Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Agenda
Wednesday, April 3, 2019
10:00am – 2:00pm PT

Meeting Location
California Health Care Foundation
1438 Webster Street #400
Oakland, CA 94612

Webinar Information
Webinar link: https://zoom.us/j/235245888
Phone: 1-669-900-6833
Access code: Code: 235 245 888

Time	Agenda Item	Presenters and Documents
10:00-10:10 *10 min.*	Welcome and call to order - Approval of past meeting summary - Board changes	Ken Stuart, Board Chair
10:10-11:10 *60 min.*	Organizational updates - General updates o BOD composition o Healthcare Payments Data Review Committee o Changes in health plans - Covered CA report on poor performers	Bruce Spurlock, Executive Director Ken Stuart, Board Chair
11:10-12:00 *50 min.*	Opioid Safe Hospital Designation - Proposed assessment & scoring - TAC & stakeholder feedback - Next steps	Alex Stack, Manager Aimee Moulin, ED BRIDGE
12:00-12:30 *30 min.*	Open forum discussion *Lunch will be provided*	
12:30-1:25 *55 min.* .	TAC analytic updates - TAC membership - Patient Safety Honor Roll 2.0 - Data refresh	Bruce Spurlock, Executive Director Mahil Senathirajah, Truven/ IBM
1:25-1:45 *20 min.*	Business plan – Financial report	Bruce Spurlock, Executive Director
1:45-2:00 *15 min.*	Wrap-up Adjourn – Next meeting: June 5, 2019 from 10:00am-12:00pm PT (virtual meeting)	Bruce Spurlock, Executive Director Ken Stuart, Board Chair

Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Summary
Wednesday, February 13, 2019
11:00am – 1:00pm PST

Attendees: Bruce Spurlock, Alex Stack, Tracy Fisk, David Hopkins, Libby Hoy, Chris Krawczyk, Lance Lang, Helen Macfie, Julie Morath, Kristoff Stremikis, Ken Stuart, Katharine Traunweiser, Frank Yoon
Guests: Aimee Moulin, Sara Windels

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting formally commenced at 11:04am Pacific Time. The meeting attendees formally introduced themselves. • The Cal Hospital Compare Board meeting summary of Dec 07, 2018 was motioned and approved.
Opioid Safe Hospital Designation	• Goal is to have an announcement of opioid safe hospitals for early adopters by fall 2019 with a survey implemented by this spring. A multi stakeholder workgroup will be formed and meet from February through April. The workgroup will first focus on process and structural measures progressing to quantifiable performance measures across multiple units. • Amy Moulin and Sarah Windels from the Bridge Program presented to the board the following impactful domains of care: 1. Prevent new chronic opioid starts – decrease discharge prescriptions 2. Promote alternative to opioid treatment for pain management while patients are in the hospital 3. Treat opioid use disorders and patients in acute opioid withdrawal while they are in the hospital 4. Prevent opioid overdoses • Bruce reviewed the measure trajectory for years 1 – 4 • David Hopkins inquired if there are other organizations conducting similar work – Aimee responded that the Bridge Program is ahead of the national curve in integrating this work in California. Lance Lange added that CA health plans are also ahead. • Bruce will bring back the final requirement list to the board for approval before the workgroup begins. The board will contact Bruce with any recommendations of those who are interested in joining the workgroup.
Organizational Updates	• Joan Maxwell and Liz Salmi have joined the TAC as new consumer representatives • Bruce has received other referrals for potential members who can expand representation of the TAC and add technical expertise • Bruce and Alex reported out on the CHCF Consumer Activation Project including the poll results, priority levels, near term and longer-term strategies. David asked if we should consider holding a conversation with IHA. • Bruce reviewed the work surrounding identifying poor performing outlier hospitals – a contract was signed with Covered CA on Feb. 13th. Initially, this work will not be published. The goal is to improve the curve and later decide if the information should be made public. The final results will be reported out at the next meeting.

	• Data Use Fees – additional information has been circulated to the board. A preliminary conversation with CMQCC took place earlier this month. CMQCC will provide CHC with data twice per year. CHC proposed to share 20% of the fees for the data that includes CMQCC maternity data. CMQCC will review and seek approval from their executive committee before providing CHC with a response. The board was supportive of this proposal.
TAC Analytic Updates	• Bruce and Alex gave the TAC updates in Mahil's absence. The CHC data was refreshed in January. CMS data is expected to be refreshed this month. • Helen Macfie requested to hold an offline discussion with Bruce and Julie Morath to review how to update the website with data re: hospitals who perform V-BACs.

Patient Safety Honor Roll 2.0	• Bruce reviewed the PSHR 1.0 methods and possible approaches for a Patient Safety Honor Roll 2.0 including:
	  o Adding measures including HCAHPS composite topics, composite measures from PSI-90 and sepsis process measure (SEP-1) to the algorithmic methodology in an effort to increase the number of eligible hospitals
	  o Using multiple years of data
	  o Creating a composite measure
	• Bruce provided a summary of the TAC discussion. The TAC agreed that scenarios 2 and 3 are the most attractive using composite measure PSI-90. The TAC proposed to consider the mix of the HCAHPS patient experience measures, modeling Honor Roll scenarios using different HCAHPS composite measures. David Hopkins, Lance Lang, and Helen Macfie expressed their concerns regarding the established threshold for low performance criteria/meeting the honor roll.
	• Bruce reviewed the future PSHR 2.0 analysis.

Business Plan	• Bruce reviewed the current financial report and annual budget for 2019. • Bruce is currently holding discussions with several of the health plans to discuss funding support for 2019. Bruce to connect with Ken Stuart offline re: Blue Shield Anthem.
Wrap Up Items	• To gain greater exposure and increase website traffic, we will be adding photos and bios of the TAC and BOD members to the CHC site. The TAC and CHC BOD to send this information to Alex Stack.
Next Meeting/Meeting Adjournment	• Next meeting: April 3, 2019 from 10:00am-2:00pm PT (California Health Care Foundation, Oakland, CA) • The meeting formally adjourned at 12:33pm Pacific Time.

Cal Hospital Compare

Board of Directors

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Cal Hospital Compare Board of Directors

April 3, 2019

10:00am -2:00pm Pacific Time

California Health Care Foundation

Phone: 1-669-900-6833

Access code: 235-245-888

Webinar link: https://zoom.us/j/235245888

Proposed Agenda

- Welcome & call to order
- Organizational updates
- Opioid safe hospital designation
- Patient safety honor role 2.0
- TAC analytic updates
- Business plan
- Wrap Up

Organizational Updates

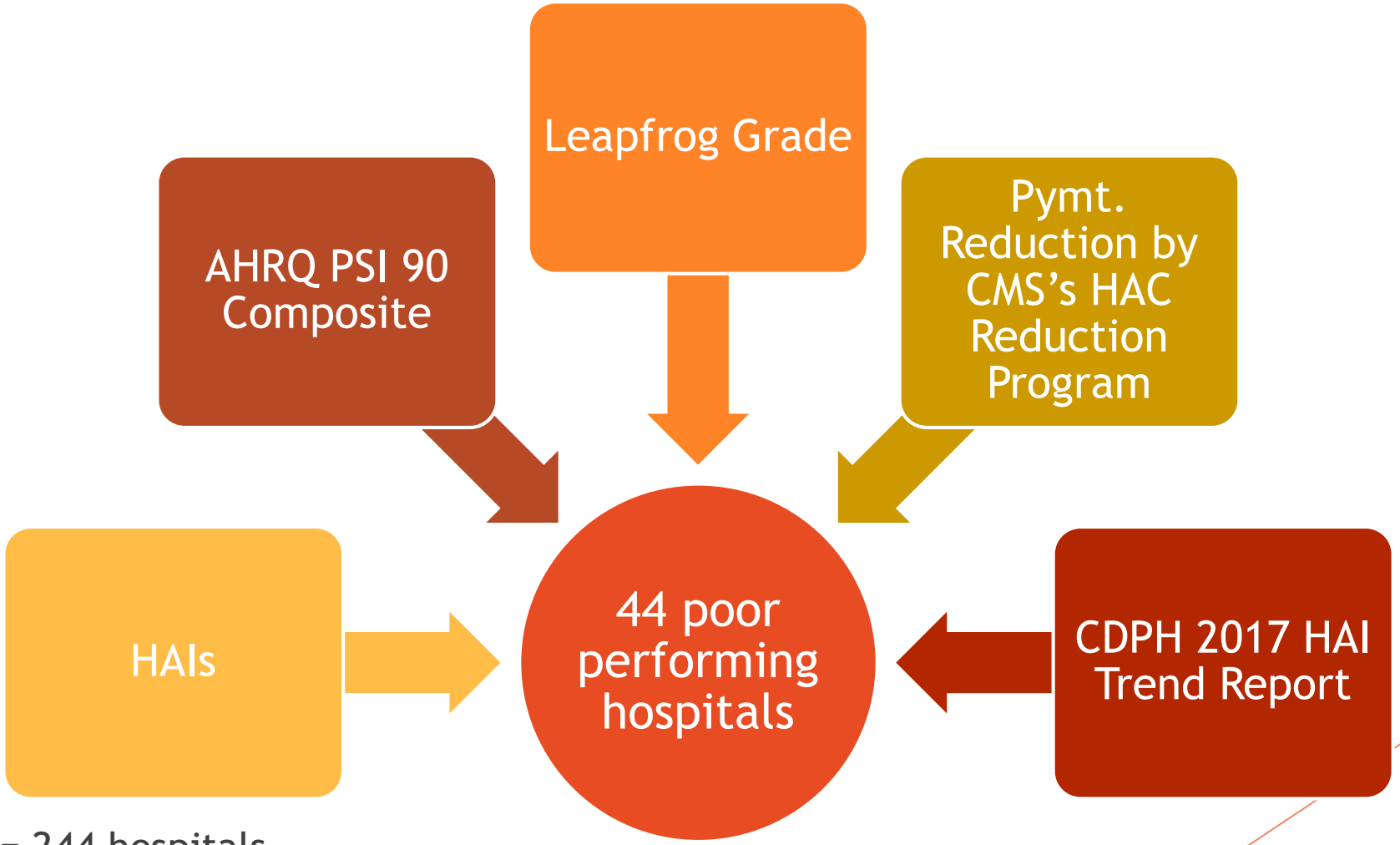
General Updates

Changes in BOD composition

Healthcare Payments Data Review Committee

Anthem update

Report on Patient Safety Poor Performers



N = 244 hospitals

Opioid Safe Hospital Designation

Opioid Safe Hospital Designation

Accelerate improvement

- Accelerate the implementation and use of effective practices with the ultimate outcome being a reduction in opioid-related deaths, more effective treatment of patients with OUD while also managing pain and associated clinical conditions effectively.

Measures of success

- Anticipate criteria will evolve over time. Focus on process and structural measures first in a defined unit progressing to quantifiable performance measures across multiple units.

Advisory Work Group Members

Patty Atkins
VP Quality, Patient Safety,
Lean Six Sigma
Sharp Healthcare

James "Jim" Leo, MD
Chief Medical Officer
MemorialCare

Karen Mark, MD
Medical Director
California Department of Health Care

Joan Maxwell
Patient Advisor
John Muir Health

Aimee Moulin, MD
Central Valley Regional Coordinator
ED-BRIDGE Central Valley

Valerie Norton, MD, FACEP
Physician Operations Executive,
Scripps Mercy Hospital
Chair, Scripps Pharmacy and
Therapeutics Council
President, Pacific Emergency
Providers

Lisa Patton, MD
Sr. Director, Behavioral Health
Research & Policy
IBM Watson Health.

Gayle Sandhu
Corporate Senior Director, Quality &
Patient Safety
Scripps Health

Mahil Senathirajah
Senior Director
IBM Watson Health

Hannah Snyder, MD
Director
Project SHOUT

Ole W. Snyder, MD
Medical Director
Scripps Health Opioid Stewardship
Program

Sarah Windels
Independent Consultant
ED BRIDGE

Paul Young
Senior Vice President, Reimbursement
Policy
Hospital Association of Southern
California

TAC & Stakeholder Feedback:

- Broad support to accelerate change in 4 domains (this is the right stuff)
- Allow for programmatic flexibility
- Present the assessment as roadmap & not guidelines for improvement
- Provide complimentary resources
- Raise the bar!
  - Be clear in the *how*
  - Include some quantitative measures

Assessment Design (10 Questions)

Measure	Intent	Level 3 (1 pt)	Level 2 (2 pts)	Level 1 Opioid Safe (3 pts)	Example *(comparative tool & resource)*
Prevent new opioid starts • Prescribing guidelines • Alternatives to opioids for pain management • Formulary management				Overdose Prevention • Naloxone education & distribution program • Hand-off to drug treatment program	
Identification & Treatment • Standardized assessment tool • MAT • BUP Waiver • MAT hand-off to outpatient setting				Cross-cutting Opioid Safe Hospital Best Practices • Organizational infrastructure • Provider/staff education • Patient education	

**Extra credit available in key areas*

Review Draft Assessment

- See meeting packet

Proposed Scoring Options

- Score at least 8 points, with at least one point in each domain OR score at least 25 points, with at least one point in each domain, etc.
- Set the curve i.e. top 25%
- Determine threshold post-assessment
- Collect baselines year 1

Measure	Level 3	Level 2	Level 1 (Opioid Safe)
Prevent new opioid starts	3	6	9 (+1)
Identification & Treatment	4	8	12 (+2)
Overdose prevention	2	4	6 (+1)
Cross-cutting best practices	3	6	9 (+1)
Total	0-12	13-24	25-36 (41)

2019 Timeline

Key Activities	Mar	Apr	May	Jun	July	Aug	Sept	Oct
Workgroup meetings & criteria development	Mar. 7 Mar. 19							
Multi-stakeholder feedback	Health plan End-user (hospital leadership) Mar. 27 CHC TAC Apr. 3 CHC BOD							
Launch		Intro. webinar Share resources	Survey Opens	**	**	**	Survey Closed	
Announce					Eval.	Eval.	Eval.	Publish Opioid Safe Hospital List

BOD Discussion

- What feedback do you have on the overall approach?
- Specifically on scoring?
- Multiple webinars to support improvement?
- What else?

TAC Analytic Updates

TAC Member Changes

Patty Atkins
- VP Quality, Patient Safety, & Lean Six Sigma
- Sharp Healthcare

John Bott
- Independent Consultant
- Healthcare Performance Measurement

Carolyn Brown
- Director, Quality and Safety
- Santa Clara Valley Medical Center

Gayle Sandhu
- Corporate Senior Director, Quality & Patient Safety
- Scripps Health

Paul Young
- Senior Vice President, Reimbursement Policy
- Hospital Association of Southern California

Patient Safety Honor Roll

Previous Guidance

Enhance methods to promote transparency and maximize eligible hospitals	• Treat hospitals equally • Do not impute missing data • TAC reviewed possible approaches
Improve methods so all hospitals can achieve honor roll status over time	• Expanding hospital eligibility • Supporting achievement
Timeframe	• PSHR “version 2.0” expected late 2019

Possible Approaches

1

Adding measures

(Feb. 25 mtg)

2

Fixed Performance Thresholds

(March 27 mtg)

3

Using multiple years of data

(future meeting as warranted)

4

Creating a composite measure

(on hold)

PSHR 1.0 Methods – A Reminder: Six Selected Measures and Leapfrog Grade

- Healthcare-Associated Infections (Source: CMS Hospital Compare Jan 2017 - Dec 2017 measurement period)
  - CLABSI
  - CAUTI
  - SSI Colon Surgery
  - MRSA
  - CDI
- AHRQ PSI 90 Composite (Source: CMS Hospital Compare October 2015 to June 2017 measurement period)
- Leapfrog Hospital Safety Grade (Source: Leapfrog Grades for Spring 2017, Fall 2017, and Spring 2018)

PSHR 1.0 Methods (cont.)

To be included in the algorithmic method, hospitals must have scores for at least 4 of the 6 measures.

Tier 1

The hospital meets the algorithm approach with two-thirds of their measures above the 50th percentile (and none below the 25th percentile) **AND** has Leapfrog Grades of at least an A, A, B for the last three reporting periods. 19 hospitals (8% of eligible hospitals).

Tier 2

The hospital meets the algorithm approach with two-thirds of their measures above the 50th percentile (and none below the 25th percentile) **OR** has Leapfrog Grades of at least an A, A, B for the last three reporting periods. 54 hospitals (23% of eligible hospitals).

⇨ *40 hospitals met algorithmic criteria alone*

Additional Measures

- HCAHPS Composite Topics
  - Nurse Communication
  - Doctor Communication
  - Responsiveness of Hospital Staff
  - Communication about Medicines
  - Discharge Information
- Component measures from PSI-90
- Sepsis process measure (SEP-1)

PSI 03 – Pressure Ulcer Rate

PSI 06 – Iatrogenic Pneumothorax Rate

PSI 08 – In-Hospital Fall with Hip Fracture Rate

PSI 09 – Perioperative Hemorrhage or Hematoma Rate

PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate

PSI 11 – Postoperative Respiratory Failure Rate

PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate

PSI 13 – Postoperative Sepsis Rate

PSI 14 – Postoperative Wound Dehiscence Rate

PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

PSHR 2.0 Scenarios Reviewed by TAC

Total CalHospitalCompare Hospitals = 327

Scenario	Eligible Hospitals	Percent of Total CHC Hospitals	Honor Roll Status	Percent of Eligible Hospitals	Use HAIs? (5)	Use PSI 90? (1)	Use PSI Component Measures? (10)	Use SEP-1? (1)	Use Patient Experience? (5)	Total Number of Measures in Scenario	Honor Roll Criteria (for hospitals meeting Minimum Measures)
PSHR 1.0	233	71%	40	17%	Y	Y	N	N	N	7	At least 2/3 of measure results above 50th percentile. **No measure result below 25th percentile**
Adding Patient Experience and SEP-1											
2	303	93%	43	14%	Y	Y	N	Y	Y	12	At least 2/3 of measure results above 50th percentile. **No measure result below 10th percentile**
3	303	93%	70	23%	Y	Y	N	Y	Y	12	At least 2/3 of measure results above 50th percentile.
Adding Patient Experience, SEP-1 and Using PSI 90 Components											
10	290	89%	42	14%	Y	N	Y	Y	Y	21	At least 1/2 of measure results above 50th percentile. **No measure result below 10th percentile**
11	290	89%	83	29%	Y	N	Y	Y	Y	21	At least 1/2 of measure results above 50th percentile. **No measure result below 5th percentile**

TAC favored scenario 2

- Increase eligible hospitals from 233 to 303
- Consistent with Honor Roll 1.0

Developing Fixed Performance Thresholds

- Current Honor Roll methodology is based on relative performance (e.g., 2/3 of measures above 50th percentile)
- Approach does not recognize collective improvement in hospital performance
- Fixed performance thresholds address goal of revising methodology "so all hospitals can achieve honor roll status over time"
- However, unlike the NTSV C-Section Honor Roll, there are no absolute targets for performance on the PSHR measures
- Proposed Approach:
  - Set thresholds for x years based on current period performance
    - For example, the 50th percentile performance on SEP-1 for the current period is 58%
    - This rate would be used as the SEP-1 PSHR threshold for x years going forward and becomes the fixed standard for Honor Roll-level performance

Modeling Impact of Fixed Performance Thresholds

- IBM Watson Health:
  - Retrieved data from prior period performance
  - Established performance thresholds based on prior period performance
  - Applied the performance thresholds based on prior period to current period performance
  - Compared the difference in the number of hospital achieving Honor Roll status
  - Note:
    - Same rates used for PSI 90 (due to spec change) and SEP-1 (first reported only for current period)
    - Therefore, changes from prior to current period based on HAI and HCAHPS measures

Results of Applying Fixed Thresholds Based on Prior Period

Scenario	Current			Current W/ Prior Thresholds				Total Number of Measures in Scenario	Honor Roll Criteria (for hospitals meeting Minimum Measures)
	Eligible Hospitals	Honor Roll Status	% of Eligible Hospitals	Eligible Hospitals	Honor Roll Status	% of Eligible Hospitals	# Honor Hosp. in Both		
Adding Patient Experience and SEP-1									
2	303	43	14%	303	55	18%	42	12	At least 2/3 of measure results above 50th percentile No measure result below 10th percentile
3	303	70	23%	303	81	27%	70	12	At least 2/3 of measure results above 50th percentile .

- The number of hospitals achieving Honor Roll Status increases:
  - From 43 to 55 for Scenario 2
- Reflects increasing overall hospital performance
- Achieves goal of allowing more hospitals to achieve Honor Roll Status over time

Outcome of March 27 TAC Meeting

- Reviewed Honor Roll development with new members
- Salient points from discussion included:
  - Reconsideration of set of measures used in Honor Roll 2.0 give some measure-specific concerns
  - Review of fixed threshold approach but no specific decision required at this stage
  - Desire to set performance bar as high as reasonable
  - Suggestion to require high performance over two measurement periods to increase stability

Ongoing Challenges

- No agreed upon national definition or data set for "Patient Safety"
  - Disagreement at TAC and Board about what measures are included/excluded reflects the national dialogue
  - A broader definition of safety with more measures and measure types increases the number of eligible hospitals AND increases the number of dissenting views
- Missing national "hard targets" with absolute level of performance identifying a "safe hospital"
  - Continual improvement emphasized over meeting a threshold
  - Is "zero" the right target?

Is there a way forward?

- For discussion:
  1. Can we vote our way forward by consensus agreement on measures to include?
  2. Can we vote our way forward on weighting of measures (policy weighting)?
     - The current algorithmic method weights all measures equally
  3. Can we add a combination of voting and harm impact to weight measures to find agreement?
  4. Should we keep Leapfrog AND another method with:
     - “Hard targets”?
     - More eligible hospitals?
  5. Use only Leapfrog?

Future PSHR 2.0 Analysis

- Examine use of CDPH HAI data (vs CMS)
- Use of multiple years of data
- Development of a composite measure (on hold)

Updates

General Updates

- Include ED as a performance category to further differentiate individual hospital ratings
- VBAC attestation

CMS Data

- Data released February 28, 2019
- No new measures added
- Website update targeted for 1st week of April

Business Plan

Board Meeting Schedule – 2019

**Schedule is in Pacific Time*

- **Wednesday, June 5, 2019 – 10:00am to 12:00pm (Call)**
- Wednesday, August 7, 2019 – 10:00am to 2:00pm (In Person - Oakland)
- Wednesday, October 2, 2019 – 10:00am to 12:00pm (Call)
- Wednesday, December 4, 2019 – 10:00am to 2:00pm (In Person – Oakland)

Cal Hospital Compare

OPIOID SAFE HOSPITAL ASSESSMENT - *DRAFT*

To address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths Cal Hospital Compare (CHC) convened a multi-stakeholder group to design an assessment for the purpose of designating select hospitals as *Opioid Safe*. The assessment is rooted in evidence-based guidelines and The Joint Commission's pain management standards. However, in the spirit of quality improvement, we invite Hospitals to use the *Opioid Safe Hospital Assessment* as a roadmap to preventing new opioid starts, opioid use disorder identification and treatment, overdose prevention, and a culture of opioid safety. In addition, we encourage Hospitals to use the assessment as a source of inspiration to design and implement programs to reduce opioid related deaths in a way that best fits the needs of your hospital and the community you serve.

The annual assessment is designed to measure opioid safety across four domains, with a focus on process and structural measures. As hospitals progress year over year CHC will introduce quantitative performance measures. So that we can align future iterations of this assessment tool with work you are already doing please share with us how you measure opioid safety activities and your current target, if you have one. Sharing this information is entirely optional and will not be used to assess opioid safety in 2019. Hospitals that score at least one point in each domain and with an overall score > 8 points will be designated as *Opioid Safe*. CHC recommends each hospital convene a multi-stakeholder team to complete the annual *Opioid Safe Hospital Assessment* to ensure accuracy and completeness. To reduce variability in results year over year, CHC recommends hospitals follow a similar process each year when completing the *Opioid Safe Hospital Assessment*. If questions arise please refer to examples provided and/or contact Alex Stack with Cal Hospital Compare via email at astack@cynosurehealth.og

Prevent new opioid starts					
Measure & Intent	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool & resource)*
Discharge Prescribing Guidelines Develop & implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new opioid starts (e.g. ED, OB, Medical IP, or OB, etc.). Key steps might include: • Research evidence-based guidelines • Multi-stakeholder review & co-design unit specific proposal that takes into consideration – • MEC/BOD approval • Workflow re-design • EHR integration • Opioid discharging prescribing guidelines are actively used most of the time	Your hospital has developed & implemented evidence-based discharge prescribing guidelines in **1 service line** (e.g. ED, Medical IP, General Surgery, or OB, etc.).	Your hospital has developed & implemented discharge prescribing guidelines in **2 service lines** (e.g. ED, Medical IP, General Surgery, &/or OB, etc.)	Your hospital has developed & implemented evidence-based discharge prescribing guidelines for at least **3 service lines including ED and general surgery** (e.g. Medical IP, &/or OB, etc.) **Extra credit (+1 pt.):** Procedure specific prescribing guidelines		Ensuring Emergency Department Patient Access to Appropriate Pain Treatment *(ACEP)* Optimizing the Treatment of Acute Pain the Emergency Department *(ACEP)* Safe and Effective Pain Control After Surgery *(ACS)* Postpartum Pain Management *(ACOG)*
	Measurement feedback (optional): how do you measure this? what measures do you use? target?				

Alternatives to Opioids for Pain Management Use evidence based multi-modal non-opioid approaches for pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation Use evidence based multi-modal non-opioid approaches for pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation. Key steps might include: • Research evidence-based guidelines • Multi-stakeholder review & co-design unit specific proposal that takes into consideration – acute versus chronic pain, OUD risk, efficacy, access to alternatives by service line, etc. • MEC/BOD approval • Workflow re-design • EHR integration • Opioid alternatives are used most of the time to treat pain	Developed & implemented a non-opioid analgesic multi-modal pain management program in the **ED** Alternative medications available in unit e.g. ketamine, regional anesthesia nerve blocks, virtual reality, Tylenol, NSAIDs, CBT, lidocaine patches, medications for neuropathic pain, etc.	Developed & implemented a non-opioid analgesic multi-modal pain management program by **specialty or procedure** Developed supportive pathways for care teams to incorporate opioid alternatives e.g. integrated pharmacy, therapy, etc.	Aligned standard order sets with non-opioid analgesic multi-modal pain management program **Extra Credit (+1 pt.)** **Hospital also offers additional services such as** **- a**cupuncture, chiropractic medicine, guided relaxation, music therapy, etc.		Alternatives to Opioids Program Non-Opioid Treatment (American Society of Anesthesiologist)
	Measurement feedback (optional): how do you measure this? what measures do you use? target?				
Formulary Management Update hospital formulary to support usage of updated guidelines for discharge prescribing, use of opioid alternatives, and most recent evidence-based guidelines on opioid co-prescriptions. Key steps might include • Research evidence-based guidelines • Multi-stakeholder review & program co-design • MEC/BOD approval • Workflow re-design • EHR integration • Opioid alternatives are used most of the time to treat pain	Developed & implemented hospital wide **standard orders sets & protocols for benzo & opioid co-prescribing** Medications to support administering opioid alternatives on hospital formulary e.g. ketamine, anesthesia nerve blocks, Tylenol, NSAIDs, CBT, lidocaine patches, medications for neuropathic pain, etc.	Implemented a **staff education program** to actively reduce dual benzo and opioid prescriptions	**Reduced opioid access at the point of care** e.g. remove drug from EHR prescribing module & require manual write up, pharmacy reviews high dose prescriptions, etc.		Doctors Are Changing San Diego's Opioid Prescribing Practices (CHCF)
	Measurement feedback (optional): how do you measure this? what measures do you use? target?				

Identification and Treatment						
Measure	**Intent**	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool & resource)*
Medicated-Assisted Treatment (MAT)	Provide MAT initiation &/or continuation in the ED and IP setting	Methadone & buprenorphine on hospital formulary	MAT is prescribed/ continued in at least 1 service line (e.g. ED, Medical IP, General Surgery, or OB, etc.) with at least one waived prescriber.	MAT is prescribed/continued in at least 2 service line (e.g. ED, Medical IP, General Surgery, or OB, etc.) with at least one waived prescriber in each. Provide evidence that patients have been administered buprenorphine and/or methadone		ED Bridge Project SHOUT Bright Spots: SFGH
Buprenorphine Waiver	Hospital based practitioners are waivered to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000)	Hospital provides support to MDs & mid-level in the ED to complete waiver (e.g. application management, protected time, financial support/reimbursed for time &/or training, contract alignment, etc.)	Hospital provides support to MDs & mid-levels in the ED & IP units	25% of all MDs & mid-levels have buprenorphine waiver **Extra credit (1pt.):** Support extends to Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwifes		SAMHSA

Overdose prevention						
Measure	**Intent**	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool & resource)*
Naloxone education & distribution program	Provide naloxone prescriptions and education for all patients, families, caregivers and friends	Stock naloxone in pharmacy Developed hospital wide order sets and protocols for naloxone distribution	Standing order in place for naloxone prescription at discharge for patients at risk of overdose	Staff trained to educate patients, families, caregivers and friends on naloxone use		Bright Spots: SFGH, Highland Hospital

	discharged with a long-term opioid prescription &/or at risk of overdose			**Extra Credit (1pt):** Naloxone/Harm reduction kits at discharge		

Cross Cutting Opioid Safe Hospital Best Practices						
Measure	**Intent**	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool & resource)*
Organizational Infrastructure	Addressing opioid misuse in the community is a strategic priority with leadership support staff	Opioid Communicate vision to all staff Project champion identified	Multi-stakeholder hospital Board actively reviews data, advises &/or designs, and implements initiatives to address gaps	Communicate progress to goal, and performance to all staff (e.g. a dashboard, all staff meeting, etc.) Celebrate successes!		Sharp
Provider/staff education	Education and promotion of the medical model of addiction across all departments to facilitate disease recognition and stigma reduction.	Provide passive education on hospital opioid prescribing guidelines, identification, and treatment, and overdose prevention	Provide training on the medical model of addiction to normalize OUD	Provide stigma reduction training		
Patient education	Actively engage patients, families, and friends in care	Provide general education to all patients regarding opioid risk and alternatives	Provide focused education to opioid naïve and opioid tolerant patients Patients are part of a shared decision-making process for acute &/or chronic pain management (e.g. develop a pain management plan pre-surgery)	Provide opportunities for patients to get involved (PFAC, peer navigator, program design, etc.) **Extra Credit (+1):** Outreach to the community and active engagement with local opiate coalition		
Discharge to Community	Develop formal connections via MOU with outpatient facilities & drug	Provide list of community-based resources to patients, family, caregivers, and friends	Developed formal connections via MOU with outpatient facilities and drug treatment programs	Actively connect MAT and OUD patients with outpatient facilities and		ED Bridge SFGH

	treatment programs who can receive referrals & provide follow up care for MAT & patients prescribed Naloxone		able to take MAT and OUD referrals from hospital	drug treatment programs for follow up care Integrated approach with care management, social work, pharmacy, etc. **Extra Credit (1pt):** Peer screeners evaluate patients with opioid addition in the ED in effort to enroll them into a drug treatment program immediately following ED discharge		
				TOTAL SCORE		