El Camino Health

AGENDA

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

Monday, May 4, 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 (04/06/2020) ***Information*** b. FY20 Quality Dashboard c. FY20 Pacing Plan d. Progress Against FY20 Committee Goals e. Hospital Update	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
4.	**QUALITY COMMITTEE FOLLOW-UP TRACKING** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:36**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Julie Kliger, Quality Committee Chair		**information 5:36 – 5:41**
6.	**PATIENT STORY** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**discussion 5:41 – 5:46**
7.	**BOARD QUALITY DASHBOARD REPORT** **ATTACHMENT 7**	Mark Adams, MD, CMO		**motion 5:46 – 6:01**
8.	**CDI DASHBOARD** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:01 – 6:11**
9.	**CORE MEASURES** **ATTACHMENT 9**	Mark Adams, MD, CMO		**discussion 6:11 – 6:21**
10.	**PROPOSED FY21 PACING PLAN** **ATTACHMENT 10**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:21 – 6:31**
11.	**DISCUSS FY21 ORGANIZATIONAL GOALS**	Mark Adams, MD, CMO		**discussion 6:31 – 6:46**

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
	ATTACHMENT 11			
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:46 – 6:49**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:49 – 6:50**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:50 – 6:51**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 6:51 – 6:52**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (04/06/2020) ***Information*** b. Medical Staff Quality Council Minutes (including API Reports)			
16.	*Health and Safety Code Section 32155* **Q3 QUALITY AND SAFETY REVIEW**	Mark Adams, MD, CMO		**discussion 6:52 – 7:02**
17.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion 7:02 – 7:07**
18.	*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 7:07 – 7:22**
19.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:22 – 7:23**
20.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:23 – 7:24**
21.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:24 – 7:29**
22.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:29 – 7:30**

Upcoming Meetings: Regular Meetings: June 1, 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, April 6, 2020
El Camino Hospital | Conference Rooms F
2500 Grant Road, Mountain View, CA 94040

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

Members Absent
Caroline Currie
Imtiaz Qureshi, MD

****via teleconference**

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. A verbal roll call was taken. Caroline Currie and Imtiaz Qureshi were absent. Melora Simon and Linda Teagle, MD were not present during roll call, but participated in the rest of the meeting. Dr. Teagle attended the meeting in person and all other members were present and participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (03/02/2020) and Proposed FY21 Committee Meeting Dates; For information: FY20 Quality Dashboard; FY20 Pacing Plan, and Progress Against FY20 Committee Goals **Movant:** Fung **Second:** Po **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Currie, Qureshi, Teagle **Recused:** None	***Consent Calendar approved***
4. QUALITY COMMITTEE FOLLOW-UP TRACKING	Ms. Kliger stated that she is still working on the Board Dashboard with the CMO, Dr. Mark Adams, and the Interim CQO, Dr. John Haughom. This item is forthcoming.	
5. REPORT ON BOARD ACTIONS	Chair Kliger asked if any Committee members had any questions about the Report on Board Actions. There were no questions.	

6. PATIENT STORY	Cheryl. Reinking, Rn, CNO, presented a positive letter from a patient who was previously a registered nurse. The patient stated that her entire experience at ECH was a very positive one and everyone was very professional every step of the way. In response to committee members' questions, Ms. Reinking stated that we have directly heard from our patients and their families including letters thanking ECH for the services they've provided during the COVID-19 Pandemic. Ms. Reinking stated that staff has been calling patients post discharge.	
7. PATIENT EXPERIENCE PLAN/PATIENT FAMILY VOICE	Ms. Reinking presented the patient experience report related to HCAHPS and the areas we are focusing on this year. Ms. Reinking, referring to the dashboard in the committee materials, reported that, through February, while the organization is meeting its goals for Discharge Information and ED satisfaction, there is room for improvement. Ms. Reinking noted that the organization's overall goal for the HCAHPS survey is to assure that for 80% of the domains we score over the 50th percentile which we currently are. She reported that interventions to make improvements include, but not limited to, ensuring strong communications between the patients and the caregivers and responsiveness related to call lights and in answering them. The likelihood to recommend score measures experience overall. Ms. Reinking commented that leader rounding has impacted this score. In response to Committee members' questions, Ms. Reinking stated that outpatient oncology is well under target due to possibly scheduling issues. There was a waiting list for a period of time. However, the issue has been corrected by extending the hours, and there is no longer a waiting list.	
8. QUALITY/ PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN – QAPI	Mark. Adams, MD, CMO, presented the QAPI for which the Board is responsible for approving. He believes it would be beneficial for the Quality Committee to review and discuss prior to Board approval. Dr. Adams explained that this plan has two major additions compared to prior years: introduction of high reliability journey and measuring quality under the STEEEP methodology. Dr. Adams stated that ECH has now consolidated quality activities to all report to the Enterprise Quality Council, which in return, then reports to the Medical Executive Committee and the Quality Committee of the Board. Dr. Adams stated that ECH now has a Patient Safety Oversight Committee and has added a Root Cause Analysis Oversight Committee. In response to the committee members' questions, Dr. Adams stated that the LEAN principles and the root cause principals will be applied across the system. **Motion:** To approve the Quality/Performance Improvement & Patient Safety Plan (QAPI) **Movant:** Ting **Second:** Po **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie & Qureshi	

	Recused: None	
9. VALUE BASED PURCHASING REPORT	Dr. Adams stated that the Value Based Purchasing Plan is a program in Medicare that started several years ago to promote quality improvement for Medicare beneficiaries. Dr. Adams stated that CMS compares to a benchmark period from the past and also other health systems across the system. For this year, ECH will be getting a .22% penalty. Generally, organizations land in a neutral area of 0, but we are slightly below. Dr. Adams stated that the four areas ECH was scored on for the past year were safety, patient experience, clinical care, and efficiency. In response to committee members' questions, Dr. Adams stated that the bay area is an anomaly compared to California for per member per year beneficiary payments.	
10. APPROVE FY21 COMMITTEE GOALS	Dr. Adams presented the Proposed FY21Committee Goals. There were a few things added such as the STEEEP and an ongoing Board Dashboard discussion. There are also attendance requirements and monitoring our Quality and Safety tracking. Chair Kliger noted that Proposed Goal #6 really represents the general work of the Committee, need not be stated as a goal and could be deleted from the Proposed Goals. Chair Kliger asked if any member of the Committee had any other comments or any other goals to add to the current list. No comments were made or items added. **Motion:** To approve the FY21 Committee Goals with the deletion of Goal #6. **Movant:** Sharma **Second:** Falwell **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie & Qureshi **Recused:** None	
11. PROPOSED FY21 ORGANIZATIONAL GOALS	Dr. Adams stated that the Proposed FY21 Organizational Goals presented are the annual incentive goals for quality and safety. Serious safety event rate (SSER) is the serious safety event per 10,000 admission days which is an important part of the quality safety pillar of zero preventable harm. Readmission Index has been a struggle this year. Dr. Adams stated that we still have not reached the target that was set. It is the largest penalty program with CMS with it being at 3%. The HEDIS is an ambulatory measure, not hospital. This is generally not publicized, but it is a big part of Medicare Advantage which is a Medicare risk. It is also a big part of MIPS (Merit Incentive Payment System). Physicians get paid based on their scoring on the MIPS program and the HEDIS measures do impact their score. The most critical one to grow our business is the Likelihood to Recommend. In response to the Committee members' questions, Dr. Adams stated that we look at every readmission and categorize them in different categories. We look at the most common causes with one common one being 'unrelated'. Another common category is cancer patients. That's an area where we definitely have started to focus more on how to address that. CMS has stated that they will not pay for chemo therapy readmissions.	

	Dr. Adams to bring back a refinement of measurements. **Motion:** To approve the FY21 Organizational Goals, but not the targets. **Movant:** Fung **Second:** Teagle **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie & Qureshi **Recused:** None	
12. PUBLIC COMMUNICATION	There was no public communication.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:21pm. **Movant:** Ting **Second:** Simon **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie & Qureshi **Recused:** None	***Adjourned to closed session at 7:21pm***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:54pm. Agenda items 14-18 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (03/02/2020) and Medical Staff Credentialing and Privileges Report; and for information: Medical Staff Quality Council Minutes including API reports.	
15. AGENDA ITEM 20: CLOSING WRAP UP	There were no closing comments.	
16. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 8:00pm. **Movant:** Teagle **Second:** Burn **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie & Qureshi **Recused:** None	***Meeting adjourned at 8:00pm***

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

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Julie Kliger, MPA, BSN
Chair, Quality Committee

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: May 4, 2020
Subject: FY 20 Quality Dashboard for April meeting

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

Summary: 1.) 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. 2.) 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:

- Mortality Index is just above target with March deaths, which were more than January or February. Many deaths related to respiratory viruses (non-COVID-19)
- Readmission Index dropped for the 3rd month; several chronically ill patients with frequent readmissions expired, and the Conversa Chat Box was applied to Pneumonia patients in March
- COVID-19 Pandemic affected ED Through put measure in March
- ECH Enterprise had ZERO Hospital-acquired infections in March: 0 CAUTI, 0 CLABSI, 0 C.Diff and 0 SSIs.
- Both Perinatal measures improved: 0 Early Elective Delivery and Primary C/S rate at 22.56%

4. Other Reviews: N/A

5. Outcomes: N/A

Suggested Committee Discussion Questions: None.

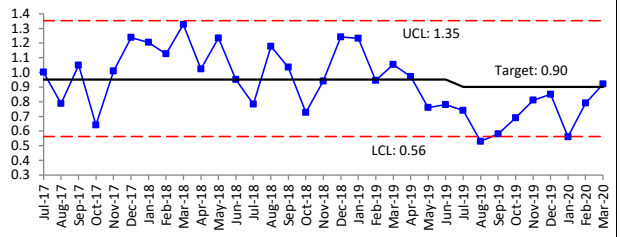
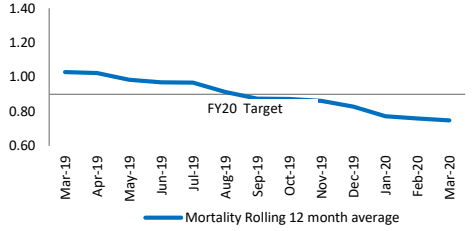
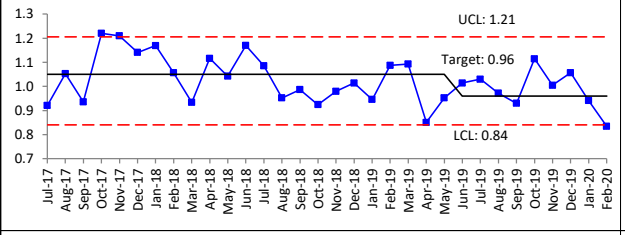
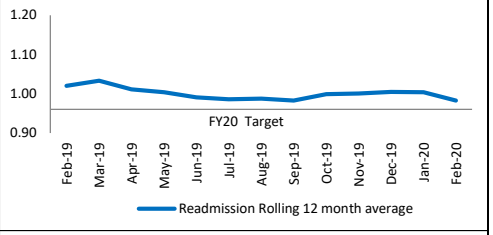
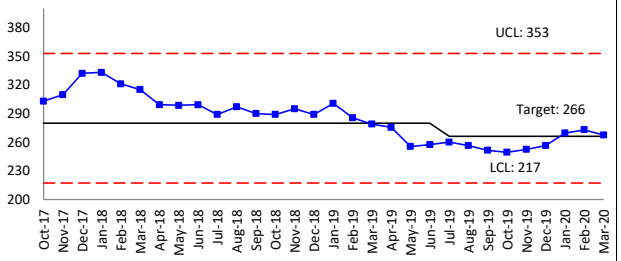
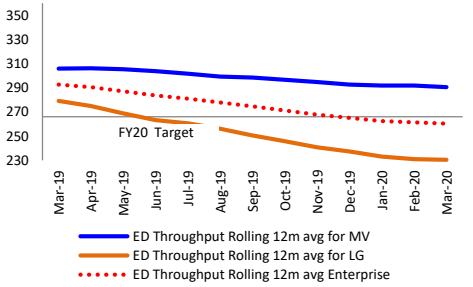
List of Attachments: FY20 Quality Dashboard, March data unless otherwise specified - final results

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

March 2020 (Unless otherwise specified)

Month to Board Quality Committee: May, 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: March 2020*	0.92 (2.27%/2.46%)	0.73 (1.45%/1.99%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: February 2020*	0.83 (7.09%/8.50%)	0.98 (7.86%/7.99%)	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: March 2020*	MV: 300 min LG: 235 min Enterprise: 268 min	MV: 289 min LG: 230 min Enterprise: 260 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

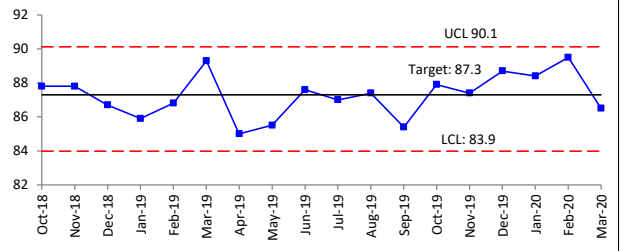
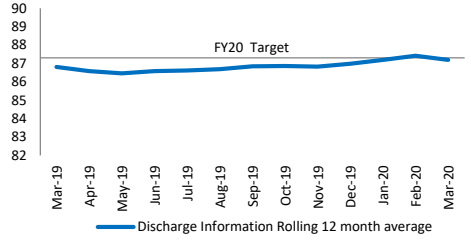
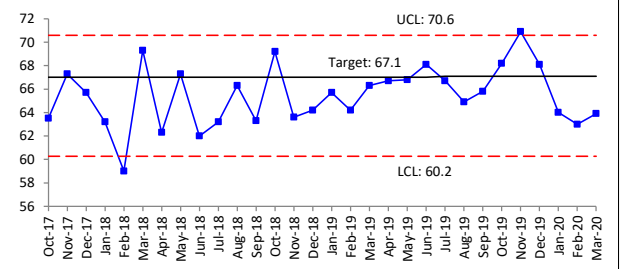
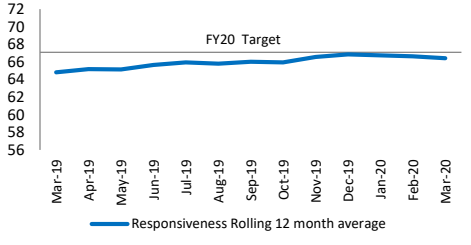
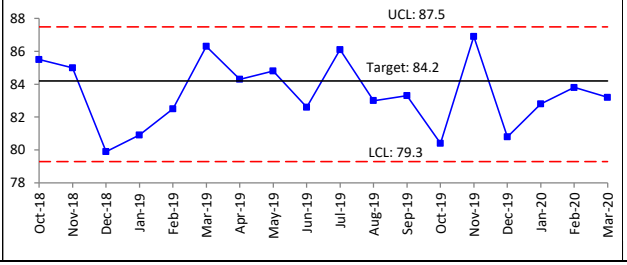
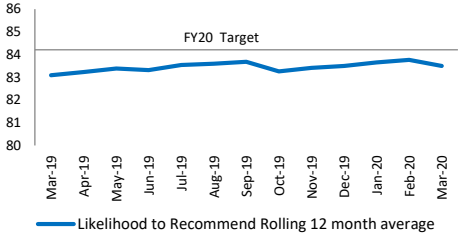
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	The number of deaths increased in February, the observed was sill less than expected. Better physician documentation on the patient's major and co-morbid conditions increases the index expected value. 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)	In March, both the ED's experienced a significant drop in their census given Shelter in Place orders due to COVID-19 pandemic. In addition, both locations went live with creating dedicated areas for separately caring for COVID-19 PUIs (persons under investigation) within the hospital premises as well as setting up ED tents in the ECH parking lots/drive-ways. Given these changes, some of the front-end processes are taking slightly longer time than usual. However, overall the throughput goal is very close to target performance for the month of March despite these unique challenges. We had to pause any earlier process improvements that were going on in March as the ED had to focus on getting the tents set up and new workflows designed for COVID-19.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *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

March 2020 (Unless otherwise specified)

Month to Board Quality Committee: May, 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: March 2020*	86.5	87.6	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: March 2020*	63.9	66.0	65.7	67.1		
6	*Organizational Goal **HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: March 2020*	83.2	83.3	83.5	84.2		

Definitions and Additional Information

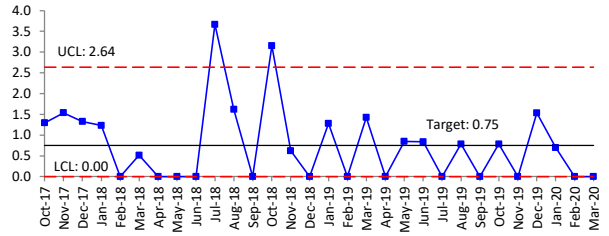
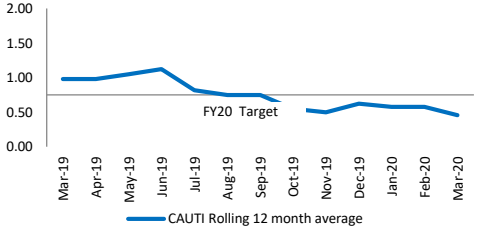
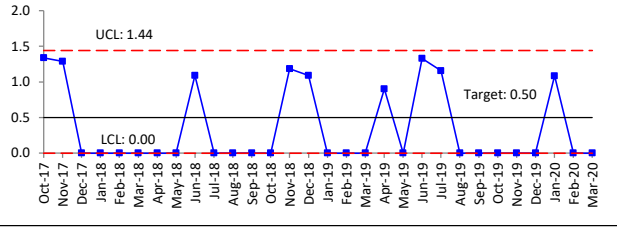
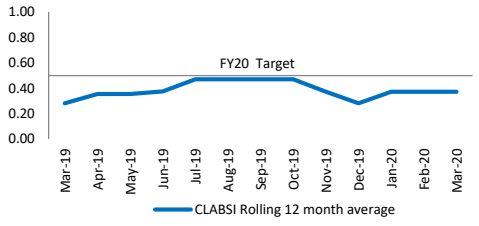
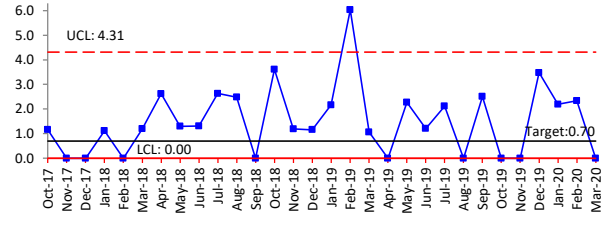
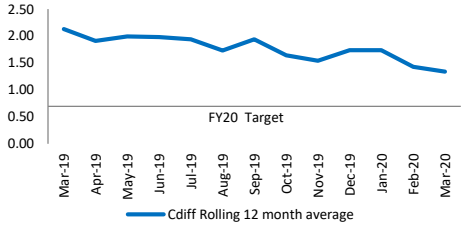
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	• Discharge Information – Although, this metric dipped in March, it is still above target for the quarter and year to date. Inpatient / Mother baby continue to perform above the goal especially in Los Gatos. We believe that post Discharge phone calls implemented towards the end of the March utilizing labor pool staff will increase this metric. Callers are making sure that discharge instructions are understood and help patients with questions and resources as needed. "Help at Home" signs are up on all units in order to help foster the discharge discussion. Leadership continues to work with low scoring nursing units on how to improve their discharge process and communication.	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. There was slight increase from the previous month. Mother/Baby 'commit to sit' where nurses commit to sit daily in order to make a connection and/or address concerns has seen an improvement in Responsiveness scores for MV MCH. Call light system malfunctions continue to be reported to facilities and repaired and a proposal for replacement of call system has been submitted. 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. During Covid-19, leader rounding has been curtailed and we have initiated virtual rounding with utilization of labor, beginning in April, to check-in on patients. This virtual round consists of a phone call into each patient checking in on them and offering to help where needed. We have created our new Service Standards Launch Team to meet and discuss update and refresh of Standards. Rollout of our new Service Standards is planned for beginning of FY21 and will contribute highly to this metric.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

March 2020 (Unless otherwise specified)

Month to Board Quality Committee: May, 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: March 2020*	0.00 (0/1131)	0.44 (5/11479)	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: March 2020*	0.00 (0/912)	0.23 (2/8554)	0.36	SIR Goal: <= 0.50		
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: March 2020*	0.00 (0/7533)	1.45 (11/75907)	1.96	SIR Goal: <= 0.70		

Definitions and Additional Information

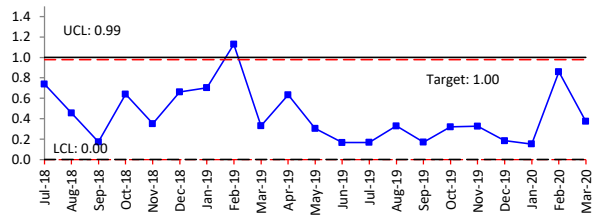
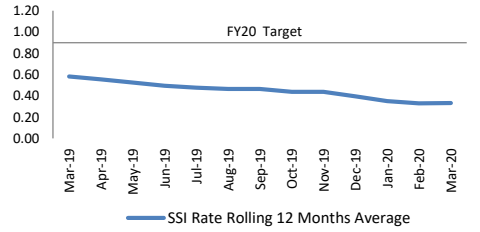
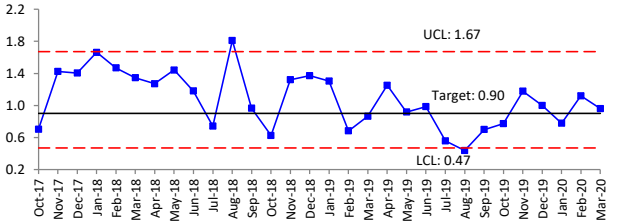
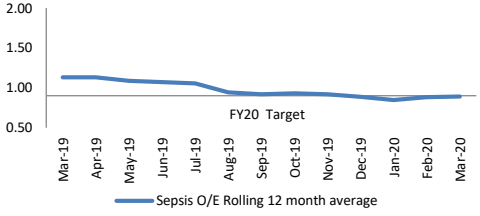
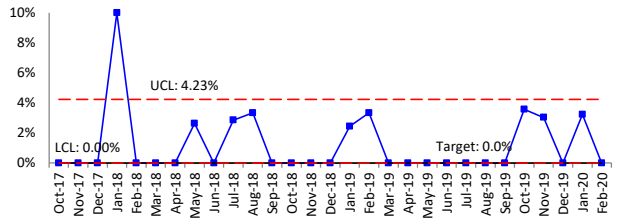
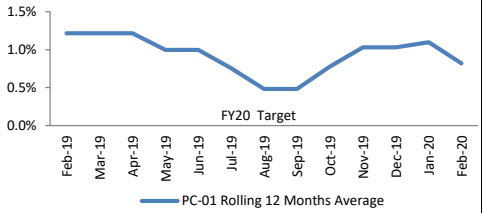
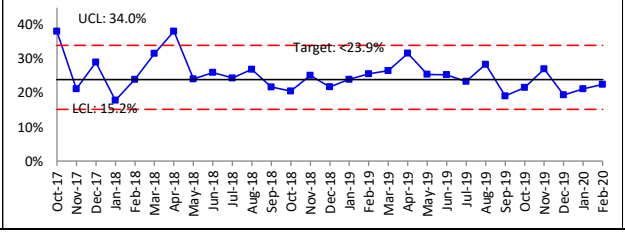
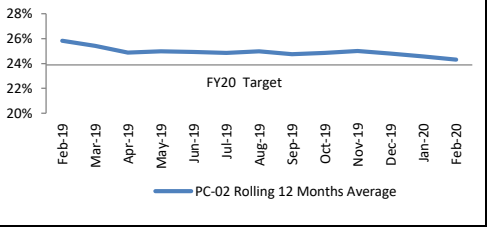
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Zero CAUTIs in February and March. In FY 20 we have had 5 months with Zero.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 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 and March. In DY 20, we have had 7 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)	Zero C.Diff infections in March.	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

March 2020 (Unless otherwise specified)

Month to Board Quality Committee: May, 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: March 2020*	0.37 (1/267)	0.32 (16/5068)	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: March 2020*	0.96 (11.81%/12.29%)	0.91 (10.04%/10.98%)	1.06	0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) *Date period: February 2020*	MV: 0.0% (0/21) LG: 0.0% (0/5) **ENT: 0.0%** (0/26)	MV: 1.35% (3/222) LG: 0.00% (0/34) **ENT: 1.17%** (3/256)	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: February 2020*	MV: 21.85% (26/119) LG: 28.57% (4/14) **ENT: 22.56%** (30/133)	MV: 23.91% (270/1129) LG: 14.97% (22/147) **ENT: 22.88%** (292/1276)	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	One SSI in March: 56 Y/o male had Spinal fusin in March, readmitted in April fo wound revision and complex closure of thoracic spine. Noting that elective surgery was stopped on March 18th. FY to date for 2020 ECH has 15 SSIs, while for FY19, ECH had 37. Quality Council receives a quarterly report on SSIs to sustain improvments made in FY 19. ERAS (enhanced recovery after surgery) will be rolling out enterprise-wide for all surgeries as elective surgery returns in May and June.		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	Sepsis Quality Committee focusing on individual measures in the bundle through manager chart review to find which pieces of the bundle need most improvement; timing of anitbiotic administraiton (1 hr vs 3 hrs), meeting MAP goal of > 65 mmHg w/l 6hrs of TOP, and have the most impact on mortality. Sepsis alert process is being modified from an "alert" to a Sepsis Code for aggressive treatment for severe sepsis. Education to Flex/RRT nurses.	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the 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	Zero occurence of an early elective delivery prior to 39 weeks gestation.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	3rd consecutive month with Primary C/S rate below the target of 23.9%.	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 (Closed Session)** ▪ **Hospital Update** ▪ **QC Follow-up Items**	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

Created April 25, 2019

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

FY2020 Q3		
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) 8. Credentials and Privileges Report Special Agenda Items: 9. Value Based Purchasing Report 10. Pt. Experience (HCAHPS) 11. Approve FY21 Committee Goals 12. Proposed FY21 Committee Meeting Dates 13. Proposed FY21 Organizational Goals 14. QAPI	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items: 6. CDI Dashboard 7. Core Measures 8. Proposed FY21 Organizational Goals (Methodology) ~~9. Approve FY21 Committee Goals (if needed)~~ 10. Proposed FY21Pacing Plan 11. Q3 FY20 Quality and Safety Review 12. Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items: 6. Readmission Dashboard 7. PSI Report 8. Approve FY21 Pacing Plan 9. Med Staff Credentialing Process 10. El Camino Medical Health Network Report

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

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 5/4/20 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 – (Complete)
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Review quarterly at the end of the meeting (Use Closing Wrap-Up Time)	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting
6. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals (Ongoing)

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

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

El Camino Health

Hospital Update
May 4, 2020
Mark Adams, MD, CMO

Since the organization has been extremely focused on our response to the COVID-19 pandemic, this report will be focused on those efforts.

Quality and Safety

On April 6, 2020, we implemented in-house COVID-19 testing and are now able to get results in two hours. To promote a "virus free" environment, we have instituted "universal masking" and are requiring all staff with patient contact to wear a mask.

We have been utilizing three predictive models to estimate a time and volume for a potential surge in patient volume. While our local vicinity has not yet experienced a surge, some areas of the County appear to be in a patient surge scenario. Thus, sheltering in place will be critical in our area for us to avoid the possibility of a patient surge due to the virus transmission. However, we do have a surge plan in place and believe we are well prepared. Accelerated Care Units (Tents) outside the Emergency Rooms at Mountain View and Los Gatos are being used to separate patients who have respiratory symptom and those who do not.

Operations

Following CDC and CDPH guidelines to create hospital bed capacity and contain the virus, as of April 22, 2020, we have continued to postpone the majority of elective and procedural cases since March 16th. We plan to resume those cases soon.

Visitor restrictions remain in place: Maternal Child Health patients are allowed one visitor. Other patients are not allowed visitors except those at end of life.

Workforce

ECH-funded "kids camps" are up and running in Mountain View and Saratoga to support our essential staff members whose children ages 3-12 are currently not attending school. Happy to report our staffing levels have been good.

Corporate and Community Health Services

CONCERN's customers are very appreciative of all the materials we are offering to support employees regarding; resilience, managing anxiety, and telecommute and have requested expansion of counseling visits and extension of services to part time employees.

Community Benefit staff reached out to our 97 current grantees acknowledging the dire situation, the need for rapid adaptation and opportunity to discuss program

adjustments; *e.g.* many services are moving online. We also approved $125,000 in additional grant funding for District grantees to support food insecurity, COVID-19 testing, telemedicine visits, and home health monitoring equipment.

The South Asian Heart Center initiated weekly community huddle every Tuesday evening and completed first community huddle on March 24th on meditation; 40 participated online. All routine appointments are now being offered online.

The Chinese Health Initiative is providing ongoing community education about COVID-19 to 5000+ CHI participants by digital communication (email and Facebook group). Educational content are culturally and linguistically tailored from the ECH COVID-19 webpage, ECH Patient Letter, CDC and Santa Clara County Public Health Department sources.

Due to the COVID-19 exposure risk, RoadRunners has drastically cut their normal everyday rides to only medical appointments and grocery store runs. We are still using Lyft for Behavioral Health clients who live out of service area.

The Health Library received a $50,000 donation to the library's restricted fund in the Foundation in memory of Erika Richards. Erika was a volunteer at the medical library and patient library at El Camino Hospital for over 20 years. A plaque will be mounted on the Library's conference door.

Marketing and Communications

We have launched a new COVID-19 news page, updated the SVMD website and all location pages to reference telemedicine visits and Carbon Health's COVID-19 assessment, added COVID-19 information notices across our entire website including special callouts on the homepage, maternal child health and emergency care pages.

The SVMD (now El Camino Health Medical Network) marketing brand architecture was finalized including visual brand treatments.

From a communications perspective, in response to the COVID-19 pandemic, we have added a special banner to our website with direct links to COVID-19 resources to top of homepage, provided updated COVID-19 FAQ's as needed (tents, virtual visits, drive-through testing) and proactively facilitated stories in local media (LATC and MVV) with a message of support for shelter in place and reassurance to the community from the El Camino Health CEO.

Internally, we are communicating more frequently with employees, the Medical Staff and patients.

El Camino Health

Philanthropy

During Periods 7 and 8 of FY20,the El Camino Health Foundation secured $368,492 and $394,617 respectively, bringing the total raised through February to $6,283,689, which is 82% of the annual goal. Further fundraising details for Periods 7 and 8 are in the attached report. In addition, the community has been exceedingly generous in supporting our response to COVID-19. Although final numbers for Period 9 (March) are not yet available, the Foundation has received in excess of $2 million as well as countless in-kind donations in the form of badly needed supplies and gift cards to support our staff and patients.

Auxiliary

The Auxiliary contributed 5,187 volunteer hours in February 2020 and 1,084 volunteer hours in March 2020. We are very disappointed to have sent our Auxillians home in Mid-March, but are glad they are sheltering in place! We miss them and their support terribly and look forward to their return when conditions are safe.

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	
12	Bring back Revised Board Level Quality Dashboard	4/6/2020	MA	on 5/4/20 Agenda	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: May 4, 2020
Subject: Report on Board Actions

Purpose:

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

Summary:

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

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

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

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	April 15, 2020	- Medical Staff Report including the Credentials and Privileges Report - Revised Medical Staff Bylaws (Restructuring Organization, Increasing length of terms etc.) - FY20 Period 7 and 8 Financials - Quality/Safety Performance Improvement and Patient Safety Plan (QAPI) - ECH Resolution 2020-02 Declaring Local Emergency (necessary first step to apply for COVID-19 FEMA funds should the organization decide to do so) - Enterprise Telestroke Agreement - Neurology Inpatient Consult Panel - Revised Executive Compensation Philosophy - Revised Executive Base Salary Administration Policy - Revised Executive Performance Incentive Plan - Urology On-Call Panels (MV and LG) - Infection Control Medical Directors Hours Increase - FY20 Board and Committee Self-Assessment Tools - Resolution 2020-03 Approving Neurology Inpatient Consult Panel Agreement for Peter C. Fung MD

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECHD Board	April 15, 2020	- ECHD Resolution 2020-02 Declaring Local Emergency (necessary first step to apply for COVID-19 FEMA funds should the organization decide to do so)
Finance Committee		- None since last report
Compliance and Audit Committee		- None since last report
Exec. Comp Committee		- None since last report

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Ms. Cheryl Reinking
Chief Nursing Officer
El Camino Hospital
2500 Grant Road
Mtn. View, CA 94040

Re: Ltr. of Commendation (for recent stay there)

Dear Ms. Reinking:

This letter is to mainly commend El Camino Hospital and its outstanding staff while I was there (Feb. 6-15). I arrived at your ER (via ambulance) after severe vomiting. After a CT Scan was done, we realized that the capsule/camera that I had swallowed on 2/3 was still in my abdomen. The ER staff made arrangements to transfer me to the 4th floor (for an operation the next day). My room number was :

Dr. Khoi Tran performed the bowel re-section on Feb. 7th and did an outstanding and amazing job (and followed up with my recovery). During my recovery, two people in the medical staff there helped me tremendously...Chris (a doctor) was able to remove the 14 stitches on my abdomen with no pain/discomfort. One of the night nurses (or doctors), Wanda, noticed that the IV line on my left arm was causing my arm to turn 'pinkish.' She set up a new IV line on my right arm. (Please complement or reward these three people for me.) All the other nurses and medical staffers there were great...all very helpful and knowledgeable.

Also, I was VERY impressed with how much each employee was willing to help others. Even if in the middle of a procedure, they were happily offering help or answering questions from other employees. (What a great place to work in!)

One suggestion: A man drew blood (for blood samples) the first 3 or 4 mornings (2/7-9). Since I don't know his name, I'll call him 'John.' His bedside manners were 'Atrocious.' He 'jabbed' my left arm hard every time he drew blood, so that my arm is still sore. I complained to some of the medical staff about him. Thankfully, they contacted someone in that dept. and were able to send in other people (all of whom were very efficient, with wonderful 'bedside manners'). I recommend that John do his work in other places, like maybe a military outpost or a prison. In my opinion, he should NOT be working at ECH.

If you need to contact me for further questions, please feel free to do so. Many thanks to you and everyone else at ECH for doing such a great job. Am VERY thankful to be alive and well now.

Respectfully,

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: May 4, 2020
Subject: Board Quality and Safety Dashboard

Purpose: Review New Board Quality and Safety Dashboard

Summary:

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

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

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

4. Assessment: The Board Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention but the Board will receive the new dashboard as a part of the Quality Committee report. A comprehensive explanation for each metric has been developed and is included for review. The format has been adjusted with the goal of simplifying it. In the future, areas of opportunities for improvement will be highlighted with additional information provided to supplement the dashboard for those areas of concern. Once the quality committee is satisfied, the actual metrics will be generated and populated onto the dashboard for the Board of Directors.

5. Other Reviews: None

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

List of Attachments: Power Point illustrating the new dashboard

Suggested Committee Discussion Questions: None

El Camino Health Quality Related Metrics

	Metric	Source	Relevance
Safe Care	Risk Adjusted Mortality		Mortality rate is a measure of the frequency of occurrence of death in a defined population during a specified interval. The risk adjusted mortality rate is a mortality rate that is adjusted for predicted risk of death. It is commonly utilized to observe and/or compare the performance of healthcare providers.
	Sepsis Mortality Index		Patients with severe sepsis or septic shock have a mortality rate of about 40%-60%, with the elderly having the highest mortality rates. Newborns and pediatric patients with sepsis have about a 9%-36% mortality rate. Experience has demonstrated that healthcare providers that adhere to sepsis best practices can significantly reduce sepsis mortality. Thus, it is a common measure of care quality among healthcare providers.
	% of Serious Safety Events (SSEs) Classified		A Serious Safety Event (SSE), in any healthcare setting is a deviation from generally-accepted best practice or process that reaches the patient and causes severe harm or death (M. Hoppes, et al. 2012). A key initial step to avoid SSEs and achieve high reliability is to identify SSEs and subsequently mobilize resources to understand why it happened, what can be done to prevent it and implement an action plan to prevent it in the future.
	Catheter Associated Urinary Tract Infection (CAUTI) – HAI		Catheter-Associated Urinary Tract Infections (CAUTI) are the most commonly reported hospital-acquired condition, and the rates continue to rise. More than 560,000 patients develop CAUTI each year, leading to extended hospital stays, increased health care costs, and patient morbidity and mortality.
	Central Line Associated Blood Stream Infection (CLABSI) – HAI		CLABSIs are serious, but preventable infections when evidence-based guidelines for central line insertion and maintenance are properly prioritized and implemented. If not prevented, CLABSIs result in increased length of hospital stay, increased cost and increased patient morbidity and mortality. An estimated 30,100 CLABSIs occur in U.S. intensive care units each year (CDC, 2015), with up to 250,000 occurring across care settings (Klevens et al., 2004). Patient mortality rates associated with CLABSI range from 12 to 25 percent (CDC, 2011) and the cost of CLABSIs range from $3,700 to $36,000 per episode (Scott, 2009).
	Clostridium Difficile Infection (CDI) – HAI		*Clostridium difficile* infections (CDI) are a leading cause of antibiotic-associated and nosocomial diarrhea. Despite effective antibiotic treatments, recurrent infections are common. With the recent emergence of hypervirulent isolates of *C. difficile*, CDI is a growing epidemic with higher rates of recurrence, increasing severity and mortality.
	Modified PSI-90 CMS HAC Reduction Program		The Hospital Acquired Condition (HAC) Reduction Program is a Medicare pay-for-performance program that supports the Centers for Medicare and Medicaid Services' (CMS) long-standing effort to link Medicare payments to healthcare quality in the inpatient hospital setting. CMS uses the Total HAC Score to determine the worst-performing quartile of hospitals. For FY 2020, the Total HAC Score is based on data for six quality measures of which PSI-90 is one. PSI-90 is a composite of several different measures.
Timely	Enterprise Patient Throughput – ED Door to Admit Order		Improving emergency department throughput is critically important to improving care, patient satisfaction and a hospital's bottom line. One of the most important components driving patient satisfaction in the ED is the amount of time it takes to see a physician upon arrival. Improved throughput can significantly cut door-to-doctor time. The ability to cut wait times and move patients through the ED in a timely way allows the ED staff to see more patients, increasing the hospital's ability to initiate needed care quickly, improve satisfaction and generate revenue.

	ED2b – Admit Decision Time to ED Departure Time for Admitted patients		The emergency department (ED) is a unique environment within the health care system, bridging the worlds of outpatient and inpatient care. CMS has made considerable investments in developing and testing the Emergency Department Patient Experience of Care (EDPEC) Surveys. In 2012, CMS launched the development of the EDPEC surveys to measure the experiences of patients (18 and older) with emergency department care. The survey respondents will include patients admitted to the hospital following their emergency department visit and those visiting the emergency department who are discharged to the community. The surveys were developed following the Consumer Assessment of Healthcare Providers and Systems (CAHPS) principles. The ED2b measure defines how to determine the duration from a Decision to Admit and the departure from an ED stay.
	OP18b – Median Time from ED Arrival to ED Departure for Discharged ED patients		The Hospital Outpatient Quality Reporting Program (Hospital OQR) is a pay for quality data reporting program implemented by the Centers for Medicare & Medicaid Services (CMS) for outpatient hospital services. The Hospital OQR Program was mandated by the Tax Relief and Health Care Act of 2006, which requires hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Measures of quality may be of various types, including those of process, structure, outcome, and efficiency. OP18b is one of those measures because timely ED care is recognized as important to high quality, safe care.
	3rd Next Available Appointment		The "third next available" appointment is defined as the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. It is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.
Effective	Risk Adjusted Readmission Index		The CMS 30-day All-Cause Hospital Readmission measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute-care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. Some readmissions are unavoidable, but they may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. CMS is applying this measure because reducing avoidable readmissions is a key component in the effort to promote more efficient, high-quality care while lowering costs.
	CMS SEP-1 Compliance Rate		A principle of sepsis care is that clinicians must rapidly treat patients with an unknown causative organism and unknown antibiotic susceptibility. CMS requires U.S. hospitals to report compliance rates with the “SEP-1” core sepsis measure. The severe sepsis bundle requires lactate measurements, blood cultures, and broad-spectrum antibiotics within 3 hours of sepsis onset. Compliance with this measure has been shown to reduce mortality, shorten length of stay and reduce costs.
	PC-01 Elective Delivery Prior to 39 Weeks Gestation		For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to elective delivery, either vaginal or operative. A survey conducted in 2007 of almost 20,000 births in hospitals throughout the U.S. revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13-21%).
	NTSV C-Section		In the U.S., nearly one in three women gives birth by cesarean section (C-section). According to The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, cesarean birth is too common in the United States and

			has increased greatly since it was first measured in the 1960s.C-sections carry serious risks of infection or blood clots, and many women experience longer recoveries and difficulty with future pregnancies. C-sections can also cause problems for babies, including breathing difficulties that need treatment in a newborn intensive care unit (NICU). In the long-term, research shows that C-sections can cause chronic pelvic pain in some women, and babies born by C-section are at increased risk of developing chronic childhood diseases like asthma and diabetes. An acceptable C-section rate is considered to be between 19 and 25%, but definitely less than 30%.
	CMS 165: Controlling High Blood Pressure		Hypertension, or high blood pressure (HBP), is a very common and dangerous condition that increases risk for heart disease and stroke, two of the leading causes of death for Americans. Compared with other dietary, lifestyle, and metabolic risk factors, HBP is the leading cause of death in women and the second-leading cause of death in men, behind smoking. Approximately 1 in 3 U.S. adults, or about 70 million people, have HBP but only about half (52%) of these people have their high blood pressure under control. As a result, CMS views control of HBP as an important measure of clinical quality.
	CMS 122: Diabetes: Hemoglobin A1c Poor Control		As the seventh leading cause of death in the U.S., diabetes kills approximately 79,500 people a year. Diabetes is a long lasting disease marked by high blood glucose levels, resulting from the body's inability to produce or use insulin properly. People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. In 2012, diabetes cost the U.S. an estimated $245 billion: $176 billion in direct medical costs and $69 billion in reduced productivity. This is a 41 percent increase from the estimated $174 billion spent on diabetes in 2007. Reducing A1c blood level results by 1 percentage point (eg, from 8.0 percent to 7.0 percent) helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent. As a result, CMS views control of diabetes as an important measure of clinical quality.
Efficient	ALOS/Expected GMLOS		Geometric mean length of stay GMLOS is based off of the patient's diagnosis-related group (DRG), which is a system of grouping together clinically similar patients. When clinically viable, reducing hospital length of stay has been proven to provide both positive results for patients and financial benefits for the institution. In many cases, hospitals do not receive additional reimbursement once a patient's stay has passed the GMLOS for their assigned DRG. Adherence to clinical best practice has been shown to reduce mortality, length of stay and costs. As a result, it is a common measure used by healthcare providers.
	OP-8 MRI Lumbar Spine for Low Back Pain		OP-8 is the Medicare imaging efficiency metric for MRI of the lumbar spine for low back pain in the outpatient hospital. It is one of the imaging efficiency metrics, and it is intended to measure appropriateness for MRI of the lumbar spine for low back pain. The goal of the measure is to reduce overuse of imaging for uncomplicated low back pain without prior attempts at antecedent conservative therapy, as overuse in this population can result in detection of incidental findings and reflect poor care coordination. The measure score seeks to guide patient selection of providers, assess quality, and inform quality improvement efforts.
	OP-10 Abdomen CT Use of Contrast Material		This measure calculates the ratio of CT abdomen studies that are performed both with and without contrast of all CT abdomen studies performed (those with contrast, those without contrast, and those with both). The goal of the measure is to promote high-quality, efficient care, to reduce unnecessary exposure to contrast materials and/or radiation, to ensure adherence to evidence-based medicine and practice guidelines, and to provide data to consumers and other stakeholders about facility imaging use.
Eq	Hospital Charity Care Support		Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or

			insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. The amount of charity care provided is a major justification for non-profit status of hospitals. According to requirements set by the Affordable Care Act (ACA), nonprofit hospitals must have written charity care and emergency care policies.
	Clinic Charity Care Support		Like hospital charity care, providing outpatient care to those who cannot afford it is an important determinant of health.
	Language Line Unmet Requests		Miscommunication in the healthcare sector can be life-threatening. The rising number of migrant patients and foreign-trained staff means that communication errors between a healthcare practitioner and patient when one or both are speaking a second language are increasingly likely. For many, access to health care is limited by their inability to communicate their medical needs, in large part because of a lack of qualified interpreters in the nation's hospitals and clinics. Hence, access to interpreters is an important determinant of high quality care.
	Length of Stay Disparity		There is evidence of racial and ethnic disparities in health care access and quality in the treatment of different ethnic and racial groups. Health disparities can be defined as inequalities that exist when members of certain population groups do not benefit from the same health status as other groups. The evolving definition of diversity is inclusive of race, ethnicity, language preference, disability status, gender identity, sexual orientation, veteran status, and socioeconomic factors. Health equity is the attainment of the highest level of health for all people. Health care disparities impact quality of care, health outcomes, length of stay and overall cost of care. Hence, measuring disparities in length of stay can be an indicator of health equity.
Patient-Centered	HCAHPS: Staff Responsiveness		The Hospital Consumer Assessment of Healthcare Providers and Systems ((HCAHPS) survey is the first national, standardized, publicly reported survey of patients' perspectives hospital care. HCAHPS, also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. The responsiveness of hospital staff measure looks at patients' feedback on how long it takes for a staff member to respond when a patient requests help. When used correctly, HCAHPS* star ratings provide valid and reliable measures of hospital quality that can compel hospitals to assess and improve patient experience.
	HCAHPS: Discharge Information		The HCAHPS communication about discharge measure summarizes how well the hospital staff communicated with patients about the help they would need at home after leaving the hospital.
	HCAHPS: Likelihood to Recommend		The HCAHPS likelihood to recommend measure summarizes how likely patients will recommend the hospital.
	Emergency Department (ED) Satisfaction		Studies show that no matter how positive the patient experience is in the hospital, no matter how much they like their nurses, hospitalists or other providers, if patients have a negative experience in the emergency department (ED), it will affect all aspects of patient satisfaction. Thus, ED satisfaction is an important measure of patient-centeredness and overall satisfaction
	OAS CAHPS: Rating 9's & 10's		The Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) collects information about patients' experiences of care in hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs). It is an important measure of patient satisfaction with care in these environments.
	CG-CAPHS Provider Communication		Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an AHRQ program that began in 1995. Its purpose is to advance our scientific understanding of patient experience with healthcare. The CAHPS Clinician & Group Survey (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices. Survey results can be used to improve care

			provided by individual providers, sites of care, medical groups, or provider networks and equip consumers with information they can use to choose physicians and other health care providers, physician practices, or medical groups. The survey includes standardized instruments for adults and children that can be used in both primary care and specialty care settings. Users can also add supplemental items. The manner in which a physician communicates information to a patient is as important as the information being communicated. Patients who understand their doctors are more likely to acknowledge health problems, understand their treatment options, modify their behavior accordingly, and follow their medication schedules. As a result, it is an important measure of patient care.

	Metric	Baseline FY2019	FY2020 Target	Q1 (unless otherwise indicated)	Q2	Q3	Q4
Safe Care	Risk Adjusted Mortality Index	0.97	≤ 0.90	0.64 (Oct 19)			
	Sepsis Mortality Index	1.06	≤ 0.90	0.61 (Oct 19)			
	% of Serious Safety Events (SSEs) Classified	New Program	Establish baseline for SSE rate 95% classified in ≤30-days	Begin categorization 12/1/19			
	Surgical Site Infections (SSI)	0.52 37/7167	SIR ≤1.0 NHSN ratio	0.17			
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	1.09	SIR ≤0.75 NHSN ratio	0.27			
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.36	SIR ≤0.50 NHSN ratio	0.37			
	Clostridium Difficile Infection (CDI) - HAI	1.96	SIR Goal: <= 0.70	1.58			
	Modified PSI-90 CMS HAC Reduction Program	0.714852	1.021817	1.010425			
Timely	Enterprise Patient Throughput – ED Door to Admit Order	FY19 284 min	266 minutes	254 minutes (Oct 19)			
	ED2b – Admit Decision Time to ED Departure Time for Admitted patients	CY18 95 minutes	CY19 <120 minutes	77 minutes (Q1)			
	OP18b – Median Time from ED Arrival to ED Departure for Discharged ED patients	CY18 183 minutes	CY19 <180 minutes	174 minutes (Q1)			
	3rd Next Available Appointment		TBD				
Effective	Risk Adjusted Readmissions Index	0.99	≤ 0.96	**0.96**			
	CMS SEP-1 Compliance Rate	74%	≥ 80%	**82.6**			
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	**ENT: 0.99%** (4/404)	0.00%	0% (0/103)			
	NTSV C-Section	**ENT: 24.9%**	≤ 23.9%				
	CMS 165: Controlling High Blood Pressure		TBD				
	CMS 122: Diabetes: Hemoglobin A1c Poor Control		TBD				
Efficient	ALOS/Expected GMLOS	0.91		0.86 (Oct 19)			
	OP-8 MRI Lumbar Spine for Low Back Pain	# of Pts 38	National Rate 38.70%	Q3 2017- Q2 2018 = 52.6%			
	OP-10 Abdomen CT Use of Contrast Material	# of Pts 1,109	National Rate 8.90%	Q3 2017- Q2 2018 = 4.4%			
Equitable	Hospital Charity Care Support	$21.6m	$23.0m	$6.8m			
	Clinic Charity Care Support	$18k	TBD	$8.8kk			
	Language Line Unmet Requests	4.60%	<5%	2.90%			
	Length of Stay Disparity	African American Asian American	None	None			
Patient-centered	HCAHPS: Staff Responsiveness	65.7	≥ 67.1	66.4 (Oct 19)			
	HCAHPS: Discharge Information	86.7	≥ 87.3	86.9 (Oct 19.)			
	HCAHPS: Likelihood to Recommend	83.5	≥ 84.2	83.2 (Oct 19)			
	Emergency Department (ED) Satisfaction	66	≥ 69.0	70.6 (Oct 19)			
	OAS CAHPS: Rating 9's & 10's	43rd %tile	≥ 35th %tile	45th %tile			
	CG-CAHPS Provider Communication		TBD				

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: May 4, 2020
Subject: FY 2020 CDI KPI Dashboard for May Meeting

Recommendation(s): To approve FY2020 CDI KPI Dasboard

Summary: 1.) Provide the Committee with the Key Process Indicators for assessing ECH's Clinical Documentation Integrity (CDI) program. 2.) Annotation is provided to explain actions taken affecting each metric.

1. Authority: This dashboard provides oversight on compliance with metrics that reflect the quality of the CDI program.

2. Background: The CDI Steering Committee provides guidance to the manager in the selection of these key metrics and in the setting of the metric goals.

3. Assessment:

- Reviewing 86% of Medicare patients with goal of 85%
- All payor patients reviewed at 83%
- Physician Response Rate to CDI queries remains at 100%, with the highest rate of agreement at 88%
- CDI query volume continues above goal at 47% of all accounts
- Improvement in both the Medical and Surgical Complications/MCC capture rate.

4. Other Reviews: The CDI Steering Committee reviews these data monthly and provides guidance aimed at performance improvement.

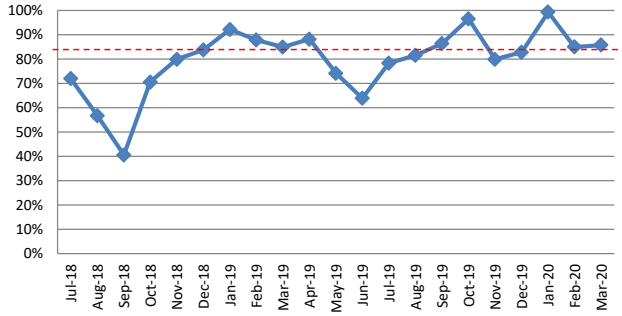
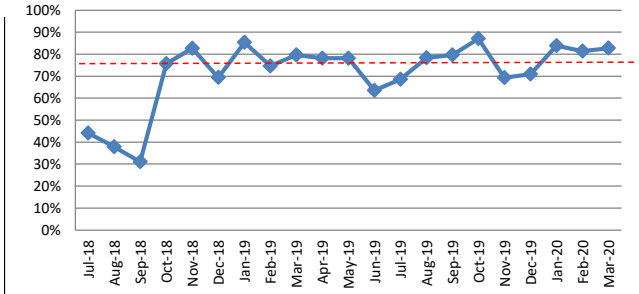
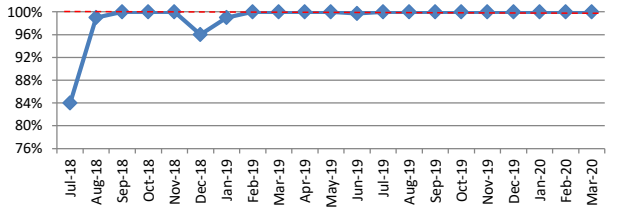
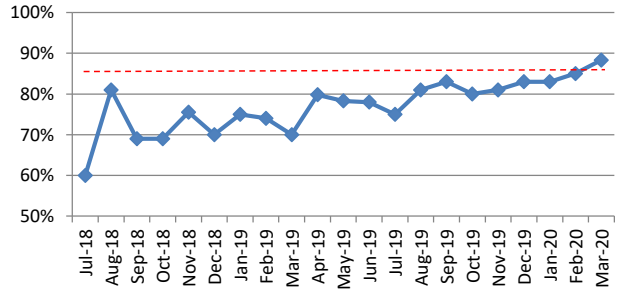
5. Outcomes: None

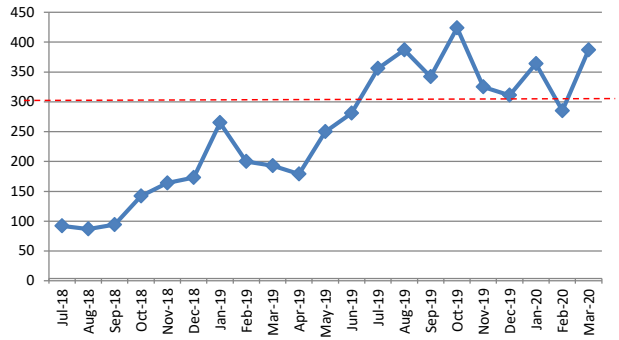
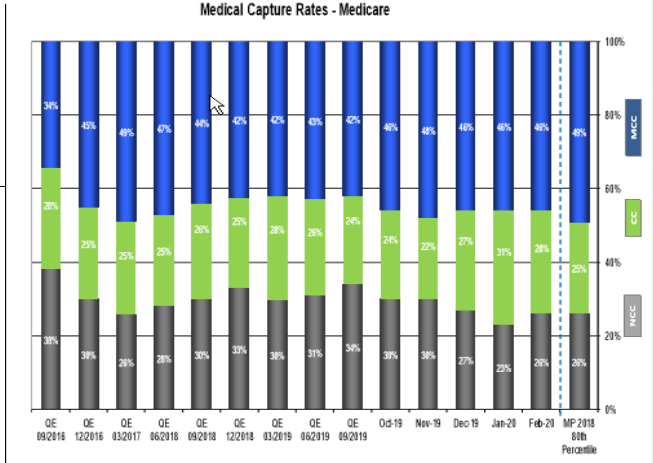
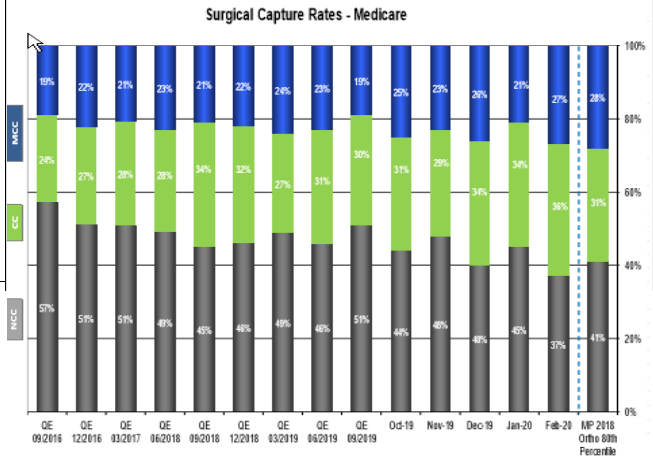
Suggested Committee Discussion Questions: None

List of Attachments: FY 2020 (April) CDI KPI Dashboard

El Camino Health

Clinical Documentation Integrity Dashboard (Monthly/ ALL adult, acute care, non-OB inpatient population)

As of April 15, 2020				Baseline	FY20 Goal	Trend	Comments
Coverage	Performance			FY2019	FY2020 goal		
1	**Medicare** *Source: iCare CDI Productivity report	March 2020 443/380 86%	FYTD 86%	75%	85%		Medicare coverage rate remained strong in March despite COVID-19 situation. CDI department reviewed thoroughly all the cases qualifying in the WQs. The rest of 14% of the cases are the ones that did not qualified in our WQs. In March number of 1 day or less LOS increased to almost to 17%.
2	**All Payor** *Source: iCare CDI Productivity report	March 2020 997/825 83%	FYTD 78%	67%	75%		Focus of review continues on ALL PAYERS. It is directed towards all ECH population expected mortality optimization. After almost one year we consistently started to cover all financial clases and payers. It started in October FY 2019. FYTD we cover 78% of all patients with a goal of 75% for the FY 2020.
Physician Response	Performance			FY2019	FY 2020 goal		
3	**Query Response Rate** *Source: iCare CDI Query report	March 2020 100%	FYTD 100%	98%	100%		Consistently 100% after implementing the new Physician Query P&P and actively addressing physician engagement. Consistently the highest rate ever registered for the existence of the CDI program and compared to similar programs around the nation. Continue monitoring the numbers in the light of recent changes to the Physician`s suspension guidlines approved by MEC.
4	**Query Agree Rate** *Source: iCare CDI Query report	March 2020 88%	FYTD 82%	73%	>85%		Agreement rate steadily increasing, surpassing in March the mark above 85% set up for the year. FYTD - 82%. Greate results reflected by the continuing education and outreach to the physicians, leaders of the hospitalists groups and service line medical directors. Results also attributed to the immense work around Query Template optimization and alignment to the new 2019 CMS guidelines.

#	Queries volume	Performance		FY2019	FY 2020 goal		
5	**Query volumes** **Source: iCare CDI Query report*	**March 2020** **387** **47**% of of all reviewed accounts	**FYTD Avg.** **353** **39**% of all reviewed accounts	**177**	35% of all reviewed accounts		Query volumes remain consistently strong due to a stabilization in the CDI staff turnaround. Worh noting that despite increased number of queries placed the response rate and agreement rate at all time high. It denotes a high engagement of the medical staff.
6	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: CLARO report	**Feb 2020** **MCC 46%** **CC 28%** **NCC 25%**	**N/A**	**Nat 80th% CMS 2018** MCC 48% CC 25% No CC 26%	**Nat 80th% CMS 2018**		Higher MCC/CC Capture Rate is better. This affects Reimbursement, Expected GMLOS & Mortality and CMI in Medicare population. National 80th Percentile is computed by CMS (MedPAR claims) and published annually on 10/1. Worht mentioning for February CC rate and Non-CC rate above and below, respectively to National 80th %ile mark.
7	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: CLARO report	**Feb 2020** **MCC 27%** **CC 36%** **NCC 37%**	**N/A**	**Nat 80th% CMS 2018** MCC 28% CC 31% No CC 41%	**Nat 80th% CMS 2018**		Surgical cases make up 20-30% of our Medicare patient volume. The biggest impact in reimbursement, CMI, GMLOS will come from increased Surgical CC/ MCC capture. Working closely with HVI, orthopedic and stroke teams to document comorbid conditions in sugical population is the focus of CDI program begining with FY 2019. With a robust CC capture rate the number of surgical cases without a comorbid conditions decreased below 80th %ile nationwide and at the lowest level registered by our program.

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: May 4, 2020
Subject: FY 2020 Core Measure Dashboard for May Meeting

Recommendation(s): To approve the FY2020 Core Measure Dashboard

Summary: 1.) Provide the Committee with the current CMS and TJC required clinical core measure data results; 2) Annotation is provided to explain actions taken affecting each metric. 3.) These core measure results are applied by CMS to several programs: CMS Value-based Purchasing program (VBP), CMS Star Ratings, Leapfrog Safety Grade, and Public Hospital Redesign and Incentives in MediCal (PRIME) program.

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 compliance with CMS measurements of clinical quality.

2. Background: These metrics are revised annually by CMS and TJC in January, and some are retired or moved to eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program.

3. Assessment: CMS has 2 sets of Core Measures: one covers acute hospitals and the second only applies to acute hospitals with inpatient behavioral health units, which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

- Perinatal measures: Zero early elective deliveries, 100% compliance with Antenatal Steroid use, Primary C/S rate below CA goal of 23.9% @ 22.9% YFTD
- Perinatal Babies: Zero CLASBI, improvement in exclusive breast feeding to 66%, Only 1.9% unexpected newborn complications
- ED Throughput measures continue higher than CMS benchmarks
- HBIPS: Flu Immunization improved, Discharges on Multiple Antipsychotic medication above benchmark, struggle continues with the all or nothing Tobacco use measure. Transition record, timely transmission of transition record and screening for metabolic disorders are all above benchmark. Restraint and seclusion use are very low and below benchmark.

4. Other Reviews: N/A

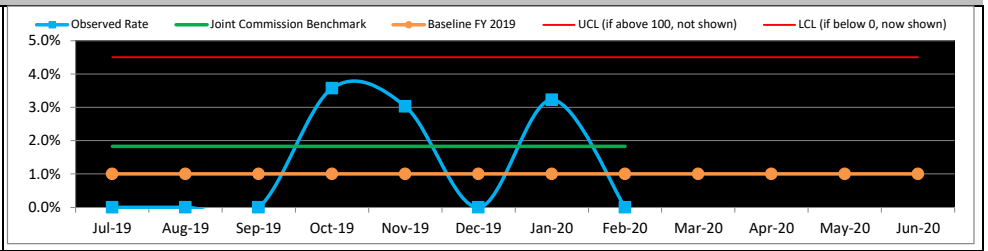
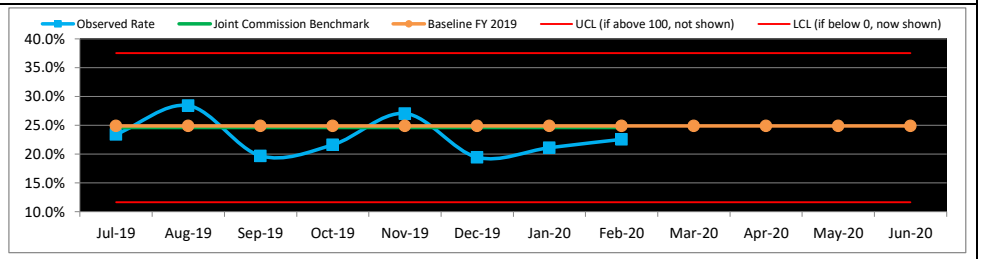
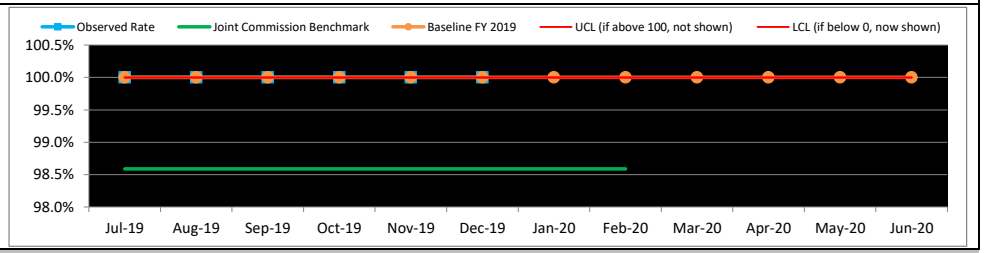
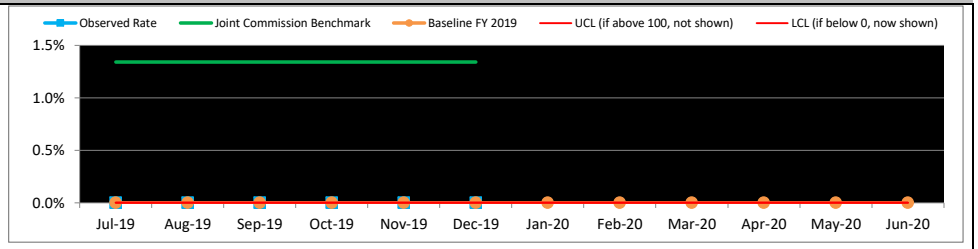
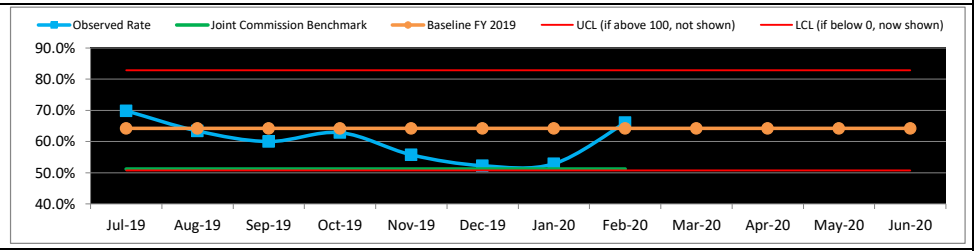
5. Outcomes: N/A

Suggested Committee Discussion Questions: None

List of Attachments: FY20 Core Measure Dashboard through February 2020.

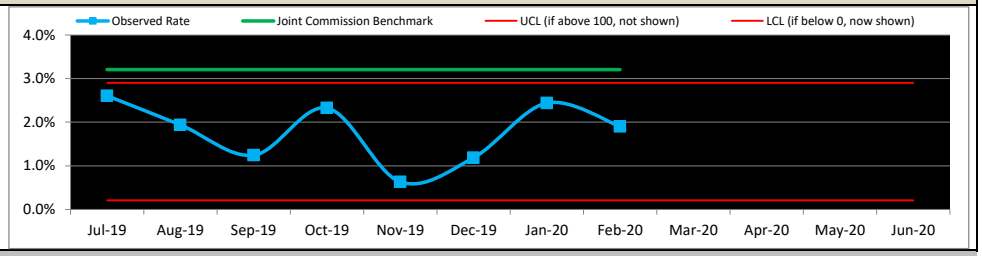
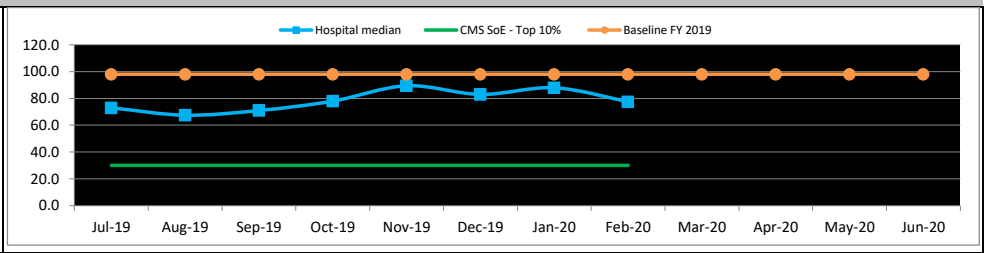
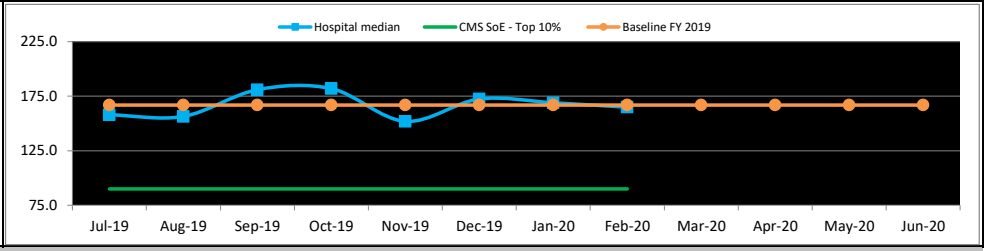
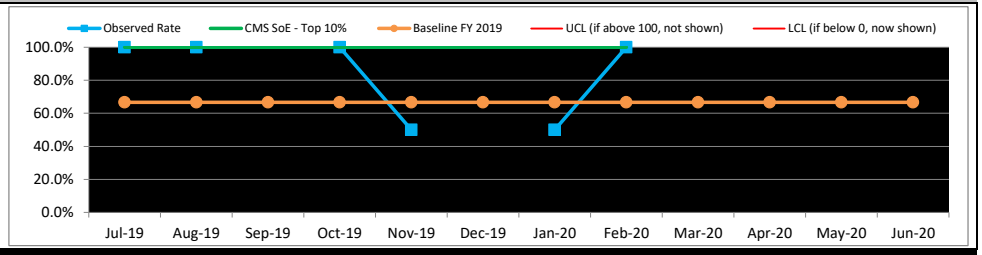
El Camino Health

Core Measures Dashboard (non-HBIPS) - FY 2020 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FYTD 2020 Performance	Baseline FY 2019	Target for FY 2020	Trend Graph
PERINATAL CARE MOTHER					
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) *Latest Data Month: FEBRUARY 2020*	ENT: 0.0% (0/26) MV: 0.0% (0/21) LG: 0.0% (0/5)	ENT: 1.2% (3/256) MV: 1.4% (3/222) LG: 0.0% (0/34)	ENT: 1.0% (4/404) MV: 1.1% (4/360) LG: 0.0% (0/44)	1.8% (Joint Commission Benchmark)	
PC-02 Cesarean Birth (lower = better) *Latest Data Month: FEBRUARY 2020*	ENT: 22.6% (30/133) MV: 21.9% (26/119) LG: 28.6% (4/14)	ENT: 22.9% (292/1273) MV: 23.9% (270/1130) LG: 15.4% (22/143)	ENT: 24.9% (455/1827) MV: 26.3% (425/1617) LG: 14.3% (30/210)	24.6% (Joint Commission Benchmark)	
PC-03 Antenatal Steroids *Latest Data Month: DECEMBER 2019 Retired beginning January 2020*	100% (3/3)	100% (18/18)	100% (55/55)	98.6% (Joint Commission Benchmark)	
PERINATAL CARE BABIES					
PC-04 Health Care-Associated BSI in Newborns (lower = better) *DECEMBER 2019 Retired beginning January 2020*	0.0% (0/4)	0.0% (0/21)	0.0% (0/70)	1.3% (Joint Commission Benchmark)	
PC-05 Exclusive Breast Milk Feeding *Latest Data Month: FEBRUARY 2020*	ENT: 66.0% (35/53) MV: 65.2% (30/46) LG: 71.4% (5/7)	ENT: 60.2% (313/520) MV: 57.4% (259/451) LG: 78.3% (54/69)	ENT: 64.2% (480/748) MV: 60.0% (386/643) LG: 89.5% (94/105)	51.2% (Joint Commission Benchmark)	

El Camino Health

Core Measures Dashboard (non-HBIPS) - FY 2020 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FYTD 2020 Performance	Baseline FY 2019	Target for FY 2020	Trend Graph
PC-06 Unexpected Complications in Term Newborns (lower = better) *Latest Data Month:* *FEBRUARY 2020*	ENT: 1.9% (5/263) MV: 1.7% (4/229) LG: 2.9% (1/34)	ENT: 1.8% (46/2580) MV: 1.8% (39/2227) LG: 2.0% (7/353)	Measure Started in Jan 2019 *thus no FY 2019 Baseline	3.2% (Joint Commission Benchmark)	
ED THROUGHPUT					
ED-2b Admit Decision Time to ED Departure Time for Admitted Patients (lower = better) *Latest Data Month:* *FEBRUARY 2020*	ENT: 78 mins MV: 95 mins LG: 34 mins	ENT: 77 mins MV: 84 mins LG: 50 mins	ENT: 98 mins MV: 103 mins LG: 84 mins	< 30 mins (CMS Standard of Excellence - Top 10% of Hospitals)	
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) *Latest Data Month:* *FEBRUARY 2020*	ENT: 165 mins MV: 168 mins LG: 131 mins	ENT: 166 mins MV: 177 mins LG: 118 mins	ENT: 182 mins MV: 199 mins LG: 132 mins	< 90 mins (CMS Standard of Excellence - Top 10% of Hospitals)	
OUTPATIENT MEASURES					
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke *Latest Data Month:* *FEBRUARY 2020*	100.0% (1/1)	77.8% (7/9)	66.7% (4/6)	100% (CMS Standard of Excellence - Top 10% of Hospitals)	

Comments	Definition	Definition Owner	Work Group	Source
Patients assessed and given influenza vaccination. Target goal is 100% CMS retired IMM2 beginning January 2019 discharges and is only collected by TJC for BHS HBIPS. Follow through of Influenza immunization nursing process i.e. documentation between October 1 and March 31 whether patient received or refused an influenza immunization. Included BPA in ordering flu vaccine and scheduled it for administration during hospitalization prior to discharge.	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%. Reports were created and shared monthly to BHS leadership to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. Education efforts targeted to remind providers that even if they prescribed antipsychotic (e.g. Abilify) to treat depression, it's stil counted as antipsychotic. Also not to bypass or work-around the hardwired discharge documentation of reason for 2 or more antipsychotics by answering NO.	Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
Target goal is 80% Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention. There is a current project focused on this measure since there is a significant drop in our performance rate.Fallouts sent to BHS team for further review and education to providers. iCare modified tobacco order set to increase compliance. Perfect Care-TOB comprises the following: TOB-1 Tobacco Use Screening 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 Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of FDA approved tobacco cessation drugs while inpatient and upon discharge	No tob 1 , same Tob 2 and 3	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
Target goal is 80% Perfect Care-SUB comprises the following: SUB-1 Alcohol Use Screening 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 Brief intervention on Unhealthy Alcohol use was added to education documentation. Patients are referred to facilities that are able to address issues with alcohol and drug use disorder.	No Sub 1, same SUB 2 and 3	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**

Comments	Definition	Definition Owner	Work Group	Source
Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% The value of integrated care is the main focus of this measure Transition Record improved significantly August 2019 is 94% r/t recent focus on Advanced Directive and also BHS team invited charge nurses, admin assistant and front life staff to the quarterly meetings.	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
Timely Transmission of Transition Record- Target goal is 75%. When TR is not complete the case not only fails TR1 but also an automatic fail of TR2 measure. Most fallouts are related to patients not having their own PCP. The education is focused on transmitting the TR to the next provider whether it's the patient's pcp or not.	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75% Fallouts r/t mising Blood glucose- documentation that the patient fasted prior to the test is required. If there is no documentation that the patient fasted, that test cannot be used for this data element.	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**
ECH is at below ECH-defined goals for both hours of physical restraint and seclusion use. Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**

Comments	Definition	Definition Owner	Work Group	Source
ECH is at below ECH-defined goals for both hours of physical restraint and seclusion use. Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**IBM CareDiscovery Quality Measures**

PROPOSED **QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE**

FY21 Pacing Plan

FY2021 Q1		
JULY 2020	**AUGUST 3, 2020**	**SEPTEMBER 8, 2020**
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 21 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals** ▪ **FY21 Pacing Plan** ▪ **Med Staff Quality Council Minutes (Closed Session)** ▪ **QC Follow-up Items** ▪ **Hospital Update**	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items 1. Q4 FY20 Quarterly Quality and Safety Review 2. Quarterly Board Dashboard Review 3. PSI Report 4. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda items: 6. Recommend FY21 Organizational Goal Metrics 7. Annual Patient Safety Report 8. FY20 Quality Dashboard Final Results 9. Pt. Experience (HCAHPS) 10. Progress on Quality and Safety Plan
FY2021 Q2		
OCTOBER 5, 2020	**NOVEMBER 2, 2020**	**DECEMBER 7, 2020**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items: 6. Report on Medical Staff Peer Review Process 7. FY21 Org. Goal and Quality Dashboard Metrics 8. FY20 Organizational Goal Achievement (Quality, Safety, HCAHPS) (If needed)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items: 6. Safety Report for the Environment of Care 7. Q1 FY21 Quarterly Quality and Safety Review 8. Quarterly Board Dashboard Review 9. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda items: 6. Readmission Dashboard 7. PSI Report 8. Progress on Quality and Safety Plan

PROPOSED **QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE**

FY21 Pacing Plan

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

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: May 4, 2020
Subject: Board Quality and Safety Dashboard

Purpose: Review proposed methodology for setting goals for FY21

Summary:

1. Situation: The Quality Committee reviewed and recommended to the Board a set of quality, safety, and experience goals for FY21. These were subsequently approved by the Board. The Quality Committee requested that management return with the methodology to be used to set the targets for the metrics to be used for the goals.

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

3. Background: There is a natural lag in producing the metrics for some of the organizational goals and new baselines must be determined for new goals. Since the targets for the FY21 goals cannot be finalized until the FY20 baselines are available, the initial interim step traditionally has been to review and adopt the methodology for determining the actual goal metrics to be applied to the baselines when available.

4. Assessment: The methodology for determining the four selected FY21 quality, safety, and experience goals have been prepared for review by the committee.

5. Other Reviews: None

6. Outcomes: The Quality Committee will review and recommend adoption of the proposed methodology.

List of Attachments: Power Point illustrating the methodology

Suggested Committee Discussion Questions:

1. Is this methodology understandable and acceptable?

El Camino Health

FY21 Quality/Safety and Experience Goals

Mark Adams MD CMO
Cheryl Reinking RN CNO
May 4, 2020

FY21 Organizational Goals

The Quality Committee approved a recommendation to the Board to adopt the following FY21 organizational goals:

- Reduction of SSER (serious safety event rate)
- Reduction of readmission index
- Improvement in HEDIS composite score
- Improvement in LTR (likelihood to recommend)

The next step now is to review the methodology proposed to determine the targets/goals

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; baseline TBD with at least 6 months of SSE classification
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