Cal Hospital Compare Board of Directors

August 4, 2021

10:00am-12:30pm Pacific Time

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

Passcode: **cyno#**

Proposed Agenda

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

Cal Hospital Compare & Cal Quality Care
Board of Directors Meeting Agenda
Wednesday, August 4, 2021, 10:00am – 12:30pm 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
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 & CQC
10:05-10:35 *30 min.*	Organizational updates – Introductions – Shanice Mzavas, Measurement Project Manager – CalHospitalCompare.org data refresh – Impact of COVID-19 on Hospitals: Qualitative Study Planned – Integrating Cal Quality Care	- **Alex Stack** Director, CHC - **Shanice Mzavas** Measurement Project Manager, CHC & CQC
10:35-11:30 *55 min.*	Cal Hospital Compare: using Healthy Places Index to identify hospitals at greatest social risk - Methodology – what drives HPI, data limitations - Focus on breastfeeding, sepsis, readmission & VBAC routinely available - TAC discussion - Next steps: Validation process	- **Mahil Senathirajah** Senior Director, IBM Watson Health
11:30–12:15 *45 min.*	Cal Quality Care - Recruiting for Cal Quality Care's Technical Advisory Committee - Scanning the measurement landscape o Current, retired, and new measures o Framework for measure selection - Timeline & deliverables	- **Debra Bakerjian** Director, UC Davis Health
12:15-12:25 *10 min.*	Business Plan - Financial report	- **Bruce Spurlock** Executive Director, CHC
12:25–12:30 *5 min.*	Adjourn – Next meeting: Wednesday, September 29, 2021, from 10:00am to 12:30pm PST	- **Ken Stuart** Board Chair

Cal Hospital Compare

Cal Hospital Compare
Board of Directors Meeting Summary
Wednesday, June 9, 2021
10:00am – 12:00pm PST via Zoom

Attendees: Jamie Chan, David Hopkins, Libby Hoy, Robert Imhoff, Chris Krawczyk, Julia Logan, 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 April 14, 2021 was motioned, seconded, and approved as submitted.
Organizational Updates	• Jamie Chan, VP, Clinical Quality with Blue Shield of California has joined the Board of Directors, replacing Seth Glickman. • Bruce updated the BOD regarding changes to the Bylaws. The BOD motioned, seconded, and approved the proposed increase board representation from 11 to 13 members. The new quorum for the BOD meetings is now seven. The Board moved, motioned, seconded and approved appointing Dr. Terry Hill, COVID-19 Medical Director with ACCMA to join the BOD.
Examining COVID-19 in Hospitals	• Alex provided a high-level overview of the study design. Mahil gave a descriptive analysis of the two key analytics based on stress and resiliency and explained the data limitations/feedback from the TAC. Helen emphasized the critical importance of factoring in geographic impact in the analysis and not solely relying on conclusions from data findings. Kristof recommended digging deeper at system size related to stress and response data. • CHC will consider expanding the number of qualitative interviews and include patient family advisors in the interview process before developing formal recommendations.
Opioid Care Honor Roll	• The program is in its third year of implementation. Alex explained the project timeline and workgroup recommendations for the 2021 program. The BOD agreed with publishing the honor roll threshold upfront.
CHC Analytics	• Mahil gave a high-level overview to the BOD. Helen suggested looking at these observations as part of an integrated network. Jamie commented that there is variation in coordination of care depending on the hospital and service area (i.e.. staffing, budget constraints, etc.). Joan is curious about patient centered data related to discharge instructions and readmissions. Robert commented that there are many variables outside of the physician situation that affect this measure. CHC will bring additional insights back to the BOD at the next meeting.

Financials	• Bruce reviewed the current financial reports – January through April 2021.
Next Meeting/Meeting Adjournment	• The next Board of Directors meeting is scheduled on Wednesday, August 4th at 10:00am PST via Zoom. • The meeting formally adjourned at 12:00pm PST.

Cal Hospital Compare

Board of Directors

Other Contributors

Welcome!

Shanice Mzavas

Measurement Project Manager

BOD Nominee

Gretchen E. Alkema, PhD

Vice President, Policy & Communications

The SCAN Foundation

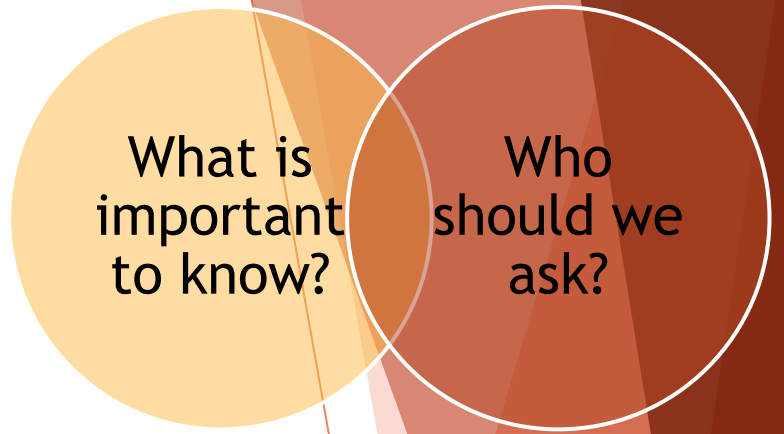
Website data refresh

Maternity Honor Roll in progress w/ announcement planned for Fall 2021

Updated measures include:

- Healthcare Acquired Infections (CY2019)
- Maternity measures (CY2020)

Impact of COVID-19 on Hospitals Qualitative Interviews



Small vs large system

Geographic regions

High COVID-19 case rates

Teaching/ non-Teaching

Large Medicaid population

Technical Advisory Committee

Alexandria Smith Davis
Director of Public Policy for Healthcare
asmithdavis@leadingageca.org

Barbara Kivowitz
Patient Family Advisor
bkivowitz@post.harvard.edu

Barb Averyt
Senior Executive Director
Health Services Advisory Group
baveryt@hsag.com

Brandi Wolf
Policy & Research Director
SEIU Local 2015
BrandiW@seiu2015.org

Colleen Murphey
Network and Strategy Manager
Health Plan of San Mateo
colleen.murphey@hpsm.org

Craig Cornett
Executive Director
California Association of Health Facilities
ccornett@cahf.org

Dan Osterweil, MD
Chief Medical Office
SCAN Health Plan
DOsterweilM.D@schanhealthplan.com

Dana Mukamel, PhD
Professor
University of California, Irvine
dmukamel@uci.edu

DeAnn Walters
Director of Clinical Affairs and Quality
California Associate of Health Facilities
dwalters@cahf.org

Debra Saliba MD, MPH, AGSF
Physician Policy Researcher
RAND Corporation
Saliba@rand.org

Edward Mariscal
Director, Public Programs & Long-Term Services & Supports
Health Net
Edward.Mariscal@HealthNet.com

Eric Carlson
Directing Attorney
Justice in Aging
ecarlson@justiceinaging.org

Gretchen E. Alkema, PhD
Vice President Policy & Communications
The SCAN Foundation
galkema@thescanfoundation.org

Jeannee Parker Martin
President & CEO
LeadingAge California
jpmartin@leadingageca.org

Jennifer Lloyd
Vice President, Medical Management
Centene Corporation
Jennifer.A.Lloyd@healthnet.com

Jennifer Wieckowski, MSG
State Program Director
Health Services Advisory Group
jwieckowski@hsag.com

Kathryn Doh
Research Scientist
California Department of Public Health
Kathryn.Doh@cdph.ca.gov

Kevin Worth, RN, MS, CNS
Executive Director, Risk Mgmt. & Patient Safety
Kaiser Permanente Northern California Region
Kevin.Worth@kp.org

Leza Coleman
Executive Director
California Long Term Care Ombudsman
lcoleman@cltcoa.org

Marty Lynch, PhD, MPA

Technical Advisory Committee

CEO Emeritus
LifeLong Administrative Offices
mlynch@lifelongmedical.org

Maya Altman
Chief Executive Officer
Health Plan of San Mateo
maya.altman@hpsm.org

Merry Holliday-Hanson
Research Scientist Supervisor
Office of Statewide Health Planning & Development
merry.holliday-hanson@oshpd.ca.gov

Michael Connors
Long Term Care Advocate
California Advocates for Nursing Home Reform
michael@canhr.org

Mike Dark
Staff Attorney
California Advocates for Nursing Home Reform
miked@canhr.org

Neil Wenger
Professor, Division of General Internal Medicine and Health Services Research
University of California, Los Angeles
nwenger@mednet.ucla.edu

Ramon Castellblanch
Chair, Solano County Alcohol & Drug Advisory Board
Professor Emeritus, Health Education
San Francisco State
ramonc@sfsu.edu

Silvia Yee
Senior Staff Attorney
Disability Rights Education & Defense Fund
syee@dredf.org

Other Contributors

Alex Stack
Director, Programs & Strategic Initiatives
Cal Hospital Compare
astack@cynosurehealth.org

Bruce Spurlock, MD
Executive Director
Cal Hospital Compare
bspurlock@cynosurehealth.org

Charlene Harrington, PhD, RN
Professor Emerita
University of California, San Francisco
Charlene.Harrington@ucsf.edu

Debra Bakerjian, PhD, APRN, FAAN, FAANP, FGSA
Clinical Professor
Betty Irene Moore School of Nursing
dbakerjian@UCDAVIS.EDU

Dominique Ritley, MPH
Senior Health Policy Analyst
UC Davis Health – Center for Healthcare Policy and Research
dritley@ucdavis.edu

Leslie Ross, PhD
Specialist
UC – San Francisco - Institute for Health & Aging
leslie.ross@ucsf.edu

Kristen Bettega
Project Manager
UC Davis Health System
kbettega@ucdavis.edu

Patrick Romano, MD, MPH, FACP, FAAP
Professor of Internal Medicine and Pediatrics
Co-Editor in Chief, Health Services Research (HSR)
psromano@ucdavis.edu

Shanice Mzavas
Measurement Project Manager
Cal Quality Care
smzavas@cynosurehealth.org

Shao-You Fang, PhD
Data Systems Analyst
UC Davis Health – Center for Healthcare Policy and Research
syfang@ucdavis.edu

Tracy Fisk

Technical Advisory Committee

Executive Assistant
Cynosure Health
tfisk@cynosurehealth.org

Integrating Cal Quality Care

Cal Quality Care Technical Advisory Committee

Welcome recommendations

Patient Advisors/ Advocates

Health Plans/Payers

Quality Improvement Organizations

State Agencies

Subject Matter Experts/ Researchers

2021 Meeting Cadence

Meeting	CY 2021					
	JUL	AUG	SEPT	OCT	NOV	DEC
Cal Quality Care Technical Advisory Committee (2 hrs)		Aug 24	Sept 15	Oct 15	Nov 19	
Cal Hospital Compare Technical Advisory Committee (2 hrs)	Jul 29		Sept 21		Nov 18	
Board of Directors (2.5 hrs)		Aug 4	Sept 29	Schedule another call?		Dec 1

2022 Meeting Cadence (Quarterly)

Meeting	CY 2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Cal Quality Care Technical Advisory Committee (2 hrs)	X			X			X			X		
Cal Hospital Compare Technical Advisory Committee (2 hrs)		X			X			X			X	
Board of Directors Virtual = 3 hrs In person = 4 hrs			X In person			X Virtual			X In person			X Virtual

Cal Hospital Compare Analytics

Integrating Healthy Places Index

Healthy Places Index

- 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 Weighting

Each Domain is weighted based on statistical modeling

ECONOMIC 0.32	EDUCATION 0.19	HEALTHCARE 0.05	HOUSING 0.05	NEIGHBOR-HOOD 0.08	CLEAN ENVIRONMENT 0.05	SOCIAL 0.10	TRANSPOR-TATION 0.16
• Poverty • Employment • Income	• Pre-school enrollment • High school enrollment • Bachelors attainment	• Insured adults	Severe cost burden low-income: • renters • owners • Homeownership • Kitchen and plumbing • Crowding	• Retail jobs • Supermarket access • Parks • Tree canopy • Alcohol establishments	• Diesel PM • Ozone • PM2.5 • Drinking Water	• Two Parent Household • Voting	• Healthy Commuting • Automobile access

Figure 1. Health Places Index Policy Action Areas (Domains), Weights, and Individual Indicators

Healthy Places Index

HPI Methodology

- Obtained hospital-level services by patient zip code from Data.CMS.Gov
  - Based on Medicare FFS member utilization
- Linked to California HPI by zip code
  - Data set has HPI by census tract mapped to zip code
- Calculated zip-code-level HPI, weighting by census tract population
- Calculated hospital-level HPI by weighting zip-code-level HPI by number of hospital cases by zip code
- Note: Lower HPI indicates higher social risk
- Unlike Dartmouth HSA, based on population treated by hospital; not a general hospital market area
  - Includes all Medicare FFS members receiving services who live in California (i.e., excludes out-of-state patients)

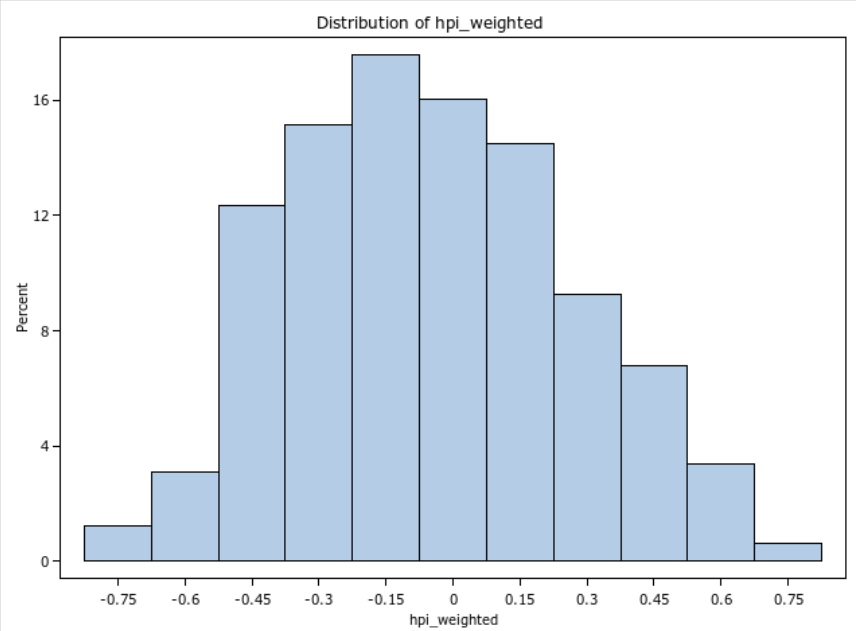
Healthy Places Index Data Sources

- Criteria for including indicators:
  - Data are publicly available
  - Evidence from the scientific literature linking the indicator to health
  - Actionability through policy, systems, and environmental change
- Limitations
  - Age of information use to develop HPI (2011- 2015), won't reflect recent demographic shifts
  - Assumes census tracts codes from which a hospital's Medicare population resides are representative of its all payer population
  - Identifies the social need of population in census tract from which patient resides. Does not directly identify patient's social need
  - Alternative indices of social need (e.g. CDC Social Vulnerability Index) may have advantages/disadvantages
  - Does not incorporate clinical risk

Distribution of Hospital HPI - Statewide

Includes all hospitals reported on CalHospitalCompare

Lower HPI Quartile = higher social risk

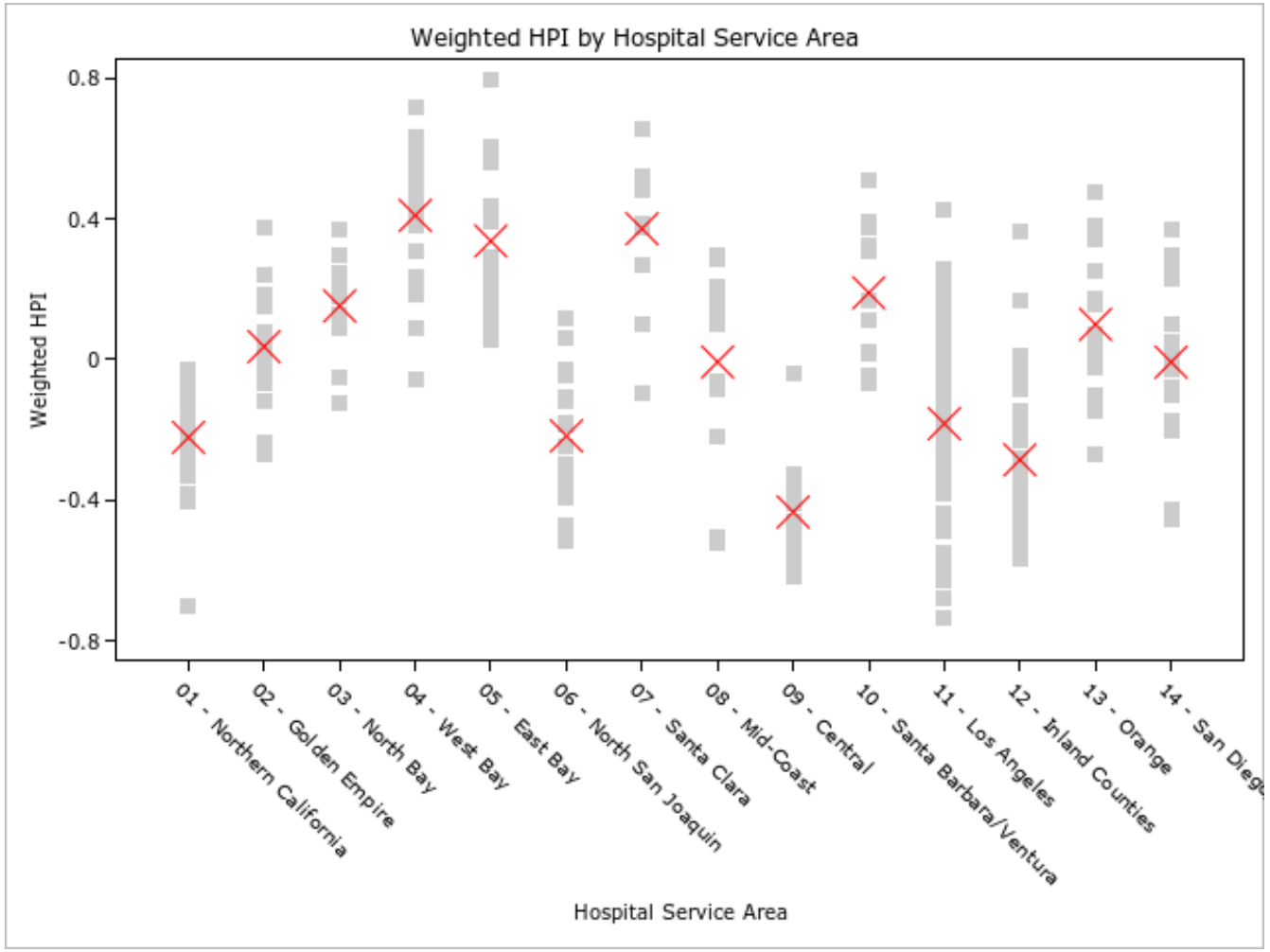


HPI centers around 0.0

N	Mean	Std Dev	Minimum	p10	Q1	50th Pctl	Q3	p90	Maximum
324	-0.05	0.31	-0.73	-0.46	-0.28	-0.07	0.17	0.38	0.80

HPI Quartile	N	Mean	Std Dev	Minimum	p10	Q1	50th Pctl	Q3	p90	Maximum
1	81	-0.44	0.11	-0.73	-0.58	-0.51	-0.44	-0.35	-0.32	-0.28
2	81	-0.17	0.06	-0.28	-0.25	-0.23	-0.17	-0.11	-0.09	-0.07
3	81	0.05	0.08	-0.07	-0.05	-0.02	0.04	0.11	0.16	0.17
4	81	0.37	0.15	0.17	0.19	0.25	0.34	0.47	0.60	0.80

Variation in HPI Across and Within HSA Geographic Regions



Grey squares show general number of hospitals in HSA
"X" is the average hospital-level HPI in the HSA

Substantial variation in average HPI across HSA regions

Also, substantial variation in hospital-level HPI within HSA – hospitals within regions can serve very different populations

Correlation Between HPI and Measure Rates

Measure	Correlation	P-Value	N
Breast Feeding	0.57	<.0001	214
VBAC Rate	0.17	0.04	153
Sepsis Management	0.15	0.01	286
HAI: SSI - Colon	0.14	0.04	203
HAI: SSI - Hysterectomy	0.14	0.22	78
Certified Nurse Midwife	0.12	0.07	218
HAI: C. Difficile	0.02	0.69	296
HAI: CAUTI	0.02	0.75	257
HAI: CLABSI	0.01	0.83	239
NTSV C-Section	-0.02	0.72	218
COPD Readmission	-0.05	0.38	265
Pneumonia Mortality	-0.06	0.34	289
COPD Mortality	-0.08	0.18	265
Heart Failure Mortality	-0.09	0.14	274
AMI Mortality	-0.13	0.08	196
Stroke Readmission	-0.13	0.05	229
HAI: MRSA	-0.15	0.03	204
Pneumonia Readmission	-0.16	0.01	287
Hip/Knee Readmission	-0.18	0.01	205
Episiotomy	-0.19	0.00	218
AMI Mortality	-0.20	0.00	206
Hospital-Wide Readmission	-0.34	<.0001	319
Heart Failure Readmission	-0.36	<.0001	277

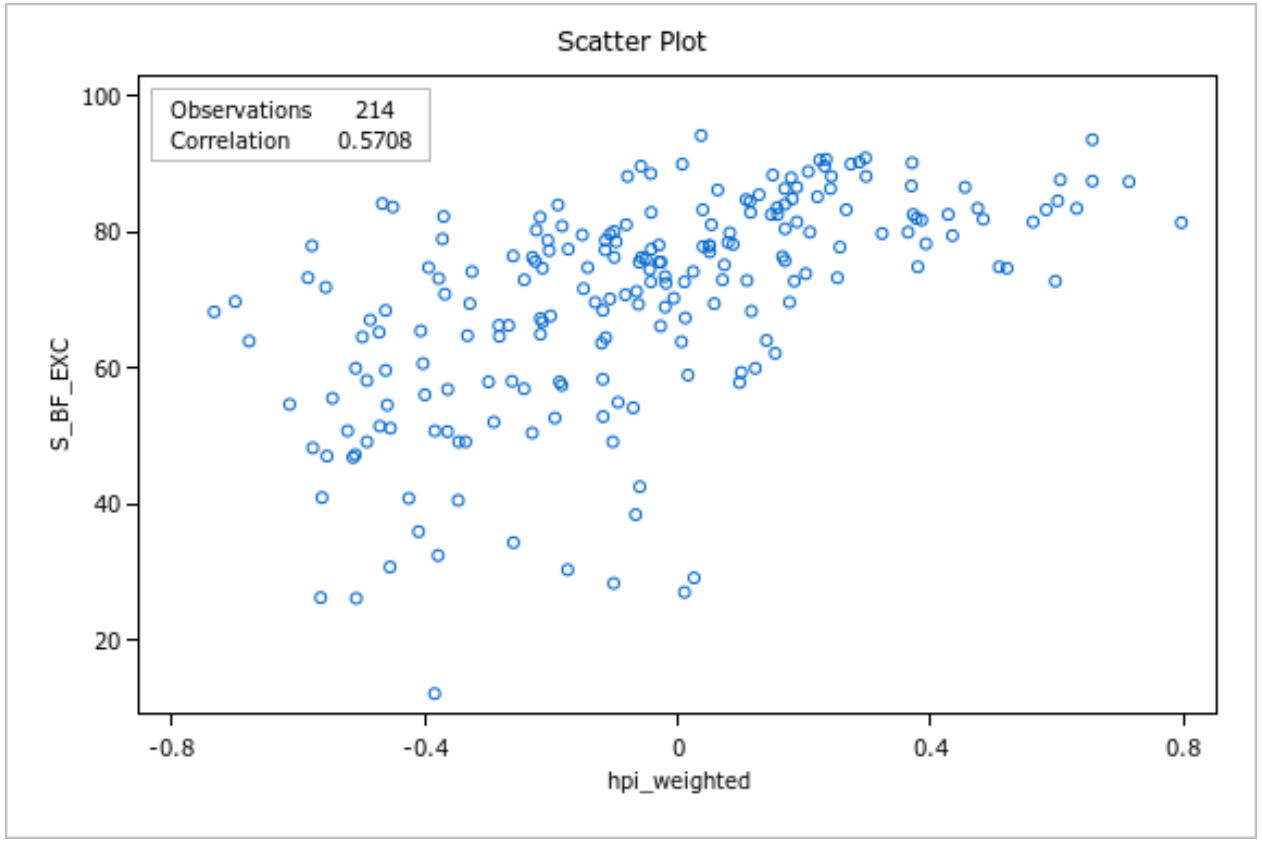
In Yellow: measures whose performance is most correlated with HPI

For all 4 measures, higher HPI (i.e., lower social risk) associated with better performance

In Green: measures whose performance is least correlated with HPI

Social risk does not appear to be associated with hospital performance on these measures

Breastfeeding, Rate by HPI Scatter Plot

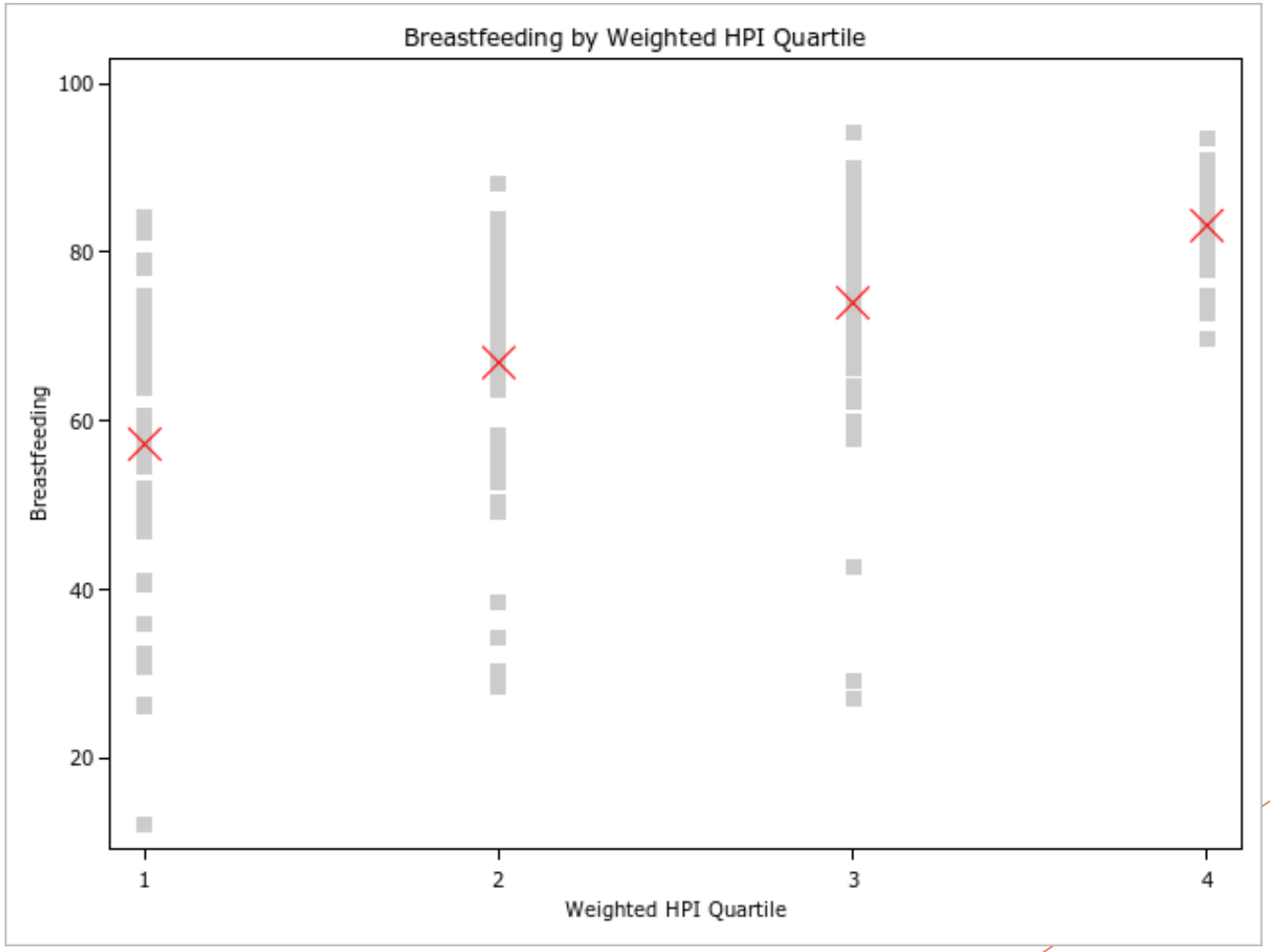


High positive correlation at -0.5708

Lower HPI indicates higher social risk

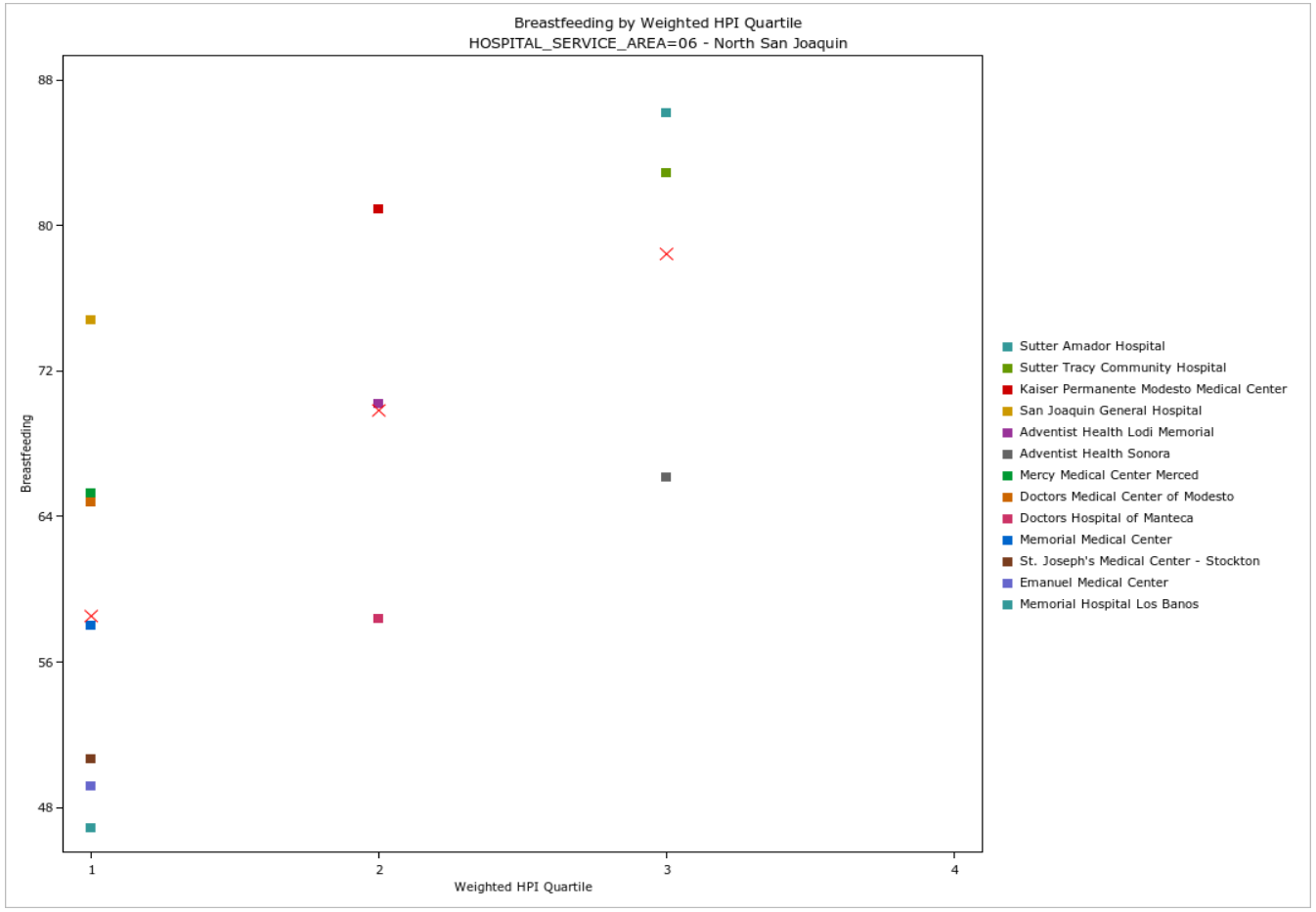
…Breastfeeding, Variation in HPI, California-wide

Less variation in fourth quartile compared to other measures



X = average hospital HPI

…Breastfeeding, Variation by HPI Quartile within North San Joaquin HSA



Consistent performance improvement across HPI quartiles

No hospitals in fourth quartile

X = average hospital HPI

Legend ordered from highest to lowest rate

…Breastfeeding Rate for Hospitals with Lowest and Highest HPI

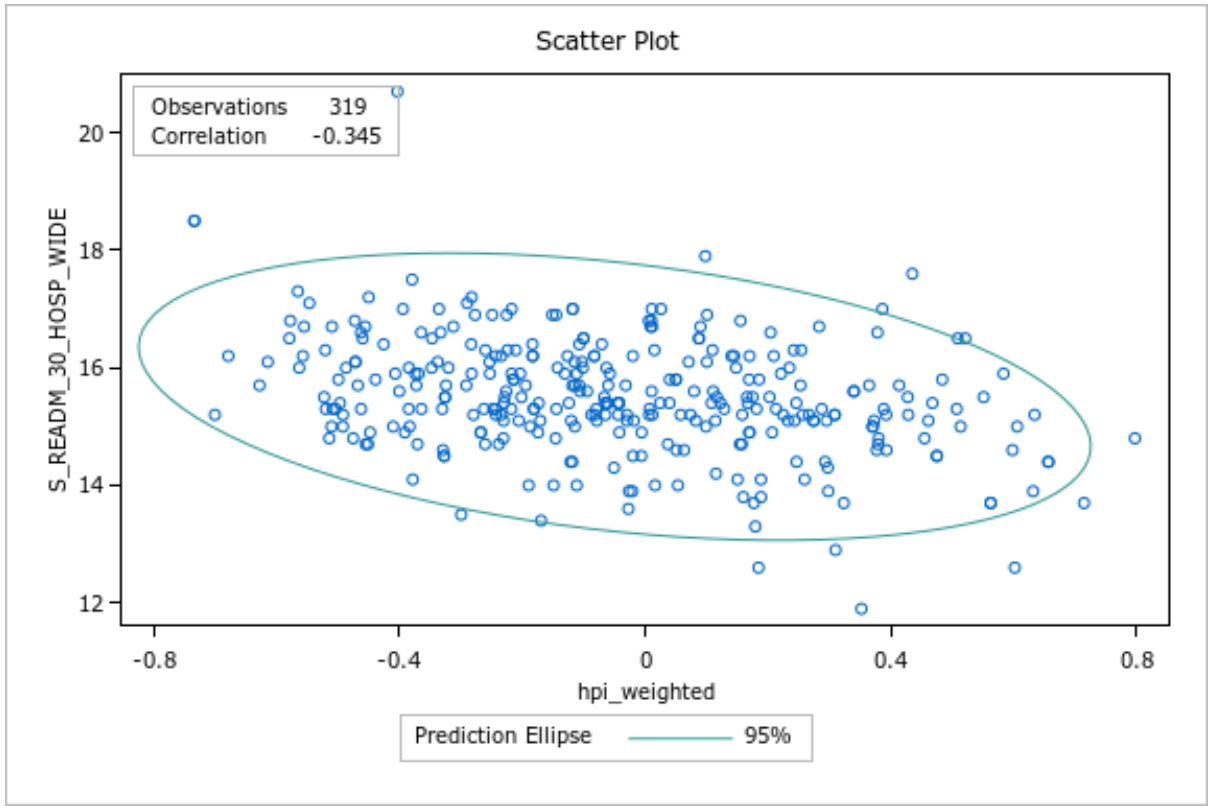
	Hospital Name	Low Hospital HPI	HOSPITAL_SERVICE_AREA	Breastfeeding
1	Martin Luther King, Jr. Community Hospital	-0.73	11 - Los Angeles	68.3
2	College Medical Center	-0.73	11 - Los Angeles	
3	Adventist Health Clear Lake	-0.70	01 - Northern California	69.8
4	California Hospital Medical Center	-0.68	11 - Los Angeles	64.0
5	Community and Mission Hospital of Huntington Park - Slauson	-0.63	11 - Los Angeles	
6	Delano Regional Medical Center	-0.61	09 - Central	54.7
7	Community Regional Medical Center	-0.58	09 - Central	78.0
8	St. Francis Medical Center	-0.58	11 - Los Angeles	48.3
9	Hemet Valley Medical Center	-0.56	12 - Inland Counties	26.3
10	East Los Angeles Doctors Hospital	-0.56	11 - Los Angeles	41.0

Hospitals with high HPI in Bay Area

	Hospital Name	High Hospital HPI	HOSPITAL_SERVICE_AREA	Breastfeeding
1	San Ramon Regional Medical Center	0.80	05 - East Bay	81.4
2	Marin General Hospital	0.71	04 - West Bay	87.4
3	El Camino Hospital	0.66	07 - Santa Clara	87.5
4	El Camino Hospital Los Gatos	0.66	07 - Santa Clara	93.6
5	Kaiser Permanente San Rafael Medical Center	0.63	04 - West Bay	
6	Sequoia Hospital	0.63	04 - West Bay	83.5
7	Kaiser Permanente Walnut Creek Medical Center	0.61	05 - East Bay	87.7
8	Mills-Peninsula Medical Center	0.60	04 - West Bay	84.6
9	John Muir Medical Center - Walnut Creek Campus	0.60	05 - East Bay	72.8
10	Kaiser Permanente Redwood City Medical Center	0.58	04 - West Bay	83.3

Lower HPI = higher social risk

Hospital-Wide Readmissions, Rate by HPI Scatter Plot



Relatively high, negative correlation at -0.345

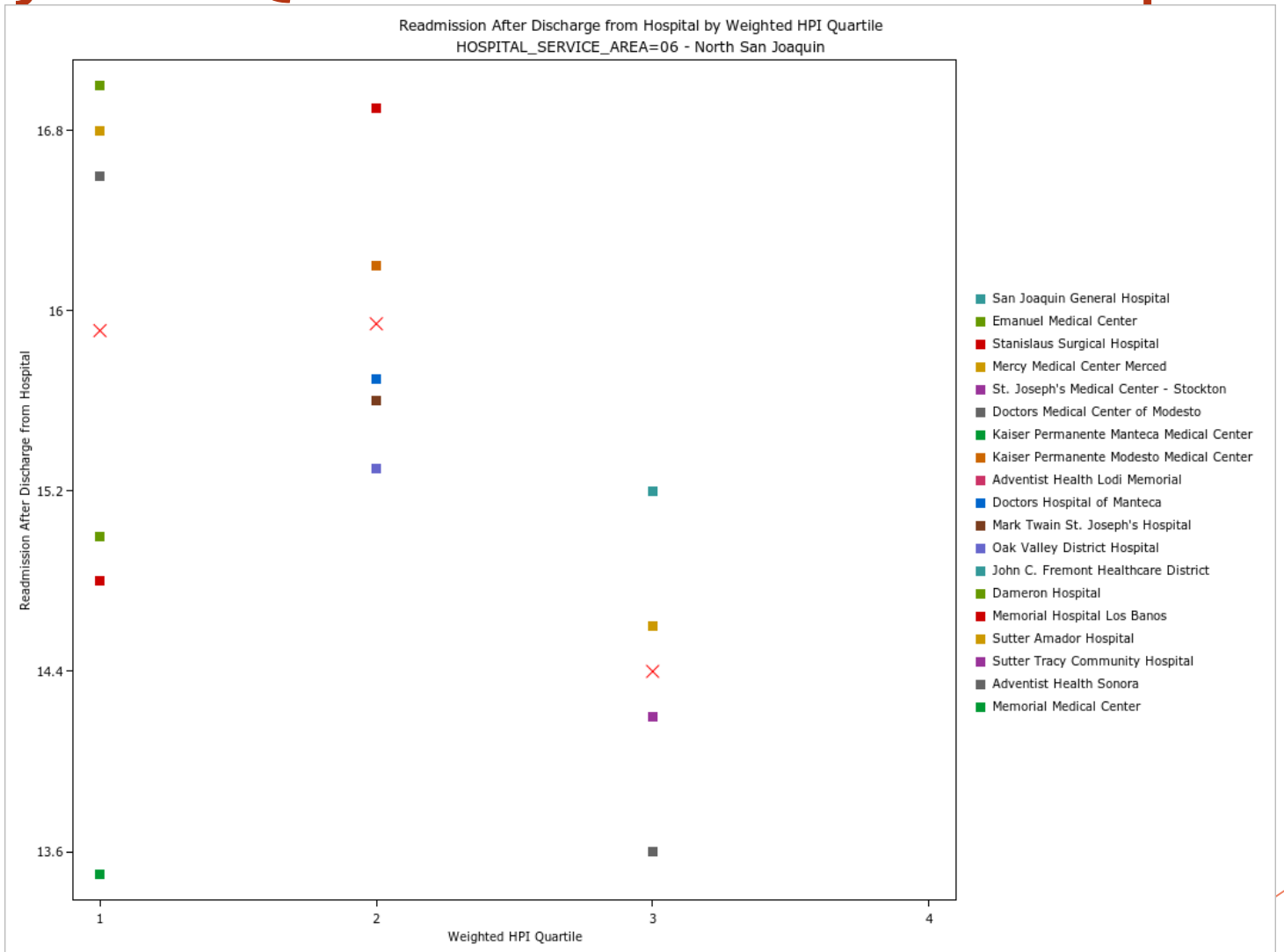
Lower HPI indicates higher social risk

…Hospital-Wide Readmissions, Variation by HPI Quartile, California-wide

Wide variation within HPI Quartiles

X = average hospital HPI

…Hospital-Wide Readmissions, Variation by HPI Quartile within San Joaquin HSA



No hospital in fourth quartile of HPI in San Joaquin

Hospitals in third quartile perform substantially better than first two quartiles

X = average hospital HPI

Legend ordered from highest to lowest rate

…Hospital-Wide Readmissions Rate for Hospitals with Lowest and Highest HPI

	Hospital Name	Low Hospital HPI	HOSPITAL_SERVICE_AREA	Hospital-Wide Readmissions
1	Martin Luther King, Jr. Community Hospital	-0.73	11 - Los Angeles	18.5
2	College Medical Center	-0.73	11 - Los Angeles	18.5
3	Adventist Health Clear Lake	-0.70	01 - Northern California	15.2
4	California Hospital Medical Center	-0.68	11 - Los Angeles	16.2
5	Community and Mission Hospital of Huntington Park - Slauson	-0.63	11 - Los Angeles	15.7
6	Delano Regional Medical Center	-0.61	09 - Central	16.1
7	Community Regional Medical Center	-0.58	09 - Central	16.5
8	St. Francis Medical Center	-0.58	11 - Los Angeles	16.8
9	Hemet Valley Medical Center	-0.56	12 - Inland Counties	17.3
10	East Los Angeles Doctors Hospital	-0.56	11 - Los Angeles	16.0

	Hospital Name	High Hospital HPI	HOSPITAL_SERVICE_AREA	Hospital-Wide Readmissions
1	San Ramon Regional Medical Center	0.80	05 - East Bay	14.8
2	Marin General Hospital	0.71	04 - West Bay	13.7
3	El Camino Hospital	0.66	07 - Santa Clara	14.4
4	El Camino Hospital Los Gatos	0.66	07 - Santa Clara	14.4
5	Kaiser Permanente San Rafael Medical Center	0.63	04 - West Bay	15.2
6	Sequoia Hospital	0.63	04 - West Bay	13.9
7	Kaiser Permanente Walnut Creek Medical Center	0.61	05 - East Bay	15.0
8	Mills-Peninsula Medical Center	0.60	04 - West Bay	12.6
9	John Muir Medical Center - Walnut Creek Campus	0.60	05 - East Bay	14.6
10	Kaiser Permanente Redwood City Medical Center	0.58	04 - West Bay	15.9

Lower HPI = higher social risk

VBAC Availability by HPI Quartile

Maternity hospitals with highest social risk provide less access to VBAC

HPI Quartile	Total Number of Hospitals	Number of Maternity Hospitals	Number of Hospitals with VBAC Available	Percent of Maternity Hospitals with VBAC Available
1	81	55	33	60%
2	81	49	38	78%
3	81	61	41	67%
4	81	49	40	82%

Lower HPI = higher social risk

Next Steps – HPI Analysis

- Overall: develop approach for evaluating/validating use of HPI to assess social risk of California hospitals
- Compare methodology to other approaches: CDC Social Vulnerability Index, Area Deprivation Index and others
- Examine relationship between HPI and other hospital characteristics
  - Payer mix, race/ethnicity, DSH
  - Others: e.g., margin, size etc.
- OSHPD: Request data to construct hospital-level-HPI using All Payer data (rather than just Medicare)
- Examine HPI correlation with other CalHospitalCompare-reported measures
- Assess correlation of components of HPI with measure rates to determine which might have most influence on variation in measure rates
- Examine characteristics of hospitals with high social risk but relatively high performance – best practices
- Others?

Re-establishing the CQC Website:

Informing Consumers About Nursing Home Quality

Deb Bakerjian, PhD, APRN

Patrick Romano, MD, MPH

August 4, 2021 CHC Board Meeting

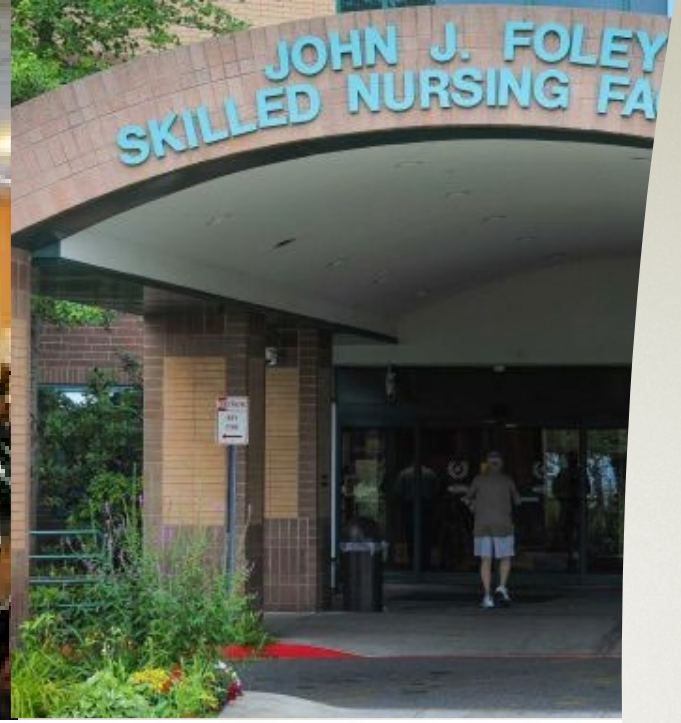
UCDAVIS
Center for Healthcare
Policy and Research

CQC August Board Meeting Goals

1. Present level setting information about nursing homes
2. Review CQC legacy website measures
3. Obtain Board feedback and answer clarifying (not evaluative) questions
4. Introduce potential framework for evaluating measures

Agenda

- Introduction
  - Define Nursing Homes
  - Why Relaunch the CQC Website?
  - Goal of Public Reporting
  - Big Questions
- Describe Legacy CQC Website
  - Legacy CQC Nursing Home Quality Measures
  - Current CMS Care Compare Measures
  - Measurement Gaps in Legacy Site
  - Next Steps for Environmental Scan
- Development of Decision Making Framework



What Are Skilled Nursing Homes?

- NHs offer post-acute and long term care services
- Less structured than hospital
- Provides care to those who can't care for themselves but need skilled nursing
- Offer various health services, social and recreational activities

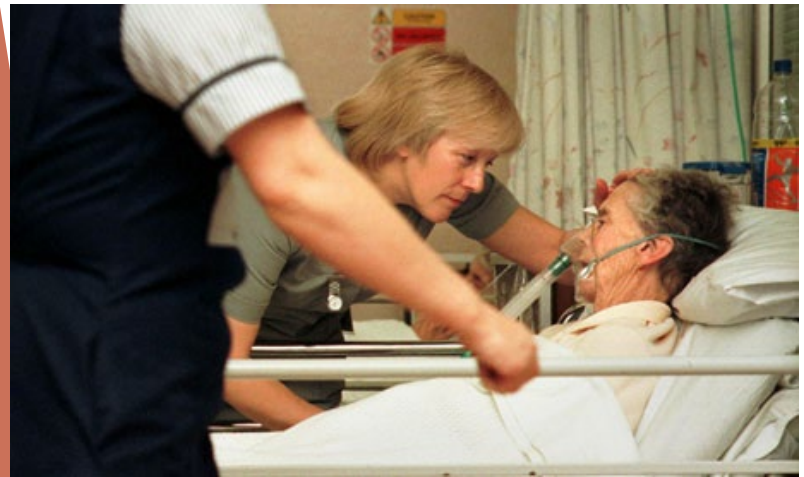
Terminology

- Nursing Homes (AKA - Nursing Facilities)
  - Skilled nursing facility (SNF)
    - Post-acute care (PAC) - short stay after hospitalization
    - Long term care (LTC) - long stay, custodial care
- Other long term care organizations
  - Assisted Living
  - CCRC – Continuing Care Retirement Centers
  - Dementia/Alzheimer's care centers
  - RCFE - residential care facility for the elderly
  - Adult Day Care

Differences Between Short and Long Stays

Post-Acute Care

- Short-stay, rehabilitation-focused
- 3-day qualifying stay for Medicare
- Level of care determined by patient driven payment model (PDPM)
- Payers - Medicare Part A for SNF or Managed Care Insurers



Long Term Care

- Long term care necessary due to functional, cognitive, and/or physical impairment
- No hospital requirement
- Level of care determined to be custodial
- Private pay, LTC Insurance or Medicaid

Differences in PAC and LTC Goals

Post-Acute Care Goals

- Stabilize acute exacerbation of chronic disease and return patient to baseline function
- Rehabilitate after surgery
- Prepare patient to be discharged home
- Ensure patient has safety awareness
- Coordinate with home health and/or family caregiver

Long Term Care Goals

- Prepare patient to consider the NH “home”
- Provide safe environment
- Maintain the highest level of function
- Coordinate with caregiver and/or family

SNF Staffing

- CMS 2001 study: 4.1 hprd (RN staffing of 0.75 hprd/ CNA staffing of 2.8 hprd)
- Current Federal requirements – no minimum hours
  - RN must be present at least 8 hrs daily, 7 days/wk
  - Licensed nurse (LVN or RN) must be on duty 24 hrs, 7 days/wk
  - CNAs – no federal requirement
- Current CA requirements
  - 3.5 HPRD
  - Some waivers are allowed
- Specific CNA training:
  - CMS requires 75 hrs of training to qualify for certification test
  - CA requires 120 hrs for CNA training
  - Currently – there is a waiver in place for CNA training extending time nursing assistants can work without finishing training

Motivation for CQC Website

- California aging population projections:
  - 2030-10.8M aged 65+ years
  - Projected to be 25% of CA population
- Individuals 85 years and older are the fastest growing segment of the population
- California public policy focus on aging
  - Governor’s Master Plan for Aging
  - Governor’s Task Force on Alzheimer's Prevention, Preparedness and Path Forward
- COVID-19: Increased emphasis on safety

Goal of Public Reporting in California

- Prime audience – consumers (families)
  - Requires consumer-friendly presentation
- To monitor the quality of care provided by LTC providers to inform:
  - Consumer decision making in selection of nursing homes
  - Nursing homes (for quality improvement & accountability)
  - Other stakeholders, including policymakers and regulators, health plans, hospitals (for patient referrals), consumer advocates, and other organizations in developing/refining policy

The Big Questions

- How should the CQC site differ from CMS Nursing Home Compare and CDPH Cal Health Find?
  - https://www.medicare.gov/care-compare/
  - https://www.cdph.ca.gov/programs/chcq/lcp/calhealthfind/pages/home.aspx
- What should CQC offer to provide added value?

Legacy CQC Nursing Home Quality Measures

Summary of Legacy CQC Website Measures

Five measure domains

1. Overview* (15 measures)
2. Staffing* (12 measures)
3. Quality of Facility* (33 measures)
4. Quality of Care* (18 measures)
5. Cost and Finances (10 measures)

*these domains include a composite rating

CQC "Overview" Domain

- **Summary**
  - Overall CalQuality Compare Rating (composite)
  - US Gov't Rating
  - US Gov't Watch List
  - Accreditation
  - Campaign for Excellence*
- **Facility Characteristics**
  - Facility Type
  - Payments Accepted
  - # of Beds
  - Type of Care Available
  - **Occupancy Rate**
- **Residents**
  - Age
  - Gender
  - Race and Ethnicity
  - Need for Assistance
  - Special Care Needs

*Dark red font indicates topics for discussion.
*Campaign for Excellence metric no longer available.

What gets a nursing home on the national watch list?

- **Actual Harm:** The facility caused serious harm or injury, impairment or in the worst case, death of a resident. – found by State investigators in published inspections
- **History of Actual Harm:** History of at least 5 actual harm findings
- **Special Focus Facility:** History of serious quality issues – as determined by CMS
- **Unsafe Staffing:** Staffing levels consistently below those levels necessary to avoid patient harm and ensure delivery of care – as determined by CMS, NASEM, and ANA
- **Worst Ratings:** The facility repeatedly received the worst possible rating for one or more of the following– as determined by CMS:
  - Overall Rating
  - Health Inspection Rating
  - Quality Rating
  - Staffing Rating
  - RN Staffing Rating

CQC Staffing Domain

- **CalQualityCompare Staff Rating (composite)**
- **Medicare Days of Care**
- **Nursing Staff Turnover**
- **Nursing Hours per Resident Day (HPRD)**
  - Supervisors and Registered Nurses (RN)
  - Licensed Vocational/Practical Nurses (LVN/LPN)
  - Certified Nursing Assistants (CNAs)
  - Total
- **Physical Therapist Hours per Resident Day**
- **Nursing Wages per Hour**
- **Benefits per Hour** (All Employees)

CQC Quality of Facility Domain

- **CalQualityCompare Facility Rating (composite)**
- **Deficiencies and Citations**
  - Quality of Care
  - Mistreatment
  - Resident Assessment
  - Resident Rights
  - Environment
  - Nutrition
  - Pharmacy
  - Administration
  - Life Safety
  - Total
- **Deficiency Severity**
  - Death or Serious Injury
  - Actual Harm
  - Minimal Discomfort
  - No Harm, with the Potential for Minimal Harm
- **Deficiency Scope**
  - Widespread
  - Pattern
  - Isolated
- **Federal Penalties and Fines**
  - Total Federal Fines
  - Denials of Payment for New Admission
- **Complaints**
  - Quality of Care
  - Staffing
  - Mistreatment
  - Resident Rights
  - Environment
  - Nutrition
  - Administration
  - Total
- **State Violations and Fines**
  - Resident Death
  - Resident Danger
  - Resident Care
  - Staffing
  - Improper Disclosure
  - Total State Fines

CQC Quality of Care Domain (CMS MIDS Measures)

- **CalQualityCare Rating (composite)**
- **Long-Stay Residents**
  - Activities of Daily Living Worsened
  - Ability to Move Independently Worsened
  - High-Risk Residents with Pressure Sores
  - Use of Catheters
  - Use of Restraints
  - Urinary Tract Infections
  - Moderate to Severe Pain
  - One or More Falls with Injury
  - Antipsychotic Use
  - Antianxiety or Hypnotic Medication Use
- **Short Stay Residents**
  - Pressure Sores
  - Moderate to Severe Pain
  - Improvements in Function
  - Emergency Department Visit
  - Rehospitalized After Nursing Home Admission
  - Successful Discharge
  - Antipsychotic Use

Current CMS QMs - Short Stay

- **Short Stay**
  - % rehospitalized
  - % with outpatient ED visit
  - % getting antipsychotic for 1st time
  - % with new or worsened pressure injuries
  - % improved in mobility
  - % who needed & got flu shot in current flu season
  - % who needed & got pneumovax

- **QRP Reporting**
  - % whose medications were reviewed and who received follow-up care when medication issues identified
  - % who experience one or more falls with major injury during their SNF stay
  - % whose functional abilities were assessed & functional goals in their treatment plan
  - % who are at or above an expected ability to care for themselves at discharge
  - % who are at or above an expected ability to move around at discharge
  - Change in residents' ability to care for themselves
  - Change in residents' ability to move around
  - Rate of successful return to home and community from a SNF
  - Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF
  - Medicare Spending Per Beneficiary (MSPB) for residents in SNFs

Current CMS QMs - Long Stay

- **Long Stay**
  - # hospitalizations per 1,000 long-stay resident days
  - # outpatient emergency department visits per 1,000 long-stay resident days
  - % who got an antipsychotic
  - % experience fall with major injury
  - % with new or worsened pressure injuries
  - % with UTI
  - % who had catheter inserted & left in place
  - % who need increased help with ADLs
  - % who needed & got flu shot in current flu season
  - % who needed & got pneumovax
- **QRP Reporting**
  - % who were physically restrained
  - % who lose control of bowel or bladder
  - % who lose too much weight
  - % who have symptoms of depression
  - % who received antianxiety or hypnotic meds

Cost and Finances

- Average Total Expenditures per Resident Day
- Expenditures as a Percent of Revenues
- Direct Care
- Other Care
- Administrative Services
- Capital Expenses
- Average Charges per Resident Day
- Resident Care Days by Payments Source
- Net Operating Income or Loss
- Operating Margin

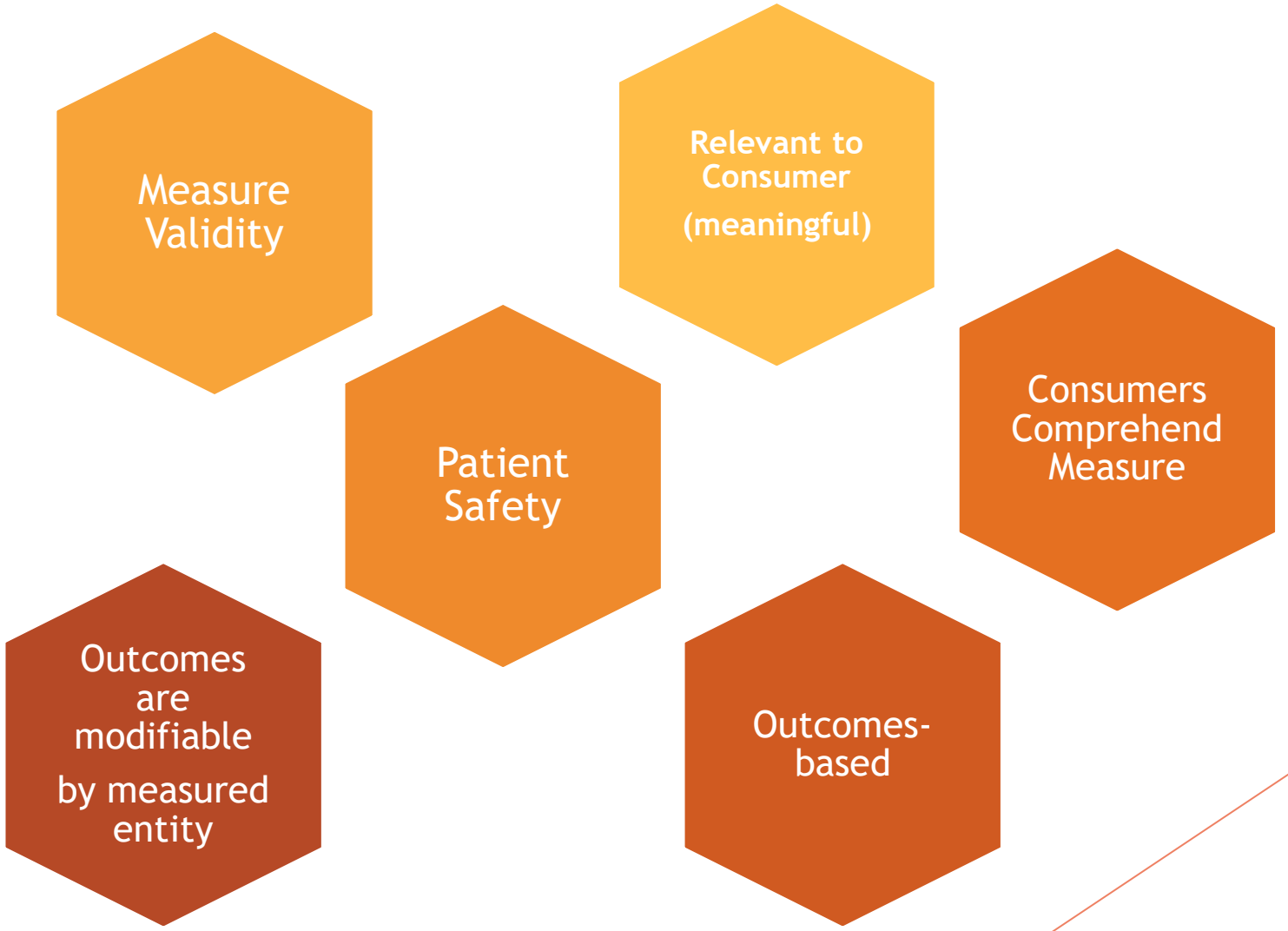
Potential Future Measures

- Rates of COVID-19 infection and mortality
- # of days out of compliance with federal staffing requirement
- Special focus facilities
- Facilities with Corporate Integrity Agreements

Development of Decision Making Framework

Next Steps

Key Factors to Consider in Selecting Measures



UCD Current Work

- **Creating an updated database**
  - Downloading and cleaning data
  - Looking for duplicate measures
- **Assessing other state sites**
  - New York, Florida, etc.
  - Examine for unique measures/data sets
- **Creating internal work plan and timeline**
  - GOAL: Data measure ready by December 2021

Established Frameworks for Measurement Selection

NQF Measure Framework

CMS “Meaningful Measures” Framework

AHRQ Criteria for Retiring or Excluding Measures

QUESTIONS ?

Timeline & Deliverables

Cal Quality Care Timeline												
Deliverables/ Meetings	**2021**						**2022**					
	JUL	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**
Defined Measure Set	X	X										
Files for bi-annual website update/ distribution					Data refresh file	Go Live					Data refresh file	Go Live
Annual Honor Roll						X						

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

Healthy Places Index

Healthy Places Index Components

- **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)

Data sources

- USEPA: U.S. Environmental Protection Agency
- USDA FARA: U.S. Department of Agriculture Food Access Research Atlas
- ACS: American Community Survey (Census)
- NLCD: National Land Cover Database
- CHAS: Comprehensive Housing Assessment System (HUD)
- ABC: Alcoholic Beverage Commission (state)
- CalEPA: California Environmental Protection Agency
- UC Berkeley
- Virginia Commonwealth University

Generally covering the period 2011 to 2015

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

…Breastfeeding, Analysis by HPI Quartile

Correlation with HPI = 0.5708,
Higher social risk strongly correlated with lower breastfeeding performance

Analysis Variable: Exclusive Breastfeeding										
HPI Quartile	N	Mean	Std Dev	Minimum	p10	Q1	50th Pctl	Q3	p90	Maximum
Overall	218	70.3	15.6	12.2	49.2	60.7	74.4	81.8	86.8	94.2
1	55	57.3	15.5	12.2	36.0	49.2	58.0	68.5	74.8	84.2
2	49	66.9	14.3	28.4	49.2	58.0	70.2	77.5	80.9	88.2
3	61	74.0	12.6	27.1	60.0	69.5	75.8	82.6	86.2	94.2
4	49	83.2	5.8	69.7	73.9	80.0	83.3	87.7	90.3	93.6

Lower HPI Quartile = higher social risk

Median in fourth quartile is 25.3%% higher than first quartile (58.0% to 83.3%)

…Hospital-Wide Readmissions, Analysis by HPI Quartile

Correlation with HPI = -0.345,
Higher social risk correlated with higher hospital-wide readmissions

Analysis Variable: Hospital-Wide Readmissions										
HPI Quartile	N	Mean	Std Dev	Minimum	p10	Q1	50th Pctl	Q3	p90	Maximum
Overall	319	15.5	1.0	11.9	14.4	15.0	15.4	16.1	16.7	20.7
1	79	15.9	1.1	13.5	14.7	15.3	15.9	16.6	17.1	20.7
2	80	15.6	0.8	13.4	14.8	15.2	15.6	16.2	16.7	17.0
3	79	15.5	0.9	13.6	14.2	14.9	15.4	16.0	16.7	17.9
4	81	15.0	1.0	11.9	13.7	14.5	15.1	15.6	16.3	17.6

Lower HPI Quartile = higher social risk

Median in fourth quartile is 0.8% lower than first quartile
Overall interquartile range is 1.1% (15.% to 16.1%)
- difference across quartiles is meaningful