

AGENDA
QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE
OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Tuesday, September 8, 2020 – 5:30pm
 El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, EL CAMINO HEALTH WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 760-083-0558#. No participant code. Just press #.

PURPOSE: 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		ESTIMATED TIMES
1. CALL TO ORDER/ROLL CALL	Julie Kliger, Quality Committee Chair		5:30 – 5:32pm
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Julie Kliger, Quality Committee Chair		information 5:32 – 5:33
3. CONSENT CALENDAR ITEMS <i>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</i>	Julie Kliger, Quality Committee Chair	<i>public comment</i>	motion required 5:33 – 5:34
Approval a. Minutes of the Open Session of the Quality Committee Meeting (06/01/2020) b. Minutes of the Open Session of the Quality Committee Meeting (08/03/2020) Information c. FY20 Quality Dashboard d. Progress Against FY21 Committee Goals e. Hospital Update f. Pacing Plan g. Report on Board Actions h. ED Patient Satisfaction i. Quality Committee Follow-Up Tracking			
4. PATIENT STORY ATTACHMENT 4	Cheryl Reinking, RN, CNO		information 5:34 – 5:39
5. PATIENT EXPERIENCE (GRIEVANCES AND PATIENT LETTERS) ATTACHMENT 5	Cheryl Reinking, RN, CNO		discussion 5:39 – 5:54
6. PROGRESS ON QUALITY AND SAFETY PLAN ATTACHMENT 6	Mark Adams, MD, CMO		discussion 5:54 – 6:24
7. QUALITY COMMITTEE SELF-ASSESSMENT REVIEW ATTACHMENT 7	Julie Kliger, Quality Committee Chair		discussion 6:24 – 6:44
8. PUBLIC COMMUNICATION	Julie Kliger, Quality Committee Chair		information 6:44 – 6:47

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

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
9. ADJOURN TO CLOSED SESSION	Julie Kliger, Quality Committee Chair	<i>public comment</i>	motion required 6:47 – 6:48
10. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Julie Kliger, Quality Committee Chair		information 6:48 – 6:49
11. CONSENT CALENDAR <i>Any Committee Member may pull an item for discussion before a motion is made.</i>	Julie Kliger, Quality Committee Chair		motion required 6:49 – 6:50
Approval <i>Gov't Code Section 54957.2.</i> <ol style="list-style-type: none"> a. Minutes of the Closed Session of the Quality Committee Meeting (06/01/2020) b. Minutes of the Closed Session of the Quality Committee Meeting (08/03/2020) Information <ol style="list-style-type: none"> c. Quality Council Minutes 			
12. Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Credentialing and Privileges Report	Mark Adams, MD, CMO		motion required 6:50 – 6:57
13. Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Annual Patient Safety Report	Mark Adams, MD, CMO		discussion 6:57 – 7:12
14. Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		discussion 7:12 – 7:22
15. ADJOURN TO OPEN SESSION	Julie Kliger, Quality Committee Chair		motion required 7:22 – 7:23
16. RECONVENE OPEN SESSION/ REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		information 7:23 – 7:24
17. CLOSING WRAP UP	Julie Kliger, Quality Committee Chair		discussion 7:24 – 7:29
18. ADJOURNMENT	Julie Kliger, Quality Committee Chair	<i>public comment</i>	motion required 7:29 – 7:30

**Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors**

Monday, June 1, 2020

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present

Julie Kliger, Chair**
George O. Ting, MD, Vice Chair
Alyson Falwell**
Peter C. Fung, MD**
Jack Po, MD**
Melora Simon**
Krutica Sharma, MD**
Terrigal Burn, MD**
Linda Teagle, MD
Imtiaz Qureshi, MD**

Members Absent

Caroline Currie

****via teleconference**

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the “Committee”) was called to order at 5:30pm by Chair Kliger. A verbal roll call was taken. Dr. Qureshi was not present during roll call. Caroline Currie was absent. Dr. Ting and Dr. Teagle participated on site and all other members were present and participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. Motion: To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (05/04/2020); For information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 Committee Goals, and Hospital Update. Movant: Simon Second: Burn Ayes: Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting Noes: None Abstentions: None Absent: Currie, Qureshi Recused: None	<i>Consent Calendar approved</i>
4. QUALITY COMMITTEE FOLLOW-UP TRACKING	Chair Kliger asked if any members of the Committee had any questions about the Quality Committee Follow-Up Tracking. None were reported.	
5. REPORT ON BOARD ACTIONS	Chair Kliger asked if any Committee members had any questions about the Report on Board Actions. No questions were reported.	

<p>6. PATIENT STORY</p>	<p>Imtiaz Qureshi, MD joined the meeting via teleconference.</p> <p>Cheryl Reinking, RN, CNO, presented a COVID-19 patient letter received by the hospital complimenting the staff regarding the way she was treated. The staff provided her with comfort which gave her the strength to continue to fight through the virus. The patient was very thankful for the doctors and referred to them as “heroes”.</p>	
<p>7. APPROVE FY21 QUALITY SAFETY EXPERIENCE INCENTIVE GOALS</p>	<p>Mark Adams, MD, CMO, presented the FY21 Quality, Safety and Experience Incentive Goals. As provided in the packet, the Proposed Fiscal Year 2021 Incentive Goals list specific strategies with certain objectives and outcomes that are measured under certain benchmarks. Dr. Adams noted that the hospital will be using external benchmark for quality and improvement purposes. There are external benchmarks for HEDIS scores and individual HEDIS measures. Dr. Adams noted that the wording “limited external benchmarks” should be struck from the materials. The wording should say “validate individual measures with external benchmarks.” Management will correct this language.</p> <p>Dan Woods, CEO, stated that CMS has halted the required filing for Quality data from March to June. With that announcement, about half of the Press Ganey’s clients stopped surveying patients. ECH has chosen to continue surveying patients.</p> <p>Chair Kliger suggested for next year attaching an appendix that goes through the rationale and the process for choosing the measures. She stated it would be helpful for committee members to understand management’s thought process. In addition, in the current FY21 Quality, Safety and Experience Incentive Goals, the HEDIS “limited external benchmarking” will be eliminated and there will be more discussions about the people strategy.</p> <p>Motion: To recommend Board approval of the FY21 Quality, Safety and Experience Incentive Goals.</p> <p>Movant: Po Second: Burn Ayes: Burn, Falwell, Fung, Kliger, Po, Qureshi, Sharma, Simon, Teagle, Ting Noes: None Abstentions: None Absent: Currie Recused: None</p>	<p><i>FY21 Quality Safety Experience Incentive Goals approved</i></p>
<p>8. READMISSION DASHBOARD</p>	<p>Dr. Adams presented the Readmission Dashboard. If a patient is readmitted after discharge within 30 days regardless of the diagnosis, it is counted in the Readmission Dashboard. Two areas the hospital will have for renewed focus on in FY21 will be pneumonia and total hip/total knee arthroplasty. Dr. Adams stated that the hospital’s surgical site infection rate was quite high last year. The hospital has rolled out a new program to be designed with a multi-prong approach hitting many of the parameters that contribute to surgical site infections. In addition, the findings conclude that there is never just one reason for surgical site infections.</p>	
<p>9. PSI REPORT</p>	<p>Dr. Adams presented the PSI Report. As referenced in the packet, there is a PSI composite that Premier prepares for hospital. That will be in the new board dashboard. Anything less than 1 is good. There is also CMS PSI90, which is CMS’ version of a composite for PSIs. That is part of the 1%</p>	

	<p>penalty program. In that report, the hospital has a PSI score that is -1.1307. That is “z-score” that CMS uses and a negative score is extremely good.</p> <p>Dr. Adams introduced Lisa Packard, MD who was present to revisit this topic from January and to answer committee members’ questions.</p> <p>Dr. Packard reported that the majority of vaginal lacerations the hospital has reported are 3rd degree, but mainly the less extensive 3rd degree lacerations. She also noted that the episiotomy rate is decreasing. Some of the risk factors of lacerations include forceps delivery, Asian ethnicities, labor induction and epidurals. Breaking down the patient population, overall ECH has about a 64% Asian OB population. 76% of the vaginal lacerations at ECH are in the Asian population.</p> <p>In response to committee members’ questions, Dr. Adams explained that part of the reason why the Asian population graph does not add up to 100% is because some do not report their ethnicities and ones that add up to more than 100% is because some people have more than one ethnicity.</p>	
<p>10. MEDICAL STAFF CREDENTIALING PROCESS</p>	<p>Dr. Adams presented the Medical Staff Credentialing Process. There is a process that the hospital takes to independently verify all of the information contained in the application such as board certification, medical degree, residency completion, etc. The National Practitioner Database is queried. If there is a time gap in the work history, the hospital determines why and what has happened during those times (i.e. Maternity leave, incarcerated, etc.). A new step that the hospital now does is background checks. Physicians will need to meet the qualifications for medical staff and once they pass, there is a process for each specialty for core privileges and special privileges (i.e. Robotics) to be considered. Once this process is complete, the recommendations for privileges go to the MEC, then to the Quality Committee then to the Board of Directors. Once a physician moves to active staff, performance in the six core competencies are evaluated every 8 months (Ongoing Professional Practice Evaluation) and at the time of renewal every two years.</p> <p>In response to a committee member’s questions, Dr. Adams explained that if there is a board certification for a specific type of practice, then they are approved. He also states that AHP’s go through a similar process. They are not members of the medical staff per se, but they still go through the same requirements for privileges based on their skill level and training. Dr. Adams also confirmed that SVMD doctors are credentialed by SVMD. However, if they wish to also work at the hospital, the credentialing will also be done at the hospital.</p> <p>Dr. Qureshi left the meeting.</p>	
<p>11. ECHMN QUALITY IMPROVEMENT PROGRAM UPDATE</p>	<p>Shabnam Husain, MD presented the ECHMN Quality Improvement Program. Dr. Husain explained that the purpose of the program is to ensure there is a formal process for Quality Improvement. The structure for quality review, peer review, and credentialing of physicians within SVMD was described. Dr. Husain stated that the SVMD Quality Committee focuses on the annual QI Work Plan. In addition, monitoring ambulatory metrics helps prevent hospital readmissions. She explained that 8 measures are approved for FY2021 and compared the results for ECMA and the San Jose Medical Group. Dr. Adams stated that many of the HEDIS scores are done by health claims data, but these are ECHMN’s internal measures.</p>	

	<p>In response to a committee member's questions, Dr. Husain explained that they are working with their operations team to improve the data being captured. .</p> <p>A few of the committee members commented that the targets are mediocre and they should be more aggressive. Dr. Adams stated that management wanted to give the committee some background; however, moving forward, they will focus more on the actual metrics and the goals.</p>	
12. PUBLIC COMMUNICATION	There was no public communication.	
13. ADJOURN TO CLOSED SESSION	<p>Motion: To adjourn to closed session at 7:25pm.</p> <p>Movant: Teagle</p> <p>Second: Po</p> <p>Ayes: Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting</p> <p>Noes: None</p> <p>Abstentions: None</p> <p>Absent: Currie, Qureshi</p> <p>Recused: None</p>	<i>Adjourned to closed session at 7:25pm</i>
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:51pm. Agenda items 14-18 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (05/04/2020) and Medical Staff Credentialing and Privileges Report; and for information: Medical Staff Quality Council Minutes including API reports.	
15. AGENDA ITEM 20: CLOSING WRAP UP	There were no closing comments.	
16. AGENDA ITEM 21: ADJOURNMENT	<p>Motion: To adjourn at 7:58pm.</p> <p>Movant: Teagle</p> <p>Second: Simon</p> <p>Ayes: Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting</p> <p>Noes: None</p> <p>Abstentions: None</p> <p>Absent: Currie & Qureshi</p> <p>Recused: None</p>	<i>Meeting adjourned at 7:58pm</i>

Attest as to the approval of the foregoing minutes by the Quality, Patient Care and Patient Experience Committee of El Camino Hospital:

Julie Kliger, MPA, BSN
Chair, Quality Committee



**Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors**

Monday, August 3, 2020

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present

Julie Kliger, Chair**
George O. Ting, MD, Vice Chair**
Alyson Falwell**
Melora Simon**
Krutica Sharma, MD**
Terrigal Burn, MD**
Michael Kan, MD

Members Absent

Jack Po, MD

****via teleconference**

Agenda Item	Comments/Discussion	Approvals/ Action
<p>1. CALL TO ORDER/ ROLL CALL</p>	<p>The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the “Committee”) was called to order at 5:33pm by Chair Kliger. A verbal roll call was taken. Jack Po, MD and Apurva Marfatia, MD were absent at roll call, but Dr. Marfatia joined the meeting during Agenda Item 8.. All other members were present. Michael Kan, MD was on site and the other committee members participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.</p>	
<p>2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</p>	<p>Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.</p>	
<p>3. CONSENT CALENDAR</p>	<p>Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar.</p> <p>Krutica Sharma, MD requested to pull the ED Departure on the Quality Dashboard for discussion. She questioned why the metrics on the ED Departure were combined with the Mountain View and Los Gatos campuses. Dr. Adams stated that each campus has a different denominator and a different plan, but management decided to average the two locations. Dr. Adams suggested generating a graph- for each campus to keep it simple. Management is trying to emphasize that this organization is an enterprise, not two separate entities, and does not want to portray the campuses as competing with each other.</p> <p>Dr. Sharma also requested to pull the C. Diff data on the Quality Dashboard for discussion. She was concerned that C. Diff. is struggling to reach the target. Dr. Adams stated that the plan is the same to include practicing hygiene and proper cleansing of the rooms to prevent patient to patient transmission. As presented in the packet, last month’s numbers were at zero, and there were a couple of cases in May. At least half of the cases are attributed to failing to document already present on admission C. Diff. infections. Cheryl Reinking, CNO, stated that CNA’s have had some additional training to help decrease the infection numbers.</p> <p>Motion: To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (06/01/2020); For information: FY20 Quality Dashboard, Progress Against FY21 Committee Goals, Hospital Update, Pacing Plan, Report on Board Actions and PSI Report.</p> <p>Movant: Sharma</p>	<p><i>Consent Calendar approved</i></p>

	<p>Second: Kan Ayes: Burn, Falwell, Kan, Kliger, Sharma, Simon, Ting Noes: None Abstentions: None Absent: Marfatia and Po Recused: None</p>	
<p>4. QUALITY COMMITTEE FOLLOW-UP TRACKING</p>	<p>Chair Kliger asked if any members of the Committee had any questions about the Quality Committee Follow-Up Tracking. None were reported. Chair Kliger stated that leadership is working on the cover memos and to bring forth any requests or ideas for further improvement. In addition, she requested the number of letters received from patients and how many were positive vs. negative.</p>	
<p>5. PATIENT STORY</p>	<p>Cheryl Reinking, RN, CNO, presented a Patient Story. In response to Chair Kliger’s request, Ms. Reinking explained that patient letters are submitted in a number of ways and some do not make it to the patient experience team. Nevertheless, she will review the ones received. Ms. Reinking also reported that she searched for a negative story but none were received recently.</p> <p>She stated that the story presented in the packet was written to the unit manager. The patient felt that hospital staff thoroughly explained everything to her throughout every step including through discharge. In addition, the patient was very satisfied that staff went over her medications and made sure that her questions were answered. She also noted that every staff member presented themselves well, and she was treated with respect. Ms. Reinking believes this is a good representation of what management is trying to do in regards to training in how to treat every patient.</p> <p>Chair Kliger suggested that training throughout the enterprise should have the exemplary staff lead in teaching others.</p>	
<p>6. EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT</p>	<p>Mark Adams, MD, CMO, presented the El Camino Health Medical Network (ECHMN) Quality Report. Dr. Adams stated that the ECHMN created a grid with various categories and looked at where they intersected to choose measures with the greatest impact. The goal is to align the whole organization so everyone is marching in the same direction. Dr. Adams stated in order to hone this down to track at a high level, a composite score was created that management can look at to track progress overall. Management set out a target of a 10% increase. One of the FY21 Organizational Performance Goals is improving the SVMD HEDIS composite score.</p> <p>In response to committee members’ questions, Dr. Adams stated that management will provide this presentation to the committee every quarter with updates. This is the second time the committee has seen the metrics and how the composite score is calculated. Dr. Adams also stated that this organization would love to be above average and the scores presented are just a starting point and there will be continued improvement over time. The organization uses the Epic Software System and management is currently in the process of building in options, such as building capabilities to get data into the right field that works for the organization.</p> <p>Chair Kliger requested that management use rolling averages, since it is a best practice, for future ECHMN Quality Reports.</p>	
<p>7. QUARTERLY BOARD QUALITY DASHBOARD</p>	<p>Dr. Adams presented the Quarterly Board Quality Dashboard based on the STEEEP Framework. The presented data is what will be transmitted to the Board so that they can have a snapshot of overall quality. Dr. Adams requested</p>	

<p>REVIEW</p>	<p>feedback prior to this data being sent to the Board. He reminded the committee that this is not just for the Quality Committee since the committee receives much more detailed information than what is being presented.</p> <p>Chair Kliger stated that she received feedback and the committee members like the dashboard and believe the data is clearly presented. She also commented that the cover memo’s content is important and complimented the coloring of making it easier to read. Dr. Burn stated that the data is very clear and he approved how it is laid out.</p> <p>Ms. Simon suggested that it might be helpful to add in COVID updates in terms of what is going on around the organization during this time.</p>	
<p>8. FY21 ORGANIZATIONAL GOALS</p>	<p>Dr. Adams presented the FY21 Organizational Performance Goal changes. The presented proposal is the final recommendation. Dr. Adams stated that the one exception is to ask the committee to adjust the baseline for Serious Safety Event (SSE) Rate. The baseline currently is stated as 4.16 and management is requesting it be 5.0. Since we do not have a true 12 months of data baseline, this would be considered a starting point rather than a true baseline. This is a multi-year journey and it is important to set a reasonable starting point especially since the SSER often increases in the first year of an HRO journey. The biggest change is that management has narrowed down the number of measures. Now there are seven (7). Dr. Adams also reported that this is the first time in the history of the organization that 80% of the Performance Goals are Quality, Safety and Service.</p> <p>Dr. Adams stated that there is also a change under Service in the Likelihood to Recommend (Inpatient). Ms. Reinking felt that using the baseline and Press Ganey’s top improvers score would put hospital at 83.6 as the target. Management also eliminated outpatient surgery because it was too narrow.</p> <p>In response to committee members’ questions, Ms. Reinking stated that management has set these methodologies using the Press Ganey calculator. Management took the baseline score and applied that to 50% of improvers.</p> <p>Action was deferred to the second open session.</p> <p>Dr. Marfatia joined the meeting.</p>	
<p>9. PUBLIC COMMUNICATION</p>	<p>There was no public communication.</p>	
<p>10. ADJOURN TO CLOSED SESSION</p>	<p>Motion: To adjourn to closed session at 7:02pm. Movant: Ting Second: Burn Ayes: Burn, Falwell, Kan, Kliger, Marfatia, Sharma, Simon, Ting Noes: None Abstentions: None Absent: Po Recused: None</p>	<p><i>Adjourned to closed session at 7:02pm</i></p>
<p>11. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT</p>	<p>Open session was reconvened at 8:11pm. Agenda items 11-16 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (06/03/2020) and Medical Staff Credentialing and Privileges Report; and for information: API reports.</p>	

	Dr. Marfatia left the meeting at the conclusion of closed session.	
12. AGENDA ITEM 8 – FY21 ORGANIZATIONAL PERFORMANCE GOALS	<p>This item was resumed following the closed session.</p> <p>Motion: To approve the FY21 Organizational Goal with the following changes: under SSE with the minimum goal set at 5.0 and the target be as stated 4.0 and the LTR (Inpatient) with the minimum set at 83.1, which reflects the current baseline for FY20.</p> <p>Movant: Kan Second: Burn Ayes: Burn, Falwell, Kan, Kliger, Sharma, and Simon Noes: Ting Abstentions: None Absent: Marfatia and Po Recused: None</p>	
13. AGENDA ITEM 20: CLOSING WRAP UP	There were no closing comments.	
14. AGENDA ITEM 21: ADJOURNMENT	<p>Motion: To adjourn at 8:13pm.</p> <p>Movant: Sharma Second: Kan Ayes: Burn, Falwell, Kan, Kliger, Sharma, Simon, Ting Noes: None Abstentions: None Absent: Marfatia and Po Recused: None</p>	<i>Meeting adjourned at 8:13pm</i>

Attest as to the approval of the foregoing minutes by the Quality, Patient Care and Patient Experience Committee of El Camino Hospital:

 Julie Kliger, MPA, BSN
 Chair, Quality Committee

**EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO**

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: September 8, 2020
Subject: FY 20 Quality Dashboard for September meeting

Recommendation(s): Review and accept the Organizational Goal and Quality Dashboard

Summary:

- Provide the Committee with a snapshot of the FY 2020 metrics monthly with trends over time and compared to the actual results from FY2019 and the FY 2020 goals.
 - Annotation is provided to explain actions taken affecting each metric.
1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on key quality metrics.
 2. Background: These thirteen (13) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2020 Quality, Efficiency and Service Goals.
 3. Assessment:
 - Mortality Index is well below target and is better than 0.76 2020 Top Performers level, @ 0.64.
 - Readmission Index reached target with June data @ 0.96..
 - Continued reduction in ED Throughput metric, below target.
 - HCAHPS metric for Discharge Information improved and is above target for June, just missing the target goal for FY20 and for Responsiveness is just below target goal for FY20. Likelihood to recommend dropped in June.
 - Only 1 – HAI: 1 CAUTI.
 - SSI @ 1 for June.
 - PC-02 Primary C/S rate increased.
 - See detailed comments in the annotation of the report.
 4. Other Reviews: None.
 5. Outcomes: N/A

List of Attachments: FY20 Quality Dashboard, June data unless otherwise specified - final results

Suggested Committee Discussion Questions: None.

Quality	FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Months Average
	Latest month	FYTD				
<p>* Organizational Goal</p> <p>Mortality Index</p> <p>Observed/Expected</p> <p>Premier Standard Risk Calculation Mode</p> <p>Date Period: June 2020</p>	0.64 (1.28%/1.99%)	0.74 (1.46%/1.98%)	0.97	0.90		
<p>*Organizational Goal</p> <p>Readmission Index (All Patient All Cause Readmit)</p> <p>Observed/Expected</p> <p>Premier Standard Risk Calculation Mode</p> <p>Index month: June 2020</p>	0.84 (7.07%/8.38%)	0.96 (7.68%/7.97%)	0.99	0.96		
<p>Patient Throughput-Median Time from Arrival to ED Departure</p> <p>(excludes psychiatric patients, patients expired in the ED and Newborns)</p> <p>Date Period: June 2020</p>	MV: 277 min LG: 215 min Enterprise: 246 min	MV: 287 min LG: 227 min Enterprise: 257 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	<p style="color: red;">FY20 Target Met, better performance than last year</p> <p>Good physician documentation continues with high expected mortality. Observed mortality less than in March and still under the expected value. For 11 months, the index has been below 1.0.</p>	Catherine Carson	<p>Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice.</p> <p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.</p>	Premier Quality Advisor
Readmission Index - All Patient All Cause Readmit (Observed/Expected)	<p>Readmission Index reached target for FY2020 at the end of June. New quality teams formed in July to continue work on improving Readmission Index in FY2021.</p>	Catherine Carson	<p>Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted).</p> <p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.</p>	Premier Quality Advisor
Patient Throughput-Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients and Newborns)	<p>Structural changes were made to the patient throughput steering team by expanding the scope from MV to enterprise as we embark on designing and rolling out potential iCare based solutions to improve patient throughput.</p> <p>The patient throughput improvement team worked on follow ups from June 4th PDSA session. Electronic hand-off to reduce waiting time for admitted ED patients is being worked on. The improvement team is working on the design of the e-handoff format and related processes.</p> <p>Capacity Management Center (CMC) moved into new space and began operations with enhanced tools from iCare. Co-location of 5 critical roles gives us efficiencies and effectiveness to manage patient flow. This also allows us to bring LG on board and start addressing patient throughput and capacity at the ECH enterprise level. New dashboards were built and made operational by our iCare team to give the PFCs and AHMs better visibility into capacity and patient flow. Updated MV ADT Criteria were rolled out and LG ADT criteria are currently being updated.</p>	Cheryl Reinking, Melinda Hrynewycz	<p>This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns.</p> <p>Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit</p> <p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.</p>	iCare Report: ED Admit Measurement Summary

Service	FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
	Latest month	FYTD				
<p>* Organizational Goal HCAHPS Discharge Information Top Box Rating of Always Date Period: June 2020</p>	88.4	87.2	86.7	87.3		
<p>* Organizational Goal HCAHPS Responsiveness of Staff Domain Top Box Rating of Always Date Period: June 2020</p>	70.3	66.5	65.7	67.1		
<p>* Organizational Goal HCAHPS Likelihood to Recommend Top Box Rating of Always Date Period: June 2020</p>	81.8	83.0	83.5	84.2		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	<p>Although there was a significant gain during the month of June, and all service areas were above the target for May, we ended the fiscal year below target by .1. Post Discharge phone calls were implemented towards the end of the March utilizing labor pool staff and this improved this metric for acute inpatient population. In April and May, we instituted a no visitor policy and this was problematic for this metric. A Family/Support person is now allowed to visit and having a support person available during the discharge instruction discussion is helpful for the patient and family. "Help at Home" signs are posted on all units in order to help foster the discharge discussion. Discharge phone were started up again mid-June with transition worker and has been effective in assisting with questions about discharge instructions and follow-up.</p>	Christine Cunningham	<p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.</p> <p><i>LCL is set to '0' if value is less than or equal to zero..</i></p>	Press Ganey Tool
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	<p>This metric is above target for the quarter but remains below target year to date. However, our Mother / Baby units on both campuses are above target for this metric. There has been a steady increase since February, and although we dipped slightly in June from 71.3 to 70.3 compared to the previous month, we were still above the target. All areas continue to address needs proactively by providing regular hourly rounding. Also working with Administrative Support (AS) to assure best practices, "words that work", and call light escalations/response structure. Call light system malfunctions continue to be reported to facilities and repaired and a proposal for replacement of call system has been submitted.</p>	Christine Cunningham	<p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.</p> <p><i>LCL is set to '0' if value is less than or equal to zero.</i></p>	Press Ganey Tool
HCAHPS Likelihood to Recommend Top Box	<p>Likelihood to Recommend is our loyalty score and the industry standard of measuring experience. Due primarily to the pandemic and feelings of isolation with our patients, the measure continues to fluctuate with the changes in visitor policy restrictions and limitations. Although May showed an improvement, June saw a decline. Fiscal year to date remained unchanged from the previous month at 83% and still represents 86th %ile compared to the national benchmark. We saw an increase in this metric for Mother / Baby patients. There is a correlation between leader rounding and likelihood to Recommend, therefore, we did a soft launch of WeCARE leader rounding during the month of June to round on patients and staff. Our new Service Standards Launch Team continues to meet, discuss and refresh of Standards.</p>	Christine Cunningham	<p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.</p> <p><i>LCL is set to '0' if value is less than or equal to zero.</i></p>	Press Ganey Tool

Quality		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend
		Latest month	FYTD			
7	Hospital Acquired Infections Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 urinary catheter days Date Period: June 2020	0.93 (1/1074)	0.47 7/14859	1.09	SIR Goal: ≤ 0.75	
8	Hospital Acquired Infections Central Line Associated Blood Stream Infection (CLABSI) per 1,000 central line days Date Period: June 2020	0.00 (0/927)	0.15 2/13639	0.36	SIR Goal: ≤ 0.50	
9	Hospital Acquired Infections Clostridium Difficile Infection (CDI) per 10,000 patient days Date Period: June 2020	0.00 (0/6840)	1.46 (14/95608)	1.96	SIR Goal: ≤ 0.70	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	One CAUTI in June in Los Gatos post op care, foley catheter in place for critical I&O monitoring and immobility. Target Met, better performance than last year Total CAUTIs FY19 = 17 Total CAUTIs FY20 = 7	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. <i>LCL is not visible if value is less than or equal to zero.</i>	CDC NHSN data base - Inf. Control
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Zero CLABIs in February, March, April, May & June (5 months). The CLABSI infections have been only in MV. LG has not had a CLABSI Infection since October 2016. FY 20 Target Met, better performance than last year Total CLABSI FY19 = 4 Total CLABSI FY20 = 2	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. <i>LCL is set to '0' if value is less than or equal to zero.</i>	CDC NHSN data base - Inf. Control
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Three C.Diff infections in May -- MV: 2, LG: 1 Zero in June. FY 20 Target NOT met, however better performance than last year. Total C.Diff FY19 = 20 Total C.Diff FY20 = 14	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. <i>LCL is set to '0' if value is less than or equal to zero.</i>	CDC NHSN data base - Inf. Control

	FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
	Latest month	FYTD				
<p>10</p> <p>Organizational Goal</p> <p>Surgical Site Infections (SSI)- Enterprise</p> <p>SSI Rate = Number of SSI / Total surgical procedures x 100</p> <p>Date period: June 2020</p>	0.17 (1/593)	0.36 (23/6428)	0.52 (37/7167)	<p>SIR Goal: <=1.0</p> <p>CDC NHSN Risk Adjusted Ratio (not an infection rate)</p>		
<p>11</p> <p>Sepsis Mortality Index, based on ICD-10 codes (Observed over Expected)</p> <p>Date Period: June 2020</p>	1.09 (13.86%/12.72%)	0.98 (10.98%/11.18%)	1.06	<p>Target: 0.90</p>		
<p>12</p> <p>PC-01: Elective Delivery Prior to 39 weeks gestation (lower = better)</p> <p>Date period: June 2020</p>	<p>MV: 0.00% (0/26)</p> <p>LG: 0.0% (0/2)</p> <p>ENT: 0.00% (0/28)</p>	<p>MV: 1.47% (5/341)</p> <p>LG: 0.00% (0/48)</p> <p>ENT: 1.29% (5/389)</p>	<p>MV: 1.11% (4/360)</p> <p>LG: 0.00% (0/44)</p> <p>ENT: 0.99% (4/404)</p>	<p>Target: 0.00%</p>		
<p>13</p> <p>PC-02: Cesarean Birth (lower = better)</p> <p>Date period: June 2020</p>	<p>MV: 24.44% (33/135)</p> <p>LG: 20.00% (5/25)</p> <p>ENT: 23.75% (38/160)</p>	<p>MV: 24.74% (412/1665)</p> <p>LG: 18.97% (48/253)</p> <p>ENT: 23.98% (460/1918)</p>	<p>MV: 26.28% (425/1617)</p> <p>LG: 14.29% (30/210)</p> <p>ENT: 24.90% (455/1827)</p>	<p>Target: <23.9%</p>		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	<p>FY20 Target Met, better performance than last year Total SSI FY19: 37 Total SSI FY20: 23, as of 7/20</p> <p>1 SSI MV in April (Laminectomy), 2 in May MV (1 Colon and 1 Craniotomy), 1 in June MV (Ovary) ERAS (enhanced recovery after surgery) was implemented for all surgeries enterprise-wide on June 30th. This healthcare best practice should reduce SSIs.</p>	Catherine Carson/Catherine Nalesnik	<p>The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIs were observed than predicted, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicted.</p> <p><i>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.. Lower Control Limit is not visible if it is less than or equal to zero.</i></p>	CDC NHSN data base - Inf. Control
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	<p>FY20 Target Not Met however better performance than last year</p> <p>Sepsis Quality Committee focusing on individual measures in the bundle through manager chart review to find which pieces of the bundle that need most improvement; timing of antibiotic administration (1 hr. vs 3 hrs.), meeting MAP goal of > 65 mmHg w/ 6hrs of TOP, and have the most impact on mortality. Sepsis deaths reviewed/scored as serious safety events if GAP exits (deviation from generally accepted practice/guidelines).</p>	Jessica Harkey, Catherine Carson	<p>Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice).</p> <p>The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality.</p> <p><i>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.</i></p>	Premier Quality Advisor
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	<p>June at Zero for both hospitals. May outcome rate above UCL</p> <p>CDI Mgr. provided OB physicians with education to document patient conditions that can exclude the patient from this measure.</p>	TJC	<p>Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed</p> <p><i>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.</i></p>	IBM CareDiscovery Quality Measures
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	<p>FYTD 2020 rate is 23.98 for the Enterprise at end of year, just slightly above the target.</p>	TJC	<p>Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation</p> <p><i>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.</i></p>	IBM CareDiscovery Quality Measures



FY21 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

STAFF: **Mark Adams, MD**, Chief Medical Officer (Executive Sponsor)

The CMO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair’s consideration. Additional clinical representatives and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Review the Hospital’s organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY20 Achievement and Metrics for FY21 (Q1 FY21) - FY22 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY22) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per Pacing Plan timeline –
4. Review Effectiveness of Board Dashboard using STEEEP Methodology and propose changes if appropriate	Semi – Annually Q2 and Q4	Review Dashboard and Recommend Changes
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Using closing wrap up time, review quarterly at the end of the meeting	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting

SUBMITTED BY: Chair: Julie Kliger, MPA, BSN

Executive Sponsor: Mark Adams, MD, CMO

Approved by the El Camino Hospital Board of Directors 6/10/2020

Hospital Update
September 8, 2020
Mark Adams, MD, CMO

Quality and Safety

On August 4, 2020, as part of our journey to become a “highly reliable organization” we replaced our QRR Safety Event reporting system with “iSAFE” reports. This stands for SAFETY ALWAYS FIRST at EL CAMINO. The new system will allow us to gather more information required for safety event investigations and follow up. Staff can access the incidents submitted and track the status of investigations as well as the outcome actions.

Operations

Our Heart & Vascular Service Line recently opened the Women’s Cardiovascular Clinic and the Cardiac Oncology Clinic in the Sobrato Pavilion and Interventional Pulmonologist Ganesh Krishna, MD completed his 60th case on the Intuitive Ion Robot.

The organization is continuing to care for COVID-positive patients as well as many other patients who are seeking healthcare at ECH. El Camino Hospital has not had more than 13 COVID-19 positive patients receiving inpatient care at any one time over the last month. PPE and other supplies are plentiful with no shortages. El Camino Health is participating in 6 clinical research studies related to COVID-19 testing and treatment (Remdesivir, Plasma).

We recently launched our new “We Care” program as part of the patient experience pillar of the strategic plan. The program will help us provide an excellent experience for our patients and their loved ones while achieving our organizational goals. “We Care” will update and embed new employee standard behaviors (last updated in 2001) for the entire organization. The acronym stands for:

- W = Warm Welcome
- E = Engage and Empathy
- C = Compassionate Communication
- A = Ask and Anticipate
- R = Respond Promptly
- E = Excellence Always

Workforce

Since many schools are opening with distance learning this fall, we are again working with the YMCA on a childcare solution for our employees. We continue to provide Foundation sponsored grants to employees in need due to COVID-related financial

issues. As of August 3rd, we provided 44 employees with grants up to \$5,000. The total Foundation fund used for this program thus far is \$185,000.

Information Services

Since the Shelter in Place mandate went in to effect, we aggressively implemented virtual and audio visits as a replacement for in person appointments for ECHMN clinics, the Wound Care Clinic, Outpatient Rehabilitation, the Perinatal Diagnostic Center, the Cancer Clinic, and Outpatient Behavioral Health Services.

We are tracking employee COVID-19 symptoms using an online tool that employees complete each day before beginning work and provides alerts and reports to our employee health and wellness team.

Carbon Health and Premier data are now in the Epic DataWarehouse to improve reporting for ambulatory business metrics. Clinic patients are able to self-schedule appointments, pre-visit questionnaires and check in for appointments via MyChart with increasing usage. El Camino Health is above the 50th percentile for appointments scheduled online as benchmarked with other organizations and trending towards the 75th percentile ranking.

The enterprise continues targeted efforts to increase MyChart adoption, an EPIC tool that serves as a conduit to improve the patient experience and personalized healthcare journey. MyChart is now live at the bedside in Maternal Child Health, NICU, Labor and Delivery, and Surgical/Pediatric units. ECH has 62,300 patients registered in MyChart and 46% of patients seen in July have active MyChart Accounts.

The "Get Well" platform implementation of our "Hospital Room and Clinic of the Future" began on our Maternal Child Health unit. This provides a state-of-the-art media platform in the patient room including personalized patient education, environmental controls, meal ordering, and integration with Epic.

El Camino Healthcare District (ECHD) Community COVID-19 Testing Program

On May 19, 2020, the ECHD Board approved funding and operations of a no cost Community COVID-19 testing program (the District Program) for asymptomatic individuals who live, work, or go to school in the District. Thereafter, on June 16, 2020, the ECHD Board modified the approval to authorize (1) prepaying of \$1.2 million in FY20 to El Camino Health to implement and manage the District Program in FY20 and FY21 and (2) distribution of \$1.2 million in FY21 to provide ongoing services to the District Program in FY21. Pursuant to this authorization, the District entered into a Services Agreement with El Camino Health to operate the District Program.

Pursuant to the agreement with El Camino Health, tests are currently being performed at the El Camino Health Mountain View Hospital campus. To provide good stewardship

of the District's tax revenues, El Camino Health is billing third party insurance and reserving District funds to cover the costs of testing when insurance is not available. As of July 31, 2020, 2,082 tests have been provided. The testing program is patient centered to facilitate quick-prescheduled appointments. Enhancements to the program included online scheduling, extended hours for appointments, and electronic results. Testing is currently being offered Monday through Friday from 7:30 am until 7:00 pm. The length of time to obtain results fluctuates with demand. As of August 3rd, we were receiving results in 3-5 days, but in prior weeks it was taking as long as 7-10 days. We are carefully communicating with patients to set expectations accordingly. Our marketing and communications plan, which includes radio, social, and print media, dramatically increased the number of tests requested and we expanded hours of operations at the MV hospital campus to meet demand.

We are now focused on expanding the program to additional sites throughout the District in ways that will be of greatest benefit to the District. To that end, we are working with leaders of the Mountain View and Los Altos Chambers of Commerce as well as the Sunnyvale Downtown Association to provide mobile testing sites within the District's business districts, particularly for employees of small businesses who are less likely to have insurance and whose work schedules make traveling to the El Camino Hospital campus impractical. Sites have been identified at the Center for the Performing Arts in downtown Mountain View, the Assistance League of Los Altos, and Murphy Park in Sunnyvale. We expect all of these sites to be up and running by no later than the last week in August.

We are also working with public school districts that have school sites within the District boundaries to plan for testing of school district personnel in advance of the beginning of the school year, even though it is anticipated that many schools will begin the year with distance learning. The timing of the intervals as well as the duration of the program has yet to be determined, but we hope to begin no later than the last week of August. We are monitoring third party insurance reimbursement for re-testing as that will impact how far the District funds can be stretched. As well, we recently reached out to the Community Services Agency of Sunnyvale and are in discussions about providing testing to their vulnerable clientele. Finally, we are working with Santa Clara County to identify "hot spots" of infection within the District where additional mobile sites may provide added benefit.

El Camino Health Medical Network (ECHMN)

Two new physicians, Atena Asiaii, MD and Tony Masri, MD join our network this month. Joining our Mountain View clinic, Dr. Asiaii, who specializes in obstetrics and gynecology, attended the Warren Alpert Medical School of Brown University and completed a fellowship at the Camran Nezhat Institute. Dr. Masri, who attended the University of Toledo College of Medicine & Life Sciences and completed a fellowship at Stanford, will serve as the Medical Director of Sleep Medicine.

Corporate and Community Health Services

Over the last several months, CONCERN offered 140 webinars attended by 6,700 individuals. Topics included the emotional impact of the pandemic and effective teleworking as well as understanding and responding to racism and social injustice topics. Our Community Benefit Staff remains in close communication with grant partners, particularly school-based services, regarding urgent needs and program adjustments in response to the pandemic

The South Asian Heart Center (SAHC) hosted five TECH (Tuesday Evening Community Huddle) virtual workshops for community members on lifestyle topics with over 100 attendees. We also trained seven college interns how to perform health coaching and yearly wellness checkups for SAHC participants and hosted two talk on "A Lifetime on Meds or a Lifestyle of MEDS" leading to program signups. We also received Centers for Disease Control recognition for our diabetes prevention program curriculum.

The Chinese Health Initiative (CHI) concluded the second group of its pilot 6-month Diabetes Prevention Program. Sixty percent of participants met the target goal of Body Mass Index at or below 23. Eighty five percent % of participants improved their A1C score. CHI hosted two Ask-A-Dietitian webinars, two diabetes prevention introduction webinars conducted in either Cantonese or Mandarin and two Qigong webinars for homebound seniors to promote increased physical activity. There were a total of 370 attendees.

Marketing and Communications

The second phase of the Return to Health campaign fully launched in early July and included a new video and refreshed digital ads. The current media plan also includes print and YouTube and runs until September. The results have been good with a month over month increase of Return to Health landing page visits. Overall, total landing page visits have surpassed those of the Shaped by You brand advertising campaign.

The primary care campaign currently running targets three consumer segments, ages 25-34, ages 35-64 and Medicare eligible. It includes direct mail and digital with segment specific messages and landing pages.

In collaboration with the District COVID-19 testing team, we launched online appointment scheduling; cross-linked from existing marketing campaign destinations and pages such as homepage, schedule page, newsroom, COVID-19 FAQs, and ECHD website. Updated location pages to reflect the Breast Health Center's move and updated the name to Women's Imaging Center.

We updated the Safe Care page on the website with new videos regarding the Women's Hospital, COVID-19 Screening & Testing, and the negative pressure rooms in the

hospital. Physician briefings videos covered Medical Staff Leadership and Willow Outpatient Surgery.

We had the following Media Coverage in July 2020:

- July 1, 2020 Architectural Record [Mental Health Pavilion at El Camino Hospital by WRNS Studio](#)
- July 3, 2020 Vator.tv [Future of Virtual Care Conference July 1 Podcast](#)
- July 6, 2020 Becker's Hospital Review [10 Hospitals Seeking Pharmacy Leaders](#)
- July 8, 2020 Vator.tv [With Healthcare Going Virtual, What's Working Now?](#)
- July 8, 2020 NBC Bay Area News (Bay City News) [Santa Clara County Unveils New Dashboard for COVID-19 Testing](#)
- July 8, 2020 Telemundo Area de la Bahia [Pick Up](#)
- July 9, 2020 Vator.tv [At Invent Health: With COVID Still Surging, How Are We Preparing?](#)
- July 14, 2020 KCBS Radio [Demand For Food-Making Robots Skyrockets During Coronavirus Pandemic](#)
- July 17, 2020 ENR California [ENR CA Announces 2020 Regional Best Project Winners](#)

Government Relations

SB 758, approved in Assembly Health on August 4, 2020, continues to progress through this year's process in the California legislature. The Bill would extend the 2030 hospital seismic deadline (to be fully operational after a major earthquake) to January 1, 2037 and create an advisory committee to examine how California's health care delivery system prepares and responds to disasters.

The bill is sponsored by California Hospital Association (CHA) to give hospitals additional time for the massive infrastructure upgrades required at a time that hospital budgets are challenged by the pandemic. If passed, this will give ECH an additional 7 years to address seismic compliance issues at our Los Gatos hospital.

Philanthropy

The El Camino Health Foundation secured \$452,147 in Period 11 of FY20 and \$321,849 in Period 12, bringing the total raised by June 30 to \$10,141,294, 132% of goal.

Auxiliary

Our Auxillians are still sheltering in place. We look forward to their return and thank them for 49,844 hours in FY20!

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY21 Pacing Plan**

Revised August 31, 2020

FY2021 Q1		
JULY 2020	AUGUST 3, 2020	SEPTEMBER 8, 2020
<p>No Committee Meeting</p> <p>Routine (Always) Consent Calendar Items:</p> <ul style="list-style-type: none"> ▪ Approval of Minutes ▪ FY 21 Quality Dashboard ▪ Progress Against FY 2021 Committee Goals (Quarterly) ▪ FY21 Pacing Plan (Quarterly) ▪ Med Staff Quality Council Minutes (Incl. API Reports Closed Session) ▪ Hospital Update 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items <p>Special Agenda Items</p> <ol style="list-style-type: none"> 1. Q4 FY20 Quarterly Quality and Safety Review 2. Quarterly Board Dashboard Review 3. EL Camino Health Medical Network Report 4. Recommend FY21 Organizational Goal Metrics 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items <p>Special Agenda items:</p> <ol style="list-style-type: none"> 7. Recommend FY21 Organizational Goal Metrics 8. Annual Patient Safety Report 9. FY20 Quality Dashboard Final Results 10. Pt. Experience (HCAHPS) 11. Progress on Quality and Safety Plan
FY2021 Q2		
OCTOBER 5, 2020	NOVEMBER 2, 2020	DECEMBER 7, 2020
<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 8. Report on Medical Staff Peer Review Process 9. FY21 Org. Goal and Quality Dashboard Metrics 10. FY20 Organizational Goal Achievement (Quality, Safety, HCAHPS) (If needed) 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 7. Safety Report for the Environment of Care 8. Q1 FY21 Quarterly Quality and Safety Review 9. Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items <p>Special Agenda items:</p> <ol style="list-style-type: none"> 8. Readmission Dashboard 9. PSI Report 10. Progress on Quality and Safety Plan

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY21 Pacing Plan**

Revised August 31, 2020

FY2021 Q3		
JANUARY 2021	FEBRUARY 1, 2021	MARCH 1, 2021
No Committee Meeting	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 7. Q2 FY21 Quality and Safety Review 8. EL Camino Health Medical Network Report 9. Quarterly Board Quality Dashboard Review 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 8. Proposed FY22 Committee Goals 9. Update on LEAN Transformation 10. Progress on Quality and Safety Plan
FY2021 Q4		
APRIL 5, 2021	MAY 3, 2021	JUNE 1, 2021
<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 8. Value Based Purchasing Report 9. Pt. Experience (HCAHPS) 10. Approve FY22 Committee Goals 11. Proposed FY22 Committee Meeting Dates 12. Proposed FY22 Organizational Goals 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar(CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow Up Items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 7. Proposed FY22Pacing Plan 8. Q3 FY21 Quality and Safety Review 9. Proposed FY22 Organizational Goals 10. EL Camino Health Medical Network Report 11. Quarterly Board Quality Dashboard Report 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 8. Readmission Dashboard 9. PSI Report 10. Proposed FY22 Organizational Goals 11. Approve FY22 Pacing Plan 12. Medical Staff Credentialing Process 13. Progress on Quality and Safety Plan

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: September 8, 2020
Subject: Report on Board Actions

Purpose: To keep the Committee informed with regards to actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. **Situation:** It is important to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.
2. **Authority:** This is being brought to the Committees at the request of the Board and the Committees.
3. **Background:** Since the last Quality Committee meeting, the Hospital Board has met once and the District Board has met once. In addition, since the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee those approvals are also noted in this report.

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECH Board	August 12, 2020	<ul style="list-style-type: none"> - FY21 Organizational Performance Goals - FY20 Period 12 Financials - FY21 Capital and Operating Budget - Increased Funding For Radiation Oncology Equipment - Medical Staff Report Including Credentials and Privileges Report
ECHD Board	August 12, 2020	<ul style="list-style-type: none"> - FY21 ECHD Consolidated and Stand Alone Budgets - Resolution Setting Annual Tax Appropriation Limit (Gann Limit)
Executive Compensation Committee	July 28, 2020	<ul style="list-style-type: none"> - FY 21 CFO Base Salary
Compliance and Audit Committee	N/A	
Finance Committee	July 27, 2020	<ul style="list-style-type: none"> - Funding for Replacement Sterile Processing Equipment NTE \$1.85 million

4. **Assessment:** N/A
5. **Other Reviews:** N/A
6. **Outcomes:** N/A

Report on Board Actions
September 8, 2020

List of Attachments: None.

Suggested Committee Discussion Questions: None.

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality, Patient Care and Patient Experience Committee (Quality Committee)
From: Cheryl Reinking, DNP(c), RN, NEA-BC; Chief Nursing Officer
Date: September 8, 2020
Subject: Emergency Department Patient Satisfaction

Purpose:

To provide periodic information to the Quality Committee regarding the organization's performance against goals on ED Patient Satisfaction: both successes and efforts to improve.

Summary:

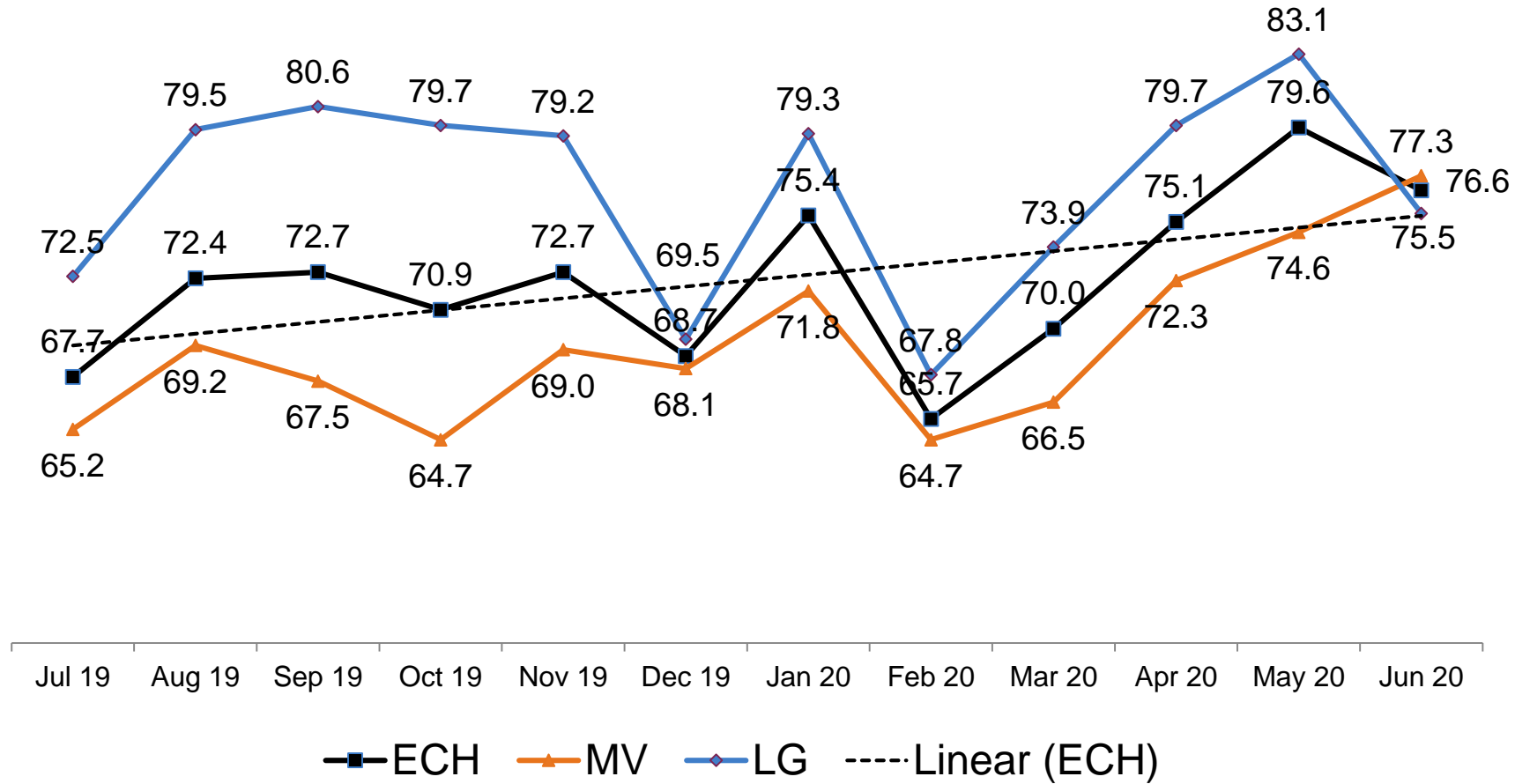
1. **Situation:** The Quality Committee has requested periodic updates on ED Patient Satisfaction.
2. **Authority:** The Quality Committee's Charter includes oversight of patient experience performance. Overall ED Patient Satisfaction and Likelihood to Recommend are important and measurable indicators of patient experience.
3. **Background:** The ED exceeded target for both Overall Satisfaction and Likelihood to Recommend as an enterprise. This is outstanding considering the pandemic as well as the fears and anxiety of our patients and staff. Mountain View was slightly under target, but the overall enterprise target made up for it. Los Gatos is much smaller and their volumes are lower so their satisfaction is higher due to this (less wait time usually). Improvement efforts at the Mountain View campus in place include: (1) Epic texting to inform patients of their progress during their ED experience, (2) implemented separate rapid respiratory care areas for both campuses to reduce anxiety related to COVID and (3) three rapid process improvement workshops completed to develop and implement improved patient flow initiatives to improve wait times.
4. **Assessment:** Both campuses are performing well in the Likelihood to Recommend domain. The Mountain View ED did not achieve its goal for Overall ED Patient Satisfaction, but has appropriate mitigation efforts in place.
5. **Other Reviews:** None.
6. **Outcomes:** N/A

List of Attachments:

1. Power Point Slides – Overall ED Patient Satisfaction and Likelihood to Recommend

Suggested Committee Discussion Questions: None. This is a consent calendar item.

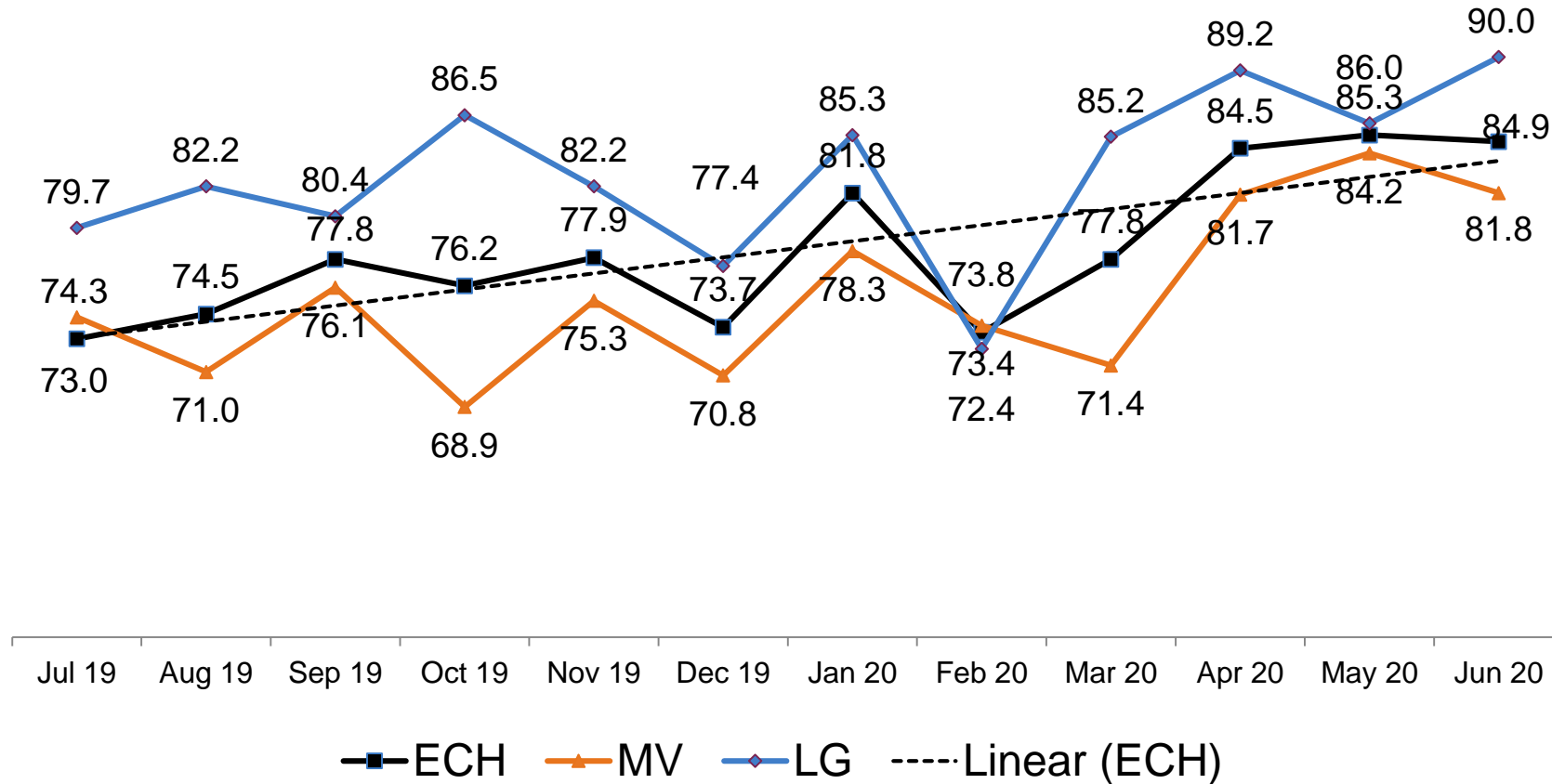
FY20 Year End ECH ED: Overall Satisfaction



Site	FY20 Top Box Goal	FY20 Top Box Year End*
ECH	69.0	72.0
MV	69.0	68.7
LG	69.0	76.8

*Year-end score is average over the fiscal year

FY20 Year End ECH ED: Likelihood to Recommend



Site	FY20 Top Box Goal	FY20 Top Box Year End*
ECH	72.5	77.9
MV	72.5	74.3
LG	72.5	83.2

*Year-end score is average over the fiscal year

Quality Committee Follow up Item Tracking Sheet (07/23/2020)

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Add a discussion around goal attainment to the pacing plan	11/4/2019	CM	Added to 2/3/20 Meeting then moved to 3//2/20 due to full agenda on 2/3/20	3/2/2020
4	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
5	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
6	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
7	Follow-Up on PSI 4, 18 and 19: 1. % breakdown by ethnicity, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for ethnic population) 2. % breakdown by low protein/vegan diets, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for diet-based population)	12/2/2019	CC/MA	On 2/3/20 Agenda; Bring back in August	
8	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
9	Bring back Revised Board Level Quality Dashboard	3/2/2020	MA	on 4/26/20 Agenda	5/4/2020
10	Bring Draft of Proposed FY21 Organizational Goals to April Meeting	3/2/2020	MA/CR	on 4/26/20 Agenda	
11	Add Review of Lean Projects to Pacing Plan for FY21	3/2/2020	JG	Added to March 2021 Meeting	5/4/2020
12	Bring back Revised Board Level Quality Dashboard	4/6/2020	MA	on 5/4/20 Agenda	5/4/2020

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP(c), RN, NEA-BC
Date: September 8, 2020
Subject: Patient Story

Purpose: To provide the Committee with patient feedback that is received by the organization and actions taken, if necessary, to improve the patient experience.

Summary:

1. **Situation:** This letter was received by the Patient Experience Department and shared with the Cancer Center leaders and staff. The patient feedback is related to his/her care at the Cancer Center with emphasis on safety precautions during the pandemic.
2. **Authority:** To view patient feedback.
3. **Background:** This letter was provided by a patient receiving care at the ECH Cancer Center. The patient provides a general overview of his care and is complimentary of most staff and physicians. The patient does indicate that he/she believes COVID-19 safety precautions are not being followed and requests they be followed. The patient also indicates the paperwork process should be improved.
4. **Assessment:** The patient made relevant and helpful points for the leaders and staff to evaluate and make changes to our processes in order to provide a safer environment.
5. **Other Reviews:** Cancer Center leaders and Staff have reviewed and made changes based on the feedback.
6. **Outcomes:** The Team has made changes as a result in the letter that includes allowing one visitor/patient. Patients are notified at their reminder call of the visitor limitations and the precautions necessary. A second waiting room was made available to provide extra space. Patients are given the option to wait outside or in the car and are notified via phone when it is their turn to be roomed.

Facilities installed marking on the Cancer Center floor to indicate the 6 feet social distancing requirements. Updated signage has been posted with detailed infection prevention protocols. All patients, visitors, and staff are mandated to wear a surgical mask provided by ECH. Patients and visitors are screened upon arrival. Patients are asked the COVID-19 screening questions during their reminder calls as well and if any affirmative answers occur, they are transferred to the Clinic Nurse for triage.

List of Attachments: Patient Letter

Suggested Committee Discussion Questions:

1. What measures throughout the organization have been taken as a result of this feedback?
2. Are there more actions to come as a result of the feedback?

↓

El Camino Health: Outpatient Oncology Survey: 06/08/2020

To: Survey Processing Dept, Press Ganey, PO Box 7006, South Bend, In

Additional comments for survey:

The administrative staff from in-take to physician assistants are generally efficient and well trained as to patient in-take, assistance, etc. A few are outstanding with some very good personnel, while there are a few who are lacking. I think the following safety failures may in part be caused by the staff being so kind to cancer patients, who walk in demanding to be treated NOW due to the nature of their condition as though they are the only patient with cancer.

On 06/08/2020, my serious concern about the administrative staff at El Camino Cancer Center was their substantial and active failure to instruct and follow through with the patients to see that all patients complied with the posted safety rules for the CV19 safety protocols. Their attitude is obvious: The safety notices are posted, and we are not going to enforce them since it will upset our patients who are already under stress due to their cancer or other conditions. I noticed the staff failed to gently remind all patients, mostly of whom were not complying with the CV 19 posted safety rules to do the following:

1. NOT bring family members to sit in the waiting room with them. Why don't the patients check in and then go wait in their cars or open patio area with their family members for a cell phone call 4 minutes before their appointment will really take place, except those who need assistance like being in a wheelchair. No patient was in a wheelchair when I was there waiting a very long time for my appointment to start. The free parking lot and open patio is in front of the Cancer Center. Why are non-patients walking around the halls and in exam rooms? They wait for a cell phone to meet the ambulatory patient in the lobby. Other Cancer centers do not allow family members in the waiting rooms. If you are not ambulatory, the assistant pushes your wheelchair in, and the family member or caregiver has to wait elsewhere until the appointment is done for pick up at the clinic front door of the reception room.
2. NOT enforcing the 6 feet safety distance. It was awful with the other patients standing less than 6 feet next to me and others because they want to get in line ASAP to get their appointment NOW. Some people were not wearing masks although they were readily available, and that was scary.
3. NOT having separate bathroom for priority lab use. All public bathrooms used for the on site lab for urine testing, etc. were also used by the public. Family members and non-patients were running in and out of the bathroom next to the lab. Shouldn't the lab patients have priority to that bathroom next to the lab? As I tried to walk into the bathroom next to the lab for testing, a non-patient ran into the bathroom in front of me. I waited in the hallway and when I tried to enter again, another non-patient just ran in front of me, saying I have to go now.

4. NOT being as efficient as they could be about the paperwork flow among the cancer center, the patient and third parties. When I am supposed to be sent documents/paperwork, I never get it in the mail. My paperwork/documents/lab results from other places are sometimes lost. The staff's attitude seems to be: Oh, I can't find it, I can't do anything about it, you need to check into it yourself, I never got the order or request from your other doctor, etc. The Cancer Center has an outstanding manager of the section which does the paperwork for the lab, lab orders to be transmitted to third parties, lab orders from third parties, etc., and I think the clinic paperwork. I found out that from other patients that when the staff says I can't do anything about that lost lab order now, etc., if you talk to the Manager, she is wonderful and goes the extra mile for the patients. Her staff should be trained for that kind of standard problem solving. You have some great empathic staff employees there, but is the center so overwhelmed in its disorganization concerning records, lab orders, etc. that the employees really can't do the job or just say they can't since it is so disorganized.

5. Most employees are good with people, but the ones who are not do not reflect well on the cancer center. I have had 2 PAs there and one of them seems to have a priority of efficiency over the patient (she gets you in and out FAST), does not seem to have much empathy for the patients. I think her name is Kathie, Kate, or Kay, although she knows what she is doing.

Anyway, please make people comply with the health safety rules.

On the whole, the El Camino Cancer Center is a place I would highly recommend to anyone due to the Managing/treating Doctor, Dr. D, who is so knowledgeable, real with people because he is not afraid of show he has a personality even though he is a famous doctor, kind, and a dedicated professional. He's the best as an outstanding doctor and as an understanding human being, which comes through even though he has hundred of patients with conditions of which there is no cure.

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP(c), RN, NEA-BC
Date: September 8, 2020
Subject: Grievance and Complaints Presentation

Purpose: To provide the Committee with information on the grievances and complaints process at ECH. patient feedback that is received by the organization and actions taken, if necessary, to improve the patient experience.

Summary:

1. **Situation:** This presentation is intended to give an overview of the FY 20 data related to complaints and grievances received by El Camino. A breakdown of grievances by IP and ED is provided as well.
2. **Authority:** To provide insight into the number of patient complaints and grievances.
3. **Background:** ECH is required to track and respond to patient grievances in a timely manner with a written response to the grievant within 30 days as per CMS regulation. However, at ECH we send a letter within 7 days acknowledging the receipt of the grievance and make every effort to respond before 30 days.
4. **Assessment:** The grievances are reviewed each week by the grievance committee to determine appropriate resolution.
5. **Other Reviews:** None
6. **Outcomes:** Each grievance is different based on the patient's concerns. The grievance committee makes every effort to create new processes/systems when there are systemic problems that emerge as a result of grievances. An example is the many safety measures that have been installed throughout the campus to insure social distancing and plexi glass at reception areas. It is difficult to know if our grievances are comparable to similar sized hospitals since this data is not publicly reported. However, we do have some insights that we are in line or better than other hospitals we have contacts with throughout the Bay Area.

List of Attachments: Patient Grievance/Complaint Presentation

Suggested Committee Discussion Questions:

1. Will the RL Solutions electronic reporting tool assist the team with managing grievances?
2. Any other changes you plan to make to the grievance resolution process?
3. How will the new WeCare program help with reducing grievances?



Grievances and Complaints – FY 20

Cheryl Reinking, DNP(c), RN, NEA-BC

Negative Feedback

- For every customer complaint, there are 26 other unhappy customers who remain silent
- 96% of unhappy customers don't complain, however 91% will simply leave and not come back
- A dissatisfied customer will tell between 9-15 people about their experience. About 13% of dissatisfied customers tell more than 20 people
- Happy customers who get their issues resolved tell about 4-6 people



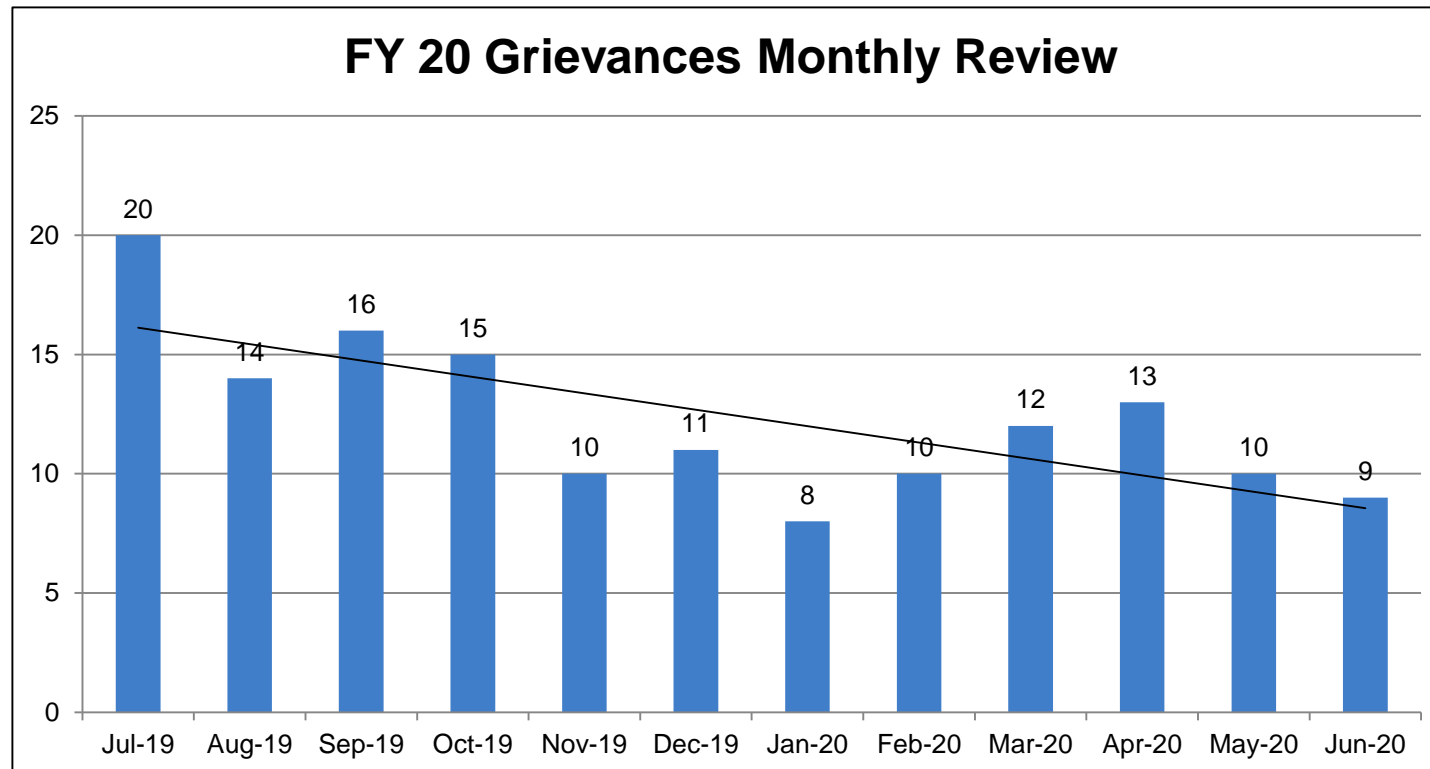
Defining the Data

- Complaint - is a concern voiced by a patient or the patient's representative, about service, care, or treatment that can be resolved quickly by the staff present. A complaint is considered resolved when the patient is satisfied with the actions taken on his or her behalf.
- Grievance - is a written or verbal complaint by a patient, or patient's representative, about the patient's care. When a verbal complaint by the patient is not resolved at the time of the complaint by staff present, it automatically becomes a grievance.
- The Joint Commission and other accreditors' complaint resolution standards also require that accredited facilities address and resolve complaints from patients and their families. All CMS and JC standards must be met and our compliance is auditable
- Healthcare organizations must develop processes for addressing patient complaints and grievances in order to comply with federal regulations and accreditation standards, as well as to protect patients and reduce liability
- Our Grievance Committee consists of multidisciplinary team and meets regularly to review and drive accountability for resolving patient complaints / grievances.

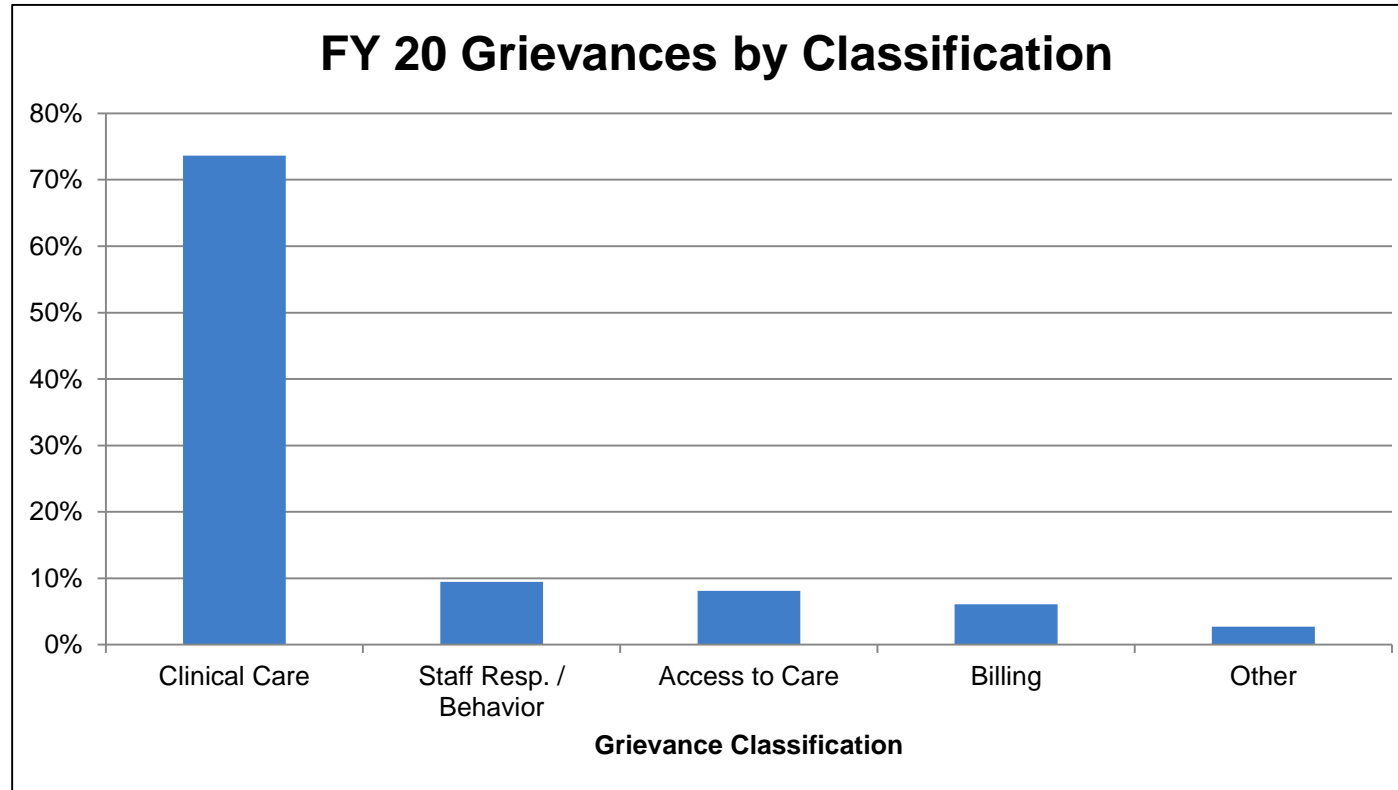
Patient Experience: Complaints and Grievances

Complaint	Grievance
Stem from minor issues that can typically be resolved by staff present at the time the concern is voiced	Typically more serious in nature and generally require investigation into allegations regarding the quality of patient care.
Billing issues (with no care issue)	Billing issues if the patient or representative states they will not pay due to care or treatment issues
Lost and Found	Concerns or issues submitted in writing; including any letter or email that come after the patient has received care
Follow up can be by phone, in person or by letter, but letter is not required	Concerns or issues not resolved while patient in house
	Follow up must be in writing, address all issues of grievance and responded to no later than 30 calendar days. CMS feels most grievances should be resolved or responded to (in writing) in 7 days.

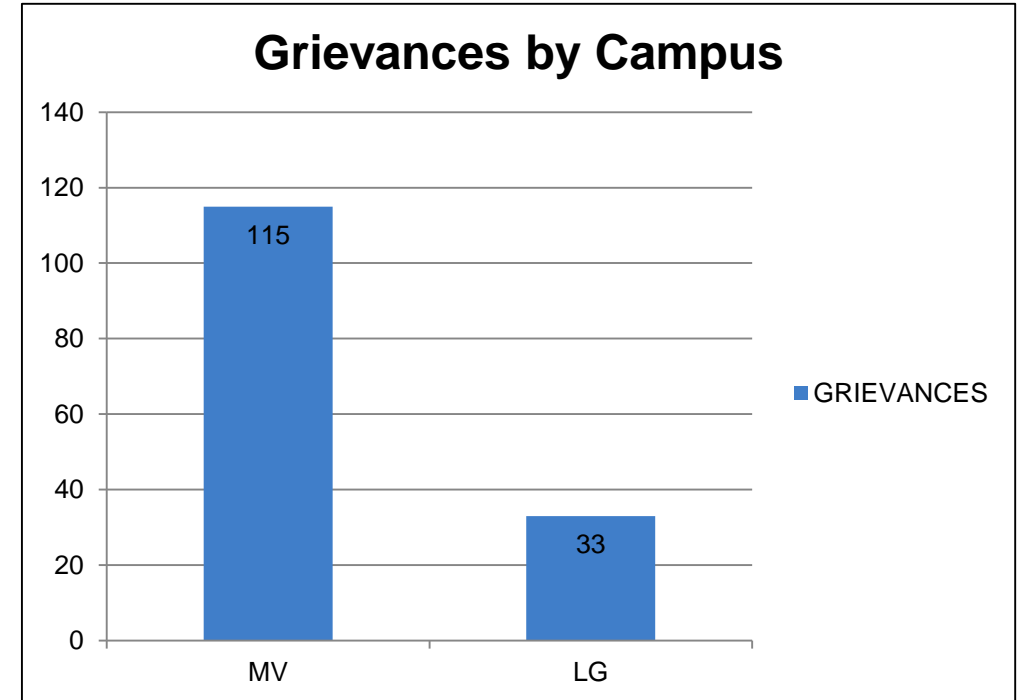
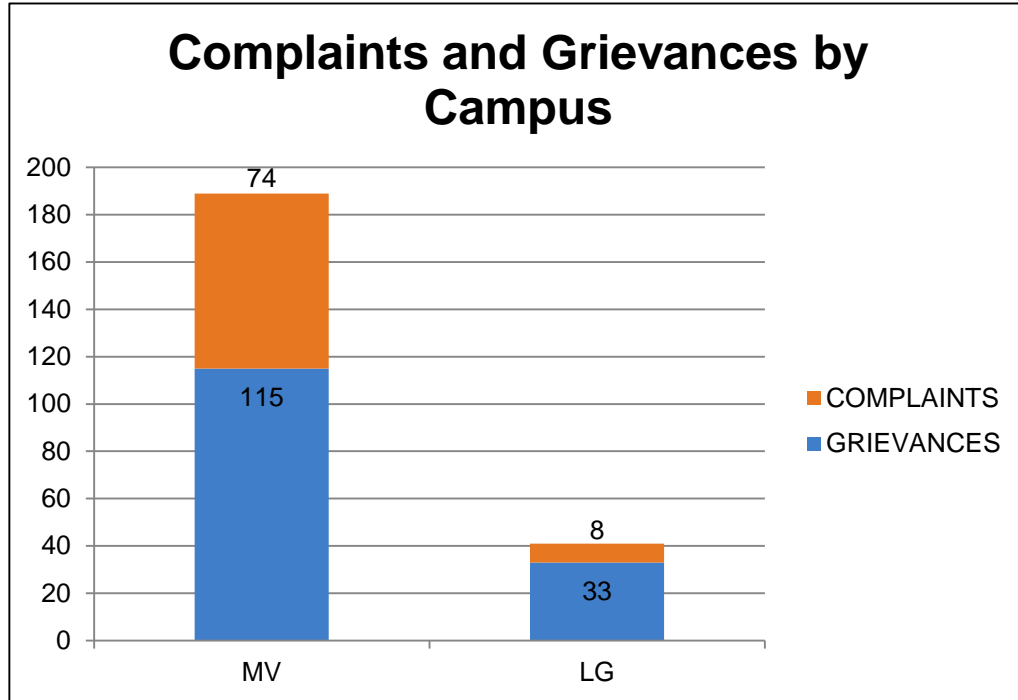
FY20 Grievances Total - 148



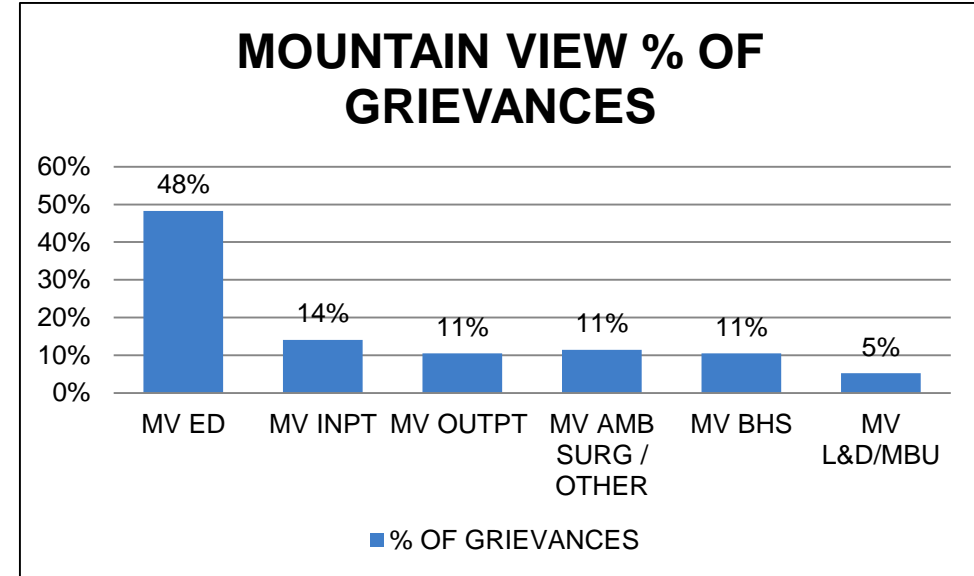
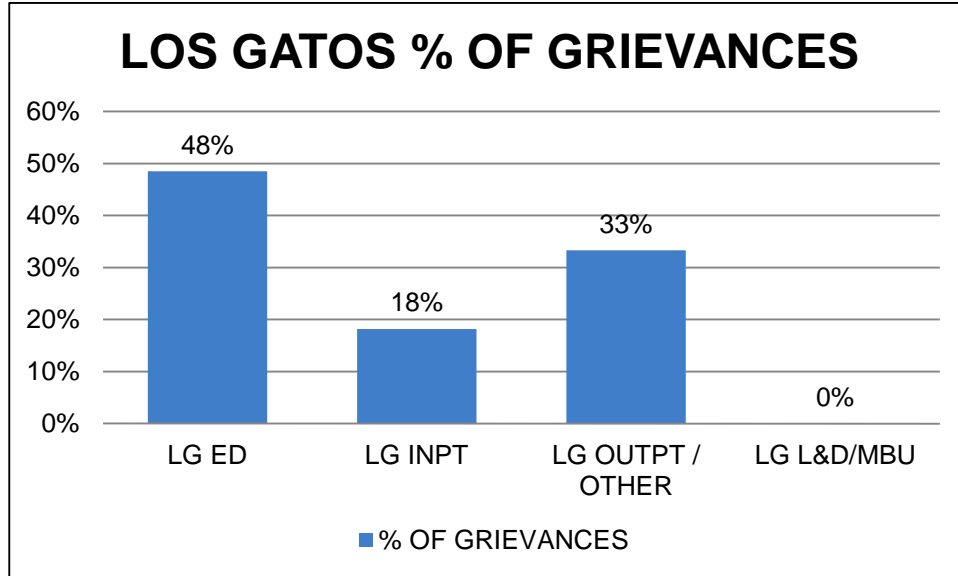
FY 20 Grievances by Classification



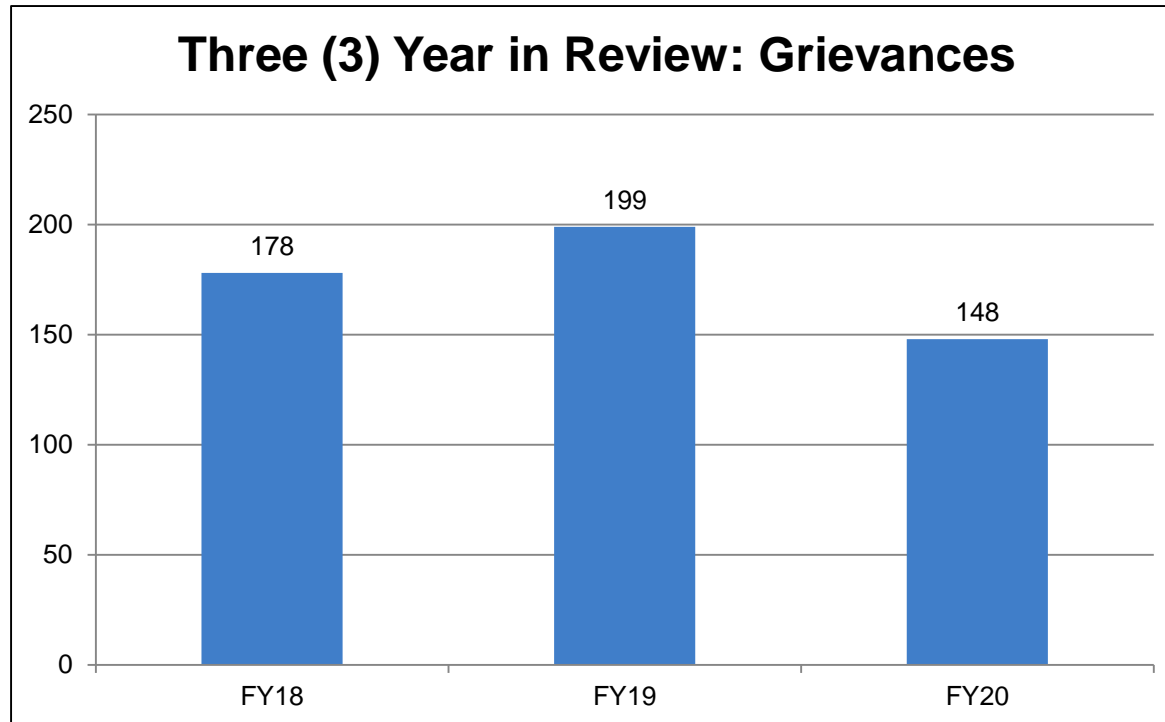
FY20 Complaints & Grievances by Campus



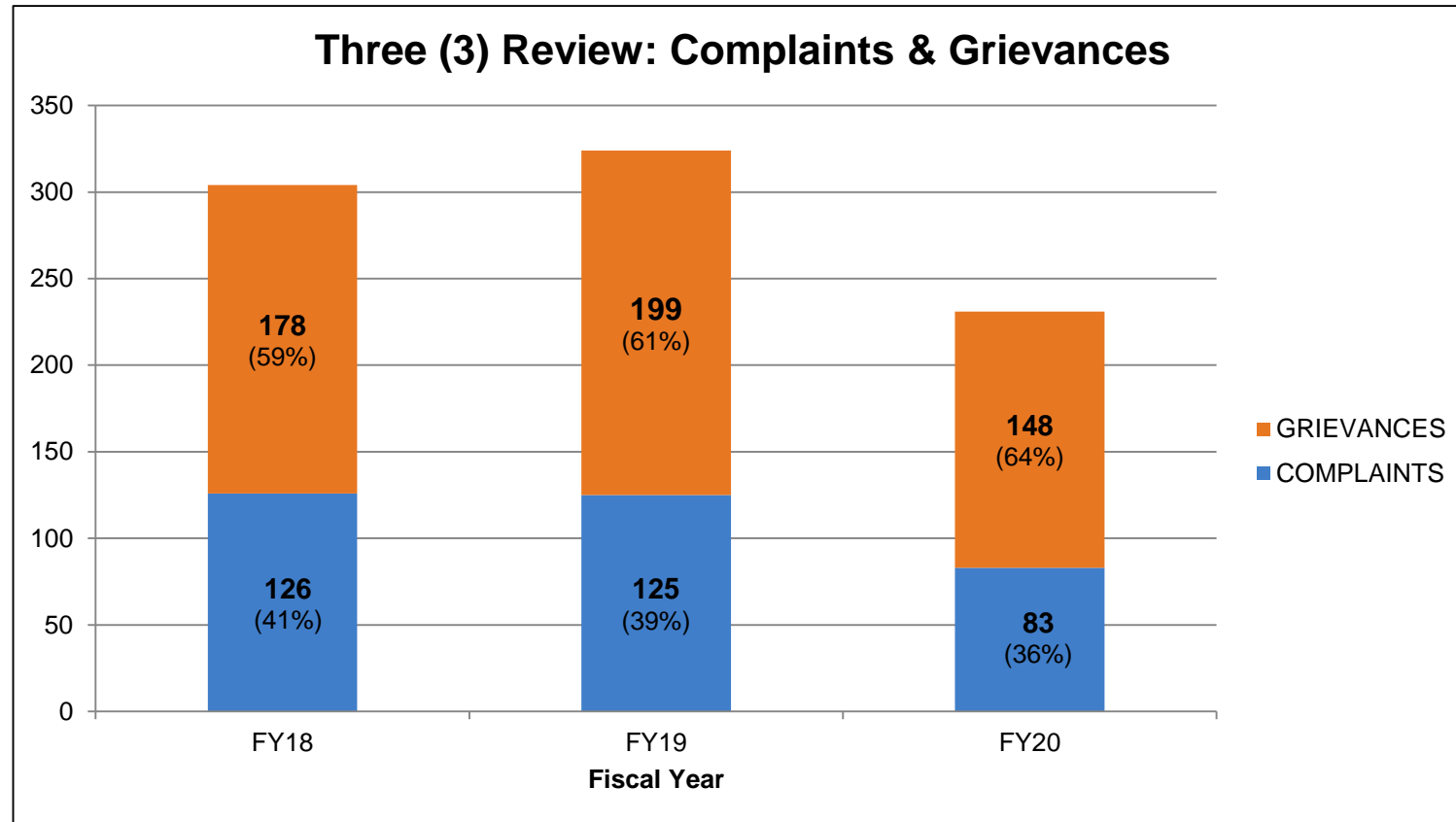
FY20 Complaints & Grievances by Campus



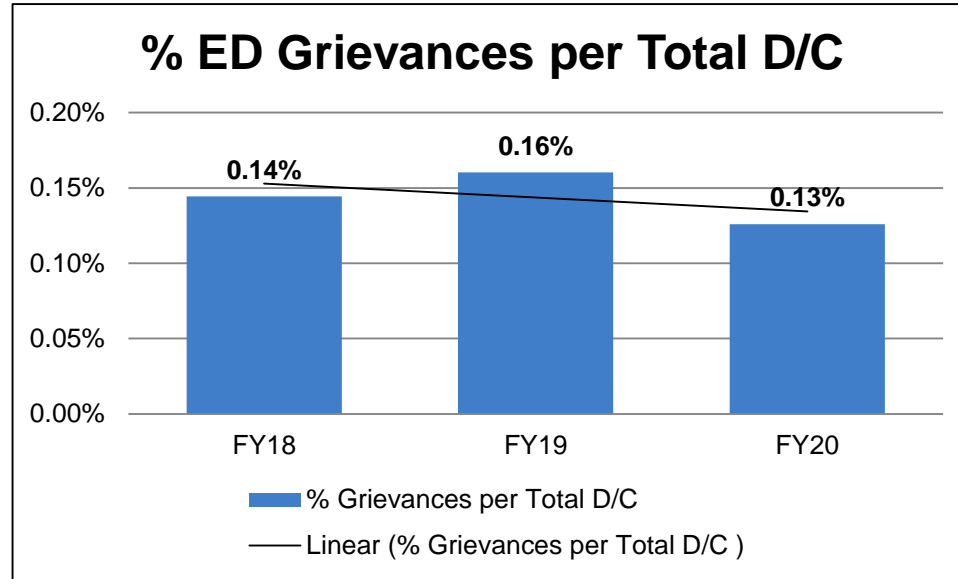
Three (3) Year Review



Complaints and Grievances: Three Year in Review

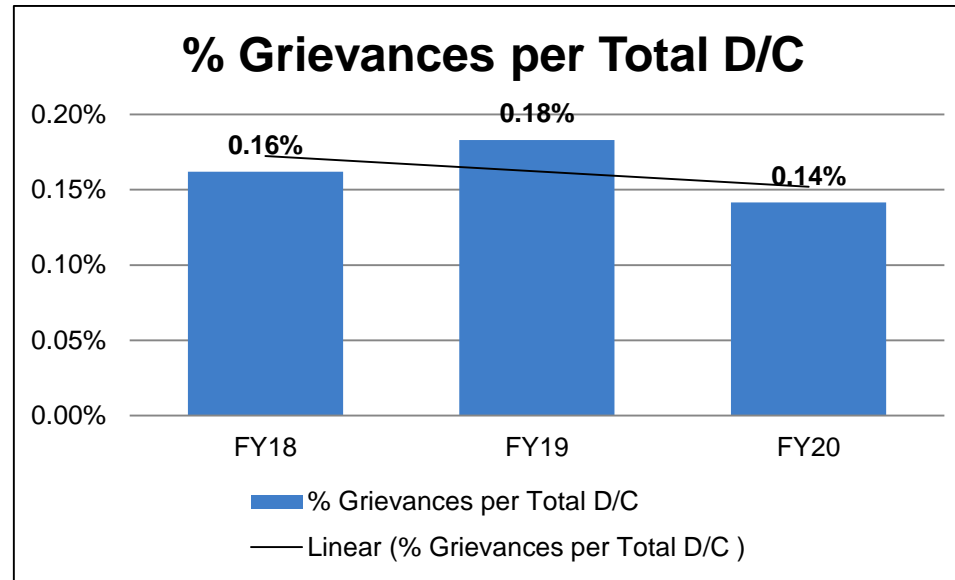


ED Grievances



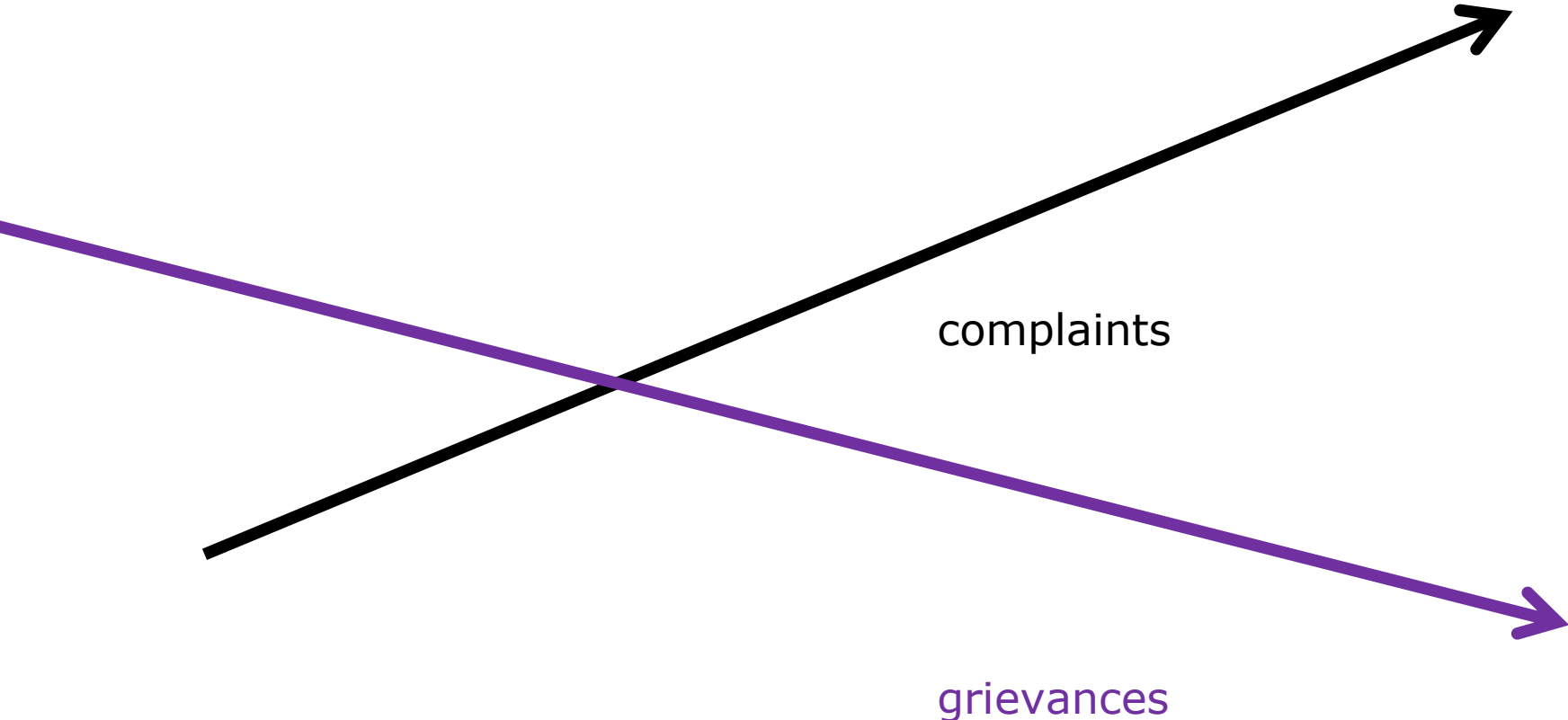
FISCAL YEAR	# ED VISITS	# ED GRIEVANCES	% Grievances per D/C
FY20	56,334	71	0.13%
FY19	62,355	100	0.16%
FY18	62,997	91	0.14%

Inpatient Grievances



FISCAL YEAR	TOTAL DISCHARGES	# GRIEVANCES	% GRIEVANCES PER D/C
FY20	54,386	77	0.14%
FY19	54,114	99	0.18%
FY18	53,733	87	0.16%

What we want....



Patient Experience Improvement Work

- Implemented RL Solutions (iSAFE) patient experience module in August 2020 – will allow us to better understand trends, location, category, days open
- RCA analysis work on grievances – partner with PI
- Develop new process from intake to resolution – in process
- Audits to be conducted for compliance
- Increased leader and nurse leader rounding – real time service recovery
- WeCare Launch with service recovery kits for all staff

Patient Letters

- We 'average' about 40 patient letters per month across MV and LG
- Approximately 92% are positive, 3% are negative and the rest are mixed
- During the height of the Covid-19 pandemic (March, April, May), we averaged over a 100 per month and the vast amount were letters of gratitude to healthcare workers

Questions



**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: September 8, 2020
Subject: Progress on Quality and Safety Plan

Purpose: The QC and Board previously approved a Quality/Performance Improvement and Patient Safety Plan (QAPI). This report will serve as an update on progress under that plan and provide the QC members an opportunity to provide feedback.

Summary:

1. **Situation:** Following a consulting engagement with Progressive Healthcare, a long term quality and safety plan was formulated and presented to the Board and Board QC in November of 2019. This was followed by a specific Quality/Performance Improvement and Patient Safety Plan (QAPI) which was presented to and approved by the QC in April of 2020. The QC has requested an update on the progress of the plan.
2. **Authority:** This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients. Creation and adoption of a QAPI is a regulatory requirement for CMS Conditions of Participation and for accreditation by The Joint Commission.
3. **Background:** Progressive Healthcare completed an initial assessment with findings of generally average quality and safety performance on both publicly reported measures and internal benchmarks all very similar to our market competitors. This work identified five key areas representing strategic opportunities:
 - A. **Governance, Leadership, and Management**
 - B. **Quality Organization Integration**
 - C. **Performance Improvement Metrics and Methods**
 - D. **Journey to High Reliability**
 - E. **Culture of Safety**
4. **Assessment:** Multiple enterprise workshops were conducted with frontline clinicians (including physicians and nurses) and managers. A common vision was developed: “To consistently deliver the highest quality care with zero preventable harm.”
 - A. Alignment of governance, leadership and management required adopting a standard definition of quality. This was accomplished by adopting the nationwide standard based on the STEEEP construct. Attention was next focused on reorganizing internal quality structures. The enterprise quality council (ECQ) was created by combining several separate and siloed committees. The ECQ is chaired by a physician—currently the past enterprise chief of staff-- and the CMO. The EQC now oversees all of the quality and safety activities. Various service lines, departments, and services are required to report

on their respective quality/performance improvement activities on a rotating basis. The medical staff has agreed to reorganize to improve engagement in quality improvement activities. Each of the newly consolidated departments—medicine, surgery, and maternal child health—have taken on the responsibility to choose areas that can benefit from quality improvement and move forward with action plans to accomplish that improvement. To connect and align the organization’s quality work, the EQC results are conveyed to the Board QC and ultimately flow to the Board itself.

- B.** Several steps have been taken to further integrate the quality and safety work. The quality department, infection prevention, clinical documentation integrity, regulatory compliance, sepsis management, the risk department, medical informatics (CMIO), medical staff credentialing and privileging, and approximately 50 medical directors all work in a matrixed relationship under the direction of the CMO. The CMO Advisory Council (CMOAC) meets regularly to maintain alignment with the enterprise quality and safety goals. All medical directors are now required to adopt one of the key organizational performance incentive goals. A new position, chief patient safety officer, has been created and will be filled soon. A weekly patient safety committee has been formed to act on any pressing operational issues that impact patient safety.
- C.** Performance improvement methods and metrics have been enhanced. Educational support has been provided to standardize our quality and safety improvement tools such as Root Cause Analysis (RCA), Common Cause Analysis (CCA), Apparent Cause Analysis (ACA), and Failure Mode and Effects Analysis (FMEA). This has allowed a more consistent and thorough review of safety events. Each result of these types of investigations now leads to specific audits to hard wire the improvements. The new RCA steering committee oversees these activities and assures that the auditing is completed. Triad leadership has been implemented whenever possible and data analytics is provided to complement these teams. We have begun to apply artificial intelligence (AI) to augment real time data into actionable information. For example, we have successfully piloted an AI driven patient “Deterioration Index” which alerts clinicians prior to more dramatic clinical emergencies such as cardiopulmonary arrest. Initial data already shows a decrease in Code Blue alerts.
- D.** Top tier performance cannot be attained without a solid foundation of a culture of high reliability (HRO). Recognizing that this is a multi-year journey to HRO status, the foundational work has begun. A key first step has been the initiation of a standardized safety event classification system. We have use the industry recognized HPI approach for classification. All incidents are reviewed and classified on a weekly basis. To enhance reporting of safety incidents, a new sophisticated incident reporting system, RL Datix, has been implemented as of August 4. This is termed iSAFE (Safety Always First at El Camino). While reporting is to be encouraged by all, we intend to particularly encourage physicians to report as they have been reluctant to do so in the past. Efforts have been made to intertwine lean into all of the quality improvement work whenever possible.
- E.** Culture of Safety is the glue that holds all of the quality and safety work together. Without a strong culture of safety hard wiring improvements are very difficult. This requires consistent leadership commitment, clear accountability, the use of a fair and just culture, transparency of quality and safety outcomes, and an environment that encourages reporting errors without fear of retribution. As an example of commitment, the organization has completely retooled the start of day enterprise wide management huddle

into a safety huddle first and foremost. Transparency and learning are emphasized over blame. Safety issues are addressed ASAP by assigning accountability and deadlines for corrective actions. The new patient experience initiative called WeCare will have an element of safety within it with a tag line of “mission zero” (referring to harm).

5. Illustration: Here’s a real time example of how these principles are being applied in the organization to address readmissions. At the governance level, readmission index is adopted by the Board and Board Quality Committee as a high level organizational performance goal. The EQC is then established as the steering committee for this effort. Our data analytics team provides us with a Pareto chart to assess the causes of readmission and then enables us to direct our efforts in a lean and efficient manner. Five action teams have been established to address the prime drivers of readmission: Cancer, Social Determinants of Health, Surgical Complications (PSI-04, e.g.), Post Acute Care Management, and Review of all Readmissions for data analysis. Additional indirect support comes from two enterprise initiatives: ICOUGH to reduce hospital acquired pneumonia and ERAS (early recovery after surgery) to reduce surgical site infections. Each team is supported by project management/lean process improvement resources.
6. Other Reviews: None
7. Outcomes: The Quality Committee will better understand the nature of the Quality/Performance Improvement and Patient Safety Plan (QAPI) and the multi-tiered approach being utilized to actualize it.

List of Attachments:

1. Quality/Performance Improvement and Patient Safety Plan (QAPI)

Suggested Committee Discussion Questions:

Does the approach make sense?

Are there areas missing that may need to be addressed?

This is a very ambitious endeavor that will fail without governing board support. How can the QC help the Board get behind this?

There is an immense amount of data that flows through the EQC. How can we help the QC and, ultimately, the Board to understand what information among all this data is relevant from a governance point of view versus management work?



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Quality/Performance Improvement & Patient Safety Plan (QAPI)

PURPOSE

The Performance Improvement & Patient Safety Plan describes the multidisciplinary, systematic performance improvement framework utilized by El Camino Health (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

ORGANIZATION OVERVIEW

El Camino Health is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View, California and a 143-bed acute hospital in Los Gatos, California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip and Knee, Hip Fracture and Spinal Fusion, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center and as "baby friendly hospital" by WHO/UNICEF.

The ECH Medical Staff includes 1606 active, courtesy or provisional physicians/independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery). Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

EI CAMINO HEALTH MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

EI CAMINO HEALTH VALUES

Quality: We pursue excellence to deliver evidence based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

HIGH RELIABILITY

El Camino's 2020 vision for quality includes a high reliability journey leading to zero preventable harm. Safety is a well-defined science and can be improved through attention to reliability culture (expectations, behaviors, teamwork, etc.) and processes (intuitive design, mistake proofing, etc.). Camino will form a steering committee to implement these high reliability practices. Implementation will include training and case-based learning, multi-disciplinary interactions to improve communication, tools, job aids, and newsletters. Real-time change management will include simulations, moments for safety before meetings, red "no interruption zones," and a cascade of safety huddles that focus on patient and team member risk assessment and mitigation. Additional support for cultural transformation will include leader rounding, safety coaches on each unit, policy changes, tools, on-line resources, and rewards/recognition.

El Camino will develop a tool kit for all executive and medical staff leaders, provide training, and monitor use. The toolkit will include techniques to lead the safety journey (e.g., how to encourage reporting, educating for safety, having a moment for safety in each meeting, sharing lessons learned), build accountability (e.g., rounding to influence, 5:1 feedback, red rules, fair and just culture), and finding and fixing problems (e.g., stop the line, top 10 work list, action planning). Leader performance evaluations will incorporate measures of safety leadership.

El Camino physician and executive leaders will work to decrease power gradients and improve interpersonal communication. In addition to the daily Safety Huddle, El Camino will develop a series of communication tools to allow for immediate frontline communication and education to decrease the risk of preventable harm. This will include internal dashboards that show the SSER (including Faces of Safety) to better personalize otherwise impersonal data.

DEFINITIONS

El Camino Health has adopted the Institute of Medicine's (IOM) Quality Framework – STEEEP – as its definition of quality. These six aims for a healthcare system comprise ECH's approach to quality:

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.

- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

SERVICES/PROGRAMS

ECH provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:	Emergency Services	Outpatient Services
Intensive & Critical Care Unit	Basic Emergency	Behavioral Services – Outpatient
Progressive Care Unit (PCU) (Step-down)		Cancer Center
Operating Room (OR)		Cardio Pulmonary Wellness Center
Post-Anesthesia Care Unit (PACU)		Outpatient Surgical Unit
Telemetry/Stroke		Endoscopy
Medical/Surgical/Ortho		Interventional Services
Pediatrics		Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI)
Labor and Delivery (L&D)		Radiation Oncology
Mother/Baby		Rehabilitation
Neonatal Intensive Care Unit (NICU) Level II and Level III		Infusion Services
Mental Health and Addictive Services (Inpatient) Psychiatry		Nuclear Medicine
Acute Rehabilitation		Wound Care Clinic
Cardiac Catheterization Services		Occupational Therapy/Physical Therapy
Cardiovascular Surgery		Speech Therapy

OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.

5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of performance improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

A. Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears ultimate responsibility for the performance and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility for implementing the Quality/Performance Improvement & Patient Safety Plan to the medical staff and hospital administration.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, cause the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting The Joint Commission and College of American Pathology accreditation standards, California Code of Regulations Including; Title 22, CMS Conditions of Participation and complying with applicable laws and regulations.

Other specific responsibilities with regard to performance improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

B. Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.14, the Medical Executive Committee is responsible for the quality and efficiency of patient care rendered by members of the Medical Staff and for the

medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

1. Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered to patients in the hospital;
2. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and making recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
3. Assisting in obtaining and maintenance of accreditation.

C. Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of a combination of campus-specific departments and enterprise departments. Enterprise departments are those departments that serve constituency at all campuses (including Mountain View – MV and Los Gatos- LG). All departments report to an Enterprise Medical Staff Executive Committee.

Other specific responsibilities with regard to performance improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A.

D. Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes performance improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

1. Adopt an approach to performance improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities
2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for performance improvement and safety giving priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and reprioritize performance improvement activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental performance improvement and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff is trained in performance improvement and safety improvement approaches and methods and receives education that focuses on safety and quality
7. Continuously measure and assess the effectiveness of performance improvement and safety improvement activities, and implement improvements for these activities

E. Medical Staff, Employees, and Contracted Services

Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, reporting adverse events, and implementing actions to sustain improvements.

F. Enterprise Quality & Patient Safety Committees: Enterprise Quality Council and Patient and Employee Safety Committees (See Flow of Information Appendix A)

The Medical Staff Bylaws describe the composition and duties of the Enterprise **Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments and information on medical record review, transfusion, tissue and autopsy review. The Quality and Safety Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues.

The Enterprise **Patient and Employee Safety Committee** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Ulcers, Hospital-acquired Infections A3 Teams (CAUTI, CLABSI, C. Diff, and Hygiene), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene and the Grievance Committee. The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital administration to develop action plans in response to the results. The Director of Risk Management also conducts risk assessments regarding the safety of patient care including Failure Mode Effects Analysis (FMEA) for new or changed hospital services. The Director of Risk Management/Patient Safety Officer provides data on the Quality Review Reports (QRR), ECH's Online System for adverse event reporting) and the adequacy of the reporting process, including updates on the number and type of QRRs, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Serious Safety Events policy to outline the process for categorizing patient safety events, including serious safety events, defining those events that reach the level of a Red Alert, ensuring compliance with all regulatory requirements for oversight of adverse events and to outline the procedure for notifying ECH leadership and the ECH Board of serious safety events.

The Enterprise **Patient Safety Oversight Committee (PSOC)** is also a subcommittee of the Quality Council and is described in the *Management of Serious Safety and Red Alert Procedure* (Administrative). The Patient Safety Oversight Committee is a committee that meets weekly to review and categorize Quality Review Reports, serious patient safety events, behavior, safety and operational issues. The Committee is comprised of the Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Medical Director for Quality Assurance, Associate Chief Medical Officer, Sr. Director/Chief Quality Officer, Director of Risk Management/Patient Safety Officer, Director of Accreditation/Public Reporting, Director of Medical Staff Services and a representative of the Medical Staff. These leaders provide direction to the organization and the Medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

The Quality Readmission and Mortality Performance Improvement Teams is a sub teams and will report to the Readmission and Mortality Steering Committee and then reports to the Enterprise Quality Council. The Quality Readmission and Mortality Performance Improvement Teams consist of a multidisciplinary approach to addressing identified trends and or patterns which have increase the readmission and or mortality rates. The teams will work on specific tasks, processes to streamline care and ensure the patients are receiving quality of care and maintaining patient safety initiatives.

The Root Cause Analysis (RCA) Steering Committee is a subcommittee and will report up to the Enterprise Patient Safety Oversight Committee (PSOC). The RCA Steering Committee focuses on events that an RCA has completed and thus has the senior leadership with the involved departments reporting on actions taken and the continuous improvement until the process change has been sustained. This process also includes the SSE's and investigation process.

G. Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and performance improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality, Safety and Risk Management Department staff serves as an internal resource for the development and evaluation of performance improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including the 10 teams addressing the Quality goals of Mortality Index and Readmission Index, ERAS Team, and the Surgical Site Infection Task Force and the HAI Teams. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of performance improvement activities from all sources
2. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
3. Managing the peer review process and the peer review data base for the medical staff and providing data and reports for the OPPE and FPPE process of the medical staff
4. Providing clinical and provider data from hospital and external registry data bases as needed for performance improvement
5. Maintaining a performance improvement and patient safety reporting calendar and communicating it to all groups responsible for performance improvement activities
6. The Director of Risk Management leads efforts to manage risk and the Quality Review Reporting (QRR) (Online System for adverse event reporting). This also includes conducting Root Cause Analyses and Intense Analyses as responses to adverse events and near misses
7. Facilitating a failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting
8. Performance improvement teams that are commissioned as a result of findings of Root Cause Analyses or Intense Analyses are led by the department's Performance Improvement Coordinator
9. Working with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"

10. Supporting Infection Prevention efforts within the hospital, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
11. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
12. Providing data as requested to external organizations, see List with data provided in Appendix B
13. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list
14. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, managing NSQIP Registry and quality improvement, the MBSAQIP, and all Transfusion review and data

H. Improving Organizational Performance

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Performance improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained.

Performance improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(s) to performance improvement. These leaders set priorities for performance improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives will be based upon the following criteria:

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of performance improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix B.

A deviation from generally accepted performance standards (GAPS) that...

SEC SAFETY EVENT CLASSIFICATION
HPI PRESS GANEY

Serious Safety Event

- Reaches the patient
- Results in moderate to severe harm or death

Serious Safety Events

Precursor Safety Event

- Reaches the patient
- Results in minimal harm or no detectable harm

Precursor Safety Events

Near Miss Safety Event

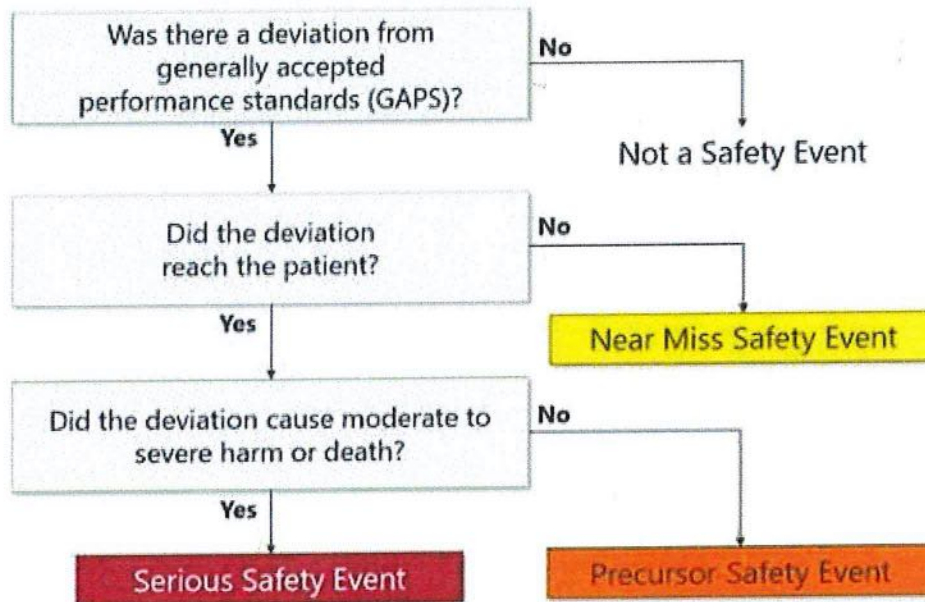
- Does not reach the patient
- Error is caught by a detection barrier or by chance

Near Miss Safety Event

Table 1 HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch

Safety Event Decision Algorithm



I. Performance Processes

1. Design

The design of processes should be in keeping with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

2. Patient Safety

ECH strives to prevent errors and adverse effects to patients that are associated with complex patient care. While patient safety events may not be completely eliminated, harm to patients can be reduced and our goal is always zero harm. To learn from and to make changes to reduce harm, all hospital-acquired conditions, infections and complications of care are reviewed and results shared with involved departments and providers. Root cause analyses and intense analyses are conducted to more clearly understand the factors involved in a near miss or untoward event. The purpose is to develop and sustain a culture of safety. The leadership, risk management and quality staff work to promote a "just culture" that focuses on the systems involved in care and to create a trust-report-improve cycle to promote reporting of all event and near misses.



3. Measurement

ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board set organizational goals for quality, service and efficiency. The data collected for priority and required are as are used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.

Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

- a. Consistent with the organization's mission, vision, goals, objectives, and plans;
- b. Meeting the needs of individuals served, staff and others;
- c. Clinically sound and current;
- d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
- e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
- f. Incorporated into the results of performance improvement activities.

Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:

- a. Establish a performance baseline;
- b. Describe process performance or stability;
- c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
- d. Identify areas for more focused data collection to achieve and sustain improvement.

4. Analysis

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.

When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.

ECH requires an intense analysis of undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

- a. Performance varies significantly and undesirably from that of other organizations;
- b. Performance varies significantly and undesirably from recognized standards;
- c. When a sentinel event occurs;

- d. Blood Utilization to include confirmed transfusion reactions;
- e. Significant adverse events and drug reactions;
- f. Significant medication errors, close calls, and hazardous conditions;
- g. Significant adverse events related to using moderate or deep sedation or anesthesia;

J. Improvement Model And Methodology

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other The Plan-Do-Study-Act (PDSA) Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

The model has two parts:

1. **Three fundamental questions, which can be addressed in any order.**
 - What are we trying to accomplish?
 - How will we know that a change is an improvement?
 - What changes can we make that will result in improvement?

This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The PDSA Cycle provides an effective framework for developing tests and implementing changes as described next.

2. **The Plan-Do-Study-Act (PDSA) Cycle**

The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

Step 1: Plan

Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?

Step 2: Do

Try out the test on a small scale. What did we observe that was not a part of our plan?

Step 3: Study

Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?

Summarize and reflect on what was learned.

Step 4: Act

Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.

In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



3. Goal Setting and Auditing Methodology

- a. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.

The acronym stands for:

S – Specific

When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:

Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).

What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.

When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.

Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.

Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."

Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

M – Measurable

What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.

A – Achievable

This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.

R – Relevant

Relevance refers focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.

T – Time-Bound

Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

- b. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.

Measure of Success (MOS) auditing process has specified the following minimums:

- Sample all cases for a population size of fewer than 30 cases
- Sample 30 cases for a population size of 30–100 cases
- Sample 50 cases for a population size of 101–500 cases
- Sample 70 cases for a population size of more than 500 cases
- Sample 100 cases for a population greater than 500 cases

To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

K. Lean Improvement Methodology:

ECH has applied the use of Lean methodology and principles to the process of performance improvement. The Performance Improvement Department provides resources to the organization in deploying Lean strategies and tools. This Department provides trained A3 team facilitators and education to the organization on Lean principles. For FY 2020, the Performance Improvement Department is focusing on using Lean tools to address Through-put involving patient flow beginning in the Emergency Departments.

Lean is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. Lean organizations deliver exactly what is needed, at the right time, in the right quantity without defects, and at the lowest possible cost. The currency of lean is value.

As you take out "muda" (i.e., waste) in the process, you take out time. Waste is anything other than the minimum amount of equipment, materials, technology, space, and a colleague's time that are essential to add value to the product or service. Lean is a long term strategy in that it takes time to change. Testing turnaround time and OR utilization are classic examples. Lean thinking specifies value from the standpoint of the customer.

Systems critical to the success of lean include reward and recognition, education and training, idea generation, communication, and engagement. Lean behaviors require everyone to be a problem-solver, managers solicit ideas from colleagues and encourage continuous improvement, everyone is treated with respect and challenged to grow professionally and personally, and everyone is transparent about results and areas for improvement. Lean leadership guiding principles require a belief that problems are "treasures" and that you will go to the "gemba" (i.e., the actual workplace) to see the actual situation for understanding.

1. Lean Principles

The five-step thought process for guiding the implementation of lean techniques is easy to remember, but not always easy to achieve:

- a. Specify value from the standpoint of the end customer by product family.
- b. Identify all the steps in the value stream for each product family, eliminating whenever possible those steps that do not create value.
- c. Make the value-creating steps occur in tight sequence so the product will flow smoothly toward the customer.
- d. As flow is introduced, let customers pull value from the next upstream activity.
- e. As value is specified, value streams are identified, wasted steps are removed, and flow and pull are introduced, begin the process again and continue it until a state of perfection is reached in which perfect value is created with no waste.

Lean practices are the actions that enable the lean process. They are tactical. Improvements are the result of their repeated execution. Examples of lean practices are many and include the 5S model, standardization, visual management, and problem solving.

L. Performance Improvement Link With Organizational Goals

ECH's Performance Improvement & Patient Safety Plan focuses on specific quality measures in three areas: quality/safety, service and efficiency. For FY 2019 and FY 2020 the Organizational Goals are:

FISCAL YEAR	QUALITY	SERVICE	EFFICENCY	PEOPLE
FY 2019	Mortality Index (Observed/ Expected Readmission Index (Observed/ Expected)	HCAHPS: Nurse Communication Responsiveness Cleanliness	Patient Throughput ED Door to Patient Floor	Employee Engagement Press Ganey Overall Engagement Score
FY2020	Mortality Index	HCAHPS: Discharge	Adjusted	Employee Engagement

FISCAL YEAR	QUALITY	SERVICE	EFFICENCY	PEOPLE
	(Observed/ Expected Readmission Index (Observed/ Expected)	Communication and Staff Responsiveness	Discharges	Press Ganey Overall Engagement Score

M. Commitment to Person-Centered Care

ECH has embraced Person-Centered Care and believes that its goal is to create partnerships among health care practitioners, patients and families that will lead to the best outcomes and enhance the quality and safety of health care. As a result, ECH has implemented a Patient and Family Advisory Council as a formal mechanism for involving patient and families in performance improvement efforts, policy and program decision making. The patient and family advisors act as champions of the ideal patient experience, and ensure its implementation across ECH. They are involved in reviewing communication to patients and families to ensure that it builds on patient and family strengths and engages them in a partnership in health care services and serve as members of some hospital committees. As needed, the advisors make recommendations to senior leaders for improvements in service quality.

N. Allocation of Resources

The CEO and the Executive Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization shall allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities shall be supported through monies allocated for education. Budgetary planning shall include resources for effective information systems, when appropriate.

O. Confidentiality

The Performance Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Performance Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information shall be presented so as to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the Performance Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality Services Department and the Medical Staff Services Department and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Sr. Director, Quality Services Department or the Compliance Officer.

P. Annual Evaluation

The Sr. Director of Quality Services, shall coordinate the annual evaluation of the program and written plan for submission to the Medical Staff Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address the program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program shall also be addressed.

Modifications shall be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Quality Council, Medical Executive Committee, and the Governing Board.

I. Cross References:

1. Management of Serious Safety Events and Red Alert Procedure
2. Medical Staff Peer Review Policy

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Attachments

[Appendix A - Information flow QA-PI-PS Plan](#)

[Appendix B- External Regulatory Compliance Indicators/Measures](#)

[Appendix C - El Camino Hospital Data Registries](#)

[Data Registries.JPG](#)

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES
Appendix B

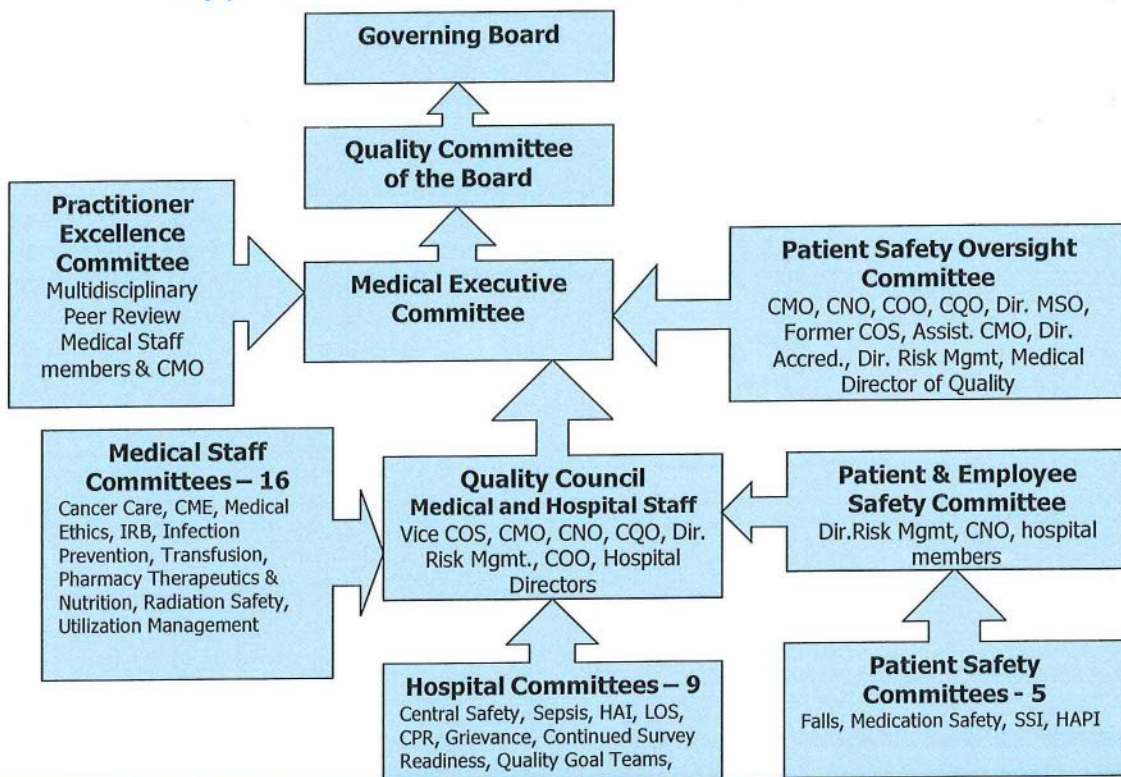
Indicator Name	Indicator Description	Regulatory/Accreditation source
Chart-Abstracted Clinical core measures		
Hospital Inpatient and Outpatient:		
OP-18:	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital Outpatient Quality Reporting (OQR) Program
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke	
PCB-05	Exclusive Breast Milk Feeding	TJC ORYX Performance Measurement Program
PCB-06.0	Unexpected Complications in Term Newboms - Overall Rate	
PCB-06.1	Unexpected Complications in Term Newboms - Severe Rate	
PCB-06.2	Unexpected Complications in Term Newboms - Moderate Rate	
PCM-02a	Cesarean Birth	
PCM-01	Elective Delivery	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
SEP-1	Early Management Bundle	Hospital Inpatient Quality Reporting (IQR) Program
SEP-3T	Sepsis Treatment 3-Hour Window	
SEP-6T	Sepsis Treatment 6-Hour Window	
SHK-3T	Septic Shock Treatment 3-Hour Window	
SHK-6T	Septic Shock Treatment 6-Hour Window	
HBIPS – Hospital-based Inpatient Psychiatric		
IMM-2	Influenza Immunization	TJC ORYX Performance Measurement Program
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate	
SUB-2	Alcohol Use Brief Intervention Provided or Offered	
SUB-2a	Alcohol Use Brief Intervention	
SUB-3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	

SUB-3a	Alcohol and Other Drug Use Disorder Treatment at Discharge
TOB-2	Tobacco Use Treatment Provided or Offered
TOB-2a	Tobacco Use Treatment
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge
TOB-3a	Tobacco Use Treatment at Discharge

Electronic Clinical Quality Measures (eCQM): Name and description	Regulatory/Accreditation source
eVTE-1 Venous Thromboembolism Prophylaxis	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis	
eSTK-2 Discharged on Antithrombotic Therapy	
eSTK-6 Discharged on Statin Medication	
ePC-05 Exclusive Breast Milk Feeding	
eED-2 Median Admit Decision Time to ED Departure Time for Admitted Patients	

Performance Improvement & Patient Safety Plan

Appendix A: Flow of Information



#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	CathPCI Registry®	ACC@(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90'. Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all patients)	HVI	Quarterly
2	Chest Pain-MI Registry® –(old ACTION)	ACC@(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI/ACS process performance: Overall AMI performance composite; STEMI performance composite: NSTEMI performance composite	HVI	Quarterly
3	ACC Patient Navigator Program Focus MI	ACC@(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	This is a national program specifically designed to enhance the care and outcomes for myocardial infarction patients.	National benchmarks, with comparison data to reduce AMI patient readmission for quality improvement project	HVI	Quarterly
4	STS/ACC TVT Registry™	STS (Society of Thoracic Surgeons) ACC@(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)– Median Post Procedure (days) and outcome (TAVR & MitraClip): In Hospital, 30 day observed and 3-year risk adjusted mortality. Risk adjusted Stroke rate	HVI	Quarterly
5	LAAO Registry™	ACC@(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per CMS indications; Proportion of LAAO procedures successful and medication strategy and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
6	AFib Ablation Registry™	ACC@(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
7	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for IsoCABG, IsoAVR and MV procedures. Composite quality rating (star rating) for IsoCABG, IsoAVR and MV procedures	HVI	Quarterly
8	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
9	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDI/F; HRS/A; CRE; VRE Associated Surveillance: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP	Quality; Nursing EW&HS	monthly Yearly
10	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards.	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
11	PVI Registry™	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Provide national benchmarks and risk adjusted outcome of carotid artery stent, carotid endarterectomy and low extremity peripheral artery intervention procedures.	Assesses the prevalence, demographics, management and outcomes of patients undergoing lower extremity peripheral arterial catheter-based interventions and includes carotid artery stenting (CAS) and carotid endarterectomy (CEA).	HVI	Quarterly
12	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
13	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality Indicators	Quality; Neuro	quarterly
14	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
15	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
16	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
17	California Maternity Quality Care Collaborative (CHQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
18	California Perinatal Quality Care Collaborative (CPOCC)	Hospital Collaborative	Perinatal Outcomes	Outcomes	Perinatal	Monthly
19	California Alliance for Nursing Outcomes	CALNOC	Actionable information and research on nursing sensitive quality indicators	Nursing Indicators	Nursing	Quarterly
20	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit level	Nursing indicators	Nursing	Quarterly
21	National Surgical Quality Improvement Program (NSQIP)	American College of Surgeons	Leading nationally validated program to measure and improve the quality of surgical care. Provides opportunity to prevent complications, save lives, and reduce costs.	Risk adjusted, case-mix adjusted mortality and complications based on 30 day outcomes.	Quality	Rolling continuous data abstraction
22	American Joint Replacement Registry	American Association of Orthopedic Surgeons	Hip and Knee Replacement Case Profile data, Risk Assessment data, and Outcomes data	Case data including implants, comorbidities, hospital complications. Patient reported outcomes Survey data from HOOS JR, KOOS JR, and PROMIS-10	Ortho Director	Rolling submission with PRO data drawn
23	The Joint Commission - Disease Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
24	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	Outcome (part of STS) risk adjusted mortality and stroke rate. Comparison with all other CA hospitals	HVI	biannually
25	Santa Clara County-AMI and Cardiac Arrest	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome. Biannually County meeting	HVI	Quarterly
26	National Cancer Data Base	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Registry	Annually
27	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Registry	Monthly
28	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
29	Hospital Based Inpatient Psychiatric Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
30	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
31	Parkinsons Registry	California Department of Public Health			HIMS Coding	Every month
32	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly

**EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO**

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services; Erica Osborne, Via Healthcare Consulting
Date: September 8, 2020
Subject: Quality Committee Self-Assessment Review

Purpose: To discuss the results of the Committee Self- Assessment and reach consensus on two “Committee Self- improvements” the Committee as a whole (1) would like to achieve in FY21 and (2) what measures it will take to achieve them.

Summary:

1. **Situation:** Every other year the El Camino Hospital Board’s Advisory Committees participate in a Self-Assessment. In late June, eight of thirteen committee members responded to a survey administered by Via Healthcare Consulting. The survey consisted of 15 questions and an opportunity for open ended responses.
2. **Authority:** The Governance Committee Charter provides that it will ensure that each Committee participates in a biennial self-assessment.
3. **Background:** Governance best practices call for boards and their committees to regularly evaluate performance and adopt improvements to fulfill their duties and responsibilities more effectively. This type of governance assessment can help a committee ensure that its structures, composition, policies and practices provide a platform for thorough oversight and deliberation, effective policy making, efficient decision making, and strong ties with and accountability to the board, the community and external regulators.
4. **Assessment:** The attached report provides a summary of the findings that were identified during the process and includes recommendations for the committee’s consideration.
5. **Other Reviews:** The Governance Committee also reviewed each of the Committee Self-Assessment reports and agreed that there is an opportunity for more robust communication between the Board and the Committees.
6. **Outcomes:** N/A

List of Attachments:

1. Quality Committee Self-Assessment Report and Executive Summary

Suggested Committee Discussion Questions:

1. Do Committee members who did not participate in the survey have the same or different perspectives from what is shown in the results?
2. What improvements would the Committee like to focus on for FY21?
3. What measures should the Committee take to achieve those improvements?



2020

**Quality, Patient Care and Patient
Experience Committee
Self-Assessment Report**

Prepared by



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Committee Self-Assessment Survey Results	5

Introduction and Executive Summary

In the interest of enhancing its committee effectiveness, members of the El Camino Hospital (ECH) Quality, Patient Care and Patient Experience Committee (QC) participated in a committee self-assessment process in the summer of 2020. Erica Osborne, Principal at Via Healthcare Consulting, provided the consulting and analysis for this effort. This report provides a summary of the findings that were identified during the process and includes recommendations for the committee's consideration.

Governance best practices call for boards and their committees to regularly evaluate performance and adopt improvements to fulfill their duties and responsibilities more effectively. This type of governance assessment can help a committee ensure that its structures, composition, policies and practices provide a platform for thorough oversight and deliberation, effective policy making, efficient decision making, and strong ties with and accountability to board, the community and external regulators. In today's rapidly changing marketplace, effective and efficient governance has never been more important to organizational performance.

Executive Summary

QC members believe the committee has worked hard over the last year to improve its performance and create greater alignment with the board on what constitutes effective quality and safety oversight at ECH. The key areas of strength include:

- Most members agree or strongly agree the QC chair provides effective leadership and direction during meetings as indicated by the highest rated survey score of 4.50.
- The current QC composition is believed to be appropriate and includes an appropriate mix of skills and perspectives.
- All members agree they understand their roles and responsibilities as specified in the charter and most believe they are effectively carrying them out.
- The current meeting frequency and duration is appropriate and allows the QC to fulfill its responsibilities.

While several members commented that there has been improvement, both the survey scores and comments indicate that members believe there is still significant room for improvement. It is also worth noting that the QC committee members consistently rated this committee's performance lower than the mean scores of the other ECH Board committees.

The assessment identified the following opportunities for improvement:

- To promote more robust discussion and the enhance committee's ability to make informed decisions, members would like additional relevant and contextual information to be provided in the meeting packets.
- There is a need for clear articulation of what is being asked of committee members for each of the topics covered (i.e., What does the committee need to accomplish and how does this relate to their responsibilities?)
- Restructuring of presentations would promote open discussion rather than the review of facts on a slide.
- Several members indicated the need to enhance communication between the committee and the executive team. At times, the relationship between the two hinders the committee's ability to effectively serve the board and the organization.

These assessment results will be discussed with committee members at the September 2020 committee meeting. It is important to note that this assessment process was designed to gauge the effectiveness and efficiency of the committee as a whole, not of the individual committee members. In addition, it was focused on the governance of the organization, not its management or operations.

Overview of the Process

A customized committee assessment was administered via the Microsoft Forms online survey tool. Committee members were asked to rate their level of agreement with 15 statements of committee effectiveness using a scale of 1-5 – from strongly agree to strongly disagree. The self-assessment also invited open-ended responses. Eight out of 13 QC members responded.

Recommendations

Based on the results of the 2020 ECH Committee Self-Assessment Process and our extensive experience in the area of governance effectiveness, Via Healthcare Consulting recommends ECH consider the following recommendations. In addition, additional education topics requested are listed.

RECOMMENDATIONS

1. Board and committee leadership should engage the executive team in developing a more effective mechanism for communication between the board and committees (*Please note this is also included as a recommendation on the Board self-assessment*).
 - Committee Chairs (or Committee Vice-Chairs when the Chair is a non-board member) should work with staff to create a more robust report out on board actions. These reports could include frequent updates on ECH strategic goals, priorities and drivers to better inform the committee's work as well as feedback on the committee's performance and the board's rationale for accepting or rejecting committee recommendations.
 - Committee members should participate in the semi-annual Joint ECH Board and Committee Educational Sessions scheduled for October 2020 and April 2021. At these meetings the CEO can provide updates on progress against the current strategic plan and information on the new strategic process.
2. Continue to refine meeting materials to promote robust discussions that actively engage members in providing a true value-add to the oversight of quality and safety at ECH.
 - Include sufficient relevant and contextual information to appropriately orient the committee to the issues being considered.
 - Clearly define each agenda topic's purpose, its relation to the committee's responsibilities, and how members can use the information to provide value.
 - Call out strategic considerations and key takeaways for each agenda item.
 - Include thought-provoking questions to help focus discussions on key issues that require deliberation.
 - Restructure presentations so they promote open discussion rather than the review of facts on a slide.
3. Consider the need for a facilitated discussion with the executive team to address committee members' concerns regarding the current dynamic and its impact on the committee's effectiveness. The objective should focus on building trust and promoting greater collaboration between the two parties

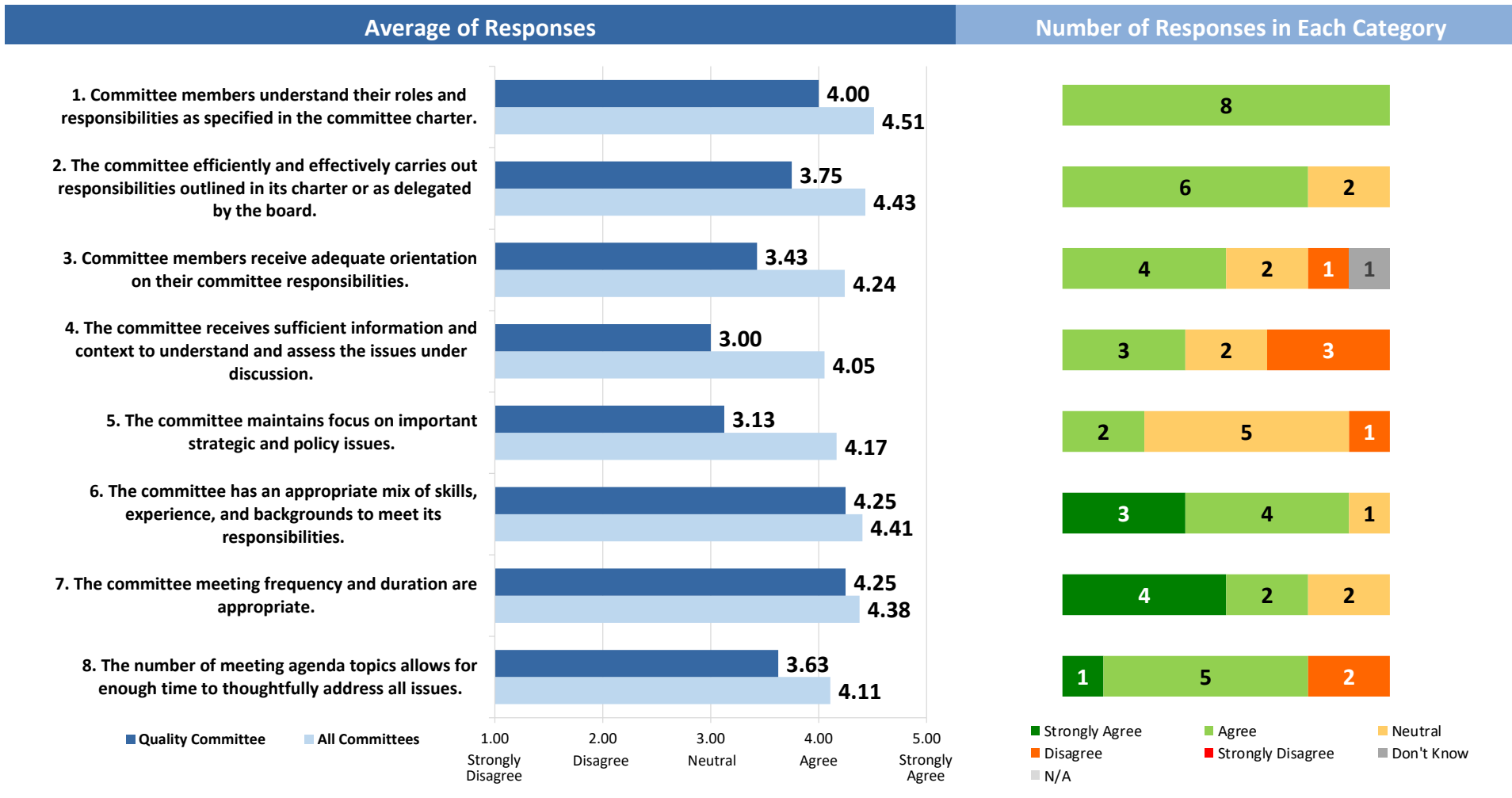
ADDITIONAL EDUCATION TOPICS TO BE COVERED OVER THE NEXT YEAR:

1. Effective governance for board committees
2. High reliability in healthcare
3. The culture of safety in healthcare
4. What "best practice" governance looks like from the perspective of some other organizations- particularly for peer review, credentialing, and discussions

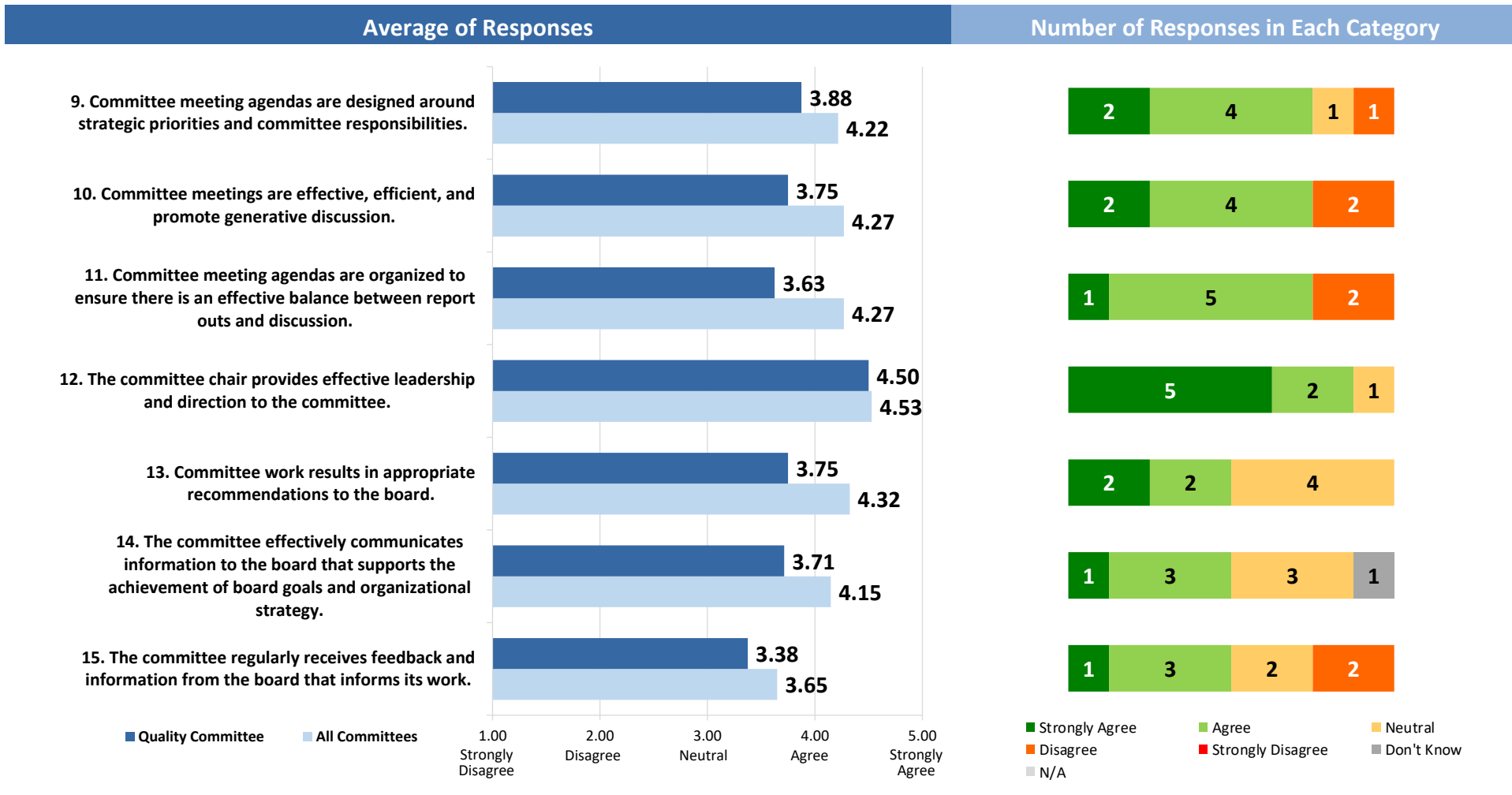


Committee Self-Assessment Survey Results

Quality, Patient Care and Patient Experience Committee Self-Assessment Results



Quality, Patient Care and Patient Experience Committee Self-Assessment Results



Summary of Comments for Committee Performance Improvement:

- The Quality Committee (QC) is required to review certain items and make recommendations to the Board for approval. Relevant contextual information for some of those items isn't always available. This has been brought up at the meetings several times. These items are often reviewed and discussed at length at other more specialized/technical committees before coming to the QC, and a summary of the discussions/decisions is seldom included as part of the QC. Given that the QC meeting may not be the best forum to repeat the detailed review already done as there is not enough time and not the same deep expertise as the technical committees, providing some context and summary of what the experts discussed and concluded would greatly enable the QC members to make an 'informed' recommendation to the Board.
- Most data provided to the QC has been reviewed already by relevant hospital committees and departments. Seeing documentation of those discussions along with their interpretation of the data is helpful to understand what has been discussed regarding this data by others closer to the work. Hearing from more service line leadership, those who are closest to the work, would help provide more context for the data, interventions to improve the data, and their point of view on how the QC can best support their work in our role.
- I think the committee could be more effective if we focus each meeting on a few focus areas, have more concrete problem statements upfront (or at least, "what is the committee trying to accomplish" statement), and then spend time considering some open-ended questions rather than just reading/reviewing information on a slide. This would provoke more discussion and lead to us aligning on solutions/ideas/etc. Those solutions should be written down and proposed or presented to the Board (depending on what our objective was from the problem statement). We should leave every meeting knowing that we made an impact because we sat together for three hours.
- Pulling out to the big picture goal more often. We discuss numbers/statistics/evaluations in the context of performance, but don't spend much time (1) aligning on what we're trying to accomplish, and (2) open-ended discussing of how we might accomplish it, which ultimately feeds into the improvement of the numbers/statistics/evals in performance. Otherwise, we're just reading off information that is already fact.
- Agenda appears at times chaotic. There are more reporting and insufficient time for discussions. The materials do not appear to be around the strategic responsibilities of the QC and to the Board. There was no feedback information loop back to the committee members.
- I'd appreciate more closed loop communication from the board - e.g., how did they react to our recommendations, what questions did they have, what would they like us to focus on next?
- I'm not sure how the Board perceives our effectiveness. I don't know if we get that feedback from them, or what success looks like for our committee. I just don't know if this sort of thing is socialized.
- At times, interactions between the Committee and the hospital executives hinders QC from being more effective in its service of the Board and of the Health System. It needs to be examined and improved. There's an 'us' vs. 'them' dynamic that is not conducive to the partnership that is needed to work together to improve quality. Executives are often on the defensive and dismissive of concerns or questions brought by the members of the Committee. The tone of the meeting is often tense. It doesn't feel like we are all on the same team, working together in earnest to examine the organization's weaknesses with the goal of improving the quality of care for our patients and families.
- This year has been a big one for this committee, and I feel like we are working more in lockstep with the board, and better understand what the board asks and needs of us. To strengthen that further, we could support and challenge management to develop a set of leading and lagging indicators that indicate the degree to which ECH is succeeding on its journey to be a high reliability organization. The current STEEP dashboard is a good start, but leaves something to be desired. In addition, we need to maintain focus on how ECH is keeping patients safe in the context of the public health emergency and further integrate the ambulatory operations of ECH.

- I think the committee has evolved over the last year and is much higher performing and more effective. When possible, doing more team building and socializing would be welcomed.
- I was disturbed by the lack of skill and insight management has brought to the question of health equity. I hope this will be addressed in the very near term, particularly as ECH is a district hospital.
- Some of the committee members sometimes ask questions that are too operational/detailed. We should figure out how to better stay in the governance level.
- Additional member training may be necessary.

Suggestions for Additional Education:

- I think the committee would benefit from education regarding effective governance for board committees, high reliability in healthcare, and culture of safety in healthcare.
- I would welcome the opportunity to see what "best practice" governance looks like from the perspective of some other organizations - particularly for peer review, credentialing, and discussions.
- I'd appreciate more closed loop communication from the board - e.g., how did they react to our recommendations, what questions did they have, what would they like us to focus on next?
- Most data provided to the Committee has been reviewed already by relevant hospital committees and departments. Seeing documentation of those discussions along with their interpretation of the data is helpful to understand what has been discussed regarding this data by others closer to the work. Hearing from more service line leadership, those who are closest to the work, would help provide more context for the data, interventions to improve the data, and their point of view on how the Committee can best support their work in our role.