Cal Hospital Compare
Board of Directors Meeting Agenda
Wednesday, June 9, 2021, 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 | Passcode: **cyno#**

Time	Agenda Item	Presenters and Documents
10:00-10:05 *5 min.*	Welcome and call to order - Approval of past meeting summary	- **Ken Stuart** Board Chair - **Bruce Spurlock** Executive Director, CHC
10:05-10:20 *15 min.*	Organizational updates – Meeting schedule – Updates to BOD bylaws – Covered CA Network Analysis	- **Alex Stack** Director, CHC - **Bruce Spurlock** Executive Director, CHC
10:20-11:20 *60 min.*	COVID-19 in CA hospitals - Study results - Healthy places index - Qualitative interviews - Recommendations - Discussion	- **Mahil Senathirajah** Senior Director, IBM Watson Health - **Hal Skinner** Consultant, IBM Watson Health
11:20-11:30 *10 min.*	Opioid Care Honor Roll 2021 - Assessment updates - Proposed 2021 honor roll threshold - Next steps	- **Alex Stack** Director, CHC
11:30–11:50 *20 min.*	Cal Hospital Compare Analytics - Review historical trends o Mortality o Readmissions	- **Mahil Senathirajah** Senior Director, IBM Watson Health
11:50-11:55 *5 min.*	Business Plan - Financial report	- **Bruce Spurlock** - Executive Director, CHC
11:55-12:00 *5 min.*	Wrap-up Adjourn – Next meeting: Wednesday, August 4, 10:00am - 12:00pm PST (Zoom Call)	- **Ken Stuart** Board Chair

Cal Hospital Compare

Board of Directors

Other Contributors

Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Summary
Wednesday, April 14, 2021
10:00am – 12:00pm PST via Zoom

Attendees: Ashrith Amarnath, Seth Glickman, David Hopkins, Chris Krawczyk, Parker Lewis, Helen Macfie, Joan Maxwell, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Kristof Stremikis, Ken Stuart, Kevin Worth, Tracy Fisk

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting formally commenced at 10:04am Pacific Time. The meeting summary of February 10, 2021 was motioned, seconded, and approved as submitted.
Organizational Updates	• Ashraf Gulzar, Quality Improvement Manager with Santa Clara Valley Medical Center has joined the TAC, replacing Carolyn Brown. • US News and World Report is interested in creating a composite measure for maternity. The composite would include overall HCAP scores from the hospitals. In the past, CMQCC has been reluctant to use a composite measure. Elliott Main and Bruce Spurlock will participate on a measure composite workgroup and based on progress, report back to the TAC about sharing CHC's data with US News and World Report. • CHC is still exploring analyses on hospital price transparency. Currently, data is insufficient to draw a clear conclusion. Kristof and Helen will share their organization's work with the Board.
COVID-19 in Hospitals	• A new workgroup will convene for a 2-part meeting in April and May to conduct a deeper dive into what type of hospitals and populations were most impacted by COVID-19 and to what extent. All board members are invited to join the workgroup. Bruce and Mahil gave an overview of the study design. The goal of the study is to gain a deeper understanding about impact during a public health emergency, not hospital performance. How can health care and policy makers be better prepared and what can we learn about culture and decision-making processes. • OSHPD will be releasing a new dashboard series of 3 visualizations in early to mid-May: looking at trends in utilization – ambulatory surgery and ED (includes COVID cases), diagnosis codes, and mortality for diagnosis codes. The data will include the first six months of 2020 inpatient, first 3 quarters of 2020 for ambulatory surgery and ED. The complete annual 2020 data file will be published in mid to late summer. • It is important to be mindful of the time horizon and consider the COVID case surges/peaks (ie. Sept 2020 vs. Jan. 2021) when analyzing variables.

CHC Analytics	• Mahil provided an overview on AMI mortality and readmissions measures. The background rate of health care's innovation and advancement is more profoundly directed to AMI compared to other conditions.
COVID-19 in CA Nursing Homes	• For profit vs non-profit SNFs had dramatically higher COVID cases and deaths. Once vaccines were distributed, any disparity went to zero. This was most likely the largest equitable distribution in nursing homes in CA for the impact on cases and deaths. Kristof offered to support additional discussions/blog if CHC bandwidth allows. Due to time constraints, additional discussion on this topic was deferred for the next Board meeting.
Financials	• Bruce reviewed the current financial reports for Q1 (January – March 2021). CHC is ahead of schedule with collecting payments from sponsors and health plans.
Next Meeting/Meeting Adjournment	• The next Board of Directors meeting is scheduled on Wednesday, June 9th at 10:00am PST via Zoom. • The meeting formally adjourned at 12:00pm PST.

Cal Hospital Compare Board of Directors

June 9, 2021

10:00am-12:00pm Pacific Time

Join Zoom Meeting: https://zoom.us/j/4437895416

Passcode: **cyno#**

Proposed Agenda

- Welcome & call to order
- Organizational Updates
- COVID-19 in CA Hospitals
- Opioid Care Honor Roll 2021
- Cal Hospital Compare Analytics
- Business plan
- Wrap Up

Welcome!

Jamie Chan, PharmD
Vice President, Clinical Quality
Blue Shield of California

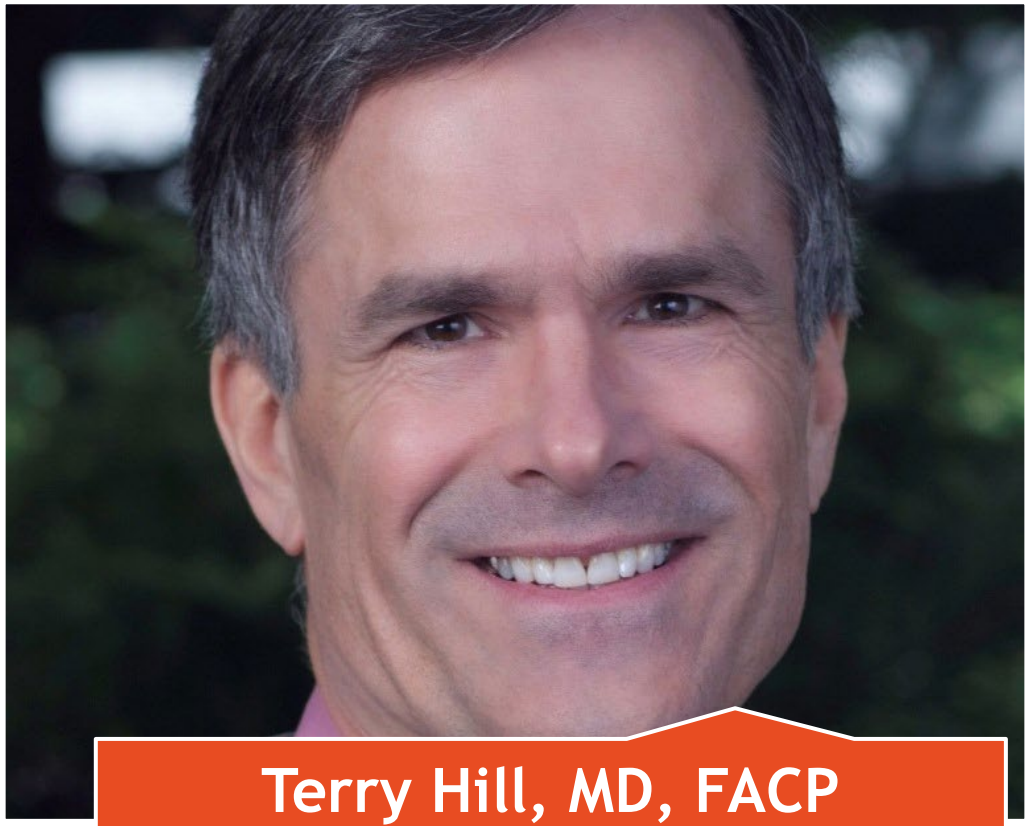
BOD Bylaws

i. Effective March 17, 2015, the Board shall be eleven (11) members. The existing Board shall elect from its members or from new candidates, two (2) representatives of health plans providing healthcare coverage to subscribers or enrollees, two (2) representatives of acute care hospitals licensed under Section 1250(a) or (b) of the California Healthcare Safety Code, three (3)representatives of consumers of health care, one of which may be from the California Healthcare Foundation, two (2) representatives of purchasers of healthcare, i.e., employers or organizations representing employers which purchase healthcare coverage, one (1) representative of the an integrated health entity and the Executive Director of the corporation.

ii. Effective July 1, 2021, the Board shall be thirteen (13) members. Along with the members identified in Section 2 subsection iii above, the Board shall elect two (2) representatives involved in the Long-Term Services & Supports Organizations in California.

iii. The Board at its discretion may invite representatives from state or federal agencies as ex officio members of the Board.

Proposed BOD Changes (Cal Quality Care)



Terry Hill, MD, FACP

COVID-19 Medical Director

ACCMA

Covered CA Network Analysis

General updates

Examining COVID-19 in Hospitals

DRAFT – additional revisions to slides in this section are in progress

Study Design

Goal

- To understand what type of hospitals and patient populations were most impacted by COVID-19 and hospital responses. Goal is not to assess hospital performance

Why?

- Identify which hospitals were most "stressed" by COVID-19 and characteristics of hospitals that were most able to respond to that stress
- Identify what else we need to know to drive data driven decision making during next PHE e.g., data gaps
- Make recommendations that support hospitals in the next PHE

How?

- Quantitative analysis
- Interviews with hospitals to provide context and insights *(2-3 hospitals)*

Deliverable:

- Issue brief for California Health Care Foundation by end of July

Advisory Committee

- Patient Advisors
- Health Plans/Payers
- Quality Improvement Organizations
- Hospital representatives
- Emergency management representatives
- Subject Matter Experts/ Researchers

Two Key Analytic Questions

- **Stress -** what type of hospitals and populations were most **impacted** by COVID-19?
  - Metrics:
    - ICU Bed Occupancy > 85% (Covid + non-Covid)*
    - Percent Adult Bed Occupancy – All (Covid + non-Covid)
- **Resiliency -** what type of hospitals were able to **respond** to the winter surge?
  - Metrics:
    - Percent Increase in Adult Staffed ICU Beds
    - Percent Increase in Adult Staffed Beds
    - Increase over Nov. 6, 2020: Pre-surge

*consistent with State re-opening criteria

Outcome Variables Used in Model and Definition

Category	Metric (adult patient pop.)	Numerator / Denominator
Stress	% ICU Bed Occupancy > 85%	**Num:** Average of total number of staffed inpatient adult ICU beds that are occupied at peak **Denom:** Average number of total number of staffed inpatient ICU beds at peak
	% Bed Occupancy	Num: Average of total number of staffed inpatient adult beds that are occupied at peak / **Denom:** Average of total number of staffed inpatient adult beds in the hospital at peak
Resiliency	% Increase in Staffed ICU Beds	**Num:** Average number of total number of staffed adult ICU beds reported at peak / **Denom:** Average number of total number of staffed adult ICU beds reported in the 7-day period on 11/6/20
	% Percent Increase in Staffed Beds	**Num:** Average number of total number of staffed adult beds reported at peak / **Denom:** Average number of total number of staffed adult beds reported in the 7-day period on 11/6/20

Explanatory Variables Included in Statistical Modeling

Domain	Variable	What it Measures	Units	Type of Variable	Source
Financial	Net Income	Financial Resources	Dollars	Continuous	OSHPD Financial
	Total Margin	Profitability	Percent	Continuous	
Facility Characteristics	Occupancy Rate	Busyness	Percent	Continuous	
	Total Census Days	Size of Hospital	Bed Days	Continuous	OSHPD Utilization
	Part of System, Size	Size of System Hospital Is In	Number of hospitals	Continuous	OSHPD Financial
	DSH Hospital	Serve Low Income/Uninsured	Yes/No	Categorical	OSHPD Financial
	Teaching Hospital	Whether hospital is a teaching hospital	Yes/No	Categorical	
	Hospital License Category	Type of hospital	Non-Profit, Investor, District, City or County, University of California	Categorical	OSHPD Utilization
Patient Characteristics	Patient Days by Payer	Mix of Payers	Medicare, Medi-Cal, Commercial	Categorical	OSHPD Financial
	Gender	Patient Gender	Male/Female	Percent of Total Discharges, Continuous with Category	OSHPD IP DC Characteristics
	Race	Patient Race	White, Asian, Black	Percent of Total Discharges, Continuous with Category	OSHPD IP DC Characteristics
	Ethnicity	Patient Ethnicity	Hispanic, Non-Hispanic	Percent of Total Discharges, Continuous with Category	
County	Weekly Case Rate	Weekly County-Level COVID Case Rate - New	Cases per 100,000 population	Continuous	CDPH COVID Cases

Data limitations/feedback from TAC

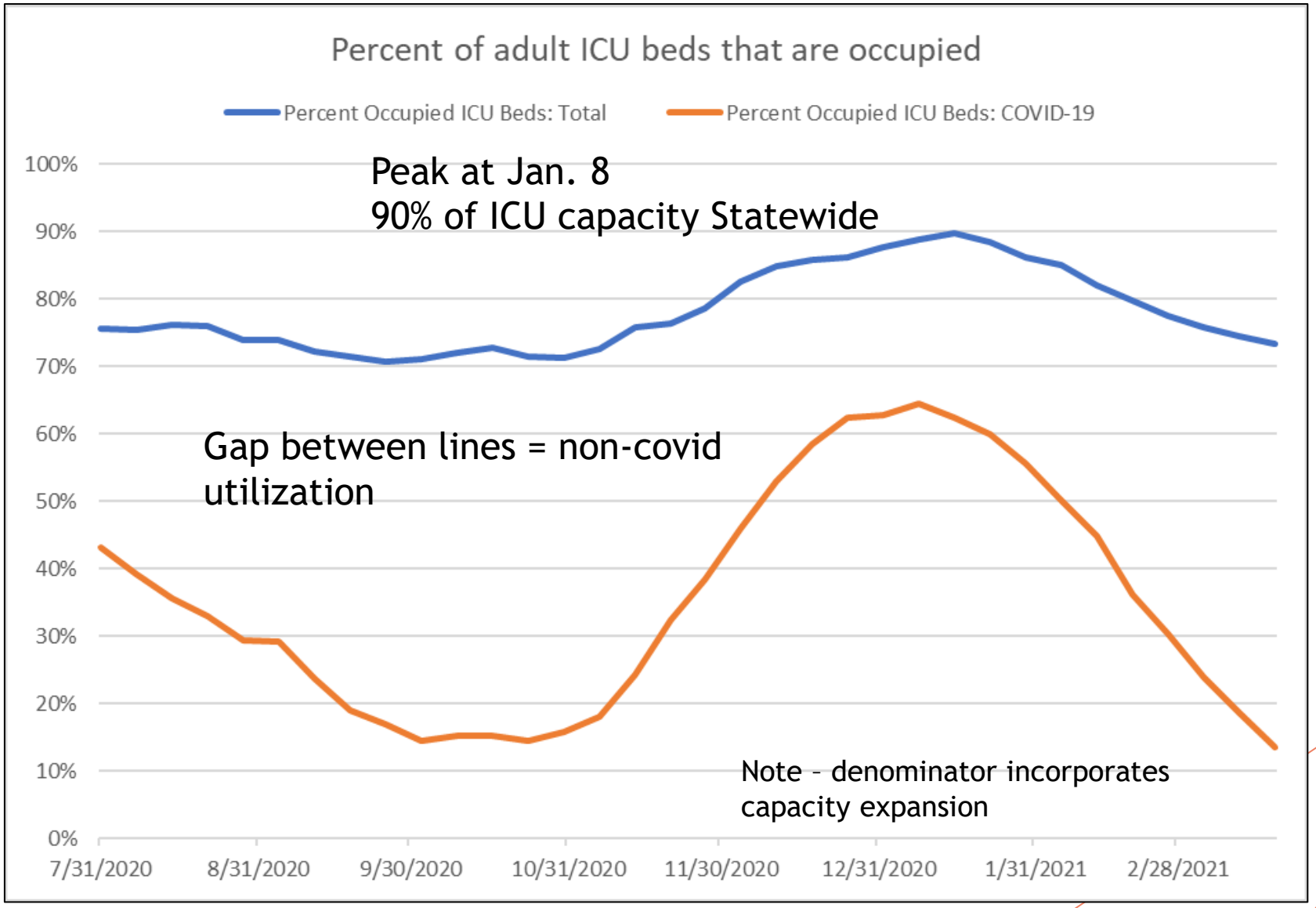
- Data accuracy
  - Used CY2019 data for a number of explanatory variables
  - Changes in ICU bed definitions
  - ICU level care was not confined to the ICU
  - “Borderline” patients
- Data granularity
  - Case rate by county vs zip code; geography matters
  - Transfers in and out of the hospital
  - Bed capacity changes as a result of canceling elective surgeries, enhanced discharge planning, end of life planning/ventilator management
- Hospital level data vs patient level data
  - Cannot assess impact of age and comorbid conditions
  - Impacts ability to make assumptions regarding disparities
- Hospital preparedness
  - Lots of lessons learned early in the pandemic that streamlined hospital operations
  - Changes in EMR, leadership, etc. also impacts readiness

Descriptive Statistics

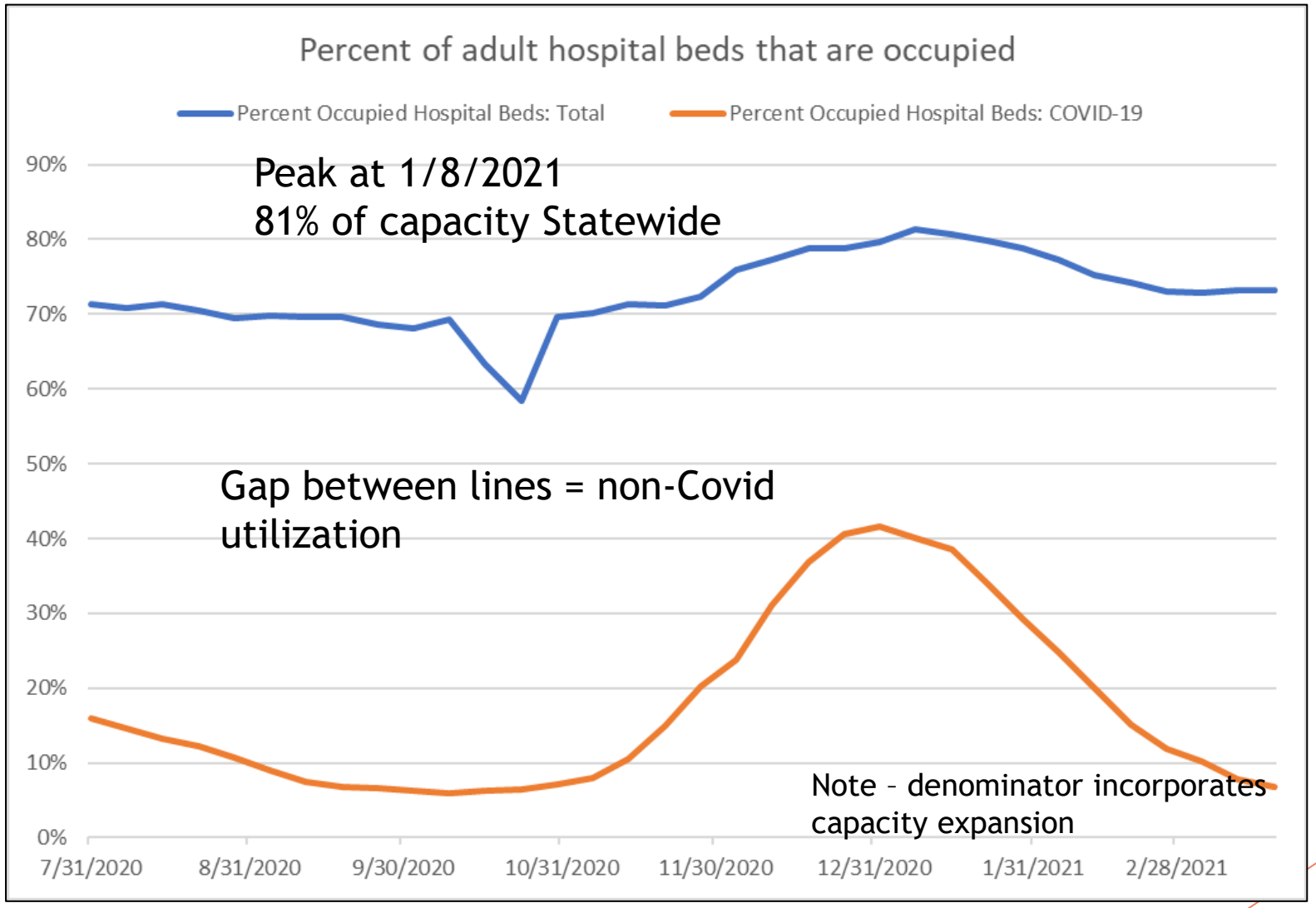
Examining COVID-19 in Hospitals

Stress: statewide trends

Percent ICU Adult Bed Occupancy

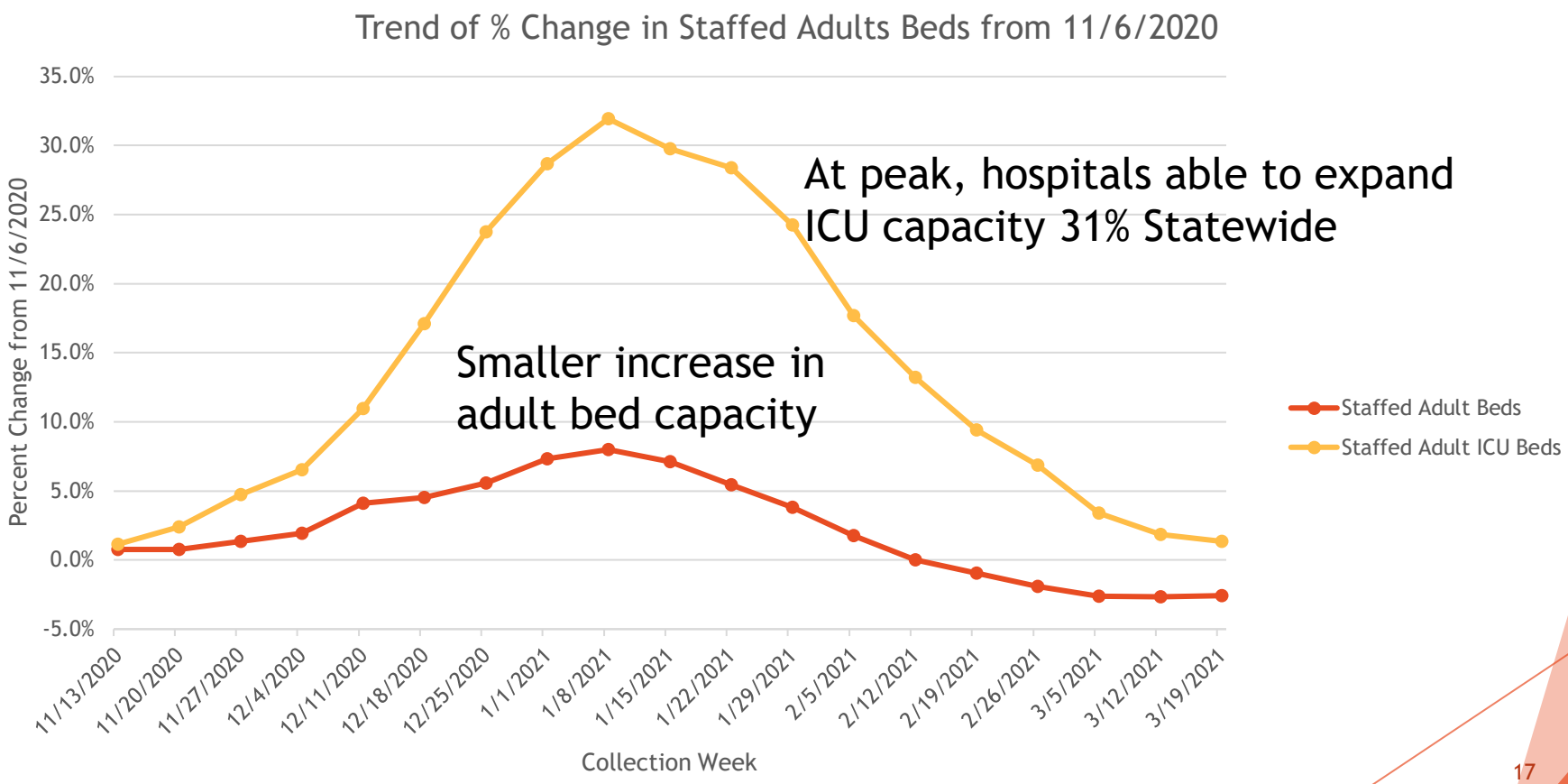


Stress: statewide trends
Percent Adult Bed Occupancy (All)



Resiliency: statewide trends (11/6/20 baseline)

Percent Increase in Adult Staffed ICU Beds and Adult Beds



Statistical Analyses

	Stress				Resilience			
	Adult Bed Occupancy (%)		ICU Occupancy 85%+		Adult Beds Percent Change		ICU Beds Percent Change	
Characteristic	**Estimate**	**P-Value**	Odds Ratio	P-value	Estimate	P-Value	Estimate	P-Value
Intercept	*0.79*				0.07		0.26	
Non-DSH Hospital (vs DSH)	**0.06**	**0.02**	0.85	0.78	-0.01	0.32	0.04	0.63
Teaching Hospital (vs Non)	-0.02	0.65	**8.45**	**0.06**	-0.01	0.44	**-0.16**	**0.20**
License Type								
Non-Profit	*Ref.*		Ref.		Ref.		Ref.	
City or County	**0.06**	**0.16**	0.31	1.30	0.02	0.58	0.14	0.30
District	0.04	0.31	3.05	1.27	0.00	0.90	-0.12	0.31
Investor	**-0.06**	**0.04**	0.88	2.29	0.05	0.54	0.01	0.92
Smoothed Terms		**P-Value**		**P-Value**		**P-Value**		**P-Value**
County COVID-19 Case Rate (per 100,000)		**<0.01**		**0.04**		0.26		**<0.01**
Medicare Days (%)		**0.08**		**0.06**		0.32		0.30
Medi-Cal Days (%)		**0.15**		0.85		0.44		0.33
Total Census Days (per SD)		**<0.01**		0.66		0.58		0.38
Net Income (per SD)		**0.18**		0.70		0.90		0.38
Total Margin (per SD)		**0.01**		0.75		0.54		**0.05**
System Size (N Hospitals)		**<0.01**		**0.02**		**0.04**		**<0.01**
Male Discharges (%)		0.43		0.34		0.91		0.88
Race - Black Discharges (%)		0.35		0.45		0.71		**0.02**
Race - Asian Discharges (%)		0.41		0.38		0.55		0.36
Ethnicity Hispanic Discharges (%)		0.26		0.35		0.45		**0.03**

?

Key findings

Response	Metric	Teaching hospital	System size	Margin & Net Income
Stress	% ICU Bed Occupancy > 85%	Teaching hospitals ~8.4 times as likely to exceed an 85% ICU occupancy threshold	Hospitals in larger systems were more likely to exceed an 85% ICU occupancy threshold than hospitals in smaller systems	Hospitals at the top of the total margin range tended to have higher occupancy.
	% Bed Occupancy		Hospitals in the middle range of system size had higher adult bed occupancy	
Resiliency	% Increase in Staffed ICU Beds	No statistically significant increase in staffed ICU beds, in fact, there was a nominal decrease	On average, hospitals in systems comprised of ~15 hospitals had greater ICU expansion	Hospitals with higher total margin tended to have lower ICU capacity expansion.
	% Percent Increase in Staffed Beds		Hospitals in the middle range of system size had a somewhat greater adult bed expansion	

*Adjusting for a range of administrative and demographic characteristics and county case rate/

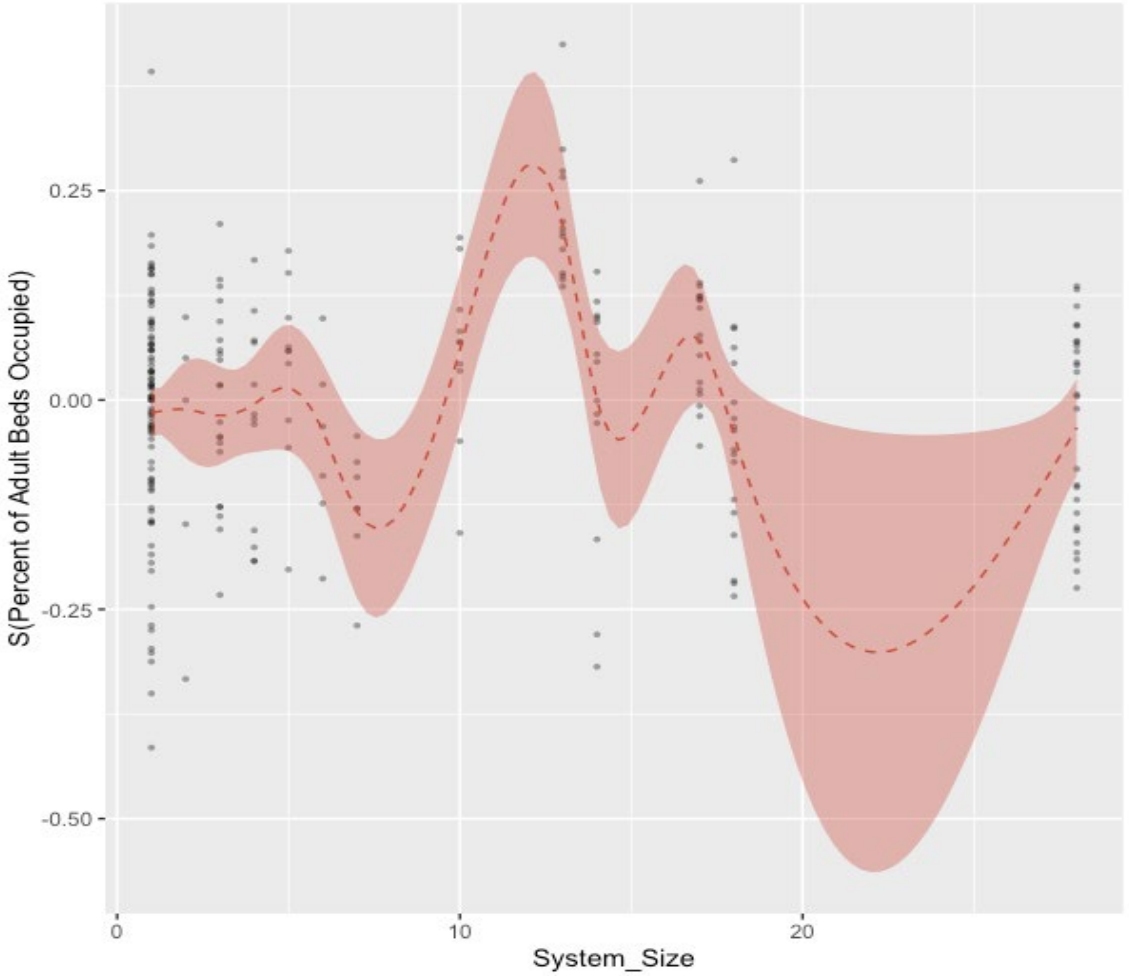
Reading between the lines

- Teaching hospital
  - Likely, larger tertiary care centers with higher transfer volume
  - Greater ICU capacity and capability to start with (larger ICUs, residents, etc.)
  - Did not have to expand ICU care into the hospital setting
  - Assume safer care?
- System size
  - Larger systems had greater stress but also resiliency…more experienced capabilities to handle a surge
  - Assume system hospitals have greater resources, ability to transfer within the system, and a more standardized approach to care
- Margin & Net Income
  - Hospitals with higher margin had higher occupancy but did not need to expand to meet the demand (e.g., higher stress but lower resiliency)
- Patient demographics
  - Did not observe a correlation between race/ethnicity and payor mix with stress and resiliency…does not mean it is not there

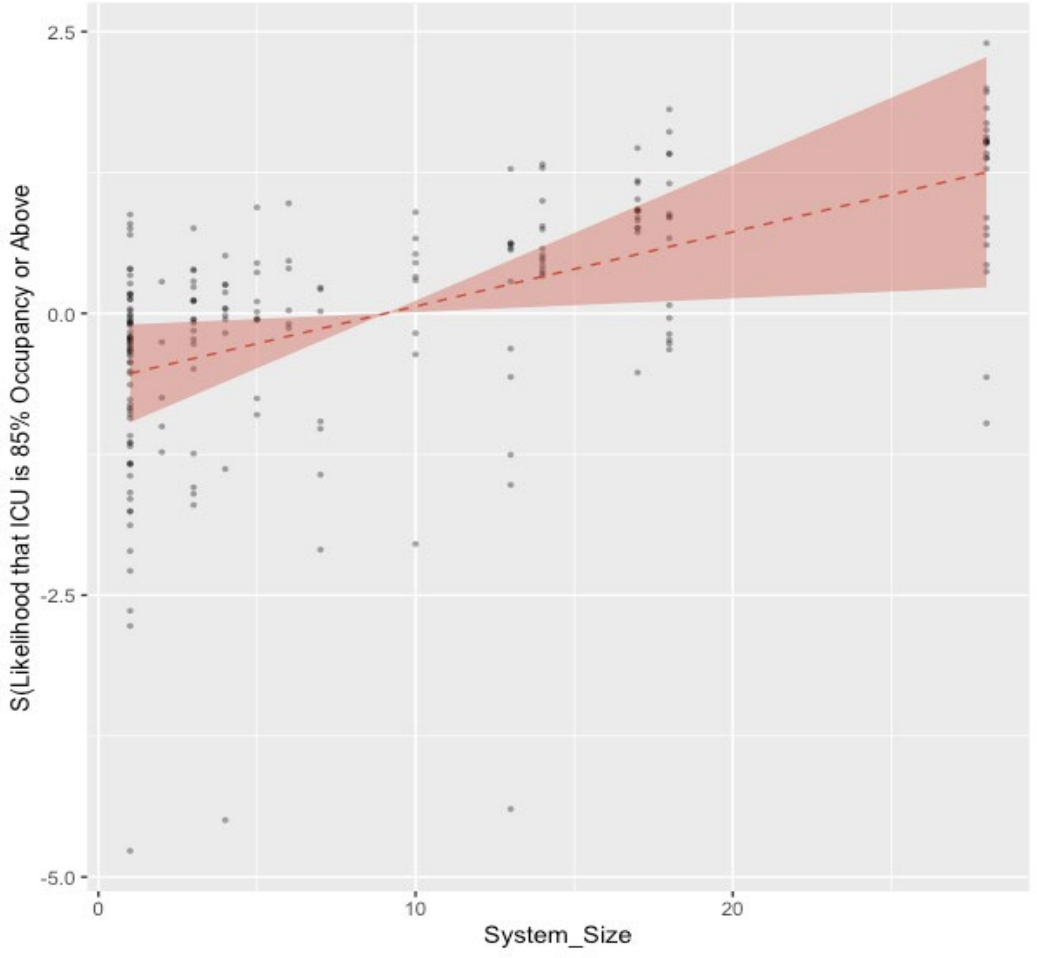
System Size

A deep dive

Stress: Adult Bed Occupancy

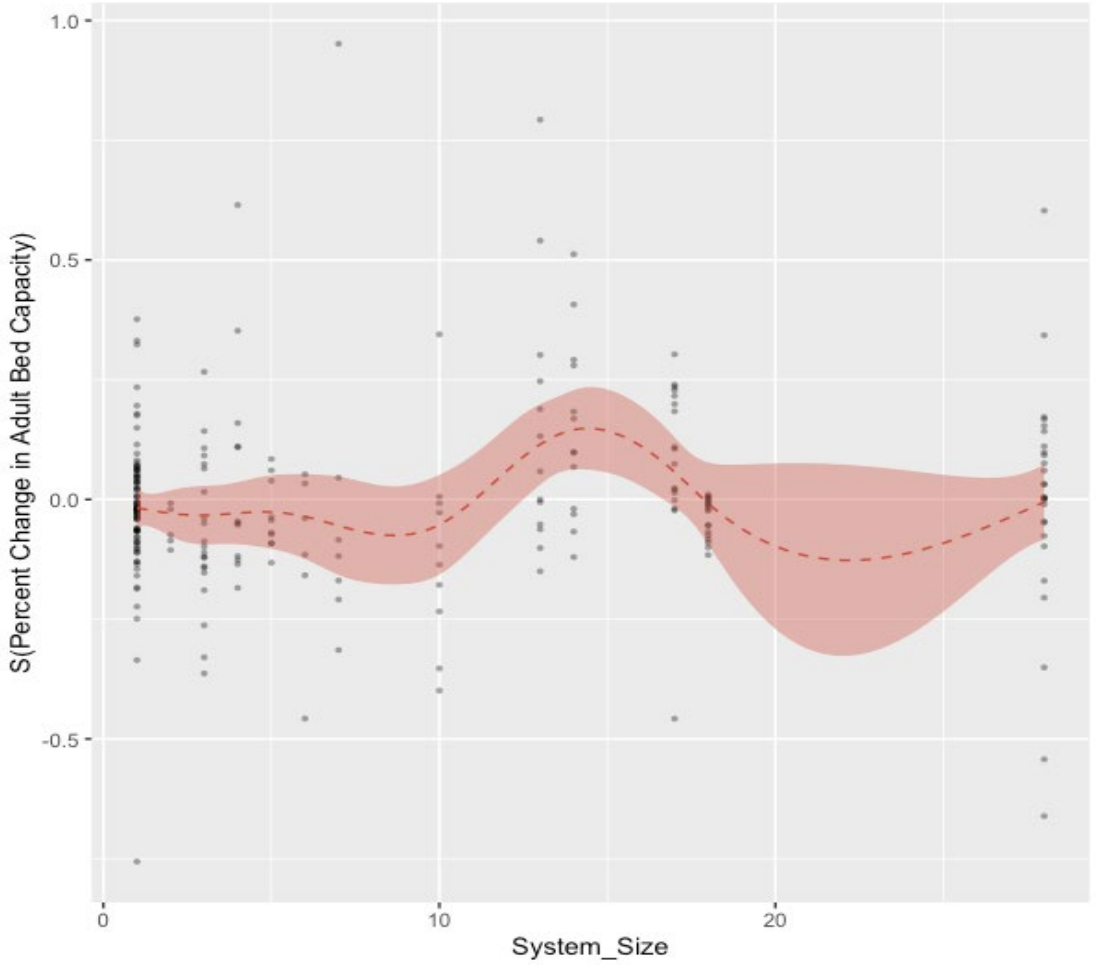


Stress: ICU Occupancy ≥85%

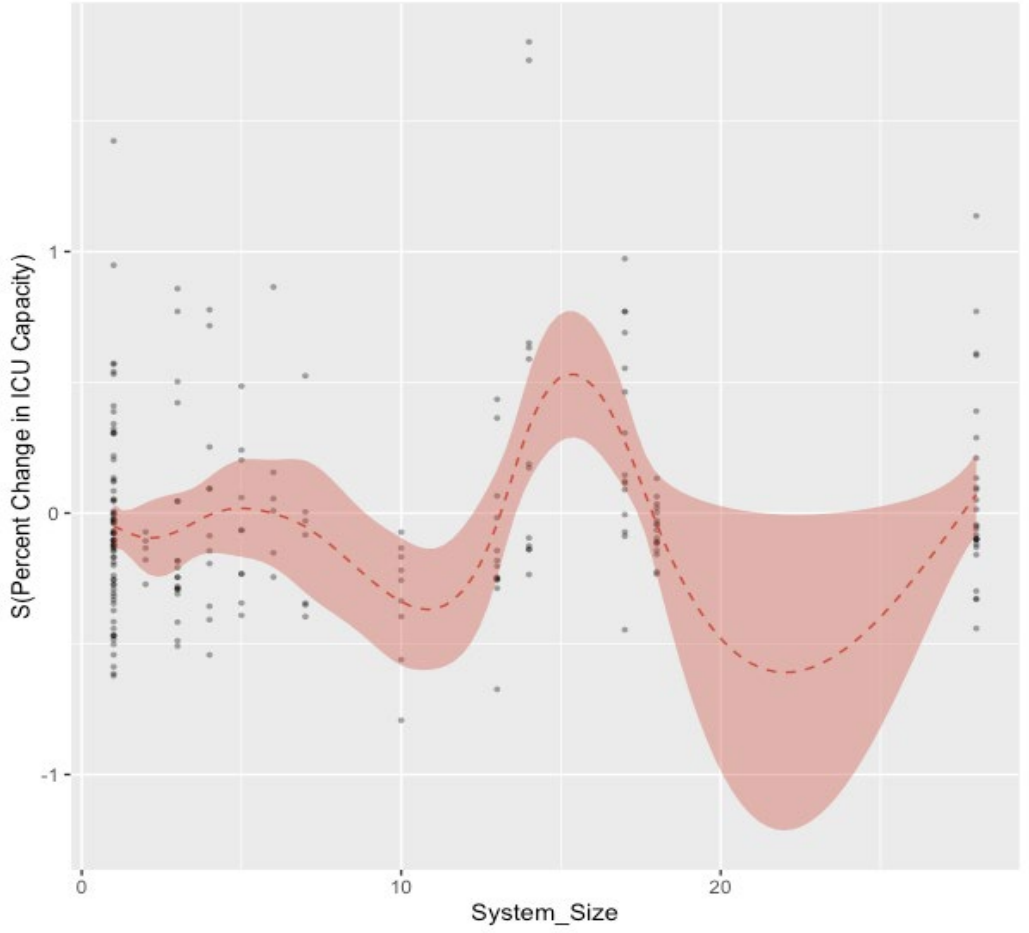


System Size (Number of Hospitals)

Resilience: Adult Bed Expansion



Resilience: ICU Expansion



System Size (Number of Hospitals)

Systems: Hospitals in North and South

	North	South
No. of hospitals in health system	70	151
DIGNITY HEALTH	17	11
KAISER FOUNDATION HOSPITALS	16	12
SUTTER HEALTH	19	
PROVIDENCE ST. JOSEPH HEALTH	5	12
PRIME HEALTHCARE SERVICES	1	13
TENET HEALTHCARE CORPORATION	6	7

Notes:

- Kaiser and Dignity: largest systems serving both North and South
- Sutter: serves only North
- Providence and Prime: serve mostly South
- Tenet: serves both North and South

Hospital System Preliminary Results

		Stress				Resilience			
Health System	Number of Hospitals in Data	Adult Bed Occupancy		ICU Occupancy 85%+		Adult Bed Percent Change		ICU Bed Percent Change	
All Other Hospitals (reference)		Estimate	P-value	Odds Ratio	P-value	Estimate	P-value	Estimate	P-value
Dignity Health	28	-3.3%	0.35	2.19	0.19	-0.6%	0.87	14.7%	0.13
Kaiser Foundation Hospitals	28	**6.4%**	**0.08**	**9.15**	**0.00**	-1.0%	0.81	**40.7%**	**<0.01**
Prime Healthcare Services	14	0.8%	0.87	Inf.	1.00	**15.2%**	**<0.01**	**48.6%**	**<0.01**
Providence St. Joseph Health Services	17	**9.5%**	**0.03**	**16.41**	**0.02**	7.2%	0.13	**34.7%**	**0.01**
Sutter Health	18	**-10.5%**	**0.02**	2.36	0.24	-3.5%	0.46	-0.1%	0.99
Tenet Healthcare Corporation	13	**18.5%**	**0.00**	0.76	0.71	**18.9%**	**<0.01**	-7.2%	0.58

Adjusted for COVID-19 County Case Rate and Demographics (Asian Race, Black Race, Hispanic Ethnicity)

Tenet reported the highest peak adult bed occupancy. **Sutter** reported the lowest.

Prime reported the highest peak ICU bed occupancy.

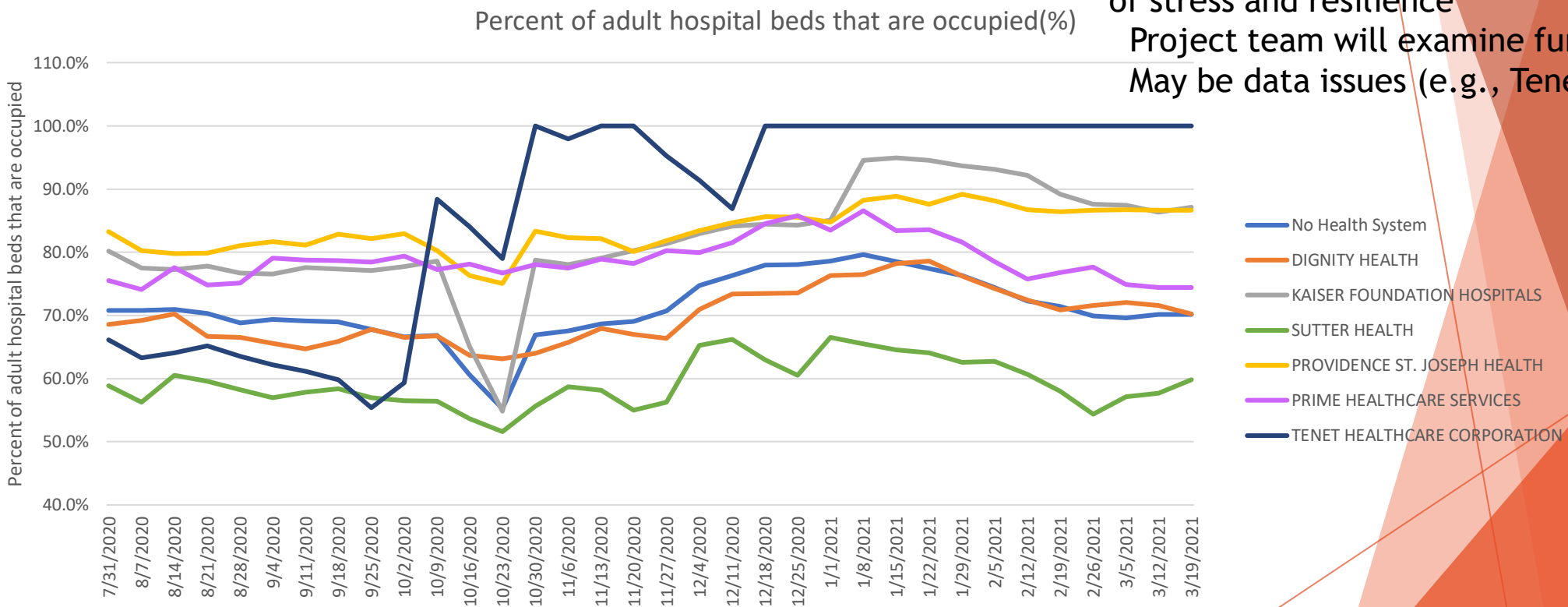
Tenet reported the highest peak adult bed expansion.

Prime reported the highest peak ICU bed expansion.

Stress: Adult Bed Occupancy by System

Tenet seemed to lower adult bed capacity but had high stress as shown here

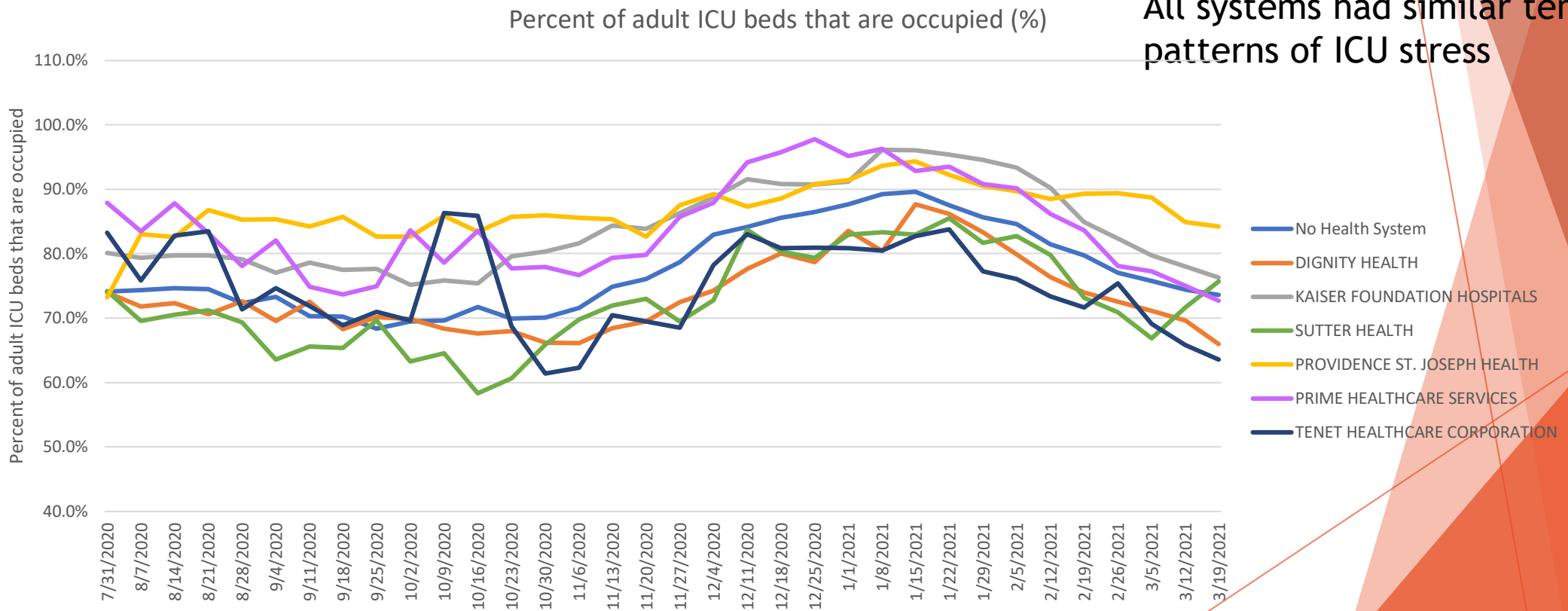
Different systems had different levels of stress and resilience
- Project team will examine further
- May be data issues (e.g., Tenet)



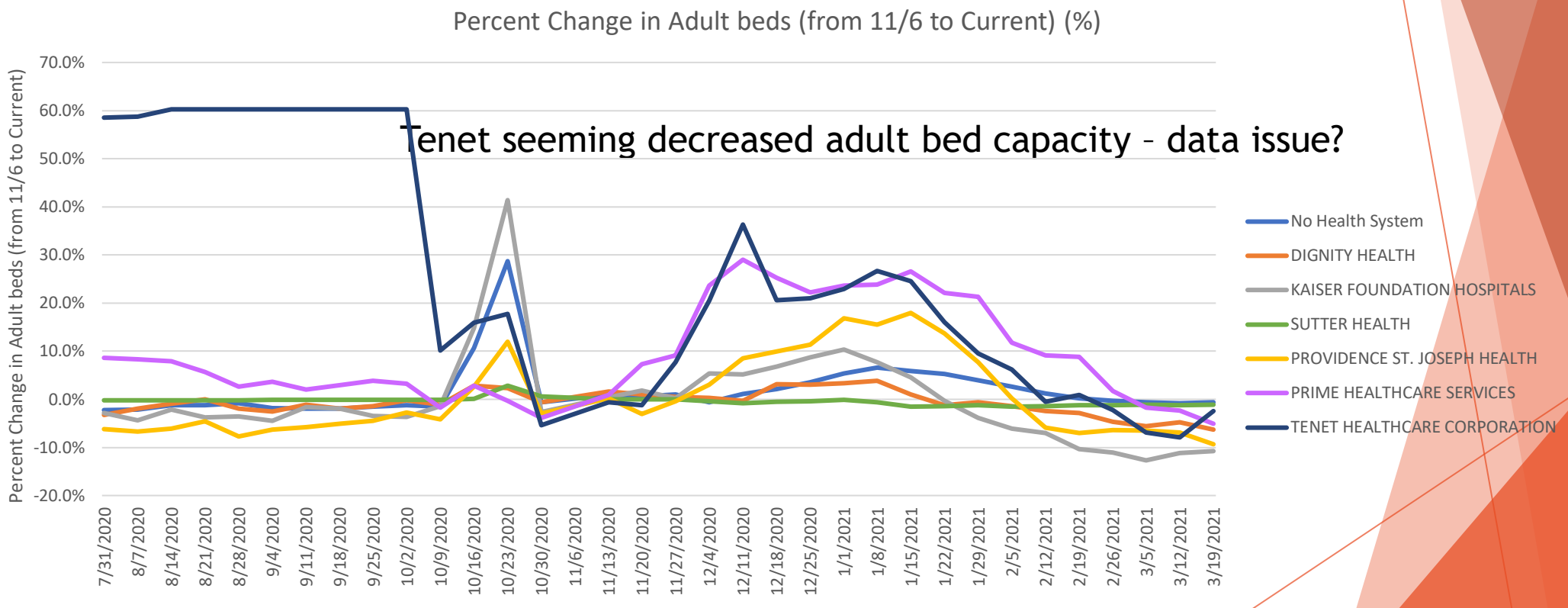
Sutter had less stress, even after adjusting for (North) county case rate

Stress: ICU Bed Occupancy by System

All systems had similar temporal patterns of ICU stress



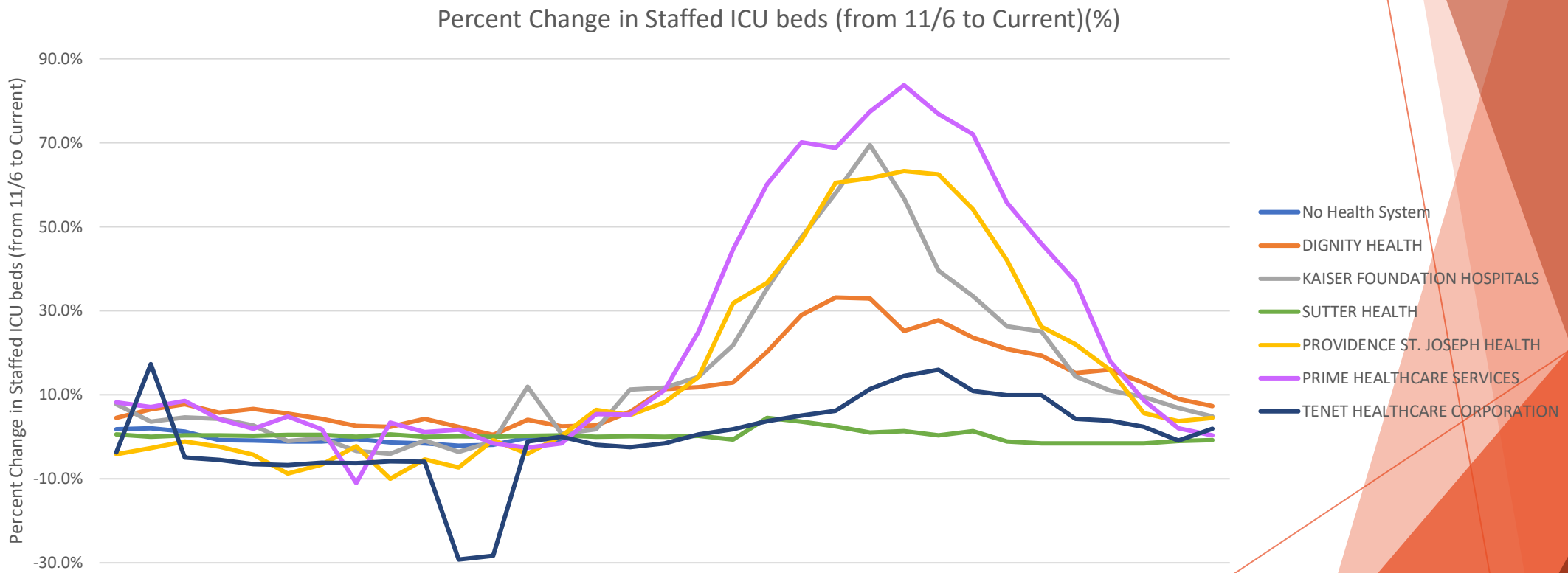
Resiliency: Adult Bed Expansion by System



Tenet seeming decreased adult bed capacity – data issue?

Sutter and Dignity had relatively little adult bed expansion

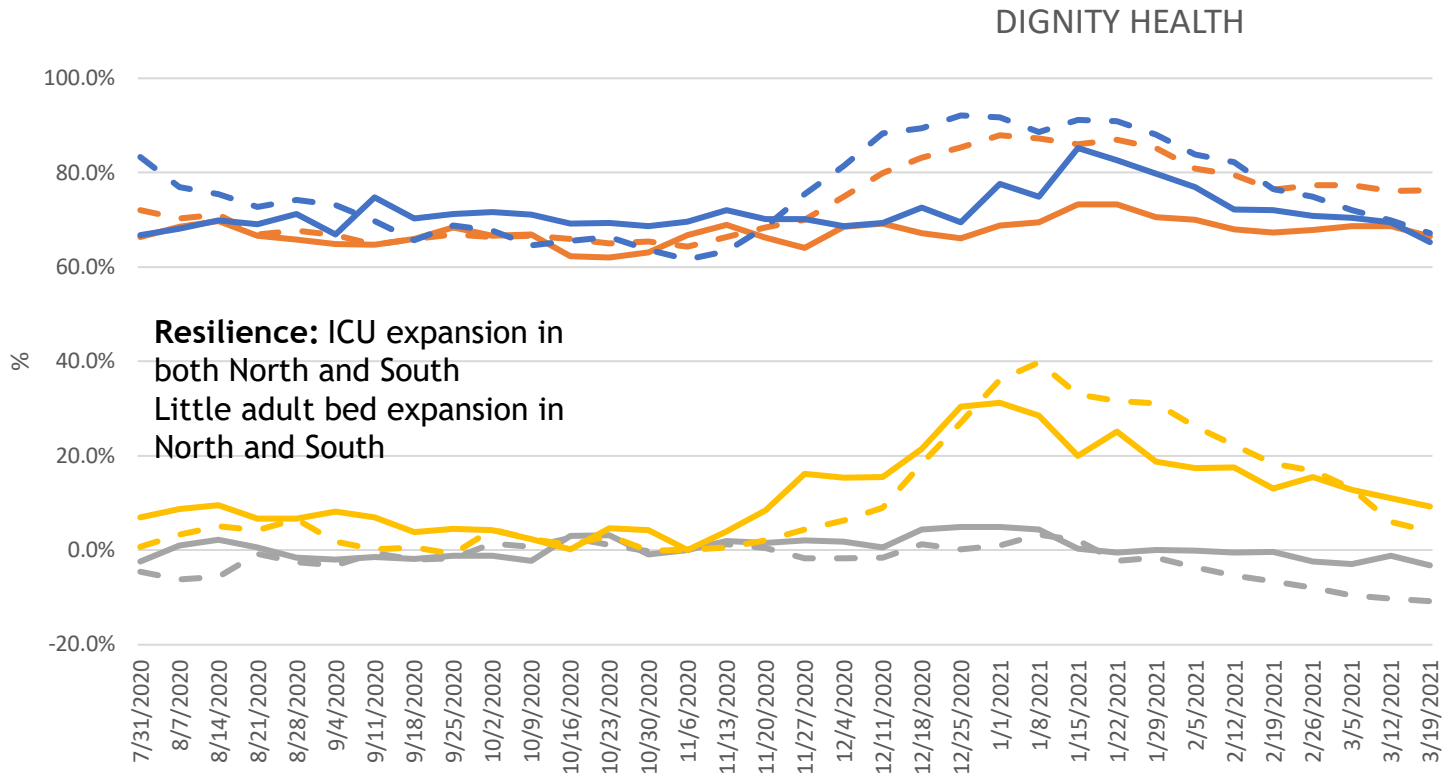
Resiliency: ICU Bed Expansion by System



All systems except Sutter had ICU expansion, some more so than others

Stress and Resilience: Dignity Health Example, North and South

Stress: More ICU and adult bed stress in south (dashed lines)



North = solid lines
South = dashed lines

- Percent of adult hospital beds that are occupied (North)
- Percent of adult hospital beds that are occupied (South)
- Percent of adult ICU beds that are occupied (North)
- Percent of adult ICU beds that are occupied (South)
- Percent Change in Adult beds (from 11/6 to Current) (North)
- Percent Change in Adult beds (from 11/6 to Current) (South)
- Percent Change in Staffed ICU beds (from 11/6 to Current) (North)
- Percent Change in Staffed ICU beds (from 11/6 to Current) (South)

Project team will examine North vs South patterns for other systems

Disparities?

Looked at HPI and a few other things

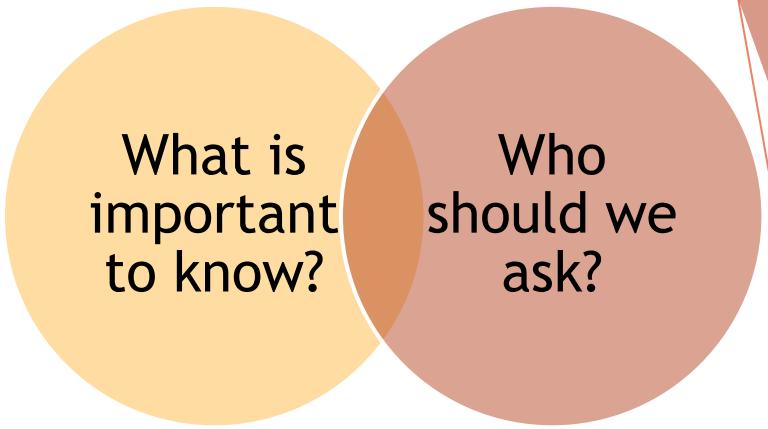
Add in correlations here

Did the scatter but don’t show them

Recommendations

- **Contextualize the data with expanded qualitative interviews and/or focus groups**
  - Most other recommendations should be on hold until these are completed
- **Next PHE**
  - How to think about teaching/system hospitals differently…does that change the emergency management game or how systems support their individual hospitals?
  - "Micro geography" probably plays a role – number of staffed beds/capita, next closest hospital
- **Data needs**
  - What's missing from the resilience story is transfers. A centralized resource for understanding the magnitude of patient movement (and also to track any quality concerns)
  - Covid case rates at the zip code or HSA level
  - An evaluation of HPI at the HSA level for individual hospitals
    - An updated HPI (to address gentrification, factor weighting, health outcomes)
  - In an ideal world race/ethnicity (with more categories of granularity) on admission. Could connect with test positive results.
- **Areas of future study**
  - Disparities on admission vs care
  - System capabilities
  - Geographical impact

Qualitative Interviews



Small vs large system

Geographic regions

High COVID-19 case rates

Teaching/ non-Teaching

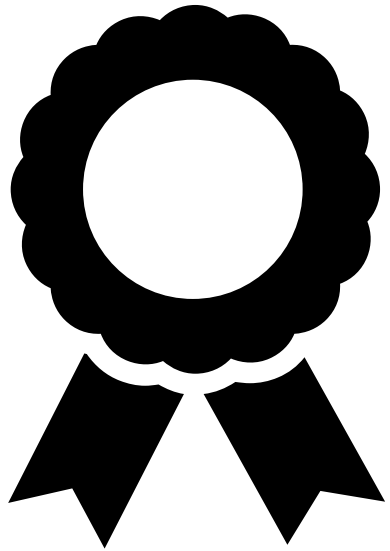
Large Medicaid population

Opioid Care Honor Roll

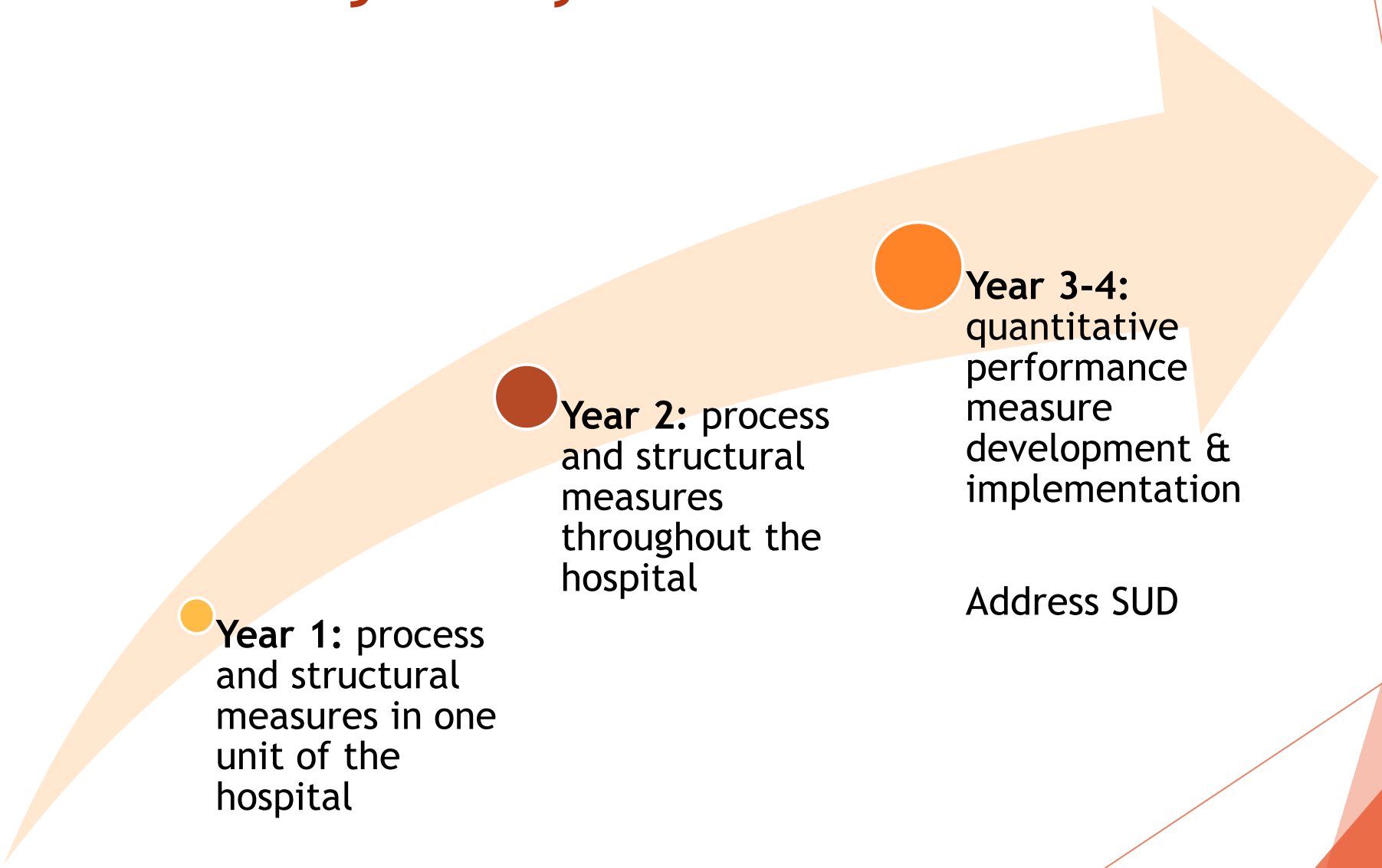
2021 Program

Opioid Care Honor Roll Program Programmatic Goals

- Activate hospitals to **accelerate** care redesign in service of reducing OUD related deaths
- **Recognize** hospitals for their performance & commitment to this effort
- Create the space for **quality improvement** & the sharing of best practices



Measure Trajectory



Workgroup recommendations

Self-assessment criteria

- Minimize changes to the 2021 self-assessment
- Focus on hardwiring best practices
- Adapt timeline

Provide measurement guidance

- Level 4 – "actively measuring & developing strategies to improve…"
- Collect measure specifications in a standardized way
- Share list of suggested measures by domain

Assess SUD

- Assess areas of focus & progress (alcohol, meth., heroin, etc.)
- Weave SUD into 2022 assessment

Set honor roll threshold in advance

- Tool to increase hospital engagement
- 1 extra credit point to "hon-roll" another hospital

Proposed 2021 Honor Roll Threshold

2020 Opioid Management Hospital Self-Assessment Results					
Count	25th%ile (14 pts)	50th%ile (21 pts)	75th%ile (27 pts)	90th%ile (30 pts)	95th%ile (31 pts)
# Hospitals	13 (79)	22 (66)	23 (44)	15 (21)	6
# Hospitals w/Extra Credit	12 (79)	18 (67)	24 (49)	6 (25)	19
		Excellent Progress	Superior Performance		

TAC Recommendations:

- Keep honor roll threshold at 75%ile or 27 points
- Also recognize
  - 50%ile or 21 points for excellent progress
  - Most improved

Honor Roll Timeline

May 2021

Launch updated self-assessment

Jun – Dec 2021

Host webinar on the 2021 Opioid Care Honor Roll

Peer learning opportunities on key topics (sprint approach)

On-demand resources

Provide office hours on how to apply for the 2021 Opioid Care Honor Roll

March 2022

Hospitals submit results by Mar 30

Announce honor roll recipients in partnership with CHHS Agency by Jun 2022

Cal Hospital Compare Analytics

Historical trends

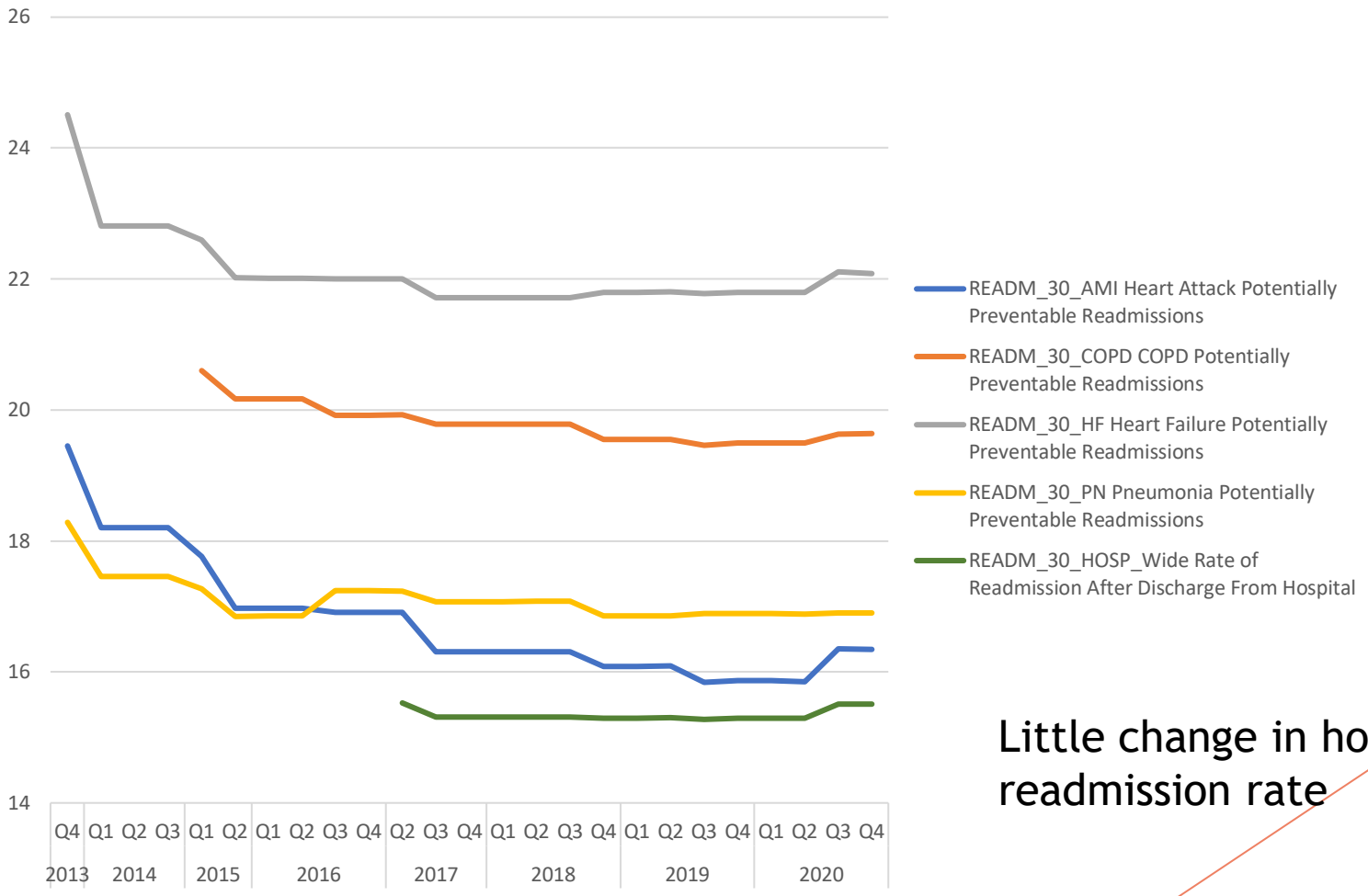
Cal Hospital Compare Analytics

- **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

Hospital-Wide Readmissions

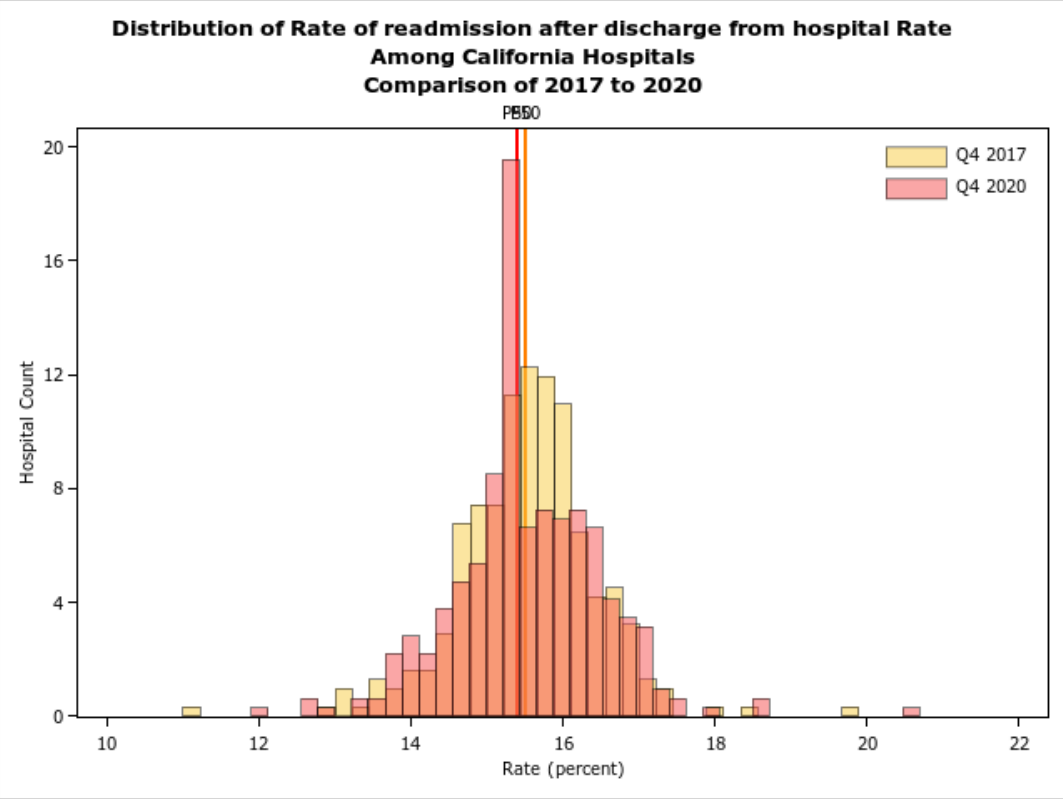
Historical trends

Hospital Readmissions Measures – Historical Trends



Little change in hospital-wide readmission rate

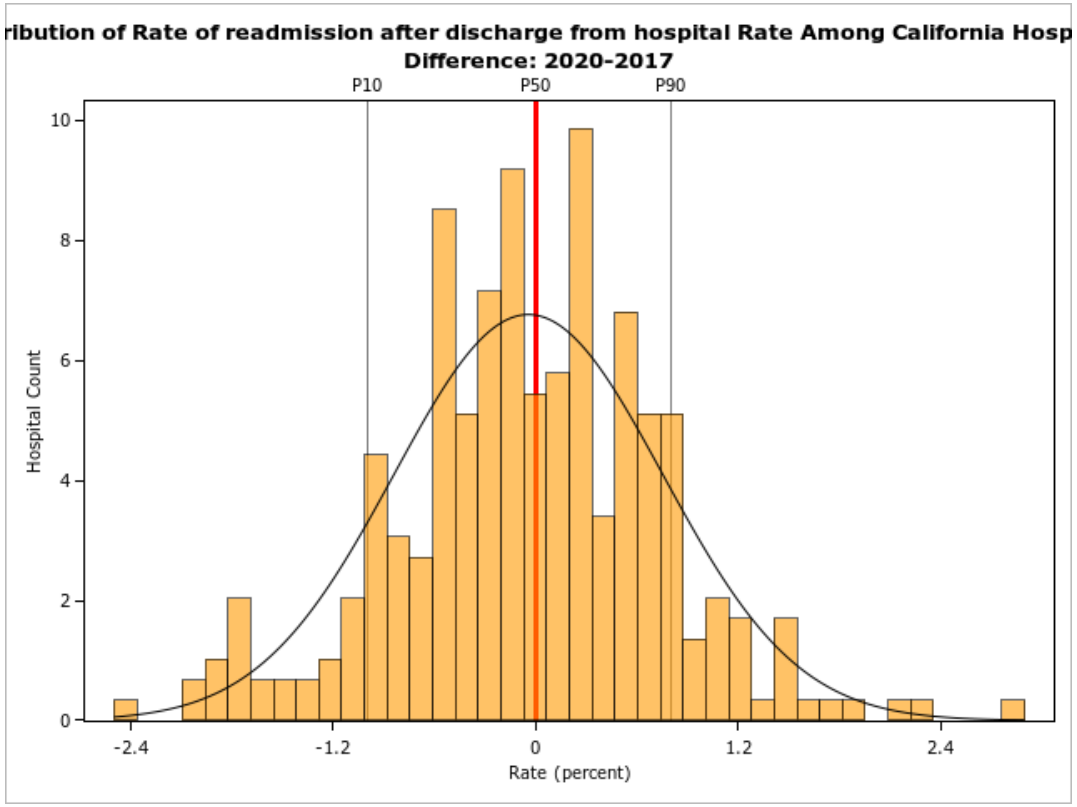
Hospital-Wide Readmissions- Change in Distributions



Very little improvement

Summary statistics											
Variable	Label	N	Mean	Std Dev	Minimum	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Maximum
t1	Q4 2017	310	15.5%	0.9%	11.0%	14.5%	15.1%	15.5%	16.1%	16.6%	19.9%
t2	Q4 2020	317	15.5%	1.0%	11.9%	14.4%	15.0%	15.4%	16.1%	16.7%	20.7%

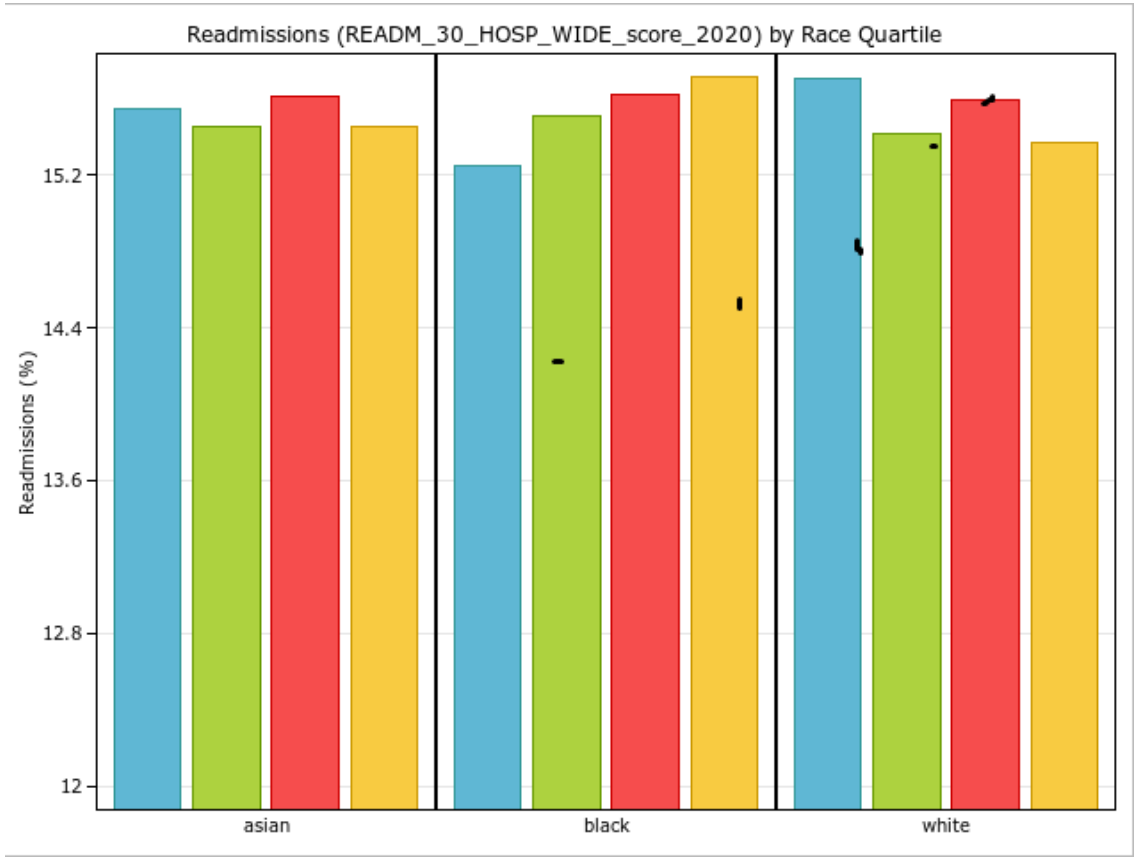
Hospital-Wide Readmissions– Distribution of Change



As many hospitals decreased as improved

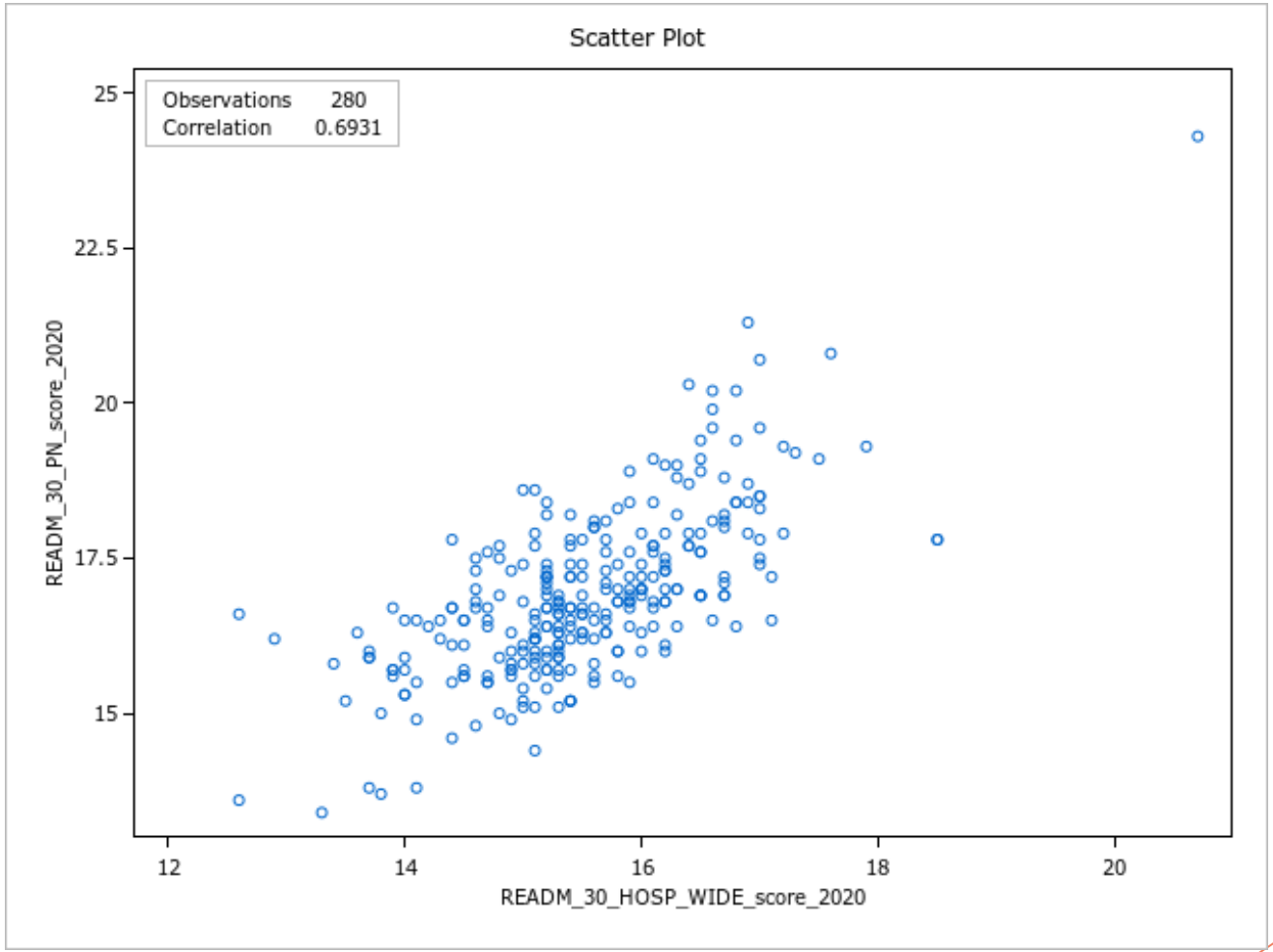
Analysis Variable: diff (2020 - 2017)									
N	Mean	Std Dev	Minimum	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Maximum
294	(0.0%)	0.8%	(2.5%)	(1.0%)	(0.5%)	0.0%	0.5%	0.8%	2.9%

Hospital-Wide Readmission: Race



Slightly higher rates in hospitals in highest quartile of percent black admissions

Hospital-Wide Correlations with Other Readmissions Measures

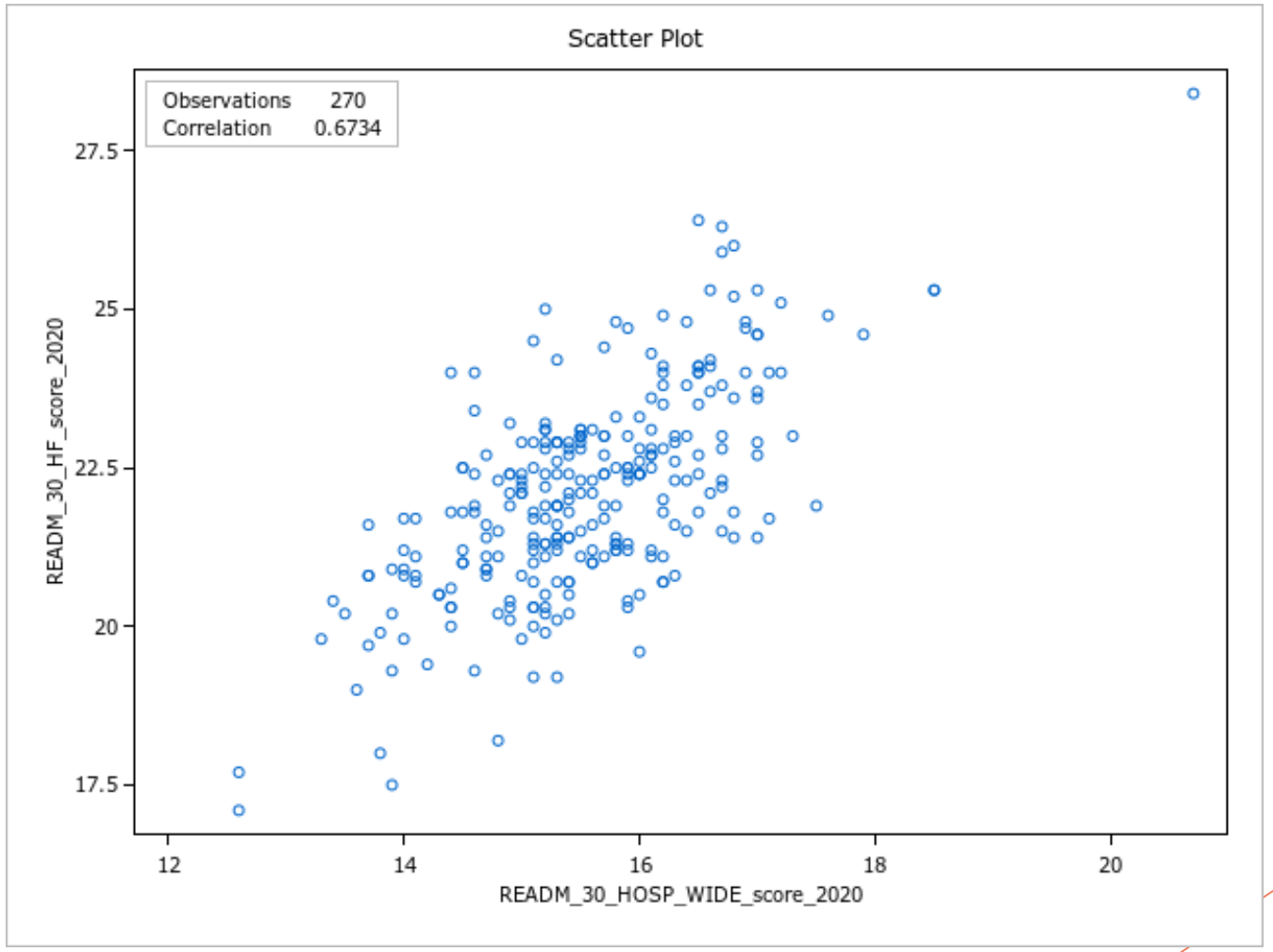


Relatively strong correlation between condition-specific readmissions measures and hospital-wide readmissions measures

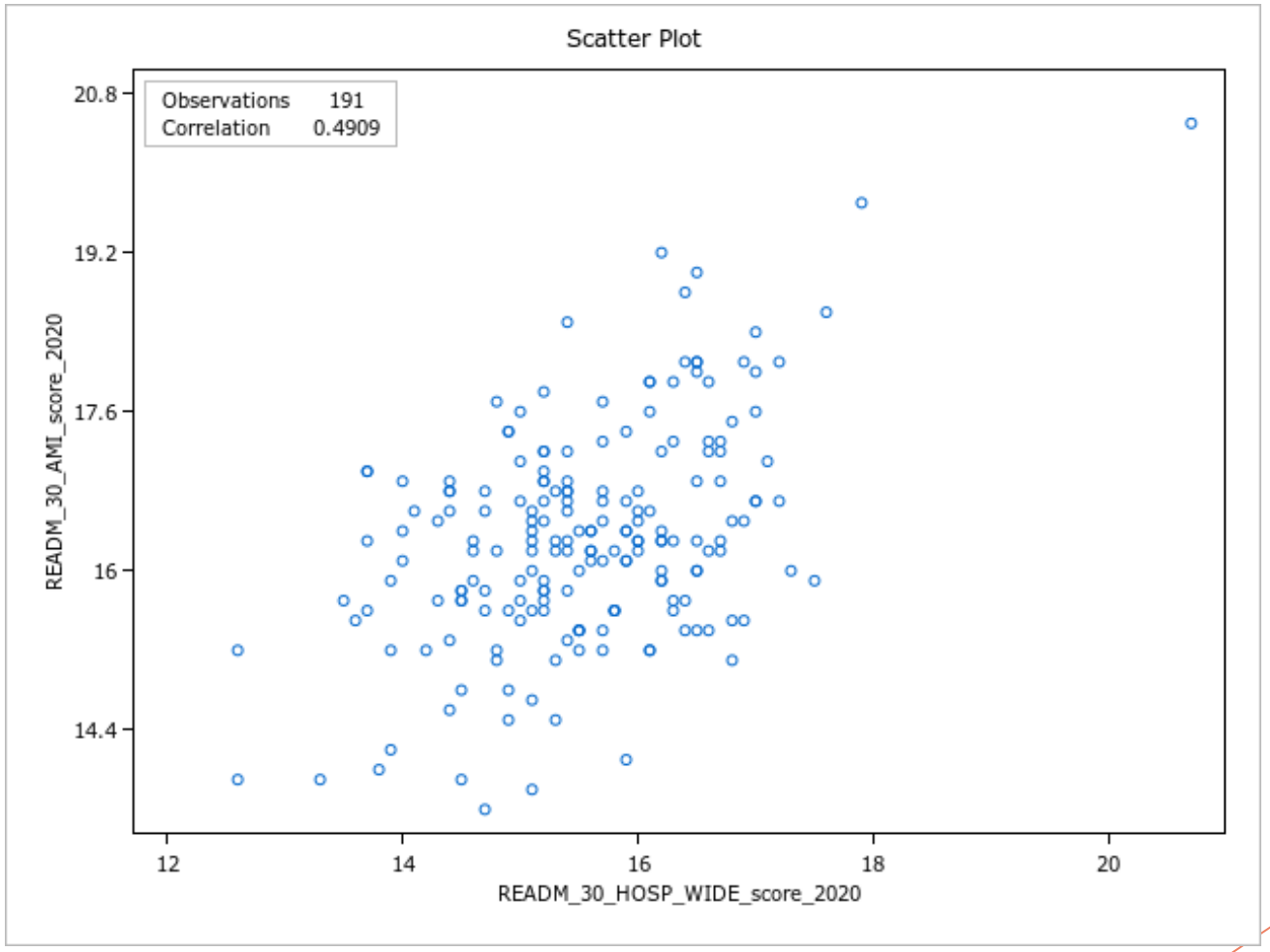
Correlations in decreasing order of strength (see subsequent slides):

- Pneumonia
- Heart Failure
- AMI
- COPD

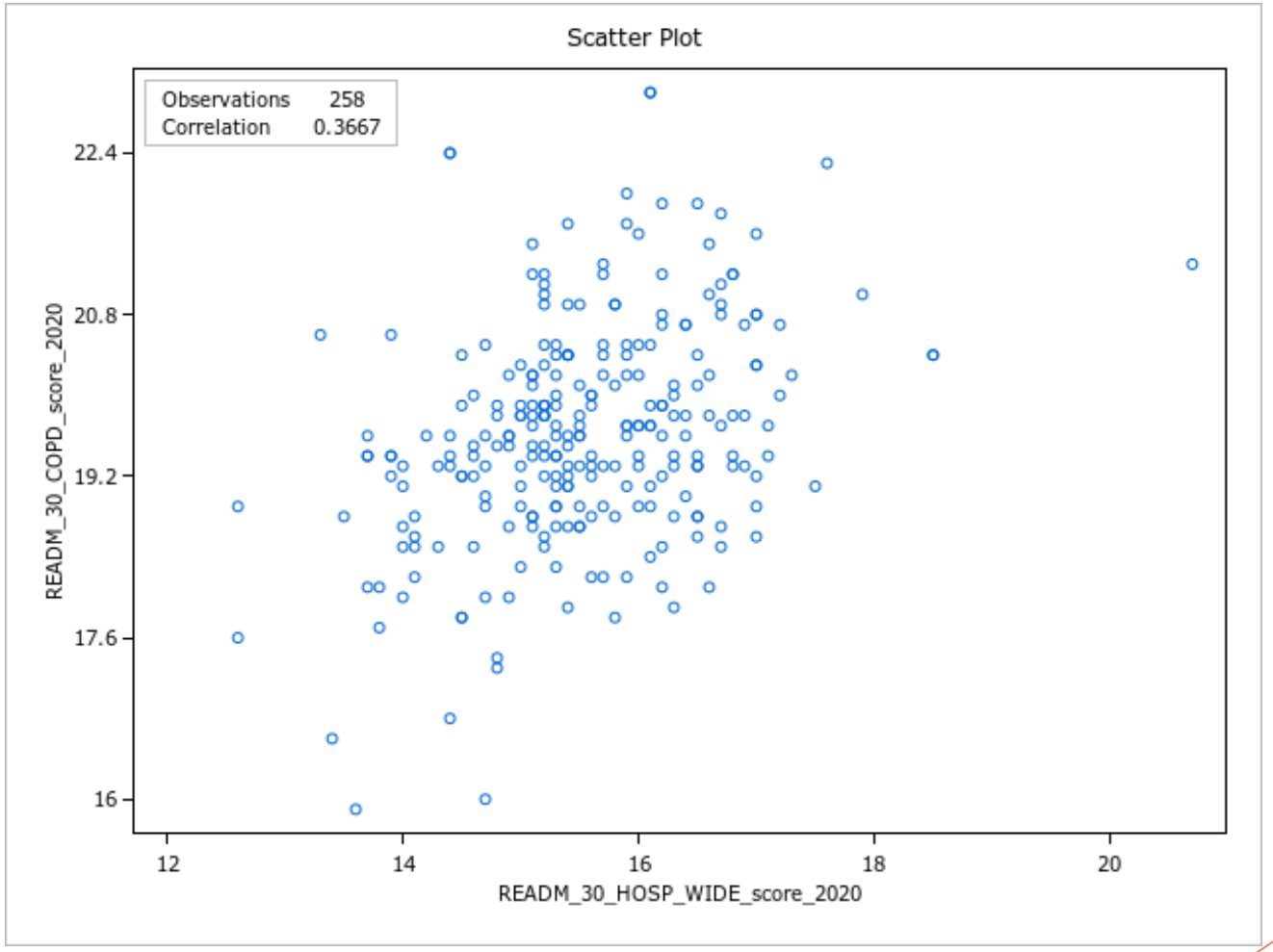
Hospital-Wide Correlations with Other Readmissions Measures



Hospital-Wide Correlations with Other Readmissions Measures



Hospital-Wide Correlations with Other Readmissions Measures



Pancreatic and Esophageal Cancer Surgery Volumes

Historical trends

Minimum Cancer Surgery Volumes

- June 2017 CHCF Issue Brief examined hospitals with low cancer surgery volumes
  - https://www.chcf.org/wp-content/uploads/2017/12/PDF-SmallNumbersCancerSurgeries.pdf
- Standards developed by Dartmouth-Hitchcock Medical Center, Johns Hopkins Hospital and Health System and University of Michigan Health System
- Only 4 hospitals meet esophagus standard of 20; 15 meet pancreatic standard of 20

	Minimum Standard
Pancreatic	20
Esophagus	20
Lung	40
Rectum	15

Identification of Low Volume Hospitals

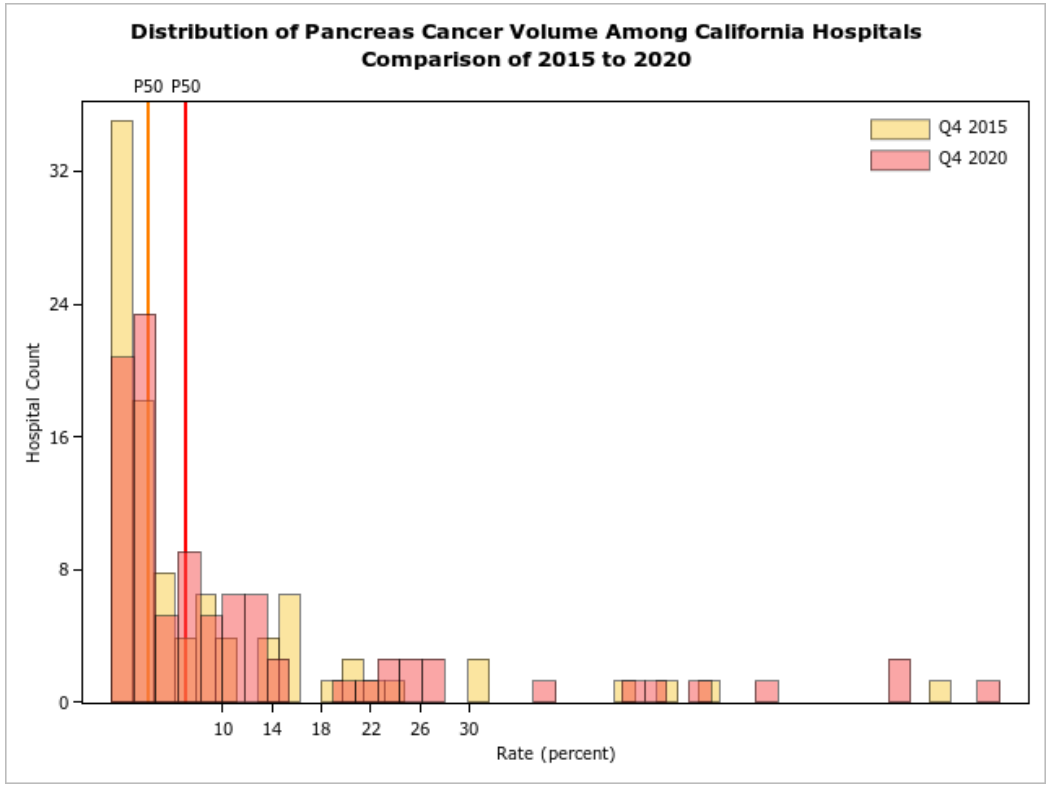
Number of hospitals doing few esophageal cancer surgeries decreased substantially from 2015 to 2020

Number of hospitals performing one pancreatic surgery increased from 2015 to 2020. Number performing two surgeries decreased

Number Of Surgeries	Number of Hospitals - Esophageal Cancer Surgery		Number of Hospitals - Pancreatic Cancer Surgery	
	2015	2020	2015	2020
1	45	30	17	35
2	28	8	24	12
3	10	8	13	12
4	9	9	4	15
5	6	1	5	1
6-10	10	9	17	20
10-20	11	11	13	10
20+	5	4	12	15

Note: Dates are “reporting years” cover measurement period of prior CY.

Distribution of Pancreatic Cancer Surgeries



Variable		N	Mean	Std Dev	Minimum	10th Pctl	Lower Quartile	Median	Upper Quartile	90th Pctl	Maximum
Pancreas Cancer Volume (without zeros)	Q4 2015	40	9.2	12.4	1	1	2	4	10	23	69
Pancreas Cancer Volume (without zeros)	Q4 2020	40	12.5	16.1	1	1	3	7	12	36	73
Pancreas Cancer Volume (without zeros)	2020-2015	40	3.3	8	-12	-4	-1	2	6	12	34

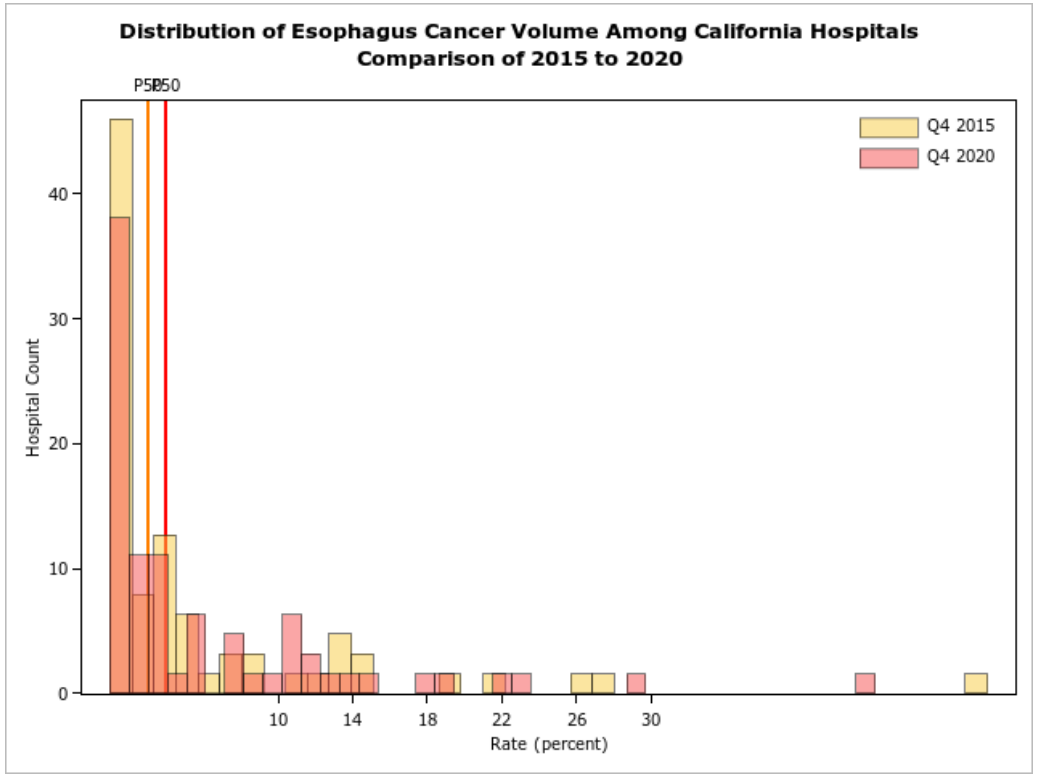
Many Hospitals Performing One Pancreatic Cancer Surgery in 2020

Hospital Demographics				Pancreatic Cancer Surgery Volume				
Hospital Name	Health Service Area	Hospital Size	Urban/Rural	2016	2017	2018	2019	2020
Eisenhower Medical Center	12 - Inland Counties	Small		5	1	1		1
St. Joseph Hospital, Eureka	01 - Northern California	Medium	3: Micropolitan areas	3	2	4	1	1
Valley Presbyterian Hospital	11 - Los Angeles	Large	1: Large metro areas	2	8	3	2	1
Arrowhead Regional Medical Center	12 - Inland Counties	Large	1: Large metro areas	2	2	2	3	1
Zuckerberg San Francisco General Hospital and Trauma Center	04 - West Bay	Medium	1: Large metro areas	2	1	1		1
Eden Medical Center	05 - East Bay	Medium	1: Large metro areas	1		1	1	1
UCLA Medical Center - Santa Monica	11 - Los Angeles	Medium	1: Large metro areas	1	1			1
Kaiser Permanente Baldwin Park Medical Center	11 - Los Angeles	Large	1: Large metro areas	1		2		1
Adventist Health St. Helena	03 - North Bay	Small	2: Small metro areas	1				1
Mercy General Hospital	02 - Golden Empire	Medium	1: Large metro areas	1	6	1	3	1
Regional Medical Center of San Jose	07 - Santa Clara	Medium	1: Large metro areas	1			2	1
Alta Bates Summit Medical Center - Alta Bates Campus	05 - East Bay	Large	1: Large metro areas	0	1	2	2	1
Sutter Delta Medical Center	05 - East Bay	Medium	1: Large metro areas	0			2	1
John Muir Medical Center - Concord Campus	05 - East Bay			0	1			1
Pioneers Memorial Healthcare District	14 - San Diego/Imperial	Medium	2: Small metro areas	0				1
Bakersfield Memorial Hospital	09 - Central	Large	2: Small metro areas	0	1	1		1
Mercy Hospital Downtown	09 - Central			0	1	1		1
Alhambra Hospital Medical Center	11 - Los Angeles			0				1
Lakewood Regional Medical Center	11 - Los Angeles			0	3	2	1	1
Monterey Park Hospital	11 - Los Angeles	Medium	1: Large metro areas	0				1
St. Francis Medical Center			1: Large metro areas	0		1		1
Adventist Health White Memorial	11 - Los Angeles	Large	1: Large metro areas	0	2	1	1	1
Kaiser Permanente Woodland Hills Medical Center	11 - Los Angeles	Medium	1: Large metro areas	0			1	1
Palmdale Regional Medical Center	11 - Los Angeles	Small		0			2	1
Sierra Nevada Memorial Hospital	02 - Golden Empire	Small	3: Micropolitan areas	0				1
Placentia-Linda Hospital	13 - Orange	Small		0		1		1
Kaiser Permanente Roseville Medical Center	02 - Golden Empire	Large	1: Large metro areas	0	1	1	1	1
Corona Regional Medical Center	12 - Inland Counties	Medium	1: Large metro areas	0	1			1
Mercy San Juan Medical Center	02 - Golden Empire	Large	1: Large metro areas	0		1	1	1
Redlands Community Hospital	12 - Inland Counties	Large	1: Large metro areas	0	1			1
St. Bernardine Medical Center	12 - Inland Counties	Medium	1: Large metro areas	0	3	1		1
St. Mary Medical Center - Apple Valley	12 - Inland Counties	Medium	1: Large metro areas	0				1
Palomar Medical Center Downtown Escondido	14 - San Diego/Imperial		1: Large metro areas	0		1		1
Sutter Tracy Community Hospital	06 - North San Joaquin	Small	2: Small metro areas	0				1
Kaweah Delta Health Care District	09 - Central	Large	2: Small metro areas	0	2	2	3	1

Top 10 Highest Volume Hospitals – Pancreatic Cancer Surgery in 2020

Hospital Demographics				Pancreatic Surgery Volume				
Hospital Name	**Health Service Area**	**Hospital Size**	**Urban/Rural**	**2016**	**2017**	**2018**	**2019**	**2020**
Stanford Health Care	07 - Santa Clara	Small		69	100	73	71	73
UCSF Medical Center - Moffitt/Long	04 - West Bay	Small		31	34	57	60	65
Ronald Reagan UCLA Medical Center	11 - Los Angeles	Medium	1: Large metro areas	42	62	62	58	64
Cedars-Sinai Medical Center	11 - Los Angeles	Large	1: Large metro areas	49	56	49	47	54
UC San Diego Health - LA Jolla, Jacobs Medical Center and Sulpizio Cardiovascular Center	14 - San Diego/Imperial	Medium	1: Large metro areas	24	29	38	37	48
Keck Hospital of USC	11 - Los Angeles			31	41	48	39	45
Hoag Memorial Hospital Presbyterian	13 - Orange	Large	1: Large metro areas	19	20	28	30	44
UC Irvine Health	13 - Orange	Medium	1: Large metro areas	46	32	42	38	36
UC Davis Medical Center	02 - Golden Empire	Medium	1: Large metro areas	20	20	27	28	27
Kaiser Permanente San Jose Medical Center	07 - Santa Clara	Large	1: Large metro areas	4	7	10	15	27

Distribution of Esophageal Cancer Surgeries



Variable		N	Mean	Std Dev	Minimum	10th Pctl	Lower Quartile	Median	Upper Quartile	90th Pctl	Maximum
Esophagus Cancer Volume (without zeros)	Q4 2015	40	6.1	8.1	1	1	2	3	7	14	48
Esophagus Cancer Volume (without zeros)	Q4 2020	40	6.6	7.7	1	1	1	4	10	15	42
Esophagus Cancer Volume (without zeros)	2020-2015	40	0.5	5.6	-26	-3	-1	0	3	5	18

Many Hospitals Performing One Esophageal Cancer Surgery in 2020

Hospital Demographics				Esophageal Cancer Surgery Volume				
Hospital Name	Health Services Area	Hospital Size	Urban/Rural	2016	2017	2018	2019	2020
Sutter Roseville Medical Center	02 - Golden Empire	Large	1: Large metro areas	5	1		1	1
Alta Bates Summit Medical Center - Summit Campus (Hawthorne)	05 - East Bay	Small		4		6	5	1
Sharp Grossmont Hospital	14 - San Diego/Imperial	Large	1: Large metro areas	4	1	3	2	1
Kaiser Permanente Fremont Medical Center	05 - East Bay	Small		4				1
O'Connor Hospital	07 - Santa Clara	Medium	1: Large metro areas	4			1	1
LAC+USC Medical Center	11 - Los Angeles	Medium	1: Large metro areas	3		2	4	1
Kaiser Permanente South San Francisco Medical Center	04 - West Bay			3		2	1	1
St. Joseph Hospital, Eureka	01 - Northern California	Medium	3: Micropolitan areas	2			1	1
Highland Hospital	05 - East Bay	Medium	1: Large metro areas	2	3	2		1
Scripps Mercy Hospital	14 - San Diego/Imperial	Large	1: Large metro areas	2	1	1		1
Sharp Chula Vista Medical Center	14 - San Diego/Imperial	Large	1: Large metro areas	2	1	3		1
MemorialCare Saddleback Medical Center	13 - Orange	Large	1: Large metro areas	2	1			1
UCLA Medical Center - Santa Monica	11 - Los Angeles	Medium	1: Large metro areas	1	2			1
Harbor - UCLA Medical Center	11 - Los Angeles	Medium	1: Large metro areas	1			2	1
El Camino Hospital	07 - Santa Clara	Large	1: Large metro areas	1	1			1
Washington Hospital Healthcare System	05 - East Bay	Medium	1: Large metro areas	1	1	3		1
Citrus Valley Medical Center - Inter-Community Campus	11 - Los Angeles	Small		1				1
Olive View - UCLA Medical Center	11 - Los Angeles	Medium	1: Large metro areas	1	1	3	1	1
Eisenhower Medical Center	12 - Inland Counties	Small		0	1			1
Riverside University Health Systems	12 - Inland Counties	Medium	1: Large metro areas	0		1		1
Hollywood Presbyterian Medical Center	11 - Los Angeles	Large	1: Large metro areas	0				1
Fountain Valley Regional Hospital and Medical Center	13 - Orange	Large	1: Large metro areas	0		2	1	1
Sherman Oaks Hospital and Health Center	11 - Los Angeles			0				1
Madera Community Hospital	09 - Central	Medium	2: Small metro areas	0				1
Desert Valley Hospital	12 - Inland Counties	Medium	1: Large metro areas	0				1
NorthBay Medical Center	03 - North Bay	Medium	2: Small metro areas	0				1
Kaiser Permanente Vacaville Medical Center	03 - North Bay	Medium	2: Small metro areas	0				1
Sutter Santa Rosa Regional Hospital	03 - North Bay	Medium	2: Small metro areas	0	3	3	2	1
Kaiser Permanente Santa Rosa Medical Center	03 - North Bay	Medium	2: Small metro areas	0				1
Community Memorial Hospital	10 - Santa Barbara/Ventura	Large	2: Small metro areas	0				1

Top 10 Highest Volume Hospitals - Esophageal Cancer Surgery in 2020

Hospital Demographics				Esophageal Cancer Surgery Volume				
Hospital Name	**Health Services Area**	**Hospital Size**	**Urban/Rural**	**2016**	**2017**	**2018**	**2019**	**2020**
Stanford Health Care	07 - Santa Clara	Small		28	21	48	43	42
UC San Diego Health - LA Jolla, Jacobs Medical Center and Sulpizio Cardiovascular Center	14 - San Diego/Imperial	Medium	1: Large metro areas	11	11	19	12	29
UCSF Medical Center - Moffitt/Long	04 - West Bay	Small		21	11	28	25	23
Keck Hospital of USC	11 - Los Angeles			48	16	26	23	22
City of Hope Helford Clinical Research Hospital	11 - Los Angeles			15	15	10	18	19
UC Irvine Health	13 - Orange	Medium	1: Large metro areas	13	4	6	12	18
Cedars-Sinai Medical Center	11 - Los Angeles	Large	1: Large metro areas	26	9	14	16	15
Ronald Reagan UCLA Medical Center	11 - Los Angeles	Medium	1: Large metro areas	19	8	20	9	14
Huntington Hospital	11 - Los Angeles	Large	1: Large metro areas	2	2	6	4	13
Kaiser Permanente Fontana Medical Center	12 - Inland Counties	Large	1: Large metro areas	13	13	12	16	12

Wrap Up

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

- **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!

Appendix I

Heat Maps by Region

Available Data:
Integrated State-Federal Hospital Database

OSHPD IP DC Characteristics

- Race / Ethnicity
- Age
- Gender
- Principal Dx & Proc
- Admission Source & Route
- Discharge Disposition

OSHPD Utilization File

- Facility Type & Ownership
- Bed Days by Floor
- Total Discharges
- EMT Diversion
- ER Admits
- Surgery Type & Volume

OSHPD Financial File

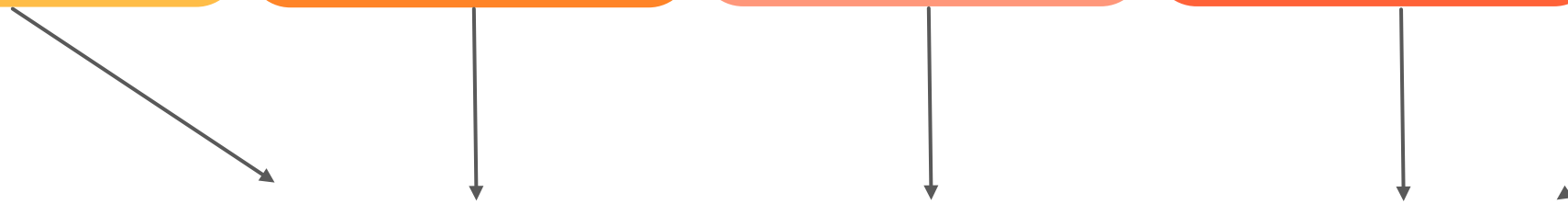
- Revenue (Gross, Net Pt, Total, etc.)
- Salaries & Wages
- FTE & Staff
- Prod & Paid Hours
- Occupied Rate & Census by Floor

CMS Hospital COVID Data

- Weekly Hospital Bed Count & Occupancy
- Weekly ICU Bed Count & Occupancy
- Weekly Confirmed COVID Patient Count

CDPH County COVID Data

- County Populations
- Weekly County Cases & Deaths
- Weekly Available ICU Beds
- Weekly ICU Confirmed Patients



Augmented CHC Crosswalk

- Uses the existing CHC Crosswalk *and* the CDPH Licensed and Certified Healthcare Facility Crosswalk
- Includes general, acute care and critical access hospitals only

Statistical Regression Modeling Steps

- Identify outcome variables
- Identify potential explanatory variables
- Examine collinearity between explanatory variables
  - If explanatory variables are highly correlated, their impact on the outcome variable may be masked
- Identify the type of statistical model that best fits the characteristics of the data
- Run the models and examine model performance characteristics
- Adjust model and rerun if necessary

Multivariable Regression
Generalized Additive Models (GAMs)

- Generalized additive models (regression) relate multiple independent (explanatory) variables to each dependent (outcome) variable.
- Generalized additive models can be fit like typical multivariable linear models (and interpreted the same way), but have the additional benefit of smoothed non-linear relationships.
- For categorical variables (DSH Hospital, Teaching Hospital, and License Type), each variable is included as it would be in a linear regression.
- For continuous variables, thin-plate regression splines are fit to the data using generalized cross validation. Think of a bendy sheet of metal that is formed to the data points. The rigidity prevents fitting the data too well (a problem with other non-linear approaches).
- These non-linear terms are useful for describing more complex relationships between explanatory variables and outcomes.
- GAMs can also be used for different families of regression (linear, logistic, Poisson, etc.)

Heat Map: COVID Case & Death Rates by Re-opening Region

Southern California higher and for a longer period
2 – 3 week shift between case and death rates

Covid Case Rate/1,000,000

	Collection Week																																
	2020																						2021										
	July	August				September				October					November				December				January					February				March		
	31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19
Bay Area	115.8	165.7	164.9	122.9	109.5	79.3	77.6	74.9	63.8	62.2	58.8	67.0	71.2	83.6	120.4	163.3	204.6	257.2	416.1	568.8	554.9	499.6	562.1	622.4	479.1	327.0	245.6	191.5	135.6	112.1	85.0	68.0	59.1	52.5
Greater Sacramento	82.0	205.9	137.8	136.4	136.3	92.5	90.7	75.6	53.6	58.4	48.2	72.2	77.9	106.7	169.7	247.8	324.4	402.5	598.0	639.5	651.5	479.9	581.0	583.3	346.8	304.6	207.6	197.6	132.6	125.0	88.7	84.8	78.3	80.3
Northern California	54.9	105.9	67.6	65.3	50.3	54.9	68.6	82.6	92.4	114.3	104.5	90.1	88.8	151.2	165.8	408.6	517.2	411.1	621.9	532.7	484.5	426.9	441.5	461.3	377.9	283.6	215.0	208.1	127.2	113.5	80.7	80.3	*	*
San Joaquin Valley	263.7	466.2	354.0	233.7	208.4	125.1	113.1	101.1	84.2	75.5	76.9	79.4	98.7	119.3	165.6	252.5	358.5	385.6	680.6	940.4	1079.2	745.9	847.3	914.6	691.5	486.4	380.8	297.1	211.8	173.7	123.3	114.2	111.6	105.6
Southern California	168.6	202.9	152.7	126.0	105.0	79.4	80.7	88.8	92.9	82.1	94.2	103.5	126.0	137.2	187.2	298.8	404.8	472.3	839.1	1206.2	1198.3	1129.6	1229.9	1287.3	873.7	618.1	431.3	288.4	175.2	133.8	98.8	106.1	58.7	51.8

Covid Death Rate/1,000,000

	Collection Week																																
	2020																						2021										
	July	August				September				October					November				December				January					February				March		
	31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19
Bay Area	1.00	1.11	0.91	1.13	1.13	1.71	2.22	1.19	1.86	1.23	1.14	1.24	1.49	1.36	0.68	0.73	0.83	1.14	1.86	2.36	2.99	2.95	5.21	5.23	6.20	6.88	6.19	5.89	5.18	4.59	2.85	2.62	1.89	2.49
Greater Sacramento	1.83	3.51	2.31	3.37	2.84	1.88	1.73	2.12	1.25	1.59	1.20	1.49	1.01	0.38	0.63	1.97	2.31	2.79	4.57	4.81	6.16	4.33	7.65	7.74	6.16	5.96	6.83	5.92	5.48	3.75	2.45	1.78	2.26	2.55
Northern California	0.21	1.67	0.83	0.21	1.67	0.21	2.29	0.42	2.09	0.83	0.83	2.29	1.04	1.25	1.04	2.09	0.21	2.71	1.46	3.13	1.25	2.92	5.84	2.92	4.59	3.96	6.88	3.55	1.67	3.75	1.67	2.09	*	*
San Joaquin Valley	3.96	7.61	4.37	4.41	7.29	3.42	3.71	4.69	2.98	2.25	1.62	2.03	1.24	1.52	1.30	1.39	1.97	1.68	3.23	5.32	7.16	8.27	6.56	7.73	10.30	10.36	13.47	12.30	8.43	7.42	8.18	4.66	2.82	4.79
Southern California	3.94	3.89	3.14	3.63	2.85	2.57	2.24	2.22	2.57	1.21	1.62	1.79	1.27	1.27	1.01	1.78	2.17	2.32	3.95	6.19	6.75	9.39	11.35	15.58	15.49	16.84	16.96	13.60	10.72	15.54	9.69	8.15	5.79	5.24

Heat Map: Adult ICU Occupancy by Health Service Area

Southern California hospital ICU occupancy impacted more intensely and for a longer period

		Collection Week																																
		2020																					2021												
		July	August				September				October					November				December				January					February				March		
		31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19
Northern California	N= 29	66.1%	70.7%	82.4%	79.7%	78.6%	83.9%	78.7%	77.8%	84.1%	77.0%	78.9%	83.4%	79.7%	78.3%	81.1%	80.8%	82.0%	82.6%	81.3%	67.5%	70.4%	70.3%	70.1%	82.0%	74.3%	66.8%	68.6%	61.2%	66.1%	70.5%	68.5%	57.3%	68.5%	73.5%
Golden Empire	N= 20	79.2%	78.0%	78.9%	79.8%	80.8%	78.5%	81.8%	79.3%	81.2%	81.5%	82.9%	82.5%	81.6%	80.8%	80.1%	81.1%	81.1%	79.4%	79.7%	84.5%	80.4%	79.4%	80.6%	81.6%	86.4%	88.7%	83.6%	85.3%	81.9%	79.4%	81.0%	83.4%	82.7%	79.2%
North Bay	N= 12	74.0%	78.4%	78.6%	82.8%	71.0%	75.5%	62.3%	71.5%	64.5%	70.3%	72.1%	71.0%	72.0%	66.9%	65.9%	70.8%	66.8%	67.9%	78.7%	82.0%	81.3%	79.8%	83.9%	91.3%	91.4%	91.2%	89.0%	81.2%	67.5%	80.3%	78.6%	80.6%	73.7%	71.8%
West Bay	N= 19	68.9%	69.9%	72.2%	68.9%	71.9%	63.9%	66.1%	63.0%	65.9%	59.5%	67.0%	70.5%	66.8%	66.4%	70.0%	68.7%	71.0%	70.0%	72.8%	74.7%	77.9%	75.7%	81.2%	77.0%	80.0%	79.1%	74.5%	72.6%	67.0%	71.3%	70.9%	68.9%	68.4%	63.1%
East Bay	N= 18	72.5%	75.5%	72.6%	72.1%	72.5%	70.1%	69.5%	69.3%	66.7%	67.2%	65.7%	66.4%	65.8%	64.7%	69.6%	73.1%	71.6%	73.8%	75.6%	79.3%	78.2%	80.6%	82.1%	84.8%	84.6%	83.3%	80.8%	80.4%	77.7%	76.1%	69.8%	73.8%	74.8%	76.6%
North San Joaquin	N= 18	79.1%	77.9%	78.2%	79.9%	70.5%	72.9%	74.4%	74.8%	69.9%	68.1%	73.6%	75.5%	76.3%	74.2%	78.4%	73.3%	76.1%	76.7%	84.6%	88.2%	95.4%	88.7%	91.1%	88.4%	90.8%	92.1%	90.6%	94.7%	91.2%	82.6%	84.9%	80.4%	81.4%	82.6%
Santa Clara	N= 8	76.9%	74.5%	78.1%	73.2%	74.7%	74.4%	75.0%	74.6%	73.6%	72.3%	71.7%	68.1%	71.2%	72.9%	76.0%	76.4%	77.9%	82.7%	85.9%	88.2%	87.0%	87.1%	86.9%	87.5%	88.9%	86.4%	87.1%	83.0%	83.1%	81.7%	82.1%	81.2%	81.5%	82.3%
Mid-Coast	N= 11	74.9%	75.2%	81.4%	76.8%	76.5%	71.6%	64.5%	65.2%	70.5%	79.5%	79.3%	69.0%	63.3%	60.3%	62.6%	71.6%	74.7%	64.4%	76.8%	80.8%	78.0%	77.0%	76.6%	75.4%	86.3%	79.7%	73.5%	68.3%	74.5%	72.0%	82.1%	66.9%	64.8%	60.7%
Central	N= 24	76.6%	74.5%	75.6%	76.8%	75.7%	72.0%	69.5%	68.0%	67.6%	67.7%	65.1%	70.8%	74.6%	71.4%	67.3%	70.3%	69.8%	79.5%	87.9%	88.0%	86.2%	89.9%	92.0%	92.4%	91.4%	84.4%	87.1%	84.5%	82.2%	78.4%	77.4%	76.2%	73.5%	74.9%
Santa Barbara/Ver	N= 12	80.3%	75.2%	79.0%	84.0%	79.5%	76.7%	75.3%	74.0%	73.7%	70.6%	68.7%	67.0%	68.3%	74.5%	76.8%	76.5%	83.5%	86.0%	76.9%	72.3%	82.5%	83.9%	87.4%	87.8%	87.0%	88.4%	87.8%	82.1%	77.0%	77.5%	75.9%	76.3%	74.8%	70.4%
Los Angeles	N= 85	74.4%	74.9%	73.8%	73.5%	71.4%	71.3%	68.9%	69.1%	67.8%	67.7%	67.5%	69.3%	69.5%	69.7%	69.0%	74.2%	75.0%	79.5%	84.7%	86.7%	88.5%	88.8%	90.1%	90.1%	92.3%	91.2%	90.5%	89.9%	86.4%	81.8%	77.1%	77.2%	74.8%	74.1%
Inland Counties	N= 39	79.4%	76.4%	77.9%	78.0%	76.8%	79.0%	80.6%	77.4%	76.9%	78.0%	78.8%	75.3%	73.9%	75.8%	77.1%	82.9%	84.4%	86.9%	87.5%	92.8%	90.4%	92.4%	92.8%	95.9%	94.2%	92.7%	87.8%	89.7%	87.2%	84.4%	80.3%	77.7%	74.1%	71.9%
Orange	N= 28	76.4%	77.8%	81.2%	78.9%	75.3%	79.4%	72.7%	71.5%	68.9%	73.7%	78.0%	76.9%	73.0%	70.0%	72.3%	75.5%	74.7%	78.2%	82.8%	87.3%	86.2%	88.5%	90.2%	90.6%	91.8%	89.6%	86.2%	85.6%	85.4%	82.6%	79.5%	77.8%	75.1%	75.3%
San Diego/Imperia	N= 20	72.2%	66.7%	66.8%	72.7%	66.7%	70.4%	70.1%	67.8%	66.1%	70.1%	69.3%	72.2%	69.4%	72.9%	75.3%	76.6%	75.5%	76.3%	80.0%	86.7%	86.8%	91.8%	89.3%	95.7%	93.8%	92.6%	91.0%	86.7%	82.8%	78.8%	75.9%	69.8%	69.1%	62.8%

Heat Map: Adult Bed Occupancy by HSA Region

Southern California adult bed occupancy impacted more intensely and for a longer period

		Collection Week																																
		2020																					2021												
		July	August				September				October					November				December				January					February				March		
		31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19
Northern California	N= 29	3.9%	6.7%	2.2%	0.6%	2.5%	0.7%	1.0%	1.4%	2.2%	1.6%	0.2%	1.2%	1.5%	0.7%	2.4%	3.2%	9.9%	15.0%	15.1%	20.9%	25.5%	22.2%	18.7%	16.1%	20.5%	14.7%	7.6%	7.6%	7.2%	4.4%	6.0%	9.2%	2.0%	1.6%
Golden Empire	N= 20	13.7%	13.8%	12.4%	11.4%	8.7%	6.8%	5.7%	6.1%	6.3%	4.9%	3.6%	3.9%	5.2%	5.6%	7.9%	11.6%	17.0%	21.1%	24.1%	29.0%	29.4%	29.5%	27.2%	27.6%	24.1%	20.6%	16.7%	12.5%	10.8%	9.7%	8.8%	6.7%	6.1%	4.8%
North Bay	N= 12	12.2%	11.8%	12.3%	11.3%	8.9%	9.3%	6.9%	5.4%	5.5%	6.8%	6.1%	6.0%	6.4%	6.4%	7.1%	8.2%	10.6%	12.7%	14.0%	21.8%	21.1%	25.3%	25.2%	26.5%	24.9%	23.3%	20.9%	18.2%	11.1%	9.1%	7.3%	5.3%	3.7%	3.0%
West Bay	N= 19	10.8%	8.7%	10.8%	10.1%	7.6%	7.8%	7.5%	7.1%	6.6%	5.7%	3.7%	2.7%	2.6%	2.6%	2.6%	3.2%	5.9%	8.5%	11.1%	16.5%	19.6%	18.7%	21.3%	20.1%	24.6%	21.5%	17.7%	14.6%	13.0%	10.7%	10.0%	8.6%	5.6%	3.6%
East Bay	N= 18	12.6%	11.5%	11.7%	12.5%	11.2%	9.8%	8.1%	6.3%	5.3%	4.6%	4.7%	4.6%	5.0%	6.1%	6.5%	7.3%	10.3%	12.9%	15.3%	20.3%	25.0%	27.7%	27.7%	26.7%	27.7%	25.4%	20.4%	17.2%	13.1%	11.0%	9.4%	9.1%	6.8%	5.4%
North San Joaquin	N= 18	28.5%	24.5%	20.5%	20.2%	16.5%	14.6%	11.4%	8.9%	6.9%	5.6%	4.8%	7.2%	6.4%	5.5%	8.7%	12.7%	19.0%	22.7%	26.1%	36.9%	39.8%	37.5%	36.8%	39.3%	37.3%	33.2%	28.0%	24.5%	21.7%	17.6%	13.5%	12.9%	14.0%	13.9%
Santa Clara	N= 8	10.0%	9.7%	9.2%	8.4%	7.8%	7.0%	6.5%	6.5%	5.8%	5.3%	5.3%	5.6%	5.7%	5.8%	7.0%	9.2%	12.2%	17.2%	20.4%	26.0%	31.2%	34.2%	35.1%	35.1%	31.9%	28.2%	24.3%	18.8%	16.3%	12.8%	11.1%	9.2%	7.5%	7.0%
Mid-Coast	N= 11	7.2%	10.1%	11.6%	10.3%	6.6%	4.2%	6.1%	5.1%	7.8%	6.9%	5.9%	5.7%	4.0%	6.3%	5.9%	8.4%	12.5%	22.6%	21.1%	27.4%	33.1%	34.3%	38.4%	38.0%	37.9%	36.0%	27.4%	24.4%	20.6%	11.3%	8.3%	7.8%	6.0%	5.9%
Central	N= 24	26.3%	25.1%	22.3%	21.0%	14.5%	12.0%	11.1%	8.9%	8.2%	7.9%	7.4%	7.7%	7.0%	7.0%	8.7%	12.9%	20.1%	25.5%	34.5%	41.2%	39.7%	44.6%	46.6%	46.0%	43.1%	36.7%	33.8%	31.4%	27.0%	22.2%	15.8%	13.3%	11.8%	10.7%
Santa Barbara/Ver	N= 12	12.1%	11.3%	9.9%	9.8%	9.1%	7.9%	6.6%	5.7%	5.9%	5.2%	5.1%	4.7%	4.6%	3.6%	5.0%	5.7%	7.6%	11.0%	14.1%	19.7%	27.1%	32.4%	34.3%	37.8%	39.7%	40.9%	34.3%	32.0%	26.7%	19.3%	14.0%	12.3%	9.9%	7.8%
Los Angeles	N= 85	17.7%	14.8%	13.8%	12.2%	11.7%	9.9%	8.2%	8.1%	7.2%	7.1%	7.6%	7.6%	7.7%	8.7%	9.4%	11.6%	15.3%	20.2%	25.1%	33.4%	41.6%	49.8%	52.4%	49.1%	46.7%	42.4%	37.1%	30.2%	23.2%	17.5%	13.3%	10.8%	8.5%	6.9%
Inland Counties	N= 39	20.7%	18.9%	15.1%	14.0%	12.8%	9.5%	7.6%	7.4%	7.3%	7.4%	7.6%	7.7%	8.8%	9.8%	10.6%	16.2%	21.5%	30.2%	31.9%	41.0%	48.2%	53.5%	53.1%	50.0%	47.0%	39.6%	34.7%	30.4%	23.4%	17.2%	11.8%	10.6%	8.1%	6.8%
Orange	N= 28	16.2%	14.8%	14.9%	13.1%	10.6%	8.1%	6.3%	5.4%	6.3%	6.0%	5.7%	5.3%	5.3%	5.8%	6.4%	8.5%	13.7%	20.8%	25.1%	34.0%	44.0%	45.3%	47.6%	45.3%	41.7%	34.9%	29.2%	26.3%	20.1%	14.8%	11.7%	9.4%	6.5%	5.6%
San Diego/Imperia	N= 20	11.6%	10.8%	9.6%	9.3%	8.9%	8.5%	8.5%	7.6%	6.9%	7.6%	7.7%	7.8%	9.0%	10.8%	10.7%	12.8%	16.6%	23.3%	27.5%	34.1%	39.7%	41.8%	41.7%	40.4%	39.0%	34.1%	31.3%	24.4%	20.1%	15.7%	12.7%	9.7%	8.3%	7.3%

Heat Map: ICU Capacity by Health Service Area
(Percent Change in adult ICU beds from 11/6 to Current)

Southern California expanded ICU capacity to a greater extent
Inland Counties had notably higher ICU expansion

		Collection Week																																		
		2020																						2021												
		July	August				September				October					November				December				January					February				March			
		31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19
Northern Californi	N= 29	-3.3%	-3.1%	-0.5%	0.1%	-2.6%	-1.7%	-1.6%	1.1%	-1.1%	1.0%	0.6%	1.7%	0.7%	1.4%	Comparison Month	-1.7%	-3.4%	-2.4%	0.1%	4.6%	3.7%	4.2%	4.2%	4.0%	6.0%	5.7%	5.4%	6.2%	6.0%	6.0%	10.7%	5.7%	5.8%	5.8%
Golden Empire	N= 20	3.2%	3.0%	6.3%	3.1%	0.8%	1.7%	-0.2%	-1.1%	-0.6%	-1.8%	-1.1%	0.9%	3.3%	2.0%		0.9%	3.2%	14.2%	11.2%	13.3%	18.8%	28.4%	30.0%	28.8%	17.3%	17.1%	14.3%	8.5%	10.0%	9.5%	8.6%	7.9%	1.0%	1.9%
North Bay	N= 12	-8.7%	-11.9%	-6.7%	-26.0%	-13.0%	-10.7%	-2.6%	-6.6%	-9.9%	-13.4%	-8.2%	-5.8%	6.0%	-4.3%		6.5%	4.5%	5.9%	2.9%	11.2%	14.2%	18.9%	18.2%	6.9%	-3.5%	1.9%	4.2%	0.5%	2.0%	5.5%	4.2%	-1.6%	-6.4%	-2.9%
West Bay	N= 19	-1.8%	0.0%	-2.7%	5.2%	1.4%	1.7%	-2.9%	-0.9%	0.5%	8.9%	-1.6%	0.3%	4.9%	-0.6%		3.6%	4.9%	-0.4%	0.0%	2.0%	4.5%	-0.1%	4.5%	6.9%	9.1%	9.5%	7.2%	9.0%	8.9%	7.4%	4.9%	4.0%	2.2%	0.4%
East Bay	N= 18	4.9%	3.1%	4.0%	2.1%	3.5%	1.4%	1.1%	-0.8%	-0.7%	0.3%	-3.4%	-2.0%	6.9%	0.0%		-2.6%	2.5%	5.6%	3.5%	5.7%	4.9%	10.2%	9.8%	16.2%	13.5%	10.0%	7.0%	7.9%	7.2%	1.1%	1.6%	0.8%	-1.0%	-1.2%
North San Joaquin	N= 18	6.7%	10.7%	11.0%	7.5%	6.0%	2.5%	3.2%	-1.6%	-1.1%	0.2%	-7.9%	-6.4%	0.3%	1.5%		1.3%	5.3%	5.4%	4.4%	6.5%	12.6%	14.7%	18.9%	13.0%	13.4%	12.9%	10.8%	4.6%	4.7%	0.7%	-3.8%	-4.5%	-1.9%	-3.9%
Santa Clara	N= 8	-2.5%	-9.4%	-6.6%	0.3%	-0.9%	2.0%	-0.2%	1.0%	-2.9%	-2.1%	-2.6%	-2.8%	5.0%	-1.9%		0.8%	1.4%	-6.4%	-5.9%	-4.8%	-1.0%	3.2%	5.0%	11.2%	9.0%	10.2%	10.0%	2.6%	2.5%	-0.5%	1.7%	-5.6%	-3.3%	-0.5%
Mid-Coast	N= 11	9.1%	11.3%	6.8%	4.5%	6.7%	7.7%	5.3%	3.6%	2.8%	1.3%	-14.1%	-9.8%	11.1%	8.1%		7.1%	9.1%	14.2%	14.9%	15.3%	18.2%	22.4%	35.8%	24.3%	16.3%	17.3%	23.3%	19.7%	10.1%	0.5%	7.7%	-0.2%	-2.4%	-6.0%
Central	N= 24	-1.4%	-2.7%	-1.4%	-0.5%	0.4%	-1.3%	-1.1%	-1.5%	-2.6%	-1.0%	-0.3%	-0.2%	0.4%	-1.1%		-1.2%	-3.3%	3.8%	3.8%	4.4%	13.6%	21.8%	17.9%	26.7%	26.6%	21.4%	19.9%	14.4%	13.7%	9.7%	7.5%	3.4%	5.7%	1.5%
Santa Barbara/Ver	N= 12	0.8%	0.6%	4.3%	-0.7%	1.0%	-2.5%	-2.1%	0.0%	-0.6%	-1.3%	-0.2%	0.4%	1.0%	-0.4%		-0.2%	1.0%	4.1%	3.4%	13.4%	12.9%	18.6%	28.1%	36.2%	17.1%	32.6%	32.4%	24.1%	4.7%	2.9%	4.8%	14.2%	0.4%	11.0%
Los Angeles	N= 85	3.8%	5.4%	2.9%	0.7%	0.3%	-0.4%	-0.1%	-1.0%	-0.4%	-1.1%	-2.1%	-0.8%	-1.4%	-0.2%		1.7%	2.8%	4.2%	5.5%	11.2%	20.0%	29.6%	37.0%	42.3%	40.6%	37.7%	32.4%	23.6%	15.2%	10.9%	5.2%	0.3%	-0.6%	-1.1%
Inland Counties	N= 39	7.2%	12.5%	6.0%	2.5%	0.0%	-0.8%	-0.3%	-0.9%	0.5%	-1.0%	-0.7%	-4.3%	-0.4%	-1.4%		3.2%	5.5%	8.8%	17.6%	24.0%	38.3%	49.6%	58.3%	63.3%	64.8%	54.6%	51.1%	39.1%	33.7%	24.7%	18.5%	15.4%	10.7%	9.6%
Orange	N= 28	-2.5%	-4.8%	-9.2%	-7.6%	-9.7%	-9.8%	-9.9%	-9.5%	-10.3%	-9.1%	-8.6%	-10.3%	-5.1%	-4.4%		-1.2%	0.0%	2.7%	4.3%	9.7%	15.4%	21.1%	24.5%	32.1%	30.8%	28.0%	16.4%	10.6%	6.5%	3.7%	6.7%	2.3%	-1.0%	-2.2%
San Diego/Imperia	N= 20	-1.5%	0.1%	-0.2%	-1.7%	-1.3%	-2.0%	-3.7%	-1.4%	-2.7%	-2.2%	-1.3%	-2.2%	-0.5%	-0.7%		-0.2%	0.6%	0.2%	6.0%	7.2%	12.6%	20.8%	30.4%	38.4%	37.8%	36.4%	26.6%	17.4%	13.0%	8.1%	3.8%	0.8%	-0.2%	0.6%

Appendix II

Healthy Places Index

Healthy Places Index

- **Question for Advisory Committee:**
  - Should analysis include consideration of Healthy Places Index and, if so, how?
- Healthy Places Index was developed by the Public Health Alliance of Southern California in partnership with the Virginia Commonwealth University's Center on Society and Health
- HPI combines 25 community characteristics into a single indexed HPI score
- Level of granularity: Census tracts, counties, congressional districts, cities, etc.
- Data are from 2011 – 2015 depending on the metric

Healthy Places Index Identifiers

- **Economic** (Above Poverty, Employed, Median Household Income)
- **Education** (Bachelor's Education or Higher, Preschool Enrollment, High School Enrollment)
- **Transportation** (Automobile Access Active Commuting)
- **Social** (Voting, Two Parents Household)
- **Neighborhood** (Tree Canopy, Supermarket Access, Retail Density, Park Access, Alcohol Availability)
- **Healthcare Access** (Insured Adults)
- **Housing** (Low-Income Homeowner Severe Housing Cost Burden, Homeownership, Housing Habitability, Low-Income Renter Severe Housing Cost Burden, Uncrowded Housing)
- **Clean Environment** (Safe Drinking Water - Contaminants, Clear Air - Ozone, Clean Air - PM, Clean Air - Diesel PM)
- **Race/Ethnicity** (Two or More Races, Native Hawaiians or Other Pacific Islanders, Whites, American Indians/Alaskan Natives, Latinos, Blacks, Some Other Races, Asians)

Healthy Places Index

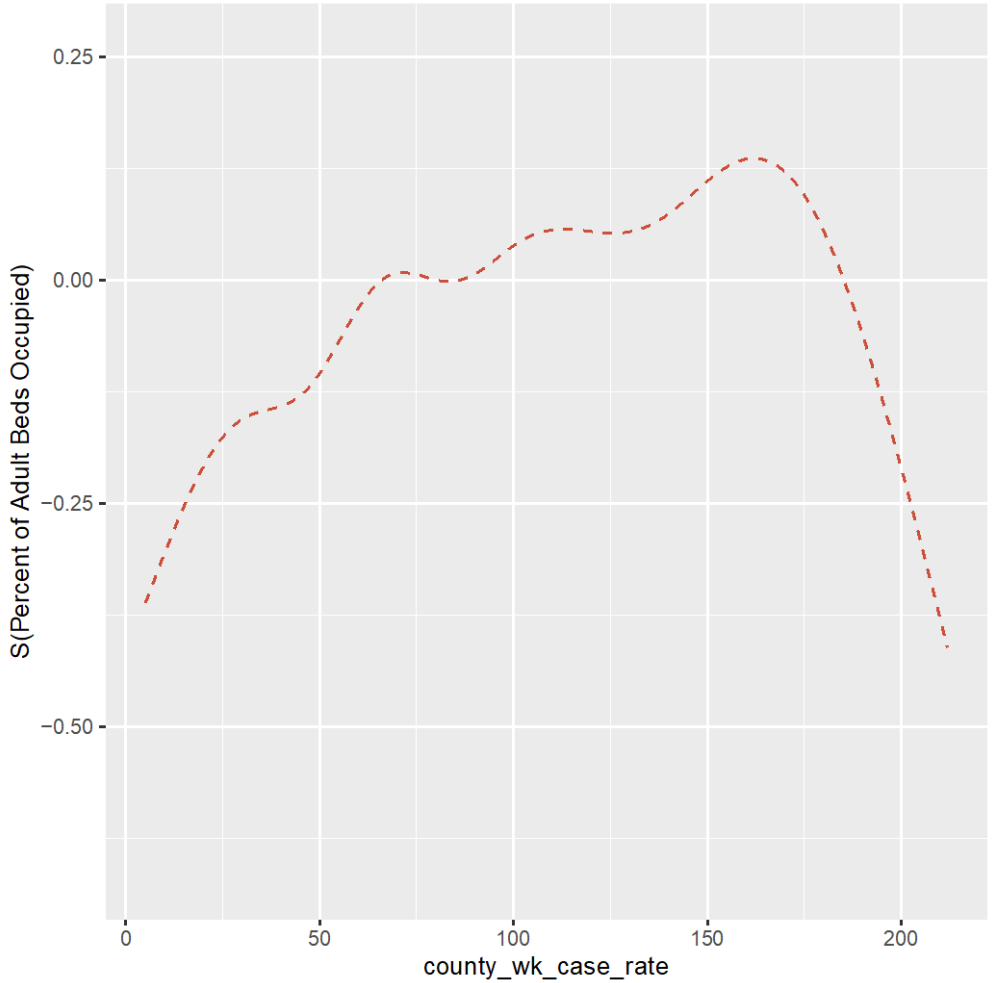
Healthy Places Index & Health Equity Re-Opening Criteria

- CA implemented the Blueprint for a Safer Economy on August 30, 2020 to reduce COVID-19 rates
- Every county is assigned a tier based on test positivity and adjusted case rate for tier assignment
  - A health equity metric took effect on October 6, 2020; in order to advance to the next less restrictive tier, each county must meet an equity metric and/or demonstrate targeted investments to eliminate disparities in levels of COVID-19 transmission, depending on its size
- **Equity Metric**
  - **Counties with populations greater than 106,000 must** ensure that the test positivity rates in its most disadvantaged neighborhoods do not significantly lag behind its overall county test positivity rate
- **Targeted Investments**
  - **All counties** must submit plans that:
    - (1) define its disproportionately impacted populations
    - (2) specify the percent of its COVID-19 cases in these populations
    - (3) shows that it plans to invest Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases grant funds at least at that percentage to interrupt disease transmission in these populations

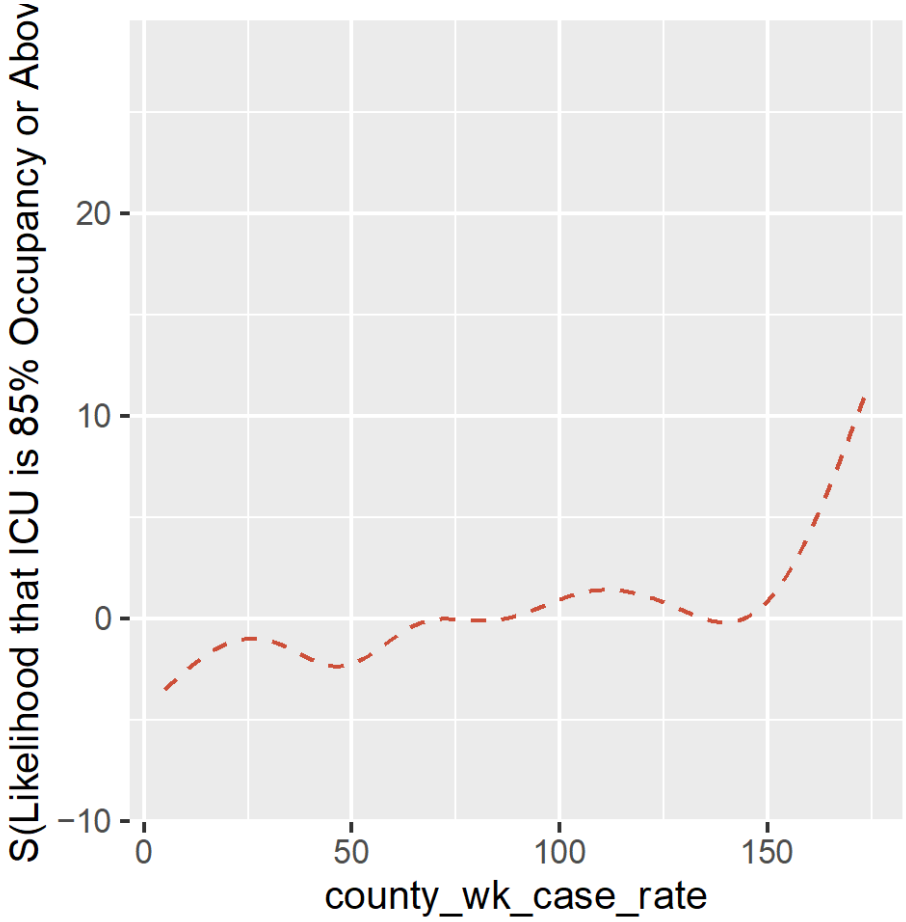
Appendix III

Additional stress plots

Stress: Adult Bed Occupancy

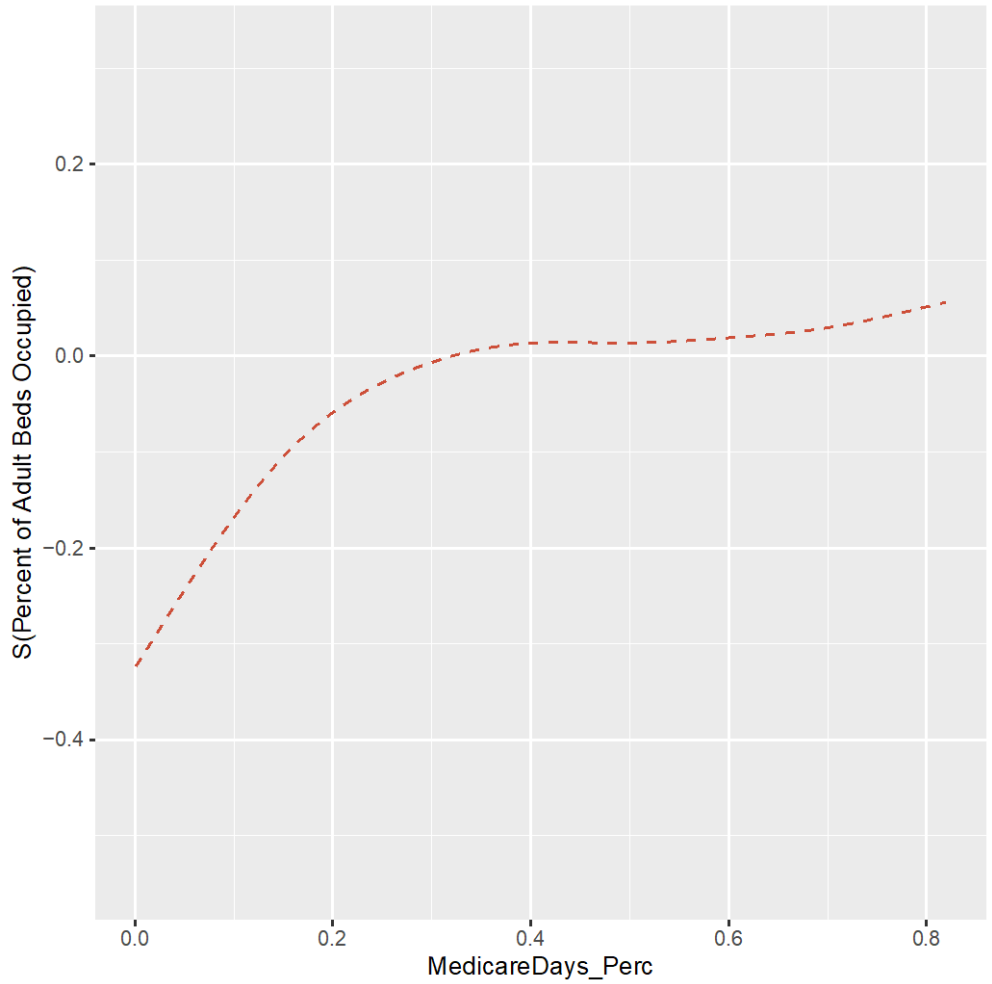


Stress: ICU Occupancy ≥85%

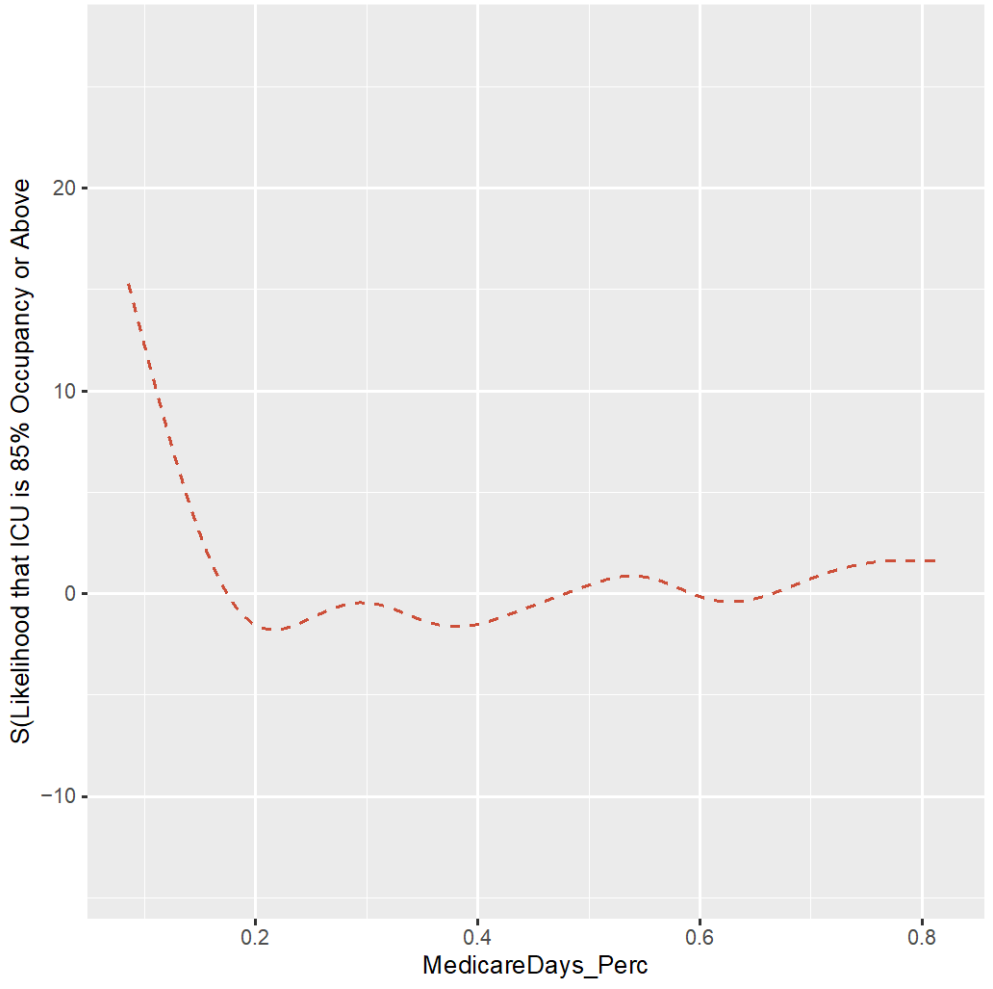


County COVID-19 Case Rate (per 100,000)

Stress: Adult Bed Occupancy

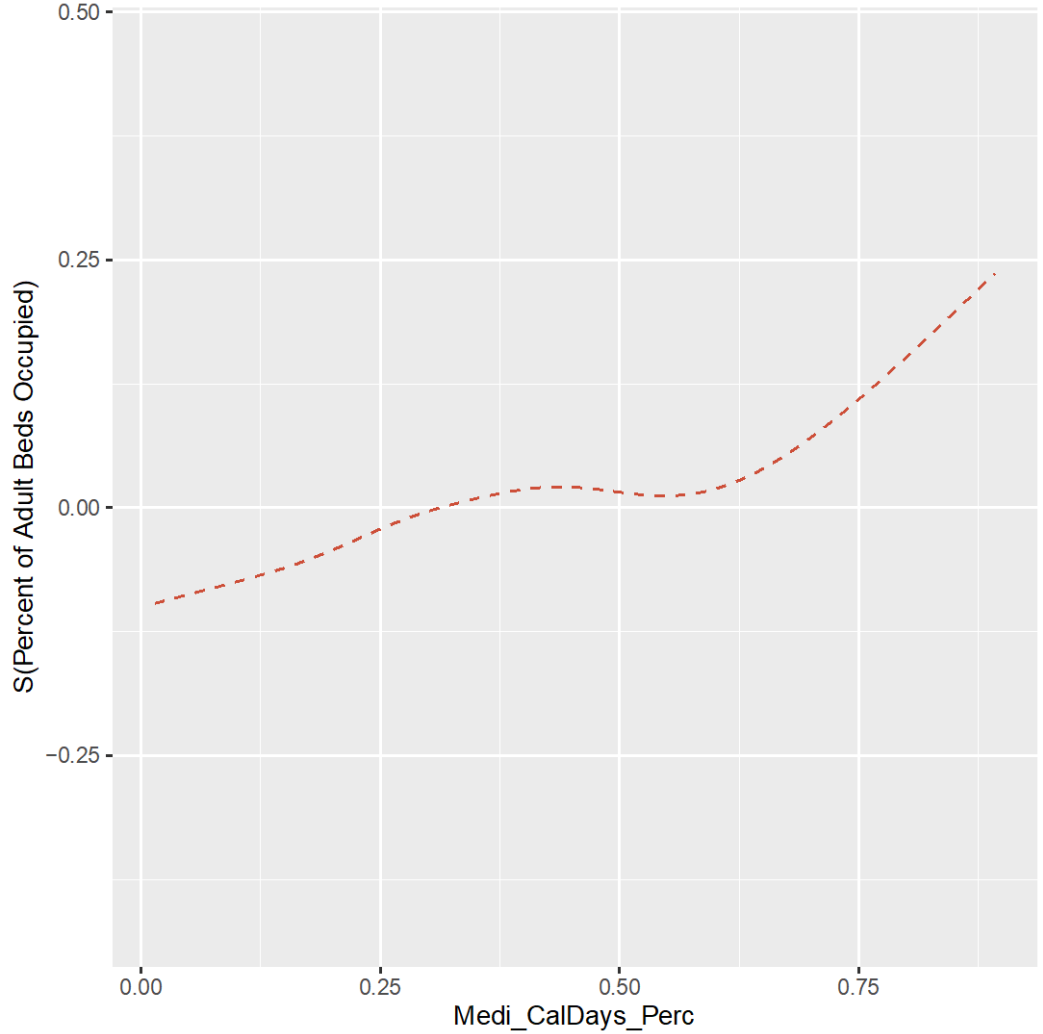


Stress: ICU Occupancy ≥85%



Medicare Days (%)

Stress: Adult Bed Occupancy

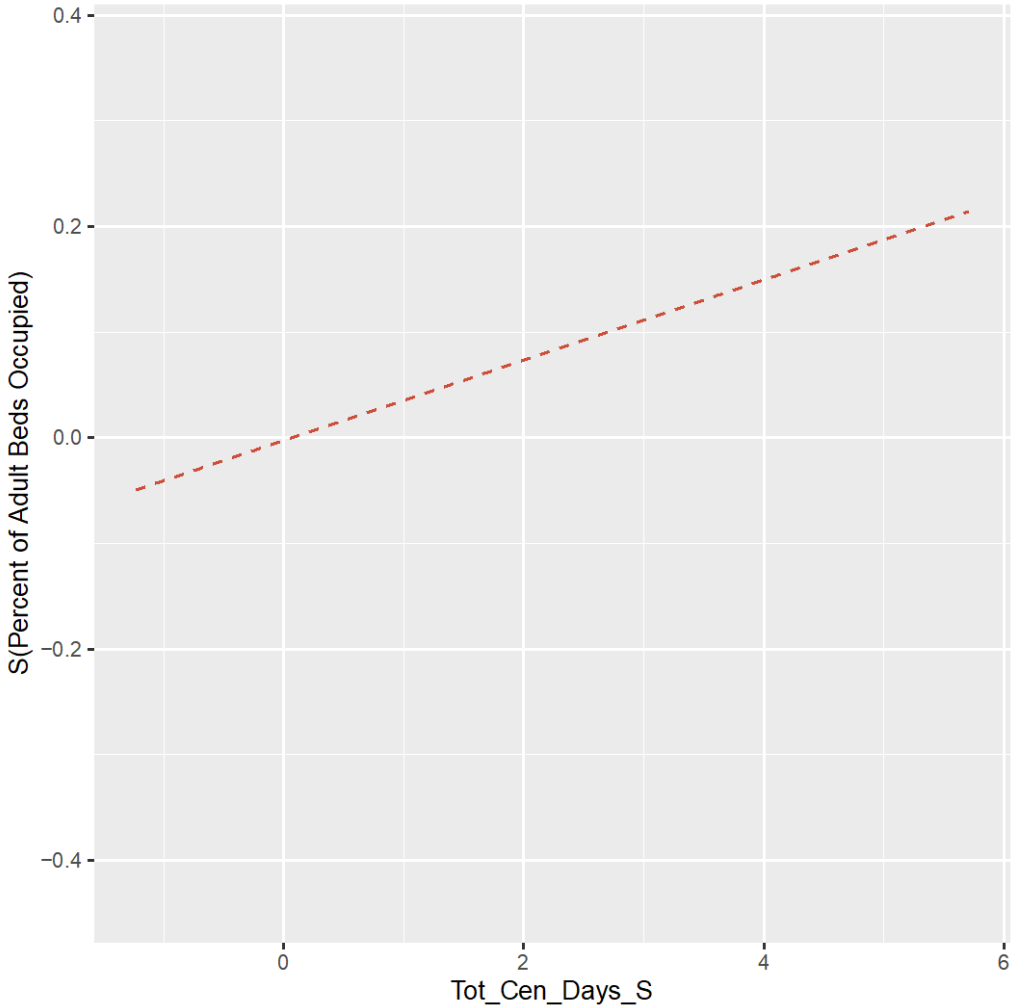


Medi-Cal Days (%)

Stress: ICU Occupancy ≥85%

Result not shown
P-value >0.2

Stress: Adult Bed Occupancy

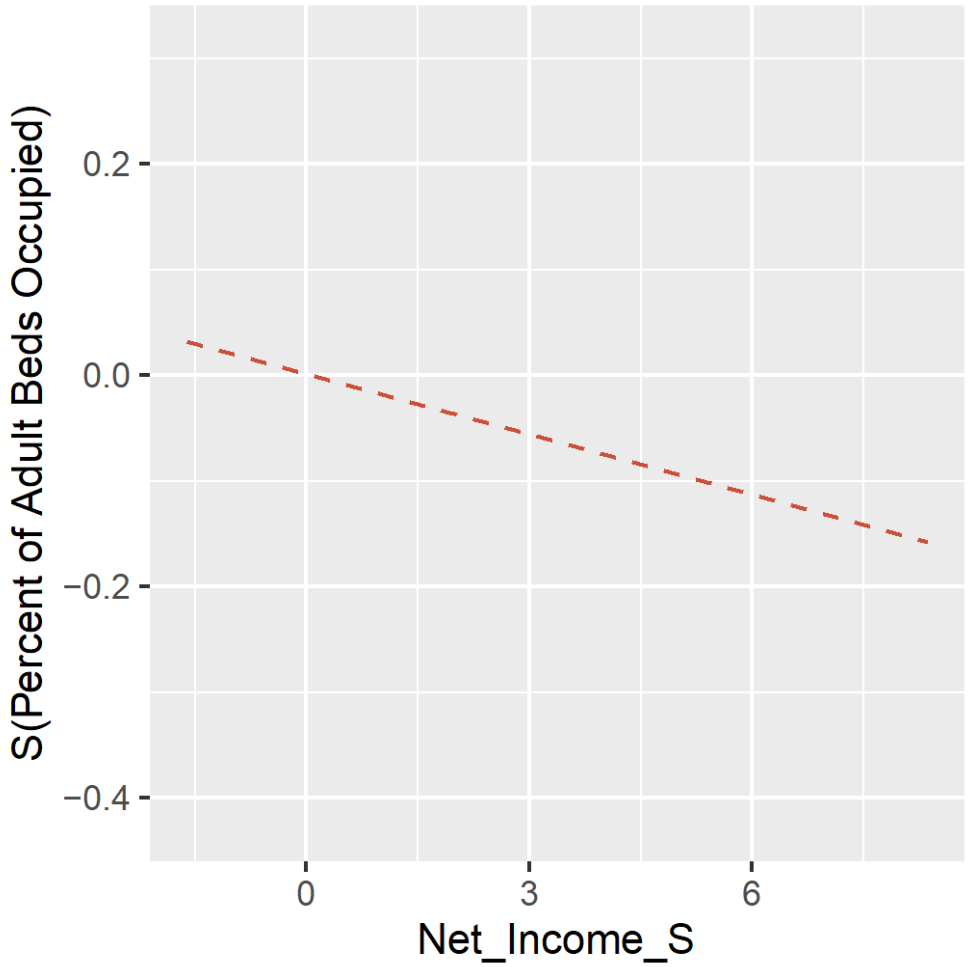


Stress: ICU Occupancy ≥85%

Result not shown
P-value >0.2

Total Census Days (per SD)

Stress: Adult Bed Occupancy

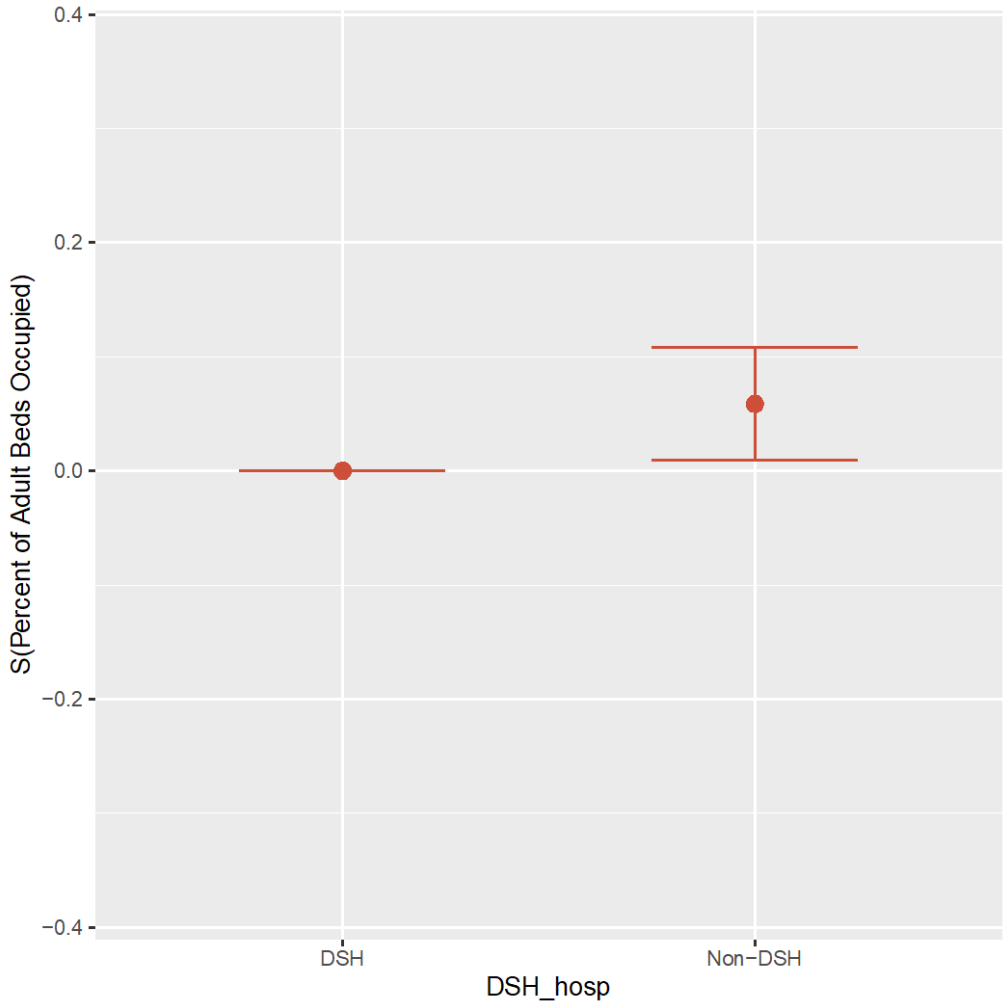


Stress: ICU Occupancy ≥85%

Result not shown
P-value >0.2

Net Income (per SD)

Stress: Adult Bed Occupancy

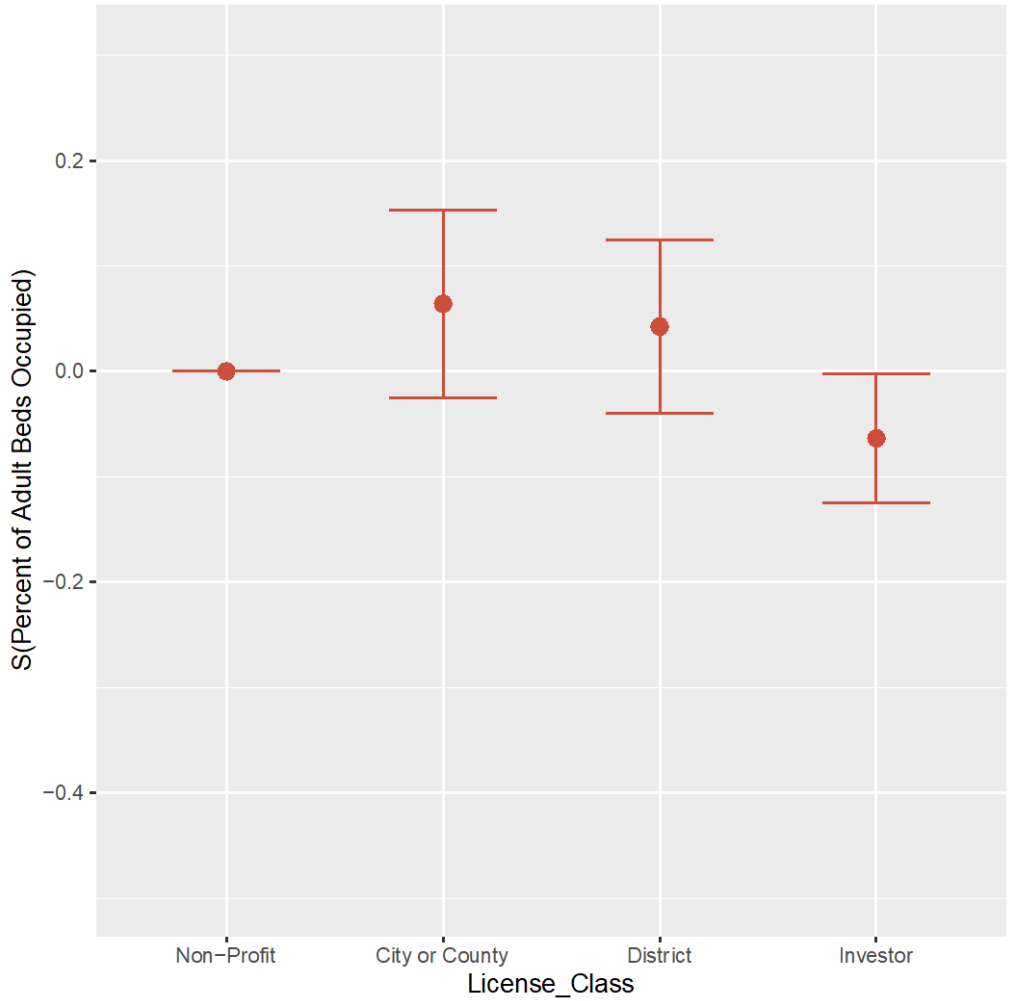


Stress: ICU Occupancy ≥85%

Result not shown
P-value >0.2

Non-DSH Hospital (vs DSH)

Stress: Adult Bed Occupancy



Stress: ICU Occupancy ≥85%

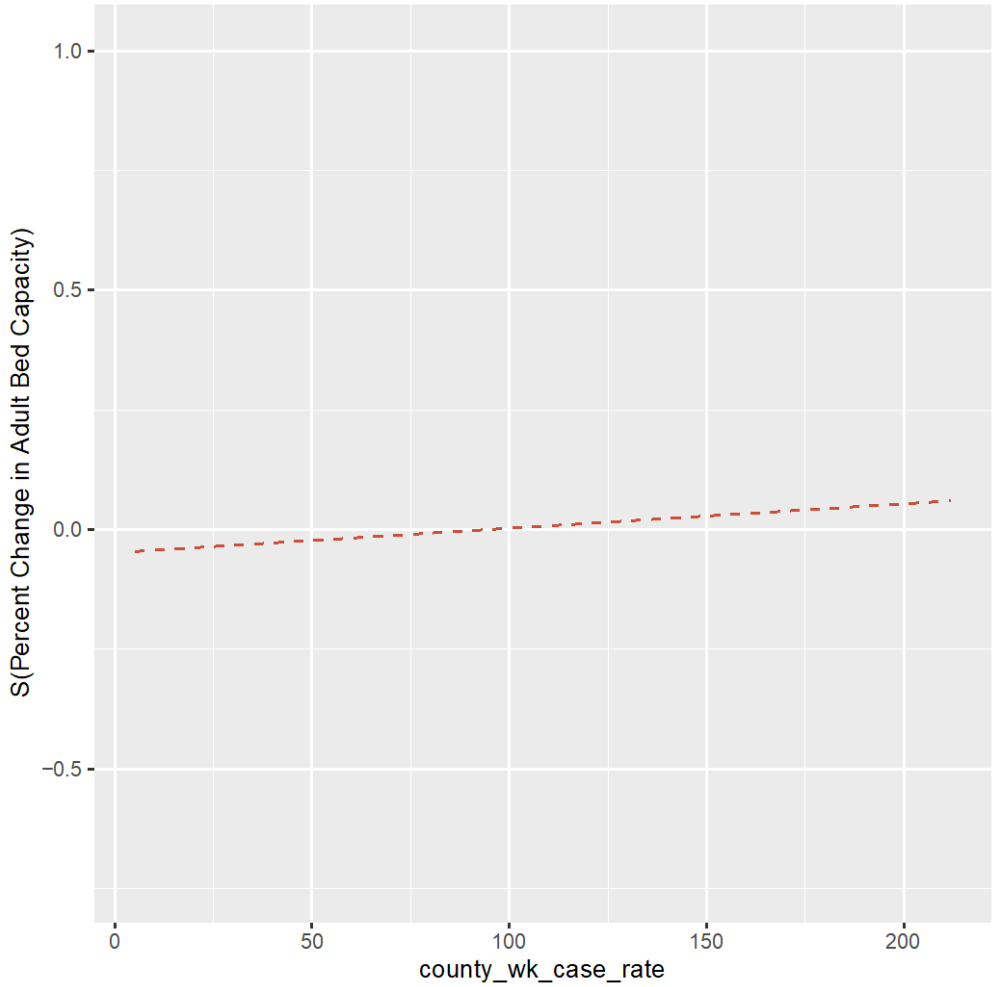
Result not shown
P-value >0.2

License Type(vs Non-Profit)

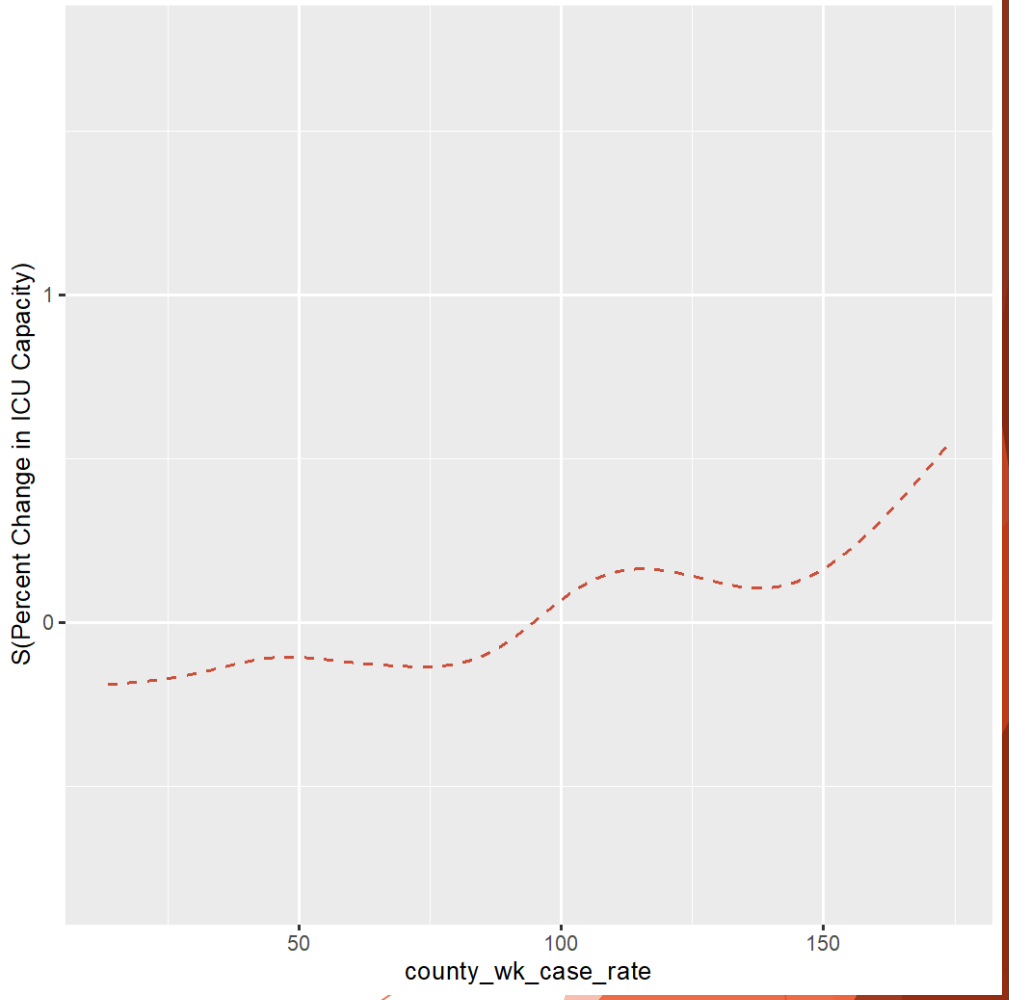
Appendix V

Additional resilience plots

Resilience: Adult Bed Expansion



Resilience: ICU Expansion

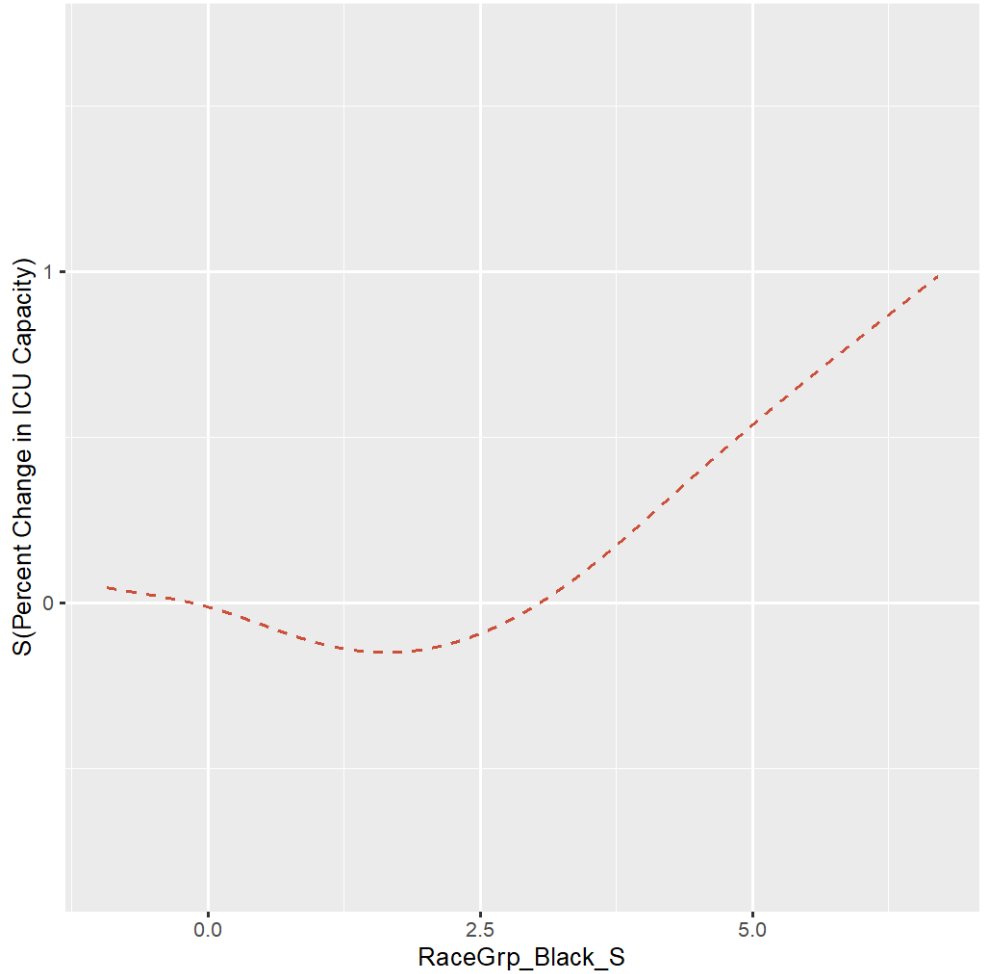


County COVID-19 Case Rate (per 100,000)

Resilience: Adult Bed Expansion

Result not shown
P-value >0.2

Resilience: ICU Expansion

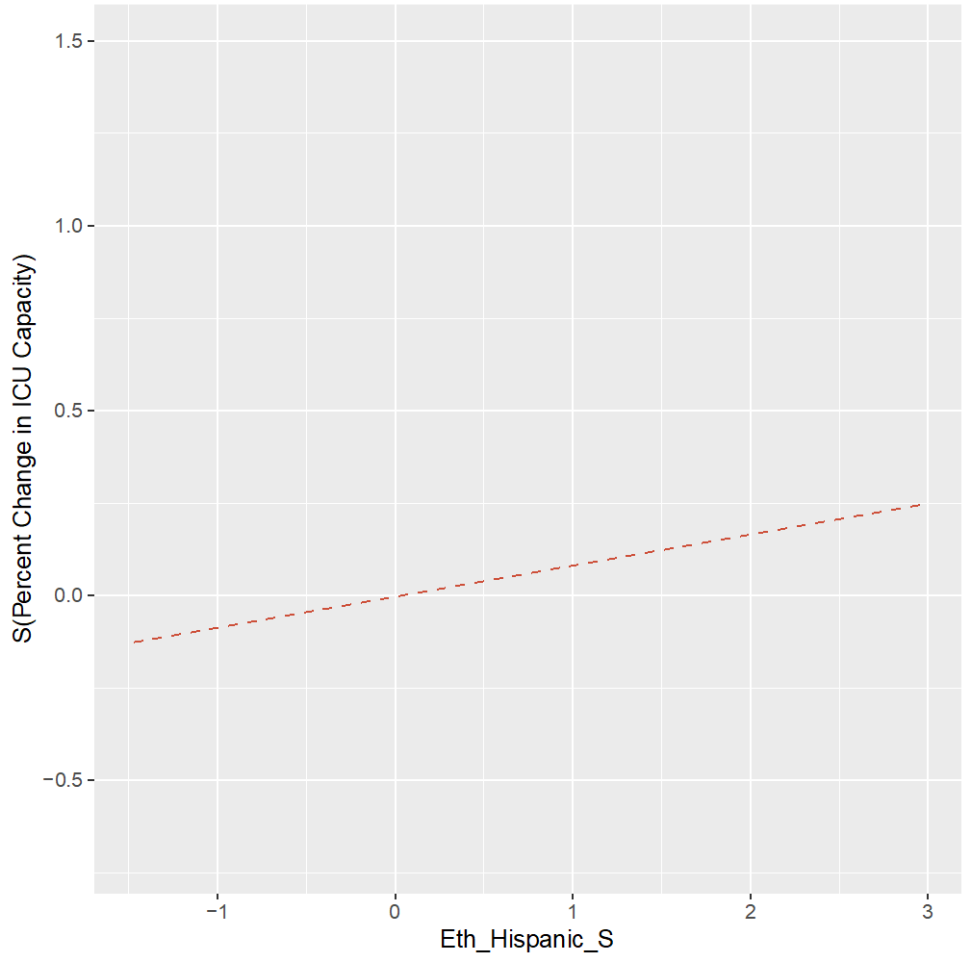


Race – Black (% Discharges)

Resilience: Adult Bed Expansion

Result not shown
P-value >0.2

Resilience: ICU Expansion



Ethnicity-Hispanic (% Discharges)

Appendix VI

Opioid Care Honor Roll

2022 Results Summary

Safe & effective

- Spread & scale of discharge prescribing remains a challenge (30% 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 SDOH

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

Opioid Management Hospital Self-Assessment (2021)

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 engagemen	

Source: *Opioid Management Hospital Self-Assessment*

Optional: Select one related measure and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria.

Opioid Care Honor Roll Measurement Guide

The following table has been adapted from the American Hospital Association, CA Bridge, and hospitals participating in the Opioid Care Honor Roll programs and includes suggested measures to track regarding hospital-based opioid treatment. Hospitals are encouraged to choose those most relevant to their processes and goals, as some of these metrics may not be applicable to every hospital.

For additional details regarding metrics and evaluation, refer to the American Hospital Association's Stem the Tide: Opioid Stewardship Measurement Implementation Guide.

Definitions of Abbreviations for Federal Programs: TJC: The Joint Commission, HEDIS: Healthcare Effectiveness Data and Information Set, MIPS (QM or IA): Merit Based Incentive Payment System (Quality Measure or Improvement Activity) (CMS), MSSP: Medicare Shared Savings Program (CMS), HIQRP: Hospital Inpatient Quality Reporting Program (CMS), Medicaid ACS: Medicaid Adult Core Set

Measure Description	Numerator	Denominator	Desired QI Trend	Alignment with Federal Quality or Accountability Programs
Safe & effective opioid use for pain management				
Total MME per prescription	Total MME	Number of opioid prescriptions	Reduction in average total MME	Medicaid ACS, MSSP
Opioid prescriptions ≤ 5 days	Number of opioid prescriptions ≤ 5 days	Total number of opioid prescriptions	Reduction in total days supply of opioids	
Number of opioid pills prescribed	Total number of opioid pills prescribed	Number of opioid prescriptions	Decrease in total number of opioid pills in the community	
Opioid prescriptions per prescriber at discharge	Number of opioid prescriptions at discharge	Patient volume per prescriber	Decrease in total number of opioid prescriptions	Medical Board of California
Patients receiving opioid only for pain management	Patients discharged with only an opioid medication for pain relief	Patients discharged with a prescription for a pain medication of any kind	Decrease in patient receiving opioids only for pain	TJC

Assess SUD

Addressing Substance Use Disorder *(OPTIONAL & progress in this domain does not count toward the 2021 Opioid Care Honor Roll)*						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
Many patients misuse more than one drug. Cal Hospital Compare is considering whether and how to address substance use disorder as part of the Opioid Care Honor Roll program in subsequent years. If applicable, please select the substance that you would most like us to address most and select the level that best describes your hospital's work in that area. • Alcohol • CNS depressants (e.g., barbiturates, benzodiazepines, etc.) • Illicit fentanyl • Heroin • Methamphetamine • Marijuana/synthetic cannabinoids • Tobacco/nicotine • Other	**No standardized process** to identify patients misusing selected substance	**Standardized process in place** to identify patients misusing selected substance in the ED and on admission (e.g., Alcohol Use Disorders Identification Test, Brief Screener for Alcohol, Tobacco, and other Drugs, NIDA single question screener, Screening to Brief Intervention, etc.) Process to **manage withdrawal** in the hospital setting for selected substance, if applicable (e.g., alcohol withdrawal protocol in place)	**Medications required for treatment on formulary, if applicable** (e.g., naltrexone bupropion, nicotine replacement therapies, etc.) **If primary treatment medications are not on formulary**, other treatment options are made available (e.g., topiramate, baclofen, gabapentin, etc.)	Treatment is offered & initiated in at least **1 service line** (ED or inpatient)	**Actively refer** patients to a community provider for ongoing treatment (e.g., residential treatment facility, outpatient clinic, telehealth, etc.) Provide **culturally competent care** (e.g., translation services, translated materials, etc.)	

Jamie Chan, PharmD
Vice President, Clinical Quality
Blue Shield of California

Jamie Chan is the Vice President, Clinical Quality for Blue Shield of California. In this role, Jamie is responsible for the development and execution of the organization's clinical quality strategy and operations.

Previously she has served as Senior Director, Clinical Quality at Blue Shield of California responsible for overseeing the Medicare Stars and Member Experience strategy. Prior to joining Blue Shield of California, Jamie worked at Kaiser Permanente as their National Executive Director for Pharmacy Quality and Medication Safety. She has managed Kaiser Permanente's California Drug Information and Professional Services Department, was the California Pharmacy Benefits Leader, and the Drug Use Management Leader for Kaiser Permanente's Northern California Region.

Jamie attended undergraduate studies at the University of California, Berkeley then earned her PharmD degree from the University of California, San Francisco. She is also a graduate of the Advanced Leadership Program from the University of North Carolina, Kenan-Flagler Business School. Jamie currently serves on the Board of Directors for the Pharmacy Quality Alliance.

Updated: 6/7/2021

Opioid Care Honor Roll Measurement Guide

The following table includes suggested measures to track hospital-based opioid treatment from the American Hospital Association, CA BRIDGE, and hospitals participating in the Opioid Care Honor Roll program. Hospitals are encouraged to choose those most relevant to their processes and goals, as some of these metrics may not be applicable to every hospital.

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Patients receiving opioid only for pain management	Patients discharged with only an opioid medication for pain relief	Patients discharged with a prescription for a pain medication of any kind	Decrease in patient receiving opioids only for pain	TJC

Opioid Care Honor Roll Measurement Guide

Cal Hospital Compare

Measure Description	Numerator	Denominator	Desired QI Trend	Alignment with Federal Quality or Accountability Programs
ALTO medications dispensed per 1,000 ED visits	Total mg of ALTO medications administered	Number of ED visits	Increase in alternatives to opioids for pain management	
MME per 1,000 ED visits	Total MMEs dispensed in the ED	Number of ED visits	Decrease opioid use for pain management in the ED	
Patients with opioids and benzodiazepines co-prescribed	Patients prescribed both opioids and benzodiazepines	All patients	Decrease in number of patients co-prescribed	HEDIS, Medicaid ACS, HIQRP, MSSP
Rates of accessing prescription drug monitoring program (PDMP)	Number of patients on opioids of any length or dose	Number of patients on opioids of any length or dose	Increased rate of PDMP utilization	MIPS IA, Leapfrog
Identifying & treating patients with opioid use disorder				
Screening for OUD on admission	Number of risk assessments documented in EHR on admission	Number of inpatient admissions	Increase in number of screens	MIPS QM
New patient starts for OUD treatment	MAT initiated	Number of patients identified with OUD	Increase in number of new starts	Medicaid ACS, CA Bridge
Referrals for OUD treatment	Number of referrals ordered	Number of patients identified with untreated OUD	Increase in referrals	Medicaid ACS, TJC
Completed/successful referrals for OUD treatment	Number of referrals completed	Number of referrals ordered	Increase in number of completed referrals	Medicaid ACS, TJC
Number of referred patients still in treatment 30 days later	Number of patients still in active treatment program	Number of treatment referrals completed	Increase in number of patients still engaged in treatment	Medicaid ACS

Opioid Care Honor Roll Measurement Guide

Measure Description	Numerator	Denominator	Desired QI Trend	Alignment with Federal Quality or Accountability Programs
Percent readmissions among patients started on MAT	Number of patients admitted for any cause within 90 days after initial MAT	Number of individuals started on MAT	Decrease in number of readmitted patients who were started on MAT	Readmission reduction programs
Overdose prevention				
Naloxone prescribed for opioid overdoses or high-risk patients	Number of naloxone prescriptions	Number of patients presenting with OD or opioid MME>50	Increase in naloxone prescriptions	CDC guidelines
Opioid prescriptions > 50 or 90 MMEs daily	Prescriptions > 50 or 90 MMEs daily	All prescriptions	Decrease in opioid prescriptions > 50 or 90 MME	
Applying cross-cutting opioid management best practices				
Percent of patients continuing opioids after 30 days	Number of patients on opioids after 30 days	Total number of patients prescribed opioids	Appropriate pain management	
Proportion of hospitalized patients who have documentation of patient defined comfort and function goals	Patients with documented comfort a function goals	Admitted patients receiving a dose of any pain medication	Increase in percentage of patients with defined goals	TJC
Patient pain management planning and education	Number of plans documented	Number of patients expected to experience pain	Increase in patients documented as having planning and education	MIPS IA, TJC
Identification and planning for patients with OUD on admission	Number of plans documented	Number of patients with OUD diagnosis	Increase in number of documented plans	Medicaid ACS
Baseline assessment of pain and opioid utilization upon admission	Number of assessments documented in EHR	Number of patients on opioids of any length or dose	Increase in number of baseline assessments	TJC

Opioid Care Honor Roll Measurement Guide

Measure Description	Numerator	Denominator	Desired QI Trend	Alignment with Federal Quality or Accountability Programs
Number of patients with an acceptable pain score > 0	Number of patients with an acceptable pain score > 0	Number of patients with pain	Setting realistic pain management expectations	
Functional outcomes and quality of life patient-reported outcomes measures (PROMs) fir treatment engaged patients	PROM score over time	Baseline PROM	Improvement in score of PROM over patient baseline	

2021 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.

To address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths, CHC publishes an annual Opioid Care Honor Roll to support continued quality improvement and recognize hospitals for their contributions fighting the epidemic. CHC uses the *Opioid Management Hospital Self-Assessment* to assess performance and progress across the following 4 domains of care:

1. Safe & effective opioid use
2. Identifying and treating patients with Opioid Use Disorder
3. Overdose prevention
4. Applying cross-cutting opioid management best practices

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.

Special note: For hospitals at any level of performance, we invite you to share detail on measures that you are currently reporting on. This will help us to understand and align future iterations of the *Opioid Management Hospital Self-Assessment* with the work that you are already doing. Providing this information is optional but highly encouraged.

For more information on the Opioid Care Honor Roll Program, register for upcoming events, and access tactical resources to support your quality improvement journey check out the Cal Hospital Compare website here.

Performance period: CY 2021

Assessment period: Jan 1, 2022 – Mar 31, 2022

Stay tuned for information on how to submit your Opioid Management Hospital Self-Assessment results!

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

Safe & Effective Opioid Use						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**

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, and family set expectations regarding pain management
• Limit benzodiazepine and opioid co-prescribing
• For opioid naïve patients:
  ○ Limit initial prescription (e.g., <5 days)
  ○ Use immediate release vs. long acting
• For patients on opioids for chronic pain:
  ○ For acute pain, prescribe short acting opioids sparingly
  ○ Avoid providing opioid prescriptions for patients receiving medications from another provider
	Developed and implemented evidence-based opioid discharge prescribing guidelines in **1 service line**, the Emergency Department OR 1 Inpatient Unit (e.g., Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	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 in at least one surgical specialty** as part of an Enhanced Recovery After Surgery (ERAS) program	Your hospital is actively **measuring and developing strategies to improve** appropriate opioid prescribing at discharge
					
					Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)	

Safe & Effective Opioid Use						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
Alternatives to Opioids for Pain Management Use an evidence based, multi-modal, non-opioid approach to analgesia for patients with acute and chronic pain. Guidelines should address the following: • Utilize non-opioid approaches as first line therapy for pain while recognizing it is not the solution to all pain • Provide pharmacologic alternatives (e.g., NSAIDs, Tylenol, Toradol, Lidocaine patches, muscle relaxant medication, Ketamine, medications for neuropathic pain, nerve blocks, etc.) • Offer 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.) • Provide care guidelines for common acute 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)	Your hospital **does not** have a standardized approach to providing alternatives to opioids for pain management	Developed and implemented a non-opioid analgesic multi-modal pain management in the **Emergency Department OR 1 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 guideline in the **Emergency Department AND 1 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, 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 **measuring and developing strategies to improve** use of opioid alternatives for pain management *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Identification and Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**

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, and/or in opioid withdrawal
• Treatment is accessible in the emergency department and in all other hospital departments
• Treatment is provided rapidly (same day) and efficiently in response to patient needs
• Human interactions that build trust are integral to treatment
 	
*Suggested guidelines for how to universally offer MAT to all patients:
• Do <u>not</u> screen patients for OUD
• Do <u>not</u> ask patients if they are interested in MAT services
  ○ May be time consuming for providers and stigmatizing for patients
• <u>Do</u> promote MAT services using signage in waiting and exam rooms, badge flare, and patient forms
• During the exam, providers routinely let patients know that their site offers MAT
  ○ So that patients can choose to disclose whether and when they need support
	Methadone and buprenorphine on hospital **formulary**	MAT is offered, initiated, and continued for those already on MAT in at least **1 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, and 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, Chaplain, etc.)
					Your hospital is actively **measuring and developing strategies to improve** access to MAT
					
					Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)	

Identification & Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
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 buprenorphine at discharge under the Drug Addiction Treatment Act of 2000 (DATA 2000). As of 2021 for providers treating ≤30 patients the X-waiver education requirement is waived. If hospital does not have X-waivered providers: • Providers may 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 and/or within the community Provides list of **community-based resources** for follow up care to patients, family, caregivers, and friends (e.g., primary care, outpatient clinics, outpatient treatment programs, telehealth treatment providers, etc.)	Hospital provides support to **practitioners* in the ED and IP units to obtain X-waiver** (e.g., provides education on changes to x-waiver education requirement, supports application process, education on how to use buprenorphine, hospital's process for providing MAT, etc.) Hospital is actively **building relationships and coordinating with post-acute services to support care transitions**	Hospital has an agreement in place with **at least one community provider to provide timely follow up care**	**Actively refer** MAT and OUD patients to a community provider for ongoing treatment (e.g., primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, etc.)	Your hospital is actively **measuring and developing strategies to improve** patient access to timely follow up care *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Overdose prevention						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
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 include 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	Hospital **does not engage in overdose prevention** strategies	**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 a long-term 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 appropriate opioid prescriptions, and/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 (see CA BRIDGE Guide to Naloxone Distribution for details)	Your hospital is actively **measuring and developing strategies to improve** access to naloxone *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
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.)	Opioid stewardship is **not a quality improvement priority**	**Multi-stakeholder team** identified opioid stewardship as a strategic priority and set improvement goals in one or more of the following areas: safe and effective opioid use, identifying and treating patients with OUD, overdose prevention, applying cross-cutting opioid management best practices (e.g., opioid stewardship committee, medication safety committee, a dedicated 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 stewardship 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 participates in **local opioid coalition**	Your hospital is actively **measuring and developing strategies** that support opioid stewardship as an organizational priority *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance misuse. Hospital actively addresses stigma through the education and promotion of the medical model of addiction, trauma informed care, harm reduction principles including, motivational interviewing across all departments to facilitate disease recognition and the use of non-stigmatizing language/behaviors (e.g., words matter).	Hospital **does not address stigma with** physicians and staff	Provides passive, **general education** on hospital opioid prescribing guidelines in **at least 2 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., MME flag for providers, 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.)	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 and treatment (e.g., M&M, lunch and learns, CME requirements, RN annual competencies, etc.) **Regularly assesses stigma** among providers and staff (e.g., audit of existing materials for stigmatizing language - internal documentation, forms, brochures, signs, annual survey, focus groups, focused leader rounding, etc.)	Your hospital is actively **measuring and developing strategies** to addresses physician and staff stigma towards OUD patients *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**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**
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.)	**Patients and families are not actively** engaged in OUD prevention, treatment, and/or quality improvement initiatives	Provides general education to **all patients, families, and friends in at least 2 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 via conversations with care providers (e.g., MAT options, opioid risk and alternatives, naloxone use, etc.) 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 **measuring and developing strategies** to improve patient and family engagement *Optional: Select one related measure that your hospital is already reporting on and provide the measure name, numerator and denominator specifications, and any inclusion/ exclusion criteria (see measurement guide for list of suggested measures)*	

Addressing Substance Use Disorder *(OPTIONAL: Progress in this domain does not count toward the 2021 Opioid Care Honor Roll)*

Measure	Level 0 (0 pt.) *Getting started*	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
Many patients misuse more than one drug. Cal Hospital Compare is considering whether and how to address substance use disorder as part of the Opioid Care Honor Roll program in subsequent years. If applicable, please select the substance that you would most like us to address and select the level that best describes your hospital's work in that area. • Alcohol • CNS depressants (e.g., barbiturates, benzodiazepines, etc.) • Illicit fentanyl • Heroin • Methamphetamine • Marijuana/synthetic cannabinoids • Tobacco/nicotine • Other	**No standardized process** to identify patients misusing selected substance	**Standardized process in place** to identify patients misusing selected substance in the ED and on admission (e.g., Alcohol Use Disorders Identification Test, Brief Screener for Alcohol, Tobacco, and other Drugs, NIDA single question screener, Screening to Brief Intervention, etc.) Process to **manage withdrawal** in the hospital setting for selected substance, if applicable (e.g., alcohol withdrawal protocol in place)	**Medications required for treatment on formulary, if applicable** (e.g., naltrexone bupropion, nicotine replacement therapies, etc.) **If primary treatment medications are not on formulary**, other treatment options are made available (e.g., topiramate, baclofen, gabapentin, etc.)	Treatment is offered and initiated in at least **1 service line** (ED or inpatient)	**Actively refer** patients to a community provider for ongoing treatment (e.g., residential treatment facility, outpatient clinic, telehealth, etc.) Provide **culturally competent care** (e.g., translation services, translated materials, etc.)	

Open ended responses:

Briefly describe the steps your hospital has taken to improve opioid stewardship across the 4 domains assessed in the 2021 Opioid Management Hospital Self-Assessment.

What would you like to learn more about in 2021 that would help you to close a gap in your work?

What else do you want us to know?

2021 OPIOID MANAGEMENT HOSPITAL SELF-ASSESSMENT

Measures	Score
Safe & effective opioid use	
Appropriate opioid discharge prescribing guidelines	
Alternatives to opioids for pain management	
Identification & treatment	
Medication Assisted Treatment (MAT)	
Timely follow-up care	
Overdose prevention	
Naloxone education and distribution program	
Cross cutting opioid management best practices	
Organizational infrastructure	
Address stigma with physicians and staff	
Patient and family engagement	
Addressing substance use disorder (OPTIONAL: Progress in this domain does not count toward the 2021 Opioid Care Honor Roll)	*NA*
"Hon-rolled" a friend *Share the Opioid Care Honor Roll opportunity with another hospital that did not participate in 2020. If they apply for the 2021 Opioid Care Honor Roll you both get 1 additional point.*	Provide hospital name(s)
Total score *(out of 32 points)*	