

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

Webinar Information

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

Phone: 1-646-876-9923

Access code: 443 789 5416

Time	Agenda Item	Presenters and Documents
11:00-11:00 10min.	Welcome and call to order - Approval of past meeting summary - Welcome Alex Stack	- Ken Stuart Board Chair
25min.	Opioid safe hospital designation - Overview & proposal - Workgroup volunteers	- Aimee Moulin CA Bridge Program - Sarah Windels CA Bridge Program
60min.	Organizational updates - Consumer representation on TAC - Consumer outreach and activation project - Contract with Covered CA; poor performing hospitals - Final data use fees <ul style="list-style-type: none"> • Discussion with CMQCC 	- Bruce Spurlock Executive Director
11:10-12:00 50min.	TAC analytic updates - Data refresh complete <ul style="list-style-type: none"> • Sepsis management measure fix - Hospital patient safety honor roll version 2.0	- Mahil Senathirajah IBM Watson Health - Frank Yoon IBM Watson Health
10min.	Business plan - Year-end financial report (2018)	- Bruce Spurlock Executive Director
15min.	Wrap-up items - Bio request for website updates Adjourn - Next meeting: April 3, 2019 from 10:00am - 2:00pm PT (California Health Care Foundation, Oakland)	- Bruce Spurlock Executive Director - Ken Stuart Board Chair

Cal Hospital Compare
Board of Directors Meeting Summary
 Friday, December 7, 2018
 10:00am – 2:00pm PST

Attendees: Bruce Spurlock, Chris Krawczyk, David Hopkins, David Pryor, Frank Yoon, Helen Macfie, Jennifer Stockey, Katharine Traunweiser, Ken Stuart, Kristoff Stremikis, Lance Lang, Libby Hoy, Mahil Senathirajah, Scott Masten, Tracy Fisk

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	<ul style="list-style-type: none"> • The meeting formally commenced at 10:03pm Pacific Time • The Cal Hospital Compare Board meeting summary of Oct 17, 2018 was approved.
Organizational Updates	<p>General</p> <ul style="list-style-type: none"> • CHC will has a new health plan representative – David Pryor with Anthem <p>Consumer activation project updates</p> <ul style="list-style-type: none"> • Bruce reviewed several emerging themes <ul style="list-style-type: none"> ○ Importance of a strong social media presence ○ Generating felt need for consumers ○ Creating more meaningful measures to consumers ○ Just in time data information for both patients and physicians at the point of decision making <p>Date use fees</p> <ul style="list-style-type: none"> • Kristof with CHCF suggested adding data specifications to the data use fees document to appeal to researchers <p>Physician Compare (MIPS) Data</p> <ul style="list-style-type: none"> • Reviewed public reporting timeline • CHC will monitor MIPS data for relevant measures (anything tied to acute care, etc.)
TAC analytic updates	<p>Hospital patient safety honor roll</p> <ul style="list-style-type: none"> • Reviewed PSHR 1.0 methodology and results • Board in agreement to use similar methodology to generate PSHR 2.0 <p>Poor performing outlier hospitals</p> <ul style="list-style-type: none"> • Reviewed methodology and results to generate list of poor performing outlier hospitals <p>Website data refresh</p> <ul style="list-style-type: none"> • Extensive website refresh with data from multiple sources – federal and statewide • Expected posting in late December 2018 – early January 2019 • Microsoft excel analytic files will be available <p>CMQCC’s active track data</p> <ul style="list-style-type: none"> • CMQCC’s Executive Committee and Cal Hospital Compare’s Board of Directors approved a proposal to use hospitals’ direct data submissions to CMQCC’s Maternal Data Center (MDC).

	<ul style="list-style-type: none"> • Starting with CY 2018 data, metrics to be publicly reported on Cal Hospital Compare include: <ul style="list-style-type: none"> ○ NTSV C-Section Rate ○ Episiotomy Rate ○ VBAC Rate and Policy ○ Percent of Deliveries by Certified Nurse Midwives (CNMs)
Business Plan	<ul style="list-style-type: none"> • Reviewed the most recent financial report and annual budget for 2019
Next Meeting/Meeting Adjournment	<ul style="list-style-type: none"> • Next meeting: February 13, 2019 from 11:00am-1:00pm PT (virtual meeting) • The meeting formally adjourned at 2:00pm Pacific Time.

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Proposed Agenda

- ▶ Welcome
- ▶ Opioid safe hospitals
- ▶ Organizational updates
- ▶ TAC analytic updates
- ▶ Business Plan

Opioid Safe Hospitals

About: opioid safe hospitals

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.

- ▶ **How:** multi-stakeholder workgroup
- ▶ **Criteria:** 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.
- ▶ **Timeline:**
 - ▶ Workgroup meeting - Feb thru Apr
 - ▶ Survey live - May thru Sept
 - ▶ Announce results - Fall 2019

Creating Opioid Safe Hospitals



- Build on the success of California hospitals in reducing low-risk C-section rates and improving patient safety performance
- Incentivize California hospitals and EDs to implement best practices around use of opiates and treatment of opioid use disorder

Low-threshold access to treatment for substance use disorders

Integrating treatment
for substance use
disorders in acute care
hospitals



Opioid Safe Hospitals

Accelerate change in 3 domains to reduce opioid-related deaths with more effective treatment and pain management

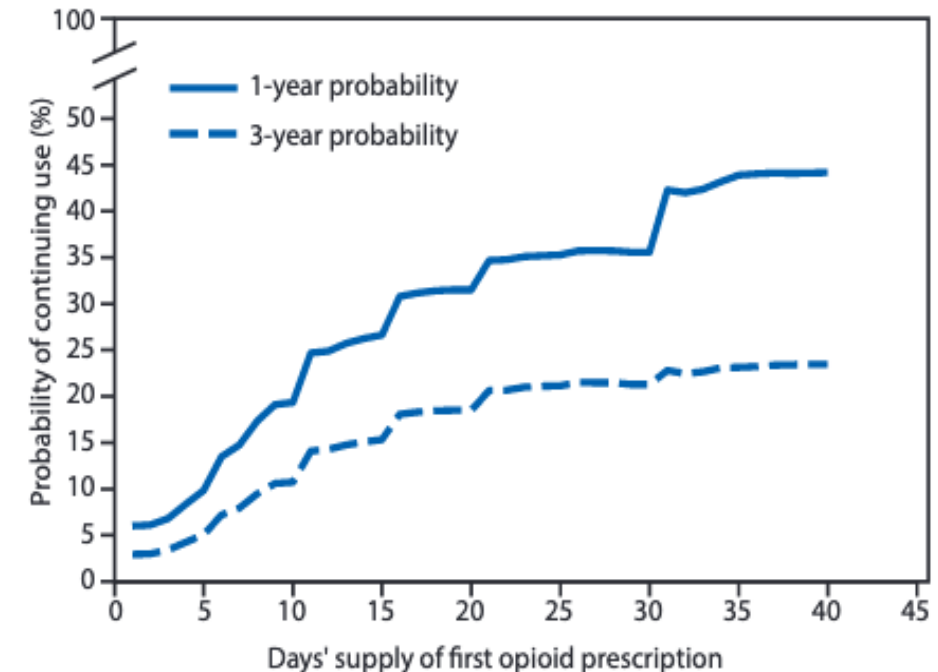
1. Prevent new chronic opioid starts
2. Identify and treat opioid use disorders
3. Overdose prevention

Prevent: new chronic opioid starts

Decrease discharge prescriptions

- Implement prescribing guidelines for ED, medical, and surgical units.
 - Using local, state, national or specialty specific recommendations.
- Have a process to give feedback to outlier prescribers

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

Promote: alternatives to opiates for pain management

- Educate and promote use of multi-modal pain treatment, including non-opioid medications, nerve blocks, and alternative modalities, such as physical, relaxation or chiropractic therapy.



Treat: opioid use disorders

- Identify and treat patients with opiate use disorder in the ED and inpatient setting
- Prevent inpatient acute opioid withdrawal through medication assisted therapy (methadone, buprenorphine)
- Cohort of X-waivered providers on staff



Prevent: overdoses

- Establish guidelines and/or protocols to dispense naloxone on discharge.
- Provide written and oral education to patients and caregivers on safe opioid use, including:
 - Risks, side effects, potential for sedation, danger of use in combination with alcohol or sedating drugs, and safe storage and disposal at home.



Measure Trajectory



Year 1: process and structural measures in one unit of the hospital

Year 2: process and structural measures throughout the hospital

Year 3-4: quantitative performance measure development & implementation

BOD Discussion

- ▶ What **feedback** do you have?
- ▶ Who from this group is interested in joining the **workgroup**? Who should we consider external to this group?

Organizational Updates

Consumer Representation on TAC



Joan Maxwell
Patient Advisor
John Muir Health



Liz Salmi
Patient Co-Chair
California OpenNotes Consortium

CHCF Consumer Activation Project

- ▶ Cynosure Health (Cynosure) recruited a **19-member national advisory group**
- ▶ Advisory group activities:
 - ▶ Reviewed of scientific and grey literature
 - ▶ Reviewed and refined a strategic framework to strengthen consumer activation and use of CHC data
 - ▶ Provided input and prioritized high-yield activities for CHC to enhance consumers' use of CHC performance data for healthcare decision making purposes

Recommendations At A Glance

Near term strategies:

- ▶ Direct to consumer outreach via strategic partnerships
- ▶ Activate consumers using intrinsic motivators
- ▶ Enhance indirect consumer outreach by co-designing with patients

Longer term strategies:

- ▶ Partner with MDs to recommend data
- ▶ Develop measures that matter

Poll Results

Priority Level:

1

- Strategic partnerships (82%)
- Activate consumers (18%)

2

- Activate consumers (64%)
- Indirect outreach (27%)
- Measures (9%)

3

- Indirect outreach (55%),
- MD partnership (18%)
- Other (27%)

Direct to consumer outreach via strategic partnerships (1)

Summary: CHC would assume a data generator role and partner with common “go to” websites for healthcare data to disseminate relevant information and/or direct consumers to the CHC website. Recommend that data disseminators have complimentary choice attributes to CHC information (i.e. in-network information, cost, physician information, etc.)

Elements	Impact (1=low, 5=high)	Effort (1=low, 5=high)	Cost (\$-\$\$\$\$\$)	Partners
Identify and develop partnerships with data disseminators (primary)	5	3	\$\$\$	Facebook, Yelp, Healthgrades, IHA CA Provider Directory Utility, Definitive Healthcare, California Maternal Quality Care Collaborative
Identify and develop partnerships with data disseminators (secondary)	5	5	\$\$\$\$\$	Covered California, Commercial Insurers, Employers, Amazon, WebMD, Amino, Vitals, Clearcost Health, Pokitdok
Understand how to leverage and measure social media outreach	4	4	\$\$\$\$	CHCF, Cynosure
Identify relevant data and key messages to disseminate via partners	3	3	\$\$	CHCF, Cynosure, IBM Watson, OSHPD, HQI, California Maternal Quality Care Collaborative, PFCCpartners

Poor Performing Outlier Hospitals



Mirror patient safety honor roll methods (where possible)



Outreach to hospitals to provide support



Signed contract with Covered California

Data Use Fees

TAC Analytic Updates

General Updates

Data refresh

- CHC website updated Jan. 2019
- Added measures: Sepsis Management, CABG Death Rate w/ Valve, CABG Death Rate no Valve
- Retired measures: Internal Mammary Artery Usage Rate

CMS Data

- New release timeline - Feb. 2019

Patient Safety Honor Roll

Possible Approaches

1

Adding
measures
(today)

2

Using multiple
years of data
(future meeting as
warranted)

3

Creating a
composite
measure
(future meeting as
warranted)

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*

Honor Roll 1.0: Hospitals Included in Algorithmic Approach

- ▶ As a reminder, the following table shows the decrease in eligible hospitals as the “minimum number of reported measures” threshold increases.

Minimum Number of Reported Measures	Number of PSHR-Eligible Hospitals (total N=327 for 2018 3Q)
1	306
2	290
3	250
4	233
5	200
6	134

Honor Roll 1.0 requires that hospital has scores for at least 4 of 6 measures

Available Leapfrog Grades = 244

Today's Mtg: Explore Adding Measures to Algorithmic Methodology

- ▶ Additional Patient Safety Measure sets Identified:
 - ▶ Use PSI component measures rather than PSI 90 composite measure
 - ▶ Use relevant patient experience measures
 - ▶ Use new SEP-1 sepsis measure
- ▶ IBM Watson Health modeled a number of scenarios, adjusting the following PSHR parameters:
 - ▶ The set of measures included in the Honor Roll
 - ▶ The “high performance threshold” that the hospital must achieve (e.g. at least 2/3 of measure rates above the 50th percentile)
 - ▶ The “poor performance threshold” below which a hospital cannot perform (e.g. no measure rate less than the 25th percentile)
 - ▶ Note that we kept the “minimum number of reportable measures” threshold as “at least more than 50% of measures” for all scenarios

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

Review Excel Document

PSHR 2.0 Scenarios

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. No low performance criteria.
Adding Patient Experience and Using PSI 90 Components and SEP-1											
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

Summary of TAC Discussion:

- ▶ General sense of TAC that scenarios 2 and 3 are the most attractive, using composite measure PSI90
 - ▶ Component PSIs are often infrequent and have tight distributions making failure on poor performance criteria more likely and overall results less stable (e.g., PSI08)
- ▶ TAC asked project team to consider the mix of the HCAHPS patient experience measures, modeling Honor Roll scenarios using different HCAHPS composite measures
 - ▶ Specifically, examine the impact of HCAHPS component measures with tight distributions

Future PSHR 2.0 Analysis

- ▶ Examine use of CDPH HAI data (vs CMS)
- ▶ Use of multiple years of data
- ▶ Use of absolute/fixed performance thresholds
- ▶ Development of a composite measure (on hold)
- ▶ HCAHPS variation

Business Plan

Board Meeting Schedule - 2019

**Schedule is in Pacific Time*

- ▶ **Wednesday, April 3, 2019 - 10:00am to 2:00pm (In-Person - Oakland)**
- ▶ 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)

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)
PSHR 1.0	233	71%	40	17%	Y	Y	N
Adding Patient Experience and SEP-1							
1	303	93%	13	4%	Y	Y	N
2	303	93%	43	14%	Y	Y	N
3	303	93%	70	23%	Y	Y	N
4	303	93%	167	55%	Y	Y	N
Adding Patient Experience and Using PSI 90 Components and SEP-1							
5	290	89%	0	0%	Y	N	Y
6	290	89%	13	4%	Y	N	Y
7	290	89%	24	8%	Y	N	Y
8	290	89%	38	13%	Y	N	Y
9	290	89%	1	0%	Y	N	Y
10	290	89%	42	14%	Y	N	Y
11	290	89%	83	29%	Y	N	Y
12	290	89%	138	48%	Y	N	Y
Other Scenarios with Different Measure Set Mixes							
13	289	88%	9	3%	Y	N	Y
14	252	77%	33	13%	Y	Y	N
15	291	89%	1	0%	Y	N	Y

Use SEP-1? (1)	Use Patient Experience? (5)	Total Number of Measures in Scenario	Honor Roll Criteria (for hospitals meeting Minimum Measures)
N	N	7	At least 2/3 of measure results above 50th percentile. No measure result below 25th percentile
Y	Y	12	At least 2/3 of measure results above 50th percentile. No measure result below 25th percentile
Y	Y	12	At least 2/3 of measure results above 50th percentile. No measure result below 10th percentile
Y	Y	12	At least 2/3 of measure results above 50th percentile. No low performance criteria.
Y	Y	12	At least 1/2 of measure results above 50th percentile. No low performance criteria.
Y	Y	21	At least 2/3 of measure results above 50th percentile. No measure result below 25th percentile
Y	Y	21	At least 2/3 of measure results above 50th percentile. No measure result below 10th percentile
Y	Y	21	At least 2/3 of measure results above 50th percentile. No measure result below 5th percentile
Y	Y	21	At least 2/3 of measure results above 50th percentile. No low performance criteria.
Y	Y	21	At least 1/2 of measure results above 50th percentile. No measure result below 25th percentile
Y	Y	21	At least 1/2 of measure results above 50th percentile. No measure result below 10th percentile
Y	Y	21	At least 1/2 of measure results above 50th percentile. No measure result below 5th percentile
Y	Y	21	At least 1/2 of measure results above 50th percentile. No low performance criteria.
Y	N	16	At least 2/3 of measure results above 50th percentile. No measure result below 25th percentile
Y	N	7	At least 2/3 of measure results above 50th percentile. No measure result below 25th percentile
N	Y	20	At least 2/3 of measure results above 50th percentile. No measure result below 25th percentile

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