

# Cal Hospital Compare/ Cal Quality Care Board of Directors Meeting

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FRIDAY, OCTOBER 29, 2021

10:00AM PT

# Proposed Agenda

- Welcome and Call to Order
- General Updates
- Cal Hospital Compare
- Cal Quality Care
- Business Plan
- Wrap Up

## Cal Hospital Compare & Cal Quality Care Board of Directors Meeting Agenda

Friday, October 29, 2021, 10:00am 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 - Introductions - Approval of past meeting summary	- <b>Ken Stuart</b> Board Chair - <b>Bruce Spurlock</b> Executive Director, CHC & CQC
10:05-10:10 5 min.	General Updates - Maternity Honor Roll Press Release - Data refresh	- <b>Tracy Fisk</b> Project Manager, CHC
10:10-10:20 10 min.	Cal Hospital Compare - Highlights from Cal Hospital Compare Historical Analysis - Impact of COVID-19	- <b>Mahil Senathirajah</b> Senior Director IBM Watson
10:20-11:40 80 min.	Cal Quality Care - LTAC Feedback - CQC measures - Honor Roll	- <b>Debra Bakerjian</b> Director, UC Davis Health
11:40-11:50 10 min.	Business Plan - Business name change - Financial report - Formative evaluation process	- <b>Bruce Spurlock</b> Executive Director, CHC
11:50-12:00 10 min.	Adjourn - Next meeting: Wednesday, December 1 <sup>st</sup> , 10:00am PT - 2022 Meeting Cadence	- <b>Ken Stuart</b> Board Chair

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## Cal Hospital Compare & Cal Quality Care Board of Directors Meeting Summary

Wednesday, September 29, 2021, 10:00am PT

**Attendees:** Gretchen Alkema Ash Amarnath, Debra Bakerjian, Richele Benevent, Kristen Bettega, Staci Gillespie, Shao-Yu Fang, Terry Hill, Chris Krawczyk, Julia Logan, Dominique Ritley, Patrick Romano, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Ken Stuart, Kevin Worth

### Summary of Discussion:

Agenda Items	Discussion
<b>Welcome &amp; call to order</b>	<ul style="list-style-type: none"> <li>The meeting was called to order at 10:07am.</li> <li>The minutes from the meeting on August 4<sup>th</sup> were moved, motioned, seconded and approved as written.</li> </ul>
<b>Cal Quality Care</b>	<ul style="list-style-type: none"> <li>The UC Davis team provided an overview of the CQC staging website and summarized the five domain discussions.</li> <li>Resident characteristics will be included in the reporting. The LTAC members felt strongly that consumers would search for nursing homes specific to age, gender and/or special needs. There were areas of controversy over how to balance the complexity of presenting all available information vs. focusing on the most relevant data. To assist with this decision making, the TAC proposed integrating an “onion layer” approach where consumers, stakeholders and “super users” can drill down/dive deeper into website content.</li> <li>The LTAC agreed to post staff vaccination rates on the website. It was not recommended to include patient vaccination rates due to the rapid change and timeliness of the data refresh. CQC is exploring with Hyper Arts the option to publish up to date staff vaccination rates through an API/live feed.</li> <li>A challenge from the consumer point of view is that wages are not anchored through regional difference or variations of the characteristics of facility. This information may be misinterpreted by the consumer.</li> <li>UC Davis is recommending holding off on reporting all staffing and cost and finance until variability is better understood. Every measure has an advocate.</li> <li>Case mix for adjustment will be published on the website if data analytics are complete by October.</li> <li>Will advocate a “less is more” approach regarding the content that initially will be posted on the website; accuracy of data being of highest importance. The BOD was supportive of this approach.</li> </ul>
<b>General Updates</b>	<ul style="list-style-type: none"> <li>The COVID stress study in winter surge is on hold until further information is provided by CHCF.</li> <li>CHC is coordinating a joint press release with CHHS announcing the current Maternity Honor Roll. The official press release is slated for late September.</li> </ul>

<b>Cal Hospital Compare Measurement Changes</b>	<ul style="list-style-type: none"> <li>• CMS issued the final rule for fiscal year 2022 on August 2<sup>nd</sup>.</li> <li>• Will bring back additional information to the BOD on COVID vaccination rates among health care professionals.</li> <li>• PSI4 was initially proposed for removal however, a lobbying campaign resulted in preserving this measure.</li> </ul>
<b>Healthy Places Index</b>	<p>Recommended resources from Board discussion:</p> <ul style="list-style-type: none"> <li>• AARP Livability Index <a href="https://livabilityindex.aarp.org/">https://livabilityindex.aarp.org/</a></li> <li>• COVID-19 Mortality At The Neighborhood Level: Racial And Ethnic Inequalities Deepened In Minnesota In 2020: <a href="https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00365">https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00365</a></li> <li>• OSHPD/HCAI has a financial series available on their website (underlying data is available on the Open Data Portal) that gives total amount at state, county and hospital level of charity care and uncompensated care - <a href="https://oshpd.ca.gov/visualizations/hospital-financial-data-interactive-series-hospital-financials/">https://oshpd.ca.gov/visualizations/hospital-financial-data-interactive-series-hospital-financials/</a></li> </ul> <p>Social Need Variation</p> <ul style="list-style-type: none"> <li>• Is it possible to map by geographic region or color code (i.e.. positive/negative) on the social needs index and highlight designated hospital ownership - private vs public hospitals?</li> <li>• What is the community responsibility for these “X” hospitals that overlap, should social determinants of health be addressed collectively?</li> </ul> <p>Hospital Characteristics</p> <ul style="list-style-type: none"> <li>• Recommendation made to perform a deeper dive into hospital ownership (i.e.. being part of an ACO), system size, and urban vs rural.</li> </ul>
<b>Business Plan &amp; Financials</b>	<ul style="list-style-type: none"> <li>• Expenses are on track, updated figures will be presented during the December BOD meeting.</li> </ul>
<b>Next Meeting/Meeting Adjournment</b>	<ul style="list-style-type: none"> <li>• Next meeting: Friday, October 29, 2021, from 10:00am to 12:30pm PST</li> <li>• The BOD will meet quarterly in 2022. Calendar invitations have been sent.</li> <li>• The meeting formally adjourned at 12:03pm PST</li> </ul>

# Introductions

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# General Updates

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# Maternity Honor Roll Announcement

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Press release  
issued on  
October 6th

[Cal Hospital Compare Announces 2021 Maternity  
Honor Roll - California Health and Human Services](#)



## Q3 Data Refresh

Updated Measures (through Sept. 2020)

Source: CMS Hospital Compare

Domain
Hip and Knee
Infections
SSI Colon Surgery
SSI Hysterectomy
Heart Conditions
Lung Conditions
Stroke
Emergency Department (ED) Care
Patient Safety
Re-hospitalizations

# Cal Hospital Compare

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# Summary Analysis Document

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\*Document in Packet: “Analysis of Cal Hospital Compare Historical Performance Data Key Findings to Date.docx”

- Discussion to occur at December 1st Board meeting
- High-level summary of 2021 analytics work performed by Watson Health & Cynosure examining patterns in CHC performance data
- Highlights findings from three focus areas:
  - Maternity
  - Readmissions and Mortality
  - Surgery Volumes
- Examines measure performance by ethnicity and hospital market area for selected measures
- Provides context regarding value in developing a “hospital social needs index”.
  - Previously presented “hospital social needs index” to Board (September)
  - Related work underway; update will be provided at December 1st Board meeting

# Cal Quality Care

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# Agenda

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- Recap measure inclusion/exclusion (Overview and Quality of Care Domains)
- Present LTAC Feedback on Staffing, Quality of Facility and Cost & Finance Domains
- Propose measures for the Nursing Home Honor Roll

# Measures Already Decided Upon: Overview & Quality of Care Short Stay

OVERVIEW DOMAIN	
CMS Composite Rating	% with <b>pressure ulcers/injuries</b> that are new or worsened (admission to discharge)
CMS Special Facility Focus	% who needed & got <b>flu shot</b> in current flu season (inc. Ineligible, declined)
Age	% who needed & got <b>vaccine to prevent pneumonia</b> (inc. Ineligible, declined)
Race and Ethnicity	% whose <b>medications</b> were reviewed and who received follow-up care when medication issues identified
Special Care Needs	% who experience one or more <b>falls w/ major injury</b> during their SNF stay
QUALITY OF CARE DOMAIN	% w/ <b>functional abilities</b> assessed & functional goals were included in their treatment plan
<b>COVID-19 Resident Vaccination</b>	% who are at or above an <b>expected ability to care for themselves</b> at discharge
% with outpatient <b>ED visit within 30 days</b> after NH admission	% who are at or above an expected ability to move around at discharge
% who got <b>antipsychotic</b> for the first time (not on initial assessment)	Change in residents' <b>ability to care for themselves</b> (average adjusted change from admission to discharge)
% who <b>improved</b> (admission to discharge) in their <b>ability to move on their own</b>	Rate of <b>successful return to home and community from a SNF</b> (without any unplanned hospitalizations for 31 days)
% <b>rehospitalized within 30 days</b> after NH admission	% who had <b>potentially preventable hospital readmission w/in 30 days</b> postdischarge from a SNF



# Measures Already Decided Upon: Quality of Care Long Stay

Change in **residents' ability to move around** (average adjusted change from admission to discharge)

Number of **hospitalizations** per 1,000 resident days

Number of **outpatient emergency department visits** per 1,000 resident days

% getting **antipsychotic**

% who experienced **fall** with major injury

% with new or **worsened pressure injuries**

% with **UTI within 30 days** prior to target assessment

% who had **catheter inserted & left in place** at target assessment

% whose **ability to move independently worsened**

% whose need for help with **ADLs** increased between target and prior assessment

% who needed & got **flu shot** in current flu season

% who needed & got **pneumovax**

% who were **physically restrained** on a daily basis

% who frequently or always **lose control of bowel or bladder**

% who **lost too much weight** ( $\geq 5\%$  in the last month, or  $\geq 10\%$  in last 6 months)

% who have **symptoms of depression** in the prior two weeks

% who received **antianxiety or hypnotic meds**

**Staffing:** COVID-19 Staff Vaccination

# Measures Recommended by LTAC: Staffing Domain

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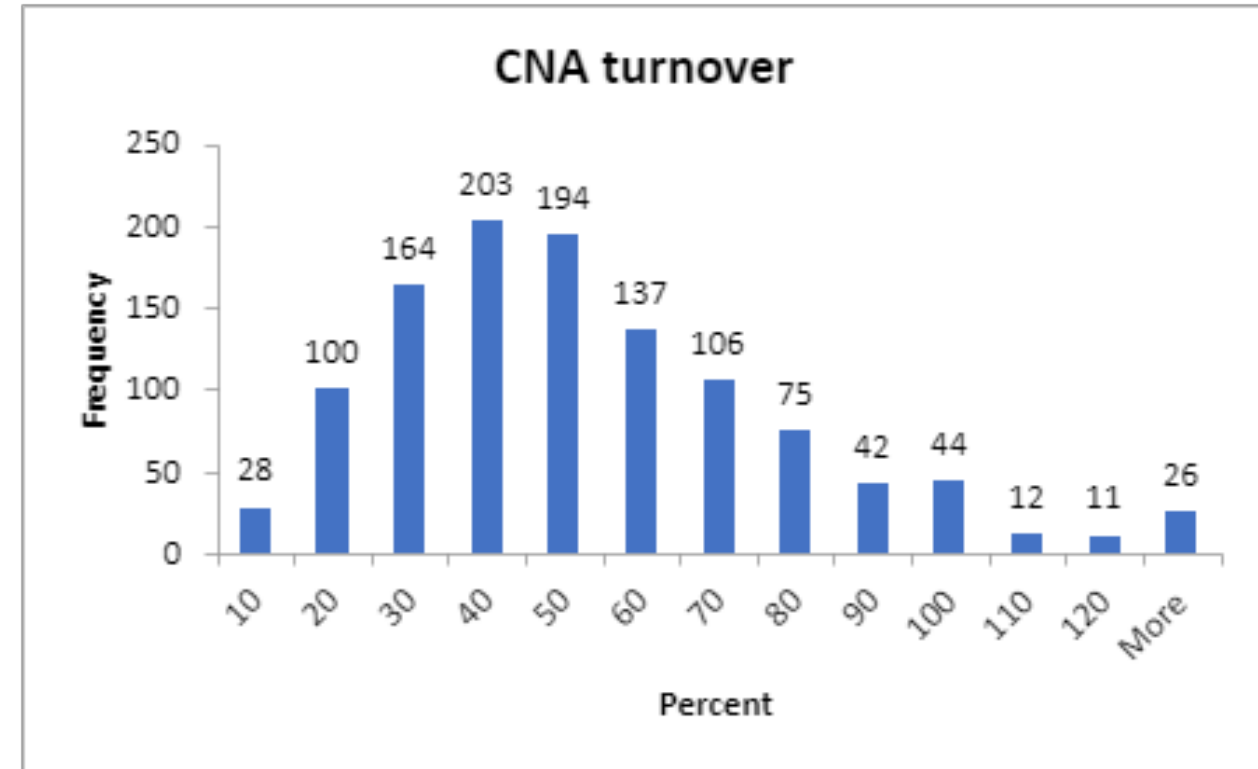
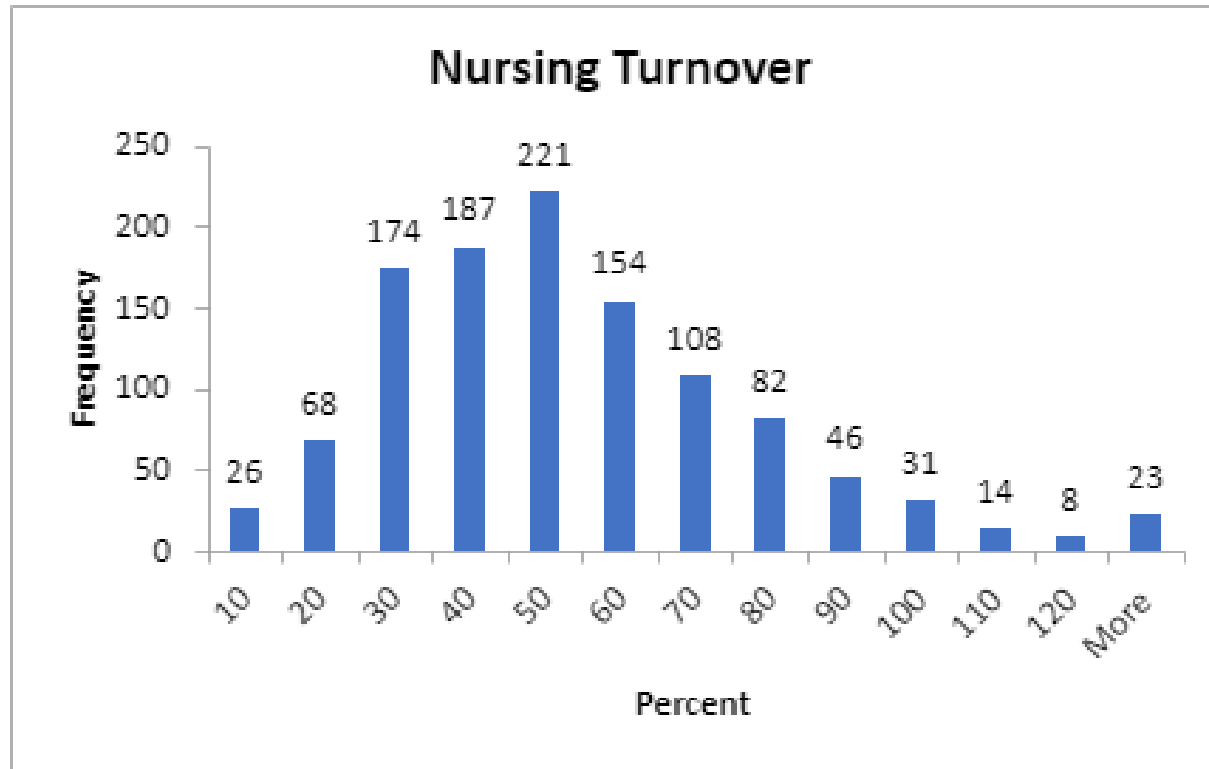
These metrics are unique CA-specific measures; understandable, meaningful, modifiable.

# Staffing Domain: Consent Agenda

Measure	Staff Recommends	Staff Does Not Recommend	Notes
Nursing Staff Turnover (%) (Rates are from 2019)	✓		Percentage of all nurses (no supervisors) who leave the facility during the year prior to the day the facility completed its most recent OSHPD cost report. NHs with low rates of change in nursing staff may provide better quality care than NHs with high turnover rates.
Nursing Hours/Resident Day (Total)	✓		California requires NHs to provide <b>at least 3.5 HPRD (hours per resident day) of direct nursing care</b> . This measure shows the average number of nursing staff hours available for resident care each day including all licensed nurses, nursing assistants, and DONs, including part-time, full time, and temporary employees.
Supervisor/RN	✓		<ul style="list-style-type: none"> <li>• Section 72329, Nursing Service Staff, requires that NHs licensed for 100 or more beds have at least one RN, awake and on duty 24 hours/day, in addition to DON</li> <li>• A charge nurse on each shift, an RN for at least 8 consecutive hours a day, 7 days a week</li> <li>• DON shall not have charge nurse responsibilities.</li> <li>• NHs must ensure that nursing staff have the competency and skills to care for residents</li> </ul>
LVN/LPN	✓		Sufficient numbers of RNs, LVNs/LPNs, and CNAs per 24-hour to provide nursing care to all residents; LVN/LPNs may serve as charge nurses
Certified Nursing Assistants (CNA)	✓		Sufficient numbers of RNs, LVNs/LPNs, and CNAs per 24-hour to provide nursing care to all residents
Physical Therapist HPRD		X	Physical therapy services are beneficial, but most relevant for short-stay patients.
Staff Vaccination Rates	✓		Recent percentage of current healthcare personnel who completed COVID-19 vaccination any time.

# Nursing Staff Turnover Rates

Nursing Turnover		CNA Turnover	
Mean	49.46	Mean	49.43
Median	45.93	Median	44.19
Mode	50	Mode	50
Range	184.79	Range	250.56
Minimum	2.35	Minimum	2.38
Maximum	187.14	Maximum	252.94
Count	1142	Count	1142



# Context for Staffing Measures

California has minimum staffing requirements of 3.5 HPRD (hours per resident day) for MOST nursing homes.

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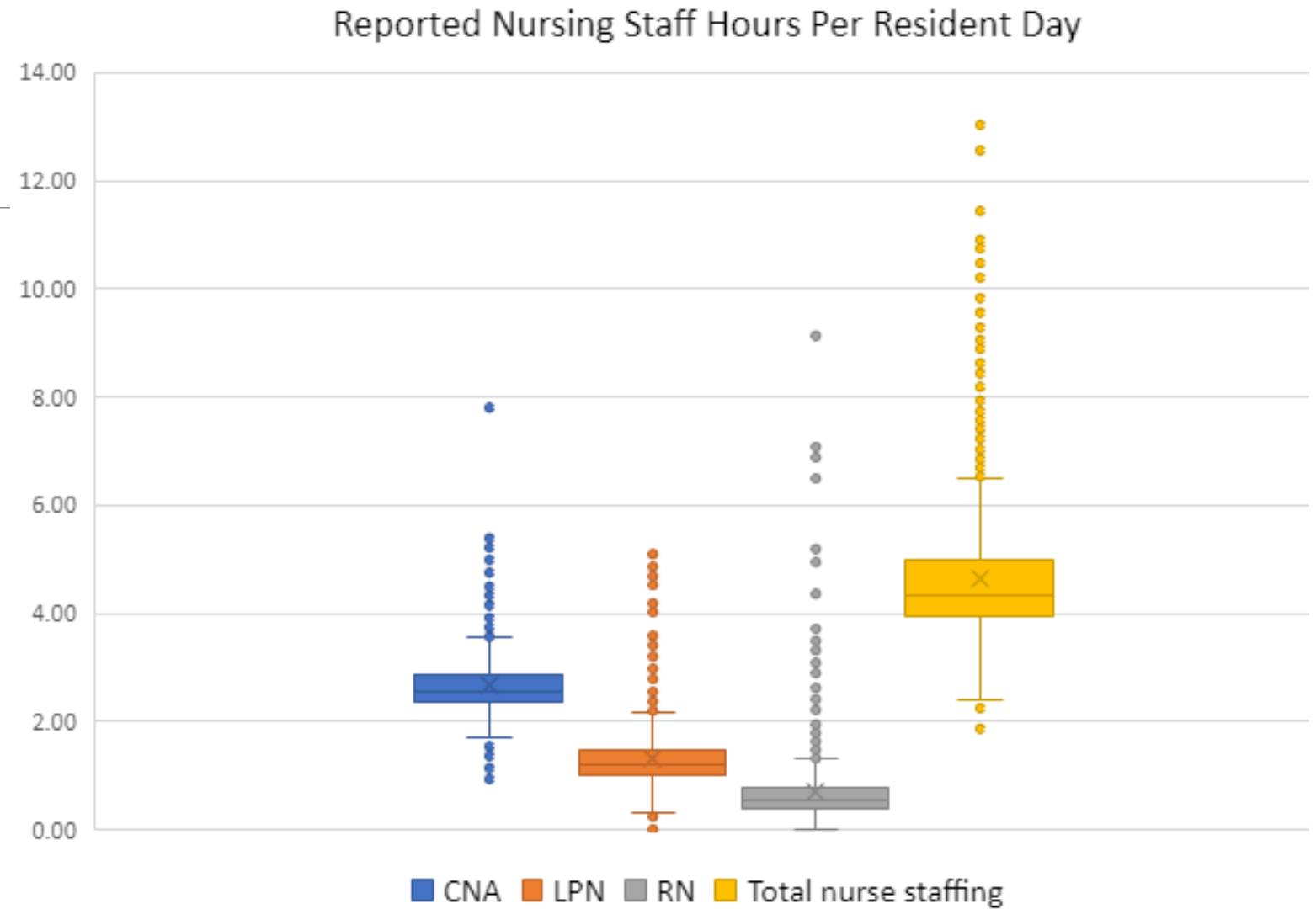
There are additional staffing requirements for Adult and Pediatric Subacute freestanding units AND Distinct Part (DP) nursing homes that are part of a hospital.

Adult subacute units		RN and LVN	CNA
	Free Standing Facility	3.8	2.0
	Distinct Part (Hospital)	4.0	2.0

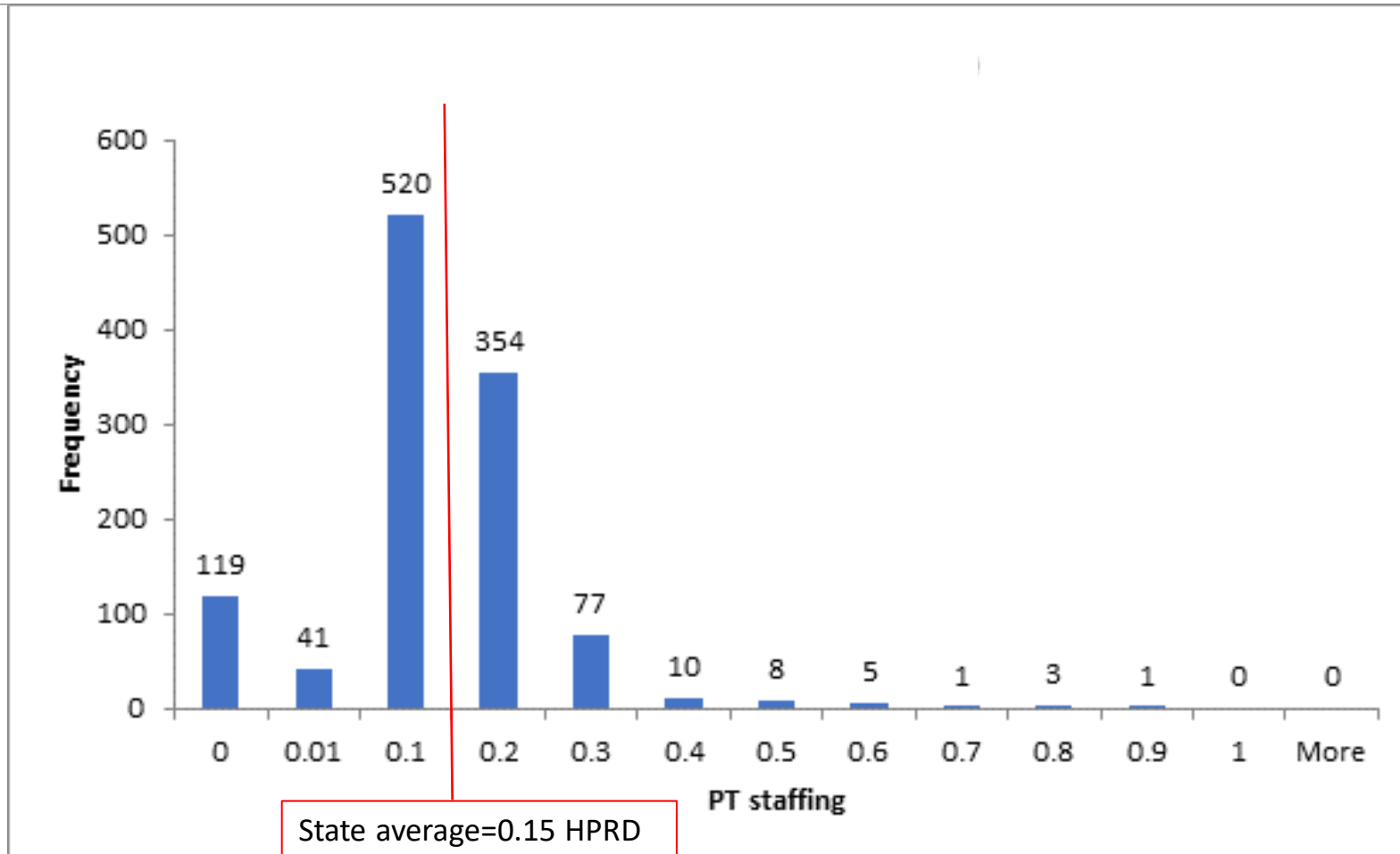
Pediatric subacute units		RN and LVN	CNA	Resp Care Practitioners
	Ventilator	5.0	4.0	3.0*
	Non-ventilator			2.0*

# Staffing HPRD

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# Distribution of Physical Therapist HPRD



# Staffing Domain: Measures for Discussion

Measure	Staff Recommends	Staff Does Not Recommend	Notes
Medicare Days of Care		X	Medicare residents tend to have short, but care-intensive stays (usually following an acute hospital admission) in nursing homes; facilities with <b>high Medicare days</b> (25% or more resident days paid by Medicare) are expected to need more staffing hours to meet the greater care needs of residents.
Nursing Wages/Hour <ul style="list-style-type: none"> <li>• Directors of nursing/supervisors</li> <li>• Licensed Nurses (RN/LVN)</li> <li>• Nursing Assistants</li> </ul>		X	Subject to local labor market characteristics; requires adjustment for comparability. Not validated measure of quality (i.e., wage premium may indicate lower quality).
Benefits/Hour (all employees)		X	Subject to local labor market characteristics; average among all employees; requires adjustment for comparability. Not validated measure of quality.



# Measures Recommended by LTAC: Quality of Facility Domain

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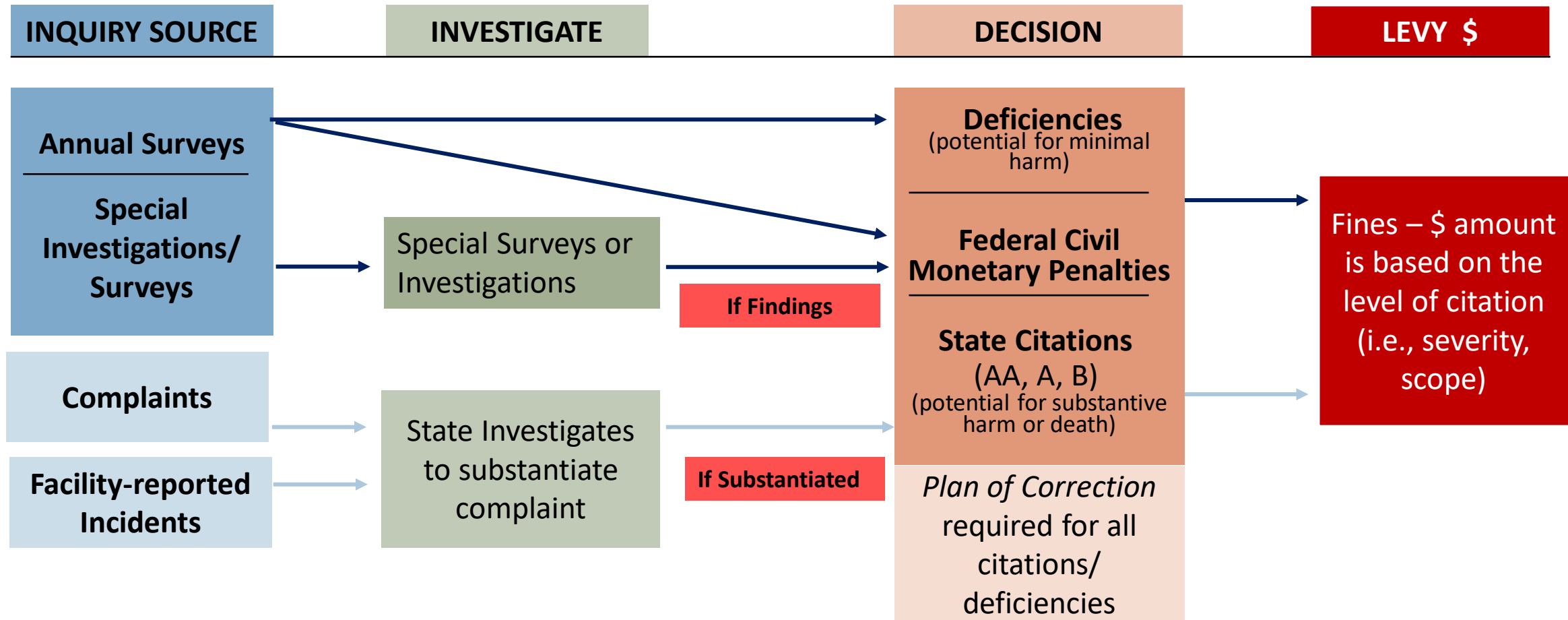
# Quality of Facility: Metrics for Discussion

Measure Deficiencies/Citations:	Staff Recommends	Staff Does Not Recommend	Notes
Quality of Care	✓		Failure to care for medical conditions and nursing needs appropriately and on a timely basis
Abuse [Mistreatment]	✓		Failure to prevent verbal, sexual, physical and mental abuse, the use of physical restraints, corporal punishment, or involuntary seclusion.
Resident Assessment	✓		Failure to properly assess each resident's care needs, and failure to develop, follow, and evaluate a care plan for each resident.
Resident Rights	✓		Failure to respect, recognize, and uphold the rights of residents
Environment	✓		Failure to maintain the resident environment in a manner that protects the health and safety of its residents, personnel, and the public
Nutrition	✓		Failure to meet each resident's nutritional needs and special dietary requirements or to properly prepare, serve, and store meals.

# Quality of Facility: Metrics for Discussion

Measure Deficiencies/Citations:	Staff Recommends	Staff Does Not Recommend	Notes
Pharmacy	✓		Failure to comply with pharmacy procedures for properly dispensing and storing medications. These standards are designed to make sure residents get the right medication at the right time.
Administration	✓		Failure to provide adequate administration and management. By law, a facility must be run in an efficient and effective manner that enables it to use its resources to attain and maintain the highest level of physical, mental and psychosocial well-being for each resident.
Life Safety	✓		Failure to create and maintain a safe environment for residents, and meet state and federal building inspection and fire codes were not met.
Total	✓		Total number of deficiencies/citations

# DEFICIENCIES, CITATIONS, & FINES



# CITATION LEVELS

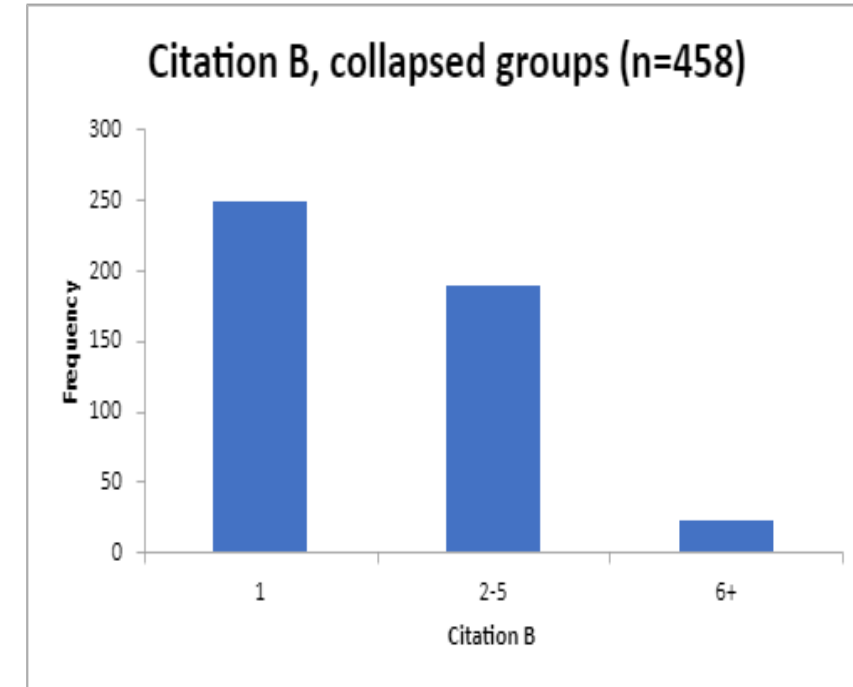
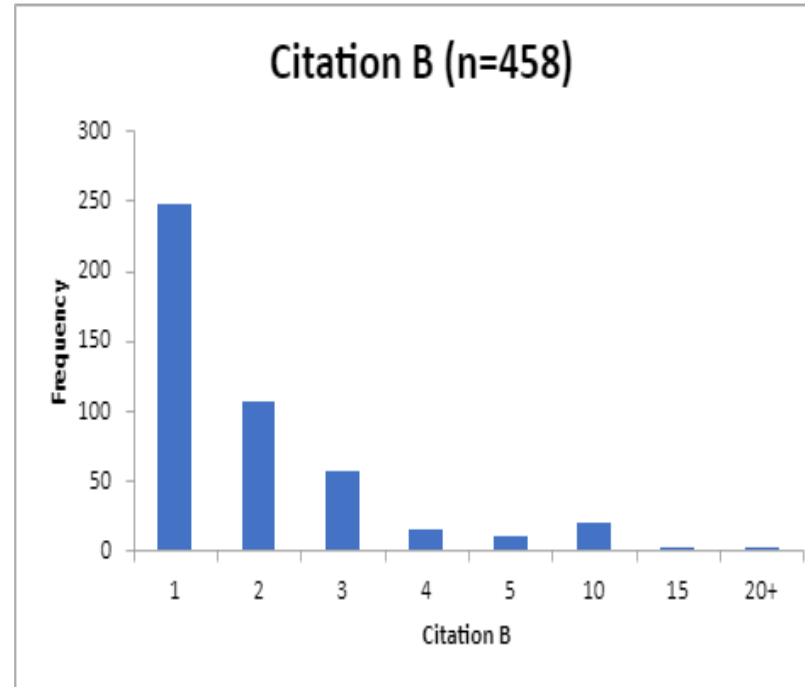
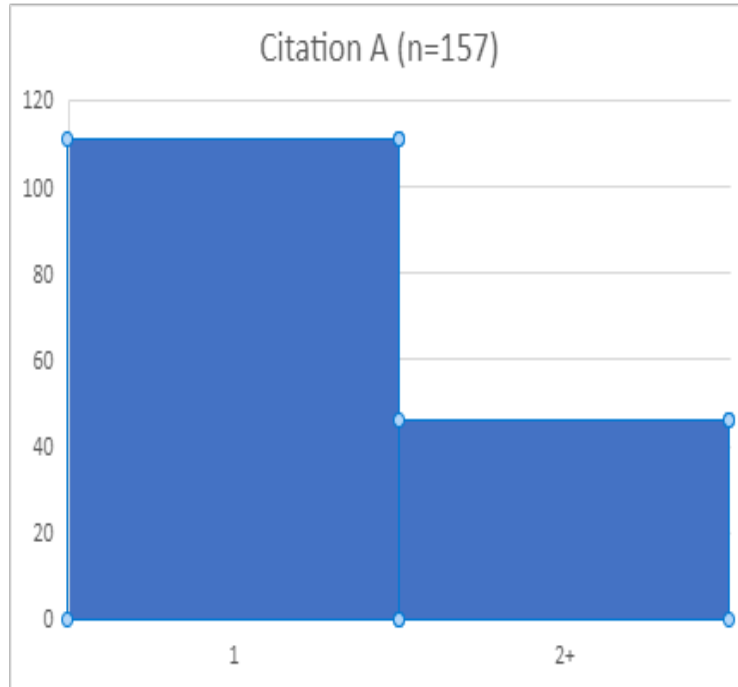
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**Class "B"** . The violation at the time of occurrence has a direct or immediate relationship to patient health, safety or security. This includes emotional and financial elements, or in the case of a patient's rights violation which produces a situation likely to cause significant humiliation, indignity, anxiety or other emotional trauma, but is not serious enough to be a Class "A".

**Class "A"** . The violation at the time of occurrence presents an imminent danger to the patient of the facility or a substantial probability that death or serious physical harm would result therefrom. Examples of "serious physical harm" would be part of the body permanently removed, rendered functionally useless, substantially reduced in capacity temporarily or permanently, and/or part of the internal function of the body inhibited in its normal performance to such a degree as to temporarily or permanently cause a reduction in physical or mental capacity, or to shorten life.

**Class "AA"** . The violation meets the definition of a Class "A" AND was a direct proximate cause of patient harm and/or death resulting from an occurrence the nature of which the regulation violated was designed to prevent.

# Distribution of Citations



**16 facilities had one AA citation each for this reporting period.**


# Quality of Facility: Metrics for Discussion


Measure	Staff Recommends	Staff Does Not Recommend	Notes
<b>Deficiency Severity</b>			<b>These categories add to 100%, which may cause confusion</b>
Death or Serious Injury	✓		Immediate jeopardy or serious harm to resident health and safety, or death occurred
Actual Harm	✓		Actual harm that is not immediate jeopardy
Minimal Discomfort	✓		No actual harm with potential for more than minimal harm that is not immediate jeopardy
No Harm, with the Potential for Minimal Harm	✓		No actual harm with potential for minimal harm
<b>Deficiency Scope</b>			<b>These categories add to 100%, which may cause confusion</b>
Widespread	✓		deficiencies are pervasive in the facility and/or represent systemic failure affecting facility population
Pattern	✓		more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice
Isolated	✓		one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.

# Scope & Severity

<b>Level 4</b> Immediate jeopardy to resident health or safety <b>CMPs Required!</b>	<b>J</b>  POC <b>Category 3 Required</b> Cat. 1 & 2 Optional	<b>K</b>  POC <b>Category 3 Required</b> Cat. 1 & 2 Optional	<b>L</b>  POC <b>Category 3 Required</b> Cat. 1 & 2 Optional
<b>Level 3</b> Actual harm that is not immediate	<b>G</b>  POC <b>Category 2 Required</b> Cat. 1 Optional	<b>H</b>  POC <b>Category 2 Required</b> Cat. 1 Optional	<b>I</b>  POC <b>Category 2 Required</b> Cat. 1 & Temporary Management Optional
<b>Level 2</b> No actual harm with potential for more than minimal harm that is not immediate jeopardy	<b>D</b>  POC <b>Category 1 Required*</b> Cat. 2 Optional	<b>E</b>  POC <b>Category 1 Required*</b> Cat. 2 Optional	<b>F</b>  POC <b>Category 2 Required*</b> Cat. 1 Optional
<b>Level 1</b> No actual harm with potential for minimal harm	<b>A</b>  No POC No Remedies Not on 2567	<b>B</b>  POC No Remedies	<b>C</b>  POC No Remedies
	<b>Isolated</b>	<b>Pattern</b>	<b>Widespread</b>

\*Required only when imposing remedy/remedies instead of or in addition to termination

 Substantial Compliance

 SQC – Any deficiency in § 483.13, § 483.15, or § 483.25 that constitutes: immediate jeopardy; pattern or widespread actual harm that is not immediate jeopardy; or no actual harm with widespread potential for more than minimal harm that is not immediate jeopardy



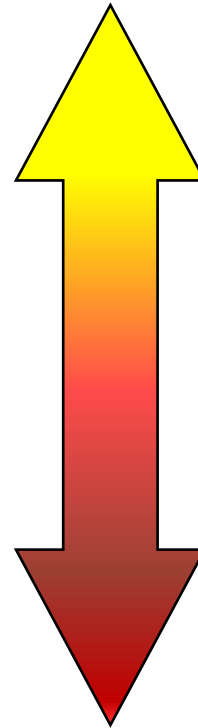
# CMS Health Deficiencies & Citations

**State total: 39,174**

**NOT AS BAD**

**State Average per facility: 33**

	Isolated	Pattern	Widespread
Level 1 no harm	0	1337	115
Level 2- Potential for more than minimal harm	25,868	9,464	1,344
Level 3- Actual harm	639	31	7
Level 4- Immediate jeopardy	82	162	125



**WORSE**

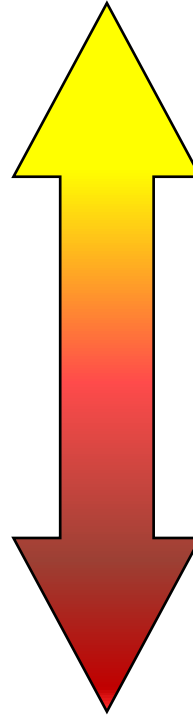
	Isolated	Pattern	Widespread
Level 1 no harm	0	1.1	0.1
Level 2- Potential for more than minimal harm	21.8	8.0	1.1
Level 3- Actual harm	0.5	0.0	0.0
Level 4- Immediate jeopardy	0.1	0.1	0.1

# CMS Health Deficiencies & Citations

**Facility 1: Total 30 (About Average)**

	Isolated	Pattern	Widespread
Level 1 no harm	0	0	0
Level 2- Potential for more than minimal harm	20	9	1
Level 3- Actual harm	0	0	0
Level 4- <b>Immediate jeopardy</b>	0	0	0

**NOT AS BAD**



**WORSE**

**Facility 2: Total 13 (Better than Average)**

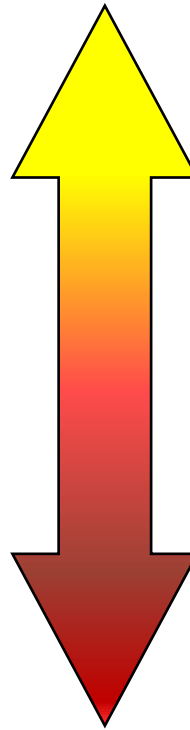
	Isolated	Pattern	Widespread
Level 1 no harm	0	2	0
Level 2- Potential for more than minimal harm	6	5	0
Level 3- Actual harm	0	0	0
Level 4- <b>Immediate jeopardy</b>	0	0	0

# CMS Health Deficiencies & Citations

**Facility 3: Total 165 (Below Average)**

	Isolated	Pattern	Widespread
Level 1 no harm	0	2	0
Level 2- Potential for more than minimal harm	99	47	7
Level 3- Actual harm	2	0	0
Level 4- Immediate jeopardy	1	7	0

**NOT AS BAD**



**WORSE**

**Facility 4: Total 70 (Below Average)**

	Isolated	Pattern	Widespread
Level 1 no harm	0	0	0
Level 2- Potential for more than minimal harm	48	9	3
Level 3- Actual harm	2	1	1
Level 4- Immediate jeopardy	1	3	2

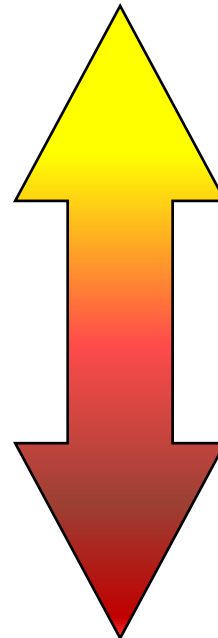
# Nursing Home Deficiencies & Citations

## Comparison of a Better Facility

State Average per facility: 33

	Isolated	Pattern	Widespread
Level 1 no harm	0	1.1	0.1
Level 2- Potential for more than minimal harm	21.8	8.0	1.1
Level 3- Actual harm	0.5	0.0	0.0
Level 4- Immediate jeopardy	0.1	0.1	0.1

NOT AS BAD



WORSE

Facility 2: Total 13 (Better than Average)

	Isolated	Pattern	Widespread
Level 1 no harm	0	2	0
Level 2- Potential for more than minimal harm	6	5	0
Level 3- Actual harm	0	0	0
Level 4- Immediate jeopardy	0	0	0

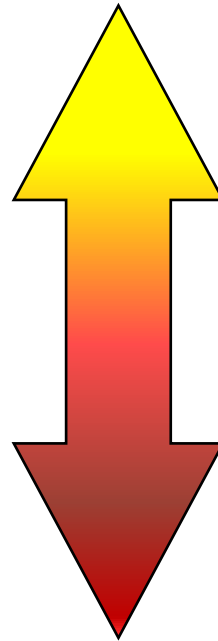
# Nursing Home Deficiencies & Citations

## Comparison of a Worse Facility

State Average per facility: 33

	Isolated	Pattern	Widespread
Level 1 no harm	0	1.1	0.1
Level 2- Potential for more than minimal harm	21.8	8.0	1.1
Level 3- Actual harm	0.5	0.0	0.0
Level 4- Immediate jeopardy	0.1	0.1	0.1

NOT AS BAD

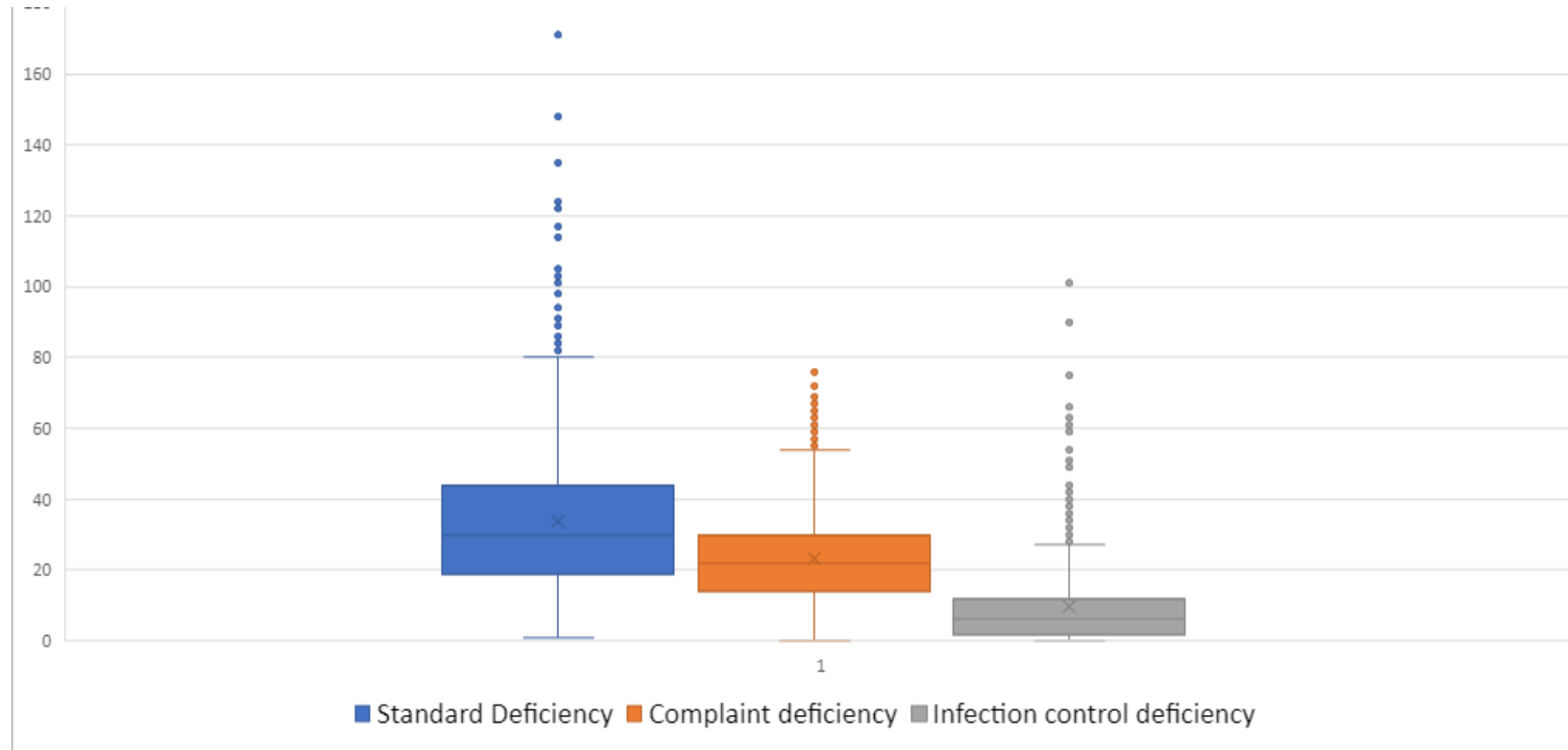


WORSE

Facility 3: Total 165 (Below Average)

	Isolated	Pattern	Widespread
Level 1 no harm	0	2	0
Level 2- Potential for more than minimal harm	99	47	7
Level 3- Actual harm	2	0	0
Level 4- Immediate jeopardy	1	7	0

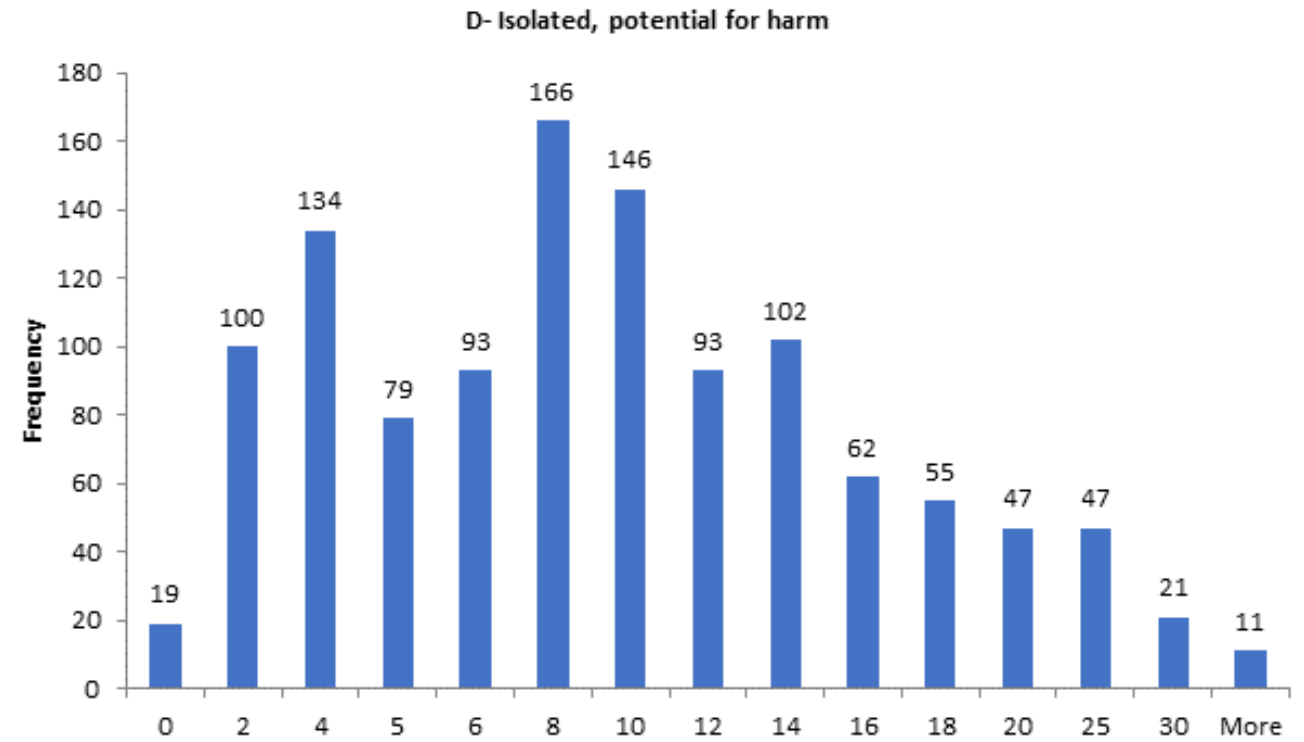
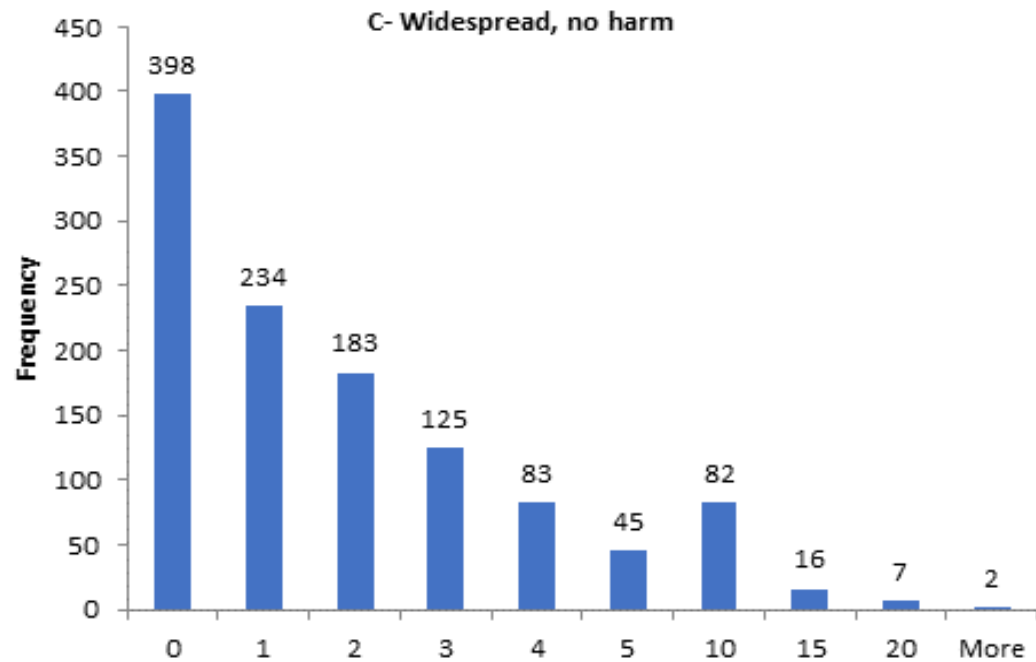
# CMS Health Deficiencies



# 8 Main Categories of Fire Deficiencies

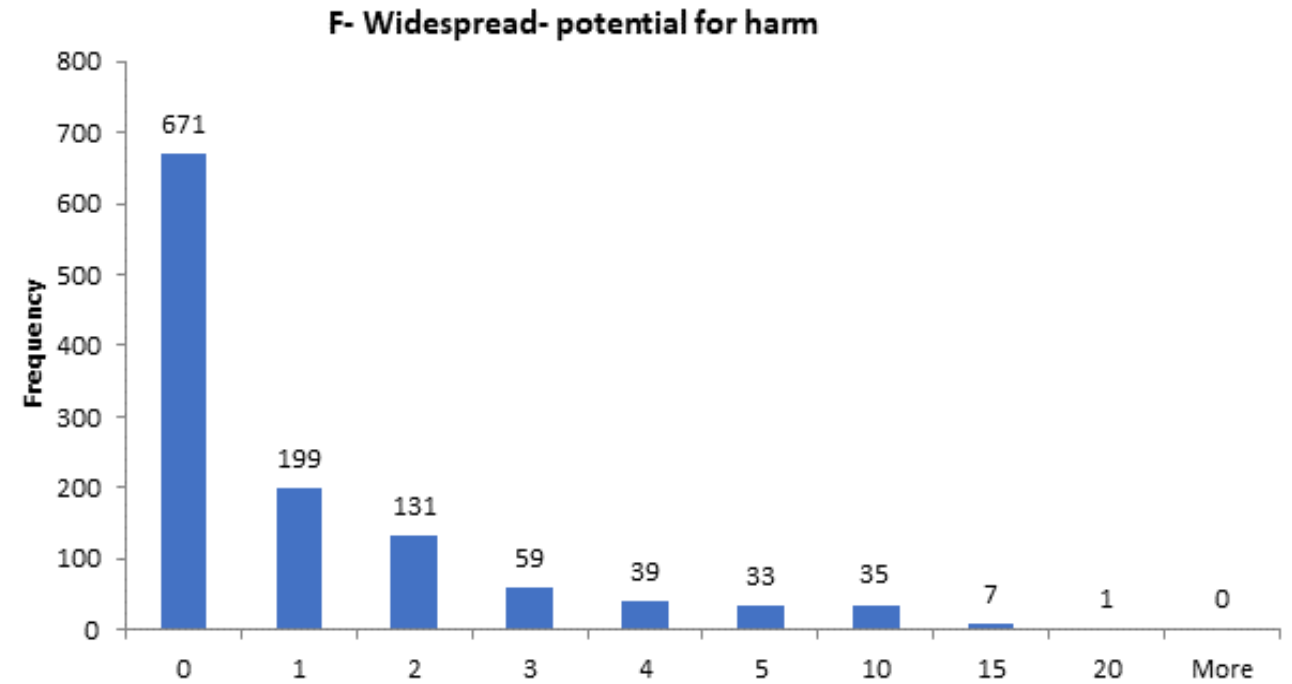
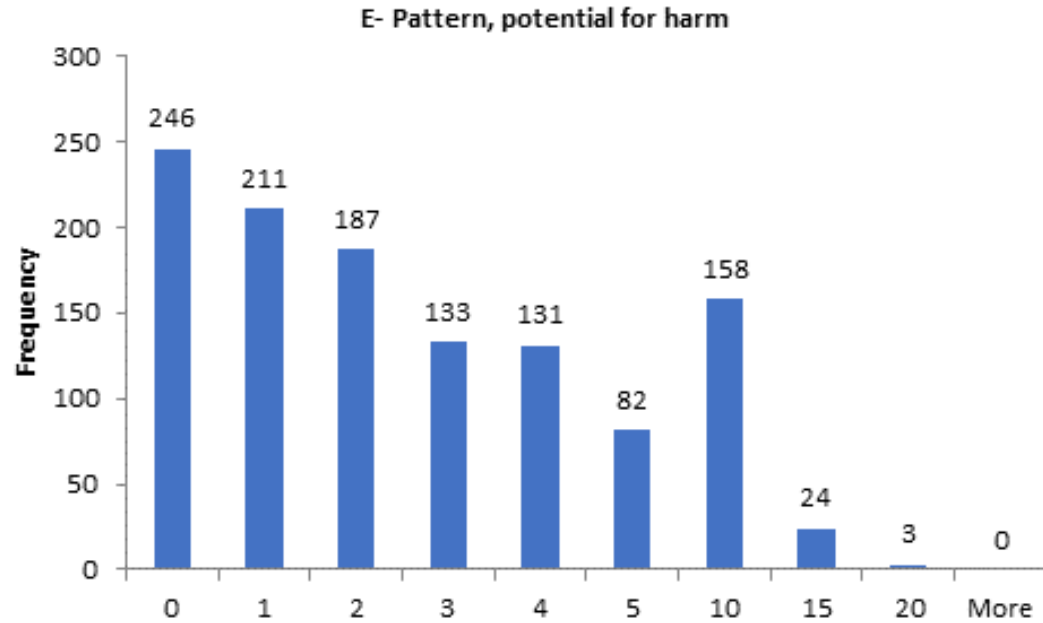
	B- Pattern, no harm	C- Widespread, no harm	D- Isolated, potential for harm	E- Pattern, potential for harm	F- Widespread, potential for harm	I- Widespread, actual harm	K- Pattern, immediate jeopardy	L- Widespread, immediate jeopardy	Grand Total
<b>Construction Deficiencies</b>	1	5	381	40	5				<b>432</b>
<b>Egress Deficiencies</b>	2	27	1343	451	124				<b>1947</b>
<b>Electrical Deficiencies</b>			4	1					<b>5</b>
<b>Emergency Preparedness Deficiencies</b>	1	2011	2090	176	127	1	1	1	<b>4408</b>
<b>Gas, Vacuum, and Electrical Systems Deficiencies</b>		90	2087	863	403				<b>3443</b>
<b>Miscellaneous Deficiencies</b>		68	791	311	91				<b>1261</b>
<b>Services Deficiencies</b>	1	16	496	114	74				<b>701</b>
<b>Smoke Deficiencies</b>	3	290	4313	1469	481			1	<b>6557</b>
<b>Grand Total</b>	<b>8</b>	<b>2507</b>	<b>11505</b>	<b>3425</b>	<b>1305</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>18,754</b>

# Distribution of Fire Deficiencies





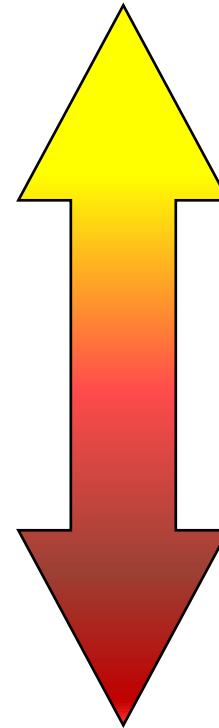
# Distribution of Fire Deficiencies



# Fire Deficiencies

NOT AS BAD

State total 18,754			
	Isolated	Pattern	Widespread
Level 1 no harm	0	8	2507
Level 2- Potential for more than minimal harm	11,505	3,425	1,305
Level 3- Actual harm	0	0	1
Level 4- Immediate jeopardy	0	1	2



WORSE

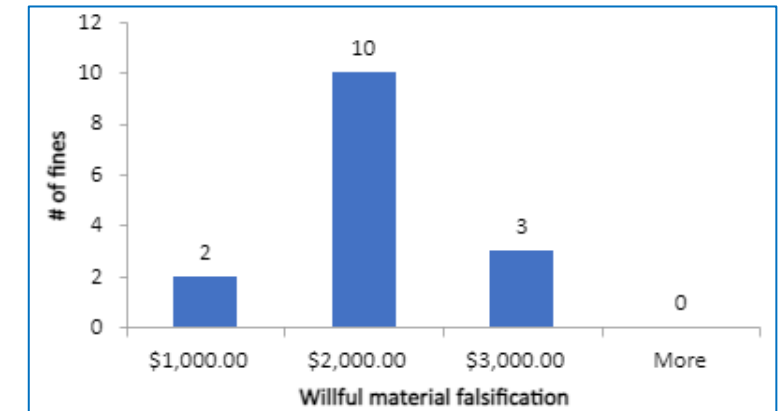
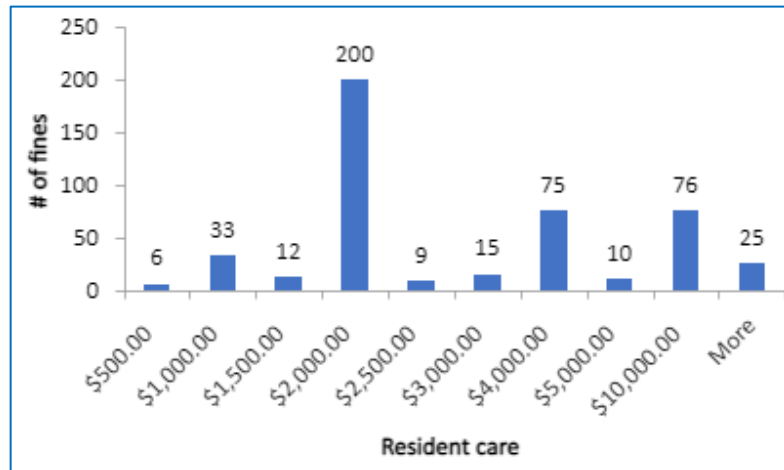
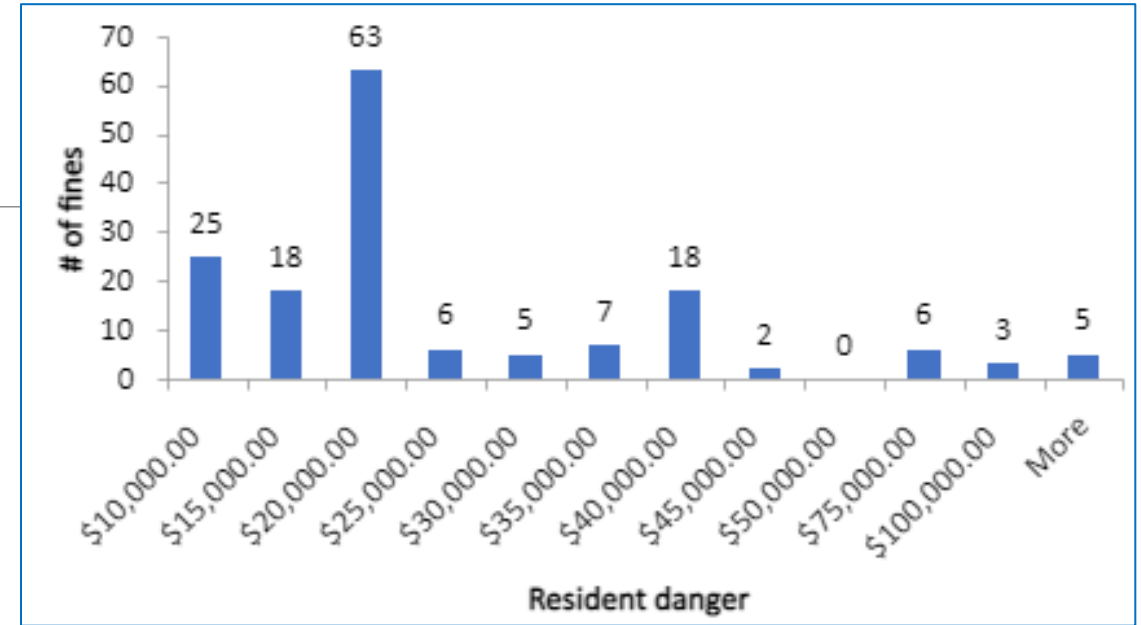
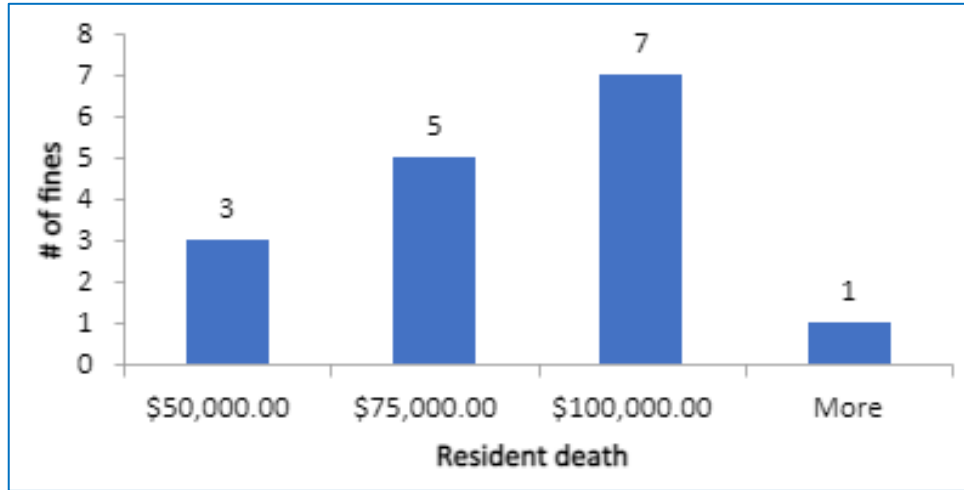
Average deficiencies per facility 33			
	Isolated	Pattern	Widespread
Level 1 no harm	0	0.0	2.1
Level 2- Potential for more than minimal harm	9.7	2.9	1.1
Level 3- Actual harm	0.0	0.0	0.0
Level 4- Immediate jeopardy	0.0	0.0	0.0

# Quality of Facility: Consent Agenda

These metrics are unique CA-specific measures; understandable, meaningful, modifiable.

Measure Facility Enforcement Actions	Staff Recommends	Staff Does Not Recommend	Notes
State Violations and Fines: Resident Death (\$)	✓		The Class AA citation is the most serious. A resident has died in such a way that the CDPH decided that the facility was responsible. The fines range from \$25,000 to \$100,000.
State Violations and Fines: Resident Danger (\$)	✓		The Class A citation is issued when a resident is in immediate danger of death or serious bodily harm. The fines range from \$2,000 to \$20,000.
State Violations and Fines: Resident Care (\$)	✓		The Class B citation is issued when a violation presents a direct or immediate risk to the resident's health, safety, or security. This can include emotional and financial elements. The fines range from \$100 to \$1,000.
State Violations and Fines: Staffing (\$)	✓		Failure to provide each resident a minimum of 3.2 hours of skilled nursing care/day. Citation carries fines of \$15,000 for failure to meet the requirement for 5-49% of the audited days; \$30,000 for failure to meet the requirement for >49% of the audited days.
State Violations and Fines: Improper Disclosure (\$)	✓		Unlawful or unauthorized access to, use, or disclosure of, a resident's medical information is not reported to the affected resident or the resident's representative, and/or to CDPH OR health record violations.
Total State Fines (\$)	✓		Total dollar amount in state fines.
<b>Federal Penalties and Fines</b>			Total # of penalties and fines
Total Federal Fines (\$)	✓		Fines are imposed once per deficiency or each day until the nursing home corrects the deficiency.
Denials of Payment for New Admission	✓		The government stops Medicare or Medicaid payments to the nursing home for new residents until the facility corrects the deficiency.

# Fines Frequencies



# Quality of Facility: Metrics for Discussion

Measure Complaints (5-year total)	Staff Recommends	Staff Does Not Recommend	Notes
Quality of Care	✓		<ul style="list-style-type: none"> <li>A complaint is a formal grievance against a facility that is filed with an ombudsman or the California Licensing and Certification (L&amp;C) Program.</li> <li>It is filed when someone has an objection to treatment or safety.</li> <li>Complaints are grouped into eight categories.</li> <li>After complaints are investigated by L&amp;C, they are deemed either substantiated (if the inspector found the claim to be true), or unsubstantiated (if there was no proof to support the complaint).</li> <li>If a complaint is substantiated, a deficiency or citation may be given to the facility.</li> </ul>
Staffing	✓		
Abuse [Mistreatment]	✓		
Resident Rights	✓		
Environment	✓		
Nutrition	✓		
Administration	✓		
Total	✓		

# Measures Recommended by LTAC: Cost and Finance Domain

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# Cost & Finance Domain: Consent Agenda

Measure	Staff Recommends	Staff Does Not Recommend	Notes
Average Total Expenditures per Resident Day		X	The average \$ amount spent on each resident per day.
Direct Care		X	Includes nursing care, nursing staff costs, social services, activities, and ancillary expenses, such as diagnostic and therapy services, patient supplies, physical therapy, respiratory therapy, occupational therapy, speech therapy, pharmacy, laboratory, and other clinical services.
Other Care		X	Includes building and facility maintenance and renovations, housekeeping, laundry, and dietary expenses such as food, storage, and preparation.
Administrative services		X	Includes general accounting, communication systems, data processing, patient admissions, public relations, professional liability and non-property related insurance, licenses and taxes, medical record activities, in-service education for nursing staff, and supplies and equipment.
Capital expenses		X	Includes expenses for leases and rental, interest and depreciation include the expenses for use of the building and equipment for the facility including leases and the rental of property related to the building, equipment, and improvements.

# Cost & Finance Domain: Measures for Discussion

Measure	Staff Recommends	Staff Does Not Recommend	Notes
Average Charges per Resident Day		X	Average \$/resident day by payer: Medicare, Medi-Cal, Self-pay and Other
Resident Care Days by Payment Source		X	Percentage of the facility's total days of care that is paid by each payer: Medicare, Medi-Cal, Self-pay and Other
Net Operating Income or Loss (5 years reported)		X	Total amount of money earned from health care operations plus non-operating revenue — after nonoperating expenses have been deducted — excluding taxes and extraordinary items
Operating Margin (5 years reported)		X	The operating margin is net income divided by health care operating revenue. This is another way of showing the percentage of profits or losses in a facility.

These metrics are impossible for consumers to interpret and may promote self-sorting and adverse selection.



# Recap: Measures In December & May

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## Measures Posted in December 2021

Overview Domain

Quality of Care Domain

Staffing Domain

Quality of Facility Domain

Nursing Home Honor Roll

## Legacy Measures Under Consideration for 2022

### Cost and Finance Domain

\*Medicare Days of Care

\*Benefits/Hour (all employees)

\*Nursing Wages/Hour

- Directors of nursing/supervisors
- Licensed Nurses (RN/LVN)
- Nursing Assistants

(\*measures are from domains in the left-hand list.)

\*Physical Therapist Hours (consider substituting consumer guidance questions about multiple categories of therapy –OT, PT, ST, etc.)

\*Fire/"Life Safety" Deficiencies

# NH Honor Roll: Measure Recommendations

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# Honor Roll

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## **Composite COVID-19 Vaccination Rate**

- NH Staff vaccination rates
- Resident vaccination rates

## **CURRENT ISSUES:**

- Weekly updates - too many blank fields
- Cannot determine accurate denominator

## **GOAL**

- Honor roll: NHs with the highest vaccination rates for both residents and staff
- Overall rates are high

## **CURRENT CALIFORNIA VACCINATION RATES**

**as of 10/24/21**

**CA Residents = 87.2%**

**US Residents = 86%**

**CA Healthcare Providers = 94.7%**

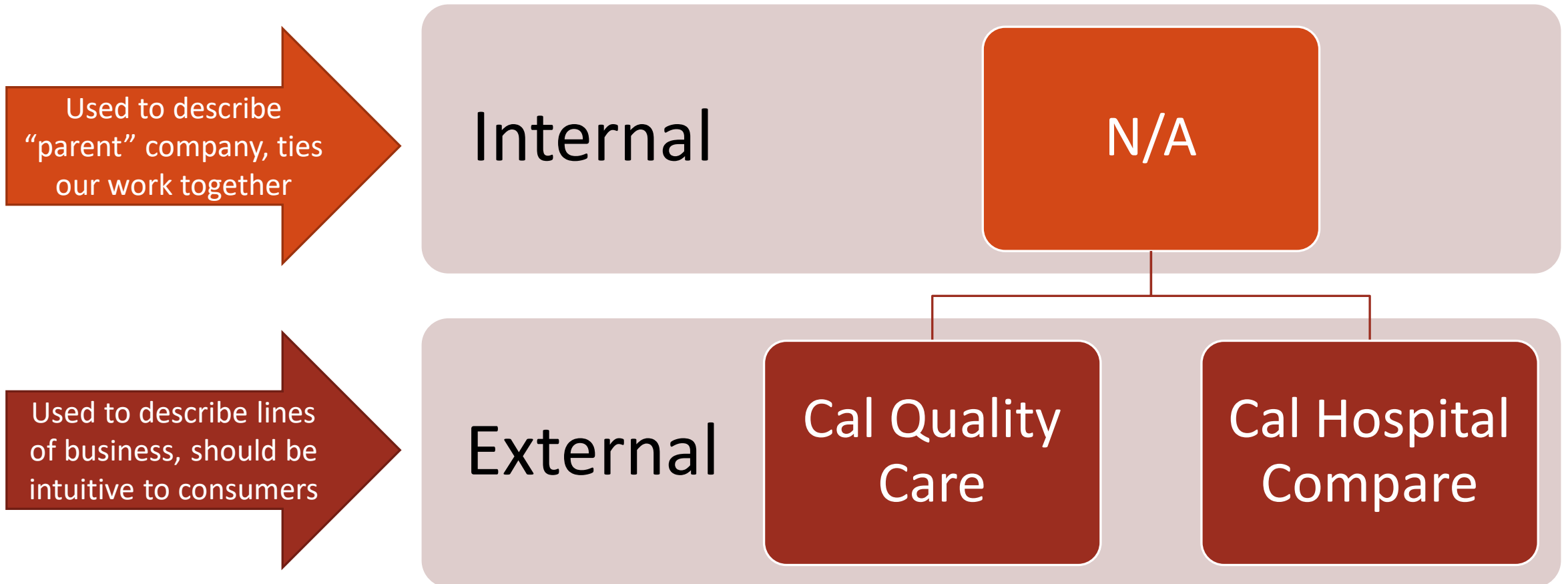
**US Healthcare Providers = 73.5%**

# Business Plan

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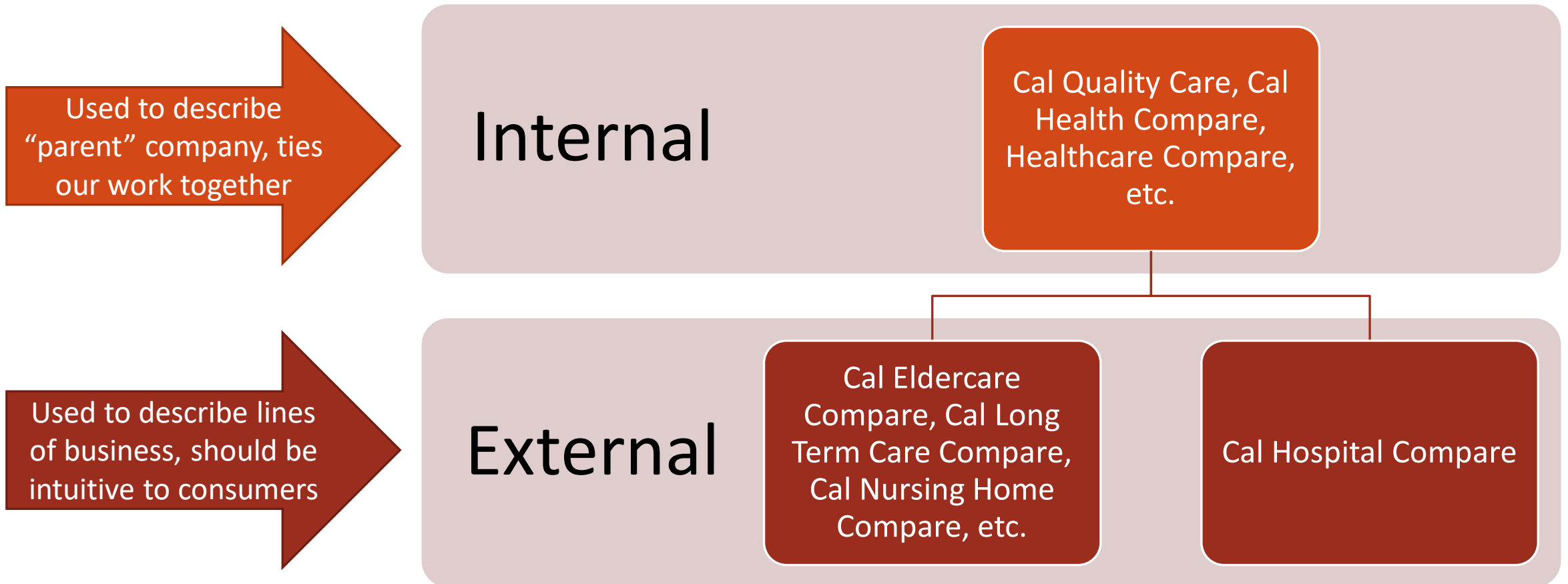
# Business Naming – Current State

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# Business Naming – Proposed Changes

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# Wrap Up

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# 2021 CHC/CQC BOD Call Schedule

(all times are Pacific Time zone)

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**Wednesday, December 1**

**10:00am to 12:30pm**



# 2022 CHC/CQC BOD Call Schedule

(all times are Pacific Time Zone)

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Thursday, March 17

10:30am to 2:30pm in Sacramento

Tuesday, June 21

11:00am to 2:00pm – virtual

Tuesday, September 13

11:00am to 2:00pm in Bay Area

Tuesday, December 13

10:00am to 1:00pm – virtual

# 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)		Feb 24		Apr 14			Jul 20			Oct 12		
Cal Hospital Compare Technical Advisory Committee (2 hrs)		Feb 15			May 10			Aug 16			Nov 15	
Board of Directors Virtual = 3 hrs In person = 4 hrs			Mar 17 In person			Jun 21 Virtual			Sep 13 In person			Dec 13 Virtual

# Thank you!

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# Appendix

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# Analysis of Cal Hospital Compare Historical Performance Data

## Key Findings to Date

October 29, 2021

### Executive Summary

As part of its 2021 work, IBM Watson Health, in conjunction with Cynosure Health, conducted a series of analyses examining patterns in Cal Hospital Compare's (CHC's) rich, historical performance data that covers the years 2014 to 2020. The purpose of these analyses is to provide useful insights to support stakeholders in assessing performance of hospitals and to support consumers in their quest to make informed decisions about their medical care.

This document provides a high-level summary of those analyses and includes three focus areas (See Appendix A for measure specifications):

- Maternity
- Readmissions and Mortality
- Surgery Volumes

The most significant, overarching observation is that public reporting, even when combined with financial penalties, may be insufficient to drive performance improvement. Active quality improvement collaboratives, with full participation from California hospitals, may be required to foster the changes in service delivery that will improve the care provided to Californians. Additionally, there are individual hospitals that made substantial gains and from whom best practices may be gleaned.

The measure analysis will continue by examining the impact of the social needs of hospital populations on hospital quality performance.

### Maternity

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#### Key Findings

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- ✓ Compared to other measure domains, the maternity measures showed the most consistent improvement and reduction in variation across hospitals.
  - ✓ This improvement was supported by the active engagement of hospitals in California Maternal Quality Care Collaborative (CMQCC) with the number of participating hospitals growing substantially in recent years.
- 

There has been a strong national focus on maternity measures and the maternity measure set has recently expanded to include a Certified Nurse Midwives Delivery rate measure. All

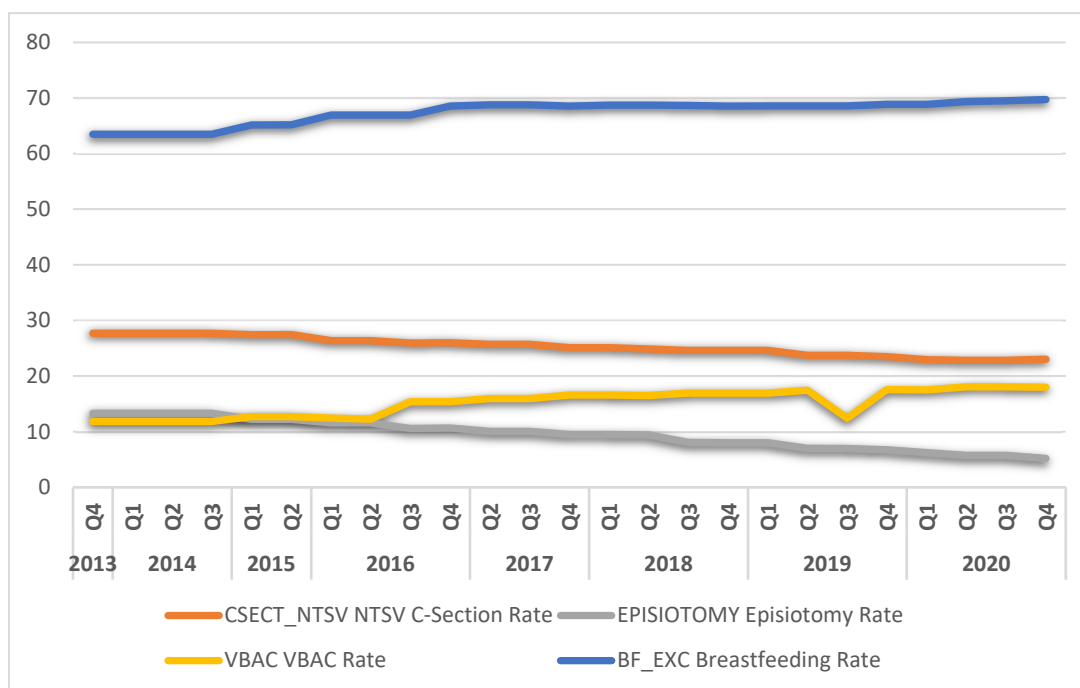
measure rates are provided by CMQCC, with the exception of the Exclusive Breastfeeding measure rate which is made publicly available by the California Department of Public Health.

The analysis examined four measures in the Maternity domain:

- Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean-Section (C-Section) (low risk): “lower is better”
- Episiotomy: “lower is better”
- Vaginal Birth After C-Section (VBAC): “lower is better”
- Exclusive Breastfeeding: “higher is better”

All four measures showed both 1) improvement in statewide rates and 2) reduction in variation across hospitals; the ideal outcome of performance measurement, reporting and improvement activities.

**Figure 1.** Maternity Rates by Quarter from 2013 through 2020



The NTSV C-Section measure is used for illustrative purposes with the distribution of hospitals rates shown below as of 2013 and 2020. The yellow shows the distribution in Quarter 4 (Q4) 2013; the pink in Q4 2020; the orange is the overlap.

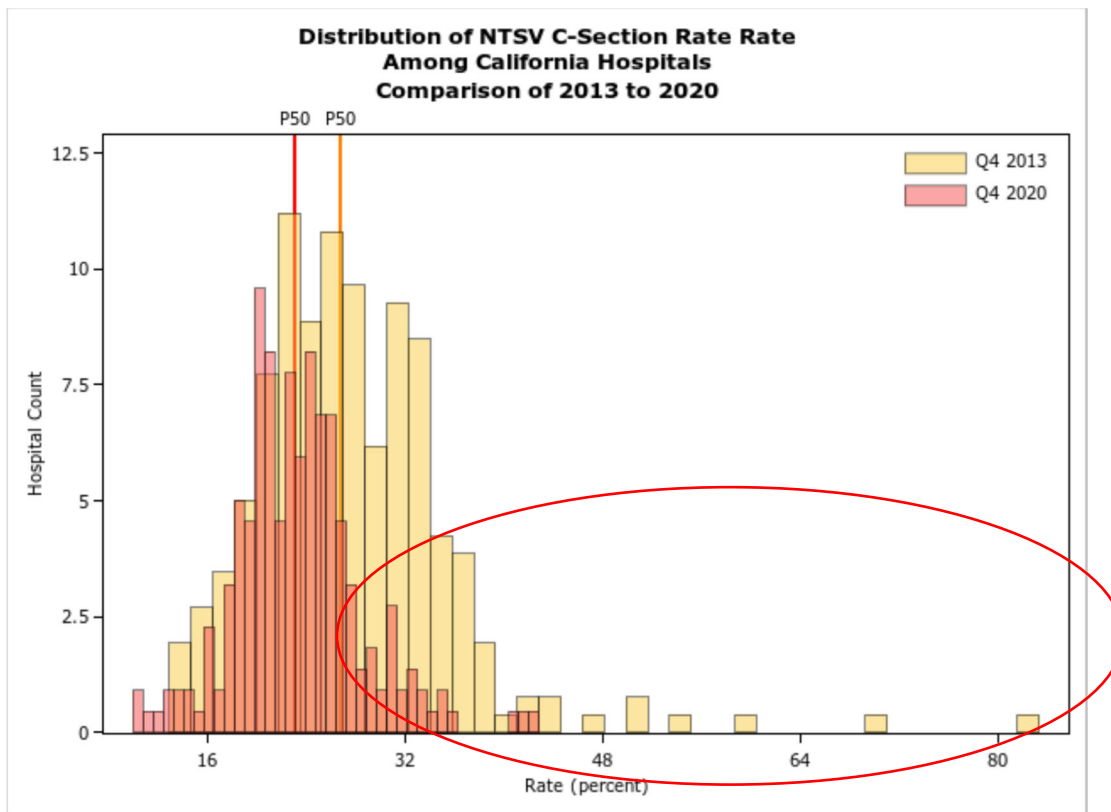
Salient points discovered include:

- The median NTSV C-Section rate decreased from 26.8% to 22.5% as reflected in the shift leftward of the distribution

- The distribution in Q4 2020 is narrower than Q4 2013 indicating the variation across hospitals decreased. The hospitals represented in Q4 2013 with the very high rates (circled in red) substantially reduced their rates.
  - This reduction in variation is quantified by examining the interquartile range, the difference between the 25<sup>th</sup> percentile rate and the 75<sup>th</sup> percentile rate. The middle 50% of hospitals are in this range.
    - The interquartile range dropped substantially from 10.0% (22.1% to 32.1%) in Q4 2013 to 5.6% (20.0% to 25.6%) in Q4 2020.

Appendix B, NTSV C-Section: Most Improved Hospitals identifies the previously poor performing hospitals that were able to substantially improve their rates.

**Figure 2.** C-Section Rates Among California Hospitals



**Table 1.** Summary Statistics

Summary statistics											
Var	Label	N	Mean	Std Dev	Min	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Max
t1	Q4 2013	259	27.7%	8.4%	13.0%	19.0%	22.1%	26.8%	32.1%	36.2%	83.3%
t2	Q4 2020	225	23.1%	5.0%	10.3%	17.9%	20%	22.5%	25.6%	28.3%	44.4%

Abbreviations: Max, maximum; Min, minimum; Pctl, percentile; Std Dev, standard deviation; Var, variable.

As noted earlier, these same patterns were seen across all of the maternity measures; a success story within the scope the CHC historical analysis.

## Readmissions and Mortality

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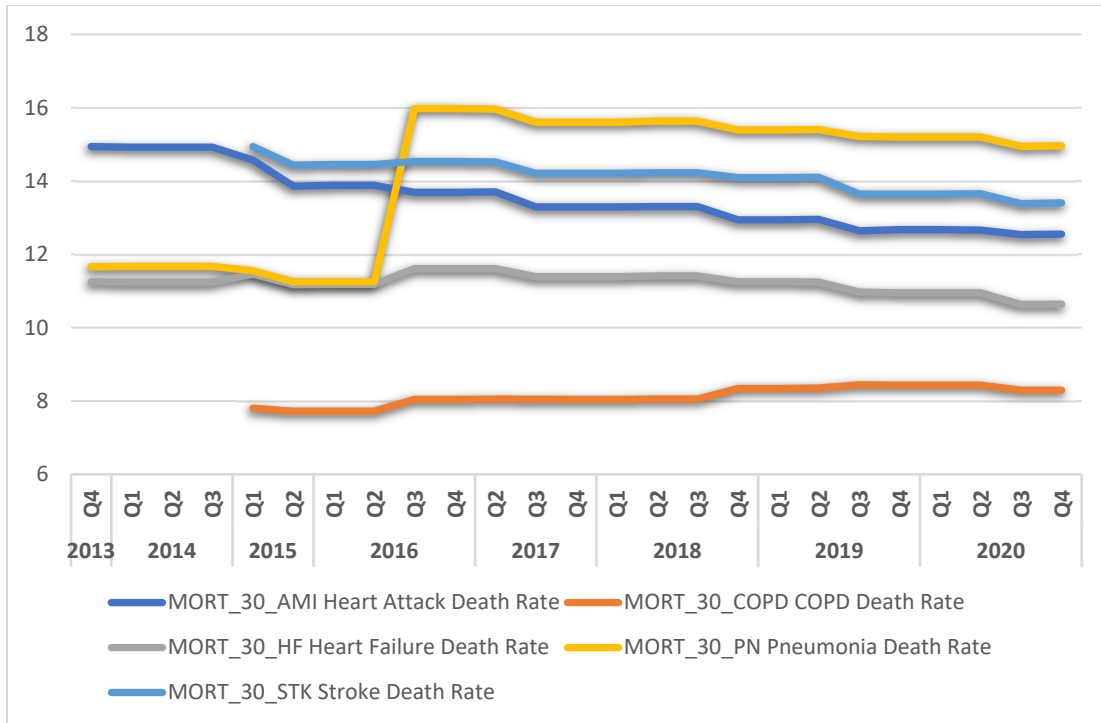
### Key Findings

- ✓ In comparison, to the maternity measures, the mortality and readmission measure analyses revealed a mixed success story.
  - ✓ With the exception of Chronic Obstructive Pulmonary Disease (COPD), statewide mortality rates showed slow improvements from 2015 to 2020.
  - ✓ However, the paired readmissions rates remained flat, with the exception of Acute Myocardial Infarction (AMI) which saw improvement.
  - ✓ There was little correlation between mortality and readmission rates indicating that different structures and processes likely underlie performance in those measure domains.
  - ✓ The Hospital-wide Readmissions measure did not show any statewide improvement from 2017 to 2020.
  - ✓ It should be noted that the mortality and readmission measures did not benefit from the same kind of statewide quality improvement initiative that CMQCC provides in the maternity domain.
- 

The analysis examined the paired readmissions and mortality measures across the following clinical areas: AMI, COPD, Pneumonia (PN) and Heart Failure (HF). As shown in Figure 3, statewide mortality rates decreased steadily over time for four of the five clinically specific measures, although improvement was relatively modest.



**Figure 3. Statewide 30-Day Hospital Mortality Rate Trends**

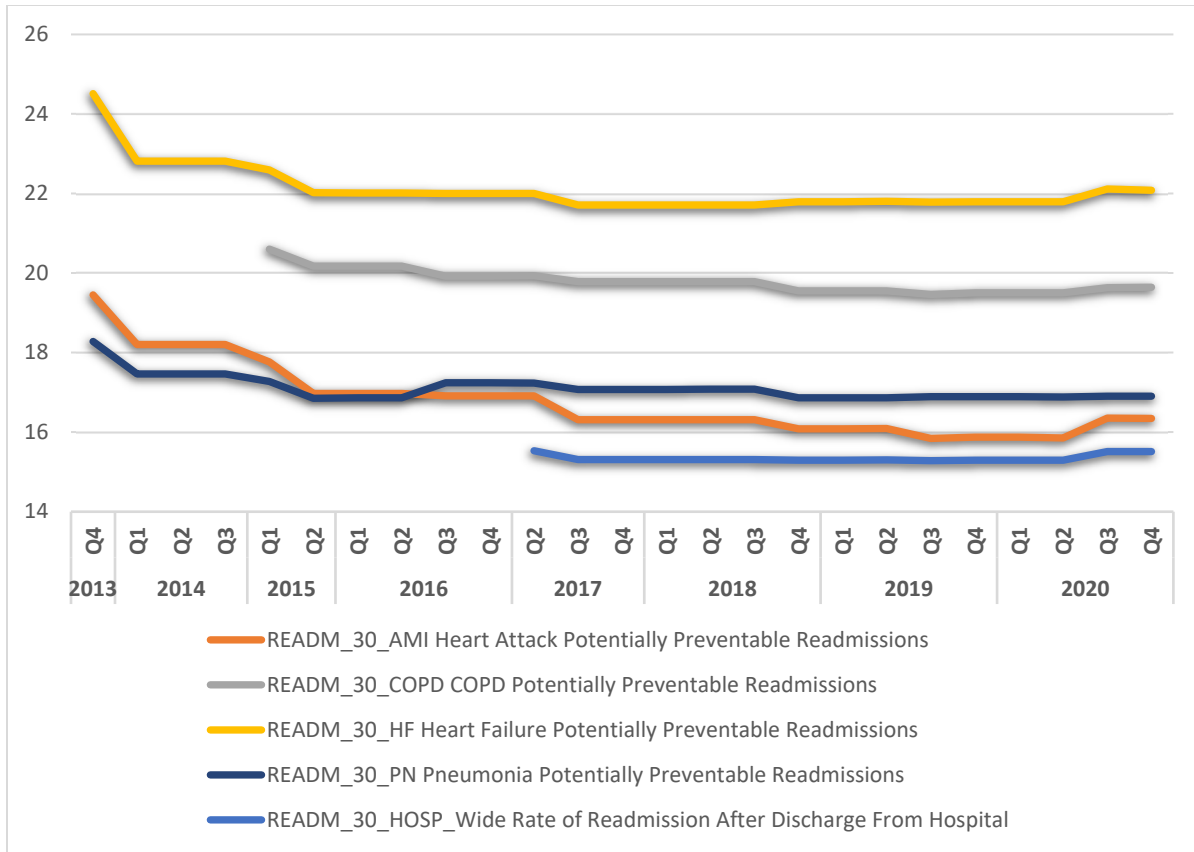


Note the PN Mortality measure, in Q3 2016, the MORT–30–PN measure underwent a substantive revision that expanded the measure cohort.

In contrast, as shown in Figure 4., the clinically specific readmissions measures have shown little change since Q1 2016, with the exception of the AMI measure. The Hospital-wide Readmission measure is also included in Figure 4 and shows virtually no change since 2017 (see Appendix C for related analysis).

Readmission rates have failed to improve despite the Center for Medicare & Medicaid Services' (CMS's) Hospital Readmission Reduction Program (HRRP) which puts up to 3% of payment at risk and public reporting of measure rates on CMS Hospital Compare.

**Figure 4. Statewide 30-Day Hospital Readmission Rate Trends**



The analysis then examined the question: “do hospitals that perform well on the clinically-specific mortality rates also perform well on the paired readmission rates”? As evidenced by the Spearman correlations coefficients appearing in the following table, there is little association between performance on the mortality and paired readmissions measures.

**Table 2. Correlation Between Readmission and Mortality Rates**

Clinical Area	Correlation Coefficient between Readmission and Mortality Rates
AMI	0.033
Heart Failure	-0.229
COPD	0.06
Pneumonia	-0.06

Abbreviations: AMI, Acute Myocardial Infarction, COPD, Chronic Obstructive Pulmonary Disease.

The analysis also examined the question: “did hospitals that improved the most on the clinically-specific mortality rates also improve the most on the paired readmission rates”? Once again, there was little correlation between hospital improvement on the mortality and readmissions measures.

Both of these findings suggest that the structures and processes that underlie performance on these measures are substantially different and, therefore, related quality improvement programs should be developed separately.

While there was little correlation between the mortality and readmissions measures, there was stronger correlation between the clinically specific readmissions measures and the Hospital-wide Readmissions measure. This finding suggests that structures and processes related to hospital readmission performance carry across hospital departments through a “hospital-level effect”.

**Table 3.** Correlation Between Clinically Specific Readmission and Hospital-Wide Readmissions Rates

Clinical Area	Correlation Coefficient between Clinically Specific Readmissions and Hospital-Wide Readmissions
AMI	0.49
Heart Failure	0.67
COPD	0.37
Pneumonia	0.69

Abbreviations: AMI, Acute Myocardial Infarction, COPD, Chronic Obstructive Pulmonary Disease.

In general, while there was little movement in most mortality and readmissions measures, the AMI measures are a success story. The patterns seen in both the AMI mortality and readmissions measures mirror those of the NSTV C-section measure: statewide improvement in rates and reduction of the variation in performance across hospitals. Appendix D: AMI Mortality and Readmission Rates provides related performance information.

## Surgery Volumes

### Key Findings

- ✓ A relatively large number of hospitals continue to perform a low number of esophageal and pancreatic surgeries potentially leading to sub-optimized outcomes.
- ✓ The balance between local availability and travel/access to higher volume hospitals warrants further policy discussion.

The historical analysis looked at esophageal and pancreatic surgery volumes. For these surgeries, increased volume has been shown to be associated with better outcomes. Therefore, the analysis focused on whether there has been a decrease over time in hospitals performing a small number of surgeries.

As shown in Table 4 below, the number of hospitals performing two or fewer esophageal surgeries decreased from 73 to 38.

However, the number of hospitals performing two or fewer pancreatic surgeries increased from 41 to 47; and the number performing one surgery increased from 17 to 35. At the same time, in 2020, there were 45 hospitals performing six or more pancreatic cancer surgeries from which patients at low volume hospitals could have sought care.

The analysis indicates that the issue of hospitals performing a low number of relatively rare cancer surgeries remains relevant, especially for pancreatic cancer surgeries. From a consumer perspective, the analysis highlights the tradeoff between the convenience of local cancer surgery availability and related referral patterns with the potentially better outcomes associated with increased surgery volume.

Note that this analysis examines two points in time and there is variation between periods.

**Table 4.** Hospital Esophageal and Pancreatic Surgery Volumes

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
11-20	11	11	13	10
>20	5	4	12	15

## Examination of Measure Performance by Ethnicity

As part of the historical analysis, the project team examined correlations between measure performance and race and ethnicity. Race and ethnicity were represented as the percent of admissions by racial/ethnic groups as derived from publicly available California Department of Health Care Access and Information (HCAI) data based on calendar year 2019.

Member-level performance measure data was not available and is a limitation of the approach. In general, performance variation driven by race may be obscured by the relatively small proportion of the patient population represented by specific racial groups.

For example, African Americans constitute 6.5%<sup>1</sup> of the California population and, although there are some hospitals that serve a high percentage of African Americans, the hospital's performance across its population is represented in the measure rates which may, in turn, mask differences by race.

However, we also examined correlations between measure performance and ethnicity (as represented by the percent of admissions that are for Hispanic patients). The Hispanic population constitutes 39.4%<sup>2</sup> of the California population as of 2021.

Table 5 shows the percent of admissions of Hispanic ethnicity. The first quartile statistics indicate that 25% of hospitals had admissions of Hispanic ethnicity ranging from 2% to 17% of all hospital admissions. In the fourth quartile, the range is 43% to 87%. These figures quantify the extent to which different hospitals serve Hispanic communities.

**Table 5.** Percent Hispanic Admission by Quartile, 2019

Quartile	Percent of Admissions of Hispanic Ethnicity	
	Quartile Minimum	Quartile Maximum
Quartile 1	2%	17%
Quartile 2	17%	28%
Quartile 3	28%	43%
Quartile 4	43%	87%

<sup>1</sup> U.S. Census Bureau (2019). Quick Facts California; Population Estimates. Retrieved from <https://www.census.gov/quickfacts/fact/table/CA/PST045219>.

<sup>2</sup> U.S. Census Bureau (2019). Quick Facts California; Population Estimates. Retrieved from <https://www.census.gov/quickfacts/fact/table/CA/PST045219>.

The analysis then examined the correlation between percent Hispanic admissions and all 90 measures reported by CHC. The measure with the strongest correlation was the Exclusive Breastfeeding measure, with hospitals serving a high Hispanic population having substantially poorer performance on the measure. As indicated in Table 6, the average rate in the quartile of hospitals with the highest percent Hispanic admissions was 16% lower than the quartile serving the lowest percent Hispanic populations (61% vs 77%). The stark difference raises questions regarding the factors driving the poorer performance including possible implicit bias.

**Table 6.** Exclusive Breastfeeding Measure Rate by Quartile of Percent Hispanic Admissions

Percent Hispanic Admissions	Breastfeeding: Average Performance
Quartile 1	77%
Quartile 2	73%
Quartile 3	68%
Quartile 4	61%

## Variation in Performance by Geographic Region

### Key Findings

- ✓ A few measures show variation in average hospital performance by hospital market area
- ✓ However, all measures show substantial hospital-level variation within hospital market areas.
- ✓ Examination of trends in NTSV C-Section shows a dramatic decrease in hospital market area variation, specifically closing of the performance gap between Northern California and Southern California.

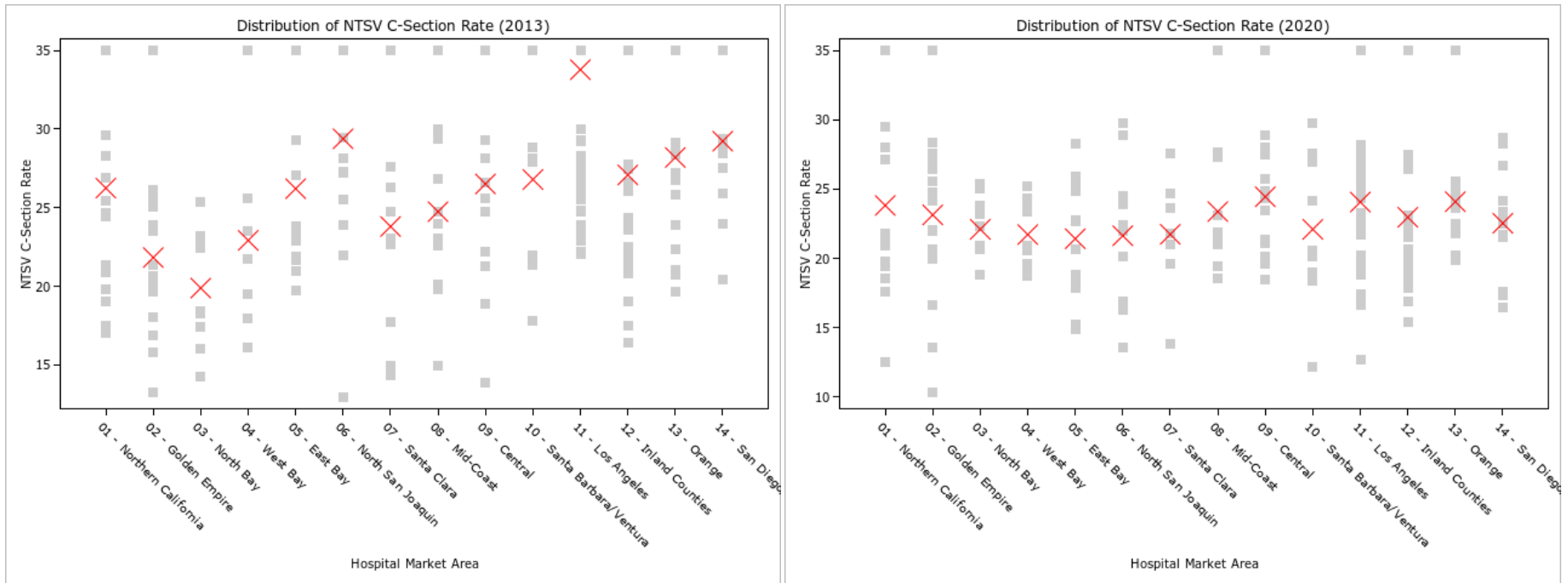
Hospital performance can vary by hospital market area for a number of reasons. Specifically, Northern California has fewer and more highly integrated hospital systems in comparison to Southern California, especially the Los Angeles market area.

The analysis examined hospital market variation in the maternity, mortality, and readmissions measure sets. Figure 5 shows the variation both across and within hospital market areas for the NTSV C-Section measure for both 2013 and 2020. The red “X’s” are the hospital average within each hospital market area. The vertical grey bars display hospital-specific rates within each market area to show the range in performance. Hospital rates over 35% were set to 35% for purposes of graphical display. However, rates were not set to 35% when calculating the market area average.

In 2003, the results show the average hospital NTSV C-Section rate in the Bay Area was substantially lower than Los Angeles and other Southern California market areas. However, by 2020, the variation across market areas had been greatly reduced to the point where the average market area rates are

similar. The CMQCC actively worked across market areas to reduce NTSV C-Section rates especially among hospitals with high rates.

**Figure 5. 2013 and 2020 NTSV C-Section Rate Comparison by Market Area**

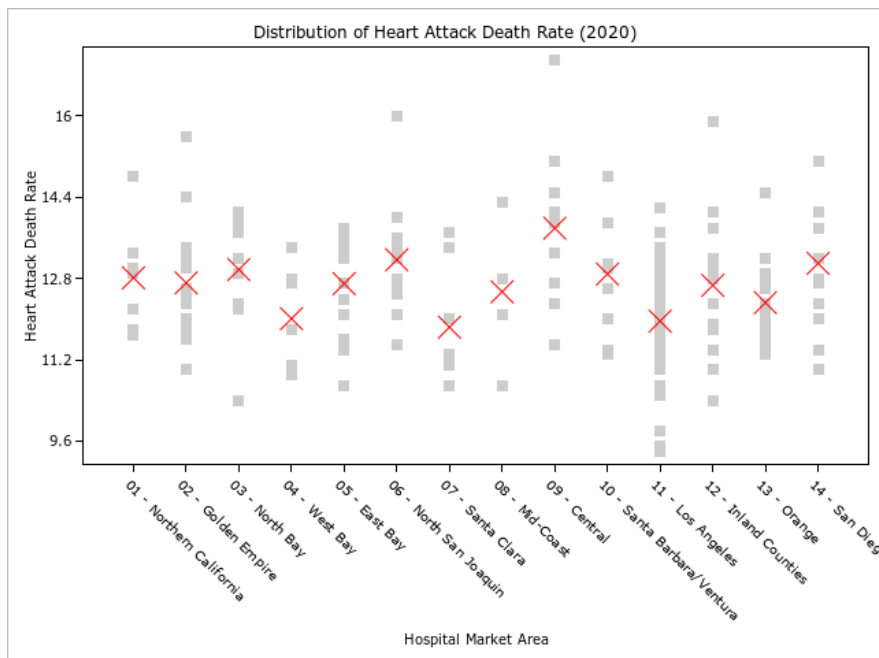


Of the other measures examined, the AMI mortality rate showed the greatest variation in average rate across hospital market areas in 2020. As shown in Figure 6, the average rate in the Central Valley, an area of high social need, was higher than other regions. The West Bay, Santa Clara and Los Angeles showed the lowest average rates.

However, for both the NTSV C-Section and AMI Mortality measure, there is substantial hospital-level variation within each market area, much greater than the variation in average rate across regions. Both measures are adjusted for clinical risk.

The analysis raises questions 1) are hospitals in the same market area serving populations with similar patient characteristics (e.g., social need) and 2) are there best practices to be gleaned from high performing hospitals within each market area from which other hospitals can benefit?

**Figure 6.** Distribution of Heart Attack Death Rate





## **Next Steps**

This historical analysis and the national imperative to identify and address social determinants of health (SDOH) led the project team to develop a novel “hospital-level social needs index” based on the patient populations served by the hospital. In contrast, most hospital market/catchment methodologies are based on hospital location.

The related analysis is underway. It explores the association between social needs and hospital performance with the goal of providing actionable information that will better enable hospitals and other stakeholders to address social needs. Preliminary results of the methodology development and testing have been presented to the Hospital – Technical Advisory Committee (H-TAC) and CHC Board and were well received. Final results of the analysis will be presented in a separate document before the end of 2021.

## Appendix A

### Measurement Specifications

Name	Source	Reporting Period Start <sup>a</sup>	Reporting Period End <sup>a</sup>
Breastfeeding Rate (CDPH)	CDPH	Q3 2013	Q4 2020
NTSV C-section Rate	CMQCC	Q3 2013	Q4 2020
Episiotomy	CMQCC	Q3 2013	Q4 2020
VBAC Rate	CMQCC	Q3 2013	Q4 2020
Heart Attack Death Rate	CMS Hospital Compare	Q3 2013	Q4 2020
COPD Death Rate	CMS Hospital Compare	Q1 2016	Q4 2020
Heart Failure Death Rate	CMS Hospital Compare		
Pneumonia Death Rate	CMS Hospital Compare	Q3 2013	Q4 2020
Stroke Death Rate	CMS Hospital Compare	Q1 2016	Q4 2020
Heart Attack Potentially Preventable Readmissions	CMS Hospital Compare	Q4 2013	Q4 2020
COPD Potentially Preventable Readmissions	CMS Hospital Compare	Q1 2015	Q4 2020
Heart Failure Potentially Preventable Readmissions	CMS Hospital Compare	Q4 2013	Q4 2020
Rate of readmission after discharge from hospital (hospital-wide)	CMS Hospital Compare	Q2 2017	Q4 2020
Pneumonia Potentially Preventable Readmissions	CMS Hospital Compare	Q4 2013	Q4 2020

Abbreviations: CDPH, California Department of Public Health; CMQCC, California Maternal Quality Care Collaborative; CMS, Centers for Medicare & Medicaid Services; COPD, Chronic Obstructive Pulmonary Disease; C-section, Cesarean section; NTSV, Nulliparous, Term, Singleton, Vertex; Q, quarter; VBAC, vaginal birth after cesarean.

<sup>a</sup>Measure reporting periods indicate the date the measure was reported not the measurement period.

## Appendix B

### NTSV C-Section: Top 10 Most Improved Hospitals

The table below identifies hospitals that had the greatest improvement in NTSV C-Section rates from 2013 to 2020. The large majority of these hospitals had much higher rates than average in 2013 and were able to substantially reduce their rates to the point where they are below the State average and below the Healthy People 2020 rate of 23.9%. Note that many are smaller hospitals.

**Table 7.** Top 10 Most Improved Hospitals

Name	City	2013		2020		Difference
		Denom	Rate	Denom	Rate	
California Median			26.8		22.5	
Hi-Desert Medical Center	Joshua Tree	166	54.4	103	27.2	-27.1
East Los Angeles Doctors Hospital	Los Angeles	179	59.9	219	34.2	-25.7
Memorial Hospital Los Banos	Los Banos	182	35.6	162	13.6	-22.0
Banner Lassen Medical Center	Susanville	78	33.7	80	12.5	-21.2
Hemet Valley Medical Center	Hemet	346	35.4	169	15.4	-20.0
Monterey Park Hospital	Monterey Park	398	50.4	301	30.6	-19.7
Community Hospital of San Bernardino	San Bernardino	513	42.3	580	22.6	-19.7
UCLA Medical Center - Santa Monica	Santa Monica	684	38.0	708	20.2	-17.8
Sutter Lakeside Hospital	Lakeport	117	36.9	96	19.8	-17.1
Doctors Hospital of Manteca	Manteca	224	33.5	134	16.4	-17.1

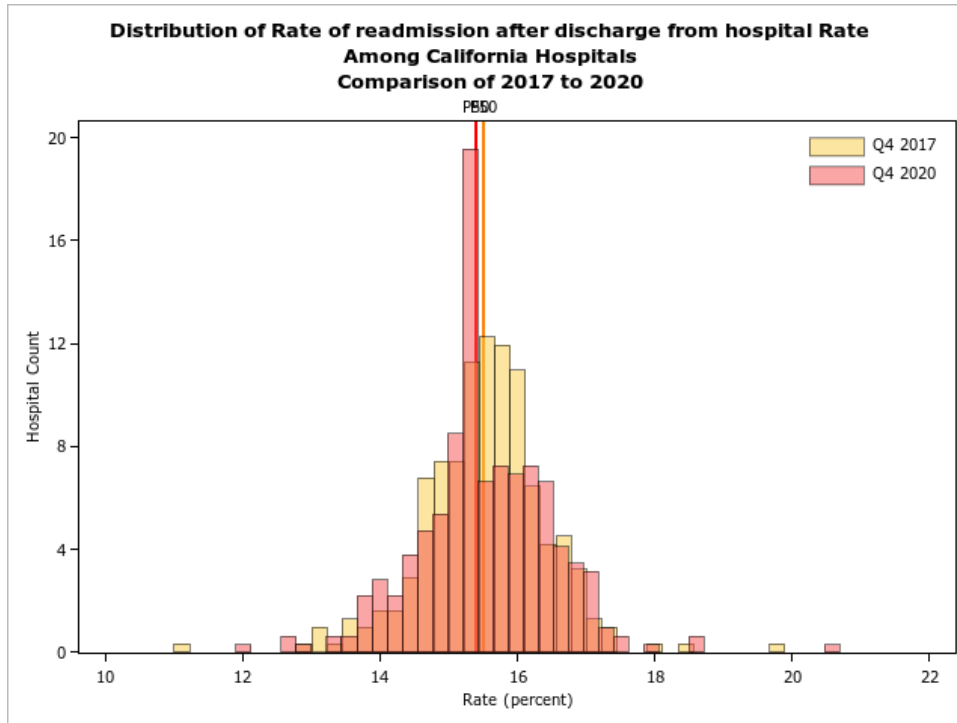
Abbreviations: Denom, denominator.

## Appendix C

### Hospital-Wide All Cause Readmission Rates

Figure 6 shows very little change in either 1) the statewide rate (as reflected by the median rate) and 2) variation across hospitals as reflected in the width of the distribution.

**Figure 7.** Distribution of Rate of Readmission After Discharge from Hospital Rate Among California Hospitals



**Table 8.** Summary Statistics

Summary statistics											
Var	Label	N	Mean	Std Dev	Min	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Max
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%

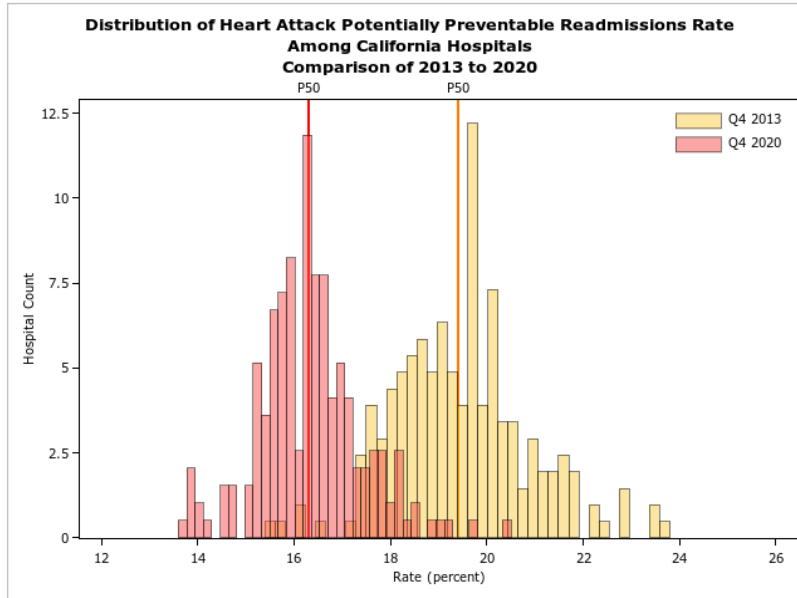
Abbreviations: Max, maximum; Min, minimum; Pctl, percentile; Std Dev, standard deviation; Var, variable.

## Appendix D

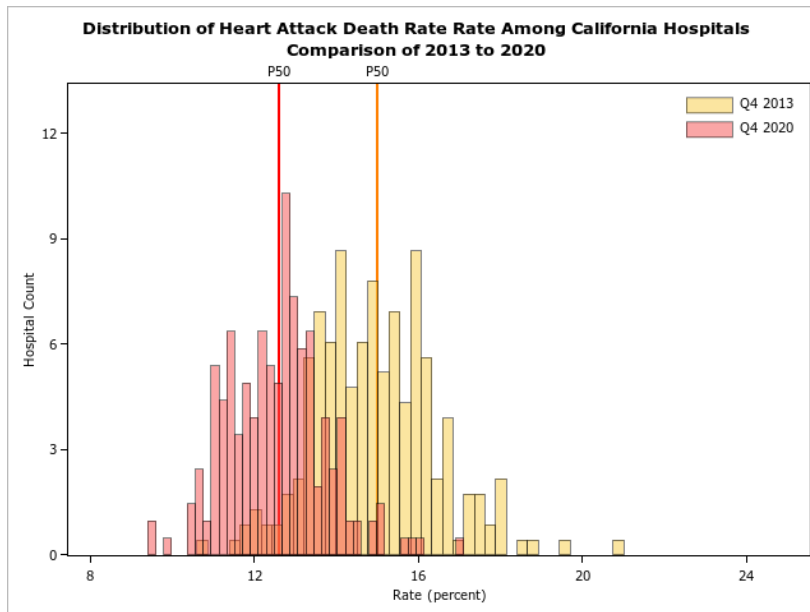
### AMI Mortality and Readmission Rates

Both the AMI mortality and readmissions rates show 1) substantial improvement in statewide rates (as reflected by the median rate) and 2) reduction in the variation across hospitals as reflected in the narrowing of the distributions.

**Figure 8.** Distribution of Heart Attack Potentially Preventable Readmissions Rate



**Figure 9.** Distribution of Heart Attack Death Rate



**Table 9.** Summary Statistics

Summary Statistics										
Variable	Year	Mean	Std Dev	Min	10th Pctl	25th Pctl	50th Pctl	75th Pctl	90th Pctl	Max
Heart Attack Potentially Preventable Readmissions	2013	19.5	1.4	15.4	17.9	18.5	19.4	20.2	21.3	23.8
	2020	16.3	1.1	13.6	15.2	15.7	16.3	16.9	17.8	20.5
Heart Attack Death Rate	2013	14.9	1.5	10.6	13.3	13.9	15.0	15.9	16.7	21.0
	2020	12.6	1.2	9.4	11.1	11.7	12.6	13.3	14.1	17.1

Abbreviations: Max, maximum; Min, minimum; Pctl, percentile; Std Dev, standard deviation; Var, variable.