El Camino Health

AGENDA

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

Monday, October 5, 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** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (09/08/2020) ***Information*** b. Progress Against FY21 Committee Goals c. Hospital Update d. Report on Board Actions e. Quality Committee Follow-Up Tracking	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:39**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**discussion 5:39 – 5:44**
6.	**FY21 ORG. GOAL AND QUALITY DASHBOARD METRICS** **ATTACHMENT 6**	Mark Adams, MD, CMO	*public comment*	**motion required 5:44 – 6:04**
7.	**FY20 ORG. GOAL ACHIEVEMENT (QUALITY, SAFETY, HCAHPS)** **ATTACHMENT 7**	Mark Adams, MD, CMO	*public comment*	**motion required 6:04 – 6:24**
8.	**HEALTH EQUITY** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:24 – 6:44**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:44 – 6:47**
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:47 – 6:48**

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
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:48 – 6:49**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 6:49 – 6:50**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (09/08/2020) ***Information*** b. Quality Council Minutes			
13.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:50 – 7:00**
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 7:00 – 7:10**
15.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:10 – 7:11**
16.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:11 – 7:12**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
17.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:12 – 7:17**
18.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:17 – 7:18**

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Tuesday, September 8, 2020
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Julie Kliger, Chair**	**Terrigal Burn, MD**
George O. Ting, MD, Vice Chair**	
Alyson Falwell**	
Melora Simon**	
Krutica Sharma, MD**	
Jack Po, MD**	
Michael Kan, MD	
Apurva Marfatia, MD	****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 5:33pm by Chair Kliger. A verbal roll call was taken. Terrigal Burn, MD was absent. All other members were present. Michael Kan, MD and Apurva Marfatia, MD were 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.	
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. Chair Kliger pulled the ED Patient Satisfaction for discussion. She questioned why there was a drop in Likelihood to Recommend (LTR) during February and December. Cheryl Reinking, CNO, explained that when the pandemic began in February the hospital had to restrict patients' family members from staying with them in the emergency room which most likely contributed to the drop in score. She also explained that December is typically one of the busiest times of the year, and patients do experience longer wait times. It is normal that there is a reduction in the patient experiences scores during this time. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (06/01/2020) and Minutes of the Open Session of the Quality Committee Meeting (08/03/2020); For information: FY20 Quality Dashboard, Progress Against FY21 Committee Goals, Hospital Update, Pacing Plan, Report on Board Actions, ED Patient Satisfaction, and Quality Committee Follow up Tracking. **Movant:** Po **Second:** Sharma **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Consent Calendar approved***

DRAFT

4. PATIENT STORY	Cheryl Reinking, RN, CNO, presented a Patient Story. She stated that the hospital received an anonymous letter from Press Ganey from a patient's experience at the Cancer Center. This patient felt unsafe and did not believe the staff was following COVID-19 protocols. Management has taken action to make changes in the Cancer Center to include designing the waiting areas to now be marked six (6) feet apart and patients will now have to wait in their cars until they are called in. In addition, training was done with the staff to ensure they explain to patients how important these protocols are to their safety. In response to a committee member's question, Ms. Reinking stated that management is monitoring the new protocols as leader rounding is expected to include that area to ensure these standards are in place.	
5. PATIENT EXPERIENCE (PATIENT GRIEVANCES AND PATIENT LETTERS)	Cheryl Reinking, RN, CNO, presented Patient Experience (Grievances and Patient Letters). She explained to the committee members that "complaints" are what are considered resolved at the time of complaint and "grievances" are what is not resolved and followed up with a written letter. Grievances are auditable and will need to show documentation of resolutions. Ms. Reinking stated there was a downward trend in grievances over the last year, and by classification, clinical care is at #1 with over 70%. Reasons vary such as medication issues, billing issues, etc. Management has taken initiative to make some improvements in lowering these scores to include implementing a new tool last month (RL Solutions) to track and trend data over time. In regards to patient letters, Ms. Reinking stated that the hospital averages about 40 letters per month with 92% being positive and 3% being negative. During COVID, it increased to about 100 per month, but mainly to show gratitude to healthcare workers. In response to committee members' questions, in regards to billing issues that affected the patient experience score, Ms. Reinking explained that patients may have received bills for tests that the patients don't remember having or didn't expect to have. In addition, Ms. Reinking stated that hospital uses discharges for the calculations for the percentage in emergency department grievances. However, Dr. Ting stated those calculations could be a problem for inpatients and suggested it could be beneficial to calculate in other ways. Ms. Reinking agreed. Ms. Reinking also stated that SVMD does their own complaint management and are not included in these numbers, but outpatient facilities are included. Dr. Sharma suggested adding any metrics for average time for response and trends in grievances.	
6. PROGRESS ON QUALITY AND SAFETY PLAN	Mark Adams, MD, CMO, presented the Progress on Quality and Safety Plan. He emphasized that the plan starts with governance leadership and management. It starts with the governing body to ensure all leaders understand the plan using the STEEEP construct. He stated that the metrics are what the committee sees in the enterprise quality dashboard every month, and the outcomes are the goals/metrics. The enterprise quality council has been brought together where all the work and quality plan gets put into place and ultimately ends up at the board. Dr. Adams stated that management huddles have been completely redesigned with safety as the number one topic. Another continued goal is readmissions. Management has set a three year goal for the readmission index target to be .90. Dr. Adams also stated that management will also be bringing medical staff and physicians to the forefront of quality improvement as each enterprise chair has been tasked to commit to quality improvement programs for their department.	

	In response to a committee member's questions, Dr. Adams stated that these goals are enterprise wide. He also stated that most of the employee that have contracted COVID-19 have been infected in the community and not in the healthcare settings. Dr. Ting commented that he was really impressed with the report. He expressed an interest in seeing what is found in readmissions rates instead of the process of how the rate was found.	
7. QUALITY COMMITTEE SELF-ASSESSMENT REVIEW	Chair Kliger presented to the committee the results of the Quality Committee Self-Assessment. She stated that eight members took the survey and is still available to those who have not taken the survey. She felt that some of the opportunities that have come forward were the request for relevant context and background so that the committee members will have a deeper understanding of the data. She stated that it is expected that every member reads the materials and for executives not to reiterate the materials already presented	
8. PUBLIC COMMUNICATION	There was no public communication.	
9. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:45pm. **Movant:** Ting **Second:** Kan **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Adjourned to closed session at 6:45pm***
10. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:31pm. Agenda items 10-16 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), Minutes of the Closed Session of the Quality Committee (08/08/2020), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
11. AGENDA ITEM 17: CLOSING WRAP UP	There were no closing comments.	
12. AGENDA ITEM 18: ADJOURNMENT	**Motion:** To adjourn at 7:32pm. **Movant:** Simon **Second:** Falwell **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Meeting adjourned at 7:32pm***

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

Prepared by: Yurike Arifin

El Camino Health

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

El Camino Health

Hospital Update
June 1, 2020
Mark Adams, MD, CMO

Operations

ECH is one of the first hospitals in the US participating in the TRILUMINATE clinical research study, sponsored by Abbott. The primary purpose of this study is to evaluate safety and effectiveness of the Tricuspid Valve Repair System (TVRS) for treating symptomatic moderate or greater tricuspid regurgitation (TR) in patients currently on medical management and who are deemed appropriate for percutaneous transcatheter intervention.

We began our extracorporeal membrane oxygenation (ECMO) program as a bridge to receiving a transplant, in the last 45 days. ECMO is a life support machine for patients with a severe and life-threatening illness that stops their heart or lungs from working properly. Patients needing an organ transplant or other care can be placed on ECMO here at ECH and then transferred to another facility that provides those services.

The Los Gatos Infusion Center opened on April 27th.

Our COVID-19 Incident Command Center is now closed and all duties have been distributed within our operations. We will continue to monitor COVID-19 cases in our community and reopen should the need arise.

Facilities

New move-in dates have been established for moving clinical departments into our new Mountain View campus buildings. Clinical departments will move into the Taube Pavilion on June 10th and into the Sobrato Pavilion on June 24th.

Workforce

ECH will continue to fund "kid's camps" at the Mountain View and Saratoga YMCAs for children ages 3-12 to support our essential staff members through what would have been the end of the normal school year. We also launched an assistance program (funded by $150,000 in donations to the ECH Foundation) to assist our employees who may be struggling financially due to the COVID-19 pandemic.

Since May 12, 2020 would have marked Florence Nightingale's 200th birthday, 2020 is the year of the nurse! We are very proud of Chief Nursing Officer Cheryl Reinking, RN, MSN, NEA-BC who is currently working on her Doctor of Nursing Practice (DNP) at the University of San Francisco. Cheryl's article, one aspect of her work towards her DNP, "*Nurses Transforming Systems of Care: The Bicentennial of Florence Nightingale's Legacy,*" was published in the May 2020 issue of Nursing Management.

Wednesday May 6th marked the beginning of the annual Nurse Week. Due to shelter in place orders, we were unable to celebrate with our original plans for the week; however, we were still able to recognize our staff.

The police and fire departments from jurisdictions throughout the El Camino Healthcare District arrived at the Mountain View campus at 3:30pm on May 6th with lights blazing and created a recognition "parade route" at the main entrance for all of our staff. Nurse week culminated on Tuesday, May 12th with roving cupcake carts delivered to all departments.

Corporate and Community Health Services

CONCERN EAP provided 15 webinars attended by 2,000 participants on topics including (1) Managing Anxiety and Stress and (2) Strategies for Remote Workers. Our Community Benefit staff administered a survey questionnaire to FY21 grant applicants to gather supplemental information as it relates to COVID-19 response efforts and engaged in discussions with current grant partners about new and changing community health needs related to the COVID-19 pandemic. We learned that our partners are rapidly pivoting the way they provide grant funded services to their clients and the community.

The South Asian Heart Center is providing virtual programs including TECH (Tuesday Evening Community Huddles) weekly on lifestyle topics, a nutrition workshop for the Aga Khan community (Ismaili branch of Shiite Islam) and a diabetes prevention program.

The Chinese Health Initiative ("CHI") staff coordinated with the ECH Foundation and Chinese community organizations for donations to the COVID-19 Emergency Response Fund. CHI initiated 2 weekly webinar series: (1) Healthy Lifestyle (diet, exercise, lifestyle medicine and emotional health), conducted by registered dieticians, a Lifestyle Medicine physician and a clinical psychologist and (2) a bilingual Qigong demo promoting physical activity.

RoadRunners is still drastically reducing their normal everyday rides to only medical appointments and grocery store runs due to the COVID-19 pandemic. We are still using Lyft for Behavioral Health clients who live out of service area. In March, RoadRunners/Lyft completed 544 rides, but only 157 rides in April.

The Health Library and Resource Center is closed to the public. We are however, taking consultation appointments by telephone for Eldercare, Medicare, Advance Healthcare Directive Assistance, Dietitian, and Pharmacist appointments.

Marketing and Communications

We launched an external interim COVID-19 campaign to patients and the community. This weekly e-newsletter featured articles and resources designed to help patients and the larger community during this challenging time. In April, we deployed three, each reaching: 57,000 El Camino Hospital patients, 12,000 SVMD patients, and 40,000 inactive patients (patients who have not had an encounter with us for at least 3 years). Staff continues email communications to SVMD and hospital patients informing them of the availability of virtual doctor visits, drive-thru testing, our enhanced safety precautions, and our respiratory clinic.

The El Camino Health Website has an updated COVID-19 page design with updated FAQs system, quick links, and clearer informational alerts. We also published 21 blog articles supporting HealthPerks and COVID-19 efforts, covering topics such as mental health, at-home activities, primary care services and general health tips.

Our team proactively facilitated several media stories including:

- NBC-11: Live interview with Dr. Lisa Packard on childbirth and COVID-19
- NBC-11: Interview with Brandi Fitzsimmons about grocery offerings in Café for employees (not yet aired)
- MV Voice: Interview with Mark Adams about the resumption of elective surgery (not yet published)
- Los Altos Town Crier: Interview with Kathryn Fisk about the YMCA Child Care Program and support for ECH workers (not yet published)

Philanthropy

During period 9 of fiscal year 2020, El Camino Health Foundation secured $2,494,585, bringing the total raised by end of March to $8,778,274, which is 114% of the annual goal. The majority of the period 9 gifts were to the rapidly launched El Camino Health COVID-19 Emergency Response Fund.

Auxiliary

Sadly, our Auxillians are still sheltering in place. However, we appreciate them helping us flatten the curve and we look forward to their return!

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality, Patient Care and Patient Committee
From: Cindy Murphy, Director of Governance Services
Date: October 5, 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 time we provided this report to the Quality Committee, the Hospital Board has met once and the District Board has met once. In addition, since the Board has delegated certain authority to the Executive Compensation Committee, the Compliance and Audit Committee and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	September 9, 2020	- FY21 Period 1 Financials - Medical Staff Report Including Credentials and Privileges Report - Appointment of Rich Juelis to the Investment Committee - Appointment of Wayne Doiguchi to the Finance Committee
ECHD Board	September 10, 2020	- Disbanded Compliance Issue Ad Hoc Committee
Executive Compensation Committee	N/A	- FY21 Executive Base Salaries - FY21 Executive Individual Performance Goals - FY20 Executive Individual Performance Goal Scores and Incentive Compensation Payments
Compliance and Audit Committee	N/A	
Finance Committee	N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

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 Health

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: October 5, 2020
Subject: Patient Experience Comments

Purpose: To provide the Committee with written patient feedback that is received via the Press Ganey HCAHPS Survey tool.

Summary:

1. Situation: These comments are regarding a patient with experience in the MV Maternal Child Health (MCH) Department at ECH received via the comment section of the Press Ganey patient experience survey too.

2. Authority: To provide insight one patient's experience in MV MCH.

3. Background: This patient was particularly commenting on her experience in Labor and Delivery at MCH MV. She commented on several of her nurses and how they provided her with support and encouragement through the labor process. She also discussed how the nurses explained things in a way she could understand. The patient had post-delivery complications and she was complimentary of the team's calmness while treating her complication.

4. Assessment: This is a positive review that is important to share with the MCH staff so they understand the difference they make in the lives of new mothers going through the birth journey. And, to reinforce to the staff those behaviors we are working to assure are consistently practiced in all areas of the organization such as explaining things in a way our patients can understand.

5. Other Reviews: None

6. Outcomes: These are positive comments we want to share with you and the entire healthcare team.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do you share this positive feedback with the staff?

2. How does this positive feedback exemplify the elements in the new WeCare program?

Press Ganey Comment
July 2020

I was there for so long because I was being induced so I met many nurses but there were 3 nurses in particular who stand out in my entire experience Susan, Marzan? (sorry if I spell her name wrong or got it wrong completely), and Valerie. Susan was so kind, compassionate, and made me feel like I could get through this. She was my nurse on Sunday and she made it a point on Monday night when I had my baby to stop by my room (even though she wasn't my nurse) to congratulate me and my husband. She made sure I knew that I did it and that is something I will never forget. Marzan- was so prepared and she explained everything to me. She had they room ready and like this baby is coming and you got this!! Even when I was in tears because I felt so defeated and I thought I couldn't do this anymore. She supported me and calmed me down. Right before her shift ended I was ready to push and she stayed a couple of minutes longer because she wanted to make sure my husband and I knew the best way to push. I was sad to see her leave but she did the BEST she could to prepare us and I will never forget that. Valerie- Was a rock star!! She was my nurse when I was ready to get this baby and she said, "lets do it!!" and we did!! She was there every step of the way with my husband and I. I had some complications after giving birth and she was so prepared and calm during the entire time. I felt like I would be ok because Valerie was there. Words cannot express how incredibly grateful I am for all these incredible woman who were by my side while I was on this life changing journey of pushing out a little human. Also I wanted to give kudos to the entire team who was there when my baby came out and when they were helping me through the hemorrhage complication obviously I don't remember everyones name but I am SO thankful for you all!!

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: October 5, 2020
Subject: FY21 Enterprise Quality, Safety, and Experience Dashboard

Purpose: Familiarize the quality committee with the updated FY21 enterprise quality, safety, and experience dashboard and seek input/suggestions for additions or deletions.

Summary:

1. Situation: The enterprise quality, safety, and experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics are selected based on a careful review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization.

2. Authority: This is an area of concern for the governing board as this directly and indirectly impacts the quality of the care delivered to El Camino patients.

3. Background: At the beginning of each fiscal year, an assessment is done to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added.

4. Assessment: Measures that have been dropped from the FY20 dashboard include HCAHPS Discharge Information and HCAHPS Responsiveness of Staff Domain because of conversion to likelihood to recommend as a more pertinent measure; and CAUTI and CLABSI which have been near zero or zero for many months. Remaining on the dashboard are readmission index, mortality index (now in top tier but needs to be monitored for any slippage), HCAHPS Likelihood to Recommend, Hospital Acquired Infections C. diff (CDI), Surgical Site Infections (SSI), Sepsis Mortality, Elective Delivery Prior to 39 weeks gestation, and C-section birth, and Patient Throughput ED. New additions are Serous Safety Event Rate (SSER), ED Likelihood to Recommend, and ECHMN (El Camino Health Medical Network) Likelihood to Recommend. The committee has requested consideration of possible COVID-19 metrics so a sample of those has been attached as well as the new dashboard. (Please recall that this dashboard is now included in the committee consent agenda each month.)

5. Other Reviews: None

6. Outcomes: The Quality Committee will review the new FY21 enterprise dashboard and provide feedback and suggestions for possible additions or deletions including consideration for possible COVID-19 metrics. This is a management dashboard but committee feedback is much appreciated. The quarterly Board STEEEP based dashboard will continue to be provided to the committee as well.

List of Attachments:

1. FY21 Enterprise Quality, Safety, and Experience Dashboard
2. Compilation of COVID-19 metrics for review and consideration

Suggested Committee Discussion Questions:

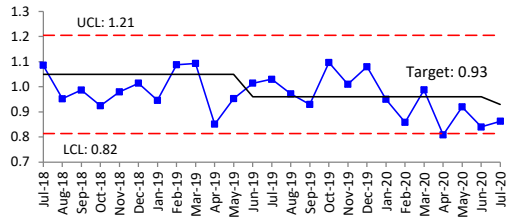
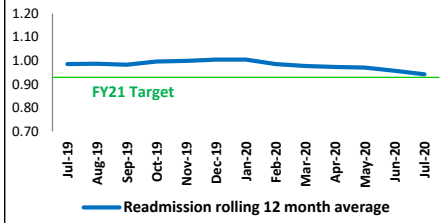
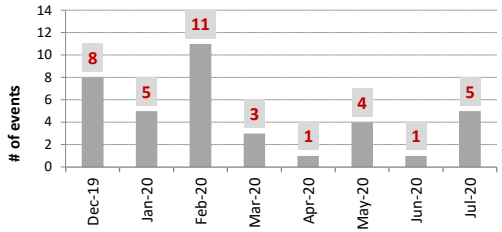
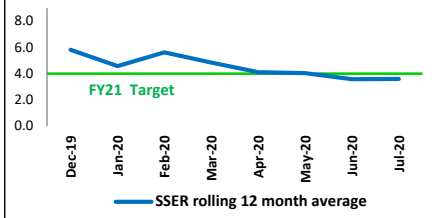
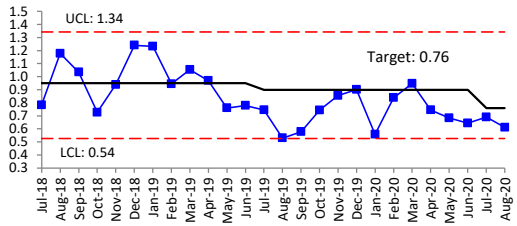
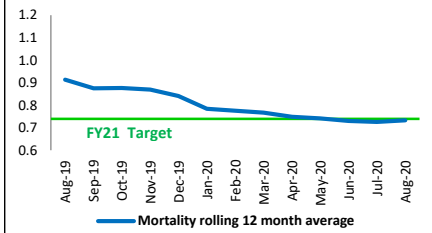
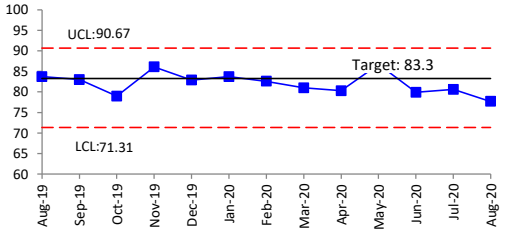
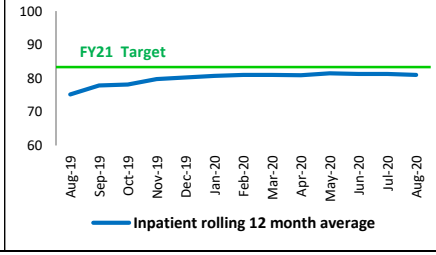
1. Based on committee members' experience, have we missed any key metrics for this dashboard?
2. Would the committee prefer to have periodic COVID-19 updates or should this be incorporated into the dashboard?

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

August 2020 (unless otherwise specified)

Month to Board Quality Committee:
October, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: July 2020*	0.86 (6.95%/8.06%)	0.86 (6.95%/8.06%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** **per 10,000 adjusted patient days** *Latest data month: July 2020*	3.75 (5/13335)	3.75 (5/13335)	3.78 (Dec 2019- Jun 2020)	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: August 2020*	0.61 (1.31%/2.14%)	0.65 (1.28%/1.98%)	0.74	0.76		
4	*Organizational Goal **Inpatient - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: August 2020*	77.7	78.4	82.8	83.3		

Definitions and Additional Information

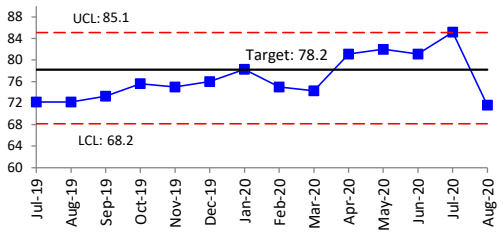
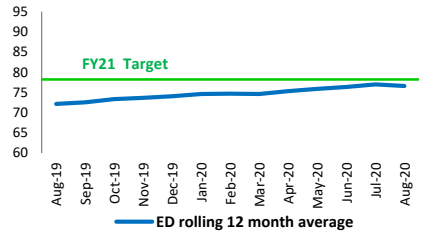
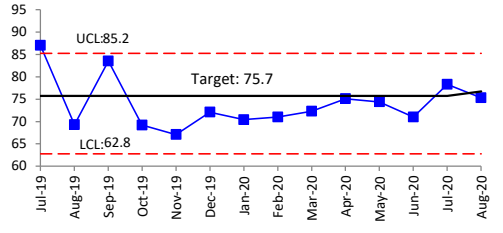
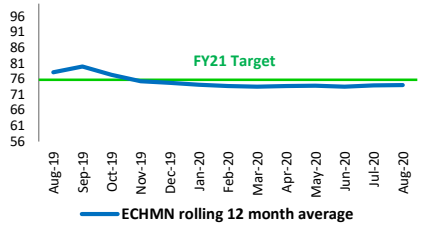
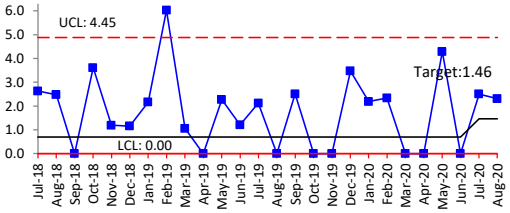
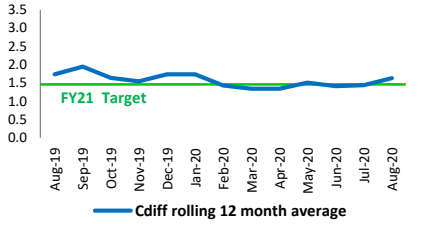
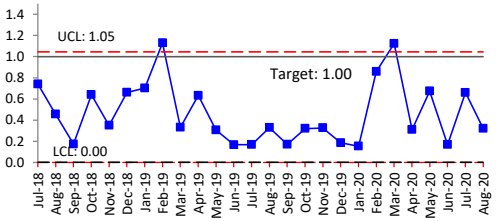
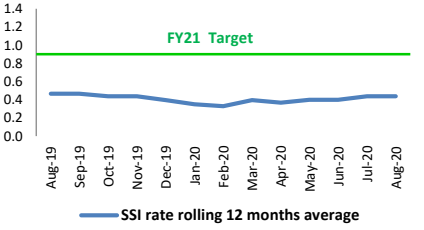
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)	The target for FY21 is 0.93, and the graph shows the drop in the target. The new Quality Goal teams to address Readmission Index got started in late July and August, and include: Weekly Readmission team, Cancer team, Post Acute Care Management team, Surgical Complications team, and Social Determinants of Health team. These teams are addressing issues that have worked previously; many readmits are cancer patients. and have surgical complications. ECH has not addressed issues with patients post acute care, and new ICD-10 coding for social determinants of health began in 2019. This team is mining data for opportunities to address issues that cause readmissions, such as food insecurity, and homelessness. Each team meets biweekly, with good results in the first month.	Catherine Carson	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). Includes Inpatient and Psych patients. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)	Serious Safety Events are classifications of adverse events that reach the patient and results in moderate to severe harm or death. A trained team of clinical leaders review all events that reach the patient that are found through mortality, sepsis, hospital-acquired infection, iSafe or through Peer review to classify each one into a serious safety event, a precursor safety event or as a near miss event. This new rate is only used internally at ECH as a barometer for the safety program and is not benchmarked against other hospitals. The objective is to reduce the serious safety events that reach our patient by correcting the issues found in the precursor safety events and preventing patient harm. The graph will change to a rolling 12-month graph after we have 12 months of data, this began in Dec. 2019,	Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI**
3. Mortality Index (Observed/Expected)	The new fiscal year target is at the Top Performers level for FY20 with Premier, and the lower target is reflected in the dip in the graph. Good physician documentation of co-morbid conditions existing in our patients and evidenced-based care provided contribute to this low observed rate and high expected rate.	Catherine Carson	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. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
4. Inpatient - HCAHPS Likelihood to Recommend Top Box Rating of 'Always' % , Unadjusted	Feedback tends to be around communication relative to procedure, delays, home care, and discharge information and process, poor treatment by some of the nurses and physicians, and cleanliness. Also, lack of visitation is a huge issue. Action: • WeCare training to help with consistency. 60% of leaders have received training. • Provide patient survey comments to leaders for their review and follow up • Leader- Patient and Staff Rounding by Nurse leaders and Ancillary leaders	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

August 2020 (unless otherwise specified)

Month to Board Quality Committee:
October, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal **ED Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: August 2020*	71.6	73.0	75.7	78.2		
6	* Organizational Goal **ECHMN (El Camino Health Medical Network): Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: August 2020*	75.3	76.9	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: August 2020*	2.31 (2/8649)	2.41 (4/16628)	1.46	<= 1.46		
8	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: August 2020*	0.32 (2/623)	0.49 (6/1229)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

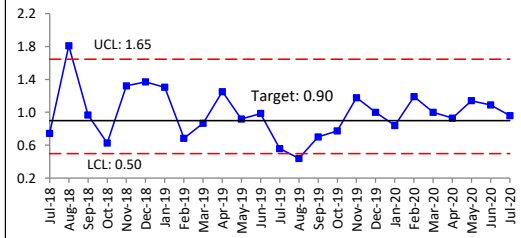
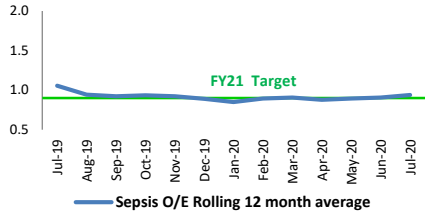
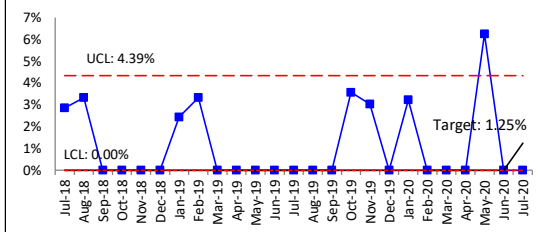
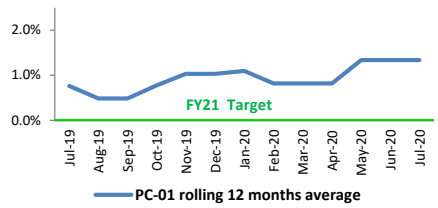
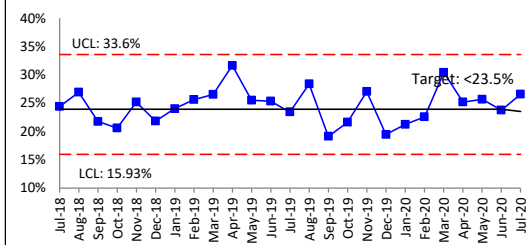
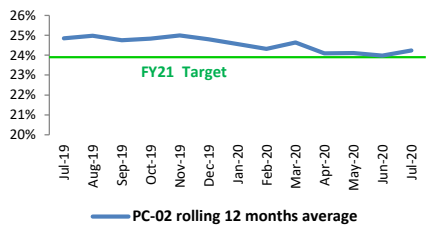
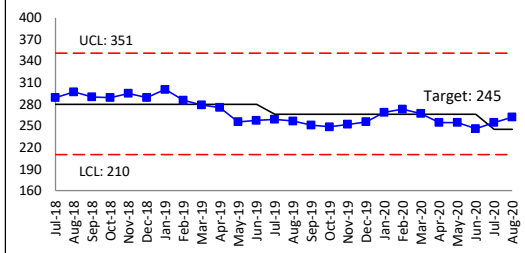
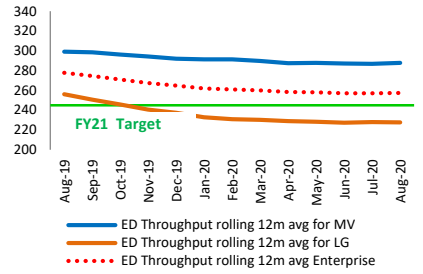
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
5. ED - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	Much of the July scores fall into August, which is when we stopped visitors in the ED again. There are issues with the waiting area and the perception of safety also dipped as people see the curtained off area of the waiting room. There are also issues with explaining wait times and delays to families members waiting outside and the smoke and heat added to this. Action: • Review texting options and offer to more patients • Train on WeCare behaviors • Work on increasing signage around safety and scripting of the registration staff on how to explain the safety measures in the ED • Review with facilities a plan for physical space	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
6. ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	Development of WeCare Training and launch end of October/November.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
7. Hospital Acquired Infection- C. Diff (Clostridium Difficile Infection)	August - MV: 2 (1-3B, 1-4B), LG: 0 FYTD - MV: 3, LG: 1 RCA events performed for HO C.Diff cases with direct care staff 1) 8/27 case: 66 yo acquired HO C.diff 22 days after admission. Risk factor: 27 doses of antibiotics due to infection. 2) 8/31 case: symptoms present on admission; Cdiff ordered on day of admission, specimen not collected until day 4. Actionable items: EPIC documentation : added row for CNAs to document stool description	Catherine Carson/Catherine Nalesnik	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN database - Inf. Control**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	**FY20 Target Met, better performance than last year** **Total SSI FY19: 37** **Total SSI FY20: 23, as of 8/20 FY21 6:** 1 - Robotic laparoscopy, TAH, BSO, readmitted in Sept. for drainage of pelvic abscess. 2 - Bilateral laminectomies, L4-5 & L3-4 Readmitted in Sept. for lumbar wound drainage.	Catherine Carson/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

August 2020 (unless otherwise specified)

Month to Board Quality Committee:
October, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: July 2020*	0.96 (10.68%/11.15%)	0.96 (10.68%/11.15%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) *Latest data month: July 2020*	MV: 0.00% (0/18) LG: 0.0% (0/9) **ENT: 0.00%** (0/27)	MV: 0.00% (0/18) LG: 0.0% (0/9) **ENT: 0.00%** (0/27)	MV: 1.47% (5/341) LG: 0.00% (0/48) **ENT: 1.29%** (5/389)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) *Latest data month: July 2020*	MV: 30.7% (43/140) LG: 20.00% (0/22) **ENT: 26.5%** (43/162)	MV: 30.7% (43/140) LG: 20.00% (0/22) **ENT: 26.5%** (43/162)	MV: 24.74% (412/1665) LG: 18.97% (48/253) **ENT: 23.98%** (460/1918)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Latest data month: August 2020*	MV: 276 min LG: 233 min **Ent: 255 min**	MV: 276 min LG: 233 min **Ent: 255 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

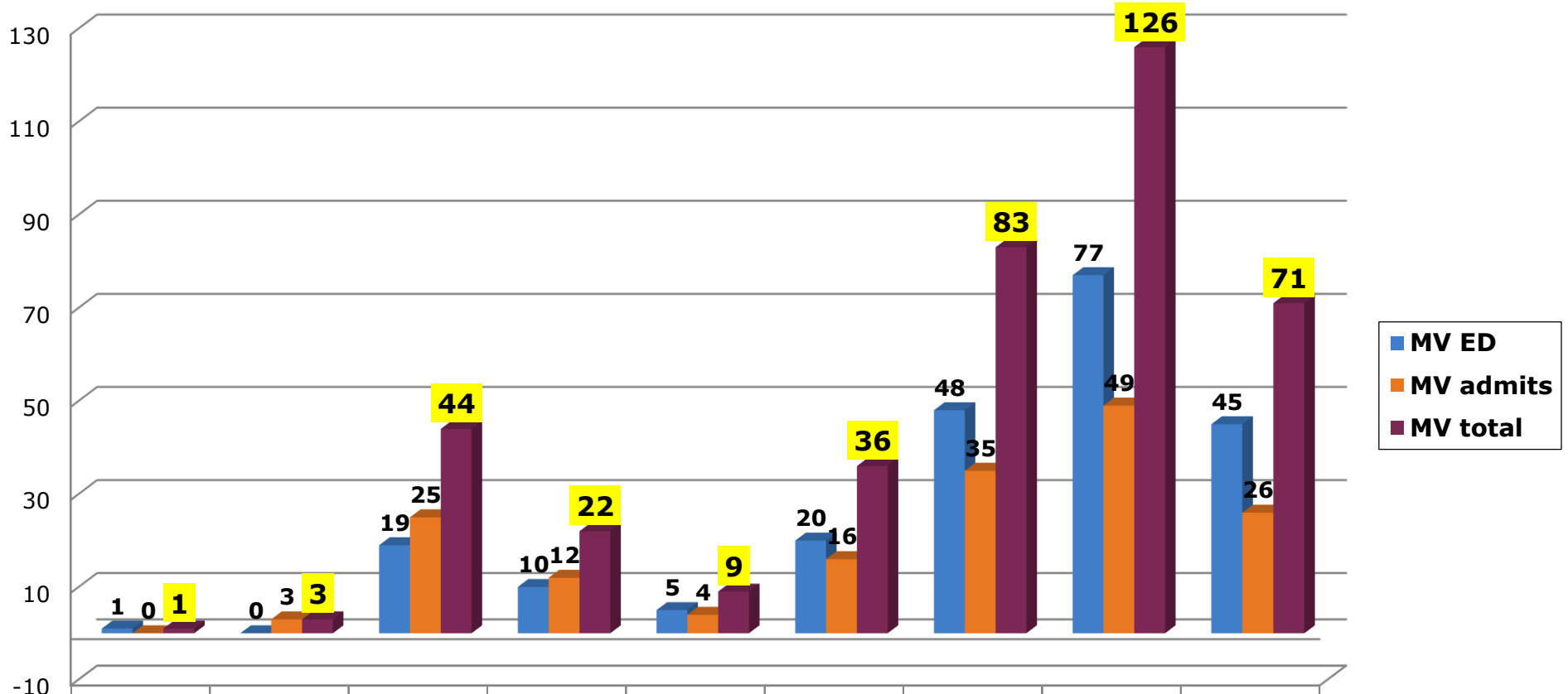
Report updated: 10/01/20

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
9. Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	The Sepsis mortality rate has dropped over the last 3 months. The Medicine Department Executive Committee has taken Sepsis and improving the Sepsis order sets for improved compliance with the bundle elements as their PI project for FY21. Smart phrases to improve physician documentation have been shared with medical staff and were revised by the ED physicians. September is Sepsis awareness month with 3 educational sessions provided to physicians and nurses.	Jessica Harkey, Catherine Carson	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). 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. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	All scheduled cases are reviewed proactively. Data is also reviewed retrospectively. o Re: FY21 Target: Some cases are completely reasonable, and should fall out but don't meet definition, so getting to zero is unlikely. After discussion with CMO, Target is revised to stay in top quartile, at 1.25.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Actions that will be starting or are in progress: o Launching OB improvement team this week (starting with small scoped issue of blood ordering process, then will focus on second stage of labor management). o Dr. Erogbogbo's work to debrief all deliveries is in process. o Identified MD outliers, will send data in the coming month and have a discussion with them. o Will have OB town halls to update on performance and learn about OB issues. o Working to ensure consistent review process—large volume of work and we don't have all the needed access yet. o FY21 target revised with CMO to 23.5%.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput-Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns	The Patient Throughput Value Stream for FY21 was kicked off with a 9 month scope of work focused on optimizing the Capacity Management Center and the entire patient throughput journey, from ED exit to ECH exit. Building on the success of last year, the targets for ED arrival through ED departure were decreased by 5%, to a new enterprise target of 245 min (median). This total is made up of three distinct buckets: 1) ED arrival to first MD consult, 2) Consult to Admit order and 3) Admit order to patient leaves the ED. This last bucket (#3) has a target of 45 minutes. Currently, the Enterprise admit order to ED departure is 56 mins FYTD which is 11 minutes above target of 45 mins. To address this gap above target, first set of work is focused on the patient Handoff and Transport process. We have posted positions for full-time Patient Flow Coordinators and the CMC is functional. Track and Status boards are up and optimized. The electronic SBAR handoff tool has been built and is in the EPIC sandbox environment, with planned go-live in mid-October.	Cheryl Reinking, Melinda Hrynewycz	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. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

COVID-19 Mountain View 395 Total Cases

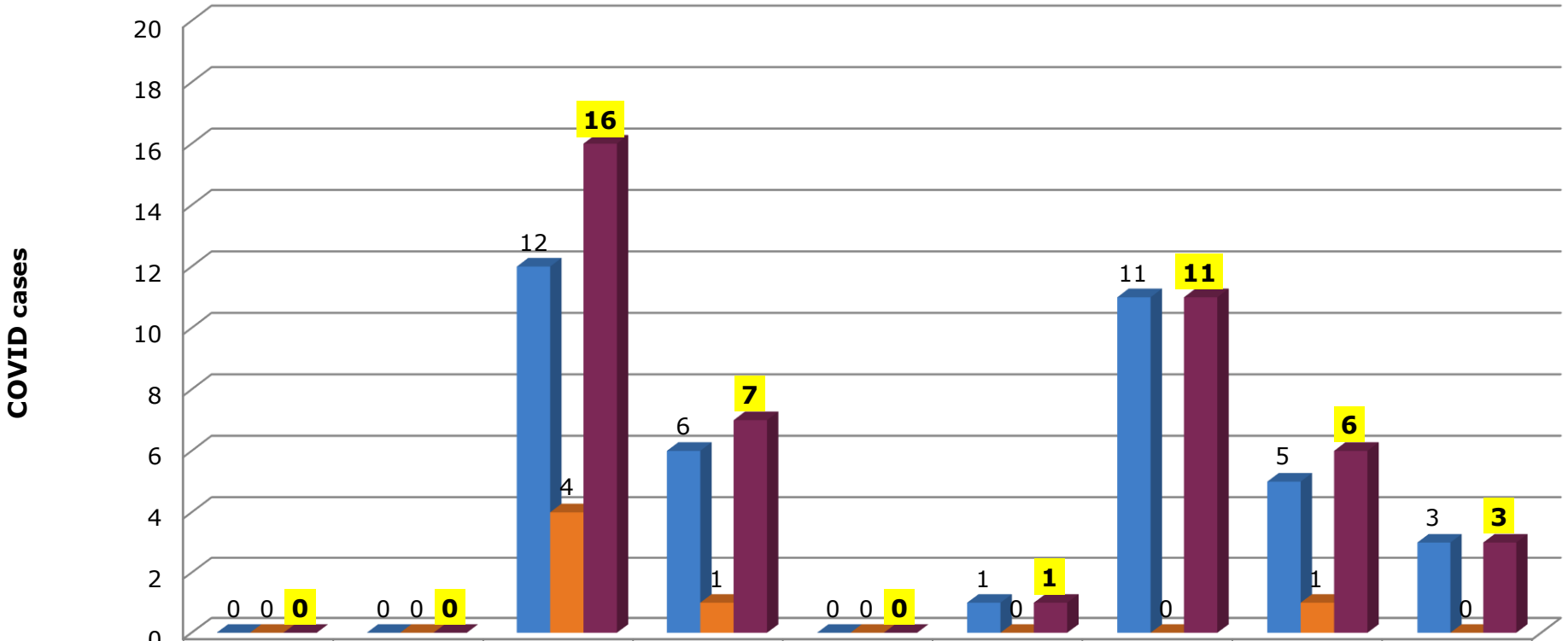
Admits: 170 ED only: 225 Deaths: 12



	January	February	March	April	May	June	July	Aug	Sep
MV ED	1	0	19	10	5	20	48	77	45
MV admits	0	3	25	12	4	16	35	49	26
MV total	1	3	44	22	9	36	83	126	71

El Camino Health

COVID-19 Los Gatos: 43 Total Cases
Admits: 6 ED only: 37 Deaths: 1

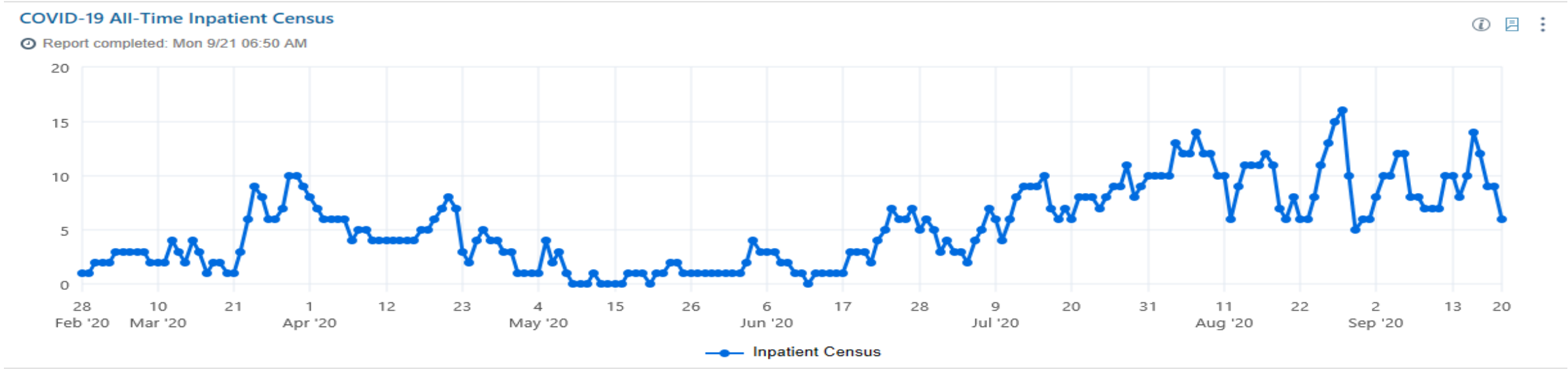


	January	February	March	April	May	June	July	Aug	Sep
LG ED only	0	0	12	6	0	1	11	5	3
LG admits	0	0	4	1	0	0	0	1	0
LG total	0	0	16	7	0	1	11	6	3

El Camino Health

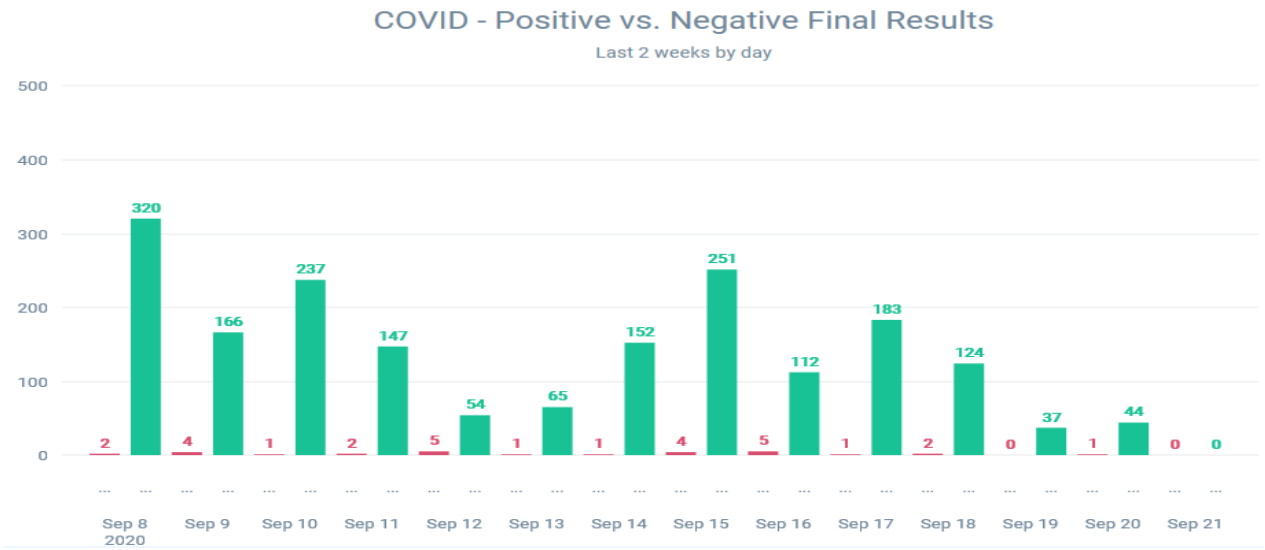
COVID Census

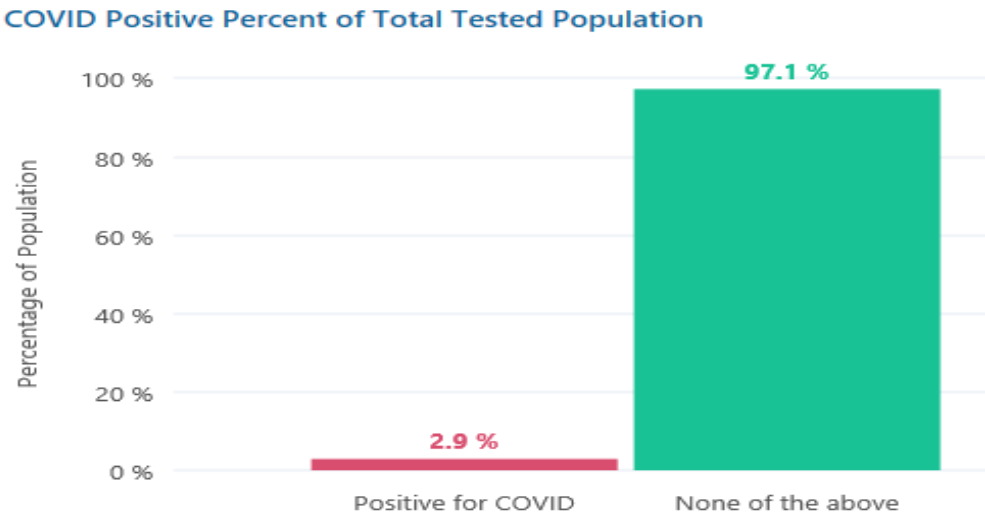
- Updated Definition: Patients with a COVID-19 Infection Status at Midnight



Trend of Patients with Final Labs

- Positive (Pink) vs. Negative (Green)
- By date of hospital or ED encounter
- Left is previous 2 weeks from today
- Right is percentage of patients who tested positive





El Camino Health

Pre-procedure Screening Results (positive only)

Month	April	May	June	July	Aug	Sep	Total
Positive cases	2	3	3	8	4	7	27

Employee COVID-19 exposures

- Confirmed conversions from employees exposed to COVID-19 patients: 3; 2 in March and 1 in July
- This represents a rate of 0.375 per month or 0.09% of the workforce
- Less than 20 over the same time period with community acquired COVID-19

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Mark Adams CMO
Date: October 5, 2020
Subject: FY20 Organizational Performance Goal Scores

Purpose and Recommendation:

Whereas the Board QC previously approved the quality, safety, and experience organizational incentive goals, they now have been modified to reflect the impact of the COVID-19 pandemic crisis. The measures have not been changed but the targets adjusted to an 8 month time frame. The QC is therefore asked to review these changes and take action as follows:

Requested motion: To recommend the Board 1) accept the modified target and stretch metrics pertaining to quality, safety, and experience as approved by the Executive Compensation Committee to reflect an 8-month goal period.

Summary:

1. Situation: In October 2019, El Camino Hospital's (ECH) Board of Directors approved FY20 Organizational Performance Goals for the Executive Performance Incentive Plan. The same goals and measures are used in the Management Performance Incentive and the Employee Engagement and Recognition plans. Due to the impact of the COVID-19 pandemic, the organization was forced to shift focus mid-year. On June 10, 2020, the Board approved (1) recalibration of the FY20 Organizational Performance Goals to an 8-month period ending February 2020 and (2) elimination of the People Goal with redistribution of its weight to the other goals.

2. Authority: The Quality Committee reviews and recommends to the Board the annual quality, safety, and experience incentive goals.

3. Background: In October 2019, when FY19 final results became available, we were able to set the baselines and the Board approved the minimum, target, and stretch metrics for the FY20 Organizational Performance Goals. In June 2020, the Board approved recalibration and elimination of the People Goal. Management's proposed approach to the recalibration as approved by the Executive Compensation Committee is described in the attached presentation.

The approach to recalibrate the metrics was presented to the Board on September 9, 2020**.**

4. Assessment: The proposed approach to recalibration reflects having 8 months (as opposed to 12 months) to achieve the goals and a higher overall score than without recalibration.

5. Other Reviews: The approach has been discussed with the executive team and the Board. Hospital associations and executive compensation consulting firms, including Mercer, have reported that other organizations are recalibrating goals in light of COVID-19.

6. Outcomes: FY 20 Executive Performance Incentive Payouts amounts are based on the organizational score and the individual goal scores approved by the Committee.

List of Attachments:

Recalibration explanation and methodology with actual values approved by the Executive Compensation Committee

El Camino Health

FY20 Organizational Performance Goals, Recalibration, and Proposed Scores

Board Quality Committee

Mark Adams CMO

October 5, 2020

Board-Approved Metrics, October 2019

STRATEGY	Weight	GOAL	OBJECTIVES/ OUTCOMES	Benchmark		Measurement Defined			Measurement Period
Finance	Threshold	Budgeted Operating Margin				95% of Budgeted			FY20
				Internal Benchmarks	External benchmarks	**Minimum**	**Target**	**Stretch**	
Quality and Safety	37.5%	Zero Preventable Harm	Risk-Adjusted Inpatient Mortality Index	1.05 in FY 18. 0.90 FY19 through 11/18. FY 19 actual: 0.97	Premier Standard Risk Calculation	0.95	0.90	0.85	FY20
			Risk-Adjusted Readmission Index	1.08 in FY 18. 1.00 through 11/18; FY 19: 0.99	Premier Standard Risk Calculation	0.99	0.96	0.94	
Service	37.5%	Exceptional Personalized Experience, Always	HCAHPS : Staff Responsiveness	65.1 through 12/18. FY19 goal 67.0; FY19 actual: 65.7	HCAHPS baseline: 65.1 (Q417-Q318)	65.7	67.1	69.7	FY20
			HCAHPS: Discharge Information	86.8 through 12/18; FY19 actual: 86.7	Improvement based on Press Ganey data for FY19 all hospitals	86.7	87.3	88.4	FY20
Growth	25.0%	Market Relevance and Access	Adjusted Discharges	Adjusted discharges 0.7% below budget through P8FY19. Planned growth is 4% in FY20		98% of Budget	100% of Budget	102% of budget	FY20

Approach to Recalibration of Metrics

- Proposed changes are based on making 8/12^{ths} of the targeted and stretch annual improvement during July 2019 - February 2020 (8 months)
- For example
  - Original Metric: Improve by 1.2 and 1.8 points at target and stretch
  - Recalibrated Metric: Improve by 0.8 and 1.2 points at target and stretch
- Recalibration was calculated if internal metric (readmissions, mortality) and using Press Ganey modeler if external metric based on % of improvers (service)
- Adjusted discharges did not require recalibration since used YTD February actual / budget

Proposed Recalibration Measurements

STRATEGY	Weight	GOAL	OBJECTIVES/ OUTCOMES	Benchmark		Measurement Defined			Measurement Period
Finance	Threshold	Budgeted Operating Margin				95% of Budgeted			YTD P8 FY20
				Internal Benchmarks	External benchmarks	**Minimum**	**Target**	**Stretch**	
Quality and Safety	37.5%	Zero Preventable Harm	Risk-Adjusted Inpatient Mortality Index	1.05 in FY 18. 0.90 FY19 through 11/18. FY 19 actual: 0.97	Premier Standard Risk Calculation	0.95	0.92	0.89	YTD P8 FY20
			Risk-Adjusted Readmission Index	1.08 in FY 18. 1.00 through 11/18; FY 19: 0.99	Premier Standard Risk Calculation	0.99	0.97	0.96	YTD P8 FY20
Service	37.5%	Exceptional Personalized Experience, Always	HCAHPS : Staff Responsiveness	65.1 through 12/18. FY19 goal 67.0; FY19 actual: 65.7	HCAHPS baseline: 65.1 (Q417-Q318)	65.7	66.6	68.3	YTD P8 FY20
			HCAHPS: Discharge Information	86.8 through 12/18; FY19 actual: 86.7	Improvement based on Press Ganey data for FY19 all hospitals	86.7	87.1	87.8	YTD P8 FY20
Growth	25.0%	Market Relevance and Access	Adjusted Discharges	Adjusted discharges 0.7% below budget through P8FY19. Planned growth is 4% in FY20		98% of Budget	100% of Budget	102% of budget	YTD P8 FY20

Summary of Recommended Changes

Mortality Index: Change Target from 0.90 to 0.92. Stretch from 0.85 to 0.89

Readmissions: Change Target from 0.96 to 0.97. Stretch from 0.94 to 0.96

Staff Responsiveness: Change Target from 67.1 to 66.6 and Stretch from 69.7 to 67.3

Discharge Information: Change Target from 87.3 to 87.1 and Stretch from 88.4 to 87.8

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: October 5, 2020
Subject: Health Equity

Purpose: Health Equity has been introduced into the enterprise quality definition represented by STEEEP. (Safe, Timely, Effective, Efficient, Equitable, Person centered care). The purpose of this agenda item is to introduce the topic more completely and facilitate a discussion with the committee regarding the role of El Camino Health in this area.

Summary:

1. Situation: One of the key components of the STEEEP definition of quality is equitable care. Health Equity is a complex topic despite the simple definition: "Everyone has a fair opportunity to attain their full health potential." In the Quality Committee self-assessment there was interest expressed regarding more attention to this topic.

2. Authority: This is an area of concern for the governing board as this directly and indirectly impacts the quality of the care delivered to El Camino patients.

3. Background: Health Equity means different things to different people. It is important that we have a common understanding of the definition of health equity along with related topics including health disparity, health inequity, health care disparity, social determinants of health, population health, and intersectionality.

4. Assessment: Health care per se is a small component of overall health. Other factors such as social determinants of health, behavior, and genetic predispositions weigh heavily on health outcomes. It is important to understand these factors when considering how to address health disparities. While there has been quite a bit of research on health disparities, much of it has been directed at areas with a much different demographic composition than Santa Clara County. This means that it is very important to first understand these differences since it is necessary to tailor any intervention to the locality. Included in the attachment background information is a case study example of how one organization in Washington State has approached this issue with help from the Robert Wood Johnson Foundation and AHRQ (Agency for Healthcare Research and Quality). I had an opportunity to work closely with this Alliance as one of their Board members representing the payers who helped fund it. (Funding was provided by county and city government, purchasers, and payers.) Collecting data is essential to be able to do this work. Once the assessment is completed, there is a defined roadmap to follow to effect change.

5. Other Reviews: None

6. Outcomes: The Quality Committee may be interested in encouraging the Board to become more invested in the promotion of health equity in our communities. Committee members may be able to provide insight and guidance to management based on their own experience.

List of Attachments:

1. Background material to pre-read to facilitate the discussion.

Suggested Committee Discussion Questions:

1. Have any of the committee members had experience in health equity work?
2. What is the role of El Camino Health in this area?
3. With a market share of only 14% in Santa Clara County, how do we develop other resources or partnerships to broaden our reach?
4. Hospital care is a small part of healthcare which is a small part of overall health. How might we consider becoming involved in the other factors that affect health such as the social determinants of health?
5. As an example, we are now focusing on social determinants of health in our readmission reduction efforts since that is one of the main drivers. Are there any suggestions for approaching this effectively?
6. What metrics should be applied to this work?

El Camino Health

Health Equity

Mark Adams, CMO

October 5, 2020

AGENDA

Definitions

Social Determinants of Health

Demographics

WA Health Alliance: Case Study

Roadmap to Achieve Equity

Role of El Camino Health

Definitions

Health Equity: Everyone has a fair opportunity to attain their full health potential

Health Disparity: difference in health outcomes between groups within a population

Health Inequity: differences in health outcomes that are systematic, avoidable, and unjust

Health care disparity: racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention

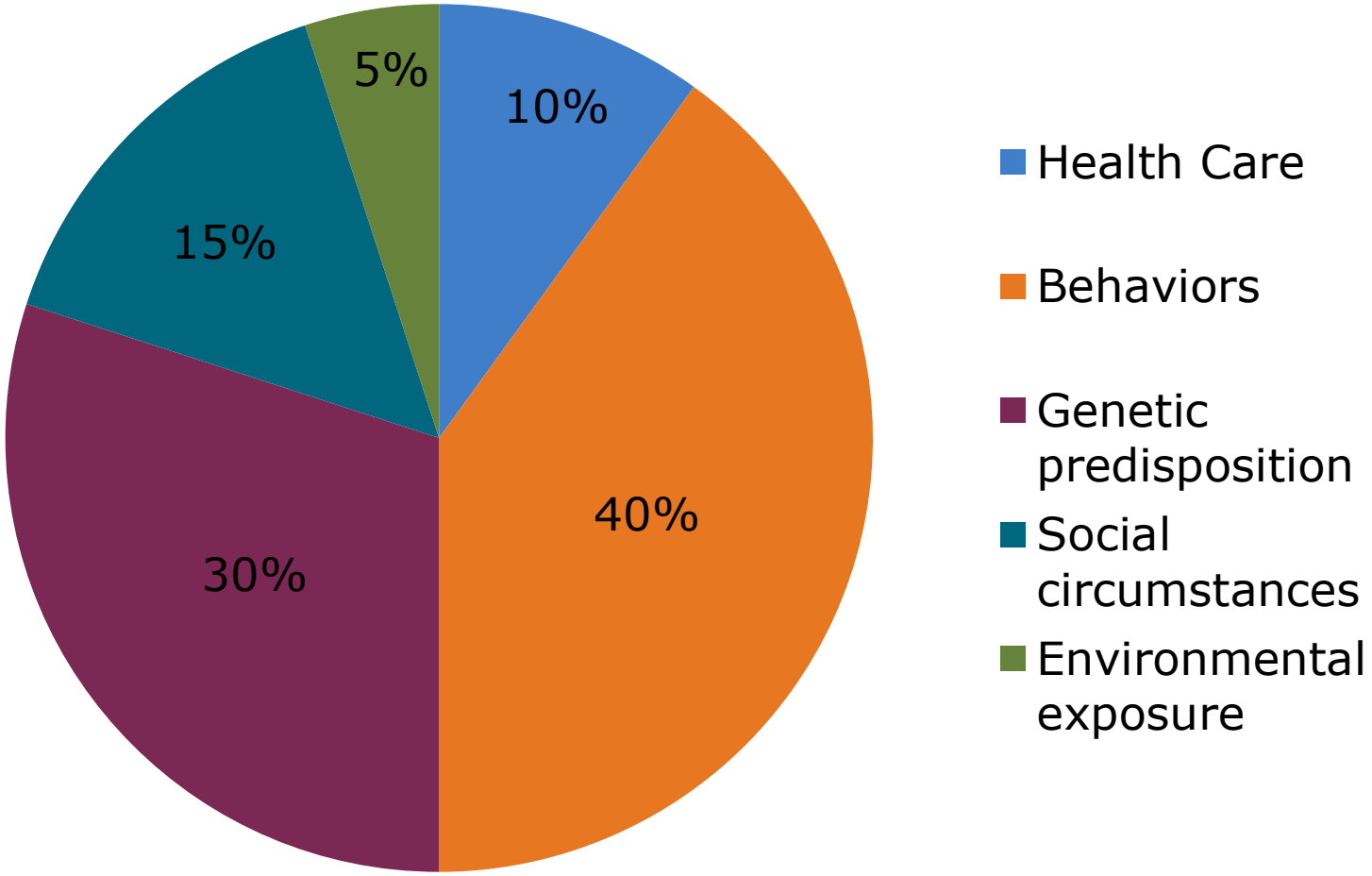
Definitions

Social Determinants of Health: the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness

Population Health: the health outcomes of a group of individuals, including the distribution of such outcomes within the group

Intersectionality: multiple social identities such as race, gender, socioeconomic status, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression

Premature Death Contributing factors



Social: employment, housing, transportation, and poverty

El Camino Health

Social Determinants of Health

- Economic Stability
  - Employment
  - Food Insecurity
  - Housing Instability
  - Poverty

Social Determinants of Health

- Education
  - Early Childhood Education and Development
  - Enrollment in Higher Education
  - High School Graduation
  - Language and Literacy

Social Determinants of Health

- Social and Community Context
  - Civic Participation
  - Discrimination
  - Incarceration
  - Social Cohesion

Social Determinants of Health

- Health and Healthcare
  - Access to Healthcare
  - Access to Primary Care
  - Health Literacy

Social Determinants of Health

- Neighborhood and Built Environment
  - Access to Foods that Support Healthy Eating Patterns
  - Crime and Violence
  - Environmental Conditions
  - Quality of Housing

Social Determinants of Health

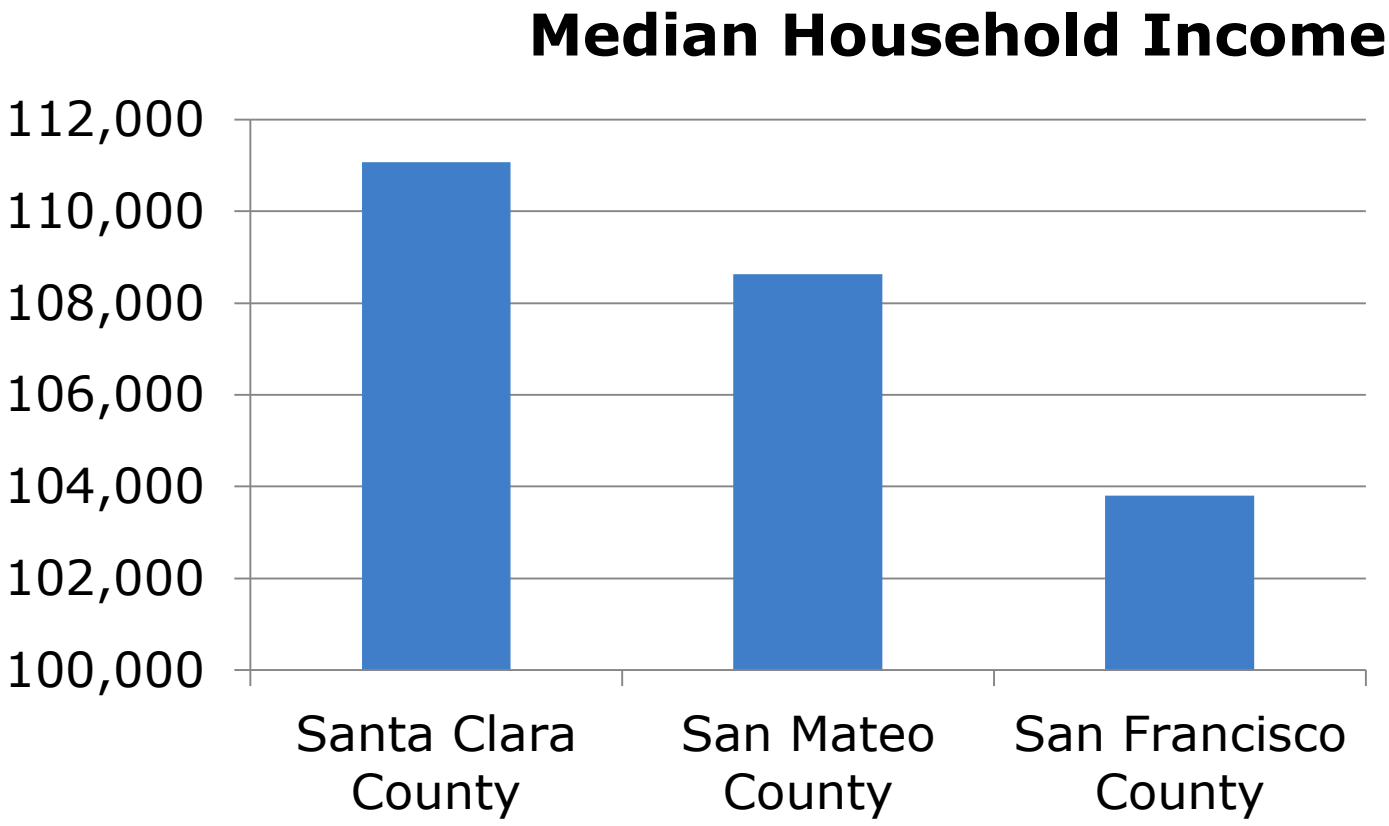
- Emerging Strategies:
  - Needs assessment
  - Health Impact Assessments (environmental…)
  - Application of “health in all policies” across all areas of government

Demographics Santa Clara County

- Population: 1.94M (Foreign born: 38.1%)
- Poverty Rate: 8.64%
- Median Age: 37.2
- Median Property Value: 1.11M
- Health Coverage: 95.9%
  - 61.9% employee plan
  - 14.4% Medicaid
  - 10.7% Medicare
  - O.423% military or VA

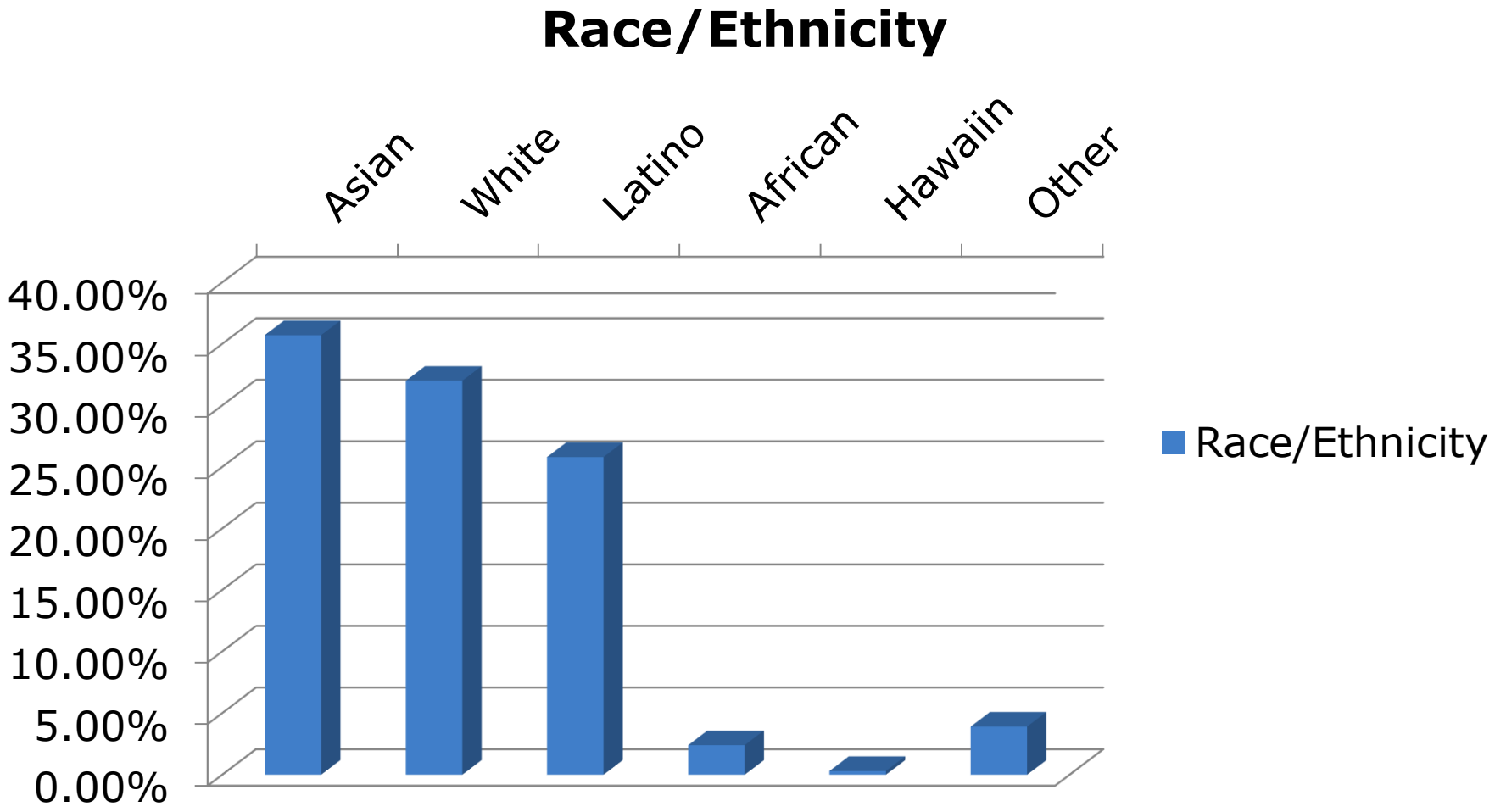
El Camino Health

Demographics Santa Clara County (5)



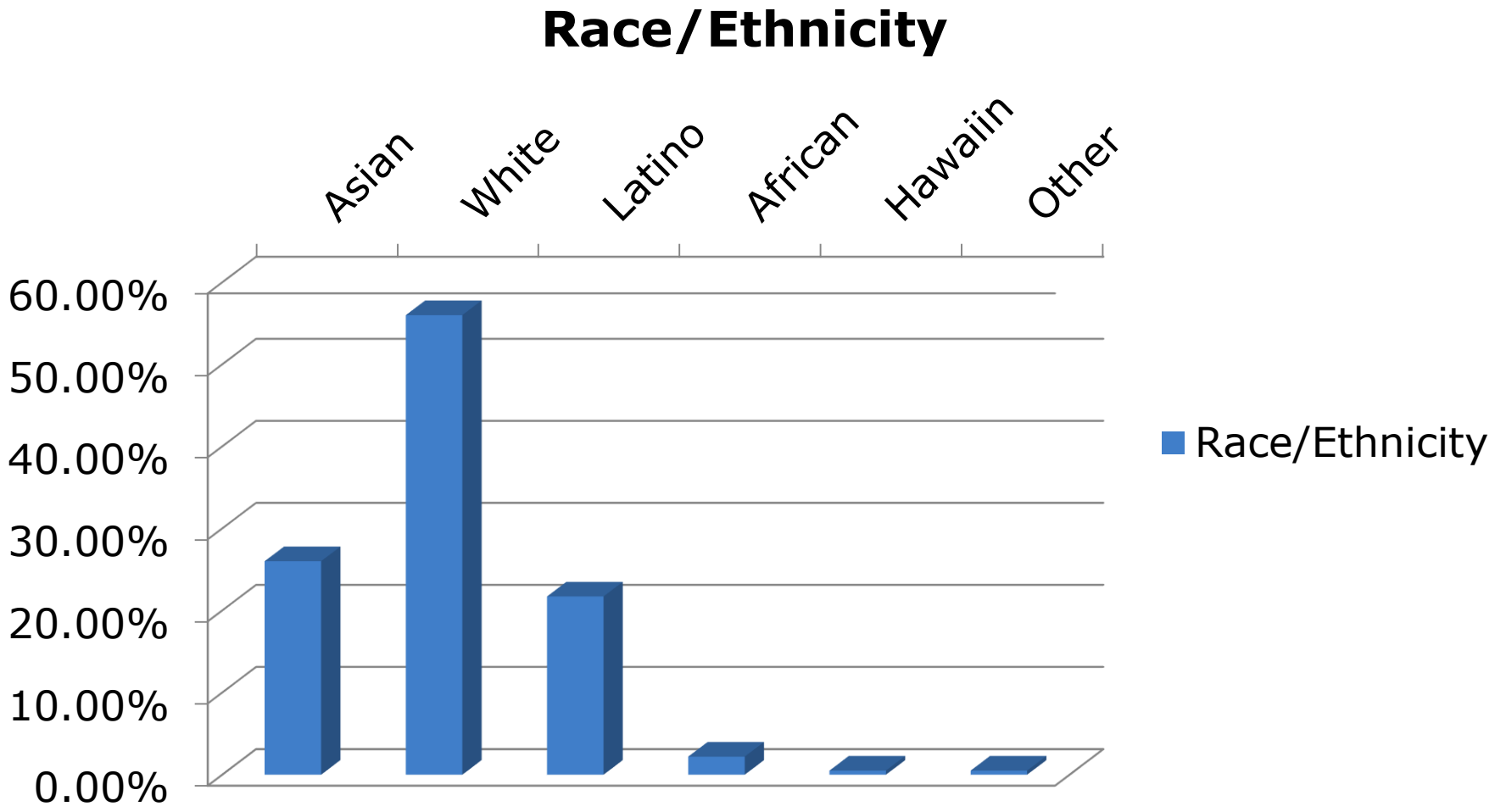
El Camino Health

Demographics Santa Clara County



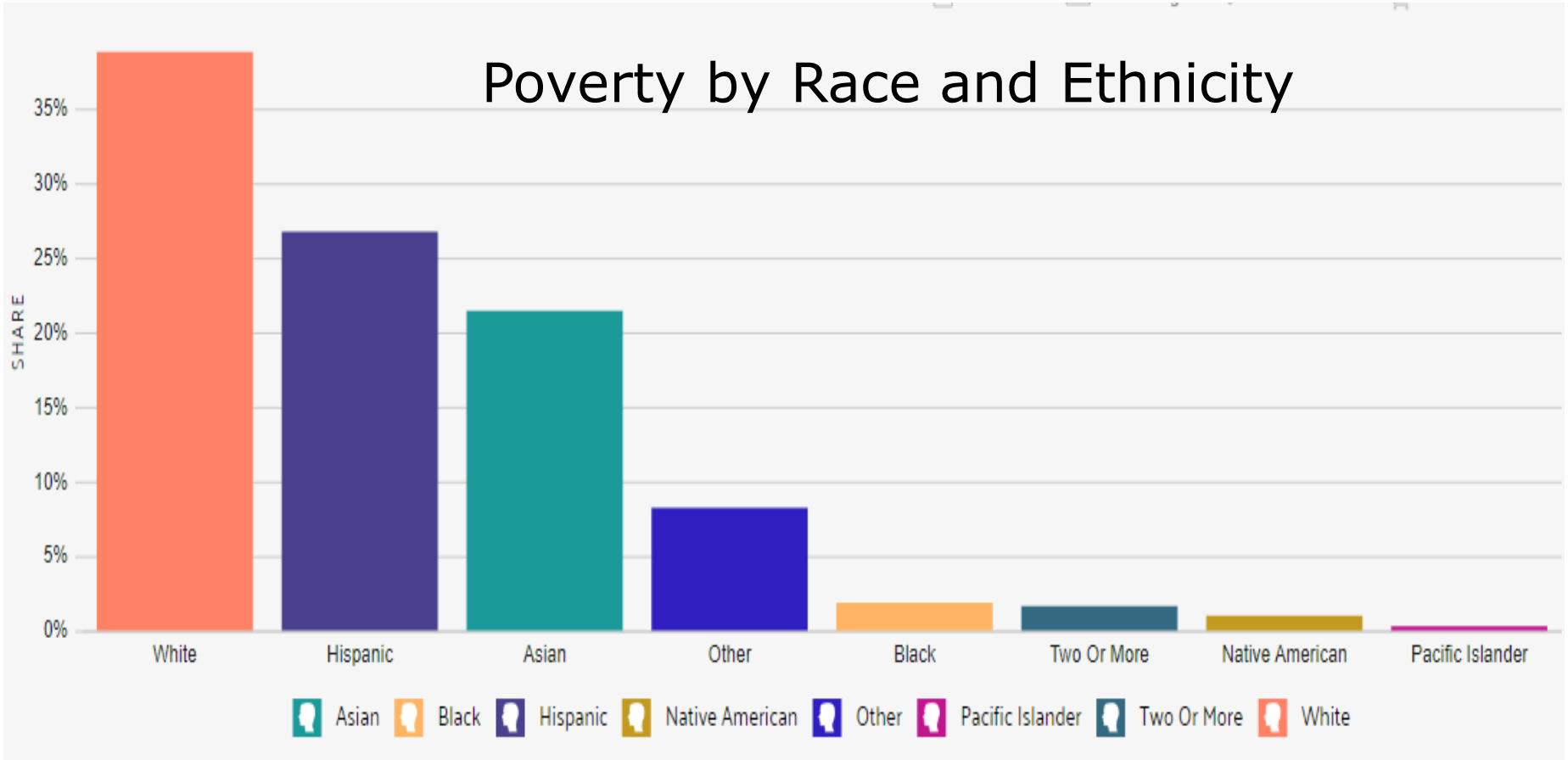
El Camino Health

Demographics Mountain View, CA



El Camino Health

Demographics Mountain View, CA




WASHINGTON
HEALTH
ALLIANCE
Leading health system improvement

WA Health Alliance: Case Study

- AHRQ Chartered Value Exchange (24)
- Board comprised of government, payers, employers, consumers, providers
- Robert Wood Johnson grant to study health equity
- Goal to improve health of WA population

WA Health Alliance

- Community Assessment
- Reliance on Medicaid and Medicare claims data
- Use commercial data for comparisons
- Requires broad community support with private-government cooperation

Example: Access to care by race/ethnicity

ACCESS TO CARE: *Percentage of patients who had a primary care visit during 2014-2015 measurement year*	Statewide Results (all races)		American Indian and Alaska Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian and Other Pacific Islander	White
	Medicaid	**Commercial**						
Ages 12–24 months	89%	98%	94%	85%	87%	90%	85%	87%
Ages 2–6 years	75%	89%	82%	68%	70%	75%	66%	76%
Ages 7–11 years	86%	90%	88%	83%	84%	88%	77%	87%
Ages 12–19 years	86%	90%	90%	81%	85%	88%	79%	87%
Ages 20–44 years	71%	92%	83%	67%	74%	77%	67%	76%
Ages 45–64 years	75%	96%	86%	70%	72%	74%	68%	74%
Ages 65+ years	84%	98%	*	*	*	*	*	*

*Did not meet public reporting denominator minimum (<160) threshold requirements

El Camino Health

Asthma

The asthma measure is intended to improve the diagnosis and care of those with asthma, including how often those with persistent asthma were prescribed appropriate asthma medication and remained on their medication at least 50% of the time.

RACIAL/ETHNIC GROUP	*Asthma*
	Managing medications for people with asthma
Statewide Medicaid (all races)	**60%**
Statewide commercial (all races)	**67%**
American Indian and Alaska Native	**55%**
Asian	**59%**
Black or African American	**56%**
Hispanic or Latino	**54%**
Native Hawaiian and Other Pacific Islander	*
White	**63%**

**Did not meet public reporting denominator minimum (<160) threshold requirements.*

Behavioral Health

Staying on antidepressant medication (12 weeks): measures the number of patients ages 18 and older newly diagnosed with depression, who were prescribed (as determined by prescription fills) an antidepressant medication, and remained on an antidepressant during the entire 12 weeks after the diagnosis

RACIAL/ETHNIC GROUP	*Behavioral Health*	
	Staying on antidepressant medication (12 weeks)	Staying on antidepressant medication (6 months)
Statewide Medicaid (all races)	**58%**	**42%**
Statewide commercial (all races)	**72%**	**56%**
American Indian and Alaska Native	**56%**	**42%**
Asian	*	*
Black or African American	**51%**	**32%**
Hispanic or Latino	**49%**	**33%**
Native Hawaiian and Other Pacific Islander	*	*
White	**64%**	**48%**

*Did not meet public reporting denominator minimum (<160) threshold requirements

Cardiovascular Disease

High-blood pressure medication generic prescriptions (antihypertensives): measures the number of prescriptions for antihypertensive drugs (ACE inhibitors and ARB) that were filled with a generic antihypertensive anytime during the one-year measurement period.

RACIAL/ETHNIC GROUP	*Cardiovascular disease*			
	Generics for cholesterol-lowering medication	Generics for high-blood pressure medication	Monitoring patients on high-blood pressure medication	Taking cholesterol medication as directed
Statewide Medicaid (all races)	**96%**	**99%**	**82%**	**57%**
Statewide commercial (all races)	**92%**	**97%**	**82%**	**76%**
American Indian and Alaska Native	**91%**	**99%**	*	*
Asian	**97%**	**99%**	*	*
Black or African American	**99%**	**100%**	**88%**	*
Hispanic or Latino	**97%**	**100%**	**87%**	**50%**
Native Hawaiian and Other Pacific Islander	**98%**	**100%**	*	*
White	**93%**	**99%**	**84%**	**61%**

**Did not meet public reporting denominator minimum (<160) threshold requirements.*

Diabetes

Blood sugar (HbA1c) testing for people with diabetes: measures number of patients ages 18 to 75 with diabetes (type 1 and type 2) whose blood sugar was tested using an HbA1c test by a doctor or other health care provider at least once in the one-year measurement period.

RACIAL/ETHNIC GROUP	*Diabetes*					
	Blood sugar (HbA1c) test		Eye exam		Kidney disease screening	
Statewide commercial (all races)	**90%**		**75%**		**86%**	
Statewide (all races)	**Medicaid**	**Medicare**	**Medicaid**	**Medicare**	**Medicaid**	**Medicare**
	63%	**91%**	**63%**	**56%**	**71%**	**73%**
American Indian and Alaska Native	**80%**	**85%**	**79%**	**50%**	**78%**	**76%**
Asian	*	**93%**	*	**57%**	*	**75%**
Black or African American	**84%**	**87%**	**52%**	**52%**	**77%**	**77%**
Hispanic or Latino	**84%**	**92%**	**48%**	**52%**	**74%**	**77%**
Native Hawaiian and Other Pacific Islander	**84%**	**N/A**	**50%**	**N/A**	**83%**	**N/A**
White	**82%**	**91%**	**50%**	**57%**	**72%**	**73%**

*Did not meet public reporting denominator minimum (≥160) threshold requirements

El Camino Health

Health Screenings

RACIAL/ETHNIC GROUP	*Health Screenings*							
	Adolescent well-care visits	Breast cancer screening		Cervical cancer screening	Chlamydia screening	Colon cancer screening		Well-child visits
Statewide commercial (all races)	**44%**	**75%**		**75%**	**39%**	**63%**		**73%**
Statewide (all races)	**Medicaid**	**Medicaid**	**Medicare**	**Medicaid**	**Medicaid**	**Medicaid**	**Medicare**	**Medicaid**
	41%	**27%**	**60%**	**55%**	**51%**	**43%**	**43%**	**58%**
American Indian and Alaska Native	41%	*	49%	56%	55%	*	38%	55%
Asian	43%	*	49%	67%	45%	*	35%	57%
Black or African American	45%	*	52%	67%	61%	37%	39%	56%
Hispanic or Latino	42%	*	53%	67%	53%	45%	33%	58%
Native Hawaiian and Other Pacific Islander	44%	*	N/A	62%	54%	*	N/A	57%
White	40%	60%	61%	63%	49%	45%	44%	58%

**Did not meet public reporting denominator minimum (<160) threshold requirements.*

El Camino Health

Access and Primary Language

QUALITY MEASURE	Statewide commercial (all languages)	Statewide Medicaid (all languages)	Asian and Pacific Island Languages	English	Other Indo-European languages	Other languages	Spanish
Access to Care							
Access to primary care (ages 12-24 months)	98%	89%	79%	88%	79%	85%	90%
Access to primary care (ages 2-6 years)	89%	75%	60%	75%	63%	68%	73%
Access to primary care (ages 7-11 years)	90%	86%	84%	86%	69%	82%	89%
Access to primary care (ages 12-19 years)	90%	86%	78%	86%	70%	78%	88%
Access to primary care (ages 20- 44 years)	92%	71%	60%	76%	62%	76%	78%
Access to primary care (ages 45-64 years)	96%	75%	70%	74%	67%	74%	73%
Access to primary care (ages 65+ years)	98%	84%	*	88%	*	97%	*

**Did not meet public reporting denominator minimum (<160) threshold requirements*

Primary Language and Quality

QUALITY MEASURE	Statewide Medicare (all languages	Statewide Medicaid (all languages)	Asian and Pacific Island languages	English	Other Indo-European languages	Other languages	Spanish
Asthma							
Managing medications for people with asthma	N/A	60%	*	62%	*	*	50%
Cardiovascular Disease							
Cholesterol-lowering medication generic prescriptions	N/A	96%	96%	94%	95%	98%	97%
High-blood pressure medication generic prescriptions	N/A	99%	100%	99%	96%	98%	99%
Monitoring patients on high-blood pressure medications	N/A	82%	*	84%	*	*	90%
Taking cholesterol-lowering medications as directed	N/A	57%	*	59%	*	*	49%
Diabetes							
Blood sugar (HbA1c) test	91%	63%	*	82%	*	*	90%
Eye exam	56%	63%	*	52%	*	*	51%
Kidney disease screening	73%	71%	*	74%	*	*	80%
Health Screenings							
Adolescent well-care visits	N/A	41%	40%	41%	34%	39%	44%
Breast cancer screening	60%	27%	*	59%	*	*	*
Cervical cancer screening	N/A	55%	66%	64%	63%	65%	64%
Chlamydia screening	N/A	51%	*	52%	*	*	49%
Colon cancer screening	43%	43%	*	43%	*	*	*
Well-child visits (ages 3-6 years)	N/A	58%	49%	58%	45%	50%	59%

Comparison to Commercially Insured

QUALITY MEASURE (*MEASURE DESCRIPTIONS CAN BE FOUND ON PAGE 31-33*)	STATEWIDE MEDICAID RATE	STATEWIDE MEDICARE RATE	STATEWIDE COMMERCIAL RATE
Access to Care			
Access to primary care (ages 12–24 months)	89%		98%
Access to primary care (ages 2–6 years)	75%		89%
Access to primary care (ages 7–11 years)	86%		90%
Access to primary care (ages 12–19 years)	86%		90%
Access to primary care (ages 20–44)**	71%	80%	92%
Access to primary care (ages 45–64)	75%	83%	96%
Access to primary care (ages 65+)	84%	79%	98%
Asthma			
Managing medications for people with asthma	60%		67%
Behavioral Health			
Antidepressant medication (12 weeks)	58%		72%
Antidepressant medication (6 months)	42%		56%
Cardiovascular Disease			
Cholesterol-lowering medication generic prescriptions	96%		92%
High-blood pressure medication generic prescriptions	99%		97%
Monitoring patients on high-blood pressure medications	82%		82%
Taking cholesterol-lowering medications as directed	57%		76%
Diabetes			
Blood sugar (HbA1c) test	63%	91%	90%
Eye exam	63%	56%	75%
Kidney disease screening	71%	73%	86%

*** Medicare is available for certain people with disabilities who are under age 65. These individuals must have*

Comparison to Commercially Insured

QUALITY MEASURE (*MEASURE DESCRIPTIONS CAN BE FOUND ON PAGE 31-33*)	STATEWIDE MEDICAID RATE	STATEWIDE MEDICARE RATE	STATEWIDE COMMERCIAL RATE
Generic Prescription Drugs			
ADHD medication generic prescriptions	78%		70%
Antacid medication generic prescriptions	89%		92%
Antidepressant medication generic prescriptions	100%		98%
Cholesterol-lowering medication generic prescriptions	96%		92%
High-blood pressure medication generic prescriptions	99%		97%
Health Screenings			
Adolescent well-care visits	41%		44%
Breast cancer screening	27%	60%	75%
Cervical cancer screening	55%		75%
Chlamydia screening	51%		39%
Colon cancer screening	43%	43%	63%
Well-child visits	58%		73%
Medication Safety			
Monitoring patients on high-blood pressure medications	82%		82%
Taking cholesterol-lowering medications as directed	57%		76%
Taking diabetes medications as directed	45%		65%
Taking hypertension medications as directed	59%		79%
Potentially Avoidable Care			
Appropriate testing for children with sore throat	66%		70%
Avoiding antibiotics for adults with acute bronchitis	30%		34%
Avoiding antibiotics for children with upper respiratory infections	93%		93%
Avoiding X-ray, MRI and CT scan for low-back pain	77%		80%
Potentially avoidable ER visits	19%		10%

Roadmap to Achieve Health Equity

- STEP 1: Link quality and equity
  - Implement basic quality improvement infrastructure
  - Stratify data by REL (race, ethnicity, language)
  - Make equity an integral component of quality improvement

Roadmap to Achieve Health Equity

- STEP 2: Create a culture of equity
  - Recognize disparities: cultural competency training and stratified performance data
  - Take responsibility: staff and providers recognize disparities and take responsibility for reducing them

Roadmap to Achieve Health Equity

- STEP 3: Diagnose the disparity
  - Conduct a root cause analysis: identify potential causes of a disparity
  - Apply an equity lens: culture, communication, and context
  - Use a priority matrix

Roadmap to Achieve Health Equity

- STEP 4: Design the Intervention
  - Levels of influence: patient, provider, microsystem, organization, community, policy
  - Strategies: education, community engagement, support, feedback, care team restructure, language and literacy services
  - Mode of delivery: in-person, telecommunication, internet, IT, print materials, multimedia

Roadmap to Achieve Health Equity

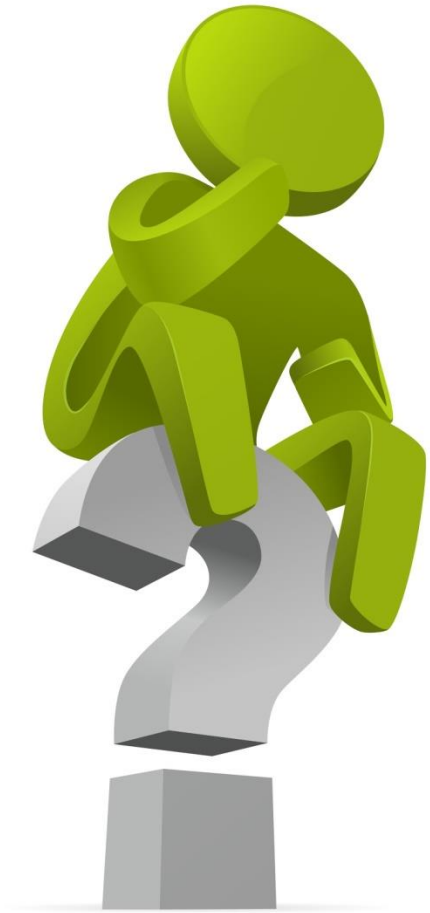
- STEP 5: Secure buy-in
  - Effective messaging: why is intervention better than the status quo
  - Key stakeholder buy-in: leadership, staff, providers, patients, community partners

Roadmap to Achieve Health Equity

- STEP 6: Implement change
  - Start small, measure often, adjust frequently
  - Pilot testing
  - Evaluation
  - Process measures
  - Outcome measures
  - Intervention tracking measures

Health Equity

- What is the role of El Camino Health?
- Does El Camino Health support diversity, inclusion, and equity as an employer?
- How does El Camino Health reach beyond the limits of medical care to affect overall health?
- What partnerships might El Camino Health pursue to achieve health equity?



El Camino Health