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

Monday, March 1, 2021 – 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.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (02/01/2021) *Information* b. Progress Against FY21 Committee Goals c. FY21 Enterprise Quality Dashboard d. Report on Board Actions e. Quality Committee Follow-Up Tracking			
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.	**PROPOSED FY22 COMMITTEE GOALS** **ATTACHMENT 6**	Mark Adams, MD, CMO		**discussion 5:44 – 6:04**
7.	**UPDATE ON LEAN TRANSFORMATION** **ATTACHMENT 7**	Mark Adams, MD, CMO		**discussion 6:04 – 6:14**
8.	**PROGRESS ON QUALITY AND SAFETY PLAN** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:14 – 6:34**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:34 – 6:37**
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:37 – 6:38**

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 6:38 – 6:39**
12. CONSENT CALENDAR *Any Committee Member may pull an item for discussion before a motion is made.* *Approval* *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (02/01/2021) *Information* b. Quality Council Minutes	Julie Kliger, Quality Committee Chair		**motion required 6:39 – 6:40**
13. *Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:40 – 6:50**
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 6:50 – 6:55**
15. ADJOURN TO OPEN SESSION	Julie Kliger, Quality Committee Chair		**motion required 6:55 – 6:56**
16. RECONVENE OPEN SESSION/ REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 6:56 – 6:57**
17. CLOSING WRAP UP	Julie Kliger, Quality Committee Chair		**discussion 6:57 – 7:02**
18. ADJOURNMENT	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:02 – 7:03**

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
Monday, February 1, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	**Members Absent**
Julie Kliger, Chair**	**Alyson Falwell**
George O. Ting, MD, Vice Chair**	
Melora Simon	
Krutica Sharma, MD	
Terrigal Burn, MD	
Michael Kan, MD	
Apurva Marfatia, MD	
Jack Po, 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 5:30pm by Chair Kliger. A verbal roll call was taken. Alyson Falwell was absent. Jack Po, MD and Michael Kan, MD joined the meeting during Agenda Item #4. All other members were present at roll call 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. **Motion:** To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (12/07/2020); For information: (b) Progress Against FY21 Committee Goals, (c) FY21 Enterprise Quality Dashboard, (d) Report on Board Actions, (e) Quality Committee Follow-Up Tracking, (f) Article of Interest **Movant:** Ting **Second:** Burn **Ayes:** Burn, Kliger, Marfatia, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Falwell, Kan, Po **Recused:** None	*Consent Calendar approved*
4. CHAIR'S REPORT	Chair Kliger gave the Chair's Report. She reviewed what occurred at the last Board meeting and announced that the hospital has achieved its fourth Magnet Designation.	
5. PATIENT STORY	Cheryl Reinking, RN, CNO, presented a Patient Story. She stated that this letter had some positive and also some negatives about a patient who came in as a new mom. Overall, the patient seemed to be happy with her labor and delivery services and experience. Her negative comments were related to the Mother Baby Unit. She commented that she did not feel supported during her breast feeding journey. Ms. Reinking stated management looked into the lactation consultant process which resulted in a change in schedule so that the	

	consultants will see the patients soon after delivery instead of after discharge. The consultants will be going in early and making several visits with the moms to make sure they are on track. If the patient is having any difficulties, then it would allow the consultant to be proactive and schedule follow-ups post discharge. In addition, Ms. Reinking also stated that they also did training with the lactation consultants on the WeCare standards ensuring how their advice may be perceived by overwhelmed new moms. She stated that management did a service recovery and talked to this specific patient. On a positive note, at the end of the letter, the patient did mention how she had one nurse who taught her how to swaddle and that meant a lot to the new mother.	
6.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Mark Adams, MD, CMO, presented the quarterly update on the El Camino Health Medical Network Report. There were three (3) main areas: HEDIS, MIPS for Medicare incentive payment system, and the NPS for the net promoter score. Overall, there was a positive trend in relation to targets versus actuals. Dr. Adams did note there was a path for improvement with less emphasis on process and more emphasis on actual patient care. Some of these targets will never be 100%, but he stated that the medical staff certainly will want to improve with every step. Moving forward, Dr. Adams recommended against changing targets mid-year either up or down as that creates uncertainty and undermines engagement. Management's goal is to get to a 5 score or as close as possible. In response to a committee member's questions, Dr. Adams stated that he believes the medical group is making real improvements. He reiterated that no matter where the target is, the group will still strive for improvement year by year.	
7.	**QUARTERLY BOARD QUALITY DASHBOARD REVIEW**	Dr. Adams presented the Quarterly Board Quality Dashboard Review. He stipulated that the mortality index target of .76 is the top tier among all participating organizations. The sepsis mortality has been reviewed very carefully and one of the challenges in this area is differentiating between COVID and non-COVID patients as the former cannot always tolerate the fluid boluses prescribed for non-COVID sepsis patients. He stated there is also an increase in severe sepsis cases due to people still not wanting to go the hospital until they are very sick. This area is being actively monitored and efforts made to improve. Ms. Reinking stated that they do a root cause analysis so the staff is very involved on what may have happened and involved in any action planning. In addition, Dr. Adams stated that there has been an increase in ED time because ~~of COVID~~of COVID. Patients being admitted need to be COVID tested which adds time to their ED visit. The physicians on the receiving end have been extremely busy and attending to the ED may take a little longer than normal. Once a decision has been made on where to take the patients, beds may not be available. In response to committee member's question, Ms. Reinking stated that Press Ganey commented that they're seeing tremendous drops in experience scores. She also stated that there were many changes made due to COVID where interactions are not always face to face, but with video or phone call to try to connect with patients in different ways.	
8.	**HEALTH EQUITY**	Dr. Adams presented an update on Health Equity. He highlighted that the hospital is still experiencing challenges with more and more people not willing to identify what race they are. He noted that if they fell in the mixed race	

	group, it would be even more challenging to break it down. Internally, many of the hospital employees are Spanish speaking only and also live outside of the service area due to the cost of living in Mountain View. According to the Equity Concentric Circles of Influence, the hospital's service area is considered extraordinarily privileged, especially when compared to other areas, such as East San Jose. Dr. Adams requested any thoughts the committee may have as to how the hospital could serve underprivileged areas. Dr. Burn suggested opening a clinic in East San Jose so that the hospital can reach out to a population with a different demographic. All committee members agreed. Ms. Simon suggested looking into who is getting sick and/or the fatality rate on specific age brackets.	
9. **PUBLIC COMMUNICATION**	There was no public communication.	
10. **ADJOURN TO CLOSED SESSION**	**Motion:** To adjourn to closed session at 6:48pm. **Movant:** Ting **Second:** Po **Ayes:** Burn, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Falwell **Recused:** None	*Adjourned to closed session at 6:48pm*
11. **AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT**	Open session was reconvened at 7:24pm. 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 (12/07/2020), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
12. **AGENDA ITEM 18: CLOSING WRAP UP**	There were no closing comments.	
13. **AGENDA ITEM 19: ADJOURNMENT**	**Motion:** To adjourn at 7:26pm. **Movant:** Burn **Second:** Kan **Ayes:** Burn, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Falwell **Recused:** None	*Meeting adjourned at 7:26pm*

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

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Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Yurike Arifin

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 HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: March 1, 2021
Subject: FY21 Enterprise Quality, Safety, and Experience Dashboard

<u>Summary</u>:

1.   <u>Situation</u>: 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.
   A.   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.
   B.   Annotation is provided to explain

2.   <u>Authority</u>: 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.

3.   <u>Background</u>: At the beginning of each fiscal year, an assessment is completed 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. These twelve (12) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2021 Quality, Efficiency and Service Goals.

4.   <u>Assessment</u>:
   A.   Readmission Index remains under target for FYTD since April 2020, but spiked in December due high # of readmissions
   B.   Zero SSEs assigned by team review for November
   C.   Mortality Index increased to 1.03 due to an increase in deaths to 62 with 42% due to Sepsis
   D.   HCAHPS Likelihood to Recommend improved though below target for hospital with impact of COVID surge and limitation on visitors. ED LTR was negatively impacted the surge of patients in January.
   E.   4 C.Diff HAIs for January due to severely ill patients who needed multiple antibiotics.
   F.   Sepsis mortality Index up again in January with 42% of January deaths due to Sepsis with very high expected value of 15.10%.
   G.   PC-01 at zero, with prospective oversight by medical director
   H.   PC-02, Cesarean Birth above target, OB Task force trending providers and reviewing cases
   I.   Patient Throughput up with COVID surge
        See additional detailed comments in the annotation of the report

5.   <u>Other Reviews</u>: None

6.   Outcomes: N/A

Suggested Committee Discussion Questions: None

List of Attachments: FYTD 2021 Enterprise Quality, Safety, and Experience Dashboard, December data unless otherwise specified - final results

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

January 2021 (unless otherwise specified)

		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* ****Latest data month: December 2020**	1.05 (8.43%/0.45%)	0.92 (8.22%/-0.67%)	0.96	0.93		
2	***Organizational Goal** **Serious Safety Event Rate (SSER)** # of events/ (FYTD Rate) *****Latest data month: November 2020**	0	3.53 (55/155886)	4.28	4.0		
3	*** Strategic Goal** **Mortality Index** *Observed/Expected* *Premier Standard Risk Calculation Mode* *Latest data month: January 2021*	1.03 (3.45%/3.34%)	0.83 (1.96%/2.37%)	0.74	0.76		
4	***Organizational Goal** **IP Enterprise - HCAHPS Likelihood to Recommend** Top Box Rating of 'Always' % , Unadjusted *Latest data month: January 2021*	82.6	80.0	83.1	83.6		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. **Readmission Index - All Patient All Cause Readmit (Observed/Expected)**	115 Readmissions in December, vs 86 in November. Of the 115 readmits: 11 were due to a new infection, 9 were due to COVID, and 8 were due to Sepsis. The January surge in COVID cases was noticeable.	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)	Zero events coded as SSEs by review team in November.	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 # of deaths increased to 62 in January vs 48 in December, with 26 (42%) due to Sepsis and the next most common death was due to COVID @ 15.	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	While the visitation policy (i.e. no visitors) affects our patient's experience, the temporary cancellation of leader rounding in November and December due to the need to have leaders provide direct patient care negatively impacted the scores as well. The best practice, "nurse leader rounding" and "leader rounding" which historically has improved LTR metric performance (including metrics below) is a focused area for improvement for all patients across the enterprise and has restarted in mid-January. Each unit (including ED, Inpatient, and Mother Baby) has developed a plan to improve their LTR scores, and performance is being reported regularly. Additionally, emphasis around WeCare Excellence Standard behaviors and leader rounding will accelerate in the coming months.	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**

		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: January 2021*	76.0	76.4	75.7	78.2		
6	* Organizational Goal **ECH MD** : Likelihood to Recommend Care Provider (SVMD only) **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: January 2021*	76.0	75.9	73.2	75.7		
7	*Hospital Acquired Infections* *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: January 2021*	4.08 (4/9801)	1.92 (12/62454)	1.46	<= 1.46 (MV: 10/ LG: 3)		
8	*Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: January 2021*	0.22 (1/465)	0.35 (14/4047)	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	Both Mountain View and Los Gatos are below our FY21 target despite an increase in the metric over the last 12 months. MV ED have had two (2) very strong months (Dec, Jan) while LG ED dipped in January due to the influx of patients. The lack of visitation also affects this metric. WeCare behavior training and measures in place to address the safety concerns of our ED patients are positively impacting our patient's perception of safety, and in turn affecting our overall score. The activation of a new bedside shift report in ED will specifically address our teamwork metric performance, which is a significant factor in ED LTR performance. Improvements in the physical wait space are in progress, with the intent of improving the environment of care.	Christine Cunningham	Likelihood to Recommend - PressGaney data (not part of HCAHPS) 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	Our SVMD Clinics are above target for the first half of FY21. We have launched WeCare to the leaders / physician leaders, who are now training their staff members.	Christine Cunningham	ECHMD – does not have HCAHPS – we use only one data point that is NPS (net promotor score), which is a likelihood to recommend care provider (SVMD only) 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)	4 cases of C. Diff in January: 2 in MV and 2 in LG: MV: 1-64 y/o admitted for CABG x2 with multiple doses of Antibiotics, developed C.Diff after 30 days of hospitalization. 2- 92 y/o admitted with recurrent UTI on multiple antibiotics w/history of C.Diff., developed new C.Diff infection after 10 days. LG: 1-76 y/o admitted for cancer diagnostic work up and chemotherapy, had only one dose of antibiotic. 2- 77 y/o admitted for Whipple procedure, and multiple antibiotics, new C.Diff infection on day 8.	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 Patient Days from EPIC**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1 SSI in January: LG: Pt post duodenal resection and kidney resection, readmitted 2days post discharge with drainage from Abd wounds, infected peritoneal fluid. OR and Procedure staff education on use of surgical scrubs continues and the development of a standard list of prep solutions for most procedure types is in progress.	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**

Enterprise Quality, Safety, and Experience Dashboard
January 2021 (unless otherwise specified)

		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: January 2021*	1.18 (17.79%/15.10%)	1.02 (12.89%/12.65%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: December 2020	MV: 0.0% (0/26) LG: 0.0% (0/6) **ENT: 0.0%** (0/32)	MV: 0.84% (1/119) LG: 2.7% (1/37) **ENT: 1.28%** (2/156)	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: December 2020	MV: 27.6% (32/116) LG: 17.6% (3/17) **ENT: 26.3%** (35/133)	MV: 27.8% (226/813) LG: 21.6% (36/167) **ENT: 26.7%** (262/980)	MV: 24.7% (412/1665) LG: 18.9% (48/253) **ENT: 23.9%** (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: January 2021*	MV: 330 min LG: 277 min **Ent: 304 min**	MV: 292 min LG: 251 min **Ent: 272 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

** PC-01, PC-02 and Readmission data are available up to December 2020

*** SSER data available up to November, FYTD data displayed in rate per 10000 Acute Adjusted Patient Days for the reporting period December 2019 to October 2020

Report updated: 2/22/21

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 index has increased since November with a very high expected index of 15.10%. All Sepsis deaths are reviewed by the Mortality Committee and cases sent o Peer review if questions arise about the care provided. The Sepsis Quality Committee has a new Sepsis dashboard that tracks bundle element compliance, antibiotics start time, Sepsis alerts, most common infection organ, and discharge location. This is will shared at the monthly Medicine Executive Committee meetings.	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	MCH continues to prospectively track EED and reach out to providers to reschedule as needed. When an EED occurs and was seemingly not indicated primary provider is contacted and informed that we are tracking and request is made to closely monitor and avoid unindicated EED. - 1 case in November occurred, based on incomplete documentation and I requested that provider to addend her H&P to reflect the patient came in in labor, not for IOL.	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	MCH is continuing to trend. Ongoing OB Task Force work to evaluate where we can make system improvements to reduce unnecessary NTSV. 1 provider currently under close tracking and monitoring for the next 6 months to evaluate that individual @ MV campus. Have spoken with other provider groups to encourage they independently look at NTSV rates as evaluate any necessary changes.	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 continues to work on stabilizing the electronic SBAR handoff, Capacity Management Center (CMC), and nurse staffing. We a piloting a new process to maintain nurse staffing for patient admissions. This process focuses on accounting for ED patients who have an 80% probability of being admitted prior to each RN hospital convenience decision time. The reduction in the number of Covid patients being transferred from Los Gatos ED to Mountain View in-patient units should positively impact the overall throughput numbers. Enhancements in Epic for daily nursing assignments are still in the works. We continue to audit and improve the utilizing of the electronic SBAR handoff process.	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**

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: March 1, 2021
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 Executive Compensation Committee, the Hospital Board has met three times and the District Board has met four times. 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	February 10, 2021	- FY21 Period 5 and 6 Financials - Delegated Authority to the Finance Committee to Approve the Annual Community Benefit Fund - Revised Community Benefit Grants Policy - Revised Finance Committee Charter - $149,000,000 in Funding for ECH Women's Hospital Expansion Project - Hospital Board Member Competencies - Appointed Director Carol Somersille to the Finance and Investment Committees - LPCH NICU PSA Payment - Enterprise Telepsychiatry Services Renewal - Medical Staff Bylaws Revisions

Report on Board Actions
March 1, 2021

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECHD Board	January 26, 2021	- Elected Lanhee J. Chen to 3rd Term as a Member of the El Camino Hospital Board of Directors - Appointed ECH Board Member Election Ad Hoc Committee - Approved Reallocation of $900,000 in funding for COVID-19 Vaccinations
	February 10, 2021	- Approved $149,000,000 in funding for ECH Women's Hospital Funding
Executive Compensation Committee	N/A	
Compliance and Audit Committee	N/A	
Finance Committee	January 25, 2021	- Interventional Radiology Call Panel – Los Gatos - Hospitalist Contract – Los Gatos - Relocation of Cardiopulmonary Wellness Center – NTE $1.875 million

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	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	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
5	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
6	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
7	Add Review of Lean Projects to Pacing Plan for FY21	3/2/2020	JG	Added to March 2021 Meeting	

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC
Date: March 1, 2021
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 nurse leaders, physicians and staff members of the departments noted by the patient in the letter. This is a complimentary letter that was received from a patient who was treated in ED and the Cardiology unit during the surge in January.

2. Authority: To view patient feedback.

3. Background: This letter was provided by a patient receiving care in the ED and the Cardiology Unit during the January Surge.   The patient spent an extended period of time in the ED and had a three day stay in the cardiology unit.

4. Assessment: The patient recognized that his time in the ED was extended because the hospital was in the COVID-19 surge period. However, the fact that the physicians and staff were compassionate and communicating frequently regarding his condition and plans for his treatment made the difference in assuring this gentleman had a good experience versus a bad one. Expectations for wait times and treatment options were communicated which is an extraordinarily important aspect to create positive patient experience.

5. Other Reviews: This patient made a special effort in his letter to recognize the nurse, Marcella, who has in turn been recognized by the organization's leadership. We wouldn't doubt that she is nominated for employee of the month! This nurse demonstrated all the best practices we expect for reducing a patient's anxiety and providing extraordinary service.

6. Outcomes: Given the extraordinarily impacted period that occurred during the surge in January, it is helpful to know that the communication was continuing to flow to our patients in the ED and inpatient areas, at least from this patient's perspective and that our staff continued to demonstrate compassionate care.

List of Attachments: Patient Letter

Suggested Committee Discussion Questions:

1.   What recognition occurs throughout the organization as a result of this feedback?
2.   Are there more actions to come as a result of the feedback?

February 4, 2021

El Camino Hospital Customer Service

Dear Customer Service Representatives,

My name is   I was a patient in your hospital almost a month ago from Thursday, January 7th around 9 a.m. until Sunday, January 10th around 11:30 a.m. I wish to take this time to commend some of the medical personnel who helped me through this difficult time.

I began the day at Urgent Care in Mountain View. Ten minutes after an EKG, I was transported to the Emergency Room of El Camino Hospital around 9 a.m. I was immediately placed in Room # 5. Due to the Covid-19 surge in January I would spend the next eight plus hours in Room # 5. I realized the pressure everyone was under and the delay of being transferred to my own room was understandable. I was greeted in Room # 5 by a Travel Nurse named Brittany. She was cheerful, helpful and provided me with the best of care over the next eight plus hours. She was always there to help me sit up and urinate into a bottle. Above all else she treated me as if she really cared about me. It was very comforting. While in Emergency, blood was drawn and an Echo Cardiogram was performed on my heart. All of those involved with these tests performed their duties in a professional way. A Dr. Ryan M. Collins was my attending provider in Emergency and he kept me informed of what had happened, what was to happen. He was up front with me and very honest with what I had been through. His bedside manner was professional and greatly appreciated.

Between 5 p.m. and 5:30 p.m. I was finally transferred to my own room in the Cardiology/Telemetry wing, Room # 3306. This would be my home for the next three and a half days. A Dr. Benjamin Chang was my consulting physician while in Room # 3306. Again he provided me with constant updates on my condition and would check in with me at least twice a day to see how I was feeling and let me know what was coming in the future, including an Angiogram on Friday morning. Again his bedside manner was very professional and greatly appreciated.

While in Room # 3306 I was made to feel at home and very comfortable by all my nurses, the nurse assistants and the Cardiology staff. I would also like to commend El Camino Hospital for serving nutritious and, more importantly to me, delicious meals three times a day. Every meal I had helped me feel better and was very tasty. The breakfasts with pancakes and French toast, I would have paid for!

Finally, I would like to take the time to salute one of your employees for going above and beyond her normal duties. If you ever give out Employee of the Month awards, I would nominate this individual.

I don't know her last name, but her first name was Marcella, my nurse from 7 a.m. to 7 p.m. on Saturday and from 7 a.m. until I left at 11:30 a.m. on Sunday. She was a breath of fresh air. She always greeted me with a smile, asked me if there was anything she could do to help me. When alarms went off because of my movement in bed, she was immediately there to silence them. She was caring in a way that was so comforting. I truly felt that she wanted to see me get better and while in my room she was not just "doing her job." I credit her with helping me with my recovery more than anyone else. She cared.

I hope this doesn't get her in trouble because I'm not sure she should have done this, but with my son and wife waiting to pick me up on Sunday, she had called for a wheel chair to take me to be picked up. It was very late and it looked like it might be even a longer time. On her own she grabbed a wheel chair and escorted me down to the front of the hospital to go home. Her concern was deeply appreciated.

Again, Marcella was the most caring and professional nurse I have ever met. She kept me informed of all my blood pressure readings, oxygen input, my temperature and all the other vitals that were checked every few hours.

Please take the time to extend my thanks to all those who provided me with the excellent care I received, with special thanks to those mentioned and especially "My Nurse of the Year," Marcella.

Finally, I'm pleased to report that I am feeling better each day and today swam 40 laps without stopping.

Sincerely yours,

FY22 COMMITTEE GOALS
Quality, Patient Care and Patient Experience Committee

El Camino Health

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	- FY21 Achievement and Metrics for FY22 (Q1 FY22) - FY23 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 (FY23) - Review Medical Staff credentialing process (FY22)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY22 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

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: March 1, 2021
Subject: LEAN Transformation Update

Purpose: Provide the committee with an update on the organization's LEAN transformation which is now integrated into the normal operations of the business.

Summary:

1.   Situation: The principles of LEAN management were re-introduced into the organization starting about 18 months ago with the help of a consultant group, Moss Adams and the Rona Group. The Quality Committee requested an update on the status of LEAN at El Camino Health.

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: The consultants provided didactic instruction to the management team and assisted with the establishment of a LEAN strategy deployment system. The hallmarks of LEAN Principles include:

      A.   Exhibiting deep respect for patients and team members

      B.   Embracing challenge

      C.   Going to see the real work through direct observation (GEMBA Rounds)

      D.   Fostering a spirit of *kaizan*, or continuous improvement, in teams and in one's self

      E.   Relying on teamwork to solve tough problems

4.   Assessment: LEAN is no longer a "program" or "project" but a tool that is embedded in the management of the organization.   Problems or challenges are now addressed using a standardized process based on the use of an A3 approach. This includes identifying the problem (scope, background, current condition, and problem statement), setting a target that can be measured, performing an analysis, proposing countermeasures, and proscribing an implementation plan.

      Many of these activities occur on a department or unit level but those that rise to the level of enterprise concerns are tracked by the LEAN Steering Team. This team has the responsibility to support the projects, make decisions when needed, resolve issues, and review status updates. Two important such activities currently being followed by the LEAN Steering Committee are a) patient throughput value stream and b) peri-operative value stream. An example of the LEAN Steering Team work is provided in the attachment.

      Finally, the best example of LEAN at work may be El Camino Health's rapid deployment of a vaccination program for both our healthcare workers and our community. LEAN principles were applied to an extraordinarily complex challenge with great success.

5.   Other Reviews: None

6.   Outcomes: LEAN principles are now being used throughout the organization to achieve our strategic goals and improve operational efficiency.

List of Attachments:

1.   Sample of LEAN Steering Team work

Suggested Committee Discussion Questions:

Do any committee members have examples of LEAN principles being applied in other organizations?
Does the committee understand the function of LEAN as a means to an end rather than the end itself?
Any suggestions regarding the LEAN principles? Are they sufficiently clear?

El Camino Health

Lean Steering Team

Mark Adams
March 1, 2021

Agenda

- **Patient Throughput Value Stream Report Out**
  – Sharmila Singh & Jina Canson

- **Periop Value Stream Report Out**
  – Ashley Lam & Susan Schubert

- **PI Portfolio Review & Discussion**
  – Christine Cunningham & Melinda Hrynewycz

El Camino Health

Patient Throughput Value Stream Update

Sharmila Singh & Jina Canson

ED Targets

MV Medians			
	FY20 Performance	**FY21 YTD**	**FY21 Target**
Arrival to Admit Order	200	200	182
Admit Order to ED Departure	78	73	45
Arrival to ED Departure	287	282	263
LG Medians			
	FY20 Performance	**FY21 YTD**	**FY21 Target**
Arrival to Admit Order	180	178	180
Admit Order to ED Departure	39	39	39
Arrival to ED Departure	227	231	227
Campus Average			
	FY20 Performance	**FY21 YTD**	**FY21 Target**
Arrival to Admit Order	**190**	**189**	**181**
Admit Order to ED Departure	**59**	**56**	**45**
Arrival to ED Departure	**257**	**257**	**245**

El Camino Health
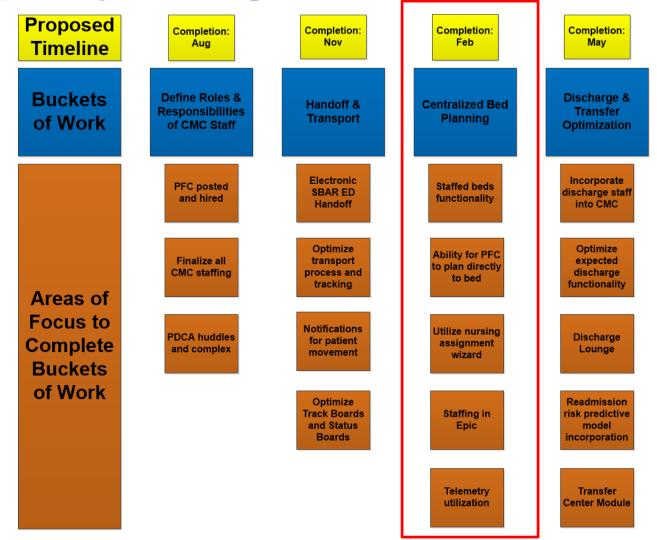
Patient Throughput Problem Statement

Enterprise admit order to ED departure is 56 mins FYTD which is 11 minutes above target of 45 mins.
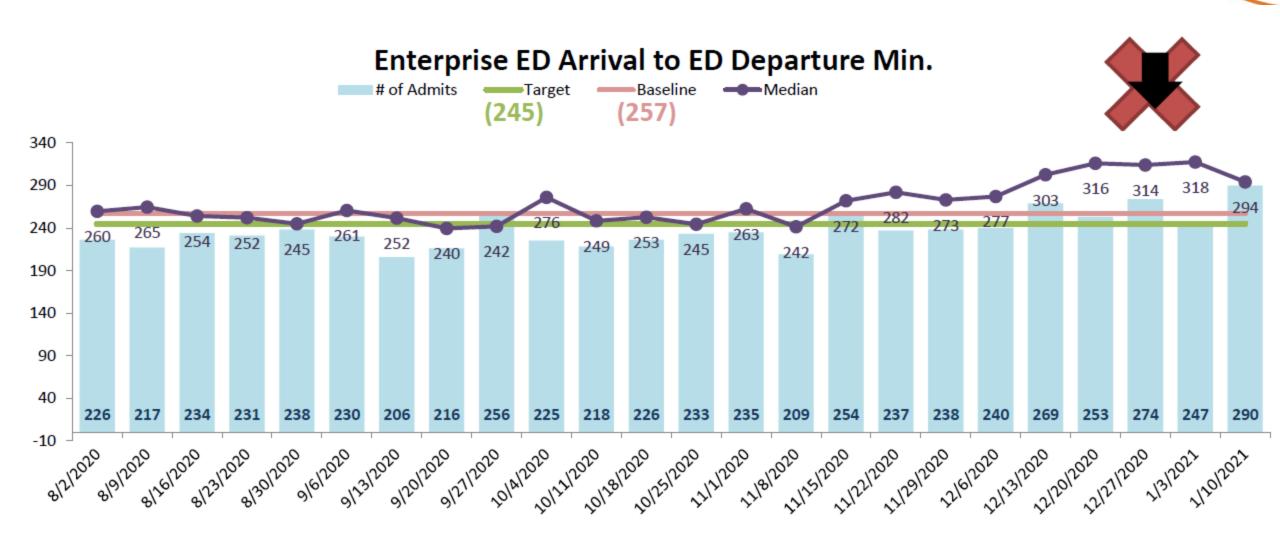
Watch: FY20 HCAHPS score for likelihood to recommend was **84.1** and the 89th %tile for patients admitted through the ED which is **5 points** less than patients not admitted through the ED (87.0 94th %tile).

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Capacity Management Value Stream

Proposed Timeline	Completion: Aug	Completion: Nov	Completion: Feb	Completion: May
Buckets of Work	Define Roles & Responsibilities of CMC Staff	Handoff & Transport	Centralized Bed Planning	Discharge & Transfer Optimization
Areas of Focus to Complete Buckets of Work	PFC posted and hired	Electronic SBAR ED Handoff	Staffed beds functionality	Incorporate discharge staff into CMC
	Finalize all CMC staffing	Optimize transport process and tracking	Ability for PFC to plan directly to bed	Optimize expected discharge functionality
	PDCA huddles and complex	Notifications for patient movement	Utilize nursing assignment wizard	Discharge Lounge
		Optimize Track Boards and Status Boards	Staffing in Epic	Readmission risk predictive model incorporation
			Telemetry utilization	Transfer Center Module

El Camino Health

6

Enterprise ED Arrival to ED Departure Min.

MV ED Admit Order to ED Departure Min.

El Camino Health

8

LG ED Admit Order to ED Departure Min.
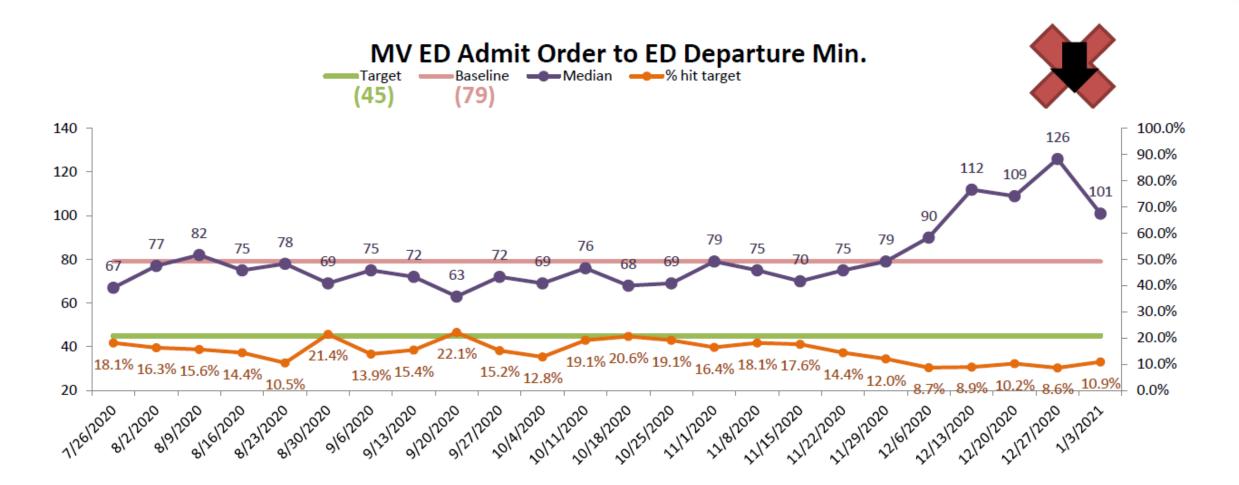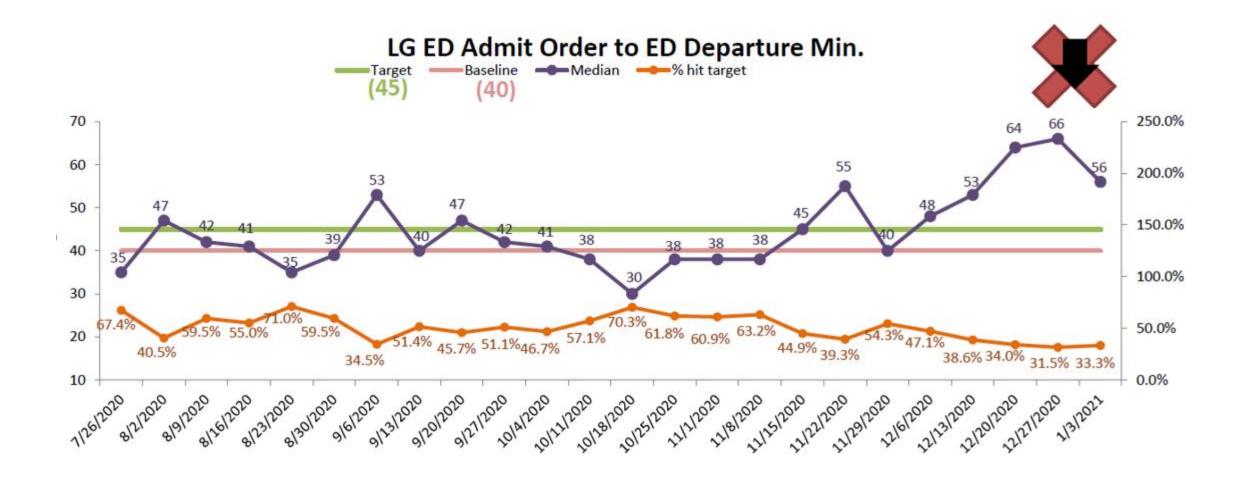
Barriers/FYIs

- Staffing
  - Union Rules: HC order

- Bucket 3 transfers – upcoming for March
  - Rounding process/providers

El Camino Health

Peri Operative Value Stream Update

Ashley Lam & Susan Schubert

Problem Statement

First case on time starts for Mountain View OR is at **50%** from July-Dec 2020. We are aiming to hit **70%** of first case on time starts.

Patients are waiting on average the following minutes:
Entering pre op to in room time: **114 minutes for MV OR, 106 for MV IR, 104 for MV Cath**

Watch: OAS CAHPS patient experience scores for likelihood to recommend are currently at **85** at the end of FY20.
Target for end of FY21 is **86.4.**

Current First Case On Time Starts (Sept- Dec 2020): 50%
Remaining Gap to Close: 20%

MD Office Factors

- Missing documentation
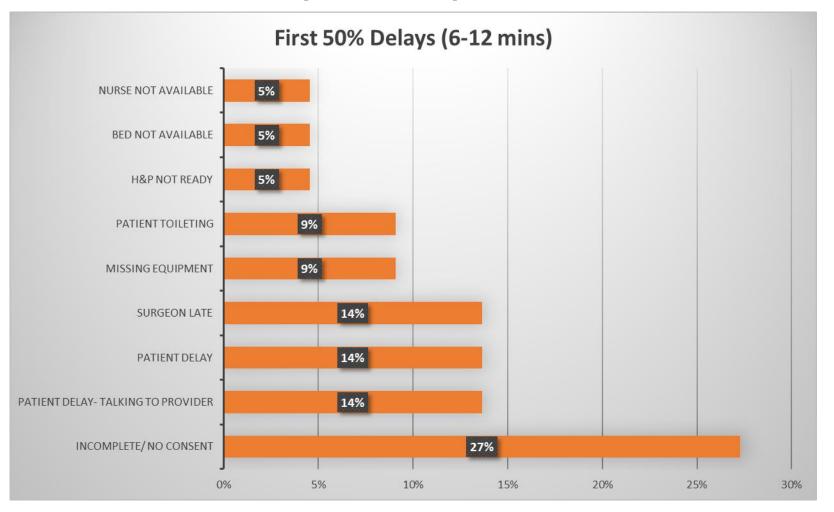- Provider late
- Room not ready

Nurses

- Long admissions assessment
- No visibility into RNs working on cases
- No visibility into when patient is ready for the OR
- Floor transfer checklist incomplete
- -taking care of missing documentation

Patients

- May arrive late/to the wrong place
- Different patient acuities
- Factors preventing surgery (skin lesion, eating prior)

El Camino Health

Gap Analysis (Where are our opportunities)?
First Case On Time Starts (October)

First 50% Delays (6-12 mins)

Category	Percentage
NURSE NOT AVAILABLE	5%
BED NOT AVAILABLE	5%
H&P NOT READY	5%
PATIENT TOILETING	9%
MISSING EQUIPMENT	9%
SURGEON LATE	14%
PATIENT DELAY	14%
PATIENT DELAY- TALKING TO PROVIDER	14%
INCOMPLETE/ NO CONSENT	27%

El Camino Health

Gap Analysis (Where are our opportunities)?
First Case On Time Starts

Second 50% Delays (13-55 minutes)

- PATIENT TOILETING
- PATIENT DELAY- TALKING TO PROVIDER
- MISSING PRE OP ORDERS — 3%
- MISSING LABS — 3%
- MISSING EQUIPMENT — 3%
- BED NOT AVAILABLE — 6%
- PATIENT DELAY — 10%
- SURGEON LATE — 10%
- NURSE NOT AVAILABLE — 19%
- H&P NOT READY — 23%
- INCOMPLETE/ NO CONSENT — 23%

El Camino Health

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Consents Implementation Plan

Who is involved?
- Schedulers MV OR, Schedulers IS, PAS staff

What?
- Current scheduling fax number will continue to receive case requests and preference card changes
    - Keep current scheduling workflow
    - Have schedulers reinforce that all other documents go to another e fax number through confirmation phone call
    - Add wording of new phone number to surgical request form

Goal?
- Reach 90% of consents available prior to pre procedure complete is clicked in EPIC

El Camino Health

Consents Implementation Plan

Who is involved?
- Schedulers MV OR, Schedulers IS, PAS staff

What?
- Have all other documents (H&Ps, consents, labs, orders, EKGs, radiology, cardiac clearance) sent to the E Fax number
- Suggest including number of days prior to surgery to include documents
- Have staff member from PAS review documents before scanning them into EPIC
  - Create template to include in document transmission
  - Create checklist for ensuring documents are good and ready to scan
  - Check for PAS staff capacity for new workflow
  - Develop workflow for when documents are not up to standard
  - Develop workflow for confirmation

Goal?
- Reach 90% of consents available prior to pre procedure complete is clicked in EPIC

Barriers

- **Global**
  - Barriers with provider implementation

PI Portfolio Review

Christine Cunningham & Melinda Hrynewycz

New Programs

- **PI Academy**

  - Pilot class kicked off last week with 3 students & 2 projects
    - Christy Lucero & Susan Johnston (project to reduce failed preps)
    - Patricia (Patti) DeMellopine (project to streamline ECT readiness)

- **PI Fellowship**

  - 1 applicant moving forward so far
  - Would like other candidates this month!

El Camino Health

Strategy Deployment

- **Strategy Deployment Cycle**

  - Starting in Feb and concluding by May

- **Service Lines/Value Streams for FY22**

  - Please submit list of ideas for projects so we can begin analysis

- **Sr. PM on LOA**

- **Kyle Berry being offered role in PI as Clinical PM**

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: March 1, 2021
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. This QAPI Plan provides the details for the implementation of the long term quality plan. It is revised each year to reflect progress and any changes that need to be made based on the LEAN PDCA cycle. The Board QC received an update on the plan implementation in September of 2020. The information in that report serves as the foundation for this update—i.e., those details will not be repeated but should be referenced by committee members. The QC has requested another 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: There are 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: The quality and safety vision remains the same: "To consistently deliver the highest quality care with zero preventable harm."

      A.   Alignment of governance, leadership and management:
          i.   Adoption of STEEEP definition of quality—COMPLETED
          ii.   Revision of enterprise daily huddle to emphasize safety---COMPLETED
          iii. Addition of safety issue feedback report to huddle---COMPLETED
          iv.   Enterprise Quality Council (EQC) functioning---COMPLETED
          v.   Consolidated med staff depts leading quality improvement---COMPLETED

      vi. Minutes of EQC flowing to QC and Board---COMPLETED
     vii. Board spends 30% of meetings on quality---INCOMPLETE

  B. Quality organization integration:
       i. Siloes eliminated and all quality activities aligned with CMO---COMPLETED
      ii. CMO Advisory Council focused on quality---COMPLETED
     iii. CDI re-purposed as Clinical Documentation Integrity---COMPLETED
      iv. EQC revamped to enhance engagement and participation---COMPLETED
      v. Patient Safety Oversight Committee in place---COMPLETED

  C. Performance improvement methods and metrics:
       i. RCA steering committee reviewing and validating audits---COMPLETED
      ii. Improve rigor in execution of event reviews for causation---COMPLETED
     iii. RCA steering committee deploys audits---COMPLETED
      iv. Rectified data discrepancies between disparate systems---COMPLETED
      v. Reduce "Code Blue" alerts with A.I.---COMPLETED
      vi. Optimize *Epic* data fields to better capture HEDIS scores---COMPLETED

  D. Journey to High Reliability:
       i. HRO Steering Committee to provide oversight---COMPLETED
      ii. Accumulate at least 12 months of SSE data to calculate SSER---COMPLETED
     iii. Classify PSE's and apply Pareto analysis---COMPLETED
      iv. Identify most common PSE causes and establish action plan---COMPLETED
      v. Select vendor to provide training for HRO tools---INCOMPLETE
      vi. Revitalize Just Culture for accountability---INCOMPLETE

  E. Culture of Safety:
       i. Encourage iSAFE reporting---IN PROGRESS
      ii. Enhance communication of safety issues---COMPLETED
     iii. Encourage and recognize good catches---IN PROGRESS
      iv. Increase frequency of safety surveys---COMPLETED
      v. Increase frequency of leader rounding---IN PROGRESS
      vi. Create safety brand, SAFETY FIRST MISSION ZERO---COMPLETED

5. <u>Other Reviews</u>: None

6. <u>Outcomes</u>: The Quality/Performance Improvement and Patient Safety Plan (QAPI) is a "field guide" for the organization used to direct the quality and safety programs. It is a direct result of the quality and safety strategic planning previously presented. It is not an end but a means to an end. The end is measured by the quality and safety metrics contained in the various dashboards used in the organization to track quality/performance improvement. El Camino now has a CMS 5 STAR rating and a Leapfrog A rating as a result of this work.

<u>List of Attachments:</u>

1. None

<u>Suggested Committee Discussion Questions</u>:

How do the outcome metrics the committee reviews monthly align with the strategic goals of the QAPI?

How might the Board allocate more time to quality discussions?

The next version of the QAPI for FY22 is under review. Does the committee have any suggestions or areas that need to be addressed?