El Camino Health

AGENDA

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

Monday, March 2, 2020 – 5:30pm
El Camino Hospital | Conference Room E&F
2500 Grant Road, Mountain View, CA 94040

Melora Simon will be participating via teleconference from 107 Crescent Avenue, Portola Valley, CA 94024.

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 – 5:35**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (02/03/2020) ***Information*** b. FY20 Quality Dashboard c. FY20 Pacing Plan d. Progress Against FY20 QC Goals e. Hospital Update f. Quality Committee Follow-up Items			
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**discussion 5:35 – 5:40**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**information 5:40 – 5:50**
6.	**PATIENT EXPERIENCE PLAN/ PATIENT FAMILY VOICE** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**discussion 5:50 – 6:10**
7.	**BOARD QUALITY DASHBOARD** **ATTACHMENT 7**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:10 – 6:30**
8.	**UPDATE ON LEAN TRANSFORMATION** **ATTACHMENT 8**	Jim Griffith, COO		**discussion 6:30 – 6:50**
9.	**GOAL ATTAINMENT** **ATTACHMENT 9**	Julie Kliger, Quality Committee Chair		**discussion 6:50 – 7:05**
10.	**PROPOSED FY21 ORGANIZATIONAL GOALS**	Mark Adams, MD, CMO; Cheryl Reinking, RN, CNO		**motion required 7:05 – 7:20**
11.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 7:20 – 7:23**

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
12.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:23 – 7:24**
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 7:24 – 7:25**
14.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 7:25 – 7:27**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (02/03/2020) ***Information*** b. Medical Staff Quality Council Minutes (including API Reports)			
15.	**MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT ATTACHMENT 15**	Mark Adams, MD, CMO		**information 7:27 – 7:37**
16.	*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 7:37 – 7:42**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:42 – 7:43**
18.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:43 – 7:44**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
19.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:44 – 7:49**
20.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:49 – 7:50**

Upcoming Meetings:

Regular Meetings: April 6, 2020; May 4, 2020; June 1, 2020
Educational Sessions: April 22, 2020

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 3, 2020
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present
Julie Kliger, Chair
George O. Ting, MD, Vice Chair
Caroline Currie
Alyson Falwell
Peter C. Fung, MD
Jack Po, MD
Melora Simon
Krutica Sharma, MD

Members Absent
Terrigal Burn, MD

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 silent roll call was taken. Ms. Simon arrived at 6:05 pm during the discussion about the consent calendar. Terrigal Burn, MD was absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: For information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 QC Goals; and Hospital Update. **Movant:** Sharma **Second:** Falwell **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Consent Calendar approved***
4. REPORT ON BOARD ACTIONS	Chair Kliger asked if any Committee members had any questions about the Report on Board Actions. No questions were reported.	
5. PATIENT STORY	Cheryl Reinking, RN, CNO, introduced the Daisy Award that ECH started in December 2019. The Daisy Award was created by a family in honor of their son, Patrick, who died in 1999 of an auto immune disease. The family was so moved by the care their son received by the nursing staff, the family created the Daisy Foundation. The Daisy Awards are written by patients/families. In January, Debra Anderson, RN, won this award for going beyond what is expected and doing what is needed. Ms. Reinking stated that this award will be given every month.	
6. PATIENT EXPERIENCE	In response to a previous request by the Quality Committee to report on areas where we can improve, Ms. Reinking presented data pulled from	

	comments from patients. She presented complaints from patients where there were complaints of being unprofessionalism, unresponsive, rude, and carelessness. Ms. Reinking presented metrics in improving communication since communication is the most important factor that influences patients to likely recommend this organization. Our goal is 84.2. Fiscal year to date is currently 83.3 so we are 0.9 below target for likelihood to recommend. As shown in the materials, courtesy and respect received the highest score. On the other hand, the physician communication is at 84.6 for the fiscal year to date, which is essentially the same trend as the nurses. Both graphs show that listening and explaining could use some work. Ms. Reinking explained that we have Care Team Coaching to improve care practices in developing relationships with patients. We've also been doing Commit to Sit to create an eye level communication to actually sit down for at least two minutes for each patient. Ms. Reinking also stated that Leader Rounding where leaders check in on the patients also makes a big difference and shows in the data presented. In response to Committee Members' questions, Ms. Reinking stated there is a very narrow difference in comparison to the national percentile ranking. The percentile ranking is constantly changing. Dr. Adams commented that nurses are always changing from shift to shift so the patients see more different nurses versus the physicians where there is a constant relationship with the same person. Nurses also can only give so much information and cannot make or communicate diagnoses. Ms. Reinking stated that usually in the winter months, there is a decline in scores. November was a very good month. There is really no explanation of variability of why the scores fluctuate. The leaders are trying to motivate behavior through sharing the data with staff.. Dr. Sharma suggested that the Commit to Sit for the managers should be on the radar for them to do productivity tracking. Also, for the behaviors, there should be accounting for differences in diversity, culture, age, etc. for both the employee and patient.	
7. PATIENT SAFETY INDICATORS 4, 18, 19	Dr. Adams presented Patient Safety Indicator (PSI) scores for 4, 18, and 19. <u>PSI 4:</u> Dr. Adams suggested the Committee should not spend a lot of time on this metric because it's a controversial patient safety index and our safety index composite is very good. That is one of the reasons we were issued a 5 star rating. The definition of PSI 4 is the death rate among surgical patients with serious treatable complications AND any surgery performed within two days of admission. This means that in many cases it is really a failure to rescue because patients can come in for a procedure while already having the condition being treated. About half of the patients already have the condition before coming into the hospital to be treated.	

Dr. Adams presented four cases that accounted for all of the PSI-04 deaths last month to illustrate why this definition is problematic:

Case #1 – Patient who comes in with massive severe cirrhosis, GI bleed, Schizophrenia, Hep C, and is severely bleeding from esophageal varices. The patient was treated with transjugular intrahepatic portosystemic shunt (TIPS), but the patient died of the underlying disease. Had that TIPS procedure not taken place, the patient would've died anyway and would not have counted for the PSI 4.

Case #2 – Patient was admitted with a strangulated hernia, bowel perforation, peritonitis and septic shock. She subsequently developed respiratory deterioration and collapse that was caused by sepsis; it would be classified as a PSI-4. The surgery was not the reason for the death and in fact was the last measure to try save the patient.

Case #3 – Patient was admitted with necrotizing fasciitis, which carries a high death rate. The patient had a host of intraabdominal catastrophes as well. From the underlying disease with some surgeries in the process, the patient could not be saved/rescued.

Case #4 – Patient was found in cardiac arrest, CPR was initiated, and the patient was brought to the ED with cryptococcal meningitis which is a fatal disease. There was an attempt to relieve pressure on the brain and because of that procedure, it becomes a PSI 4 even though the procedure did not affect or influence the course or the patient.

In response to Committee Members' questions, Dr. Adams stated that none of the cases presented went to Peer Review because it was felt that these were not issues of clinical care but rather underlying diseases of the patients. Had the physicians not acted to try to save the patients from these underlying diseases, our score would be much lower. Dr. Adams stated that this comes from CMS and we have no say in this. Dr. Mallur stated that every mortality is reviewed by Mortality Review team which is different from the Peer Review team. If there is found to be a care problem, then it is sent to Peer Review.

Dr. Po also agreed that part of the role is to see if the process isn't working. It is up to the Mortality Committee to make that judgement. If we don't trust that process, then we can re-evaluate, but right now, the process should be trusted.

Chair Kliger requested for future meetings of a higher level of understanding what goes to peer review, mortality committee, etc. She also requested that when there is grouped data, it would be helpful to understand the committee ultimately responsible for the review.

<u>PSI 18 & 19:</u>

Dr. Adams stated that PSI 18 & 19 relate to trauma in vaginal birth with or

	without instrumentation. There was a taskforce implemented to do the OB Trauma Report presented. Dr. Adams stated that the ethnicity of our patient population poses a much higher risk for this injury. El Camino has a higher rate, aside from Santa Clara County, related to 3rd and 4th degree laceration associated with vaginal deliveries. The Asian ethnicity makes up 62% of the child bearing population in Mountain View, which contributes to a higher risk based on national published data. This correlates statistically in the data underlying PSI 18 & 19. Another factor is induction with the reason being that it is more stressful. Nonetheless, there are things we can do to mitigate the risk factors such as decreasing the use of instrumentation. The committee suggested to getting rates from Asian, specifically South Korea, and compare those rates. In addition, Chair Kliger suggested statistical data and to revisit this topic in July.	
8. BOARD QUALITY DASH REPORT	Dr. Adams stated that the CMS Star rating has been released and El Camino Hospital has received a 5-Star rating. In additional, California started the "Patient Safety Honor Roll" this year to which El Camino Hospital proudly made the list. Dr. Adams presented the STEEEP report. The PSI 90 for composite score is very good. If you see an E, that means Enterprise metric, H is hospital specific, and A is ambulatory specific. We don't always have baseline data for SVMD, but they should be included going forward. Dr. Adams stated that OP-8 and OP-10 are important when CMS looks at efficiency and value of care, which the hospital is in red at the moment. This relates to people who have back pain. This should be lower. In response to Committee members' questions, Dr. Adams stated unmet requests for translation services is not at a 0 because some of the languages requested were not in the list of languages on the iPad translator and it could also be related to dialects being too specific. Chair Kliger stated this should be presented quarterly to help guide the conversation for the board to understand how we're doing and a plan of correction. In addition, the report being presented to the Quality Committee should be reviewed and discussed with internal management committees beforehand. Members of the Committee agree that any suggestions for changes to the proposed Dashboard be sent to Ms. Murphy via email.	
9. DRAFT REVISED COMMITTEE CHARTER	Dr. Adams stated that the Chiefs of the Medical Staff regularly attend the Quality Committee meetings and believe that they should serve as voting members; one from Los Gatos and one from Mountain View. Dr. Fung suggested for the Chiefs to vote and Vice Chiefs to vote in their absence. **Motion:** To recommend that the board approve include the two (2) Chiefs of	

	the Medical Staff as voting members and for the Vice Chiefs to vote in their absence. **Movant:** Po **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Nayes:** None **Abstentions:** None **Absent:** Burn **Recused:** None Dr. Adams also suggested the Committee members be able to review the Medical Executive Committee's monthly credentialing and privileging reports to make recommendations to the Board. **Motion:** For the Committee to review the Medical Executive Committee's monthly credentialing and privileging reports to make recommendations to the Board. **Movant:** Po **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	
10. SVMD REPORTING TO QUALITY COMMITTEE	Dr. Adams stated that there is no report other than what is current being worked on. SVMD is under construction and a SVMD dashboard will be forthcoming. The first report would be at the end of first quarter. To answer the Committee members' questions, Dr. Adams stated that there is no definite person who will be reporting on behalf of SVMD. They currently don't have a CQO. They have a chair of their Quality Committee and that will most likely be who will be presenting.	
11. PUBLIC COMMUNICATION	There was no public communication.	
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:45pm. **Movant:** Po **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Adjourned to closed session at 7:45pm***
13. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:59pm. Agenda items 13-17 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (12/2/2019); and for information: Medical Staff Quality Council Minutes.	
14. AGENDA ITEM 19: CLOSING WRAP UP	None noted.	

15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 8:00pm. **Movant:** Fung **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Meeting adjourned at 8:00pm***

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

_____
Julie Kliger, MPA, BSN
Chair, Quality Committee

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: March 2, 2020
Subject: FY 20 Quality Dashboard for March meeting

Recommendation(s): N/A

Summary:

- Provide the Committee with a snapshot of the FY 2020 metrics monthly with trends over time and compared to the actual results from FY2019 and the FY 2020 goals.
- Annotation is provided to explain actions taken affecting each metric.

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on key quality metrics.

2. Background: These thirteen (13) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2020 Quality, Efficiency and Service Goals.

3. Assessment:

- Continued reduction in Mortality Index, at top decile level with other hospitals
- Readmission Index has increased and is not stable
- Only HCAHPS Discharge Information metric is above target.
- HAIs continue to occur but in low numbers: 1 CAUTI, 1 CLABSI, 2 .C.Diff
- Surgical Site Infections are ½ of occurrence in FY19
- Sepsis Mortality Index is continues to decrease, below target. Focus on improving each for the 3-hr bundle elements
- Perinatal Measures of Primary C/S (PC-02) and Early Elective Delivery (PC-01) are being address by MCH Service Line and Medical Director, with great improvement in December.

4. Other Reviews: N/A

5. Outcomes: N/A

List of Attachments:

FY20 Quality Dashboard, January data unless otherwise specified - final results

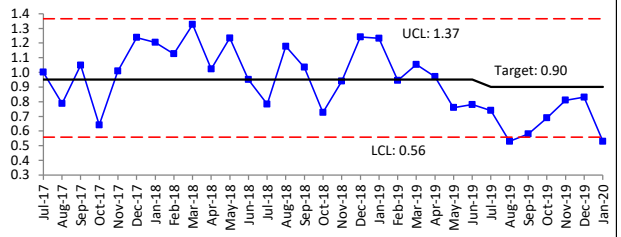
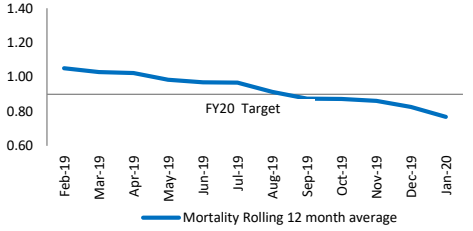
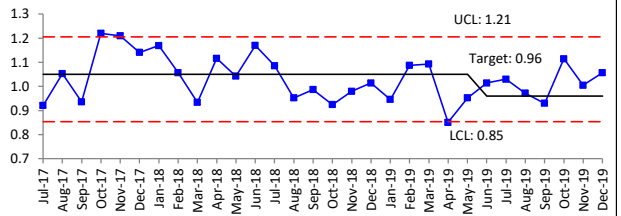
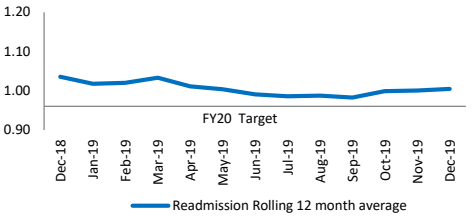
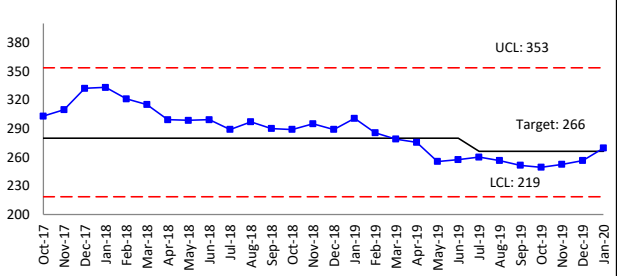
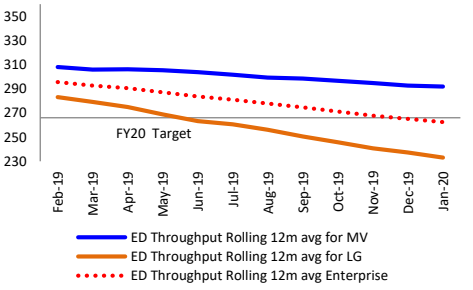
Suggested Committee Discussion Questions: None.

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

January 2020 (Unless otherwise specified)

Month to Board Quality Committee: March, 2020

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Months Average
Quality		**Latest month**	**FYTD**				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: January 2020*	0.53 (1.08%/2.06%)	0.68 (1.30%/1.92%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: December 2019*	1.06 (8.38%/7.93%)	1.02 (7.92%/7.79%)	0.99	0.96		
3	**Patient Throughput-Median Time from Arrival to Head In Bed** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Date Period: January 2020*	MV: 312 min LG: 227 min Enterprise: 270 min	MV: 286 min LG: 227 min Enterprise: 257 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

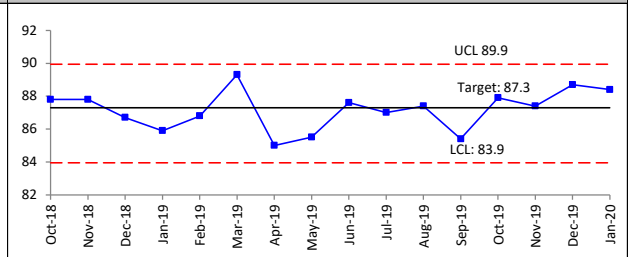
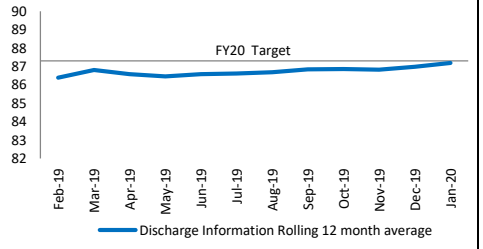
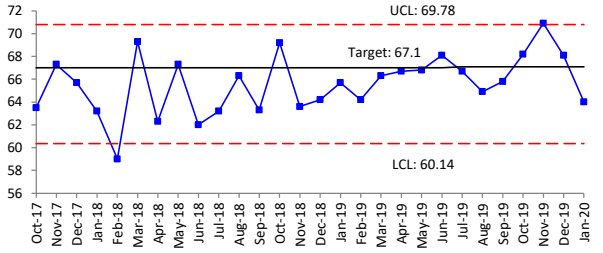
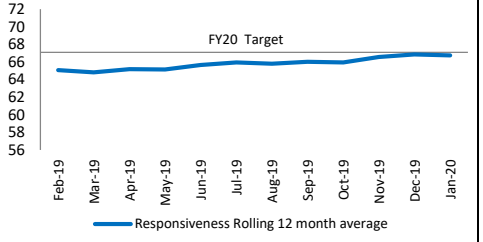
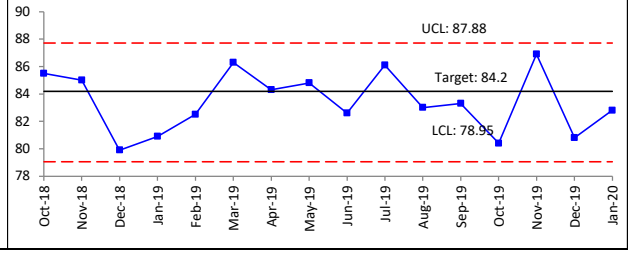
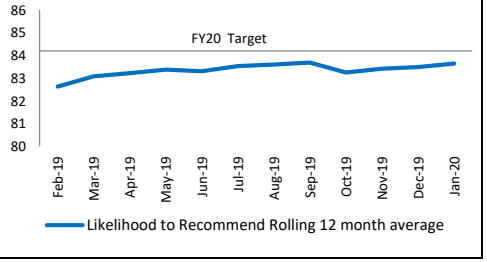
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	In FY18 & FY19, January has been a peak month for deaths and this is not seen this year in FY20. Better physician documentation on the patient's major and co-morbid conditions increases the index expected value, while the observed deaths were less than expected.	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 Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
Readmission Index - All Patient All Cause Readmit (Observed/Expected)	This index increased in December and is not yet stable. Respiratory Therapy Department plan to add Pneumonia patients in the use of the Chat Box app Conversa, the second highest readmission diagnosis after COPD. Readmissions usually increase over the winter months, as you can see in previous years.	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). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients and Newborns)	Both campuses experienced high seasonal patient volumes impacting their throughput performance for January. Despite these high volumes, teams have continued to keep their throughput performance trending in the right direction compared to the high surge season last fiscal year. Los Gatos continues to monitor stabilization of improvements identified during their first 2 Rapid Process Improvement Workshops to help improve the initiation of care and ancillary testing. MV continues to run small experiments during their construction phase to keep throughput going. Work is in process to help implement and enhance elements of Daily Management System related to ED throughput on both campuses. 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.	Cheryl Reinking, Dolly Mangla	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 *LCL is set to '0' if value is less than or equal to zero.*	**iCare Report: ECH ED Arrival to Floor**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

January 2020 (Unless otherwise specified)

Month to Board Quality Committee: March, 2020

		FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
Service		Latest month	FYTD				
4	* Organizational Goal **HCAHPS Discharge Information** **Top Box Rating of Always** *Date Period: January 2020*	88.4	87.5	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: January 2020*	64.0	66.8	65.7	67.1		
6	**HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: January 2020*	82.8	83.3	83.5	84.2		

Definitions and Additional Information

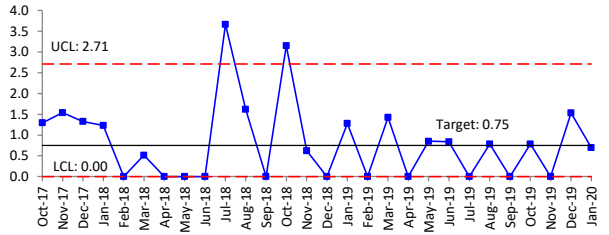
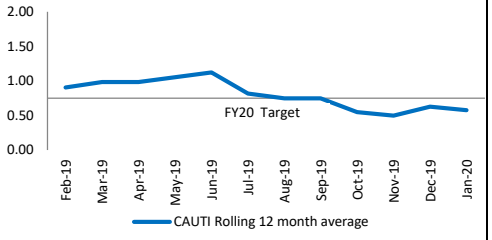
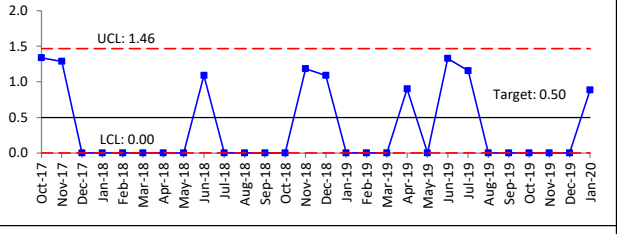
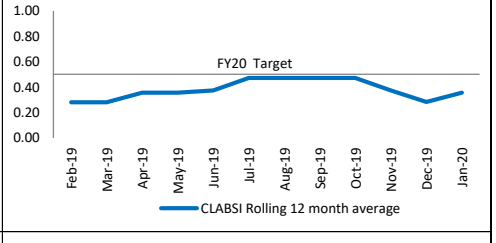
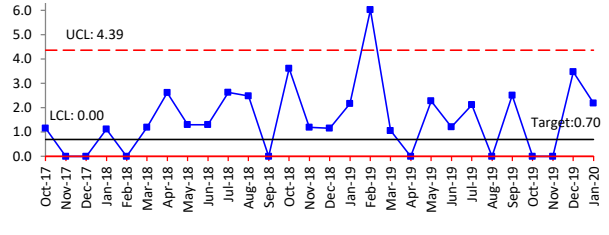
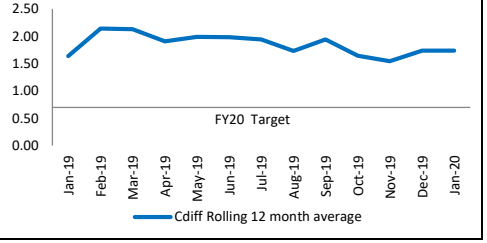
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	• Discharge Information – this metric is on target for the quarter and year to date. Strong improvements have been made in Inpatient / Mother baby especially in Los Gatos. Continued work is being done on implementing the proven best practice of post discharge phone calls. "Help at Home" signs are up on all units in order to help foster the discharge discussion. Committee continues to work with low scoring nursing units and has seen improvements.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero..*	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	• Staff Responsiveness – this metric is below target for the quarter and year to date. Current initiatives include Mother/Baby 'commit to sit' where nurses commit to sit daily in order to make a connection and / or address concerns. Communication training for the non-clinical staff is also in process. Hourly rounding /purposeful rounding program is being reviewed in order to improve its efficacy. Inpatient units have seen some progress due to implementation of No Pass Zone and are passing out buttons to involve/remind all staff of this initiative. Current Call light system has provided challenges as staff continue to experience difficulty hearing patient requests, thereby extending response time. Committee exploring methods to improve response time by collaborating with CNA's and non-clinical personnel.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**
HCAHPS Likelihood to Recommend Top Box	• HCAHPS: Likelihood to Recommend – Likelihood to Recommend is our loyalty score and the industry standard of measuring experience. Although not quite at target, ECH continues to have strong LTR scores and high percentile (87th%tile) compared with others in the nation. Continued emphasis on leader rounding, and updating and reinvigorating our service standards will contribute to this metric.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

January 2020 (Unless otherwise specified)

Month to Board Quality Committee: March, 2020

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend	
Quality		Latest month	FYTD				
7	***Hospital Acquired Infections*** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: January 2020*	0.70 (1/1432)	0.55 (5/9025)	1.09	SIR Goal: <= 0.75		
8	***Hospital Acquired Infections*** *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: January 2020*	0.88 (1/1130)	0.32 (2/6211)	0.36	SIR Goal: <= 0.50		
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: January 2020*	2.19 (2/9126)	1.50 (9/59823)	1.96	SIR Goal: <= 0.70		

Definitions and Additional Information

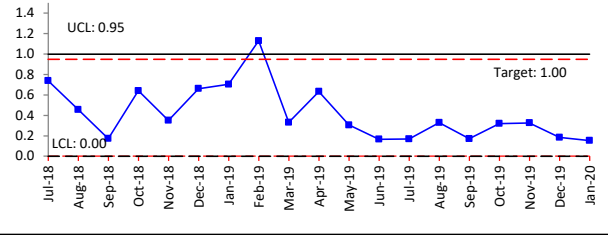
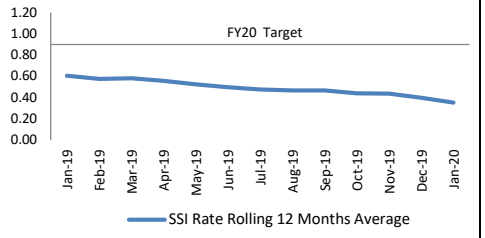
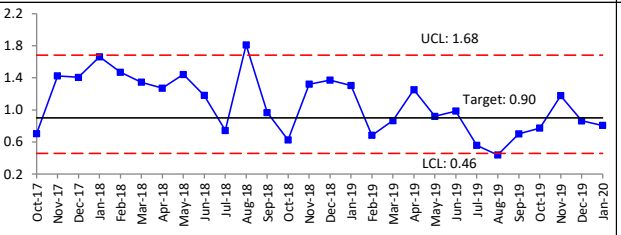
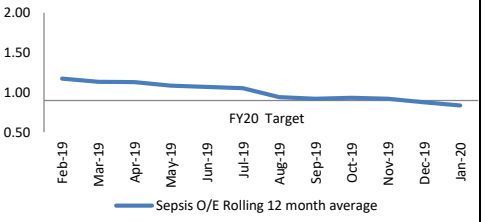
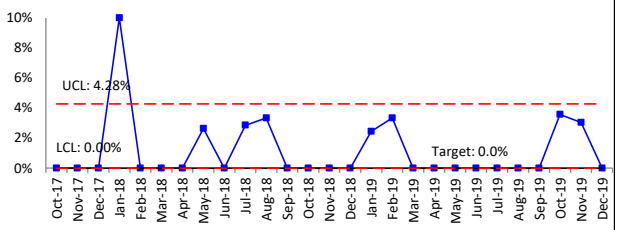
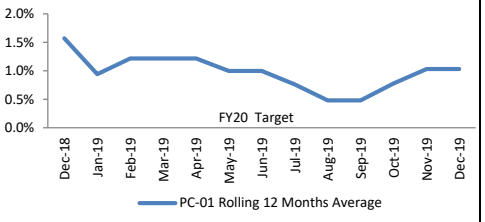
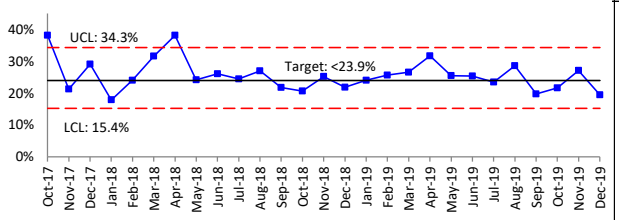
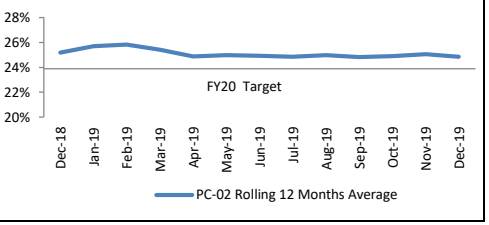
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	1- CAUTI case in January in MV, 75 y/o female admitted with Altered LOC, with negative urine culture on admission. 17 days after Foley catheter placed for retention, new UTI identified.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is not visible if value is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Zero CLABSI in November and December 2019; 5 consecutive months without CLABSI. Trend ended with 1 CLABSI in January on 4A: Pt admitted for Whipple w/morbid obesity, pancreatic cancer. PICC line inserted for TPN infusion and 7 days later Sepsis alert called w/CLABSI.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	2 C.Diff infections in MV in January:1) 77 y/o admitted from SNF with negative surveillance, for redo of knee replacement, 11 doses of ABX after surgery, developed C.Diff infection days later. 2) 72 y/o admitted from SNF w/negative surveillance, developed C.Diff toxin on day #4 after one dose Ceftiaxone.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

January 2020 (Unless otherwise specified)

Month to Board Quality Committee: March, 2020

		FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
		Latest month	FYTD				
10	**Organizational Goal** **Surgical Site Infections (SSI)-Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Date period: January 2020*	0.15 (1/655)	0.24 (10/4219)	0.22 (37/7167)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: January 2020*	0.81 (9.17%/11.36%)	0.87 (9.28%/10.65%)	1.06	0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) Date period: December 2019	MV: 0.00% (0/29) LG: 0.00% (0/6) ENT: 0.0% (0/35)	MV: 1.2% (2/173) LG: 0.00% (0/26) ENT: 1.01% (2/199)	MV: 1.11% (4/360) LG: 0.00% (0/44) ENT: 0.99% (4/404)	0.0%		
13	**PC-02: Cesarean Birth** (lower = better) Date period: December 2019	MV: 20.25% (32/158) LG: 13.64% (3/22) **ENT: 19.4%** (35/180)	MV: 24.35% (207/850) LG: 14.91% (17/114) **ENT: 23.24%** (224/964)	MV: 26.28% (425/1617) LG: 14.29% (30/210) **ENT: 24.90%** (455/1827)	<23.9%		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1 SSI in January in MV in 49 y/o with Lumbar laminectomy on 1/9. Readmitted 13 days later with need for I&D and Debridement of wound (Proteus and Staph coag neg). FY to date, ECH has 9 SSIs compared to a total of 37 for FY19. At this rate we will end FY20 with 18 or less. This is directly related to the SSI sub team commissioned by the Quality Council in April 2019 and improvements in OR Prep and attention to Preop ABX by the OR staff and Anesthesiologists.		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated. *Upper Control Limit and Lower Control Limit 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 data base - Inf. Control**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	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. This will result in capture by ECH of more sepsis cases with secondary diagnosis. The cases pulled for Sep-1 abstraction used the correct definition.	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 Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	No occurrences of early elective delivery prior to 39 weeks gestation.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Good improvement on the C/S rate at MV. Physicians received their unblinded Primary C/S rates in early December and information on C/S was shared among members. Discussions at OB Leadership meetings on C/S and limits by payors of not sending their patients to a hospital with a greater that 23.9% Primary C/S rate occurred.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY20 Pacing Plan

FY2020 Q1		
JULY 2019	**AUGUST 5, 2019**	**SEPTEMBER 9, 2019**
No Board or Committee Meetings **Routine Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 20 Quality Dashboard** ▪ **Progress Against FY 2020 Committee Goals** ▪ **FY20 Pacing Plan** ▪ **Med Staff Quality Council Minutes**	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY20 Quality Dashboard (Discuss - should this be on consent? Only discuss if something outside normal variation? Deeper Dive Quarterly?) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 1. FY19 Quality Dashboard Results (Includes FY19 Org. Incentive Goals) 2. LEAN Progress Report 3. Q4 FY19 Quarterly Quality and Safety Review 4. Physician Engagement 5. Committee Recruitment (If needed) 6. Who makes up census in the ED? 7. draft Board-level QC reporting 8. PSI-90 metrics	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Introduction of New Members 8. Annual Performance Improvement Reports (rotating departments) Special Agenda items: 9. Update on Patient and Family Centered Care 10. Recommend FY20 Organizational Goal Metrics 11. Annual Patient Safety Report 12. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals) 13. Pt. Experience (HCAHPS) 14. ED Pt. Satisfaction (Press Ganey) 15. Quality and Safety Strategic Plan
FY2020 Q2		
OCTOBER 7, 2019	**NOVEMBER 4, 2019**	**DECEMBER 2, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Standing Agenda Items: 8. Report on Medical Staff Peer Review Process 9. FY20 Org. Goal and Quality Dashboard Metrics 10. FY19 Organizational Goal Achievement (M, RA)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Safety Report for the Environment of Care 11. Q1 FY20 Quarterly Quality and Safety Review 12. Debrief 10/23 Session 13. Q&S Plan	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotate) Special Agenda items: 8. Readmission Dashboard 9. PSI- Indicators 10. Peer Review Process 11. Drill Down on Q1 Q&S Review
FY2020 Q3		

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY20 Pacing Plan

JANUARY 2020	FEBRUARY 3, 2020	MARCH 2, 2020
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Q2 FY20 Quality and Safety Review 9. Update on Patient Care Experience 10. Draft Revised Charter (C&P, Chiefs) 11. SVMD Reporting to Quality Committee 12. Follow up on PSI 4, 18, 19	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Proposed FY21 Committee Goals 9. Proposed FY21 Organizational Goals 10. Update on Patient and Family Centered Care 11. Update on LEAN Transformation 12. Goal Attainment ~~12.~~13. Board Quality Dashboard Report

FY2020 Q4

APRIL 6, 2020	MAY 4, 2020	JUNE 1, 2020
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments – PLUS Bring Back HIMS, Ortho. Antimicrobial from October) Special Agenda Items: 8. Value Based Purchasing Report 9. Pt. Experience (HCAHPS) 10. Approve FY21 Committee Goals 11. Proposed FY21 Committee Meeting Dates 12. Proposed FY21 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Approve FY21 Committee Goals (if needed) 11. Proposed FY21 Organizational Goals 12. Proposed FY21Pacing Plan 13. Q3 FY20 Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. 9. Readmission Dashboard 10. PSI-90 Pt. Safety Indicators 11. Approve FY21 Pacing Plan 12. Leapfrog Survey

El Camino Health

FY20 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	- FY19 Achievement and Metrics for FY20 (Q1 FY20) (Complete) - FY21 Goals (Q3 – Q4) (On 3/2/20 Agenda))	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 (FY20) (Complete) - 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 timeline – (Paced)
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – (On 3/2/20 Agenda)
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Review quarterly at the end of the meeting (Use Closing Wrap-Up Time)	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting
6. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals (Ongoing)

SUBMITTED BY: **Chair**: Julie Kliger, MPA, BSN
Executive Sponsor: Mark Adams, MD, CMO

Approved by the ECH Board of Directors 6/12/2019

El Camino Health

Hospital Update
March 2, 2020
Mark Adams, MD, CMO

Quality and Safety

As verbally reported last month, we are very proud to announce that El Camino has been awarded a Five Star- Rating from the Centers for Medicare and Medicaid (CMS)!

The CMS Hospital Compare overall hospital rating summarizes a variety of measures across 7 areas of quality into a single star rating (1 to 5, five being the best) for each hospital. Once reporting thresholds are met, a hospital's overall hospital rating is calculated using only those measures for which data are available. This may include as few as 9 or as many as 51 measures. The average is about 37 measures. The 7 groups of measures are:

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Effectiveness of Care
6. Timeliness of Care
7. Efficient Use of Medical Imaging

In addition, the California Health and Human Services Agency (CHHS) recognized both El Camino Hospital Mountain View and El Camino Hospital Los Gatos with the 2019 Patient Safety Honor Roll Award. This award recognizes 77 adult, acute care hospitals with high safety profiles in comparison to other hospitals. This Honor Roll offers Californians a rigorously evaluated list of hospitals that have consistently demonstrated a strong culture of safety across multiple departments and offers hospitals yet another valuable tool to evaluate and celebrate their own performance in comparison to others. The 77 hospitals represent 24% of the 327 adult, acute care hospitals considered for the Honor Roll.

As well, CHHS recognized El Camino Hospital Los Gatos with the 2019 Maternity Honor Roll Award. This award recognizes hospitals that achieve a Cesarean section rate of 23.9% or less for low-risk, first birth deliveries and have a high patient safety profile in comparison to other hospitals across a variety of domains. For 2019, 134 hospitals of all 235 hospitals that offer maternity services in California received the award.

As we continue to solidify ourselves as a well-recognized program in the field of interventional pulmonology, I am pleased to report that Dr. Ganesh Krishna, interventional pulmonologist, co-authored a manuscript entitled "Standardized Bleeding Definitions After Trans Bronchial Lung Biopsy," which was accepted for publication by

CHEST, a tier 1 journal for pulmonology and the official publication for American College of Chest Physicians (ACCP).

Operations

The Nursing Division submitted our supplemental application materials for Magnet Designation and we expect a decision in the next 6-8 weeks.

We have developed and implemented a performance improvement/LEAN nursing fellowship program to further enhance patient care processes at our two hospital campuses. We assigned two clinical nurses to the performance improvement department where they will be mentored by performance improvement experts for 6 months, after which they will return to their previous positions. After they return to their positions, we will expect them to lead performance improvement/LEAN activities within the organization and we will assess whether they have measurable impact on patient flow.

Workforce

We launched our new SOS (Support Our Staff) Program, which we created to provide targeted support after a traumatic event such as an unanticipated patient death, medical error, or workplace violence event. The SOS team is a group of ECH employees trained in crisis support and stress management. This peer support team is available to employees who need support and guidance while experiencing a reaction to a stressful event or adverse outcome 7 days/week and 24 hours/day.

Over 300 employees attended the 53rd Annual Employee Service awards on the evening of January 30, 2020. At the event, we recognized employees with between 15 and 45 years for service-a combined total of 4,110 years of service! In addition, the 2019 Employees of the Month, Excellence in Action, Excellence in Nursing, Leadership in Action and Teamwork in Action awards were presented.

We also began our "Storytellers" initiative on February 3, 2020. This new interactive engagement program is centered on a bi-weekly video – a story about ECH's mission, culture, or values, which will inspire discussion and debate. Employee insights and engagement are the keys to strengthening our organization and ensuring we raise the bar every day. A short (less than 5 minute) ECH Storyteller video will be sent out every other week throughout 2020 that will allow employees, physicians, and others to see, share, and reflect on a variety of stories that describe who we are as an organization. By sharing our own stories, and learning from the stories of others, we will help create and sustain an environment where teams are aligned and empowered with trust and purpose.

Corporate and Community Health Services

Community Benefit grantees (97) submitted their midterm reports, which includes narratives on progress, and metric performance against targets. Staff is in the process of reviewing and assessing the reports and will address any areas of concern with the grantees. We also released our online FY21 Community Benefit grant applications and grant guidebook on the ECH and ECHD websites. Applications are due February 28, 2029. Broad notification to the community accompanied the release. Community Benefit staff also visited 18 of our grant programs with a focus on cementing partnerships with staff.

The South Asian Heart Center Initiated corporate outreach to Deserve Corporation and on boarded 50 employees to AIM to Prevent Diabetes program, recruited a new Health Education Coordinator and began new monthly Diabetes Prevention Program group that includes El Camino Health employees.

The Chinese Health Initiative (CHI) collaborated with (1) 99 Ranch Market in Mountain View to hold the first grocery tour conducted by registered dietitian for CHI's diabetes prevention program participants and (2) Cupertino and Saratoga Library to host in-person Ask-A-Dietitian workshops for 45 participants. CHI also conducted its first Ask-a-Dietitian webinar to promote healthy eating for diabetes prevention and held an annual volunteer appreciation event honoring 30 of our 70-80 volunteers that help with CHI's community outreach & education efforts each year.

Marketing and Communications

Gentry Magazine, which has print circulation of 102,700 and a digital version online, published an article on the Taube Pavilion. The Mountain View Voice recently covered the flu and mental health peer support, speaking with Dan Shin, MD and Michael Fitzgerald, respectively.

El Camino Health's corporate brand awareness advertising full integrated campaign launched across TV, digital, radio and print on January 13. The announcement campaign will run through June. On Monday, January 13, the urgent care sites powered by Carbon Health were updated onsite and online to reflect the El Camino Health brand. The El Camino Health website homepage was updated to reflect new language about emergency room process, helping set expectations for patients and families and supporting the patient experience.

Information Services

Eighty four percent of our patients adopt Emergency Department texting. This service provides secure texts to patients in the ED to keep them informed of status and next steps with the impact of improving the patient experience. These text messages communicate timing, physician orders, when results will be ready, notice of discharge, and a thank you for trusting us with their care. Survey feedback from July to December

2019 demonstrated 134 patient comments with 49% stating the texting was helpful. As this was early in the implementation phase, we expect the percent to trend higher each quarter.

Twenty nine percent of our patients have adopted MyChart, which provides patient access to their personal medical record, bill pay and online scheduling. It also provides leading edge technology such as a welcome Kiosk that greets patients when they arrive to the clinic, notice to patient that an earlier appointment is now available (Fastpass) and the ability to prepare for their visit by completing pre-visit questionnaires etc. We are adding new features on an ongoing basis to increase patient use. Improving adoption and use of MyChart impacts patient experience, patient loyalty and stickiness with our organization.

Philanthropy

During Periods 5 and 6 of FY20, El Camino Health Foundation secured $3,638,315, bringing the total raised through December to $5,520,580, which is 72% of the annual goal. Further fundraising details are in the attached report.

Auxiliary

The Auxiliary contributed 4,601 volunteer hours in December 2019 and 6,113 volunteer hours in January 2020.

Quality Committee Follow up Item Tracking Sheet (02/12/20)

#	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	
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	
4	Add a discussion about SVMD, LLC reporting to the Quality Committee agenda	12/2/2019	CM	on 2/3/20 Agenda	2/3/2020
5	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	
6	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	
7	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	
8	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	
9	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	
10	Add discusison about adding Chiefs of Staff as members of the Committee to the Pacing Plan	12/2/2019	CM	on 2/3/20 Agenda	2/3/2020
11	Bring back Revised Board Level Quality Dashboard	2/6/2020	MA	on 3/2/20 Agenda	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: March 2, 2020
Subject: Report on Board Actions

Purpose:

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

Summary:

1. Situation: It is important to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

2. Authority: This is being brought to the Committees at the request of the Board and the Committees.

3. Background: Since the last Quality Committee meeting, the Hospital Board has met once and the District Board has met once. In addition, since the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee those approvals are also noted in this report.

A. ECH Board Actions: February 12, 2020

- Approved FY20 Periods 5 & 6 Financials
- Approved Revised Executive Compensation Philosophy Adding the Chief Quality Officer as a Participant in the Executive Compensation Program
- Approved FY20 Chief Quality Officer Base Salary and Salary Range
- Approved Stroke Panel on Call Arrangement with Peter C. Fung MD
- Approved Appointment of Jack Po, MD to the Compliance and Audit Committee (Left the Investment Committee)
- Approved Appointments to SVMD, LLC Board of Managers
- Approved Revised Quality Committee Charter (1) Adding Chiefs of the Medical Staff as Ex Officio Members and Vice Chiefs as alternates and (2) Including Review of Medical Staff Credentialing and Privileges Report as part of the Committee's Scope of Responsibility.
- Approved Procedure for Delegating Authority to the Board's Committees
- Approved Appointments of Ken Alvares and Mike Kasperzak to the Governance Committee
- Approved FY2O/21 Board Education Plan
- Approved Bariatric Surgery and MV Interventional Radiology Call Panels

B. ECHD Board Actions: January 28, 2020

- Approved FY 20 YTD Consolidated and Stand Alone Financials

- Authorized the CEO to execute Consent Agreement transferring Grant Funds from MayView Community Clinic to Ravenswood
- Approved Draft Revised Process for Election of Non District Board Members to the ECH Board

C. Finance Committee Actions: January 27, 2020

- Los Gatos Urology Call Panel Agreement

D. Compliance and Audit Committee: None since last report.

E. Executive Compensation Committee Actions: None since last report.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

El Camino Health

Patient Comments

Cheryl Reinking, CNO

March 2, 2020

Patient Comments

- **OAS:** Excellent infection prevention procedures. Really felt clean! Map to facility is poor, where to park is unclear - how to get to parking unclear (in back). Overall, great! (D/C 12/31/19)

- **OAS:** Directions from parking to the main hospital were very confusing. (11/15/19)

- **OAS:** The valet parking attendant was not there when we arrived. My wife spent 15-20 minutes trying to find a parking space.

Patient Comments

- **IP:** No one was at the security desk at 1am and my husband was able to walk in from the parking lot and into my room without question. He was concerned about my and baby's security, especially if we were asleep. (d/c 11/28/19)

- **ED:** As I've already described, the staffs are all brilliant. But there are still lot of area to be improved such as waiting time, easiness of finding parking space, or cell phone charging station, etc. (12/5/19)

- **OP LG**: More signage in parking area would help. Need to go to side entrance area. (10/29/19)

Patient Comments

- **OPS MV:** Two things you did not ask about: 1. communications: I received countless emails and texts about this one appointment, even a text at 6am which woke me up. It was almost to the point of harassment. A mammogram is not the center of my life and it was crazy the amount of communication I received (and continue to get). 2. parking: the person who did the test told me about the new facility and that there will be more parking - which is great. BUT in the deluge of emails and texts, could one of them mention that the parking was HORRIBLE at this time (so I wouldn't be late) AND (to try to get patients to not give up on your location) that you are moving to better facilities? (1/30/20)

- **OP MV**: Parking is a real problem. We came on the 19th and couldn't even get Valet. We appreciate the Lab personnel so much - clerical, phlebotomist, -everyone. I supervisor was asking younger patients to take a brief survey on the 20th, and ignored us. Too bad. We have used this Lab loyally for years. Maybe she thought we were too old to answer her survey. Valet parking is inconsistent. (12/20/19)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board of Directors
From: Cheryl Reinking, RN, MS, Chief Nursing Officer
Date: March 2, 2020
Subject: Patient Centered Care at El Camino Health

Purpose:

This presentation is to provide an update and information on El Camino Health's commitment to integrating patient and family centered care principles into many aspects of the patient experience across the enterprise.

Summary:

1. Situation: Integration of Patient and Family Centered Care principles through the implementation of Patient and Family Advisory Councils (PFAC) is a contemporary approach to insuring the voice of patient/family is heard and acted upon by the organization in its efforts to improve quality, safety, and patient experience.

2. Authority: This information is intended to inform the board on the many ways ECH partners with our patients and families to improve quality, safety, and the patient/family experience

3. Background:

- PFAC's as a fundamental approach to improving patient and family centered care is well documented in the healthcare literature
- ECH has had a PFAC in place since 2013 and the group has been maturing over the past 7 years.
- The accomplishments and insights provided by the PFAC and NICU FAB have been significant as we continue to incorporate the voice of the patient/family in all improvement activities.
- The board should remain informed regarding how the voice of the patient/family and community members is incorporated to improvements or changes the organization is considering or needs to consider

4. Assessment: Patient Family Centered care and the implementation of PFAC's at ECH have been successful. However, the prevalence of infusing the voice of the patient in more areas across the organization has potential in the future.

5. Other Reviews: The Patient Experience Steering Committee monitors the work of the PFAC.

6. Outcomes: Integrating the voice of the patient into improvements allows ECH to create new processes or procedures with the patient's preferences in mind. Therefore, a more complete and properly designed process producing the intended outcome will be implemented.

List of Attachments: Patient Centered Care at El Camino Health:
The Patient and Family Advisory Councils

Suggested Committee Discussion Questions:

1. How does the PFAC help us achieve our Mission, Vision, and Values?
2. How does Patient Family Centered Care help us achieve our strategic priorities?

El Camino Health

Patient Centered Care at El Camino Health: The Patient and Family Advisory Councils

Cheryl Reinking, RN, MS, NEA-BC

Chief Nursing Officer

What is Patient and Family Centered Care ?

Patient and Family Centered Care (PFCC) is an innovative approach to planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.

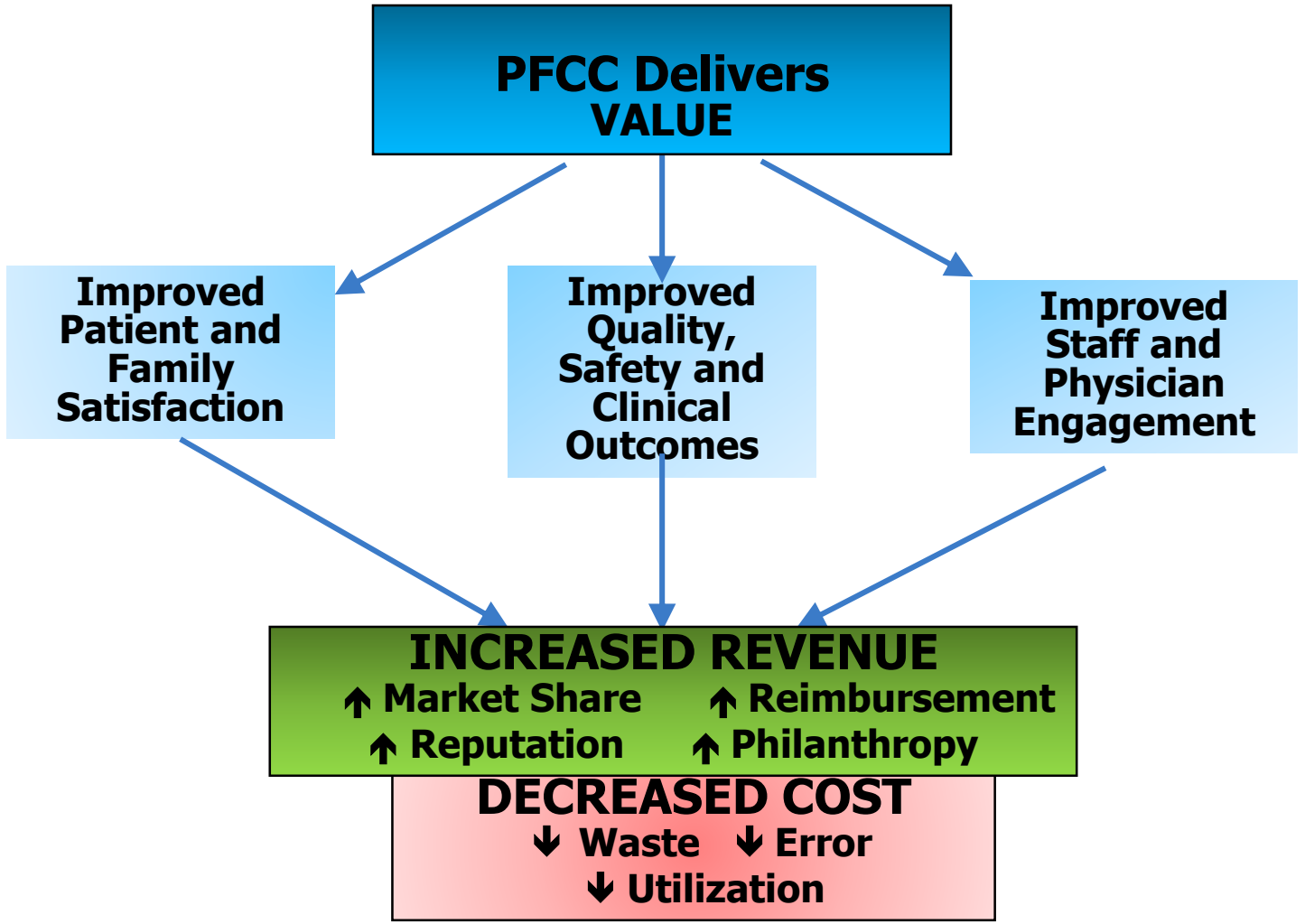
"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."

Key Elements

The four principles of PFCC are:

- People are treated with respect and dignity.
- Health care providers communicate and share complete and unbiased information with patients and families in ways that support them and are useful.
- Patients and family members build on their strengths by participating in experiences that enhance control and independence.
- Collaboration among patients, family members, and providers occurs in policy and program development and professional education, as well as in the delivery of care.

Why do this?



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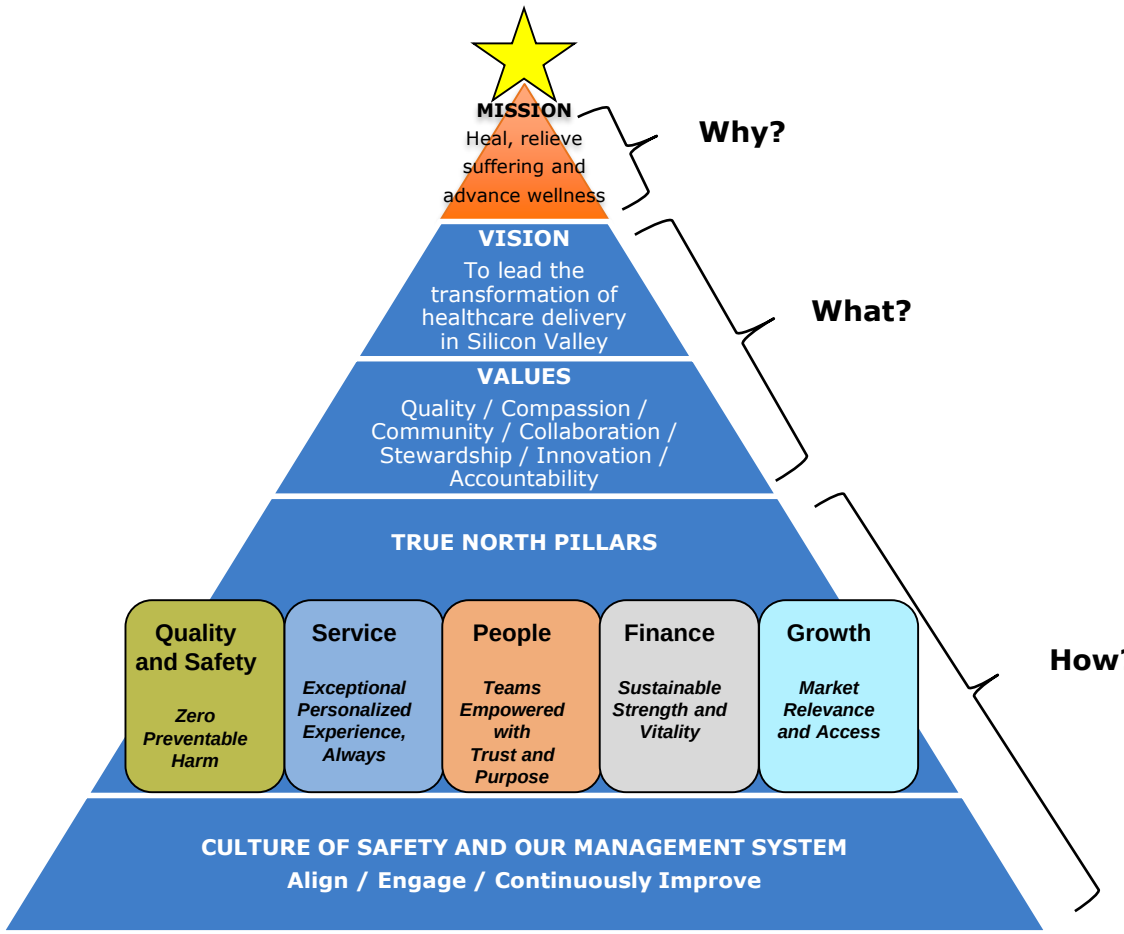
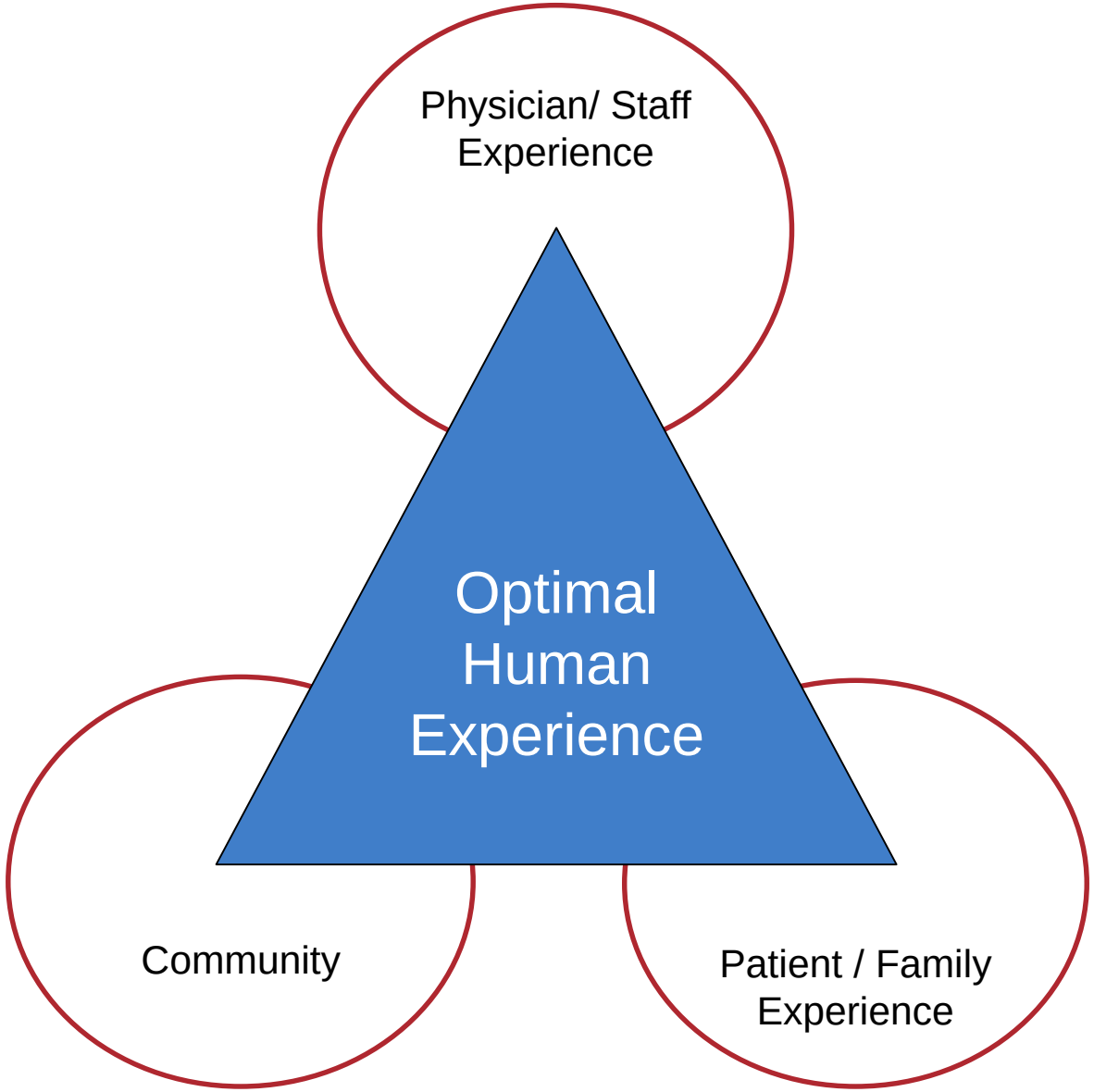
True North: Exceptional, Personalized Experience, Always





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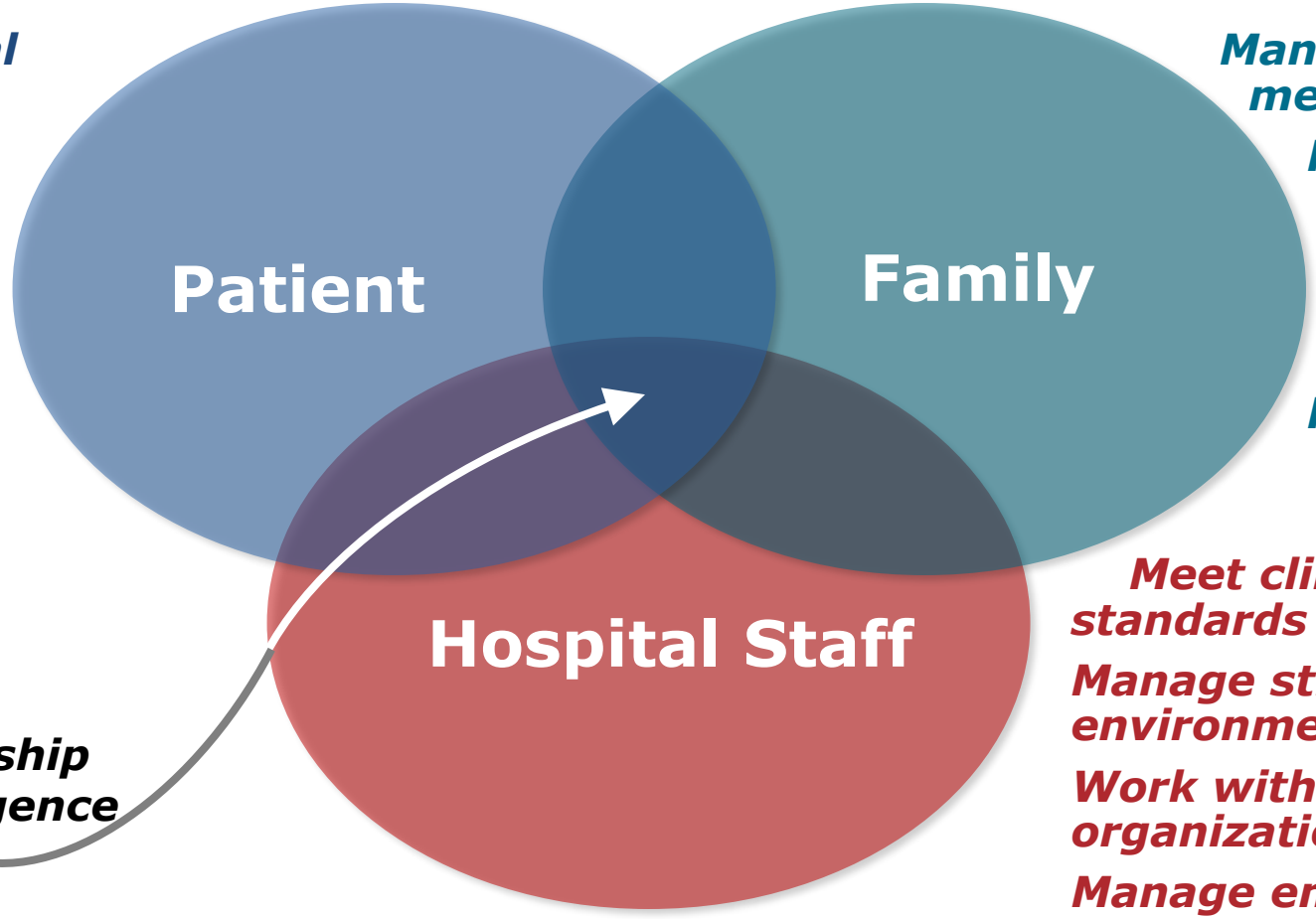
Partnership Model



Manage medical condition

Manage personal life

Receive tangible and emotional support

Manage patient's medical condition

Manage family's personal life

Receive tangible and emotional support

Maintain autonomy

Meet clinical and regulatory standards

Manage stressful high pace work environment

Work within complex siloed organization

Manage emotions in caring for patients/families

Partnership Convergence

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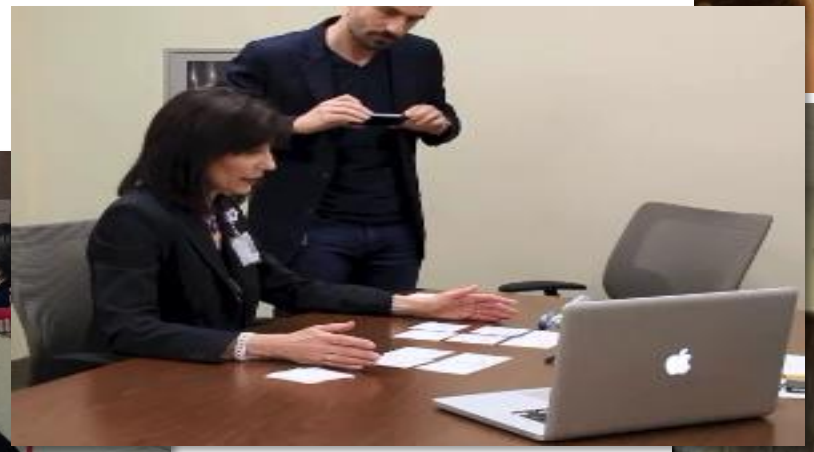
Different Ways to Work

- PFAC
- Workgroup/committee
- Focus groups
- Improvement events



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Patient / Family Advisor's Role

Current role as patient, caregiver and consumer of healthcare

New role as part of the Patient and Family Partner Program

Advisor

Share patient perspective, feedback and insight, recommendations, consent and confirm, influence, power is unidirectional-staff makes decision

Advocate

Empowered, spokesperson, change agent

Partner

Works collaboratively , participate fully, test new ideas, diversity of opinions acceptable, equal voice, de-centralize knowledge and power, co-determination of work, understand and value viewpoint of other team members, decision is multi-directional

REACTIVE → **PROACTIVE**

El Camino Health

PFA are patients and family volunteers who engage in partnership with the organization to ensure that the policies, programs and practices related to the design, delivery and evaluation of care meet patient and family needs. They are essential team members whose feedback and input are crucial to improving the overall care experience.

-PFA job description, El Camino Health

The Patient and Family Advisory Council

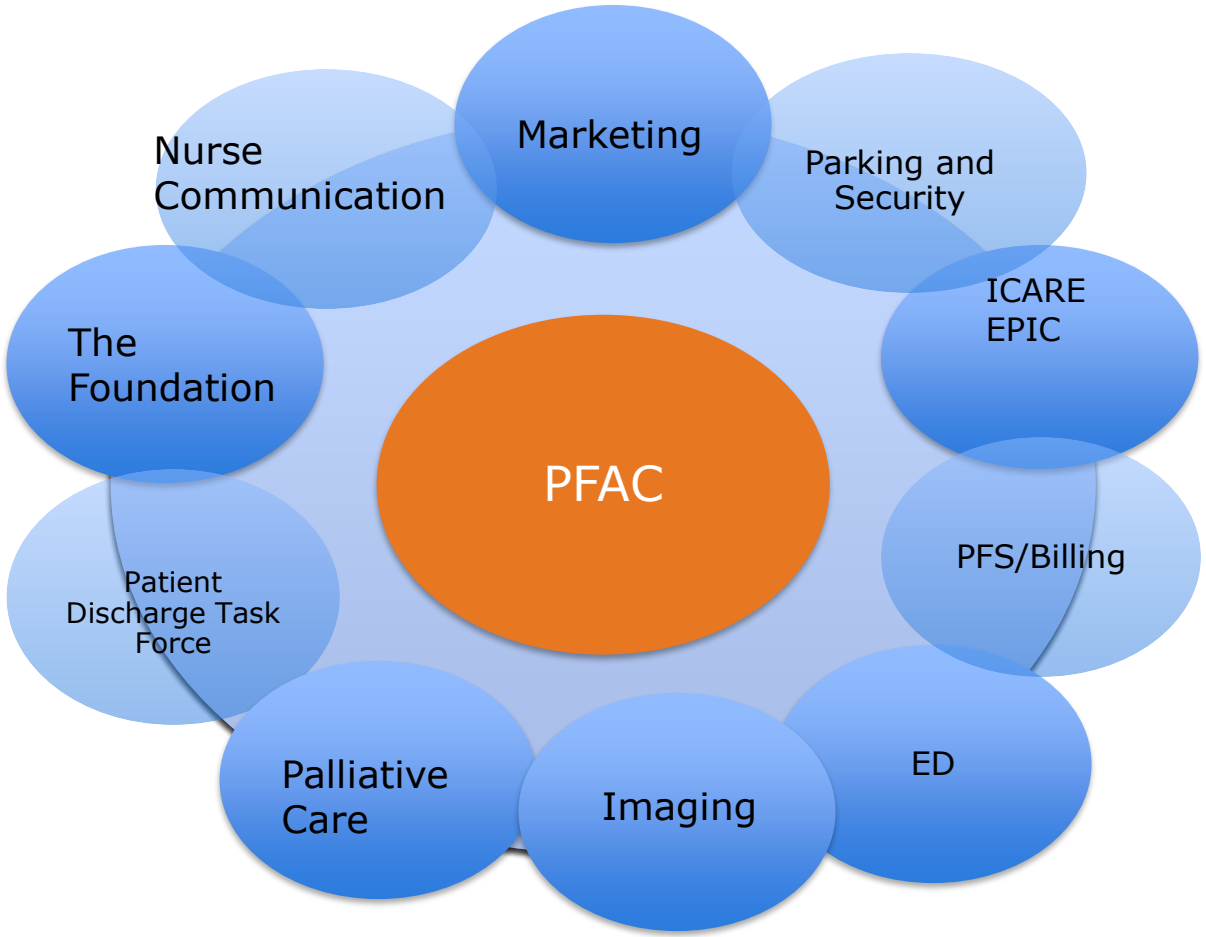
Innovative forum for constructive dialogue between patient, family, staff and physicians

El Camino Health

The El Camino Health Care PFAC

- First meetings in July 2013, Re-launch in March of 2018
- Meets monthly for two hours
- Members must complete three step screening and orientation
- Currently has 11 patient and family members and 3 staff
- Represents diverse experiences in a variety of clinical venues
- Serves as resource to efforts outside of PFAC meetings, such as RPIWs, staff trainings and workgroups

Areas of PFAC Influence in 2019



Examples of Specific Efforts Supported by the PFAC

- Modified Palliative Care Patient Education and Marketing Materials
- Revised Patient billing and messaging
- Spoke at each mandatory ED communication training
- Extended hours of front information desk and re-location of security in ED
- Drafted scripting for EVS and nurse communication efforts
- Championed Digital Patient Survey
- Advocated for gender neutral forms in Mother Baby
- Members on Nurse Responsiveness Team, ED Champion Workgroup, Pharmacy and Therapeutics, Quality Committee of the Board and various RPIWs

PFAC Consolidated Goals

Facility

More EV charging ports

Signage

Improve patient waiting areas

Front desk open later-Complete

Healthy Food Choices

Security

Facility security

ED Security desk closer to door-Complete

Applications

Simplify or consolidate

Bedside Care

Transfers at change of shift

Improve ED experience for patients and families

Information/Education

Visitor Info/ EC health offerings

Hospital Finances/Billing

Inclusivity of forms-Done in Maternal/Baby

Translation materials to other languages

Discharge Instructions

Parking

Communication regarding options during construction

Better signage for Valet-In Progress

Patient and Family Centered Care

Family/caregivers Resources

Patient/Family speaker Program

Neonatal Intensive Care Unit: Family Centered Care Program

The Family Advisory Board (FAB) Accomplishments

- NICU Parent Peer to Peer Buddy Support Program
- Snacks available for parents on the unit (grab and go)
- Upgrade of parent sleep room
- ROAR (Reach Out And Read) Program
- Cuddle Program
- Parent Access Badges
- Out of the Box Program (Skin to Skin for NICU babies)
- My Chart Bedside
- Hand Expression for Breastfeeding

NICU Team Presenting NICU PFCC at Vermont Oxford Network

El Camino Health

Value for Patients /Families in the Program

"This place has changed since they started listening to us"

"I love learning about how the hospital works and getting to know the doctors and nurses as colleagues"

"What we are doing makes a difference- I really feel valued and useful"

"Healthcare is evolving and I like being part of that."

"I know patients and families are getting better care"

Value for Staff and Physicians

- "Patient's voice is an amazing resource."
- "I am reminded of why I am in health care."
- "… saved us time in getting to a solution that works."
- "Hear when options are needed versus a single solution."
- "Patients helped further our objectives."

"… heard a completely different perspective."

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: March 2, 2020
Subject: Board Quality and Safety Dashboard

Purpose: Review New Board Quality and Safety Dashboard

Summary:

1. Situation: There is a desire to simplify the enterprise quality and safety dashboard that is reported to the Board of Directors as part of the Quality Committee report to the Board.

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.

3. Background: In response to this request—simplified quality and safety dashboard that the Board can use as a tool to monitor quality and safety without repeating the oversight work of the Board Quality Committee—a new dashboard has been created. This new dashboard is based on the STEEEP definition of quality and safety that is a national standard adopted by the IHI (Institute for Healthcare Improvement). This will provide a snapshot of key metrics based on those categories. This is a common format used by many other organizations. Several committee members provided feedback for modifications. This was also introduced to the Board.

4. Assessment: The Board Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention but the Board will receive the new dashboard as a part of the Quality Committee report.

5. Other Reviews: None

6. Outcomes: The Quality Committee will become familiarized with this new dashboard construct.

List of Attachments:

1. Power Point illustrating the new dashboard

Suggested Committee Discussion Questions:

1. None

El Camino Health

Board Quality Dashboard Report

Dr. Mark Adams
Chief Medical Officer
March 2nd, 2020

Board Quality Dashboard

- Purpose: To provide a snapshot of a curated group of quality and safety measures/metrics to the Board of Directors based on STEEEP
- Caveat: The Quality Committee will continue to review more in depth reports such as the enterprise quality dashboard and the Quality Council reports

Board Quality Dashboard

- Committee member feedback for discussion:
  - Expand the equitable care measures
  - Add ambulatory timeliness measures
  - Add ambulatory safety measures such as opiate and benzodiazepines use
  - Add ambulatory provider communication measure (CG-CAHPS)
  - Add NTSV C-section rate
  - Some measures more general and some more specific
  - Explanations for measures below target—this will need to be added on another page based on results to avoid too much clutter
  - What should be reported to the QC and what gets escalated to the Board

Board Quality Dashboard

- The QC is now receiving quite a bit of information flowing from the Quality Council and the many quality and process improvement initiatives.
- While the QC can and should review certain problematic areas that can be identified from the Quality Council, the QC should be spending more time discussing strategic issues such as the journey to high reliability or the ERAS program, consumer/customer experience, etc.
- The QC, in turn, should report to the Board on the results of those strategic discussions rather than dwelling on specific metrics. There may be metrics to support the strategy but the metrics should not be the main focus. The new Board quality dashboard provides the overview of the metrics for that purpose. The quarterly quality and safety report should also be presented to the Board for regulatory purposes.

	Metric	Baseline FY2019	FY2020 Target	Q1 (unless otherwise indicated)	Measure Period	Top Tier
Safe Care	Risk Adjusted Mortality Index	0.97	≤ 0.90	0.64 (Oct 19)	FYTD	0.77
	Sepsis Mortality Index	1.06	≤ 0.90	0.61 (Oct 19)	FYTD	0.84
	% of Serious Safety Events (SSEs) Classified	New Program	Establish baseline for SSE rate 95% classified in ≤30-days	Begin categorization 12/1/19	FYTD	
	Surgical Site Infections (SSI)	0.52 37/7167	SIR ≤1.0 NHSN ratio	0.17	FYTD	
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	1.09	SIR ≤0.75 NHSN ratio	0.27	FYTD	
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.36	SIR ≤0.50 NHSN ratio	0.37	FYTD	
	Clostridium Difficile Infection (CDI) - HAI	1.96	SIR Goal: <= 0.70	1.58	FYTD	
	Modified PSI-90 CMS HAC Reduction Program	0.714852	1.021817	1.010425	FYTD	
Timely	Enterprise Patient Throughput – ED Door to Admit Order	FY19 284 min	266 minutes	254 minutes (Oct 19)	FYTD	
	ED2b – Admit Decision Time to ED Departure Time for Admitted patients	CY18 95 minutes	CY19 <120 minutes	77 minutes (Q1)	CYTD	
	OP18b – Median Time from ED Arrival to ED Departure for Discharged ED patients	CY18 183 minutes	CY19 <180 minutes	174 minutes (Q1)	CYTD	
	3rd Next Available Appointment		TBD		FYTD	
Effective	Risk Adjusted Readmissions Index	0.99	≤ 0.96	**0.96**	FYTD	
	CMS SEP-1 Compliance Rate	74%	≥ 80%	**82.6**	FYTD	
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	**ENT: 0.99%** (4/404)	0.00%	0% (0/103)	FYTD	
	NTSV C-Section	**ENT: 24.9%**	≤ 23.9%		FYTD	
	CMS 165: Controlling High Blood Pressure		TBD		FYTD	
	CMS 122: Diabetes: Hemoglobin A1c Poor Control		TBD		FYTD	
Efficient	ALOS/Expected GMLOS	0.91		0.86 (Oct 19)	FYTD	
	OP-8 MRI Lumbar Spine for Low Back Pain	# of Pts 38	National Rate 38.70%	Q3 2017- Q2 2018 = 52.6%	Annual	
	OP-10 Abdomen CT Use of Contrast Material	# of Pts 1,109	National Rate 8.90%	Q3 2017- Q2 2018 = 4.4%	Annual	
Equitable	Hospital Charity Care Support	$21.6m	$23.0m	$6.8m	FYTD	
	Clinic Charity Care Support	$18k	TBD	$8.8kk	FYTD	
	Language Line Unmet Requests	4.60%	<5%	2.90%	FYTD	
	Length of Stay Disparity	African American Asian American	None	None	FYTD	
Patient-centered	HCAHPS: Staff Responsiveness	65.7	≥ 67.1	66.4 (Oct 19)	FYTD	
	HCAHPS: Discharge Information	86.7	≥ 87.3	86.9 (Oct 19.)	FYTD	
	HCAHPS: Likelihood to Recommend	83.5	≥ 84.2	83.2 (Oct 19)	FYTD	
	Emergency Department (ED) Satisfaction	66	≥ 69.0	70.6 (Oct 19)	FYTD	
	OAS CAHPS: Rating 9's & 10's	43rd %tile	≥ 35th %tile	45th %tile	FYTD	
	CG-CAHPS Provider Communication		TBD		FYTD	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Jim Griffith, COO
Date: March 2, 2020
Subject: Lean Transformation Journey Update

Purpose:

To update the Committee on the organization's lean transformation journey and engage in dialogue around progress that has been made and the key next steps to accelerate the lean journey. ECH is committed to lean as an organization-wide operating system that consistently puts the patient first and relentlessly focuses on increasing value to the patient.

Summary:

1. Situation: El Camino Health is utilizing lean methodology to increase operational efficiency, improve the patient experience, elevate and improve quality, and deliver value to patients and physician within our system. The journey to a lean organization is a multi-year process.

2. Authority: The Quality Committee requested an update on the status of the organization's journey to a lean enterprise.

3. Background: The organization has focused lean efforts in the following areas over the past year.

- Strategy Deployment and Organization-Wide Goal Setting (Hoshin)
- Value Stream Improvements
    - MV ED Throughput (ED Door to Floor) Value Stream
    - LG ED Throughput (ED Door to Floor) Value Stream
    - MV Cancer Center (Infusion) Value Stream
- Lean Leadership Development Training Classes in the above 3 Focus Areas
- Executive Leadership Coaching

4. Outcomes: The organization has experienced benefit from all three value streams as outlined in the presentation materials.

- ECH is continually refining the strategy deployment process to determine the organization's goals for the coming fiscal year and ensuring that they are visible and cascaded to the front line.
- Leaders throughout the organization have been trained in lean and are applying the principles on a daily basis.
- ED Door to Floor times have decreased significantly while the patient experience percentile rankings have improved. ED volumes are also up 4% during the past twelve months.
- The Mountain View Oncology Infusion Center has made targeted operational improvements while supporting growth of 15%+ year-over-year.
- Overall, more than $5 million of improvement to the organization has been measured as a result of lean focus projects.

List of Attachments:

1. PowerPoint

Quality Committee
March 2, 2020

Suggested Committee Discussion Questions:

1. How does this help us achieve our mission, our vision?
2. How does this fit with our values?
3. How have physicians been engaged in the lean transformation project?
4. How does this fit with our strategic priorities?
5. What are the next steps in the lean journey?
6. How will lean support the journey to a high reliability organization?

El Camino Health

Lean Transformation Journey Update

Jim Griffith, Chief Operating Officer
Mark Adams, MD, Chief Medical Officer
Cheryl Reinking, Chief Nursing Officer
March 2, 2020

WHAT IS LEAN?

- Lean is a management system based on a philosophy that organizations do best when they:
  - Put the Customer/Patient first: relentless focus on increasing “value” to our customers/patients, understanding what they want or need
  - Organizationally Learn & Develop our People: Root cause problem solving to improve processes, systems and sustain improvements. And, we learn by going and seeing (gemba)!
  - High fidelity data for analysis and decision making

WHAT IS LEAN? contd…

- Lean is a management system based on a philosophy that organizations do best when they have:
  - Mindset of servant leadership
  - Mindset of “change is necessary and good”
  - Mindset of being hard on the process not people
  - Engagement by everyone to improve the systems (processes) to *consistently* deliver good care and services
  - Respect for people: customers and staff

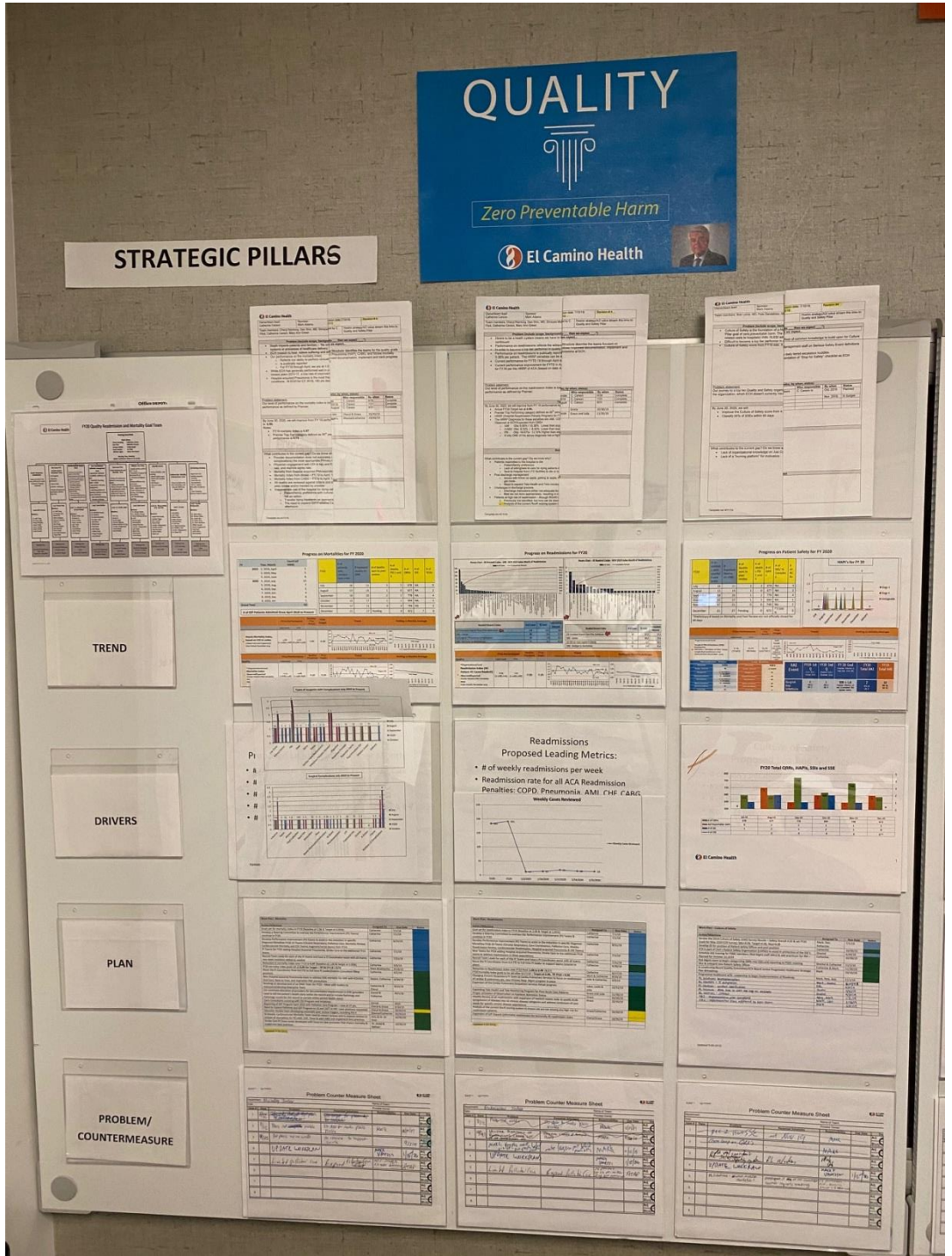
Major Areas of Interventions – FY20

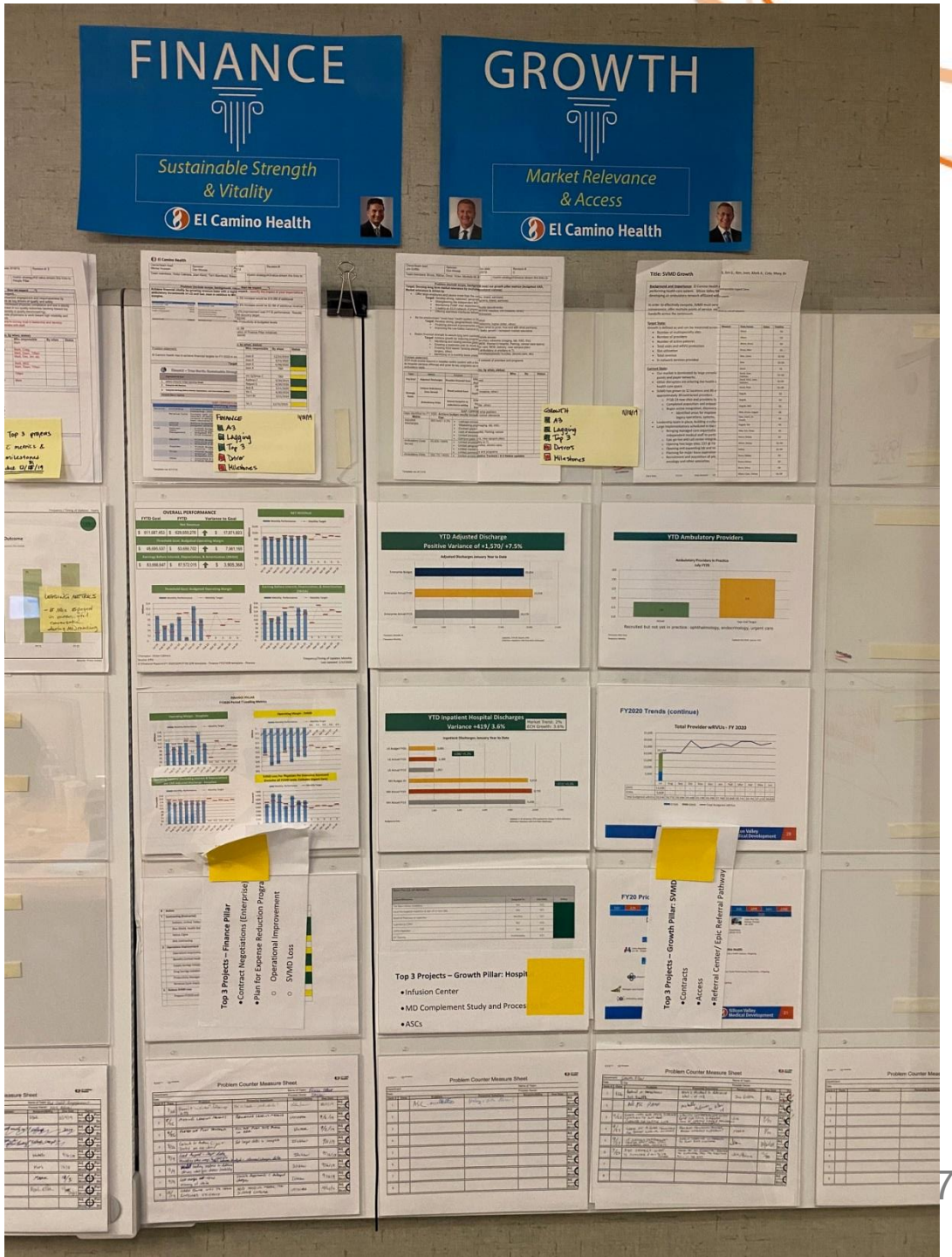
- Strategy Deployment and Organization-Wide Goal Setting (Hoshin)
- Value Stream Improvements
  - MV ED Throughput (ED Door to Floor) Value Stream
  - LG ED Throughput (ED Door to Floor) Value Stream
  - MV Cancer Center Value Stream
- Lean Leadership Development Training Classes in the above 3 Focus Areas
- Executive Leadership Coaching

Strategy Deployment – FY20 Accomplishments

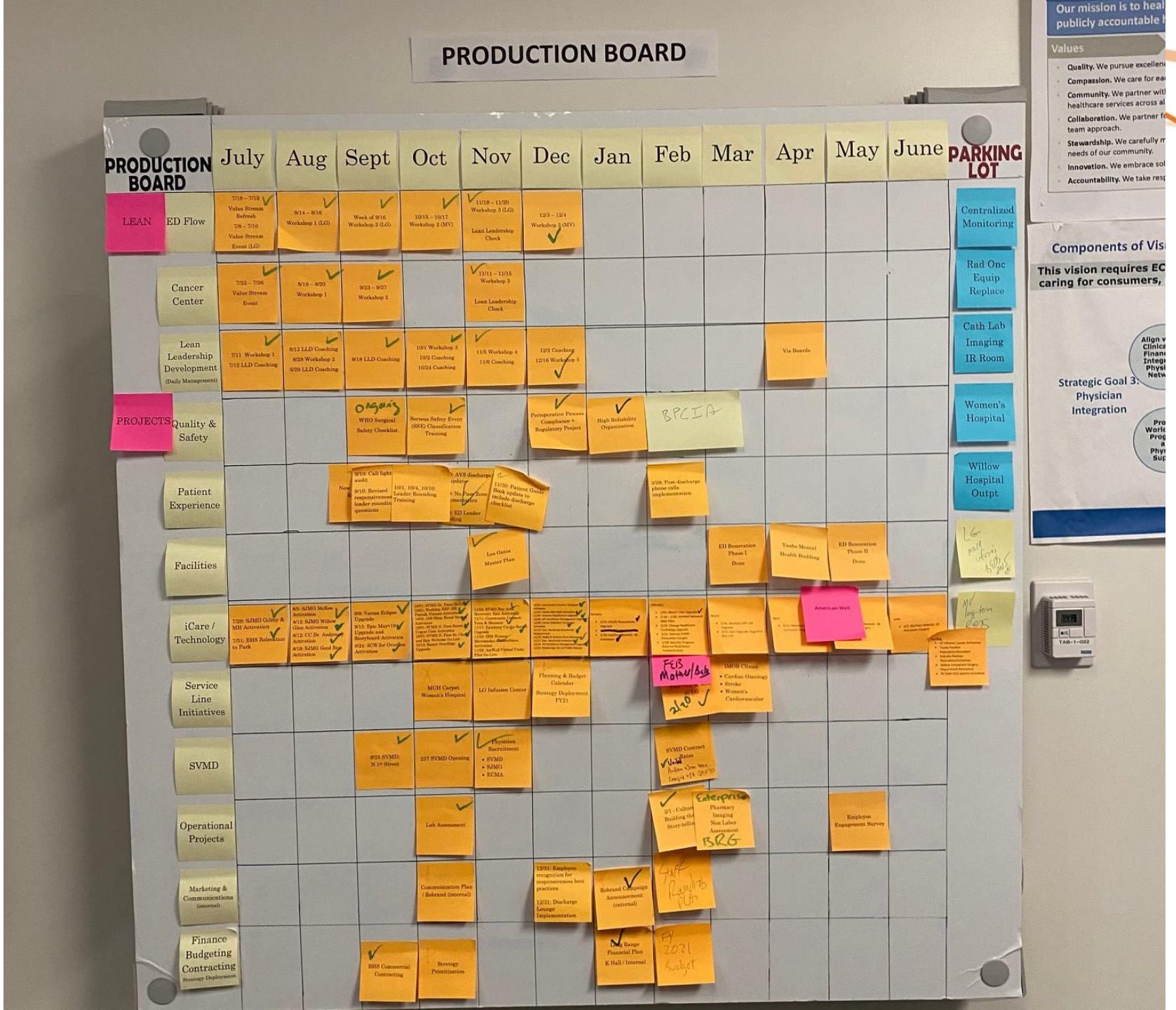
- Well-Functioning Strategy Room and Improvements Planned
- Standard Work for Checking on Pillar Goals and underlying Strategic Initiatives
- A3 Coaching of Pillar Champions and their teams
- Retreat for prioritizing top strategic initiatives for each Pillar
- Planning for Strategy Deployment process started for FY21

Strategy Deployment Room


QUALITY
Zero Preventable Harm
El Camino Health
STRATEGIC PILLARS
TREND
DRIVERS
PLAN
PROBLEM/ COUNTERMEASURE
Readmissions
Proposed Leading Metrics:
• # of weekly readmissions per week
• Readmission rate for all ACA Readmission
Penalties: COPD, Pneumonia, AMI, CHF, CABG


FINANCE
Sustainable Strength & Vitality
El Camino Health
GROWTH
Market Relevance & Access
El Camino Health
YTD Adjusted Discharge
Positive Variance of +1,570/ +7.5%
YTD Ambulatory Providers
YTD Inpatient Hospital Discharges
Variance +419/ 3.6%
FY2020 Trends (continue)
Top 3 Projects – Finance Pillar
•Contract Negotiations (Enterprise)
•Plan for Expense Reduction Progra
Operational Improvement
SVMD Loss
Top 3 Projects – Growth Pillar: Hospit
•Infusion Center
•MD Complement Study and Proces
•ASCs
Top 3 Projects – Growth Pillar: SVMD
•Contracts
•Access
•Referral Center/ Epic Referral Pathway
Problem Counter Measure Sheet

Production Board

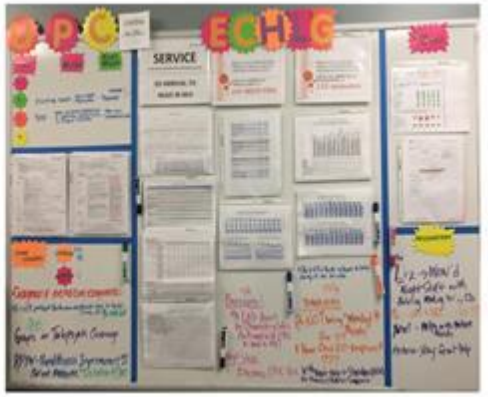


Lean Leadership Development – FY20 Accomplishments

- 5 1-Day Training Workshops completed from July 19 to Dec 19
- Leaders & front line including Executive Leaders attended
- Visual Management System Boards in place in MV ED, LG ED,
- Daily Huddles
- Daily Status and Weekly Status Reviews are helping connecting daily front-line work to the organizational goals
- Front-Line Teams engaged in identifying and working on improvement ideas
- Gemba walks being conducted by Executive Leaders
- All Leaders practicing the use of Coaching Kata to foster problem solving thinking

Improvement Huddle Board

LG ED

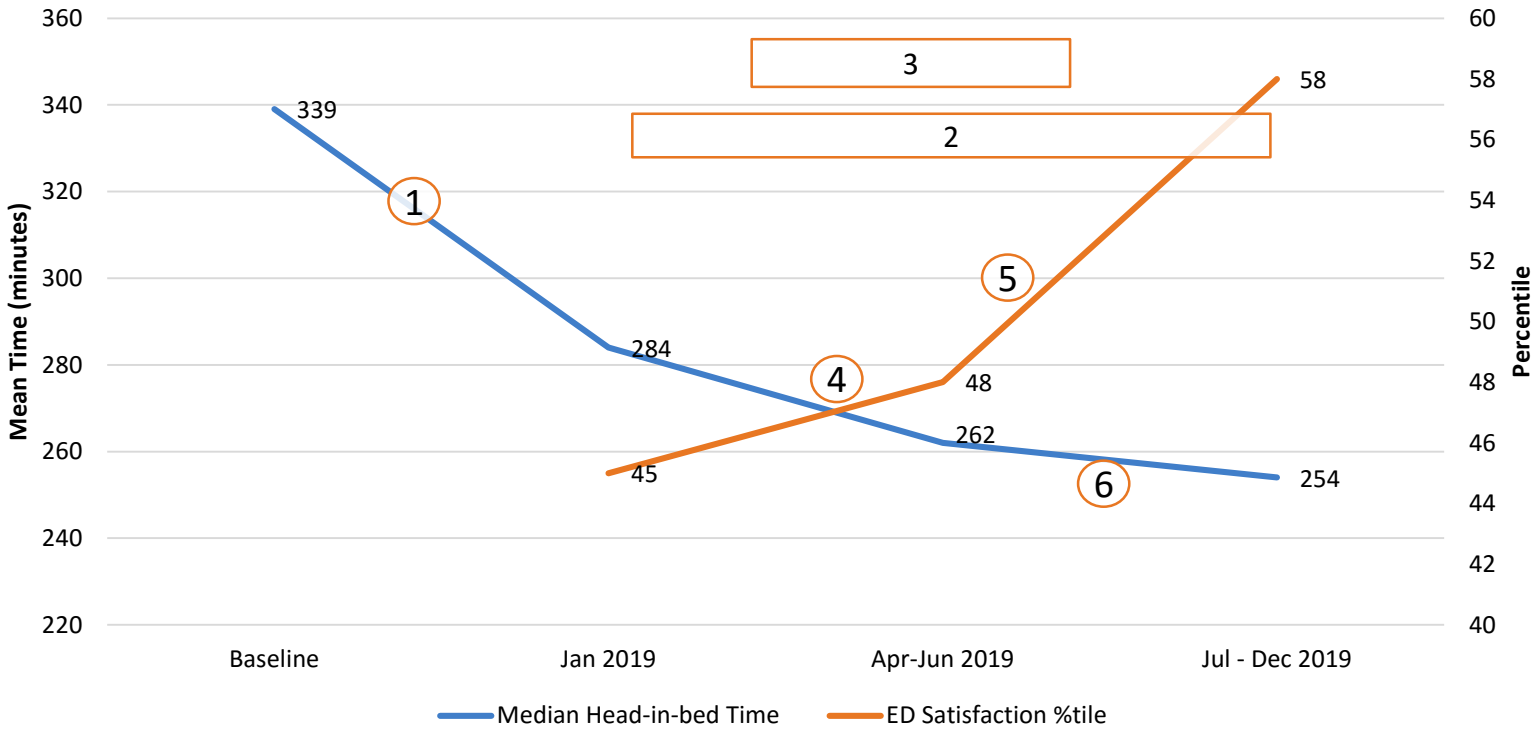


Value Stream Improvements – FY20 Accomplishments

- 3 VSM events were conducted in July 2019 in MV ED, LG ED, and MV Cancer Center
  - ED Throughput value streams focused on improving “Arrival to Head in Bed” Median performance
  - MV Cancer Center value stream focused on operational efficiencies to support planned growth in the service line
- 2 RPIWs and 1 Improvement Working session have been completed in LG ED and MV ED respectively to help implement recommendations that were identified during the VSM events
- Throughput performance metrics get sent out at a daily and weekly cadence to create visibility on performance system-wide
- 2 RPIWs have been completed for the Cancer Center Value Stream
- Strong physician leadership and involvement in all value streams

Enterprise Patient Throughput Has Improved Considerably

- Lean methodologies have allowed us to improve throughput times, while improving satisfaction



Initiatives:

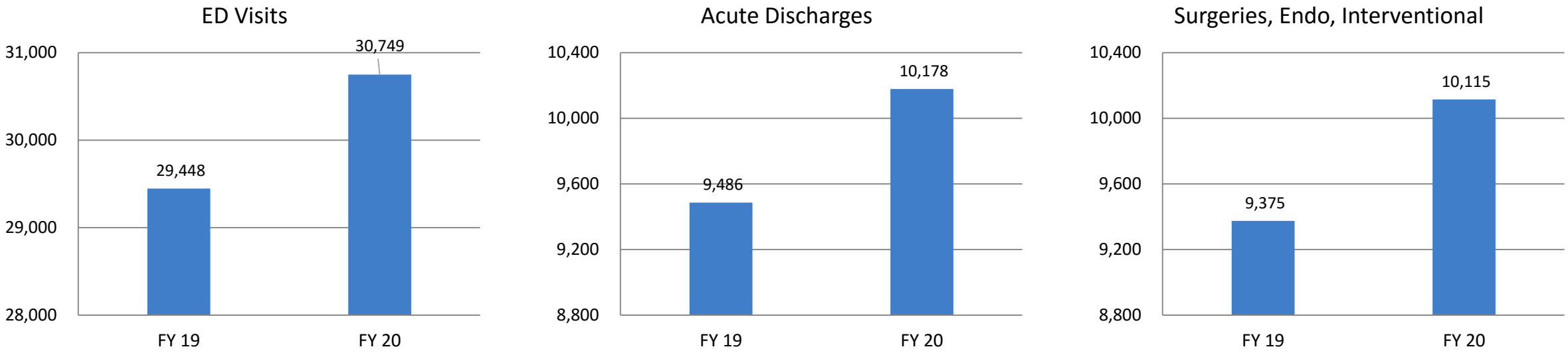
1. Initial Lean work
2. Engaged ED providers in data analysis and workshops
3. Opened bed capacity command center
4. Converted 3CW to inpatient beds (10)
5. Launched Epic ED status update texting
6. Began MV ED construction project; Proactive service recovery including gift cards & ear plugs

Drivers and Takeaways:

- The original enterprise baseline for ED arrival to head in an inpatient bed median time was 339 minutes.
- In the first six months of FY2020, another 8 minutes has been reduced despite higher volumes and patient acuity:
  - Overall ED volume is up 4% during July – December 2019 compared to the same time period in 2018. The higher acuity visits (level 4 and 5) are up 9.4% while the lower acuity visits are flat during the same time period.

Key Drivers of Growth

- Two primary strategies have increased growth:
  1. Implementation of Lean – increased capacity and access throughout the enterprise
  2. Recruiting and/or hiring of physicians in key services and disciplines to achieve growth



Lean Methodology Focus:

- Beginning 2019 ECH reemphasized utilizing Lean methodologies in 3 key areas: MV ED, LG ED, and the Outpatient Oncology Infusion Center.
- In line with ED visit growth (detailed on slide 6), acute inpatient discharges are up 7% ahead of last year.
- Surgeries and overall procedural volume is up 10% ahead of last year due to gains in all major service lines.
- The number of proceduralists and surgeons is now 321 versus 293 last fiscal year: an increase of 28.

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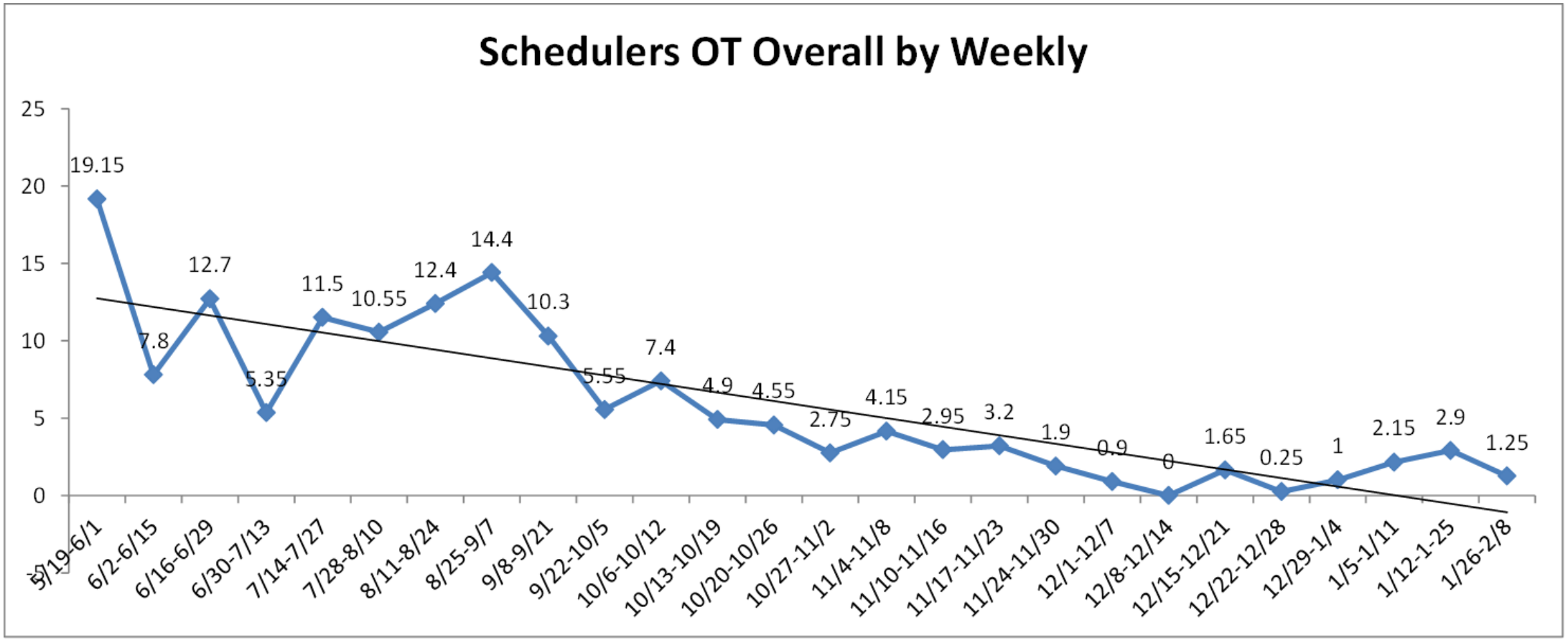
- ***Source:*** *EMR data – July through December of FY2020 compared to FY19*

Cancer Center Value Stream



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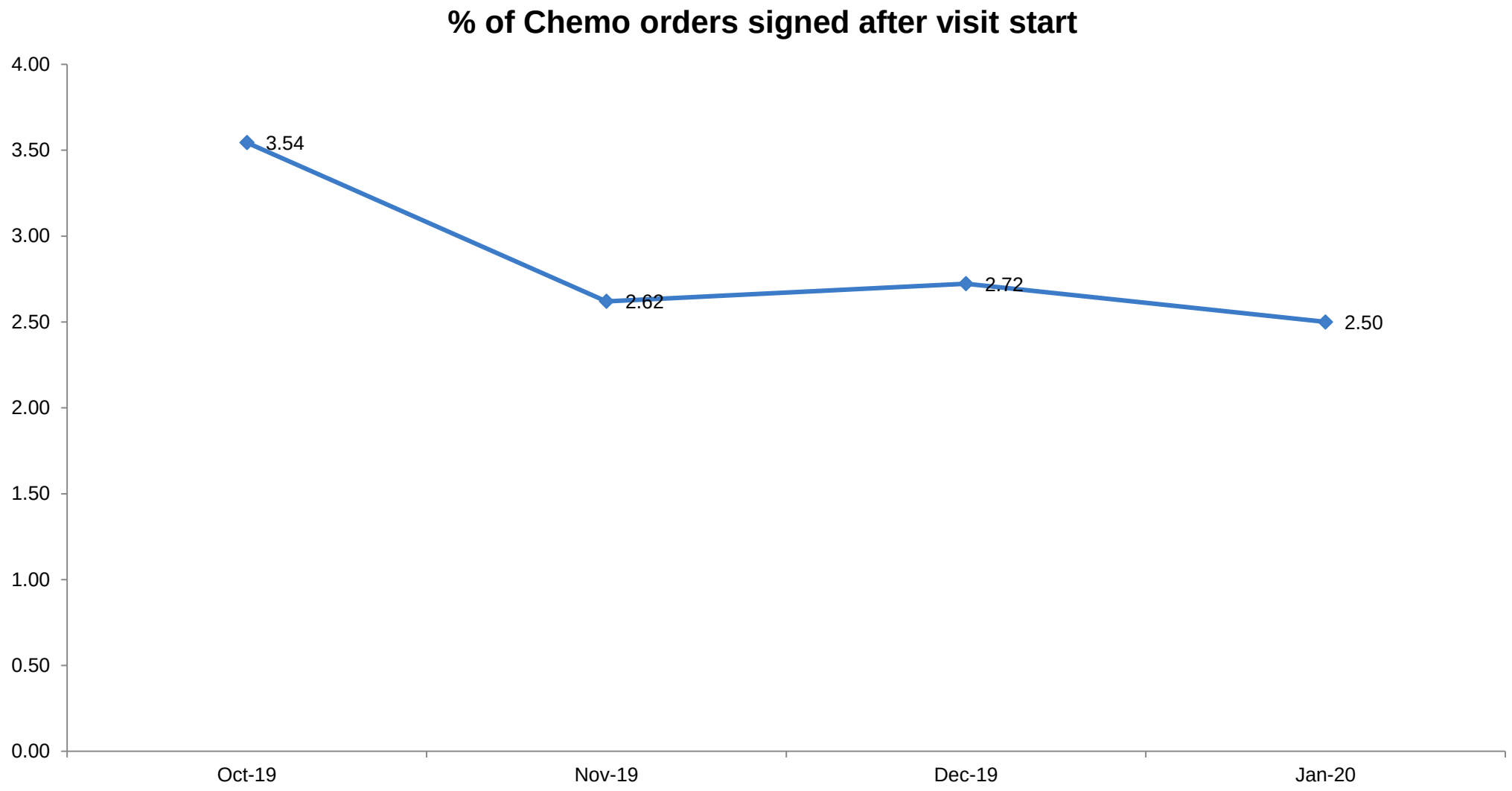
Cancer Center Value Stream



Return On Kaizen –

- **Cancer Center:** Target was a reduction of Scheduler's OT hours through standard work in communication and documentation to resolve missing documentation**.** With OT trending down, the projected annual decrease of OT by 382 hrs./yr. would result in a value of savings over $25,600/year.

- ***ED's****: Target reduction of LOS from admit to head in bed. The LOS is trending down in both the LG & MV E.Ds. If LOS's maintains at the Dec YTD values, then over the next 12 months, the impact would be:*
  - ***LG: ED capacity freed/year, in hours- 3237***
    - *Soft dollar value of freed capacity- $633,119*
    - Potential increased throughput/year- 1325
    - Potential add net revenue at $1952/patient $2,586,400
  - **MV: ED capacity freed/year 3809**
    - Soft dollar value of freed capacity $407,425
    - Potential increased throughput/year 930
    - Potential add net revenue at $2217/patient $2,061,810

What’s Next?

FY 20 & 21 Strategy Deployment Timeline

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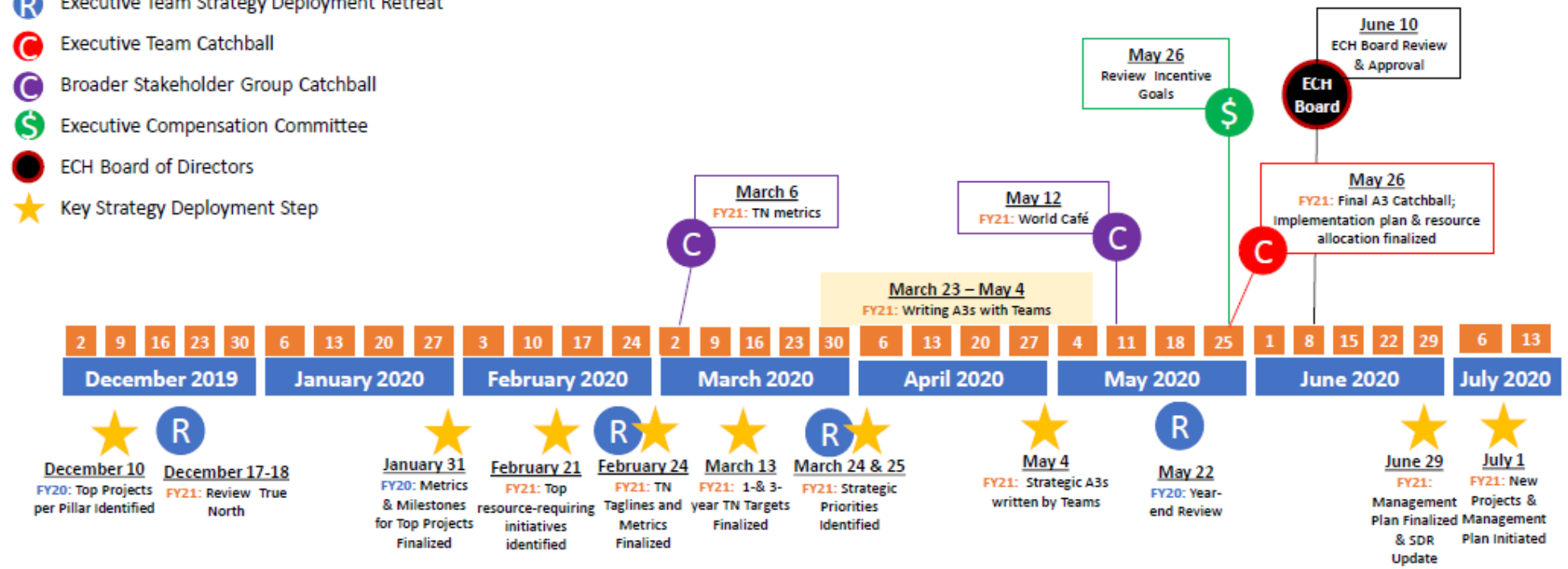
- Executive Team Strategy Deployment Retreat
- Executive Team Catchball
- Broader Stakeholder Group Catchball
- Executive Compensation Committee
- ECH Board of Directors
- Key Strategy Deployment Step



Executive Team

Dan Woods, CEO
Mark Adams, CMO
Omar Chughtai, VP Operations
Christine Cunningham, CXO
Kathryn Fisk, CHRO
Jim Griffith, COO
Bruce Harrison, SVMD President
Vineeta Hiranandani, VP Marketing & Communications
Iftikhar Hussein, CFO
Deb Muro, CIO
Cheryl Reinking, CNO

Catchball Sessions

3/6/2020	True North measures
5/12/2020	World Café: A3s
5/26/2020	Left & right A3s

Exec Team Strategy Deployment Retreat (FY21 only)

12/17-18/2019	Review True North definitions & metrics
2/24/2020	TN Taglines & Metrics Reviewed & Finalized; start targets discussion
3/24-25/2020	Identify & select top 3 strategic priorities

Key Strategy Deployment Step

12/10/2019	FY20: Top projects per Pillar identified
1/31/2019	FY20: Leading metrics & milestones for Top Projects finalized
2/21/2020	Identify top resource requiring initiatives
2/24/2020	FY21: TN taglines and 1 & 3-year metrics finalized
3/13/2020	FY21: 1 & 3 year TN Targets finalized
3/24-25/2020	FY21: Strategic Priorities identified
5/4/2020	FY21: Strategic A3s written by Teams
6/29/2020	FY21: Management Plan finalized & SDR Update

Last Updated: 2/3/2020

Value Stream Improvements – What's Next

MV ED:

- MV RPIW in early March for ED Triage workflow in new space
- MV 5S in April of the newly remodeled area of the ED
- Begin A3 thinking project to understand delays in admit order to HIB metric performance for CCU, PCU, Tele units, 2C at MV this week
- Progress being made on project plan related to enhancements to CMC processes underway

LG ED & MV Cancer Center:

- Focus on hardwiring process changes from their 2 RPIWs and Daily Management System elements
- LG – 5S in the ED over next 2 months

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EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Julie Kliger, Quality Committee Chair
Date: March 2, 2020
Subject: Goal Setting and Attainment

Purpose:

To discuss and reach consensus as to how we should philosophically think about setting quality and service goals for the organization. Specifically, how "inspirational" or "aspirational" the organizational goals that are tied to the incentive payment program should be.

Summary:

1. Situation: Each year, this Committee receives recommendations from management for the next year's quality and service organizational goals. These goals are tied to incentive payment programs for employees throughout the organization (executive, management and front line staff) as well as to contractual payments to Medical Directors.

2. Authority: This Committee, per its charter, recommends Board approval of the quality and service organizational goals.

3. Background: Last year, when the organizational goals for FY20 came before the Committee, some committee members raised the issue of how "inspirational" or "aspirational" the organizational goals should be. Due to timing issues we were unable to devote as much time as we might have liked for this discussion. We should also keep on mind that the goals should be "SMART" (**S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**imely). In addition to using the SMART framework, management also relies on the following criteria when developing the organizational goals.

- Does it support our mission and impact the patient?
- Does it affect many different categories of patients?
- Is it easily understood?
- Is it used in the public domain as a quality proxy?
- Does it reach broadly across the organization?
- Does it have a financial impact?
- Can we reliably measure it and compare it to a benchmark?

4. Assessment: N/A

5. Other Reviews: None.

6. Outcomes: SMART organizational goals that will enable us to ultimately achieve longer term strategic goals.

List of Attachments: None.

Goal Setting and Attainment
March 2, 2020

Suggested Committee Discussion Questions:

1. How should we set goals to help us achieve with our strategic priorities?
2. What is the risk of setting incentive goals that are "too" aspirational? Is there a risk? Do we have a clear plan for addressing that risk? Are we willing to accept the risk?
3. Likewise, what is the risk of setting goals that are not aspirational "enough?"