Cal Hospital Compare
Board of Directors Meeting Agenda
Thursday, October 29, 2020
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 - Welcome new members	- **Ken Stuart** Board Chair - **Bruce Spurlock** Executive Director, CHC
10:05-10:15 *10 min.*	Organizational updates - Q3 website data refresh complete - CMS Hospital Compare reporting update - Honor roll reporting timeline	- **Alex Stack** Director, CHC - **Mahil Senathirajah** IBM Watson Health
10:15 – 10:45 *30 min.*	Patient Activation Proposal - How to engage patients where they are? - Proposed approaches - Next steps	- **Alex Stack** Director, CHC - **Andy Krackov** Hillcrest Advisory
10:45 – 11:15 *30 min.*	Opioid Care Honor Roll - Review Results - Determine relevant threshold - Communications timeline - Next steps	- **Alex Stack** Director, CHC
11:15 -11:35 *20 min.*	Long Term Care Grant - Review results - Next steps	- **Mahil Senathirajah** IBM Watson Health
11:35-11:55 *20 min.*	Business plan – 2021 Data Use Fees – Financial report	- **Bruce Spurlock** Executive Director, CHC
11:55-12:00 *5 min.*	Wrap-up Adjourn – Next meeting: Wednesday December 16, 9:00am - 11:00am PST (Zoom Call)	- **Ken Stuart** Board Chair

Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Summary
Thursday, July 9, 2020
10:00am – 12:00pm PT via Zoom Webinar

Attendees: Ashrith Amarnath, Seth Glickman, David Hopkins, Libby Hoy, Robert Imhoff, Parker Lewis, Julia Logan, Joan Maxwell, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Kristof Stremikis, Ken Stuart, Kevin Worth, Frank Yoon, Tracy Fisk

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting formally commenced at 10:01am Pacific Time. The meeting minutes for April 1, 2020 was motioned, seconded, and approved as submitted. • The board members formally introduced themselves.
Board Representation	• The Board welcomed new members Dr. Ashrith Amarnath, Dr. Seth Glickman and Dr. Julia Logan. Parker Lewis with IBM Watson Health has also joined as a contributor.
Healthcare Payments Data Review Program	• Ken Stuart participated in the review committee. The report successfully passed through legislation – timeline for the implementation of the claim database is 2023.
Updates	• Mahil reviewed the details for the recently awarded CHCF grant examining factors and disparities associated with COVID cases and deaths in California Skilled Nursing Facilities (SNFs). Goal is to integrate the three SNF relateddata sets. An advisory group will guide the study and reporting of the results in September 2020. Charlene Harrington and Leslie Ross with UCSF will also support this project. • Alex provided an overview of the Honor Roll Reporting Timeline. The CHC website is currently being refreshed with Q2 data. The 5-part webinar series for the Opioid Care Honor Roll began on June 23rd. The Opioid Management Hospital Self-Assessment window is open from June 22-October 9th. In addition, a blog – Engaging California Hospitals to Address the Opioid Crisis has been posted on the CHCF website and an opioid care change package/blueprint for success has been created and published, • Mahil discussed the COVID Impacts on CMS Hospital Compare Reporting. On May 22nd, CMS issued guidance regarding the suspension of CMS Hospital Compare reporting of specific cycles due to COVID. The next CMS data hospital set is expected to be released on Sept. 30, 2019.
Planning for the Near Future	• Bruce and Alex reviewed the CHC website analytics and the overall drivers (i.e. new data and/or announcements) that impact website traffic. What can be done to drive engagement in a more meaningful way in the coming year? Libby mentioned that consumers are interested in data but do not always view it the same as stakeholders. Bruce will convene a workgroup to explore this further. • The CHC project team identified possible topics of analyses and Mahil reviewed these topics with the BOD. The TAC consensus was to focus on the topics in order of priority: 1) examination of the impact of socio-economic factors on hospital

	performance, 2) examination of historical trends in the measure set and performance changes, and 3) examination of the urban vs. rural hospital performance. Kristof favored the impact of race and socio-economic factors and regional analyses and questioned if the other topics would be relevant to policy makers. Joan is interested in readmissions and mentioned that patients may also be interested in telehealth practices when data is made available. Seth suggested possibly conducting analysis around regionalized care and interhospital transfers, specifically from rural to urban areas. Kristof will send the Board a study on pre and post-merger of rural hospitals and impacts of care patterns. Alex polled the board members to rank their favorite topics of analysis based on 1) impact of socio-economic factors on hospital performance, 2) historical trends in the measure set and performance changes, and 3) urban vs rural hospital performance. The board ranked their topics of priority as 1, 2 & 3 in order, respectively. Board members also expressed interest in better understanding the impact of hospital consolidation on quality.
Maternity Care Honor Roll	• Alex discussed the implications for the 2020 honor roll using 2019 data. The TAC recommended excluding any hospitals without current valid data – Ken concurred. • The Board motioned, seconded, and approved to only consider participating hospitals who submit data to CMQCC when identifying honor roll recipients. Board also asked the project team to consider whether and how to account for the variation in performance across smaller hospitals.
Next Meeting/Meeting Adjournment	• The next Board of Directors meeting is scheduled on September 3, 2020 at 11:00am PT via Zoom. The in-person meeting on October 29th has been converted to a virtual call. • The meeting formally adjourned at 12:03pm PT.

Cal Hospital Compare

Board of Directors

Other Contributors

Cal Hospital Compare Board of Directors

October 29, 2020

10:00am-12:00pm Pacific Time

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Proposed Agenda

- Welcome & call to order
- Organizational updates
- Patient activation proposal
- Opioid care honor roll
- Long term care grant results
- Business plan
- Wrap Up

Organizational Updates

Q3 2020 Website Data Refresh *Complete*

Updated measures include:

- CMS Data
- No new measures
- Reviewing whether to retire CJRR measures

COVID Impacts On CMS Hospital Compare Reporting

CMS Hospital Compare Refresh Dates and Measurement Periods	
Date CMS Hospital Compare Data Set Release Date	**Most Recent Date of Any Measure that Was/Will Be Refreshed**
End of April, 2020	**Received:** June 30, 2019
End of July 2020	**Received:** Sept 30, 2019
Uncertain: End of October, 2020	**Possible:** December 31, 2019 but, per CMS guidance of May22, reporting is voluntary. Unclear what CMS will report and make available on CMS Hospital Compare and when. Note that data from other sources (CMQCC, OSHPD, CDPH HAI, breastfeeding likely will come in as usual in Q4 2020, mostly covering measurement period CY2019).
End of January, 2021	**Likely suspended** since CMS May 22 guidance indicates that "CMS will not count data from Jan. 1, 2020 to June 30, 2020"; referencing the measurement period.
End of April, 2021	**Likely suspended** since CMS May 22 guidance indicates that "CMS will not count data from Jan. 1, 2020 to June 30, 2020"; referencing the measurement period.
End of July 2021	**Possible resumption** of reporting and availability of CMS Hospital Compare. However, given COVIDs impacts are likely to go beyond June 2020, CMS could extend the period for which it "won't count data" to Q3 2020.

**On May 22, CMS issued guidance regarding the suspension of CMS Hospital Compare reporting for specific cycles due to COVID*

2020 Honor Roll Reporting Timeline

Preparing for joint press release with CHHS in Dec/Jan 2020

Patient Safety Poor Performers

- May

Maternity Honor Roll

- September

Opioid Care Honor Roll

- October 9 – application deadline
- November/December - notify hospitals of their results

Patient Safety Honor Roll

- December; dependent on Q4 CMS data refresh & publication of the Fall 2020 Leapfrog Hospital Safety Grade

Patient Activation Proposal

Bringing Cal Hospital Compare hospital performance data to where patients already are

Direct to consumer outreach via strategic partnerships

- Using this approach, CHC assumes a primary role as a data/score generator that leverages strategic partnerships with organizations who have more intimate and frequent connection with consumers.

  Critical to success is:

  - Understanding healthcare consumers' online behavior and crafting relevant messages.
  - Identifying and developing strategic partnerships with data disseminators that have complimentary choice attributes to CHC information (i.e. MD, cost, network) at both the local and statewide/national level
  - Packaging CHC data into easily accessible and distributable products

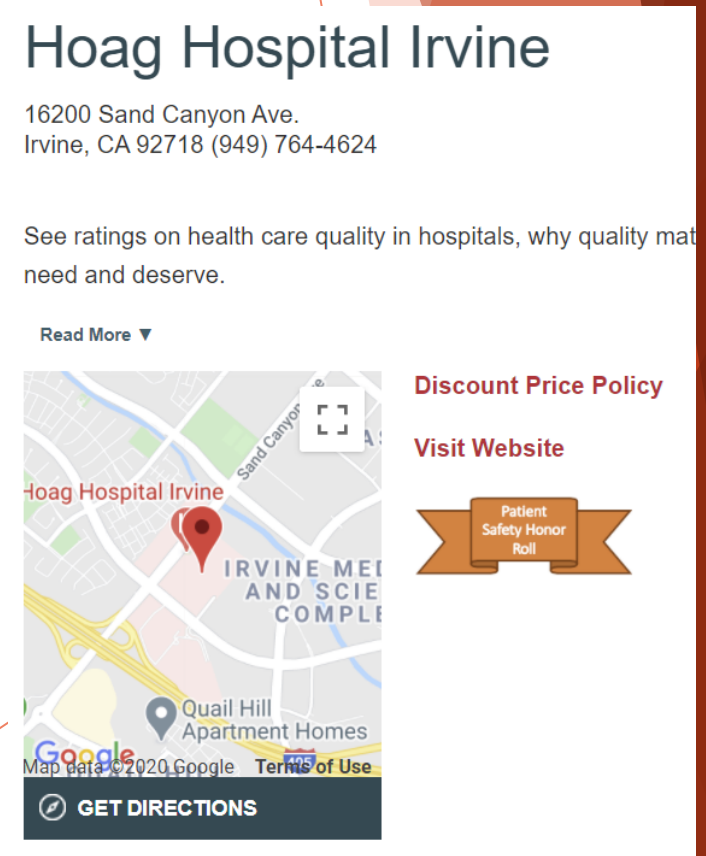
Key Stakeholder Interviews

- Who We Interviewed:
  - Patient advisors: Mary Schramke, Barbara Kivowitz, Joan Maxwell
  - Indu Subaiya, founder of Health 2.0
  - Scott Christman, chief data officer, CDPH
  - Chaeny Emanavin, director of CHHS' office of innovation
  - Greg Downing, former head of innovation for HHS (federal)

Stakeholder Interviews: Key Learnings

Use Consumer Friendly Displays of Data

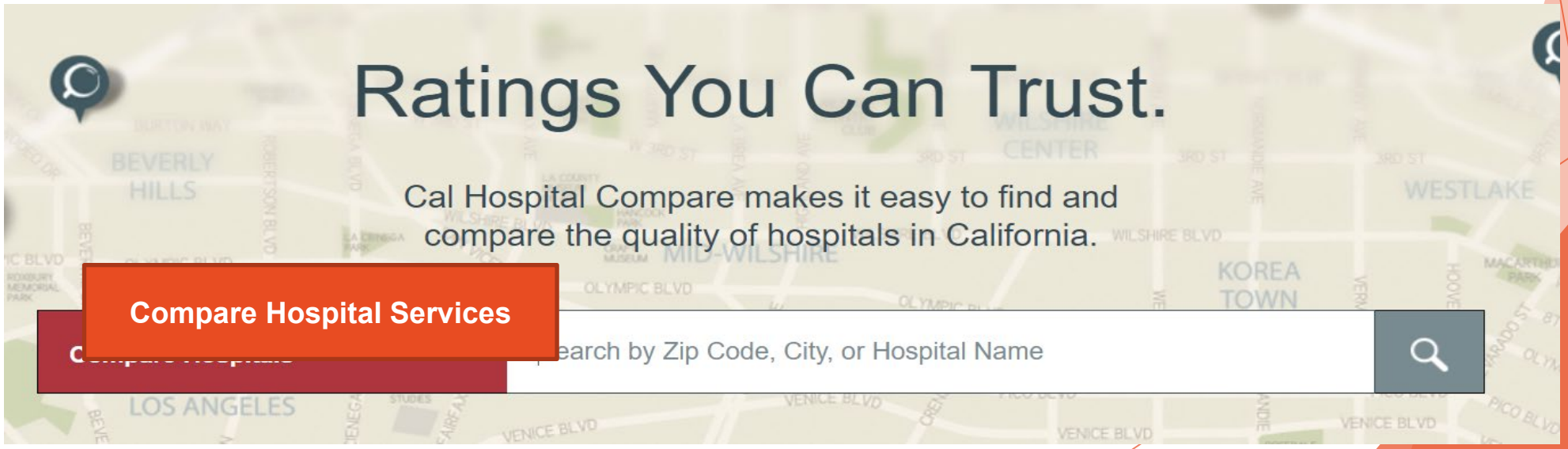
Iconography (e.g., best-in-class ribbons, the Cal Hospital Compare ratings) are easier to understand than percentages or number of cases.



Stakeholder Interviews: Key Learnings

Break it Down by Condition

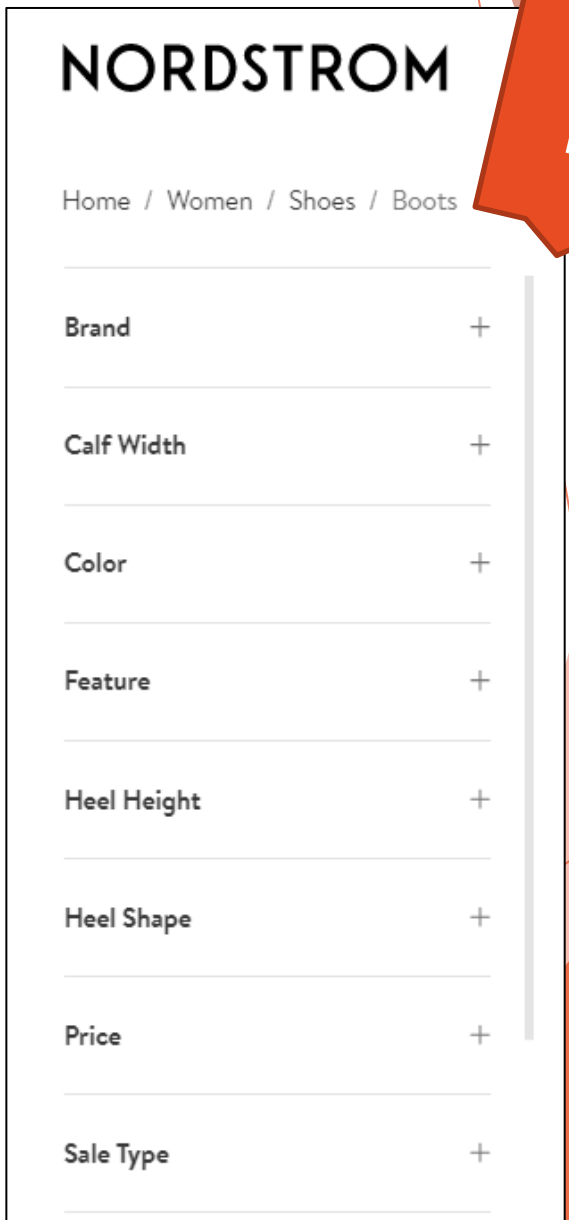
Overall, patients search by condition and not by hospital. Therefore hospital-wide performance dashboards are not of primary interest to consumers. Meet them where they are by first showing data on maternity care, hip and knee, etc.



Stakeholder Interviews: Key Learnings

Allow for Personalization by Flipping the Display to Focus on Patients' Needs

Ask website visitors what procedures they're interested in viewing, and, rather than showing all results at once, let them drill down to shop for their care.



Retail Example

Possible Directions

Strategic Partnerships

Others?

Health Plans

- Commercial insurers
- Covered CA
- Insurance brokers

Employers

- Self-insured employers
- Amino
- PBGH

Consumer Health Sites

- Vitals
- WebMD
- Healthgrades
- Office of the Patient Advocate
- US News & World Report
- Condition-specific associations

Media outlets

- Newspaper
- Radio
- Journal publications

Social Media/Web Gateways

- Yelp
- Nextdoor
- Facebook
- Google
- Amazon
- Twitter
- LinkedIn

Government agencies

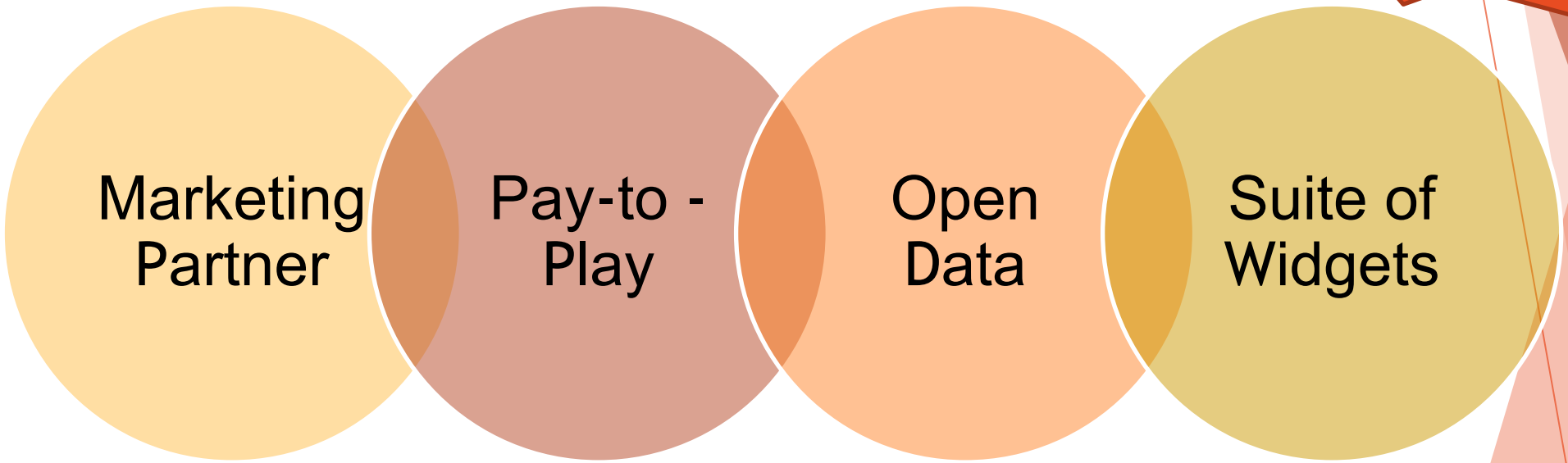
- Office of the Patient Advocate
- DHCS
- OSHPD
- CDPH

Providers

- Hospitals
- Physicians (patient-doctor communication tools)

Broad Directions to Consider

What strategy most resonates with you?

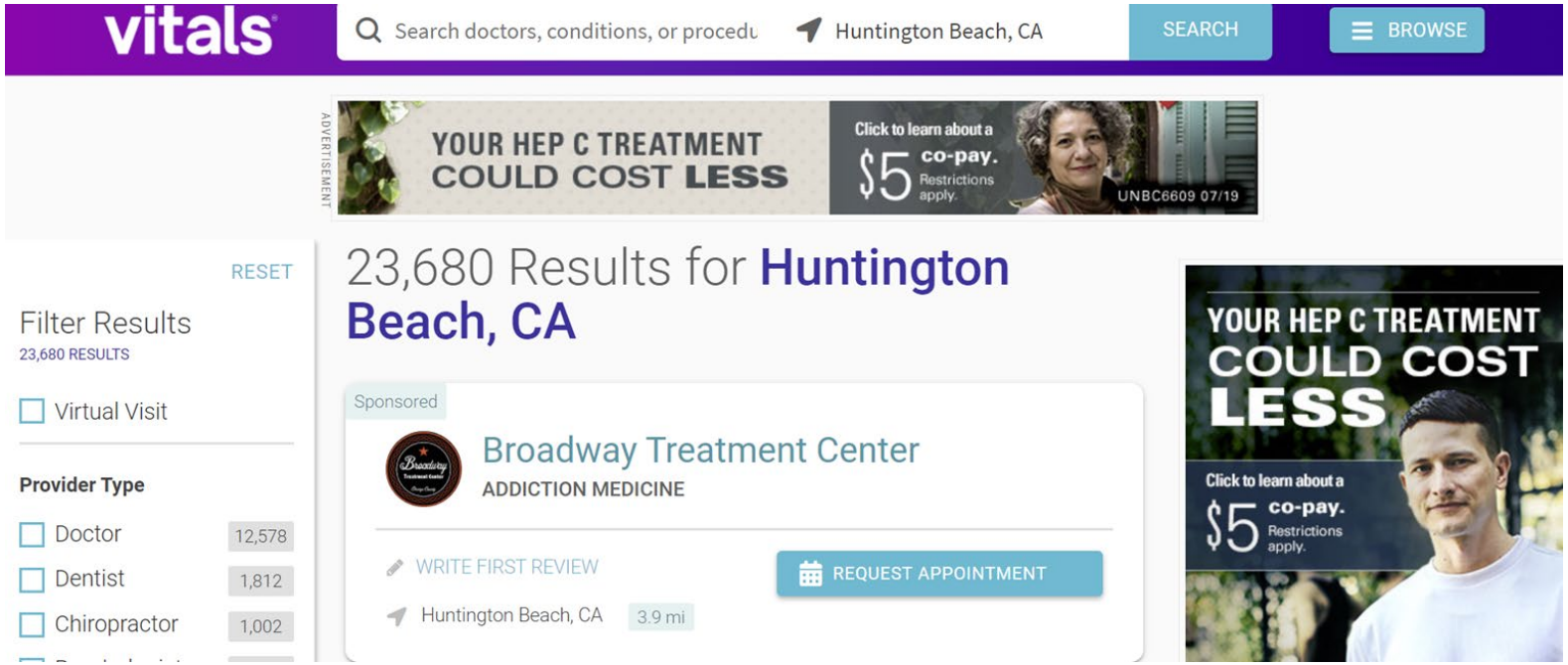


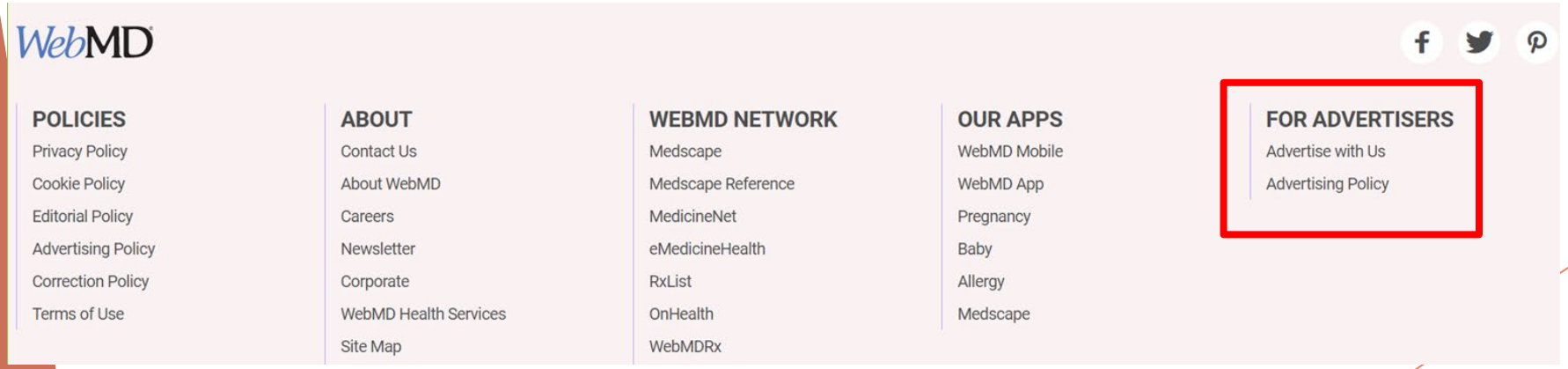
Marketing Partnerships

- Ready-made collateral that's easy for others to disseminate
  - Patient mailers from health plans
  - Digital "mailers" (e.g., e-mails from health plans
  - Web advertising partnerships

Pay-to-Play

Segment consumer needs and find where they go on the web, then buy search advertising on those sites





Open Data Strategy

- Provide datasets and encourage others to integrate these data into their website/apps
- We can pilot this approach through a data challenge
- We can aim for a big win – e.g., Facebook, Google, a deeper partnership with Yelp

Data Challenge Example:
The COVID-19 Symptom Data Challenge

Open Data Example - Yelp

Hoag Memorial Hospital

Claimed

543 reviews Details

Hospitals Edit

Open Open 24 hours Hours updated over 3 months ago

Write a Review | Add Photo | Share | Save

Maternity Care Data

View More

C-Section Rate (NTSV)
Below Average Rate

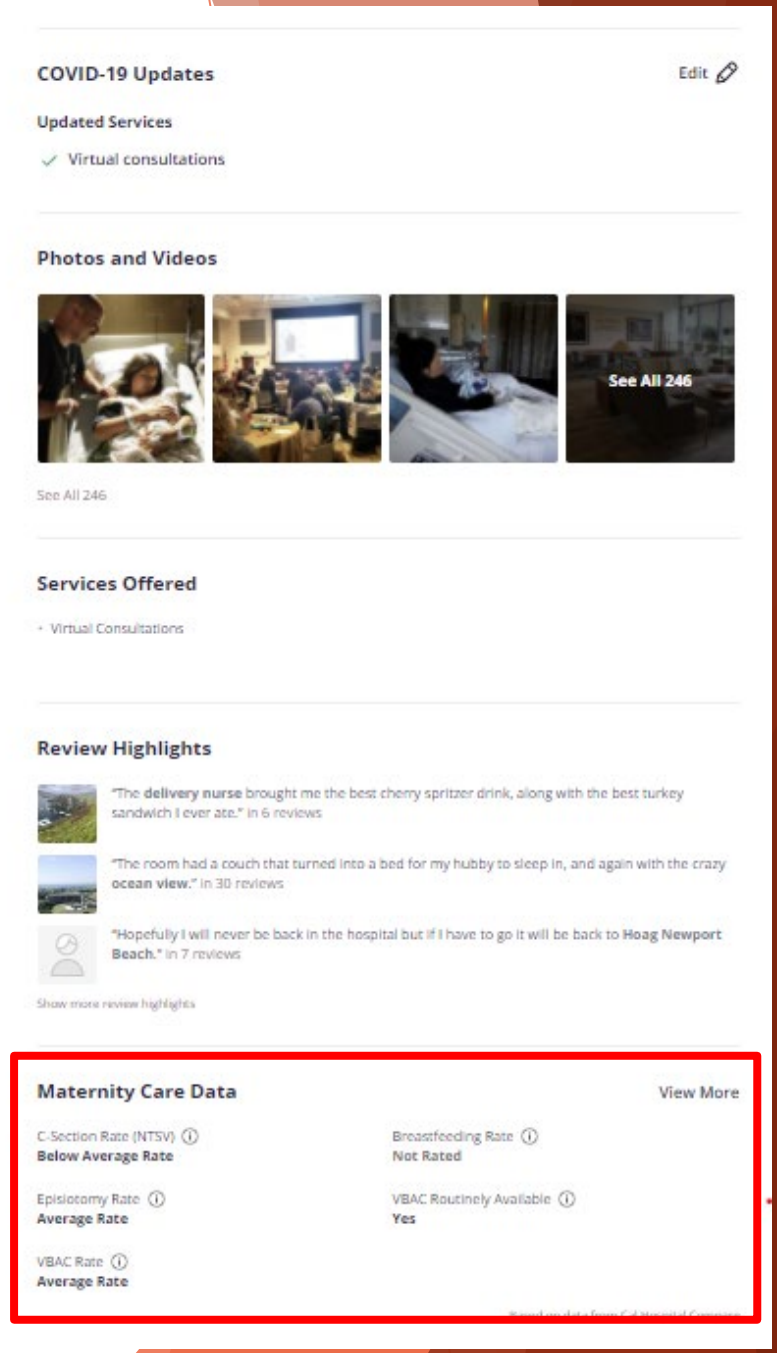
Breastfeeding Rate
Not Rated

Episiotomy Rate
Average Rate

VBAC Routinely Available
Yes

VBAC Rate
Average Rate

Based on data from Cal Hospital Compare



Build a Suite of Nicely Designed Widgets to Place on Other Sites

- Example widget here

What's Driven Traffic to Our Site?

Jul 2017: Maternity measures on Yelp

May 2019: Opioid Care Honor Roll Program Launch

Dec 2019 Honor Roll Announcement: Maternity, Patient Safety & Opioid Care

Sept 2020: Healthnet promotes mother & baby data on FB

Website Traffic

Strategy	Pros	Cons	Likely Impact (1 = low, 5 = high)	Cost ($ = $5,000, $$$$$ = $50,000)	Partners
Marketing Partnerships	• Mass outreach • Build awareness • Print and/or digital • Control the messaging with readymade collateral	• Build business case • Voluntary • Messages may not be delivered at the right time	3	Start up - $$ Ongoing - $	Health Plans Covered CA Hospitals
Pay-to-Play	• Builds awareness • Meets consumers where they are and connects to the site	• Website visitors may be wanderers, not shoppers • Consumers need direction on how to access the website • Sustained advertising required	2	Start up: $ to $$$ *(variable)* Ongoing: $ to $$$ *(variable)*	Facebook Google WebMD Vitals
Open Data *(Provide datasets)*	• Innovation (We'll get ideas we didn't consider) • Organizations can tailor messages to their own audience • Collaboration with close partners	• Minimal control over implementation, display, timing, and/or messaging • Need to make data accessible via API	3	Start up - $$$$$ for a data challenge & API development Ongoing - $	Health 2.0 Healthcare startups - building apps Government agencies Health plans
Suite of Widgets	• Interactive • Meets consumers when they're primed • Focused (e.g. maternity care, ortho surgery, etc.)	• Build the business case • Identify and convince partners to take this on	4	Start up - $$$$ Ongoing - $	Health plans Covered CA Large employers Hospitals Newspapers

Discussion

- What other information do you need to decide?
- What strategy most resonates with you?
- What strategy brings the most value to Cal Hospital Compare partners, hospitals, and patients?

Next steps


Build out priority strategy
Identify pilot opportunity
Go live 2021

Opioid Care Honor Roll

Develop a relevant threshold to recognize hospitals

Program Goals

- Recognize all CA hospitals for their efforts addressing the opioid epidemic; with a goal of ~115 hospitals participating in 2020
- Accelerate quality improvement across the complete spectrum of opioid stewardship activities as measured by the Opioid Management Hospital Self-Assessment (e.g. can't just do one thing well)
- Provide targeted technical assistance to support hospital achieve honor roll status

For BOD: Develop a relevant threshold to recognize honor roll hospitals

Opioid Care Honor Roll 2020 Timeline

Q1

- Convene workgroup
- Test self-assessment 2.0
- Launch resource library

Q2-Q3

- Finalize self-assessment tool
- Invite hospitals to submit self-assessment starting Jun 22
- 5-part learning webinar series

Q4

- Self-assessment window closes Oct 9
- Announce honor roll recipients in partnership with CHHS Agency
- 2021 planning

Opioid Care Honor Roll
2020 Webinar Series Roadmap

Opioid Management Hospital Self-Assessment

Self-assessment window
Jun 22 – Oct 9

Measure	Level 1 *Basic Mgmt.* (1 pt)	Level 2 *Hospital Wide Standards* (2 pts)	Level 3 *Integration & Innovation* (3 pts)	Level 4 *Practice Improvement* *(4 pts)*
Safe & Effective Opioid Use • Appropriate opioid discharge prescribing guidelines • Alternatives to opioids for pain management			Overdose Prevention • Naloxone education & distribution program	
Identification & Treatment • Medication Assisted Treatment (MAT) • Timely follow up care			Cross-cutting Opioid Management Best Practices • Organizational infrastructure • Address stigma with physicians & staff • Patient & family engagement	

Source: *Opioid Management Hospital Self-Assessment*

About Participating Hospitals

CA Hospitals

91

New Hospitals

45

Returning Hospitals

46

CA Bridge Sites

37

2019, 2020 & CA Bridge Site

23

About Participating Hospitals

Gap to Goal

- Outreach
- COVID-19 & other competing priorities
- Voluntary
- Other opportunities to engage in QI

Hospital Feedback

- Self-assessment process is a win-win!
- Takes a team to complete

Data Validation

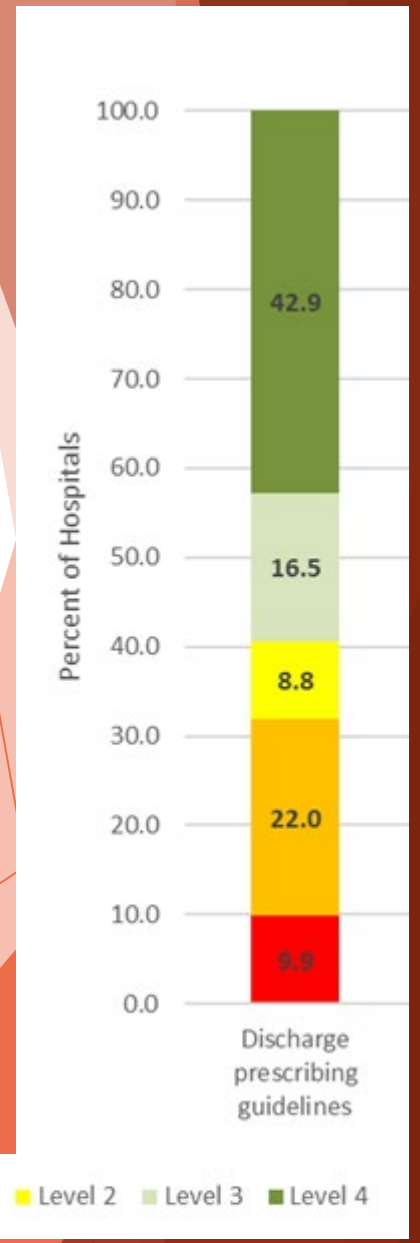
- Project Team reviewed all results against comments

Q1 – Discharge Prescribing Guidelines

Safe & Effective Opioid Use				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*

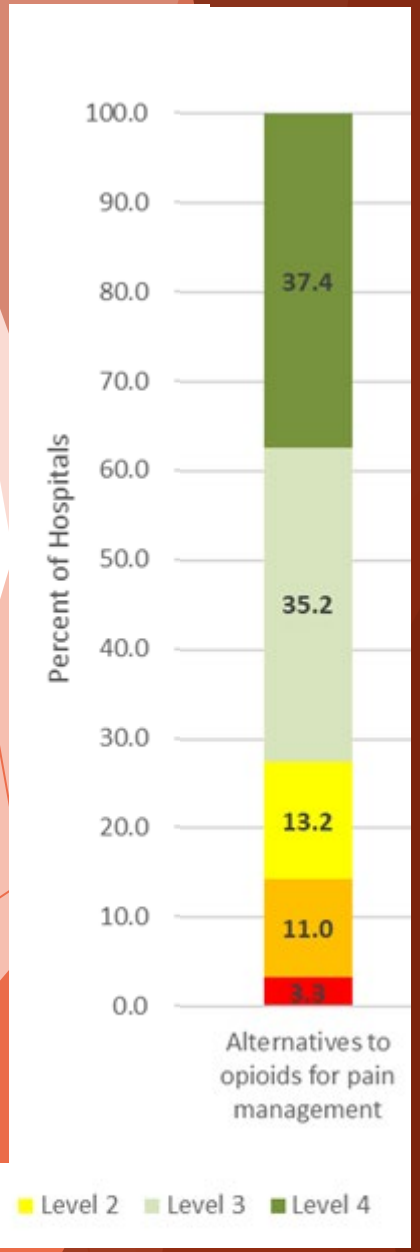
Appropriate Opioid Discharge Prescribing Guidelines
 	
Develop and implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new starts in opioid naïve patients and for patients on opioids to manage chronic pain. Possible exemptions: end of life, cancer care, sickle cell, and palliative care patients.
 	
Service line prescribing guidelines should address the following:
• Opioid use history (e.g. naïve versus tolerant)
• Pain history
• Behavioral health conditions
• Current medications
• Provider, patients & family set expectations regarding pain management
• Limit benzodiazepine and opioid co-prescribing
• For opioid naïve:
  ○ Limit initial prescription (e.g. <7 days)
  ○ Use immediate release vs. long acting
• For patient on opioids for chronic pain:
  ○ For acute pain, prescribe short acting opioids sparingly
  ○ For chronic pain, avoid providing opioid prescriptions for patients receiving medications from another provider
	Developed and implemented evidence-based opioid discharge prescribing guidelines across **2 service lines**, the Emergency Department and 1 Inpatient Unit (e.g. Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented **hospital wide** opioid discharge prescribing guidelines	Developed and implemented evidence-based opioid discharge prescribing **guidelines for surgical patients** as part of an Enhanced Recovery After Surgery (ERAS) program	Your hospital is **actively monitoring & developing strategies to improve opioid prescribing** e.g. rate of e-prescribing, Morphine Milligram Equivalent (MME)/patient, co-concurrent prescribing of benzos. & opioids, etc.
				
				Extra Credit (1 pt.)
				For one **measure** what is the **%** improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.

	Briefly describe the steps your hospital has taken to promote safe & effective opioid use at discharge			



Q2 – Alternatives to Opioids for Pain Management

Safe & Effective Opioid Use				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*
Alternatives to Opioids for Pain Management Use an evidence based, multi-modal, non-opioid approach to analgesia for patients with acute and chronic pain. Components of a multi-modal, non-opioid analgesic program should 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 • Care guidelines for common acute care diagnoses e.g. pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation (ALTO Protocol). • Opioid use history (e.g. naïve versus tolerant) • Patient and family engagement (e.g. discuss realistic pain management goals, addiction potential, and other evidence-based pain management strategies that could be used in the hospital or at home) • Pharmacologic alternatives (e.g. NSAIDs, Tylenol, Toradol, Lidocaine patches, muscle relaxant medication, Ketamine, medications for neuropathic pain, nerve blocks, etc.) • Include available non-pharmacologic alternatives (e.g. TENS, comfort pack, heating pad, visit from spiritual care, physical therapy, virtual reality pain management, acupuncture, chiropractic medicine, guided relaxation, music therapy, aromatherapy, etc.)	Developed and implemented a non-opioid analgesic multi-modal pain management in the **Emergency Department OR one Inpatient Unit** (e.g. Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented a non-opioid analgesic multi-modal pain management guidelines in the **Emergency Department AND one Inpatient Unit** (e.g. Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital offers at least at least 1 non-pharmacologic alternative for pain management	Developed **supportive pathways** that promote a team-based care approach to identifying opioid alternatives e.g. integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, use of non-pharmacologic alternatives, etc. **Aligned standard order sets** with non-opioid analgesic, multi-modal pain management program (e.g. changes to EHR order sets, set order favorites by provider, etc.)	Your hospital is **actively monitoring & developing strategies to improve use of alternatives to opioids for pain management** e.g. adherence to guidelines, rate of use of alternatives to opioids by service line, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
	Briefly describe the steps your hospital has taken to promote the use of alternatives to opioids for pain management.			

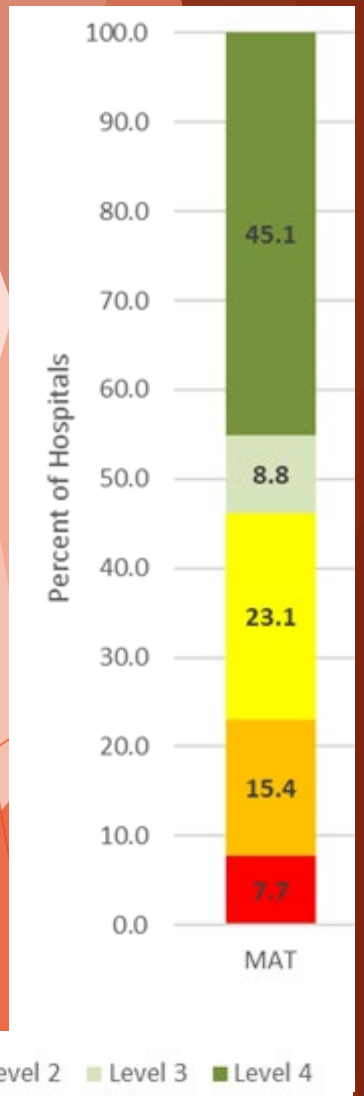


Q3 – Medication Assisted Treatment

Identification and Treatment				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*

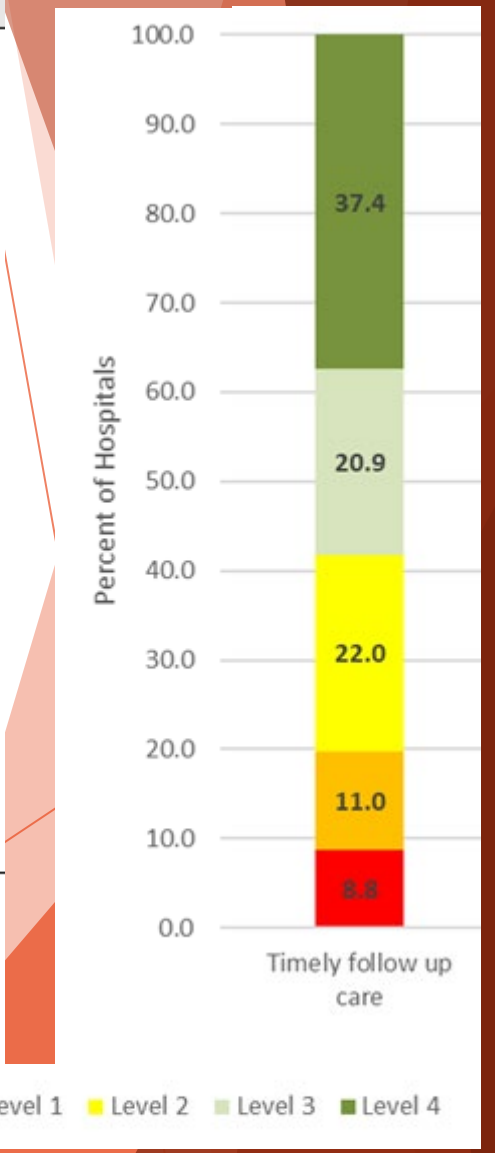
Medication Assisted Treatment (MAT)
 	
Provide MAT for patients identified as having Opioid Use Disorder (OUD), or in withdrawal, and continue MAT for patients in active treatment.
 	
Components of a MAT program should include:
• Identifying patients eligible for MAT, on MAT, &/or in opioid withdrawal
• Treatment is accessible in the emergency department and in all other hospital departments.
• Treatment is provided rapidly (same day) & efficiently in response to patient needs.
• Human interactions that build trust are integral to how substance use disorder treatment is provided.
 	
*Suggested guidelines for how to universally offer MAT to all patients:
• Do <u>not</u> screen all patients for OUD
• Do <u>not</u> ask all patients if they are interested in MAT services
  ○ May be time consuming for providers & stigmatizing for patients
• <u>Do</u> promote MAT services using signage in waiting & exam rooms, badge flare, & patient forms
• During the exam, providers routinely let patients know that their site offers MAT
  ○ So that patients can choose to disclose whether & when they need support
	MAT is offered, initiated, & continued for those already on MAT in at least **one service line** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)
	
	Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT
		MAT is offered, initiated, & continued for those already on MAT in at least **2 service lines** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	MAT is **universally offered*** to all patients presenting to the hospital
			
			One or more **hospital staff** has the time and skills to **engage with patients** on a human level, motivating them to engage in treatment (e.g. a hospital employee embedded within either an emergency department or an inpatient setting to help patients begin and remain in addiction treatment – commonly known as a Substance Use Navigator, Case Manager, Social Worker, Patient Liaison, Spiritual Care, etc.)
				Your hospital is **actively monitoring & developing strategies to improve access to MAT** e.g. number of patients identified with OUD and provided MAT, # of buprenorphine. prescriptions, etc.
				
				Extra Credit (1 pt.)
				For one **measure** what is the **%** improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.

	Briefly describe the steps your hospital has taken to provide patients access to MAT.			



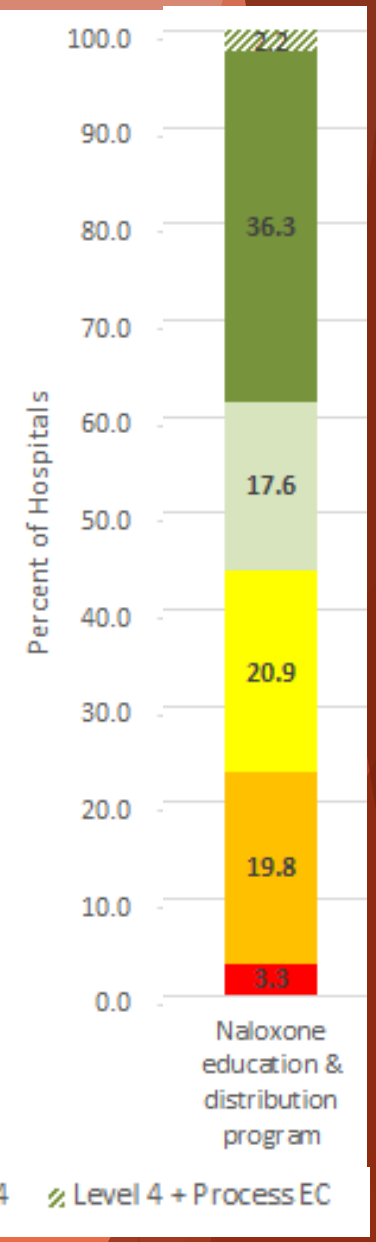
Q4 – Timely Follow Up Care

Identification & Treatment				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*
Timely follow up care Hospital coordinates follow up care for patients initiating MAT within 72 hours either in the hospital or outpatient setting. Hospital based providers and practitioners must have a X-waiver to prescribe or dispense buprenorphine at discharge under the Drug Addiction Treatment Act of 2000 (DATA 2000). If hospital does not have X-waivered providers: • Providers provide a loading dose for long effect, provide follow up care in the ED that is in alignment with the DEA Three Day Rule or connect patient to X-waivered community provider for immediate follow care If hospital has X-waivered providers: • Prescribe sufficient buprenorphine until patient's follow up appointment with community provider within 24 to 72 hours *Practitioners= MDs, physician extenders, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives (see SUPPORT Act for details)	Hospital **identifies X-waivered providers** within the hospital &/or within the community Provides list of **community-based resources** to patients, family, caregivers, and friends (e.g. primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, etc.) Hospital has an agreement in place with **at least one community provider** • If no X-waiver **community provider must accept referrals within 72 hours** • If X-waivered **community provider to provide timely follow up care**	**Actively refer** MAT & OUD patients to a community provider for ongoing treatment (e.g. primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, etc.)	Hospital provides support to **select practitioners* in the ED and IP units to obtain X-waiver** (coordinates free training opportunities, supports application process, utilizes grant funds to cover training cost, provides protected time, bonus opportunity, etc. in alignment with your hospital's employment model)	Your hospital is **actively monitoring & developing strategies to improve care transitions for MAT patients** in accordance with HIPAA e.g. number of patients referred to community provider for follow up care, number of patients presenting to community provider for follow up care, number of ED &/or IP shifts in 30 days with a provider on shift that is x-waivered, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
	Briefly describe the steps your hospital has taken to ensure patients on MAT have access to timely follow up care.			



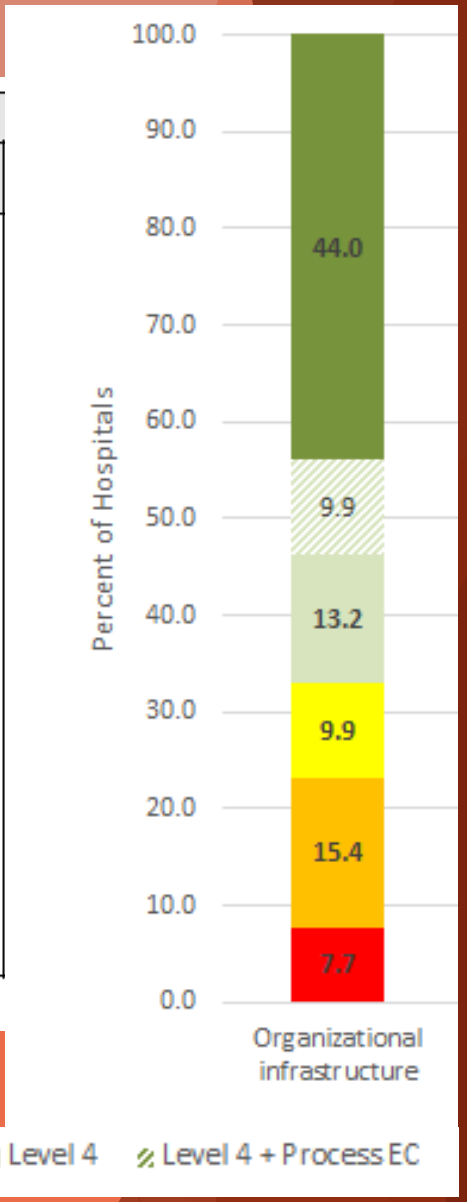
Q5 – Overdose Prevention

Overdose prevention				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*
Naloxone education and distribution program Provide naloxone prescriptions and education to all patients, families, caregivers and friends discharged with an opioid prescription and/or at risk of overdose. *Staff - MD, PA, NP, Pharmacist, RN, LVN, Health Coach, Substance Use Navigator, Clinical Social Worker, Research Staff, Emergency Department Technician, Clerk, Medical Assistant, Security Guard, etc. trained to distribute naloxone and provide education on how to use it	**Identify overdose prevention resources within hospital, health system, and community** (e.g. training programs, community access points, low/no-cost options, community pharmacies with naloxone on hand, community coalitions, California Naloxone Distribution Program, etc.)	**Standard workflow** for MDs and physician extenders in place for providing naloxone prescription at discharge for patients with an opioid prescription and/or at risk of overdose; discharge prescriptions sent to patient's pharmacy of choice (e.g. naloxone incorporated into a standard order set for opioid prescriptions, &/or referral to low or no cost distribution centers, etc.)	**Standing order** in place allowing approved staff* to educate and distribute naloxone in hand to all patients, caregivers, at no cost while in the hospital setting under the California Naloxone Distribution Program; this should be an ED led process in collaboration with pharmacy	Your hospital is **actively monitoring & developing strategies to improve access to overdose prevention** e.g. rate of naloxone prescription at discharge after opioid poisoning, overdose, and/or prescribed opioids at discharge rate of staff training to distribute naloxone kits, etc. **Extra Credit (1 pt.)** For one **measure** what is the **%** improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal. **Extra Credit (1 pt.)** Your hospital is actively monitoring & improving overdose prevention strategies using **social determinants of health data**
	Briefly describe the steps your hospital has taken to prevent opioid overdose deaths.			



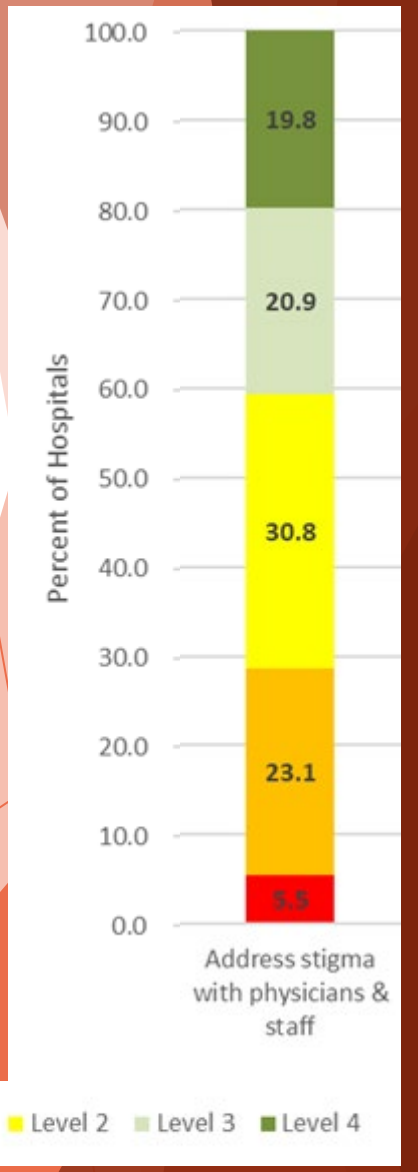
Q6 – Organizational Infrastructure

Cross Cutting Opioid Management Best Practices				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*
Organizational Infrastructure Opioid stewardship is a strategic priority with multi-stakeholder buy in and programmatic support to drive continued/sustained improvements in appropriate opioid use (e.g. executive leadership, Pharmacy, Emergency Department, Inpatient Units, General Surgery Information Technology, etc.)	**Multi-stakeholder team** identified opioid stewardship as a strategic priority and set improvement goals in one or more of the following areas: safe & effective opioid use, identifying and managing patients with OUD, preventing harm in high-risk patients, applying cross-cutting organizational strategies. (e.g. opioid stewardship program, quality improvement team, subcommittee of the Board, etc.) **Executive sponsor/project champion identified**	**Communicated program, purpose, goal, progress to goal to appropriate staff** (e.g. a dashboard, all staff meeting, annual competencies, etc.) Opioid management is included in **strategic plan** **Hospital/health system leadership plays an active role** in reviewing data, advising and/or designing initiatives to address gaps	Hospital is actively **building relationships & coordinating with post-acute services to support care transitions** **Extra Credit (1 pt.)** Hospital is part of a learning network (e.g. community coalition, large scale learning collaborative, etc.)	Your hospital is **actively monitoring & developing strategies to improve its opioid management strategies** e.g. hospital wide &/or county wide opioid prescribing rate, Morphine Milligram Equivalent (MME) /patient, rate of OUD related deaths, buprenorphine prescribing rate, etc. **Extra Credit (1 pt.)** For one **measure** what is the **%** improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
	Briefly describe the steps your hospital has taken to make opioid management a quality improvement priority.			



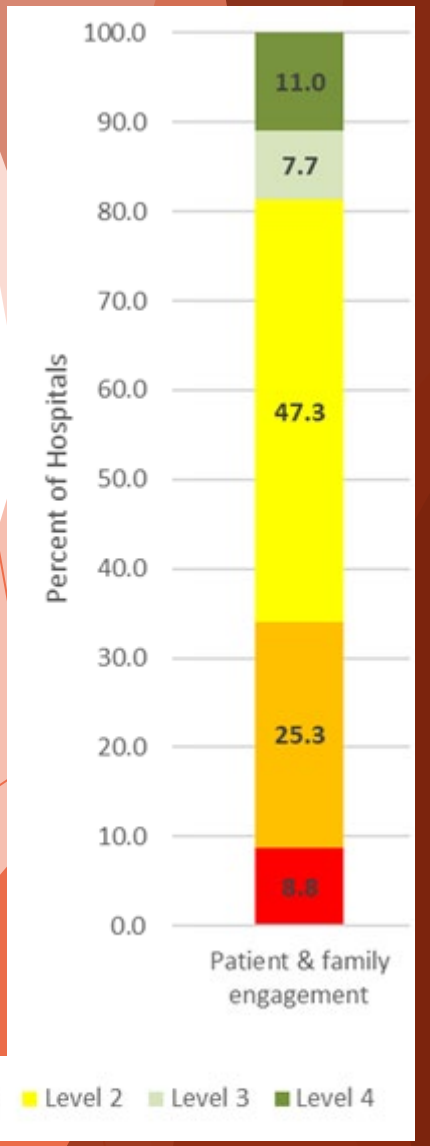
Q7 – Address Provider & Staff Stigma

Cross Cutting Opioid Management Best Practices				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance use. Hospital actively addresses stigma through the education and promotion of the medical model of addiction, trauma informed care, harm reduction principles, motivational interviewing across all departments to facilitate disease recognition and the use of non-stigmatizing language/behaviors.	Provides passive, **general education** on hospital opioid prescribing guidelines in **at least two service lines**, identification, and treatment, and overdose prevention to appropriate providers and staff (e.g. M&M, lunch and learns, flyers/brochures, CME requirements, RN annual competencies, etc.)	Provides **point of care decision making support** e.g. automatic pharmacy review for long-term opioid prescription, auto prescribe naloxone with any opioid prescription, reminder to check CURES, flag concurrent opioid and benzo prescribing, etc. **Extra Credit (1 pt.)** Regularly assess perceived & internalized opioid related stigma & knowledge of OUD treatment in providers and staff	Trains appropriate providers and staff on, some combination of, the **medical model of addiction, harm reduction principles, motivational interviewing and how to provide trauma informed care** to normalize opioid use disorder & treatment (e.g. M&M, lunch and learns, CME requirements, RN annual competencies, etc.	Your hospital is **actively monitoring & developing strategies to reduce provider/staff stigma toward opioid addiction** e.g. provider prescribing patterns, number of patients identified with OUD, etc. Provides **targeted follow up and support to providers and staff based on performance** **Extra Credit (1 pt.)** For one **measure** what is the **%** improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
	Briefly describe the steps your hospital has taken to support appropriate providers & staff in providing evidence-based, compassionate care for patients with OUD or at risk.			

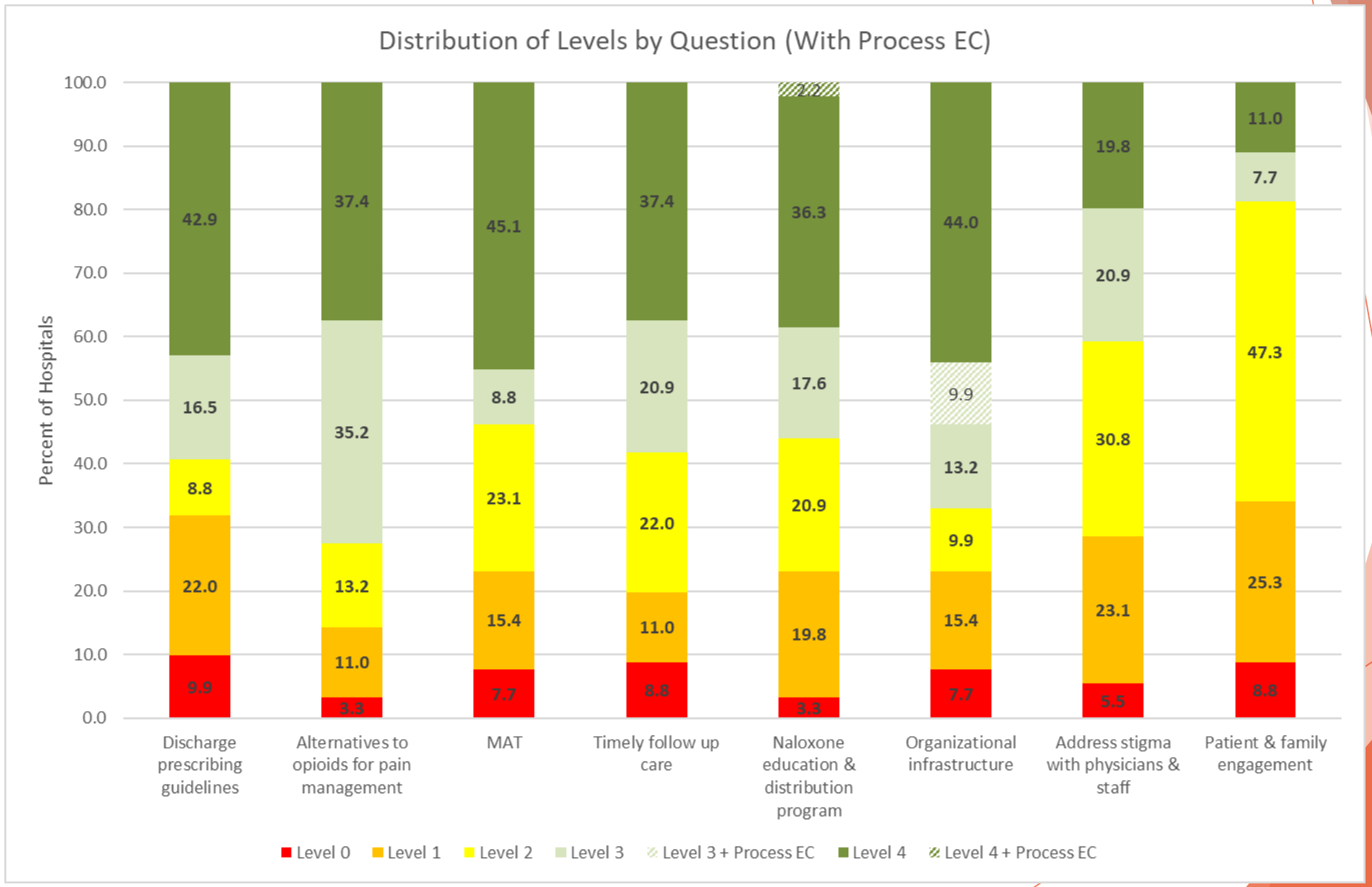


Q8 – Patient & Family Engagement

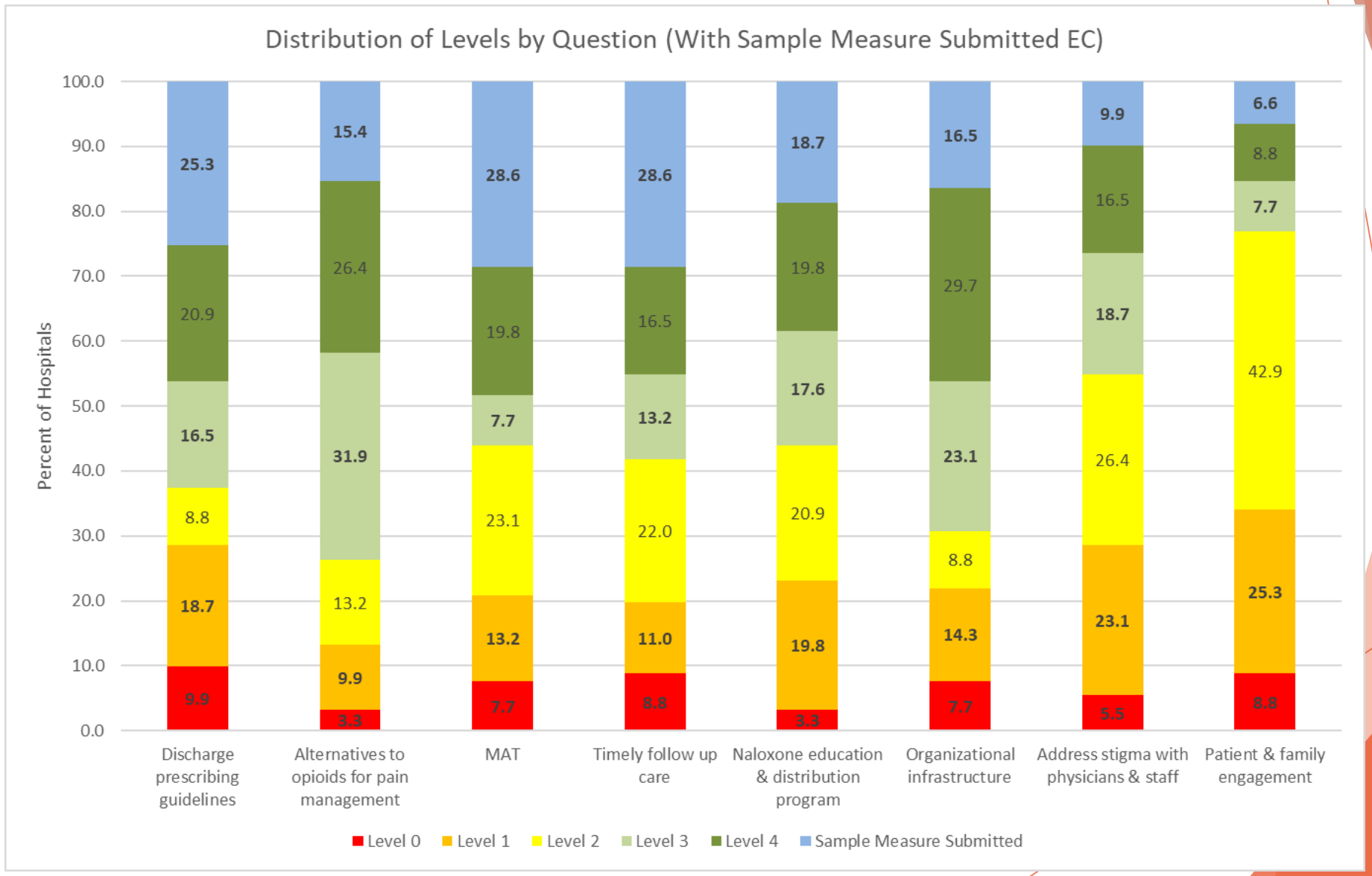
Cross Cutting Opioid Management Best Practices				
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*
Patient and family engagement **Actively engage** patients, families, and friends in appropriately using opioids for pain management (opioid prescribing, treatment, and overdose prevention via naloxone, hospital quality improvement initiatives, etc.)	Provides general education to **all patients, families and friends in at least two service lines** (e.g. ED, Burn Care, General Medicine, Behavioral Health, OB, Cardiology, Surgery, etc.) 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, set pain expectations, risk associated with opioid use, etc.)	Provides opportunities for **patients and families to engage** in hospital wide opioid management activities (Patient Family Advisory Council, peer navigator, program design, etc.)	Your hospital is **actively monitoring & developing strategies to improve patient & family engagement on opioid care** e.g. MME/patient, # MAT starts, # naloxone kits distributed w/ education, # of patients involved in QI/year, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
	Briefly describe the steps your hospital has taken to actively engage patients and families in opioid stewardship strategies.			



Results


Distribution of Levels by Question (With Process EC)
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
42.9
16.5
8.8
22.0
9.9
37.4
35.2
13.2
11.0
3.3
45.1
8.8
23.1
15.4
7.7
37.4
20.9
22.0
11.0
8.8
36.3
17.6
20.9
19.8
3.3
44.0
9.9
13.2
9.9
15.4
7.7
19.8
20.9
30.8
23.1
5.5
11.0
7.7
47.3
25.3
8.8
Discharge prescribing guidelines
Alternatives to opioids for pain management
MAT
Timely follow up care
Naloxone education & distribution program
Organizational infrastructure
Address stigma with physicians & staff
Patient & family engagement
Level 0
Level 1
Level 2
Level 3
Level 3 + Process EC
Level 4
Level 4 + Process EC

Measurement Extra Credit



Results Summary

Safe & effective

- Spread & scale of discharge prescribing remains a challenge (40% in the ED only)
- Others have discharge prescribing across ED, Surgery, and OB
- Offering alternatives to opioids for pain management continues to be area with greatest progress, consistent with findings from last year

Identification & treatment

- Most hospitals are offering MAT in at least 2 services lines (ED & IP)
- Surprised how many are considering themselves as "universally" offering MAT
- Most participants have invested in a dedicated resource to accelerate their work (FT or PT)
- Most are actively building community partnerships & supporting care transitions
- At least 50% are supporting practitioners to obtain the x-waiver

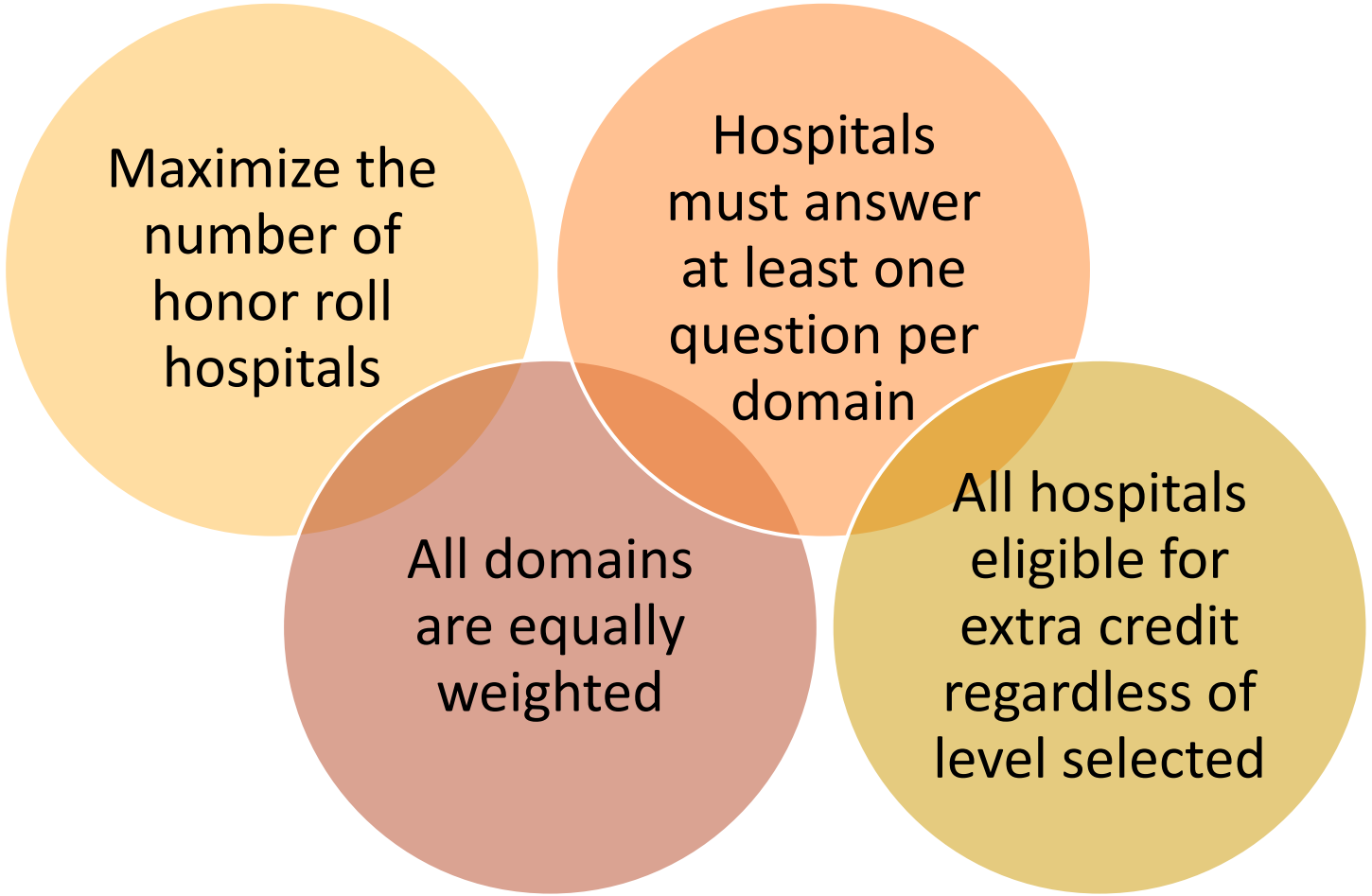
Overdose prevention

- ~55% of hospitals have implemented a Naloxone Distribution program!!
- Only 1 hospital is looking at their using a SDOH lens

Cross cutting best practice

- Opioid stewardship teams in place, opioids are a strategic priority
- 10% of hospitals are involved in a learning collaborative, think this is underreported
- Continued opportunity to address stigma & PFE
- Surprised how many hospitals are providing POC decision support – EMR is key to this work
- Small percentage of hospitals providing stigma reduction training
- No one is regularly assessing stigma
- Hospitals have improved engaging patients in care at the bedside vs quality improvement activities

Proposed Honor Roll Criteria



Proposed Threshold

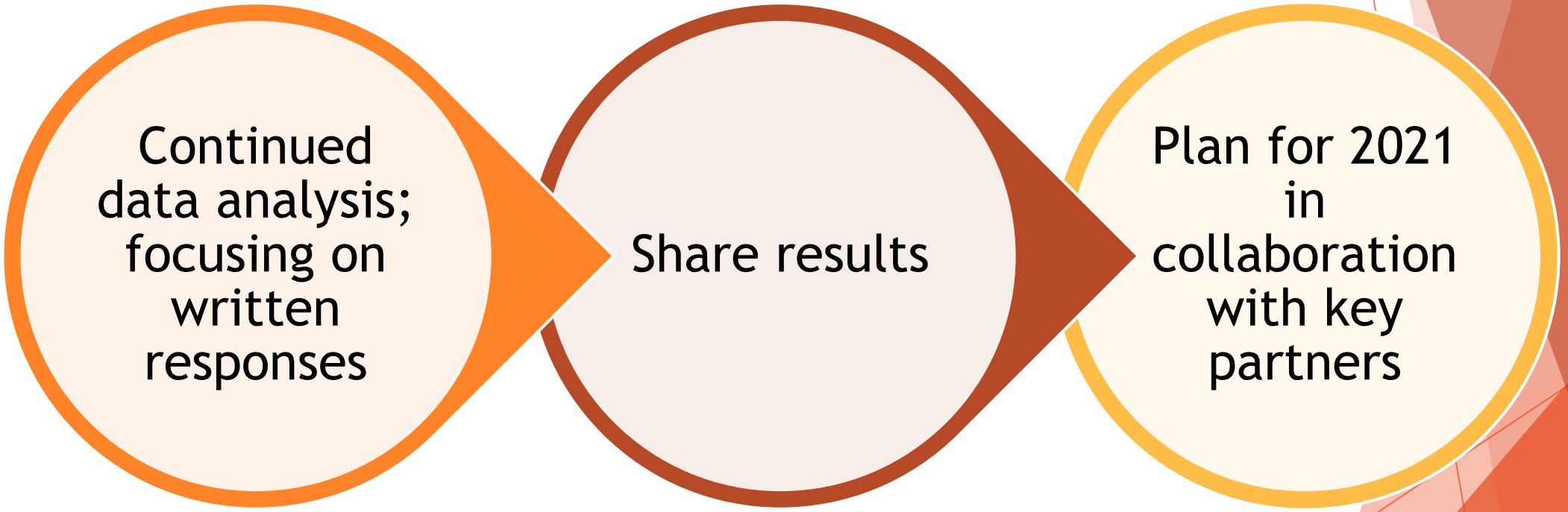
Domain/Question		N	Without Extra Credit									
			Mean	Min	5th %ile	10th %ile	25th %ile	50th %ile	75th %ile	90th %ile	95th %ile	Max
Safe and Effective Opioid Use	Discharge prescribing guidelines	91	2.60	0.00	0.00	1.00	1.00	3.00	4.00	4.00	4.00	4.00
	Alternatives to opioids for pain management	91	2.92	0.00	1.00	1.00	2.00	3.00	4.00	4.00	4.00	4.00
	Total	91	5.53	0.00	1.00	3.00	4.00	6.00	8.00	8.00	8.00	8.00
Identification and Treatment	MAT	91	2.68	0.00	0.00	1.00	2.00	3.00	4.00	4.00	4.00	4.00
	Timely follow up care	91	2.67	0.00	0.00	1.00	2.00	3.00	4.00	4.00	4.00	4.00
	Total	91	5.35	0.00	1.00	2.00	3.00	6.00	8.00	8.00	8.00	8.00
Overdose Prevention	Naloxone education & distribution program	91	2.68	0.00	1.00	1.00	2.00	3.00	4.00	4.00	4.00	4.00
	Total	91	2.68	0.00	1.00	1.00	2.00	3.00	4.00	4.00	4.00	4.00
Cross Cutting Opioid Safe Hospital Best Practices	Organizational infrastructure	91	2.80	0.00	0.00	1.00	2.00	3.00	4.00	4.00	4.00	4.00
	Address stigma with physicians & staff	91	2.26	0.00	0.00	1.00	1.00	2.00	3.00	4.00	4.00	4.00
	Patient & family engagement	91	1.87	0.00	0.00	1.00	1.00	2.00	2.00	4.00	4.00	4.00
	Total	91	6.93	0.00	1.00	3.00	4.00	7.00	9.00	11.00	12.00	12.00
Total Points		**91**	**20.49**	**1.00**	**7.00**	**9.00**	**14.00**	**21.00**	**27.00**	**30.00**	**31.00**	**32.00**
# of Hospitals (without Extra Credit)					3	3	13	22	23	15	6	
# of Hospitals (with Extra Credit)					3	3	12	18	24	6	19	

*Disqualified hospitals - 6

Cumulative Count	25th%ile (14 pts)	50th%ile (21 pts)	75th%ile (27 pts)	90th%ile (30 pts)	95th%ile (31 pts)
# Hospitals	71	47	25	14	6
# Hospitals EC	71	55	27	20	19

TAC recommendation: set honor roll threshold @ 55%ile

Next Steps


Continued data analysis; focusing on written responses
Share results
Plan for 2021 in collaboration with key partners

Long Term Care Grant

Examining Factors and Disparities Associated with COVID Cases and Deaths in California Long Term Care Facilities

Examining Factors and Disparities Associated with COVID Cases and Deaths in California Long Term Care Facilities

Aug. 14
Mtg #1

- Define committee goals & process
- Review components of study design
- Select study variables (outcome and explanatory)

Sept. 1
Mtg #2

- Review & discuss study results
- Develop policy recommendations

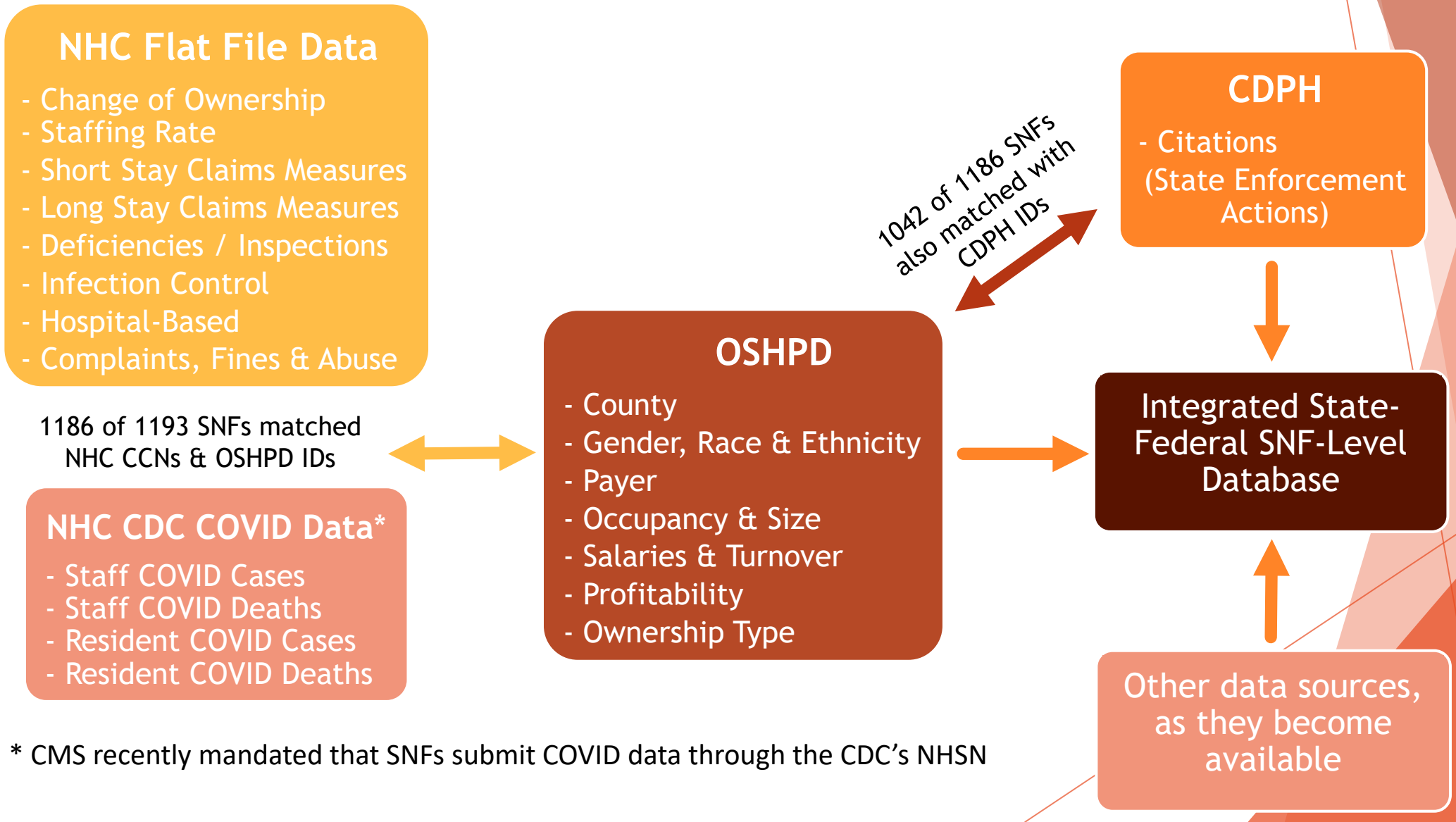
Sept. 22
Mtg #3

- Refine policy recommendations
- Provide feedback on communication materials & channels with a focus on actionability

Early Oct.
Report with recommendations

- Create a set of recommendations for stakeholders to target and accelerate improvement in care, infection prevention and patient safety

The Data: Integrated State-Federal SNF-Level Data Database



* CMS recently mandated that SNFs submit COVID data through the CDC's NHSN

Study Results

Category	Factors	Case Rate Ratio*			Death Rate Ratio*		
		May 24	Aug 9	May 24 - Aug 9	May 24	Aug 9	May 24 - Aug 9
External	County level case rate**	2.02	1.33	*Not sig*	3.45	2.37	*Not sig*
Facility	Facility size (beds)	2.14	1.55	*Not sig*	*Not sig*	1.97	*Not sig*
	Fines		0.79	*Not sig*	*Not sig*	*Not sig*	*Not sig*
	For profit ownership - non-chain For profit ownership - chain	5.56 4.53	*Not sig*	*Not sig*	*Not sig*	*Not sig*	*Not sig*
	Medicare residents	*Not sig*	*Not sig*	*Not sig*	2.37	*Not sig*	0.53
	Short stay residents re-hospitalized after a nursing home admission	*Not sig*	*Not sig*	*Not sig*	*Not sig*	1.46	*Not sig*
Staffing	Nursing turnover	*Not sig*	1.30	*Not sig*	*Not sig*	*Not sig*	*Not sig*
	RN staffing	*Not sig*	0.55	*Not sig*	*Not sig*	0.54	*Not sig*
	Total staffing	0.51	*Not sig*	*Not sig*	*Not sig*	*Not sig*	*Not sig*
Resident	Age: 65-84 Age: Older than 85	*Not sig*	1.42 1.50	*Not sig*	0.46	1.45	*Not sig*
	Black/African American	2.46	1.40	0.48	3.01	*Not sig*	0.36
	Latinx	*Not sig*	1.57	*Not sig*	[49]	*Not sig*	*Not sig*
	Males	*Not sig*	1.47	2.66	0.35	*Not sig*	3.80

*$p \leq 0.10$
** County level case rate reference group: bottom 3 quartiles

Study Results

Ownership

For Profit

For-profit nursing homes, both independent or as part of a chain, had COVID-19 case rates **4-5x higher** in comparison to non-profit/government nursing homes.

Resident Demographics

Race, Ethnicity, Gender

In May, nursing homes with **greater than 6.3% of black residents had COVID-19 case rates that were ~2.5 times higher** in comparison to nursing homes with less than ~1.5% Black residents.

By August nursing **homes with more than 26% Latinx residents had a 57% higher case rate** than nursing homes having fewer than 5.5% Latinx residents.

Between May and August, nursing homes with **more than 48.9% male residents experienced a more than 2.5-fold increase in COVID-19 case rates.**

Study Results

Staffing

Total Staffing, RN Staffing, RN Turnover

Early in the pandemic, nursing homes **with total staffing greater than 4.42 hprd had case rates that were halved** compared to nursing homes with less than 3.8 hprd.

Nursing homes with **RN staffing greater than 0.67 hprd had 50% fewer COVID-10 cases.**

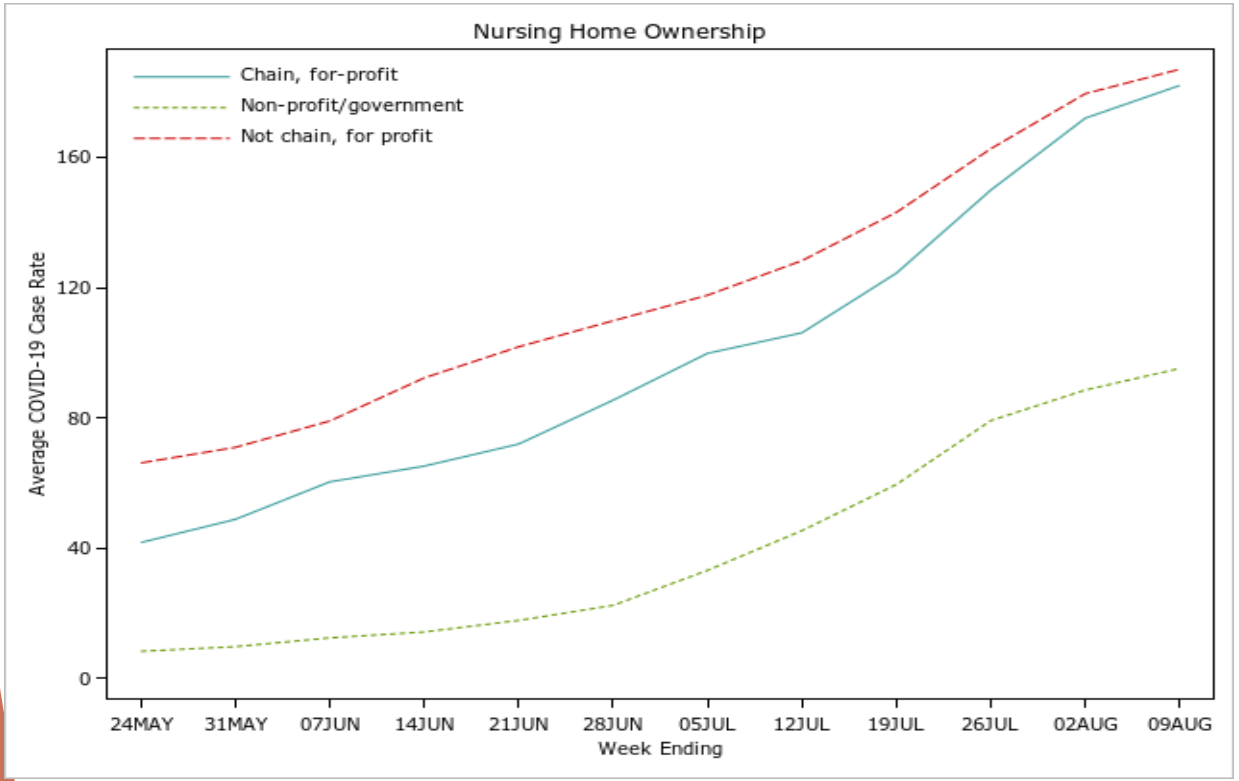
Nursing homes with **RN turnover greater than 50% had 30% higher COVID-19 case rates** compared to nursing homes with the lowest nursing turnover.

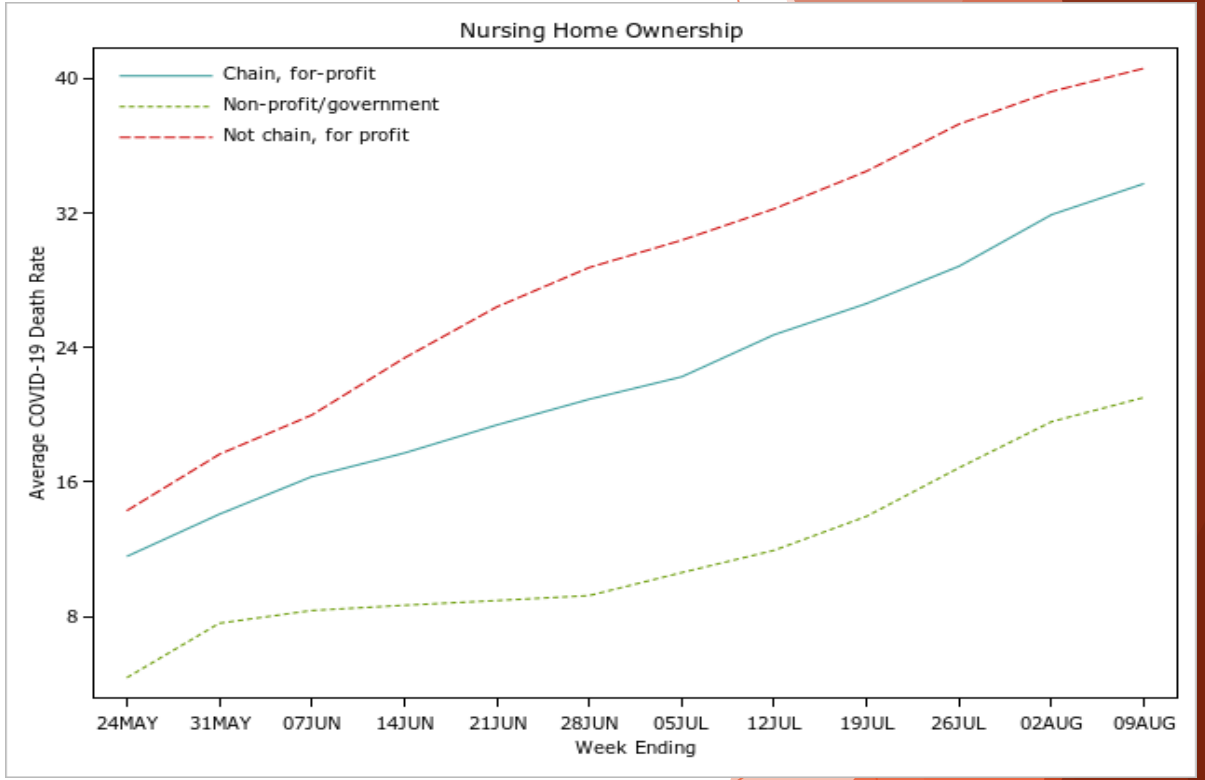
Facility Size

# of Licensed Beds

In August, larger nursing homes, as defined as having **greater than 120 licensed beds, had COVID-19 case rates at least 55% greater than those nursing homes having 68 or fewer licensed beds.**

Select Descriptive Statistics





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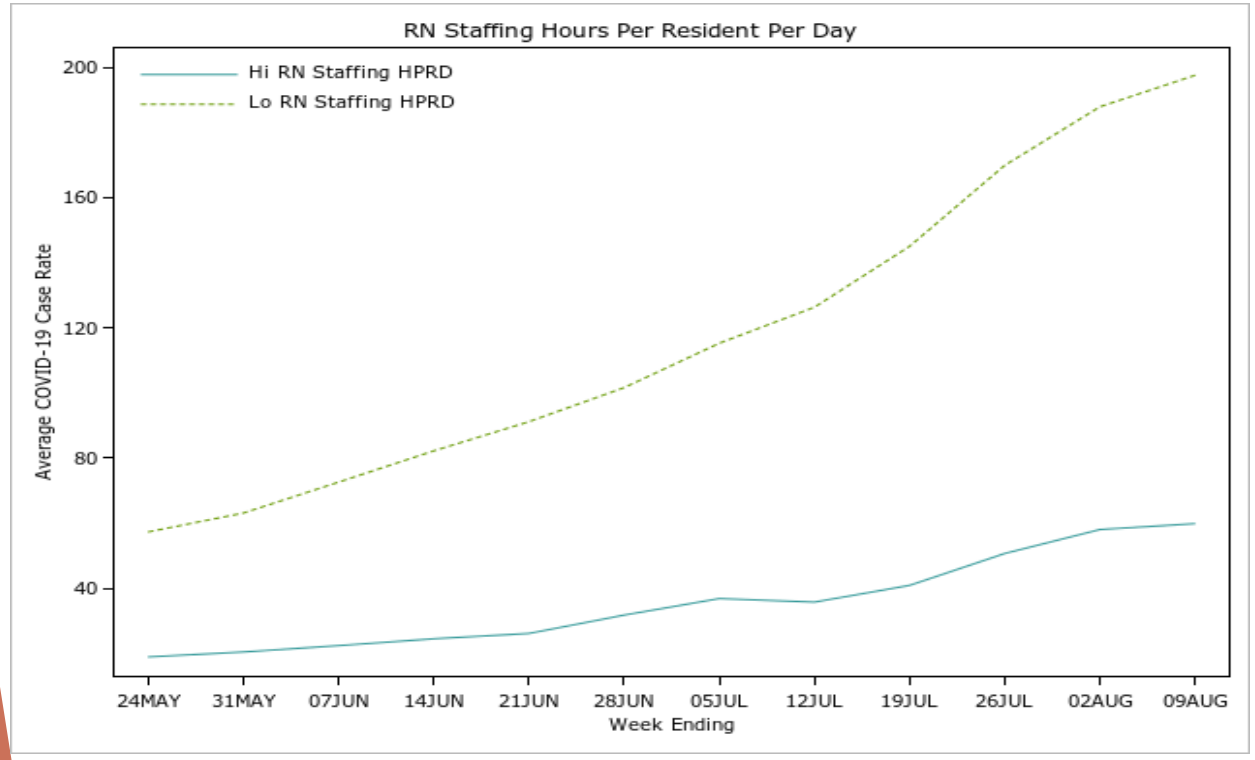

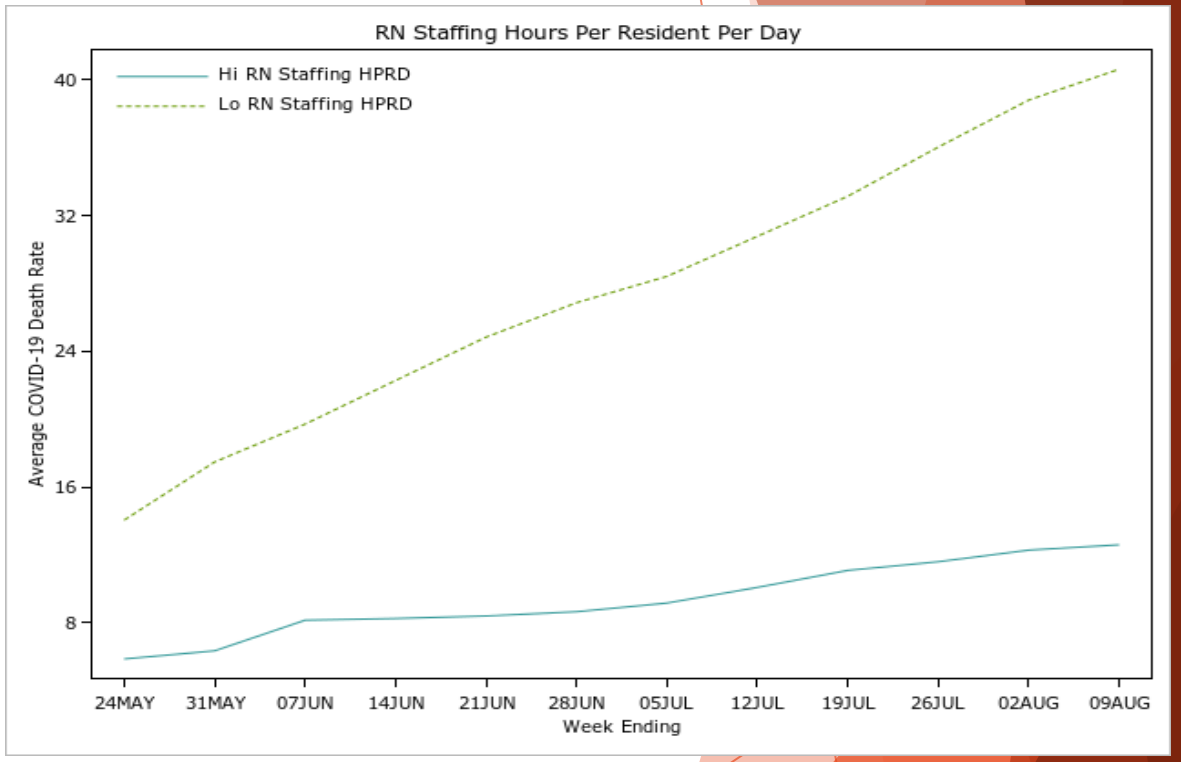

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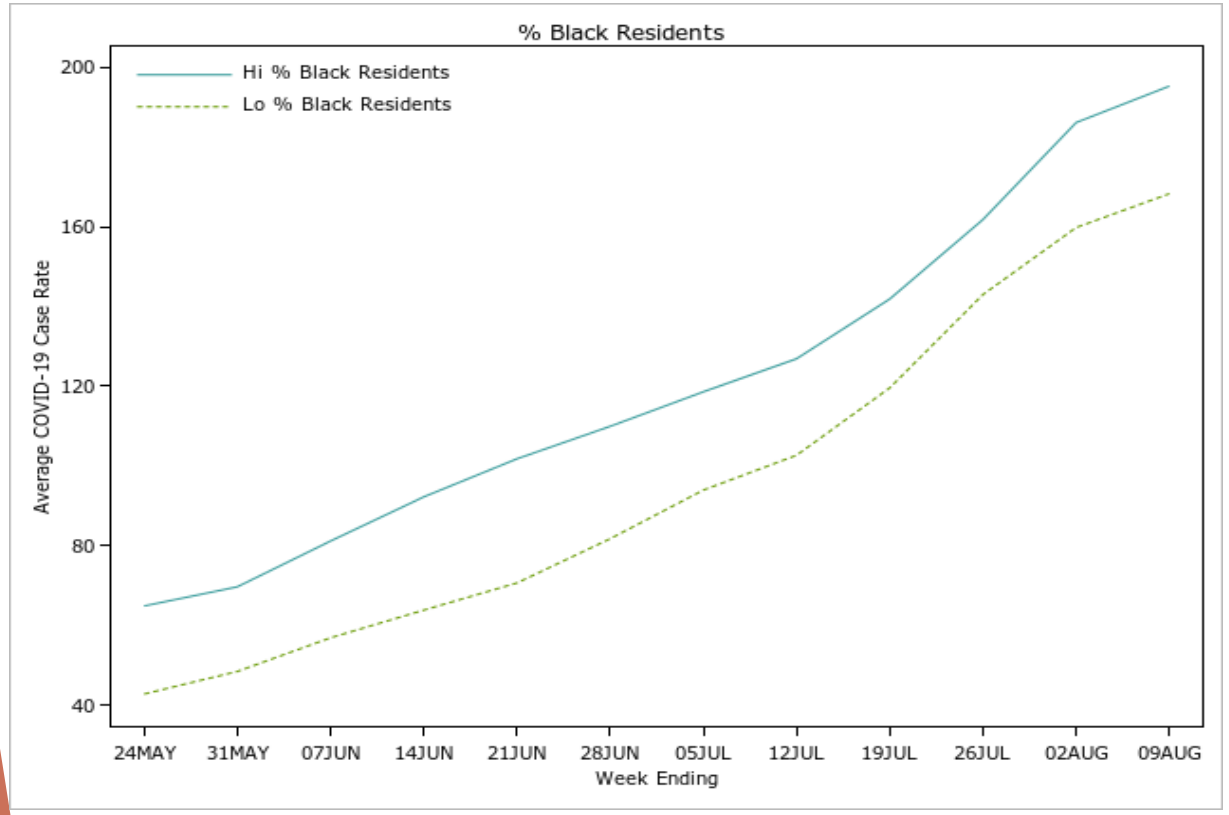

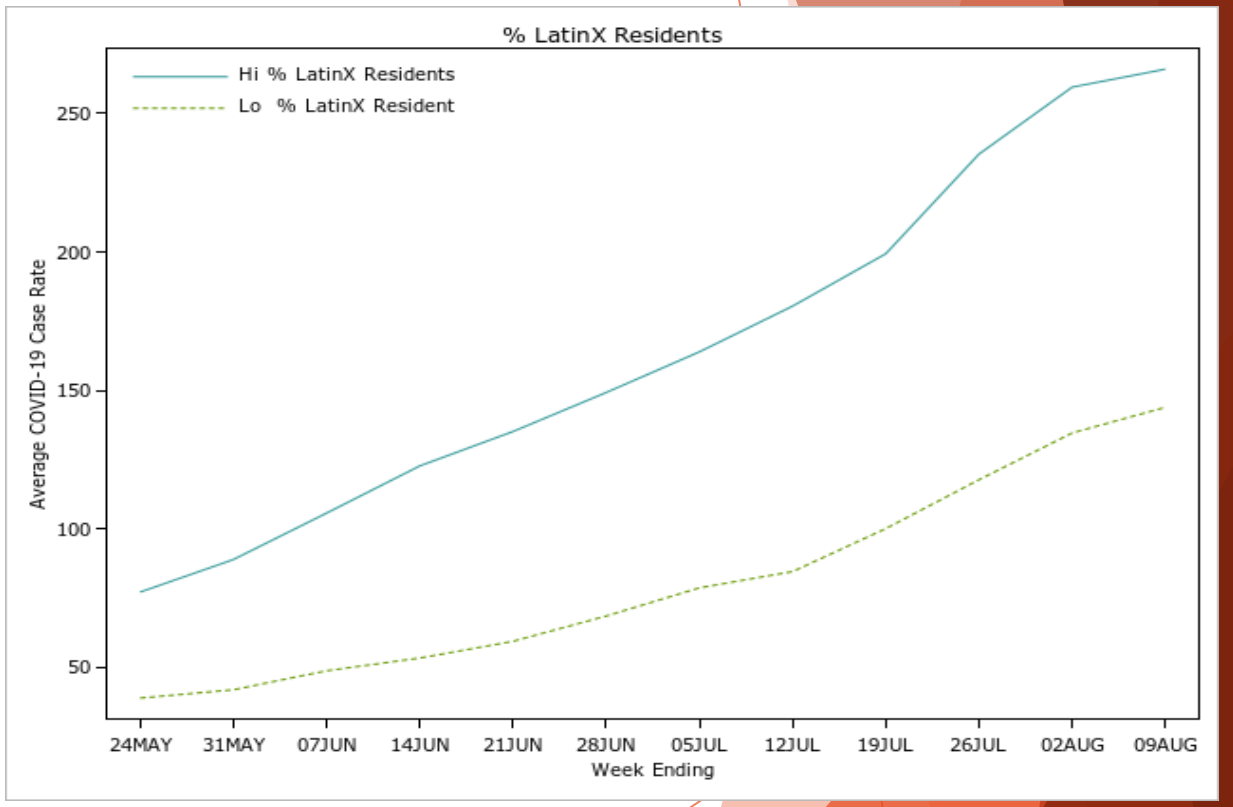

Proposed Recommendation Categories

- Future Studies
- Data Enhancements
- Facility Size and Design
- Staffing Related
- Facility Ownership
- Testing/Infection Prevention

What is an "At-risk" facility?

Use the factors in the models that were significant and had a strong influence on infections and deaths.

Identify each facility the top quartile of SNFs in each factor - presence in the top quartile of one becomes one "signal"

Increasing number of "signals" indicates a higher risk

Construct a list of facilities with the greatest number of "signals"

Next Step

- Disseminate final report with recommendations to partners & other key stakeholders by late November/December

Wrap Up

2020 - 2021 BOD Call Schedule
(all times are Pacific Time Zone)

- **Wednesday, December 16, 2020 9:00am to 11:00am**
- Tuesday, February 10, 2021 10:00am to 12:00pm
- Wednesday, April 14, 2021 10:00am to 12:00pm
- Wednesday, June 9, 2021 10:00am to 12:00pm
- Wednesday, August 4, 2021 10:00am to 12:00pm
- Wednesday, September 29, 2021 10:00am to 12:00pm
- Wednesday, December 1, 2021 10:00am to 12:00pm

Thank you!

Cal Hospital Compare Advisory Group
Consumer Activation Recommendations

Background: Public reporting of healthcare performance, part of what is known as the "transparency movement", was originally envisioned to empower consumers to make (and improve) health care choices with the ultimate outcome that the market place would respond to consumer activation. A plethora of organizations emerged to produce useful performance information and the scope of public reporting on all aspects of the health system expanded in a parallel fashion. Yet, the number of consumers actually seeking and using the information remains quite small.

Cal Hospital Compare (CHC) has been publishing hospital performance for over a decade and has undertaken numerous studies and steps to enhance consumer use of its data with limited impact. The most recent effort to partner with Yelp to publish maternity quality data has yielded a modest, positive impact. The CHC Board directed staff to explore alternative ways to grow consumer utilization of hospital performance data and the California Health Care Foundation (CHCF) funded a project to create a prioritized approach in a larger framework to advance consumer activation.

Method: Cynosure Health (Cynosure) recruited a 19-member national advisory group of with diverse backgrounds such as consumers, patient advocates, academic transparency experts, employers/purchasers, measurement scientists, marketing/branding experts and former members of the CHC Board involved with previous consumer outreach activities (appendix 1). After compiling a review of the scientific and grey literature, Cynosure then designed and facilitated a series of four advisory group meetings to:

1. Review and refine a strategic framework to strengthen consumer activation and use of CHC data.
2. Provide input and prioritize high-yield activities for CHC to enhance consumers' use of CHC performance data for healthcare decision making purposes.

Recommendations: The advisory group acknowledges healthcare decision making is highly complex with emotional, personal values, qualitative and quantitative components. Consumers trend toward simplifying this process by using qualitative/emotional information (i.e. use recommendation from a family/friend, prioritize an existing physician relationship). Rather than focus solely on driving consumers to a modified or visually-oriented CHC website, the advisory group recommends the following short term and long-term strategies in rank order (appendix 2). The advisory group took into consideration impact, effort, and cost of each initiative during the ranking process (appendix 3). In addition, for any of the following strategies to be successful, steps should be taken to strengthen CHC's brand and reputation in the market as a go-to resource for healthcare data.

Near term strategies:

1. **Direct to consumer outreach via strategic partnerships:** Using this approach, CHC assumes a primary role as a data/score generator that leverages strategic partnerships with more intimate and frequent connection to consumers to disseminate or distribute relevant performance information. Critical to success is:
    a. Understand healthcare consumers' online behavior and craft relevant messages.
    b. Identify and develop strategic partnerships with data disseminators that have complimentary choice attributes to CHC information (i.e. MD, cost, network) at both the local and statewide/national level
    c. Package CHC data into an easily accessible and distributable product

    The advisory group recommends that CHC consider hiring a Social Media Engagement/ Communications Specialist to provide expertise direct to consumer content and to

develop/manage partnerships. CHC contributors Ateev Mehrotra, Ted von Glahn and Andy Krackov can also provide advisory support on data and messaging. The CHC executive director will participate in prioritizing, building and providing leadership to the partnerships and the CHC project manager can provide day to day guidance and project management support.
Impact Assessment: The advisory board members acknowledge consumers pull data from a variety of different sources - no one size fits all – and that it is easier to tap into existing consumer pathways then create new ones. By partnering with a variety of existing disseminators of healthcare data we can tap into a larger consumer pool than just those that frequent Yelp. Yelp is one of several avenues by which Cynosure has disseminated CHC data in the past with modest results. We know there is likely a tipping point with number of partners or number of consumers at each partner that view the data, but we were not able to tease out how many and what kinds of partners would bring us to the magical number. This activity is not time limited, however. That is, CHC could constantly add new partnerships to reach more consumers over time. Likely, there are technology mechanisms that would allow for a rapid assimilation of data onto a variety of different platforms that would streamline the process.

2. **Activate consumers using intrinsic motivators:** Drive consumer activation by highlighting the consequences of healthcare decisions including not making or allowing others to make decisions. The initial step would be to identify key intrinsic motivators for "shoppable" conditions and determine how best to leverage this information to support data driven decision making. This strategy may influence direct to consumer outreach via CHC only and/or with its strategic partners. The ultimate goal is to create a "felt need" by consumers to acquire performance data based on the personal nature of poor and superior performance.
Impact Assessment: Many of the advisory group members with experience in measuring consumer behavior described the difficulty determining the impact of any one initiative and recommended we initially focus efforts on the strategy and engage experts later to provide guidance on how to effectively measure success, such as a Social Media Engagement/ Communications Specialist. During some of the initial discussions we talked through how we could use leverage google analytics, focus group research, and/or data collected via our strategic partners to inform our impact strategy. Others suggested that we could use Facebook ads and resultant attention/click throughs to determine the optimal messaging strategy. Much like the marketing world where "Impressions" are a quantitative but indirect indicator, "felt need" is truly only indirectly measured.

3. **Enhance indirect consumer outreach by co-designing with patients:** CHC should actively utilize feedback from patients and their families to enhance website features to strengthen consumer engagement. Tactics might include search engine optimization, adaptive web-based reporting, and the inclusion of patient stories and other qualitative data.
Impact Assessment: This is an emerging field without in-depth quantitative support. The presumption is that "engaging the customer" at the earliest process is a component of human centered design that has traction in the business world as an effective method to enhance the product. As with the other near-term strategies, a formal quantitative analysis would likely involve a combination of google analytics, data from strategic partners or other sources. An interesting outcome of this approach is the opportunity to participate in measure design projects that are funded by the federal government, philanthropies or other entities involved with clinical measures.

Longer term strategies:

4. **Partner with MDs to recommend data:** Partner with providers to disseminate relevant data to consumers. Consumers rely heavily on their physician's recommendation in making healthcare decisions. However, other initiatives that involves partnering with physicians to transform care delivery are widely experimental. The advisory group recognizes the challenges with this initiative and recommends learning from other states during similar work (ex. NYS Health) and other small test of change before moving forward.
   Impact Assessment: Any experiment to engage MDs with recommending CHC data would involve a measurement arm. Examples could be the use of iPads to review data (yielding google analytics), brief surveys on the value of the data recommended (such as a net promoter score) or more rigorous surveys assessing consumers use of the information.
5. **Develop measures that matter:** Expand existing reportable measures to reflect range of criteria consumers' use to make decisions, such as: condition specific information, relational attributes, cultural competencies, outcomes.
   Impact Assessment: An important source of the value of this approach would emerge from the beginning of the process – understanding what consumers truly desire. This would include a mixed methods approach and further quantitative testing would be an integral part of the entire measure development process.

Conclusion: A diverse and experienced national advisory group organized to enhance consumer activation of hospital performance data recommends a fundamentally different primary role for CHC – to act as a data/score generator and develop partnerships with organizations where consumers seek health-related and other information. Social media sites are one possibility but not the only or most important partners to consider. Over time, CHC should also work on using intrinsic motivators to create a "felt need" to activate consumer seeking behavior for performance data. Other activities should be pursued based on resources and organizational bandwidth and some will take a more concerted, multi-level approach, likely with additional stakeholders.

CHC is currently developing an ongoing funding mechanism to pursue these priorities in the near term. As opportunities and alignment with other initiatives, projects and funding opportunities arise, CHC can expand and accelerate the scope of work and pursue other recommendations from the advisory group.

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Appendix 2: Poll ranking results from Dec. 14, 2018 Advisory Group Mtg (n=11)

Priority Level	Strategy
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%)

Appendix 3: Considerations

Strategy	Impact (1=low, 5=high)	Effort (1=low, 5=high)	Cost (1=$20,000 – 5=$100,000)	Potential Partners
1. Direct to consumer outreach via strategic partnerships:	5	3	3	Amazon, Amino, Definitive Healthcare, California Maternal Quality Care Collaborative (CMQCC), CHC Board & Partners, Covered California, Commercial Insurers, Employers, Facebook, Google, Healthgrades, IHA CA Provider Directory Utility, WebMD, Vitals, Yelp
2. Activate consumers using intrinsic motivators	5	4	4	CHC Board & Partners, Covered California, Employers, PFCCpartners
3. Enhance indirect consumer outreach by co-designing with patients	3	3	2	Google analytics, IBM Watson, PFCCpartners, WordPress,
4. Partner with MDs to recommend data	4	5	5	EMR Vendor, IBM Watson, integrated health systems, physician organization
5. Develop measures that matter	3	5	4	CHC Board & Partners, CMS, CMQCC, PFCCpartners

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Understanding and Promoting Consumer Activation through Cal Hospital Compare: Literature Review

Cynosure Health conducted an in-depth review of relevant academic literature on consumer activation, public reporting, and related topics (Appendix I). Notable efforts include the CMS and AHRQ grants on "Building on the Science of Public Reporting," the Robert Wood Johnson Foundation's Aligning Forces for Quality Grants, New York State's report on lessons learned in creating an All Payer Database, and research on the intersection of patient activation and data driven decision making. The literature review revealed the following:

Consumer trends:

Overall, most consumers are unaware of publicly available, comparative reports on hospital, provider nursing home, etc. quality and/or cost.[1] A 2016 Public Agenda survey found that only 20% of Americans have tried to compare prices across multiple providers before getting care. However, trends of growing consumer activation are slowly increasing, especially among younger consumers with higher incomes and those with major health issues.[1,2] In general, younger consumers are more trusting of online information but older consumers are interacting and engaging with their healthcare online more than ever before .[2,14] The Deloitte Center for Health Solutions 2015 Survey of US Health Care Consumers found that consumers with major health issues generally show the highest level of engagement but it is unclear the impact of socioeconomic factors on this trend.[1,2,10,20]

A 2017 national survey conducted by Mehrotra et al found that most respondents believe that price shopping for care is important and do not believe that higher-cost providers were of higher quality. Interestingly, the majority of these same respondents reported they do not actively utilize available quality and price transparency tools when making healthcare decisions.[13] This is true in other countries, including Germany and the United Kingdom, that have adopted similar quality and/or price transparency tools to promote patient choice.[17,18] However, studies show that once consumers are exposed to quality and price transparency tools they find them helpful, would likely use them future, and recommend the tools to others.[22,33] For example, New York State Health and Consumer Reports conducted a study comparing the usability of several web based cost estimator tools. The study found that most participants were not aware of these tools but after participating in the study 75% would recommend the tools to others.[33]

A 2003 study by Hibbard et al suggests that comprehension, motivation, and the actual use of the information are increased when cognitive effort is reduced, when the decisionmaker is moved closer to the actual experience, and when the meaning of information is highlighted for the decision-maker.[16,23,24,27,29] In addition, a 2017 study examining hospital choice in Germany found that experienced consumers often want more information and have higher levels of decision confidence whereas inexperienced consumers trend toward simplifying the decision-making process by relying on their doctor, social environment or use stereotypical choice schemes (e.g. always choose the nearest hospital).[17] However, consumers' choice may be complicated by benefit design.
In the 2016 Public Agenda survey most consumers seeking care for joint replacement surgery and maternity reported having some choice among physicians but fewer choices for hospitals.[21]

Designing for consumer activation:

The 2017 UHF study report consumers value the following: condition specific information, clinician level information, patient experience and patient reported outcomes, structural and service quality attributes

of the delivery system, characteristics of the information itself (plain language, avoidance of acronyms timeliness, ability to customize), ease of use, and that the data includes both quality and cost.[1,19] However, these findings are juxtaposed against many studies that find consumers, at the point of decision making, prefer a "less is more" approach to comparative data.[24,27]

Suggested recommendations:
Thought leaders and researchers suggest a variety of levers may be utilized to strengthen healthcare consumer activation and data driven decision making, including but not limited to:

- **Influence** what doctors advise. Most patients still rely heavily on their physician's recommendation when making healthcare decisions.[10] One study suggest that consumers are more likely to trust a website recommended by their doctor yet only 17% report being recommended online content by their physician.[14]
- **Incentivize** physicians and/or patients to suggest or identify high quality, low cost care. One approach might include insurers setting a market rate for "shoppable services" and patients pay the difference.
- **Design** hospital quality comparison tools in a way that has broad appeal to a diverse group of healthcare consumers. A 2012 survey by The Joint found that most consumers can interpret data on leading hospital compare websites. This suggest that designing for resonance, not interpretation, is the iterative next step. Some more novel suggestions include: easy to use adaptive web-based reporting, the use of analytical and emotional content, and measures that matter beyond what is currently reported by hospitals.[1]
- **Integrate** quality data into the larger tech ecosystem. Some studies have shown marginal success in increasing consumer use of public reports by leveraging social media (Google, Facebook, Twitter). In addition, a 2017 study by Maurer et al found that consumers seeking maternity care were significantly more likely to visit websites and adopt behaviors to inform care when the following interventions were present: text message and email reminders, videos and materials describing the relevance of quality measures, and tools to support discussions with clinicians.[1,19,27,31]

Perceived gaps in literature:
There is a wealth of academic literature on consumer activation and related topics, but research at the intersection of consumer activation *and* hospital public reports is lacking. Particularly, how best to incorporate hospital quality data into the larger tech ecosystem. Another gap in understanding is *whether* and *how* to design hospital quality comparative tools for all consumers or a subset of consumers for shoppable services.[1]

In addition, there is little research on the effectiveness of engaging physicians to support consumer activation and hospital choice. Some studies suggest that physicians do not trust publicly reported hospital data and may be unwilling to share available information with their patients for multiple reasons.[1,18]

The role of insurers in driving consumer activation is also in question. For example, insurers have tried fostering the use of price transparency tools using the high deductible health plan model. The result was decreased spending on both valuable and wasteful healthcare services; not price shopping.[9]

Appendix I: Literature Review (September 2018)

*Bold = recommended reading, *= full article not currently available in SharePoint*

Title	Authors	Year	Methods	Select Findings
Building on the Science of Public Reporting Research Grants[1]	CMS & AHRQ	2012 to 2016	- CMS and AHRQ supported 17 studies to inform the content, design, dissemination, and underlying data and methodology of public reports.	- Consumers' infrequent use of public reports of health care quality and resource use is due to reports' poor design, irrelevant content, and inadequate dissemination, rather than a lack of interest in the information. - CHC could leverage published findings and associated resources and toolkits, as well as outreach to grantees to inform the proposed project.
Health care consumer engagement: No "one size fits all" approach[2]	Deloitte Center for Health Solutions	2015	- Deloitte Center for Health Solutions 2015 Survey of Health Care Consumers.	- Evidence that consumer engagement is trending upward in three important areas: partnering with providers, tapping online resources, and relying on technology. - Deloitte mentions that consumer trust in online information sources is rising (e.g., one fourth of consumers have looked at a scorecard to compare provider performance). - Deloitte finds that the following are the most engaged consumers: Poorer health status, younger, and higher income.
When patient activation levels change, health outcomes and costs change, too[3]	Greene, Hibbard, Sacks, Overton, & Parrotta	2015	- Authors examined the extent to which the Patient Activation Measure was associated with health outcomes and costs over time, and whether changes in activation were related to expected changes in outcomes and costs. - Data were from adult primary care patients from a single large health care system where the Patient Activation Measure was routinely used (Fairview Health in MN).	- Higher activation was associated with 9 of 13 better health outcomes—including better clinical indicators, more healthy behaviors, and greater use of women's preventive screening tests—as well as with lower costs two years later. - Findings suggest that efforts to increase patient activation may help achieve key goals of health reform and that further research is warranted to examine whether the observed associations are causal.
Making sense of "consumer	Mittler, Martsolf,	2013	- Conceptual framework to classify consumer engagement initiatives	- Distinguishes between consumer engagement (performance of specific behaviors) and activation

Title	Authors	Year	Methods	Select Findings
engagement" initiatives to improve health and health care: A conceptual framework to guide policy and practice[4]	Telenko, &Scanlon		toward advancing policymakers' and practitioners' knowledge of their value and fit in various contexts. - Builds on the individually focused transtheoretical model of behavior and the broader, multilevel social ecological model. - Authors searched and reviewed the literature available through PubMed for existing conceptual models of consumer engagement in health; then turned to the gray literature, using Google to search for the phrase "consumer engagement."	(capacity and motivation to performance those behaviors). - Note: Authors were part of the independent Aligning Forces for Quality evaluation team (funded by RWJF).
The aligning forces for quality experience: lessons on getting consumers involved in health care improvements[5]	Mende & Roseman	2013	- RWJF Aligning Forces for Quality (AF4Q) community progress; focused on consumer perspectives and engagement. - Authors mention that all AF4Q communities were required to make available to the public information about comparing the quality of care among health care providers and engage consumers in making informed health care decisions (among others).	- As the communities matured, the RWJF provided specific guidance on engaging consumers through the promotion of consumer access to health and comparative performance information (documented in a 2009 memo from the RWJF to communities). - Alliances that were successful with consumer engagement reported that they needed to periodically revisit strategies. - If consumers are to access and use comparative performance information, it must be displayed in a consumer-friendly way, with clearly defined and understandable measures presented in a format that makes it easy to identify patterns of provider performance across multiple measures.
Early experiences with consumer engagement initiatives to improve chronic care[6]	Hurley, Keenan, Martsolf, Maeng, & Scanlon	2006	- Report on the RWJF-funded aligning forces for quality (AF4Q) designed to improve quality and efficiency by promoting public reporting and expanding the involvement of consumers.	- Communities reported that securing the resources and sustaining enthusiasm to maintain and expand consumer engagement programs will be a major challenge. - Gains from consumer engagement initiatives will be determined by promoters' ability to translate slogans and rhetoric to real strategies and actions.

Title	Authors	Year	Methods	Select Findings
eHealth for Patient Engagement: A Systematic Review[7]	Barello, Triberti, Graffigna, Libreri, Serino, Hibbard, & Riva	2016	- In this paper the authors reviewed findings from literature about the use of eHealth in engaging patients in their own care process. - Comprehensive literature search resulting in the inclusion of eleven studies.	- The perceived value of the tool is correlated with a consumer's intention of using it. - Several studies show that the use of e-health increases a consumer's PAM. - Most e-health tools rely on a consumer's analytical skills. There is an opportunity to approach the design of e-health tools spanning multiple domains of engagement: behavioral, cognitive, & emotional.
The problem with composite indicators[8]	Barclay, Dixon-Woods, & Lyratzopoulos	2018	- Evidence based opinion editorial outlining six common problems associated with composite indicators; specifically, hospital quality & safety metrics.	- Use of composite indicators is a popular approach to representing hospital comparison data. - Generally, there is a lack of transparency & standardization in the methodologies used to create the composite score resulting in "false positives & negatives." - Many composite indicators would be improved by reflecting the aims and preferences of consumers using a clear process.
What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics[9]	Brot-Goldberg, Chandra , Handel, & Kolstad	2017	– Analysis of administrative data from a large self-insured firm over six consecutive years during the time window, 2006 and 2015.	- Found no evidence of consumers learning to price shop after two years in high-deductible coverage. - Consumers reduce quantities across the spectrum of health care services, including potentially valuable care & wasteful care.
How Do Patients Choose Physicians? Evidence from a National Survey of Enrollees in Employment-Related Health Plans[10]	Harris	2003	– Randomized survey of individuals between the ages of 21 and 64 with employer-related health benefits, drawn from a nationally representative panel of households.	- Small percentage of respondents actively searched for a physician. - Reduced consumer activation associated with poor health status, higher levels of service use in the past year, and stronger ties to individual physicians. - Ethnic minorities appear to be more active consumers. - In general, most consumers relied on existing relationships and word of mouth to choose physicians.

Title	Authors	Year	Methods	Select Findings
Association Between Availability of a Price Transparency Tools and Outpatient Spending[11]	Desai, Hatfield, & Hicks	2016	- Using a matched difference-in-differences design, outpatient spending among employees offered the price transparency tool was compared with that among employees from other companies not offered the tool.	- Among employees at 2 large companies, offering a price transparency tool was not associated with lower health care spending. - The tool was used by only a small percentage of eligible employees.
Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans[12*]	Chernew, Zooper, Larsen-Hallock, & Morton	2018	- A National Bureau of Economic study on how individuals with private health insurance choose providers for lower-limb MRI scans	- A consumer's decision on where to go for a MRI largely correlates with physician recommendation; regardless of cost, quality, and/or distance. - Less than 1 percent of individuals used a price transparency tool to search for the price of their services in advance of care.
Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information[13]	Mehrotra, Dean, Sinaiko, & Sood	2017	- Nationally representative survey of 2,996 nonelderly US adults who had received medical care in the previous twelve months to assess how frequently patients are price shopping for care and the barriers they face in doing so.	- Only 3% had compared costs across providers before receiving care. - Low rates of price shopping do not appear to be driven by opposition to the idea. - Most respondents believed that price shopping for care is important and did not believe that higher-cost providers were of higher quality. - Common barriers to shopping included difficulty obtaining price information and a desire not to disrupt existing provider relationships.
Consumer Health Online 2017 Research Report[14]	Brightline Strategies	2017	– Surveyed 1,509 adults in the U.S. aged 18+ who engaged in health-related information online in the last 12 months. – Data was weighted to reflect the general population of adults aged 18 and over nationwide.	- Consumers are defining "health" with wellness/fitness-focused words versus traditional healthcare words. - Older generations are interacting and engaging with their healthcare online more than ever before. - Most consumers turn to the internet first for health-related information.

Title	Authors	Year	Methods	Select Findings
				- Consumers are likely to trust a website recommended by their doctor yet only 17% report being recommended online content by their doctor. - In general, younger generations are more trusting of online information versus older consumers.
Exploring Consumer Understanding and Use of Electronic Hospital Quality Information[15]	The Joint Commission & RWJF	2012	– A total of 24 prototype reports were created from existing elements of Hospital Compare® and Quality Check® to evaluate how differing presentations of data influence the interpretations of consumers. – Consumer focus groups were used to assess the comprehension of various prototypes created from existing hospital quality reports.	- Generally, consumers can interpret data on leading hospital compare websites. - Consumers consistently ask to see all information that they believe is related to the quality of their care but want to also see information specific to their medical condition. - As the volume of information presented goes down interpretation accuracy improves.
How do healthcare consumers process & evaluate comparative healthcare information? A qualitative study using cognitive interviews[16]	Damman, Hendricks, Rademakers, Delnoij, & Groenewegen	2009	– Using semi-structured cognitive interviews (n = 20) consumers were asked to think aloud and answer questions related to three Dutch web pages providing comparative healthcare information.	- Barriers to effective use of comparative healthcare information include: too much information and ambiguity of terms presented.
Insurees' preferences in hospital choice—A population-based study[17]	Schuldt, Doktor, Lichters, Vogt, & Robra	2017	- Conducted a Discrete-Choice-Experiment (DCE) on hospital choice with 1500 randomly selected participants (age 40–70) in three different German cities.	- In Germany, only about 1/3 of all consumers know about online hospital comparison tools. - General Practitioners make limited use of hospital comparison websites to support patient choice. - Experienced consumers wanted more information and had higher levels of decision confidence. - Inexperienced consumers trended toward simplifying the decision-making process by relying on their doctor, social environment or using stereotypical choice schemes (e.g. always choose the nearest hospital).

Title	Authors	Year	Methods	Select Findings
Patient Choice – The King's Fund[18]	Dixon, Robertson, Appleby, Burge, Devlin, & Magee	2010	– This study was conducted in four local health economies in England, between August 2008 and September 2009, using a mixed method that combined interviews with patients, GPs and senior executives from hospital providers (including the private sector) with patient questionnaires.	- Most consumers want choice, but few make use of available information. - Most GPs believe that only a few consumers want choice based on socioeconomic factors. - GPs do not trust or have access to 'reliable information' on quality and distrust information provided by hospitals.
Empowering New Yorkers with Quality Measures that Matter to Them[19]	Rogut, Kothari, & Audet	2017	- United Hospital Fund (UHF) Quality Institute engaged in a 15-month inquiry to examine more than 70 publicly accessible websites, supported by the New York State Health Foundation.	- Consumers value the following: 1) condition specific information, 2) clinician level information, 3) patient experience and patient reported outcomes, 4) structural and service quality attributes of a practice, 5) characteristics of the information itself (plain language, avoidance of acronyms, timeliness, ability to customize)
Right Place, Right Time: Improving Access to Health Care Information for Vulnerable Patients[20]	Altarum Institute, Oliver Wyman, & RWJF	2017	- Altarum Institute conducted interviews and focus groups with 65 consumers and a nationally representative mail and web survey of 4,068 consumers, fielded in June through August 2016. - Results are weighted to be nationally representative based on US census demographic characteristics.	- Referrals from friends, family, and providers are the most important sources of information when choosing a new doctor, followed by online patient reviews. - Consumers are rarely aware of official quality comparisons, this is especially true for lower income consumers.
Qualities that Matter[21]	Schleifer, Silliman, Rinehart, & Diep (Public Agenda & RWJF)	2017	- Public Agenda conducted nationally representative surveys of people who have experienced one of three common types of health care for which quality and costs can vary: type 2 diabetes care, joint replacement surgery and maternity care.	- Consumers believe interpersonal and clinical qualities of doctors and hospitals are important for high-quality healthcare but did not spend much time researching this when selecting a provider or hospital. Spent more time researching their care and insurance coverage. - Most consumers had at least some choice among doctors. But fewer people who recently had a joint replacement or gave birth had much choice among hospitals.

Title	Authors	Year	Methods	Select Findings
				- Few people across the three groups are aware of quality variation or price variation for doctors or for hospitals.
Increasing the Use of Comparative Quality Information in Maternity Care[22*]	Maurer, Carman, Firminger, & Hibbard	2017	- This randomized controlled trial tested an intervention to increase uptake of hospital-level maternity care quality reports among 245 pregnant women in North Carolina	- The intervention included three enhancements to the quality report offered to the control: (a) biweekly text messages or e-mails directing women to the website, (b) videos and materials describing the relevance of quality measures to pregnant women's interests, and (c) tools to support discussions with clinicians. - Compared with controls, intervention participants were significantly more likely to visit the website and report adopting behaviors to inform care.
Making comparative performance information more comprehensible[23]	Damman, Harmsen, de Jong, Hibbard, & Timmermans	2016	- An experimental between-subjects and within-subjects design with manipulations of comparative performance information (CPI) presentation formats.	- Presentation formats enhanced consumer understanding of CPI, most importantly the use of overall performance scores, word icons and colored dots, and a reduced number of providers displayed reduced cognitive effort and fostered easy interpretation.
Less is More in Presenting Quality Information to Consumers[24*]	Dieckman, Dixon, Hibbard, & Mertz	2008	- Meta-analysis of three relevant studies.	- "Less is more" when presenting consumers with comparative performance information to make hospital choices; reduces cognitive burden.
Hospital Performance Reports: Impact on Quality, Market Share, And Reputation[25]	Hibbard, Stockard, & Tusler	2005	- To determine if the report affected how consumers viewed the quality of hospitals in their community all respondents were asked which hospitals had fewer preventable complications and which made fewer medical mistakes.	- Respondents who had not been exposed were significantly less likely to name a highly rated hospital in either in the immediate or two-year-post surveys. - Recall of poorly performing hospitals was better than recall of high performers.

Title	Authors	Year	Methods	Select Findings
Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?[26]	Hibbard, Stockard, & Tusler	2003	- Used an experimental design to evaluate the impact of a public hospital performance report on subsequent hospital quality improvement efforts. - Alliance (a large employer-purchasing cooperative in the Madison, Wisconsin area) produced and disseminated this report.	- Making performance information public stimulates quality improvement in the areas where performance is reported to be low
Supporting Informed Consumer Health Care Decisions: Data presentation approaches that facilitate the use of information in choice[27]	Hibbard, & Peters	2003	- This paper reviews what is known from studies of human judgment and decision-making and discusses their implications for supporting informed consumer choice.	- Evidence suggests that comprehension, motivation, and the actual use of the information are increased when cognitive effort is reduced, when the decisionmaker is moved closer to the actual experience, and when the meaning of information is highlighted for the decision-maker.
Increasing the Impact of Health Plan Report Cards By Addressing Consumers' Concerns[28]	Hibbard, Harris, Mullin, Lubalin, & Garfinkel	2000	- Used a controlled experimental design to evaluate the comparative effectiveness of presenting health plan decisions in terms of protecting oneself from possible risk versus obtaining a gain or benefit.	- Consumers understand report-card information best when it is succinct and conveys a message of risk, not benefit.
Will Quality Report Cards Help Consumers?[29]	Hibbard, & Jewett	1997	- This study assesses the relationship between the salience of quality information and how well it is understood by consumers. - The analysis is based on survey data and content analysis from focus-group data (104 participants).	- Comprehension of quality information is strongly related to the salience of that information. Comprehension drives salience. - If consumers do not understand information, they are more likely to dismiss it as unimportant.

Title	Authors	Year	Methods	Select Findings
New York's All- Payer Database: A New Lens for Consumer Transparency[30]	APCD Council NYS Health	2015	- Report offers lessons learned from other states that have developed (or were developing) similar systems and highlighted the perspectives of key stakeholders in New York State; and made recommendations to policymakers for developing a robust APD.	- In 2011, New York State passed legislation enabling the creation of an all-payer database (APD). However, the APD gained little traction in the 5 years post the enabling statue. - The APD could serve as a resource for price transparency, quality oversight, payment reform, policy research, health systems transformation, and consumer transparency. - Report recommended the following actions to create a consumer friendly APD: 1) develop a phased approach to APD data release based upon use cases, 2) develop price transparency tools, 3) include self-funded data sources in the APD, 4) develop a stakeholder engagement and communications process regarding the APD startup functions; and 5) formalize an APD data quality program. - Note: since the release of this report the state has moved forward with much of the proposed recommendations. In May 2018, NYS Health Connector website launched. The State is finalizing the APD's governance structure and advisory group.
Advancing Health Care Transparency: A National Inventory of Tools to Guide State Policy[31]	Honest Health, Human Services Research Institute, & NYS Health	2018	- Honest Health conducted a national inventory of health care transparency tools - Honest Health and the Human Services Research Institute (HSRI) summarized the findings and have recommended next steps.	- Key best practices for creating a health care transparency tool include: ease of use, information tailored to consumers, includes provider information, cost data is representative of the total cost of care, relevant quality data, data shows variation in cost versus quality. - Public outreach efforts, content generation, and coordination with existing user channels are needed to educate and engage audiences. - Note: a national inventory of health care transparency tools can be found here http://www.healthcaretransparency.org/

Title	Authors	Year	Methods	Select Findings
Defining the Goals of Healthcare Price Transparency[32]	Mehrotra, Schleifer, Shefrin, & Ducas	2018	- Opinion editorial of key subject matter experts in consumer activation in the healthcare space	- Price transparency tools should include the total cost of care (insurer and consumer) for a set of common procedures on a website that policymakers, employers, journalists, researchers, and consumers could easily access. - Giving providers total price data at the point of care does not influence ordering habits. - Most consumers do not discuss price with their providers.
Assessing and Improving Cost Estimator Tools for Consumers[33]	NYS Health, & Consumer Reports	2016	- Assessed the quality and usability, from a consumer perspective, of 11 health insurance plan websites in New York, including their cost estimator tools. - Evaluated eight public facing websites that present healthcare price information and data, including five that were national and three sites that were based in one state only.	- As consumers bear a greater burden of healthcare costs, they are increasingly looking for information on ways they can control their out of-pocket spending. - Prior to participating in the interview and web-usability test, only five of the 40 consumers (12.5%) interviewed had previously used the cost estimator tools on their insurer's site. - However, after participating in our study, 75 percent (30 of 40) said they recommend the website to others. - Users preferred quality and price to be presented together. - Most of our consumer testers said their heightened awareness from participating in this research would change their future behavior
What Can We Say about the Impacts of Public Reporting? Inconsistent Execution Yields Variable Results	Hibbard	2008	- Editorial report.	- Inconsistent execution of public reporting has yielded variable results in consumer activation. - Author suggest that we should improve the execution of public reporting efforts and only then reevaluate the effect of public reporting on quality.

Title	Authors	Year	Methods	Select Findings
It Isn't Just about Choice: The Potential of a Public Performance Report to Affect the Public Image of Hospitals	Hibbard, Stockard, & Tusler	2005	- The Quality Counts hospital report was released in the fall of2001. Ap re/ post design was used to evaluate the impact of the report.	- Those in the employee panel were much more likely to have seen the report. - Those who read the report carefully were significantly more likely to identify the high- and, especially, the low-performing hospitals. - There is some evidence that the report created a viral affect with those who saw it, remembered it, and shared the information with others.
Why Not Give Consumers a Framework for Understanding Quality?	Hibbard & Pawlson	2004	- Focus groups were conducted in 2001 to determine what performance information consumers would like to see to help them select a physician.	- The findings indicated that consumers' understanding of health care quality information was expanded to include a broader array of factors when a cogent framework was used to present quality information. - Recommend that the IOM framework be used, meaning public reports would routinely include the key categories of effectiveness, safety, and patient centeredness.
Engaging Health Care Consumers to Improve the Quality of Care	Hibbard	2003	- Conceptual framework and review of the literature.	- Increasing the coproducer role would require system and provider change, as well as an increase in consumers' skills and knowledge and a change in their understanding of their appropriate role.

Title	Authors	Year	Methods	Select Findings
Making Health Care Report Cards Easier to Use	Hibbard, Peter, Slovic Finucane, & Tusler	2001	- The study used an experimental design to examine how different presentation approaches affect the use of information.	- The findings indicate that there are data presentation approaches that help consumers who have lower skills use information more accurately. Some of these presentation strategies (for example, relative stars) improve comprehension among the lower skilled, and other strategies (for example, evaluative labels) appear to aid those in the midrange of comprehension skill

2020 OPIOID MANAGEMENT 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, Maternity, and Opioid Care Honor Roll.

To address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths, CHC will publish an annual Opioid Care Honor Roll in 2020 and 2021 to support continued quality improvement and recognize hospitals for their contributions fighting the epidemic. Honor roll hospitals will be determined using a relevant threshold based on a combination of baseline data from the 2019 pilot year and current submission cycle. To measure opioid stewardship CHC received funding from California Health Care Foundation (CHCF) to collaboratively design the *Opioid Management Hospital Self-Assessment*. This self- assessment measures progress across 4 domains:

1. Safe & effective opioid use
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 e.g. to achieve a Level 3 score your hospital must have also implemented the strategies outlined in Levels 1 and 2. Similarly, if your hospital has addressed some of the components outlined in Level 4 but not Level 3 then your hospital may fall into the Level 3 or even the Level 2 category. CHC recommends each hospital convene a multi-stakeholder team to complete the *Opioid Management 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.

For more information on the Opioid Care Honor Roll Program, register for the 2020 Webinar Series, results and learnings from the 2019 pilot year, and access tactical resources to support your quality improvement journey check out the Cal Hospital Compare website here.

Submit responses and any supporting documents via e-survey here
Assessment period: Jun 22 – Oct 9, 2020

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

Safe & Effective Opioid Use						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*

Appropriate Opioid Discharge Prescribing Guidelines
 	
Develop and implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new starts in opioid naïve patients and for patients on opioids to manage chronic pain. Possible exemptions: end of life, cancer care, sickle cell, and palliative care patients.
 	
Service line prescribing guidelines should address the following:
• Opioid use history (e.g. naïve versus tolerant)
• Pain history
• Behavioral health conditions
• Current medications
• Provider, patients & family set expectations regarding pain management
• Limit benzodiazepine and opioid co-prescribing
• For opioid naïve:
  ○ Limit initial prescription (e.g. <7 days)
  ○ Use immediate release vs. long acting
• For patient on opioids for chronic pain:
  ○ For acute pain, prescribe short acting opioids sparingly
  ○ For chronic pain, avoid providing opioid prescriptions for patients receiving medications from another provider
	Developed and implemented evidence-based opioid discharge prescribing guidelines across **2 service lines**, the Emergency Department and 1 Inpatient Unit (e.g. Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented **hospital wide** opioid discharge prescribing guidelines	Developed and implemented evidence-based opioid discharge prescribing **guidelines for surgical patients** as part of an Enhanced Recovery After Surgery (ERAS) program	Your hospital is **actively monitoring & developing strategies to improve opioid prescribing** e.g. rate of e-prescribing, Morphine Milligram Equivalent (MME)/patient, co-concurrent prescribing of benzos. & opioids, etc.
				
				Extra Credit (1 pt.)
				For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
						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)
						
						Stem the Tide: Addressing the Opioid Epidemic (AHA)
						
						No Shortcuts to Safer Opioid Prescribing (NEJMP); article available upon request

	Briefly describe the steps your hospital has taken to promote safe & effective opioid use at discharge					

Safe & Effective Opioid Use						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*
Alternatives to Opioids for Pain Management Use an evidence based, multi-modal, non-opioid approach to analgesia for patients with acute and chronic pain. Components of a multi-modal, non-opioid analgesic program should 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 • Care guidelines for common acute care diagnoses e.g. pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation (ALTO Protocol). • Opioid use history (e.g. naïve versus tolerant) • Patient and family engagement (e.g. discuss realistic pain management goals, addiction potential, and other evidence-based pain management strategies that could be used in the hospital or at home) • Pharmacologic alternatives (e.g. NSAIDs, Tylenol, Toradol, Lidocaine patches, muscle relaxant medication, Ketamine, medications for neuropathic pain, nerve blocks, etc.) • Include available non-pharmacologic alternatives (e.g. TENS, comfort pack, heating pad, visit from spiritual care, physical therapy, virtual reality pain management, acupuncture, chiropractic medicine, guided relaxation, music therapy, aromatherapy, etc.)	Developed and implemented a non-opioid analgesic multi-modal pain management in the **Emergency Department OR one Inpatient Unit** (e.g. Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented a non-opioid analgesic multi-modal pain management guidelines in the **Emergency Department AND one Inpatient Unit** (e.g. Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital offers at least at least 1 non-pharmacologic alternative for pain management	Developed **supportive pathways** that promote a team-based care approach to identifying opioid alternatives e.g. integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, use of non-pharmacologic alternatives, etc. **Aligned standard order sets** with non-opioid analgesic, multi-modal pain management program (e.g. changes to EHR order sets, set order favorites by provider, etc.)	Your hospital is **actively monitoring & developing strategies to improve use of alternatives to opioids for pain management** e.g. adherence to guidelines, rate of use of alternatives to opioids by service line, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.		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) Stem the Tide: Addressing the Opioid Epidemic (AHA) No Shortcuts to Safer Opioid Prescribing (NEJMP); article available upon request
	Briefly describe the steps your hospital has taken to promote the use of alternatives to opioids for pain management.					

Identification and Treatment						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*

Medication Assisted Treatment (MAT)
 	
Provide MAT for patients identified as having Opioid Use Disorder (OUD), or in withdrawal, and continue MAT for patients in active treatment.
 	
Components of a MAT program should include:
• Identifying patients eligible for MAT, on MAT, &/or in opioid withdrawal
• Treatment is accessible in the emergency department and in all other hospital departments.
• Treatment is provided rapidly (same day) & efficiently in response to patient needs.
• Human interactions that build trust are integral to how substance use disorder treatment is provided.
 	
*Suggested guidelines for how to universally offer MAT to all patients:
• Do <u>not</u> screen all patients for OUD
• Do <u>not</u> ask all patients if they are interested in MAT services
  ○ May be time consuming for providers & stigmatizing for patients
• <u>Do</u> promote MAT services using signage in waiting & exam rooms, badge flare, & patient forms
• During the exam, providers routinely let patients know that their site offers MAT
  ○ So that patients can choose to disclose whether & when they need support
	MAT is offered, initiated, & continued for those already on MAT in at least **one service line** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)
	
	Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT
		MAT is offered, initiated, & continued for those already on MAT in at least **2 service lines** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	MAT is **universally offered*** to all patients presenting to the hospital
			
			One or more **hospital staff** has the time and skills to **engage with patients** on a human level, motivating them to engage in treatment (e.g. a hospital employee embedded within either an emergency department or an inpatient setting to help patients begin and remain in addiction treatment – commonly known as a Substance Use Navigator, Case Manager, Social Worker, Patient Liaison, Spiritual Care, etc.)
				Your hospital is **actively monitoring & developing strategies to improve access to MAT** e.g. number of patients identified with OUD and provided MAT, # of buprenorphine. prescriptions, etc.
				
				Extra Credit (1 pt.)
				For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.
						[Buprenorphine Hospital Quick Start Algorithm](#) (CA 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)
						
						[Substance Use Navigator](#) (CA BRIDGE)

	Briefly describe the steps your hospital has taken to provide patients access to MAT.					

Identification & Treatment						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*
Timely follow up care Hospital coordinates follow up care for patients initiating MAT within 72 hours either in the hospital or outpatient setting. Hospital based providers and practitioners must have a X-waiver to prescribe or dispense buprenorphine at discharge under the Drug Addiction Treatment Act of 2000 (DATA 2000). If hospital does not have X-waivered providers: • Providers provide a loading dose for long effect, provide follow up care in the ED that is in alignment with the DEA Three Day Rule or connect patient to X-waivered community provider for immediate follow care If hospital has X-waivered providers: • Prescribe sufficient buprenorphine until patient's follow up appointment with community provider within 24 to 72 hours *Practitioners= MDs, physician extenders, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives (see SUPPORT Act for details)	Hospital **identifies X-waivered providers** within the hospital &/or within the community Provides list of **community-based resources** to patients, family, caregivers, and friends (e.g. primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, etc.) Hospital has an agreement in place with **at least one community provider** • If no X-waiver **community provider must accept referrals within 72 hours** • If X-waivered **community provider to provide timely follow up care**	**Actively refer** MAT & OUD patients to a community provider for ongoing treatment (e.g. primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, etc.)	Hospital provides support to **select practitioners* in the ED and IP units to obtain X-waiver** (coordinates free training opportunities, supports application process, utilizes grant funds to cover training cost, provides protected time, bonus opportunity, etc. in alignment with your hospital's employment model)	Your hospital is **actively monitoring & developing strategies to improve care transitions for MAT patients** in accordance with HIPAA e.g**.** number of patients referred to community provider for follow up care, number of patients presenting to community provider for follow up care, number of ED &/or IP shifts in 30 days with a provider on shift that is x-waivered, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.		Buprenorphine Hospital Quick Start Algorithm (CA 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) Substance Use Navigator (CA BRIDGE)
	Briefly describe the steps your hospital has taken to ensure patients on MAT have access to timely follow up care.					

Overdose prevention						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*
Naloxone education and distribution program Provide naloxone prescriptions and education to all patients, families, caregivers and friends discharged with an opioid prescription and/or at risk of overdose. *Staff - MD, PA, NP, Pharmacist, RN, LVN, Health Coach, Substance Use Navigator, Clinical Social Worker, Research Staff, Emergency Department Technician, Clerk, Medical Assistant, Security Guard, etc. trained to distribute naloxone and provide education on how to use it	**Identify overdose prevention resources within hospital, health system, and community** (e.g. training programs, community access points, low/no-cost options, community pharmacies with naloxone on hand, community coalitions, California Naloxone Distribution Program, etc.)	**Standard workflow** for MDs and physician extenders in place for providing naloxone prescription at discharge for patients with an opioid prescription and/or at risk of overdose; discharge prescriptions sent to patient's pharmacy of choice (e.g. naloxone incorporated into a standard order set for opioid prescriptions, &/or referral to low or no cost distribution centers, etc.)	**Standing order** in place allowing approved staff* to educate and distribute naloxone in hand to all patients, caregivers, at no cost while in the hospital setting under the California Naloxone Distribution Program; this should be an ED led process in collaboration with pharmacy	Your hospital is **actively monitoring & developing strategies to improve access to overdose prevention** e.g. rate of naloxone prescription at discharge after opioid poisoning, overdose, and/or prescribed opioids at discharge rate of staff training to distribute naloxone kits, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal. **Extra Credit (1 pt.)** Your hospital is actively monitoring & improving overdose prevention strategies using **social determinants of health data**		Overdose Prevention and Take-Home Naloxone Projects (Harm Reduction Coalition) Naloxone Kit Materials (Harm Reduction Coalition) How to Develop a No-Cost Naloxone Distribution Program (Highland Hospital)
	Briefly describe the steps your hospital has taken to prevent opioid overdose deaths.					

Cross Cutting Opioid Management Best Practices						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*
Organizational Infrastructure Opioid stewardship is a strategic priority with multi-stakeholder buy in and programmatic support to drive continued/sustained improvements in appropriate opioid use (e.g. executive leadership, Pharmacy, Emergency Department, Inpatient Units, General Surgery Information Technology, etc.)	**Multi-stakeholder team** identified opioid stewardship as a strategic priority and set improvement goals in one or more of the following areas: safe & effective opioid use, identifying and managing patients with OUD, preventing harm in high-risk patients, applying cross-cutting organizational strategies. (e.g. opioid stewardship program, quality improvement team, subcommittee of the Board, etc.) **Executive sponsor/project champion identified**	**Communicated program, purpose, goal, progress to goal to appropriate staff** (e.g. a dashboard, all staff meeting, annual competencies, etc.) Opioid management is included in **strategic plan** **Hospital/health system leadership plays an active role** in reviewing data, advising and/or designing initiatives to address gaps	Hospital is actively **building relationships & coordinating with post-acute services to support care transitions** **Extra Credit (1 pt.)** Hospital is part of a learning network (e.g**. c**ommunity coalition, large scale learning collaborative, etc.)	Your hospital is **actively monitoring & developing strategies to improve its opioid management strategies** e.g. hospital wide &/or county wide opioid prescribing rate, Morphine Milligram Equivalent (MME) /patient, rate of OUD related deaths, buprenorphine prescribing rate, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.		Stem the Tide: Addressing the Opioid Epidemic (AHA) CA Opioid Overdose Surveillance Dashboard (CDPH)
	Briefly describe the steps your hospital has taken to make opioid management a quality improvement priority.					

Cross Cutting Opioid Management Best Practices						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance use. Hospital actively addresses stigma through the education and promotion of the medical model of addiction, trauma informed care, harm reduction principles, motivational interviewing across all departments to facilitate disease recognition and the use of non-stigmatizing language/behaviors.	Provides passive, **general education** on hospital opioid prescribing guidelines in **at least two service lines**, identification, and treatment, and overdose prevention to appropriate providers and staff (e.g. M&M, lunch and learns, flyers/brochures, CME requirements, RN annual competencies, etc.)	Provides **point of care decision making support** e.g. automatic pharmacy review for long-term opioid prescription, auto prescribe naloxone with any opioid prescription, reminder to check CURES, flag concurrent opioid and benzo prescribing, etc. **Extra Credit (1 pt.)** Regularly assess perceived & internalized opioid related stigma & knowledge of OUD treatment in providers and staff	Trains appropriate providers and staff on, some combination of, the **medical model of addiction, harm reduction principles, motivational interviewing and how to provide trauma informed care** to normalize opioid use disorder & treatment (e.g. M&M, lunch and learns, CME requirements, RN annual competencies, etc.	Your hospital is **actively monitoring & developing strategies to reduce provider/staff stigma toward opioid addiction** e.g. provider prescribing patterns, number of patients identified with OUD, etc. Provides **targeted follow up and support to providers and staff based on performance** **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.		Selection of relevant web-based trainings (Harm Reduction Coalition) Clinical Opioid Withdrawal Score (Project SHOUT) Trauma Informed Care: Overview (SAMHSA) A New Brief Opioid Stigma Scale to Assess Perceived Public Attitudes and Internalized Stigma: Evidence for Construct Validity (J Subst Abuse Treat)
	Briefly describe the steps your hospital has taken to support appropriate providers & staff in providing evidence-based, compassionate care for patients with OUD or at risk.					

Cross Cutting Opioid Management Best Practices						
Measure	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Score**	**Foundational Resources** *(full resource library here)*
Patient and family engagement **Actively engage** patients, families, and friends in appropriately using opioids for pain management (opioid prescribing, treatment, and overdose prevention via naloxone, hospital quality improvement initiatives, etc.)	Provides general education to **all patients, families and friends in at least two service lines** (e.g. ED, Burn Care, General Medicine, Behavioral Health, OB, Cardiology, Surgery, etc.) 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, set pain expectations, risk associated with opioid use, etc.)	Provides opportunities for **patients and families to engage** in hospital wide opioid management activities (Patient Family Advisory Council, peer navigator, program design, etc.)	Your hospital is **actively monitoring & developing strategies to improve patient & family engagement on opioid care** e.g. MME/patient, # MAT starts, # naloxone kits distributed w/ education, # of patients involved in QI/year, etc. **Extra Credit (1 pt.)** For one **measure** what is the % improvement over a rolling 12-month period? Please include measure name, numerator/ denominator, date range, & goal.		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)
	Briefly describe the steps your hospital has taken to actively engage patients and families in opioid stewardship strategies.					
				TOTAL *(out of 43 points)*		

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Factors Driving COVID-19 Cases & Deaths in California Nursing Homes
Cal Hospital Compare
October 2020

**Selected excerpts from full draft issue brief*

Methodology

This project assessed factors that put nursing home residents at increased risk of infection and mortality from COVID-19. The CHC Project team analyzed the following nursing home outcome variables and explanatory factors at two points in time: May 24, 2020 and August 9, 2020. The May 24 data is the earliest data available from CMS after the onset of the pandemic in early 2020. The August 9 data was the most recently available data at the time of running the regression analyses. The analyses examined both 1) explanatory factors at each of the two time periods and 2) changes in explanatory factors between the two time periods as the pandemic progressed. The full list of explanatory factors included in the regression modeling appears in Appendix D.

The study population included 1,150 nursing homes across the state of California. For the analyses, only nursing homes with complete data for all variables were used, resulting in a sample size of 825 nursing homes for May 24, 2020 and 841 nursing homes at the August 9, 2020 time point.

Outcome Variables
1) Number of nursing home residents with laboratory positive COVID-19 2) Number of nursing home residents with suspected or laboratory-confirmed positive COVID-19 who died in the facility or another location

Primary Explanatory Factors	
Category	**Measure**
External	• County level COVID-19 case rate
Facility	• Size (licensed beds) • Chain and ownership status • Fines, deficiencies, complaints • Short-stay residents who were re-hospitalized after a nursing home admission • Payer source
Staffing	• Nursing turnover • RN staffing • Total staffing
Resident	• Age • Gender • Race/ethnicity

Limitations

This project analyzed nursing home performance using publicly reported data at the facility level. Without resident-level data certain explanatory factors could only be measured at the facility level. In

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addition, due to rapid changes in nursing home reporting requirements related to COVID-19 the data accuracy is unknown. The data limitations are as follows:

- Payer Source: The financial reports provided by OSHPD do not separate Medi-Cal managed care from Medicare and private managed care plans. Therefore, we were unable to make strong correlations between payer source and COVID-19 cases and deaths.
- Resident characteristics: This project used the OSHPD nursing home utilization data on resident characteristics (which is collected for December 31st of each year) to obtain age, gender, and race/ethnicity. The number of residents with mental illness, Alzheimer's, developmental disabilities, did not appear to be accurate to the CHC Project Team nor the advisory group and therefore excluded from this study. Moreover, nursing home resident utilization data on one day per year may not be representative of the data throughout the year.
- Other: Detailed data on testing, access to PPE, and staffing during the pandemic was not available.

Results

In May 24.7% of CA nursing homes had at least one resident with COVID-19 and 15.5% had at least one resident death attributable to COVID-19. By August there were 65.7% CA nursing homes with at least one resident with COVID-19 and 37.4% had at least one COVID-19 resident death. The study found strong relationships between several explanatory factors and nursing home COVID-19 case and death rates. The key findings are summarized below.

Key findings (for the complete results see Appendix E):

- Early in the pandemic, for-profit nursing homes, both independent or as part of a chain, had COVID-19 case rates that were 4 to 5 times higher in comparison to non-profit government nursing homes. The ownership status of a nursing home had the greatest impact on COVID-19 case rate, over and above nursing home size (i.e., number of licensed beds), county COVID-19 case rate, resident racial composition, age of the residents, and other factors examined in this project.
- As the pandemic spread, some demographic factors of the general population-- such as gender, age, and race/ethnicity -- became more significant risk factors, while nursing home characteristics, such as ownership, no longer played a significant role in COVID-19 case rates. For example:
    - In May, nursing homes with greater than 6.3% of black residents had COVID-19 case rates that were ~2.5% higher in comparison to nursing homes with less than ~1.5% Black residents. By August nursing homes with more than 26% Latinx residents had a 50% higher case rate than nursing homes having fewer than 5.5% Latinx residents.
    - Between May and August, nursing homes with more than 48.9% male residents experienced a more than 2.5-fold increase in COVID-19 case rates.
- Throughout the pandemic, nursing home staffing levels were strongly correlated with COVID-19 case rates and deaths. Experts recommend, at a minimum, 0.75 RN hours per resident day (hprd)

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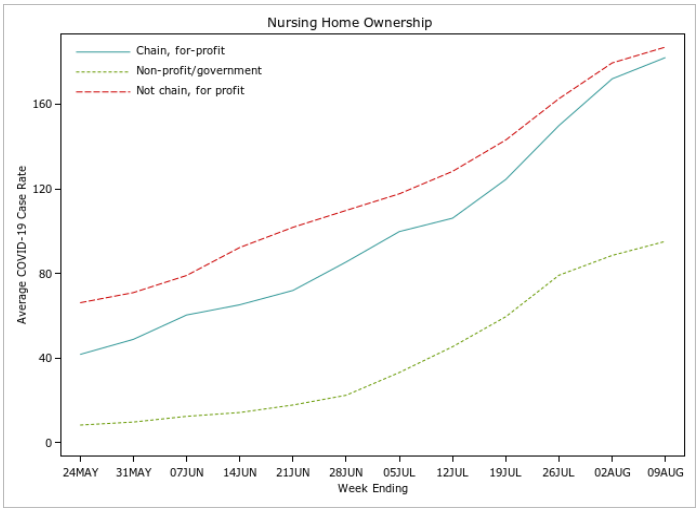
and 4.1 total staffing hprd. The total staffing recommendation combines staffing hours for RN, LVN, and CNAs.[1]

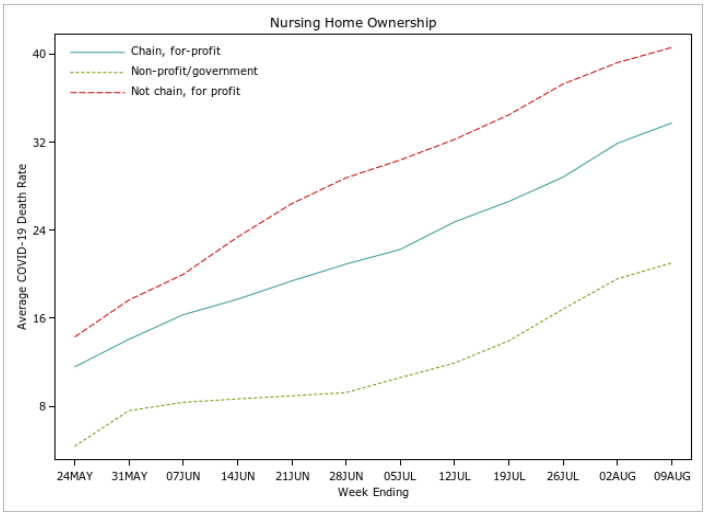
- Early in the pandemic, nursing homes with total staffing greater than 4.42 hprd had case rates that were halved compared to nursing homes with less than 3.8 hprd.
- As the pandemic progressed, RN staffing provided greater protection against COVID-19 cases and deaths. Nursing homes with RN staffing greater than 0.67 hprd had 50% fewer COVID-10 cases. In addition, nursing homes with RN turnover greater than 50% had 30% higher COVID-19 case rates compared to nursing homes with the lowest nursing turnover.

- In August, larger nursing homes, as defined as having greater than 120 licensed beds, had COVID-19 case rates at least 55% greater than those nursing homes having 68 or fewer licensed beds.

The following graphs illustrate the importance of select explanatory variables and their impact on COVID-19 case rate and/or death rate over time (May 24 – August 9, 2020). Graphs 3 thru 8 compares the top quartile of nursing home performers (Hi) against the bottom three quartiles (Lo).

Graph 1: Nursing Home Ownership and Average COVID-19 Case Rate
Graph 2: Nursing Home Ownership and Average COVID-19 Death Rate





As shown in Graphs 1 and 2 respectively, the COVID-19 case rate and death rate for for-profit nursing homes that operate as part of a chain is consistently higher than non-profit and government nursing homes.

Graph 3: Nursing Home Size and Average COVID-19 Case Rate
Graph 4: Nursing Home Size and Average COVID-19 Death Rate

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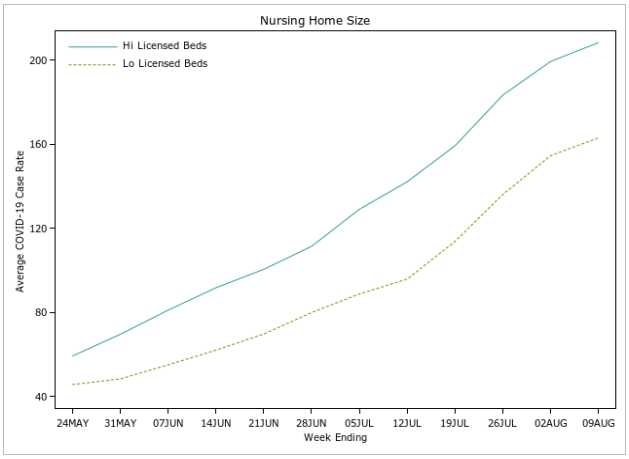
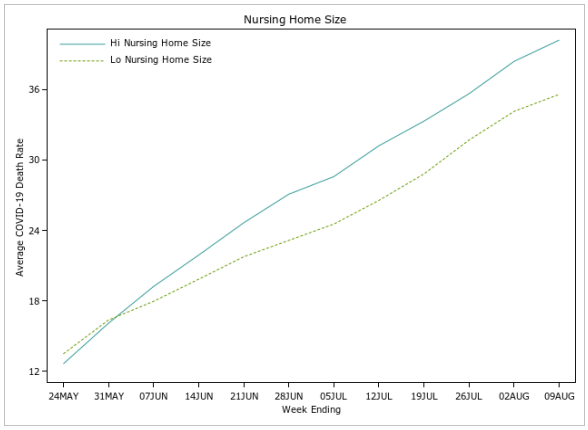
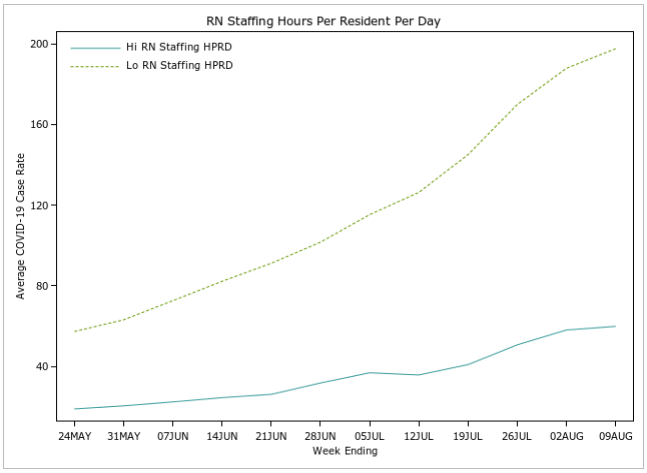
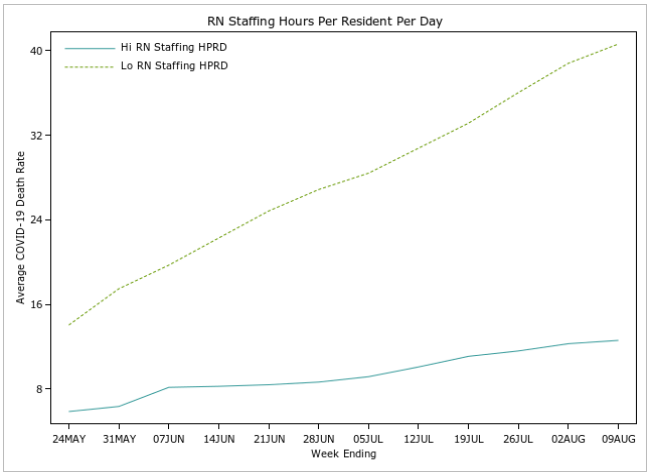




As shown in Graphs 3 and 4 respectively, the COVID-19 case rate and death rate are consistently higher for larger nursing homes (facilities with greater than ~120 licensed beds) versus smaller nursing homes (facilities with less than ~70 licensed beds).

Graph 5: RN Staffing Hours per Resident Per Day (HPRD) and Average COVID-19 Case Rate
Graph 6: RN Staffing Hours per Resident Per Day (HPRD) and Average COVID-19 Death Rate

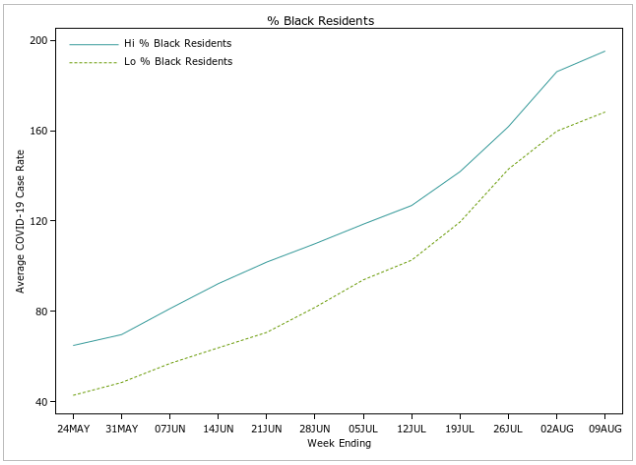


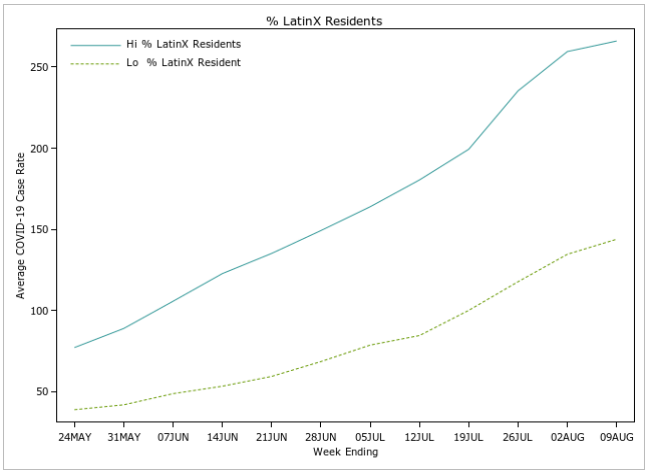


Experts recommend, at a minimum, 0.75 RN hours per resident day (hprd). As shown in Graphs 5 and 6 respectively, the COVID-19 case rate and death rate are lower for nursing homes with higher levels of RN hprd (i.e. greater than 0.67 hprd). The gap between nursing homes with high levels of staffing versus low becomes wider as time goes on, therefore highlighting the protective effect of RN staffing against COVID-19 infections and deaths.

**Selected excerpts from full draft issue brief*

Graph 7: % Black Residents and Average COVID-19 Case Rate
Graph 8: % LatinX Residents and Average COVID-19 Death Rate





As shown in Graphs 7 and 8, The COVID-19 case rate is disproportionality higher in nursing homes with a higher percentage of Black and Latinx residents as evidenced by the gap between the two lines over time. The difference in COVID-19 case rate becomes even greater as the pandemic progresses (see August time point) for nursing homes with a higher percentage of Latinx residents.

Recommendations

Based on the results and existing research, several recommendations were developed that could meaningfully improve the quality of care in nursing homes during the current pandemic and beyond. Some of the recommendations could be acted upon immediately while others can be implemented over the next 12 to 24-months. The recommendations are intended for policy makers, improvement organizations (such as ombudsman organizations, resident/family advocacy groups, and Quality Improvement Organizations (QIOs)), and nursing home administrators.

Future Research Studies

Our data were from publicly available sources that aggregated factors at the facility level. Identifiable patient level data is not publicly available and would enhance and augment the results and recommendations of our analysis.

There are several important studies that could be conducted to inform policy makers, consumers, and providers, including:

- A repeat of this study in the mid-fall to determine if the explanatory factors have continued to evolve and how. A time series methodology may be appropriate.
- Qualitative studies examining the impact of high-priority potential explanatory variables where public data or well described measures do not exist. This could include how unique nursing

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home management, policies, and practices may have impacted COVID-19 case and death rates. Examples include;
    - Visitation policies
    - PPE use and other infection prevention practices
    - Staff training practices
- Case studies of nursing homes considered "at-risk" facilities with no COVID-19 cases (which may reveal "best practices") AND "low-risk" facilities with outbreaks to determine potentially modifiable factors, practices, infrastructure, or other features.
- Analyses that support a more accurate assessment of the impact of Medi-Cal as the payer given the lower re-imbursement rates and challenges Medi-Cal enrollees face accessing healthcare. Medi-Cal is a proxy for income and analyses could reveal economic disparities resulting in COVID-19 related health disparities. As described below, related data availability issues separating Medi-Cal Managed Care from other Managed Care would need to be resolved.
- Evaluate excess deaths of California nursing home residents during the pandemic and quantify the types of non-COVID-19 excess deaths.
- Estimate the impact of specific policy changes on COVID-19 infection and death rates.
- Study the impact of hospital COVID-19 admissions from and discharges to nursing homes on COVID-19 infection rates and deaths.
- A formal data validation study in a sample of nursing home data submissions for the new public database, National Health Care Safety Network COVID-19 [24] commissioned by CDPH.

Improvements Related to the Availability of Nursing Home Data

Enriched and Publicly Available Nursing Home COVID-19 Data

Recommend CPDH publish more detailed information, on a weekly basis, to monitor COVID-19 or other infections disease outbreaks in nursing homes. Although California has some nursing home information on public dashboards, these are not all located in one area and not easily accessible for consumers to use. Likewise, both county nursing home data and CMS nursing home data are more precise with the exact number of COVID-19 infections while CDPH masks numbers under 11 for the same facilities.

For example, a one-stop nursing home information dashboard, updated at least weekly, with data available for the public by download or API, could include:

- Number of residents, number of infection and deaths for residents (and staff)
- PPE supply
- Staffing hours per resident day (hprd) using the Payroll Based Journal (PBJ) data files and staffing waivers
- Weekly number of tests and testing results for residents & staff

Transparent Financial Reporting

**Selected excerpts from full draft issue brief*

Currently, data on nursing home resident days by Medi-Cal managed care cannot be separated from nursing home resident days by Medicare and private managed care plans. Furthermore, the state appears to have conflicting data definitions and/or data submission guidance for Medi-Cal managed care. Having access to health insurance payment is a critical component for understanding the dynamics of care within nursing homes. The literature review revealed that for low-income beneficiaries who qualify for Medicare and Medi-Cal, or "dual-eligibles," is associated with longer length of stay and poor resident outcomes.[10]

- Recommend OSHPD and DHCS send a joint All Facility Letter (AFL) indicating the optimal strategy for reporting Medi-Cal Managed care utilization and OSHPD to change the data definitions.
- OSHPD could replace its annual nursing home utilization survey with the CMS Minimum Data Set (MDS) quarterly to summarize and publicly report the total number of residents by:
    - Demographics, resident conditions, medical conditions, limitations in activities of daily living, nursing care needs, and therapy needs.
    - Race and ethnicity data could be reported as a combined single category

Facility Size and Design

Larger nursing home size, facilities with greater than ~120 beds, was found to be a factor associated with higher COVID-19 infection and death rates. This is consistent with previous studies on the impact of facility size on general nursing home quality and performance.[2,5,9,14] Although this study was not able to examine facility design on the spread of COVID-19, e.g. multi-resident rooms and shared bathrooms, this was found to be a factor in a previous study and obviously makes infection control and isolation more difficult. [14] Also, larger facilities present greater opportunities for staff to transmit infections among residents. The importance of training all staff on infection control is paramount.

- Immediately, CDPH should augment a collaborative learning program among California nursing homes and Quality Improvement Organizations (QIOs) to share effective practices given the current facility size and design to prevent infections and reduce spread of infections.
- Immediately and where feasible, nursing homes should reduce the number of residents within the largest facilities as well as increase the number of residents living in single or private rooms, recognizing this may have financial consequences for the facility.
    - Cohorting COVID-19 cases in separate areas of the facility should be a priority
    - Increase the amount of open space so that residents can maintain social distance, including during visits with family and friends.
- OSPHD should conduct a survey of nursing homes on the age of buildings, the size and design of buildings, the number of residents per room and bathrooms, and other building features.
- For the long term, California could establish a statewide taskforce to study the feasibility and financial mechanisms for the future modernization, redesign and rebuilding of nursing homes

**Selected excerpts from full draft issue brief*

to reduce the size of facilities, develop single rooms for residents, and expand shared spaced to allow for greater social distancing.

Staffing Requirements

In our analysis, higher staffing was found to protect against COVID-19 cases and deaths. Higher total staffing hours (greater than or equal to 4.42 hprd) and higher RN staffing hours (greater than or equal to 0.67 hprd) provided protection against COVID-19 case rates.

While the data does not provide an explanation why total staffing (RN, LVN, and CNA) was more important early on and RN staffing more important as the pandemic evolved, we hypothesize that as nursing homes were attempting to cope with the acute crisis, having sufficient total staff available were important for providing care and implementing interventions that decreased the risk of resident infections. Later in the pandemic as more was known about the novel coronavirus and PPE and testing were being distributed to nursing homes, facilities with higher RN staffing may have been better able to provide the necessary supervision, training and disease management to incorporate the equipment and knowledge that resulted in a lower COVID-19 case rate. Our findings of higher total and RN staffing being associated with fewer infections, deaths, and COVID-19 outbreaks is consistent with current COVID-19 research in the nursing home environment.[2,6,9,15,20]

In addition, we found higher RN turnover rates (greater than 50%) was associated with a likelihood of a higher resident COVID-19 case rate. Numerous studies on general nursing home quality have shown that low turnover rates contribute to improved quality of care.[11,12,13]

Currently, California allows facilities to be given workforce shortage and resident acuity waivers that further reduces facility staffing levels. These levels are well below current evidence-based standards.[2] In light of these findings, state policymakers could consider:

- DHCS should develop a pathway for nursing homes to increase their staffing levels to evidence-based levels over the next two years by redesigning the Medi-Cal reimbursement system.
- Immediately, CDPH should require nursing homes to meet CMS requirements that “The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment…” (See 42 C.F.R. § 483.70(e), November 28, 2017).
- CDPH and DHCS should be given authority to eliminate workforce shortage and resident acuity waivers for nursing homes over the next two years by using Medi-Cal direct care wage and benefit pass throughs.
- DHCS should require nursing homes to reduce average annual nursing turnover rates to 25 percent within two years by using Medi-Cal direct care wage and benefit pass throughs.

**Selected excerpts from full draft issue brief*

- CDPH should obtain nursing home Payroll Based Journal (PBJ) data submitted to CMS to monitor and enforce nursing home staffing requirements.
- CDPH should promote skill enhancement (provide opportunities for staff to obtain related certifications, training, & other professional development), especially related to infection prevention.
- Allowing select family members and friends to be deemed essential workers in the time of crisis to supplement resident care.

Ownership Oversight

Most striking, early on in the pandemic, was the degree that nursing home ownership status had on COVID-19 case rate, over and above nursing home size (i.e. number of licensed beds), county COVID-19 case rate, resident racial composition, and age of the residents. For-profit chains and non-chains had between 4.5-5.6 the COVID-19 case rate compared to non-profit and government facilities. While the reasons for these differences are not clear, this finding is consistent with other COVID-19 studies.[5,9,14] In light of these findings, state policymakers could consider:

- DHCS should be given authority to increase the annual financial disclosure of nursing homes by requiring a consolidated financial report for all related party organizations and entities including management, property, and parent companies in the coming year.
- DHCS should be given authority to establish financial controls on cost centers for each nursing home company rather than only cost controls on the Medi-Cal expenditures.
- Consider creating a targeted Medical Loss ratio (MLR) threshold for all nursing home payers
- Immediately, CDPH should strengthen regulatory oversight, especially in “at-risk” facilities, to ensure that all nursing meet minimum federal nursing home standards for quality including staffing, infection control, sanitation, and emergency requirements.

Health Equity Promotion and Infection Prevention

This study found that nursing homes with higher percentages of residents who are in the oldest age group, males, and those who are Black or Latinx were found to have higher COVID-19 case and death rates. These residents appear to be at higher risk for COVID-19 infections and deaths, after controlling for ownership, county COVID-19 infection rates, staffing, facility size and other factors.

- CDPH should distribute vaccines to residents and staff in “at-risk” facilities first.
- Rather than investigating outbreaks in facilities retrospectively, immediately CDPH should consider enhanced oversight for “at-risk” facilities based on a new understanding of factors associated with COVID-19 infections and death.
- Oversight can include targeted educational, operational and infection prevention support and monitoring “at-risk” facilities to prevent outbreaks.
- Immediately, CDPH should strengthen training protocols to ensure that all nursing home staff are knowledgeable about infection control, sanitation, and emergency requirements.
    - Trainings are at least annual, culturally sensitive, etc.

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    - Require the designated Infection Preventionist to be CIC Certified
- Immediately, CDPH should ensure that all facilities should be following CDPH guidance for are testing staff weekly for COVID-19.
- Immediately, CDPH should evaluate and report other health care associated infections (HAIs) (e.g. C. diff, CAUTI, etc.) in CA nursing homes like what exists in the hospital community.

CAL HOSPITAL COMPARE
HOSPITAL PERFORMANCE DATA FEES (2021)

For more than a decade, Cal Hospital Compare has been providing Californians with objective hospital performance ratings. Cal Hospital Compare is a non-profit organization that is governed by a multi-stakeholder board, with representatives from hospitals, purchasers, consumer groups, and health plans. Prior to 2016, Cal Hospital Compare was known as the California Hospital Assessment Task Force (CHART). CHART was first established in 2004 for the purposes of developing a statewide hospital performance reporting system using a multi-stakeholder collaborative process. We use an open and collaborative process to aggregate multiple sources of public data, and to establish relevant measures and scoring.

Industry Collaboration

- California Department of Public Health
- California Health Care Foundation
- California Maternal Quality Care Collaborative
- California Office of Statewide Health Planning and Development
- Centers for Medicare and Medicaid Services
- Covered California
- Leapfrog Hospital Safety Grades
- SmartCare California
- Yelp

Trusted Data

- The website is always free to use and offers fully open access
- The information is objective, unbiased and relevant to consumers and other stakeholders
- Users will never see advertising or promotion of one hospital over others
- Our partnership with IBM Watson Health provides rich analytics and reliable data

Contact

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Email: bspurlock@cynosurehealth.org
www.calhospitalcompare.org

Option 1: Cal Hospital Compare Sponsorship

Unlimited data access, organizational leadership and performance intelligence.

- Participation in Cal Hospital Compare governance via Technical Advisory Committee and Board of Directors; operational decision making, establish priorities and setting future directions
- Quarterly data files including all measures in a usable format; memos outlining measurement updates, trends, and implications.
- Patient safety, maternity, and opioid honor roll reports, including patient safety poor performing outlier hospitals not publicly available.
- Honor roll methods are aligned with and useful for assessing Covered California network requirements.
- Access to all Technical Advisory Committee exploratory analyses produced with IBM Watson Health.
- Sponsors can submit custom query requests for Technical Advisory Committee review (pending resource availability).
- Up to 15 hours annually of clinical and technical assistance provided by Bruce Spurlock, MD, Cal Hospital Compare's Executive Director.

$125,000/year

Option 2: Performance Intelligence Subscription

Includes all performance metrics and scores along with reports and performance insights

- Participation in Cal Hospital Compare governance via Technical Advisory Committee; reviews measures, reports, trends and provides input to the Board of Directors.
- Quarterly data files including all measures in a usable format; memos outlining measurement updates, trends, and implications.
- Patient safety, maternity, and opioid honor roll reports, including patient safety poor performing outlier hospitals not publicly available.
- Up to 10 hours annually of clinical and technical assistance provided by Bruce Spurlock, MD, Cal Hospital Compare's Executive Director.

$65,000/year

Option 3: Purchaser Related Performance Data

Includes Cal Hospital Compare's Patient Safety, Maternity, and Opioid Care Honor Roll Reports and related metrics for ALL hospitals; with expanded maternity measures and patient safety poor performing outlier hospitals not publicly available.

- Annual patient safety, maternity, and opioid care honor roll reports, including patient safety poor performing outlier hospitals not publicly available.
- Data files includes relevant measures in an easy to use analytic file.
- Patient safety and poor performers data set includes select healthcare associated infections, AHRQ PSI 90, Sepsis Management, HCAHPS, and Leapfrog Hospital Safety Grade.
- Maternity data set includes NTSV c-section, VBAC, breastfeeding, episiotomy rates and deliveries by certified nurse midwife
- Opioid care data set includes self-assessment results and related analyses for hospitals participating in the Opioid Care Honor Roll program.

$45,000/year

Option 4: Select Purchaser Related Performance Data

Includes Cal Hospital Compare's Patient Safety, Maternity, and Opioid Care Honor Roll Reports and related metrics for SELECT* hospitals; with patient safety poor performing outlier hospitals not publicly available.

- Annual patient safety, maternity, and opioid care honor roll reports, including patient safety poor performing outlier hospitals not publicly available.
- Data files includes relevant measures in an easy to use analytic file.
- Patient safety and poor performers data set includes select healthcare associated infections, AHRQ PSI 90, Sepsis Management, HCAHPS, and Leapfrog Hospital Safety Grade for SELECT hospitals only.
- Maternity data set includes NTSV c-section rate for ALL hospitals.
- Opioid care data set includes self-assessment results and related analyses for hospitals participating in the Opioid Care Honor Roll program.

$35,000/year

**SELECT hospitals include only those hospitals that make either the patient safety poor performer's list, patient safety and opioid care honor rolls.*

Option 5: Custom data request

Customized data request for measures not included in data subscription options 3 and 4.

- Initial consultation with both Cal Hospital Compare and IBM Watson Health team members to optimize request design.
- Analytic-ready data file(s) designed to meet your specifications.
- Example data request may include hospital wide readmission rate, sepsis management, death rate, surgical site infections, etc.

Starting at $5,000