Cal Hospital Compare

Board of Directors - Meeting Agenda

Wednesday, October 17, 2018 from 10:00am – 12:00pm PT

Web-Conference

Phone: 1-646-558-8656 / Access Code: 443-789-5416#

Webinar link: https://zoom.us/j/4437895416

Time	Agenda Item	Presenters and Documents
10:00-10:05 5 min.	Welcome and call to order – Approval of past meeting summary	
10:05-10:50 45 min.	Organizational updates – Consumer activation project – Patient safety honor roll – Covered California's request – Health plan engagement – Considerations for data use fees	Bruce Spurlock, Executive Director Lance Lang, Covered California Jennifer Stockey, CHC
10:50-11:00 10 min.	Business plan – Financial report	Bruce Spurlock, Executive Director
11:00-11:55 55 min.	Data analytic updates – Hospital patient safety honor roll – Board feedback on criteria – Considerations for "version 2.0" – New measure for public reporting – Sepsis process measure (SEP-1) – Maternity data – Statewide trends – C-section honor roll timeline	Mahil Senathirajah, Watson Health Jennifer Stockey, CHC Supporting documents CHC Honor Roll Revisions
11:55-12:00 5 min.	Adjourn – Next meeting: Friday, December 7, 2018 from 10:00am-2:00pm PT (in Oakland)	Bruce Spurlock, Executive Director

Cal Hospital Compare Board Meeting Summary

August 16, 2018

Attendees: Bruce Spurlock, Jack Asher, Tracy Fisk, David Hopkins (via phone), Libby Hoy (via phone), Chris Krawczyk (via phone), Lance Lang, Helen Macfie, Scott Masten, Julie Morath (via phone), Celia Ryan, Mahil Senathirajah, Jennifer Stockey, Kristof Stremikis, Ken Stuart, Katie Traunweiser, Frank Yoon (via phone)

Summary of Discussion:

Agenda Items	Action
Call to Order/Board Items	• The meeting was called to order at 10:05 am Pacific Time. • The Cal Hospital Compare Board Meeting Summary of June 18, 2018 was approved.
	Discussion

New Consumer Activation Project	• Kristof informed the board that the purpose of the project is about collecting the relevant information that is available
	• Jack inquired how exactly will this project make a difference to consumers
	  o Bruce commented that CHC has attempted to meet consumers where they are (e.g., Yelp)
	  o Lance mentioned the trend of EHRs (Susan Delbanco – wrote an article relevant to this topic)
	  o Ken remarked that his health plan is self-insured and self-administered ("best doctors" approach)
	  o For this project, how can we best package this data?
	  o Discussed strategies – benefit design vs. building this into the work flow
	  o Bruce mentioned the hypothesis that is described in the driver diagram
	  ▪ Consumers need to feel like their care decisions have consequences
	  o Libby recommended including several patient-family leaders in California and will send recommendations to the CHC team.
	  o Julie explained that most of the efforts in the field are focused on the adult; but we need to focus on younger people who are initially forming ideas about healthcare.
	  o Jack inquired about Consumer Reports
	  ▪ Bruce mentioned that Consumer Reports is transitioning out of the hospital reporting work. Kristina Mycek with Consumer Reports will participate on the new Advisory Group.

Data Interest/Use	• Bruce mentioned that the CHC data has value and that organizations that sponsor the board should receive the data they request while others would pay for this information. • Lance stated that with more resources, we can accomplish more. Could we get all plans in the state? If so, could we obtain sophisticated tool sets? **Action Item:** To brainstorm ideas that have more depth in terms of charging for requested data
Hospital Patient Safety Honor Roll	• Frank provided an overview of the methods • Lance mentioned that his goal is of less relative scoring, and more "measurement against a target"

	• Bruce mentioned the topic of target setting – this was addressed with the board in the past and the group decided against it (i.e., not to develop targets) • Helen: If you incentivize for zero, then there can be a drive to game (although she didn't use this exact term) • Lance brought up the Brent James presentation; do not want to punish improvement, want to drive folks out of the bottom performance area • Lance mentioned that health plans should include quality as one of the parameters in designing networks; this patient safety honor roll is a "quality improvement project with a timeline" – we have a deadline and an evaluation. • Celia stated that PSI 90 measures are released regularly, but have a long tail (meaning, that if an organization changes performance, it will not "show up" in the data for a while). Should we start thinking about what the reporting period should be? • Helen questioned if Leapfrog was still on the table. Bruce confirmed that it was, and the board had not had the opportunity to discuss yet.

	• Julie provided an informal report on the HQI board discussion (in part, related to Leapfrog)
	• HQI has clinical representation from Sutter, Sharp, Children's, UCSF, etc.
	• One health system calculated that it costs $200,000 to participate in Leapfrog, so they have decided not to move forward in reporting. Instead, they decided to redirect those funds toward improvement efforts.
	• "Black box" methods were more troubling to some people on the hospital leadership team
	  o Ken asks if it's just economic (the concerns about Leapfrog) – Julie says those who get As think Leapfrog is great.
	• Julie mentioned that HQI will be publicly reporting to increase transparency. Includes: CLABSI, CAUTI, Colon SI, NTSV C-Sections, VTE 6, Sepsis mortality.
	
	Bruce provided an overview and drew a diagram of the tiered approach. The original purpose for the hospital patient safety honor roll was to drive improvement.
	• Whichever approach we choose, we want to stimulate improvement
	• Two-Tiered approach:
	  o Bruce framed as a non-technical solution – should we come up with targets, other strategies, etc.? This would be a temporary solution as we work to improve the methods.
	• Tier 1 – Bruce explained this concept as focusing on "excellence"
	• Tier 2 – Similar to a best in class, with an expectation to improve
	
	Feedback on the tiered approach:
	• Julie expressed that she is not in favor of the Leapfrog approach. HQI is conducting structured interviews and mentioned that there is technology that is being developed that could be attached to the two tiers.
	• Lance would like to use more current data, in an improving environment. Also acknowledged that ADEs are not available and would like the ADEs included in the methods.
	• Jack questioned if there are negative consequences to this approach? The board agreed there were not.
	• Kristof preferred the algorithmic approach, okay with tiers
	• Kate preferred the tiered approach. Stated that it is ideal to have sepsis and maternity care in the methods.
	• Celia prefers the tiered approach - makes sense to her
	• Ken favored the algorithm, okay with tier
	• Helen approved of the tier (doesn't think Leapfrog is going away)

	• Scott preferred the algorithm; concerned about the hospitals not included
	• Libby preferred the tiered approach
	• Chris voted on the tiered approach, recommended using the current distribution for a cut-points (that we could use as targets moving forward. Also concerned about the hospitals "missing"
	• David proposed to launch something, even though there is no perfect approach; intrigued by Julie's approach – would like the algorithmic approach to include measures. David underscored that the purpose is to improve.
	
	What is the right size for Tier 1 vs 2?
	• Celia stated that we want buy-in — need people to be able to achieve the targets
	• Tier 1 – Top 10% (needs to be around 25 or so hospitals)
	• Tier 2 — 25%
	• Julie emphasized that the goal is improvement over time
	
	Next Steps:
	• Increase the circle to include smaller hospitals
	• Create a method for developing targets
	• Messaging matters:
	  o Connect with SmartCare and Press Secretary
	  o Honor roll is more difficult to comprehend than C-section (with set target)
	  o Julie will spend time socializing – networking what's coming and why
	• Other: the board held a brief discussion about whether state or national targets should be used for the hospital honor roll. David mentioned that he favors national data.

Cal Hospital Compare Bank Accounts	• Ken inquired about pursuing transferring CHC funds to a banking institution/account that charges less fees. **Action Item:** Bruce and Tracy will research options and follow up with details.
OSHPD	• Chris presented the NTSV C-section visualization. • As a next step, OSHPD would like to distribute on social networks; will provide embargoes links to partners in the event they would like to promote.

Nurse Midwife Deliveries	• Board preferred the following language:
	  o Personal choice indicator
	  o Personal choice information
	Action Item: CHC will connect with CMQCC on timing for posting this language on the website

Website Performance Displays	• To edit "lower is better wording" • Possible approach (keep an eye on this as we move forward with the consumer activation project) is to have two "layers" of information. For example, just the rating icons with a "drill down" to rating icons and rates.
Next Meeting/Meeting Adjournment	• The next Cal Hospital Compare Board of Directors Call (via Zoom webinar) is scheduled on October 17, 2018. • The meeting formally adjourned at 1:48pm Pacific Time.

Cal Hospital Compare Board of Directors Meeting

October 17, 2018

10:00am-12:00am Pacific Time

Phone: 1-646-876-9923

Access code: 443 789 5416

Webinar link: https://zoom.us/j/4437895416

Proposed agenda

- Welcome
- Organizational updates
- Data analytic updates
- Business plan
- Adjourn

Organizational updates

Consumer Activation Project

- Understanding and Promoting Consumer Activation through Cal Hospital Compare
- Short-term project funded by CHCF
- Primary objectives
  - Finalize a working theory of consumer activation
  - Categorize prior promotional efforts and impact
  - Creating and prioritizing pilot tests to increase consumer activation
- Upcoming Advisory Group meetings
  - October 25th at 10:00 am PT/12:00 pm CT
  - November 16th at 10:00 am PT/12:00 pm CT and
  - Holding December 14th at 10:00 am PT/12:00 pm CT

Patient safety honor roll

Pt. Safety Honor Roll Updates

- Stakeholders decided not to launch patient safety with c-section honor roll
- CHC is in the process of scheduling a meeting with the Secretary to discuss options for announcing the patient safety honor roll

Covered California's request

Health plan and data use updates

Health plan engagement

Plans

- Anthem (Exchange Director)
- Blue Shield (Program Manager; Actuarial Analyst)
- Health Net (Senior Quality Improvement Specialist)
- LA Care (Project Manager)
- Partnership HealthPlan (Chief Medical Officer)

Others

- Safety Net Institute (California public health care systems)
- Reporters

Considerations for data use fees

- Data aggregation
- Data validation
- Analytic-ready datasets
- Timely measures
- Novel measures
- Performance categories

Considerations for data use fees

State APCDs

- General appropriations (New Hampshire)
- Fee assessments on plans and facilities (Vermont)
- Medicaid match (Utah)
- Membership dues (Wisconsin)
- Data sales (Maine)

Standard fee structure

- Public benefit
- Standard users (internal use)
- Commercial users (resellers)

Pricing based on

- Data file extracts
- Customized reports
- Annual licenses

Data Client Category	<50,000 enrollees	50,000-100,000 enrollees	100,101-500,000 enrollees	500,000+ enrollees
Reduced tier	$8,000	$12,000	$15,000	$20,000
Standard tier	$9,600	$14,400	$18,000	$24,000
All others	$11,500	$17,280	$21,600	$28,800

Custom analytic reports

Fees for customized reports typically range from $7,500 to $17,500 depending on the client's requirements. The request process includes an initial design and development fee of $1,200, credited to the cost of the overall report. If the client's business requirements are sufficiently defined in its report request and in the initial 1-2 hour design session, this fee may be waived.

Board discussion

- Are data use fees only applicable to plans?
- Should CHC consider different pricing options (e.g., single file extract vs. annual membership)?
- Comparable pricing considering this is mostly public use data?

Business plan

Data analytic updates

Hospital patient safety honor roll

Tiered Honor Roll

This alternative approach uses both the Algorithm and Leapfrog criteria. At a high level, the tiers are:

- **Tier 1**: “Best in class” hospitals that are high performing across most measures
- **Tier 2**: Hospitals that are performing well on some measures, and that have the opportunity to improve performance and reach Tier 1 status

Definition: Tier 1

Hospitals must meet both the Algorithmic and Leapfrog benchmarks

- Algorithm: At least two-thirds of measures above the 50th percentile and none below 25th percentile; minimum of four measures available **AND**
- Leapfrog: A, A, B or higher in last three reporting periods
- Total = **19 hospitals** (8% of eligible hospitals)

Definition: Tier 2

Hospitals must meet either the Algorithmic or Leapfrog benchmarks

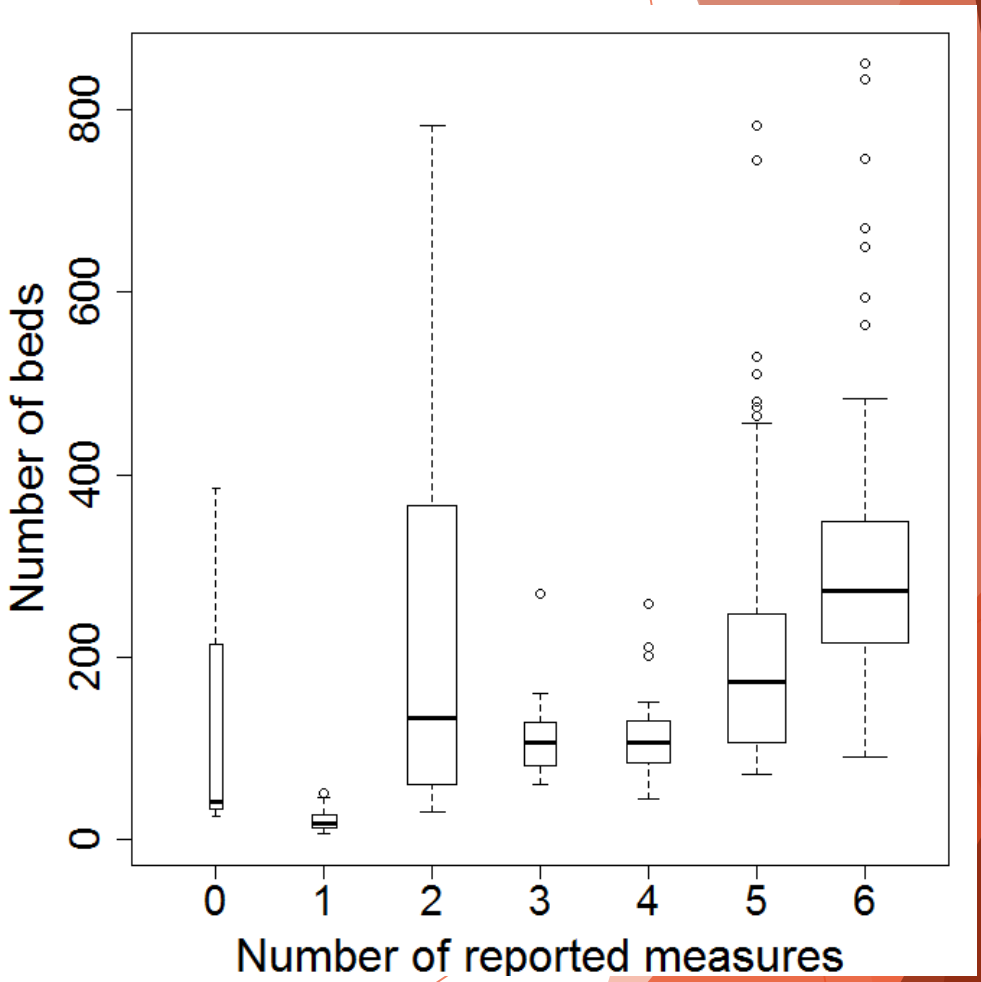
- Algorithm: At least two-thirds of measures above the 50th percentile and none below 25th percentile; minimum of four measures available **OR**
- Leapfrog: A, A, B or higher in last three reporting periods
- Total = **54 hospitals** Tier 2 (23% of eligible hospitals)

Considerations for “version 2.0”

Data Reporting and Honor Roll Eligibility

- Eligibility criterion for honor roll **systematically excludes** hospitals of certain types – e.g., hospitals with fewer beds that don't report at least 4 measures

Minimum Number of Measures	Number of Available Hospitals
None	359
One	321
Two	301
Three	251
Four	234
Five	200
Six	133



Source: CMS FY 2018 IPPS Impact File

Increasing Honor Roll Inclusivity

- Without reported measure results, comparing hospital performance becomes a *missing data* analysis
- For example, requiring hospitals to report 4 or more measures for honor roll eligibility is akin to a complete case analysis – we drop hospitals with incomplete data
- **How can we better include hospitals that report fewer than 4 measures?**

Approaches for Increasing Inclusivity

1. **Change eligibility criteria**: Require fewer reported measures or add more measures to the list for honor roll determination
2. **Develop patient safety composite**: Leverage the hospital's reported results and "fill in" missing values by weighting methods
3. **Impute missing measure results**: Leverage the distribution of *other* hospitals' measure results to fill in missing values
4. **Latent class modeling**: Apply advanced methods to determine hospitals' true patient safety performance, akin to CMS Hospital Compare Star Ratings

TAC's recommended next steps

Explore options for the following:

- Multiple years of data
- Additional measures
  - Sepsis process measure (SEP-1)
  - HCAHPS measures
- Different criteria for smaller hospitals
- Setting targets for the honor roll

New measure for public reporting (SEP-1)

SEP-1 Measure Background

- Measure implemented by CMS in 2015
- Measure results recently made publicly available through CMS Hospital Compare
- Current measurement period is Jan. 1, 2017 to Oct. 1, 2017
- Results based on full calendar year 2017 data expected to be released in October 2018
- IBM Watson Health examined distribution of currently available rates

SEP-1 Measure Definition

- Measure Name: Early Management Bundle, Severe Sepsis/Septic Shock
- Measure Type: Process
- Measure Results: Percentage, higher is better, single rate
- Measure Denominator:
  - Inclusion Criteria: Discharges age 18 and over with an ICD-10-CM diagnosis of Sepsis, Severe Sepsis, or Septic Shock
  - Exclusion Criteria: Directive for comfort care, administrative contraindication to care, LOS > 120 days, transfer in from another acute care facility, patient death

…SEP-1 Measure Definition

Numerator: “All or nothing” measure

Patients who received all six of following:

- Received within three hours of presentation of severe sepsis:
  1. Initial lactate level measurement
  2. Broad spectrum or other antibiotics administered
  3. Blood cultures drawn prior to antibiotics
- AND received within six hours of presentation of severe sepsis:
  4. Repeat lactate level measurement only if initial lactate level is elevated
- Received within three hours of presentation of septic shock or initial hypotension:
  5. Resuscitation with 30 ml/kg crystalloid fluids
- AND ONLY IF hypotension persists after fluid administration, received within six hours of presentation of septic shock:
  6. Vasopressors

…SEP-1 Measure Definition

- AND ONLY if hypotension persists after fluid administration or initial lactate >= 4 mmol/L, received within six hours of presentation of septic shock:
  - Repeat volume status and tissue perfusion assessment consisting of either:
    - A focused exam including:
      - ▫ Vital signs, AND
      - ▫ Cardiopulmonary exam, AND
      - ▫ Capillary refill evaluation, AND
      - ▫ Peripheral pulse evaluation, AND
      - ▫ Skin examination

    OR

    - o Any two of the following four:
      - ▫ Central venous pressure measurement
      - ▫ Central venous oxygen measurement
      - ▫ Bedside Cardiovascular Ultrasound
      - ▫ Passive Leg Raise or Fluid Challenge

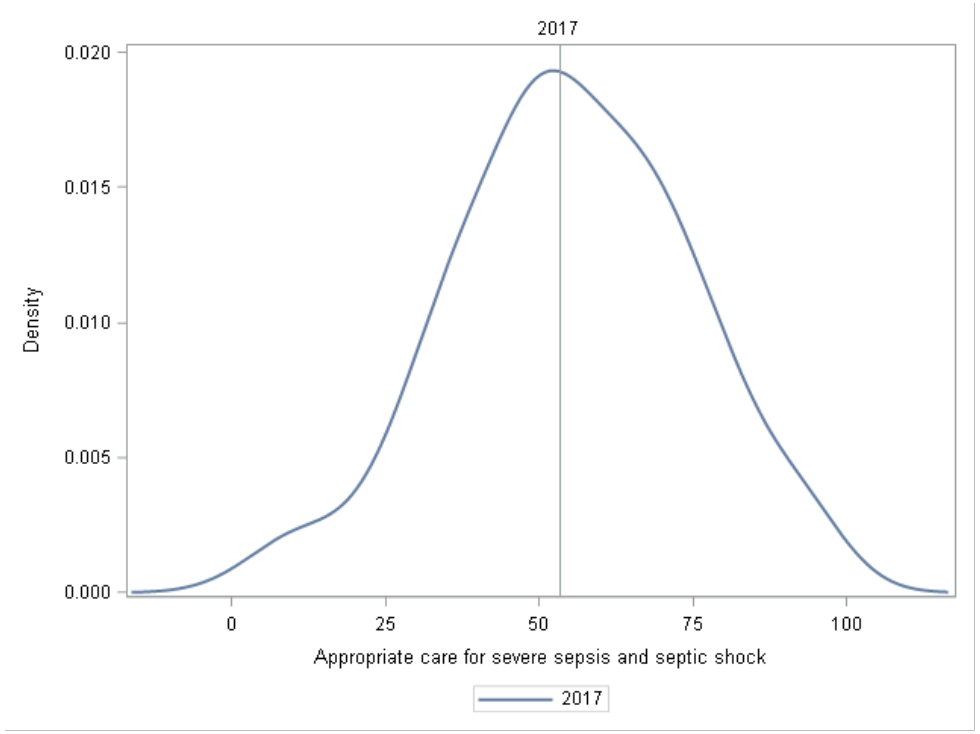
Measure Discussion

There has been much discussion about SEP-1:

- There is widespread support for increased attention to sepsis quality - diagnosis and treatment
- Although technical and implementation issues have been raised, the measure is an established component of CMS' measure set and is NQF endorsed
- The following summarizes some of the issues that have been raised
  - Strength of clinical evidence base varies from component to component – "all or nothing" doesn't recognize this
  - Clinical concern regarding inflexibility in requirements (e.g., amount of fluid required for resuscitation)
  - "No clear accurate and reliable test for sepsis" – "sepsis trigger" is error prone and "will result in over-treatment"
  - Measure collection is burdensome/costly, moreso than other measures
    - Detailed abstraction, "one hour per patient"
    - Measure is very clinically/logistically complex
  - Small hospitals don't have sufficient resources, concern about inequities
  - Involves coordination of multiple care teams across different units

Distribution of SEP-1 Scores

Year	N	Pop Mean	Avg Score	Min	P10	Q1	Median	Q3	P90	Max
2017	298	53.4	54.9	0.0	31.0	42.0	55.0	68.0	80.0	100.0



- Relatively large number of hospitals with available scores
- Wide variation in rates

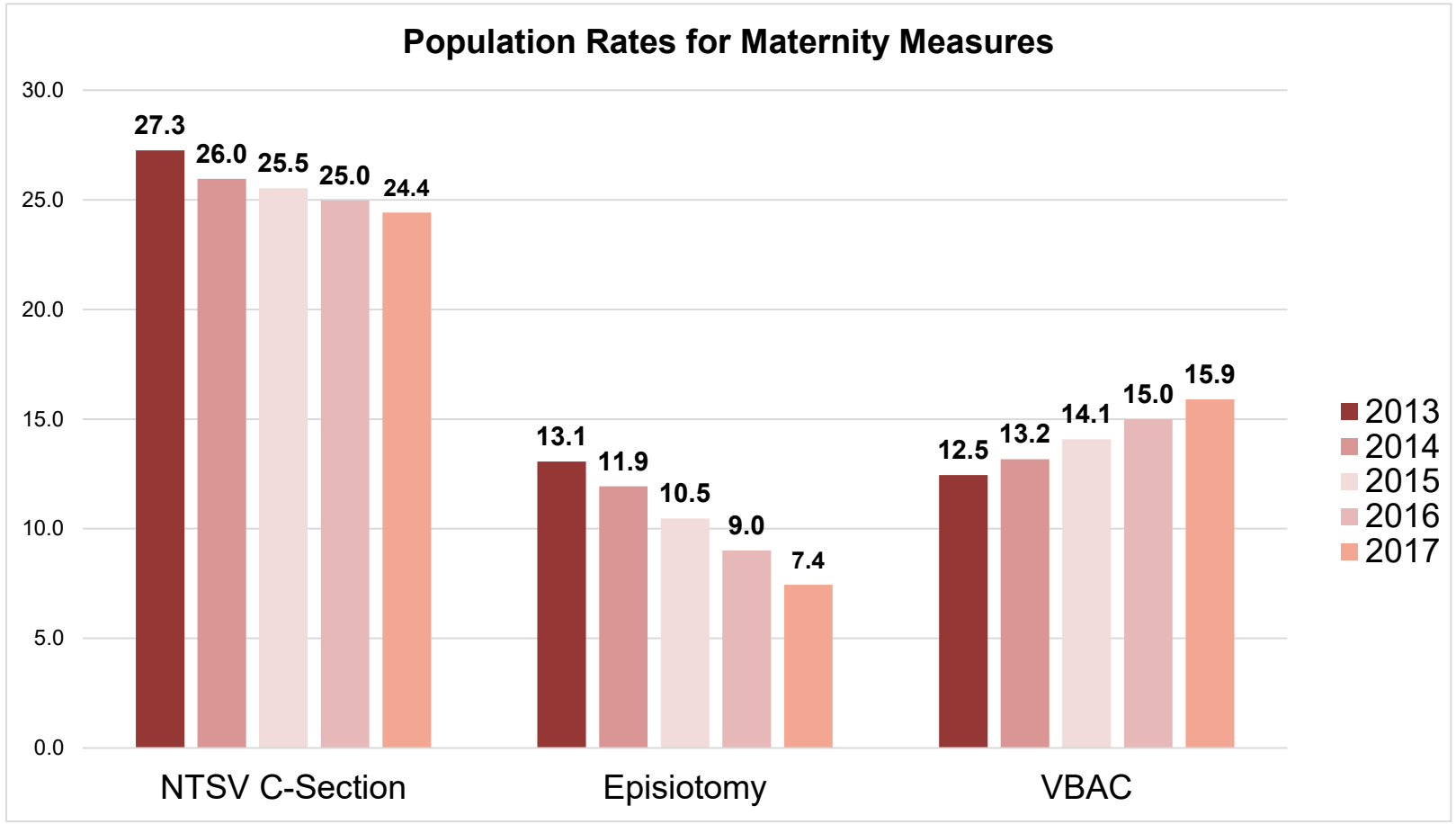
Maternity data

Maternity Data: Findings

High-level observations:

- Continued, gradual improvement in NTSV C-Section, Episiotomy and VBAC Rates
- Some shifting in and out of the NTSV C-Section Honor Roll
- Continued wide variation in performance across hospitals

Statewide Performance (2013-2017)



Based on set of hospitals reported by CHC. May be slightly different from population rates reported by CMQCC.

Total C-Sections Avoided in 2017

- Due to the decrease in NTSV C-Section rate from 2013 to 2017, a projected 4,450 C-Sections were avoided in 2017

Total 2017 NTSV C-Section Denominator	155,005
2013 NTSV C-Section Population Rate	27.3%
2017 "Expected" Number of C-Sections (if rate remained at 27.3%)	42,316
2017 Actual Number of C-Sections	37,866
C-Sections Avoided	**4,450**

C-Section Statewide Performance Trends

NTSV C-Section Honor Roll Snapshot

- Defined as NTSV C-Section Rate <= 23.9%
- Total change from 2016 to 2017
  - Hospitals on 2017 Honor Roll = 124
  - Hospitals on 2016 Honor Roll = 112

    Net change = 12 hospital added

- Change breakdown for 2017
  - Hospitals leaving the Honor Roll in 2017 = 23
  - Hospitals joining the Honor Roll in 2017 = 35

Hospitals with NTSV C-Section Rate Changes

	Hospital Count	Average Percentage Point Change *=2017-2016*
Rate decreases	135	-3.0
Rate increases	106	3.2

Hospitals that *left* the honor roll (1/2)

HOSPITAL NAME	Score (%)
Twin Cities Community Hospital	24.9
Petaluma Valley Hospital	24.0
Redlands Community Hospital	26.4
Mendocino Coast District Hospital	37.5
Lompoc Valley Medical Center	27.0
Doctors Medical Center of Modesto	25.5
Mercy Medical Center Mount Shasta	32.7
Mercy Hospital of Folsom	24.3
Hi-Desert Medical Center	24.1
O'Connor Hospital	24.3
St. Mary Medical Center	26.5
San Gabriel Valley Medical Center	24.2
Desert Valley Hospital	29.5
Kaiser Permanente Roseville Medical Center	25.0
Adventist Health Simi Valley	26.3
Plumas District Hospital	25.0

List continued on the next slide…

Hospitals that *left* the honor roll (2/2)

HOSPITAL NAME	Score (%)
Kaiser Permanente Walnut Creek Medical Center	25.0
Community Memorial Hospital	26.9
Lucile Packard Children's Hospital Stanford	26.3
Tulare Regional Medical Center (no longer offering maternity services)	
University of California Davis Medical Center	30.4
Adventist Health St. Helena	29.5
Rideout Memorial Hospital	24.5

Hospitals that *joined* the honor roll (1/2)

HOSPITAL NAME	Score (%)
Mills-Peninsula Medical Center	23.9
Washington Hospital Healthcare System	23.9
Garfield Medical Center	23.7
Kaiser Permanente South Sacramento Medical Center	23.5
AHMC Anaheim Regional Medical Center	23.3
Kaiser Permanente Santa Clara Medical Center	23.2
Methodist Hospital of Sacramento	23.1
Kaiser Permanente San Diego Medical Center	23.1
Saint Louise Regional Hospital	23.1
Santa Barbara Cottage Hospital	23.0
Citrus Valley Medical Center - Queen of the Valley Campus	22.9
Mercy Medical Center Merced	22.6
Providence Little Company of Mary Medical Center San Pedro	22.6
Centinela Hospital Medical Center	22.3
Stanford Health Care - ValleyCare - Pleasanton	22.3
NorthBay Medical Center	22.1
Scripps Mercy Hospital Chula Vista	22.0

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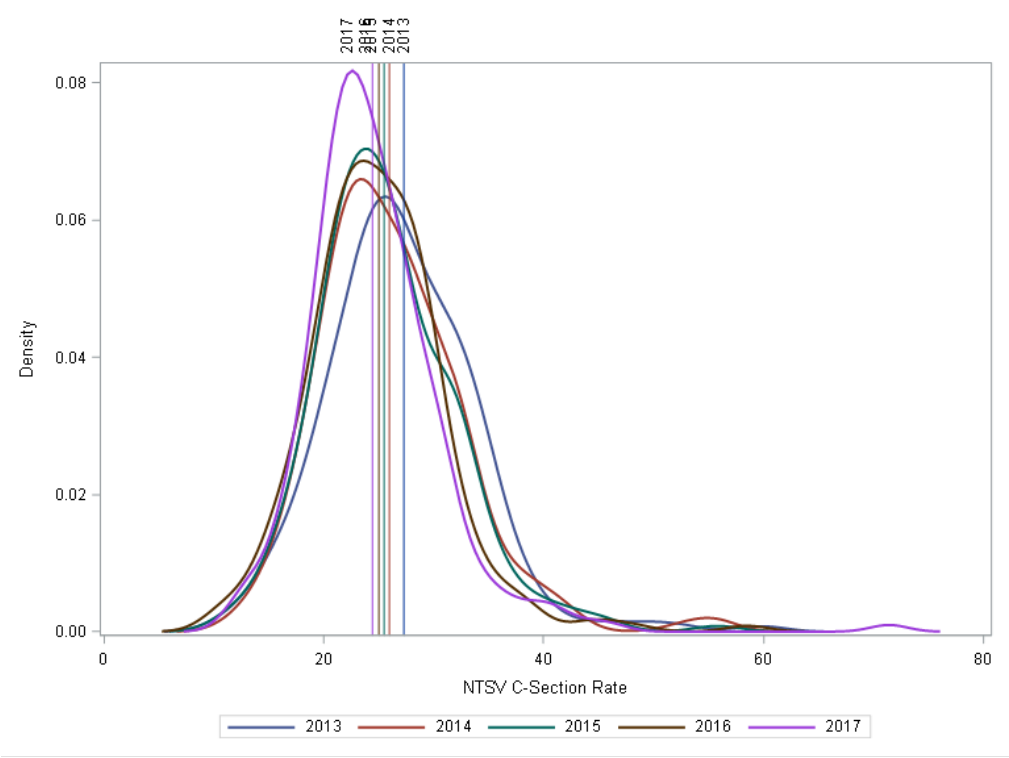
Hospitals that *joined* the honor roll (2/2)

HOSPITAL NAME	Score (%)
California Pacific Medical Center - St. Luke's Campus	21.8
George L. Mee Memorial Hospital	21.7
UC Irvine Health	21.7
St. Rose Hospital	21.5
Madera Community Hospital	21.2
Palo Verde Hospital	21.2
Marian Regional Medical Center	20.6
UC San Diego Health - La Jolla, Jacobs Medical Center and Sulpizio Cardiovascular Center	20.5
UC San Diego Health - Hillcrest, UC San Diego Medical Center	20.5
St. John's Regional Medical Center	20.4
Providence Saint John's Health Center	20.1
Sierra View Medical Hospital	19.9
Palomar Medical Center Escondido	18.8
St. Joseph Hospital, Eureka	18.3
Doctors Hospital of Manteca	17.8
Memorial Medical Center	17.5
Mercy Medical Center Redding	16.3
Greater El Monte Community Hospital	15.4

Variation Remains High, Incremental Improvement - NTSV C-Section

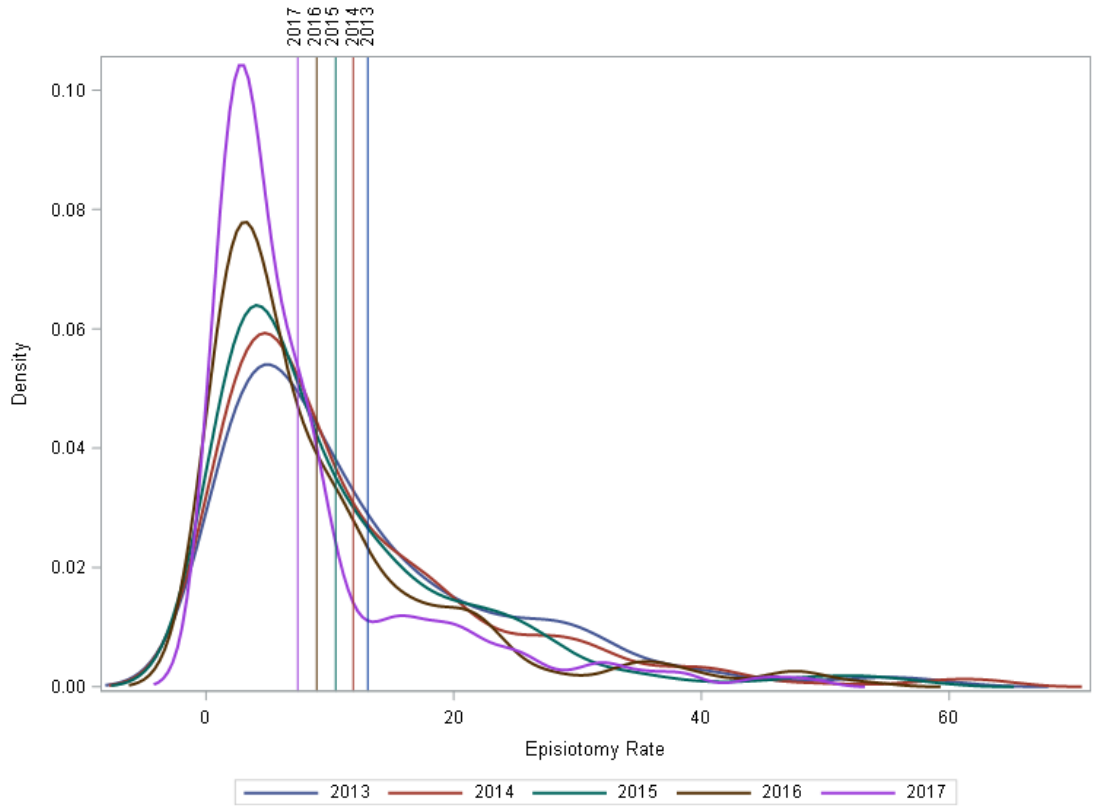
Year	N	Pop Mean	Avg Score	Min	P10	Q1	Median	Q3	P90	Max
2013	232	27.3	27.2	11.2	19.5	23.0	26.4	31.3	34.5	68.8
2014	235	26.0	26.4	12.0	19.2	21.7	25.3	30.0	33.3	70.0
2015	234	25.5	25.9	11.1	18.5	21.4	25.1	29.3	33.0	76.9
2016	243	25.0	25.1	10.5	18.0	21.0	24.4	28.6	31.7	78.6
2017	241	24.4	24.6	11.9	18.3	20.8	23.7	27.3	30.8	71.4



- Although gap has narrowed, there is still a wide range in performance from the 10th to 90th percentile hospitals rates

Variation Remains High, Incremental Improvement - Episiotomy

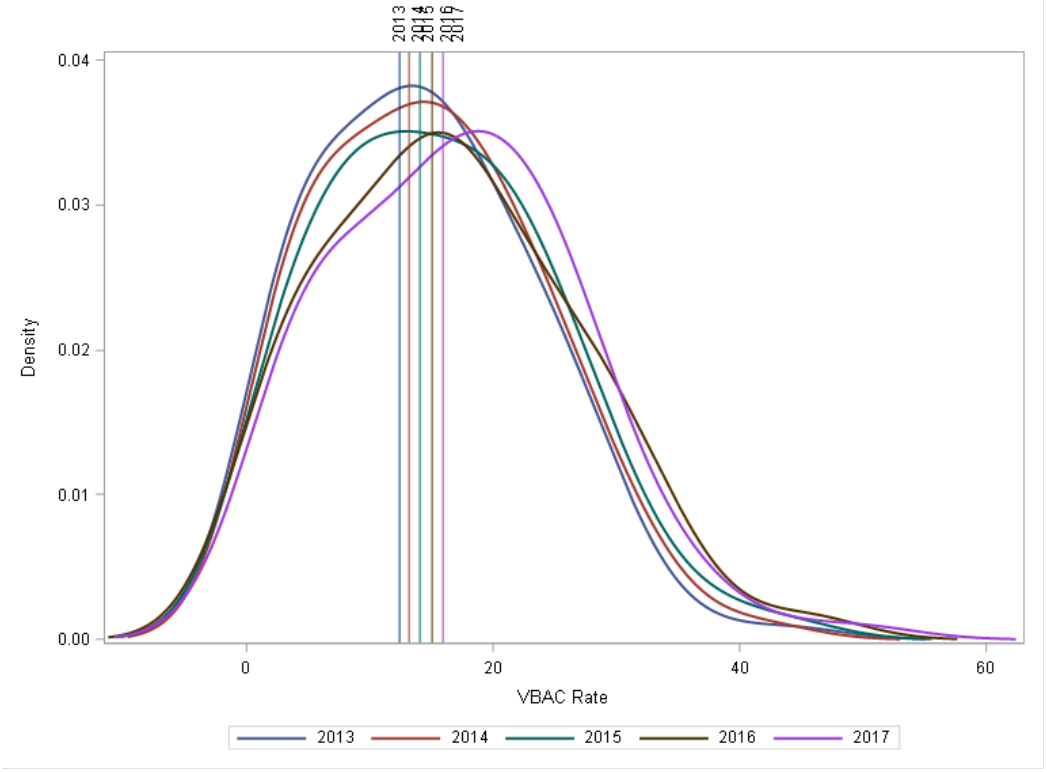
Year	N	Pop Mean	Avg Score	Min	P10	Q1	Median	Q3	P90	Max
2013	232	13.1	12.4	0.6	2.3	4.2	9.1	16.8	29.1	59.3
2014	235	11.9	11.7	0.4	2.0	3.8	7.7	15.7	27.5	62.5
2015	234	10.5	10.7	0.0	1.9	3.4	6.8	14.6	24.5	57.6
2016	243	9.0	9.5	0.0	1.3	2.8	5.6	12.1	22.1	53.1
2017	241	7.4	8.0	0.0	1.3	2.5	4.6	8.8	20.0	49.0



- Although gap has narrowed, there is still a wide range in performance from the 10th to 90th percentile hospitals rates

Variation Remains High, Incremental Improvement - VBAC

Year	N	Pop Mean	Avg Score	Min	P10	Q1	Median	Q3	P90	Max
2013	128	12.4	14.3	1.2	2.6	6.6	13.4	20.7	26.1	44.5
2014	137	13.1	14.8	0.5	3.3	7.0	14.8	20.7	26.7	42.8
2015	137	14.0	15.5	0.0	3.0	8.1	15.0	21.8	27.9	45.3
2016	145	15.0	16.5	0.0	3.0	8.9	15.7	23.4	30.6	46.4
2017	144	15.9	17.1	0.7	3.8	9.1	17.5	24.5	29.0	51.0



- Although gap has narrowed, there is still a wide range in performance from the 10th to 90th percentile hospitals rates

C-section Honor Roll Timeline

- The third annual NTSV C-Section Honor Roll will be announced on **October 23, 2018**

Board Meeting Schedule

- Next meeting: Friday, December 7th from 10:00am – 2:00pm PT in Oakland
- Availability poll will be circulated for 2019 meetings options (please stay tuned)