Cal Hospital Compare Board of Directors

April 14, 2021

10:00am - 12:00pm PST

Proposed Agenda

- Welcome & call to order
- Executive session
- Organizational updates
- COVID-19 in CA Hospitals
- Cal Hospital Compare Analytics
- COVID-19 in Skilled Nursing Facilities

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Wrap Up



Cal Hospital Compare Board of Directors Meeting Agenda

Wednesday, April 14, 2021, 10:00am - 12:00pm PT

Webinar Information

Webinar link: <u>https://zoom.us/j/4437895416</u> | Phone: 1-669-900-6833

Access code: Code: 443 789 5416 | Passcode: cyno#

Time	Agenda Item	Presenters and Documents
10:00-10:05	Welcome and call to order	- Ken Stuart
5 min.	- Approval of past meeting summary	Board Chair
		- Bruce Spurlock
		Executive Director, CHC
10:05-10:35	Executive Session	- Bruce Spurlock
30 min.	- CQC Data Partner	Executive Director, CHC
	- Business plan/financial report	
10:35-10:45	Organizational updates	- Alex Stack
10 min.	 New to the Technical Advisory Committee 	Director, CHC
	 US News & World Report – maternity measures & 	- Bruce Spurlock
	composite	Executive Director, CHC
	 Hospital price transparency 	
10:45-11:00	COVID-19 in CA hospitals	- Mahil Senathirajah
15 min.	- Study goals	Senior Director, IBM
	- Workgroup process & timeline	Watson Health
	- Preliminary outcome & explanatory variables	
	- Proposed study design	
	- Discussion	
11:00–11:35	Cal Hospital Compare Analytics	- Mahil Senathirajah
35 min.	- Review historical trends	Senior Director, IBM
	 Mortality 	Watson Health
	 Readmissions 	
	- Discuss whether and how to share findings	
11:35–11:55	COVID-19 in Skilled Nursing Facilities	- Alex Stack
20 min.	- Study background & initial findings	Director, CHC
	- Data refresh looking at fall/winter surge	- Mahil Senathirajah
	 Impact of vaccine on disparities 	Senior Director, IBM
	 Changes in explanatory variables 	Watson Health
	- Discuss whether and how to share findings	
11:55-12:00	Wrap-up	- Ken Stuart
5 min.	Adjourn	Board Chair
	– Next meeting: Wednesday, June 9, 10:00am - 12:00pm	
	PST (Zoom Call)	

Cal Hospital Compare Board of Directors Meeting Summary Wednesday, February 10, 2021 10:00am – 12:00pm PT via Zoom Webinar

Attendees: Ash Amarnath, Seth Glickman, David Hopkins, Chris Krawczyk, Thai Lee, Julia Logan, Helen Macfie, Joan Maxwell, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Kristof Stremikis, Ken Stuart, Kevin Worth, Tracy Fisk

Agenda Items	Discussion
Welcome & call to	• The meeting was called to order at 10:03am PT.
order	• The minutes from the Board meeting on December 16, 2020 were motioned,
	seconded, and approved as written.
Organizational	Ken Stuart provided an update on the CA Healthcare Payment Data Program
Updates	Advisory Committee. OSHPD plans to complete buildout of their program by the
	The National Coalition of Healthcare are conducting several roundtable
	The National Coalition of Healthcare are conducting several founditable
	in the consumer decision making process. A future roundtable will convene to
	discuss ACDPs as an effective resource for purchase and policy makers. In
	addition a state all paver database advisory committee is being formed
	 Bruce discussed a recent study on COVID conducted by Kaiser that addressed
	the impacts of race and ethnicity in patient level data where access to care was
	identified as the largest disparity.
	 Dr. Craig Ueio, Corporate Quality Leader with Scripps Health, has replaced
	Gavle Sandhu representing the TAC.
	• Alex provided an update on the 2020 honor roll timeline. The Patient Safety
	Honor Roll results are expected to be released in February.
	• CHC with CHCF are exploring conducting a new study to better understand the
	impact of COVID-19 in the hospital setting. Will look at outcomes measures
	including occupancy rates, demographics, and ethnic and racial disparities. The
	TAC agreed to serve as the advisory committee should this study move forward.
	• Proposals have been submitted to obtain funding to reinstate the Cal Quality
	Care website. Board members are encouraged to review the RFP and participate
	in the proposal review process. CHC is also researching acquiring a data partner.
	Board members are welcome to send Bruce or Alex any recommendations.
Patient Safety	• Mahil reviewed the Tier 1 and Tier 2 criteria, summary of changes and results for
Honor Roll & Poor	the PSHR and poor performing hospitals. Bruce pointed out that a deeper dive
Performers	into Leap Frog scores for Tier 2 criteria would be beneficial. Those hospitals with
	two signals increase confidence that is indicative of a potential problem.
	Hospitals can achieve honor roll status and still be listed as a poor performer in
	other areas. Hospitals identified as poor performing are notified via email

Summary of Discussion:



	correspondence. Upon receiving payment and Board approval, health plans are
	sent the poor performer report and list of hospitals.
	• Economic disparities play a partial role that impact a hospital's Leap Frog grade.
	Kevin Worth is interested in further understanding the quality structure and level
	of support low performing public hospitals have. Julia recommended connecting
	with the Dept. of Health and Human Services to further drill down in the how
	and why and moving forward together.
CHC Analytics	• Mahil gave an overview of the descriptive and measure analysis. OSHPD has
	data available on race and ethnic disparities. This topic will be deferred for
	further discussion at the next BOD meeting.
Financials	• The Board motioned, seconded, and approved the current financial statements.
Next	• The next Board of Directors meeting is scheduled on April 14, 2021 at 10:00am PT
Meeting/Meeting	via Zoom.
Adjournment	• The meeting formally adjourned at 12:00 PT.



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Other Contributors

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Board of Directors

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Organizational Updates

Welcome to TAC



Ashraf Gulzar Quality Improvement Manager Santa Clara Valley Medical Center

US News & World Report

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Maternity measures & composite



Hospital Price Transparency

Hospital price transparency helps Americans know the cost of a hospital item or service before receiving it. **Starting January 1, 2021**, each hospital operating in the United States will be required to provide clear, accessible pricing information online about the items and services they provide in two ways:

- 1. As a comprehensive machine-readable file with all items and services.
- 2. In a display of shoppable services in a consumer-friendly format.

This information will make it easier for consumers to shop and compare prices across hospitals and estimate the cost of care before going to the hospital.

<u>CMS plans to audit a sample of hospitals for compliance starting</u> CMS and reviewing analyses of non-compliance, and hospitals n Despite this cautious approach, our findings were not encouraging: Of the 100 hospitals in our sample, 65 were unambiguously noncompliant. Of these 65,

- 12/65 (18 percent) did not post any files or provided links to searchable databases that were not downloadable.
- 53/65 (82 percent) either did not include the payer-specific negotiated rates with the name of payer and plan clearly associated with the charges (n = 46) or were in some other way noncompliant (n = 7).

Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule

COVID-19 in CA Hospitals

Hospital COVID-19 Study

Comprehensive Hospital Preparedness Checklist for Coronavirus Disease 2019 (COVID-19)

Planning for a community outbreak of Coronavirus Disease 2019 (COVID-19) is critical for maintaining healthcare services during

a response. The Centers for Disease Control and hospitals (acute care facilities) assess and impr Because of variability of outbreaks, as well as c of the hospital/community, scope of services), circumstances. This checklist should be used as COVID-19 preparedness plan. Additional inforr

An effective COVID-19 hospital preparedness p departments, emergency management agenc hospitals should refer to state and federal pan gov/flu/pandemic-resources/pdf/pan-flu-repo applicable state and federal regulations and w Federal Data Reveal Which Hospitals Are Dangerously Full This Week. Is Yours?

January 25, 2021 · 3:50 PM ET

on Accreditation of Healthcare Organizations (JCAHO). Comprehensive COVID-19 planning can also help facilities plan for other emergency situations.

All U.S. hospitals should be prepared for the possible arrival of patients with COVID-19. All he trained, equipped and capable of practices needed to: (1) Prevent the spread of COVID-19 w and isolate patients with possible COVID-19 and inform the correct facility staff and public h number of patients with confirmed or suspected COVID-19 as part of routine operations; (4) of patients in the context of an escalating outbreak while maintaining adequate care for oth any healthcare personnel that might be exposed to COVID-19; and (6) Communicate effective appropriate external communication related to COVID-19.

'People are going to die': Hospitals in half the states are facing a massive staffing shortage as Covid-19 surges

By OLIVIA GOLDHILL @OliviaGoldhill / NOVEMBER 19, 2020

Study Design

- Goal: To understand what type of hospitals and populations were most impacted by COVID-19 and to what extent
- Analytic Component:
 - Data quality assessment
 - Descriptive statistics
 - Multi-variate regression
- Qualitative Component
 - Interviews with hospitals to provide context and insight
- Identify implications for hospitals and other stakeholders
- Product: issue brief
- ► Goal is <u>not</u> to assess hospital performance

Timeline

Timeline					Accepting workgroup volunteers
Deliverable	April	May	June	July	August
Workgroup Meetings	End of April - share preliminary findings, descriptive statistics, get workgroup feedback	Mid. May - finalize quantitative analysis	Jun 1 -bring back to TAC for feedback/discussion		
Quantitative Analysis					
Qualitative Interviews		Identify 2 -3 interviewees	Complete interviews		
Report				Final draft by July 31	Finalize report for publication

Data Sources

Source	Dataset	Most Recent Update	Date Obtained	Measurement Period
	Hospital Inpatient - Characteristics by Facility	10/01/20	02/24/21	CY 2019
OSHPD	Hospital Utilization File	12/15/20	02/24/21	CY 2019
	Hospital Financial File	1/13/21	02/24/21	CY 2019
CMS	COVID-19 Reported Patient Impact and Hospital Capacity by Facility	03/29/21	3/29/21	07/31/2020 - 03/19/21

Potential Outcome Variables

Metric	Numerator / Denominator
What percent of adult ICU beds are occupied?	Num: Average of total number of staffed inpatient adult ICU beds that are occupied
	Denom: Average number of total number of staffed inpatient ICU beds
What percent of adult hospital beds are occupied?	Num: Average of total number of staffed inpatient adult beds that are occupied /
	Denom: Average of total number of staffed inpatient adult beds in the hospital
What percent of hospitalized adult ICU patients are	Num: Average number of patients currently hospitalized in a designated adult ICU bed who have laboratory-confirmed COVID-19 /
COVID patients:	Denom: Average of total number of staffed inpatient adult ICU beds that are occupied
What percent of hospitalized adult patients are	Num: Average number of patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed COVID-19 /
COVID patients?	Denom: Average of total number of staffed inpatient adult beds that are occupied

Summary of Potential Explanatory Variables

- Numerous variables available from OSHPD across multiple domains:
 - ► Financial
 - Staffing
 - Facility Type
 - Volume
 - Patient Characteristics
- Study will incorporate County-level COVID Case Rate



Potential OSHPD Explanatory Variables

Domain	Variable Considered	IP Discharge Characteristics	Utilization	Financial
	Revenue (Total Operating, Net Patient, Gross, IP/OP by Payer)			х
Financial	Expenses & Net Income			x
Tinanciat	Contractual Agreements & Capitation Premiums by Payer			x
	Salaries & Wages, Benefits			X
	Average Staffed Bed			x
Staffing	FTEs & Active Medical Staff			x
Starring	Total Productive Hours or by Employee			х
	Total Paid Hours			х
	Open / Closed, Category		x	х
Facility	Trauma Center, Teaching		x	
Туре	Investor vs. Non-Profit, Parent vs. Consolidated		x	x
	County, Urban vs. Rural		x	x

Potential OSHPD Explanatory Variables

Domain	Variable Considered	IP Discharge Characteristics	Utilization	Financial
	Total Beds and Bed Days by Floor / Type		x	x
	Total Discharges and Discharges by Floor / Type		х	х
	Intra-Hospital Transfers by Type		х	
	Total Census Days and Census Days by Floor / Type		x	
Facility	Total ALOS and ALOS by Floor / Type		х	
Volume	ALOS by Payer			x
, otomic	ALOS by IP Discharge	X		
	License Bed and Available Bed Occupancy Rate			Х
	EMT Diversion and EMT Severity		Х	
	Surgery Type, Volume, and Minutes		Х	Х
	Clinical OP Visits			X
	IP Discharges by Admission Source, Admissions Type, Disposition	X		
	Admissions from ER		Х	
	IP Discharges by Race / Ethnicity, Age, Zip Code Group, Sex	x		
	IP Discharges by Payer Source	x		
Patient	IP Discharges by Principal Diagnosis / Procedure Groups	Х		
Characteristics	Total Discharges by Payer			х
	Adult Psychiatric Ages / Payers		х	
	Total and Adjusted Patient Days by Payer		16	Х
	Outpatient Visits by Payer			X

Additional CMS Hospital COVID-19 Variables

Domain	Variable Considered	7-Day Average	7-Day Sum	7-Day Coverage
	Total Number of Staffed Inpatient and Outpatient Beds	Х	х	х
	Total Number of Staffed Inpatient Adult Beds	х	х	x
Staffed Bed	Total Number of Staffed Inpatient Adult Beds Occupied	x	x	x
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Total Number of Staffed Adult ICU Beds	Х	х	x
	Total Number of Staffed Adult ICU Beds that are Occupied	Х	x	x
Patient Types &	Hospitalized Patients in Inpatient Beds with Confirmed / Suspected COVID-19	Х	х	x
COVID-19	Hospitalized Patients in Adult ICU Bed with Confirmed / Suspected COVID-19	x	x	x
Providus Dav	Patients Admitted Previous Calendar Day with Confirmed / Suspected COVID-19		x	
Admissions by	Patients by Age Admitted Previous Calendar Day to Adult Inpatient Bed with Confirmed / Suspected COVID-19		х	
	Patient Visits to the ED Who Were Seen Previous Calendar Day Related to COVID-19		х	

What percent of adult ICU beds are occupied?



Percent of adult ICU beds that are occupied:



What percent of adult hospital beds are occupied?



Percent of adult hospital beds that are occupied:



Cal Hospital Compare Analytics

Historical trends

Cal Hospital Compare Analytics

Goal of Comprehensive Measure Analysis

- To examine longitudinal trends in both the measure set and performance to provide actionable insights
- Review measure set and methodology and consider enhancements to improve consumer reporting

In depth examination of CalHospitalCompare's performance history

- Changes in the measure set over time; migrating from process to outcome measures, including impact of specification changes and rebasing
- Examine the absolute changes in performance over time
- Examine hospital and/or demographic factors that are associated with the most improved/worsened performance.
 - Hospital size, system ownership, urban vs rural, occupancy, payer mix, financial performance, staffing etc
 - ► Could also include sociodemographic information in the hospitals geographic area
- Multivariate regression can be run to more precisely quantify the factors driving both 1) performance differences across hospitals and 2) changes in performance over time

Mortality Measures - Historical Trends



0																										
	Q4	Q1	Q2	Q3	Q1	Q2	Q1	Q2	Q3	Q4	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
	2013		2014		20	15		20	16			2017			20	18			20	19			20	20		

Note on the PN Mortality measure:

The MORT-30-PN measure underwent a substantive revision that expanded the measure cohort to include: 1) patients with a principal discharge diagnosis of pneumonia (the current reported cohort; 2) patients with a principal discharge diagnosis of aspiration pneumonia; and 3) patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission. This technical update was published in the FY 2016 IPPS final rule (80 FR 49567).

Readmissions Measures - Historical Trends



14																									
	Q4	Q1	Q2	Q3	Q1	Q2	Q1	Q2	Q3	Q4	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	2013	3	2014		20	15		20	16			2017	,		20	18			20	19			20	20	

READM_30_AMI Heart Attack Potentially Preventable Readmissions

- READM_30_COPD COPD Potentially Preventable Readmissions
- ——READM_30_HF Heart Failure Potentially Preventable Readmissions
- READM_30_PN Pneumonia Potentially Preventable Readmissions

AMI Mortality - Change in Distributions



Variable	Year	Mean	Std Dev	Minimum	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Maximum
Lloort Attack Dooth Doto	2013	14.9	1.5	10.6	13.3	13.9	15.0	15.9	16.7	21.0
Heart Allack Death Rate	2020	12.6	1.2	9.4	11.1	11.7	12.6	13.3	14.1	17.1

AMI Readmissions - Change in Distributions



Variable	Year	Mean	Std Dev	Minimum	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Maximum
Heart Attack Potentially	2013	19.5	1.4	15.4	17.9	18.5	19.4	20.2	21.3	23.8
Preventable Readmissions	2020	16.3	1.1	13.6	15.2	15.7	16.3	16.9	17.8	20.5

Correlation: AMI Readmissions and Mortality



While overall performance improved, there is little correlation between hospitals that perform well on AMI mortality and AMI readmissions (as of 2020)

AMI Mortality - Distribution of Change



	Analysis Variable: diff (2020 - 2013)											
Ν	Mean	Std Dev	Minimum	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl				
183	(2.4%)	1.6%	(8.3%)	(4.3%)	(3.3%)	(2.2%)	(1.4%)	(0.6%)				

AMI Readmissions - Distribution of Change



	Analysis Variable: diff (2020 - 2013)											
Ν	Mean	Std Dev	Minimum	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Maximum			
163	(3.1%)	1.7%	(8.3%)	(5.3%)	(4.1%)	(3.1%)	(2.0%)	(1.1%)	0.9%			

Correlation Between Percent Change in AMI Mortality and Readmissions



Top 10 Improved Hospitals - AMI Mortality

Name	2013	2020	Difference
Kaweah Delta Health Care District	21.0	12.7	-8.3
Methodist Hospital of Sacramento	19.5	12.0	-7.5
St. Joseph Hospital, Eureka	18.7	11.8	-6.9
MemorialCare Long Beach Medical Center	17.1	11.5	-5.6
Adventist Health Lodi Memorial	18.0	12.5	-5.5
Seton Medical Center	17.1	11.8	-5.3
El Centro Regional Medical Center	17.6	12.3	-5.3
Santa Barbara Cottage Hospital	16.4	11.3	-5.1
Dominican Hospital	15.7	10.7	-5.0
Arrowhead Regional Medical Center	17.8	12.8	-5.0

Rightmost "outliers" moving into body of distribution

Top 10 Improved Hospitals - AMI Readmissions

Name	2013	2020	Difference
Sherman Oaks Hospital and Health Center	23.8	15.5	-8.3
Seton Medical Center	23.4	15.4	-8.0
Olympia Medical Center	23.4	16.5	-6.9
MemorialCare Long Beach Medical Center	22.8	15.9	-6.9
Huntington Beach Hospital	22.8	16.3	-6.5
Beverly Hospital	22.3	15.9	-6.4
Bakersfield Memorial Hospital	22.4	16.3	-6.1
St. Joseph's Medical Center - Stockton	21.3	15.4	-5.9
Alta Bates Summit Medical Center - Summit Campus (Hawthorne)	20.5	14.6	-5.9
Glendale Memorial Hospital and Health Center	21.5	15.7	-5.8

Rightmost "outliers" moving into body of distribution

Differences in AMI Mortality and Readmissions: African American

				Variable	Year	10th Pctl	25th Pctl	50th Pctl	75th Pctl
		Def'n of Qu	artile: Pct	AMI Readmissio	ons 2020	15.2	15.7	16.3	16.9
		Admission	s African	AMI Mortality	2020	11.1	11.7	12.6	13.3
	1	Amer	ican		1			_	
Quartile	Number of Hospitals	Minimum	Maximum						
				Ave. AMI Morality	Ave. AM	I Readr	nission		
				Rate		Rate			X
1	78	0.0%	1.9%	12.8		16.0			
2	79	1.9%	4.5%	12.4		16.5			
3	79	4.5%	9.9%	12.5		16.3			
4	78	10.1%	64.1%	12.4		16.4			

Relatively little difference in AMI Readmission or Mortality rates by

race

90th Pctl 17.8 14.1

Differences in AMI Mortality and Readmissions: White

				Variable	Year	10th Pctl	25th Pctl	50th Pctl	75th Pctl
				AMI Readmissio	ns 2020	15.2	15.7	16.3	16.9
		Def'n of Ou	artilo: Dct	AMI Mortality	2020	11.1	11.7	12.6	13.3
		Admissio	ns White						
Quartile	Number of	Minimum	Maximum						
	Hospitals								
				Ave. AMI	Av	e. AM	I		
				Morality Rate	Readm	ission	Rate		
1	79	1.4%	46.2%	12.5		16.6			
2	80	46.2%	67.2%	12.3		16.2			
3	80	67.2%	80.9%	12.5		16.2			
4	80	80.9%	98.6%	12.8		16.3			
									_

Relatively little difference in AMI Readmission or Mortality rates by

race

90th

Pctl

17.8 14.1

Differences in AMI Mortality and Readmissions: Asian

				Variable	Year	10th Pctl	25th Pctl	50th Pctl
				AMI Readmissi	ons 2020	15.2	15.7	16.3
		Defined Ou	artila. Dat	AMI Mortality	2020	11.1	11.7	12.6
		Der n of Qu	iartile: Pct					
		Admissio	ns Asian		1			7
Quartile	Number of Hospitals	Minimum	Maximum					
				Ave. AMI	Av	e. AM	I	
				Morality Rate	Readm	ission	Rate	
1	77	0.0%	1.7%	12.7		16.2		
2	78	1.9%	4.9%	12.6		16.3		
3	78	4.9%	10.7%	12.3		16.4		
4	78	10.9%	97.0%	12.5		16.4		

Relatively little difference in AMI Readmission or Mortality rates by race

75th

Pctl

16.9

13.3

90th

Pctl

17.8

14.1

COVID-19 in CA Nursing Homes

New findings

CA NH COVID Study

- Key Lesson Learned:
 - Importance of continuous research. Factors significant earlier in the pandemic (May 24) were different from those later in the pandemic (August 9) as virus spread
- Team updated study with January 31, 2021 data
- Key Question: What factors were most strongly associated with the winter surge and how did they compare with previous results
- <u>Changed</u> Outcome Variables to:
 - Cumulative Case Rate per 1,000 residents: from Nov. 1 to Jan. 31
 - Cumulative Death Rate per 1,000 residents: from Nov. 1 to Jan. 31

Updated Regression Results

- ► Key Finding 1:
 - Unlike earlier in the pandemic, there was less difference in case and death rates based on previously explanatory factors including race, ethnicity, nurse staffing and size
 - Possible implication: COVID was able to penetrate all types of nursing homes
 - Notable exception is that for-profit status still strongly associated with cases and deaths
- Key Finding 2:
 - Ultimately, preparations during the summer were unable to prevent the fall surge
- Key Finding 3:
 - As of January 31, previously observed disparities based on race, ethnicity, staffing and size dramatically diminished in comparison to prior periods in the pandemic; with some exceptions.
 - Possibly linked to comprehensive, more equitable vaccination

Spread of COVID from Aug. 9 to Jan. 31

Category		Cases 9-Aug Deaths		31-Jan	Percent Change	
		Cases	18,352	56,214	206%	
Resident	Deaths	3,296	8,251	150%		
Staff	Cases	14,647	47,511	224%		
Staff		Deaths	73	152	108%	
		Cases	778	1,080	39%	
	Any Resident	Deaths	457	895	96%	
Number of SNFs	Any Staff	Cases	1,010	1,139	13%	
	Ally Stall	Deaths	53	115	117%	

42

Total CA SNFs = 1,149

By Jan. 31:

- Only 69 SNFs had no resident cases
- Only 10 SNFs had no staff cases

... Updated Regression Results

Explanatory Variable	Cumulative Case Rate - May 24 to Aug 9	Surge: Cumulative Case Rate Nov. 1 to Jan. 31
	Rate Ratio	Rate Ratio
Percent Male	1.26	0.93
Percent African American	1.40	0.89
Percent Latinx	1.54	1.03
RN Staffing	0.54	1.13
Total Nurse Staffing	0.85	0.80
For-Profit, Chain	1.65	1.77
For-Profit, Non-Chain	1.50	1.66
Size - Number of Beds	4.84	0.98
Nursing Turnover	1.26	1.05
Total Deficiencies	1.25	1.01
County Case Rate	1.23	0.91

Methodology:

- Regression compared top quartile to bottom quartile
- Rate ratio is the increased likelihood of cases in top quartile
 - E.g., as of Aug. 9, SNFs in highest quartile of percent Latinx residents had a 54% higher case rate than the bottom quartile

Key Observations:

- During the Nov. 1 to Jan. 31 surge, factors that were previously explanatory, diminished in impact
 - E.g., during surge, SNFS in the highest quartile of percent Latinx residents has only a 3% higher case rate than the bottom quartile
- Key exception: for-profit status continued to be strongly explanatory

Cases and Deaths in SNFs: For-Profit vs Non-Profit



			Weekly As o	of Jan. 31	Cumulative of Res	e Number (ident	Cumulative of St	e Number aff
Comparing Top Quartile to Bottom Quartile	Ν	No of Residents	Cases per 1,000	Deaths per 1,000	Cases	Deaths	Cases	Deaths
Part of Chain by Licensee Type of Control								
Chain, Investor	440	33,995	6.4	1.4	26,584	3,788	20,311	48
Non-Profit	117	5,582	4.3	2.5	2,401	506	3,530	9
Not Chain, Investor	418	29,262	4.6	1.1	20,939	3,041	17,723	63

Cases and Deaths in SNFs: High Percent LatinX Residents



Wrap Up

2021 BOD Call Schedule

(all times are Pacific Time Zone)

Wednesday, June 9, 2021

10:00am to 12:00pm

Wednesday, August 4, 2021

Wednesday, September 29, 2021

Wednesday, December 1, 2021

10:00am to 12:00pm

10:00am to 12:00pm

10:00am to 12:00pm

Thank you!

Appendix

COVID in CA Nursing Homes

Trend Graphs

- Trend graphs on following slides show weekly SNF resident case and death rates by resident and SNF characteristics
- In general, compares e.g. SNFs in highest quartile of percent Latinx residents to lowest quartile

Cases and Deaths in SNFs: For-Profit vs Non-Profit



Comparing Top Quartile to Bottom Quartile	Ν	No of Residents	Cases per 1,000	Deaths per 1,000	Cases	Deaths	Cases	Deaths
Part of Chain by Licensee Type of Control								
Chain, Investor	440	33,995	6.4	1.4	26,584	3,788	20,311	48
Non-Profit	117	5,582	4.3	3 2.5	2,401	506	3,530	9
Not Chain, Investor	418	29,262	4.6	6 1.1	20,939	3,041	17,723	63

Cases and Deaths in SNFs: High Percent LatinX Residents



Cases and Deaths in SNFs: High Percent Black Residents



Cases and Deaths in SNFs: Large vs Small Facilities



			Weekly As of Jan. 31		Resident		Staff	
Comparing Top Quartile to Pottom Quartile	N	No of Posidonts	Casas par 1 000	Deaths par 1 000	Casas	Dootho	Casas	Deaths
Comparing top Quartile to Bottom Quartile	IN	NO OF Residents	Cases per 1,000	Deaths per 1,000	Cases	Deaths	Cases	Deaths
Licensed Beds								
Lo (<= 61.5)	261	9,173	2.3	1.4	5,418	809	5,457	15
Hi (> 120)	252	29,288	5.8	1.2	21,481	3,222	16,445	55

Cases and Deaths in SNFs: RN Staffing Level



			Weekly As of Jan. 31		Cumulative Number of C Resident		Cumulative Number of Staff	
Comparing Top Quartile to Bottom Quartile	N	No of Residents	Cases per 1,000	Deaths per 1,000	Cases	Deaths	Cases	Deaths
Lo (<= .35)	279	20,550	6.18	1.27	15,233	2,312	11,838	45
Hi (> .70)	278	16,037	3.68	1.06	8,300	1,014	8,738	19