Governance Leadership in Health Care Reform

November 30, 2010—Web Seminar

Welcome & Program Overview

Peggy Broussard Wheeler
California Hospital Association
Agenda

- Health Care Reform—The Federal Perspective
  *Anne O’Rourke*

- Key Elements of Reform—The Big Picture
  *Anne McLeod*

- Accountable Care Organizations and Health Benefit Exchanges
  *Dietmar Grellmann*

- The Role of Quality—A Pillar of Health Care Reform
  *Debby Rogers*

Faculty: Anne O’Rourke

*Anne O’Rourke* is senior vice president for federal relations for the California Hospital Association. Based in Washington, D.C., Anne manages CHA’s Federal Relations office in Washington and represents the CHA membership before Congress and the White House, and serves as the liaison to other state and national health organizations.
Health Care Reform—The Federal Perspective

Anne O’Rourke
California Hospital Association

Impetus for Reform: The Growing Uninsured Population

Source: U.S. Census Bureau
Why California Needs Reform

- Nearly 8.2 million Californians are uninsured
  - Nearly 25 percent of Californians are uninsured
- California hospitals have absorbed more than $12.2 billion in uncompensated care in 2009

Impetus for Reform: The Growing Health Care Cost Burden

<table>
<thead>
<tr>
<th>Year</th>
<th>NHE as % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>5.9%</td>
</tr>
<tr>
<td>1969</td>
<td>6.7%</td>
</tr>
<tr>
<td>1974</td>
<td>7.8%</td>
</tr>
<tr>
<td>1979</td>
<td>8.6%</td>
</tr>
<tr>
<td>1984</td>
<td>10.2%</td>
</tr>
<tr>
<td>1994</td>
<td>11.7%</td>
</tr>
<tr>
<td>1999</td>
<td>13.6%</td>
</tr>
<tr>
<td>2004</td>
<td>13.5%</td>
</tr>
<tr>
<td>2009</td>
<td>15.6%</td>
</tr>
<tr>
<td>2014</td>
<td>17.3%</td>
</tr>
<tr>
<td>2019</td>
<td>17.4%</td>
</tr>
<tr>
<td>2020</td>
<td>19.3%</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services (CMS)
The Alternative—Without Health Reform …

- Budget and deficit pressures could have resulted in deeper reductions in provider payments without the benefits of expanded coverage.
- Without reform, by 2019 the number of uninsured people could grow by 10 to 30 percent.

The Political Climate: 112th Congress

<table>
<thead>
<tr>
<th>House*</th>
<th></th>
<th>Senate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Democrats</td>
<td>GOP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>193</td>
<td>242</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Democrats</td>
<td>GOP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>53</td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prominent California Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
</tr>
<tr>
<td>Jerry Lewis</td>
</tr>
<tr>
<td>David Dreier</td>
</tr>
<tr>
<td>Darrell Issa</td>
</tr>
<tr>
<td>Wally Herger</td>
</tr>
<tr>
<td>Kevin McCarthy</td>
</tr>
</tbody>
</table>

- The White House still holds the veto pen.
Congressional Agenda: The Good and Bad for Hospitals

Bad news
- Deficit reduction
- Spending cuts

Good news
- Regulatory relief
- Labor agenda

The Future for Health Care Reform

- “Repeal and Replace”
- “Death by a thousand cuts”

<table>
<thead>
<tr>
<th>GOP Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Individual Mandate</td>
</tr>
<tr>
<td>IRS’ Ability to Enforce Tax Penalties</td>
</tr>
<tr>
<td>Center for Medicare and Medicaid Innovation</td>
</tr>
</tbody>
</table>
Thank you

Anne O’Rourke
Senior Vice President, Federal Relations
California Hospital Association
(202) 488-4494
aorourke@calhospital.org

Faculty: Anne McLeod

Anne McLeod is senior vice president of Health Policy for the California Hospital Association and serves as CHA’s health care reform resource for member hospitals. Using her knowledge of both federal and state health care reform legislation and regulations, Anne coordinates CHA’s efforts on the development, communication, and implementation of CHA’s strategic plan for health care reform. Most recently, she provided leadership for the design, development and implementation of the hospital fee program signed into law by Governor Schwarzenegger in 2009.

Before joining CHA in 2007, Anne served as a financial executive at several of California’s hospitals and health systems, and in California’s banking industry.
Health reform can be defined as the collective set of state and federal legislative and regulatory actions that seek to improve value and ensure coverage and access to everyone.
Implementing Reform

Payment

- Delivery system reforms
- Payment policy changes
- Program integrity
- Patient safety and quality

Value

Bundling, shared savings
HAC, Re-admit, VBP

Quality

ACOs, Medical Homes, CMMI
FCA, RAC, CMP, MIP
County-based Coverage Expansion

- Medicaid coverage expansion (<133 FPL) (MCE)
- Health Care Coverage Initiative (134-200 FPL) (HCCI)
- Through December 31, 2013
- County spending used for federal fund claiming
- Estimated 500,000 lives, ages 19-64
California Health Benefit Exchange (CHCB)

- **AB 1602 and SB 900**
  - First state in the nation to enact legislation post ACA
- **AB 1602**
  - Establishes duties and operations of the CHBE
- **SB 900**
  - Establishes CBHE as an independent state entity and creates a five-member board

Other Coverage/Reform Legislation

- **SB 1163** – Medical insurance rate review
- **SB 1088** – Dependent coverage up to 26 years
- **AB 2244** – Pre-existing denial for kids
- **AB 2345** – Preventive services
- **AB 2470** – Prohibits cancellation/rescission
- **SB 227/AB 1887** – High-risk pool
Risk Management is an Important Consideration in Health Care Reform

---

Corporate Governance

---

Strategic Issues for Hospitals

- Enhance efforts to improve quality
- Increase clinical and operational efficiencies
- Increase efforts to improve patient satisfaction
- Reduce avoidable readmissions
- Assess and strengthen planning for HIT
- Examine readiness for payment and care redesign
- Foster physician alignment and clinical integration
- Develop new organization competencies
Governance Considerations

- Define the Board's role for health care reform and risk
  - Insight and advice
  - Define expectations for communications/information
- Communicate the risk tolerance level
  - Organizational culture—meaningful interactions
- Review strategies developed by management
  - Provide insight and work collaboratively
- Benchmark and evaluate
  - Establish reporting and monitoring needs

Thank you

Anne McLeod
Senior Vice President, Health Policy
California Hospital Association
(916) 552-7536
amcleod@calhospital.org
Questions

Online questions:
Type your question in the Chat Box, hit enter

Phone questions:
To ask a question hit *1
To remove a question hit *2

Faculty: Dietmar Grellmann

Dietmar Grellmann is senior vice-president, Managed Care and Professional Services, for the California Hospital Association. Dietmar represents hospitals on managed care and other issues before the California Legislature, California Department of Managed Health Care and other regulatory agencies.

Prior to joining CHA, he was Deputy Legislative Secretary to Governor Pete Wilson and responsible for health, insurance and financial services issues. In addition, Dietmar was also served as the Director of the State Office of Insurance Advisor.
Accountable Care Organizations & Health Benefit Exchanges

Dietmar Grellmann
California Hospital Association

- Patient Protection and Affordability Act of 2010 (ACA), Section 3022
- Medicare Shared Savings Program
- The basics: who, what, why and when?
Accountable Care Organizations

What?
- A formal legal structure to receive and distribute shared savings
- Structure that includes clinical and administrative management systems
- Three-year contractual commitment
- At least 5,000 Medicare beneficiaries and primary care physicians
- Process to coordinate care and improve quality of care
- Patient-centered processes and reporting requirements as required by HHS

Who?
- Professionals in group practice arrangements
- Networks of individual practices of professionals
- Partnerships or joint venture arrangements between hospitals and professionals
- Hospitals employing professionals
- Other groups of providers of services and suppliers HHS determines appropriate
Accountable Care Organizations

Why?

- Triple aim
  1. Patient experience
  2. Quality
  3. Reduce per capita costs*

* Don Berwick, MD, CMS Administrator

When?

- January 1, 2012
- First draft of regulations expected around the end of the year
Impact of the elections

- Bipartisan support for reducing costs (and improving care)

Is the carrot big enough?

- No new money!
- California already ahead of the nation in coordinated care models

There is no stick.
Strategic analysis:
- Future role in the community

Success is dependent on developing a collaborative partnership
- Culture
- Location
Considerations for hospital leaders

- Deep management bench: vision
- Expensive: EMR, increased regulation, data collection and reporting
- Management and financial challenges
  - Attribution
  - Benchmark reset

Legal challenges

- Federal: antitrust, Stark, CMP, tax-exempt entities
  - Safe harbors and waivers
- Department of Managed Health Care
  - Spectrum of assumed risk
    - Shared Savings – partial capitation – global risk
    - RBO (SB 260) – limited Knox-Keene – full Knox-Keene
    - Possibilities: two-year waiver moving to licensure
Center for Medicare and Medicaid Innovation (CMMI)

- Patient Protection and Affordability Act of 2010 (ACA), Section 3021
- To test, evaluate and expand different payment structures and methodologies to reduce costs and improve quality

CMMI: The Secret Revealed

- Effective January 1, 2011
- $10 billion allocated for pilots through 2019
- Statute suggests a list of potential models
- Significant discretion to CMS
- Possible ACO alternative
In conjunction with federal tax credits – improve affordability of health care coverage

133 – 400 FPL if no other benefits provided

Under the ACA, Exchanges must:

- Determine eligibility for a tax credit
- Select health plans that will offer coverage through the Exchange
- Provide comparative information
- Serve as the sole location for consumers to use tax credits to purchase health coverage

Essential health benefits package (in and out)

**All Plans**

- **All Plans** must offer the four “precious metal” plans
  - Bronze = 60% actuarial value (percent of cost of EHB Pkg paid)
  - Silver = 70%
  - Gold = 80%
  - Platinum = 90%
- Catastrophic plan for >30 or affordability exemption
- Other benefit options
CA Health Insurance Exchange: Considerations

- 2014 deadline
- Unknown size (1.25 to 8 million enrollees)
- Coordination with Medi-Cal, Healthy Families, county-based coverage and administrative structure
- Role of the California Exchange in the insurance market
  - California Exchange as entire market
  - California Exchange as a simple pass through for the subsidy
  - California Exchange works with the outside market but drives goals through selective contracting

CA Health Benefit Exchange

- AB 1602 and SB 900
- First state in the nation to enact legislation post ACA
- AB 1602
  - Establishes duties and operations of the California Exchange
- SB 900
  - Establishes California Exchange as an independent state entity and creates a five-member board
Five-member board
- Two gubernatorial appointees
- One appointee of Senate Rules committee
- One appointee of the Speaker of the Assembly
- Ex-officio member – Secretary HHS

Demonstrated expertise in at least two areas
- Individual coverage
- Small employer coverage
- Plan administration
- Health care finance
- Administering public or private health care delivery system
- Purchasing health plan coverage
California residents
Other organizational considerations:

- Strict conflict of interest provisions bar anyone working for insurers, agents/brokers, providers
- Staff will be civil service with executive staff exempt from civil service
- Unpaid board positions
- Subject to open meeting/public record act laws
- Insurance contracts available after one year, except for pricing

Exchange operations

- Individual and small group markets will be separate
- Seamless transition between California Exchange and Medi-Cal/other enrollment
- Selective contracting with carriers and requires plans:
  - Sell all five levels of coverage in and out of the California Exchange
  - Non-participating providers may not offer catastrophic only policies
  - Requires non-participating carriers to offer at least one “precious metal” coverage level
Plan certification

- State to establish criteria
- Publish RFP
- Develop scoring criteria
- Respondents scored
- Certify plans that meet/exceed thresholds
- California Exchange not prohibited from accepting all plans

CHA principles

- Payers in/out of Exchange subject to same licensure
- Payers must have equal access to potential enrollees
- Premiums must be actuarially sound market rates and payments to providers individually negotiated
- Enrollees should have choice of providers
- Predatory practices shall be prohibited
Thank you

**Dietmar Grellmann**
Senior Vice President, Managed Care and Professional Services
California Hospital Association
(916) 552-7572
dgrellmann@calhospital.org

Faculty: Debby Rogers

**Debby Rogers, RN,** is vice president for Quality and Emergency Services for the California Hospital Association. At CHA, Debby oversees legislative and regulatory initiatives for California hospitals related to quality and emergency services.

Prior to joining CHA, she was the associate secretary for Legislative Affairs for the California Health and Human Services and also spent ten years with the Legislature as a consultant on Health and Human Services issues. Debby also has many years of experience as a registered nurse, base hospital coordinator, emergency clinical nurse specialist and nurse manager.
The Role of Quality—
A Pillar of Health Care Reform

Debby Rogers
California Hospital Association

Increasing Focus on Quality, Patient Safety and Value

- Freedom from accidental injury (Institute of Medicine Report 1999)
- Secure from danger, harm, or evil
- Condition of being protected against failure, damage, error, accidents, or harm
- A judgment of the acceptability of risk associated with using a technology in a given situation
- Achieving intended outcomes
Startling Facts

- 200,000 deaths from potentially preventable medical errors
- 1.5 MILLION preventable adverse drug events (ADEs) annually (including errors of omission)
- 25% of ADEs causing harm are PREVENTABLE
- $3.5 BILLION annual added costs/year
- 1,700,000 hospital-acquired infections (HAI)/year
- 100,000 HAI deaths/year
- Media and public image – stories of error

On average, an inpatient is exposed to ONE medication error (excluding wrong time) EVERY day (+/-)
How Hazardous Is Health Care?

(Leape)

DANGEROUS
(>1/1000)

Health Care

Mountain Climbing

Bungee Jumping

REGULATED

Driving

Chemical Manufacturing Chartered Flights

ULTRA-SAFE
(<1/100K)

Scheduled Airlines

European Railroads

Nuclear Power

Three Keys to Health Care Reform

Access

Cost

Quality

Value
Value-Based Purchasing

- Applies to all acute care Inpatient Prospective Payment System (IPPS) hospitals
- Implementation starting in FY2013 (10/2012)
- Limited to current measures for FY2013
  - Heart attack
  - Heart failure
  - Pneumonia
  - Surgical safety
  - Patient experience
  - Infections
- Secretary has authority to expand the measures (FFY 2014) (Section 3011 ACA)

CMS Proposed Value-Based Purchasing

CMS delivered to Congress a value-based purchasing (VBP) proposal in late 2007 that would link quality to payment to ensure the right care is delivered to the right patient at the right time.

The proposal includes:
- A specified percentage of hospital payment would be conditional on performance
  - 70% clinical care
  - 30% patient experience
- Would reward both improvement and attainment
- Would use both financial incentives and public reporting to drive quality improvement
Hospital Readmissions

- Effective October 1, 2012
- Three condition areas to start:
  - Heart failure, heart attack, pneumonia care
- Expansion by October 2014
  - Lung disease, heart surgery, heart catheterization, other vascular procedures (under development)
- Maximum payment reduction for individual facilities: 1.0% in FY2013, increasing to 3.0% in FY2015 and thereafter
  (Section 3021 ACA)

Hospital Acquired Conditions (HACs) that CMS No Longer Reimburses

- Object left in during surgery
- Air embolism
- Blood incompatibility
- Catheter associated urinary tract infections
- Pressure ulcers
- Vascular catheter associated infections
Hospital Acquired Conditions (HACs) that CMS No Longer Reimburses (cont.)

- Mediastinitis after coronary artery bypass graft
- Hospital-acquired injuries (including fractures, dislocations, intracranial injury, crushing injury, and burns)
- Deep-vein thrombosis/pulmonary embolism
- Glycemic control
- Wrong site, wrong patient, wrong procedure, surgery

Hospital Acquired Conditions

- Implements additional HAC payment reduction in FY2015
- IPPS hospitals with highest rates for HAC (bottom 25%) will be subject to payment penalty
  - Based on all Medicare fee-for-service claims and present on admission coding
- ACA requires HHS to conduct a study on expanding the HAC policy for Medicaid
  (Section 3008 ACA)
### The Financial Stakes are High!

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary directed to solicit input from multi-stakeholder group and others on a National Quality Strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A plan must be submitted to Congress on January 1 to include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: all numeric reductions represent a percentage point reduction from the market basket rate. For example, if the market basket is projected to be 3% and the reduction is 2 percentage points, then the remaining amount for the update is 1%.*

### National Quality Strategy—Framework

- Secretary directed to solicit **input from multi-stakeholder group** and others on a National Quality Strategy
- A plan must be submitted to Congress on January 1 to include:
  - Better Care
  - Better Health
  - Lower Costs

*(Section 3011 ACA)*
National Quality Strategy—Principles for Priorities

- Person-centeredness and family engagement
- Will address all ages, populations, service locations, and sources of coverage
- Eliminating disparities
- Seeks to align the efforts of public and private sectors

Systems Approach to Safety

- Systems achieve the exact results they were “designed” to achieve
- Fallibility (error) is an inevitable part of the human action
- One will not (easily) eliminate error from human activity
- To achieve safe outcomes, one must change the conditions under which people work
What Can Hospitals Do: Error-Proofing Systems

Make doing the right thing easy

Reminders
- Checklists or alarms to prompt specific action
  - Keystone Project, Michigan and
  - WHO checklist promulgated by Atal Gwande, MD

Differentiation
- Color coding, sizing, numbering, separating

Constraints
- Limit performance or restrict

Affordances
- Visual clues to use product/tool correctly

Heparin Errors in Hospital Neonatal ICU

10 Unit/ml 10,000 Unit/ml
Building on Aviation’s Lessons Learned

- Investigation and sharing of events and near misses in a non-punitive way
- Culture of safety
- Communication and team training
- Social psychology/group dynamics
- Root cause analysis

How Trustees Can Impact Quality

- Mission
- Values and culture
- Performance
- Organizational leadership
- Organizational strategy
- Organizational resource allocation
Using Dashboards

What is a dashboard?

- A visual representation of performance—can be a spot in time, or trended
- Compares performance to a benchmark—national or other
- Measure progress towards goals
- Understand what you are given … ask for clarification

![Target Key: Better Than Expected, Expected, Worse Than Expected]

<table>
<thead>
<tr>
<th>CORE Measures</th>
<th>Performance Compared to National Overall Observed Rate</th>
<th>Q4 06</th>
<th>Q1 07</th>
<th>Q2 07</th>
<th>Q3 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM1: Aspirin/Acetaminophen</td>
<td>Green</td>
<td>Green</td>
<td>Yellow</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>AM2: Aspirin/Discharge</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>AM3: ACEI/ARB for LVSD</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>AM4: Adult Smoking Cessation</td>
<td>Yellow</td>
<td>Yellow</td>
<td>Yellow</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>AM5: Beta Blocker / Discharge</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>AM6: Beta Blocker / Arrival</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>AM7: Thrombolysis Timing</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Performance Compared to Risk-Adjusted Expected Rate</th>
<th>Q4 06</th>
<th>Q1 07</th>
<th>Q2 07</th>
<th>Q3 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cesarean Section Rate</td>
<td>Red</td>
<td>Red</td>
<td>Yellow</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>Primary Cesarean Section Rate</td>
<td>Yellow</td>
<td>Yellow</td>
<td>Yellow</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>Repeat Cesarean Section Rate</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>VBAC Rate</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Inpatient Mortality</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
</tr>
</tbody>
</table>
California Hospital and Patient Safety Organization (CHSPO)

- CHPSO was established by the CHA Board in 2006 to collect, aggregate and analyze confidential information patient safety information
- Enables identification of patterns of failure across all hospitals
- Proposes measures to eliminate risks and hazards
- CHPSO is dedicated to eliminating preventable harm and improving the quality of health care delivery in California hospitals
Anthem Blue Cross (ABC)
Hospital Council of Northern and Central California (HCNCC)
Hospital Association of Southern California (HASC)
Hospital Association of San Diego and Imperial Counties (HASD&IC)
National Health Foundation (NHF)

Targeted Patient Safety Initiatives

- Ventilator-associated pneumonia (VAP)
- Catheter-associated urinary tract infections (CAUTI)
- Central line blood stream infections (CLBSI)
- Sepsis mortality
- Perinatal birth trauma
- Pre-term elective deliveries
Summary: Future of Patient Safety

- The alignment of quality and the financial well-being of our health systems are intricately intertwined – opportunity to ensure leadership is on the same page
- Focus on systems, to reduce error, harm and save lives
- Data must be interpreted for actionable interventions

Summary: Future of Patient Safety (cont.)

- Fair and just culture
- State regulators are our new partners in care
- Our legislative imperatives are becoming more prescriptive as the threshold of tolerance for error is dropping
Thank you

**Debby Rogers**
Vice President, Quality and Emergency Services  
California Hospital Association  
(916) 552-7537  
drogers@calhospital.org

Questions

**Online questions:**  
Type your question in the Chat Box, hit enter

**Phone questions:**  
To ask a question hit *1  
To remove a question hit *2
Web Seminar Evaluation

Thank you for participating in today’s seminar. An online evaluation will be sent to you shortly.

For questions regarding the content of today’s program contact Peggy Broussard Wheeler at (916) 552-7689 or pwheeler@calhospital.org

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.