Cal Hospital Compare
Board of Directors Meeting Agenda
Wednesday, June 5, 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
10:00-10:10 *10 min.*	Welcome and call to order - Approval of past meeting summary	Ken Stuart, Board Chair
10:10-10:30 *20 min.*	Organizational updates - Welcome Thai Lee, Covered California - Covered CA report on poor performers o Letter to QHPs o Hospital notification *in progress* o Report overlap	Bruce Spurlock, Executive Director Ken Stuart, Board Chair
10:30–11:30 *60 min.*	TAC analytic updates - Patient Safety Honor Roll o Current state o Version 2.0 - ED as a performance category - General updates o CMS data refresh o Maternity measures	Mahil Senathirajah, IBM Watson Health Frank Yoon, IBM Watson Health Alex Stack, Director
11:30-11:40 *10 min.*	Opioid Safe Hospital Designation - Update & next steps	Alex Stack, Director
11:40-11:50 *10 min.*	Business plan – Financial report	Bruce Spurlock, Executive Director
11:50-12:00 *10 min.*	Wrap-up Adjourn – Wednesday, August 7, 2019 – 10:00am to 2:00pm **(In Person - Oakland)**	Bruce Spurlock, Executive Director Ken Stuart, Board Chair

Cal Hospital Compare

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

Attendees: Bruce Spurlock, Alex Stack, Tracy Fisk, Libby Hoy, Chris Krawczyk, Lance Lang, Helen Macfie, Mahil Senathirajah, Kristof Stremikis, Ken Stuart, Kevin Worth

Guests: Aimee Moulin, BRIDGE

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting commenced at 10:04am Pacific Time. The meeting attendees formally introduced themselves. • The Cal Hospital Compare Board meeting summary of February 13, 2018 was motioned and approved.
Organizational Updates	• Celia Ryan, passed away in December 2018 and Kevin Worth is now representing Kaiser as a board member. • Julie Morath is stepping down from the board and has resigned from her position with HQI. Patty Atkins is replacing Julie on the CHC board. CHC is currently looking to add a second hospital representative to replace Julie Morath. HQI is continuing with CHIPSO, data analytics; most of the work in the improvement space is no longer housed within HQI. Helen Macfie will continue to monitor CHC's role over the next 3-6 months. • Libby Hoy shared updates for PFE with HQI and HSAG • Ken Stuart and Chris Krawczyk provided an overview of the Healthcare Payment Data Review Committee: o State or federal dollars for an all payers claims database is spearheaded by OSHPD. A multi-stakeholder committee is being created. The NAVO consulting group is supporting the initiatives. The APCD Council is establishing a common layout for the collection of APCD data. The first deliverable is a report due back to the legislature in June 2020. A standard data set for all plans are in development by the US Department of Labor, including self-funded plans. The review committee will meet monthly and provide recommendations to OSHPD. o All meetings and information will be made publicly available on the OSHPD website. Board members are welcome to attend the meetings. OSHPD is currently in discussions with Medi-Cal regarding receiving their claims data. o Kristof Stremikis commented that this is an amazing opportunity for the state. He questioned if the data can potentially be linked with CHC to compliment quality with cost data and encouraged the board. Kristof recommended that board members submit a use case. • Anthem Update o Mark Reynolds and David Pryor reviewed CHC's data and concluded that the vast majority of measures do not have great discrimination. After further analysis, Anthem made the decision not to fund CHC in 2019 but explained that there is a strong possibility that participation will resume in 2020. A formal memo was created

	and distributed to the board. Bruce commented that CHC can sustain through 2019, particularly with the support of data use fees and/or the Covered CA poor performers report. o Lance Lange questioned what the best approach is moving forward in determining the foundation for scoring measures. IBM Watson provided some analysis on this - when hospitals do not submit all the data impacts "scoring/tiering" – either no rating or only give 3 categories, time-based measures could potentially add depth to the scoring (need standard deviation info). Bruce discussed alternative ways CHC can develop thresholds to differentiate the data. Bruce's opinion is that the most logical venue to generate equity is through the CA health plans. • Report on Patient Safety Poor Performers o Alex Stack reviewed the poor performer report which with a combination of signals/methodology, identified 44 poor performing hospitals. The report is confidential and should not be distributed. o Hospitals will need to be contacted that they are listed on the report. Bruce will notify the board when the hospitals have been contacted. Health plans and others will be required to pay a fee to access the report. o The report was formally motioned, seconded and approved by the board.
Opioid Safe Hospital Designation	• Alex Stack introduced Aimee Moulin who provided an overview on the Opioid Safe Hospital Designation program. Alex Stack reviewed the draft opioid safe hospital assessment and explained the methodology behind its design. Feedback was gathered from the Opioid Workgroup, TAC and stakeholders to help develop this tool. Alex also reviewed the proposed scoring options. • The board formally motioned, seconded and approved to formally adopt and utilize the opioid safe hospital assessment tool • CHC will host a five part no cost opioid safe hospital webinar education n series starting May 9th. The webinars are designed for Chief Medical Officers, Chief Nursing Officers, Chief Quality Officers, Quality and Emergency Department leadership, and other individuals involved in improving opioid safety.
TAC Analytic Updates	• Per the board's recommendation, additional members have been added to the TAC to include Patty Atkins, John Bott, Carolyn Brown, Gayle Sandhu and Paul Young.
General Updates	• CHC is exploring whether to include ED measures as a performance category to further differentiate individual hospital ratings • The CMS data was released February 28, 2019 and the CHC website will be refreshed in April.
Patient Safety Honor Roll	• PSHR version 2.0 is expected to be released in late 2019. • Mahil Senathirajah reviewed the four possible approaches including adding measures, fixed performance thresholds, using multiple years of data, and creating a composite measure • Kevin Worth emphasized that effective patient communication correlates with HCAHPS and safety. • Bruce discussed the current ongoing challenges being that there is no agreed upon national definition or data set for patient safety and there is missing national data "hard targets "with absolute level of performance identifying a "safe hospital". What is the best way to move forward, what process makes the most sense and is voting an option to find a consensus? The board recommended seeking feedback from the TAC.

Business Plan	• Bruce reviewed the current financial report and annual budget for 2019.
Next Meeting/Meeting Adjournment	• The next CHC Board Meeting will be held on June 5, 2019 from 10:00am-12:00pm PT via Zoom webinar • The meeting formally adjourned at 1:34pm Pacific Time

Cal Hospital Compare

Board of Directors

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Cal Hospital Compare Board of Directors

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Proposed Agenda

- Welcome & call to order
- Organizational updates
- TAC analytic updates
- Opioid Safe Hospital Designation
- Business plan
- Wrap Up

Organizational Updates

Welcome!

- Thai Lee, Senior Quality Specialist, Covered California

Covered CA report on poor performers

- Letter to QHPs
- Hospital notification *in progress*
- Report overlap

Report Overlap: PSHR 1.0 & Poor Performer

Hospital	PSHR 1.0 *Two-thirds above the 50th percentile & none below the 25th percentile*	Poor Performer *Two-thirds below 50th percentile & none above the 75th percentile*

Adventist Health Glendale	• Achieved via LF score; did not meet the algorithmic criteria
	• 2 measures < 25th percentile
	  • HAI5 (MRSA)
	  • PSI90
		• Met the algorithmic criteria

UCSF Moffit/Long Beach	• Achieved via LF score; did not meet the algorithmic criteria
	• 2 measures < 25th percentile
	  • HAI3 (SSI: Colon)
	  • HAI6 (C. diff)
		• Met the algorithmic criteria
		• Payment Reduction Determined by CMS HAC Reduction Program
		• CDPH 2017 HAI Trend

BOD Discussion

- Leave hospitals on both reports?
- Remove hospitals from the PSHR and leave on the Poor Performer report?
- As a general rule, Inclusion on the Poor Performer Report excludes a hospital from the PSHR?
- Remove hospitals from both reports?

TAC Analytic Updates

PSHR Current State

Version 1.0
(HAI & PSI90)

- Secretary announcement in progress

Version 2.0

- Expand eligible hospitals
- Identify relevant measures & process
- Consider fixed threshold – *on hold*

Previous Guidance

Enhance methods to promote transparency and maximize eligible hospitals	• Treat hospitals equally • Do not impute missing data
Improve methods so all hospitals can achieve honor roll status over time	• Expanding hospital eligibility • Supporting achievement • TAC reviewed possible approaches
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
(for discussion)

Summary of TAC Discussion To Date

- **Adding Measures:** Project Team modeled the impact of adding measures to the composite: HCAHPS, Sepsis Measure and use of PSI component measures
  - Total of 15 scenarios evaluated
  - Analysis showed that addition of the measures achieved the goal of expanding the number of eligible hospitals: from 233 to 303
- **Fixed Performance Thresholds:** Project Team also modeled the establishment of fixed performance thresholds based on prior year data and their application to current year data
  - Approach succeeded in enabling more hospitals to achieve PSHR status over time as performance improves
- However, TAC members raised concerns about the addition of specific measures and their connection to patient safety (e.g., HCAHPS patient experience measure re: Nurse Communication)

…Summary of TAC Discussion To Date

- In response, at the May 29 TAC meeting, Project Team presented options to revise the methodology so that PSHR is based on either:
  1. a composite measure
  2. a revised algorithmic approach
- **Rationale:** both options provide TAC/Board with opportunity to weight measures potentially allaying TAC members' concerns
  - For example, the HCAHPS Nurse Communication measure could be down-weighted

Outcome of TAC Meeting

- TAC had a rich discussion of the pros/cons/implications of the approaches
  - Inclusion of structural measures
  - Need to expand number of hospitals eligible for PSHR
- However, TAC did not come to a conclusion re: either of the two options

TAC Discussion Reflects Ongoing Challenges in Patient Safety Field

- 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?

Board Guidance

- For discussion
  1. How important is it to expand number of eligible hospitals?
     - Accomplished through addition of measures
  2. How important is it to broaden the definition of patient safety?
     - Also implies addition of measures
  3. How important is it to allow all hospitals to achieve PSHR status over time?
  4. Should CHC embark on development of a more complex methodology: composite measure, alternative algorithmic approach?
     - Will the opportunity to weight domains/measures address concerns regarding the inclusion/exclusion of specific measures?

ED Wait Time Measures

ED Wait Time Measures – Performance Categorization

- Currently, CHC does not assign performance categories to ED Wait Time measures because they are measured in minutes
  - *ED1* – Average Time patients spent in the emergency department before they were admitted to the hospital
  - *OP18* – Average time patients spent in the emergency department before being sent home
  - *OP20* – Average time patients spent in the emergency department before they were seen by a health professional
  - *OP21* – Average time patients spent in the emergency department with broken bones before getting pain medication
- IBM Watson Health's statistician reviewed the data available to determine if there is a reasonable way to assign performance categories consistent with the rigorous statistical approach used for other measures
  - That approach incorporates the statistical uncertainty in measure rates

…ED Wait Time Measure – Performance Categorization

- **Conclusion:** ED Wait Time measures cannot be scored since required measure information (specifically, hospital-level standard deviation) is not available.
- As an alternative, ED Wait Time measures could be scored without consideration of statistical uncertainty in rate by directly applying thresholds:
  - Poor: Above 90th percentile
  - Below Average: Between 75th and 90th percentile
  - Average: Between 25th and 75th percentile
  - Above Average: Between 25th and 10th percentile
  - Superior: Below the 10th percentile

…ED Wait Time Measure – Performance Categorization

- Pros:
  - Enables performance categorization for ED wait time measures
- Cons
  - Scoring approach ignores statistical uncertainty
  - Incorporating statistical uncertainty in performance categorization is an essential feature of Cal Hospital Compare's proprietary methodology; the alternative approach is statistically inconsistent with it
- TAC reviewed issue but did not have a strong, collective opinion
- **Question for Board:** Does Board support scoring of measures by direct comparison to thresholds?

General Updates

CMS Data

- Q2 data update complete
- No new measures added

Maternity Data

- Annual data refresh scheduled for June, 2019 using CMQCC's active track data for CY2018
- New measure: Percent Deliveries by Certified Nurse Midwives

Opioid Safe Hospital Designation

DESIGNATING OPIOID SAFE HOSPITALS

Cal Hospital Compare

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. 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

The self-assessment period starts May 13, 2019 and closes September 18, 2019.

To learn more about the *Opioid Safe Hospital Designation program* please join us for a one-hour free kick-off webinar on May 9 at 11:00 am PST. This webinar is designed for Chief Medical Officers, Chief Nursing Officers, Chief Quality Officers, Quality and Emergency Department leadership, and other individuals involved in improving opioid safety. **At the end of the webinar, participants will have:**

- Considered the value of participating in the *Opioid Safe Hospital* program
- Examined four domains of opioid safety as measured by the *Opioid Safe Hospital Self-Assessment* and exchanged strategies for evaluating your hospital's performance
- Described how to leverage *the Opioid Safe Hospital Self-Assessment* to enhance the vital work your hospital is already doing to reduce opioid related deaths
- Heard from peer hospitals the steps they have taken to implement opioid safe strategies as outlined in the *Opioid Safe Hospital Self-Assessment*
- Communicated how CHC can support hospital progress through a 4-part monthly webinar series starting June 2019

Register online HERE for the upcoming May 9th kick-off webinar,

***Addressing California's Opioid Epidemic – Introducing the Opioid Safe Hospital Program*, & subsequent no cost 4-part *Opioid Safe Hospital* Webinar Series**

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

Program Launch

Webinar Series

- Kickoff webinar May 9th
- Specific technical assistance Jun – Sept
- CMEs available

Resources

- Relevant resources available on Cal Hospital Compare & mapped to self-assessment tool

Self-Assessment

- Survey window May 13 – Sept 18, 2019
- Submit responses via e-survey
- Spot “audits”

Program Trajectory

Coordinate announcements with Honor Rolls

Funding for 3 years

Transition to Substance Use Disorder in 2020

Capture/spread successes & lessons learned

Scale support nationally

Resources & Follow Up Materials

Resources:

About the Opioid Safe Hospital Designation

Frequently Asked Questions

Opioid Safe Hospital Self Assessment

To further accelerate hospital progress, CHC will offer a no cost, 5-part webinar series, with peer-to-peer support, starting May 2019 with the kick-off webinar. The webinar series is designed for Chief Medical Officers, Chief Nursing Officers, Chief Quality Officers, Quality and Emergency Department leadership, and other individuals involved in improving opioid safety. CHC will actively work with Opioid Safe Hospital Program participants to select relevant topics for the webinar series. Registration links below (*please note all webinars are scheduled for 11am PST*):

Webinar #1 (May 9): Addressing California's Opioid Epidemic – Introducing the Opioid Safe Hospital Program

Webinar #1 Recording

Webinar #1 Slide Presentation

Source: *Cal Hospital Compare Website – About – Opioid Safe Hospital Designation*

TAC Next Steps

- Encourage your hospitals and peers to apply
- Develop relevant threshold
- Announce Opioid Safe Hospitals Fall 2019

Business Plan

Board Meeting Schedule – 2019

**Schedule is in Pacific Time*

- **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)

Appendix: PSHR Methodologies

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*

Typical Steps in Developing a Composite

In considering right approach to PSHR 2.0, review of key steps in typical composite development might be useful

- TAC Question: Which of these steps should we adopt, maximizing PSHR value within project resources?

1. Identify and review available measures
2. Select measures
    - Typical Considerations: clinical importance/impact, availability, performance gaps, external target, risk adjustment, harmonization, evidence-base, reliability, validity, feasibility, usability
3. Optional: Assign measures to domains
    - Example domains: HAIs, PSIs, HCAHPS

…Typical Steps in Developing a Composite

4. Standardize measure scores (e.g., z-scores)
5. Weight domains and/or measures

   Options include:

   1. Policy-based (consensus of CHC TAC and Board)
      - Consider same type of factors as for measure selection
   2. Reliability weighted
      - Determined by empirical characteristics of component measures, e.g., their correlations, reliability
   3. Opportunity weighted
      - Weighted by size of denominator populations
   4. Equal weighting

…Typical Steps in Developing a Composite

6. Establish standards and adjustments for missing data
   - Minimum denominator sizes
   - Re-distribute weights
7. Calculate single hospital-wide composite score
8. Establish threshold for PSHR qualification
   - Based on composite score
   - Necessary to consider relative scoring thresholds (e.g., 75th percentile and above of composite score)
9. Compare hospital composite score to threshold to determine PSHR status
10. Option: establish fixed performance threshold to apply to future years

Illustrative Example of Key Composite Step – Domain Weighting

- Previous work identified four domains
- Questions:
  - Does TAC wish to identify and weight domains or, alternatively, move directly to simply weighting individual measures?
  - Are there other domains to be considered?
  - What information would TAC need to support domain policy weighting decisions?

	Domain	Number of Measures	Policy Weight Assigned by TAC - Example
1	HAI	5	40%
2	PSI	10	35%
3	HCAHPS	5	20%
4	SEP-1	1	5%
		Total	**100%**

…Illustrative Example of Key Composite Step – Measure Weighting

- For policy weighting, consider the following measure attributes: clinical importance/impact, availability, performance gaps, external target, risk adjustment, harmonization, evidence-base
- Illustrative example using HAIs on next slide
- For clinical importance/impact and evidence-base, IBM Watson Health would obtain information from NQF reports and conduct a mini-literature review to bring to TAC
  - For example, Archives of Surgery article shows trauma patients with HAIs had mortality odds ratio 1.5 to 1.9 times higher than control
  - IBM Watson Health analysis showed excess LOS and higher costs for admissions with CAUTI

…Illustrative Example of Key Composite Steps – Measure Weighting

Measure	Impact - Total California Infections	Availability - # Reporting Hospitals	Performance Gap				External Target - National Target SIR by 2020*	Risk Adjusted?	Harmonization - Used by Leapfrog?	Harmonization - NQF Endorsed?	TAC Decision to Include?	TAC Assigned Policy Weight
			P25	P50	P75	Percent Of Hospitals with Rate < 1.0						
CLABSI	1,331	225	0.41	0.71	1.10	70%	0.50	Yes	Yes	Yes	Yes	30%
CAUTI	2,037	248	0.46	0.85	1.39	60%	0.75	Yes	Yes	Yes	Yes	10%
Colon: SSI	667	190	0.26	0.80	1.36	59%	0.70	Yes	Yes	Yes	No	N/A
MRSA	620	182	0.40	0.75	1.20	65%	0.5	Yes	Yes	Yes	Yes	40%
C. Diff.	6,724	285	0.54	0.74	0.98	78%	0.7	Yes	Yes	Yes	Yes	20%

* from HHS Office of Disease Prevention and Health Promotion

Alternative Algorithmic Approach

- Simplified alternative to full composite measure development
- Maintain approach of assessing performance of each measure against target
  - E.g., measure rate must be better than 50th percentile of CalHospitalCompare hospitals
- TAC assigns points to measures to reflect their policy weights
- Establish minimum measure criteria
  - E.g., hospital must have available rates for measures that account for 50% or more of total possible points
- Establish minimum point threshold for PSHR qualification
  - E.g., hospital must achieve at least 75% of available points
  - Necessary to consider relative scoring thresholds
- Table on following slide illustrates approach

Example of Alternative Algorithmic Calculation

Example for Hospital XX

Measure	Threshold Criteria	Threshold (SIR)	Hospital Rate (SIR)	Did Hospital Pass Threshold ?	Measure Points (Assigned by TAC)	Points Achieved by Hospital	
CLABSI	Better than 50th percentile	1.00	0.99	Yes	10	10	
CAUTI	Better than 50th percentile	0.80	0.70	Yes	15	15	
Colon: SSI	Better than 50th percentile	0.90	1.00	No	5	0	
MRSA	Better than 50th percentile	1.10	1.00	Yes	5	5	
C. Diff.	Better than 50th percentile	0.80	N/A	N/A	15	N/A	
	Total Available Points (based on available hospital measures) =					35	A
	Total Possible Points (All Measures)					50	B
	Percent Available Points of Total Possible					70%	=A/B
	Does Hospital Meet Minimum Measure Criteria (rates available for more than 50% of Total Possible Points)					**Yes**	
	Total Points Achieved by Hospital =					30	C
	Percent Points Achieved of Available					86%	=C/A
	Min. Percent of Available Points Required to Qualify for PSHR =					75%	
	Does hospital qualify for Honor Roll?					**Yes**	