El Camino Health

AGENDA

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

Monday, April 6, 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 1-866-365-4406 MEETING CODE 9407053#.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (03/02/2020) b. Proposed FY21 Committee Meeting Dates ***Information*** c. FY20 Quality Dashboard d. FY20 Pacing Plan e. Progress Against FY20 QC Goals	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:35**
4.	**QUALITY COMMITTEE FOLLOW-UP TRACKING** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**information 5:35 – 5:37**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Julie Kliger, Quality Committee Chair		**information 5:37 – 5:42**
6.	**PATIENT STORY** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**discussion 5:42 – 5:52**
7.	**PATIENT EXPERIENCE (HCAHPS)** **ATTACHMENT 7**	Cheryl Reinking, RN, CNO		**discussion 5:52 – 6:12**
8.	**QUALITY/PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN - QAPI** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:12 – 6:32**
9.	**VALUE BASED PURCHASING REPORT** **ATTACHMENT 9**	Mark Adams, MD, CMO		**discussion 6:32 – 6:42**
10.	**APPROVE FY21 COMMITTEE GOALS** **ATTACHMENT 10**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:42 – 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
11.	**PROPOSED FY21 ORGANIZATIONAL GOALS** **ATTACHMENT 11**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:52 – 7:12**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 7:12 – 7:15**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:15 – 7:16**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 7:16 – 7:17**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 7:17 – 7:19**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (03/02/2020) ***Information*** b. Medical Staff Quality Council Minutes (including API Reports)			
16.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**discussion 7:19 – 7:29**
17.	*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 7:29 – 7:34**
18.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:34 – 7:35**
19.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:35 – 7:36**
20.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:36 – 7:41**
21.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:41 – 7:42**

Upcoming Meetings:

Regular Meetings: 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, March 2, 2020
El Camino Hospital | Conference Rooms E&F
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	
Imtiaz Qureshi, MD	
Linda Teagle, 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 silent roll call was taken. Dr. Sharma was not present during roll call and arrived at 5:45 pm during Agenda Item #5 (Patient Story). Ms. Simon participated via teleconference and arrived in person at 6:15 pm during Agenda Item #7 (Quality Dashboard). Caroline Currie 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: Minutes of the Open Session of the Quality Committee Meeting (02/03/2020); For information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 QC Goals, Hospital Update, & Quality Committee Follow-up Items **Movant:** Po **Second:** Falwell **Ayes:** Ting, Burn, Falwell, Fung, Kliger, Po, Qureshi, Teagle & Simon **Noes:** None **Abstentions:** None **Absent:** Currie & Sharma **Recused:** None Chair Kliger announced a new Chief Quality Officer has been hired. Mr. Woods reported that the offer has been accepted and the anticipated start date is around April 13, 2020.	***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	Ms. Reinking presented patient comments regarding non-nursing, non-clinical, and ancillary related patient experience. There were many comments about parking whether it's with confusion with parking or the parking attendants. There are several improvements regarding parking that could be made such as signage, building a new garage available for parking, and way finding for where to park. Dr. Ting stated that he gets many questions from patients regarding where something is located and suggested that more signage be implemented and/or updated. Ms. Reinking commented that with the new building opening, there will be more signage and will double check to make sure this gets done. Ms. Reinking stated that we have had valet parking at the Los Gatos campus now for the last several months. There was also a complaint of no one being at the security desk at 1:00 am. This issue has now been fixed. Ms. Reinking also reported that a patient also felt they were overly communicated with when getting a mammogram. Patient received a text at 6:00 am, which woke her up. Issues were addressed with the radiology department to adjust their time. The same patient also had issues with parking with the valet being unavailable.	
6. PATIENT EXPERIENCE PLAN/PATIENT FAMILY VOICE	Chair Kliger reminded the committee about why Patient Experience is being included now to the agenda. Last year, there were recommendations to include more patient voices. We want to be hearing and thinking about how does the patient family advisory committee feed into the quality goals and how it supports and informs the quality strategy. Ms. Reinking presented patient experience through the Patient and Family Centered Care (PFCC) to develop partnerships through mutual understanding with the experience of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care. Ms. Reinking states that the four principles are something that we should all abide by with respect, communication, building on strengths, and promoting collaboration. With the True North diagram, we will need to think about how we are optimizing that human experience through our staff, community and family experience. Ms. Reinking presented the partnership model explaining that patients, family and staff would want to meet in the middle to become partners in managing the complexity of all emotions involved. There are several different ways to work with the patients and families to really embed their voice being taken to heart through the Patient and Family Advisory Council (PFAC), workgroups, focus groups, and improvement events. With the Patient/Family Advisor (PFAC) role, they let the hospital know how to be proactive on issues that may arise, such as parking issues. The PFAC meets monthly for two hours. It has 11 patient and family members and 3 staff members. Some areas the PFAC influences are marketing, billing, parking, security, emergency room, and even the electronic health record process with EPIC. Examples of special efforts supported by PFAC include modifying marketing materials, revised patient billing and messaging, and advocating for gender neutral forms in Mother Baby. Ms. Reinking reported the Family Advisory Board (FAB) accomplishments in the NICU department. They created a NICU Parent Peer to Peer Buddy Support Program which pairs parents who have gone or are going through similar situations. They also placed more books in the NICU and reading more to the babies. They have a Cuddle Program where babies who don't	

	have parents available have skin to skin contact with volunteers. Lastly, there is also an app that allows parents to see their baby's information through My Chart Bedside. In response to Committee member's questions, Ms. Reinking stated that members of the PFAC have a two year term, but not everyone rotates at the same time. In terms of the PFAC goals, they are goals that are brought forward through our surveys, patients, and staff. Anyone can bring forward any issues to address. To pick on what to work on, they are categorized by priority and how they align with our strategy.	
7. BOARD QUALITY DASHBOARD	Chair Kliger requests for Dr. Adams to answer what the strategy was used and coming to deciding why these indicators presented in the dashboard and not the other indicators. Dr. Adams stated that the purpose of the dashboard is to provide a snapshot to the Board, not the Quality Committee. While this is being looked at and discussed with the Quality Committee, this is only to provide to the Board a snapshot using the quality and safety measures based on STEEEP. There were committee member feedbacks for discussion that Dr. Adams addressed. The most challenging is under the cost effective part under "efficient" in STEEEP because there were many different measures that feed into that. Dr. Adams reminded the committee that this dashboard is still under construction that can be changed overtime. While there may be some areas that we want to focus on, we also want this committee to be engaged in strategic discussions as well and not just solely focused on metrics. For example, we are on a journey to high reliability. There are lots of impacts and influences in high reliability work which impacts quality and safety. That could be a rich discussion that this committee could have and just looking at the metrics alone is not taking advantage of the expertise of this committee. Dr. Adams states there are at least 2300 known quality metrics. As we go to topic number 9, the cover sheet spells out nicely on the logic used on what strategy was used. There has been a couple of metrics that were suggested and added to the dashboard. Dr. Adams reminded the committee that this is a living dashboard that can be changed. It will never be perfect. It's very difficult to keep everyone happy since some say too much detail, some say too little detail, etc. Chair Kliger. suggested having some metrics around Behavioral Health, Women's Health, and/or Cardiology/Structural Heart. There were also some survey results around culture and safety, and it would be good to have some of those scores in here. In addition, we all have different opinions and philosophies, and it would be beneficial to put something on the agenda to discuss how to better utilize better reporting. For example, is there some value that derived from the types of reports that are made where we feel they reflect medical care or care coordination? Also, regarding efficiency, we are always behind on value based purchasing and that might be a good thing to put on the dashboard. It also might be good to have the percentage of lean projects that are on track because they speak to how we're doing fundamentally. Lastly, there is a lot of real estate on the dashboard for baseline metrics and she doesn't need to see any of that. Chair Kliger wants to see how we're doing. For example, what is top tier? This is coming to the Board so it can oversee where we are falling out and the management plan to correct that. If we have the right metrics, that will feed into strategy. Dr. Ting requested statistics and not opinion. He wants the dashboard to be	

	supported by evidence. Dr. Sharma suggested that she wants to see more information. Dr. Fung asked how there could be so much data for people to digest, understand, and discuss. He stated that this is going to be overwhelming in terms of time, etc. While we want to capture as much data as possible, the Board does not have the time, resources, or energy to go into all of that. He believes that we have to be realistic and thing of a genius way on how to capture the information. First, high priority is obviously what we don't do well. We have to set priority and how we would need to go through that, not every month, but alternate months or perhaps quarterly. He believes the committee should help Dr. Adams. Chair Kliger reiterated that while the utility of this is being determined, this is not a dashboard that the Quality Committee will be discussing. This will probably go in the consent item. The board will be reviewing these metric items maybe every quarter. She states that this item is not ready for a motion. There will be another round to have some revisions with some of the materials and incorporating suggestions as best as possible.	
8. UPDATE ON LEAN TRANSFORMATION	Mr. Griffith presented an update on LEAN transformation. He explained that LEAN is much more than just a set of tools. It's a cultural transformation aligning bringing value to our patients making the environment better for our patients and doctors. The mindset of LEAN is that projects are never more important than the people involved. Respect for others, respect for doctors, respect for colleagues is of the utmost importance in Lean Leadership Principals. We have designed much of the education around the Lean Leadership Principals. It is a daily system operating management system to drive performance whether it's operational or quality. The past 12 months was spent on strategy and deploying that strategy to the front lines. We have also taken doctors, front line staff, and executives to one day courses to not only learn those principals, but how to apply those principals. Mr. Griffith showed a visual of management's strategy deployment room to illustrate how each organizational goal and strategic goal is being monitored. There is also a production board to give us visibility into all the work going on in the organization. Organizations are notorious for piling on project after project after project which can lead to staff burnout. This is an attempt to rationalize the workload down to the frontline. Mr. Griffith stated that 3 to 5 days are spent on each value stream, finding the current state, and moving to a future state. Out of those, we prioritize the improvements and go to rapid process improvements workshop. The way we have been able to measure the value of our LEAN work is in our volume. These improvements are helping financially, they're having patients get care better, and helping physicians clarify what is important. Lastly, we have quantified this with our finance department and we're looking at about $5M on the conservative side of our benefit to the organization in our ED. The organization aggregately is now growing at about 11% year to year and historically it's been growing about 1 to 2%. Christine Cunningham stated that LEAN is the engine that powers our performance and more importantly, it powers our improvements. It turns 3500 of our employees into problem solvers. It makes problems visible. We can't fix what we can't see. We are focusing on goal deployment. All of our employees know what our goals are and we are really making sure that we have a culture of transparency and openness so that they feel the ability to problem solve and sustain the solution. In response to committee member's questions, Mr. Griffith stated that we	

	have a check in schedule that we have to report on our Lean Leadership Steering Committee which happens for some people weekly. We've all been trained on the GEMBA rounds. We also have our forms, coaching strategy and have offered to help and assist. Ms. Cunningham also stated that there is currently something in the works called Everyday Improvement Ideas where frontline staff can bring ideas including potential solutions. Chair Kliger requested to hear future updates and possibly including the leading indicator for quality into the dashboard.	
9. GOAL ATTAINMENT	Chair Kliger stated that this is a question around how inspirational should the goals be. It is time to hear the philosophy and different thoughts from the members. She has opened up this conversation on what this philosophy should be, nevertheless reminded the members that we are not in the position to tell the hospital how to go about goal attainment.	
10. PROPOSED FY21 ORGANIZATIONAL GOALS	Dr. Adams stated that the goals are not ready. We only have a half year of data today, so we don't even have a baseline. Mr. Woods stated that there are strategic goals, and then there are also annual incentive goals. Ms. Simon was confused on why we did not have anything to review pursuant to the pacing plan; however, Dr. Adams stated that once we have a baseline, we will present to the committee. Chair Kliger requested that a draft of the FY21 Quality and Safety Organizational Incentive Goals be presented to the Committee at its April meeting for discussion.	
11. PUBLIC COMMUNICATION	There was no public communication.	
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:23pm. **Movant:** Ting **Second:** Simon **Ayes:** Ting, Burn, Falwell, Fung, Kliger, Po, Simon, Sharma, Qureshi, & Teagle **Noes:** None **Abstentions:** None **Absent:** Currie **Recused:** None	***Adjourned to closed session at 7:23pm***
13. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 8:00pm. 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 (02/03/2019) and Medical Staff Credentialing and Privileges Report; and for information: Medical Staff Quality Council Minutes including API reports.	
14. AGENDA ITEM 19: CLOSING WRAP UP	Board Quality Dashboard needs to come back will need more work. Committee members would like more on the progress on the Lean work. Lastly, please to bring draft of the Organization Incentive goals to the April meeting.	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 8:02pm. **Movant:** Ting **Second:** Burn **Ayes:** Ting, Burn, Falwell, Fung, Kliger, Po, Simon, Sharma, Qureshi & Teagle **Noes:** None	***Meeting adjourned at 8:02pm***

	Abstentions: None **Absent:** Currie **Recused:** None	

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 Health

Quality Committee Meetings
Proposed FY21 Dates

RECOMMENDED CC DATE THURSDAYS	CORRESPONDING HOSPITAL BOARD DATE
Monday, August 3, 2020	Wednesday, August 19, 2020
Monday, September 8, 2020	Wednesday, September 9, 2020
Monday, October 5, 2020	Wednesday, October 14, 2020
Monday, November 2, 2020	Wednesday, November 11, 2020
Monday, December 7, 2020	Wednesday, December 9, 2020
Monday, February 1, 2021	Wednesday, February 10, 2021
Monday, March 1, 2021	Wednesday, March 10, 2021
Monday, April 5, 2021	Wednesday, April 7, 2021
Monday, May 3, 2021	Wednesday, May 12, 2021
Monday, June 1, 2021	Wednesday, June 9, 2021

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: April 6, 2020
Subject: FY 20 Quality Dashboard for April meeting

Recommendation(s): Review and accept the Quality & Safety Dashboard

Summary:

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

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

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

3. Assessment:

- Continued reduction in Mortality Index, at top decile level with other hospitals
- Readmission Index has dropped to below 1.0.
- ED Throughput metric name was changed to "Median Time from Arrival to ED Departure.
- Both HCAHPS Discharge Information and Likelihood to Recommend improved.
- The only HAI's in February was 2 with C. Difficle
- Zero SSI noted in February.
- Sepsis Mortality Index has increased with more Sepsis cases identified.

4. Other Reviews: N/A

5. Outcomes: N/A

Suggested Committee Discussion Questions: None.

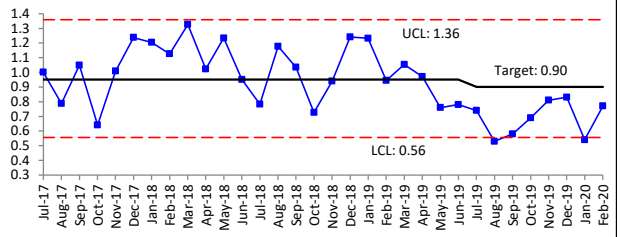
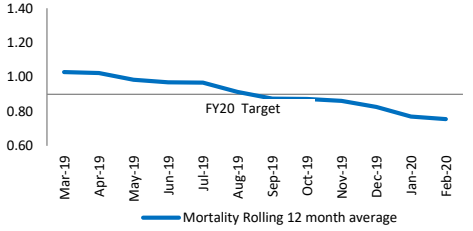
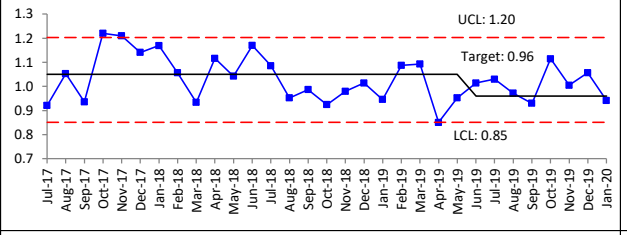
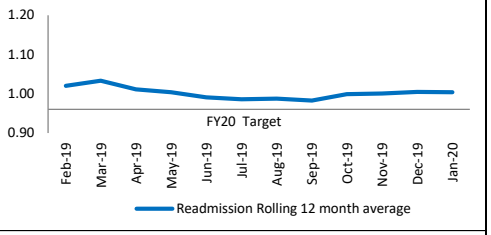
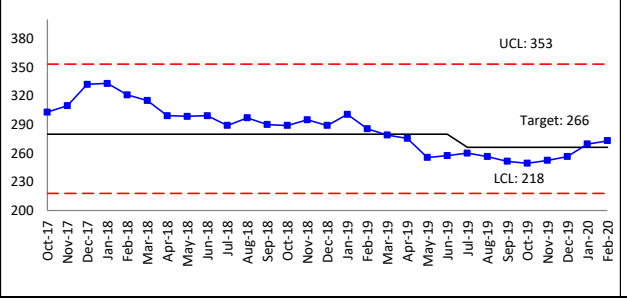
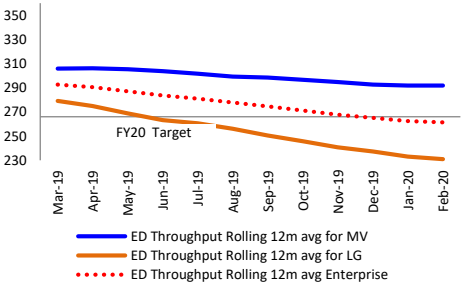
List of Attachments: FY20 Quality Dashboard, February data unless otherwise specified - final results

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

February 2020 (Unless otherwise specified)

Month to Board Quality Committee: April, 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: February 2020*	0.77 (1.62%/2.11%)	0.69 (1.35%/1.94%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: January 2020*	0.94 (8.17%/8.68%)	1.01 (7.97%/7.92%)	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: February 2020*	MV: 306 min LG: 240 min Enterprise: 273 min	MV: 288 min LG: 229 min Enterprise: 259 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

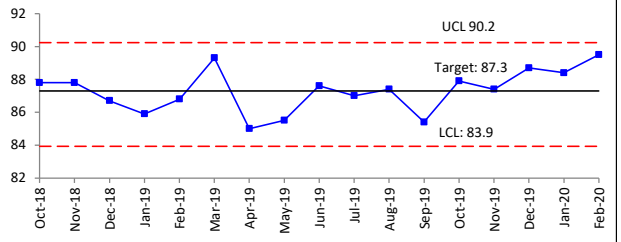
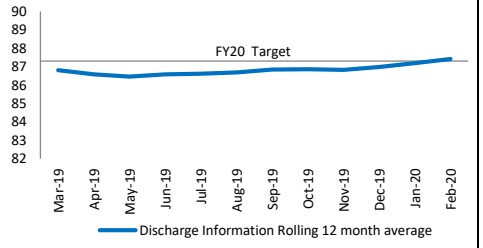
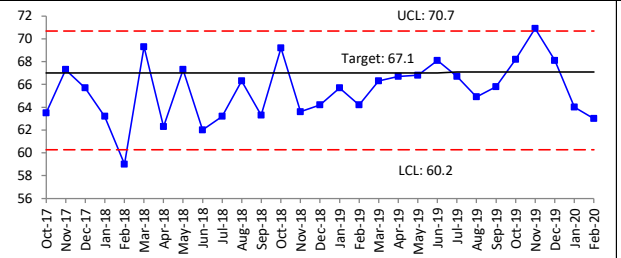
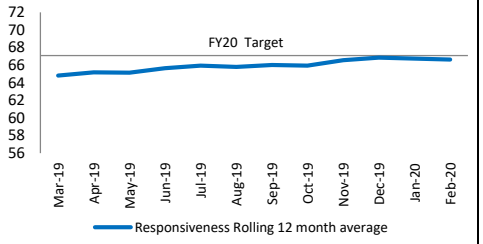
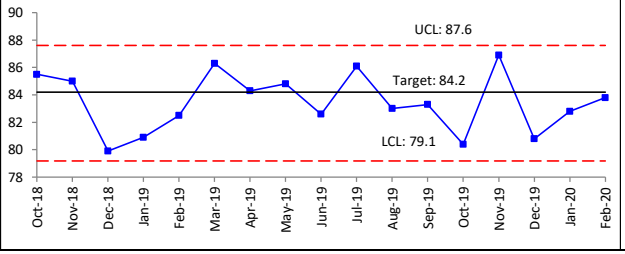
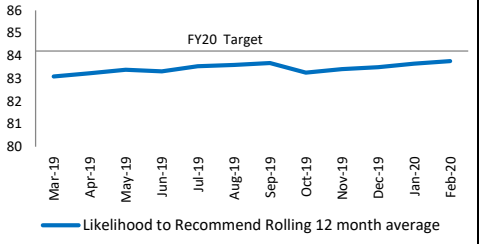
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	The number of deaths increased in February, the observed was sill less than expected. Better physician documentation on the patient's major and co-morbid conditions increases the index expected value. FYTD we are well below target @ 0.69.	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)	Readmissions were reduced in January, and with the use if the Conversa Chat box for the Pneumonia population, in February, we hope to see a continued reduction. .	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)	This org goal is renamed as, "Arrival to ED Departure" given the process change in ED that went live on Feb 11th, 2020. Like last month, teams have continued to keep their throughput performance trending in the right direction compared to the high surge season last fiscal year. In addition, there was a process change implemented in mid-February to help address some billing and compliance issues that will impact the measurement of the end point of this metric. Instead of patients being pulled into their bed in Epic once they reach the unit, they will be placed into their bed by the ED staff as they depart the Emergency room. This will remove the physical transportation time once we get to 100% compliance with the new process. Meanwhile, both campuses are working on sustaining other process improvements and elements of their daily management systems.	Cheryl Reinking, Dolly Mangla	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *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

February 2020 (Unless otherwise specified)

Month to Board Quality Committee: April, 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: February 2020*	89.5	87.7	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: February 2020*	63.0	66.3	65.7	67.1		
6	*Organizational Goal **HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: February 2020*	83.8	83.3	83.5	84.2		

Definitions and Additional Information

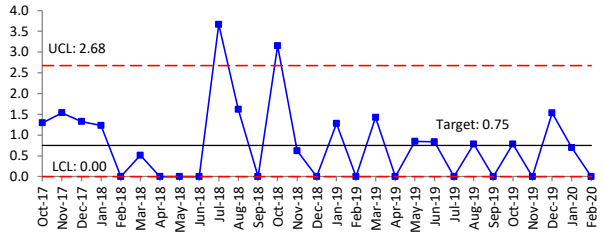
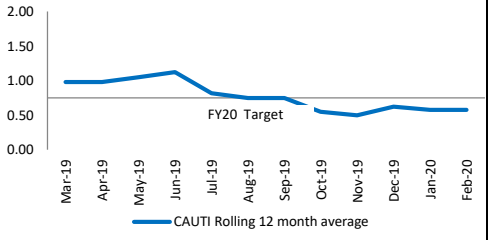
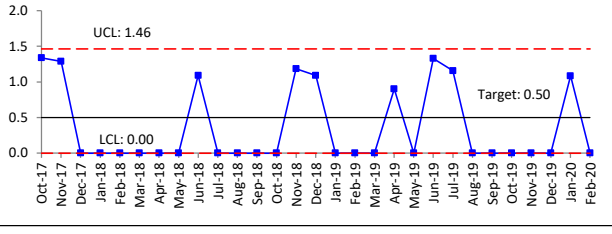
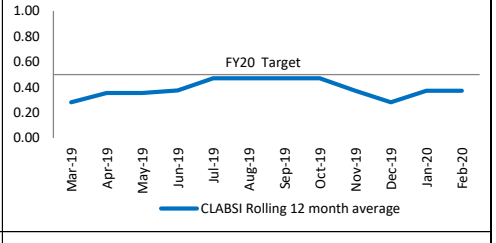
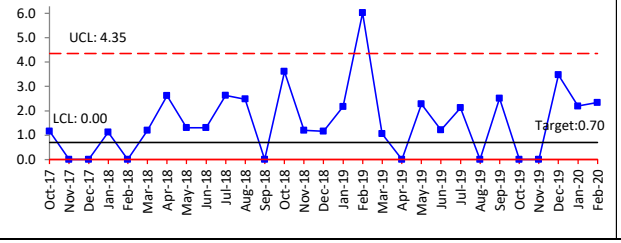
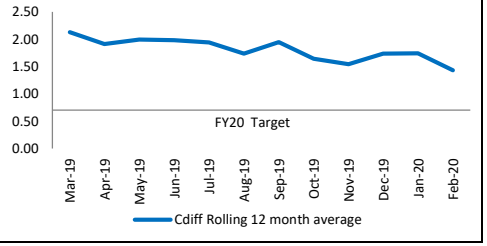
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	• Discharge Information – this metric is above target for the quarter and year to date. Strong improvements have been made in Inpatient / Mother baby especially in Los Gatos. 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. Committee focusing on units with the lowest scores and high volume. Mother/Baby 'commit to sit' where nurses commit to sit daily in order to make a connection and/or address concerns has seen has seen an improvement in Responsiveness scores for MV MCH. Call light system malfunctions have been reported to facilities and repaired. Continue to submit requests for system as needed. Proposal for replacement is in the works. Working with Admin Support (AS) to assure best practices, "words that work", and call light escalation/response structure is in place and utilized. Hourly rounding /purposeful rounding program is being reviewed in order to improve its efficacy Communication training for the non-clinical staff has been placed on Hold.	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 (88th%tile) compared with others in the nation. Continued emphasis on leader rounding, updating and reinvigorating our service standards, will contribute to this metric. Leader-patient rounding will continue by Nurse Leaders and was recently restructured for non-nursing leaders to focus rounding on staff. Questions were updated in Vocera rounding tool.	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

February 2020 (Unless otherwise specified)

Month to Board Quality Committee: April, 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: February 2020*	0.00 (0/1323)	0.48 (5/10348)	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: February 2020*	0.00 (0/1638)	0.26 (2/7642)	0.36	SIR Goal: <= 0.50		
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: February 2020*	2.34 (2/8551)	1.61 (11/68374)	1.96	SIR Goal: <= 0.70		

Definitions and Additional Information

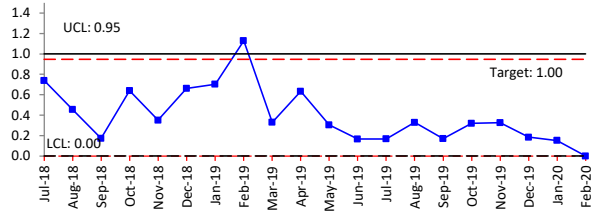
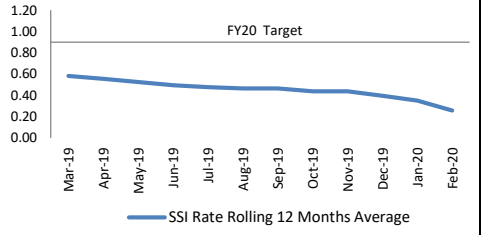
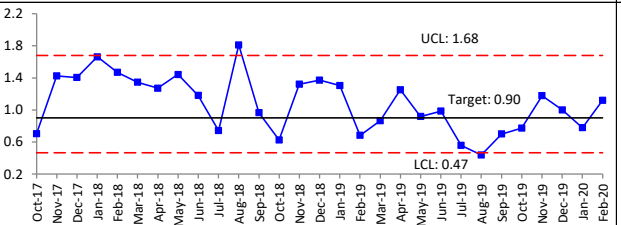
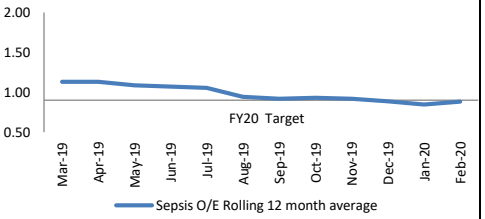
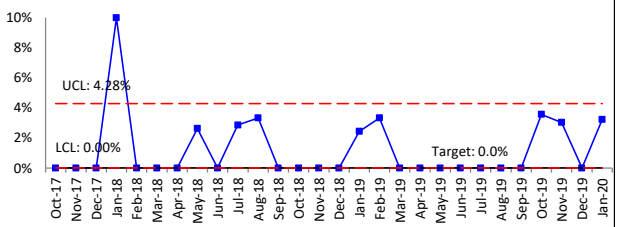
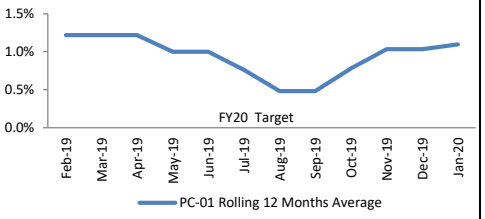
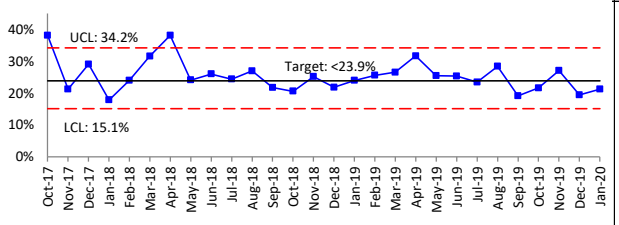
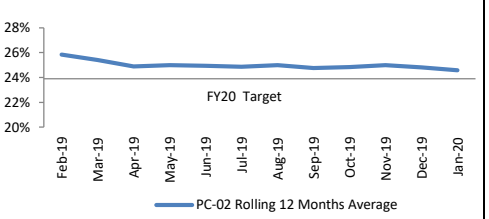
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Zero CAUTIs in February. In FY 20 we have had 4 months with Zero.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the 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 CLABIs in February. In DY 20, we have had 6 months with zero.	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 cases in MV in February: 1)69 y/o male admitted from home w/Staph Bacteremia, received 4 Antibiotics and steroids, C. diff antigen positive on 5th day. 2)87 y/o female admitted from home w/anemia, anasarca, neutropenia, constipation. C. diff antigen positive on day 5, after 8 doses of one ABX.	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

February 2020 (Unless otherwise specified)

Month to Board Quality Committee: April, 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: February 2020*	0.00 (0)	0.21 (10)	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: February 2020*	1.12 (13.87%/12.39%)	0.91 (9.86%/10.84%)	1.06	0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) *Date period: January 2020*	MV: 3.57% (1/28) LG: 0.00% (0/3) **ENT: 3.22%** (1/31)	MV: 1.5% (3/201) LG: 0.00% (0/29) **ENT: 1.30%** (3/230)	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: January 2020*	MV: 23.13% (37/160) LG: 5.26% (1/19) **ENT: 21.23%** (38/179)	MV: 24.16% (244/1010) LG: 13.53% (18/133) **ENT: 22.92%** (262/1143)	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	Zero SSIs were found in February, the first month with zero since the focus on SSIs began in February 2019. Infection Control Medical Director has updated the Inpatient Antibiotic Surgical Prophylaxis Selection guide with the ABX Stewardship Pharmacist and Anesthesia Chair, to be rolled out in April and provided updated best proactive recommendations.		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). The revised Sepsis case definition used for hospital data finds more Sepsis patients and more deaths than last year, as we expected.	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	1 instance of an early elective delivery prior to 39 weeks gestation. Case failed because Pt. indused with Oxytoxcin at 38 weeks, 4 days, before labor started. Pt. c/o headache not relieved by Tylenol, BP normal, no pre-eclampsia.	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	Second month of reduction in Primary C/S rate at MV @ 23.13% and below target.	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 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) ~~7.~~8. Credentials and Privileges Report Special Agenda Items: ~~8.~~9. Value Based Purchasing Report ~~9.~~10. Pt. Experience (HCAHPS) ~~10.~~11. Approve FY21 Committee Goals ~~11.~~12. Proposed FY21 Committee Meeting Dates 13. Proposed FY21 Organizational Goals ~~12.~~14. QAPI	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) ~~7.~~8. Credentials and Privileges Report Special Agenda Items: ~~8.~~9. CDI Dashboard ~~9.~~10. Core Measures ~~10.~~11. Approve FY21 Committee Goals (if needed) ~~11.~~12. Proposed FY21 Organizational Goals ~~12.~~13. Proposed FY21Pacing Plan ~~13.~~14. 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) ~~7.~~8. Credentials and Privileges Report Special Agenda Items: ~~8.~~9. ~~9.~~10. Readmission Dashboard ~~10.~~11. PSI-90 Pt. Safety Indicators ~~11.~~12. Approve FY21 Pacing Plan 13. Leapfrog Survey ~~12.~~14. Med Staff Credentialing Process

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 4/6/20 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

Quality Committee Follow up Item Tracking Sheet (03/03/20)

#	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	Ongoing
3	Add a discussion around goal attainment to the pacing plan	11/4/2019	CM	Added to 2/3/20 Meeting then moved to 3//2/20 due to full agenda on 2/3/20	3/2/2020
4	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
5	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
6	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
7	Follow-Up on PSI 4, 18 and 19: 1. % breakdown by ethnicity, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for ethnic population) 2. % breakdown by low protein/vegan diets, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for diet-based population)	12/2/2019	CC/MA	On 2/3/20 Agenda; Bring back in August	
8	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
9	Bring back Revised Board Level Quality Dashboard	3/2/2020	MA	on 4/26/20 Agenda	
10	Bring Draft of Proposed FY21 Organizational Goals to April Meeting	3/2/2020	MA/CR	on 4/26/20 Agenda	
11	Add Review of Lean Projects to Pacing Plan for FY21	3/2/2020	JG	Added to March 2021 Meeting	

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: April 6, 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, Patient Care and Patient Experience Committee meeting, the Hospital Board has met once and the District Board has met not. 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	March 11, 2020	- Medical Staff Report including the Credentials and Privileges Report - Relocation of Outpatient Behavioral Health Services Clinic
ECHD Board		- None since last report
Finance Committee		- Annual Summary of Physician Financial Arrangements
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.

[redacted]

January 15, 2020

Dan Woods CEO
El Camino Hospital
2500 Grant Rd.
Mountain View, CA. 94040

Dear Mr. Woods,

I was recently a patient at your Mountain View El Camino Hospital. While at your facility, I experienced the most wonderful, caring and professional people throughout my stay.

I retired 3 years ago after a 40 year career as a Registered Nurse. I have worked at many different medical facilities during my career. My last 15 years of employment was at the Sutter Maternity and Surgery Center in Santa Cruz in the Perioperative area.

Every aspect of my visit to El Camino was amazing, from the moment I entered the hospital lobby and was greeted by the volunteer staff and all the way through the Admitting office, Preop, introduction to my Anesthesiologist and OR staff, Recovery staff, Surgical floor staff, Physical Therapy, Occupational Therapy, Nutitional and Discharge Services.

I realize there are many factors that make a business run well. Whatever you are doing, it's working. One of the more obvious indicators of a well run business, is the satisfaction of the personnel who work there. Every single person I encountered appeared sincerely happy to be there.

Thank you to everyone at El Camino who made my experience incredibly satisfying every step of the way.

Sincerely,

[redacted]

A special thank you to the following staff who helped me through my stay:

Akira Yamamoto MD - Surgeon
Valentino Demayo - ARNP
Deborah M Lew MD - Anesthesiologist
Tom – Surgical Technician
Joanne – Preop RN
Julie – Recovery Room RN
Kathy- Recovery Room RN
Gloria- Surgical Floor RN
Cindy - Surgical Floor CNA

Melanie- Surgical Floor RN
Arturo- Surgical Floor CNA
Mark – Surgical Floor RN
Marina- Surgical Floor CNA
Stacie – PT
Kathy- OT

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: April 6, 2020
Subject: Patient Experience Update

Purpose: The purpose of this agenda item is to provide an update on survey data related to patient experience specifically related to HCAHPS data year to date with an overview of organizational goal progress and initiatives to address and improve our scores.

Summary: The Patient Experience Steering Committee reviews HCAHPS data related to organizational goals and strategic goals on a regular basis. The data is provided in a dashboard format over the fiscal year with categories from the patient survey that include Likelihood to Recommend, Responsiveness, and Discharge Information. Further, the data is presented for each category for service areas including inpatient and maternal/child health (MCH). The data is viewed using this format because MCH has unique needs that should be addressed specifically for that patient population. The focus of this presentation is to illustrate the progress we are making to achieve our goals and the areas of improvement we are addressing.

1. Situation: Teams are meeting to work on the FY 20 Organizational Service goals which are Responsiveness and Discharge Information composite questions for the HCHAPS survey. In addition, we have teams working on the strategic goals of ED Satisfaction and the Likelihood to Recommend.

2. Authority: Transparency in providing these data from our patient surveys is essential communication that gives a window into the perception of patients have of our service in these areas.

3. Background: The HCHAPS survey is delivered to a percentage of patients discharged from the hospital and for those who visit the outpatient areas including ED. Our scores are publicly reported to CMS and are posted on the CMS compare website. During the COVID-19 outbreak, CMS is suspending some publicly reporting data including HCAHPS. We have made the decision to continue surveying our patients.

4. Assessment: The scores indicate that throughout the enterprise we are meeting the discharge information and ED Satisfaction composite target. However, the Responsiveness and Likelihood to Recommend target is not being met. The hospital has developed numerous improvements strategies to address the scores with specific best practices based on the patient population.

5. Other Reviews: N/A

6. Outcomes: The hospital will continue to monitor our scores and has implemented 100% discharge phone calls using labor pool personnel to reassure patients who have been at ECH during the COVID-19 pandemic.

List of Attachments: See Power Point

Suggested Committee Discussion Questions:

1. Do you see anything missing from the best practices we are employing to improve our HCAHSP scores?

2. Is there anything you need from the board to continue your improvement journey in patient experience?

El Camino Health

Patient Experience (HCAHPS)

Cheryl Reinking, RN, MS, NEA-BC
Chief Nursing Officer
April 6, 2020

FY20 Goals YTD - Enterprise

Enterprise	FY19 07/1/18 - 06/30/19	Target	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	FYTD	Trend
LTR		84.2														
IP Units (Top Box)	83.2		86.1	83.5	82.9	78.8	85.4	82.7	83.1	81.9					83	
IP %tile	*87*		92	87	85	74	90	85	85	83					86	
IP 'n'	*2357*		209	231	170	189	158	179	237	216					1581	
MCH (Top Box)	84.2		86.9	81.9	83.9	85.3	90.9	74.5	81.7	90.9					84.4	
MCH %tile	*89*		93	83	88	90	97	57	82	97					89	
MCH 'n'	*710*		61	72	62	68	55	55	60	55					488	
Total (Top Box)	83.4		86.1	83	83.3	80.4	86.9	80.8	82.8	83.8					83.3	
Total %tile	*87*		92	85	86	79	93	79	85	88					87	
Responsiveness		67.1														
IP Units (Top Box)	61.6		62.4	59.6	61.4	66.5	68.1	69.6	62.1	58.3					63.4	
IP %tile	*23*		24	14	20	44	54	63	24	14					33	
IP 'n'	*2232*		197	217	159	177	152	163	228	203					1488	
MCH (Top Box)	77.6		79.6	75.6	75.5	71.9	77.7	64.1	70.8	78.8					74.4	
MCH %tile	*88*		90	82	82	70	87	34	68	91					81	
MCH 'n'	*707*		59	72	60	67	55	55	58	55					481	
Total (Top Box)	65.7		66.7	64.9	65.8	68.2	70.9	68.1	64	63					66.3	
Total %tile	*43*		45	35	40	53	67	57	33	31					51	
Discharge		87.3														
IP Units (Top Box)	86.9		87.8	88.6	85.9	88.2	87.5	89.1	89.2	89.4					88.3	
IP %tile	*42*		52	61	32	55	48	63	64	65					54	
IP 'n'	*2156*		192	216	158	179	153	170	220	201					1480	
MCH (Top Box)	86.2		85.8	82.9	84.2	86.6	87.3	87.7	85.3	90					86.1	
MCH %tile	*35*		30	13	19	38	46	47	26	71					32	
MCH 'n'	*706*		60	71	61	68	55	53	59	55					482	
Total (Top Box)	86.7		87	87.4	85.4	87.9	87.4	88.7	88.4	89.5					87.7	
Total %tile	*40*		42	47	27	53	47	58	55	66					45	
ED Satisfaction																
Overall (top box)	66.7	69	67.7	72.4	72.7	70.9	72.7	68.7	75.4	65.7					70.8	
ED %tile	*43*	55	43	62	63	56	65	46	85	35					58	
ED 'n'	*1892*		191	150	122	128	126	120	139	96					1072	
LTR (top box)	71.3	72.5	73	74.5	77.8	76.2	77.9	73.7	81.8	73.4					76	
ED %tile	*60*		62	67	78	73	78	65	88	66					74	
ED 'n'	*1819*		185	145	117	126	122	118	137	94					1044	

FY20 Goals YTD – Mountain View

Mountain View	FY19 07/1/18 - 06/30/19	Target	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	FYTD	Trend
LTR	Baseline	84.2														
IP Units (Top Box)	84.3		91.6	88	83.1	80.1	90.7	82.8	84.8	84.7					85.7	
IP %tile	*90*		97	95	86	78	96	85	89	90					92	
IP 'n'	*1663*		143	167	124	136	107	134	171	170					1152	
MCH (Top Box)	81.6		86.5	80.8	82.7	82.4	88.4	77.6	78.8	88.6					83	
MCH %tile	*83*		93	80	85	84	95	69	73	95					86	
MCH 'n'	*561*		52	52	52	51	43	49	52	44					395	
Total (Top Box)	83.6		90.3	86.3	83	80.7	90	81.4	83.4	85.5					85	
Total %tile	*88*		96	93	85	80	96	81	86	91					91	
Responsiveness		67.1														
IP Units (Top Box)	59.8		63.1	60.3	63.7	62.3	70	67.1	57.8	57.2					62.2	
IP %tile	*16*		27	16	30	24	62	52	11	11					27	
IP 'n'	*1578*		138	158	119	132	101	123	165	158					1094	
MCH (Top Box)	75.1		75.4	70.1	73.5	67.9	73.5	64.9	67.5	77.2					71.2	
MCH %tile	*81*		82	62	75	52	75	38	53	88					70	
MCH 'n'	*560*		50	52	51	50	43	49	50	44					389	
Total (Top Box)	64.1		66.8	62.9	66.9	64.1	71.1	66.4	60.2	62.1					64.8	
Total %tile	*34*		46	25	46	31	67	47	18	27					40	
Discharge		87.3														
IP Units (Top Box)	87		87.8	88.4	87.8	87.9	90.7	88.7	89.1	89.8					88.8	
IP %tile	*43*		52	58	52	53	79	58	63	69					60	
IP 'n'	*1539*		133	154	116	129	104	125	159	159					1079	
MCH (Top Box)	86.1		85.3	84.3	84.1	85	84.9	87.2	85	87.5					85.4	
MCH %tile	*34*		26	20	18	24	24	42	23	45					26	
MCH 'n'	*558*		51	51	51	51	43	47	51	44					389	
Total (Top Box)	86.8		87	87.4	86.6	87.1	89	88.3	88.1	89.3					87.9	
Total %tile	*41*		42	47	38	44	64	54	51	64					49	
ED Satisfaction																
Overall (top box)	63.2	69	65.2	69.2	67.5	64.7	69	68.1	71.8	64.7					67.4	
ED %tile	*29*		32	50	42	30	48	44	60	31					42	
ED 'n'	*1249*		121	102	74	75	79	67	71	66					655	
LTR (top box)	67.7	72.5	69	71	76.1	68.9	75.3	70.8	78.3	73.8					72.5	
ED %tile	*47*		47	54	72	47	71	55	79	67					62	
ED 'n'	*1205*		116	100	71	74	77	65	69	65					637	

FY20 Goals YTD – Los Gatos

Los Gatos	FY19 07/1/18 - 06/30/19	Target	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun	FYTD	Trend
LTR	Baseline	84.2														
IP Units (Top Box)	80.5		72.1	69.1	82.6	75.5	74.5	82.2	78.8	71.7					75.8	
IP %tile	*80*		47	36	84	61	67	84	73	47					62	
IP 'n'	*694*		61	55	46	53	51	45	66	46					429	
MCH (Top Box)	94		88.9	85	90	94.1	100	50	100	100					90.3	
MCH %tile	*99*		96	90	96	99	99	3	99	99					97	
MCH 'n'	*149*		9	20	10	17	12	6	8	11					93	
Total (Top Box)	82.9		75.4	72.6	83.9	80	80.6	78.4	81.1	77.2					78.4	
Total %tile	*86*		60	49	88	78	79	72	80	68					72	
Responsiveness		67.1														
IP Units (Top Box)	65.8		58.9	59.6	54.1	78.9	63.8	76.8	72.2	62.2					66.6	
IP %tile	*43*		11	14	4	89	31	86	73	27					51	
IP 'n'	*654*		54	51	40	45	51	40	63	45					394	
MCH (Top Box)	87.6		100	88.8	87.5	84.4	95.8	58.3	91.7	85.5					88.1	
MCH %tile	*99*		99	99	98	96	99	12	99	98					99	
MCH 'n'	*147*		9	20	9	17	12	6	8	11					92	
Total (Top Box)	69.9		65.8	68.8	61	80.6	70.9	74.6	74.5	66.4					70.9	
Total %tile	*63*		40	56	17	92	66	81	81	50					69	
Discharge		87.3														
IP Units (Top Box)	86.6		87.7	89.3	80.5	89	80.6	90	88.9	87.6					86.9	
IP %tile	*39*		51	68	6	65	7	71	60	46					39	
IP 'n'	*617*		55	53	42	50	49	45	59	42					401	
MCH (Top Box)	86.5		88.9	79.2	85	91.2	95.8	91.7	87.5	100					89.1	
MCH %tile	*38*		64	4	24	83	97	84	45	99					63	
MCH 'n'	*148*		9	20	10	17	12	6	8	11					93	
Total (Top Box)	86.6		87.7	87	81.4	89.6	85	90.2	89.3	90.3					87.4	
Total %tile	*39*		50	42	9	69	24	73	65	73					44	
ED Satisfaction																
Overall (top box)	73.8	69	72.5	79.5	80.6	79.7	79.2	69.5	79.3	67.8					76.3	
ED %tile	*73*		62	86	89	87	86	50	86	44					78	
ED 'n'	*643*		70	48	48	53	47	53	68	30					417	
LTR (top box)	78.3	72.5	79.7	82.2	80.4	86.5	82.2	77.4	85.3	72.4					81.3	
ED %tile	*82*		82	88	84	94	89	77	93	62					87	
ED 'n'	*614*		69	45	46	52	45	53	68	29					407	

FY20 Strategic Goals YTD – Domains

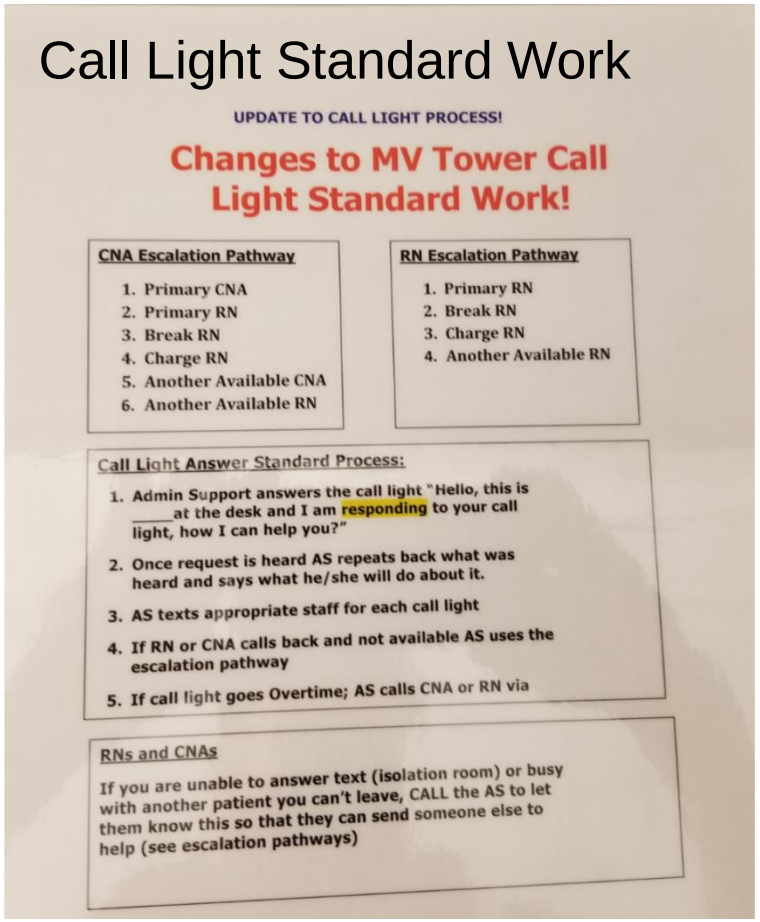
ECH Enterprise Strategic Goals	Target	FY20 TD 2/29/20
HCAHPS (National)	80% >50th %tile	80%
Rate the Hospital 0-10	>50th %tile	71
Recommend the Hospital	>50th %tile	88
Communication w/ Nurses	>50th %tile	55
Responsiveness of Hospital Staff	>50th %tile	49
Communication w/ Doctors	>50th %tile	68
Hospital Environment	>50th %tile	53
Communication About Pain	>50th %tile	53
Communication About Medication	>50th %tile	62
Discharge Information	>50th %tile	47
Care Transitions	>50th %tile	71
ED Overall (National)	>55th %tile	59
OASCAHPS Rate the Hospital (CA Peer)	>35th %tile	45
Outpatient Overall (CA Hospital)	>55th %tile	63
Outpatient Oncology Overall (National)	>60th %tile	36

FY20 Strategic Goal – 80% over the 50th percentile

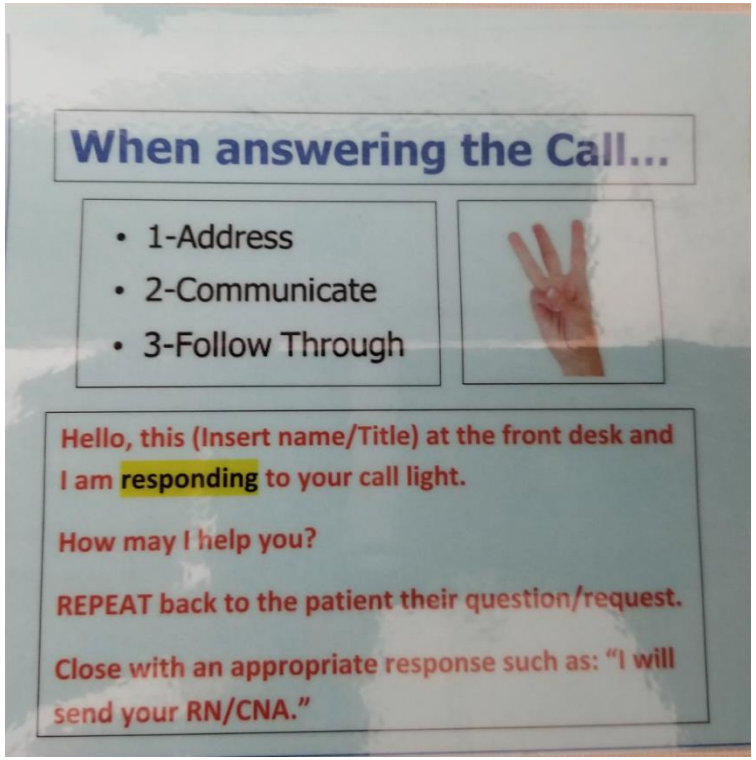
Patient Experience Updates

Staff Responsiveness – this metric is below target for the quarter and year to date. Committee focusing on units with the lowest scores and high volume. Mother/Baby 'commit to sit' where nurses commit to sit daily in order to make a connection and/or address concerns has seen has seen an improvement in Responsiveness scores for MV MCH. Call light system malfunctions have been reported to facilities and repaired. Continue to submit requests for system as needed. Proposal for replacement is in the works. Working with Admin Support (AS) to assure best practices, "words that work", and call light escalation/response structure is in place and utilized. Hourly rounding /purposeful rounding program is being reviewed in order to improve its efficacy Communication training for the non-clinical staff has been placed on Hold.

Call Light Standard Work



Call Light Cards



El Camino Health

Patient Experience Updates

Discharge Information – this metric is above 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.

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 (88th%tile) compared with others in the nation. Continued emphasis on leader rounding, updating and reinvigorating our service standards, will contribute to this metric. Leader-patient rounding will continue by Nurse Leaders and was recently restructured for non-nursing leaders to focus rounding on staff. Questions were updated in Vocera rounding tool.

Patient Comments re: COVID-19

"Everyone was very professional but also kind and they helped us understand how to prevent from spreading it at home as well. That was appreciated".

"I think that under the circumstances, with the Corona Virus, the staff did a great job. I know they were really, really busy last night but I commend them all"

"It was all very good and I marvel at the care I got when they were under such duress"
"Absolutely the most caring and professional staff. Every last one of them! I couldn't believe it! They were amazing"

"A coordinated effort to screen people at the door for wellness and direct people to waiting areas very good. Technician knowledgeable and kind.

Questions?

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: April 6, 2020
Subject: Quality/Performance Improvement & Patient Safety Plan (QAPI)

Recommendation(s): Approve this revised Quality/Performance Improvement & Patient Safety Plan (QAPI). This plan has been reviewed and revised by the ECH Quality Council, the ePolicy Committee and the Medical Executive Committee.

Summary:

- CMS Conditions of Participation requires the hospital to have a Quality Assessment and Performance Improvement Program, often referred to as QAPI and this is reflected in Joint Commission standards as well. This plan is to provide a road map and explanation of how this work is accomplished at ECH.
- CDPH through SB 158 requires all acute hospitals to establish a Patient Safety Committee and Plan, and articulates the information to be included. Both plans are combined into one document at ECH.

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This Plan provides guidance for this oversight.

2. Background: This Plan provides an overview of how quality assessment and performance improvement is organized at ECH, the approaches to both patient safety and performance improvement work and the organizational structure that supports these processes.

3. Assessment:

- This is a revision from the 2018 version approved by this Committee in June 2018.
- This plan is to be reviewed annually. It was not reviewed in the summer of 2019 due to the 2 CMS Complaint Surveys.
- The name of the plan has been changed so that it is recognized by CMS and CDPH surveyors as ECH's QAPI Plan.
- The definition of quality adopted by this Committee is included – STEEEP
- An overview of ECH's High Reliability Journey is provided
- The restructure of medical staff and hospital committees is provided with a chart
- Revision of the required CMS and TJC "Core" Measures in included

4. Other Reviews: N/A

5. Outcomes: N/A

Suggested Committee Discussion Questions: None.

List of Attachments: 2020 Quality/Performance Improvement & Patient Safety Plan (QAPI)

El Camino Health

Origination:	*05/2018*
Effective:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Catherine Carson: Senior Director Quality*
Area:	*Quality, Risk & Patient Safety*
Document Types:	*Plan*

Quality/Performance Improvement & Patient Safety Plan (QAPI)

PURPOSE

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

ORGANIZATION OVERVIEW

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

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

EI CAMINO HEALTH MISSION

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

EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

EI CAMINO HEALTH VALUES

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

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

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

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

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

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

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

HIGH RELIABILITY

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

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

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

DEFINITIONS

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

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

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

SERVICES/PROGRAMS

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

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

OBJECTIVES

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

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

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

A. Governing Board

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

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

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

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

B. Medical Executive Committee (MEC)

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

medico-administrative obligations of the medical staff.

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

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

C. Medical Staff Departments and Divisions

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

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

D. Leadership and Support

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

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

E. Medical Staff, Employees, and Contracted Services

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

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

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

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

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

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

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

G. Quality Services Department

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

The Quality Services Department is also responsible for:

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

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

H. Improving Organizational Performance

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Performance improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. Performance improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(s) to performance improvement. These leaders set priorities for performance improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

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

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

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

SEC SAFETY EVENT CLASSIFICATION
HPI PRESS GANEY

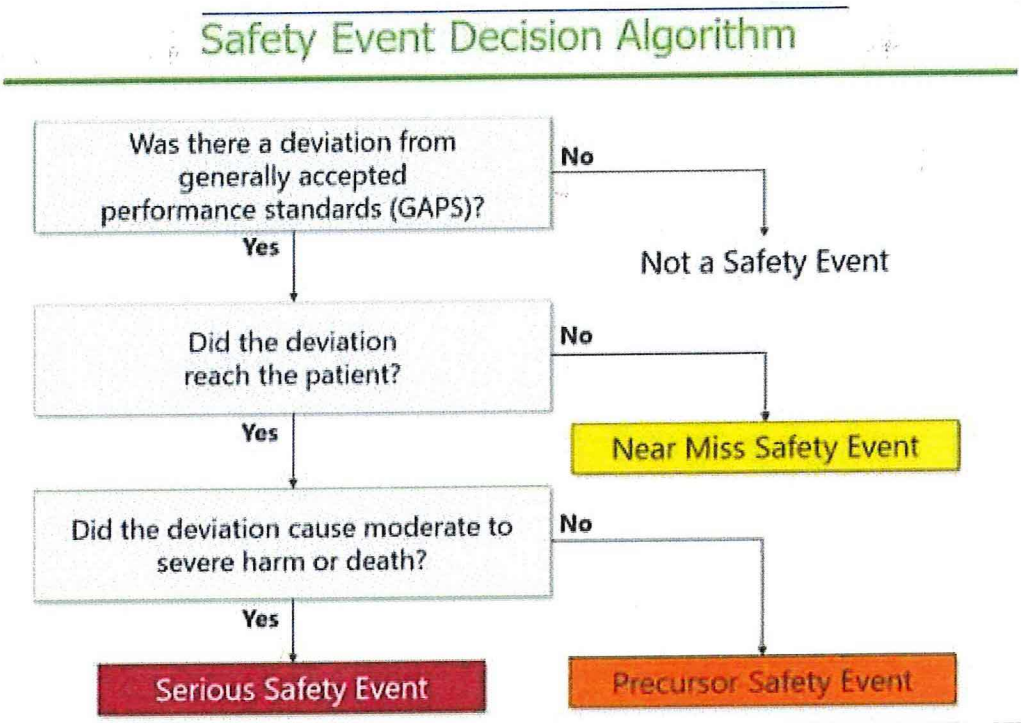
Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event
- Does not reach the patient
- Error is caught by a detection barrier or by chance

Table 1 HPI SEC Levels of Harm

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



I. Performance Processes

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

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

3. **Measurement**

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

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

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

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

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

4. Analysis

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

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

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

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

d. Blood Utilization to include confirmed transfusion reactions;

e. Significant adverse events and drug reactions;

f. Significant medication errors, close calls, and hazardous conditions;

g. Significant adverse events related to using moderate or deep sedation or anesthesia;

J. Improvement Model And Methodology

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

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

The model has two parts:

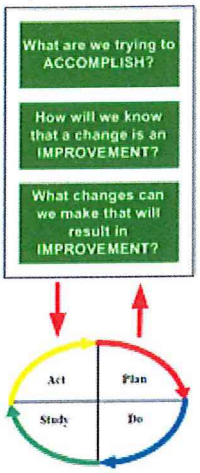
1. ***Three fundamental questions, which can be addressed in any order.***
   - What are we trying to accomplish?
   - How will we know that a change is an improvement?
   - What changes can we make that will result in improvement?

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

2. ***The Plan-Do-Study-Act (PDSA) Cycle***
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.
   Step 1: Plan
   Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
   Step 2: Do
   Try out the test on a small scale. What did we observe that was not a part of our plan?
   Step 3: Study
   Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
   Summarize and reflect on what was learned.
   Step 4: Act

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

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



3. Goal Setting and Auditing Methodology
   a. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
   The acronym stands for:
   S – Specific
   When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
   Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
   What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
   When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.
   Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
   Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
   Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

M – Measurable
What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.
A – Achievable
This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.
R – Relevant
Relevance refers focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.
T – Time-Bound
Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

b. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid. Measure of Success (MOS) auditing process has specified the following minimums:
    - Sample all cases for a population size of fewer than 30 cases
    - Sample 30 cases for a population size of 30–100 cases
    - Sample 50 cases for a population size of 101–500 cases
    - Sample 70 cases for a population size of more than 500 cases
    - Sample 100 cases for a population greater than 500 cases
      To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

K. Lean Improvement Methodology:

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

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

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

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

1. **Lean Principles**

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

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

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

L. Performance Improvement Link With Organizational Goals

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

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

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

M. Commitment to Person-Centered Care

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

N. Allocation of Resources

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

O. Confidentiality

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

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

P. Annual Evaluation

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

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

I. Cross References:

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

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

Attachments

Appendix A - Information flow QA-PI-PS Plan
Appendix B- External Regulatory Compliance Indicators/Measures
Appendix C - El Camino Hospital Data Registries
Data Registries.JPG

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES
Appendix B

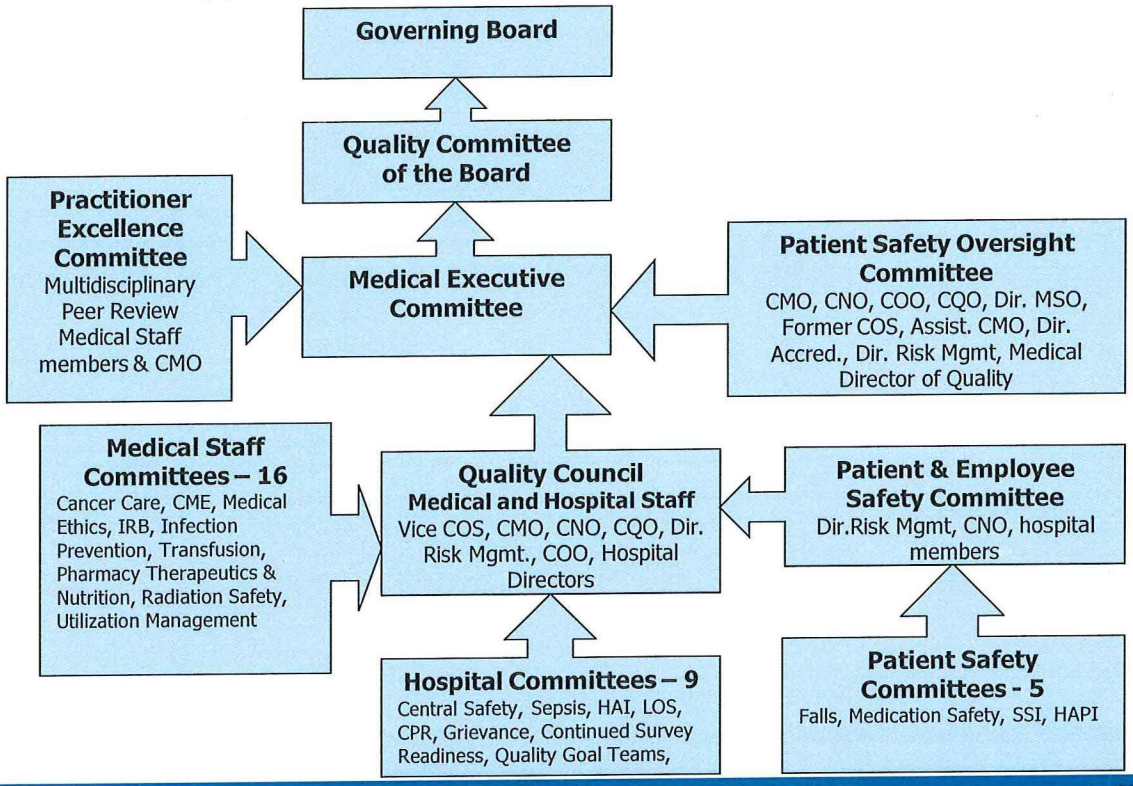
Indicator Name	Indicator Description	Regulatory/Accreditation source
Chart-Abstracted Clinical core measures Hospital Inpatient and Outpatient:		
OP-18:	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital Outpatient Quality Reporting (OQR) Program
OP-23	Head CT or MRI Scan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

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

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

Performance Improvement & Patient Safety Plan

Appendix A: Flow of Information



El Camino Hospital Data Registries – February 2020 Appendix C

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

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

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

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: April 6, 2020
Subject: Value Based Purchasing (VBP) estimated impact for Federal Fiscal Year 2021

Recommendation(s): Review report noting measure results that are below benchmark in red.

Summary: Provide the Committee with a preview of estimated impact of VBP measures on ECH DRG payments effective October 1. 2020 (FFY 2021)

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients.

2. Background: Value Based Purchasing is CMS' effort at Pay for Performance. In its 8th year, VBP adjusts Medicare inpatient reimbursement based on hospital's performance on quality, safety, and patient experience measures. Medicare withholds 2% of a hospital's anticipated DRG payments. Hospitals can earn back all of the 2% and more if it performs well, or lose some if it does not.

3. Assessment:

- Estimated net impact of VBP for FFY2021is $ (195,983) or -0.22%, compared to a loss of $(312,918) for FFY2020, a negative impact of -0.34%.
- Medicare Spending per Beneficiary score improved from last year (1.02 to 0.99), earning a 1 point improvement score and allowing a domain score of 10
- The Mortality rates for both Pneumonia and Heart Failure did not meet benchmark.
- CAUTI score above benchmark in calendar year 2019 in which HAI reduction was a quality organizational goal in FY2019.
- Organization goal focus continues on HCAHPS measures in Person/Community Engagement.

4. Other Reviews: N/A

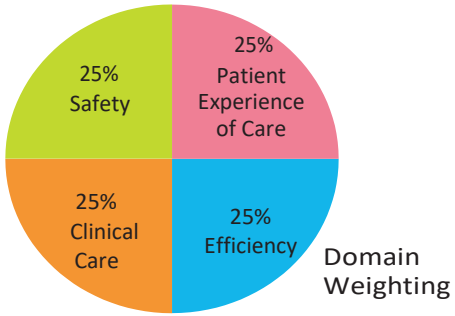
5. Outcomes: N/A

Suggested Committee Discussion Questions: None.

List of Attachments: ECH Value-Based Purchasing estimate for FY 2021

Hospital Value-Based Purchasing: El Camino Hospital

FFY 2021 (effective 10/1/2020)



Base Operating DRG Payments	Withhold Amount/ % of revenue -2.00%	Bonus Amount/ +1.78%	Net Impact / -0.22%	Estimated Total Score
$90,880,358	$1,817,607	$ 1,612,624	$ -195,983	31.75%

Safety (25% of Total Performance Score) Domain Score = 26

Baseline period		Performance period	
HAI: CY 2017		HAI: CY 2019	
Description	Threshold	Performance	Benchmark
Catheter-Associated Urinary Tract Infection	0.77	1.161	0.000
Central Line-Associated Blood Stream Infection	0.492	0.274	0.000
Clostridium difficile Infection	0.748	0.553	0.067
Methicillin-Resistant *Staphylococcus aureus* Bacteremia : HO LabID	0.763	1.290	0.000
Surgical Site Infection: Colon Surgery (HAI 3) Abdominal Hysterectomy (HAI 4)	 0.754 0.726	 0.505 0.577	 0.000 0.000
Surgical Site Infection Composite	N/A	N/A	N/A

Infections are SIRs. Lower is better for all measures.
**Threshold values will be modified when re-baseline data is released.*

Person/Community Engagement (25% of Total Score) Domain Score = 29

Baseline period		Performance period	
CY 2017		CY 2019	
Description	Performance (%)	Threshold (%)	Benchmark (%)
Communication with Nurses	80%	79.06	87.36
Communication with Doctors	82%	79.91	88.10
Responsiveness of Hospital Staff	64%	65.77	81.0
Communication about Medicines	63%	65.83	74.75
Hospital Cleanliness and Quietness	66.5%	65.61	79.58
Discharge Information	85%	87.38	92.17
Care Transitions	53%	51.8	63.32
Overall Rating of Hospital	79%	71.8	85.67

Higher is better for all scores.

Clinical Outcomes (25% of Total Performance Score) Domain Score = 62

Baseline period			Performance period	
Mort - 7/2011–12/2017			7/2016–6/2019	
THA/TKA Complications – 1/2017-12/2017			1/2019–12/2019	
Measure ID	Description - Mortality Rate	Threshold	Performance	Benchmark
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate	0.14	0.11	0.12
MORT-30-HF	Heart Failure (HF) 30-day mortality rate	0.12	0.09	0.09
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.16	0.16	0.13
MORT-30-COPD	COPD 3-day mortality rate	0.08	0.08	0.09
THA/TKA	Primary THA/TKA complication rate	0.03	0.02	0.02

Efficiency (25% of Total Performance Score) Domain Score = 10.0

Baseline period			Performance period	
CY 2017			CY 2019	
Measure ID	Description	Threshold	Performance	Benchmark
MSPB-1	Medicare Spending per Beneficiary	Median MSPB ratio hospitals during performance period 0.99	0.99	Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.85

Lower is better for all scores.

Adapted by Qualis Health from materials provided by Stratis Health and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the U.S. Department of Health and Human Services.

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Value-Based Purchasing Report

Quality Committee

Mark Adams, MD, Chief Medical Officer

April 6th , 2020

Prepared by Catherine Carson, Sr. Director Quality

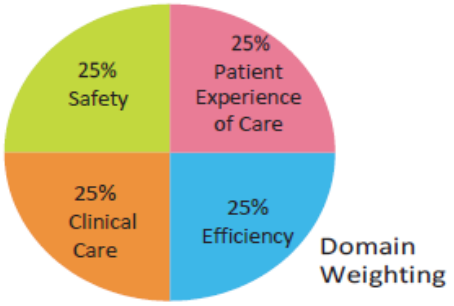
Hospital Value-Based Purchasing
FFY 2021 (effective October 1, 2020)

Base Operating DRG Payments	Withhold Amount/ % of revenue -2.00%	Bonus Amount/ +1.78%	Net Impact / -0.22%	Estimated Total Score
$90,880,358	$1,817,607	$ 1,612,624	$ -195,983	31.75%

FFY 2020

Base Operating DRG Payments	Withhold Amount/ % of revenue -2.00%	Bonus Amount/ +1.71%	Net Impact / -0.34%	Estimated Total Score
$91,362,923	$1,827,258	$1,514,340	312,918	27.63

Domain	Domain Score	Domain Score	Weighted Score	Estimated Impact
Person Engagement	29.0%	25%	7.3%	$ -(7,000)
Clinical Outcomes	58.0%	25%	14.3%	$ 494,300
Safety	28.0%	25%	7.0%	$ (24,300)
Efficiency	10.0%	25%	2.5%	$ (335,400)



Safety

Safety (25% of Total Performance Score) **Domain Score = 26**			
Baseline period		Performance period	
HAI: CY 2017		HAI: CY 2019	
Description	Threshold	Performance	Benchmark
Catheter-Associated Urinary Tract Infection	0.77	1.161	0.000
Central Line-Associated Blood Stream Infection	0.492	0.274	0.000
Clostridium difficile Infection	0.748	0.553	0.067
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Infections are SIRs. Lower is better for all measures.
**Threshold values will be modified when re-baseline data is released.*

Person and Community Engagement

Person/Community Engagement (25% of Total Score) **Domain Score = 29**			
Baseline period		Performance period	
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Description	Performance (%)	Threshold (%)	Benchmark (%)
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Overall Rating of Hospital	79%	71.8	85.67

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Clinical Outcomes

Clinical Outcomes (25% of Total Performance Score) **Domain Score = 62**				
Baseline period			Performance period	
Mort - 7/2011–12/2017			7/2016–6/2019	
THA/TKA Complications – 1/2017-12/2017			1/2019–12/2019	
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MORT-30-COPD	COPD 3-day mortality rate	0.08	0.08	0.09
THA/TKA	Primary THA/TKA complication rate	0.03	0.02	0.02

Efficiency

Efficiency (25% of Total Performance Score) **Domain Score = 10.0**				
Baseline period			Performance period	
CY 2017			CY 2019	
Measure ID	Description	Threshold	Performance	Benchmark
MSPB-1	Medicare Spending per Beneficiary	Median MSPB ratio hospitals during performance period 0.99	0.99	Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.85

Lower is better for all scores.

El Camino Health

Proposed DRAFT 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
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

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: April 6, 2020
Subject: FY21 Organizational Goals

Purpose: Review the proposed FY21 Organizational Goals for quality, safety, and experience

Summary:

1. Situation: The Board Quality Committee reviews the proposed organizational goals for the upcoming fiscal year, FY21, and recommends to the Board to approve those that apply to quality, safety, and patient experience.

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: Prior to the beginning of each upcoming fiscal year, the management team performs an assessment of the status of the organization's progress toward the true north goals of each of the foundational pillars. Based on this assessment, management seeks broad input from the organization's leadership to develop appropriate strategic goals. Management then curates a selection of key strategic goals which ultimately serve as incentive goals if approved by the compensation committee.

4. Assessment: Management is proposing the following quality, safety, and patient experience organizational goals for FY21: Reduction of SSER, Reduction of Readmissions, and Likelihood to Recommend.

5. Other Reviews: None

6. Outcomes: The Quality Committee will endorse these organizational goals and recommend adoption by the Board of Directors.

List of Attachments:

1. Power Point reviewing the reasoning behind choosing these particular goals.

Suggested Committee Discussion Questions:

1. Are these goals appropriate based on the principles of goal setting?

El Camino Health

FY21 Quality/Safety and Experience Goals

Mark Adams MD CMO
Cheryl Reinking RN CNO
April 6, 2020

Organizational Goals

- Distinguish between visionary/aspirational goals vs. organizational goals:
  - Vision is defined as the desired future. This is considered aspirational and supported by long term strategic goals. As an example: "El Camino will transform healthcare and improve the health of the community."
  - Organizational goals are annual and operational. These are based on the SMART goals construct: Specific, Measurable, Attainable, Relevant, Time-bound

Organizational Goals

Guiding Principles for Annual Goal Selection:

- Significantly impacts quality and safety
- Easy to understand
- Broad reach across the organization
- Impacts financial performance
- Impacts consumer choice
- Aligns with strategic goals

Organizational Goals

Criteria for Consideration:

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

Organizational Goals

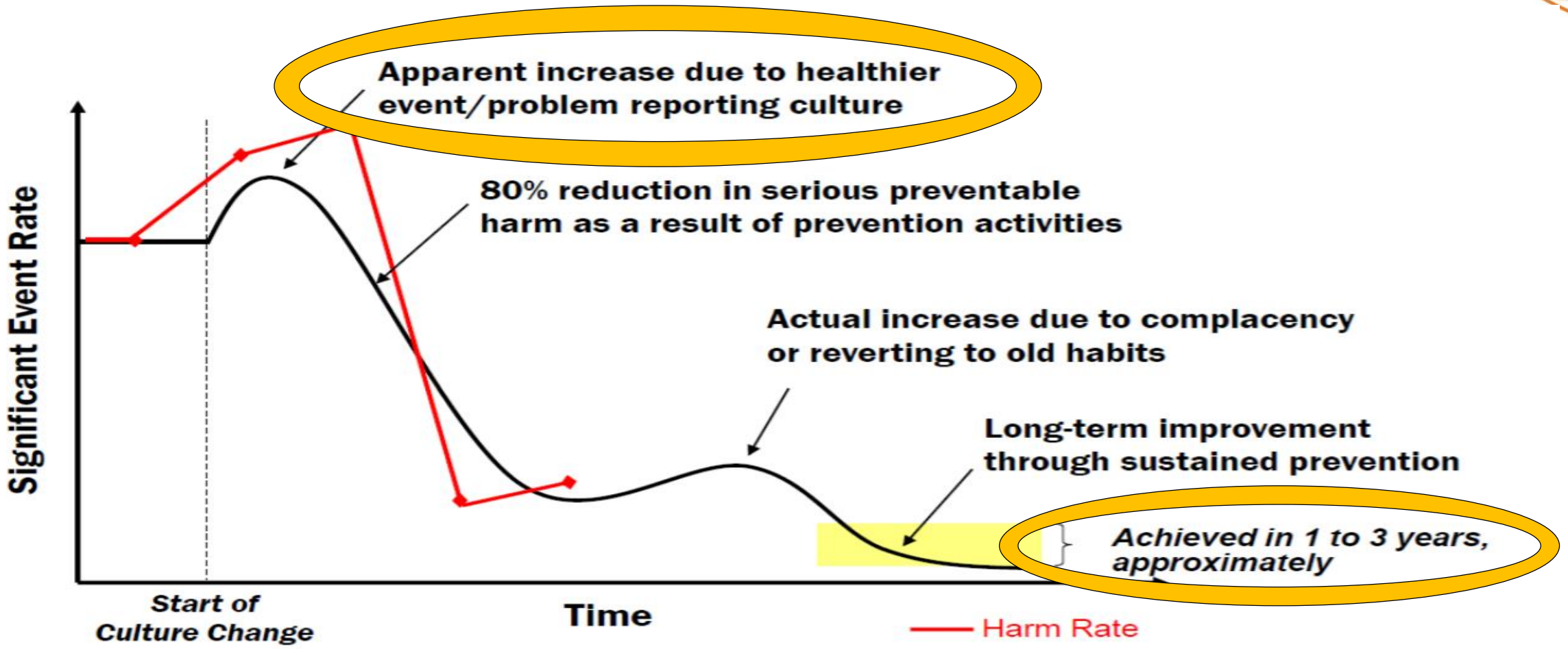
- Proposal for FY21:
  - SSER: Directly correlates to quality pillar and no preventable harm; basic measure of HRO
  - Readmission Index: Impacts inpatient and outpatient operations; largest financial impact with CMS readmission penalty program; supports BPCI-A work
  - HEDIS Composite
  - Likelihood to Recommend

Organizational Goals
SSER Reduction

1. Does it support our mission and impact the patient? YES
2. Does it affect many different categories of patients? Affects all patients
3. Is it easily understood? No harm easy to understand
4. Is it used in the public domain as a quality proxy? Not directly today
5. Does it reach broadly across the organization? Impacts all areas
6. Does it have a financial impact? Significant
7. Can we reliably measure it and compare it to a benchmark? Easily measured and benchmarked

Probability of Success

Typical Journey to High Reliability



Source: HPI

Organizational Goals
Readmissions Reduction

1. Does it support our mission and impact the patient? YES
2. Does it affect many different categories of patients? YES, many categories
3. Is it easily understood? YES
4. Is it used in the public domain as a quality proxy? YES, CMS, Consumer Reports, e.g.
5. Does it reach broadly across the organization? YES All patient areas
6. Does it have a financial impact? YES, CMS readmission penalty program, BPCI-A, e.g.
7. Can we reliably measure it and compare it to a benchmark? YES, national benchmark available

Organizational Goals
HEDIS Composite

1. Does it support our mission and impact the patient? YES
2. Does it affect many different categories of patients? YES, all ambulatory patients
3. Is it easily understood? Commonly used by payers, employers
4. Is it used in the public domain as a quality proxy? Generally no but can be accessed publicly
5. Does it reach broadly across the organization? Tracks across the continuum of care
6. Does it have a financial impact? YES, MIPS, Medicare Advantage, e.g.
7. Can we reliably measure it and compare it to a benchmark? YES, National benchmark

Organizational Goals
Likelihood to Recommend

1. Does it support our mission and impact the patient? YES
2. Does it affect many different categories of patients? YES, All patients
3. Is it easily understood? YES
4. Is it used in the public domain as a quality proxy? YES, driver of HCAHPS, consumer choice
5. Does it reach broadly across the organization? YES, all employees can impact
6. Does it have a financial impact? YES, contributes to VBP, market share
7. Can we reliably measure it and compare it to a benchmark? YES, national benchmark

FY21 Quality Goals

Top Tier Performance with Zero Preventable Harm

Measure	FY21 Target	Why did we select this metric?	Target setting logic / methodology
Serious Safety Events	Decrease SSER from x to y (expected 4-5/10,000 adjusted patient days)	Key indicator for our HRO journey	Improve by 1/10,000 ad pt days
Hospital Readmissions	Readmission Index	Key indicator for readmission penalty program, BPCI-A	Interim target to step up to top performer level (premier) in two years
Healthcare Effectiveness Data and Information Set (HEDIS)	HEDIS aggregate score of the 8-10 measures selected (from x to y)	Key indicator of quality and safety in the ambulatory area	10% improvement over new hospital baseline assuming April re-measure comparable to 2019 baseline of 3.76

FY21 Service Goals

Exceptional Personalized Experience Always

Measure	FY21 Target	Why did we select this metric?	Target setting logic / methodology
Likelihood to Recommend	Improved individual (not composite) LTR top box score by y (based on final FY20 #'s in: Inpatient Mother/ Baby Emergency Department Outpatient Surgery Outpatient Services Oncology ECHMD	LTR is the national gold standard to measure patient loyalty, experience, brand loyalty and an overall measure of perceived quality and safety	Methodology for improvement will look at baseline scores and use the Press Ganey calculator as a guide with minimum at 50% of improvers, target at 30% of improvers, and maximum at 10% of improvers

El Camino Health