El Camino Health

AGENDA

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

Monday, August 3, 2020 – 5:30pm

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

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

1-669-900-9128, MEETING CODE: 369-007-4917#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
	Approval ***a.*** Minutes of the Open Session of the Quality Committee Meeting (06/01/2020) ***Information*** b. FY20 Quality Dashboard c. Progress Against FY21 Committee Goals d. Hospital Update e. Pacing Plan f. Report on Board Actions g. PSI Report			
4.	**QUALITY COMMITTEE FOLLOW-UP TRACKING ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:39**
5.	**PATIENT STORY ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**information 5:39 – 5:44**
6.	**EL CAMINO MEDICAL HEALTH NETWORK QUALITY REPORT ATTACHMENT 6**	Mark Adams, MD, CMO		**discussion 5:44 – 6:14**
7.	**QUARTERLY BOARD QUALITY DASHBOARD REVIEW ATTACHMENT 7**	Mark Adams, MD, CMO		**discussion 6:14 – 6:44**
8.	**FY21 ORGANIZATIONAL GOALS ATTACHMENT 8**	Mark Adams, MD, CMO	*public comment*	**motion required 6:44 – 6:49**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:49 – 6:52**

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
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:52 – 6:53**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:53 – 6:54**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 6:54 – 6:55**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (06/01/2020) ***Information*** b. API Reports: Palliative Care: Stroke Program, Anesthesia Services, Palliative Care, Peri-Operative Services			
13.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Medical Staff Credentialing and Privileges Report	Mark Adams, MD, CMO		**motion required 6:55 – 7:00**
14.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Q4 Quality and Safety Report	Mark Adams, MD, CMO		**discussion 7:00 – 7:15**
15.	*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 7:15 – 7:25**
16.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:25 – 7:26**
17.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:26 – 7:27**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:27 – 7:29**
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:29 – 7:30**

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, June 1, 2020
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

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

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

	penalty program. In that report, the hospital has a PSI score that is -1.1307. That is "z-score" that CMS uses and a negative score is extremely good. Dr. Adams introduced Lisa Packard, MD who was present to revisit this topic from January and to answer committee members' questions. Dr. Packard reported that the majority of vaginal lacerations the hospital has reported are 3rd degree, but mainly the less extenisve3rd degree lacerations. She also noted that the episiotomy rate is decreasing. Some of the risk factors of lacerations include forceps delivery, Asian ethnicities, labor induction and epidurals. Breaking down the patient population, overall ECH has about a 64% Asian OB population. 76% of the vaginal lacerations at ECH are in the Asian population. In response to committee members' questions, Dr. Adams explained that part of the reason why the Asian population graph does not add up to 100% is because some do not report their ethnicities and ones that add up to more than 100% is because some people have more than one ethnicity.	
10. MEDICAL STAFF CREDENTIALING PROCESS	Dr. Adams presented the Medical Staff Credentialing Process. There is a process that the hospital takes to independently verify all of the information contained in the application such as board certification, medical degree, residency completion, etc. The National Practitioner Database is queried. If there is a time gap in the work history, the hospital determines why and what has happened during those times (i.e. Maternity leave, incarcerated, etc.). A new step that the hospital now does is background checks. Physicians will need to meet the qualifications for medical staff and once they pass, there is a process for each specialty for core privileges and special privileges (i.e. Robotics) to be considered. Once this process is complete, the recommendations for privileges go to the MEC, then to the Quality Committee then to the Board of Directors. Once a physician moves to active staff, performance in the six core competencies are evaluated every 8 months (Ongoing Professional Practice Evaluation) and at the time of renewal every two years. In response to a committee member's questions, Dr. Adams explained that if there is a board certification for a specific type of practice, then they are approved. He also states that AHP's go through a similar process. They are not members of the medical staff per se, but they still go through the same requirements for privileges based on their skill level and training. Dr. Adams also confirmed that SVMD doctors are credentialed by SVMD. However, if they wish to also work at the hospital, the credentialing will also be done at the hospital. Dr. Qureshi left the meeting.	
11. ECHMN QUALITY IMPROVEMENT PROGRAM UPDATE	Shabnam Husain, MD presented the ECHMN Quality Improvement Program Dr. Husain explained that the purpose of the program is to ensure there is a formal process for Quality Improvement. The structure for quality review, peer review, and credentialing of physicians within SVMD was described. Dr. Husain stated that the SVMD Quality Committee focuses on the annual QI Work Plan. In addition, monitoring ambulatory metrics helps prevent hospital readmissions. She explained that 8 measures are approved for FY2021 and compared the results for ECMA and the San Jose Medical Group. Dr. Adams stated that many of the HEDIS scores are done by health claims data, but these are ECHMN's internal measures.	

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

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

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Julie Kliger, MPA, BSN
Chair, Quality Committee

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality, Patient Care, and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ, Sr. Director, Quality
Date: August 3, 2020
Subject: FY 20 Quality Dashboard for June meeting

Recommendation(s): To review and accept the Organizational Goal and Quality Dashboard.

Summary:

1. Situation: 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.

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

3. 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.

4. Assessment:

- Mortality Index is well below target of 0.90 and is better than 0.73 2019 Top Performers level, @ 0.64. In addition, the index has consistently been under 1.0 for last 11 months.
- Readmission Index increased slightly for June data and below target for May @ 0.88, pushing the FYTD value to just above target @ 0.97. Pneumonia, stroke, and post total hip/knee arthroplasty continue as top three reasons for readmission.
- Continued reduction in ED Throughput metric, below target.
- HCAHPS metrics for Discharge Information improved and are above target for June, just missing the target goal for FY20. Responsiveness is also improved for June and just below target goal for FY20. Likelihood to recommend dropped in June.
- Only 1 – HAI: 1 CAUTI.
- SSI @ 1 for June.
- PC-02 Primary C/S rate increased.
- See detailed comments in the annotation of the report.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. FY20 Quality Dashboard, June data unless otherwise specified - final results

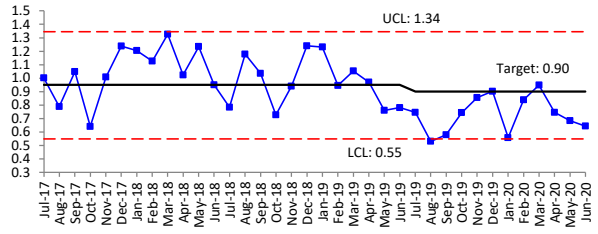
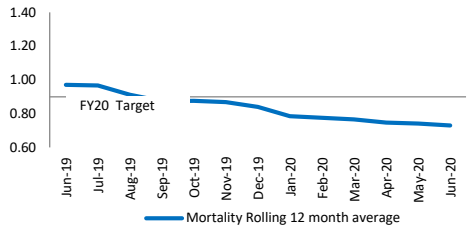
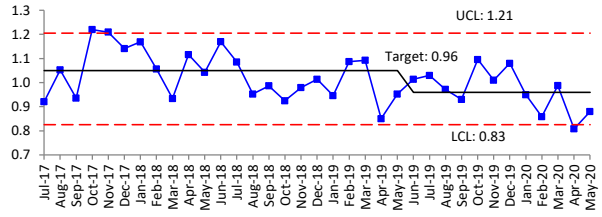
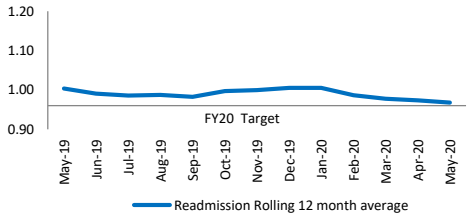
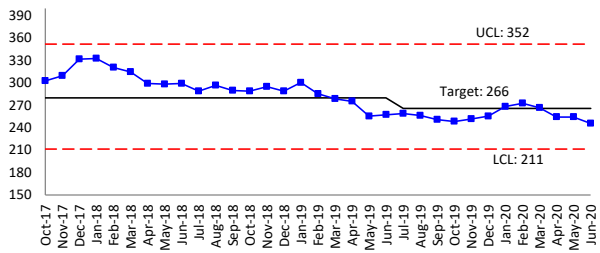
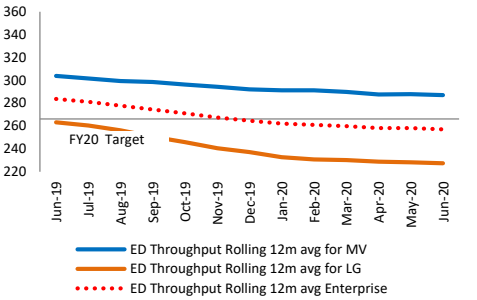
Suggested Committee Discussion Questions: None.

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

June 2020 (unless otherwise specified)

Month to Board Quality Committee:
August, 2020

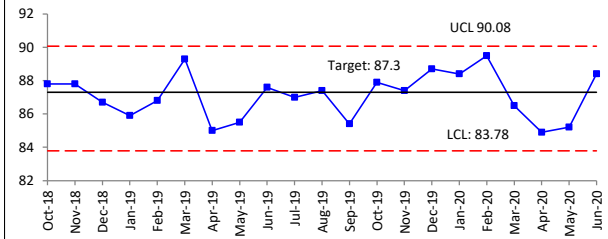
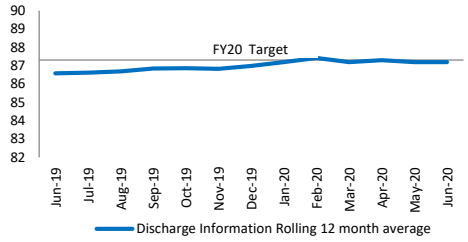
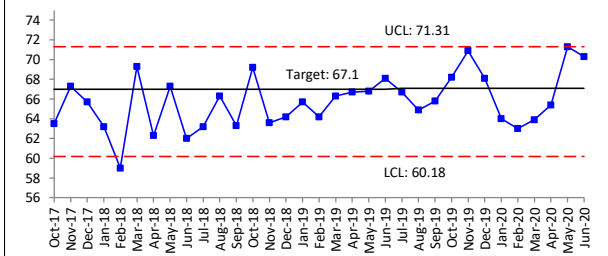
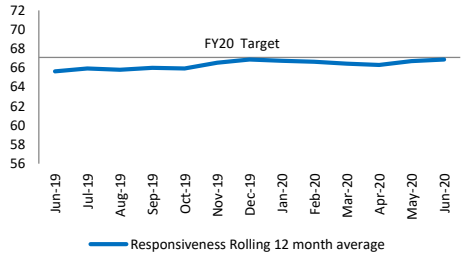
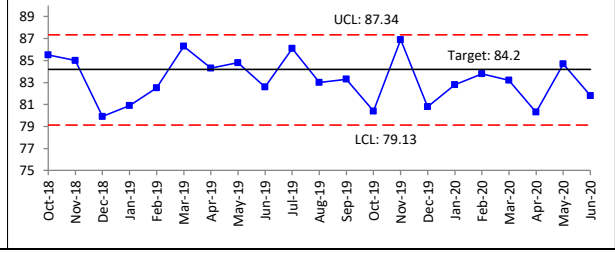
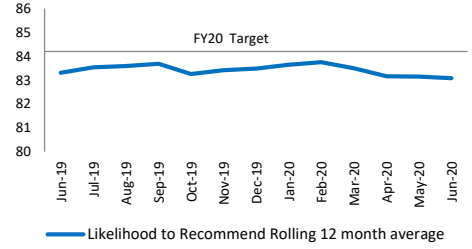
		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Months Average
Quality		**Latest month**	**FYTD**				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: June 2020*	0.64 (1.28%/1.99%)	0.74 (1.46%/1.98%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: May 2020*	0.88 (6.67%/7.61%)	0.97 (7.71%/7.94%)	0.99	0.96		
3	**Patient Throughput-Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Date Period: June 2020*	MV: 277 min LG: 215 min **Enterprise: 246 min**	MV: 287 min LG: 227 min **Enterprise: 257 min**	MV: 304 min LG: 263 min **Enterprise: 284 min**	266 min (5% improvement from last year's target, 280)		

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

June 2020 (unless otherwise specified)

Month to Board Quality Committee:
August, 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: June 2020*	88.4	87.2	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: June 2020*	70.3	66.5	65.7	67.1		
6	*Organizational Goal **HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: June 2020*	81.8	83.0	83.5	84.2		

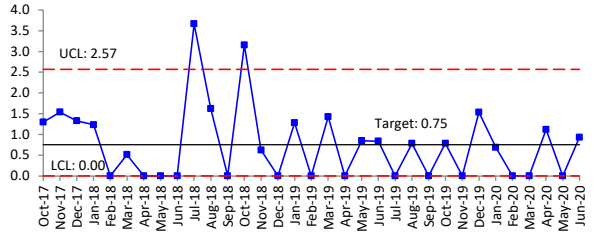
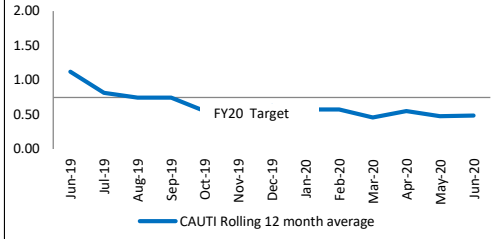
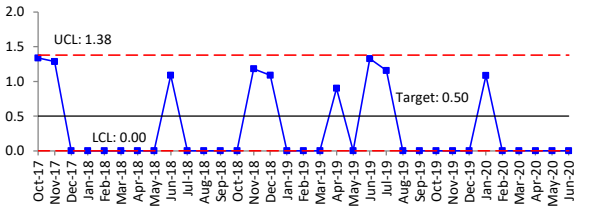
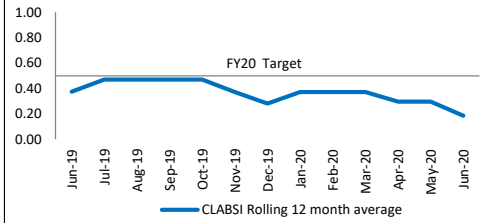
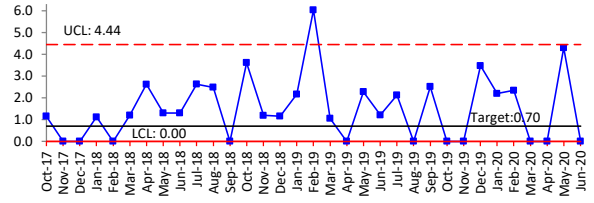
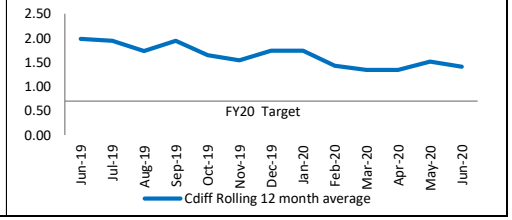
El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

June 2020 (unless otherwise specified)

Month to Board Quality Committee:

August, 2020

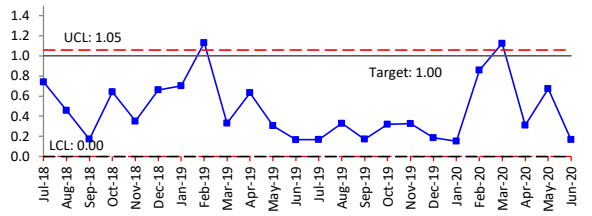
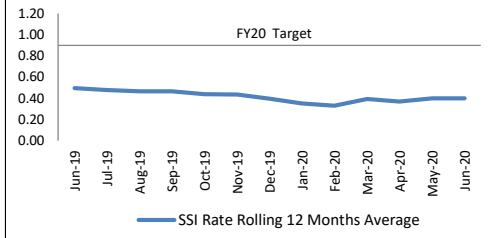
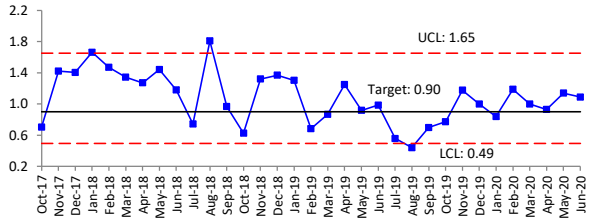
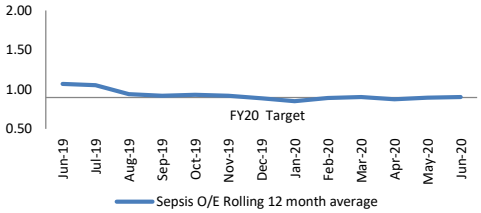
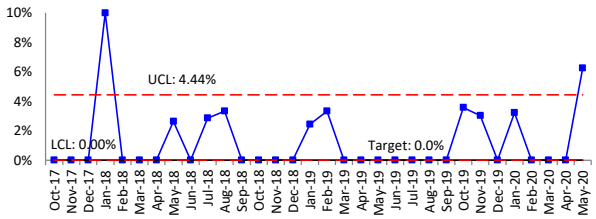
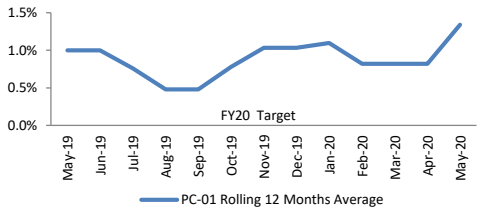
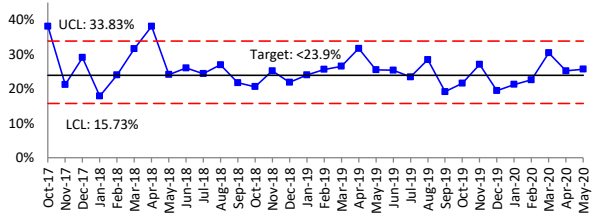
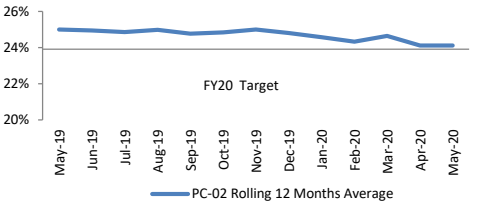
		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend	
Quality		Latest month	FYTD				
7	***Hospital Acquired Infections*** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: June 2020*	0.93 (1/1074)	0.48 (7/14486)	1.09	SIR Goal: <= 0.75		
8	***Hospital Acquired Infections*** *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: June 2020*	0.00 (0/927)	0.20 (2/10135)	0.36	SIR Goal: <= 0.50		
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: June 2020*	0.00 (0/6840)	1.46 (14/95608)	1.96	SIR Goal: <= 0.70		

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

June 2020 (unless otherwise specified)

Month to Board Quality Committee:
August, 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: June 2020*	0.17 (1/593)	0.36 (23/6428)	0.52 (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: June 2020*	1.09 (13.86%/12.72%)	0.98 (10.98%/11.18%)	1.06	0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) *Date period: May 2020*	MV: 7.69% (2/26) LG: 0.0% (0/6) **ENT: 6.25%** (2/32)	MV: 1.59% (5/315) LG: 0.00% (0/46) **ENT: 1.39%** (5/361)	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: May 2020*	MV: 26.00% (39/150) LG: 24.32% (9/37) **ENT: 25.67%** (48/187)	MV: 24.77% (379/1530) LG: 18.86% (43/228) **ENT: 24.00%** (422/1758)	MV: 26.28% (425/1617) LG: 14.29% (30/210) **ENT: 24.90%** (455/1827)	<23.9%		

El Camino Health

FY21 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

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

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

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

El Camino Health

Hospital Update
August 3, 2020
Mark Adams, MD, CMO

Operations

Our lab is now performing COVID-19 antibody testing in limited circumstances with a physician's order. The purpose of this program is to identify individuals who may have been exposed or contracted the disease and were either not tested or did not develop any symptoms. Antibody testing will give us a better understanding of how widespread the disease has been in our community. We are also offering COVID-19 testing for active infections to all physicians who see patients at our facilities.

Dan Woods, CEO, was extremely happy to report that, in accordance with CDC and Santa Clara County guidelines, we were able to relax our restrictions on visitors effective June 1, 2020! Though contact with loved ones is a critical part of every patient's experience and recovery, the restrictions do vary throughout the enterprise.

Facilities

We are still on track for moving clinical departments into our new Mountain View campus buildings. Clinical departments will move into the Taube Pavilion on June 10th and into the Sobrato Pavilion on June 24th. OSHPD approved a modernization plan for our outpatient surgery center in the Willow Pavilion, which we have three years to complete.

Workforce

We extended temporary telecommuting agreements until June 15, 2020 for many employees who do not directly support clinical operations. We will use this time to evaluate and implement needed modifications to our work areas to provide for social distancing.

Through the generosity of the El Camino Health Foundation, we continue to fund YMCA kids camps in Mountain View and Saratoga for our employees' children age 3 -12. Effective June 8, 2020, the program will transition to a summer camp curriculum.

The Silicon Valley Business Journal named Catherine Nalesnik, RN, Senior Director, Infection Prevention, as a Woman of Influence for her role in helping the organization navigate our way through the pandemic. Catherine is an inspiration to all of us, maintaining focus and calm throughout. Of course, she could not have done it without her team and our infectious disease physicians who the Board recognized at their June 10, 2020 meeting.

El Camino Health

El Camino Health Medical Network (ECHMN)

Mary Kilkenny, MD and Angela Pollard, MD, both Board-Certified in Obstetrics and Gynecology, are joining the ECHMN through employment with El Camino Medical Associates (ECMA). Dr. Kilkenny is a recognized leader in the local medical community and has an excellent reputation amongst patients as well. Dr. Kilkenny's vision is to partner with El Camino Health to further develop its community based ob/gyn practice in support of our growth plan and she will serve as the ECHMN's Medical Director for ob/gyn. Dr. Pollard has been practicing in the community for over 20 years and is a member of the El Camino Hospital Medical Staff. She also has an excellent reputation amongst patients in the local community. She will vacate the office she currently leases on our Mountain View Campus so she may practice together with Dr. Kilkenny.

Corporate and Community Health Services

CONCERN:EAP launched our BetterHelp partnership for online therapy and has seen significant utilization. As well, use of our online digital hub, Luma, is also increasing for counseling and work-life cases due to the current shelter in place order.

Our Community Benefit team surveyed all 120 FY21 grant applicants and to understand how applicants are adapting their programs during the pandemic. Staff gained a better understanding of how agencies will adjust programs for COVID-19 circumstances and what factors to watch for FY21. We also responded to COVID-19 crisis with six new ECH grants and one new sponsorship totaling $95,000 in May.

New Grants:

- West Valley Community Services
- LifeMoves
- Better Health Pharmacy
- Indian Health Center
- Gardner Family Health Network
- Peninsula Healthcare Connection

Sponsorship:

- Veggielution

The South Asian Heart Center completed TECH (Tuesday Evening Community Huddles) weekly on lifestyle topics with 893 attendees, hosted and online Exercise Workshop for the Agah Khan community and a nationwide talk for Andhra community.

The Chinese Health Initiative (CHI) coordinated with El Camino Health Foundation to develop a bilingual safety communication "ECH Returns to Health," which was sent to over 5000 CHI participants and CHI Network physicians. CHI also completed 2 weekly webinar series: (1) Healthy Lifestyle – conducted by registered dieticians, a lifestyle

medicine physician and a clinical psychologist and 2) bilingual Qigong class. Total attendance for these webinars was 1257.

The Health Library and Resource Center is still closed to the public, but staff, physicians, and nurses are still using it and we are offering consultation by phone for Eldercare, Medicare, and Advance Healthcare Directive assistance as well as dietitian and pharmacist appointments.

Marketing and Communications

The marketing team has implemented a number of initiatives designed to help patients and the larger community through our "Return to Health" campaign during this challenging time. Our weekly e-Newsletter features articles and resources and in May we added messages to inform the community that ECH is open for elective procedures, surgeries and physician appointments and to reassure them that it is safe care. In May, four e-newsletters were deployed with each communication reaching 69,000 patients and community members. The team also created a patient brochure detailing what ECH is doing to continually enhance patient safety in light of the challenges posed by the pandemic. The patient experience team is distributing it to patients. We are also using Google and Facebook to communicate these messages.

The team also added a great deal of content to the El Camino Health Website. We launched a landing page for our "Return to Health" campaign, published the 2020 Nursing Annual Report microsite, including CNO welcome video and patient testimonials and launched (1) onsite and external location pages for the Los Gatos Cancer Center, (2) a new virtual donor board for the El Camino Health Foundation and (3) a new safety page within the patients & visitors guide.

The website now also features videos for resumed elective procedures (physician briefings), employee testimonials about working in healthcare and the police & fire department appreciation event. We published 11 blog articles covering COVID-19 health tips such as managing anxiety, safely enjoying outdoors, and protecting mental health during pregnancy as well as seven newsroom stories highlighting staff (Shaped by Us) in Infection Prevention, The Stroke Center, Community Benefit, Pharmacy, CCU, and Cancer Care. We cross promoted many of these videos, blogs, and newsroom stories on social media.

The media team has proactively facilitated several media stories including:

- Mountain View Voice (MVV): Flood of Food Deliveries Keeps Hospital Staff in High Spirits
- MVV: A Public Safety Salute for El Camino's Nurses and Hospital Staff
- Los Altos Town Crier (LATC): YMCA Child Care Supports Hospital Workers

We have also been featured in other media:

- Patch.com: Military Planes To Soar Over Bay Area For Memorial Day
- Daily Post: North County Will Finally Get Covid-19 Testing
- LATC: Simitian Holds Telephone Town Hall Sunday (Dr. Mark Adams, CMO, was a panelist)
- LATC: Local Families Join Forces With Laundromats to Help Those in Need
- Mercury News: Nurse Finds Fostering Kittens Good for Her Mental Health During COVID-19 Pandemic
- ABC7: Coronavirus kindness: South Bay Nurse Says Fostered Kittens Saved Her Life While Self-Quarantining After COVID-19 Exposure
- NBC-Sports Bay Area: Ex-Shark Ward Figuring Out Next Step of His Hockey Journey (References El Camino Health as the hospital where his child was born.)

We continue with internal communications to employees and the Medical Staff that provide updates about COVID-19 related matters as well as the turn toward operational recovery.

Philanthropy

During period 10 of fiscal year 2020, El Camino Health Foundation secured $589,024, bringing the total raised by end of April to $9,367,298, which is 122% of the annual goal. This includes a $250,000 donation to the Taft Center for Clinical Research to support El Camino Health's COVID-19 clinical trials. More detail follows in the attached report including a very long list of "in-kind" donors who donated meals for ECH employees and Personal Protective Equipment for use in our inpatient and outpatient departments.

Auxiliary

Once again, I find myself reporting to you that our Auxillians are still sheltering in place. We look forward to their return!

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised July 1, 2020 **FY21 Pacing Plan**

FY2021 Q1

JULY 2020	AUGUST 3, 2020	SEPTEMBER 8, 2020
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 21 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals (Quarterly)** ▪ **FY21 Pacing Plan (Quarterly)** ▪ **Med Staff Quality Council Minutes (Incl. API Reports - Closed Session)** ▪ **Hospital Update**	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items 1. Q4 FY20 Quarterly Quality and Safety Review 2. Quarterly Board Dashboard Review 3. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items Special Agenda items: 7. Recommend FY21 Organizational Goal Metrics 8. Annual Patient Safety Report 9. FY20 Quality Dashboard Final Results 10. Pt. Experience (HCAHPS) 11. Progress on Quality and Safety Plan

FY2021 Q2

OCTOBER 5, 2020	NOVEMBER 2, 2020	DECEMBER 7, 2020
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items Special Agenda Items: 8. Report on Medical Staff Peer Review Process 9. FY21 Org. Goal and Quality Dashboard Metrics 10. FY20 Organizational Goal Achievement (Quality, Safety, HCAHPS) (If needed)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Safety Report for the Environment of Care 8. Q1 FY21 Quarterly Quality and Safety Review 9. Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items Special Agenda items: 8. Readmission Dashboard 9. PSI Report 10. Progress on Quality and Safety Plan

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised July 1, 2020 **FY21 Pacing Plan**

FY2021 Q3		
JANUARY 2021	**FEBRUARY 1, 2021**	**MARCH 1, 2021**
No Committee Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Q2 FY21 Quality and Safety Review 8. EL Camino Health Medical Network Report 9. Quarterly Board Quality Dashboard Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up items Special Agenda Items: 8. Proposed FY22 Committee Goals 9. Update on LEAN Transformation 10. Progress on Quality and Safety Plan
FY2021 Q4		
APRIL 5, 2021	**MAY 3, 2021**	**JUNE 1, 2021**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up items Special Agenda Items: 8. Value Based Purchasing Report 9. Pt. Experience (HCAHPS) 10. Approve FY22 Committee Goals 11. Proposed FY22 Committee Meeting Dates 12. Proposed FY22 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar(CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow Up Items Special Agenda Items: 7. Proposed FY22Pacing Plan 8. Q3 FY21 Quality and Safety Review 9. Proposed FY22 Organizational Goals 10. EL Camino Health Medical Network Report 11. Quarterly Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. Placeholder for FY21 Quality Dashboard 7. QC Follow-Up Items Special Agenda Items: 8. Readmission Dashboard 9. PSI Report 10. Proposed FY22 Organizational Goals 11. Approve FY22 Pacing Plan 12. Medical Staff Credentialing Process 13. Progress on Quality and Safety Plan

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Cindy Murphy, Director of Governance Services
Date: August 3, 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 twice and the District Board has met twice. In addition, since the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	June 10, 2020	- FY20 Period 10 Financials - FY21 Community Benefit Grant Program Funding - Medical Staff Report - Deferral of Revisions to Executive Salary Ranges for FY21 - Medical Director Agreements - FY21 Board and Committee Master Calendar - FY21 Advisory Committee Goals - FY21 Advisory and Committee Liaison Agreements - Restructuring of FY 20 Incentive Goals
	July 8, 2020	No Approvals
ECHD Board	June 16, 2020	- FY20 YTD Financials - Allocation of $7,830,671 in FY18 Capital Outlay Funds to Mountain View Women's Hospital Expansion Project - Modification to District Funded Community COVID-19 Testing Program Authorization - Funding for FY21 Community Benefit Grant Program - Appointed Director Miller as Liaison to the Community Benefit Advisory Council
	July 15, 2020	- Appointment of Ad Hoc Committee to Review Compliance Issue

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Finance Committee		- None since last report
Compliance and Audit Committee		- None since last report
Exec. Comp Committee		- 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

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director, Quality
Date: August 3, 2020
Subject: Patient Safety Indicator (PSI) Scores Q4 FY20 compared to FYTD Q1-Q4 2020

Purpose:

To provide an update on the AHRQ Patient Safety Indicators for Q3 FY20.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

2. Authority: The Quality Committee of the Board is responsible for oversight of quality and safety.

3. Background: The PSIs can be used to help hospitals in the following ways:

- Identify potential adverse events that might need further study;
- Provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record;
- Include indicators for complications occurring in hospital that may represent patient safety events; and
- Indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager and are then sent through the Medical Staff's Peer review process for trending by physician. The following is of note for FY20 Q4:

- 5 of the 17 PSIs are over the Premier Mean for Q4 2020. They include pressure ulcers, death in surgical patients with treatable complications, unrecognized abdominopelvic accidental puncture or laceration, OB trauma vaginal delivery with instrument and Trauma vaginal delivery without instrument.
- 2 of the PSIs, Unrecognized Abdominopelvic Accidental Puncture or Laceration, and Birth Trauma Injury to Neonate, had only 1or 3 patients.
- PSI-18-OB Trauma Vaginal Delivery with Instrument and PSI-19 - OB Trauma Vaginal Delivery without Instrument involve 12 and 16 patients in Q4.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: Patient Safety Indicator (PSI) Scores Q4 FY20 compared to FYTD Q1-4 2020.

Suggested Committee Discussion Questions: None

Patient Safety Indicator (PSI) Report - Q4 FY20

Rate Measures

Patient Safety Indicator		Numerator (FY20, Q4)	Denominator (FY20, Q4)	Rate/1000 (FY20 Q4)	Premier Mean*	Numerator (FY20, Q1-4)	Denominator (FY20, Q1-4)	Rate/1000 (FY20 Q1-4)	Premier Mean*
PSI-02	Death in Low Mortality DRGs	0	121	0.00	0.54	0	675	0.00	0.54
PSI-03	Pressure Ulcer	1	1,310	0.76	0.46	5	6,918	0.72	0.46
PSI-04	Death in Surgical Pts w Treatable Complications	6	27	222.22	120.99	16	103	155.34	120.99
PSI-06	Iatrogenic Pneumothorax	0	2,171	0.00	0.14	2	11,577	0.17	0.14
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	2,025	0.00	0.10	0	10,130	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	0	1,772	0.00	0.10	2	9,764	0.20	0.10
PSI-09	Perioperative Hemorrhage or Hematoma	1	732	1.37	1.84	3	3,902	0.77	1.84
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	0	396	0.00	0.75	1	2,310	0.43	0.75
PSI-11	Postop Respiratory Failure	0	319	0.00	4.18	2	1,888	1.06	4.18
PSI-12	Perioperative PE or DVT	2	771	2.59	2.61	7	4,081	1.72	2.61
PSI-13	Postop Sepsis	0	383	0.00	3.46	4	2,282	1.75	3.46
PSI-14	Postop Wound Dehiscence	0	265	0.00	0.65	0	1,250	0.00	0.65
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	1	663	1.51	0.82	6	3,169	1.89	0.82
PSI-17	Birth Trauma Injury to Neonate	3	1,055	2.84	4.02	17	4,332	3.92	4.02
PSI-18	OB Trauma Vaginal Delivery with Instrument	12	57	210.53	107.66	45	237	189.87	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	16	686	23.32	15.45	83	2,821	29.42	15.45

Count Measures

Patient Safety Indicator		Cases (FY20 Q4)	Premier Mean Cases*	Cases FY20 Q1-4)	Premier Mean Cases
PSI-05	Retained Surgical Item or Unretrieved Device Fragment	0	0.16	0	**0.16**

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

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
5	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing

Patient Story

Hello Andria,

Last Wednesday, [redacted], I underwent a cardiac ablation procedure by Dr. [redacted] and was hospitalized overnight. The care I received by the doctors, nurses and staff was fantastic. In particular, I would like to acknowledge the following individuals for their exceptional service:

Sheila, the day nurse after I moved from post-op to my room. Sheila welcomed me, reviewed my situation with me, including the monitoring, medication schedule, when I would see Dr. [redacted] again and the discharge plan. She answered my questions and made sure I was comfortable. Her warm and calm demeanor assured me that I was in good hands.

Junior (not sure of his title), cheerfully helped me with toileting and hygiene and getting up and about walking, observing me and correcting my gait. He was a good conversationalist.

Yen, the night nurse, was cheerful and attentive, making sure I was getting the right meds at the right time, answering questions and generally making sure everything was on track.

Weina, (not sure of her title), cheerfully helped with toileting and hygiene, monitoring and whatever else needed to get done to get me ready for discharge.

Glenda, the nurse responsible for making sure I was ready to go, was particularly attentive to my needs, made sure I did some walking, and made a point of saying that, while my numbers were good, it was how I felt that would be the determining factor for my release. She even got me the apple sauce I requested!

The shift changes were seamless, with each nurse introducing the next one. I appreciated the wall board; it was informative and they kept it updated.

While all this may seem like, "just doing my job," it was the <u>way</u> each of them did what they did that made the difference for me. Each one was personable, warm, good-humored, and attentive to detail. Since I also had a knee injury this attention was important. Overall, everyone I had contact with, but especially Sheila, Junior, Yen, Weina and Glenda, made for a stay that facilitated my healing process and exceeded my expectations.

I appreciated your introducing yourself and checking on me before I left. I also appreciated your colleague, I'm sorry I didn't get her name, I believe she was the supervising nurse, introducing herself when I first arrived in the room.

Andria, thank you for your professionalism and everything else you do to guide and support your clinical staff in providing such wonderful care. I regret that I was unable to offer my comments earlier. I hope this is still helpful to you.

With warmest regards,

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: August 3, 2020
Subject: El Camino Medical Health Network Quality Report

Purpose: To provide the first quarterly report on the El Camino Medical Health Network Quality metrics to the El Camino Hospital Board's Quality, Patient Care and Patient Experience Committee for review and discussion.

Summary:

1. Situation: Silicon Valley Medical Development is a wholly-owned subsidiary of El Camino Hospital. SVMD, under the dba of El Camino Health Medical Network (ECHMN), provides primary and specialty care in five locations plus two urgent care centers. ECHMN contracts via a professional services agreement with two physician groups—El Camino Medical Associates (ECMA) and San Jose Medical Group (SJMG). The Medical Groups are responsible for providing qualified providers to staff the clinics and provide clinical care. The Medical Groups are responsible for ensuring the providers satisfy professional standards and qualifications, and in collaboration with SVMD, develop programs, policies, procedures and committees for utilization management, quality assurance, risk management, peer review and credentialing applicable to the provision of services to Clinic patients. SVMD reports to a Board of Managers that is responsible to oversee operations, financial performance, and quality, safety, and patient experience.

2. Authority: The El Camino Hospital (ECH) corporation is the sole member of SVMD, LLC (dba ECHMN). The Operating Agreement between SVMD and ECH reserves certain authority ("reserved powers") to ECH and also provides a cadence for SVMD reporting to the ECH Board and its Advisory Committees. The SVMD Board of Managers serves as the governing body for SVMD. SVMD has a Quality Improvement Committee ("QIC") that provides reports to the SVMD Board of Managers. Going forward, the SVMD QIC will also be reporting to the Quality, Patient Care and Patient Experience Committee on a quarterly basis.

3. Background: The SVMD organization includes a Quality Improvement Committee along with a Credentialing Committee and a Peer Review Committee. These committees are populated by members of both physician groups, SJMG and ECMA. The El Camino Health (ECH) CMO is an ex officio member of the SVMD Quality Improvement Committee. The SVMD Quality Improvement Committee monitors compliance, utilization management, case management, population health management, grievances, risk management, patient safety, credentialing, peer review, patient experience, and network quality performance.

4. Assessment: The QIC has selected 8 leading metrics to monitor and improve for 2020/2021. An overview of these are provided in Attachment 1. The metrics were chosen based on a review of common top priority metrics across HEDIS and MIPS in addition to the Committee's perspective priorities for improvement. Data for these measures will come from the Epic electronic medical record. These metrics will be used both for MIPS which is based on a calendar year and the enterprise quality goals which are based on a fiscal year hence the reference to 2020/2021. We have developed an internal scoring system so that we can produce a "HEDIS Composite Score" to be used to track high level progress. This methodology is illustrated in the attachment..

5. Outcomes: The Board Quality Committee will review these metrics on a quarterly basis as part of their oversight responsibilities.

List of Attachments

1. SVMD Quality Metrics

Suggested Committee Discussion Questions:

1. What questions do the Committee members have about the metrics presented?
2. Are these the right metrics to report to this Committee?
3. Shall we provide a deep dive on the metrics on a rotating basis?

Silicon Valley Medical Development

2020/2021 Quality Metrics

2020 Quality Metrics

- SVMD selected 8 Quality Outcome Metrics to monitor, measure and improve.

- The selected metrics are representative indicators of how well SVMD performs as a system in preventative care, curative care and chronic disease management.

- EPIC and MIPS scoring data and ranking system was used as the benchmark for provider and system level reporting.

- For strategic and high level target setting purposes, a "**1-5 Composite Scoring system**" was developed utilizing EPIC and MIPS deciles.

    - Quality Measure were given a 1-5 score range reflecting the corresponding range in their respective MIPS ranges.
    - A "**1**" signifying the lowest decile range and "5" being in the highest decile range.
    - The composite score is the total points for the 8 measures divided by 8

Quality Metrics

Measure ID	Points 1	Points 2	Points 3	Ponits 4	Points 5	Epic/ MIPS Perfor-mance Score	Compo-site Measure Score	Target	Target Point Score
Documentation of Current Medications in the Medical Record	0-6.45	6.46-88.81	88.82-99.68	99.69-100	100	75	2	89	3
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0-0.41	0.42-23.88	23.89-73.96	73.97-98.35	98.36-100	36	3	47	3
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) **	>99.46	99.45-92.62	92.61-59.09	59.08-37.89	37.88-31.41	46	4	45	4
Breast Cancer Screening	0-0.27	0.28-27.28	27.29-69.35	69.36-88.26	88.27-100	29	3	48	3
Colorectal Cancer Screening	0-0.12	0.13-19.33	19.34-70	70.01-90.81	90.82-100	23	3	45	3
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0-0.92	0.93-24.15	24.16-90.28	90.29-99.99	100	88	3	90	4
Falls: Screening for Future Fall Risk	0-0.03	0.04-21.67	21.68-90.35	90.36-99.5	99.6-100	0	1	56	3
Controlling High Blood Pressure	0-19	20-39.99	40-59.99	60-79.99	80-100	52	3	63	4
Total							**2.75**		**3.375**

2020/2021 QI Target Composite Score

(3.0)

2020 Targets were set based on current national averages.

Epic data is incomplete and unstable at this time

Measure	Target (National Averages)	
CMS-68 Documentation of Current Medications	89%	3
CMS-69 Preventive Care & Screening: Body Mass Index (BMI) and Follow-up Plan	47%	3
CMS-122 Diabetes: HgbA1c Poor Control (>9%)	45%	4
CMS-125 Breast Cancer Screening	48%	3
CMS-130 Colorectal Cancer Screening	45%	3
CMS-138 Preventive Care & Screening: Tobacco Use & Cessation Intervention	90%	4
CMS-139 Falls: Screening for Future Fall Risk	56%	3
CMS-165 Controlling High Blood Pressure	63%	4

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: August 3, 2020
Subject: Board Quality and Safety Dashboard

Purpose: To review and provide input on the 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 the request for a simplified quality and safety dashboard that the Board can use as a tool to monitor quality and safety performance without repeating the oversight work of the Quality Committee, the attached dashboard has been created. This new dashboard is based on the STEEEP definition of quality and safety (Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered) that is a national standard adopted by the IHI (Institute for Healthcare Improvement). This tool will provide a snapshot of key metrics based on those categories. This is a common format used by many other organizations.

4. Assessment: The Board's 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. The intent is for the Board to review those areas of potential concern.

There are several areas below target for FY20 Q4. They include:

- The sepsis mortality index has increased over the past few months from 0.98 in Q2 to 1.05 in Q4. Each death has been carefully and thoroughly reviewed looking for root or common causation. The following issues were identified:
    - There have been cases where the SEP-1 bundle elements have not been fully deployed.
    - During the pandemic, many patients have waited too long to seek medical care which has resulted in more end stage sepsis patients appearing for treatment creating a challenge in reversing the pathophysiology.
    - An additional challenge has been the need to limit fluid resuscitation in COVID-19 patients to prevent pulmonary complications.
    - More emphasis will be placed on application of the bundle in the right circumstances.
- C. Difficile Infection (CDI) is currently higher than goal (1.52 for FY20 Q4 vs. the SIR Goal of <= 0.70). The trend, however, is moving in the right direction with some months, including June, at 0.. Continued reinforcement of infection control measures is necessary to further reduce this Hospital-Acquired Infection (HAI). Otherwise, HAI metrics are improved and the most recent CMS Hospital Acquired Conditions [HAC] penalty program results are completed, and El Camino will receive no penalty in that program, which is great news.

- The enterprise PC-01, pre-term elective deliveries, is above target (3.28% for FY20 Q4 vs. goal of 0.00%) and will require continued effort to decrease that metric. PC-02, NTSV C-Section has been hovering near the target and will also require continued vigilance.
- In the efficient category, there has been a change in how the LOS is measured. The arithmetic observed LOS/Geometric expected LOS index was being generated by 3M through the finance department. We have terminated our 3M contract so now are obtaining this index through our Premier Care Science source. This accounts for the across the board red in that category as the equivalent index does not match that which had been provided by 3M. Basically, the 3M index of 1.0 roughly corresponds to a Premier Care Science index of 1.3. We will need to reset the target for the future accordingly.
- Finally, there are several categories in patient experience that are near but below target. These include:
    - Discharge Information (86.2 in FY20 Q4 vs goal of ≥87.3)
    - Likelihood to Recommend (82.27 in FY20 Q4 vs. goal of ≥84.2)
    - Net Promoter Score (73.2 in FY20 Q4 vs. goal of 78.8 NPS)
- Several initiatives are being deployed to improve those scores such as post-discharge phone calls, a new WeCare program to enhance communication with patients, and more emphasis on discharge information/communication. In the ambulatory space, SVMD uses Net Promotor Score (NPS), which is close but below target. Other Reviews: None

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

List of Attachments:

1. PowerPoint illustrating the new dashboard

Suggested Committee Discussion Questions:

1. Are there any questions regarding the "red" metrics?
2. Does this dashboard provide the Board with an adequate snapshot of our quality, safety, and experience status?
3. Would the Committee like to use findings on this dashboard to drive agenda items for more in depth reviews going forward?
4. What supporting information would be useful to the Committee to assist in evaluating the metrics?

El Camino Health

Month to Quality Committee of the Board: August 2020

Quarterly Board Quality Dashboard (STEEEP Dashboard) FY 20 End of Q4

Quality Domain	Metric	Baseline	Target	Performance				
		FY 19	FY 20	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FYTD 20 thru June
Safe Care	Risk Adjusted Mortality Index	0.97	≤ 0.90	0.61	0.78	0.76	0.69	0.73
	Sepsis Mortality Index	1.06	≤ 0.90	0.69	0.98	1.01	1.05	0.98
	% of Serious Safety Events (SSEs) Classified (New program began categorization 12/1/1/19)	New Program	Establish baseline 95% classified in ≤30-days	Began 12/1/19	100% (Dec only)	100% (Jan & Feb)	100%	100%
	Surgical Site Infections (SSI)	0.52	SIR ≤1.0 NHSN ratio	0.22	0.28	0.60	0.37	0.36
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	1.09	SIR ≤0.75 NHSN ratio	0.27	0.77	0.26	0.67	0.48
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.36	SIR ≤0.50 NHSN ratio	0.39	0.00	0.36	0.00	0.20
	Clostridium Difficile Infection (CDI) - HAI	1.96	SIR Goal: <= 0.70	1.58	1.18	1.59	1.52	1.46
	Modified PSI-90 CMS HAC Reduction Program	0.71	1.02	1.010	0.899	0.965	0.991	0.919
Timely	Enterprise Patient Throughput - ED Door to Admit Order	205 min	TBD	188 min	187 min	197 min	185 min	190 min
	Patient Throughput - Median Time Arrival to ED Departure	284 min	266 min	256 min	252 min	270 min	252 min	257 min
	OP18b - Median Time from ED Arrival to ED Departure for Discharged ED patients	CY18 183 min	CY19 <180 min	163 min	164 min	168.5 min	169 min (Apr & May)	167 min
Effective	Risk Adjusted Readmissions Index	0.99	≤ 0.96	0.96	1.06	0.92	0.84 (Apr & May)	0.97
	CMS SEP-1 Compliance Rate	74%	≥ 80%	82.6%	70.0%	68.0%	55% (Apr & May)	70.86%
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.99% (4/404)	0.00%	0% (0/103)	2.08% (2/96)	0.99% (1/101)	3.28% (Apr & May) (2/61)	1.39% (5/361)
	PC-02 NTSV C-Section	ENT: 24.9%	≤ 23.9%	23.97%	22.55%	24.56%	25.45% (Apr & May)	24.00%
	SVMD: CMS 165 Controlling High Blood Pressure (New)	48.7% (470/966) (CY19)	TBD	49.1%	49.7%	51.7%	49.32%	51.2%
	ECMA: CMS 165 Controlling High Blood Pressure	43.1% (767/1778) (CY 19)	TBD	43.9%	43.4%	54.4%	54.28%	50.4%
	SVMD: CMS 122 Diabetes Hemoglobin A1c Poor Control (New)	48.6 % (1081/2223) (CY 19)	TBD	46.9%	46.7%	48.7%	39.60%	43.3%
	ECMA: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.1% (402/933) (CY 19)	TBD	38.5%	41.3%	51.0%	47.62%	43.6%
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.08	1.00	1.32	1.26	1.34	1.30	1.32
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 16)	0.89 (best decile all hospitals CY 18)	0.99 (CY 18) 4Q 2019	None Annual data only			0.99
Equitable	Hospital Charity Care Support	$21.6m	$23.0m	$6.8m	$6.6m	$5.8m	$8.2m	$20.5m
	Clinic Charity Care Support	$18k	TBD	$9.8k	$7.8k	$10.6k	16.0k	44.3k
	Language Line Unmet Requests (data collection started Q2)	4.60%	<5%	Began Q2	2.90%	0.09%	0.65%	0.34%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	African American	None	4.09	3.97	4.18	3.89	4.05
		White		3.67	3.76	4.02	3.74	3.79
		Asian American		3.65	3.04	3.75	4.33	3.64
Patient-centered	HCAHPS: Staff Responsiveness	65.7	≥ 67.1	66.4	69.1	63.6	69.0	66.5
	HCAHPS: Discharge Information	86.7	≥ 87.3	86.9	88.0	88.1	86.2	87.2
	HCAHPS: Likelihood to Recommend	83.5	≥ 84.2	83.2	82.7	83.3	82.27	83.4
	Emergency Department (ED) Satisfaction	66	≥ 69.0	70.6	70.8	70.9	77.1	70.7
	OAS CAHPS: Rating 9's & 10's	43rd %tile	≥ 35th %tile	41 %tile	52 %tile	41 %tile	47th %tile	32nd %tile
	NRC Net Promoter Score	71.9 NPS	78.8 NPS	74.4	70.4	71.1	73.2	72.3

Report updated 7/20/20

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: August 3, 2020
Subject: FY21 Incentive Goals

Purpose: Review final FY21 Incentive Performance Goals

Summary:

1. Situation: The Quality Committee reviewed and recommended to the Board a set of quality, safety, and experience goals for FY21. These were subsequently approved by the Board. The Quality Committee requested that management return with the methodology to be used to set the targets for the metrics to be used for the goals. This was accomplished with the understanding that the final metrics for some of the goals will not be available until later in the year.

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: There is a natural lag in producing the metrics for some of the organizational goals and new baselines must be determined for new goals. Since the targets for the FY21 goals cannot be finalized until the FY20 baselines are available, the initial interim step traditionally has been to review and adopt the methodology for determining the actual goal metrics to be applied to the baselines when available. Since the Quality Committee approved the goals last month, some changes have been made based on: a) recommendation from the Executive Compensation Committee(ECC) to shorten the number of goals; b) some of the baseline metrics are now available; and c) the Finance Committee has already approved the newest iteration. The only change in the quality, safety, and experience goals since the QC last reviewed these goals was the deletion of the Likelihood to Recommend (LTR) for Outpatient Surgery. This was done to reduce the number of goals as cited above and this particular goal has very limited scope for a goal that applies to the entire organization. The measurements of the LTR metrics have been adjusted to include the actual scores.

4. Assessment: The FY21 Incentive Goals are now finalized except for the readmission index which will not be available until mid-September. The Incentive Goals impact everyone in the organization as well as physician medical directors. Quality, Safety, and Patient Experience for the first time will constitute 80% of the incentive plan.

5. Other Reviews: None

6. Outcomes: The Quality Committee will review and confirm the quality, safety, and patient experience portion of the FY21 Organizational (Incentive) Performance Goals. Final approval rests with the ECC and the Board.

List of Attachments: Goal chart

Suggested Committee Discussion Questions: None

Proposed Fiscal Year 2021 Organizational Performance Goals

True North Pillar	Weight	GOAL	OBJECTIVES/OUTCOMES	Benchmark		Measurement Defined			Measurement Period
				Internal Benchmarks	External Benchmark	Minimum	Target	Stretch	
Threshold		Operating EBIDA	Return to, and maintain positive EBIDA	FY19: 16.9%. FY20 YTD P11: 11.5%		≥ 3% EBIDA			FY21
Quality and Safety	40.0%	Zero Preventable Harm	Serious Safety Event (SSEs) Rate	Dec 19-May 20 – 4.16 SSEs per 10K adj. pt. days	External Baseline – best practice is to reduce to zero	Maintain Baseline	Improve by 1/10K adj. pt. days	Additional 10% improvement over target	FY21
			Risk-Adjusted Readmission Index	FY 20 Target = 0.96. FY 20 Actual: 0.98 (through April)	Premier Standard Risk Calculation	Lower of FY20 Target or Baseline	Close gap to top performers (15%ile) by 50%	Close gap to top performers (15%ile) by 75%	FY21
			Medical Network: Healthcare Effectiveness Data and Information Set (HEDIS) Composite Score	FY20 composite score: 2.75 Aggregate score of the 8 selected measures	Internal Calculation; validate individual measures with external benchmarks	2.75 *Maintain baseline*	3.0 *10% improvement*	3.2 *15% improvement*	FY21
Service	40.0%	Exceptional Personalized Experience, Always	Likelihood to Recommend (LTR) – Inpatient	FY 19: 83.2 FY 20 : 83.1	Press Ganey Top 30% of performers	82.6 *50% of improvers*	83.6 *30% of Improvers*	85.2 *10% of Improvers*	FY21
			LTR – Emergency Department	FY 19: 71.3 FY 20: 75.7	Press Ganey Top 30% of performers	76.4 *50% of improvers*	78.2 *30% of Improvers*	80.7 *10% of Improvers*	FY21
			LTR – El Camino Health Medical Network	FY19 Baseline: 71.9 FY20 Q3: 71.1	NRC Net Promoter FY20 Q3 50%ile: 78.8	72.9	75.9	78.9	FY21
Finance	20.0%	Sustainable Strength and Vitality	Operating EBIDA margin	FY19: 16.9%. FY20 Projected: 9.1%	S&P Global Ratings AA rating: 11.1%	90% of Budget	100% of Budget	110% of Budget	FY21