El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Monday, October 3rd, 2016, **5:30 p.m.**
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, California

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 – 5:36
	Approval: a. Minutes of Quality Committee Meeting - August 29, 2016 **Information:** b. Pacing Plan c. Patient Story **d.** Research Article			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	David Reeder, Chair Quality Committee		**Discussion** 5:36 – 5:39
6.	**QUALITY PROGRAM UPDATE: CONTINUUM OF CARE – BPCI** **ATTACHMENT 6**	Margaret Wilmer, Senior Director of Integrated Care		**Discussion** 5:39 – 5:54
7.	**FY17 EXCEPTION REPORT** **ATTACHMENT 7**	Dan Shin, MD, Medical Director of Quality and Patient Safety		**Discussion** 5:54 – 6:04
8.	**NEW METRIC SELECTION FOR FY17 EXCEPTION REPORT** **ATTACHMENT 8**	Shreyas Mallur, MD Associate Chief Medical Officer	*Public comment*	**Possible Motion** 6:04 – 6:14

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: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
October 3, 2016

	AGENDA ITEM	PRESENTED BY		
9.	**FY16 ORGANIZATIONAL GOAL ACHIEVEMENTS** **ATTACHMENT 9**	Mick Zdeblick, Chief Operating Officer		**Discussion** 6:14 – 6:24
10.	**FY17 ORGANIZATIONAL GOALS** - Pain Reassessment Target Goals **ATTTACHMENT 10**	Cheryl Reinking, RN Chief Nursing Officer	*public comment*	**Possible Motion** 6:24 – 6:34
11.	**PUBLIC COMMUNICATION**	David Reeder, Chair Quality Committee		**Information** 6:34 – 6:37
12.	**ADJOURN TO CLOSED SESSION**			6:37– 6:38
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		6:38 – 6:39
14.	**CONSENT CALENDAR** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee		**Motion Required** 6:39 – 6:42
	Approval: Meeting Minutes of the Closed Session *Gov't Code Section 54957.2.* - August 29, 2016 **Information:** Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Meeting Minutes of Quality Council - June 1, 2016			
15.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* CMO Report	Shreyas Mallur, MD Associate Chief Medical Officer		**Discussion** 6:42 – 6:47
16.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Harm Report	Sheetal Shah, Risk Manager		**Discussion** 6:47 – 7:02
17.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Greeley Report	Dave Francisco, MD Chairman of the Greeley Subcommittee		**Discussion** 7:02 – 7:16
18.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Red and Orange Alert	Shreyas Mallur, MD Associate Chief Medical Officer		**Discussion** 7:16 – 7:26

Agenda: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
October 3, 2016

AGENDA ITEM	PRESENTED BY		
19. RECONVENE OPEN SESSION/REPORT OUT	David Reeder, Chair Quality Committee		7:26 – 7:29
To report any required disclosures regarding permissible actions taken during Closed Session.			
20. ADJOURNMENT	David Reeder, Chair Quality Committee		7:30 p.m.

Upcoming FY 17 Quality Committee Meetings

- **November 2, 2016**
- **December 5, 2016**

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

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, August 29th, 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; Robert Pinsker, MD; Mikele Bunce, Nancy Carragee, Katie Anderson, Alex Tsao, Melora Simon and Wendy Ron.	Diana Russell, RN	None

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 29th day of August, 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 5:36 p.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 August 1, 2016 meeting and the FY17 Committee Goals were approved). **Movant:** Bunce **Second:** Simon **Ayes:** Reeder, Fung, Pinsker, Bunce, Carragee, Anderson, Ron, Simon and Tsao. **Noes:** None **Abstentions:** None **Absent:** Russell **Excused:** None **Recused:** None	***The Open Minutes of the August 1st, 2016 and the FY17 Committee Goals were approved.***
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report further detailed in the packet with the Committee and reported	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	on the Board decision to not renew the current CMO contract. This was a mutual decision and Ms. Ryba will continue through Oct 31, 2016. The Board has designated an AdHoc Committee to engage a Search firm for the Interim CEO position and Permanent CEO position. Mr. Reeder further reported that an interim CEO should be named within the next few weeks.	
6. SEPSIS PROGRAM UPDATE	Kelley Nguyen, RN, Program Coordinator gave an overview of the Sepsis Program to the Committee. Mrs. Nguyen reviewed the current definition, who is at risk, ECH sepsis volume and length of stay, requirements for Severe Sepsis & Septic Shock, accomplishments to date, current performance, and a look at FY17 Projects and Gaps. Mrs. Nguyen asked if the Committee had any questions or concerns to address and a brief discussion ensued.	***None***
7. FY17 EXCEPTION REPORT	Dr. Dan Shin, MD, Medical Director of Patient Safety and Quality Assurance presented the FY17 Exception Report to the Committee. He reported that seven metrics are stable, but highlighted that responsiveness of hospital staff and communication about medication remain below average. Dr. Shin asked the Committee for feedback and discussion ensued regarding counter measures to improve these metrics.	***None***
8. NEW METRIC SELECTION FOR FY17 EXCEPTION REPORT	Dr. Will Faber, MD, Chief Medical Officer presented the Committee with discussion regarding the metric selection for the FY17 Exception Report. Dr. Faber proposed the deletion of Specimen Labeling and the addition of Sepsis. This would be in addition to tracking the Organizational Quality Pain Reassessment Goals. Dr. Faber asked the Committee for feedback and discussion ensued. The Committee generally agreed with Dr. Faber's recommendations and asked for further development at next month's meeting.	
9. FY17 ORGANIZATIONAL GOALS – PAIN MANAGEMENT DISCUSSION	Cheryl Reinking, RN, Chief Nursing Officer reviewed with the Committee the Pain Management Goals current metric definitions and targets. The metrics for one half of this goal, the HCAPHS Pain Patient Satisfaction goal, was supported by the Committee. The other half of the goal, Pain Reassessment, was discussed with the following comments: 1) general support for the Pain	

Agenda Item	Comments/Discussion	Approvals/Action
	Reassessment definition, 2) general support for the measurement period to be Q4, FY17, and 3) the Committee challenged the Pain Reassessment minimum, target, and maximum goals of 60%, 70%, and 90% proposed by management. The challenge was that current performance of 56% is pretty close to the minimum goal, therefore, management was asked to reassess the minimum and target goal for Pain Reassessment. It was recommended that the Min, Target, Max targets be revised to 75%, 80%, and 90%. *To be agendized next month for further discussion.	
10. PATIENT AND FAMILY CENTERED CARE THEME	RJ Salus, Director of Patient Care Services, presented the Committee with Planetree's current state assessment and findings including the following further detailed in the packet: • Organizational Strengths - Distinct Customer Loyalty, Quality of Professional Staff, Clinical Excellence, Community Presence & Reputation, Talent Development, Volunteers, and Daily Huddles • Opportunities – inconsistencies between Policy and Practice • Strategic Recommendations and Potential Approaches - Uniformity of Policies and Practices Involving Family, and Develop Mechanisms to Proactively Share the Medical Record with Patients. • ECH Steering Committee Next Steps to confirm short to medium range priorities, key strategy: better incorporate patient's designated "care partner" in pain management and length of stay efforts, identify site visits, attendees and set objectives & expectations. Mr. Salus asked the Committee for feedback and a brief discussion ensued.	
11. PUBLIC COMMUNICATION	None	***None***
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:06 p.m. **Movant:** Simon **Second:** Pinsker **Ayes:** Reeder, Fung, Pinsker, Bunce, Carragee, Anderson, Ron, Simon, and Tsao.	***A motion to adjourn to closed session at 6:40 p.m. was approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Noes: None **Abstentions:** None **Absent:** Russell **Excused:** None **Recused:** None	
13. AGENDA ITEM 17 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 13– 16 were reported in closed session.* Chair Reeder reported that Closed minutes of the June1, 2016 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.	***None***
14. AGENDA ITEM 18 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:22p.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
Chair, ECH Quality, Patient Care and
Patient Experience Committee

Pacing Plan

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE
FY2017 PACING PLAN

FY2017: Q1		
JULY - No Meeting	**AUGUST 1, 2016**	**AUGUST 29, 2016 (*In place of Sept Meeting*)**
Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2017 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 ▪ Committee Recruitment ▪ Review FY17 Committee Goals **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 2017 Organizational Goals (Metrics) ▪ Update on PFCC **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 3, 2016	**NOVEMBER 2, 2016**	**DECEMBER 5, 2016**
▪ Approve FY 16 Organizational Goal Achievements ▪ 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**	▪ Committee Goals for FY17 Update ▪ iCare Update ▪ Update on PaCT Plan ▪ 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**	▪ 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

FY2017 PACING PLAN

FY2017: Q3		
JANUARY 30, 2017	**FEBRUARY 27, 2017**	**MARCH – No Meeting**
▪ 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 2018 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 3, 2017	**MAY 1, 2017**	**JUNE 5, 2017**
▪ Finalize FY 2018 Committee Goals ▪ Proposed Committee meeting dates for FY2017 ▪ Review DRAFT FY2018 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 FY18 Organizational Goals (as needed) ▪ Set proposed committee meeting calendar for FY 2018 ▪ 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 FY18 ▪ 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

September 5, 2016

El Camino Hospital Board of Directors
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Lanhee J. Chen, JD, PhD
Dennis Chiu, JD
Neal H. Cohen, MD, MPH, MS
Jeffrey M. Davis, MD
Peter C. Fung, MD, MS, FACP, FAAN, FAHA
Julia E. Miller
David Reeder, MS
Tomi Ryba, MHA, President and Chief Executive Officer
John L. Zoglin, MBA

Jepte De Alba
975 East William Street
San Jose, CA 95116

RE: Nancy Padilla

Dear Board of Directors:

My name is Jepte De Alba and I am 59 years old. I was born in Mexico and moved to this wonderful country looking for better opportunities for my family and I. I am an american citizen. I am writing this letter with great sadness and disappointment regarding the care that my late sister received by some of the doctors that were in charge of her treatment. I would like to let you know that that I don't have any intentions of making this a legal matter, rather I would simply like to express my opinion of how I felt during the last days of my sister's life that she spent at El Camino Hospital.

My sister's name is Nancy Padilla. She was born on 10/27/1954 in Mexico. Unfortunately, my sister developed pancreatic cancer. I would like to thank Dr. Jiali Li who showed care, compassion, and the highest level of professionalism during the time she cared for my sister. Dr Li understood that due to the pain I was suffering, I could not process information very well and she always took the time to explain the procedures to me with the patient. I was also pleased with the way my sister was welcomed and treated by the team that provided chemotherapy from the receptionist to the nurses, I felt that they made this uncomfortable process more bearable for my sister, Nancy. The entire

department smiled at her and that was very important because it helped her to forget why she was there and restored faith in Nancy's heart and give her back a sense of being human which unfortunately was taken away from her many times by the other physicians that were supposedly taking care of her. I became very frustrated and sometimes hurt by that Dr. [redacted] Dr. [redacted] and Dr. [redacted] handled my sister's care during her last days of life. I understand that the doctor's I just mentioned see people dying I guess on a daily basis but this is my first sister that died. I felt that it was my responsibility to do whatever possible to keep her alive. It was very painful for me to see that some of the conversations that the doctors had about my sister's life took place in front of her. I know that even though she was sedated, I know in my heart that she was somehow aware of what was happening. I cannot imagine what a person might feel when decisions of their life and death are made in front of them. My experience from the moment I took my sister to the Emergency Room in May, 2016 was very traumatic because the lack of empathy of the nurses and treating physicians was beyond belief. I would like, if possible, to tell you thins in person in one of your board meetings how the treatment of my sister and her death affected my family and me.

You can reach me at 408-726-5169 or you can write me a letter and send it to my house at: 975 East William Street San Jose, CA 95116.

I hope to hear from you soon.

Sincerely yours,

Jepte De Alba

Research Article

The road to value-based care:

Your mileage may vary

A report from the Deloitte Center for Health Solutions

Deloitte University Press

About the authors

Wendy Gerhardt is a research manager with the Deloitte Center for Health Solutions, Deloitte Services LP. She is responsible for helping Deloitte's health care, life sciences, and government practices through the conduct of research at the Center to inform health care system stakeholders about emerging trends, challenges, and opportunities. Prior to joining Deloitte, she held multiple roles of increasing responsibility in strategy/planning for a health system and research for health care industry information solutions. Gerhardt holds a Bachelor of Business Administration degree from the University of Michigan and a Master of Arts degree in health policy from Northwestern University.

Leslie Korenda is a research manager with the Deloitte Center for Health Solutions, Deloitte Services LP. She is responsible for helping Deloitte's health care, life sciences, and government practices through the conduct of research at the Center to inform health care system stakeholders about emerging trends, challenges, and opportunities. Prior to joining Deloitte, she worked in the private and public sectors and in a variety of health care settings, including federal agencies, local health departments, medical centers/health systems, and community health organizations. Korenda received a Bachelor of Science from Virginia Tech and a Master of Public Health from Yale University.

Dr. Mitch Morris is the Vice Chair and Global Leader for the Health Care Providers Practice, including consulting, audit, tax, and financial advisory services. Dr. Morris has more than 30 years of health care experience in consulting, health care administration, research, technology, education, and clinical care. Earlier, he served as a Senior VP of health systems and CIO at MD Anderson Cancer Center, where he was also Professor in Gynecologic Oncology and in Health Services Research..

Gaurav Vadnerkar is an assistant manager with the Deloitte Center for Health Solutions, Deloitte Support Services India Pvt. Ltd. Vadnerkar focuses on life sciences and health care research publications and thought leadership development. Prior to joining Deloitte, he held a diverse range of roles in the knowledge process outsourcing industry, working closely on business research projects for global life sciences firms. Vadnerkar holds a PhD in pharmaceutical sciences and has also authored research papers for peer-reviewed international scientific journals.

Contents

Executive summary

THE market shift toward value-based care (VBC) presents unprecedented opportunities and challenges for the US health care system. Instead of rewarding volume, new value-based payment models reward better results in terms of cost, quality, and outcome measures. These largely untested models have the potential to upend health care stakeholders' traditional patient care and business models.

The level of dollar investment in VBC is substantial and some health care organizations are actively preparing for the transition to VBC while others are hesitating. Their reluctance to shift to VBC is understandable: The level of financial investment is substantial and the current fee-for-service (FFS) payment structure is still highly profitable for some. The shift has already begun in some markets, though, to build key capabilities.

As other organizations plan their route to VBC, it is important to understand that there is no single, "right" payment model that fits all situations. Experience gained in markets where the shift to VBC is under way shows that the transition is much like a road trip—different routes and modes of transportation can get travelers to their destination. By implementing a holistic process and leveraging robust supporting data—much like following a GPS system—a health care organization can develop payment models that work for individual situations and populations.

There are many road tests, routes, and transportation modes available. Determining the best "route and transportation mode" with VBC is challenging given the many and differing options. When considering how to effectively operate under the payment models, organizations should take stock of their market position and core capabilities. For example, examining spending variation may highlight areas where payers and providers can focus to deliver on VBC's promise. A sample accountable care organization (ACO) model depicts one potential approach for successfully structuring across providers to share risks and benefits. Health care stakeholders should understand how the various models work, including their associated incentives, risks, and potential financial impacts.

Pressure to reduce costs and improve quality and outcomes are likely to continue. Health care providers that start to develop VBC models now may gain early advantages that will enable them to compete more effectively in the future. When the market shifts further toward value, those not ready may be left behind while those on their road trip may be well positioned. Understanding how the models work is a first step. How to embark upon the road trip depends on each stakeholder's selected route.

Traveling the road to value-based care

THE shift by US health care organizations toward VBC is a lot like taking a road trip to a never-before-visited destination via never-before-traveled roads. Some organizations do not know which route to take; others are not sure they even want to leave home. Many physicians, health system executives, and other stakeholders agree that the journey is unavoidable—the transition from traditional FFS toward payment models that promote value is happening. In some markets, it has already occurred. Stakeholders are investing major dollars and adoption is increasing.

Value-based payment models aim to reduce spending while improving quality and outcomes (see sidebar). According to a 2014 survey, 72 percent of surveyed health executives said that the industry will switch from volume to value.[1] In addition, a Deloitte 2014 survey of US physicians found that, although many have limited experience with value-based payment models, they forecast half of their compensation in the next 10 years will be value-based.[2]

Drivers of the shift to value-based payments include unsustainable costs, stakeholders' push for value, and federal government support for new payment approaches. Additionally, new laws and regulations, more robust data, increased health care system sophistication, and risk mitigation approaches are accelerating the pace of change (see sidebar and appendix B for more detail).

Payers and other stakeholders are making significant investments in VBC initiatives:

- Aetna dedicated 15 percent of its 2013 spending to VBC efforts and intends to grow that amount to 45 percent by 2017.[3]
- The Centers for Medicare and Medicaid Services (CMS) appropriated $10 billion per year for the next 10 years for

THE SHIFT TO VALUE-BASED CARE

The US health care system's current FFS-based payment model offers incentives for providers to increase the volume of services they furnish. Although providers have professional goals of improving health outcomes, the FFS model does not reward them for this. Due to concerns about rising costs and poor performance on quality indicators, employers, health plans, and government purchasers of health care are pushing for a transition to value-based payment models. The premise of value-based payments is to align physician and hospital bonuses and penalties with cost, quality, and outcomes measures (see appendix A for more detail on drivers).

WHAT ARE VALUE-BASED PAYMENT MODELS?

Health care organizations are experimenting with variations and combinations of four main types of value-based payment models (see appendix B for detailed descriptions of the models).

1) **Shared savings**—Generally calls for an organization to be paid using the traditional FFS model, but at the end of the year, total spending is compared with a target; if the organization's spending is below the target, it can share some of the difference as a bonus.

2) **Bundles**—Instead of paying separately for hospital, physician, and other services, a payer bundles payment for services linked to a particular condition, reason for hospital stay, and period of time. An organization can keep the money it saves through reduced spending on some component(s) of care included in the bundle.

3) **Shared risk**—In addition to sharing savings, if an organization spends more than the target, it must repay some of the difference as a penalty.

4) **Global capitation**—An organization receives a per-person, per-month (PP/PM) payment intended to pay for all individuals' care, regardless of what services they use.

innovation efforts, many of which center on forms of VBC.[4] These include the Pioneer Accountable Care Organization (ACO) model, Medicare Shared Savings Program (MSSP), and Bundled Payments for Care Improvement (BPCI).

- Blue Cross Blue Shield health plans spend more than $65 million annually, about 20 percent of spending on medical claims, on VBC.[5]

Participation in value-based payment models is growing:

- The Department of Health & Human Services (HHS) set a goal of tying 30 percent of payments for traditional Medicare benefits to value-based payment models by the end of 2016 and 50 percent by 2018.[6]
- Two hundred and twenty organizations participated in the MSSP in 2014.[7]
- Nearly 7,000 organizations participate in the BPCI.[8]
- Twenty health systems, health plans, consumer groups and policy experts formed the Health Care Transformation Task Force, and aim to have 75 percent of their business based on value by 2020.[9]

Marketplace test drives

SOME US health care providers have already adopted value-based payment models. Others are still determining whether they should make the transition, since their revenue relies largely on traditional FFS payments. Still others have chosen to "test drive" value-based payment models before full adoption. Two examples of the latter are the Sacramento ACO and Northwest Metro Alliance in Minneapolis (see sidebar for details). These test drives offer examples of what other organizations may launch into on a broader scale. They also paint a picture of the collaboration required across stakeholders. Both targeted populations in regional markets where they utilize physician alignment and care coordination to achieve value.

Health plans, health systems, and physician groups were travel partners in each of these ACOs. The Sacramento ACO was comprised of the California Public Employees' Retirement System (CalPERS), a physician group (Hill Medical Group), and a health system (Dignity Health). The ACO's goal was to develop a competitive entity for reducing costs and improving quality.[10] The result of this test drive was $59 million in savings to CalPERS in its first three years.[11] The Northwest Metro Alliance was formed by health plan provider HealthPartners and the physicians and hospitals of Allina Hospitals and Clinics. It had similar goals, and saw the ACO's cost of care decline to 90 percent of the market average.[12]

Markets with value-based payment models

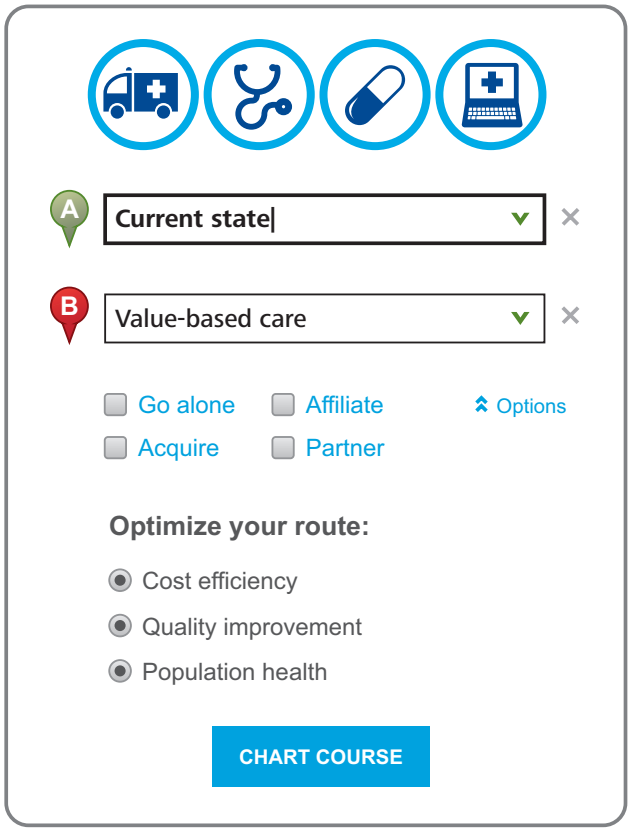
	Sacramento, CA[13]	Minneapolis, MN[14]
Name	Sacramento ACO	Northwest Metro Alliance
Target population	40,000 (CalPERS)	300,000
Payer	Blue Shield of California	HealthPartners
Health system/ physicians	Hill Medical Group, Dignity Health	HealthPartners, Allina Hospitals and Clinics
Focus	• Care coordination • Spending (utilization, readmissions)	• Care coordination • Data models • Electronic information sharing

Biopharmaceutical companies (biopharma) and medical technology (medtech) companies are also engaged in test drives. Their value-based payment model activity involves collaborations with providers and health plans on specific populations.

Several biopharma companies have been partnering with health plans to test drive value-based payment models targeting drugs and interventions for specific populations, such as diabetes and non-spinal fractures. Payments are based on outcomes and quality performance.[15]

Medtech companies, Boston Scientific, Johnson & Johnson, and Medtronic, are exploring risk-based payment models with providers. Some arrangements include potentially paying a rebate to providers if a device does not meet performance goals. Other arrangements are considering assuming a portion of a hospital's readmissions penalty if, for example, a patient implanted with a cardiac device is readmitted for heart failure.[16]

Figure 1. Charting your course for value-based payment models



Graphic: Deloitte University Press | DUPress.com

Which route is best?

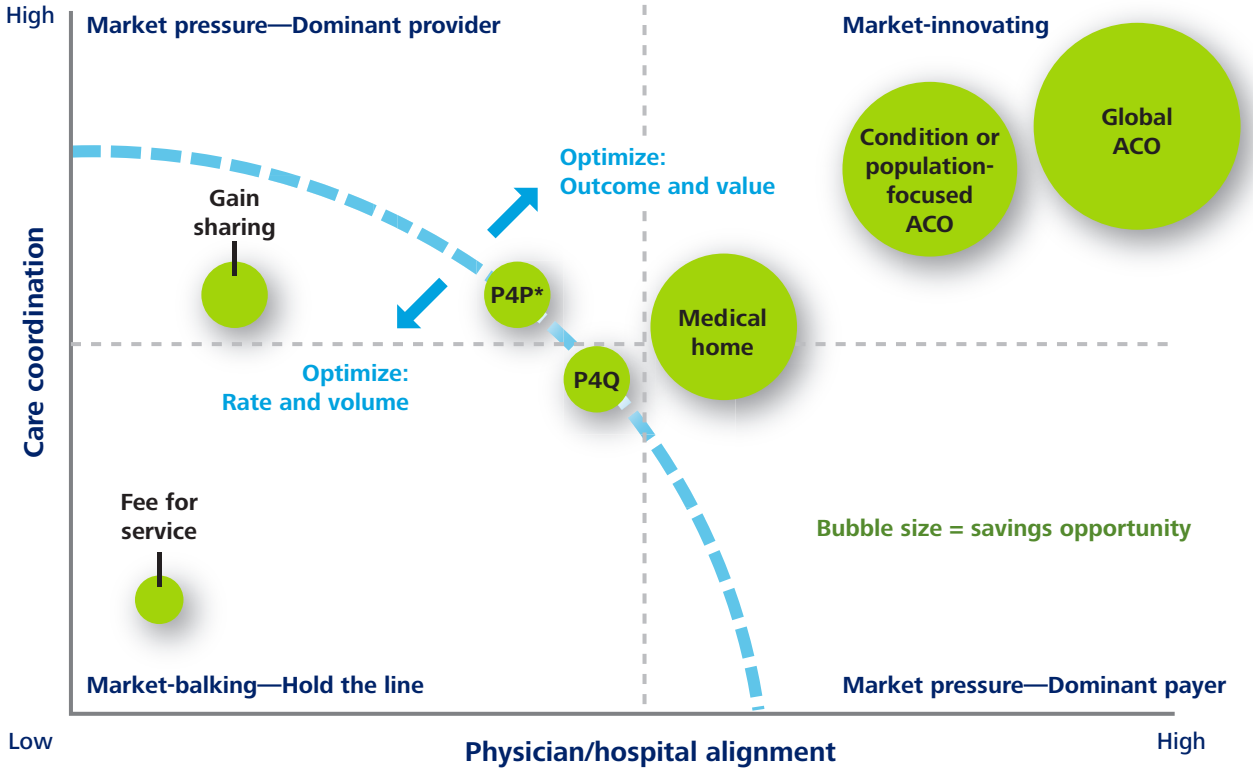
Much like any first trip to a new destination, the journey to VBC can be filled with uncertainties. A traveler may use a GPS system to identify several alternative routes, yet find that the shortest way has unexpected traffic jams, speed traps, or other delays that a longer route avoids. Similarly, a "GPS-like" approach (figure 1) could identify a variety of routes for organizations starting their journey to VBC, but each may vary in length and require different capabilities, partnerships, and investments along the way.

In addition to taking test drives, health care organizations may adopt incremental, value-based payment models to ease their transition. Industry observers anticipate that the use of value-based payment models will begin with methods like shared savings and pay for performance, which involve limited financial risk for providers. Organizations and their payment models then may transition more fully to VBC over time as they develop more experience and a tolerance for financial risk (see sidebar and appendix B).

For those planning to take the road trip to its ultimate destination, some observers expect that value-based payment models which create both potential bonuses (upside risk) and penalties (downside risk) would be most likely to demonstrate results. However, models combining more financial risk plus more potential upside are likely to prompt wary providers to first take a test drive.

Once models with both upside and downside risk become more prolific, it is anticipated that adoption will increase for payment models involving full financial risk for providers with an enrolled population, such as a global capitation for ACOs, or significant risk-sharing with payers (figure 2). Global capitation and ACO models require the highest levels of care coordination and physician/hospital alignment.

Figure 2. Transitions to value-based payment models will likely vary by market[17]



* Includes payment for episode of care.
Source: Deloitte analysis of models.

Graphic: Deloitte University Press | DUPress.com

Moreover, adoption is most likely to occur in markets where "travel partners" are well-suited; for example, where physician/hospital alignment is greatest and capabilities around care coordination (which requires both data and clinical integration) are strongest.

An important consideration: Spending variation

VBC rests on the premise that there are opportunities for industry stakeholders to reduce costs. Before entering into value-based payment arrangements, therefore, providers should consider identifying cost- and quality-based opportunities for achieving better value. One potential area for improvement is spending variation.

Numerous studies have documented spending variation across geographic regions for the same health care services. Some studies show spending for the same condition (with the same quality results) varies by up to 30 percent,[18] suggesting that this amount could be saved if the right incentives and capabilities are in place. Of course, it takes time to realize system improvements; a more realistic goal might be 5–15 percent savings generated over three to five years.

Variation in Medicare spending for joint replacement, for example, shows potential savings opportunities in the areas of care management and patient settings (figures 3 and 4). Deloitte analyzed Medicare data to see how much variation exists for this type of common and costly hospital procedure. Data

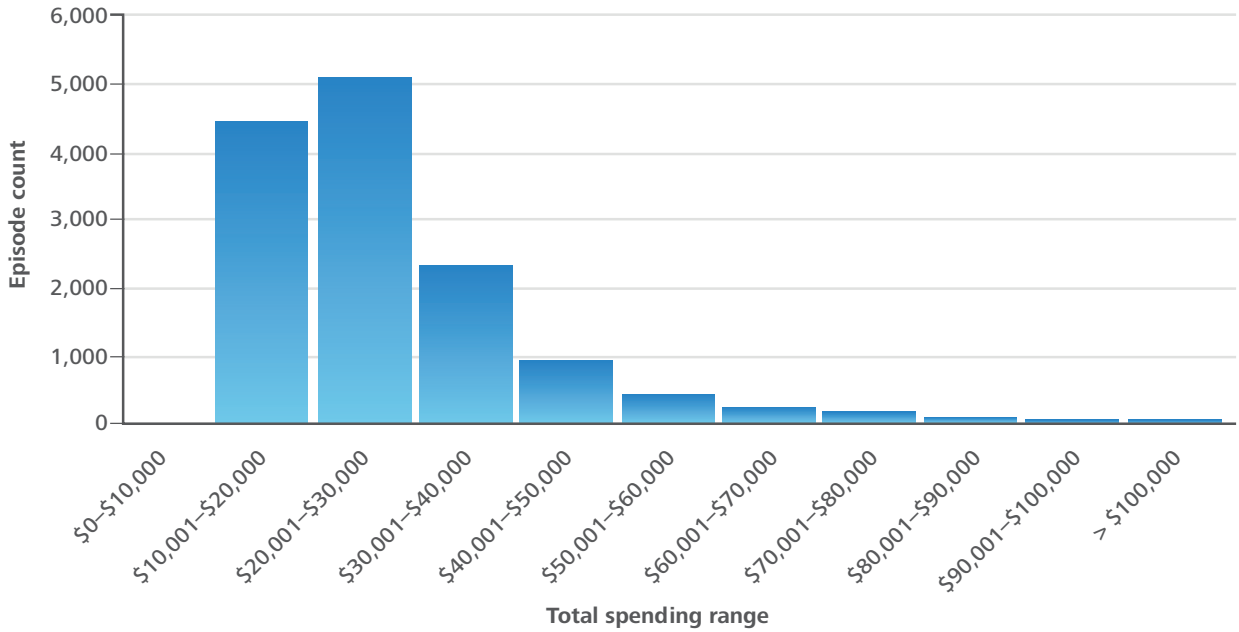
Figure 3. Medicare spending on joint replacements in 90-day bundles[19]

	DRG 470—Joint replacement w/o complications	
Number of cases	13,971	
Median total spending	$23,601	
Mean total spending	$28,439	
Standard deviation of total spending	$15,327	
Post-discharge time period spending by type	**Share in spending (percent of total)**	**Variation in spending (coefficient of variation*)**
Readmissions	4.5%	375%
Physician/professional	5.2%	113%
Hospital outpatient	2.6%	174%
Part B pharmacy	0.2%	1079%
DME	0.6%	1560%
Post-acute providers	33.3%	124%

Source: Deloitte analysis of 90-day bundles from CMS Limited Data Set, 2012. See appendix for further details.

* Note: The higher the coefficient of variation, the higher the amount of variation in spending.

Figure 4. Distribution of Medicare spending on joint replacements in 90-day bundles[20]



Source: Deloitte analysis of 90-day bundles from CMS Limited Data Set, 2012. See appendix for further details.

Graphic: Deloitte University Press | DUPress.com

is from the Centers for Medicare and Medicare Services' (CMS) Limited Data Set, which includes a representative sample of claims data from randomly selected Medicare members. This particular dataset is especially useful for analyzing bundled payments (see appendix C for further methodology details).

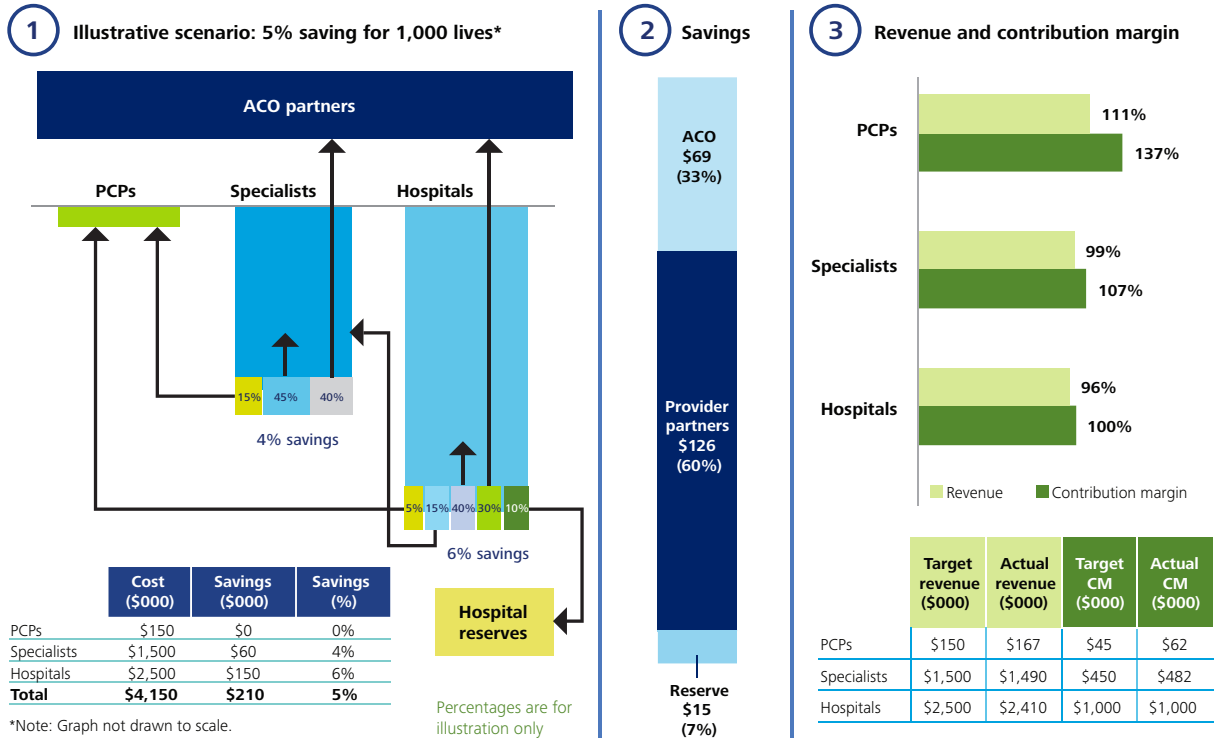
Deloitte's analysis found opportunities for savings if organizations can reduce variation in care delivery and thereby reduce variation in spending—the difference between the median and mean for a type of episode is one indicator of the overall potential. For example, for Diagnosis Related Group (DRG) 470, the most common type of hospitalization related to joint replacement, there is a 17 percent difference between the median and the mean (figure 3). This analysis explored the elements of spending both during and after the hospital stay to gain insights on the drivers of variation. For joint replacement, the variation in spending after the hospital stay and readmission is primarily driven by Part B drugs and medical technology (durable medical equipment [DME]), despite their being small portions of the total cost.

Implementation of value-based payment models may require looking at data on spending components to understand the potential savings opportunities. This might include, for example, spending on pharmacy (Deloitte's analysis only includes specialty drugs paid through Medicare Part B) or care which is provided over a longer period of time. Such an analysis might capture more variation in physician service use beyond the 90 days post service. In addition, clinical expertise should be applied with data analysis to understand how to appropriately realize identified savings without hurting outcomes. This is usually an iterative process with physicians to gain a shared understanding of what is causing the variation, and what can be done about it clinically.

Ready for a road trip?

ON the road trip to VBC, providers generally do not travel alone—fellow travelers may include payers, other health care providers, and ancillary service providers (for example, post-acute providers and biopharma companies). The stakeholders should be aligned toward the shared goal of value. Shared savings arrangements are emerging that better align incentives and encourage engagement among these stakeholder types. Here is an illustrative scenario (figure 5): an ACO that consists of a hospital and primary care and specialty physicians serving 1,000 patients. The scenario illustrates how value-based payments can be shared to engage multiple stakeholders. The modeling assumes—which is typical—that

Figure 5. Illustrative global ACO shared savings[21]



	Cost ($000)	Savings ($000)	Savings (%)
PCPs	$150	$0	0%
Specialists	$1,500	$60	4%
Hospitals	$2,500	$150	6%
Total	**$4,150**	**$210**	**5%**

*Note: Graph not drawn to scale.

	Target revenue ($000)	Actual revenue ($000)	Target CM ($000)	Actual CM ($000)
PCPs	$150	$167	$45	$62
Specialists	$1,500	$1,490	$450	$482
Hospitals	$2,500	$2,410	$1,000	$1,000

Source: Deloitte actuary analysis.

Graphic: Deloitte University Press | DUPress.com

Figure 6. Required capabilities for administration/risk-bearing under each payment model[22]

Payment model	Plan capabilities					Provider capabilities				
	IT infra-structure/ information services	Business operations/ administra-tive (RCM, claims mgmt. & processing	Data collection, sharing, and analysis	Analytics (for population health, cost, and care coordination analysis)	Planning/under-standing market/ population needs	IT infra-structure/ information services	Business operations/ administra-tive (RCM, claims mgmt. & processing	Data collection, sharing, and analysis	Analytics (for population health, cost, and care coordination analysis)	Planning/under-standing market/ population needs
FFS	Advanced	Advanced	Advanced	Basic	Intermediate	Basic	Basic	Basic	Basic	Basic
Shared savings	Advanced	Advanced	Advanced	Basic	Intermediate	Intermediate	Intermediate	Intermediate	Basic	Basic
Bundles	Intermediate	Intermediate	Intermediate	Intermediate	Intermediate	Intermediate	Advanced	Intermediate	Intermediate	Advanced
Shared risk	Basic	Basic	Intermediate	Intermediate	Basic	Advanced	Advanced	Advanced	Advanced	Advanced
Global capitation	Basic	Basic	Intermediate	Intermediate	Basic	Advanced	Advanced	Advanced	Advanced	Advanced

Source: Deloitte synthesis of literature and subject matter expert interviews. See appendix for definitions of each capability.

Note: Tables are intended to be a representation, not exhaustive.

Basic capability required
Intermediate capability required
Advanced capability required

Graphic: Deloitte University Press | DUPress.com

the payer (for example, a health plan) provides the ACO a bonus if it can reduce total spending by 5 percent. If the ACO generates savings, it can distribute the resulting bonus in a way that helps each type of provider sustain a reasonable margin.

Within the illustrative ACO:

1. Some of the highest spending was for hospital care (as is typical), followed by specialists and primary care physicians. The ACO agreed that most of the savings, therefore, would come from lower spending on hospital care (6 percent) and specialist care (4 percent).

2. The ACO realized these savings—possibly by increasing its investment in primary care and better managing chronic conditions. It kept some funds (33 percent) for future investments. The remainder was shared among participating providers.

3. Because of hospitals' disproportionate share of spending, this example illustrates that a small share of these savings greatly rewards physicians.

4. Hospitals may need to increase market share in order to be made whole financially since they lose revenue unless they can eliminate the excess capacity that is generated by enhancing care coordination. This example emphasizes the importance of pricing risk-sharing deals to a market-competitive medical expense per-member/per-month payment in aggregate.

Don't forget to pack

Just as travelers on an extended road trip require supplies such as fuel, maps, snacks, and other supplies, stakeholders on a VBC journey might require capabilities such as care coordination, clinical integration, and physician alignment. Figure 6 summarizes some of the capabilities needed for value-based payment models versus FFS, based on Deloitte's analysis and synthesis of pertinent literature. For example, more robust administrative capabilities may be needed to support value-based payment models. Also, as health systems assume more financial risk, they may decide to take over certain care coordination, disease management, data analysis, and administrative

functions from a health plan (or other payer). Some health plans are offering support (as well as value-based payment models) to help health systems do this.

Ultimately, there is no single "right" route or transportation mode for the trip to value-based payments—in fact, a provider may change routes or vehicles/models along the way.

Starting the *process* of getting to an equitable, risk-mitigated, aligned incentive model is what is important. This process requires a strong market, target population, and clinical data to determine what price point will result in a competitive rate and an appropriate share/target for each involved party. The process also requires informed physician and hospital leadership armed with data that can show what is needed to get to this price point, financial scenarios that illustrate a feasible path forward, and an opportunity analysis that demonstrates how savings can be generated.

Some organizations may lack the necessary capabilities for certain value-based payment models (figure 6), making those models "closed roads" which require a detour or "carpool-only lanes" which require a partner.

When evaluating potential payment models, a provider's approach may consist of:

- Understanding their market position
- Assessing their capabilities
- Conducting a financial analysis
- Aligning around opportunities

Implications for travelers

The implications of more widespread use of value-based payment models vary by stakeholder:

Health systems/hospitals

Many health systems and hospitals are developing ACOs and other partnering arrangements to implement value-based payment models. Some may do this to get preferential market share through arrangements with payers. Other systems are less heavily involved, reflecting less pressure to do this in their markets. As providers evaluate their strategies, they should consider how well-equipped they are to successfully reduce spending while maintaining quality and access in areas such as readmissions and ancillary services. Certain value-based payment models may require more sophisticated IT platforms, extensive data analytics, and planning. Some health systems and hospitals may lack such capabilities and, therefore, need to invest in new systems and processes or partner with others that already have them. In addition, providers may need the financial acumen to understand the risks involved with each particular payment model.

Ancillary providers (for example, post-acute care providers, biopharma, medtech, and supply companies)

Ancillary providers may undergo considerable scrutiny as health care organizations implement value-based payment models. Hospitals and health systems will likely be looking for partners and suppliers that can offer lower prices, reduce spending (either overall or for a service bundle), and contribute to better quality scores and outcome measures. If a post-acute care organization can demonstrate that its care management techniques result in lower hospital readmissions or a pharmaceutical manufacturer can bundle its product with a successful disease management approach that improves quality ratings, they will be viewed as a preferred partner relative to ancillary providers operating under "business as usual."

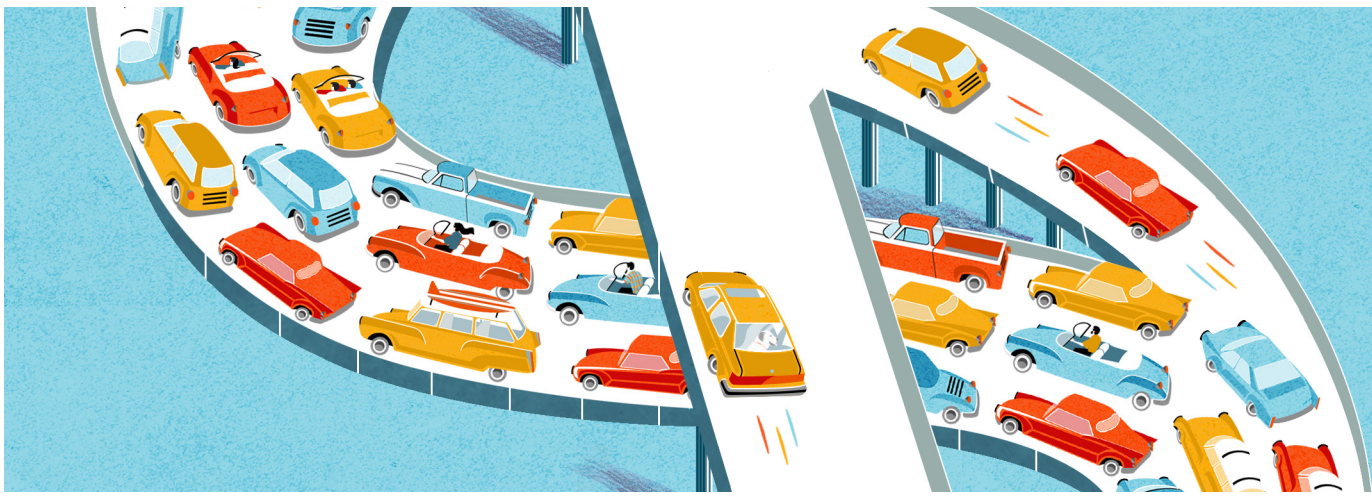
In addition to providers and payers, biopharma and medtech companies have started to test drive value-based payment models with other stakeholders. As adoption grows among these ancillary providers, they also will need to determine which travel partner and route to take.

Destination: A model that delivers on value

THE market shift to value-based payment models is inevitable, driven by the pressure to reduce costs and improve quality and outcomes. Employers, health plans, government payers, and consumers are asking the health care system to deliver on value; these new payment models are a fundamental component of that process. There is no single "right" approach that will work for all stakeholders or in all markets. The choice of model (or combination of models) will depend on each stakeholder's capabilities, market position, financial situation, and VBC goals.

Advantages to early participation by health care providers that start to develop value-based payment models now include greater experience and market share. They can gain core competencies to participate successfully in the future and may gain increased market share, as a first mover in the market, from health plans. When the market shifts further toward value, those not ready may be left behind while those on their road trip may be well positioned.

The pressure will likely only get stronger to shift toward more complex and financially risky payment models. Whether they decide to travel solo or with partners, health care organizations that leave now on their trip to VBC can put in place the necessary capabilities and processes that may give them first-mover advantage and increased market share, while others may be left behind.



Appendix A: Drivers of the shift toward value-based payment models

- **Unsustainable costs and awareness of potential for savings:** In 2012, the United States spent $2.8 trillion on health care, representing nearly 17 percent of the country's gross domestic product (GDP).[23] According to estimates, spending will reach nearly $5 trillion (20 percent of GDP) by 2021.[24] The FFS payment model for health care is considered one of the major drivers of high costs because it encourages the use of more services (and expensive ones).[25] Spending variation is also a concern; consumers with similar conditions/procedures experience wide variation in services and resulting expense.[26] The variation—not explained by differences in quality—suggests an opportunity for savings if providers adopt more consistent approaches to care that are shown to be both effective and efficient.

- **Recognition that FFS drives volume, not value:** The current FFS system largely fails to financially reward high-quality or coordinated health care across providers. The incentive with FFS is to provide more services and treatment, as payments are dependent upon quantity, not quality. Value-based payment models change incentives to focus on value by rewarding better outcomes and lower spending.

- **New laws, regulations, and pilots:** The Affordable Care Act (ACA) of 2010 reflected purchaser (employers, health plans, government payers, and, increasingly, individuals) concerns about costs and their goals for better value. It included a permanent program in Medicare that allows organizations to choose to participate in accountable care organizations (ACOs) using shared savings/risk payment models and pilots for bundled payments. Both are examples of payment models that are intended to stem spending and improve quality and coordination. Other examples include broadened use of pay for performance in traditional and managed Medicare programs and readmission penalties for hospitals.

Appendix B: Description of payment models

Figure 7. Description of major payment models[27]

Payment model	Description/how provider organization is paid	Maturity	Potential financial risk to providers
Fee-for-service (FFS)	• Each covered medical service or procedure is paid a set fee after it has occurred	• Started in its current form with the launch of Medicare in 1965 • Prospective payments (per-admission payments to hospitals) began in the early 1980s	• Low risk • Risk is in volume
Shared savings	• Paid under FFS until year-end reconciliation • Shared savings bonuses are paid if expenditures do not exceed cost-containment goals • Bonuses given if quality goals are achieved • No financial risk if cost or quality goals are not met	• Not yet widely adopted • A growing number of these contracts have started since the passage of the Affordable Care Act (ACA) in 2010, which established a permanent, voluntary program and Medicare pilot • Some commercial and Medicaid purchasers have sponsored these	• Medium risk • Risk is only from collecting for savings, no fines from losses • Risk is in not managing costs and missing savings opportunities • Risk with severity of patients' illness
Bundles	• Episode-based payment • Payment for all services across multiple providers and care settings for a treatment or condition during a defined time period	• Started in the mid-1980s by two commercial payers (Prudential, United Healthcare) for solid organ transplants • Further traction with CMS heart bypass demonstration in the 1990s and bundles for end-stage renal disease • Grew to include limited number of procedures (e.g., cardiovascular and orthopedic) during the late 1990s/ early 2000s • The ACA included Medicaid demonstrations (2012) and Medicare pilots (2013) for bundles • Now being piloted for chronic conditions	• Medium-high risk • Risk from collecting for savings and being fined for losses • Risk is in volume • Risk is in not managing costs and missing savings opportunities • Risk with severity of patients' illness

Payment model	Description/how provider organization is paid	Maturity	Potential financial risk to providers
Shared risk	• Paid under FFS until year-end reconciliation • Savings bonuses if cost containment and quality goals (upside) are achieved • At risk for a portion of spending that exceeds a cost containment target (downside)	• Not yet widely adopted • Medicare Shared Savings Program proposed rule in 2012 suggests that ACOs will be expected over time to take on shared risk, in addition to shared savings • In 2008, Aetna launched a pilot with its Medicare Advantage program and NovaHealth, an independent physician group in Maine, that shared risk and resulted in quality and efficiency improvements[28]	• High risk • Risk from collecting for savings and being fined for losses • Risk is in not managing costs and missing savings opportunities/being penalized • Risk with severity of patients' illness
Global capitation	• Single, comprehensive payment for a person over a period of time • Intended to account for all of the expected costs of care for a patient or group of patients for a defined time period	• Began with managed care growth in the late 1980s/early 1990s, although use declined in the face of backlash from consumers • Use of global payments (newer version of capitation aka total cost of care contracting) is growing (e.g., BCBS MA in 2009; CalPERS in 2010; Oregon Medicaid in 2011)	• Highest risk • Risk from collecting for savings and being fined for losses • Risk is in not managing costs and missing savings opportunities/being penalized • Risk with severity of patients' illness

Source: Deloitte synthesis of literature and subject matter expert interviews

Figure 8. Variations on fee-for-service (FFS) payments

Payment model	Description
Care coordination fee	• Originally used in Medicaid, this model is now also common in many patient-centered medical home arrangements. • The primary care physician is paid an amount per member/per month (usually small) for managing patient care between visits or as a participation incentive. Can be for all patients or for high-risk patients.
Payments for non-face-to-face care	• Payments are made to physicians for phone calls/phone care, email correspondence, texting (when the physician has to initiate manually), telemedicine, Skyping, or other video visits, etc. • Interactions may substitute for in-person care; there is potential to increase overall utilization if each communication is paid for separately.
Pay for performance	• Grew in popularity in the later 1990s and early 2000s. • Small bonuses are paid to providers if they have better performance when compared with a benchmark. • The model has most often been assessed using quality metrics that gauge adherence to care processes. • Evaluations have found relatively minor financial and outcomes/quality improvement.[29]

Appendix C: Methodology for analyzing joint replacement spending

The methodology leveraged the CMS Limited Data Set:

- The sampled dataset includes the claims of 5 percent randomly selected members.
- Data is for 2011, the most recent year available from CMS, without inflation adjustment.
- Pharmacy claims are not part of the CMS dataset.
- The dataset excludes members in Medicare Advantage, as their claims are not included in the CMS dataset.
- The dataset excludes dual-eligible members.

Defined episodes of care are based on the following:

- Episodes use the CMS definition from its Bundled Payments for Care Improvement (BPCI) initiative.
- Episodes are triggered by specified inpatient admission, as defined by Diagnosis Related Group (DRG) codes.
- Episodes include trigger admission, professional, outpatient, and ancillary services during admission, and all related post-discharge services (defined by CMS) within 90 days after discharge.
- Unit cost is normalized for geographic variation (for example, wage index difference).
- The summary excludes supplemental payments, such as Disproportionate Share Hospital (DSH), Indirect Medical Education (IME), capital payment, and so on.

Endnotes

1. HealthLeaders Media Intelligence, "Industry survey: HealthLeaders Media 2014, Forging healthcare's new financial foundation," January 2014, http://content.hcpro.com/pdf/content/299648.pdf, accessed August, 12, 2014.
2. Elizabeth Stanley, Mitch Morris, and Leslie Korenda, "Preparing for the inevitable: The path to physician success in a value-based world," Deloitte Center for Health Solutions Physician Survey 2014, December 2014, http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/physician-survey-value-based-care.html, accessed December 15, 2014.
3. Aetna, "2013 Investor Conference," December 2013, http://www.aetna.com/investors-aetna/assets/documents/2013%20Investor%20Conference/2013-Investor-Conference-Presentation.pdf, accessed December 15, 2014.
4. US Department of Health and Human Services, "Centers for Medicare & Medicaid Services (CMS): Center for Medicare & Medicaid Innovation," http://www.hhs.gov/budget/fy2015-hhs-budget-in-brief/hhs-fy2015budget-in-brief-cms-innovation-programs.html, accessed December 15, 2014.
5. Medbill, "Blue Cross' $65 billion move away from fee-for-service medicine," July 14, 2014, http://medbill.net/2014/07/blue-cross-65-billion-move-away-from-fee-for-service-medicine/, accessed December 15, 2014.
6. Paul Demko, "HHS sets goals for expanding new Medicare payment models," *Modern Healthcare*, January 26, 2015, http://www.modernhealthcare.com/article/20150126/NEWS/301269811?utm_source=modernhealthcare&utm_medium=email&utm_content=20150126-NEWS-301269811&utm_campaign=mh-alert, accessed January 26, 2015.
7. Centers for Medicare and Medicaid Services, "Fact sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth," November 10, 2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-10.html, accessed December 15, 2014.
8. Centers for Medicare and Medicaid Services, "BPCI Model 2: Retrospective acute & post acute care episode," http://innovation.cms.gov/initiatives/BPCI-Model-2/index.html, accessed December 15, 2014; Centers for Medicare and Medicaid Services, "BPCI Model 3: Retrospective acute & post acute care episode," http://innovation.cms.gov/initiatives/BPCI-Model-3/index.html, accessed December 15, 2014.
9. Emily Rappleye, "20 major health systems, payers pledge to convert 75% of business to value-based arrangements by 2020," *Becker's Hospital Review*, January 28, 2015, http://www.beckershospitalreview.com/finance/20-major-health-systems-payers-pledge-to-convert-75-of-business-to-value-based-arrangements-by-2020.html, accessed February 16, 2015.
10. Alexander Cohen, Sarah Klein, and Douglas McCarthy, *Hill Physicians Medical Group: A market-driven approach to accountable care for commercially insured patients*, The Commonwealth Fund, October 2014, http://www.commonwealthfund.org/~/media/files/publications/case-study/2014/oct/1770_cohen_hill_physicians_aco_case_study.pdf, accessed October 24, 2014.
11. Ibid.
12. George Isham, "Minnesota and the emerging ACO," *MetroDoctors*, March/April 2011, https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_008972.pdf, accessed October 24, 2014.
13. Cohen, Klein, and McCarthy, *Hill Physicians Medical Group*.
14. George Isham, "Minnesota and the emerging ACO."
15. Elizabeth Stanley, Paul Keckley, and Glenn Snyder, *Value-based pricing for pharmaceuticals: Implications of the shift from volume to value*, Deloitte Center for Health Solutions, 2012, http://deloitte.wsj.com/cfo/files/2012/09/ValueBasedPricingPharma.pdf, accessed December 15, 2014.

16. Jaimy Lee, "Device makers explore risk contracts with hospitals," *Modern Healthcare*, December 6, 2014, http://www.modernhealthcare.com/article/20141206/MAGAZINE/312069964, accessed December 15, 2014.

17. Deloitte analysis of models.

18. David E. Wennberg, Shannon Brownlee, Elliott S. Fisher, Jonathan S. Skinner, and James N. Weinstein, "Improving quality and curbing health care spending: Opportunities for the Congress and the Obama administration," *Dartmouth Atlas*, December 2008 , http://www.dartmouthatlas.org/downloads/reports/agenda_for_change.pdf, accessed October 17, 2014.

19. Deloitte analysis of Centers for Medicare & Medicaid Services' Limited Data Set, 2012.

20. Ibid.

21. Deloitte actuary analysis.

22. Deloitte synthesis of academic literature and subject matter expert interviews.

23. Anne B. Martin, Micah Hartman, Lekha Whittle, and Aaron Catlin, "National health spending in 2012: Rate of health spending growth remained low for the fourth consecutive year," *Health Affairs* 33, no. 1 (2014): p. 67, doi:10.1377/hlthaff.2013.1254.

24. Centers for Medicare and Medicaid Services, "National Health Expenditure Projections 2011-2021," September 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf, accessed October 7, 2014.

25. Darshak Sanghavi, Kate Samuels, Meaghan George, and Rio Hart, *The beginner's guide to new health care payment models*, The Brookings Institution, July 23, 2014, http://www.brookings.edu/blogs/up-front/posts/2014/07/23-alternative-health-care-payment-model-beginner-guide, accessed October 7, 2014; G. William Hoagland, Loren Adler, and Leah Ralph, *What is driving U.S. health care spending? America's unsustainable health care cost growth*, Bipartisan Policy Center, September 20, 2012, http://dhhs.ne.gov/publichealth/licensure/documents/HealthCareSpending.pdf, accessed October 7, 2014.

26. Niall Brennan, Nicole Cafarella, S. Lawrence Kocot, Aaron McKethan, Marisa Morrison, Nadia Nguyen, Mark Shepard, and Reginald D. Williams II, *Improving quality and value in the U.S. Health Care System*," The Brookings Institution, August 2009, http://www.brookings.edu/~/media/Research/Files/Reports/2009/8/21%20bpc%20qualityreport/0821_bpc_qualityreport.PDF, accessed October 7, 2014; Darshak Sanghavi, Kate Samuels, Meaghan George, Kavita Patel, Sarah Bleiberg, Frank McStay, Andrea Thoumi, and Mark B. McClellan, *Case study: Transforming cancer care at a community oncology practice*, The Brookings Institution, July 05, 2014, http://www.brookings.edu/research/articles/2014/07/05-transforming-cancer-care-oncology-practice, accessed October 7, 2014.

27. Deloitte synthesis of academic literature and subject matter expert interviews.

28. Thomas F. Claffey, Joseph V. Agostini, Elizabeth N. Collet, Lonny Reisman, and Randall Krakauer, "Payer-provider collaboration in accountable care reduced use and improved quality in Maine Medicare Advantage Plan," *Health Affairs* 31, no. 9 (2012): p. 2074, DOI:10.1377/hlthaff.2011.1141.

29. Meredith B. Rosenthal, Bruce E. Landon, Katherine Howitt, HyunSook Ryu Song, and Arnold M. Epstein, "Climbing up the pay-for-performance learning curve: Where are the early adopters now?" *Health Affairs* 26, no. 6 (2007): p. 1674, DOI:10.1377/hlthaff.26.6.1674.

Contacts

Mitch Morris, MD
Vice Chair and Global Leader, Health Care Providers Practice
Principal
Deloitte Consulting LLP
mitchmorris@deloitte.com

Jim Whisler
National Leader, Health Actuarial Practice
Principal
Deloitte Consulting LLP
jwhisler@deloitte.com

Brian Flanigan
Principal
Deloitte Consulting LLP
bflanigan@deloitte.com

Sarah Thomas, MS
Research Director
Deloitte Center for Health Solutions
Deloitte Services LP
sarthomas@deloitte.com

Harry Greenspun, MD
Director
Deloitte Center for Health Solutions
Deloitte Services LP
hgreenspun@deloitte.com

Acknowledgements

Special thanks to **Jim Whisler**, **Brian Flanigan**, **Sarah Thomas**, and **Harry Greenspun** for their support of and contributions to this project.

Additionally, the authors would like to thank **David Betts**, **Mark Bethke**, **Kumar Kanisan**, **Yabo Wu**, **Kathryn Robinson**, **Aleem Khan**, **Kiran Jyothi Vipparthi**, **Mohinder Sutrave**, and the many others who contributed their ideas and insights to this project.

About the Deloitte Center for Health Solutions

The Deloitte Center for Health Solutions is the health services research arm of Deloitte LLP. Our goal is to inform all stakeholders in the health care system about emerging trends, challenges, and opportunities using rigorous research. Through our research, roundtables, and other forms of engagement, we seek to be a trusted source for relevant, timely, and reliable insights. To learn more about the Deloitte Center for Health Solutions, its projects and events please visit: www.deloitte.com/centerforhealthsolutions.

Deloitte Consulting LLP's value-based care capabilities include strategy, assessment, program design, and care delivery model implementation. Our professionals have helped design and implement multiple value-based care and population health investments for health plan, provider, life sciences, and employer clients. Work with clients often includes insight from Deloitte Consulting LLP's Health Actuarial Services, which focus on building tailored models that facilitate the ability to answer the right questions and develop a fact base to help make critical decisions. Read more about Deloitte's value-based care and health actuarial services, or reach out to the contacts listed in the report for more information.

 Follow @DU_Press

Sign up for Deloitte University Press updates at DUPress.com.

About Deloitte University Press

Deloitte University Press publishes original articles, reports and periodicals that provide insights for businesses, the public sector and NGOs. Our goal is to draw upon research and experience from throughout our professional services organization, and that of coauthors in academia and business, to advance the conversation on a broad spectrum of topics of interest to executives and government leaders.

Deloitte University Press is an imprint of Deloitte Development LLC.

ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Quality Committee Meeting Date: October 3, 2016
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	For Information
	Background: IN FY16 we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. Recently, staff was asked to supplement the Chair's verbal report with the attached written report.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : To inform the Committee about recent Board actions	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: None. This is an informational item	
	LIST OF ATTACHMENTS: Report on August and September 2016 Board Actions	

August and September 2016 Board Actions*

1. August 10, 2016 El Camino Hospital Board Approvals
    a. FY 16 Period 12 Financials (FY16 Budget was met)
    b. Approved final funding for the following projects:
        i. Behavioral Health Services Building - $72,5000,000
        ii. Integrated Medical Office Building - $247,000,000
        iii. Central Plant Upgrades (to support new construction) - $7,500,000
    c. Appointed two new members to the Finance Committee – Joseph Chow and Boyd Faust
    d. Disbanded the Board's iCare Ad Hoc Committee
    e. Recommended the District Board adopt the following as the highest priority Hospital Board member competencies for FY2017 –
        i. Understanding of complex market partnerships
        ii. Long-range strategic planning
        iii. Healthcare insurance industry experience
        iv. Finance experience/entrepreneurship
        v. Experience in clinical integration/continuum of care
2. August 10, 2016 El Camino Healthcare District Board meeting Approvals: Approved final funding for the following projects that exceeded $25,000,00 0 in a single transaction.
    a. Behavioral Health Services Building - $72,5000,000
    b. Integrated Medical Office Building - $247,000,000
3. August 27, 2016 – El Camino Hospital Board voted not to renew the CEO's contract. Ms. Ryba's last day of employment will be October 31, 2016.
4. September 14, 2016 El Camino Hospital Board Actions
    a. FY 16Organizational Goal Achievement @ 67% (slightly above target)
    b. FY17 Organizational Goal Metrics
    c. ED Gastroenterology and Neurointerventional On Call Panel Agreements
    d. CEO Search Ad Hoc Committee of the Board
    e. FY17 Internal Audit Work Plan
    f. Silicon Valley Medical Development Primary Care Clinic and Physician Contracts
    g. FY 16 CEO Incentive Plan Payment
    h. FY 17 CEO Salary Range

*This list is not meant to be exhaustive, but includes agenda items the Board s voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

ATTACHMENT 6

CONFIDENTIAL

BPCI Update

Margaret Wilmer, Sr. Director Integrated Care
Mike Goran, MD, Optum

Quality Committee
October 3, 2016

Bundled Payments for Care Improvement (BPCI) Overview

- Medicare shared savings demonstration program to improve patient care quality and reduce costs through better coordination of care.
- Program applies to FFS Medicare patients with Part A & B, who have qualifying "inpatient" stay
- Participation is voluntary for physicians and hospitals, except for mandatory bundles such as CJR and upcoming cardiac bundle
- Retroactive FFS reimbursement remains the same for all providers
- Cost target is based on 2009-2012 experience by DRG; Medicare automatically takes 2% discount (Medicare's guaranteed savings)
- Upside and downside risk

Why Participate in the Bundled Payment Program?

- Medicare is moving rapidly to Value Based Reimbursement (VBR) that links fee for service payments to quality and outcomes, and shifts the focus from volume to value.
- Other payers are also moving to Value Based Reimbursement
- ECH is preparing for VBR and the assumption of risk by participating in the Bundled Payment for Care Improvement Program (BPCI) and other risk based programs and contracts.
- ECH goal is to partner with physicians and post acute providers to improve patient quality and reduce costs across the continuum.
- Building care management and analytic infrastructure to serve BPCI and upcoming VBC programs

ECH's Participation in BPCI

- ECH partnered with Optum two years ago to develop partnerships and care model to manage risk for the entire episode of care
- Starting April 2015, two initial bundles were selected: Pneumonia and Chronic Obstructive Pulmonary Disease. Effective October 2015, three more bundles were added: Stroke, Total Joint Replacement, and Hip and Femur Fracture
- ECH has risk for initial hospital stay and 90 days post discharge. ECH earns shared savings if costs are lower than target price and owes CMS if costs are above target price.
- Steering Committee created to oversee BPCI that includes PAMF, independent physicians and aligned post acute providers.
- Care management, data and analytics infrastructure built to coordinate care across continuum and measure results.
- Within ECH, the Integrated Care Department has primary responsibility for supporting this clinical and cultural transformation.

Governance and Physician Leadership

- BPCI Steering Committee – ECH and PAMF executives and physicians in management, UM, and clinical roles; quarterly meetings
- BPCI Operating Committee – ECH Internal; monthly
- Post-acute Providers, Service Lines – Monthly and quarterly meetings
- Designated PAMF and Independent Medical Directors – Drs. Kopardekar and Yaskin
- Quality and UM Physician Leadership – Drs. Michelle Pezzani and Sanjay Agarwal

Case Management

- Integrated Care clinical team responsible for case finding and post-discharge case management
- IC clinical team includes clinical manager, 3 RNs, 1 Pharmacist, 1 Social Worker, 1 Data Analyst
- IC clinical team collaboration with Care Coordinators/Discharge Planners, Hospitalists, Inpatient Rehab, and Service Lines
- IC clinical team conducts weekly SNF interdisciplinary team UM meetings and conducts house visits as needed
- Collaboration with aligned post-acute providers
  - Six Skilled Nursing Facilities (SNF)
  - Three Home Health Agencies (HHA)
- BPCI SNFist at each aligned provider
- IC clinical team schedules follow-up appointment with PCP
- Weekly clinical rounds on BPCI patients

Quality Measures

- Medication reconciliation for each transition of care
- Use of high risk medications
- Screening for fall risk
- Physician follow-up appointment within seven days of acute discharge
- Aligned Post-acute Care Provider reporting
- Root Cause Analysis of Readmissions
- Advance Directive and POLST
- Clinical pathways delegated to service lines
  - Respiratory Care (COPD and Pneumonia)
  - Stroke
  - Orthopedics

BPCI Results to Date

- Opportunity is to reduce use and cost of post acute services
  - Improve transitions and coordination of care
  - Align hospital, physicians, and post-acute providers
  - Reduce variation in practice patterns
- Results to date have been mixed
  - Aligned providers have reduced SNF LOS
  - Too many outlier, high cost episodes
- CMS financial results for the 2015 show shared savings losses
  - April-June $80, 807
  - July-September $59,700
  - October-December $414,615
- Bundles generating gains/losses have varied from quarter to quarter
  - April-June: PNA gain offset by larger COPD losses
  - July-September: COPD gain offset by larger PNA losses
  - October-December: Hip & Femur, COPD gains offset by larger TJR, PNA, Stroke losses
- Access to detailed performance data is now driving change management

Dashboard of Key Metrics

BPCI Monthly Performance At-A-Glance
Key Performance Indicators
Dashboard

Anchor Month	BPCI Volume	Acute LOS	SNF %	SNF Baseline	HHC %	HHC Baseline	IRF %	IRF Baseline	Readmit %	Readmit Baseline	SNF ALOS	SNF ALOS Baseline	Aligned SNF %	Aligned HHC %	Med Rec %	POLST %	AD %	Post D/C MD FU %	Volume PAMF %
2015 - April	45	4.31	33.3%	21.9%	33.3%	26.7%	0.0%	0.3%	20.0%	26.1%	24.1	28.3	20%	60%	97.8%	42.2%	48.9%	38.9%	26.7%
2015 - May	31	5.74	58.1%	22.6%	51.6%	26.4%	0.0%	0.3%	29.0%	25.6%	37.2	27.9	33%	38%	100.0%	32.3%	51.6%	42.9%	25.8%
2015 - June	27	5.44	33.3%	22.5%	29.6%	25.6%	0.0%	0.4%	25.9%	26.0%	18.8	30.5	56%	25%	100.0%	33.3%	77.8%	42.9%	48.1%
2015 - July	16	5.25	12.5%	24.7%	43.8%	24.2%	6.3%	0.5%	25.0%	24.0%	20.5	28.7	50%	29%	100.0%	37.5%	62.5%	62.5%	25.0%
2015 - August	17	3.88	35.3%	19.4%	41.2%	24.0%	0.0%	0.4%	29.4%	22.4%	30.8	28.6	0%	29%	100.0%	35.3%	64.7%	42.9%	29.4%
2015 - September	19	5.11	26.3%	23.5%	57.9%	27.0%	5.3%	0.3%	42.1%	26.4%	26.7	30.8	60%	36%	100.0%	21.1%	57.9%	100.0%	57.9%
2015 - October	81	3.37	30.9%	38.4%	58.0%	43.2%	9.9%	5.4%	19.8%	14.2%	31.9	32.8	16%	32%	100.0%	18.5%	53.1%	33.3%	35.8%
2015 - November	81	3.83	42.0%	35.5%	50.6%	38.3%	9.9%	4.2%	19.8%	17.5%	25.2	31.5	24%	27%	91.4%	16.0%	43.2%	72.7%	46.9%
2015 - December	73	4.88	37.0%	33.4%	46.6%	37.3%	8.2%	4.3%	13.7%	18.1%	26.0	30.2	33%	15%	98.6%	16.4%	52.1%	66.7%	49.3%
2016 - January	80	4.18	32.5%	34.2%	31.3%	38.7%	6.3%	6.0%	12.5%	15.6%	22.7	32.9	38%	32%	100.0%	21.3%	36.3%	84.6%	51.3%
2016 - February	82	4.05	37.8%	35.3%	32.9%	37.2%	4.9%	3.2%	11.0%	15.4%	26.0	30.1	65%	48%	100.0%	12.2%	36.6%	93.1%	47.6%
2016 - March	101	3.63	26.7%	35.1%	31.7%	38.4%	4.0%	3.9%	13.9%	15.4%	26.5	30.4	52%	34%	99.0%	13.9%	28.7%	92.7%	45.5%
2016 - April	87	3.64	32.2%	36.3%	37.9%	41.2%	5.7%	5.3%	17.2%	16.9%	22.9	32.1	29%	24%	98.9%	11.5%	24.1%	93.9%	36.8%
2016 - May	76	3.32	30.3%	37.9%	27.6%	40.5%	10.5%	5.7%	11.8%	15.8%	27.6	30.4	57%	14%	100.0%	10.5%	5.3%	95.7%	40.8%
2016 - June	58	3.19	32.8%	36.3%	29.3%	39.4%	5.2%	3.9%	N/A	N/A	N/A	N/A	42%	18%	100.0%	19.0%	1.7%	94.7%	43.1%
2016 - July	74	3.46	28.4%	36.8%	41.9%	40.1%	8.1%	5.7%	N/A	N/A	N/A	N/A	62%	32%	N/A	13.5%	2.7%	95.7%	40.5%
2016 - August	84	2.98	28.6%	36.2%	32.1%	41.9%	7.1%	6.8%	N/A	N/A	N/A	N/A	58%	15%	N/A	4.8%	3.6%	100.0%	44.0%
GRAND TOTAL	1032	3.87	32.9%	33.9%	38.7%	37.6%	6.3%	4.3%	N/A	N/A	N/A	N/A	41%	29%	N/A	17.2%	31.6%	81.0%	42.3%

BPCI Dashboard Notes:

- Includes all bundle categories: Pneumonia, COPD, TJR, Hip & Femur procedures, Stroke
- Actuals and baseline figures adjusted based on patient DRG mix
- Readmit rate is based on unique patient readmits over 90-day period
- Medicare reconciled data available seven months following end of episode period
- Medicare reconciled data above is for period April 2015-December 2015
- IRF is Inpatient Rehabilitation Facility, such as ECH's Acute Rehab Hospital in Los Gatos.

Challenges and Priorities

Challenges

- Multiple outliers related to complex patients with major medical conditions and comorbidities, compounded by psychosocial, behavioral, and palliative care needs
- Care Coordination compliance with tracking/documenting, referral to aligned providers, comprehensive discharge planning, proactive use of lowest possible level of care
- Physician leadership and alignment of goals; lack of incentives and hierarchy; clinical variation and practice patterns
- Criteria for selecting discharge disposition and inherent conflict with acute rehab

Priorities to improve care and generate shared savings

- Reduce SNF and Acute Rehab admissions
- Reduce SNF LOS
- Prevent unnecessary ER visits and hospital readmissions

Priority Action Plan

PRIORITY	GOAL	OWNER	TACTICS
Reduce SNF/Acute Rehab Utilization	Decrease referrals to SNFs for the following bundles: ○ TJR ○ COPD ○ PNA ○ Stroke Decrease referrals to Acute Rehab for the following bundles: ○ TJR ○ Hip and Femur	Ownership is Care Coordination with support from IP Rehab	• Enhance and train CCs on script; documentation in Epic - CC iCare Module • AMPAC • Consistent application of Medicare Criteria for Acute Rehab with support from Orthopedic Service Line
Reduce SNF LOS	Decrease SNF LOS for all bundles with emphasis on elective TJR patients and long stays	Ownership is Integrated Care with support from aligned SNFs	• Weekly case review IDT/IC meetings with SNFs • Establish projected LOS; hold SNFs accountable • Hospitalists and Inpatient Rehab document expected LOS

Priority Action Plan

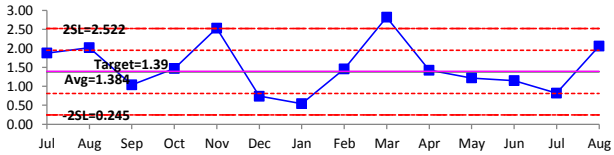
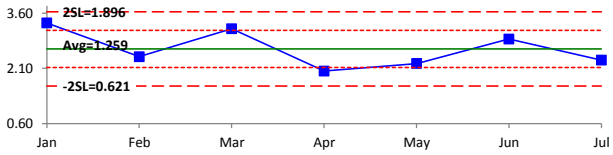
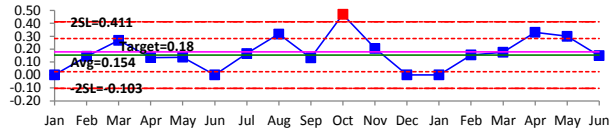
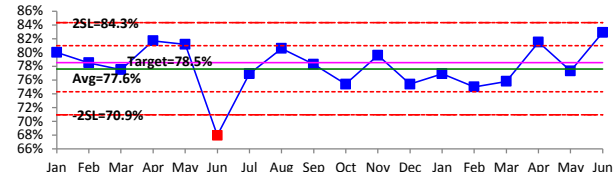
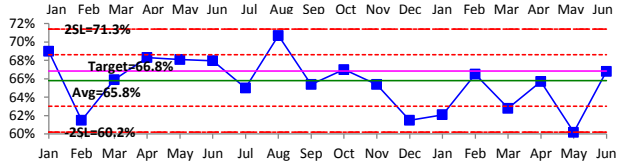
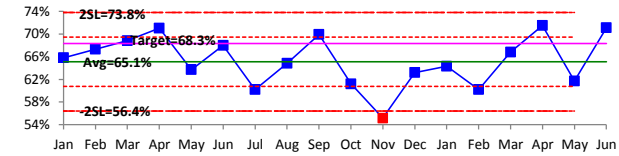
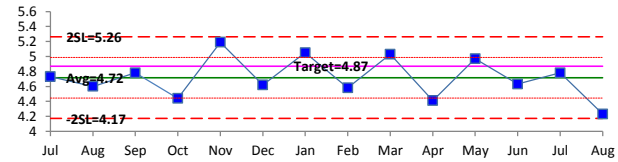
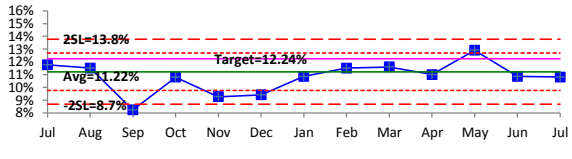
PRIORITY	GOAL	OWNER	TACTICS
Channel Patients to Aligned Providers	Increase proportion of patients referred to aligned SNFs/HHC and decrease proportion that are referred to non-aligned SNFs/HHC for all bundles	Ownership is Care Coordination	• Script and selection materials and process • Hospitalist and Specialist support • CC iCare Module
Reduce Readmissions	Decrease readmission rate for the following bundles ○ PNA ○ COPD ○ Stroke ○ TJR episodes with fracture ○ Hip & Femur	Ownership Integrated Care and Nursing	• Identify patients at high risk for RA during anchor admit and support with intense case management and coordination of care • Physician Follow-up Appointments • Identify patients at high risk for readmission and assure that physician follow-up appointments are received within 3 days

ATTACHMENT 7

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

Date Reports Run: 4/18/2016

		Performance		Baseline	FY17 Goal	Trend
SAFETY EVENTS				FY2016	FY2017	
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: August 2016*	10/4863	2.06	1.51	1.39 (goal for FY 16)	
2	**Medication Errors** *Errors / 1000 Adj Total Patient Days* *Date Period: July 2016*	32/13758	2.33		0.00	
COMPLICATIONS				FY 2016	FY 2017	
4	**Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: June 2016*	1	0.15	0.20	0.18 (goal for FY 16)	
SERVICE				FY 2016	FY 2017	
5	**Communication with Nurses** *(HCAHPS Score)* *Date Period: June 2016*	190/229	82.9%	78.0%		
6	**Responsiveness of Hospital Staff** *(HCAHPS Score)* *Date Period: June 2016*	148/221	66..8%	64.9%		
7	**Communication About Medicines** *(HCAHPS Score)* *Date Period: June 2016*	107/151	71.1%	64.7%		
EFFICIENCY		Performance		Jan-Jun 2016 (6-month ave)	FY 2017	
8	★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: August 2016*	**FYTD 807 01-06/16 2509**	**FYTD 4.53 01-06/16 4.78**	4.78	4.87	
9	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: July 2016*	**FYTD 42/389 01-06/16 288/2497**	**FYTD 10.80 01-06/16 11.53**	11.53	At or below 12.24	

J Pao, Sr. Director, Clinical Quality and Patient Safety, Clinical Effectiveness
P Griesbach, Mgr, Cln Variation, Clinical Effectiveness

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2015 Definition	FY 2016 Definition	Source
Patient Falls	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	Joy Pao; Cheryl Reinking	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**
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; Eric Pifer	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	Eric Pifer, MD; Mick Zdeblick; Joy Pao; Petrina Griesbach	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)	Eric Pifer, MD; Margaret Wilmer; Joy Pao; Petrina Griesbach	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**

ATTACHMENT 8

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	New Metric Selection for FY17 Exception Report Quality Committee Meeting Date: October 3, 2016
	Responsible party:	William Faber, MD, CMO
	Action requested:	Possible Motion
	Background: We are currently evaluating the metrics for the FY17 Exception Report. The Committee has previously discussed eliminating the Specimen Labeling metric and the addition of Sepsis Management Improvement metrics. With the evaluation of the measurement for Sepsis in mind, we are looking for the fluid order to come no later than two hours from time of presentation. This should insure that fluids could be completed in the three hour window. After we look at the baseline data from Q4 Fiscal Year 2016, we can determine an appropriate goal for decreasing the time frame. We can express the goal in decreased minutes or decreased percent of minutes. The following is the proposed measurement: <u>Proposed Measurement:</u> Patient Population: Patients presenting to the Emergency Department. Measure: Minutes from **Time of Presentation** (two or more SIRs and suspected source of infection and one or more organ dysfunction criteria) to **IV crystalloid fluid order** equaling or exceeding 30 ml/Kg patient weight. Expected Outcome: Minutes < 120. CMS exclusions apply.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : None.	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: To replace current Specimen Labeling with Sepsis Management Improvement on the FY17 Exception Report	
	LIST OF ATTACHMENTS: N/A	

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

ATTACHMENT 9

FY16 Organizational Goal Achievement

Performance Measurement | **Results and Scoring**

Organizational Goals FY16	Benchmark	2015 ECH Baseline	Minimum	Target	Maximum	Weight	Evaluation Timeframe	Actual Year End	Performance Level Achieved	Weighted Score
Threshold Goals										
Joint Commission Accreditation	Standard Threshold	Full Accreditation	Full Accreditation			Threshold	FY 16	Full Accreditation	Met	N/A
Budgeted Operating Margin	90% threshold recommended by Exec Comp Consultant	Met	90% of Budgeted			Threshold	FY 16		Met	N/A
Patient Safety & iCare										
Achieve iCare Tier 1 Metric: Medication Reconciliation at Discharge	Epic Benchmark: 97% accuracy is 90%ile at stable state	May - Jun FY15 Actual	6 Months Post Go-Live: 60%	6 Months Post Go-Live: 75%	6 Months Post Go-Live: 90%	34%	May, 2016	97%	100%	34.0%
Achieve Medicare Length of Stay Reduction	Internal Improvement	Jan - June FY15 Actual for LOS: 5.17	.10 Day Reduction, Readmission at or below FY15	.20 Day Reduction, Readmission at or below FY15	.30 Day Reduction, Readmission at or below FY15	16.5%	Jan - Jun FY16	4.78 result. Reduction = 0.39 days	100%	16.5%
Maintain Current Readmission Rates for Same Population (One month delay for readmission- Based on Index Admit Date)	Internal Improvement	Jan - June FY15 Actual for Readmission: 12.67	Readmission at or below FY 15	Readmission at or below FY 15	Readmission at or below FY 15	16.5%	Jan - Jun FY16	11.50 (287/2496)	100%	16.5%
Smart Growth										
Achieve Enterprise Planned Growth (300 Discharges, 300 Outpatient Visits)	Internal Goal: 120 net, per each metric, is Threshold	FY15 Actual increase of 310 discharges and 145 procedures	80% (240/240)	100%	120% (360/360)	33%	FY 16	Decrease of 463 discharges and 660 procedures	0%	0.0%
					TOTAL:	100%				67.0%

Percent of Maximum Achieved	**67.0%**
Percent of Target Achieved	**100.5%**

ATTTACHMENT 10

ECH FY17 Organizational Goals

DRAFT

Organizational Goals FY17		Benchmark	2016 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe
Threshold Goals								
Budgeted Operating Margin		90% threshold *[Recommended by Exec Comp Consultant (FY16)]*	TBD	90% of Budgeted			Threshold	FY 17
Quality, Patient Safety & iCare								
Quality Pain Management	**Pain Reassessment** (% Pain Reassessment Documented within 60 min on RN Flowsheet)	Internal Improvement	56%	75%	80%	90%	34%	Q4 FY17
	Pain Patient Satisfaction (CMS HCAPHS Pain Management % Scored Top Box)	Internal Improvement	72.9% *FY 2016 Q1 - Q3 [9-month measurement)*	73%	74%	76%		
LOS & Readmission	Achieve Medicare **Length of Stay** Reduction while Maintaining Current **Readmission Rates** for Same Population	Internal Improvement	FY16 Max Goal 4.86 LOS Readmission Target 12.39%	4.81 .05 Day Reduction from FY16 Max, Readmission at or below FY16 Target	4.76 .10 Day Reduction from FY16 Max, Readmission at or below FY16 Target	4.66 .20 Day Reduction from FY16 Max, Readmission at or below FY16 Target	33%	FY17
Smart Growth								
Achieve budgeted inpatient growth (surgical and procedural cases plus Deliveries and NICU), and budgeted outpatient growth (surgical and procedural cases plus infusion).		Internal Documentation	TBD	99% of Budgeted Volume	100% of budgeted Volume	102% of Budgeted Volume	33%	FY 17