Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Agenda
Wednesday, October 2, 2019
10:00am – 12:00pm PT

Webinar Information
Webinar link: https://zoom.us/j/4437895416
Phone: 1-669-900-6833
Access code: Code: 443 789 5416

Time	Agenda Item	Presenters and Documents
10:00-10:05 *5 min.*	Welcome and call to order - Approval of past meeting summary	- **Ken Stuart** Board Chair
10:05-10:35 *30 min.*	Organizational updates - Changes to TAC Composition - Date use fees - Long Term Care data (calqualitycare.org)	- **Bruce Spurlock** Executive Director, CHC - **Alex Stack** Director, CHC
10:35-11:15 *40 min.*	Cal Hospital Compare Honor Rolls - Opioid Care o Preview results o Determine threshold o Recognition recommendations - Maternity Preview - Announcement approach & timeline	- **Alex Stack** Director, CHC - **Mahil Senathirajah** IBM Watson Health
11:15-11:35 *20 min.*	TAC analytic updates - California Hospitals with Poor Patient Safety Performance Report - Q3 CMS data refresh	- **Mahil Senathirajah** IBM Watson Health - **Frank Yoon** IBM Watson Health
11:35-11:45 *10 min.*	Business plan – Financial report	- **Bruce Spurlock** Executive Director, CHC
11:45-11:55 *10 min.*	Executive Session - Discuss compensation arrangement for CHC Executive Director, Bruce Spurlock	- **Ken Stuart** - Board Chair
11:55-12:00 *5 min.*	Wrap-up Adjourn – Next meeting: Wed., Dec 4, 2019 from 10:00am-2:00pm PT in Oakland (in-person)	- **Ken Stuart** Board Chair

Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Summary
Wednesday, August 7, 2019
10:00am – 2:00pm PST
Oakland, California

Attendees: Bruce Spurlock, Alex Stack, Mahil Senathirajah, Ken Stuart, Libby Hoy, Robert Imhoff, Jim Konkos, Lance Lang, Thai Lee, Bianca Openiano, Frank Yoon, David Hopkins, Kristof Stremikis, Kevin Worth

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting commenced at 10:01am Pacific Time. The meeting attendees formally introduced themselves. • The Cal Hospital Compare Board meeting summary of June 5, 2019 was motioned and approved.
Organizational Updates	• Robert Imhoff, President of the Hospital Quality Institute, has formally joined the CHC TAC and Board of Directors. HQI will be taking a more global approach, focusing on cultural issues including improving work environment for healthcare workers. A program is currently being created and will be marketed to the hospitals. HQI will also increase focus on data analysis and patient safety and quality. Lance Lang expressed an interest to partner on these opportunities.
TAC Analytic Updates	• Bruce and Lance will meet with Secretary Ghaly on August 12th to discuss and determine the timeline of public announcements for the Maternity Honor Roll, Patient Safety Honor Roll and the Opioid Safe Hospital Designation. • CHC is working with a web developer on how to best recognize honor roll recipients on the CHC webpage.
Maternity Honor Roll Preview	• Alex Stack gave an overview of the Maternity Honor Roll. Goal is to have a 12-month rolling period with a semi-annual update. Those hospitals that are not participating in CMQCC will still be included in the latest data that will determine if they make the honor roll. CHC will provide this data to Yelp. A new preference maternity measure, percentage of deliveries by Certified Nurse Midwives, is now being reported.
Website Updates	• The CHC website now features photos and bios of the TAC and board members. Board meeting materials will be posted on the website later this month.
Health Care Payments Database	• Ken Stuart serves on the Health Care Payment Data Review Committee. They are currently working closely with OSHPD and other stakeholders to identify data and payors that will be mandated in addition to identifying external users who will be able to access this data for research and use. A final report will be sent to legislature by July 2020.
Patient Safety Honor Roll	• Mahil provided an update on PSHR version 1.0 and 2.0 and summarized the TAC discussion to date. The goal is to expand eligible hospitals and accurately identify hospitals for inclusion on the PSHR.

	• Bruce and Mahil reviewed the Leapfrog analysis and CHC measure sets. Leapfrog shared their scoring data with CHC. Leah Binder at Leapfrog will propose that they consider one deviation. Ken and Libby agreed that hospitals should be held to higher standards. • Frank Yoon gave a high-level overview of the Leapfrog analysis used to identify poor performing outlier hospitals and the PSHR honorees. All poor performing hospitals were notified of their scores via email correspondence from Bruce. Lance suggested consulting with the author of the Hopkins article regarding the mortality related to the poor performer outlier scores with a goal to create clinical meaning. • Mahil provided a summary of the last TAC discussion and proposed next steps. The honor roll will be finalized in the fall. • The Board motioned, moved, seconded, and approved to accept the proposal to use three periods of reporting for the honor roll methods. • The poor performer report will be available in January 2020. • The Board motioned, seconded, and approved to endorse staff proposals on poor performing hospitals and to finalize the honor roll this fall.
General Updates	• Mahil gave a brief update on the data refresh, ED, and maternity measures.
Business Plan	• Bruce reviewed the current financial reports with the board members. • Bruce to forward the data use fees to Bianca Openiano for reference. • Bruce proposed a compensation increase of up to 25% for increased responsibilities serving as Executive Director of the Board.
Opioid Safe Hospital Designation	• Alex updated the board members on the program. The self-assessment window closes September 18th. Survey responses are currently low. There are two webinars remaining out of the 5-part webinar series (Aug 27 & Sept. 12). • The board members questioned if "Opioid Safe" should be portrayed differently or renamed to not include the word "safe". Libby Hoy will consult with her colleagues about ideas for using different terminology. • The opioid safe hospital results will be shared on the next board call.
Next Meeting/Meeting Adjournment	• The next CHC Board Meeting will be held on October 2, 2019 from 10:00am-12:00pm PST via Zoom webinar. • The meeting formally adjourned at 1:01pm Pacific Time.

Cal Hospital Compare

Board of Directors

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Cal Hospital Compare Board of Directors

October 2, 2019

10:00am-12:00pm Pacific Time

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Access code: 443 789 5416

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Proposed Agenda

- Welcome
- Organizational updates
- Cal Hospital Compare Honor Rolls
  - Opioid Care
  - Maternity
  - Announcement approach & timeline
- TAC analytic updates
- Business plan
- Executive session
- Wrap Up

Organizational Updates

Changes to TAC Consumer Representation

Liz Salmi
Patient Co-Chair
California OpenNotes Consortium

Data Use Fees

Data use fees for CHC partners?

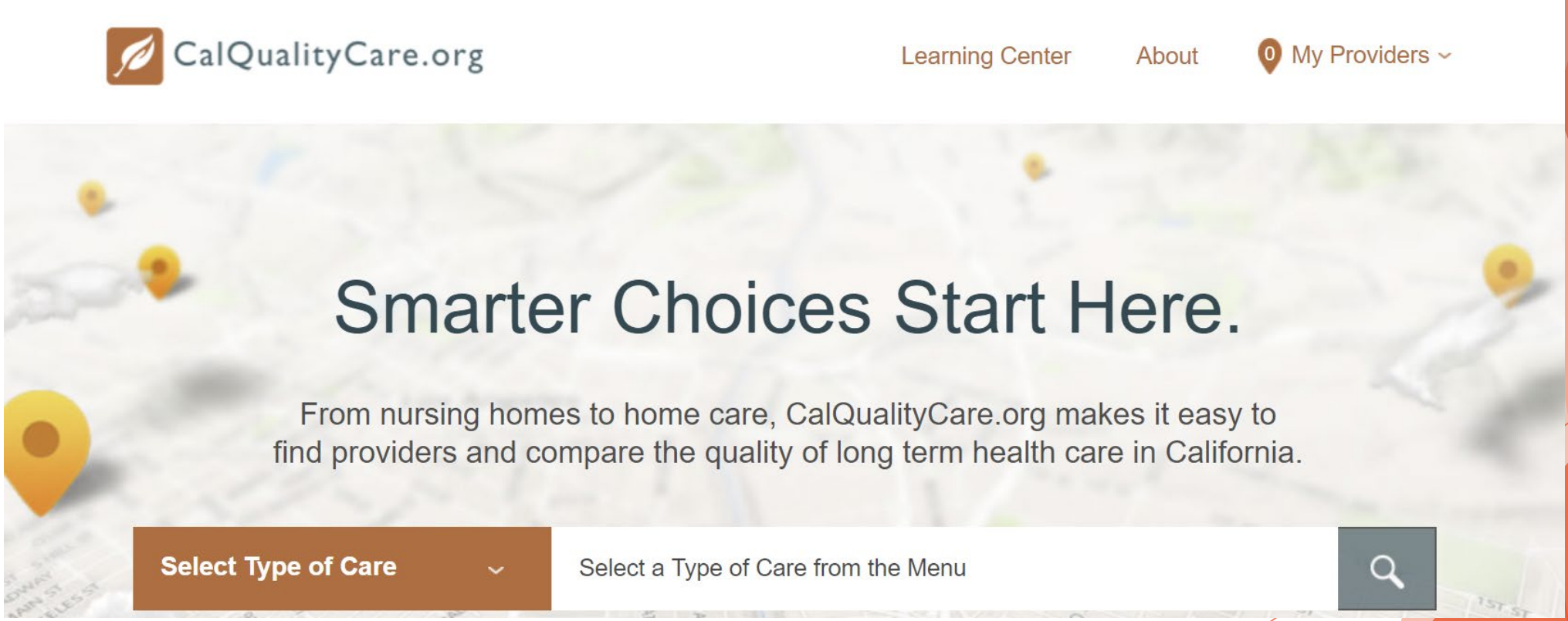
Received

- Molina Healthcare
- Healthnet
- Oscar Health Plan
- Western Health Advantage
- Chinese Community Health Plan
- Anthem
- Valley Health Plan

Awaiting Response

- LA Care
- Sharp

Long Term Care Data



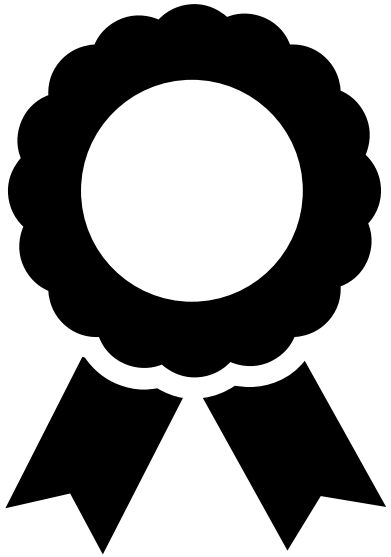
Opioid Care

Cal Hospital Compare Honor Rolls

Previously known as the Opioid Safe Hospital Designation

2019 Goals

- Activate hospitals to accelerate care redesign in service of reducing OUD related deaths & recognize work to date
- Launch the Opioid Care Honor Roll & virtual learning collaborative
- Establish baseline performance
- Set relevant (attainable) threshold for hospitals to achieve this designation
- Surface stories & lessons learned via 1:1 interviews



TAC Discussion

- Considerations for Year 1 (2019)
  - Threshold
    - Point system approach focusing on levels of performance
    - Fixed threshold
  - Strong support for recognizing all hospitals in some way with ~½ making the honor roll with ~20 points
- Considerations in support of Year 2 activities (2020)
  - Respondent analysis to support outreach
    - Selection bias
    - Geographic distribution
    - % patients impacted by honor roll hospitals
  - Continued QI
    - Share resources & best practices to support closing gaps
    - Identify & leverage champions

TAC Recognition Recommendations

Recognize all for participating

- Include list in press release & partner communications

Most Improved (Year 2)

Honor Roll Recognition

- Include list in press release & partner communications
- Badge on CHC badge on website
- Certificate
- Feature opportunity

Triple Crown

- Special recognition for hospitals on all 3 CHC honor rolls

Self-Assessment Scoring

Measure	Level 3	Level 2	Level 1*
Prevent new opioid starts			
Dx Prescribing	1	2	3 (+1)
Alt. to opioids for pain mgmt.	1	2	3 (+1)
Identification & Treatment			
MAT	1	2	3
Bup. Waiver	1	2	3 (+1)
Overdose prevention			
Naloxone education & distribution	1	2	3 (+1)
Cross-cutting best practices			
Org. infrastructure	1	2	3 (+1)
Provider/staff engagement	1	2	3
Patient engagement	1	2	3 (+1)
Dx to community	1	2	3 (+1)
Total	0-9	9-18	18-27(34)

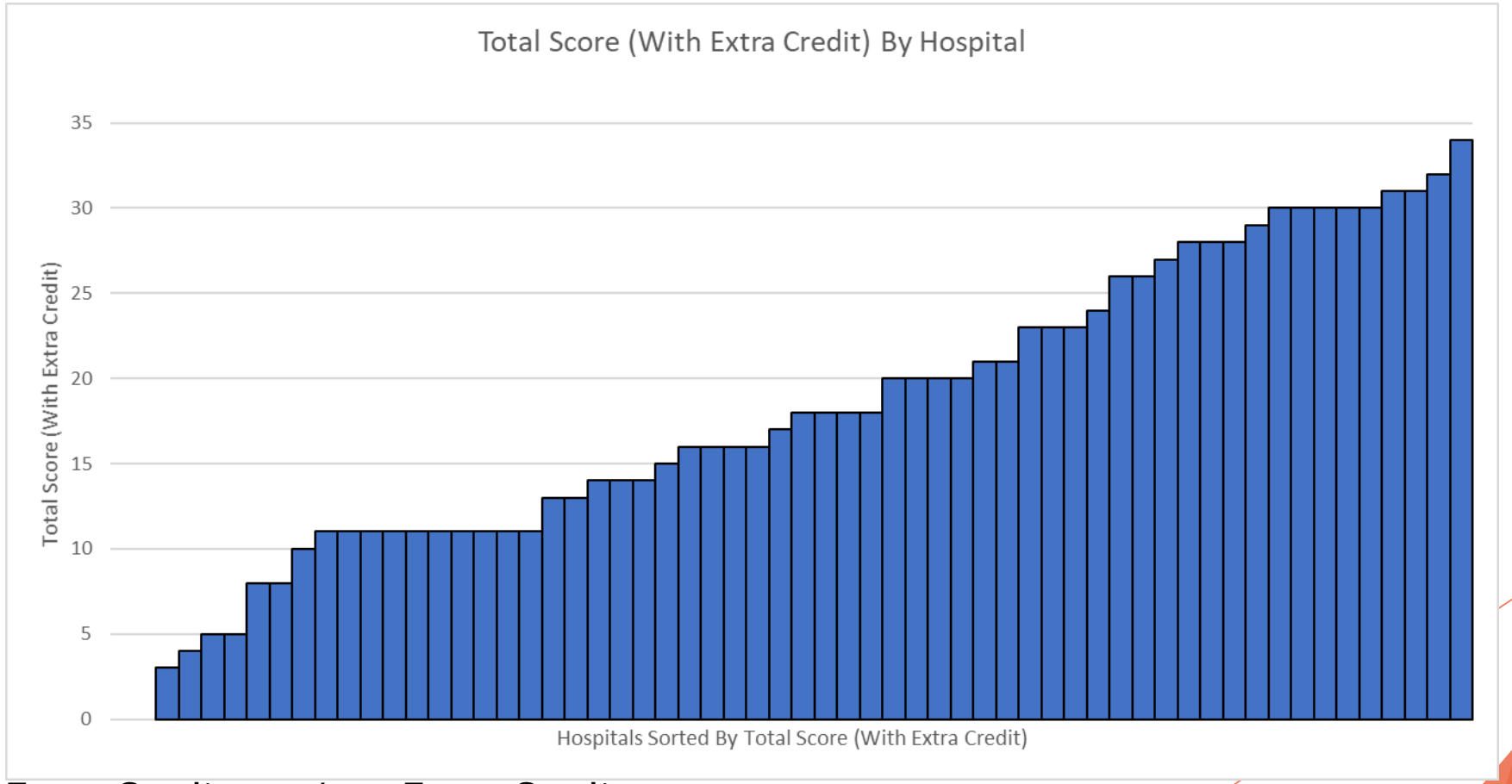
**Extra Credit (EC) = +1*

Results

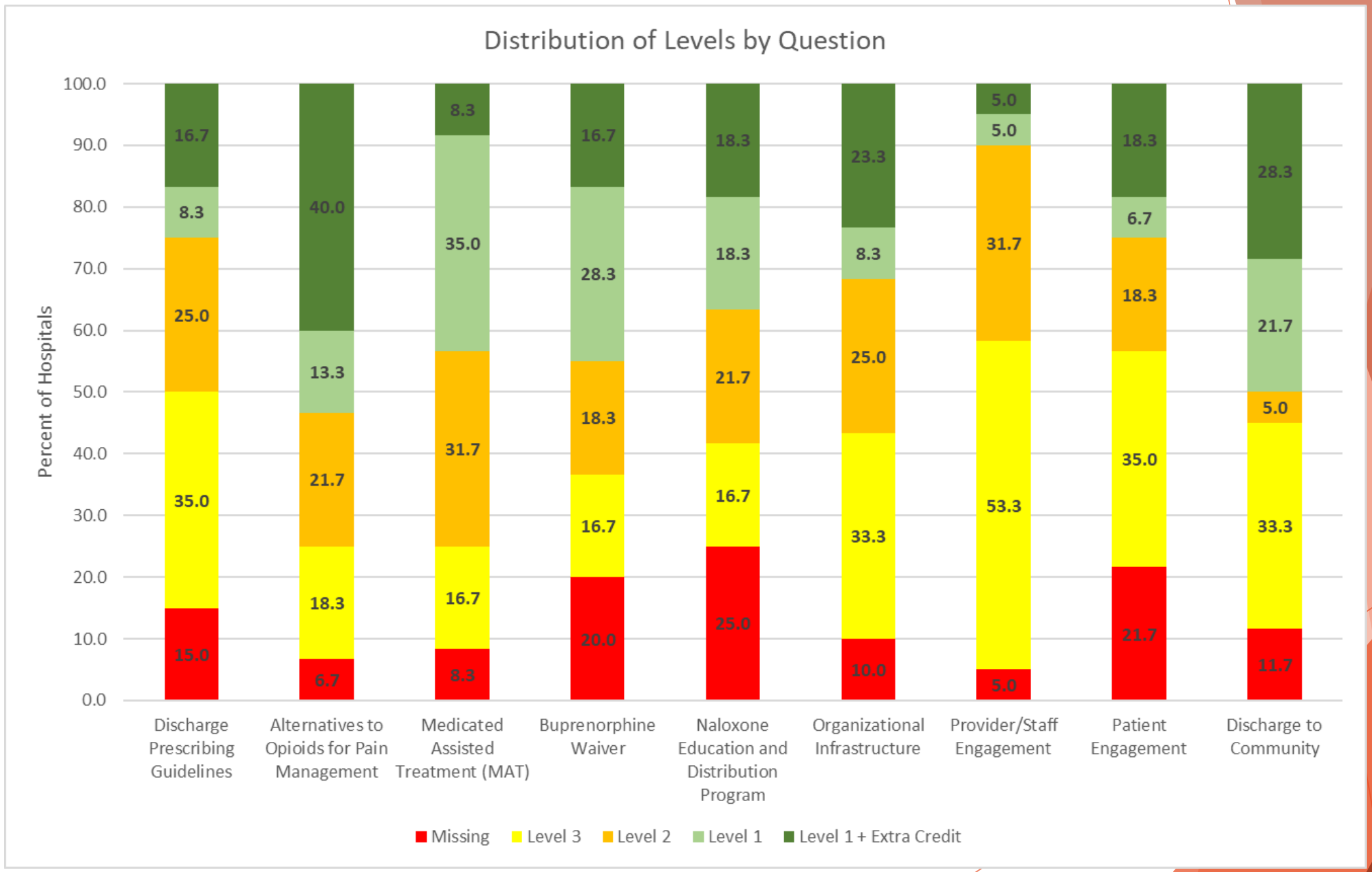
60 applicants

17.9 | 16.2 pts.*
Avg. Total Score

34 | 27 pts.* - Max
0 pt. - Min



*w/ Extra Credit | w/out Extra Credit


Distribution of Levels by Question
Percent of Hospitals
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Discharge Prescribing Guidelines
16.7
8.3
25.0
35.0
15.0
Alternatives to Opioids for Pain Management
40.0
13.3
21.7
18.3
6.7
Medicated Assisted Treatment (MAT)
8.3
35.0
31.7
16.7
8.3
Buprenorphine Waiver
16.7
28.3
18.3
16.7
20.0
Naloxone Education and Distribution Program
18.3
18.3
21.7
16.7
25.0
Organizational Infrastructure
23.3
8.3
25.0
33.3
10.0
Provider/Staff Engagement
5.0
5.0
31.7
53.3
5.0
Patient Engagement
18.3
6.7
18.3
35.0
21.7
Discharge to Community
28.3
21.7
5.0
33.3
11.7
Missing
Level 3
Level 2
Level 1
Level 1 + Extra Credit

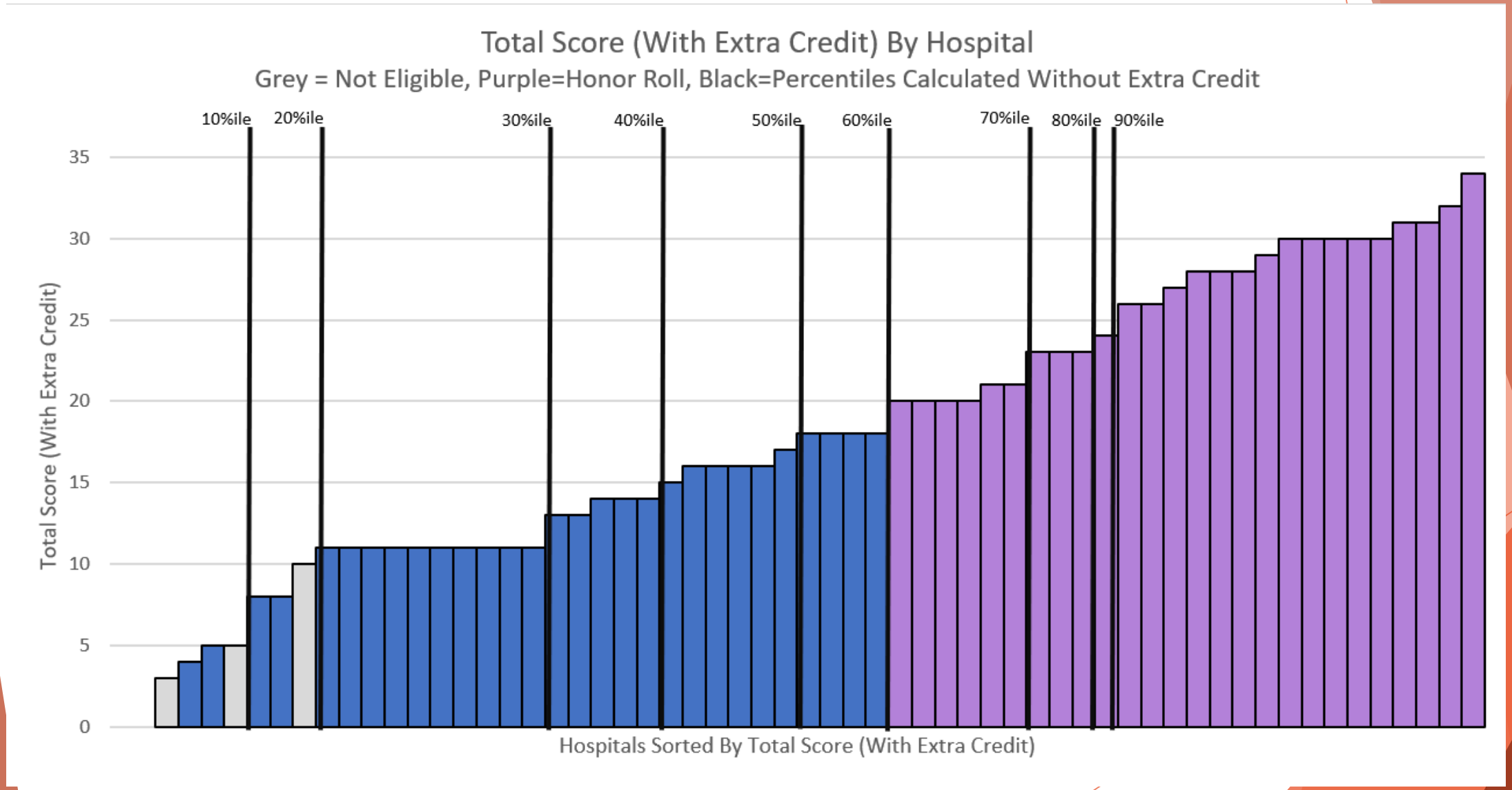
Analysis (19 scenarios)

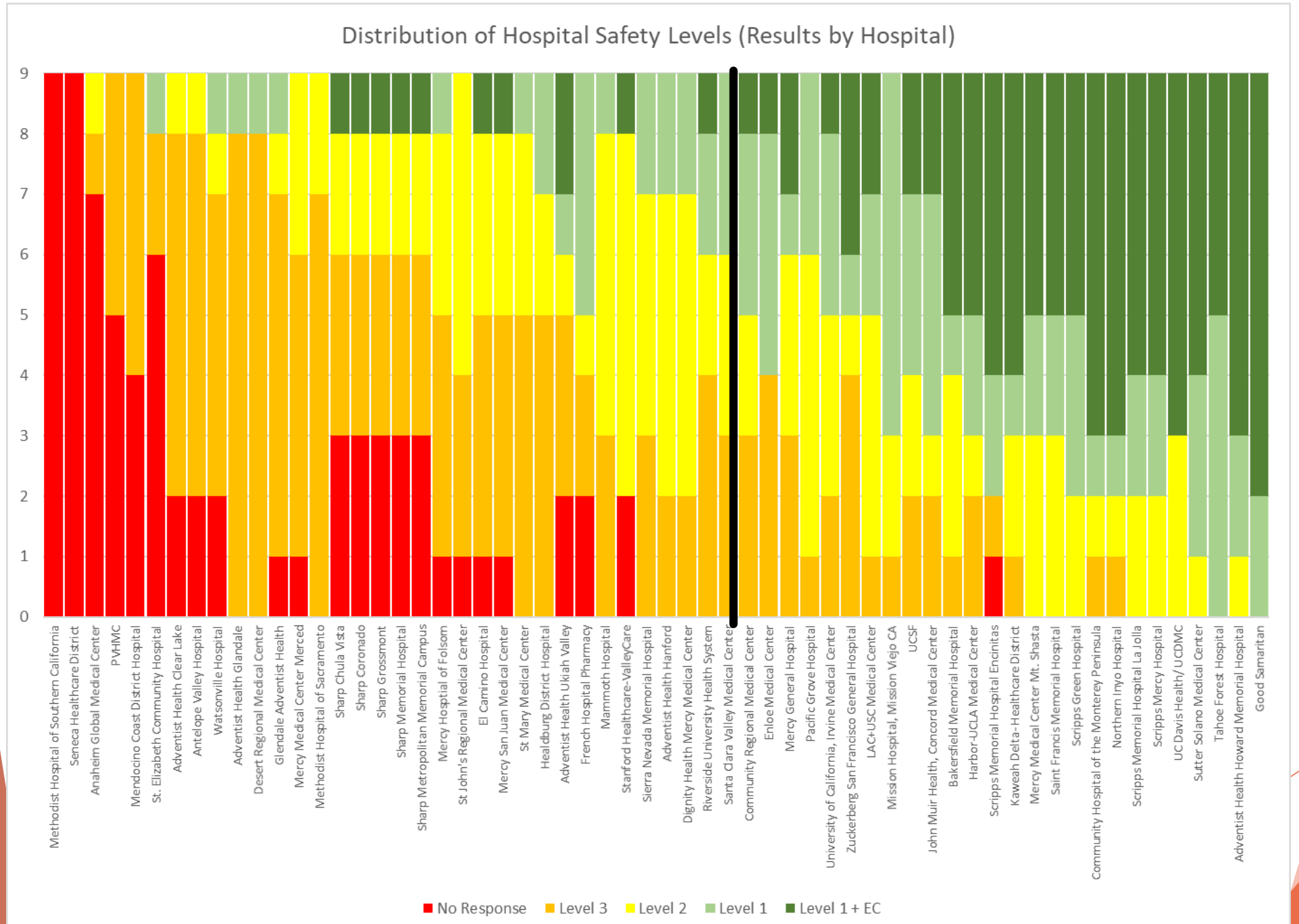
- Considerations
  - Maximize number of eligible hospitals
  - All domains equally weighted
  - Challenging domains/questions e.g. Overdose Prevention
- Proposed threshold
  - Eligibility
    - Hospitals must answer at least one question per domain EXCEPT Overdose Prevention Domain
  - Threshold
    - Cut points calculated over ALL hospitals, excludes Extra Credit

Proposed Thresholds

At least One Question Answered Per Domain, Except Overdose Prevention Domain					
Scenario	**Eligible Hospitals**	**% Total Hospitals**	**Honor Roll Status**	**% Eligible Hospitals**	**Honor Roll Criteria** (overall points include EC, cut points calculated over ALL hospitals w/out EC)
11	55	92%	16	29%	Overall points greater than 90th percentile (25 points)
19	55	92%	17	31%	Overall points greater than 80th percentile (24 points)
18	55	92%	20	36%	Overall points greater than 70th percentile (22.5 points)
17	55	92%	26	47%	Overall points greater than 60th percentile (20 points)
13	55	92%	30	55%	Overall points greater than 50th percentile (17 points)

Honor Roll Hospital – 60th percentile (20 pts)




Distribution of Hospital Safety Levels (Results by Hospital)
9
8
7
6
5
4
3
2
1
0
Methodist Hospital of Southern California
Seneca Healthcare District
Anaheim Global Medical Center
PVHMC
Mendocino Coast District Hospital
St. Elizabeth Community Hospital
Adventist Health Clear Lake
Antelope Valley Hospital
Watsonville Hospital
Adventist Health Glandale
Desert Regional Medical Center
Glendale Adventist Health
Mercy Medical Center Merced
Methodist Hospital of Sacramento
Sharp Chula Vista
Sharp Coronado
Sharp Grossmont
Sharp Memorial Hospital
Sharp Metropolitan Memorial Campus
Mercy Hospital of Folsom
St John's Regional Medical Center
El Camino Hospital
Mercy San Juan Medical Center
St Mary Medical Center
Healdburg District Hospital
Adventist Health Ukiah Valley
French Hospital Pharmacy
Mammoth Hospital
Stanford Healthcare-ValleyCare
Sierra Nevada Memorial Hospital
Adventist Health Hanford
Dignity Health Mercy Medical Center
Riverside University Health System
Santa Clara Valley Medical Center
Community Regional Medical Center
Enloe Medical Center
Mercy General Hospital
Pacific Grove Hospital
University of California, Irvine Medical Center
Zuckerberg San Francisco General Hospital
LAC+USC Medical Center
Mission Hospital, Mission Viejo CA
UCSF
John Muir Health, Concord Medical Center
Bakersfield Memorial Hospital
Harbor-UCLA Medical Center
Scripps Memorial Hospital Encinitas
Kaweah Delta-Healthcare District
Mercy Medical Center Mt. Shasta
Saint Francis Memorial Hospital
Scripps Green Hospital
Community Hospital of the Monterey Peninsula
Northern Inyo Hospital
Scripps Memorial Hospital La Jolla
Scripps Mercy Hospital
UC Davis Health/UCDMC
Sutter Solano Medical Center
Tahoe Forest Hospital
Adventist Health Howard Memorial Hospital
Good Samaritan
No Response
Level 3
Level 2
Level 1
Level 1 + EC

Opioid Care Honor Roll (20 pts.) Hospital Characteristics

Strengths:

- Developed and implemented evidence-based discharge prescribing guidelines for at least 2-3 service lines including ED and General Surgery
- Non-opioid analgesic multi-modal pain management program in two or more service lines & integrated into standard work
- MAT is actively prescribed/ continued in at least 2 service lines to providers* in the ED and IP units to obtain buprenorphine waiver and has at least one or more waivered providers
- **Standing order &/or standard work for care teams prescribe naloxone at discharge, patient education program in place, &/or naloxone provided in hand at discharge**
- Communicated program, purpose, goal, progress to goal to all staff with Board support
- Actively connect MAT and OUD patients with outpatient facilities and drug treatment programs for follow up care

Opportunities:

- Passive engagement of providers, staff and patients

Proposed Honor Roll Hospitals (20 pts.)

Hospital	Total Pts.	Total Pts. (No EC)	Missing
Adventist Health Howard Memorial Hospital	32	26	0
Bakersfield Memorial Hospital	26	22	0
Community Hospital of the Monterey Peninsula	30	24	0
Community Regional Medical Center	20	19	0
Enloe Medical Center	20	19	0
Good Samaritan	34	27	0
Harbor-UCLA Medical Center	26	22	0
John Muir Health, Concord Medical Center	24	22	0
Kaweah Delta- Healthcare District	28	23	0
LAC+USC Medical Center	23	21	0
Mercy General Hospital	20	18	0
Mercy Medical Center Mt. Shasta	28	24	0
Mission Hospital, Mission Viejo CA	23	23	0
Northern Inyo Hospital	30	24	0
Pacific Grove Hospital	20	20	0
Saint Francis Memorial Hospital	28	24	0
Scripps Green Hospital	29	25	0
Scripps Memorial Hospital Encinitas	27	22	1
Scripps Memorial Hospital La Jolla	30	25	0
Scripps Mercy Hospital	30	25	0
Sutter Solano Medical Center	31	26	0
Tahoe Forest Hospital	31	27	0
UC Davis Health/ UCDMC	30	24	0
UCSF	23	21	0
University of California, Irvine Medical Center	21	20	0
Zuckerberg San Francisco General Hospital	21	18	0

Note: See spreadsheet for full list of hospitals that submitted for the Opioid Care Honor Roll

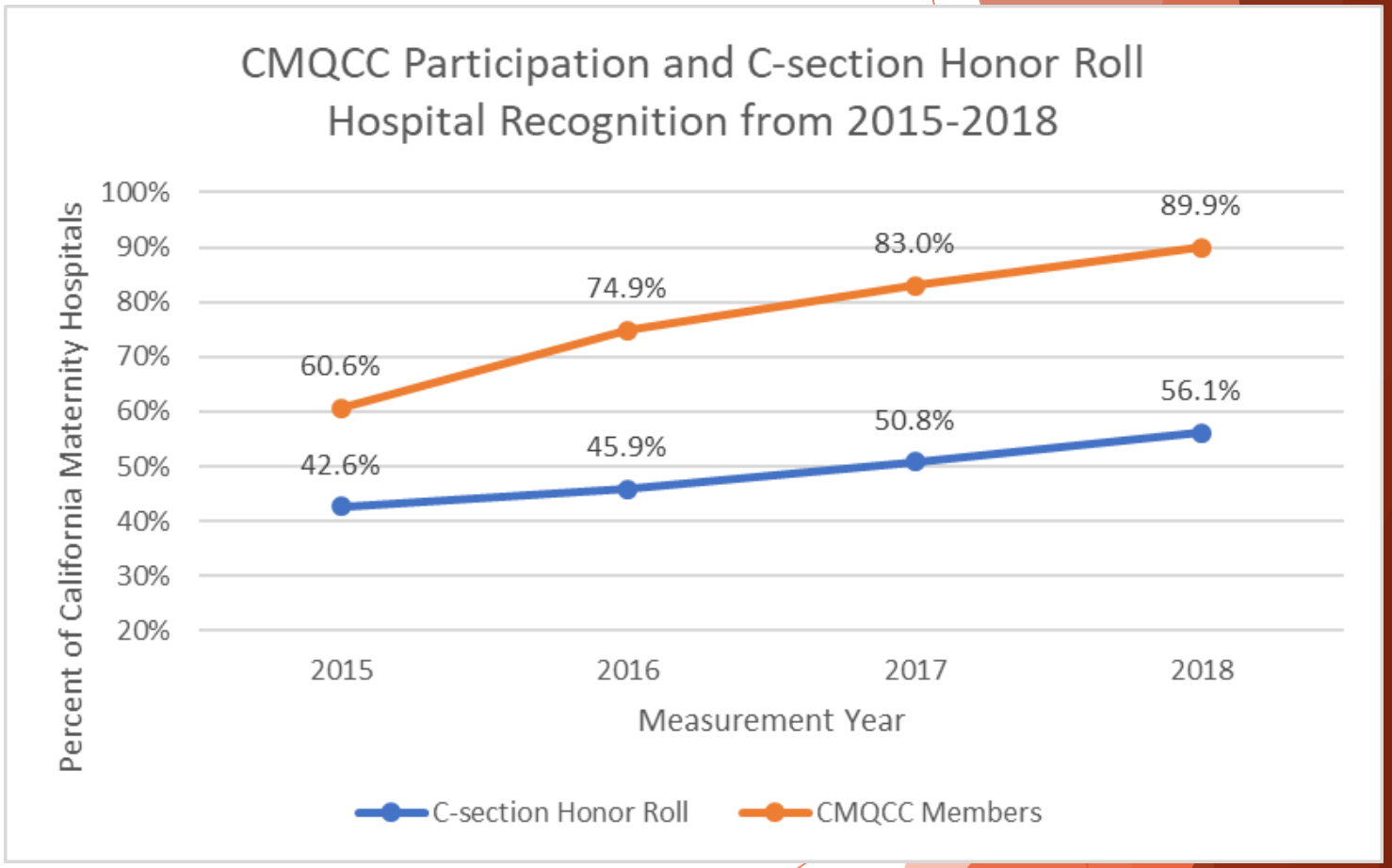
Maternity

Cal Hospital Compare Honor Rolls

Maternity Trends

- Public recognition for California maternity hospitals ≤ Federal Healthy People 2020 **target rate of 23.9%** for C-sections for low-risk, first time births
- 2019 Honor Roll - **133 out of 237 eligible hospitals**

TAC discussion:
- Hold threshold at 23.9%
- Consider layering in c-section rates by race & ethnicity



Approach & Timeline

Sept.

- Preliminary honor roll analysis
- Draft messaging

Oct.

- Finalize honor roll analysis; refresh data wherever possible
- Test messaging
- Notify hospitals & mail certificates

Nov.

- Joint press release &/or media conference call with CA HHS
- Special recognition for hospitals on all 3 honor rolls
- Leverage Partner communications
- Badge on website

California Hospitals with Poor Patient Safety Performance Report

Using Leapfrog Grade Point Averages

Poor Performers Report Timeline

- First Patient Safety Poor Performers list made available to hospitals, health plans and Covered California during Summer 2019
- Next Patient Safety Poor Performers list expected to be released Jan.-Feb. 2020
- TAC charged with improving methodology, specifically addressing the use of Leapfrog information

Reminder of Approach: Honor Roll "Inverse" Method

- Target hospitals must report at least 4 of 6 measures

Algorithm	Poor Performance	
	Benchmark	**Exemption**
	2/3 of measure results <u>below</u> 50th percentile	None

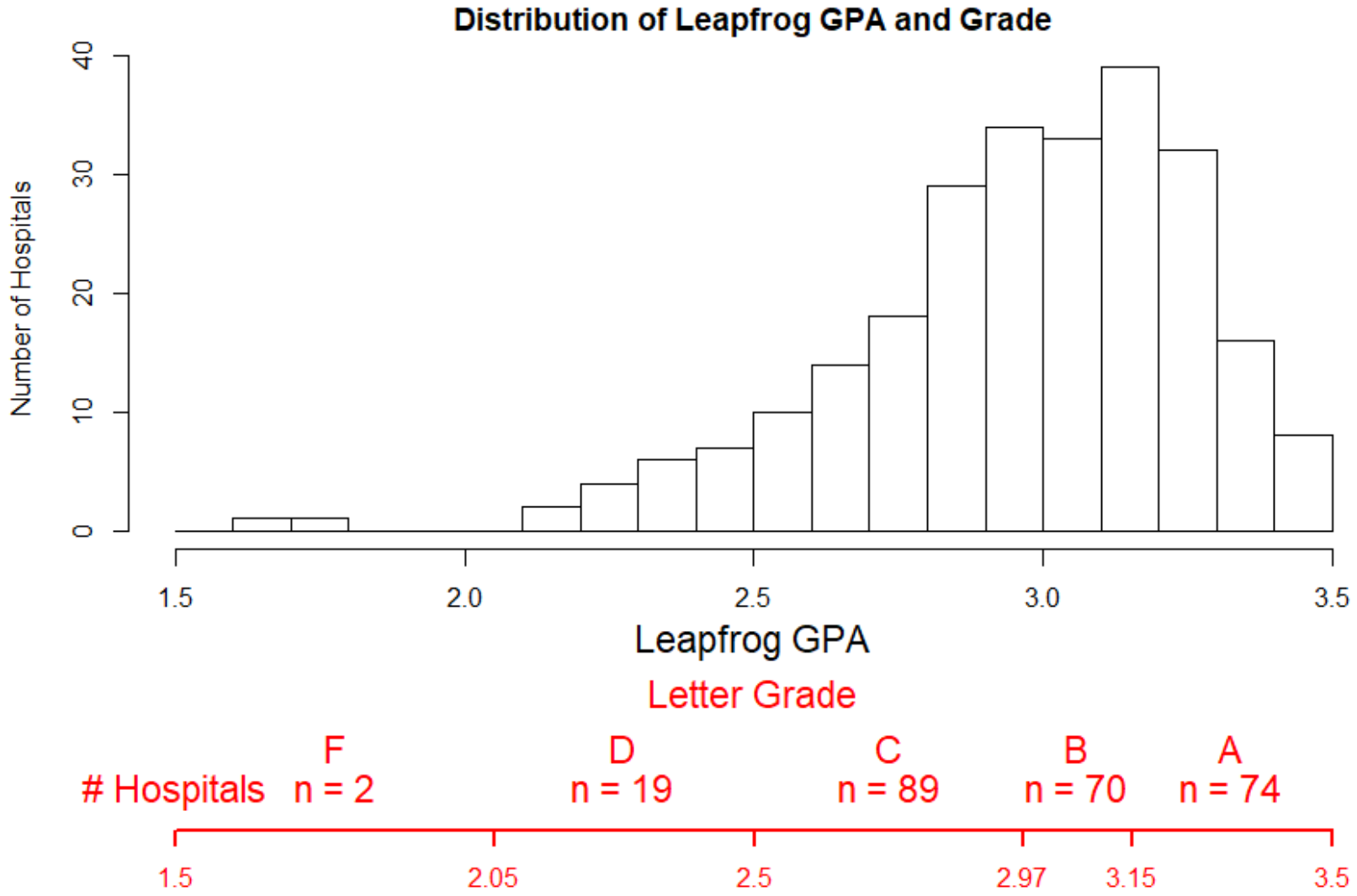
OR

Leapfrog	Poor Performance
	Two D's and an F

Poorly Performing Outliers

- Three ways to identify poor performing hospitals
  1. Algorithm
  2. Leapfrog
  3. Algorithm and Leapfrog
- Results
  - Total Poor Performers = 45
  - Algorithm Only = 40 (17% of the 233 hospitals with four or more measures)
  - Leapfrog Only = 4 (1.6% of the 244 graded hospitals)
  - Both = 1
- Due to the distribution of hospitals scores across letter grades, few hospitals identified from Leapfrog criteria

Leapfrog GPAs and Grades



Leapfrog Poor Performers

- Poorly performing hospitals can be identified by Leapfrog GPA thresholds
- IBM Watson Health modeled the use of the following GPA cutpoints
  - Scenario 1: GPA < 2.5 (i.e., grade D or lower)
  - Scenario 2: GPA < 2.67 (approx. equivalent to a C minus)
  - Scenario 3: GPA < 2.75 (approx. equivalent to a C)
- Algorithmic criteria kept at: 2/3 measures below 50th percentile
- We also created two tiers of poor performers, similar to the high performer honor roll:
  - Tier 1 = Meets algorithmic **and** Leapfrog poor performer criteria
  - Tier 2 = Meets algorithmic **or** Leapfrog poor performer criteria

Leapfrog Poor Performers - Results

Total Cal Hospital Compare Hospitals = 326							
Scenario	Eligible Hospitals		Alg.	LF	Tier 1 (AND)	Tier 2 (OR)	Criteria At least 2/3 of measure results below 50th percentile
	Alg.	LF					
1	302	251	67	21	17	71	Leapfrog Average GPA < 2.5
2	302	251	67	41	24	84	Leapfrog Average GPA < 2.67
3	302	251	67	53	26	94	Leapfrog Average GPA < 2.75

TAC Discussion

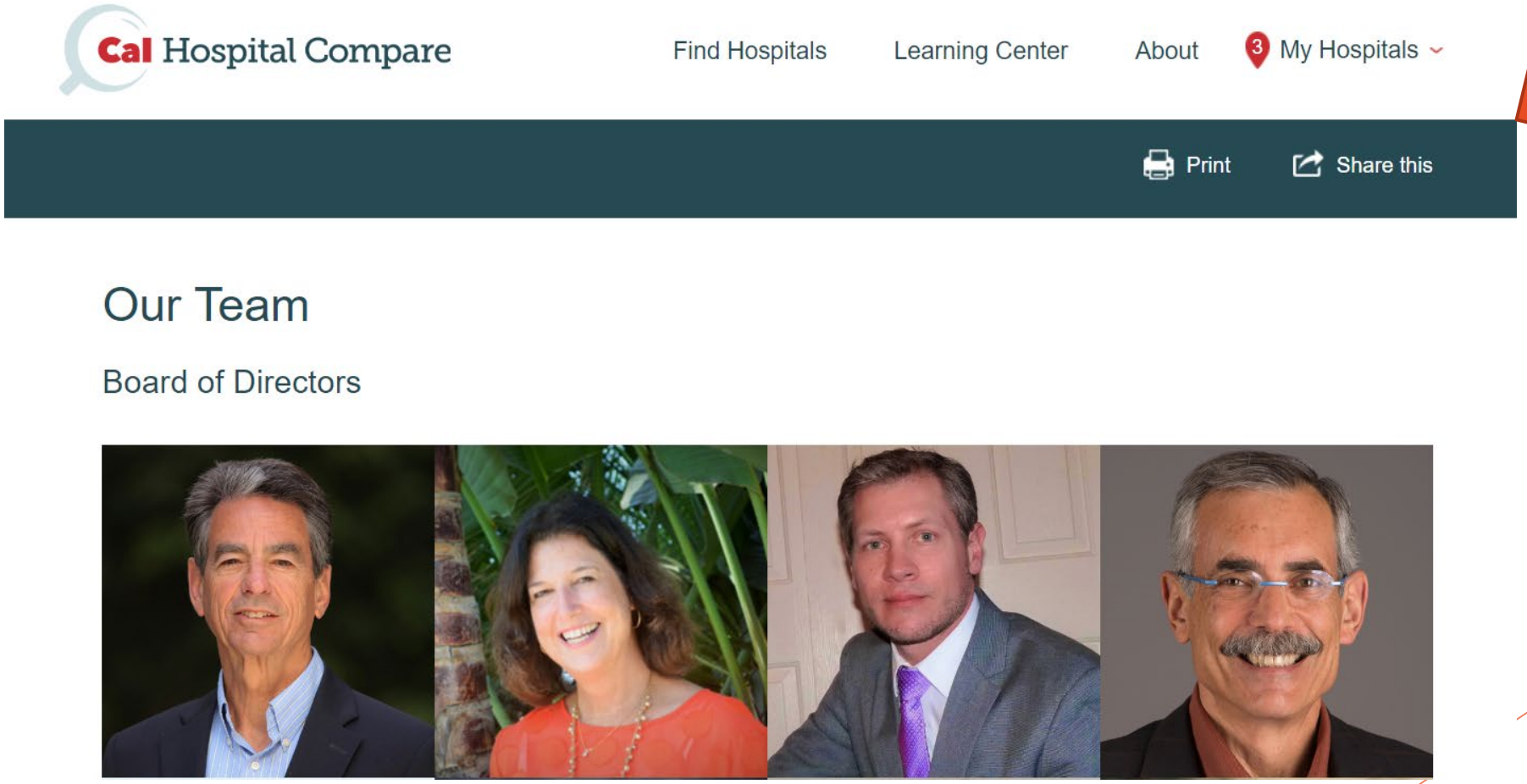
- Continued support for the Poor Patient Safety Performance Report
- Some members expressed support for using two signals to identify poor performing hospitals to support QI (Alg. AND Leapfrog)
- Other members were in support of a more conservative approach to identify poor performing hospitals if QI is not the aim (Algorithmic OR Leapfrog)

Q3 Data Refresh

Data Analytic Updates

Website Updates

If you haven't already, please send your bio & picture to Tracy Fisk



Source: http://calhospitalcompare.org/about/our-team/

2020 Board of Directors Meeting Schedule

- Wednesday, January 23, 2020 – 10:00am to 12:00pm PST (Zoom Call)
- Thursday, March 20, 2020 – 10:00am to 2:00pm PST (Oakland)
- Thursday, May 14, 2020 – 11:00am to 1:00pm PST (Zoom Call)
- Tuesday, July 9, 2020 – 10:00am to 2:00pm PST (Oakland)
- Thursday, September 3, 2020 – 11:00am to 1:00pm PST (Zoom Call)
- Thursday, October 29, 2020 – 10:00am to 2:00pm PST (Oakland)
- Wednesday, December 16, 2020 – 9:00am to 11:00am PST (Zoom call)

Board Meeting Schedule – 2019

**Schedule is in Pacific Time*

- **Wednesday, December 4, 2019 - 10:00am to 2:00pm (In Person - Oakland)**

Thank you!

Cal Hospital Compare

OPIOID SAFE 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. In effort to accelerate improvement and recognize high performance by California hospitals, CHC publishes an annual Patient Safety Honor Roll and Low-Risk C-section Honor Roll.

To address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths, this fall CHC will designate select hospitals as *Opioid Safe* for the purpose of supporting continued quality improvement and recognizing hospitals for their contributions fighting the epidemic. CHC along with other partners will publicly recognize hospitals designated as *Opioid Safe*. To measure opioid safety CHC received funding from California Health Care Foundation (CHCF) to collaboratively design the *Opioid Safe Hospital Self-Assessment*. This self- assessment measures *opioid safety* across 4 domains:

1. Preventing new opioid starts
2. Identifying and managing patients with Opioid Use Disorder
3. Preventing harm in high-risk patients
4. Applying cross-cutting organizational strategies

Instructions: For each measure please read through the measure description then select the level that best describes your hospital's work in that area. Please note that the levels build on each other, meaning a hospital must have implemented Levels 3 and 2 to achieve Level 1. CHC recommends each hospital convene a multi-stakeholder team to complete the *Opioid Safe 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.

Time permitting, please share how your hospital measures opioid safe activities, current performance targets (if any), and any helpful tactical tools that you have come across and/or developed. Sharing this information is entirely optional and will not be used to assess opioid safety in 2019. As hospitals progress year over year, CHC will introduce quantitative performance measures and aim to align future iterations of this self-assessment tool with work hospitals are already doing. In addition, CHC is committed to providing resources to support continued progress to all hospitals participating in the Opioid Safe Hospital Program.

Submit responses and any supporting documents via e-survey at calhospitalcompare.org
Assessment period: May 13 – Sept 18, 2019

Questions? Contact Alex Stack, Director, Programs & Strategic Initiatives via email at astack@cynosurehealth.og

Prevent new opioid starts					
Measure	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool and resource)*
Discharge Prescribing Guidelines Develop and implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new starts on long-term opioid treatment (with exceptions for palliative care). Service lines may include ED, Medical IP, General Surgery, and/or OB. Service line specific prescribing guidelines must address the following: • Opioid use history (e.g. naïve versus tolerant) • Pain history • Current medications • Daily dosage/MME • Use of extended-release or long-acting opioids • Benzo and opioid co-prescribing Guidelines are adhered to most of the time.	Your hospital has developed and implemented evidence-based discharge prescribing guidelines in **1 service line** (e.g. ED, Medical IP, General Surgery, or OB, etc.)	Your hospital has developed and implemented discharge prescribing guidelines in **2 service lines** (e.g. ED, Medical IP, General Surgery, and/or OB, etc.)	Your hospital has developed and implemented evidence-based discharge prescribing guidelines for at least **3 service lines including ED and General Surgery** (e.g. Medical IP, and/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) Alternatives to Opioids Program (St. Joseph's Regional Medical Center) Non-Opioid Treatment (American Society of Anesthesiologist)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				

Alternatives to Opioids for Pain Management Use evidence based, multi-modal, non-opioid approach to analgesia for pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation. Components of a multi-modal, non-opioid analgesic program must address the following: • Program goal is to utilize non-opioid approaches as first line therapy for pain while recognizing it is not the solution to all pain • Opioid use history (e.g. naïve versus tolerant) • Patient engagement (e.g. discuss realistic pain management goals and addiction potential • Pharmacologic alternatives (e.g. NSAIDs, Tylenol, Toradol, Lidocaine patches, muscle relaxant medication, Ketamine, medications for neuropathic pain, nerve blocks, etc.) • Non-pharmacologic alternatives (e.g. virtual reality pain management, acupuncture, chiropractic medicine, guided relaxation, music therapy, etc.)	Developed and implemented a non-opioid analgesic, multi-modal pain management program in the **ED** Medications to support administering opioid alternatives **on hospital formulary** and available in unit	Developed and implemented a non-opioid analgesic multi-modal pain management program by **specialty or procedure** (e.g. cardiac care, ortho, rehab, OB, etc.) Developed **supportive pathways** for care teams to incorporate opioid alternatives e.g. integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, etc.	**Aligned standard order** sets with non-opioid analgesic, multi-modal pain management program **Extra credit (+1 pt.):** Hospital offers >2 non-pharmacologic alternatives		Stem the Tide: Addressing the Opioid Epidemic (AHA) Doctors Are Changing San Diego's Opioid Prescribing Practices (CHCF) No Shortcuts to Safer Opioid Prescribing (NEJMP); article available upon request
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				

Identification and Treatment					
Measure	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool and resource)*
Medicated Assisted Treatment (MAT) Provide MAT initiation and/or continuation in the ED and IP setting Components of a MAT program must include: • Identifying patients eligible for MAT and on MAT • How to address complicating factors • Symptom management • Set re-evaluation time intervals • MAT in the ED (DEA 72 hours rule means patients may return to the ED for up to 3 days)	Methadone and buprenorphine on hospital **formulary**	MAT is prescribed/ continued in at **least 1 service line** (e.g. ED, Medical IP, General Surgery, or OB, etc.); methadone and buprenorphine available in unit	MAT is prescribed/ continued in at least **2 service lines** (e.g. ED, Medical IP, General Surgery, or OB, etc.). At least 5 patients have been administered/ continued MAT with in the last 6 months across the 2 services lines		Buprenorphine Guide (ED BRIDGE) Complete Guide: Inpatient Management of Opioid Use Disorder: Buprenorphine (Project SHOUT) Complete Guide: Inpatient Management of Opioid Use Disorder: Methadone (Project SHOUT) Quick Guide: Acute Pain and Perioperative Management in Opioid Use Disorder (Project SHOUT) Buprenorphine Waiver Management (SAMHSA) How to Pay for It: MAT in the ED (CHCF)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				
Buprenorphine Waiver Hospital based practitioners are waivered to prescribe or dispense buprenorphine at discharge under the Drug Addiction Treatment Act of 2000 (DATA 2000). Hospital provides support and/or infrastructure to providers* to complete waiver; includes a mix of financial and non-financial incentives (e.g. application management, protected time, financial support/reimbursed for time and/or training, contract alignment, etc.) *Provider = MDs and/or physician extender	Hospital provides support to providers* **in the ED** to complete buprenorphine waiver	Hospital provides support to providers* **in the ED and IP units** to obtain buprenorphine waiver Hospital has **at least one waivered provider*** in one service line providing MAT	Hospital has **at least one waivered provider* in two service lines providing MAT** **Extra credit (+1 pt.):** Support extends to Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives		
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				

Overdose prevention					
Measure	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool and resource)*
Naloxone education and distribution program Provide naloxone prescriptions and education to all patients, families, caregivers and friends discharged with a long-term opioid prescription and/or at risk of overdose	**Naloxone stocked** in outpatient pharmacy Developed hospital wide order sets and protocols for naloxone distribution	**Standing order and/or standard work** for MDs and physician extenders in place for 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. hospital outpatient pharmacy, community based preferred pharmacy, etc.)	**Staff trained to educate** patients, families, caregivers and friends on naloxone use **Extra credit (+1 pt.):** Naloxone kits distributed at discharge		Overdose Prevention and Take-Home Naloxone Projects (Harm Reduction Coalition) Naloxone Kit Materials (Harm Reduction Coalition)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				

Cross Cutting Opioid Safe Hospital Best Practices					
Measure	**Level 3 (1 pt.)** *Safe*	**Level 2 (2 pts)** *Safer*	**Level 1 (3 pts)** *Safest*	**Score**	**Example** *(comparative tool and resource)*
Organizational Infrastructure Opioid safety is a strategic priority with multi-stakeholder buy in and programmatic support to drive continued/sustained improvements in opioid safety (e.g. executive leadership, pharmacy, ED, IP units, etc.)	**Multi-stakeholder team** identified opioid safety as a strategic priority and set improvement goals in one or more of the following areas: prevent new opioid starts, identification and treatment, overdose prevention, cross cutting opioid safe best practices. **Executive sponsor/project champion identified**	**Communicated program, purpose, goal, progress to goal to all staff** (e.g. a dashboard, all staff meeting, annual competencies, etc.) Aligned QI initiatives with opioid safety initiatives	**Hospital Board plays an active role** in reviewing data, advising and/or designing initiatives to address gaps Celebrate successes! **Extra credit (+1 pt.):** Hospital is part of a learning network to improve opioid safety		Stem the Tide: Addressing the Opioid Epidemic (AHA)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				
Provider/staff engagement Education and promotion of the medical model of addiction across all departments to facilitate disease recognition and stigma reduction	Provides passive, **general education** on hospital opioid prescribing guidelines, identification, and treatment, and overdose prevention to all providers and staff (e.g. M&M, lunch and learns, push resources, CME requirements, RN competencies, etc.) Provides **targeted follow up and support to providers and staff based on performance**	Provides **training on the medical model of addiction** to normalize opioid use disorder Implemented a **staff education program** to actively reduce dual benzo and opioid prescriptions	Provides **stigma reduction** training		Selection of relevant web-based trainings (Harm Reduction Coalition) Clinical Opioid Withdrawal Score (Project SHOUT)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				

Patient engagement **Actively engage** patients, families, and friends in opioid safe practices (opioid prescribing, treatment, and overdose prevention via Naloxone)	Provides general education to **all patients, families and friends** regarding opioid risk, alternatives, and overdose prevention (e.g. posters about preventing or responding to an overdose, brochures/fact sheets on opioid risk and alternative pain management strategies, general information on hospital care strategies on website or portal, etc.)	Provides **focused education** to opioid naïve and opioid tolerant patients (e.g. MAT options, opioid risk and alternatives, Naloxone use, etc.) through verbal communication/conversations with care providers Patients are part of a shared decision-making process for acute and/or chronic pain management (e.g. develop a pain management plan pre-surgery)	Provides opportunities for **patients and families to engage** in hospital wide opioid safety activities (PFAC, peer navigator, program design, etc.) **Extra credit (+1 pt.):** Outreach to the community and active engagement with local opiate coalition		Buprenorphine-Naloxone: What You Need to Know - Flyer (Project SHOUT) Know your options for successful treatment - Flyer (Project SHOUT) Advancing the Safety of Acute Pain Management (IHI) Safe and Effective Pain Control After Surgery (ACS)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				
Discharge to Community Develop formal connections via MOU with outpatient facilities and drug treatment programs who can receive referrals and provide follow up care for MAT and patients prescribed Naloxone	Provides list of **community-based resources** to patients, family, caregivers, and friends	Developed **formal connections** via MOU with **outpatient facilities and drug treatment programs** able to take MAT and OUD referrals from hospital	**Actively connect** MAT and OUD patients with outpatient facilities and drug treatment programs for follow up care Integrated approach with care management, social work, pharmacy, etc. **Extra credit (+1 pt.):** Substance Use Navigators/ Peer screeners evaluate patients with opioid addiction in the ED in effort to enroll them into a drug treatment program immediately following ED discharge		Stem the Tide: Addressing the Opioid Epidemic (AHA)
	Measurement feedback (optional): How do you measure this? What measures do you use? Performance target?				
				TOTAL SCORE	