AGENDA

Quality, Patient Care and Patient Experience Committee Meeting of the El Camino Hospital Board

Monday, May 2nd, 2016, 5:30 p.m.
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, California
Jeff Davis will be participating via teleconference from the following address:
1919 Connecticut Avenue NW, Washington, DC

Purpose: The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is to advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		
1.	**CALL TO ORDER**	David Reeder, Chair Quality Committee		5:30 – 5:31 p.m.
2.	**ROLL CALL**	David Reeder, Chair Quality Committee		5:31 – 5:32
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		5:32 – 5:33
4.	**CONSENT CALENDAR ITEMS:** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee	*public comment*	**Motion Required** 5:33 – 5:38
	Approval: a. Minutes of Quality Committee Meeting - February 29, 2016 b. Minutes of Quality Committee Meeting - April 4, 2016 c. Draft FY Quality Committee Meeting Calendar d. Environment of Care Policies *i. New Policies – (0 Policies)* *ii. Policies with Major Revisions- (1 Policies)* - *6.04 Utility Systems – Equipment Inventory* *iii. Policies with Minor Revisions (8 Policies)* *iv. Policies with no Revisions – Reviewed (5 Policies)* *v. Policies to Archive (1 Policy)* **Information:** e. Pacing Plan f. Patient Story			

A copy of the agenda for the Regular Committee Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at 650-988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		
	g. Research Article h. Committee Charter **ATTACHMENT 4**			
5.	**REPORT ON BOARD ACTIONS**	David Reeder, Chair Quality Committee		**Discussion** 5:38 – 5:43
6.	**FINALIZE FY17 COMMITTEE GOALS** **ATTACHMENT 6**	David Reeder, Chair Quality Committee	*public comment*	**Possible Motion** 5:43 – 5:53
7.	**DRAFT FY17 ORGANIZATIONAL GOALS** **ATTACHMENT 7**	Mick Zdeblick, Chief Operating Officer		**Discussion** 5:53 – 6:03
8.	**FY16 EXCEPTION REPORT** **ATTACHMENT 8**	Daniel Shin, MD, Medical Director Quality Assurance and Patient Safety		**Discussion** 6:03 – 6:23
9.	**PUBLIC COMMUNICATION**	David Reeder, Chair Quality Committee		**Information** 6:23 – 6:26
10.	**ADJOURN TO CLOSED SESSION**			6:26 – 6:27
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		6:37 – 6:28
12.	**CONSENT CALENDAR** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee		**Motion Required** 6:28 – 6:30
	Approval: Meeting Minutes of the Closed Session *Gov't Code Section 54957.2.* - February 29, 2016 - April 4, 2016 **Information:** Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* - Meeting Minutes of Quality Council March 2, 2016			
13.	*Health and Safety Code Section 32106(b)* for a report involving health care facility trade secret. - Committee Self-Assessment Results	Dave Reeder, Chair Quality Committee		**Discussion** 6:30 – 6:50
14.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Red Alert and Orange Alert Update	Daniel Shin, MD, Medical Director Quality Assurance and Patient Safety		**Discussion** 6:50 – 7:15

Agenda: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
May 2, 2016

	AGENDA ITEM	PRESENTED BY		
15.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Chair Quality Committee		7:15 – 7:20
	To report any required disclosures regarding permissible actions taken during Closed Session.			
16.	**ADJOURNMENT**	David Reeder, Chair Quality Committee		7:20p.m.

FY 16 Quality Committee Meetings

- **June 1, 2016**

a. Minutes of Quality Committee Meeting - February 29, 2016

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, February 29th, 2016
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California
Katherine Anderson participated via teleconference from the following address:
Alpha Motoazabu 3-8-48, Motoazabu, Minatu-ku, Tokyo

Members Present	Members Absent	Members Excused
Dave Reeder; Peter Fung, MD; Diana Russell, RN; Jeffrey Davis, MD; Nancy Carragee, Mikele Bunce, Wendy Ron, Alex Tsao, Melora Simon, and Katie Anderson (via teleconference).	Lisa Freeman	Robert Pinsker, MD

A quorum was present at the El Camino Hospital Quality, Patient Care and Patient Experience Committee on the 29th day, February, 2016 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Committee Chair Dave Reeder at 5:36p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted. **Motion:** To approve the consent calendar (Open Minutes of the February 1, 2016 Meeting and Environmental Policies were approved). **Movant:** Davis **Second:** Russell **Ayes:** Anderson, Davis, Fung, Russell, Bunce, Reeder, Carragee, Simon, Tsao, and Ron. **Noes:** None **Abstentions:** None **Absent:** Freeman	***The Open Minutes of the February 1, 2016 Meeting and Environmental Policies were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Excused: Pinsker **Recused:** None	
5. CMO TRANSITION	Chair Reeder updated the Committee on the CMO Transitional Plan & Medical Leadership Team, and clarified the role transfers throughout Dr. Pifer's transition. Dr. Dan Shin will assume all Quality and Patient Centered Care areas, Dr. Dave Francisco will assume On Call and Medical Directors areas, and Dr. Shreyas Mallur, our new Associate Chief Medical Officer, will oversee Quality and Medical Directors at our Los Gatos Campus. Chair Reeder expressed his thanks and appreciation to Dr. Pifer for his diligence in serving the Quality Committee and his steadfast focus on Patient Safety.	
6. REPORT ON BOARD ACTIONS	Chair Reeder reported that the Board is currently focused on the recent land purchase in South San Jose, and the recent Board approval of opening 5 Urgent Care Facilities within the Silicon Valley.	***None***
7. PROPOSED FY17 COMMITTEE GOALS	Dr. Pifer, Chief Medical Officer, reviewed the Proposed FY17 Committee Goals to include: 1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care, and Patient Experience Committee. 2. Biannually review peer review process and medical staff credentialing process. 3. Develop a plan to review exceptions for goals that are being monitored by the management team and report those exceptions to the El Camino board of directors. 4. Review and oversee a plan to ensure the safety of the medication delivery process. The plan should include a global assessment of adverse events and it should include optimizations to the medication safety process using the new iCare tool. Dr. Pifer asked the Committee for feedback and discussion ensued. The Committee asked for the addition of a goal addressing further development of the Patient and Family Centered Care plan.	***None***
8. FY 16 EXCEPTION REPORT	Dr. Pifer, Chief Medical Officer, reviewed the exception report and noted that most metrics have remained stable	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	or improved. Falls improved in December and January and specimen labeling errors remain low. However, surgical site infections increased in November and the metric that remains a priority is medication errors. The exception report showed that December has improved, but medication errors should remain a top priority. Dr. Pifer reported that he and Cheryl Reinking continue to chair weekly medication safety meetings with a large multi-disciplinary team. This team is working on system improvements with medication workflow. Dr. Pifer submitted the Weekly Medication Safety minutes to reflect the current action plans in place. Dr. Pifer asked the Committee for feedback and discussion ensued. * Dr. Pifer asked that Dr. Kemper and Catherine Nalesnik be invited to the April 4th Committee meeting in order to speak to the Surgical Site Infections.	
9. PATIENT AND FAMILY CENTERED CARE UPDATE	Mick Zdeblick, Chief Operating Officer, gave a brief overview of the Patient and Family Centered Care Plan. Mr. Zdeblick reported that since the last Quality Committee meeting senior management held a FY16 & FY17 Priority Setting Retreat. At this retreat all of the efforts required to successfully close out FY16 were reviewed. Major strategic efforts were also outlined. The consensus of the discussion was that now may not be the best time to launch a new endeavor focused on Patient Family Centered Care. Mr. Zdeblick asked the Committee for feedback and discussion ensued. The Committee voiced concern and requested further investigation and development of the Patient and Family Centered Care theme with anticipated implementation by end of FY17.	***None***
10. GREELEY PROJECT REVIEW	Dr. Pifer presented the Greeley Project to the Committee. He further explained that the Greeley Company has been retained to conduct our peer review, and assessment of our Enterprise Scope of Services. Dr. Pifer asked the Committee for feedback and discussion ensued.	
11. PUBLIC COMMUNICATION	None	***None***
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:12 p.m. **Movant:** Freeman **Second:** Carragee	***A motion to adjourn to closed session at 7:12 p.m. was approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Ayes: Anderson, Davis, Fung, Russell, Bunce, Reeder, Carragee, Simon, Tsao, and Ron. **Noes:** None **Abstentions:** None **Absent:** Freeman **Excused:** Pinsker **Recused:** None	
13. AGENDA ITEM 18 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 15 – 17 were reported in closed session.* Chair Reeder reported that the February 1, 2016 Quality Committee Closed Minutes were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates, and upcoming Semi-Annual Board and All Committee Meeting on March 23, 2016.	***None***
14. AGENDA ITEM 19 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:28p.m.	***None***

Attest as to the approval of the Foregoing minutes by the Quality Committee and by the Board of Directors of El Camino Hospital:

_____

Dave Reeder
Patient Experience Committee

b. Minutes of Quality Committee Meeting - April 4, 2016

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, April 4th, 2016
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder; Peter Fung, MD; Diana Russell, RN; Lisa Freeman, and Alex Tsao.	Jeffrey Davis, MD; Nancy Carragee, Mikele Bunce, Melora Simon, Katie Anderson, and Wendy Ron.	Robert Pinsker, MD

A quorum was not present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 4th day, April, 2016 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Committee Chair Dave Reeder at 5:37p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted. ****Chair Reeder asked that the items on the consent calendar (Open Minutes of the February 29, 2016 Meeting, Draft Quality Committee Meeting Calendar, and Environmental Policies) to be agendized for approval the May 2nd, 2016 meeting due to lack of quorum.***	***None due to lack of quorum. Item to be agendized for the May 2nd, 2016 Meeting for approval.***
5. REPORT ON BOARD ACTIONS	Chair Reeder reported that the Board is currently focused on the Budget, Urgent Care Centers, and Primary Care Centers. He further reported that we are behind budget largely in part to the decrease in volumes and Investment returns.	***None***

Agenda Item	Comments/Discussion	Approvals/Action
6. COMMITTEE CHARTER	Chair Reeder presented the Committee with the current Quality Committee Charter for review. He asked if any members had any concerns or revisions to the charter. None were noted.	
7. PROPOSED FY17 COMMITTEE GOALS	Chair Reeder reviewed the Proposed FY17 Committee Goals to include #5 as requested by the Committee: 1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care, and Patient Experience Committee. 2. Biannually review peer review process and medical staff credentialing process. 3. Develop a plan to review exceptions for goals that are being monitored by the management team and report those exceptions to the El Camino board of directors. 4. Review and oversee a plan to ensure the safety of the medication delivery process. The plan should include a global assessment of adverse events and it should include optimizations to the medication safety process using the new iCare tool. 5. Further investigate Patient and Family Centered Care and develop an implementation plan. Chair Reeder noted that further discussion of the Patient and Family Centered Care Theme will be address later in the meeting at Agenda Item 10.	***None***
8. DRAFT FY17 ORGANIZATIONAL GOALS	Dr. Dan Shin presented the Draft FY17 Organizational Goals to the Committee further detailed in the packet. He also presented the Committee with 3 Patient Safety and iCare Goal options to include: Medication Errors, Pain Reassessment, and Patient Satisfaction Pain Management Score. Dr. Shin asked the Committee for feedback and discussion ensued. The Committee generally agreed with the Pain Management goals for recommendation to the Board as the Patient Safety and iCare Goal Option. ****This item will be agendized for approval at the May 2nd, 2016 Quality Committee Meeting.***	***None due to lack of quorum. Item to be agendized for the May 2nd, 2016 Meeting for approval.***
9. FY 16 EXCEPTION REPORT	Dr. Shin, Medical Director of Quality Assurance and Patient Safety, reviewed the exception report and noted that most metrics have remained stable or improved. Specimen labeling errors decreased to "zero" in February due to new hand-held technology, Surgical site	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	infections decreased for two months in November and December, and medication errors have stabilized after iCare implementation. Dr. Carol Kemper; Medical Director for Infection Prevention, and Catherine Nalesnik, RN; Manager for Infection Prevention, attended and reviewed our active surveillance processes for surgical site infections, infection control, reporting requirements, and reporting time frames for 30-day versus 90-day surveillance measures post-operatively. Dr. Kemper reported that we are achieving a Standardized Infection Ratio of less than 1.0 in 28 of 29 surgeries (goal is less than 1.0) that are reported to the National Healthcare Safety Network. Dr. Shin asked the Committee for feedback and discussion ensued.	
10. PATIENT AND FAMILY CENTERED CARE UPDATE	Cheryl Reinking, Chief Nursing Officer, gave a brief overview of the Patient and Family Centered Care Plan. She updated the Committee on current progress and confirmed the actions we want to undertake in the next 6 - 9 months. RJ Salus, Director of Patient Experience further detailed the current Timeline, and the Alignment of projects of FY16 going forward, Governance, and Programs elements already in place. Mr. Salus asked the Committee if they had any comments or questions and discussion ensued. There was discussion regarding implementation of Patient and Family Centered Care (PFCC) including: 1. Defining Planetree's role during Q4 of FY 2016. 2. Facilitating stakeholder conversation in Q1 of FY 2017. 3. Building a roadmap with PaCT and Planetree by Q2 FY 2017. 4. Aligning current efforts to increase patient-centrism, and incorporate PaCT (Lean). 5. PFCC projects to include NICU family-centered patient transport, ED experience mapping, family housing, medication administration, and patient transport.	***None***
11. PUBLIC COMMUNICATION	Chair Reeder asked if there was anyone present with Public Communication for the Quality Committee. A public guest presented material to the Committee regarding an incident during her mother's ER visit	

Agenda Item	Comments/Discussion	Approvals/Action
	which led to urgent surgery. She cited process failures, lack of adequate care, and inadequate response from the hospital. She asked that this case be re-examined. Chair Reeder asked that Joy Pao, MD, Senior Director of Quality, Patient Safety, and Clinical Effectiveness, and RJ Salus, Director of Patient Experience follow up with further investigation of this case.	
12. AGENDA ITEM 17 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 12 – 16 were reported in closed session.* Chair Reeder reported that no actions were taken in closed session due to lack of quorum, and noted the upcoming Quality Committee Meeting dates.	***None***
13. AGENDA ITEM 18 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:36p.m.	***None***

Attest as to the approval of the Foregoing minutes by the Quality Committee and by the Board of Directors of El Camino Hospital:

_____

Dave Reeder
Patient Experience Committee

c. Draft FY Quality Committee Meeting Calendar

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Draft #1 - FY 17 Quality Committee Meeting Calendar

Recommended Quality Committee Date	Corresponding Hospital Board Date
No Meeting	July 2016 – No Meetings
August 1, 2016	August 10, 2016
September 5, 2016	September 14, 2016
October 3, 2016	October 12, 2016
**Monday October 31, 2016 or Wednesday, November 2, 2016*	November 9, 2016
December 5, 2016	December 2015 – No meetings
No Meeting	January 11, 2017
January 30, 2017	February 8, 2017
February 27, 2017	March 8, 2017
April 3, 2017	April 12, 2017
May 1, 2017	May 10, 2017
June 5, 2017	June 14, 2017

Environment of Care Policies

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL

NEW POLICIES				
Policy Number	**Policy Name**	**Department**	**Date**	**Summary of Policy Changes**
POLICIES WITH MAJOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Utility Systems- Equipment Inventory	Utility Management	3/16	Redefining of equipment inventory to high-risk and non-high risk categories
POLICIES WITH MINOR REVISIONS				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
	Fire Safety Management Work Group Responsibilities	Safety Management	3/16	Revised A3
	Employees Responsibility for Fire Prevention	Safety Management	3/16	Included contractors and volunteers to the statement
	Code Red- Fire Response	Safety Management	3/16	Updated locations to include Cedar Pavilion
	Fire Protection Plan	Safety Management	3/16	Wording and location updated to match current building configurations
	Interim Life Safety Measures	Safety Management	3/16	Removed reference to additional fire drills in areas of construction exceeding 3 months
	Fire Drills	Safety Management	3/16	updated language to match current equipment and building configurations
	Reporting Utility Systems or Equipment Failures	Utility Management	3/16	Removal of references to Evergreen and Rose Garden Dialysis
	Utilities Systems or Equipment Failure Response	Utility Management	3/16	Change location where policies are stored to online locations
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	**Policy Name**	**Department**	**Review or Revised Date**	
	Fire Safety Management Plan Development	Safety Management	3/16	
	Fire Watch	Safety Management	3/16	
	Utilities Management Plan	Utility Management	3/16	
	Utilities Management Work Group	Utility Management	3/16	
	Employees Responsibilties for Utilities Management	Utility Management	3/16	
POLICIES TO ARCHIVE				
Policy Number	**Policy Name**	**Department**	**DATE ARCHIVE**	
	Reducing Organizational Acquired Illness	Utility Management	3/16	Necessary sections are covered in another policy under Infection Control

- 6.04 Utility Systems – Equipment Inventory

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Utility Management - 6.04 Utility Systems - Equipment Inventory
CATEGORY:	Safety – Environment of Care
LAST APPROVAL:	05/2012

TYPE:	☑ Policy	☐ Protocol	☐ Scope of Service/ADT	
	☐ Procedure	☐ Standardized Process/Procedure		
SUB-CATEGORY:	Utility Management			
OFFICE OF ORIGIN:	Facilities Services			
ORIGINAL DATE:	06/1998			

I. COVERAGE:

All El Camino Hospital staff, medical staff, and volunteers.

II. PURPOSE:

To ensure utility systems and fixed equipment that have an impact on the care of a patient is included in the inventory and are inspected and maintained in a manner consistent with best practices, organizational experience and applicable codes and standards

III. POLICY STATEMENT:

The inventory of utility systems and equipment is to include all building systems and fixed building equipment that supports the care of the patient.

IV. PROCEDURE:

A. The following utility system categories are included in the utilities management plan:
   1. Domestic Water Systems
   2. Electrical - Emergency Power Systems
   3. Electrical - Normal Power Systems
   4. Elevators, Dumbwaiters and Pneumatic Tube Systems
   5. Fire Detection, Alarm, Control & Communication Systems
   6. Heating, Ventilation and Air Conditioning Systems
   7. Medical Information Data Systems
   8. Medical Gas & Vacuum Systems
   9. Natural Gas Systems
   10. Nurse Call Systems
   11. Sewer Systems
   12. Steam Boiler Systems
   13. Telephone & Paging Systems

B. The detailed inventory of Utility Systems and Equipment is maintained according to the department specific policies and procedures in the Facilities Services Engineering Management Database Program.

C. The hospital establishes and uses risk criteria for identifying, evaluating, and creating an inventory of operating components. These criteria address the following:

- High Risk (including Life Support equipment

  The hospital identifies High Risk operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. High risk components include life support equipment.

- Infection Control

  The hospital identifies Infection Control operating components of utility systems on the inventory for which there is a risk of infection or harm to a patient or staff member should the component fail.

- Non-High Risk~~Support of the Environment~~

  The hospital identifies Non High Risk operating components of utility systems on the inventory for which there is no risk or harm to a patient or staff member should the component fail.

- ~~Equipment Support~~
- ~~Communication~~

~~D. This Risk Criteria format resides within the TMS Maintenance Management system in Facilities Services. The layout and values are as follows:~~

~~**Utilities Management Asset Risk Criteria**~~

~~**Equipment Support Categories (E)**~~

- ~~Non-Patient Related (Miscellaneous) .....(1)~~
- ~~Communications .....(2)~~
- ~~Climate/ Comfort (Support of the Environment) .....(3)~~
- ~~Patient Related (Miscellaneous) .....(4)~~
- ~~Infection Control .....(5)~~
- ~~Fire/ Life Safety .....(6)~~
- ~~Life Support .....(7)~~

~~**Likelihood of Failure (F)**~~

- ~~Greater Than Five Years .....(1)~~
- ~~Approximately Three Years .....(2)~~
- ~~Approximately One Year .....(3)~~
- ~~Approximately Six Months .....(4)~~

~~- Less Than Three Months .....(5)~~

~~**Impact on the Environment of Care (Failure) (I)**~~

~~- Very Low .....(1)~~
~~- Low .....(2)~~
~~- Medium .....(3)~~
~~- High .....(4)~~
~~- Very High .....(5)~~

~~**Preventive Maintenance Requirement (P)**~~

~~- Not Required .....(1)~~
~~- Annually .....(2)~~
~~- Semi-Annually .....(3)~~
~~- Quarterly .....(4)~~
~~- Monthly .....(5)~~
~~- Bi-Weekly .....(6)~~
~~- Weekly .....(7)~~

~~**Environmental Use Classification (U)**~~

~~- Non-Patient Care Areas .....(1)~~
~~- Treatment/ Procedure/ Support/ Exam Areas .....(2)~~
~~- General Patient Care Areas .....(3)~~
~~- Critical Care Areas/ Emergency Services .....(4)~~
~~- Surgical Areas .....(5)~~

V. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Utility Management Work Group	01/2016
Central Safety Committee:	02/09/2016
ePolicy Committee:	
Operations Committee:	
Board of Directors:	
Historical Approvals:	*4/01, 11/03, 8/06, 06/09, 04/12*

Pacing Plan

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE
PROPOSED FY2017 PACING PLAN

FY2017: Q1		
JULY - No Meeting	**AUGUST 3, 2015**	**AUGUST 31, 2015**
Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2016 Committee Goal Completion Status ▪ Pacing Plan ▪ Quality Council Minutes ▪ Patient Story ▪ Research Article	▪ Review and discuss quality summary with attention to risks and overall performance ▪ Corporate scorecard trending **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ APPROVE FY 2016 Organizational Goals (Metrics) ▪ Approve FY 15 Organizational Goal Achievements ▪ Update on PaCT Plan ▪ Year-end review of RCA **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**
FY2017: Q2		
OCTOBER 5, 2015	**NOVEMBER 2, 2015**	**DECEMBER 7, 2015**
▪ Safety Report for the Environment of Care (consent calendar) **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Committee Goals for FY16 Update ▪ ICare Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ iCare Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

PROPOSED FY2017 PACING PLAN

FY2017: Q3		
JANUARY – No Meeting	**FEBRUARY 1, 2016**	**FEBRUARY 29, 2016**
	▪ Patient and Family Centered Care ▪ Service Line Update ▪ Top Risk Case Review **Committee Members to complete on-line self-assessment tool.* **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Begin Development of FY 2017 Committee Goals (3-4 goals) ▪ Peer Review/Care Review Process ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**
FY2017: Q4		
APRIL 4, 2016	**MAY 2, 2016**	**JUNE 1, 2016**
▪ Finalize FY 2017 Committee Goals ▪ Proposed Committee meeting dates for FY2017 ▪ Review DRAFT FY2017 Organizational Goals ▪ Annual Review of Committee Charter ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Review DRAFT FY17 Organizational Goals (as needed) ▪ Set proposed committee meeting calendar for FY 2017 ▪ Review Committee Assessment Results ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ PFAC Update (6 months since Jan) ▪ Review and Discuss Self-Assessment Results ▪ Develop Pacing Calendar for FY17 ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

Patient Story

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Patient Story

A 60-year-old gentleman was admitted through the ED with worsening shortness of breath over the past 2 months. The cause of his symptoms was myocardial infarction and congestive heart failure. Subsequent examination indicated that in order to fully recover he would need extensive cardiovascular surgery – coronary artery bypass grafting (CABG) and an aortic valve replacement. However, it was noted that is teeth were a significant source of infection that would prevent his candidacy for surgery.

To complicate the situation, the patient had a difficult social status with no means of support, living in a van. His health plan coverage (Medicaid) also didn't cover dental care. But the cardiovascular surgeon could not safely proceed with the surgery until the dental work was completed for this gentleman. The Social Worker brought this to the leadership of Care Coordination leadership.

The Care Coordination Director and her team worked tirelessly to secure funding for the dental surgery and made it possible. It took coordination between multiple hospital departments – including working with the Medical Staff Office to find a dental surgeon with privilege to operate at ECH, collaborating with the Operating Room to arrange for sterilization of the oral surgeon's instruments and provision of an operating room for the oral surgery, and anesthesia for sedation.

The patient received his teeth extractions on March 14th and his cardiothoracic surgery on March 15th. He made excellent progress as an inpatient and was arranged to discharge to the Los Gatos Acute Rehabilitation facility.

The Social Worker recalled that when she notified the patient of the arrangements made for dental surgery he became tearful and voiced his appreciation for ECH stating that any other hospital would have just *thrown him back out on the street to continue suffering*.

The Care Coordination Team and other staff member went through colossal efforts to ensure the best care was available and provided to the patient. It is a true story of patient-centeredness!

Research Article

SPECIAL ARTICLE

Two-Year Costs and Quality in the Comprehensive Primary Care Initiative

Stacy Berg Dale, M.P.A., Arkadipta Ghosh, Ph.D., Deborah N. Peikes, M.P.A., Ph.D., Timothy J. Day, M.S.P.H., Frank B. Yoon, Ph.D., Erin Fries Taylor, M.P.P., Ph.D., Kaylyn Swankoski, M.A., Ann S. O'Malley, M.P.H., M.D., Patrick H. Conway, M.D., Rahul Rajkumar, M.D., J.D., Matthew J. Press, M.D., Laura Sessums, J.D., M.D., and Randall Brown, Ph.D.

ABSTRACT

BACKGROUND

The 4-year, multipayer Comprehensive Primary Care Initiative was started in October 2012 to determine whether several forms of support would produce changes in care delivery that would improve the quality and reduce the costs of care at 497 primary care practices in seven regions across the United States. Support included the provision of care-management fees, the opportunity to earn shared savings, and the provision of data feedback and learning support.

METHODS

We tracked changes in the delivery of care by practices participating in the initiative and used difference-in-differences regressions to compare changes over the first 2 years of the initiative in Medicare expenditures, health care utilization, claims-based measures of quality, and patient experience for Medicare fee-for-service beneficiaries attributed to initiative practices and a group of matched comparison practices.

RESULTS

During the first 2 years, initiative practices received a median of $115,000 per clinician in care-management fees. The practices reported improvements in approaches to the delivery of primary care in areas such as management of the care of high-risk patients and enhanced access to care. Changes in average monthly Medicare expenditures per beneficiary did not differ significantly between initiative and comparison practices when care-management fees were not taken into account (–$11; 95% confidence interval [CI], –$23 to $1; P=0.07; negative values indicate less growth in spending at initiative practices) or when these fees were taken into account ($7; 95% CI, –$5 to $19; P=0.27). The only significant differences in other measures were a 3% reduction in primary care visits for initiative practices relative to comparison practices (P<0.001) and changes in two of the six domains of patient experience — discussion of decisions regarding medication with patients and the provision of support for patients taking care of their own health — both of which showed a small improvement in initiative practices relative to comparison practices (P=0.006 and P<0.001, respectively).

CONCLUSIONS

Midway through this 4-year intervention, practices participating in the initiative have reported progress in transforming the delivery of primary care. However, at this point these practices have not yet shown savings in expenditures for Medicare Parts A and B after accounting for care-management fees, nor have they shown an appreciable improvement in the quality of care or patient experience. (Funded by the Department of Health and Human Services, Centers for Medicare and Medicaid Services; ClinicalTrials.gov number, NCT02320591.)

From Mathematica Policy Research, Chicago (S.B.D.), Princeton, NJ (A.G., D.N.P., F.B.Y., K.S., R.B.), and Washington DC (E.F.T., A.S.O.); and the Centers for Medicare and Medicaid Services, Baltimore (T.J.D., P.H.C., R.R., M.J.P., L.S.). Address reprint requests to Ms. Dale at Mathematica Policy Research, 111 E. Upper Wacker Dr., Chicago, IL 60601, or at sdale@mathematica-mpr.com.

This article was published on April 13, 2016, at NEJM.org.

DOI: 10.1056/NEJMsa1414953

Fee-for-service payments give providers the incentive to favor volume over value in the delivery of health care and can produce fragmented care that often lacks coordination, is not patient-centered, and is not proactive in population health management.[1-3] Although efforts to improve the delivery of care through changes in primary care (e.g., the use of patient-centered medical homes [PCMHs]) have expanded rapidly in recent years,[4,5] early evidence of their effect on the quality and cost of health care is mixed.[6]

In October 2012, the Centers for Medicare and Medicaid Services (CMS), in collaboration with 39 private and public payers, launched the Comprehensive Primary Care Initiative. The initiative was intended to test a new approach to the payment and delivery of primary care for 4 years in seven regions across the United States, with the goal of improving quality and reducing costs.[7] The participating primary care practices were required to make changes in care delivery that would build their capability in five functional areas: access to and continuity of care, planned care for preventive and chronic needs, risk-stratified care management, engagement of patients and their caregivers, and coordination of care with patients' other care providers. The initiative did not require practices to have or obtain external recognition as PCMHs.[8] The initiative supports the efforts of these practices by offering enhanced payment, data feedback, and learning support.[7]

The initiative presents an opportunity to evaluate a new multipayer model of payment and primary care delivery in a large and diverse set of practices. In this study, we assess the effects of the initiative on Medicare expenditures, the use of services, selected measures of the quality of care, and patient experience during the first 2 years of the initiative.

Methods

Intervention

The CMS selected seven regions — including four states (Arkansas, Colorado, New Jersey, and Oregon) and three metropolitan areas (Cincinnati–Dayton [Ohio and Kentucky], Hudson Valley–Capital District [New York], and Tulsa, Oklahoma) — on the basis of the extent of payer interest in the initiative and geographic diversity.[9-11] Multipayer participation helps facilitate practice transformation by aligning incentives.[12] Within the selected regions, CMS chose 502 practices (defined according to physical address) from 978 applicants, using, in large part, a score that weighted meaningful use of electronic health records (EHRs) heavily and did not include expenditures or measures of quality (with "meaningful use" referring to the use of EHR technology to improve the quality of health care and to meet other objectives specified by CMS incentive programs). Scores were not associated with a practice's expenditures per Medicare beneficiary at baseline or at follow-up. Most of the practices included in the initiative had substantial room to improve care delivery when the initiative began.[13]

Enhanced payment to initiative practices by CMS and most of the 39 other participating payers was in the form of care-management fees that were not based on visits but were paid on a per-beneficiary per-month basis (in addition to traditional fee-for-service payments) for patients attributed to practices to support and maintain the delivery of enhanced primary care services. (Details of the intervention are provided in Section 1 in the Supplementary Appendix, available with the full text of this article at NEJM.org.) Medicare fee-for-service beneficiaries were attributed on a quarterly basis to practices that delivered the plurality of their primary care visits during a 2-year look-back period (Section 2 in the Supplementary Appendix). For each attributed Medicare beneficiary, CMS paid risk-based, care-management fees that ranged from $8 to $40 per beneficiary per month in the first 2 years of the initiative. The fee level was based on the patient's hierarchical condition category (HCC, a measure of risk for subsequent expenditures) at the time a beneficiary was first attributed to an initiative practice.[14] Other payers (including Medicare Advantage plans, Medicaid managed care, commercial insurers, and CMS [on behalf of Medicaid fee-for-service agencies in some regions]) paid lower fees, in part reflecting the lower average acuity level of their patients.

Annually, beginning in year 2, practices were eligible to share in any Medicare fee-for-service savings resulting from reduced total expenditures, including care-management fees. Many non-Medicare payers also offered practices the opportunity to share in savings. Approaches to calculating shared savings varied across payers.

The approach of Medicare involves calculating savings at the regional level. If a region achieves savings, a practice in that region is eligible to share savings only if it first obtains a minimum number of quality points on the basis of its performance across a set of claims-based measures of quality, electronic measures of clinical quality, and measures of patient experience. The first shared savings distributions occurred in 2015 and were based on savings from 2014 (see Section 1 in the Supplementary Appendix).

Practices also received practice-level feedback reports with quarterly data on Medicare fee-for-service expenditures and service use at the regional, practice, and patient level and received annual data on patient experience and practices' approaches to care delivery. CMS also funded activities that supported clinician learning, including webinars, in-person meetings, and individualized practice coaching.

STUDY DESIGN

We analyzed the 497 practices that were still participating at the end of the first quarter of the initiative (5 practices dropped out after assessing the terms and conditions of participation). We used propensity score matching to select 7 groups of comparison practices — 1 for each region. We selected up to 5 comparison practices per initiative practice to ensure that there were similar characteristics across patients (e.g., age, sex, chronic conditions, and prior expenditures and use of services), practices (e.g., meaningful use of EHRs and number of clinicians), and markets (e.g., mean county income) (Section 3 in the Supplementary Appendix).[15] There were a total of 908 comparison practices.

We drew 30% of comparison practices from those that applied to the initiative but were not selected and 70% of comparison practices from those in areas that were near initiative regions and had similar demographic and market factors. Applicants that were not selected to participate in the initiative provided a strong set of potential comparison practices because they expressed the same motivation to participate in the initiative (motivation cannot be observed for practices in external markets), were in the same markets as the initiative practices, and did not differ significantly from initiative practices in baseline risk-adjusted Medicare expenditures or service use (Section 4 in the Supplementary Appendix). Because there were too few unselected applicant practices to ensure close matches for all initiative practices on the matching criteria, we also included comparison practices from nearby markets.

STUDY OVERSIGHT

The New England Institutional Review Board (IRB) granted the initiative an IRB exemption on the basis of the federal common rule (section 45 CFR 46.101[b][5]), because the purpose of the study was to evaluate a public benefit program. The CMS program team designed and administered the execution of the model for the initiative. The manuscript was approved for submission through a standard CMS communications clearance process.

OUTCOMES AND DATA

Measures of practice transformation were developed with the use of 37 items from a care-delivery module in a survey of practices that were self-scored on a scale of 1 to 12 points, with higher scores reflecting better approaches to the delivery of primary care. Data were collected from all initiative practices in two survey rounds fielded on the Internet in months 1 through 3 of the initiative and again in months 19 through 22. Twenty-five items were taken from the PCMH assessment instrument (PCMH-A, version 1.3).[16] The other items were taken from other surveys or created for the evaluation of the initiative. Members of the evaluation team also visited 21 diverse initiative practices across the seven regions to gather detailed information on program implementation.

We used Medicare claims files (research-identifiable files) from the Virtual Research Data Center. We assessed the effect of the initiative on our primary outcome measures — annualized expenditures in Medicare Parts A and B per beneficiary per month without accounting for care-management fees (gross expenditures) and with accounting for care-management fees (net expenditures). These expenditures did not include beneficiary payments or capitated payments from Medicare for prescription drugs.

To explore the reasons for any changes in expenditures, we also examined utilization measures as secondary outcomes. These outcomes included the annualized number of hospitalizations and outpatient emergency department visits

(i.e., visits that did not lead to an admission), numbers of visits to specialists and primary care clinicians, unplanned readmissions within 30 days after a hospital discharge, and hospitalizations for ambulatory-care–sensitive conditions (conditions for which appropriate ambulatory care can prevent or reduce the need for admission to the hospital). Other secondary measures included measures of quality of care (whether patients with diabetes underwent testing for glycated hemoglobin, lipid, and urinary protein levels and had an eye examination, as well as summary measures of whether patients received all or none of these tests, and whether patients with ischemic vascular disease underwent testing for lipid levels) for all beneficiaries and for beneficiaries in the top HCC quartile; continuity of care (determined on the basis of the proportion of primary care office visits at the attributed practice) (see Section 5 in the Supplementary Appendix for a definition of claims-based outcomes); and measures of patient experience.

Outcomes for patient experience were drawn from two rounds of a patient survey distributed by regular mail 8 to 12 months and 21 to 24 months after the initiative began. We sampled a cross section of Medicare fee-for-service beneficiaries who had been attributed to the practice and had visited the practice in the preceding year. More than 25,000 beneficiaries attributed to initiative practices and nearly 9000 beneficiaries attributed to comparison practices responded in each round (we oversampled initiative practices to support practice-level feedback). The survey included six domains of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Patient-Centered Medical Home Survey (Section 6 in the Supplementary Appendix).[17] Response rates for patients from initiative and comparison practices were 45% and 46%, respectively, in the first round and 48% and 47% in the second round.

STATISTICAL ANALYSIS

The sample for our claims-based analysis included 432,080 Medicare beneficiaries attributed to initiative practices and 890,110 beneficiaries attributed to comparison practices during any quarter of the first 2 years of the initiative (October 1, 2012, through September 30, 2014). Our analyses were based on a difference-in-differences framework. For most analyses, each beneficiary contributed up to one observation to the regression analysis during the baseline period (October 1, 2011, through September 30, 2012), one during the first year of the initiative (October 1, 2012, through September 30, 2013), and one during the second year of the initiative (October 1, 2013, through September 30, 2014); however, for the analysis of continuity of care, each beneficiary contributed only two observations, one for a 2-year baseline period (October 1, 2010, through September 30, 2012) and one for a 2-year intervention period (October 1, 2012, through September 30, 2014).

Beneficiaries new to Medicare after the initiative began were included in the analysis but did not contribute a baseline observation. We assigned beneficiary-level weights equal to the product of the share of the year for which the beneficiary was covered by the Medicare fee-for-service program, and a weight ensuring that initiative and comparison practices were balanced (Section 3 in the Supplementary Appendix). Our intention-to-treat approach continued to include in the sample beneficiaries who had died or were no longer attributed to their original practice (because they had begun to obtain the plurality of their primary care visits from a different practice). This approach also continued to include beneficiaries if the practice to which they had been attributed had closed (4 practices), had withdrawn from the initiative (12 practices), had been removed from the initiative (4 practices), had merged (2 practices became 1 practice), or had split (3 practices became 6 distinct practices) (Section 7 in the Supplementary Appendix).

We estimated linear regressions for measures of patient experience and Medicare expenditures with and without care-management fees; zero-inflated negative binomial models for overall hospitalizations, hospitalizations for ambulatory-care–sensitive conditions, and emergency department visits; negative binomial models for the number of primary care and specialist visits; and logistic models for readmissions and claims-based quality-of-care measures. The regressions controlled for beneficiary characteristics before the initiative began — demographics (age, race and ethnic group, and sex), region, original reason for Medicare eligibility, Medicaid dual eligibility status, and HCC score — and the baseline characteristics of the beneficiary's attributed practice, thus netting out remaining observable,

preexisting differences between initiative beneficiaries and comparison beneficiaries that were not accounted for by the matching of practices' mean patient characteristics. Regressions for patient experience also controlled for patients' prior use of services and self-reported educational level and were weighted to adjust for a potential bias toward nonresponse. All standard errors accounted for the clustering of patient outcomes within practices (Section 3 in the Supplementary Appendix). We performed all statistical analyses with Stata software, version 13.

For two-tailed tests at the 5% significance level, our analysis had 80% power to detect differences in annualized Medicare expenditures that were at least 2% higher or lower than the mean for comparison practices ($16 per beneficiary per month, which is less than the average care-management fee). We did not adjust P values for multiple comparisons but did attempt to avoid type I errors by focusing on summary measures when possible and by using a conservative significance level of 0.01 for all measures of secondary outcomes.

RESULTS

ENHANCED PAYMENTS

The median total care-management fees from all payers combined over the first 2 years of the initiative were approximately $389,000 per practice, or about 15% of annualized practice revenue, which translates to a median amount of $115,000 per clinician or a mean of $131,000 per clinician. This amount varied according to practice and region depending on the number of participating payers, the number of patients attributed to practices by each participating payer, and each payer's payment amount.

CHANGES IN PRIMARY CARE DELIVERY

The responses of the practices to the modified PCMH-A survey suggested considerable improvement overall since the start of the initiative (from an average of 6.5 at baseline to an average of 8.8 after 2 years on the basis of a 12-point scale used to assess approaches to the delivery of primary care, with higher numbers indicating better approaches), particularly with regard to risk-stratified care management and access to care, for which the averages increased from 4.6 to 9.7 and from 7.0 to 9.6, respectively (Section 8 in the Supplementary Appendix). The practice survey and site visits indicated that efforts to undertake transformation were often challenging. Common challenges included refining workflows and procedures for the purpose of implementing, documenting, and reporting initiative requirements, trying to incorporate new staff roles (such as that of care manager) into the primary care team, and trying to overcome the incompatibility of EHRs when attempting to communicate with other providers. Initiative practices began to stratify patients according to risk systematically and hired or repurposed staff to help manage the care of high-risk patients, particularly with respect to providing patient education, monitoring the care of patients with chronic conditions, and providing follow-up after discharge from the hospital or emergency department. To improve patients' access to care, practices worked on increasing patients' use of patient portals, decreasing wait times for appointments, increasing telephone access to the practice, and increasing after-hours access to clinicians by means of e-mail, telephone, or in-person visits.

Selected comparison practices and initiative practices had similar characteristics, and the expenditures for and use of services by their attributed Medicare fee-for-service beneficiaries were similar at baseline. (Table 1, and Section 3 in the Supplementary Appendix). The trajectory of Medicare expenditures was similar in the two groups in the 2 years before the initiative began (Fig. 1); regression-adjusted quarterly expenditures increased over time in both groups as beneficiaries became older or died.[18] Nearly 4% of both initiative and comparison beneficiaries died during each of the first 2 years of the initiative (P=0.34 and 0.72, respectively).

EFFECTS ON EXPENDITURES AND SERVICE USE

During these first 2 years, difference-in-differences estimates showed no significant differences (at the 5% level) in the growth of expenditures, without or with the inclusion of care-management fees. Without fees, average expenditures in the initiative practices increased $11 less (95% CI, −$23 to $1) per beneficiary per month than those in the comparison practices (difference, 1.3%; P=0.07) (Table 2). With fees, average expenditures in the initiative practices increased $7 more (95% CI, −$5 to $19) per beneficiary per month than those in the comparison practices

Table 1. Baseline Characteristics of Initiative Practices and Matched Comparison Practices.*

Characteristic	Initiative Practices	Comparison Practices	Difference between Initiative and Comparison Practices	P Value
Percentage of practices with ≥1 clinician who was a Medicare meaningful EHR user as of June 2012†	79	79	0	1.0
Percentage of practices with state- or NCQA medical-home recognition by autumn 2012	39	37	3‡	0.20
Mean no. of clinicians§	4.2	4.6	0.4	0.64
Percentage of practices' clinicians with primary care specialty§	94	94	0	0.92
Percentage of practices owned by larger organization§	55	54	1	0.85
Percentage of practices located in medically underserved area¶	11	14	−3	0.17
Percentage of practice's county that is urban‖	78	75	3	0.08
Mean no. of attributed Medicare beneficiaries**	635	698	−63	0.14
Percentage of attributed Medicare beneficiaries who are white**	91	92	−1	0.23
Mean HCC score among attributed Medicare beneficiaries‖††	0.99	1.00	−0.01	0.57
Annualized inpatient hospital visits among attributed Medicare beneficiaries (mean no./patient) **	0.26	0.26	0	0.91
Annualized emergency department visits among attributed Medicare beneficiaries (mean no./patient)**	0.57	0.58	−0.01	0.48
Average annualized total Medicare Part A and B expenditures among attributed Medicare beneficiaries ($)**	7224	7172	52	0.71

* The same data sources were used for practices in the Comprehensive Primary Care Initiative and comparison practices. Means are weighted to account for matching. Patient-level averages are based on the services used between January 2010 and February 2012 among Medicare fee-for-service beneficiaries attributed to practices during the period before the beginning of the initiative (May 2010 through April 2012). NCQA denotes National Committee for Quality Assurance.
† A meaningful electronic-health-record (EHR) user is a clinician who qualifies for Centers for Medicare and Medicaid Services (CMS) incentive programs by having used certified EHR technology to improve the quality of health care and to meet other objectives specified by CMS.
‡ The actual difference was 2.9; the apparent discrepancy is due to rounding.
§ Data are from SK&A, a health care marketing vendor.
¶ Numbers are based on 2009 data from the Health Resources and Services Administration (HRSA).
‖ Data are from the 2009 Area Health Resource Files provided by the HRSA.
** Data are from the CMS Virtual Research Data Center.
†† Hierarchical condition category (HCC) scores were calculated by CMS such that the average for the Medicare fee-for-service population nationally was 1.0. A patient with a risk score of 1.30 was predicted to have costs that would be approximately 30% above the average, whereas a patient with a risk score of 0.70 was expected to have costs that would be approximately 30% below the average.

(difference, 0.9%; P=0.27). A one-sided equivalence test did not support the conclusion that reductions in expenditures without fees equaled or exceeded the fees CMS paid (P=0.87).

Results for overall expenditures were generally consistent across variations in model specifications, the length of time before the initiative included in the baseline, the composition of the comparison practices, and the composition of the sample (i.e., whether we followed beneficiaries attributed in any quarter versus only those attributed in the first quarter), and they did not vary systematically across key subgroups of practices. The estimated effects on Medicare expenditures were larger in magnitude but similar in percentage for high-risk beneficiaries. Effects on expenditures varied across initiative regions. Relative to the comparison group, initiative practices had significant reductions in expenditures when fees were not included in two regions — New Jersey and Tulsa (P = 0.005 and 0.026, respectively) — and significant increases in net expenditures when fees were included in Cincinnati–Dayton (P = 0.006) (Section 4 in the Supplementary Appendix).

Relative to comparison practices, the number of hospitalizations did not change significantly for initiative practices over the 2-year period (P=0.13) (Table 2), but growth in the number of visits to primary care physicians was 3% less for

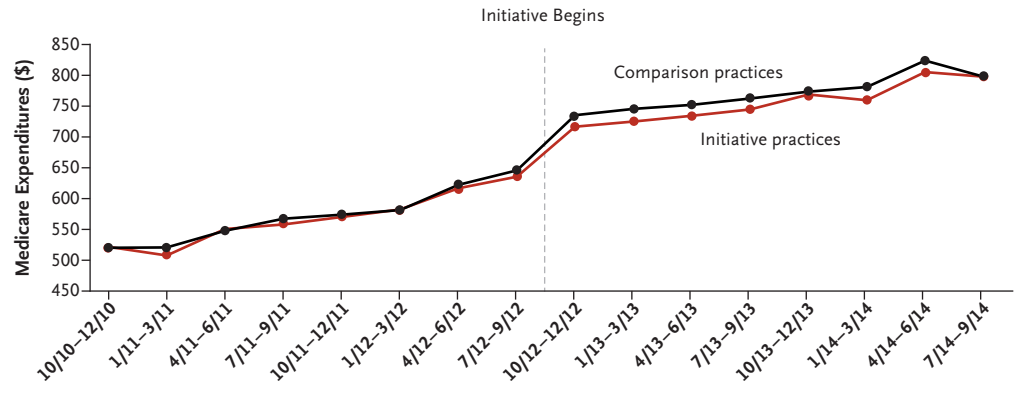


Figure 1. Regression-Adjusted Medicare Expenditures without Care-Management Fees.

Mean values were adjusted with the use of a regression analysis that controlled for patient characteristics (including hierarchical condition category scores, which are a measure of risk for subsequent expenditures) and practice characteristics. Data are based on Medicare claims for October 2010 through September 2014. The term "initiative" refers to the Comprehensive Primary Care Initiative.

initiative practices than for comparison practices (P<0.001). There were no significant differences in other outcomes for utilization.

EFFECTS ON QUALITY OF CARE AND PATIENT EXPERIENCE

Generally, the initiative did not have significant effects on the processes used as measures of the quality of care for the full sample (Table 3). However, for high-risk patients (the top HCC quartile) with diabetes, the increase in the likelihood of receiving all four recommended tests for diabetes was significantly greater among patients in initiative practices than among patients in comparison practices, with a difference of approximately 3 percentage points in each follow-up year (P=0.001 in year 1 and P=0.01 in year 2). (See Section 4 in the Supplementary Appendix for detailed results on secondary outcomes.)

Patient ratings of care indicated small improvements with regard to the support providers offered to help patients take care of their own health (3.8 percentage points, P<0.001) and to discuss with patients decisions related to medication (3.2 percentage points, P=0.006). These changes were driven by small improvements (<2 percentage points) in initiative practices and small declines in comparison practices (Table 4). There were no significant effects on other composite measures: ability of patients to obtain timely appointments, care, and information; how well providers communicate with patients; provider's knowledge of care patient received from other providers; and overall rating of providers by patients.

DISCUSSION

This evaluation of the large, multipayer initiative after its initial 2 years contributes to our understanding of new approaches to the payment for and delivery of primary care. Prior studies of diverse interventions that focused on the transformation of primary care have been limited and have yielded mixed results.[19-33] Most published studies either examined pilot interventions in single markets[19-28] with small numbers of practices[21-27] and one or a few payers[19,21-26,28] or did not examine expenditures.[19,24-25,27,29-32] Five studies were conducted in multiple markets and included large numbers of practices or clinics,[29-33] but three of these were executed in unusual settings and involved only one payer,[29,32-33] and one has not yet examined outcomes.[30] In contrast, our study involved a substantial investment from CMS and others through multipayer collaboration, included a large number of practices in diverse regions, and did not require PCMH recognition but did require practices to meet specific requirements across various aspects of care delivery.

Our results suggest that initiative practices are

Table 2. Effects on Medicare Fee-for-Service Expenditures per Beneficiary and Service Use in Years 1 and 2 of Intervention.*

Expenditure or Utilization	Baseline		Years 1 and 2		Adjusted Difference-in-Differences (95% CI)	Relative Difference	P Value
	Initiative Practices	Comparison Practices	Initiative Practices	Comparison Practices			
	adjusted mean					%	
Total Medicare expenditures ($/beneficiary/mo)							
Without initiative care-management fees	629	631	784	798	−11 (−23 to 1)	−1	0.07
With initiative care-management fees	629	631	802	798	7 (−5 to 19)	1	0.27
Utilization							
Hospitalizations (annualized rate/1000 beneficiaries)	255	256	301	307	−5 (−12 to 2)	−2	0.13
Outpatient emergency department visits (annualized rate/1000 beneficiaries)	435	448	479	495	−4 (−13 to 5)	−1	0.40
Primary care visits in all settings (annualized rate/1000 beneficiaries)	6879	7142	7912	8405	−230 (−357 to −103)	−3	<0.001
Specialist visits in all settings (annualized rate/1000 beneficiaries)	12,471	12,534	13,257	13,326	−6 (−152 to 141)	0	0.94
Admissions for ambulatory-care-sensitive conditions (annualized rate/1000 beneficiaries)†	49	51	67	68	1 (−2 to 3)	1	0.54
Likelihood of 30-day readmission after discharge (%)	13.3	13.2	14.5	14.8	0 (−0.9 to 0.3)	−2	0.30
Likelihood of 14-day follow-up visit with any provider after discharge (%)	63.1	63.2	62.5	63.1	0 (−1.5 to 0.6)	−1	0.40

* Data are from Medicare claims, October 2011 through September 2014. The relative difference is the absolute difference-in-differences estimate as a percentage of what the Comprehensive Primary Care Initiative group mean would have been in the absence of the initiative (i.e., the unadjusted initiative group mean minus the difference-in-differences estimate). Our sample includes the 432,080 Medicare beneficiaries attributed to initiative practices and 890,110 attributed to matched comparison practices during any quarter in the first 2 years of the initiative. The analysis included up to three observations per beneficiary (for the year before the initiative and for each year of the initiative), totaling 3,578,630 observations for the initiative and comparison beneficiaries together, with the exception of readmissions and 14-day follow-up visits, for which the analysis included 865,146 discharges. Estimates here were based on regressions with a single indicator for the first 2 years of the initiative; Section 4 of the Supplementary Appendix provides separate yearly estimates.

† Ambulatory-care–sensitive conditions are conditions for which appropriate ambulatory care can prevent or reduce the need for admission to the hospital.

The New England Journal of Medicine

Table 3. Effects on Claims-Based Process-of-Care and Continuity-of-Care Measures for Medicare Fee-for-Service Beneficiaries.*

Measure	Baseline		Year 2		Adjusted Difference-in-Differences (95% CI)	Relative Difference	P Value
	Initiative Practices	Comparison Practices	Initiative Practices	Comparison Practices			
	adjusted mean (%)				*percentage points*	%	
Quality of care							
For patients with diabetes							
Glycated hemoglobin level tested	76.5	78.8	78.2	80.3	0.2 (–1.6 to 1.9)	0	0.87
Lipid level tested	83.6	83.8	84.0	83.7	0.6 (–0.7 to 1.9)	1	0.40
Eye examination performed	54.6	54.9	56.7	56.0	1.0 (–0.2 to 2.3)	2	0.11
Urine protein level tested	58.5	59.9	64.1	63.9	1.6 (–0.4 to 3.6)	3	0.12
All above tests performed	29.8	31.5	33.3	33.9	1.2 (–0.5 to 2.9)	4	0.18
None of above tests performed	6.1	5.6	5.0	5.2	–0.6 (–1.2 to –0.1)	–11	0.03
For patients with ischemic vascular disease							
Lipid level tested	80.6	81.2	77.8	78.2	0.3 (–1.3 to 1.8)	0	0.75
Continuity of care							
Primary care visits at attributed practice	84.0	81.6	72.2†	70.0†	–0.2 (–1.6 to 1.2)	0	0.80

* Data are from Medicare claims, October 2011 through September 2014. The relative difference is the absolute difference-in-differences estimate as a percentage of what the initiative group mean would have been in the absence of the initiative (i.e., the unadjusted initiative group mean minus the difference-in-differences estimate). This table includes results for year 2 only for quality-of-care outcomes; results for year 1 are provided in Section 4 in the Supplementary Appendix. For quality of care, the analysis included up to three observations per beneficiary (for the year before and for each of the first 2 years of the initiative), totaling 398,415 observations for patients with diabetes and 405,346 observations for patients with ischemic vascular disease. For the continuity-of-care measure, each beneficiary attributed in the first quarter of the initiative contributed two observations (one for the 2-year period before and another for the first 2 years of the initiative) for a total of 1,277,724 observations across the two periods.

† For continuity of care, the adjusted mean percentages were calculated with the use of data from years 1 and 2 of the study.

Table 4. Effects on Patient Experience for Medicare Fee-for-Service Beneficiaries — Difference in Differences of Predicted Probabilities of the Most Favorable Responses, 2013 and 2014.*

Composite Measure	2013		2014		Difference in Differences	P Value
	Initiative Practices	Comparison Practices	Initiative Practices	Comparison Practices		
	percent with most favorable response				*percentage points*	
Timely appointments, care, and information — 5 questions asking about patient's ability to get timely appointments, timely answers to medical questions, and no more than a 15-minute wait at time of appointment	52.2	53.6	52.7	52.0	2.1	0.05
Providers' communication with patients — 6 questions asking how often providers explained things clearly, listened carefully to the patient's health questions and concerns, provided easy-to-understand information, knew important information about the patient's medical history, showed respect for and spent enough time with patient	79.4	80.5	79.7	80.4	0.5	0.56
Providers' knowledge of care received from other providers — 2 questions asking how often provider seemed informed and up-to-date regarding care patient received from specialists and whether practice staff spoke with patient at each visit about all medications patient was taking	75.7	76.5	76.1	75.8	1.1	0.20
Support for patients in caring for their own health — 2 questions asking whether someone in provider's office discussed with patient his or her specific goals for health and whether there were things in life that make it hard for patient to take care of his or her health	45.9	48.0	47.8	46.1	3.8	<0.001
Discussion of medication with patients — 3 questions asking if the patient talked about starting or stopping a prescription medicine, how often the provider talked about the reasons the patient might and might not want to take the medicine, and what the patient thought was best	59.9	62.7	61.5	61.1	3.2	0.006
Patient rating of providers — 1 question asking patient to rate his or her provider on scale of 0 (the worst provider possible) to 10 (the best provider possible)	74.9	76.2	75.6	76.3	0.6	0.62

* Data are from surveys conducted in 2013 and 2014 among a sample of attributed Medicare fee-for-service beneficiaries in the initiative and matched comparison practices. Patients were asked about their experiences in the preceding 12 months. Following the scoring instructions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey, we created six composite measures using 19 survey questions. We first calculated patient-level composite scores — a measure of the percentage of questions in each composite that the patient responded to with the most favorable response — by averaging binary indicators for whether the patient's response to the survey question was the most favorable across each question in the composite. We then ran an ordinary least-squares regression on patient-level composite measures, controlling for baseline patient and practice characteristics to obtain the composite measures for the initiative and comparison samples.

transforming care delivery. However, midway through the intervention, relative to comparison practices, the initiative has not yet generated savings in Medicare Part A and B expenditures that are sufficient to cover care-management fees. The 3% reduction in primary care visits, albeit a small contributor to total expenditures, suggests that nonbillable calls, e-mails, and interactions related to care management, supported by initiative fees, may have supplanted or reduced the need for office visits. We did observe statistically significant but small improvements in two of six domains of patient experience but no appreciable improvements in the quality-of-care measures.

There are a few possible reasons why these findings were not more favorable. First, practices may need more time to fully implement changes in care delivery that translate to improved outcomes.[34,35] In addition, since many practices were not necessarily attuned to the details of shared savings, more time may be required for the incentive of shared savings to influence care. It is also possible that primary care practices need stronger value-based incentives, accompanied by consistent incentives for other providers who care for the same patients. In addition, improvements in care that occurred in comparison practices owing to influences such as the growth of accountable care organizations, the increase in penalties for high readmission rates, and other efforts to transform primary care may have made it more difficult for initiative practices to generate savings or broader improvements in quality relative to the comparison practices. Finally, it is possible that practices will reduce expenditures enough to offset a lower fee; CMS will reduce its average fee to $15 per beneficiary per month in the last 2 years of the initiative, reducing not only the gross savings required to reach cost neutrality but also the resources available to achieve those savings.

This study has several limitations. First, practice participation in the initiative is voluntary, and our analysis is limited to their attributed Medicare fee-for-service beneficiaries. Second, because patient experience was not measured before the initiative began, there may have been preexisting differential trends between initiative and comparison practices. Finally, although comparison practices were well matched to initiative practices on the basis of observed characteristics, there could have been differences in unobserved characteristics that influence outcomes.

Analysis of the final 2 years of the initiative will determine the ultimate effect of this approach. As CMS increasingly pays for health care through alternative payment models that reward quality and value, the initiative may help inform future policies guiding models for primary care delivery in the United States.[36]

The views expressed in this article are solely those of the authors and do not necessarily represent the policy or views of the Centers for Medicare and Medicaid Services (CMS).

Supported by the Department of Health and Human Services, CMS, under contract HHSM-500-2010-00026I/HHSM-500-T0006.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

We thank the participating practices and payers and the CMS Comprehensive Primary Care Implementation Team and its contractors for their continual cooperation and willingness to share information and data with the evaluation team; the Research and Rapid Cycle Evaluation Group of CMS for feedback on earlier versions of the manuscript and input into the overall research design; countless staff (too many to name here) from our larger team at Mathematica Policy Research and Group Health Research Institute for their contributions to the evaluation; and Grace Anglin, Richard Chapman, Lara Converse, Tyler Fisher, Mark Flick, John Holland, Jeffrey Holt, Neetu Jain, Zachary James, Nikkilyn Morrison, Brenda Natzke, Connie Qian, Rachel Shapiro, and Xiaofan Sun; Drs. Karen Bogen, Nancy Clusen, Jesse C. Crosson, Nancy Duda, Mariel Finucane, Kristin Geonnotti, Rosalind Keith, Dmitriy Poznyak, Lori Timmins, and Aparajita Zutshi, all from Mathematica Policy Research; and Dr. Robert Reid from Group Health Research Institute.

REFERENCES

1. Bodenheimer T, Pham HH. Primary care: current problems and proposed solutions. Health Aff (Millwood) 2010;29:799-805.
2. Dentzer S. Reinventing primary care: a task that is far 'too important to fail.' Health Aff (Millwood) 2010;29:757.
3. Berenson RA, Rich EC. How to buy a medical home? Policy options and practical questions. J Gen Intern Med 2010;25:619-24.
4. Edwards ST, Bitton A, Hong J, Landon BE. Patient-centered medical home initiatives expanded in 2009-13: providers, patients, and payment incentives increased. Health Aff (Millwood) 2014;33:1823-31.
5. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. Washington, DC: Patient-Centered Primary Care Collaborative, March 2007 (http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf).
6. Peikes D, Zutshi A, Genevro JL, Parchman ML, Meyers DS. Early evaluations of the medical home: building on a promising start. Am J Manag Care 2012;18:105-16.
7. Centers for Medicare & Medicaid Services. Comprehensive Primary Care Initiative (http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/).
8. Centers for Medicare & Medicaid Services. Comprehensive Primary Care (CPC) Initiative: primary care practice solicitation (http://innovation.cms.gov/Files/x/CPC_PracticeSolicitation.pdf).

9. Peikes D, Taylor E, Dale S, et al. Evaluation of the Comprehensive Primary Care Initiative: design report. Princeton, NJ: Mathematica Policy Research, February 28, 2014.
10. Taylor EF, Dale S, Peikes D, et al. Evaluation of the Comprehensive Primary Care Initiative: first annual report. Princeton, NJ: Mathematica Policy Research, January 2015 (https://innovation.cms.gov/files/reports/cpci-evalrpt1.pdf).
11. Peikes D, Taylor EF, Dale S, et al. Evaluation of the Comprehensive Primary Care Initiative: second annual report. Princeton, NJ: Mathematica Policy Research, April 13, 2016 (https://innovation.cms.gov/files/reports/cpci-evalrpt2.pdf).
12. Rajkumar R, Conway PH, Tavenner M. CMS — engaging multiple payers in payment reform. JAMA 2014;311:1967-8.
13. Shapiro R, Peikes D, Dale S, et al. Fixing primary care: insights from practices in CMS's Comprehensive Primary Care Initiative. Presented at the AcademyHealth 2013 Annual Research Meeting, Baltimore, June 25, 2013.
14. Pope GC, Kautter J, Ellis RP, et al. Risk adjustment of Medicare capitation payments using the CMS-HCC model. Health Care Financ Rev 2004;25:119-41.
15. Hansen BB. Full matching in an observational study of coaching for the SAT. J Am Stat Assoc 2004;99:609-18.
16. Safety Net Medical Home Initiative. Patient-Centered Medical Home Assessment (PCMH-A), version 4.0. Seattle: MacColl Center for Health Care Innovation, Group Health Cooperative, September 2014 (http://www.improvingchroniccare.org/downloads/pcmha.pdf).
17. Scholle SH, Vuong O, Ding L, et al. Development of and field test results for the CAHPS PCMH Survey. Med Care 2012; 50 Suppl:S2-10.
18. Hogan C, Lunney J, Gabel J, Lynn J. Medicare beneficiaries' costs of care in the last year of life. Health Aff (Millwood) 2001;20:188-95.
19. Friedberg MW, Rosenthal MB, Werner RM, Volpp KG, Schneider EC. Effects of a medical home and shared savings intervention on quality and utilization of care. JAMA Intern Med 2015;175:1362-8.
20. Friedberg MW, Schneider EC, Rosenthal MB, Volpp KG, Werner RM. Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care. JAMA 2014;311:815-25.
21. Reid RJ, Coleman K, Johnson EA, et al. The Group Health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. Health Aff (Millwood) 2010;29:835-43.
22. Gilfillan RJ, Tomcavage J, Rosenthal MB, et al. Value and the medical home: effects of transformed primary care. Am J Manag Care 2010;16:607-14.
23. Werner RM, Duggan M, Duey K, Zhu J, Stuart EA. The patient-centered medical home: an evaluation of a single private payer demonstration in New Jersey. Med Care 2013;51:487-93.
24. Rosenthal MB, Friedberg MW, Singer SJ, Eastman D, Li Z, Schneider EC. Effect of a multipayer patient-centered medical home on health care utilization and quality: the Rhode Island Chronic Care Sustainability Initiative pilot program. JAMA Intern Med 2013;173:1907-13.
25. Heyworth L, Bitton A, Lipsitz SR, et al. Patient-centered medical home transformation with payment reform: patient experience outcomes. Am J Manag Care 2014;20:26-33.
26. Reid RJ, Fishman PA, Yu O, et al. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Am J Manag Care 2009;15(9):e71-87.
27. Kern LM, Dhopeshwarkar RV, Edwards A, Kaushal R. Patient experience over time in patient-centered medical homes. Am J Manag Care 2013;19:403-10.
28. Maeng DD, Davis DE, Tomcavage J, Graf TR, Procopio KM. Improving patient experience by transforming primary care: evidence from Geisinger's patient-centered medical homes. Popul Health Manag 2013;16:157-63.
29. Werner RM, Canamucio A, Shea JA, True G. The medical home transformation in the Veterans Health Administration: an evaluation of early changes in primary care delivery. Health Serv Res 2014;49: 1329-47.
30. McCall N, Haber S, Van Hasselt M, et al. Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration: first annual report. Research Triangle Park, NC: RTI International, 2015 (https://downloads.cms.gov/files/cmmi/MAPCP-FirstEvaluationReport_1_23_15.pdf).
31. Jaén CR, Ferrer RL, Miller WL, et al. Patient outcomes at 26 months in the patient-centered medical home National Demonstration Project. Ann Fam Med 2010;8:Suppl 1:S57-67, S92.
32. Reddy A, Canamucio A, Werner RM. Impact of the patient-centered medical home on veterans' experience of care. Am J Manag Care 2015;21:413-21.
33. Kahn KL, Timbie JW, Friedberg MW, et al. Evaluation of CMS's Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) demonstration: final second annual report. Santa Monica, CA: RAND, 2015.
34. Nutting PA, Crabtree BF, Miller WL, Stange KC, Stewart E, Jaén C. Transforming physician practices to patient-centered medical homes: lessons from the National Demonstration Project. Health Aff (Millwood) 2011;30:439-45.
35. McNellis RJ, Genevro JL, Meyers DS. Lessons learned from the study of primary care transformation. Ann Fam Med 2013;11:Suppl 1:S1-5.
36. Burwell SM. Setting value-based payment goals — HHS efforts to improve U.S. health care. N Engl J Med 2015;372: 897-9.

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

APRIL 14, 2016

The Virtues and Vices of Single-Payer Health Care

Jonathan Oberlander, Ph.D.

The 2016 U.S. presidential campaign has produced many surprises. One unexpected turn is the reemergence of single-payer health insurance on the public agenda. Senator Bernie Sanders has made Medicare for All a centerpiece of his platform. His opponent for the Democratic party's presidential nomination, former Secretary of State Hillary Clinton, has criticized Sanders's plan as unrealistic. An old debate has thus reopened. What are the virtues and vices of single-payer reform? Is it a realistic option for the United States or a political impossibility?

First, a note on language. "Single payer" is often used loosely to refer to everything from Canadian national health insurance to the British National Health Service (NHS) and even Obamacare — though depicting the Affordable Care Act (ACA) as a "slippery slope" to single payer is bizarre, given that it relies on private insurance. U.S. observers often mistakenly lump all foreign health systems together under the single-payer label — a classification that grossly oversimplifies the range of models in place elsewhere.[1,2] In some rich democracies (Germany, the Netherlands, and Switzerland among them) people enroll in multiple insurance plans, which are typically highly regulated and are operated by private companies or nonprofit associations. Alternatively, in the NHS, the government traditionally owned most hospitals and directly employed many physicians.

Most U.S. single-payer advocates instead have in mind emulating Canada, where all legal residents in each province or territory receive coverage from one government insurance plan for medically necessary hospital and physician services. Canadians can obtain private policies for supplemental services not covered by the government plan. The government does not directly employ most doctors, nor does it own most hospitals, though their payments come from the single provincial insurance program. Canadian national health insurance arrangements — and Taiwan has a similar system — resemble traditional U.S. Medicare, with public financing for privately delivered services.[3] Sanders is not the only presidential candidate to find this model appealing. Donald Trump has praised the Canadian program, though recently he suggested it wouldn't work here.

Proposals for U.S. single-payer reform have a long history. A 1943 bill subsequently endorsed by President Harry Truman in 1945 envisioned national health insurance funded through payroll taxes. That bill and subsequent efforts by the

Truman administration to pass universal insurance went nowhere. However, Medicare, conceived in the 1950s and enacted in 1965, embodied the single-payer model. Medicare's architects saw it as the cornerstone of a national health insurance system. They believed that Medicare would eventually expand — with children perhaps the next group to join the program — to cover the entire population. That aspiration was never realized. Meanwhile, Congress created Medicaid as a separate program for some categories of low-income Americans, including families with dependent children, further fragmenting the insurance pool.[4]

Single payer enjoyed strong support during the early 1970s among liberal Democrats such as Senator Ted Kennedy (D-MA), yet it never came close to passing. Subsequently, its political fortunes faded. Democratic policymakers increasingly pursued incrementalism (primarily through Medicaid expansion) and more conservative models that relied on private insurance (managed competition) as the only feasible reform routes. Medicare itself underwent a transformation as the role of private insurers in the program grew substantially. The 2010 ACA represented both a landmark achievement in expanding access to insurance and the culmination of a turn away from single payer. In 2009, the House of Representatives did pass legislation creating a Medicare-like government insurance program that would be available to the uninsured in competition with private plans. But this "public option" couldn't clear the Senate. Even with a Democratic president and large Democratic congressional majorities, a narrow remnant of single payer failed to pass.

Nevertheless, the single-payer approach enjoys a dedicated following among groups such as Physicians for a National Health Program, and Sanders's embrace has generated renewed attention for the idea. Regardless of the outcome of the 2016 election, the single-payer debate will persist. The enduring appeal of Medicare for All is understandable, given the fragmented, inequitable, costly, profit-driven, and wasteful nonsystem that prevails in the United States. The ACA's shortcomings are sufficiently serious, single-payer adherents argue, that Obamacare has left unsolved many of U.S. medicine's major problems. For all the ACA's considerable achievements, health insurance and medical care are still unaffordable for many people. In a country where nearly 30 million persons remain uninsured, where health insurance is increasingly thinned out by rising deductibles and cost sharing, where even insured patients face staggering bills and the prospect of medical bankruptcy, where myriad insurers and payment systems generate astonishing complexity, and where more money is spent on administration than on heart disease and cancer,[5] it's no surprise to hear calls for sweeping change.

In a country where nearly 30 million persons remain uninsured, even insured patients face staggering bills, and more money is spent on administration than on heart disease and cancer, it's no surprise to hear calls for sweeping change.

The lessons of Canadian national health insurance are as straightforward as they are neglected. Having a single government-operated insurance plan greatly reduces administrative costs and complexity. It concentrates purchasing power to reduce prices, enables budgetary control over health spending, and guarantees all legal residents, regardless of age, health status, income, or occupation, coverage for core medical services.[1,2] Canadian Medicare charges patients no copayments or deductibles for hospital or physician services. Controlling medical spending does not, the Canadian experience demonstrates, require cost sharing that deters utilization. The Canadian system is hardly perfect. All countries struggle with tensions among cost, access, and quality; at times, Canada has grappled with fiscal pressures, wait lists for some services, and public dissatisfaction.[1] Yet its problems pale in comparison to those in the United States.

The substantive virtues of single-payer programs are compelling. But so are their political liabilities. Medicare for All, which aims to constrain health care spending, faces intense opposition from insurers, the medical care industry, and much of organized medicine. It would trigger

fierce resistance from conservatives and the business community and anxiety in many insured Americans fearful about changing coverage and the specter of rationing. The ACA's comparatively conservative reform approach inspired false charges of "socialized medicine," "pulling the plug on grandma," and "death panels." It takes only a little imagination — or a look back at the history books — to predict the reactions that an actual single-payer plan would evoke.

Single payer would also require the adoption of large-scale tax increases. Although Americans would save money by not paying premiums to private insurers, the politics of moving immense levels of health care spending visibly into the federal budget are daunting, given the prevailing antitax sentiment. Furthermore, converting our long-established patchwork of payers into a single program would require a substantial overhaul of the status quo, including the ACA.[4] Then there are the familiar institutional barriers to major reform within U.S. government, including the necessity of securing a supermajority of 60 votes in the Senate to overcome a filibuster.

An audio interview with Dr. Oberlander is available at NEJM.org

In short, single payer has no realistic path to enactment in the foreseeable future. It remains an aspiration more than a viable reform program. Single-payer supporters have not articulated a convincing strategy for overcoming the formidable obstacles that stand in its way. Nor have they, despite substantial public support for single payer, succeeded in mobilizing a social movement that could potentially break down those barriers. The pressing question is not about whether Medicare for All can be enacted during the next presidential administration — it can't — but where health care reform goes from here.

It's possible that some states could, through waivers that begin in 2017, consider adding a public option to their marketplaces or even adopt single-payer systems. Yet Vermont's recent struggles to make a modified single-payer plan work underscore the challenges to state action. At the federal level, incremental steps toward Medicare for All, such as expanding program eligibility to younger enrollees, are conceivable — though challenging in this political environment. Moreover, the fight over Obamacare is not over. Preserving and strengthening the ACA, as well as Medicare, and addressing underinsurance and affordability of private coverage is a less utopian cause than single payer. I believe it's also the best way forward now for U.S. medical care.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the University of North Carolina, Chapel Hill.

1. White J. The 2010 U.S. health care reform: approaching and avoiding how other countries finance health care. Health Econ Policy Law 2013;8:289-315.
2. Marmor TR, Freeman R, Okma KGH, eds. Comparative studies and the politics of modern medical care. New Haven, CT: Yale University Press, 2009.
3. Maioni A. Health care in Canada. Don Mills, ON: Oxford University Press, 2015.
4. Starr P. Remedy and reaction: the peculiar American struggle over health care reform. New Haven, CT: Yale University Press, 2011.
5. Cutler D, Wikler E, Basch P. Reducing administrative costs and improving the health care system. N Engl J Med 2012;367:1875-8.

DOI: 10.1056/NEJMp1602009

What Do I Need to Learn Today? — The Evolution of CME

Graham T. McMahon, M.D.

The point at which a clinician takes ownership of his or her own learning agenda is a pivotal moment in professional growth. But as postgraduate medical education evolves to become more learner-centric, new approaches and expectations have created pressures on the continuing medical education (CME) system and left some physicians frustrated.

Now that information is ubiquitous, simple information exchange has relatively low value; in its place, shared wisdom and the opportunity to engage in problem solving in practice-relevant ways have become key. Physicians seeking professional development can recognize when they're actively learning and tend to embrace activities that allow them to do so. Education that's inadequate, inefficient, or ineffective, particularly when participation is driven by mandates, irritates physicians who are forced to revert to "box-checking" behavior that's antithetical to durable, useful learning.

Committee Charter

Quality, Patient Care and Patient Experience Committee Charter

Purpose

The purpose of the Quality, Patient Care and Patient Experience ("Quality Committee") committee is to advise and assist the El Camino Hospital Board of directors in constantly enhancing and enabling a culture of quality and safety at ECH. The committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the El Camino strategic plan related to delivering high quality healthcare to the patients that we serve. High quality care is defined as care that is:

- Culture of safety that mitigates risk and utilizes best practice risk prevention strategies
- Patient-centered
- Delivered in an efficient and effective manner
- Timely
- Delivered in an equitable, unbiased manner

The organization will measure the degree to which we have achieved high quality healthcare using the CMS value based purchasing program among other measures.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. In addition, the Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management and quality improvement.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

The Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Quality Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Quality Committee may also include (A) no more than nine (9) external (non-director) members who possess knowledge and expertise in assessing quality indicators, quality processes (e.g., LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff matters, and members who have previously held executive positions in other hospital institutions (e.g., CNO, CMO, HR); and (B) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine external members are recommended to serve on this committee.
- All Committee members shall be appointed by the Board Chair, subject to approval by the Board, for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair of the Committee shall be a Hospital Board member.

Staff Support and Participation

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as senior members of the ECH staff may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff.

General Responsibilities

The Committee's primary role is to develop a deep understanding of the organizational strategic plan, the quality plan and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and

with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for:

- Ensuring that performance metrics meet the Board's expectations
- Align those metrics and associated process improvements to the strategic plan and organizational goals and quality plan
- Ensuring that communication to the board and external constituents is well executed.

Specific Duties

The specific duties of the Quality Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT) to benchmark progress using a dashboard
- Oversee management's development of Hospital's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services
- Review reports related to ECH-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    a. ECH-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan
    b. ECH-wide patient safety goals and hospital performance relative to patient safety targets
    c. ECH-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports and risk management reports
    d. ECH-wide LEAN management activities and cultural transformation work
    e. ECH-wide patient satisfaction and patient experience surveys
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to include, but not be limited to, The Joint Commission (TJC), Department of Health and Human Services, and Office of Civil Rights
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements
- Review sentinel events and red alerts as per the hospital and board policy
- Oversee organizational performance improvement for both hospital and medical staff activities and ensure that tactics and plans, including large-scale IT projects that target clinical needs, are appropriate and move the organization forward with respect to objectives described in the strategic plan
- Ensure that ECH scope of service and community activities and resources are responsive to community need.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans. Annually, the committee should do a self-evaluation to determine the degree to which we have achieved our specific objectives related to quality of care.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for review and approval.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board and the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

Approved as Revised: 11/12/14; 4/8/15

ATTACHMENT 6

Quality, Patient Care and Patient Experience Committee
Goals for FY 2017 - PROPOSED

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Quality Committee helps to assure that exceptional patient care and patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

Staff: Eric Pifer, MD, CMO

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff, VP of Patient Care Services, physicians, nurses, and members from the Community Advisory Councils or the community-at-large. The CEO is an ex-officio of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care, and Patient Experience Committee.	▪ Q1 – Goals ▪ Q3 - Metrics	▪ Review, complete, and provide feedback given to management, the governance committee, and the board.
2. Biannually review peer review process and medical staff credentialing process.	▪ Every other year	
3. Develop a plan to review exceptions for goals that are being monitored by the management team and report those exceptions to the El Camino board of directors.	▪ Q3	

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
4. Review and oversee a plan to ensure the safety of the medication delivery process. The plan should include a global assessment of adverse events and it should include optimizations to the medication safety process using the new iCare tool.	▪ Q2	Review the plan and approve.
5. Further investigate Patient and Family Centered Care and develop an implementation plan.	▪ Q2	Review the plan and approve.

Submitted by:
Dave Reeder, Chair, Quality Committee
Daniel Shin, MD, Executive Sponsor, Quality Committee

ATTACHMENT 7

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

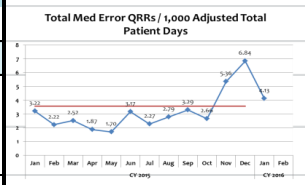
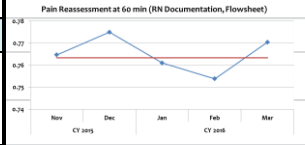
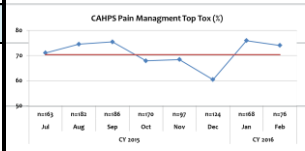
Performance Measurement

Organizational Goals FY17: Draft	Benchmark	2016 ECH Baseline	Minimum	Target	Maximum	Weight	Evaluation Timeframe
Threshold Goals							
Joint Commission Accreditation	Standard Threshhold	Full Accreditation	Full Accreditation			Threshold	FY 17
Budgeted Operating Margin	90% threshold recommended by Exec Comp Consultant (FY16)	TBD	90% of Budgeted			Threshold	FY 17
Patient Safety & iCare							
Exploring one goal from the following: Pain Management, Med Rec at Admission, Medication Safety (Quality Committee will finalize in April)						34%	FY17
Achieve Medicare Length of Stay Reduction while Maintaining Current Readmission Rates for Same Population	Internal Improvement	TBD	.05 Day Reduction from FY16 Target, Readmission at or below FY16 Target	.10 Day Reduction from FY16 Target, Readmission at or below FY16 Target	.20 Day Reduction from FY16 Target, Readmission at or below FY16 Target	33%	FY17
Smart Growth							
Targeted Growth, &/or Geographic Expansion (3/14-15 Strategic Retreat to address potential goals)						33%	FY 17
					TOTAL:	100%	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

DRAFT – For Board Quality Discussion

Note the baselines may change, and or the targets

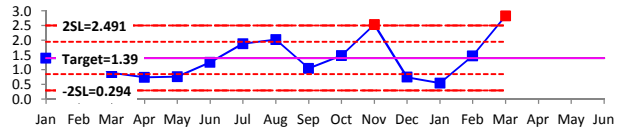
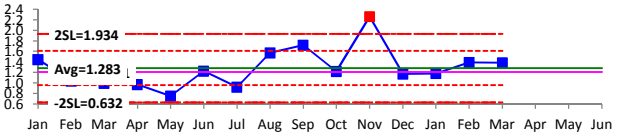
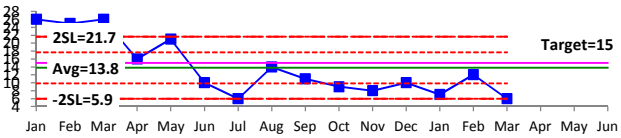
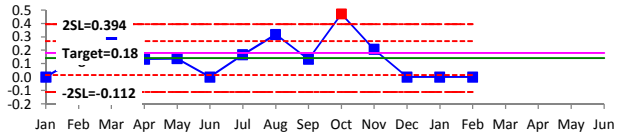
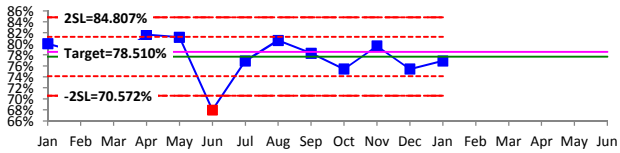
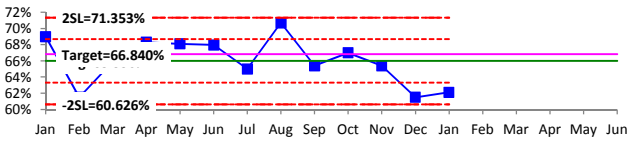
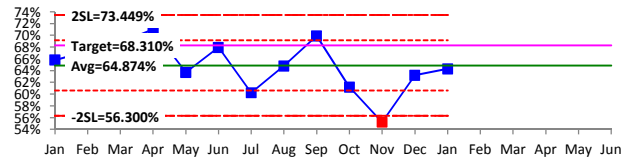
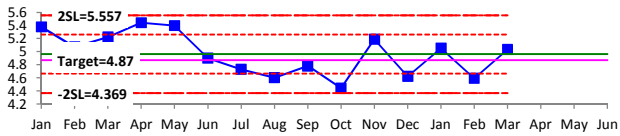
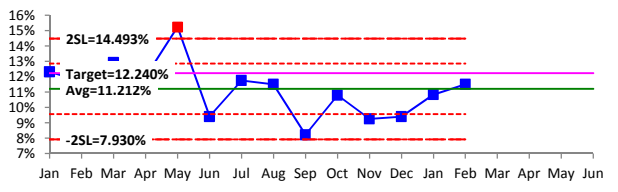
Organizational Goals FY17: Draft	Benchmark	2016 ECH Baseline	Minimum	Target	Maximum	Weight	Evaluation Timeframe	Baseline Trend
Patient Safety and iCare Goal Options								
Option 1: Medication Safety Indicator		*CY 2016*						
Med Errors (Total Medication Error QRRs / 1,000 Adjusted Total Patient Days)	Internal Improvement	3.56	3.49 2% decrease	3.42 4% decrease	3.35 6% decrease	34%	FY 17	
Option 2: Pain Management Indicator		*Post Go-Live*						
Pain Reassessment (% Pain Reassessment Documented within 60 min on RN Flowsheet)	Internal Improvement	76.3%	80.2% 5% increase	82.4% 8% increase	84.0% 10% increase	34%	FY 17	
		FY 2016 Q1-2						
Patient Satisfaction Pain Management Score (% Scored Top Box for CMS CAHPS - Pain Management)	Internal Improvement	70.3%	71.7% 2% increase	74.5% 6% increase	75.9% 8% increase	34%	Jul 2016 - May 2017	

ATTACHMENT 8

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

Date Reports Run: 4/18/2016

		Performance		Baseline	FY16 Goal	Trend
SAFETY EVENTS				FY2015	FY2016	
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: March 2016*	12/5321	2.82	1.39	1.39	
2	**Medication Errors** *Errors / 1000 Adj Total Patient Days* *Date Period: March 2016*	20/13643	1.38	1.21	1.21	
3	**Specimen Labeling Errors** *# Specimen Labeling Errors / Month* *Date Period: March 2016*	6	0	23	15	
COMPLICATIONS		**Performance**		**FY2015**	**FY2016**	
4	**Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: February 2016*	1	0.15	0.19	0.18	
SERVICE		**Performance**		**FY2015**	**FY2016**	
5	**Communication with Nurses** *(HCAHPS Score)* *Date Period: January 2016 (still open until end March)*	164/213	76.9%	78.5%	78.5%	
6	**Responsiveness of Hospital Staff** *(HCAHPS Score)* *Date Period: January 2016 (still open until end March)*	120/194	62.1%	66.8%	66.8%	
7	**Communication About Medicines** *(HCAHPS Score)* *Date Period: January 2016 (still open until end March)*	93/144	64.3%	68.3%	68.3%	
EFFICIENCY		**Performance**		**Jan-Jun 2015**	**Jan-Jun 2016**	
8	★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: March 2016*	**FYTD 3568 01-06/16 1251**	**FYTD 4.78 01-06/16 4.89**	5.17	5.07 (Min) 4.97 (Target) 4.87 (Max)	
9	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: February 2016*	**FYTD 323/3110 01-06/16 91/816**	**FYTD 10.39 01-06/16 11.15**	12.24	At or below 12.24	

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2015 Definition	FY 2016 Definition	Source
Patient Falls	Jane Truscott; Mae Dizon; Joy Pao; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when staff attempts to minimize the impact of the fall, it is still a fall). *Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.*		**QRR Reporting and Staff Validation**
Medication Errors	Chris Tarver; Poopak Barirani; Cheryl Reinking; Joy Pao	Medication Safety Committee; P&T Committee	5 Rights MEdication Errors: [# of Med Errors (includes: Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Route.) divided by Adjusted Total Patient Days (includes L&D & Nursery)]* 1,000 *Excludes: Wrong Time, ADR, Contrast Reaction, Incorrect Dose, "Not Yet Rated" Med errors, No risk identified and near miss*		**QRR Reporting and Staff Validation**
Mislabeled Specimens	Edwina Sequeira; Cheryl Reinking	QIPSC	Number of blood and nonblood Laboratory specimens collected by non-Lab staff that are unlabeled or contain incomplete or incorrect information for patient ID, specimen source/site, date/time, collector initials. Soft ID GoLive in May 2015 for select units, MCH full GoLive date after iCare implementation in Nov 2015.		**Staff Manual Tracking (Thara Trieu, Laboratory)**
Surgical Site Infection	Catherine Nalesnik; Joy Pao; Carol Kemper, MD	Infection Control Committee	(Number of Deep Organ Space infections divided by the # of all sugery cases)*100 counted by the month procedure under which infection was attributed to and not by the month it was discovered. All Surgery Cases in the 29 Surgical Procedural Categories required by the California Department of Public Health.		**IC Surveillance and NHSN Data Reporting**
Communication with Nurses	RJ Salus; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	Percent of inpatients responding "Always" to the following 3 questions [% Top Box]: 1. *During hospital stay, how often did the nurses treat you with courtesy and respect?* 2. *During hospital stay, how often did nurses listen carefully to you?* 3. *During hospital stay, how often did nurses explain things in a way you can understand?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Responsiveness of Hospital Staff	RJ Salus; Dan Shin; Shreyas Mallur; Dave Francisco	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. *During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?* 2. *How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted (for patients who needed a bedpan)?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Communication About Medicines	RJ Salus; Cheryl Reinking; Bob Blair	Patient Experience Committee	Percent of inpatients (who received meds) responding "Always" to the following 2 questions [% Top Box]: 1. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? 2. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Average Length of Stay	Michelle Pezzani; Diane Anderson; Mick Zdeblick; Cheryl Reinking	LOS Steering Committee	Average LOS of Medicare FFS, Paitents discharged from an Acute Care or Intensive Care unit. Excludes expired patients. Includes final coded patients aged 65 an older at the time of the encounter. The baseline period is from Jan-June 2015 and the performance period is from Jan-June 2016.		**EDW Data Pull, Department of Clinical Effectiveness**
30-Day Readmission (LOS-Focused)	Michelle Pezzani; Diane Anderson; Mick Zdeblick; Cheryl Reinking Margaret Wilmer	Readmission Committee	Percent of Medicare inpatient discharges return for an unplanned IP stay for any reason within 30 days, aged ≥65. Excludes patients who die, leave AMA or are transferred to another acute care facility; excludes admits to ECH Rehab and Psych admissions and for medical treatment of cancer.		**EDW Data Pull, Department of Clinical Effectiveness**