g., 0.97/nat'l ave=1.00)
*Website will also include tips on choosing a home health provider and other consumer education tools.	

Overview of Home Health in CA

Ownership type	N	%
Not Available	4	0%
Government	3	0%
For Profit	3022	96%
Non-Profit	134	4%
Total	3163	

Licensed/Certified	N	%
Licensed only	1296	41%
Licensed & Certified	1864	59%
Not licensed/Not certified	3	0%
Total	3163	

Services offered	N	%
Nursing Care	1807	100%
Physical Therapy	1778	98%
Occupational Therapy	1754	97%
Speech Pathology	1731	96%
Medical Social	1778	98%
Home Health Aid	1763	98%
**214 facilities are too new to have data*		

Accreditation	N	%
The Joint Commission	950	30%
Community Health Accreditation Partner	184	6%
Accreditation Commission for Health Care	518	16%
Not accredited	1511	48%
Total	3163	

Quality of patient care star rating	N	%
1	14	1%
1.5	92	7%
2	141	11%
2.5	181	14%
3	216	17%
3.5	225	17%
4	188	15%
4.5	139	11%
5	99	8%
Total N	1295	

*726 facilities- The number of patient episodes for this measure is too small to report.

Wrap Up

Cal Healthcare Compare
BOD Meeting Schedule - 2023

(all times are Pacific Time Zone)

• **Wed. April 26**	**10:00am to 2:00pm – in person, Oakland**
• Tues. July 25	12:00 to 2:00pm –virtual
• Tues. October 24	12:00 to 2:00pm – virtual

2023 Meeting Cadence

Meeting	CY 2023											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Cal Long Term Care Technical Advisory Committee - LTAC (2 hrs)	Jan 24 12 - 2pm			April 4 12 – 2pm		Jun 28 10am – 12pm			Sept 26 12 – 2pm			Dec 13 10am – 12pm
Cal Hospital Compare Technical Advisory Committee - HTAC (2 hrs)	Jan 12 11am – 1pm			April 12 12 – 2pm			July 12 11am – 1pm			Oct 11 12pm – 2pm		
Board of Directors - Cal Healthcare Compare Virtual = 2 hrs In person = 4 hrs		Feb 7 12-2pm		April 26 10am - 2pm, in person Oakland			July 25 12 – 2pm			Oct 24 12 – 2pm		
Executive Committee Meetings - TBD (45 mins – 1 hour)												

Thank you!

Appendix

Cal Healthcare Compare
Hospital Community Health Needs Index

What is the Hospital Community Health Needs Index?

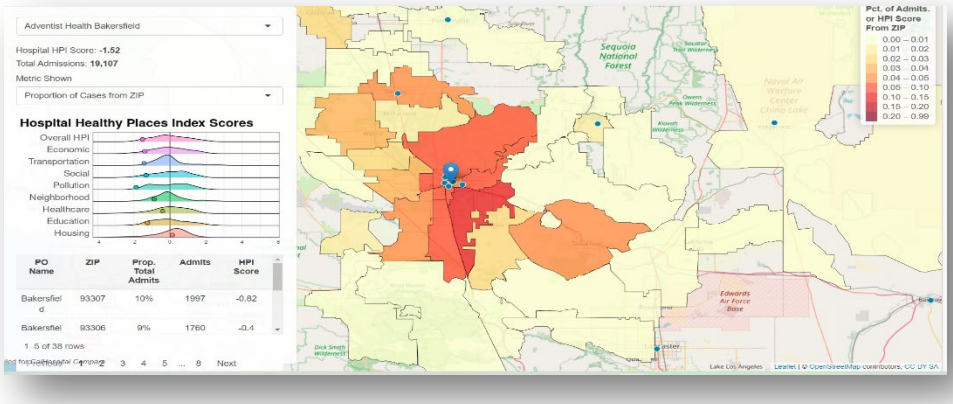
HCHNI is an analytic tool that maps specific neighborhoods and hospital admissions to identify social factors that most impact health outcomes. By mapping these vulnerable neighborhoods, hospitals can better identify challenges to focus on at the community level and target potential interventions to address these challenges. Hospitals can help drive change related to equity, social needs and continuity of care.

HCHNI Facts

- Data available for 312 California hospitals covering over 50 counties and 1700 zip codes
- Data can be viewed for 8 domains (economic, education, housing, healthcare access, neighborhood, pollution, social and transportation)
- Users can look at the average score for all 8 domains or view the proportion of admissions for your hospital by zip code

How would a hospital benefit from using the HCHNI?

Users can search for any hospital in California to learn what zip code hospital admissions are coming from as well as how those neighborhoods are faring. Neighborhoods with a lower HCHNI score are reflected as a darker color on the map. These neighborhoods indicate a higher correlation to social needs.



How can I access HCHNI data?

- Access to hospital and neighborhood specific data are available by subscribing to an annual membership. Click Subscribe Here to view membership plans and sign up for an account.
- New subscribers will receive access to the website and individualized technical assistance from a CHC team member to collaborate on interpreting the results and identify actionable next steps.

Questions about HCHNI or are you interested in a brief demo before subscribing?

Please contact us at calcompare@gmail.com

Hospital Community Health Needs Index

HCHNI was developed by Cal Healthcare Compare in partnership with the Public Health Alliance of Southern California, creators of the California Healthy Places Index™.

2023 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. Since 2019, CHC has used 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: **We invite all adult and pediatric acute care hospitals to apply.** 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 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.

For more information on the Opioid Care Honor Roll Program and to access resources to support your quality improvement journey, including our measurement guide and resource library, check out the Cal Hospital Compare website here.

2023 Opioid Care Honor Roll Program

Performance period: April 2022 – March 2023

Assessment period: January 1, 2023 – March 31, 2023

Stay tuned for information on how to submit your 2023 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*	**Level 5 (5 pts.)** *Sustainability*

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; prescribed and illicit
• 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; these guidelines may be department specific	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	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period
						
						Hospital continues to **monitor performance but** implementing appropriate opioid discharge prescribing is no longer an active QI initiative
						
						Great job!

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*	**Level 5 (5 pts.)** *Sustainability*
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 guidelines 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 guidelines 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 approach to identifying opioid alternatives (e.g., integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, shared decision making with patient and family, 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	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance but** implementing strategies to ensure alternatives to opioids for pain management are provided is no longer an active QI initiative **Great job!**

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*	**Level 5 (5 pts.)** *Sustainability*
Medication Assisted Treatment (MAT) Provide MAT for patients (adults and youth) identified as having 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 on how to universally offer MAT to all patients: • Do not screen patients for OUD • Do not ask patients if they are interested in MAT services; this may be time consuming for providers and stigmatizing for patients • Do promote MAT services using signage in waiting and exam rooms, badge flare, and patient forms • Do let patients know that their site offers MAT during the exam 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 for adults and youth	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.) Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT for adults and youth	MAT is **universally offered*** to all patients (adults and youth) presenting to the hospital One or more **hospital staff** has the time and skills to **engage with patients** (adults and youth) on a human level, motivating them to engage in treatment (e.g., a hospital employee embedded within either an ED 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, Peer Mentor, Chaplain, etc.)	Your hospital is actively **measuring and developing strategies to improve** access to MAT	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but MAT is no longer an active QI initiative **Great job!**

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*	**Level 5 (5 pts.)** *Sustainability*
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 *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, mental health 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 and/or schedule** MAT and OUD patients with a community provider for ongoing treatment (e.g., primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, mental health provider, etc.)	Your hospital is actively **measuring and developing strategies to improve** patient access to timely follow up care	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but implementing strategies to ensure timely follow up care is no longer an active QI initiative **Great job!**

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*	**Level 5 (5 pts.)** *Sustainability*
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 & other harm reduction resources within hospital, health system, and community** (e.g., community access points, low/no-cost options, community pharmacies with naloxone on hand, community coalitions, safe injection sites, safe opioid disposal sites, community access points for fentanyl test strips, 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 Project; 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 & other harm reduction services	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but providing free naloxone kits to patients and families is no longer an active QI initiative **Great job!**
	Extra credit (1 pt.) Your hospital provides patients and families one or more of the following harm reduction services: access to low cost or no cost fentanyl test strips and safe injection kits, and information on how to properly store and dispose of opioid medications					

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*	**Level 5 (5 pts.)** *Sustainability*
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 and treatment (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, key performance indicators, and 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 or learning collaborative** Hospital has an accurate and automated process to collect data on **appropriate PDMP utilization and safe use of opioids (eCQM)**	Hospital is actively **measuring and developing strategies** that support opioid stewardship as an organizational priority Hospital **benchmarks performance** against publicly available data such as the California Overdose Surveillance Dashboard, Healthy Places Index, Opioid Care Honor Roll results, Bridge Navigator Program metrics, etc.	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but enhancing organizational infrastructure is no longer an active QI initiative **Great job!**

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*	**Level 5 (5 pts.)** *Sustainability*
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance misuse. Hospital actively addresses stigma, including but not limited to, through the education and promotion of the medical model of addiction, trauma informed care, motivational interviewing, and by offering harm reduction services across all departments to facilitate disease recognition, greater access to patient partnerships, 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 trauma informed care** to normalize OUD and treatment (e.g., stigma reduction training, 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 including medical records and patient forms, 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	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but addressing stigma is no longer an active QI initiative **Great job!**

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*	**Level 5 (5 pts.)** *Sustainability*
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, harm reduction services provided by the hospital and within the community, risk associated with illicit fentanyl use, 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 including risk associated with illicit fentanyl, alternatives, and overdose prevention strategies (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 pain management 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., establish realistic pain trajectory and pain management plan with a special focus on managing pain associated with common procedures such as c-sections and hip/knee, risk and side effects associated with opioid use, etc.)	Provides opportunities for **patients and families to engage** in hospital wide opioid management activities (Patient Family Advisory Council, Youth Advisory Council, volunteer or paid peer navigator positions, program design, etc.)	Your hospital is actively **measuring and developing strategies** to improve patient and family engagement Measurement includes **patient experience and/or patient reported outcomes** (e.g., patient states that they were given education on the risk/benefits associated with long term opioid use, treatment options, etc.)	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but addressing stigma is no longer an active QI initiative **Great job!**

Additional hospital information:

Open ended responses:

1. Briefly describe the steps your hospital has taken to improve opioid stewardship across the 4 domains assessed in the 2023 Opioid Management Hospital Self-Assessment.
2. What would you like to learn more about in 2024 that would help you to close a gap in your work?
3. What else do you want us to know?

Optional responses: This data will help us to understand and align future iterations of the *Opioid Management Hospital Self-Assessment* and program resources with the work that you are doing. For the most recent 12 months we invite you to share the following metrics:

1. Number of OUD related ED visits / total ED volume
2. Number of OUD related inpatient admissions / total inpatient admissions
3. Number of naloxone doses prescribed, dispensed, and/or distributed

Other:

1. Is your hospital part of a hospital system? If yes, what is the name of the hospital system?
2. Select YES to opt IN sharing your assessment results and open-ended responses with others in the program for the purposes of spreading bright spots and lessons learned. If yes, please let us know if you would like us to include your contact information so that others in the program can reach out to learn more. Your responses and contact information will be visible only to others in the program.
3. Select YES to opt IN data sharing with our improvement partners, CA Bridge, and the Health Services Advisory Group.

2023 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	
"Hon-rolled" a friend *Share the Opioid Care Honor Roll opportunity with another hospital that has not yet participated in our program. If they apply for the 2023 Opioid Care Honor Roll you both get 1 additional point.*	Provide hospital name(s)
Total score *(out of 42 points)*	

Board of Directors

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