El Camino Health

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

Monday, November 2, 2020 – 5:30pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

1-669-900-9128, MEETING CODE: 760-083-0558#. No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (10/05/2020) *Information* b. Progress Against FY21 Committee Goals c. FY21 Enterprise Quality Dashboard d. Hospital Update e. Report on Board Actions f. Quality Committee Follow-Up Tracking g. CDI Dashboard h. Core Measures i. Article of Interest			
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:39**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**discussion 5:39 – 5:44**
6.	**QUARTERLY BOARD DASHBOARD REVIEW** **ATTACHMENT 6**	Mark Adams, MD, CMO		**discussion 5:44 – 6:04**
7.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT** **ATTACHMENT 7**	Bruce Harrison, President, SVMD/ Mark Adams, MD, CMO		**discussion 6:04 – 6:34**
8.	**SAFETY REPORT FOR THE ENVIRONMENT OF CARE** **ATTACHMENT 8**	Ken King, CASO		**discussion 6:34 – 6:44**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:44 – 6:47**

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:47 – 6:48**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:48 – 6:49**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (10/05/2020) ***Information*** b. Quality Council Minutes	Julie Kliger, Quality Committee Chair		**motion required 6:49 – 6:50**
13.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:50 – 7:00**
14.	*Health and Safety Code Section 32155* **Q1 FY21 QUARTERLY QUALITY AND SAFETY REVIEW**	Mark Adams, MD, CMO		**discussion 7:00 – 7:15**
15.	*Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:* - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**discussion 7:15 – 7:20**
16.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:20 – 7:21**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:21 – 7:22**
18.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:22 – 7:27**
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:27 – 7:28**

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, October 5, 2020
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	**Members Absent**
Julie Kliger, Chair**	
George O. Ting, MD, Vice Chair**	
Alyson Falwell**	
Melora Simon**	
Krutica Sharma, MD**	
Jack Po, MD**	
Terrigal Burn, MD**	
Michael Kan, MD	
Apurva Marfatia, 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. Michael Kan, MD and Apurva Marfatia, MD attended the meeting in person. All other members were present and participated telephonically. Dr. Marfatia periodically left the meeting to attend to patient care. 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. None were noted. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (09/08/2020); For information: Progress Against FY21 Committee Goals, Hospital Update, Report on Board Actions, and Quality Committee Follow up Tracking. **Movant:** Po **Second:** Burn **Ayes:** Burn, Falwell, Kan, Kliger, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Marfatia **Recused:** None	*Consent Calendar approved*
4. CHAIR'S REPORT	Chair Kliger reported that there is a strong interest from this committee and the board to dig deeper into strategy. Chair Kliger stated that instead of reviewing presentations in the packet, the committee and management can better use meeting time for feedback and input to provide guidance for the executives. She stated that the organization has advanced from where the committee was two years ago and the level of conversations and issues that are being discussed. Nevertheless, the board still requests more information since most of the board members are not clinicians.	
5. PATIENT STORY	Cheryl Reinking, RN, CNO, presented a Patient Story. She stated that this is not a letter but rather a comment that came through Press Ganey from a survey	

	that was sent. She noted that comments received usually aren't this long and she thought it was good for the committee to hear about the nice long comment of an experience of a new mom and how the nurses treated her. Ms. Reinking highlighted three nurses that were kind and compassionate. The patient had complications during her birth and highlighted how the entire team mobilized to provide their attention to her.	
	In response to committee members' question, Ms. Reinking stated that every comment that the organization gets from Press Ganey is read by the nurse leaders and posted in the break room for all employees to see. The recognition is ongoing for nurses and other staff. Ms. Reinking also stated that, to enhance the pre-delivery education that is required, the staff starts from the very beginning before the moms even come to the hospital. Due to the pandemic, all pre-delivery education is done through Zoom.	
6.	**FY21 ORG. GOAL AND QUALITY DASHBOARD METRICS**	Mark Adams, MD, CMO, presented the FY21 Org. Goal and Quality Dashboard Metrics. Dr. Adams stated that this dashboard highlights only high priority measures that management looks at throughout the enterprise at all levels. However, they are not the only metrics being looked at. There were 13 measures in FY20 and management has adjusted that to 12 for FY21. Dr. Adams asked if any Committee members had any questions, concerns, or suggestions. In response to committee members' questions, Dr. Adams confirmed that it would be possible for a metric to be added back. The trigger for putting back a metric would be having a negative trend over several months. Dr. Adams also stated that for the elective surgeries, for them to have to be approved by the Chiefs of Staff, the moms would need to be less than 30 weeks and have detrimental effects on the newborn if surgery isn't done. He confirmed that C-sections aren't approved or disapproved by the Chiefs of Staff. Dr. Po suggested to set limits on when to put the metric back on the dashboard. Ms. Simon requested metrics for staff COVID-19 infections that come from the community or infections that come from the patients.	
7.	**FY20 ORG. GOAL ACHIEVEMENT (QUALITY, SAFETY, HCAHPS)**	Mark Adams, MD, CMO, presented the FY20 Org. Goal Achievement (Quality, Safety, HCAHPS). He stated the materials presented in the packet are the recalibration measurements. Because of the recalibrations of the Target, the Stretch was also recalibrated. The changes were in the Quality and Safety and Service sections. **Motion:** To recommend approval of the FY20 Org. Goal Achievement (Quality, Safety, HCAHPS). **Movant:** Po **Second:** Kan **Ayes:** Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
8.	**HEALTH EQUITY**	Mark Adams, MD, CMO, gave a presentation on Health Equity. He explained that Health Equity is providing equitable care and quality of care and looking into demographics surrounding the organization. He stated when looking at Santa Clara County, it has the fifth highest median household income in the	

	United States. Demographics would also be much different than other parts of the country. He requested comments, concerns, and suggestions from the Committee members. In response to committee members' questions, Dr. Adams stated that there is still a language barrier that hinders quality of care at El Camino Hospital. He also questioned how the hospital can lead, assist, or partner with others in relation to where patients go to get their healthcare needs met. There are twice as many people going outside of the District than the people going within the District. Dr. Adams also stated that the data for race, gender, etc. could come from many sources. One of the difficulties in tracking these numbers is due to the fact that there is a growing number of people refusing to identify race and/or gender. There is also a growing number of mixed race individuals in the community. Dr. Ting raised a concern about being biased against some populations being only narrowed down to race and gender. He state there are other options that can be explored such as obesity, mental health, etc. as the only thing presented were race and gender.	
9. **PUBLIC COMMUNICATION**	There was no public communication.	
10. **ADJOURN TO CLOSED SESSION**	**Motion:** To adjourn to closed session at 6:48pm. **Movant:** Ting **Second:** Sharma **Ayes:** Burn, Falwell, Kan, Kliger, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Marfatia **Recused:** None	*Adjourned to closed session at 6:48pm*
11. **AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT**	Open session was reconvened at 7:08pm. Agenda items 11-15 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (09/08/2020), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
12. **AGENDA ITEM 17: CLOSING WRAP UP**	There were no closing comments. Chair Kliger requested the pacing plan be revised to add systematic approach to triggers for adding back in metrics for review in November and Health Equity in February.	
13. **AGENDA ITEM 18: ADJOURNMENT**	**Motion:** To adjourn at 7:11pm. **Movant:** Burn **Second:** Simon **Ayes:** Burn, Falwell, Kan, Kliger, Po, Sharma, Simon, Ting **Noes:** None **Abstentions:** None **Absent:** Marfatia **Recused:** None	*Meeting adjourned at 7:11pm*

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

_____
Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Yurike Arifin

FY21 COMMITTEE GOALS
Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

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

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

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

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2020 (unless otherwise specified)

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of *available* data)	Rolling 12 Month Average
		Latest month	FYTD				
1	***Organizational Goal** **Readmission Index (All Patient All Cause Readmit)** *Observed/Expected* *Premier Standard Risk Calculation Mode* ******Latest data month: August 2020*	0.91 (7.17%/7.88%)	0.89 (7.10%/7.99%)	0.96	0.93		
2	***Organizational Goal** **Serious Safety Event Rate (SSER)** **# of events** ******Latest data month: August 2020*	6	11	4.28	4.0		
3	*** Strategic Goal** **Mortality Index** *Observed/Expected* *Premier Standard Risk Calculation Mode* *Latest data month: September 2020*	0.90 (1.68%/1.86%)	0.75 (1.41%/1.89%)	0.74	0.76		
4	***Organizational Goal** **IP Enterprise - HCAHPS Likelihood to Recommend** Top Box Rating of 'Always' % , Unadjusted *Latest data month: September 2020*	81.3	80.7	83.1	83.6		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. **Readmission Index - All Patient All Cause Readmit (Observed/Expected)**	ECH observed a higher number of readmissions in August (95) when compared to July (84). The Weekly Readmissions Team also noted an increase in August readmisisions due to refusal of palliative care in 7 cancer patients at end of life. These patients will be readmitted for symptom management that is not controlled at home and until they expire.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). Includes Inpatient and Psych patients. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)	The # of Serious Safety Events in July and August are related to the increase in Surgical Site Infections (which by definitioin are SSEs). ECH has 5 SSEs in July of which 4 were SSIs, 6 in August of which 5 were SSEs. See the comments under metric #8 for more details. The remaining SSE involved a hypoglycimic event and was reported to CDPH.	Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI**
3. Mortality Index (Observed/Expected)	One reason for this increase in this index is the reduction in the expected mortality in September @ 1.89. In August, physician documentaiton of the severity of illness in the mortallity was very high at 2.14 . There were also more deaths in September (29) as compared to August (24).	Catherine Carson	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
4. Inpatient - HCAHPS Likelihood to Recommend Top Box Rating of 'Always' % , Unadjusted	Inpatient Total – Incentive Goal that includes Inpatient and MBU – 80.7 against a target of 83.6 This metric saw an increase in the month of September from the previous month but is still below the yearly target. The lack of visitation policy due to Covid-19 is driving this metric. Increased leader and nurse leader rounding and the roll out of our WeCare Behavioral Standards will help improve this metric.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**

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| | | Enterprise Quality, Safety, and Experience Dashboard | | | | |
| | | **September 2020** (unless otherwise specified) | | | | |
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El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2020 (unless otherwise specified)

Month to Board Quality Committee:

November, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of available data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	*** Organizational Goal** **ED Likelihood to Recommend** Top Box Rating of 'Always' %, Unadjusted *Latest data month: September 2020*	75.9	73.9	75.7	78.2		
6	*** Organizational Goal** **ECHMN** (El Camino Health Medical Network)**: Likelihood to Recommend** Top Box Rating of 'Always' %, Unadjusted *Latest data month: September 2020*	74.1	76.2	73.2	75.7		
7	*Hospital Acquired Infections* *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: September 2020*	0.00 (0/8329)	1.60 (4/24957)	1.46	<= 1.46		
8	**Organizational Goal** **Surgical Site Infections (SSI)- Enterprise** SSI Rate = Number of SSI / Total surgical procedures x 100 *Latest data month: September 2020*	0.18 (1/550)	0.56 (10/1779)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
5. ED - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	ED- Incentive Goal 73.9 against a target of 78.2 Both Mountain View and Los Gatos are below our FY21 target despite an increase in the metric over the last 12 months. The lack of visitation, which is contributing to communications issues is being reviewed as this is a concern with our patients and families. Increased text options as well as a new revised visitor policy will help in the future.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
6. ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	8. SVMD –incentive goal 76.2 against a target of 75.7 Our SVMD Clinics are above target for Q1 FY21. We are currently focusing on the WeCare Rollout for SVMD which will occur for both leaders, staff and physicians in mid-November.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
7. Hospital Acquired Infection- C. Diff (Clostridium Difficile Infection)	No C.Difficile infections in the month of September!	Catherine Carson/Catherine Nalesnik	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN database - Inf. Control**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1 new SSI in MB in September; pt with robotic laparoscoic distal pacreatectomy developed abdominal abscess. October Quality Council briefed on increase of SSIS to 10 in 1st qtr of FY21. SSI taskforce reformed; OR managers/directors/educators met to develop an action plan to address issue with causal organisms, all but 1 are skin flora. OR action plan focusing on Handwashing, traffic in/out of Operating rooms, and audit/observaiton of surgical scrubs by nursing, physicains, techs and PA/NPs to begin in November. OB and Cath Lab to be included as 3 SSIs were involving Hysterectomies and Pacermaker insertion.	Catherine Carson/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average .Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**

Enterprise Quality, Safety, and Experience Dashboard

September 2020 (unless otherwise specified)

Month to Board Quality Committee:
November, 2020

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of available data)*	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: September 2020*	0.93 (11.71%/12.55%)	0.76 (8.43%/11.04%)	0.98	0.90	UCL: 1.65; Target: 0.90; LCL: 0.50	Sepsis O/E Rolling 12 month average; FY21 Target
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** *(lower is better)* ****Latest data month: August 2020**	MV: 0.00% (0/21) LG: 11.1% (1/9) ENT: 3.33% (1/30)	MV: 0.00% (0/39) LG: 0.0% (1/18) ENT: 1.75% (1/57)	MV: 1.47% (5/341) LG: 0.00% (0/48) ENT: 1.29% (5/389)	1.3%	UCL: 4.39%; LCL: 0.00%; Target: <1.3%	PC-01 rolling 12 months average; FY21 Target
11	**PC-02: Cesarean Birth** *(lower is better)* ****Latest data month: August 2020**	MV: 31.3% (47/150) LG: 31.7% (13/41) ENT: 31.4% (60/191)	MV: 30.7% (43/140) LG: 20.00% (0/22) ENT: 29.18% (103/353)	MV: 24.74% (412/1665) LG: 18.97% (48/253) ENT: 23.98% (460/1918)	23.5%	UCL: 33.6%; LCL: 15.87%; Target: <23.5%	PC-02 rolling 12 months average; FY21 Target
12	****Strategic Goal* Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Latest data month: September 2020*	MV: 271 min LG: 226 min Ent: 249 min	MV: 279 min LG: 231 min Ent: 255 min	MV: 304 min LG: 263 min Ent: 284 min	MV: 263 min LG: 227 min Ent: 245 min	UCL: 351; Target: 245; LCL: 210	ED Throughput rolling 12m avg for MV; ED Throughput rolling 12m avg for LG; ED Throughput rolling 12m avg Enterprise; FY21 Target

** updated up tp August

Report updated: 10/27/20

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
9. Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Though increased, Sepsis mortality index remains below the target. All mortalities are reievwed for bundle failures, for serioius safety events and may also be sent to Peer review.	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	All scheduled cases are reviewed proactively. Data is also reviewed retrospectively. o Olny one case of ealry elective delivery at LG with clear indicaiton for an early delivery in a patient with significant autoimmune disease and recent complication of oligohydramnios.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	New providers at LG. Service Line Leader and Medical Director are reviewing each case and sharing information with MCH medical staff.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput- Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns)	The Patient Throughput Value Stream for FY21 was kicked off with a 9 month scope of work focused on optimizing the Capacity Management Center and the entire patient throughput journey, from ED exit to ECH exit.To address Enterprise admit order to ED departure first set of work is focused on the patient Handoff and Transport process. We have posted positions for full-time Patient Flow Coordinators and the CMC is functional. Track and Status boards are up and optimized. The electronic SBAR handoff tool for ED transfers went live on 10/20/20. his change eliminates the need for a voice to voice transfer between the ED and the accepting floor RN, and removes the barrier of the RN's playing phone tag while helping to reduce the patient wait time in the ED. The entire nursing leadership team has been supporting the go-live, and all RN's have been trained and are starting this new handoff process. We are collecting feedback to optimize and stabilize the process throughout November.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

El Camino Health

Quality and Safety

El Camino Health (ECH) nursing teams are focusing on sustaining improvement in two hospital-acquired infections, Catheter Associated Urinary Tract Infections (CAUTI) and Central Line Associated Blood Stream Infections (CLABSI). We measure this in different ways. However, to show sustained improvement, we use days since last infections. We implemented many nursing interventions including following a nurse driven urinary catheter removal protocol, enhanced perineal care, and daily removal prompts for both central lines and urinary catheters in iCare to prevent these hospital-acquired infections and have made significant progress.

CAUTI:
MV: 256 days since last CAUTI
LG: 122 days since last CAUTI

CLABSI:
MV: 254 days since last CLABSI
LG: 1,445 days since last CLABSI

Operations

The Quest dual diagnosis intensive outpatient program started at the beginning of October 2020. The program is designed for adolescents ages 13-18 that are still in high school and have an identified substance use problem or other habitual problem behaviors such as excessive screen use or video gaming. Youth in this program are also experiencing symptoms of a co-occurring mental health condition. This program addresses an unmet need in our community by providing a treatment option that was previously unavailable in our region. The services provided will engage youth in identifying healthy new coping skills, the development of safe peer relationships, and a focus on healthy family interactions with Saturday dedicated as a family involvement day.

ECH has achieved Magnet Designation, which is the highest and most prestigious credential for nursing excellence and quality patient care that an organization can receive, three times. As I reported last month, our virtual "site visit" for our fourth Magnet Designation is scheduled for November 10-12, 2020. Three expert nurse appraisers will complete a comprehensive review via Zoom of our nursing division to validate, verify, and amplify all of the written information we submitted to the American Nurses Credentialing Center (ANCC). The appraisers will visit units to hear directly from nurses providing patient care to validate the excellent practice environment that exists

at ECH. The appraisers will also visit with other members of the hospital staff and community who interact with nurses to provide feedback on interactions. We are grateful to Board members Gary Kalbach and Julie Kliger for agreeing to participate in this important process by joining the executive team in welcoming the appraisers on the first day. The Magnet Commission will vote on the final outcome in December 2020 or January 2021.

Our Clinical Research program has 7 active studies and 20 more in the pipeline. ECH is the second site in the world to open the Phase I COVID-19 Clinical Trial with Pfizer that includes an ascending (24-hr part 1) and extended (120-hr part 2) intravenous infusion of an investigational drug for patients with mild to moderate COVID-19. We are also partnering in a Phase I study with Gilead for an outpatient COVID-19 treatment using an inhalable version of Remdesivir

Workforce

We initiated our company-wide employee pulse surveys on September 30th. These surveys have four questions in the domains of quality, safety, collaboration and leadership. We have two additional pulse surveys planned throughout the year as well as the full annual survey in May 2021. We will follow up in specific departments as indicated by the results and continuously re-evaluate the frequency of the surveys throughout the year.

Financial Services

As previously reported, ECH received a $76.2M loan in April 2020 as part of the Medicare Accelerated and Advance Payment Program for future Medicare volume that was included in the CARES Act. When the Act was passed, loans were to be recouped by Medicare starting 120 days after receipt. However, on September 30, 2020, the President signed a bipartisan bill that extends the recoup period from the initial 120 days to one year after the loan was issued. The recoupment rate will be lowered from its current 100% level to 25% for the first 11 months of repayment, and 50% for the six months afterward. Hospitals will have 29 months after payments to begin to pay back the funds in full before interest will begin to accrue. The interest rate will be lowered from the current 9.6% to 4.0%.

El Camino Health Medical Network

Because Santa Clara County terminated the lease for our Morgan Hill clinic location, we moved to a new temporary location in a medical office building on Juan Hernandez Drive. Our new suite is under construction in the same building and will open by March 2021.

Our hospitalist and intensivist agreement with Santa Clara County, O'Connor and St. Louise Hospitals terminated September 30th. The County entered into a contract with Vituity to provide these services for those hospitals. ECHMN's hospitalists will begin at ECH's Los Gatos Hospital on October 1st. Our intensivists will join the El Camino intensivist call schedule and they will also provide services at O'Connor Hospital through a short-term contract ECHMN entered into with Vituity.

Dr. Angela Pollard, an established ob/gyn on the El Camino Medical staff, will join our medical network in October. Dr. Pollard will join the practice of Dr. Mary Kilkenny in Campbell, who joined in July.

Information Services

Epic awarded ECH $185,000 for achieving Cum Laude in Epic's Honor Roll Program, which reflects our devotion to excellence and our commitment to distinguishing our organization as a leader in patient care and best practices in the use of the EMR. We also received CHIME's "Most Wired" designation for the fourth year in a row. In 2020 we increased from Level 8 to Level 9, receiving the Performance Excellence Award. The program's mission is to elevate the health and care of communities around the world by encouraging the optimal use of information technology while driving change in the industry.

MyChart adoption continues to rise with 52% of active ECHMN patients enrolled. MyChart Bedside is now live at our Mountain View campus on 7 of 10 inpatient units as well as in Labor and Delivery. Epic is now integrated with the Social Security Administration, which improves the patient experience by expediting patient disability approvals from 30 - 60 days to 24 – 48 hours.

COVID-19 Testing

ECH continues to provide testing through the El Camino Healthcare District Community COVID-19 Testing Program. Over 6000 tests have been administered at sites throughout the District including our Mountain View campus, public school sites and downtown retail locations. We are investigating including students in addition to school employees at public school sites. Capacity at the Mountain View campus is 100 tests per day and 200 tests per day at the pop-up sites. We continue to bill insurance, but use District funds where insurance is not available.

In addition to supporting the District Program, ECH will begin administering a no-cost testing program at sites in the Los Gatos area. With the support of the Community Benefit Advisory Council, $50,000 has been authorized for this initiative.

El Camino Health

Corporate and Community Health Services

CONCERN's website has a new contemporary look and feel consistent with current disruptors in the industry. At the request customers, our culturally competent mental health professionals are providing consultation on diversity, equity and inclusion.

The South Asian Heart Center hosted talks for the South Asian Senior Association and VITI Engineering group on "A Lifetime on Meds or a Lifestyle of MEDS," completed two MEDS Lifestyle virtual workshops with Juniper Networks and hosted and evening huddle with Dr. Palaniappan whose work specifically seeks to address the gap in knowledge of health in Asian subgroups and other understudied racial/ethnic minorities.

The Chinese Health Initiative launched monthly Ask-a-Doctor webinar. This month's session was conducted by Dermatologist Lillian Soohoo on "Skincare during COVID-19." We also launched a webinar series on Emotional Health & Resilience Education with Dr. Lee, a Clinical Psychologist and began two 8-week Qigong classes to promote physical activity and mind-body alignment.

Marketing and Communications

The recovery brand advertising campaign, Return to Health, continues to perform well. Since its launch in April 2020, we have had almost 59,000 page views. Our campaign to inform consumers that ECH offers primary care services through ECHMN just concluded in the market. The campaign targeted three different consumer segments: 25-34 year olds, 35-63 year olds and ages 64+.

Our search engine marketing campaigns and social media campaigns across Google and Facebook continue to drive visibility of services, supporting recovery efforts, and highlighting safety practices. Key areas include ASPIRE, Cancer Care, Cardiology, Emergency Care, Mother-Baby, Primary, Urgent, and Specialty Care.

We enhanced Find-a-Doctor profiles on the ECH website with residency labels and historical order of education. Star ratings have been added to over 85 physician profiles. We also added new video with the enterprise chair of the medicine department and five safe care videos narrated in Mandarin. We published three blog articles with healthy cooking recipes and when to choose the ER.

Some of the media coverage El Camino Health in September 2020:

- September 2, 2020 -- Los Altos Town Crier -- Local School Districts, Nonprofits Among El Camino Healthcare District Grantees
- September 16, 2020 -- Silicon Valley Business Journal -- Structures Awards: El Camino's New Mental Health Center Avoids Institutional Feel

- September 21, 2020 -- Healthcare Design -- PHOTO TOUR: Behavioral Health Center Taube Pavilion
- September 22, 2020 -- Medical Construction & Design -- New Facilities Add Behavioral Health, Multi-Disciplinary Services to Mountain View Community
- September 23, 2020 -- Mountain View Voice -- Downtown Mountain View Hosts Three Full Days of Free COVID-19 Testing
- September 25, 2020 -- Green Building and Design -- Design for Wellness Defies Stereotypes at This Behavioral Health Facility

For the month of September, El Camino Health proactively posted tweets, Facebook posts and LinkedIn posts on a range of topics including safe care, primary and urgent care, heart disease and mental health.

Government Relations

We are in compliance with the updated Health Officer Order of the County of Santa Clara issued on September 16, 2020 requiring COVID-19 testing by larger healthcare systems. The new testing Order amends the categories of patients to whom healthcare facilities must provide COVID-19 diagnostic testing, amends the timeframes by which healthcare facilities must provide testing as well as results, requires clear notice to patients regarding how to access testing through their healthcare provider, and requires healthcare facilities to ensure that accessing COVID-19 diagnostic testing is easy and straightforward. Santa Clara County elected officials and the County Emergency Operations Center remain pleased with El Camino Health's robust COVID-19 testing. ECH staff partnered with Supervisor Joe Simitian's office on a press release to help advertise the District Program's COVID-19 testing sites. Mountain View Mayor Margaret Abe-Koga praised El Camino Health for being one of the entities widely offering testing in her community during a September 16 press conference and Los Altos Mayor Jan Pepper praised El Camino Health's pop-up site in Downtown Los Altos during the same press conference.

Philanthropy

El Camino Health Foundation secured $304,397 in period 2 of fiscal year 2021, which is ten percent of goal for the year.

Auxiliary

I am pleased to report that we welcomed back a small group of our Auxiliary Escort Service to our Mountain View campus and the Front Desk and Outpatient Surgery Unit Services to our Los Gatos campus on Monday, September 28, 2020.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

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

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

Summary:

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

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

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

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECH Board	October 14, 2020	- Resolution Recognizing the El Camino Health Foundation for Establishing COVID-19 Relief Fund - FY21 Period 2 Financials - FY20 Financial Audit and Cash Balance and 403(b) Plan Audits - Quality Committee Report Including Credentials and Privileges Report - FY20 Organizational Performance Score - FY21 Readmissions Organizational Performance Goal Metrics - Neuro-Interventional Call Panel - Medical Director, Cardiac Rehabilitation

Report on Board Actions
November 2, 2020

Board/Committee	Meeting Date	Actions (Approvals unless otherwise noted)
ECHD Board	October 20, 2020	- FY20 Year End Consolidated Financials - FY20 Year End Community Benefit Report - ECHD Conflict of Interest Code - FY20 Year End ECHD Stand Alone Financials - FY20 Financial Audit - FY21 Period 2 Financials - Appointment of District Director George Ting as Chair of the ECH Board Member Election Ad Hoc Committee and as Liaison to the Community Benefit Advisory Council - Revisions to the ECHD Community Benefit Grants Policy (moves up timeline for notification to the public regarding grant funding cycle)
Executive Compensation Committee	September 22, 2020	- FY21 Executive Base Salaries - FY21 Executive Individual Goals - FY21 Executive Compensation Incentive Payouts
Compliance and Audit Committee	N/A	
Finance Committee	N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

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

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	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	5/4/2020
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	5/4/2020
12	Bring back Revised Board Level Quality Dashboard	4/6/2020	MA	on 5/4/20 Agenda	5/4/2020

To:	Quality Committee
From:	Catherine Carson, MPA, BSN, RN, CPHQ
	Sr. Director/Chief Quality Officer
Date:	November 2, 2020
Subject:	FY 2020 CDI KPI Dashboard for November Meeting

Recommendation(s): To approve this report.

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, in the setting of the metric goals and assesses productivity monthly.

3.   Assessment:
- Reviewing 88% of Medicare patients with goal increased in FY 21 from 85% to 88%
- All payor patients reviewed at 81%, the goal of 82%
- Physician Response Rate to CDI queries remains at 100%, with an agreement at 85%
- CDI query volume continues above goal at 41% of all reviewed accounts
- Slight reduction 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: N/A

Suggested Committee Discussion Questions: N/A

List of Attachments: FY 21 September CDI KPI Dashboard

El Camino Health

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

As of October 10, 2020			Baseline	FY21 Goal	Trend	Comments
CDI Coverage	Performance		FY2020	FY2021 goal		
1 **Medicare** *Source: iCare CDI Productivity report*	**September 2020** **506/445** **88%**	**FYTD** **88%**	**85%**	**88%**		In September, CDI team was impacted by some IT issues related to iCARE update and some unplanned LOAs. Nonetheless, Medicare review rate continue to remain consitently above 85%. The team managed to reduce backlog of reviews and queries thus, making the accounts readily available for reporting, coding and billing. Medicare 1 day LOS and patients admitted and discharge during the weekends represent the barrier for achieving review rates above 90%. The goal for the year is set up for 88% Medicare review coverage.
2 **All Payor** *Source: iCare CDI Productivity report*	**September 2020** **1062/866** **81%**	**FYTD** **82%**	**80%**	**82%**		Focus of review continues on all financial classes. It is directed towards all ECH population expected mortality and readmission optimization. For the past 2 FYs, CDI staff cosistently reviewed above 80% of all inpatinet adult, non-OBG patients. Despite reduced staff, required PTO reduction and IT issues, the team succeeded to mitigate any delays in the process.
Physician Response	Performance		FY2020	FY 2021 goal		
3 **Query Response Rate** *Source: iCare CDI Query report*	**September 2020** **100%**	**FYTD** **100%**	100%	100%		Agreement rate remains at 100% mainly due to strong adherence to Physicina Query policy, escalation protocols and robust physician engagement. The rate is the highest 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 and changes in electronic physician query process in iCare.
4 **Query Agree Rate** *Source: iCare CDI Query report*	**September 2020** **85%**	**FYTD** **83%**	83%	>85%		Agreement rate achieved for the first time the milestone of 83% for the year (FY2020). September noticed a slight decrease compared to all time high - July 2020, mainly due to changes in physicina query workflow implemented with May 2020 iCare upgrade and less than optimal communicated to the team. Work continues around hospitalist groups, service lines education/training on both campuses. Query Templates optimization efforts continue with addoption of Epic rich text editor and CMS transition to FY 2021, on October 1st.

Queries volume	Performance		FY2020	FY 2021 goal		

#		Performance		FY2020	FY 2021 goal	Chart	Notes
5	**Query volumes** *Source: iCare CDI Query report*	**September 2020** 353 **41**% of of all reviewed accounts	**FYTD Avg.** 360 **47**% of all reviewed accounts	Queries Avg. **348**	Query 40% of all reviewed accounts		Query volumes remain consistently strong due to a stabilization in the CDI staff turnaround and staff education continuing education around new query opportunities. Worh noting that despite increased number of queries placed, the response rate and agreement trends high. It denotes a high level of engagement and support from the medical staff.
6	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: Tableau CDI Dashboard* *Higher MCC/CC Capture Rate better reflects severity of population*	**Sep 2020** **MCC** 47% **CC** 27% **NCC** 26%	N/A	**Nat 80th%** **CMS 2018** MCC 48% CC 25% No CC 26%	**Nat 80th%** **CMS 2018**		The CC/MCC rate can impact Reimbursement, expected GMLOS, Mortality&Readmission Index and CMI in Medicare population. National 80th Percentile is computed by CMS (MedPAR claims) and published each Oct. Worht mentioning from May through Aug 2020 CC/MCC rate was the highest ever for the program. Mainly driven by less elective admission and higher census of severe patinets + COVID-19 cohort.
7	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Tableau CDI Dashboard* *Higher MCC/CC Capture Rate better reflects severity of population*	**Sep 2020** **MCC** 37% **CC** 31% **NCC** 32%	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 rate. For the last 5 months the overall CC/MCC combined rate was 72-75%, highest ever. Mainly driven by better documentaion of comorbidties by surgical staff but also driven by less elective cases and more complex procedures.
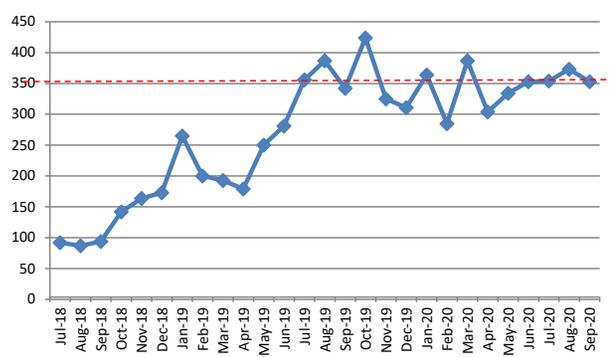
El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
              Sr. Director/Chief Quality Officer
Date: November 2, 2020
Subject: FY 2020 Core Measure Dashboard for November Meeting

Recommendation(s):   To approve this report.

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, Primary C/S rate below target of 24.8% @ 24%
      • Perinatal Babies: PC-05 Exclusive Breast Milk feeding improved to 71%. Only 2% unexpected newborn complications
      • ED Throughput measures continue higher than CMS benchmarks
      • HBIPS: Flu Immunization improved, Discharges on Multiple Antipsychotic medication are below benchmark, struggle continues with the all or nothing Tobacco use measure. Transition record, timely transmission of transition record is above benchmark and screening for metabolic disorders is below 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

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

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2020 Performance	Baseline FY 2019	Target	Trend Graph
PERINATAL CARE MOTHER					
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) *Latest Data Month: June 2020*	ENT: 0% (0/28) MV: 0% (0/26) LG: 0% (0/2)	ENT: 1% (5/389) MV: 1% (5/341) LG: 0% (0/48)	ENT: 1% (4/404) MV: 1% (4/360) LG: 0% (0/44)	1.8% (Joint Commission Benchmark)	
PC-02 Cesarean Birth (lower = better) *Latest Data Month: June 2020*	ENT: 24% (38/160) MV: 24% (33/135) LG: 20% (5/25)	ENT: 24% (461/1916) MV: 25% (414/1668) LG: 19% (47/248)	ENT: 25% (455/1827) MV: 26% (425/1617) LG: 14% (30/210)	24.8% (Joint Commission Benchmark)	
PERINATAL CARE BABIES					
PC-05 Exclusive Breast Milk Feeding *Latest Data Month: June 2020*	ENT: 71% (42/59) MV: 68% (32/47) LG: 83% (10/12)	ENT: 61% (470/768) MV: 58% (382/660) LG: 81% (88/108)	ENT: 64% (480/748) MV: 60% (386/643) LG: 90% (94/105)	>52% (Joint Commission Benchmark)	
PC-06 Unexpected Complications in Term Newborns (lower = better) *Latest Data Month: June 2020*	ENT: 2% (6/296) MV: 2% (6/248) LG: 0% (0/48)	ENT: 2% (64/3798) MV: 2% (51/3246) LG: 2% (13/552)	ENT: 1% (22/1733) MV: 1% (19/1485) LG: 1% (3/248)	<3% (Joint Commission Benchmark)	
ED THROUGHPUT					
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) *Latest Data Month: June 2020*	ENT: 189 mins MV: 199 mins LG: 153 mins	ENT: 168 mins MV: 182 mins LG: 127 mins	ENT: 185 mins MV: 199 mins LG: 124 mins	< 90 mins (CMS Standard of Excellence - Top 10% of Hospitals)	
OUTPATIENT MEASURES					

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2020 Performance	Baseline FY 2019	Target	Trend Graph
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke *Latest Data Month: June 2020*	No Case met the measure criteria	73% (8/11)	67% (4/6)	100% (CMS Standard of Excellence - Top 10% of Hospitals)	

Comments	FY 2019 Definition	Definition Owner	Work Group	Source
Patients assessed and given influenza vaccination. Target goal is 100%; FY 2019 rate is 92%. CMS retired IMM2 beginning January 2019 discharges and is only collected by TJC for HBIPS. Follow through of Influenza immunization nursing process i.e. documentation during flu season 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 MHAS team	IBM CareDiscovery Quality Measures
Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%; FY 2020 rate is 81% 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 MHAS team	IBM CareDiscovery Quality Measures
Target goal is 80% FY 2020 rate is 28%. 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 MHAS 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 MHAS team	IBM CareDiscovery Quality Measures
Target goal is 80% FY 2020 rate is 96% 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 MHAS team	IBM CareDiscovery Quality Measures

Comments	FY 2019 Definition	Definition Owner	Work Group	Source
Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% FY2020 rate is 88% 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 MHAS 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 MHAS team	IBM CareDiscovery Quality Measures
Timely Transmission of Transition Record- Target goal is 75%; FY2020 rate is 74% 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 MHAS 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%; FY2020 rate is 95% 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 MHAS team	IBM CareDiscovery Quality Measures
ECH is within 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 MHAS team	IBM CareDiscovery Quality Measures

Comments	FY 2019 Definition	Definition Owner	Work Group	Source
ECH is within 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 MHAS team	IBM CareDiscovery Quality Measures

The High-Performance Medical Group

From Aggregations of Employed Practices to an Integrated Clinical Enterprise

- In Search of Full Value
- An Integrated Identity
- Infrastructure for Shared Success
- Individual Behavior Aligned with Strategy

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Table of Contents

Available Within Your Health Care Advisory Board Membership

Over the past several years, the Health Care Advisory Board has developed numerous resources to assist members in addressing physician strategy. The most relevant resources are outlined on the right. All of these resources are available in unlimited quantities through the Health Care Advisory Board membership.

Strategic Guidance for Physician Alignment in an Era of Reform

The High-Performance Medical Group Toolkit (24104)
Resources for Building Physician Integration

The Accountable Physician Enterprise (21109)
Partnering with Physicians to Transform Care Delivery

Building the High-Performance Physician Network (20921)
Roadmap for Assessing and Implementing a Clinical Integration Strategy

Transforming Primary Care (21164)
Building a Sustainable Network for Comprehensive Care Delivery

Strategy-Aligned Physician Compensation Plans (17985)
Utilizing the Right Incentives to Improve Physician Alignment and Increase Doctor Satisfaction

To Order Via Advisory.com

To order copies of these and other Health Care Advisory Board presentations, please visit our website: www.advisory.com/hcab/publications

Tools to Support Delivery System Redesign

Accountable Care Readiness Diagnostic

This turnkey strategic planning tool assesses your organization's ability to prosper under emerging accountable payment models.

Medical Home Health Coach Practice Impact Calculator

This Excel-based tool calculates the return on investment from adding a dedicated diabetes health coach to primary care practices transitioning to a medical home model.

Clinical Integration Investment Calculator

This Excel-based tool is intended to aid organizations in assessing whether to pursue a CI strategy by calculating expected baseline investment costs in four key areas: information technology, program staffing, project development, and administrative expenses.

To Access Data and Analytic Tools

To access these and other Health Care Advisory Board tools, please visit our website: www.advisory.com/hcab/tools

Crimson Practice Management and Medical Group Strategy Council

In addition to the resources available through the Health Care Advisory Board membership, the Advisory Board Company offers two programs focused on physician practice performance: the Medical Group Strategy Council and Crimson Practice Management.

Crimson Practice Management arms practice leadership with the information needed to collaborate with providers to improve practice performance and increase demonstrable contribution to the health system.

The Medical Group Strategy Council offers concrete, replicable best practice research on employed medical group management.

Contact Us

For additional information on the **Medical Group Strategy Council** please visit our website http://www.advisory.com/Research/Medical-Group-Strategy-Council

For additional information on **Crimson Practice Management** please visit our website http://www.advisory.com/Technology/Crimson-Practice-Management

Elevate Medical Group Performance through Proven Best Practice Solutions

With physician employment on the rise, hospitals face no shortage of complex challenges. The Medical Group Strategy Council aims to be every practice management executive's one-stop shop for targeted direction and support against the critical challenges confronting physician practices—offering detailed best-practice profiles and implementation guides, opportunity assessments, analytical tools, and more.

Imperatives for Medical Group Success
✓ How can we develop an engaged and strategically aligned physician culture?
✓ Are we recruiting and retaining the correct providers?
✓ In light of our strategic priorities, how should we design our compensation plan?
✓ How we can we effectively communicate the value of the medical group to the broader organization?
✓ How should we structure practice governance and encourage physician leadership?

Collaborate with Physicians to Optimize Practice Performance

Building on the success of the Crimson platform, Crimson Practice Management leverages best-in-class analytics to deploy physician-centric methodology for sharing performance data in order to improve the direct performance of owned physician practices and to elevate their total contribution to the health system.

Focus on Opportunities with Maximum Impact

Maximize Practice Capacity
- Increase practice capacity with a comprehensive look across provider productivity, practice operations, patient access, mid-level provider utilization, and patient panel management. Improvements will yield mutual returns in physician compensation, practice bottom line, and health system contribution
- Research indicates that each additional practice visit generates approximately $480 in total health system revenue. Adding just one encounter per week per physician in a 50-provider practice quickly exceeds $1.2M

Prevent Revenue Leakage
- Alleviate physician anxiety stemming from a rise in the visibility of auditors by employing comprehensive coding reviews and benchmarks across E&M, procedural, and drug charges
- Appropriate coding can often yield more than $15,000 per physician annually without increasing audit risk

Increase Billing Office Performance
- Identify root causes of collections inefficiencies to accelerate and increase cash collections.
- Improve performance across all revenue cycle functions, including bad debt, A/R days and charge lag
- Adhering to point-of-service collections alone can yield more than $10,000 per physician annually

Advisors to Our Work

The Membership would like to express its deep gratitude to the individuals and organizations that shared their insights, analysis, and time with us. The research team would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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The High-Performance Medical Group

Study in 10 Conclusions

Seeking Full Value from the Employment Investment

1 **As Physician Employment Grows, Hands-Off Management Approach Falling Short**

Many hospitals and health systems are reaching a critical mass of employed physicians, but in continuing to manage practices as autonomous, loosely integrated units, are missing opportunities to realize full value from greater scale.

2 **"High-Performance Medical Groups" Capitalize on Cohesion**

Organizations that have fostered integration between physician practices offer an alternate model, leveraging the coordinated employed enterprise to achieve strong operational and clinical results.

3 **Group Success Due to Strategic, Not Structural, Factors**

Successful groups vary in structural factors such as size, market, or history, but share three defining characteristics: identity as a unified, physician-led network; infrastructure to enhance group performance; and incentives designed to engage individual physicians against group goals.

4 **Imperative to Begin the Integration Journey Now**

Although many medical groups have had decades to organize, systems today must accelerate integration to avoid falling behind amid rapid market changes; even those with just a few employed physicians can begin laying groundwork for group creation.

Attributes of the High-Performance Medical Group

5 **Common Physician Culture Undergirds All Group Activities**

A formal, physician-led commitment to common values drives group strategy and physician actions; while culture varies, all groups treat care as a team-based sport and assess physician value more broadly than the practice-level bottom line.

6 **Integrated Physician Team Key to Referral Retention, Care Coordination**

Culture-linked hiring and onboarding, combined with partnership-building activities, perpetuate group identity and foster an environment in which coordinated care and in-network referrals are the norm.

7 **Meaningful Decision-Making Authority Placed in Physician Hands**

Recognizing physician leadership as crucial to engagement of the rank-and-file, groups build comprehensive physician governance structures, invest in leadership development, and involve medical group leaders in system-level strategy-setting.

8 **Infrastructure Supports Collaborative Performance Improvement**

Full and open information transfer—via an enterprise-wide information network—promotes care coordination, enhances patient access, and drives formal improvement processes; additional tools deployed at scale allow physicians to optimize practice operations and clinical delivery.

9 **Transparency a Primary Tool for Motivating Physician Behavior**
Respecting physicians' natural skepticism, groups use open, two-way communication to win buy-in for strategic decisions, while also capitalizing on physicians' competitive tendencies by sharing (often unblinded) individual performance data to drive behavior change.

10 **Compensation Change Utilized Sparingly and Strategically**
Unlike hospitals that view compensation as the primary means of influencing physician behavior, high-performance groups turn to financial incentives only when other motivational levers fail—altering compensation primarily when the existing model becomes a legitimate barrier to change.

Failing to Capture Full Value from Rising Physician Employment

Fueled by demographic shifts within the physician workforce, declining reimbursement, and new imperatives for care delivery redesign, physician employment by hospitals and health systems is on a sharp upswing. Across the country, organizations report that their employed ranks have grown significantly as market forces push hospitals and physicians toward tighter alignment. As a result, many hospitals are rapidly approaching a critical mass of employed physicians across many specialties.

Yet even as the employed ranks swell, many hospitals continue to manage practices as standalone units. Still cognizant of practice losses in the 1990s, they have focused primarily on stabilizing practice solvency, mimicking the structure and incentives of private practice. In addition, hospitals have taken a hands-off approach to practice management in a belief that autonomy is attractive to physicians wary of hospital control.

In protecting practice silos, however, hospitals are failing to capture the potential benefits of growth in the employed ranks—an expanded referral network, enhanced patient access, operational economies of scale, opportunities to improve quality, and enhanced care coordination. As a result, many are seeking a new approach to practice management, one that enables them to leverage the employed enterprise as an integrated medical group.

Thwarted by Fragmentation, Unable to Make Bigger Mean Better

Confluence of Forces Sparking Sharp Employment Growth…

Market Share Protection

Evergreen need to fill critical coverage gaps, recruit for high-growth service lines, or lock in "splitter" physicians

Physician Instability

Demographic shifts, worsening financials, reform uncertainty leading to greater proactive physician interest in an employment relationship

Future Option Value

Looming reimbursement risk shift—requiring a tightly integrated physician base—giving employment a subtle edge as hospitals consider alignment options

…But Practice Silos Thwarting the Potential Benefits of Scale

Performance Metric	Potential Improvement with Larger Scale	Reason for Current Performance Gaps
Practice Finances	Achieve economies of scale, eliminate operational variation	Protection of practice firewalls inhibits consolidation, cost-sharing; considerable process variability remains
Referral Volumes	Capture more patients within loyal referral network	Inhibited by weak relationships between practices; many physicians do not know who else is employed
Patient Access	Leverage broad network to expand appointment availability	Few levers to win physician buy-in for disruptive access redesign; practice silos prevent sharing of mid-level providers
Care Reliability	Engage broad physician base against clinical quality and cost goals	Emphasis on individual productivity, lack of system affinity provide little incentive to focus on quality
System Efficiency	Provide full scope of services and coordinate care across provider types	Thwarted by emphasis on individual performance, weak peer relationships, lack of infrastructure

Source: Health Care Advisory Board interviews and analysis.

Defining the High-Performance Medical Group

A subset of organizations have taken an alternative approach to practice management, successfully managing employed physicians at scale. By fostering cohesion among practices, these "high-performance medical groups" have historically generated strong financial, clinical, and operational results.

Yet little guidance exists on what specific organizational attributes and practices make high-performance medical groups successful. To answer that question, the Health Care Advisory Board launched the High-Performance Medical Group Initiative.

Through this Initiative, we identified more than 25 medical groups that excelled on financial, clinical, and other strategic indicators and conducted in-depth conversations and site visits with these organizations in order to understand the sources of strong performance. This publication details the key findings from that research effort.

The groups profiled in this publication differ significantly on structural factors such as size, composition, or history. Yet all have something deeper in common, sharing the 15 core attributes listed on this page. These attributes, explored further in this publication, are the foundation of the groups' strong performance results.

Wide Variety on Surface Factors, But Set of Shared Strategies at Root

Areas of Variability Between High-Performing Groups

Size
Range from 200 physicians to 1,400

History
Age range from a few years to more than a century

Ownership
Mix of hospital-owned subsidiaries, independent groups, integrated delivery systems

Market Type
Mix of urban, suburban, semi-rural and rural

Payment Model
Range from pure fee-for-service to capitation

15 Attributes in Common

1 An Integrated Identity

Creating Common Culture

1. Shared Vision and Formalized Cultural Expectations
2. Unified Identity Projected to Non-Physician Stakeholders

Fostering the Partnership

3. Cultural Expectations Hardwired in Recruiting and Onboarding
4. Meaningful Interpersonal Relationships Between Physicians

Formalizing Physician Control

5. Centralized Physician-Led Governance Model
6. Frontline Physicians Active in Leadership
7. Investment in Broad-Based Physician Leadership
8. Strategic Alignment Between Health System and Group

2 Infrastructure for Shared Success

Extending Performance-Enhancing Tools

9. Enterprise-Wide Information Network
10. Formal Processes for Data-Driven Performance Improvement
11. Scaled Resources to Support Care Delivery

3 Individual Behavior Aligned with Strategy

Leveraging Transparency

12. Effective Bidirectional Communication Processes
13. Dissemination of Unblinded Physician Performance Data

Designing Strategy-Aligned Compensation

14. Compensation Narrowly Tailored to Advance Group Objectives
15. Staged Adoption of New Compensation Plans

Source: Health Care Advisory Board interviews and analysis.

Shifting from Aggregators to Integrators, Starting Today

This publication profiles mature medical groups, painting an aspirational picture of what a successful employed physician network may become. For many hospitals, building a similar high-performance group will require a significant investment of time and resources. The timeline here, which shows the typical progression of medical group development, describes the journey ahead.

While building an integrated medical group requires investment, the decision to forego or delay this journey may be equally costly. As the ranks of employed physicians grow, so do the risks of failing to capture full value from that investment. In the near term, those risks include missed opportunities for quality and cost improvement, revenue lost to out-of-network referrals, or strategically inappropriate acquisition offers. In the long term, failure to build an integrated partnership with employed physicians jeopardizes hospitals' ability to meet emerging standards for care coordination and management.

Although many successful medical groups have organized over decades, hospitals today must accelerate integration to avoid falling behind amid rapid market changes. Even those with just a few employed physicians can begin to build common culture and invest in network infrastructure. Ultimately, these steps lay the groundwork to create not just a high-performance medical group, but a high-performance health system.

Timeline for Constructing the High-Performance Medical Group

Laying the Foundation for Coordination

Capturing Early Returns from Integration

Leveraging the Enterprise for Care Redesign

Medical Group Integration

- Define and codify common culture
- Create communication protocols
- Build physician governance
- Invest in leadership training
- Begin to invest in common EMR
- Establish peer hiring, service standards
- Develop group dashboard
- Design onboarding program
- Share individual performance data
- Centralize referral scheduling
- Reward quality
- Establish access protocols
- Define clinical pathways
- Redesign primary care
- Deploy care management resources
- Reward coordination

Time

Source: Health Care Advisory Board interviews and analysis.

Essay: In Search of Full Value

Dramatically Increasing Physician Employment—Almost Overnight

Across the country, hospital employment of physicians is rising rapidly. From large health systems to small community hospitals, organizations are making significant investments in practice acquisitions. Even hospitals that divested practices in the 1990s are now actively re-engaged in employment strategy. As a result, a large number of hospitals and health systems have seen dramatic growth in their employed physician networks, with many doubling or tripling in size across just a few short years.

Across the Country, Practice Acquisitions on a Clear Upswing

- Five-hospital system
- 80 physicians employed by foundation, up from zero in 2008

- Two-hospital system
- 230 employed physicians, up from 25 in 2005

- Two-hospital system
- 800 employed physicians, up from 50 in 2008

- Three-hospital system
- 311 employed physicians, up from 70 in 2008

- 210-bed hospital
- 100 employed physicians by 2012, up from 21 in 2009

- Five-hospital system
- 260 employed physicians, up from 70 in 2008

> **Everything Old Is New Again**
>
> "We had a bad experience with employment in the 1990s and didn't think we'd do it again. But things change, and now employment's our primary alignment strategy. At this point, we're employing far more than we ever thought we would."
>
> *Chief Medical Officer*
> *Four-hospital health system in the Northwest*

Source: Health Care Advisory Board interviews and analysis.

Emerging Trends Exacerbating Traditional Employment Drivers

A confluence of forces is driving rapid employment growth today. First, hospitals are seeking to protect market share and secure coverage for critical service needs. These evergreen goals are largely responsible for a modest rise in employment activity across the last several years.

Two more recent forces, however, are now accelerating the employment trend. First is instability within the physician workforce, as demographic shifts, declining reimbursement, and uncertainty about the impact of health care reform lead independent practices to seek refuge with hospital partners.

At the same time, hospitals are increasingly recognizing that closer physician relationships will be critical as emerging payment models tie a greater portion of reimbursement to cost and quality improvement. As a result, many hospitals that may have once preferred less intensive alignment models are now opting for practice acquisition in preparation for meeting these new market imperatives.

The following pages look at these two forces in greater detail.

Physician, Payment Changes Adding Fuel to the Fire

Causes of Increased Physician Employment

Market Share Protection	**Physician Instability**	**Future Option Value**
Need to fill critical coverage gaps, recruit for high-growth service lines, or lock in "splitter" physicians	Demographic shifts, worsening financials, reform uncertainty leading to greater proactive physician interest in an employment relationship	Looming reimbursement risk shift—requiring a tightly integrated physician base—giving employment a subtle edge as hospitals consider alignment options

Traditional Drivers → *Today's Challenge* → *Tomorrow's Imperative*

Changing Demographics, Financial Woes Sparking Physicians' Search for Shelter

For physicians, several factors are creating a "perfect storm" of instability, leading them to question the viability of independent practice.

The first of these factors is the changing demographics of the physician workforce, as an aging, individualistic physician base is replaced by a new generation that highly values work-life balance and collaborative care. Younger physicians are thus seeking larger groups, leading to recruitment difficulties for many independent practices.

Second, many physicians are finding it increasingly difficult to maintain a solvent independent practice. Practice costs are rising rapidly, while reimbursement has stagnated or, in some cases, declined.

Finally, like hospitals, physicians are also recognizing that emerging payment models will require connection to a broader care network and large investments in care management and information technology infrastructure. To prepare for these changes, physicians are seeking to align with better-resourced partners.

As a result, a majority of hospital leaders report increased interest in employment among physicians across specialties. Notably, the highest employment interest is among cardiologists, who not coincidentally have seen recent threats to reimbursement for key sources of practice revenue, such as ancillary services.

Physicians of All Stripes Shifting Away from Private Practice

Changes in the Physician Marketplace

Demographic Shifts

- Large number of older physicians approaching retirement
- New generation placing greater premium on work-life balance, team-based care

Worsening Financials

- Key specialties (e.g. cardiology, oncology) confronting new reality of reimbursement cuts
- Practice costs rising faster than revenue

Reform Uncertainty

- Primary care physicians seeking well-capitalized partners to support investment in care coordination resources
- Specialists seeking tight network alignment to assuage fears of losing referral streams

Driving Increased Employment Interest

Hospital Leaders Reporting Increase in Employment Requests from Physicians

70%
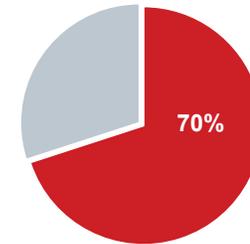
Interest in Hospital Employment by Specialty

Cardiology	OB/GYN	Primary Care	Emergency Medicine	Pediatrics	Anesthesiology
63%	50%	49%	48%	48%	48%
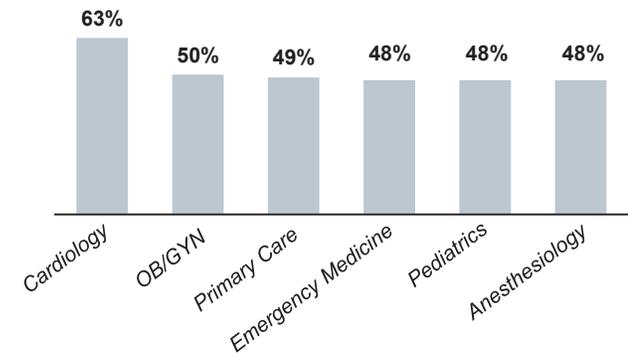
Source: Merritt Hawkins & Associates Survey of Final Year Medical Residents, 2008, 2011; "From Courtship to Marriage Part I: Why Health Reform is Driving Physicians and Hospitals Closer Together," PriceWaterhouseCoopers Health Research Institute, December 2010; Health Care Advisory Board interviews and analysis.

Hospitals and Health Systems Securing Option Value for the Future

With payment reform on the horizon, hospitals and health systems are also recognizing that tighter alignment with physicians will be critical to success for any reimbursement model that places providers at greater risk for patient outcomes. Deep physician alignment is imperative for emerging reimbursement structures such as bundled payments or shared-savings models, which require systems to maximize quality while reducing unnecessary utilization and closely managing expenses.

Only a handful of hospitals are proactively acquiring physicians for the express purpose of taking on population risk or competing as an accountable care organization. But for many more, even the looming possibility of a shift toward greater reimbursement risk seems to be influencing employment decisions. Hospitals that might previously have sought out less intensive alignment options now seem more willing to consider practice acquisition, if only for the option value of having physicians in place to build the care management enterprise when it is needed.

Physicians at the Center of a New Care Management Enterprise

Physician Contributions to Care Management Imperatives

Utilization

- Prevent unnecessary inpatient admissions
- Minimize inappropriate or duplicative care delivery
- Refer patients to most appropriate and efficient specialists, sites of care

Clinical Outcomes

- Minimize preventable readmissions
- Proactively manage chronic illness to prevent low-margin inpatient utilization
- Promote community wellness for at-risk populations

Expense Management

- Follow evidence-based care pathways
- Streamline costs through adherence to care standards
- Develop economies of scale across continuum for all growth service lines

Source: Health Care Advisory Board interviews and analysis.

Igniting an Arms Race for Physician Talent

In many markets, the forces driving employment—physician instability, shifting reimbursement, and the desire to protect market share—are combining to create combustible situations, where a single employment offer can start a chain reaction.

Consider pseudonymed Ramsdell Memorial Hospital, which received an employment request from a cardiology practice struggling to recruit physicians to replace two retiring partners. Seeking to protect the stability of its cardiovascular service line, Ramsdell made an acquisition offer. Shortly thereafter, the town's other four cardiology practices also requested similar offers. When Ramsdell's competitor responded with a more attractive acquisition package, Ramsdell was forced to increase its own offer or risk losing business. After an 18-month bidding war, all cardiologists in the market were employed.

Ramsdell's CEO noted that the sense of a "feeding frenzy" seems familiar to those who had a similar experience in the 1990s. Many hospitals feel they have no choice but to accelerate employment activity in order to protect their core business.

Markets Ripe for Tipping as Independent Providers Pick Sides

Other cardiologists learn of deal, seek out own employment offers

Ramsdell forced to sweeten own offer to avoid loss of cardiology market share

Bidding war cycle repeats with primary care physicians, orthopedic surgeons

February 2010

June 2011

Cardiology practice, struggling to recruit, approaches Ramsdell about employment

Competitor hospital targets cardiologists with more attractive employment deal

Other specialties hear of cardiology offers, seek deals of their own

Case in Brief: Ramsdell Memorial Hospital[1]

- 400-bed hospital, located in the Southeast
- Located in a two-hospital town
- Minimal employment experience prior to cardiology bidding war

A Feeding Frenzy

28 Number of independent cardiologists in market before bidding war

0 Number of independent cardiologists after

Reaching a Critical Mass—and Bringing Old Fears to the Fore

In the wake of rising acquisition activity, many hospitals today are employing large numbers of physicians across multiple specialties and service areas. Employed physicians represent a critical mass within the medical staff, in contrast to past years when employment was used more sparingly.

Rising employment has the potential to bring a greater number of physicians into strategic alignment with the hospital. Yet for many organizations, the rapid increase in practice acquisition mainly serves to magnify long-held concerns about employed physicians: that practice subsidies are too high, that the hospital is getting little additional downstream return for its investment, and that employed physicians are disconnected from system performance goals.

Growth Magnifies Longstanding Hospital Concerns About Employment

Yesterday's Model: Employing Sporadically
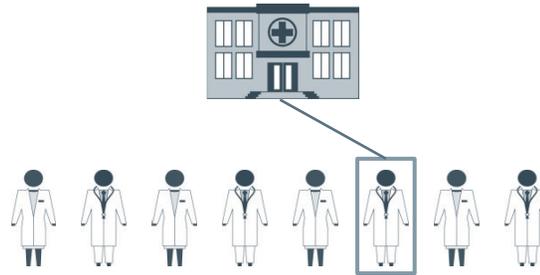
- Employment driven by one-off reactive decisions, such as need to fill coverage gaps, grow service lines
- Employed physicians represent small portion of medical staff, only a handful of specialties or geographic service areas

Today's Reality: Acquiring to Scale
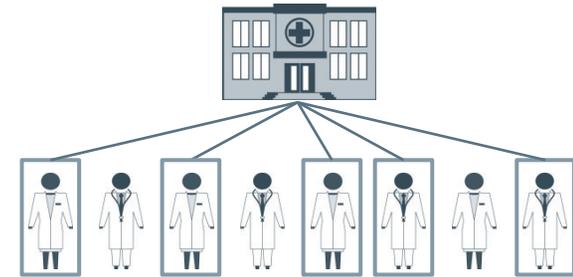
- Employment increasingly broad-based and far-reaching, driven by larger strategic goals
- Employed physicians represent growing portion of medical staff, cover multiple specialties and geographic service areas

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Common Hospital Concerns About Physician Employment

"A Drag on the Bottom Line"
Employed physicians perceived as a money-losing proposition, requiring considerable financial subsidy

"Paying for What We Already Get"
Hospitals failing to capture additional downstream revenue as physicians maintain old referral patterns even after acquisition

"Not Equal to Integration"
Physicians seen as uninterested in and unwilling to support system goals for care reliability, efficiency despite direct financial ties

Source: Health Care Advisory Board interviews and analysis.

Hands-Off Practice Management Approach Falling Increasingly Short

Despite concerns about physician employment, most hospitals have in fact succeeded at managing employed practices against the goals that, until recently, have seemed most important.

Across the past decade, hospitals' main objectives for physician employment have been two-fold: first, to minimize losses on individual practice financial performance, and second, to avoid antagonizing physicians wary of hospital control. Hospitals have successfully built management models to meet those objectives, improving the bottom line by mimicking the financial incentives of private practice and assuaging physician concerns by protecting individual physician autonomy and practice silos.

However, hospitals' success against these objectives may inhibit the realization of broader aims for the employed enterprise, such as growing market share and in-network referrals, recruiting a new generation of physicians interested in team-based care, or building processes to meet new imperatives for care reliability and efficiency.

Changing Market Demands Heightening Risk of Lost Opportunities

Traditional Employment Approach Maximizes Practice Autonomy…

Practice Management Tenet	Rationale
High premium on maintaining physician autonomy from larger system	Perceived as recruiting lever
Incentives to maximize individual productivity	Minimizes practice subsidy
Limited standardization of practice operations, clinical decisions, referral patterns	"Keeps the peace"—avoids antagonizing physicians wary of hospital control

…But Fails to Meet Evolving Goals for the Employed Enterprise
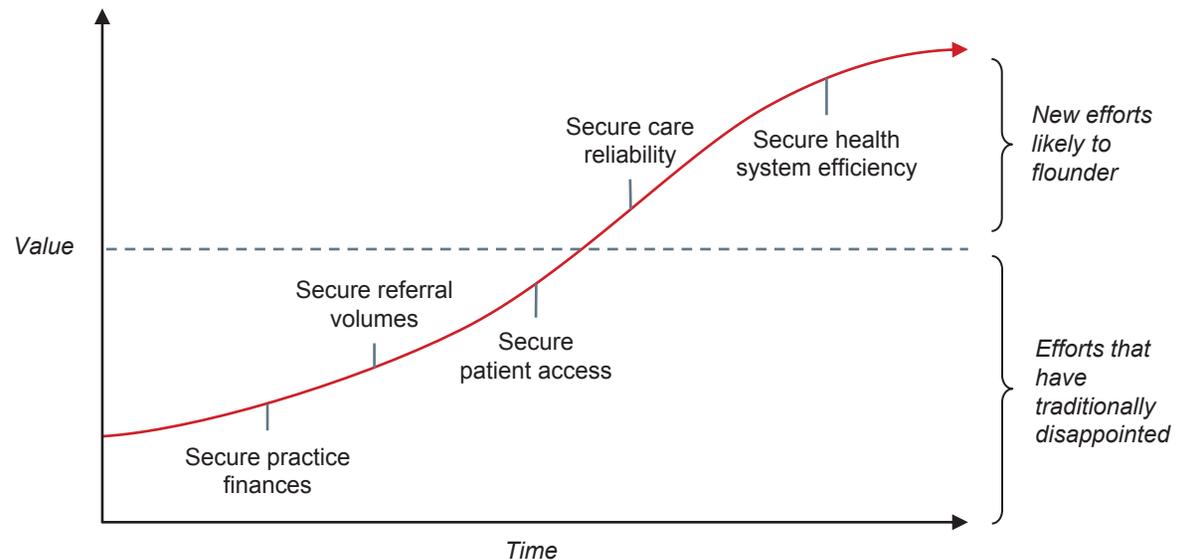
Source: Health Care Advisory Board interviews and analysis.

Prioritizing Practice Autonomy Thwarts Achievement of Broader Goals

As the employed network grows in size, the potential disadvantages of managing employed physicians within silos become more pronounced. In theory, a larger employed network could provide hospitals with an opportunity to capture many benefits of scale, including enhanced in-network referrals, improved patient access, and cross-continuum care coordination. However, in focusing on employed physicians as autonomous units, rather than leveraging the network as a coordinated whole, many hospitals are falling short of realizing these gains.

As a result, many hospitals are seeking a new approach to practice management, one that shifts from viewing employed practices as autonomous entities to instead treating them as members of a larger, integrated "medical group."

Thwarted by Fragmentation, Unable to Make Bigger Mean Better

Goals for the Employed Physician Enterprise

Performance Metric	Potential Improvement with Larger Scale	Status Quo	Reason for Current Performance Gaps
Practice Finances	Achieve economies of scale, eliminate variation in practice operations	(Moderate Capture)	Protection of practice firewalls inhibits consolidation and cost-sharing; considerable process variability remains
Referral Volumes	Capture more patients within loyal referral network	(Minimal Capture)	Inhibited by weak relationships between practices; many physicians do not know who else is employed
Patient Access	Leverage broad network to expand appointment availability	(Significant Capture)	Few levers to win physician buy-in for disruptive access redesign; practice silos prevent sharing of mid-level providers
Care Reliability	Engage broad physician base against clinical quality and cost goals	(Minimal Capture)	Emphasis on individual productivity, lack of system affinity provide little incentive to focus on quality
System Efficiency	Provide full scope of services and coordinate care across provider types	(No Capture)	Thwarted by emphasis on individual performance, weak peer relationships, and lack of infrastructure for care coordination

Complete Capture	Significant Capture	Moderate Capture	Minimal Capture	No Capture

Source: Health Care Advisory Board interviews and analysis.

"High-Performance Medical Groups" Able to Capitalize on Cohesion

A number of medical groups do have a history of successfully managing employed physicians at scale. These organizations work to foster cohesion among physicians rather than promoting autonomy, a practice management approach that appears to result in strong financial, clinical, and operational performance. As such, these high-performance medical groups represent a model for hospitals that hope to realize greater value from the growing employed base.

Yet little guidance exists on what specific organizational attributes and practices make high-performance medical groups successful. To answer that question, the Health Care Advisory Board launched the High-Performance Medical Group Initiative.

Through this Initiative, we identified more than 25 medical groups that excelled on financial, clinical, and other strategic indicators, and conducted in-depth conversations and site visits with these organizations in order to understand the sources of strong performance. This publication details the key findings from that research effort.

Handful of Organizations Effectively Leveraging Scale, Integration

Identifying the High-Performance Medical Group

- Stable group-level financial indicators
- Strong group- or system-level quality outcomes
- Low physician turnover rates compared to market average
- Wide utilization of sophisticated clinical information technology
- Robust market share or evidence of recent growth
- Emphasis on care coordination and disease management

A Representative Sample of Research Participants

- 25+ medical groups with demonstrated high performance on financial and quality indicators
- Minimum size of 200 physicians, typically representing full range of specialties
- All early adopters of processes and systems for care redesign and risk management

Advocate Health Care

Indiana University Health

Henry Ford Health System

Billings Clinic

HealthPartners

SHARP

NorthShore University HealthSystem

Marshfield Clinic
Don't just live. Shine.

Kelsey-Seybold Clinic
Your Doctors for Life

Dean
Partners who care

BAYLOR HEALTH CARE SYSTEM

Source: Health Care Advisory Board interviews and analysis.

Strong Medical Group Performance Not Linked to Structural Factors

Immediately clear from the research is that strong group outcomes are not due to structural factors. High-performance medical groups vary widely in size, history, ownership model, or market type. The lack of connection between surface characteristics and strong performance is also validated by the few studies evaluating medical group performance published in the academic literature.

On the Surface, Successful Employed Networks Show Wide Variety

Areas of Variability Between High-Performance Groups

Size
Range from 200 physicians to 1,400

Ownership
Mix of hospital-owned subsidiaries, independent groups, integrated delivery systems

Payment Model
Range from pure fee-for-service to capitation

History
Age range from a few years to more than a century

Market Type
Mix of urban, sub-urban, semi-rural and rural

Something More Ephemeral at Work

"Although research suggests a link between group practice organizational attributes and quality or efficiency, researchers don't know exactly why these links exist, nor the direction of causality. Most likely, the attributes of cohesion, scale, and affiliation are proxies for other, more difficult to study, characteristics."

Laura Tollen
Author, "Physician Organization in Relation to Quality and Efficiency of Care"

Source: Tollen L, "Physician Organization in Relation to Quality and Efficiency of Care," The Commonwealth Fund, 2008, available at www.commonwealthfund.org, accessed September 10, 2011; Health Care Advisory Board interviews and analysis.

Identifying Three Shared Imperatives for Medical Group Success

Instead, three deeper defining characteristics set high-performance medical groups apart from other employed practices. These characteristics are consistent among all of the groups profiled within this publication, regardless of group structure.

First, groups maintain an identity as a unified, integrated, self-governing network. Their physicians have made a foundational commitment to common values, to care for patients as a team, and to work together to run their practices.

Second, groups build an infrastructure to support this commitment. This infrastructure includes platforms for information sharing, dedicated efforts to eliminate unwarranted variability, and resources to help physicians implement best-practice standards.

Third, groups deploy levers designed to engage individual physicians against strategic goals, recognizing that even the greatest commitment to a team must also be supported by personal rewards.

Each of these areas is described in more depth across the next several pages.

High-Performance Networks Exhibit a Core Set of Common Attributes

Impact on Performance

Individual Engagement Levers
- Effective bidirectional communication
- Unblinded performance data sharing
- Strategy-aligned compensation

Infrastructure for Shared Success
- Enterprise-wide information network
- Formal performance improvement processes
- Scaled resources for care delivery

An Integrated Identity
- Shared vision, formalized cultural expectations
- Functional physician team
- Comprehensive physician governance

Degree of Physician Integration

Source: Health Care Advisory Board interviews and analysis.

Common Culture Lays Groundwork for All Group Activities

An integrated identity provides the foundation of high-performance medical groups. Physicians within the group view themselves as part of a larger whole and understand that their own success is linked to strong performance by the broader team.

At the base of this identity is a common culture—an intangible attitude that has practical impact in driving group strategy. To make culture tactical, groups first bring physicians together to define values and expectations. While culture varies between organizations, high-performance medical groups tend to share certain tenets, such as collegiality and transparency.

Once physicians have coalesced behind a shared vision, groups then take steps to translate values into tangible elements of group practice and management, making culture enforceable on a day-to-day basis.

Setting Group Vision and Codifying Values the First Stage of Integration

Two Steps in Creating an Integrated Identity

1 **Defining Group Values and Norms**

- Physician-led discussion
- Sample questions: What are typical cultural hallmarks of an integrated medical group? Which of these are right for us?
- Resulting principles shared with, embraced by all employed physicians and practice staff

2 **Transforming Values into Everyday Practice**

- Physician compact that translates values into clear responsibilities and enforceable expectations
- Adoption of shared brand to communicate integrated identity to both physicians and patients
- Holistic assessment of employed physician value by parent system in setting budgetary expectations

Common Hallmarks of Group Culture

Trait	Translation in Practice
Cohesive	Physicians maintain a shared purpose and make decisions based on common strategy
System-aligned	Physicians view themselves as integral part of larger health system, act in accordance with broader network goals
Collegial	Physicians perceive patient care as a team endeavor, maintain strong personal and professional relationships with peers
Patient-centered	Group has processes to streamline handoffs, centralize patient information, reduce service duplication
Physician-led	Physicians maintain control over key decisions, particularly those affecting clinical care and day-to-day practice operations
Transparent	Information about group strategy, group and individual performance is shared regularly with physicians and staff
Accountable	Group is organizing toward population-level quality and cost management with a focus on chronic disease management, care coordination, and robust primary care

Source: Health Care Advisory Board interviews and analysis.

Strong Partnership Between Physicians Essential to Referrals, Coordination

Also central to capturing the benefits of integration is building a team that works well together. High-performance groups recognize the many ways that collegiality and cultural fit pay off, fostering interpersonal connections that facilitate in-group referrals, create a more coordinated patient care experience, and minimize physician turnover.

These efforts begin at hiring: through careful recruiting and selection, groups take pains to ensure that any physician brought on board is a good fit, often walking away from candidates who—while attractive on paper—will not represent a strong cultural match.

On an ongoing basis, groups also take steps to build cohesion among physicians. Peer mentoring programs create connections between new and experienced physician partners within practice areas, while regular all-group forums provide an opportunity to build connections across specialties and practice sites.

Building Collegiality Across the Physician Life Cycle

Starting Off On the Right Foot

Providing Continuous Support

Cultivating Cohesion

- Provide opportunities for networking across practice sites and specialties
- Structure group meetings to be efficient and relevant, and provide incentives for attendance

Assimilating New Physicians

- Establish standard onboarding process to acclimate new physicians to group culture
- Pair new physicians with experienced mentors to reinforce culture, accelerate peer network development

Acclimation to Organization

Hiring and Recruiting Strategies

- Clearly define cultural expectations in recruiting to allow "right" candidates to self-select
- Empower physicians to define culture-linked hiring standards
- Screen practices pre-acquisition for cultural fit

Medical Group Tenure

Source: Health Care Advisory Board interviews and analysis.

Providing Meaningful Physician Authority Over Group Decision Making

While a common culture and a strong partnership provide the bedrock for group creation, fully realizing an integrated identity also requires that physicians have a direct stake in medical group strategic decision making. This tenet represents an ideological shift for many hospitals, which often grant physicians an advisory role but reserve decision-making power for non-physician administrators.

By contrast, high-performance medical groups provide comprehensive governance authority for physicians. Effective medical group governance has three core tenets: a governance structure that centralizes decision making across all physicians and penetrates deep into practice front lines; strong support for physician leadership development; and processes to align physician governance with broader health system strategy.

Evolving Beyond Leadership Lip Service

Key Elements of a Physician-Driven Leadership Model

Physician-Led Governance Structure

- Effective practice management infrastructure
- Physician-led, professionally managed
- Integration with health system (e.g., understanding the revenue cycle from both sides)

Deep Physician Leadership Bench

- Appropriate tools, training resources available for effective leadership preparation, development
- Adequate administrative, management support for physicians in leadership roles
- Incentive structure in place to reward, create value for leadership roles

Alignment with System Strategy

- Medical group impacts, informs health system strategy
- Medical group decisions in lock step with health system goals
- Health system strategy clearly articulated to medical group
- Medical group accountable for performance on goals set by organization

> **"**
>
> **Recognizing the Need to Let Go of Control**
>
> "Physicians are some of the most loyal people on the planet. They want their hospital to succeed. If you allow them to help in a real way, they'll solve problems. If you control them, they'll fight you every step of the way."
>
> *Administrator*
> *250-physician medical group*

Source: Health Care Advisory Board interviews and analysis.

Information Exchange, Shared Resources Support Physician Performance

Construction of an infrastructure that allows physicians to function as a team is the second key strategy used by high-performance medical groups.

Core to this infrastructure is an enterprise-wide information network that enables seamless data flow between physicians, supporting improved clinical care while sending important cultural signals that information is a group asset. Data also fuels formal performance improvement processes, another tactic used by medical groups to generate strong outcomes.

Finally, successful medical groups provide physicians with tools to put performance improvement into action, deploying resources at scale to optimize both operational and clinical performance.

Providing "Arms and Legs" for Group Success

Core Components of the High-Performance Medical Group Infrastructure

Enterprise-Wide Information Network

- Seamless information exchange across physician practices
- Investment in single-vendor electronic medical record for all group members
- Additional IT systems to elevate performance (e.g., disease registry, clinical decision support, practice management)
- Physician engagement in protocol development, data capture process, adherence to clinical decision algorithms

Data-Driven Performance Improvement Processes

- Comprehensive dashboard providing multi-faceted, system-level view of employed network performance
- Formal process to prioritize and select improvement initiatives
- Physician-led development of best-practice solutions
- Iterative, data-driven approach to implement new standards and protocols

Scaled Resources to Support Care Delivery

- Recognition of key barriers to implementation of improvement initiatives (e.g., lack of physician time or tools)
- Economies of scale captured within administrative functions (e.g., revenue cycle, human resources)
- Extension of next-generation group-level support to facilitate clinical transformation (e.g., disease management staff, centralized referral scheduling)

Source: Health Care Advisory Board interviews and analysis.

Capitalizing on Intrinsic Physician Characteristics to Motivate Individual Behavior

Finally, high-performance medical groups recognize that, no matter how effective group culture and infrastructure, personal rewards and recognition still play an important role in driving physician behavior. Successful groups carefully align these physician motivators with group needs.

The performance levers deployed by successful employed networks capitalize on common physician traits. Responding to physicians' natural tendency toward skepticism, groups ensure complete transparency in communication. They also leverage physicians' innate sense of ambition by sharing individual performance data, often unblinded, to utilize this competitive dynamic to drive performance.

In addition, high-performance groups use financial incentives to align physician behavior, but do so sparingly, turning to compensation change only when other motivational levers fail. This practice stands in sharp contrast to many hospital employers, who tend to look at compensation as a primary means of influencing physician behavior.

Performance Levers Linked to Typical Physician Traits

The "Three C's" of Physician Motivation

	Skeptical	Ambitious	Risk Averse
Typical Physician Trait	Concerned about being marginalized, undervalued	Constantly striving for "straight A's," hate to be outperformed	Wary of change, particularly when own income at risk

	Communication	Competition	Compensation
Resulting Performance Lever	• Transparent downward communication of rationale for group strategy • Structured forums to capture upward feedback from line physicians	• Opportunities for physicians to access holistic data on own performance • Sharing of unblinded data to foster peer pressure	• Use of compensation as motivational tool only as a last resort, primarily when existing model serves as legitimate barriers to behavior change • Staged adoption of new compensation plans

Order of Deployment

Integration Investment Costs Outweighed by Risks of Failing to Act

Building the high-performance medical group will require hospitals to make a significant investment in the employed physician network. At least in the short term, the costs associated with creating integrated identity, constructing shared infrastructure, and effectively deploying individual performance levers may appear to increase the "subsidy" paid by hospitals to support employed physicians.

Yet a decision to forego or delay integration may be equally costly. As the ranks of employed physicians grow, so do the risks of failing to capture full value from that investment due to fragmentation and variability. Notably, these risks extend beyond the employed base to the hospital's relationship with its independent physicians, who—in weighing their own options for alignment amid market changes—regard employed physicians as a bellwether for whether the hospital will be a strong partner for all physicians as the reimbursement environment shifts.

Looking Beyond Increased "Subsidy" to Identify Broader Returns

A Significant Investment

Investments Needed to Build a High-Performance Medical Group
Clinical and administrative support staff (e.g., health coaches, data analysts)
Enterprise-wide information network (e.g., EMR, disease registry, physician performance monitoring platform)
Non-productivity compensation incentives not supported by external reimbursement (e.g., patient satisfaction metrics)
Physician leadership training, incentive support
Physical space for shared services (e.g., centralized referral scheduling center)
Re-branding following practice name change

Yet Also High Costs to Integration Delay

Decisions to Undo

- Employment contracts structured around individual interests
- Acquisition of physicians who are a poor organizational fit
- Non-standard infrastructure investments by individual practices

Missed Opportunities

- Failure to win recruiting battles for physicians seeking collegial, coordinated environment
- Loss of referral business, market share to out-of-network providers
- Poor engagement of employed physicians around system quality, efficiency goals

Red Flags for Independents

- Indication that hospital is a poor partner for non-employment alignment relationship (e.g., clinical integration) due to underinvestment in medical group resources, lack of employed physician engagement

Source: Health Care Advisory Board interviews and analysis.

Ample Opportunities to Accelerate the Integration Process

Creating a coordinated, cohesive medical group will not happen overnight, but it is an attainable goal. Although many high-performance medical groups have had decades to organize, hospitals today can find ways to accelerate integration. Even those with just a few employed physicians can begin to build common culture and invest in network infrastructure. Such practices can strengthen the small employed network while also positioning the organization well for further growth in the physician ranks.

Timeline for Constructing the High-Performance Medical Group

Laying the Foundation for Coordination

Capturing Early Returns from Integration

Leveraging the Enterprise for Care Redesign

Medical Group Integration

Define and codify common culture

Build physician governance

Create communication protocols

Begin to invest in common EMR

Invest in leadership training

Develop group dashboard

Establish peer hiring, service standards

Design onboarding program

Share individual performance data

Centralize referral scheduling

Reward quality

Establish access protocols

Define clinical pathways

Redesign primary care

Deploy care management resources

Reward coordination

Time

Source: Health Care Advisory Board interviews and analysis.

Ultimately Aiming to Build the High-Performance Health System

Ultimately, hospitals that build a high-performance medical group can position themselves both to capture short-term returns around increasing quality and market share, and to succeed against emerging imperatives for care management and clinical transformation should new payment models take hold. These imperatives will require hospitals to manage quality and coordinate care far more effectively than before, while also continuing to achieve their longstanding central mission of improving the health of the community.

Physicians are crucial partners in that effort. By enhancing coordination among employed physicians, hospitals can use that integrated enterprise as the launching pad for a performance-focused, accountable physician network that engages both employed and independent physicians. In leveraging the employed base to drive improvement across the medical staff, hospitals can begin to build not just a high-performance medical group, but a high-performance health system.

Three Objectives for the Hospital-Physician Enterprise

Live on Medicare Margins

- Create and follow clinical protocols and care standards
- Secure referral streams
- Prevent low-margin medical admissions, ED utilization
- Maximize capture of ambulatory and inpatient revenue

Prepare for Heightened Accountability

- Treat patients at most appropriate site of care
- Coordinate handoffs across the care continuum
- Proactively manage chronic illness
- Minimize duplicative care delivery

Advance the Mission

- Build a patient-centric health care delivery system
- Provide high-quality, high-service, low-cost clinical care
- Improve overall health and wellness of the community

Source: Health Care Advisory Board interviews and analysis.

The High-Performance Medical Group

The remainder of this publication explores in greater detail the 15 key attributes that distinguish high-performance medical groups from other physician employers. As such, they provide a blueprint for building a high-performance medical group. Hospitals hoping to attain similar results with their employed physicians should consider how they will incorporate each of these elements into their own practice management approach.

The attributes profiled are organized into the three core categories discussed earlier: integrated identity, infrastructure for shared success, and strategy-aligned levers to motivate individual behavior. Each of these attributes makes a crucial contribution to the success achieved by high-performance medical groups.

15 Attributes of Effective Employed Physician Networks

1
An Integrated Identity

Creating Common Culture

1. Shared Vision and Formalized Cultural Expectations
2. Unified Identity Projected to Non-Physician Stakeholders

Fostering the Partnership

3. Cultural Expectations Hardwired in Recruiting and Onboarding
4. Meaningful Interpersonal Relationships Between Physicians

Formalizing Physician Control

5. Centralized Physician-Led Governance Model
6. Frontline Physicians Active in Leadership
7. Investment in Broad-Based Physician Leadership
8. Strategic Alignment Between Health System and Group

2
Infrastructure for Shared Success

Extending Performance-Enhancing Tools

9. Enterprise-Wide Information Network
10. Formal Processes for Data-Driven Performance Improvement
11. Scaled Resources to Support Care Delivery

3
Individual Behavior Aligned with Strategy

Leveraging Transparency

12. Effective Bidirectional Communication Processes
13. Dissemination of Unblinded Physician Performance Data

Designing Strategy-Aligned Compensation

14. Compensation Narrowly Tailored to Advance Group Objectives
15. Staged Adoption of New Compensation Plans

Source: Health Care Advisory Board interviews and analysis.

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I. An Integrated Identity

- Creating Common Culture
- Fostering the Partnership
- Formalizing Physician Control

At High-Performance Medical Groups, Patient Care Viewed as a "Team Sport"

Perhaps the most fundamental difference between a high-performance medical group and traditional hospital employment is how physicians perceive their role within the organization.

When acquiring practices, hospitals have traditionally protected a private-practice mindset that views care as an "individual sport." Physicians see their success as dictated almost entirely by their own activities, with little perceived value derived from association with a larger system. By fostering this mentality, hospital employers have perpetuated an independent and individualistic identity among employed physicians.

By contrast, physicians who are members of a high-functioning medical group unilaterally perceive value in being part of a larger organization. In the group setting, care is a "team sport." Physicians understand that their activities drive group success, and that organizational success in turn drives the physician's own personal rewards. This integrated sense of physician identity rests at the core of every high-performance medical group.

Integrated Physicians See Link Between Individual, Group Outcomes

Mindset of the Traditional Employed Physician

My Success Depends on My Individual Behavior
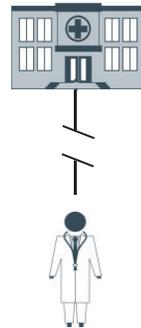
- My individual activities lead to my personal financial and clinical success

- Strong financial and clinical performance of my parent organization and physician colleagues has little impact on my personal success

Mindset of the Integrated Employed Physician

My Success Is Enhanced by Collaboration

- My individual activities lead to the financial and clinical success of my parent organization and physician colleagues

- Strong financial and clinical performance of my parent organization and physician colleagues enhances my personal success

Source: Health Care Advisory Board interviews and analysis.

Common Culture, Physician Governance Lay Groundwork for Group Mentality

High-performance medical groups use three major strategies to build an integrated identity and a commitment to mutual success among physician members.

First, they define common culture—an intangible but shared attitude that has practical impact in driving group strategy. To make culture tactical, groups bring physicians together to codify the values and responsibilities shared by all group members.

Second, high-performance groups take steps to build a team that works well together. They perpetuate culture through well-defined hiring and onboarding processes, and foster interpersonal relationships among physicians to build collegiality.

Finally, high-performance groups put key decisions directly in the hands of physician leaders. True physician governance is seen as crucial to building a sense of physician engagement and commitment.

Each of these strategic categories contains a subset of specific attributes shared by high-performance medical groups. The rest of this section examines these attributes in more detail.

Three Major Strategies Build Commitment to Mutual Success

Impact on Integrated Identity

Formalizing Physician Control

- Attribute #5: Centralized Physician-Led Governance Model
- Attribute #6: Frontline Physicians Active in Leadership
- Attribute #7: Investment in Broad-Based Physician Leadership
- Attribute #8: Strategic Alignment Between Health System and Group

Fostering the Partnership

- Attribute #3: Cultural Expectations Hardwired in Recruiting and Onboarding
- Attribute #4: Meaningful Interpersonal Relationships Between Physicians

Creating Common Culture

- Attribute #1: Shared Vision and Formalized Cultural Expectations
- Attribute #2: Unified Identity Projected to Non-Physician Stakeholders

Organizational Culture Shift Required

Source: Health Care Advisory Board interviews and analysis.

Shared Culture Drives Strategic Decision Making and Physician Behavior

A common, unified physician culture is universally identified by high-performance medical groups when asked what sets them apart. Although intangible on its own, culture produces practical results, driving all aspects of group strategy and operations.

Every high-performance medical group is slightly different, and culture varies accordingly. Yet most successful employed networks tend to share certain values, such as collegiality, transparency and—where the group is hospital-owned—a belief that employed physicians are an integral part of the larger health system. These values translate directly into common operating standards and behaviors.

An Intangible Attitude, with Many Practical Results

Common Hallmarks of High-Performing Medical Group Culture

Cultural Trait	Translation in Practice
Cohesive	Physicians maintain a shared purpose and make decisions based on common strategy
System-aligned	Physicians view themselves as integral part of health system, act in accordance with network goals
Collegial	Physicians perceive patient care as a team endeavor, maintain strong relationships with peers
Patient-centered	Group has processes to streamline handoffs, centralize patient information, reduce service duplication
Physician-led	Physicians maintain control over key decisions, particularly those affecting clinical care and day-to-day practice operations
Transparent	Information about group strategy, group and individual performance is shared regularly
Accountable	Group is organizing toward population-level quality and cost management with a focus on chronic disease management, care coordination, and robust primary care

> "
> "We have a collaborative culture. **It's the way we've always done business, and it drives everything we do—how we pay our physicians, who we hire, how we make decisions.** We don't have specific structures in place to promote cooperation across departments. Our physicians just know they should walk down the hall and ask a colleague. I can't imagine the number of 'sidewalk consultations' that happen here each day."
>
> *James Hoyle, MD*
> *Medical Director, Kelsey-Seybold Clinic*

Source: Health Care Advisory Board interviews and analysis.

Creating Common Culture Requires Defining Values, Codifying Expectations

Longstanding medical groups have often maintained a common culture for so long that they struggle to articulate how it began. For newer medical groups, however, the process of creating a shared group identity typically incorporates two key stages.

The first step is to define the values the group will prioritize and the expectations it will have for members. Once physicians have coalesced behind a shared vision, groups then take steps to codify values and expectations, not just by writing them down, but by finding ways to enforce them on a day-to-day basis.

Two Questions to Consider in Establishing an Integrated Identity

**How Will We Define
Group Values and Norms?**

• What are typical cultural hallmarks of an integrated medical group? Which of these are right for us?

• How will we engage physicians in the process of setting cultural expectations in order to ensure their buy-in?

**How Will We Transform
Values into Everyday Practice?**

• How will we codify and communicate the new expectations and values of our integrated enterprise?

• How will we ensure that we "live our values" and enforce new expectations moving forward?

Source: Health Care Advisory Board interviews and analysis.

Letting Physicians Define Own Culture and Values Crucial for Acceptance

Medical group culture cannot be defined and mandated from above by health system administrators. Rather, asking physicians to articulate for themselves what values they will espouse is crucial for acceptance of the new identity.

As an example, consider pseudonymed Macoun Health Network, which has recently taken steps to integrate employed physicians into a single medical group. Macoun's integration process has been fully driven by physician leaders, who worked across several months to define the vision for an integrated, collaborative group and the process needed to achieve that objective.

After vetting their plans with nearly 50 physicians seen as opinion leaders, the integration team called a meeting of all Macoun's employed physicians. With the system CEO at their side, they presented the arguments for integration and defined the type of group they proposed to create. Leaders made it clear that the process would not proceed without buy-in from the majority of employed physicians.

At the end of the meeting a large majority of physicians expressed support for the integration concept, and many stepped up to volunteer for leadership roles—an indication of how a clear, physician-driven vision and communication process can streamline the shift to a new culture of collaboration.

Physician Ownership of Vision-Setting Process Leads to Broad Support

Defining Culture for a New Integrated Enterprise

1. Multispecialty physician team selects integration strategy, creates tactical "strawman principles" for new group

2. 15-physician Joint Physician Leadership Committee identifies hallmarks of effective group practice, refines guiding principles, develops work plan

3. Proposed work plan, principles presented individually to 50 physicians seen as opinion leaders for approval

4. At meeting of all employed physicians, health system CEO and physician leaders unveil vision for integrated group, request participation from rank-and-file physicians in further defining and building group structures

Guiding Principles

- All decisions place patient interests first
- Physicians are expected to be team leaders and team players
- Fair decision-making processes
- Systems thinking
- Measurement based
- All work to reduce unexplained variation
- All work to deliver increased value to customers
- Interdependencies and diversity are respected and embraced
- Open to work with all clinicians who are willing to support our patient-first goals, mission, and vision

60+

Out of 350 physicians, number volunteering immediately to serve on three planning committees

Case in Brief: Macoun Health Network[1]

- Five-hospital system located in the Midwest
- Maintained 400 employed physicians organized in 15 subsidiaries under three management groups
- In 2010, began process of creating single integrated physician group at request of physician leaders seeking to improve coordination

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

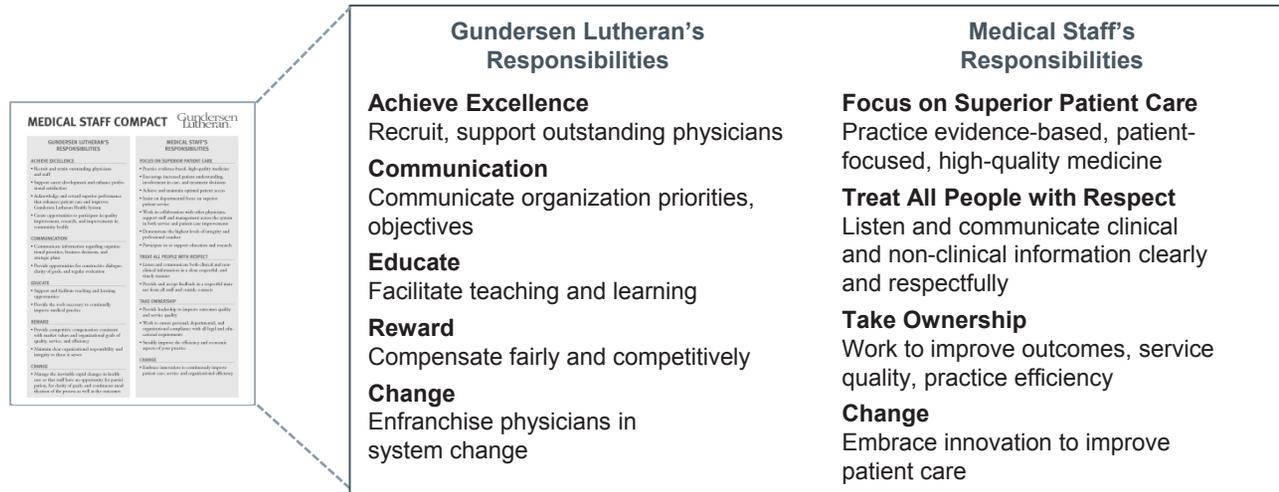# Physician Compact Codifies Mutual Expectations, Makes Culture Tangible

A second key step in building integrated identity is to translate physician-defined values into everyday practice, enabling the medical group to communicate and enforce its expectations for participating physicians. Many high-performance medical groups achieve this aim through a written physician compact.

For example, this page shows the compact used at Gundersen Lutheran Health System in Wisconsin, which employs a significant majority of its medical staff. The compact clearly delineates expectations and responsibilities for both the health system and its physicians, codifying the values and behaviors that the organization views as most vital to its success. More than just a guidepost for physicians, the compact is enforceable: employed physicians must sign it, and health system leaders note they have terminated more physicians for failing to meet these citizenship standards than for providing poor-quality care.

Strong compacts should also be jointly defined by physicians and hospital leaders, specific in the responsibilities outlined, directly related to behaviors within a physician's control, and unambiguous in their expectations.

Translating Values into Everyday Actions

Gundersen Lutheran's Medical Staff Compact

Gundersen Lutheran's Responsibilities	Medical Staff's Responsibilities
Achieve Excellence Recruit, support outstanding physicians	**Focus on Superior Patient Care** Practice evidence-based, patient-focused, high-quality medicine
Communication Communicate organization priorities, objectives	**Treat All People with Respect** Listen and communicate clinical and non-clinical information clearly and respectfully
Educate Facilitate teaching and learning	
Reward Compensate fairly and competitively	**Take Ownership** Work to improve outcomes, service quality, practice efficiency
Change Enfranchise physicians in system change	**Change** Embrace innovation to improve patient care

Case in Brief: Gundersen Lutheran Health System

- Three-hospital health system based in LaCrosse, Wisconsin
- Leverages a physician-led governance structure to drive organizational culture
- Codifies hospital, physician expectations and responsibilities through medical staff compact

For the complete Gundersen Lutheran Health System Medical Staff Compact, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Klein S, "Gundersen Lutheran Health System: Performance Improvement Through Partnership," *The Commonwealth Fund*, August 2009, available at: http://www.commonwealthfund.org, accessed May 1, 2010; Health Care Advisory Board interviews and analysis.
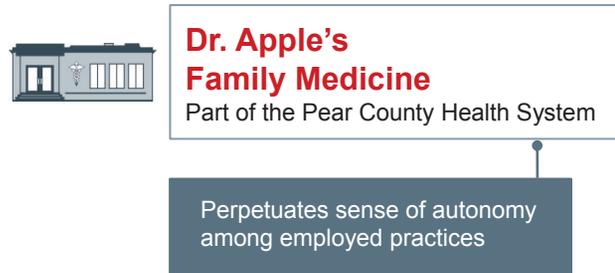
Shared Branding Reflects New Identity, Facilitates Physician Culture Shift

Shared medical group branding represents another way to translate identity into practice. Frequently, health systems will choose to leave a practice's original name in place following an acquisition, in an effort to ease the transition to employment for physicians and patients. However, this strategy has the net impact of perpetuating a sense of autonomy—an outcome that might once have been viewed favorably, but that now may serve as a barrier to building a cohesive medical group.
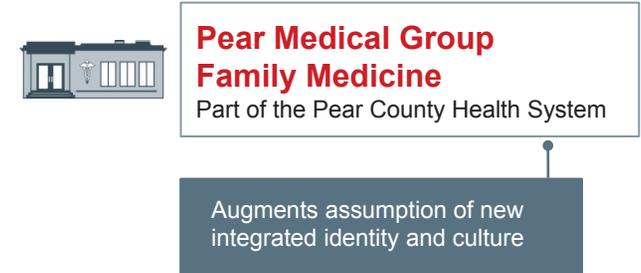
As a result, every high-performance medical group studied in this research has developed a common brand for all member physicians, recognizing that the name represents a tangible representation of the group's shared identity, processes and success.

High-Performance Groups Promote Group Over Individual Practice Brands

Traditionally Hiding the Larger Affiliation

Dr. Apple's Family Medicine
Part of the Pear County Health System

Perpetuates sense of autonomy among employed practices

Adopting an Integrated Brand Instead

Pear Medical Group Family Medicine
Part of the Pear County Health System

Augments assumption of new integrated identity and culture

What's in a Name?

"I want our physicians to have an attitude about who they work for. When you ask a Cleveland Clinic doctor who he works for, he sticks out his chest and has an attitude. He's proud, and so he's willing to invest in making sure that reputation continues to be meaningful. I want our physicians to have that same kind of pride in this organization."

Administrator
250-physician medical group

Source: Health Care Advisory Board interviews and analysis.

Illustrate the Benefits of Coherent Branding During the Acquisition Process

Loss of individual brand identity can represent an uncomfortable change for physicians. As a result, high-performance medical groups often work to describe the benefits of a common brand early in the practice acquisition process.

This page shows how the pseudonymed Macoun Health Network approaches this challenge. Macoun involves marketing staff during acquisition negotiations to discuss the benefits of an integrated brand—the appeal to patients, the potential positive impact on referrals, and the carryover from larger system marketing efforts. This effort is designed to help new physicians recognize the value of membership in a larger group, while also providing tools and processes to ease the transition and communicate the value of the affiliation to patients and other stakeholders.

Easing the Brand Transition for New Practices

Making an Upfront Case for Common Branding

Patient Preferences

- Present focus group results showing power of system brand

- Discuss patient preference for coordinated care

Physician Referral Opportunity

- Emphasize opportunity to strengthen referral relationships

- Highlight number of other employed physicians also using brand

Lower Marketing Costs

- Present data on the amount of advertising conducted by health system

- Explain how practices carrying system name will indirectly benefit from group-wide advertising

Case in Brief: Macoun Health Network[1]

- Five-hospital system, located in the Midwest
- Implemented coherent branding strategy for employed practices to foster perception of coordination, better leverage marketing funds
- Discusses marketing with physicians during practice acquisition negotiations

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

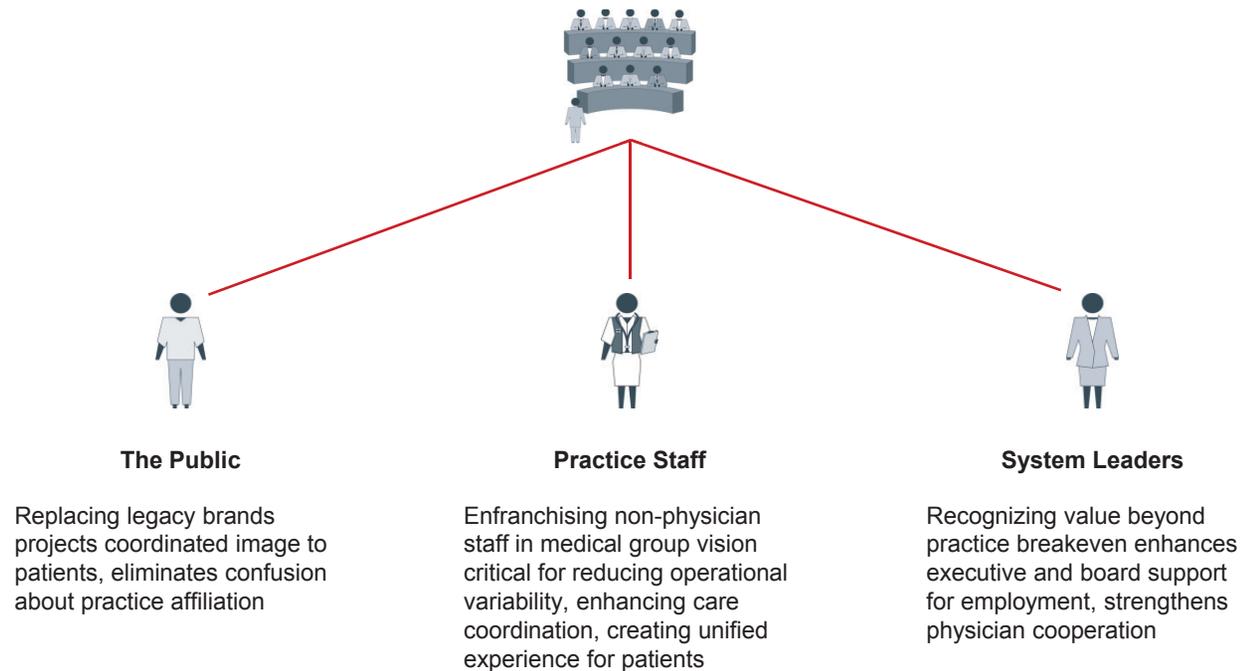# Communicating the Benefits of Integration to Other Constituencies

While physicians are the most important constituency to consider in developing an integrated identity, other stakeholders also must understand the benefits of a unified medical group in order to fully capture the value of integration. Projection of a common, coordinated identity to these constituencies is a second core attribute of high-performance medical groups.

Three audiences must be considered in this process. First, high-performance groups help patients understand the benefits of care coordination, a strategy that may pay off in enhanced market share. Second, groups work to engage non-physician practice staff, who play an important role in reducing variability and creating a consistent patient experience. Finally, groups ensure that leaders of the larger health system perceive employed physicians as more than just red ink on the balance sheet—a broader view of value that is crucial to making appropriate decisions about employment strategy and strengthening physician cooperation for health system initiatives.

How high-performance medical groups approach each of these constituencies is explored across the following pages.

Reposition Medical Group's Value in Everyone's Eyes

Shifting Perceptions for Three Key Audiences

The Public

Replacing legacy brands projects coordinated image to patients, eliminates confusion about practice affiliation

Practice Staff

Enfranchising non-physician staff in medical group vision critical for reducing operational variability, enhancing care coordination, creating unified experience for patients

System Leaders

Recognizing value beyond practice breakeven enhances executive and board support for employment, strengthens physician cooperation

Source: Health Care Advisory Board interviews and analysis.

Displaying a Coordinated Face to Consumers

In communicating with patients, high-performance medical groups work to emphasize the benefits of coordination and cohesiveness. Although physicians accustomed to autonomy may worry that patients will perceive integration as a negative change, many medical groups argue that the opposite is true, especially as patients increasingly come to recognize the disadvantages of care fragmentation and variability.

For example, a recent study found that a significant minority of patients would be willing to switch health insurers in order to obtain improved care coordination. While this finding is an indirect indication of whether they would also switch providers, high-performance medical groups believe a message of integration does resonate. As a result, they emphasize the benefits of coordination in consumer marketing and other patient communications, while also taking steps to assure patients that increased integration does not mean loss of access to favorite physicians or staff.

Message of Comprehensive, Cohesive Care Resonates with Patients
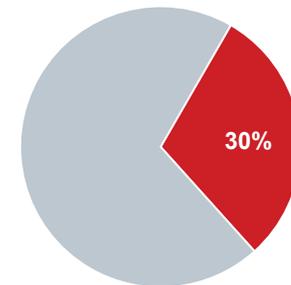
Fearing Loss of Brand Equity…

- Will patients value my practice less if they know it is part of a larger system?
- Will association with other physicians or the hospital dilute patients' perception of my practice quality?

…But Failing to Recognize Integration's Appeal

*Patients Willing to Switch Insurers
for Improved Care Coordination*

n=4,008

30%

> ## Winning Hearts, Minds, and Market Share
>
> "We've seen a steady increase in market share over the last few years. There are several contributing factors, but I believe it's partly because all of our advertising emphasizes team-based, coordinated care. The message of integration is definitely starting to catch on with consumers."
>
> *Medical Director*
> *300-physician integrated delivery system*

Source: "2010 Survey of Health Care Consumers," Deloitte Center for Health Solutions, available at www.deloitte.com, accessed April 3, 2011; Health Care Advisory Board interviews and analysis.

Integration Message Not Reaching Practice Staff

High-performance medical groups also ensure that non-physician practice staff recognize the rationale for and impact of integration, particularly when transitioning from a more autonomous practice management approach. The case of McIntosh Medical Group (a pseudonym) highlights the perils of failing to enfranchise all employees within the practice when setting the vision for a newly integrated network.

McIntosh took steps to build cohesion among employed physicians, who understood and supported the concept of integration. But these efforts did not extend to frontline or back-office practice staff, who were left disengaged and confused. Indeed, during a visit to one practice site, McIntosh's president realized that some frontline staff had no idea that the larger medical group existed at all. As a result, staff members gave inaccurate messages to patients and resisted adoption of standardized protocols, while employee engagement dropped across the enterprise.

Frontline, Back-Office Personnel Also Targets for Identity Shift

Results of Physician-Only Integration Campaign

Staff and Patient Confusion
Frontline staff unaware of group affiliation, provide mixed messages to patients

Unwarranted Operational Variation
Practices continue to maintain disparate methods for co-pay collection, lab referrals, other administrative procedures

Poor Employee Engagement
System-wide survey finds practice staff feel disconnected, unmotivated

"

Who Are We Now?

"I went to visit one of our member practice sites and introduced myself to the receptionist. She called back to the physician, 'I have somebody here from McIntosh Medical Group. I have no idea what that is. Should I send him back?'"

President, McIntosh Healthcare Medical Group

Case in Brief: McIntosh Healthcare Medical Group[1]
- 350-physician group in the Midwest affiliated with two-hospital system
- Recent rapid growth in employed base, emphasis on value-based purchasing led to push for integrated medical group
- Integration efforts involved physicians in defining culture, establishing governance but failed to engage practice staff in similar discussions

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Multi-Pronged Campaign Builds Knowledge, Cohesion Among Staff Members

Recognizing that staff engagement was vital to realizing full value from the integration investment, McIntosh Medical Group's leaders launched a multi-faceted education campaign. To start, they held forums to discuss the value of being part of a larger medical group and created networking opportunities for staff members across practices to become acquainted.

McIntosh also worked to make the new culture tangible for staff. Similar to the compact created for physicians, they published a handbook of standards and tied staff compliance to performance reviews. At the same time, McIntosh implemented small rewards for employees who helped practices work toward group goals. Leaders credit these efforts with allowing the group to realize improvements in several key areas of operations.

Deploying Teaching Forums and Incentives to Enhance Integration

McIntosh Medical Group's[1] Staff Integration Strategy

Leadership Forums

- Educate staff on rationale, process for integration
- Provide opportunities for staff feedback

Team Events

- Bring staff from different practices together to socialize, discuss practice-level operational issues

Practice Protocols

- Define common standards for telephone wait time, other operations
- Monitor staff compliance and outcomes

System Recognition

- Provide small incentive to practice staff for meeting system goals
- Publicly commend staff who best represent group values

Impact of Integration Campaign	
Frontline operating metrics (e.g., phone and office wait times)	⬆
In-network referrals	⬆
Staff satisfaction	⬆
Patient satisfaction	⬆

1) Pseudonym.

Expanding System Leaders' Focus Beyond the Practice-Level Bottom Line

Perhaps the most critical audience to consider is senior health system leadership—the executives and board members ultimately responsible for setting employment strategy. In many organizations, executives traditionally adopt a relatively narrow view of employed practice value, concentrating on the size of the "subsidy" paid to employed physicians.

Systems with high-performance medical groups, however, recognize that focusing exclusively on the practice-level bottom line paints an incomplete picture of medical group value, obscuring legitimate reasons for on-paper losses and failing to account for downstream revenue. They also realize that an overly narrow definition of value can translate into real and negative consequences for medical group performance, leading the system to miss important opportunities for performance improvement or to overlook needed strategic investments that could strengthen the group and larger health system.

Perhaps most importantly, focusing only on the practice subsidy can also breed alienation among employed physicians. This mentality risks setting up a contentious relationship between physicians and system leaders, rather than fostering the sense of coordination and collaboration that integration is designed to achieve.

Myopic System View of Employment's Value Inhibits High Performance

Often Focused Only on One (Disappointing) Aspect of Performance

Net Income per Employed Physician, 2010

75th Percentile	50th Percentile	25th Percentile
($81 K)	($190 K)	($282 K)
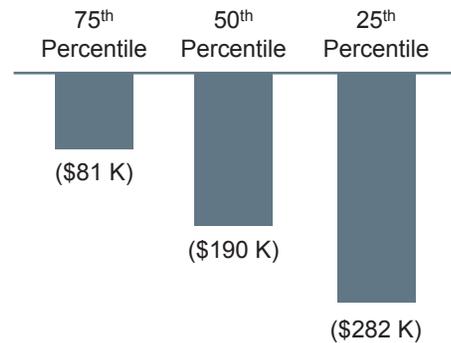
Missing the Broader Picture— and Potential Opportunities

Problems with Limited Budget Focus

- Fails to distinguish true practice efficiency opportunities from legitimate reasons for negative bottom line (e.g., incorporation of practice ancillaries into hospital service line)

- Does not account for practice's downstream business or care management impact, potentially leading to underinvestment in less profitable but still crucial specialties

- Encourages "us vs. them" sense of alienation between employed physicians and health system, inhibiting integration efforts

> **"**
>
> **Sending the Wrong Message**
>
> "That sense that they're just a drain on the bottom line is incredibly demoralizing for physicians. How can we expect them to recognize the value of being a part of a larger organization if we don't in turn recognize the broader value they bring to us?"
>
> *Chief Operating Officer*
> *1,000-physician medical group*

Source: Medical Group Management Association, *Cost Survey for Multispecialty Practices,* 2011; Health Care Advisory Board interviews and analysis.

Standalone Profitability Not an Expectation for High-Performance Groups

Systems with high-performance medical groups unilaterally take a broader view when evaluating medical group value, with most using one of the two strategies detailed on this page for assessing financial performance.

In the most common accounting strategy, the system continues to maintain and evaluate a separate medical group budget. However, leaders assume that this budget will show a loss, recognizing the impact of such decisions as the removal of practice ancillaries or the strategic value associated with acquiring a "money-losing" primary care practice. Instead of working to get all practices to break even, medical group leaders focus their efforts on ensuring that the loss stays within reasonable expectations, based on past performance and local market conditions, and establish benchmarks for improvement over time. Thus, while this method still evaluates the employed enterprise as a separate entity, it nonetheless reflects an integrated approach to assessing medical group value.

A handful of organizations take the concept of integrated financial assessment one step further, accounting for employed physician costs and revenue at the system service line level. In this methodology, medical group leaders focus their—and their physicians'—attention on maximizing the overall profitability of the service line, communicating clearly that employed physicians are a vital part of the larger health system enterprise.

Two Common Options for Assessing Owned Medical Group Finances

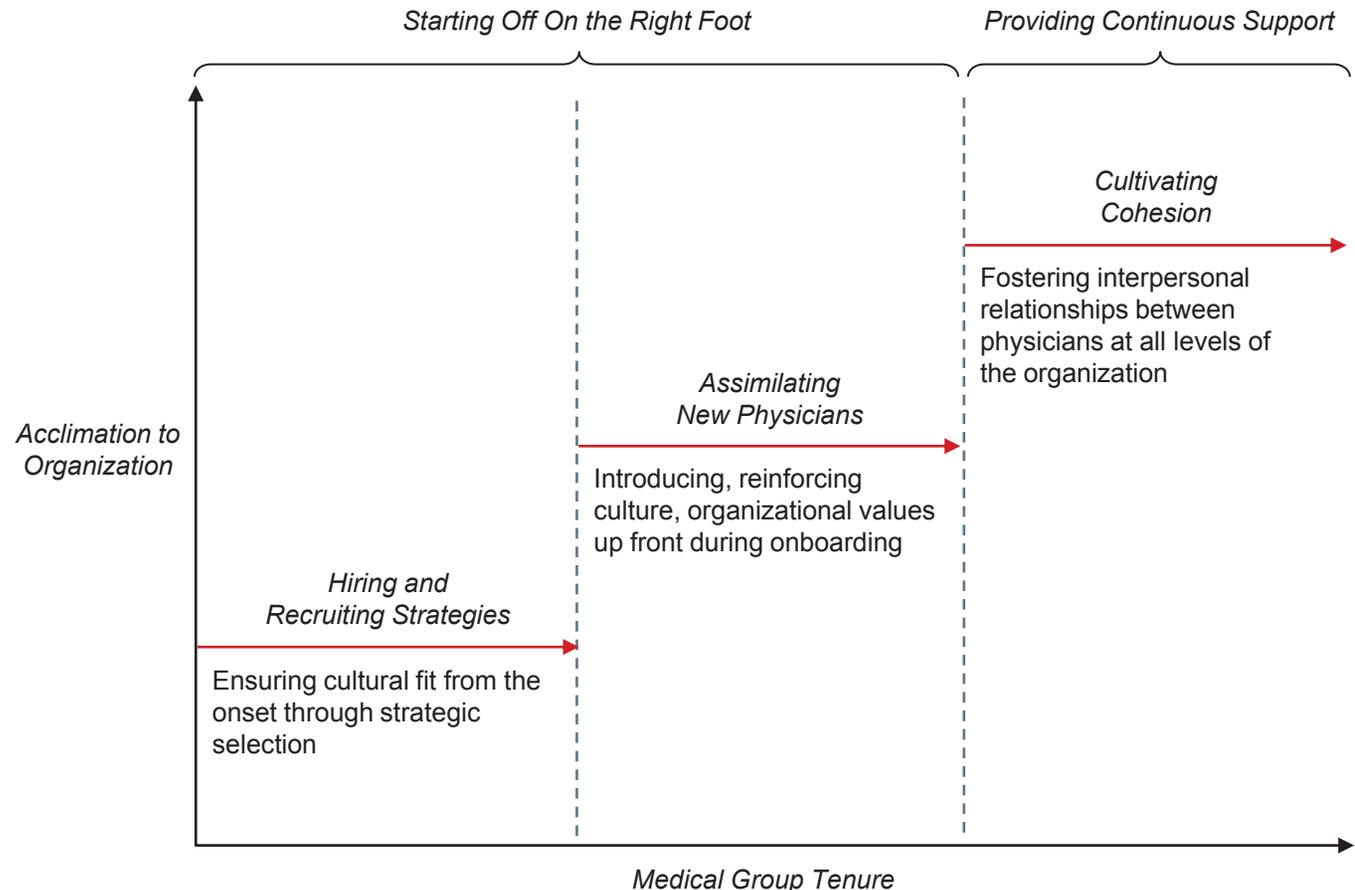|	Budgeting Beyond Break Even	Integrated Service Line Accounting
Description	• Health system assumes medical group will run at a loss • Financial expectations based on historical performance and market norms, rather than national benchmarks	• Health system evaluates budget for entire service line, including both inpatient and ambulatory performance • Overall service line profitability the most important goal; physician compensation and subsidy subsumed under service line costs
Key Considerations	• Most effective when loss supported by additional metrics to quantify positive practice value (e.g., quality improvement, in-network referrals) • May still inhibit achievement of system-level integration when compared to integrated service line accounting method	• Most effective when employed physicians comprise significant portion of medical staff • Medical group still maintains own infrastructure (e.g., governance) • Requires expansion of hospital-focused service line mentality (e.g., creation of primary care service line)

An upcoming whitepaper from the Health Care Advisory Board will examine service line accounting in more detail. This paper will be available in early 2012 at www.advisory.com/HCAB.

Source: Health Care Advisory Board interviews and analysis.

Strengthening Interpersonal Relationships Among Physician Peers

For high-performance medical groups, defining and promoting a common group culture is the first step in creating integration among employed physicians. Once this culture is established, successful groups focus on building a team that works well together, establishing a sense of collegiality among physician partners that encourages coordination around patient care, cross-network referrals, and other collaborative behaviors.

To foster a strong physician partnership, medical groups rely on two primary strategies. First, through targeted hiring and careful onboarding, they ensure that all new physicians are a good "fit" with the organization and can adapt quickly to cultural norms. Second, recognizing that coordination is difficult if physicians within the network do not know each other, they institute formal strategies to cultivate interpersonal relationships among physician peers.

Medical Groups Perpetuate Culture Across the Employment Life Cycle

Starting Off On the Right Foot

Providing Continuous Support

Cultivating Cohesion

Fostering interpersonal relationships between physicians at all levels of the organization

Assimilating New Physicians

Introducing, reinforcing culture, organizational values up front during onboarding

Acclimation to Organization

Hiring and Recruiting Strategies

Ensuring cultural fit from the onset through strategic selection

Medical Group Tenure

| Attribute #3: Cultural Expectations Hardwired in Recruiting and Onboarding | Attribute #4: Meaningful Interpersonal Relationships Between Physicians |

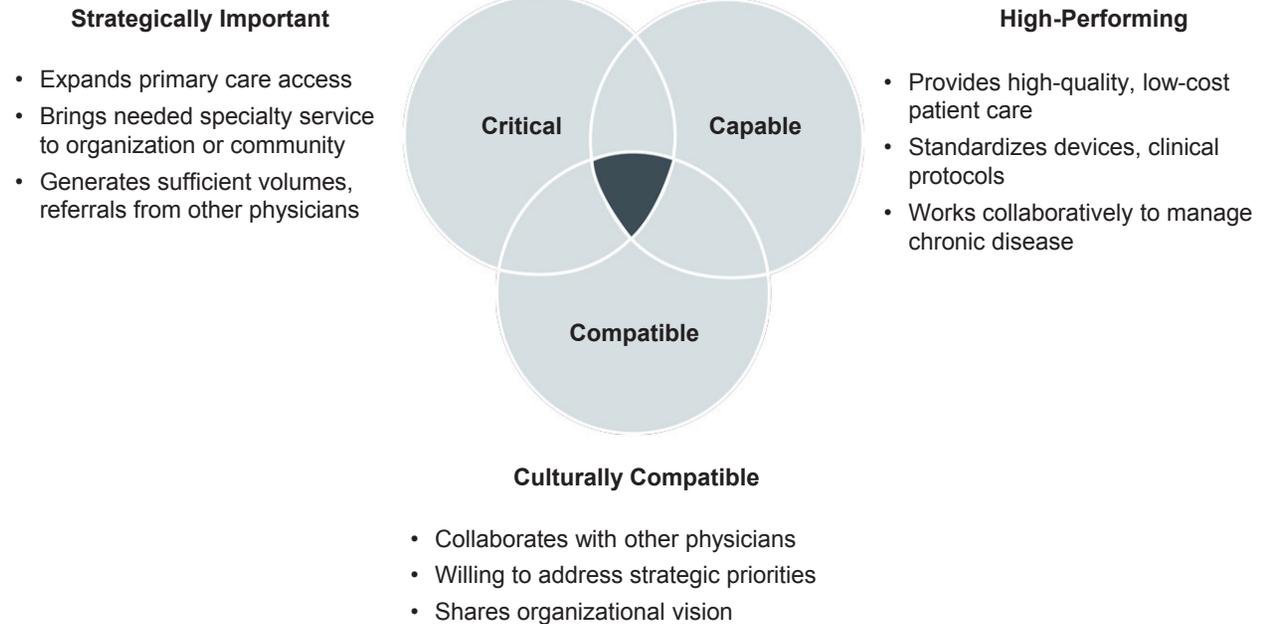Source: Health Care Advisory Board interviews and analysis.

Cultural Compatibility Assessment Crucial to Effective Hiring Decisions

The process of fostering a strong physician partnership begins at hiring. High-performance medical groups maintain strict standards for adding a new physician partner or acquiring a practice, considering three essential qualities in assessing a candidate's fit.

First, they evaluate strategic importance. Will the physician bring in new business from other physicians or add new services to the group? Second, groups assess whether the physician is clinically capable, placing a premium on quality and efficiency.

What truly sets high-performance groups apart from other employers, however, is how strongly they embrace the third tenet, hiring for cultural compatibility. As the group's collective success hinges on collaboration, hiring only candidates who meet organizational norms—even if that means walking away from physicians who could otherwise bring financial or strategic benefits—is critical. Groups also assert that this strategy is financially advantageous for the practice, as physicians who fit well are more likely to stay with the group, to refer to their in-network peers, and to minimize disruptive behavior.

Seeking Physician Partners with a Complete Set of Attributes

Strategically Important

- Expands primary care access
- Brings needed specialty service to organization or community
- Generates sufficient volumes, referrals from other physicians

High-Performing

- Provides high-quality, low-cost patient care
- Standardizes devices, clinical protocols
- Works collaboratively to manage chronic disease

Critical | Capable | Compatible

Culturally Compatible

- Collaborates with other physicians
- Willing to address strategic priorities
- Shares organizational vision

Key Benefits of Selective Hiring

Increases Physician Retention	*Improves Patient Satisfaction*	*Minimizes Cost of "Bad Apples"*	*Fosters Interpersonal Relationships*
• Reduces recruiting costs, resources • Minimizes vacancies • Maintains consistent level of productivity	• Supports consistent patient experience across enterprise • Reduces discontinuity from turnover, miscommunication	• Reduces individual behaviors that disrupt group performance • Avoids conduct issues that harm overall morale	• Builds connections that facilitate in-group referrals • Encourages team ownership of patient care

Source: Health Care Advisory Board interviews and analysis.

Defining Cultural Expectations During Recruiting Allows Candidates to Self-Select

Hiring a compatible physician is a two-way process. As the medical group focuses on assessing whether candidates are desirable partners, prospective physicians are in turn evaluating the group's dynamics and practice environment. Communicating group values from the outset helps candidates make an informed and timely decision about whether to pursue partnership.

Braeburn Medical Group (a pseudonym) recognized the need to better communicate organizational values during recruiting after the group embraced a principle of reducing care variability several years ago. Several physicians had trouble with the shift to greater standardization, and Braeburn saw turnover rise, particularly among newly hired physicians.

As a result, Braeburn chose to redesign its hiring process around transparent communication of its culture and group practice style. Key to this process was describing the benefits of the group's practice style in a comprehensive recruitment packet. With this information in hand, informed recruits asked more pointed questions, shortening the recruitment process. Four years later, Braeburn's turnover is half the national average.

Early Focus on Values Streamlines Recruitment, Maximizes Retention

Detailed Recruiting Packet Tells the Whole Story

- Informs candidates of practice culture
- Defines organizational strategy, dedication to eliminating unnecessary variability in clinical and operational processes
- Provides detailed history of the organization, recent achievements in quality improvement and physician satisfaction
- Focuses on differentiating organization from its competitors
- Provides contact information for candidates with outstanding questions

Appealing to the Right Physicians

"Previous recruiting efforts did not reflect our commitment to care standardization. Our recruiting now showcases what is exceptional about Braeburn. The physician recruitment packet sends a signal into the market to all physicians looking for the unique practice environment we provide. Our turnover rate is on a downward trend."

Director, Office of Physician Recruitment
Braeburn Medical Center

Case in Brief: Braeburn Medical Center[1]

- Multispecialty group practice with over 350 physicians affiliated with a 250-bed acute care hospital located in the South
- Culturally based engagement efforts redefine recruitment as system implements care standards
- Recruiting packet sent to every candidate prior to interview; includes annual report, organization facts and figures, organizational history, current strategy, recent achievements, and guide to living in the area

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Empowering Rank-and-File Physicians to Define the Ideal Partner

Physicians should play a central role in defining cultural standards for new physician hires. Consider the case of NorthShore University HealthSystem Medical Group, a 700-physician employed network in Evanston, Illinois. NorthShore established a rigorous, three-step process for evaluating candidates for employment. Before even scheduling an interview, NorthShore assesses whether the candidate fills a strategic need and evaluates the physician's past performance, looking at quality metrics and reputation.

But the most effective part of candidate selection is NorthShore's "Hiring for Fit" process, a behavioral interview designed from the ground up to evaluate cultural compatibility with the group.

To hone the interview, leaders surveyed more than 100 physicians in the group, asking them to identify the attributes they would expect in a new colleague. The responses informed an interview guide that covers six core competencies, provides sample questions, and offers guidance on interpreting responses. Using this guide, physician interviewers grade candidates on each competency, compare notes, and then make the hiring decision.

Behavioral Interview Guide Standardizes Candidate Evaluation

Physician Interview Guide

Physician evaluated on six categories, including:

- Clinical expertise
- Ability to build loyal patient base
- Interpersonal skills
- Work ethic/time management
- Ability to work within a system
- Technological competence

Sample questions provided to aid candidate assessment

Physician responses evaluated on scale of having "Not Met," "Met," or "Exceeded" organizational standards, expectations

Competencies clearly defined to ensure understanding of evaluation criteria among interviewers

Case in Brief: NorthShore University HealthSystem Medical Group

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system, located in Evanston, Illinois
- Created three-step candidate screening process to identify ideal physicians for employment
- Peer-led interview process evaluates strategic importance, performance quality, cultural fit of each candidate

Source: Health Care Advisory Board interviews and analysis.

Ensuring Cultural Fit Encourages Long-Term Stability of Physician Base

NorthShore's efforts have resulted in a much more selective and stable physician network. For example, administrators report they no longer quickly and automatically extend employment offers to specialists in new growth markets. Rather, they now assess cultural fit even for physicians who previously looked too good on paper to pass up.

This hard line on cultural fit is paying notable returns, especially around retention. The group improved its turnover rate, down from 12 percent historically to just 4 percent now. NorthShore also reports that involving frontline physicians in the hiring process continues to pay dividends down the road. Physicians who are actively involved in candidate selection feel invested in those colleagues once they are hired and work to make sure that they are positioned well for successful practice.

Effective Hiring Stems Physician Turnover

Preempting Problematic Relationships

Candidate Evaluation Form

Name: Dr. Perry Russet[1]
Specialty: Gastroenterology

☑ **Strategic Importance**

Meets an important community need and will be a valuable source of referrals

☑ **Performance Record**

Strong reputation and historically high performance on quality metrics

☒ **Cultural Compatibility**

Exhibits self-centered attitude, unreasonable expectations, and lack of willingness to work collaboratively

Hired   **Not Hired**

Employed Physician Annual Turnover Rate

*NorthShore University
HealthSystem Medical Group*

12–15%

4%

Historical Rate   Current Rate
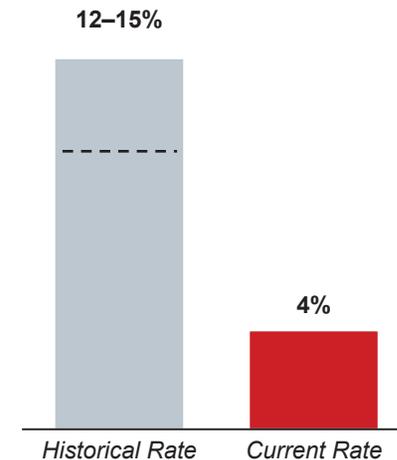
1) Pseudonym.

Expanding Cultural Assessment to Entire Practice

While hiring for cultural compatibility is relatively straightforward when interviewing a single physician, it becomes more difficult when evaluating a larger practice for acquisition. Even high-performance medical groups sometimes find themselves forced to bring on physicians who are not a good fit as individuals when acquiring a practice that is otherwise a strong strategic match.

In response to this challenge, Fairview Health Services in Minnesota created a "change assessment tool" that helps it quantify how well the practice overall will mesh with the rest of the group. The tool includes more than 50 standardized questions designed to evaluate cultural fit. Fairview generally brings on all physicians within the practice, even those who would not have been hired on their own; however, the tool helps Fairview identify what problem areas it will need to address immediately post-acquisition and allows the group to intervene early, before major issues take root.

Screening Tool Looks Beyond Individual Physicians to Evaluate Practice Fit

Practice Acquisition Requires Group-Level Assessment of Fit, Compatibility
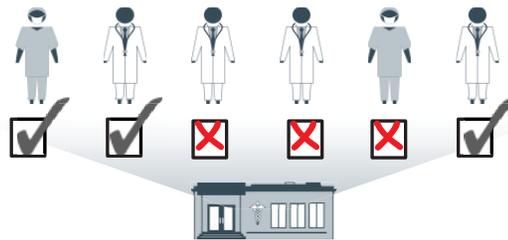
Key Cultural Indicators	
Business Strategy	Achievement
Mission, Vision, Values	Environment
Human Resource Philosophy	Perspective
Communication	Quality
Leadership	Organizational Structure

Assessment Tool Identifies Barriers to Smooth Transition Process

- 50+ questions enable objective evaluation of critical items impacting cost, scope, effort of transaction

- Scoring system provides quantified method to assess cultural compatibility of acquired practice

- Standardized tool guarantees consistent feedback across all evaluators, for all practices

- Identification of problematic items allows opportunity to address issues prior to integration

- Completed assessments serve as a communication tool during onboarding process

For complete Change Assessment Tool, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Case in Brief: Fairview Health Services

- 1,647-bed, multi-hospital system with 750 employed physicians located in Minneapolis
- Developed Change Assessment Tool to diagnose cultural similarities, differences of potential practice acquisitions
- Overall findings determine level of resources afforded for transition, cultural integration

Reinforcing Group Values Through Comprehensive Onboarding Process

Hiring for fit is critical to get the right new physicians in the door. But high-performance groups also realize that the onboarding process provides a crucial first opportunity to demonstrate their culture in action to new physicians.

HealthTexas Provider Network, a subsidiary of Baylor Health Care System, has designed a comprehensive onboarding program that includes both formal and informal forums intended to teach physicians about culture and build relationships with peers. Courses offered are diverse and in-depth, going well beyond the traditional, basic administrative introduction most employers offer to new physicians.

The HealthTexas courses are structured to communicate the organization's values at every turn—a campaign to win the hearts and minds of new physicians, disguised as simple orientation. Group leaders feel this robust and standardized process has been especially key to successfully integrating large numbers of physicians across a recent period of rapid acquisition and growth.

Acculturating New Physicians at Every Opportunity

Key Strategies for Engaging New Physicians

Standard Onboarding
Introduce new providers to organization, clinical practice, strategic priorities

Specialty Forums
Provide venue for new physicians to develop relationships with peers within their specialty

Practice Leader Meetings
Provide updates for leaders of newly acquired practices to connect with system leaders and communicate strategy to frontline physicians

Group-Wide Networking Opportunities
Utilize key meetings, including Baylor Health Care System Orientation, Physician Spring Forum, regional Town Halls to create cross-specialty relationships

Comprehensive Curriculum Ensures Acclimation

Agenda Items from HealthTexas Care Provider Onboarding Training	
Topic	**Presenter**
Stewardship or Rationing? Prudence, Equanimity, Justice in the Allocation of Medical Resources	Chairman, Service Excellence Committee Chairman of the Board, HTPN[1]
Physician/Patient Communication	Clinical Psychologist
Volunteer Opportunities	Family Medicine Practitioner
Social Media	Director, Marketing
Review of Press Ganey Data	Chairman, Service Excellence Committee

For complete Onboarding Training Curriculum, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Case in Brief: HealthTexas Provider Network

- Medical group with 500+ physicians, affiliated with Baylor Health Care System located in Dallas, Texas
- Conducts regular orientations for all new physicians, including standardized two-day onboarding process that assimilates large acquired practices

1) HealthTexas Provider Network.

Source: Health Care Advisory Board interviews and analysis.

Standardized Mentorship Program Fosters New Hire Success, Reinforces Culture

Culture-linked hiring and onboarding are about selecting and orienting new physicians. For sustainable integration, organizations must then build bonds between those physicians and other members of the group.

Spread out across multiple practice sites, physicians often lack opportunities to work together or to develop strong relationships. Successful medical groups work to create forums for relationship-building between physicians, recognizing that the investment pays dividends in the form of improved referral retention and care coordination.

At the individual level, high-performance medical groups use formal mentoring programs to build one-on-one relationships between new and tenured physicians. For example, WellSpan Medical Group created a systematized process that matches each new physician with a more experienced provider in his or her clinical specialty. The program prompts mentors to meet regularly with mentees and provides resources to support mentors in making those meetings productive.

WellSpan's program not only benefits new physicians, but has positive impact for mentors as well: in program evaluations, they report feeling a greater sense of connectedness to the group than before. All in all, 100 percent of participants rate the program as personally worthwhile.

Making an Investment in Each New Physician

- Each new physician matched with unpaid mentor in his/her own department, specialty
- Formal relationship lasts one year

- Checklist, handbook facilitate regular meetings between mentor, mentee,
- Contain links to guide physicians to resources, ensure productive sessions

Highlighting the Mutual Benefits of Mentorship

Mentee Feedback

- Feel supported throughout first year
- Provides familiarity with system, practice culture
- Accelerates peer network development
- Appreciate connection to dedicated peer resource, organized process

Mentor Feedback

- Feel invested in the success of new physician recruits
- Reminds of, reinforces organizational culture
- Increases attachment to organization

For complete Mentoring Checklist, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Case in Brief: WellSpan Medical Group

- 500-provider medical group within WellSpan Health, located in York, Pennsylvania
- Formalized once ad-hoc mentoring relationships occurring organically across many clinical departments
- Program evaluation at one-, three-, six-, nine-, and twelve-month intervals reveals mentoring benefits for both mentors and mentees, shows 100 percent satisfaction with the mentoring program to date

Source: Health Care Advisory Board interviews and analysis.

Enhancing Efficiency, Relevance of All-Group Meetings to Bolster Attendance

Beyond one-on-one relationship building, high-performance medical groups bring all physicians together on at least a quarterly basis. These all-group sessions provide an important opportunity to share strategy and to build connections across specialties.

At many organizations, all-physician meetings lack focus or allocate too much time to airing grievances. A poorly run meeting can backfire as an integration tool if physicians feel the group is squandering their time. As a result, high-performance groups take steps to ensure that meetings are relevant and productive.

Several years ago, St. John's Clinic in Missouri eliminated its all-group meetings after sustained poor attendance. Physicians felt the sessions had turned into "complaining sessions." Needing a forum to engage physicians on key issues, however, St. John's decided five years ago to revive the meetings, this time with a revamped formula. Leaders adhere to a formal agenda and observe a strict time limit. St. John's also offers incentives to make meetings worth physicians' time.

Most importantly, St. John's holds all comments until after the meeting. Leaders are always available for those who want to continue discussion. But the meetings now align with the interests of the majority. As a result, physician feedback has been overwhelmingly positive, and participation has increased dramatically.

Physician-Friendly Format Drives Attendance, Sparks Engagement

Run an Effective Meeting
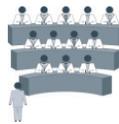
- In-person meetings
- Forward thinking, highly scripted, well-formed agenda
- Dynamic speakers invited
- Two-hour time limit strictly observed

Show Physicians What's in It for Them

- $1,000 incentive for attending all four meetings
- Penalties for failing to attend minimum of two meetings
- Catered meal, cocktails provided to maximize networking opportunities

Provide Separate, Informal Forum for Feedback

- Feedback and discussion of individual issues welcome after the meeting
- Leadership present after meeting for ad-hoc discussions
- Physicians encouraged to stay, socialize

Case in Brief: St. John's Clinic

- 470-physician multispecialty group within St. John's Health System, located in St. Louis
- Sought to improve historically low attendance at all-physician meetings
- New meeting format dedicates first hour to dinner and socialization, second hour to speaker content
- Now hosts four well-attended two-hour meetings per year

Average Physician Attendance
All-Physician Meetings

50–75	250–300
Before Format Change	With New Meeting Format
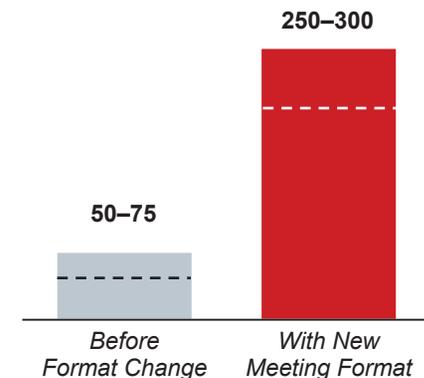
Source: Health Care Advisory Board interviews and analysis.

Meaningful Physician Authority Required for True Success in Integration

Beyond creating common culture and fostering partnership among physicians, high-performance groups formalize group identity through physician governance. Their experiences suggest that physicians will only be willing to truly engage in working toward group success if they feel peers are in control of key clinical and operational decisions.

True physician-led governance stands in sharp contrast to how many hospitals have traditionally managed employed practices. Physicians may serve in an advisory role, offering opinions, but decisions are made by health system management. Physicians have little opportunity to impact group or system strategy.

By contrast, high-performance medical groups put key decisions directly in the hands of physician leaders. Every group profiled in this publication unilaterally invests physicians with near-complete control over day-to-day clinical and operational decisions affecting practices. While health system leaders retain reserve powers and play a role in setting larger strategy, physicians have primary oversight of general practice operations.

Evolving Beyond Leadership Lip Service

Traditional Hospital-Based Employment Model

Influence, But No Real Control
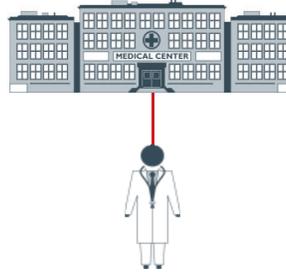
- Acknowledgement of physician leadership roles, titles, but little actual decision-making power
- Physician leaders removed from vision-setting process
- Little capacity for physician leaders to drive health system strategy

High-Performance Medical Group Model

Power Vested in Physicians

- Recognition that physician leaders have same status as hospital leadership within system
- Full physician control over key decisions affecting clinical, practice operations
- Health system role limited to reserve power retention, broader strategy-setting

A Critical Concession of Control

"Physicians are some of the most loyal people on the planet. They want their hospital to succeed. If you allow them to help in a real way, they'll solve problems. If you control them, they'll fight you every step of the way."

Administrator
250-physician medical group

Source: Health Care Advisory Board interviews and analysis.

Constructing a Leadership Model with Broad Control and Deep Penetration

Seeking to extend physician control across the network and down to the front lines, high-performance medical groups build leadership models with three essential elements.

First, they construct a centralized governance structure that pulls representatives from across the medical group, bringing together physicians from different practice sites and specialties to make strategic decisions for the enterprise as a whole. This governance structure also reaches down to the practice level, where physicians are placed in charge of day-to-day operational activities.

To populate this governance structure, successful groups also invest heavily in developing and supporting physician leaders, providing formal training programs, financial incentives, and other needed resources.

Finally, high-performance groups create processes to ensure that even as physicians assume responsibility for their own decisions, the group remains aligned with larger health system strategy.

Each of these elements is examined in more detail across the following pages.

Three Key Elements of Effective Physician Leadership

Physician-Led Governance Structure	Deep Physician Leadership Bench	Alignment with System Strategy
• Effective practice management infrastructure	• Appropriate tools, training resources available for effective leadership preparation, development	• Medical group impacts, informs health system strategy
• Physician-led, professionally managed	• Adequate administrative, management support for physicians in leadership roles	• Medical group decisions in lock step with health system goals
• Integration with health system (e.g., understanding the revenue cycle from both sides)	• Incentive structure in place to reward, create value for leadership roles	• Health system strategy clearly articulated to medical group
		• Medical group accountable for performance on goals set by organization

Source: Health Care Advisory Board interviews and analysis.

Centralized Decision Making Enables Consistency Across Group

To begin, this page examines key elements of an effective physician governance structure. In high-performance medical groups, governance is unified across all physicians, creating a forum for coordination among practices. Many groups note that centralized decision making is more important for building a sense of integration among physicians than structural consolidation of employed practices; physicians may be employed through different subsidiaries, but if unified through shared governance, will operate as an integrated whole.

Within the typical centralized governance structure, the medical group board oversees high-level strategy. Board representation is split between hospital and physician leaders and is kept small—usually only eight to 12 members—to facilitate consensus decision making.

The medical group board typically reports up to the health system board or system CEO. This direct reporting relationship sends an important signal to physicians that they are valued players within the larger system.

Underneath the board typically sit a host of physician-run committees that oversee operational issues such as information technology or quality improvement. This structure works to ensure that physicians have responsibility for all key decisions that impact operations and clinical practice.

Building a Unified Governance Structure

Physician Decision-Making Power Across All Levels of the Organization

Hospital/System (Parent Board)

Medical Group Joint Policy Board

- Split between hospital, physician leaders
- Small enough to effectively reach consensus decisions
- Sets high-level group strategy
- Approves major initiatives
- Hospital may retain reserve powers

Physician Operating Committee

- Composed of physicians only
- Tackles areas such as contracting, quality improvement, IT, other key strategy issues

Principles of Decision Making

- ☑ Pulls leadership from across the medical group

- ☑ Ensures equal representation across specialties

- ☑ Assumes broad responsibility for clinical, operational aspects of physician practice

For sample Organizational Charts, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Health Care Advisory Board interviews and analysis.

Recognizing the Need for Frontline Leadership

Complementing effective centralized decision making at the top of the organization, high-performance medical groups also extend leadership to frontline physicians, engaging practice leaders to coordinate on decisions that affect physicians' day-to-day operations.

Consider the case of NorthShore University HealthSystem Medical Group. NorthShore is a large, rapidly growing group, and its 28 primary care practices are spread across a wide geographic area, with limited communication between them. This fragmentation impeded the group's efforts to enhance care coordination and in-network referrals and to reduce care variability between member physicians.

Network Lacks Natural Connections Across Practices

Employed PCP Network

28 PCP Practices
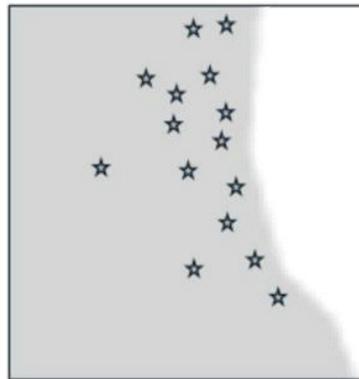
Leadership Challenges

Large geographic distance creates fragmentation

No formal leadership structure among PCPs

Lack of communication channels between network leaders, frontline physicians

Case in Brief: NorthShore University HealthSystem Medical Group

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system located in Evanston, Illinois
- 28 PCP practices across medical group lacked clear hierarchy, connection between practices and group leadership
- Lead Physician Committee successfully organizes groups, creates communication link between network leadership and community practices

Source: Health Care Advisory Board interviews and analysis.

Delegating Practice-Level Strategy to Physicians—and Realizing the Results

To create a vehicle for uniting PCPs, NorthShore created a PCP Lead Physician Committee, containing leaders selected by each of the group's 28 primary care practices. This committee fosters dialogue both between practices and with NorthShore's group leadership, and works to advance the medical group's broader strategic goals.

For example, group leaders tasked the committee with enhancing primary care patient access in the wake of stagnant growth. After exploring various possibilities, the committee proposed a centralized access program for cross coverage and expanded practice hours.

After collaborating to implement the changes, NorthShore's PCPs increased both patient loyalty scores and office visits, which translated into an increase for PCP income as well.

Key to NorthShore's success is that physicians affected by the decisions owned the initiatives and so were more willing to pursue solutions. Had administrators, rather than the PCPs themselves, suggested changes such as expanded weekend hours, the proposal could have generated considerable resistance from physicians instead.

Linking Community Practices Leads to Enhanced Access, Financial Performance

Providing Formal Structure

PCP Practices   PCP Lead Physician Committee   Medical Group Leadership
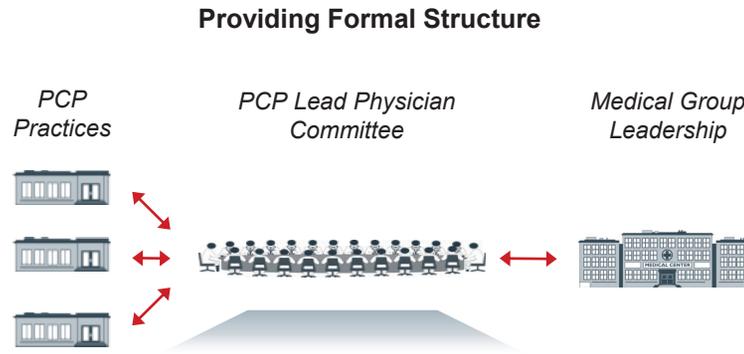
- Composed of 28 PCP leaders, one from each local practice
- Relays physicians' needs to medical group leadership
- Informs PCP practices of executive strategic initiatives
- Proposes action steps to target network goals

Improvement on Patient Loyalty Drivers
Physicians with Score of 5 on a 1–5 Scale

Driver	2004	2006
Exam Room Wait	23%	34%
Same-Day Walk-Ins	51%	64%
Follow-Up Appointment	70%	77%
Timely Return of Phone Calls	48%	56%
Phone Access	45%	62%

■ 2004   ■ 2006

PCPs Proactively Offering Solutions

Objective:
Expand patient access to PCP practices

Committee Recommendations:
1. Weeknight hours
2. Weekend hours
3. Sunday morning pediatric walk-in hours
4. Increased phone access

Loyalty Driving Success

20% Increase in overall patient loyalty

24% Increase in work RVUs

15% Increase in compensation per physician

Source: Health Care Advisory Board interviews and analysis.

Site Director Forum Mitigates Differences Among Specialties

High-performance medical groups also work to extend collaboration between frontline leaders across specialties.

To foster cross-specialty communication, WellSpan Medical Group in Pennsylvania brings all of its practice leaders together in a monthly Site Director Meeting. Originally conceived as a way to enhance top-down communication between medical group leaders and practice sites, these meetings have also evolved into an effective forum to work out problems that cut across specialty lines.

For example, WellSpan recently asked the site directors to develop standards for care handoffs and referrals. The resulting discussion highlighted many misconceptions that existed between PCPs and specialists about why poor referral communication occurred. By airing those grievances, site directors were able to reach a consensus decision on referral communication standards.

Overcoming the "Us versus Them" Mentality

Site Director Meetings Help Physicians See Eye to Eye

- Lead physicians at primary care, specialty sites represent each practice's individual needs

- Open, face-to-face discussion reduces preconceived notions, reveals similar challenges among practices

- Group has effectively identified several opportunities to create standards across practices (e.g., referral process norms)

Finding Common Ground

"A PCP said, 'Why can't the specialist just call me on the phone?' A specialist said 'I would like all PCPs who have told their nurses not to forward calls during a patient visit to raise their hands.' All of them raised their hands."

Thomas McGann, MD
Senior Vice President, WellSpan Health
President, WellSpan Medical Group

Case in Brief: WellSpan Medical Group

- 500-provider medical group within WellSpan Health, located in York, Pennsylvania
- Monthly Site Director Meetings focus on mutually applicable issues, promoting common level of understanding across practices and specialties, propose solutions to cross-specialty issues
- Aim of meetings to communicate strategy, rationale for organization's decisions back to each practice

Source: Health Care Advisory Board interviews and analysis.

Creating a Heavy Demand for Physician Leaders

Building a governance structure with adequate breadth and depth requires medical groups to bring a considerable number of physicians into the leadership ranks. For many groups, half or more of their physicians serve in some leadership capacity, from committee membership up to senior executive positions.

Meeting this leadership demand may seem daunting to the many hospitals that struggle to engage physicians in leadership roles. Prepared only for clinical practice, physicians often lack the leadership training needed to govern and manage effectively.

At the same time, however, a significant number of physicians do possess the personal attributes needed to be an effective leader, such as strong interpersonal skills or a solutions-oriented attitude. The challenge is to first identify these potential leaders and then to deploy appropriate resources to support them.

Group Must Train a Majority of Physicians for Leadership Roles

Filling the Leadership Void

Leaders Needed at 200-Physician Medical Group

Senior Physician Executives	5
Division Chiefs, Medical Directors	12
Committee Chiefs, Chairs	10
Physician Practice Managers	30
+ Physician Committee Participants, Members	40
TOTAL	**97**

Skill Set More Common Than Expected

- **Strong Interpersonal Skills:** Respected by peers, staff for both clinical, non-clinical skills

- **Elevated Commitment:** Additional time volunteered to support medical staff initiatives

- **System-Oriented Thinking:** Proactive identification of systematic concerns requiring further investigation

Source: Health Care Advisory Board interviews and analysis.

Executive Forum Offers Opportunity to Identify High-Potential Leaders

NorthShore University HealthSystem Medical Group utilized a standing discussion forum with the group's CEO to identify physicians with strong leadership potential. The forum is open to all physicians with a leadership title—even those serving only in nominal roles—and provides group executives with an opportunity to communicate around strategy with a large number of physicians.

As NorthShore was working to build up its leadership base, the discussion forums also offered an ancillary benefit. By monitoring who participated in and contributed most meaningfully to the forums, NorthShore was able to identify strong candidates for more senior leadership roles. These physicians were then elevated into central governance positions, often replacing low-performing or disengaged peers.

Establishing a Venue for Leaders to Emerge
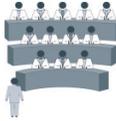
An Open Invitation

- Regular forum with medical group CEO intended to give all titled leaders[1] a venue to voice concerns

- Attendees include leaders in both formal, informal roles

True Leaders Emerge

- CEO able to identify leaders who are engaged, elevate their role

- Forum an opportunity to transition from leaders in name to leaders in action

Stronger Than Before

- Process resulted in replacement of low-performing leaders with effective, engaged physicians

- New leaders provide valuable review, feedback of work plans, strategic initiatives

Case in Brief: NorthShore University HealthSystem Medical Group

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system located in Evanston, Illinois
- High-potential physician leaders informally identified through their regular attendance at physician forums
- Group continues to meet quarterly, providing valuable information, feedback to senior leadership

1) Includes division heads, primary care leads, committee chairs, other informal but high-potential leaders.

Source: Health Care Advisory Board interviews and analysis.

Administrative Support Helps Physicians Balance Competing Demands

Once medical groups have identified high-potential leaders, they must also provide them with the support and skills necessary to be effective.

A key challenge for many physicians is having adequate time to devote to leadership duties. Physician leaders are most effective if they remain at least partially active in clinical practice, allowing them to truly understand the challenges faced by their peers. But balancing the demands of clinical work with leadership responsibilities is often difficult.

As a result, many high-performance medical groups support physician leaders through a "dyad" leadership model. In this model, physician leaders are paired with an administrative counterpart. The administrator oversees the operational tasks of management, while physician leaders are free to focus on interfacing with other clinicians. Most high-performing medical groups see this pairing as so crucial that they extend the dyad model to every level of management.

Leveraging the Physician-Administrator Dyad Model

Physician

Duties

- Oversees physician productivity, staffing, recruitment
- Provides physicians with performance feedback and improvement plan
- Provides clinical oversight
- Convenes, leads physician leadership groups

Skills

- Displays strong understanding of clinical data, physician practice economics
- Respected by PCPs, specialists

Administrator

Duties

- Oversees support staff, practice equipment, supply needs
- Manages logistics of payer contracting negotiations
- Monitors, prepares compensation reports
- Assesses, implements quality improvement initiatives

Skills

- Displays strong communication, organizational skills
- Engages diverse stakeholders from physicians, office staff to payers, employers

Source: Health Care Advisory Board interviews and analysis.

Investing in Physician Leadership Training and Development

Development of management and leadership skills—not something typically taught in medical school—is another core need for emerging physician leaders. High-performance medical groups therefore invest heavily in leadership training.

HealthTexas Physician Network, part of the Baylor system, views leadership service as an important way to acculturate new physicians. As the group has undergone a period of rapid growth in recent years, it has worked to quickly engage new physicians in committee roles, with the expectation that many of these physicians will subsequently assume more senior leadership responsibilities within the organization,

As part of this commitment, HealthTexas provides formal leadership development training. All new leaders go through a five-month course introducing them to Baylor's sophisticated quality improvement program and are coached on fundamental business and management skills.

Group Sets a High Bar for Physician Commitment, Organizational Support

Requirements for All Physician Leaders
✔ Demonstrated success in quality improvement project
✔ Completion of ABC Baylor Course
✔ Meeting thresholds for patient satisfaction
✔ Exhibition of good citizenship (meeting attendance)
✔ At least one year spent on committee
✔ Ability to demonstrate leadership skills
✔ Acceptance by other physicians as leader

Resources for Physician Leaders

- **ABC Baylor:** Five-month, internally developed course with a focus on continuous quality improvement attended by rising physician leaders, practice administrators

- **School of Management:** Year-long course, offered every other year with a focus on acclimating experienced physician leaders to management roles

Case in Brief: HealthTexas Physician Network

- 500+ physician medical group affiliated with Baylor Health Care System, located in Dallas, Texas
- Group investment in incentive, high premium on leadership bolsters involvement
- Network invests in leadership development through formal training, strict requirements

Source: Health Care Advisory Board interviews and analysis.

Establishing a Sense of Shared Responsibility for Leadership Development

To increase the feasibility and attractiveness of leadership service, HealthTexas Physician Network also compensates its physicians for leadership duties. The group pays physicians at an hourly, fair market value-based rate for leadership duties, helping to defray productivity and revenue lost due to time spent away from clinical practice.

Although many other high-performance medical groups also compensate for leadership service, HealthTexas goes a step further than most. To stress the impact that leaders are making for all physicians, HealthTexas funds its stipends through a so-called "leadership tax"—a fee paid by every physician in the medical group that explicitly goes toward leadership compensation. This strategy communicates that physician leadership is so important to group success that all physicians are expected to make a contribution toward it in some way, whether through time or money.

The net result of these support systems is that HealthTexas has an impressive 30 percent of its physicians serving in leadership roles.

Required Contribution Communicates Importance of Leadership Service

HealthTexas Leadership Incentive Fund

Committee Participation

Pooled contribution: $65 per month per physician required to fund organization's committee pay structure

$150/hour[1]

Committee Chair

$200/hour[1]

30% — Estimated percent of physicians in compensated leadership roles

$3,300 — Amount earned annually by physician committee member attending all meetings
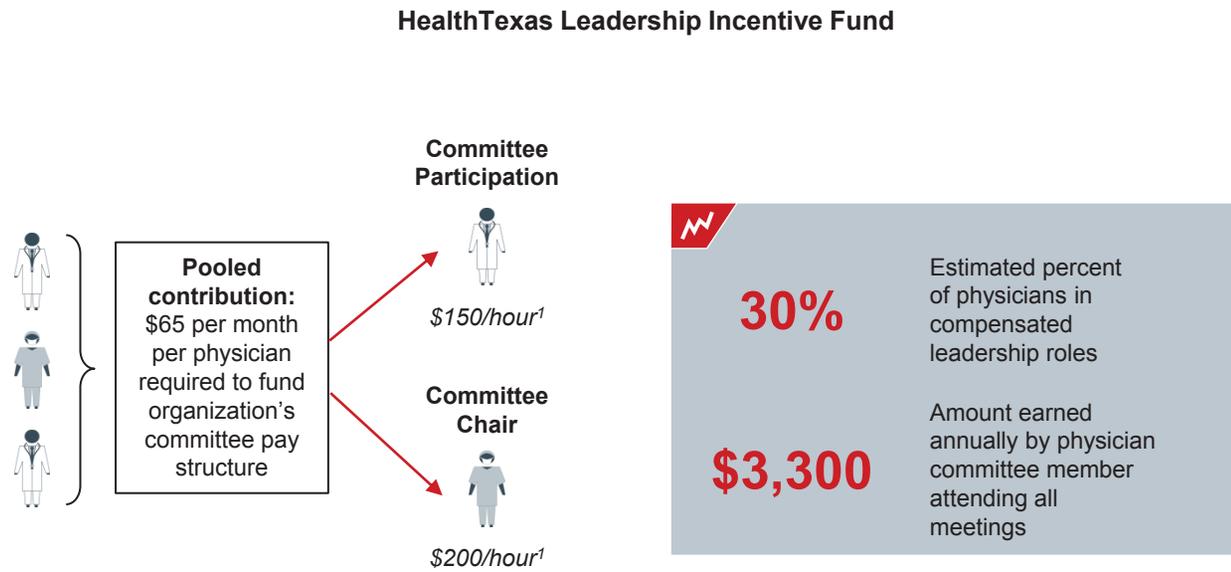
1) Rate applies to hours dedicated to leadership role.

Excessive Autonomy Preventing Strategic Alignment

The final core element of effective physician governance is alignment with system strategy. In creating a physician-led medical group, health systems must avoid inadvertently fostering discord between physicians and the rest of the organization.

Akero Health Medical Group is a pseudonymed multispecialty network affiliated with a multi-hospital system. Akero has a thriving medical group governance structure, and the group is operationally and financially successful, with practice losses dropping considerably across the past five years.

However, Akero's physician leaders typically make decisions with little consideration of how those choices impact, or are impacted by, larger health system strategy. The group is a successful business unit, but not a strategic partner—group-level integration has failed to improve physician attachment to system goals.

Self-Governance, Group-System Alignment Potentially in Conflict

Autonomous but Disconnected

- Financially stable group not aligned with health system

- Medical group unaware of system strategy due to poor communication

- Physician input not solicited, medical group decisions do not further system strategy

Missing Out on Benefits of Integration

- Health system failing to realize value of closely aligned medical group

- Missed opportunities include cross-continuum referral capture, improved care coordination, physician support of clinical, efficiency goals

Case in Brief: Akero Health Medical Group[1]

- 380-physician multispecialty group located in the East
- Medical group operationally and financially sound, but operates autonomously with little input from system; frequently makes decisions in conflict with system strategic goals
- Future stability, success of organization jeopardized by failure to realize benefits of physician integration

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Elevating Medical Group Leaders to System Senior Executive Ranks

A more integrated approach is offered by Indiana University (IU) Health Physicians, a large multispecialty medical group in the Midwest. Like many high-performance groups, IU has created system-physician alignment by elevating the medical group's CEO to a seat at the system's highest executive table.

In that capacity, the CEO is able to ensure that medical group decision making reflects system needs and concerns. With a direct line between them, the medical group and health system can tailor their strategic plans and performance scorecards to match each other. Individual physician performance is thus linked directly back to system success.

At the same time, the CEO's role as a senior system executive allows him to influence system decision making, ensuring that larger organizational strategy also reflects physicians' needs and concerns. For example, the medical group CEO recently encouraged health system leaders to incorporate diabetes-specific metrics into system-level performance scorecards, noting that while diabetes management indicators are most directly applicable on the ambulatory (rather than inpatient) side, their relevance to the system as a whole would grow as the organization took on more reimbursement risk.

Strengthening the Link Between System and Physician Group Strategy

Impact of Placing Medical Group CEO on System Senior Executive Committee

Benefits to Medical Group

- Representation in key decisions impacting clinical, practice operations
- Consideration of physician practice concerns when setting high-level strategy
- Senior, bidirectional line of communication to facilitate feedback, input between system, group

Benefits to Health System

- Physician perspective on decisions impacting system-wide care delivery
- Channel to communicate rationale for system-level strategy decisions, fostering support
- Safeguard to ensure practice-level activities in sync with system strategy

Case in Brief: Indiana University Health Physicians

- 1,100-physician medical group affiliated with Indiana University Health System, located in Indianapolis, Indiana
- Medical group leadership present at health system executive vice president meetings
- Direct line of communication contributes to a more comprehensive view of care delivery in system strategy, aligned performance scorecards

Source: Health Care Advisory Board interviews and analysis.

An Integrated Identity

The box on this page provides a brief overview summary of the eight attributes used by high-performance medical groups to develop an integrated identity. These elements involved in creating common culture, fostering partnership between physicians, and formalizing physician control represent the first level of foundational tenets for the high-performance medical group.

Takeaway Summary for Health System Leaders

Attribute #1: Shared Vision and Formalized Cultural Expectations
Acknowledge the need for a unified culture across all employed physicians and engage physicians to define and codify the core values of the medical group; link group tenets to enforceable performance standards

Attribute #2: Unified Identity Projected to Non-Physician Stakeholders
Communicate value of integration to practice staff and patients through common branding and operations; develop comprehensive system perspective of medical group value beyond bottom-line performance

Attribute #3: Cultural Expectations Hardwired in Recruiting and Onboarding
Design candidate selection and onboarding processes to ensure that physician partners meet strategic and quality goals, fit organizational culture, and are capable of working collaboratively

Attribute #4: Meaningful Interpersonal Relationships Between Physicians
Foster interpersonal relationships between new and tenured physicians through formalized mentoring; perpetuate collegial relationships among physicians through efficient, regular group-wide forums

Attribute #5: Centralized Physician-Led Governance Model
Formalize physician control of key operational and strategic decisions through centralized, physician-led governance; aim for governance unifying all physicians across specialties and corporate divisions

Attribute #6: Frontline Physicians Active in Leadership
Create leadership roles that allow frontline physicians to improve practice performance and care delivery; create an organizational structure that maximizes their impact on practice-level decisions

Attribute #7: Investment in Broad-Based Physician Leadership
Recognize the need for a large number of physicians to serve in medical group leadership roles; actively seek high-potential leadership candidates and provide them with the training and tools needed to succeed

Attribute #8: Strategic Alignment Between Health System and Group
Recognize that physician autonomy should not impede hospital-physician integration; elevate medical group leadership to senior executive team to ensure bidirectional communication and strategic alignment

Source: Health Care Advisory Board interviews and analysis.

An Integrated Identity

The box on this page contains key questions for health system leaders to discuss as they consider their own progress toward creating an integrated identity among employed physicians.

Key Questions for Health System Leaders

- Can system leaders and physicians articulate a common vision for the medical group culture? What are our core values? How do we engage our physicians to formalize these tenets, and integrate them into practice?

- Do our current branding efforts reinforce our integrated identity and the advantages of integration for patients? How do we work with frontline staff to create a consistent experience for patients across the group?

- Does our physician leadership encompass a broad range of physicians across specialties, sites of practice, and tenure? How do we identify high-potential leaders to expand leadership ranks and support them in balancing these duties with care delivery?

- Do we have active, physician-led medical group governance? How do we unify governance to enable common decision making across the group? How do we create robust leadership at the practice level?

- How do we help system leaders and board members embrace a comprehensive view of medical group performance? How do we build processes to ensure the health system and physicians are working toward shared goals?

Source: Health Care Advisory Board interviews and analysis.

II. Infrastructure for Shared Success

- Extending Performance-Enhancing Tools

Infrastructure Facilitates Care Coordination, Performance Improvement

Construction of an infrastructure that allows physicians to function as a team is the second key strategy used by high-performance medical groups. If building an integrated identity is designed to win physicians' "hearts and minds" for closer collaboration, medical group infrastructure is designed to provide physicians with "arms and legs" for collective performance improvement and shared success.

The high-performance medical group infrastructure includes three key attributes, each of which is explored further across the following pages.

First, groups construct an information technology backbone that enables seamless data flow and supports clinical care. Second, they develop a physician-led, data-driven process to identify performance improvement opportunities and to respond with standardized solutions. Finally, high-performance groups deploy a set of network-level resources that help physicians implement those improvements, capitalizing on group scale to advance clinical care beyond the capabilities of a single provider acting alone.

Deploying the Tools for Collaborative Achievement

Level of Collaborative Achievement

Attribute #11:
Scaled Resources to Support Care Delivery

Attribute #10:
Formal Processes for Data-Driven Performance Improvement

Attribute #9:
Enterprise-Wide Information Network

Investment in Performance Improvement Infrastructure
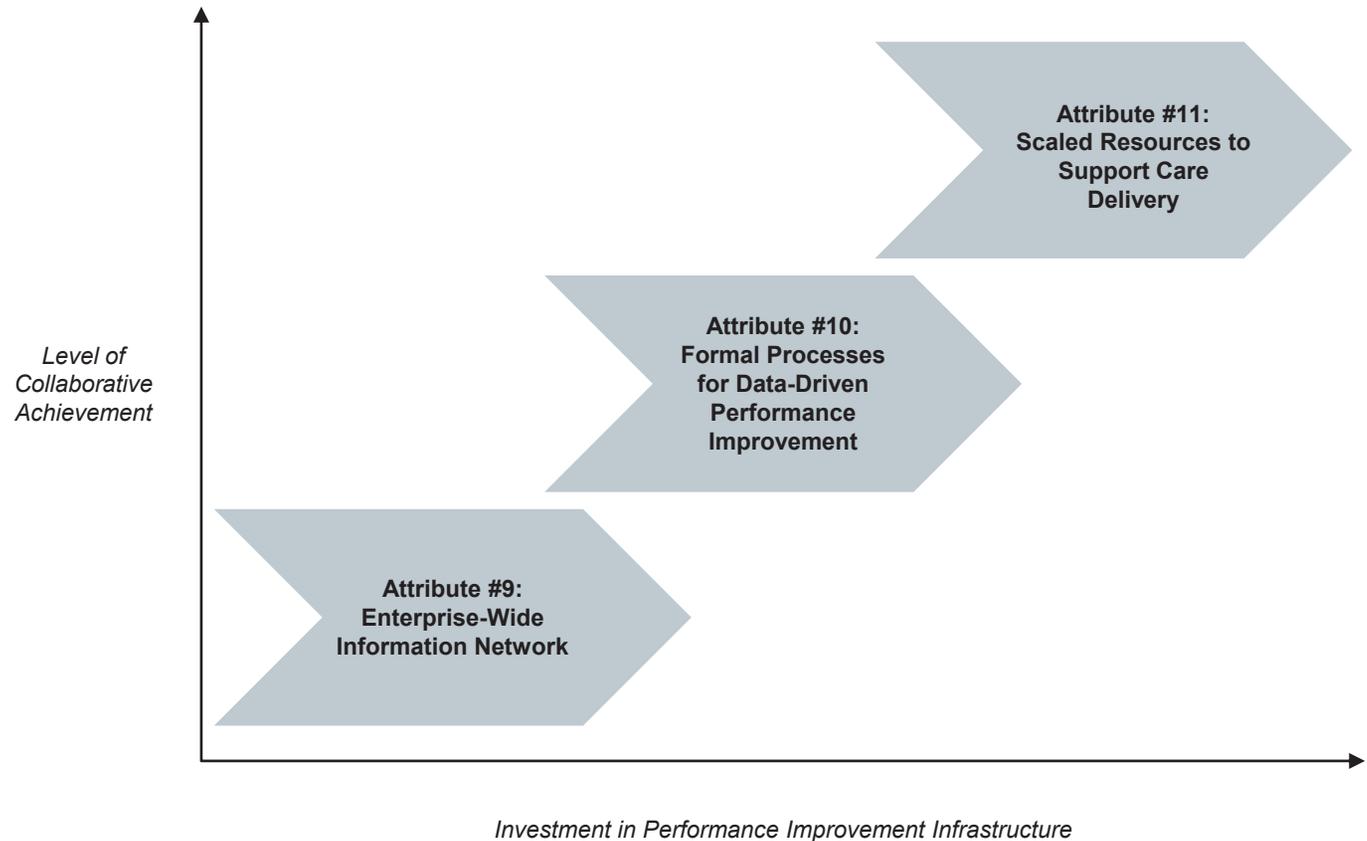
Source: Health Care Advisory Board interviews and analysis.

Seamless Information Exchange a Long-Held Ambition

For high-performance medical groups, free-flowing exchange of patient information has long been a core value. Indeed, more than 100 years ago, one of the nation's first group practices—the Mayo Clinic—converted to a unified patient record and built a massive pneumatic tube system to move data between clinic sites.

Full and open information transfer allows physicians to provide better clinical care. More importantly, it sends a cultural signal that information is a group asset and that colleagues have nothing to hide. As one group administrator noted, "When everyone in the group knows what is going on elsewhere, medicine can truly be a team sport."

Today, Mayo's pneumatic tube system has been replaced by an electronic medical record (EMR). The EMR's benefits go far beyond data sharing, allowing groups to build in value-added features such as clinical decision support, care pathways, and data analytics. As a result, high-performance medical groups have unilaterally adopted enterprise-wide EMR systems, often far earlier than others in the market.

Placing a High Premium on Comprehensive Data Availability

The Historical Precedent

© 2011 Stanford School of Medicine, Norbert von der Groeben, http://med.stanford.edu/ism/2010/january/tubes-01 11.html### html

Technology in Brief: Pneumatic Tube System at the Mayo Clinic

- 3,700-physician health system based in Rochester, Minnesota
- In 1907, created single-unit patient record system and built comprehensive pneumatic tube network for transporting records
- Pneumatic tubes shuttle foot-long containers throughout, across buildings to enable sharing information
- Two pneumatic tube systems span 10 miles, connecting 94 clinic sites

The Modern (and More Effective) Replacement

100% High-performamce medical groups using an enterprise-wide EMR

EMR Attributes	Benefit
Standard field to enter information	Creates capacity to pull accurate data, analyze quality
Ability to flag care protocols	Increases ability to standardize care pathways
Clinical decision support	Allows instant verification of proper course of action
Information on past care interventions	Averts conflict in care regimen, adverse medication interactions
Full access to patient information	Prevents unnecessary repeat documentation, provides full medical history

Source: Health Care Advisory Board interviews and analysis.

Designing an Information System with Maximum Functionality

Two considerations are key to high-performance medical groups' use of EMR technology and the resulting benefits.

First, medical groups invest not just in any EMR, but in a single-vendor, enterprise-wide platform providing the same user interface across all practices. Several groups have even chosen to replace existing functional but disparate EMR systems originally selected by individual practices, citing a common platform as the only way to both ensure transparency and hardwire standard operating protocols.

For example, Gala Health Network (a pseudonym) invested several million dollars to replace its EMR network after spending years trying unsuccessfully to patch together disparate systems. Notably, this change was driven by Gala's physicians, who were frustrated with the shortcomings of legacy platforms and lobbied for new technology despite the potential negative impact on productivity.

Second, medical groups recognize that even the most advanced EMR lacks all the capabilities needed to drive group performance. As a result, they also invest in complementary platforms, such as disease registry or practice management software. These systems provide services that the EMR cannot, such as the ability to identify care gaps for chronic disease patients or evaluate population-level performance.

Common EMR Platform, Use of Additional Technologies Drive Effectiveness

Investing in a Single-Vendor Platform

Epic   **Allscripts**

eClinicalWorks   **CERNER**
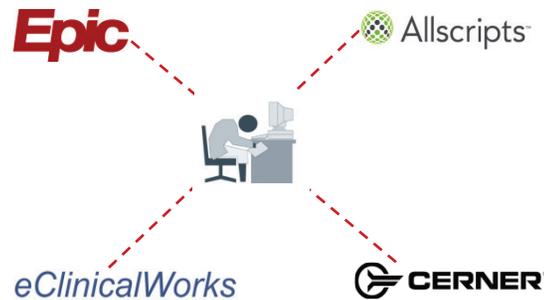
- Missed common baseline information
- Needed hardwired standards across the system

Case in Brief: Gala Health Network[1]

- 1,500-physician, seven-hospital system located in the Midwest
- Invested in system-wide EMR to support commitment to effective physician integration

Augmenting with Other Systems

Information Needed to Drive Performance

EMR

- Disease Registry
- Practice Management Software
- Clinical Decision Support
- ePrescribing
- CPOE[2]
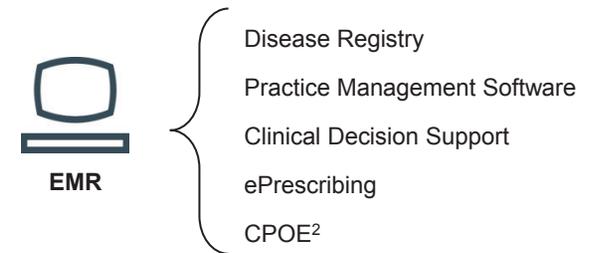
Advantages of Comprehensive Information System

	Advantage
✓	Ensures compliance with clinical standards
✓	Fosters sense of integration across all physicians
✓	Alerts physician of adverse medication interactions
✓	Provides database of results on clinical outcomes
✓	Tracks care site transitions
✓	Reviews test results, referral diagnoses instantly

1) Pseudonym.
2) Computerized physician order entry.

Source: Health Care Advisory Board interviews and analysis.

Elevating Performance Through a Comprehensive Information Platform

The Marshfield Clinic in Wisconsin provides an example of a comprehensive information network at work. Its robust IT infrastructure includes a myriad of data systems. The clinic's home-grown EMR is the gateway into this infrastructure, which also includes a number of other supporting technologies. The goal of Marshfield's extensive IT effort is to put as much information as possible at every physician's fingertips, driving proactive care management for those patients most at risk.

Marshfield was a participant in the Medicare Physician Group Practice (PGP) Demonstration, which tested a shared-savings reimbursement model. Participating organizations were charged with decreasing spending for an assigned group of Medicare beneficiaries by at least 2 percent; once that threshold was reached, PGP sites were eligible to receive 80 percent of any additional savings realized. Out of 10 participants, Marshfield was one of only two organizations to earn bonuses during every year of the demonstration project, a success it credits in part to its comprehensive information backbone.

With a Myriad of Data at Their Fingertips, Physicians Able to Excel

Information-Powered Care Delivery at Marshfield Clinic

EMR

Electronic Access to Lab Results	Delivers lab results in real time, customized by specialty
Disease Registries	Facilitate preventive health prompts, capacity to adjust for chronically ill
ePrescribing	Highlights list of preferred alternates, flags allergies, potential ADEs[1]
CDSS[2]	Provides real-time guidance for key clinical decisions
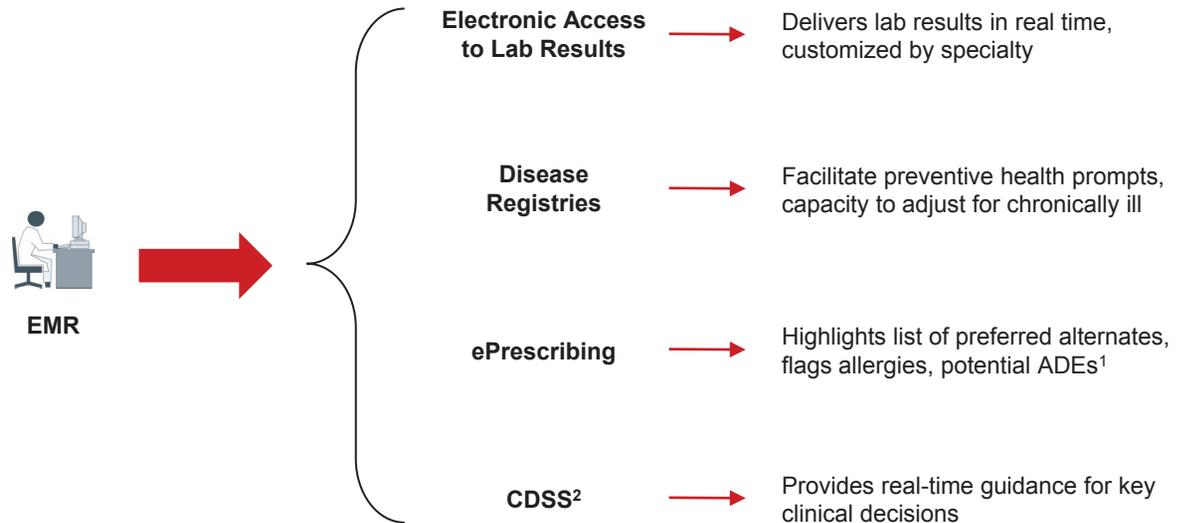
Case in Brief: Marshfield Clinic

- 800-physician, not-for-profit multispecialty group practice located in Marshfield, Wisconsin
- Developed a custom electronic health record, telemedicine network
- Electronic network supports care delivery in 33 rural communities in northern, central, and western Wisconsin

1) Adverse drug events.
2) Clinical decision support systems.

Physician Input Key to Maximizing IT Effectiveness

Physician support is another critical consideration for IT effectiveness. Physicians play a key role in developing system protocols, ensuring that data is properly entered, and using the system to its fullest capability on an ongoing basis.

As a result, high-performance medical groups are careful to engage and train physicians around IT at every opportunity. This practice begins, as Marshfield's president notes, during the development phase, when physicians are integrally involved in selecting and testing IT systems. Once the information system is operational, medical groups invest time and energy in training physicians on how to use it properly and constantly reinforce how physicians' use of the system links back to larger goals for patient safety and quality.

Enfranchising Physicians at Every Step

Develop Clinical and Operational Protocols

- Involve experts across all specialties in creation of evidence-based care standards

- Solicit physician feedback prior to rollout

- Ensure physician review process for updating standards
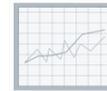
Ensure Accurate Data Capture

- Engage physician champions to set example, train colleagues on standardized data entry

- Ensure physicians understand link between accurate data entry, improved patient care

Adhere to Clinical Decision Algorithms

- Highlight data indicating that decision support results in higher quality care

- Deploy physician-led communication strategy linking algorithms to clinical excellence

> "If you look at our system, it wasn't developed by some IT folks in a vacuum. Doctors are on the development team."
>
> *Ken Ulrich, MD*
> *President, Marshfield Clinic*

The Knowledge-Powered Medical Group

This page summarizes the four necessary capabilities of the high-performance information network—a system that both supports the best possible performance at the moment of care and fuels analysis that engenders additional, ongoing improvement.

Four Hallmarks of Effective IT Platforms

Establishes Baseline for Performance

- Captures complete picture of clinical, operational performance
- Standardizes physician performance evaluation to increase accuracy

Hardwires Clinical Standards

- Provides clinical decision support to remove unwarranted variation
- Encourages consensus-driven care protocols to increase overall patient safety

Manages Patients Proactively

- Identifies patients most in need of disease management, intense interventions

Enables Cross-Network Visibility

- Builds system for care coordination
- Elevates the patient experience
- Creates virtual format for real-time communication
- Increases visibility to schedule availability across network

Source: Health Care Advisory Board interviews and analysis.

Enabling Enterprise-Wide Performance Management

With an enterprise-wide information network in place, the high-performance medical group's next strategy is to use that data to drive performance improvement.

High-performance medical groups typically follow a four-step process to identify and address opportunities for performance improvement. They begin by developing a comprehensive executive-level dashboard that provides a holistic view of medical group performance across a range of operational, financial, and clinical indicators. Groups then use that dashboard to identify areas of underperformance and prioritize interventions based on an analysis that weighs likely benefits and physician reaction.

Once the group has selected an improvement opportunity, it looks for solutions within its own ranks, pulling together physicians to create "economies of intellect" around best-practice standards. Finally, groups roll those standards out gradually, building on strong initial results to generate enthusiasm and buy-in among physicians.

Translating Data into Solutions

Drawing Actionable Insights from Data

Deploying Data-Driven Solutions

Adoption of Best Practices

Element #1

Build a Comprehensive Dashboard

Element #2

Select Areas for Improvement

Element #3

Develop Standardized Solutions

Element #4

Roll Out the Standard

Time
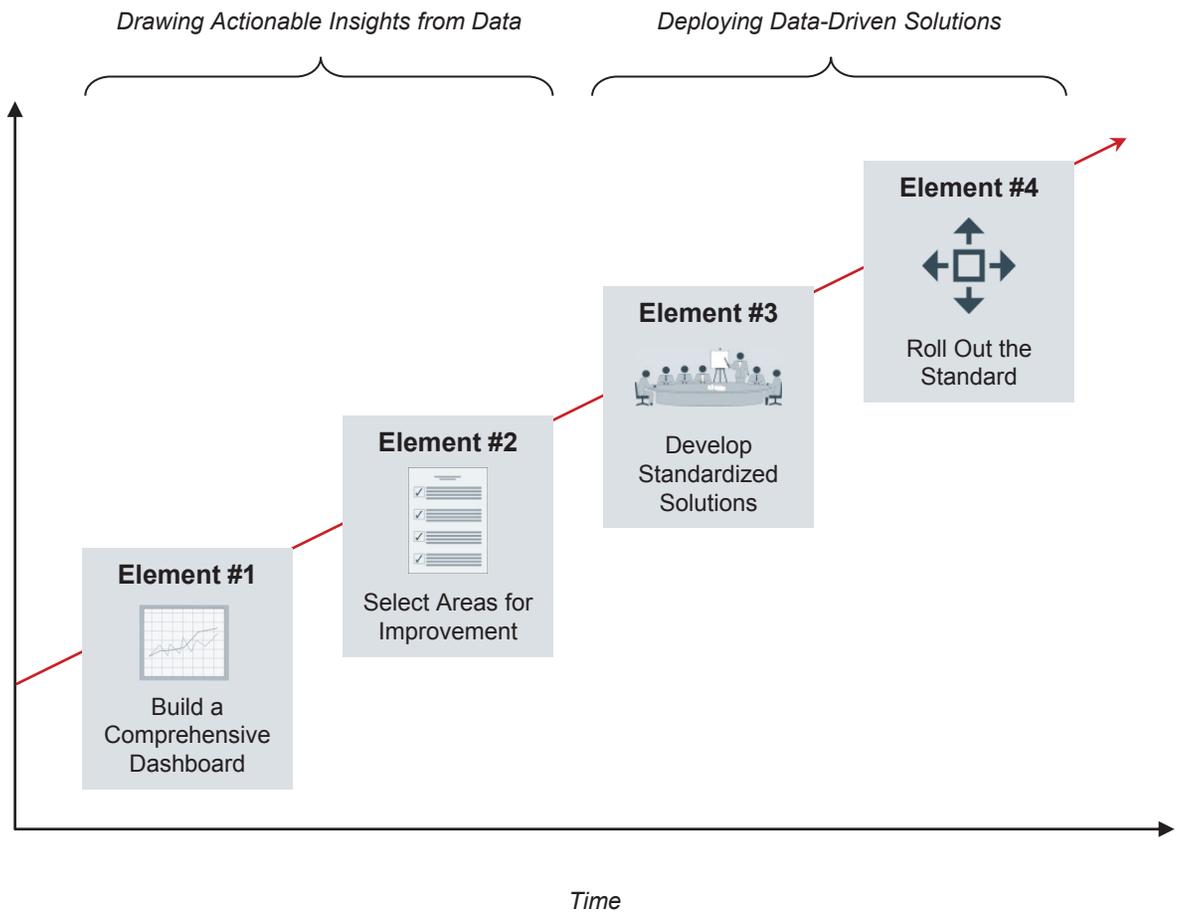
Source: Health Care Advisory Board interviews and analysis.

Expanding Performance Focus Beyond the Financials

At the root of the performance improvement process is the executive dashboard, which gives medical group leadership a bird's-eye view into group activity and outcomes.

This dashboard provides a more comprehensive view of medical group performance than the typical physician practice report cards, which primarily focus on employed physicians' productivity and financial outcomes. By contrast, the high-performance medical group dashboard incorporates a broader set of indicators, such as clinical outcomes, patient and peer satisfaction, or physician citizenship. This holistic view allows the group to identify a wide range of opportunities for performance improvement.

Successful Groups Adopt Multi-Faceted View of Network Performance

Status Quo Groups Solely Focused on Practice Financials

Performance Dashboard for Employed Physicians

Profit and Loss Statement	$____
Bad Debt	$____
Days in A/R	____
Expense per wRVU	$____
Revenue per wRVU	$____
Medical Group Income	$____

Characteristics of a High-Performance Group Dashboard

Offers both broad and comprehensive view of practice performance

Provides system-level perspective on practice value beyond financial transactions

Identifies critical areas requiring performance improvement

Source: Health Care Advisory Board interviews and analysis.

Aggregating Data from Multiple Sources for Complete Performance Visibility

To populate the comprehensive performance dashboard, medical groups pull information from a range of data sources, including both inpatient and ambulatory clinical and administrative information systems. Additional data, such as peer and patient feedback, may be collected by hand.

Based on conversations with high-performance medical groups, the Health Care Advisory Board has created a "pick list" of commonly used dashboard metrics. This list, which is available through the Advisory.com website, organizes metrics along three dimensions of value.

Monitoring Metrics Across Three Performance Dimensions

Myriad of Data Sources

Clinical Systems
- Disease registry
- EMR

Administrative Systems
- Practice management system
- Financial/billing system

Other Data Sources
- Patient satisfaction
- Peer feedback
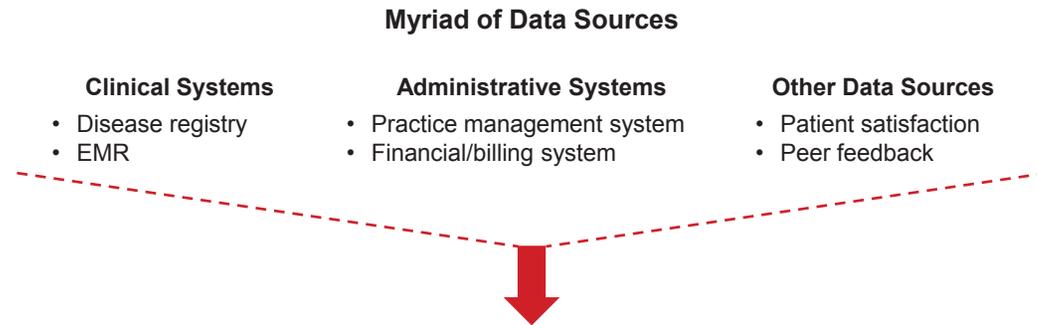
Comprehensive Group Performance Dashboard
Sample Metrics

Care Sustainability	Care Outcomes	Care Management
Practice/Group-Level Expenses	Evidence-Based, Specialty-Specific Metrics	Care Coordination Processes
Practice-Level Revenue	Care Standard Adherence	Primary Care Transformation
Downstream Revenue	Readmission Reduction Metrics	Patient Engagement

For complete Medical Group Dashboard Metric Pick List, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Health Care Advisory Board interviews and analysis.

Honing in on Realistic and Actionable Performance Improvement Targets

The dashboard's role is to highlight opportunities where performance is lagging. The next step in the performance improvement process is to decide which of those opportunities are most worth pursuing.

The Marshfield Clinic invests considerable effort into performance management, another crucial factor in its success with the Physician Group Practice Demonstration. As part of this effort, Marshfield conducts a four-step assessment process to determine which potential improvement initiatives will be most feasible.

With physicians involved at every step, Marshfield first determines whether a particular initiative is actionable and feasible given the analytical and human resources available. If so, Marshfield then conducts a cost-benefit analysis of the potential opportunity. Finally, Marshfield considers physician response, rejecting initiatives likely to generate too high a level of resistance. This process results in a prioritized list of physician-championed, actionable initiatives with concrete performance goals.

Sequence of Questions Allows Clinic to Prioritize Potential Initiatives
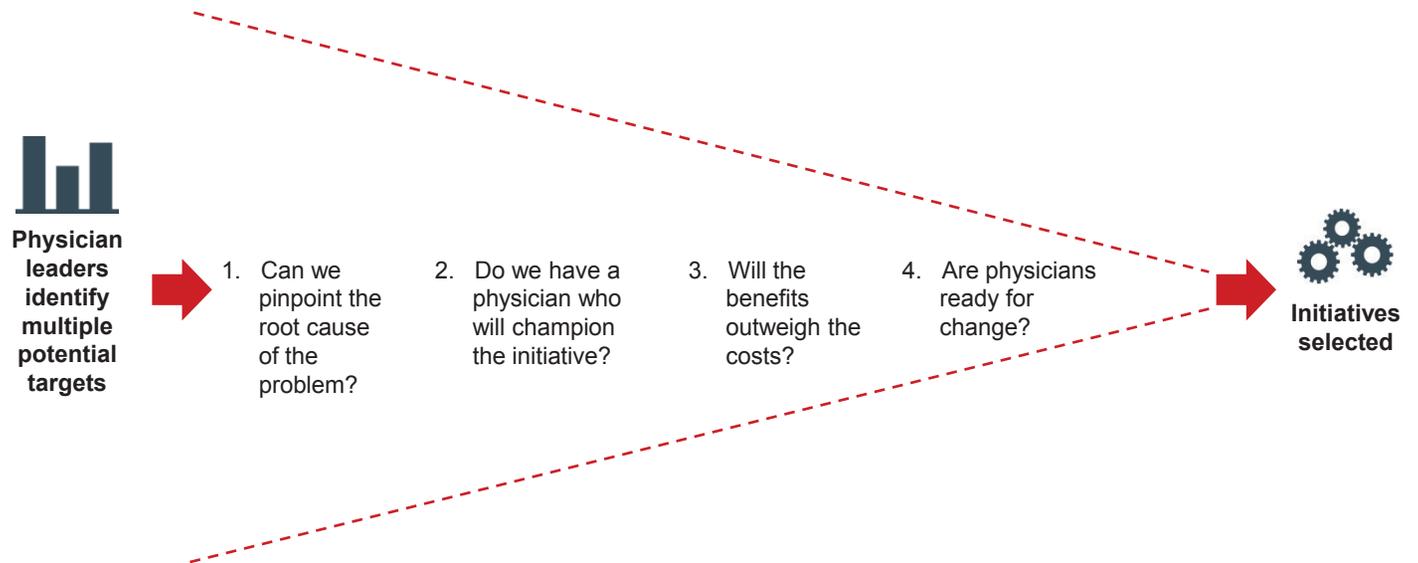
Physician leaders identify multiple potential targets

1. Can we pinpoint the root cause of the problem?

2. Do we have a physician who will champion the initiative?

3. Will the benefits outweigh the costs?

4. Are physicians ready for change?

Initiatives selected

Case in Brief: Marshfield Clinic

- 800-physician multispecialty group practice located in Marshfield, Wisconsin
- Developed data-driven system to select performance improvement initiatives
- Operations group, system implementation team jointly identify metrics to determine rollout timeline, measure success

Capitalizing on "Economies of Intellect" to Surface Best-Practice Solutions

Once medical groups have identified a viable improvement opportunity, they next work to develop best-practice solutions. Successful groups look first for those best practices within their own ranks, pulling together physicians from across the organization to create "economies of intellect."

Atrius Health, a tightly knit network of standalone medical groups in Massachusetts, believes strongly that unnecessary variation leads to inefficiency and poor outcomes. As a result, Atrius works closely to identify the most effective clinical and operational practices in use by member physicians and to spread those practices across the network as standard operating protocols.

To facilitate this process, Atrius created the Quality Improvement Council, staffed by representative physicians from across the network. Using data provided by network administrators, the council identifies the top three and bottom three performing physician practices on a metric of interest. The group next brings those physicians together to discuss what has made them successful or where they have struggled. The committee then uses that information to develop a best-practice standard that can be effectively implemented by other network physicians.

Physician-Led Process Identifies Highest Performers to Serve as Network Model

Bringing Together Physicians from Across the Network

Quality Improvement Council

- Composed of representatives from all 28 member practices

- Meets monthly to discuss quality performance, address shortfalls

Finding Best Practices Within Network Ranks

Focus on one quality measure monthly; identify high-, low-performing practices

Draw on experience of outlier practices to develop standards

Implement quality standards across practices

Case in Brief: Atrius Health

- Alliance of five non-profit, community-based independent physician groups located in Central and Eastern Massachusetts
- Draws on experiences of high-performing practices to resolve common clinical quality challenges
- Expanded model of best practice standardization to pharmacy operations, plans to extend to financial operations in future

Source: Health Care Advisory Board interviews and analysis.

Minimizing Physician Resistance to Standardization Through Careful Pilot Process

Physician involvement in the development of a best-practice standard, while critical, is no guarantee that the new protocol will be easily accepted by other physicians. Even high-performance medical groups sometimes struggle to overcome physicians' general resistance to the concept of standardization. As a result, successful groups pay careful attention to how they deploy new standards, implementing changes in a way designed to maximize physician comfort.

One such method is to roll out a new standard gradually. For example, the Marshfield Clinic in Wisconsin pilots all new initiatives first at "maven" sites— practices that are generally receptive to change and will likely implement the initiative successfully. During the pilot process, Marshfield refines the initiative as needed and collects data showing a positive impact. It then uses that information to build enthusiasm for the initiative from other practices.

"Maven" Sites Pave the Way Before Broad Rollout
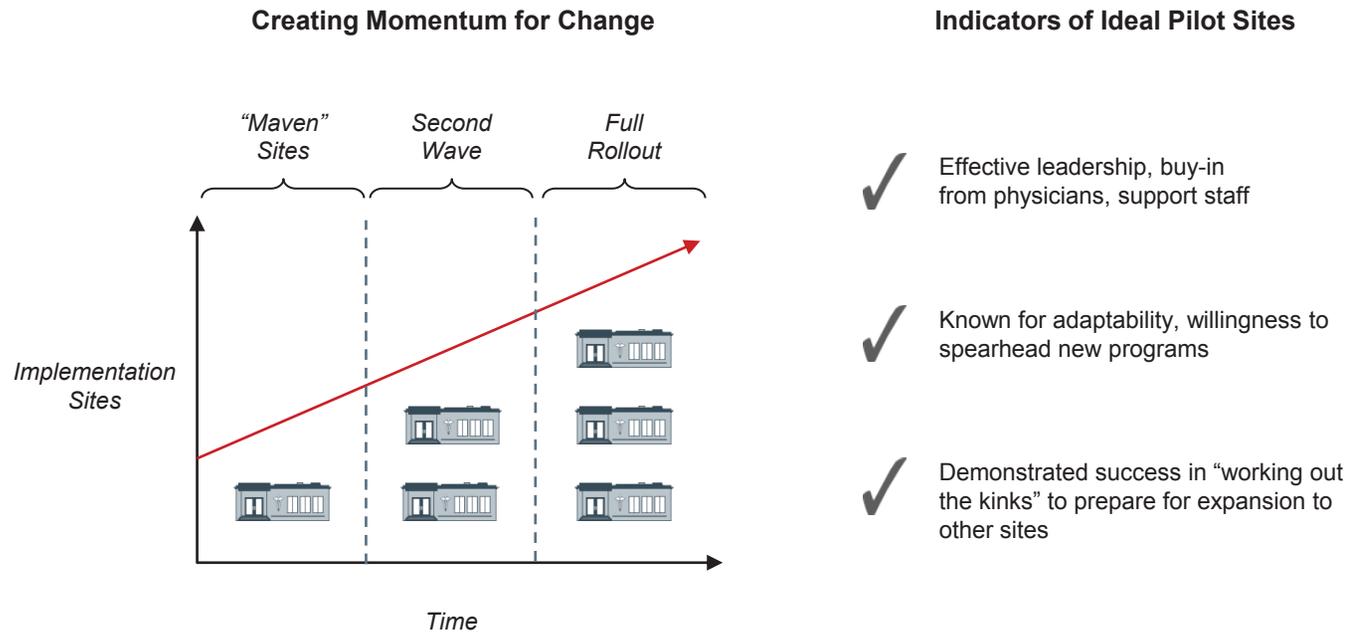
Creating Momentum for Change

Implementation Sites

"Maven" Sites   *Second Wave*   *Full Rollout*

Time

Indicators of Ideal Pilot Sites

✓ Effective leadership, buy-in from physicians, support staff

✓ Known for adaptability, willingness to spearhead new programs

✓ Demonstrated success in "working out the kinks" to prepare for expansion to other sites

Case in Brief: Marshfield Clinic

- 800-physician multispecialty group practice located in Marshfield, Wisconsin
- Physicians practice at more than 50 sites, increasing challenge of deploying initiative
- When rolling out performance improvement initiatives, high-performing sites undergo pilot first in order to demonstrate early success, create enthusiasm around the initiative

Source: Health Care Advisory Board interviews and analysis.

Leveraging Positive Data to Reinforce Physician Buy-In

Another tactic to generate acceptance for new standards is to demonstrate clearly the benefits that will result from the change—particularly those benefits that affect the physician personally.

NorthShore University HealthSystem Medical Group strives to support all change improvement initiatives with comprehensive data to this effect. For example, several years ago, the medical group recognized that its revenue cycle was highly inefficient, with an average days in accounts receivable of 120. In response, physician leaders created a new standardized process to improve cash flow.

To generate physician support for the change, NorthShore demonstrated to physicians exactly how standardized revenue cycle improvements translated into a personal increase in compensation. As a result, physicians were largely willing to embrace the standard. NorthShore was able to reduce days in accounts receivable significantly, while also generating physician goodwill that it has leveraged in subsequent standardization efforts.

Highlighting the Personal Benefits of a Process Change
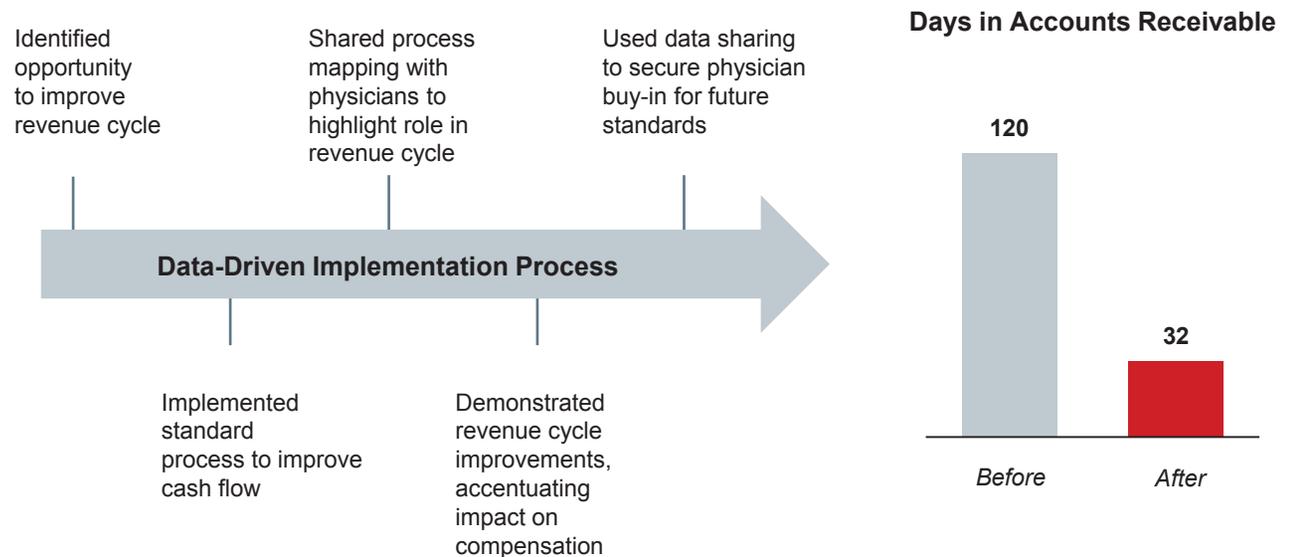
Identified opportunity to improve revenue cycle

Shared process mapping with physicians to highlight role in revenue cycle

Used data sharing to secure physician buy-in for future standards

Data-Driven Implementation Process

Implemented standard process to improve cash flow

Demonstrated revenue cycle improvements, accentuating impact on compensation

Days in Accounts Receivable

120

32

Before   *After*

Case in Brief: NorthShore University HealthSystem Medical Group

- 700-physician medical group within NorthShore University HealthSystem, a four-hospital health system located in Evanston, Illinois
- Monitored and shared outcomes data to assure physicians of initiative success, secured physician buy-in for expanded standardization beyond revenue cycle
- Utilized physician feedback to resolve difficulties across expansion

Source: Health Care Advisory Board interviews and analysis.

Implementing Changes Gradually to Allow Physicians Time to Adapt

Iterative implementation of new initiatives is another key element of change management at NorthShore University HealthSystem Medical Group. NorthShore deploys new standards and protocols in incremental steps, pausing after each adjustment to check impact and reassure physicians.

For example, when NorthShore's primary care practice leaders decided to standardize extended office hours in order to improve patient access, they began by asking physicians to stay open late for just one night a week. Medical group leaders then collected data to show how this single change had positively impacted patient satisfaction, practice revenue, and physician compensation.

Pleased with the results, the physicians themselves suggested additional evening hours. When that too yielded positive results, physicians were willing to consider organizing across practices to open on weekends as well. By implementing the change slowly, backed by data every step of the way, NorthShore was ultimately able to smoothly implement a change that would likely have generated significant resistance had it been forced on physicians all at once.

Designing an Iterative Rollout Process

Ongoing Evaluation of Outcomes

Supporting Long-Term Success at NorthShore University HealthSystem Medical Group

- Implement Change
- Collect Data
- Assess Outcomes
- Share Outcomes with Physicians

Step-by-Step Expansion of Primary Care Access

1 Physicians agree to proposal by primary care practice leaders to extend office hours for one evening per week

2 Data demonstrates positive return from initial change; physicians suggest extending additional hours on other evenings

3 Data continues to reveal positive impact on patient satisfaction, physician revenue; physicians agree to work weekends

Source: Health Care Advisory Board interviews and analysis.

Early Wins Build Goodwill Needed to Tackle More Complex Problems

Standards that impact only administrative or back-office functions are typically easier for physicians to accept than protocols that influence clinical decisions. But initial success around operational standards can demonstrate to physicians the positive impact of reducing variability and build goodwill for subsequent efforts to implement best-practice protocols affecting clinical work.

As a result, many high-performance medical groups choose to begin by standardizing relatively uncontroversial areas such as revenue cycle or physician onboarding processes, clearly demonstrating to physicians both the group and individual benefits that result. With each successful implementation of a new process or protocol, physician resistance drops. Many high-performance groups report that they are now at a stage where physicians themselves have proposed extending standardization into once-contentious clinical areas.

Generating Physician Buy-in with a Track Record of Success

Gradual Rollout of Performance Improvement Standards

Standardizing Practice Operations and Finance

Standardizing Clinical Performance

Implementation Difficulty

Care Pathway Adoption

Patient Access, Referral Protocols

Physician Performance Monitoring

EMR Adoption

Clinical Improvement Initiatives

Back-Office Processes

Physician Compensation

Physician Hiring, Onboarding

Front-Office Procedures

Time
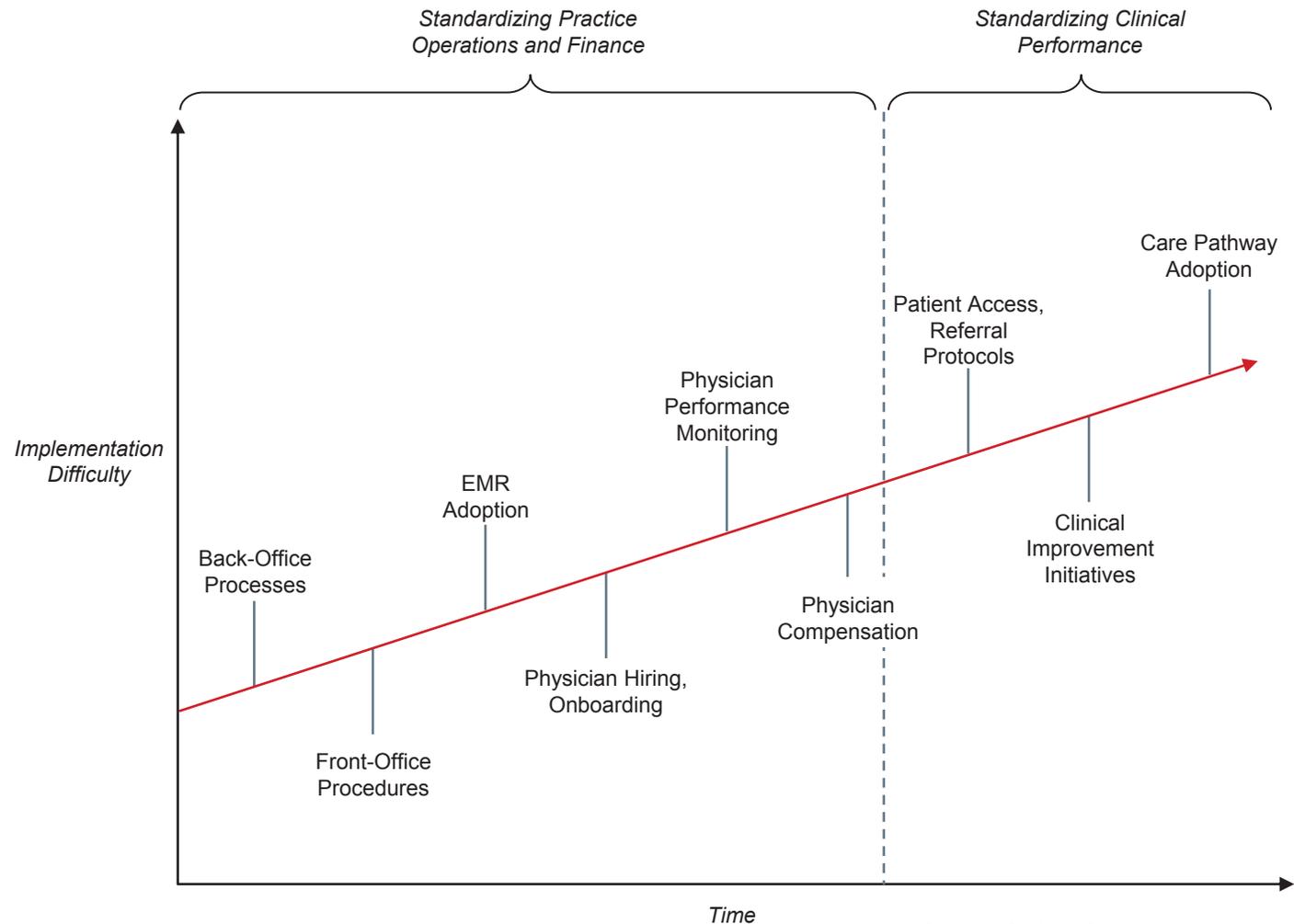
Source: Health Care Advisory Board interviews and analysis.

Expanding the Potential for Scale Across the Network

Physician buy-in for change is necessary but not sufficient to achieve true performance improvement. On their own, most physicians are ill-equipped to implement improvement initiatives and standards, whether due to lack of time, knowledge, or resources. High-performance medical groups respond by providing support at scale—resources are built by the group, then leveraged by all, providing practices with capabilities that none could afford alone.

For many health system employers, the concept of scaling services across practices has been limited to business functions, such as human resources, billing, or information technology support. High-performance groups take scale a step farther, building group-level resources to support physicians in optimizing care delivery as well.

Supporting Clinical as Well as Administrative Functions

Individual Practices Lacking Key Ingredients for Improvement Initiatives

Time

"Everyone in my practice is busy seeing patients and couldn't possibly take on another project…"

Skill Set

"I really don't even know how to do this. It's completely outside of my job description..."

Resources

"I'd love to hire a diabetes care manager, but I don't have the dollars or patients to support a full-time position..."

Providing Group-Level Resources to Enable Performance Change

Traditional Opportunities for Scale	*Next-Generation Opportunities for Scale*
☑ Revenue cycle	☐ Performance management support
☑ Human resources	☐ Patient access
☑ Ancillary services	☐ Referrals management
☑ Information technology support	☐ Care management resources

Source: Health Care Advisory Board interviews and analysis.

Overcoming Barriers to Care Transformation

Centralized care management resources can greatly accelerate care transformation in physician practices that may not be able to afford or justify full-scale resources individually. As a practical example, consider the challenges that primary care physicians face as they implement a medical home model.

Medical homes leverage a team of providers and information technology such as a disease registry to provide comprehensive, coordinated care. To meet this objective, practices must make a significant investment in team staffing, build infrastructure to enhance patient access, strengthen referral relationships, and support the practice through disruptive change. Any one of these changes would be difficult for an individual primary care practice to make on its own.

Without Scaled Resources, Medical Home Adoption an Upward Climb

Common Challenges to Medical Home Implementation

Limited Management Capability

- Time consuming to design new model, outline transformation
- New requirements likely for data collection, analysis

Insufficient Care Network

- Specialists not aligned to similar quality goals
- Poor coordination of ongoing patient information
- Necessary referral relationships lacking, weak

Inadequate Staffing for Comprehensive Care Delivery

- Multiple levels of staff required to provide top-of-license care
- Individual practices may struggle with flexing providers to meet patient needs

Poor PCP Practice Economics

- Practices operating at a loss
- Financially unable to take on major restructuring or additional staff members

Source: Health Care Advisory Board interviews and analysis.

Facilitating the Transition to Team-Based Care

Scaled resources provided by the medical group can support PCPs through the medical home transition. This page describes two models for resource deployment: providing in-practice care teams that PCPs can access within their own office or establishing an external practice resource, such as an outpatient chronic care center. The most appropriate model for each organization depends on physician needs and hospital resources, but both provide PCPs with access to resources that would be too costly for any single practice to develop on its own.

Details on each model for care management support are provided on the following pages.

Providing Medical Home Resources at a Network Level

Models of Team-Based Care

Characteristics	In-Practice Care Team	External Practice Resource
Description	Hospital provides support that practices are able to access within their practice, at their discretion	Hospital provides external support for group of practices; may be network-wide outpatient center
Type of Resource	Could include registered nurse (RN), dietitian, and/or chronic disease educator	Typically comprises RNs, nurse practitioners; may also include dietitians, trained educators, mental health providers
Applicability	Resource may be permanently placed within practice	May be utilized by both employed and independent physicians

Source: Health Care Advisory Board interviews and analysis.

Deploying a Single Care Team to Benefit Multiple Practices

Carondelet Health Network in Tucson offers an example of an organization that provides a scalable in-practice resource to support team-based care. The system leases a diabetes care management team to its employed physicians. (Independent practices may lease the team as well.) This model allows Carondelet to build scale by distributing the costs of the care team across several practices.

Physicians have the ability to determine how frequently to host the care team based on the needs of their patient panel. For some practices, the team comes to the practice one full day each week. For others, the team may be leased for only one afternoon each month. To finance the care team, the practice bills out for the appropriate level of care provided by team members. This new revenue usually covers the cost of the team, making the program a break-even opportunity.

Distributing Resource Costs Across Sites

Care Team Lease
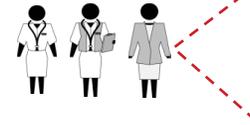
- Hired and trained by system
- Leased out to practices at hourly rate
- Includes RN, registered dietitian, diabetes navigator
- Elevates quality of diabetes care

Diabetes Care Team
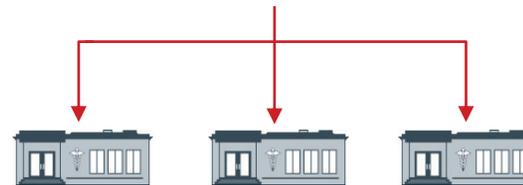
Physician Practices

Case in Brief: Carondelet Health Network

- Four-hospital system located in Tucson, Arizona
- Growing diabetes population prompts comprehensive outpatient diabetes strategy
- Physician practice bills to the payer, compensates care team with hourly rate; diabetes navigator, community health outreach worker covered by grant funding

Source: Health Care Advisory Board interviews and analysis.

Centralizing Care Team Resources at the System Level

Middlesex Hospital in Connecticut offers an example of the second model for deploying care management support: a centralized, external care team resource. Under this model, PCPs refer patients to Middlesex's Center for Chronic Care Management, an outpatient facility where care managers provide patient education and self-management support. The center proactively communicates with practices regarding treatment plans and patient compliance, ensuring that PCPs remain informed and building a seamless experience for patients. This bidirectional exchange of information is critical for patient and physician satisfaction.

Middlesex originally developed the Center for Chronic Care Management more than 10 years ago in preparation for capitation. Although risk contracts never materialized, strong physician support and improved patient outcomes encouraged the hospital to continue operating the center.

Practices Share Access to Advanced Care Management Program

Center for Chronic Care Management

Members of Medical Group
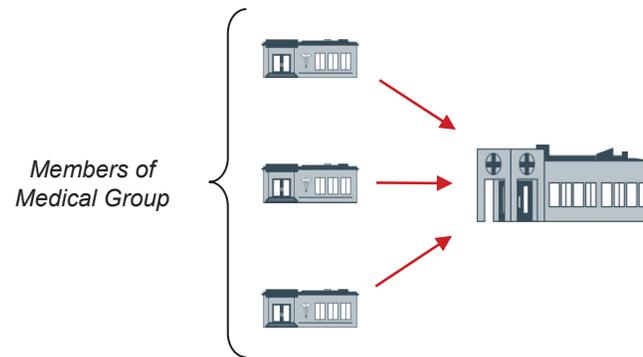
- Patients referred to center, provided intensive education
- Care managers notify referring PCP of patient progress
- Patient graduates once self-management achieved

Knowledge of Disease Symptoms
Percentage of CHF Patients

80% Before
100% After
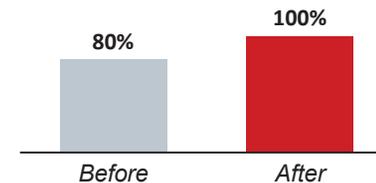
Annual HbA1c Testing
Percentage of Diabetes Patients

74% Before
84% After
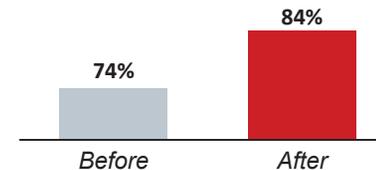
Case in Brief: Middlesex Hospital

- 150-bed hospital located in Middletown, Connecticut
- Through physician-hospital organization (PHO), created Center for Chronic Care Management to assist PCPs in managing patients with chronic disease, history of tobacco use
- Created 10 years ago in anticipation of capitation; continued because of improved outcomes

Patient Access, Physician Training Additional Candidates for Support at Scale

Beyond care transformation, high-performance medical groups deploy a number of other shared resources to aid physicians in optimizing care delivery, both in the practice and at a central level.

For example, in an effort to improve patient access, medical groups may maintain a pool of physician extenders who can float between sites. This allows practices that do not, on their own, have adequate patient volumes to support a full-time mid-level to secure additional coverage as needed, rather than turning patients away. At the same time, many high-performance groups also maintain a centralized scheduling service that helps patients make timely appointments with another in-group provider when their own physician is unavailable, preventing leakage outside the network.

When combined with administrative support, these resources have an additive effect, ultimately improving both clinical and financial performance.

Successful Medical Groups Frequently Provide a Range of Resources

Centralized Appointment Scheduling

- Coordinates in-network referrals, post-referral communication
- Facilitates practice cross-coverage to enhance patient access

Floating Physician Extenders

- Deployed as needed to support practice sites with inadequate patient volumes to fund full-time mid-level or nurse

Physician Performance Improvement Assistance

- Includes coaches, proctors, and training programs
- Designed to support physicians struggling to meet group's performance expectations

Dedicated Human Resources Staff

- Oversee culture-linked medical group hiring and onboarding programs
- Respond to questions about compensation, other physician-specific concerns

Source: Health Care Advisory Board interviews and analysis.

Infrastructure for Shared Success

The box on this page provides a brief overview summary of the three attributes used by high-performance medical groups to develop an infrastructure for shared success. These performance-enhancing tools represent the second level of core elements maintained by the high-performance medical group.

Takeaway Summary for Health System Leaders

Attribute #9: Enterprise-Wide Information Network
Recognize the importance of seamless information exchange in building transparency and driving high-value care; build a common information management platform capable of not just data integration, but also identifying performance gaps, hardwiring care standards and advancing population health

Attribute #10: Formal Processes for Data-Driven Performance Improvement
Create a robust data-driven performance improvement process across the medical group; engage physician leaders to prioritize initiatives, define standards and accelerate roll-out across practices

Attribute #11: Scaled Resources to Support Care Delivery
Create economies of scale across practices to support practice-level operational and financial success; organize centralized medical group resources to enable practices to deliver comprehensive, coordinated care

Source: Health Care Advisory Board interviews and analysis.

Infrastructure for Shared Success

The box on this page contains key questions for health system leaders to discuss as they consider progress toward building infrastructure among their own employed practices.

Key Questions for Health System Leaders

- Do our information systems support seamless information exchange across all practices? Can our IT systems support clinicians in complying with care standards and making the best clinical decisions?

- How do we build a performance dashboard that provides a comprehensive view of employed practice performance? Do we have the systems to provide the information necessary to populate that dashboard? How do we choose metrics that are specific and actionable?

- Do we have the capabilities to not only exchange and aggregate data, but also analyze that information to identify care gaps and performance shortfalls? How will we act to elevate performance and engage physicians in change?

- How receptive are our physicians to standardizing elements of practice operations and care delivery?

- What avenues exist for physicians to share their ideas for improvement?

- What resources do our physicians need to improve care delivery? How can we leverage economies of scale across practices to accelerate new care model development?

Source: Health Care Advisory Board interviews and analysis.

III. Individual Behavior Aligned with Strategy

- Leveraging Transparency
- Designing Strategy-Aligned Compensation

Capitalizing on Intrinsic Physician Characteristics to Motivate Individual Behavior

No matter how effective group culture and infrastructure, personal rewards and recognition still play an important role in driving physician behavior. As a result, high-performance medical groups put careful thought into the design of individual incentives that can engage physicians against group goals.

The performance levers deployed by successful employed networks capitalize on common physician traits, as shown on this page. Responding to physicians' natural tendency toward skepticism, they ensure complete transparency in communication, building systems for both downward and upward feedback. They also leverage physicians' innate sense of ambition by sharing individual performance data, often in unblinded fashion, to maximize the competitive effect.

In addition, groups turn to compensation to motivate physician behavior. However, most high-performance groups deploy financial incentives sparingly, mindful of physicians' tendency toward risk aversion. Rather, they alter compensation primarily when other motivational levers fail or when compensation itself serves as a barrier to change. This practice stands in contrast to many hospital employers, who tend to look at compensation as the primary means of influencing physician behavior.

These performance levers are each linked to specific attributes explored across the following pages.

Performance Levers Linked to Typical Physician Traits

The "Three C's" of Physician Motivation

	Skeptical	Ambitious	Risk Averse
Typical Physician Trait	Concerned about being marginalized, undervalued	Constantly striving for "straight A's," hate to be outperformed	Wary of change, particularly when own income at risk
	Communication	**Competition**	**Compensation**
Resulting Performance Lever	Consistent downward messaging, opportunities for upward feedback in order to win physician trust	Transparent sharing of performance data to fuel peer pressure	Use of compensation as motivational tool only as a last resort, with steps taken to carefully manage change

Order of Deployment →

Attribute #12: Effective Bidirectional Communication Processes

Attribute #13: Dissemination of Unblinded Physician Performance Data

Attribute #14: Compensation Narrowly Tailored to Advance Group Objectives

Attribute #15: Staged Adoption of New Compensation Plans

Source: Health Care Advisory Board interviews and analysis.

Striving for Complete Transparency from the Top Down

In high-performance medical groups, transparency is a core cultural tenet. Full and open communication is seen as crucial to building trust, reassuring physicians that leaders and colleagues are not hiding anything that might affect their practice or patients.

Effective downward communication requires medical group leaders to provide frequent, proactive updates to rank-and-file physicians, employing a variety of communication vehicles (written, in-person, and electronic) to account for physicians' different preferences and schedules. Leaders should communicate around all group activities and initiatives, no matter how small. Communication should also clearly explain the rationale for new decisions or process changes, linking initiatives back to group strategy and, where possible, identifying the group and individual benefits that will result.

Leaders of High-Performance Groups Hold No Secrets

Elements of a Successful Downward Communication Strategy

Available and Accessible

- Delivered at regular, frequent intervals

- Requires minimal physician effort to participate in dialogue

- Employs range of communication modes

Comprehensive Coverage

- Reports on new initiatives, status of current projects, group quality, and financial performance

- Explains rationale behind key decisions

Personally Relevant

- Constantly links group actions, initiatives back to shared strategy, vision

- Connects organizational change to individual physician benefits, concerns

"

No Secrets

"I tell physicians that they should know everything I know. There is nothing I can't tell them about the reasons behind the decisions we make. Trust correlates directly with level of communication from the top."

Craig Samitt, MD
CEO, Dean Clinic

Source: Health Care Advisory Board interviews and analysis.

Deploying a Multi-Pronged Downward Communication Strategy

Dean Clinic in Wisconsin offers a good example of a comprehensive communication strategy in practice. A large independent physician group, Dean has actively embraced care transformation and is often cited as a model for organizations seeking to assume greater responsibility for population management and accountable care. As a result, Dean has implemented a significant number of changes across the past few years, making open communication particularly important.

Dean's leaders have created multiple forums to distribute information throughout the group. They hold regular meetings with both frontline leaders and rank-and-file physicians. The clinic also produces a written newsletter for physicians, and Dean's CEO provides regular electronic updates via a widely read executive blog. In all, Dean errs toward over-communication, with leaders believing that having some physicians feel inundated with information is preferable to having others feel left in the dark.

Erring Toward Over-Communication

A Comprehensive Communication Strategy at Dean Clinic

In Person

- Frequent in-person meetings between board, frontline physician leaders, rank-and-file physicians to convey strategy

- Facilitated meetings between representatives of physician practices to discuss ongoing initiatives, resolve concerns

In Print and Online

- Newsletter produced by communications staff updates physicians on ongoing projects, announces new initiatives

- Executive blog provides forum for CEO to communicate organizational strategy, vision

- Materials delivered regularly over e-mail

Case in Brief: Dean Clinic

- Integrated system composed of 500 physicians and a 300,000-member health plan located in Madison, Wisconsin

- Redesigned care model as part of long-standing vision to deliver value-based care

- To enhance physician support for redesign, strengthened downward and upward communication channels

- Communication strategy generates physician support for strategic initiatives

Source: Health Care Advisory Board interviews and analysis.

Establishing Robust Opportunities for Upward Feedback

Effective communication requires more than top-down messaging. Physicians also need an opportunity to share their thoughts with leaders, making communication a two-way process.

To address the need for upward feedback, Dean Clinic has created online forums in which group leaders begin conversations about key initiatives, then step back to allow individual physicians to discuss and debate. Dean uses the online forums for many new initiatives, such as a recent successful effort to win approval for a new physician compact.

The online forums run through open listservs housed on the clinic's Intranet site, enabling physicians across Dean's expansive market to log in at their own convenience. Given the high premium that the clinic's culture places on transparency, the forums are not confidential, but the lack of anonymity has not been a barrier to physician use. In fact, Dean's leaders note that many physicians seem more willing to comment online than in person, and that discussion is often more balanced and civil as a result.

Dean Uses Online Forums to Engage the "Silent Majority"

Dean Online Physician Forums

- Intranet-linked tool used to gather input on key initiatives, such as new physician compact
- Listserv model allows physicians and leadership to post in an ongoing conversation
- CEO and executive leadership begin online conversations to solicit physician feedback, prompt discussion
- Leadership responds to all comments, questions
- Users may not remain anonymous

Key Benefits

- Allows physicians to offer feedback without attending meetings
- Enables CEO to provide direct feedback to frontline physician input
- Avoids monopoly of conversation by a vocal minority
- Creates conversation among all physicians across broad market

Online, "Squeaky Wheels" Get No Grease

"A vocal minority tends to dominate face-to-face meetings, but online the 'silent majority' is much more likely to speak its mind."

Craig Samitt, MD
CEO, Dean Clinic

Source: Health Care Advisory Board interviews and analysis.

Transparency About Individual Physician Performance No Longer Optional

While open, bidirectional communication provides the platform to engage physicians and present the rationale for change, sharing individual physician performance data is also critical to drive behavior change.

In an effective data-sharing process, physicians have regular access to clear, comprehensive, and accurate information about their individual performance against key strategic metrics, as well as information that compares their performance to others within the group. This transparency allows physicians to recognize specific opportunities for performance improvement. Even more important, transparency also can generate peer pressure that plays off physicians' desire to avoid being seen as an outlier.

High-performance medical groups are distinguished from other employers by how extensively they use data to leverage physicians' natural ambitious tendencies. The groups profiled in this publication all monitor a wide range of physician performance indicators and frequently share that information not just with the individual physician, but with his or her peers as well.

Data Sharing a Mandatory First Step in Performance Improvement

Hallmarks of an Effective Data-Sharing Process

- Reported regularly and frequently
- Organized in an intuitive, easy-to-understand format
- Places performance comparisons in statistical context
- Meets reasonable standards for data integrity (e.g., statistically valid, timely, focused on outcomes within physician's individual control)
- Supplemented with additional information as needed (e.g., access to patient-level details for further analysis)

Key Impacts on Physician Behavior

1 *Establishes Clear Targets*

Access to individual data allows physicians to identify specific areas of underperformance

2 *Generates Peer Pressure*

Comparison to other physicians in group spurs (often rapid) behavior change

Source: Health Care Advisory Board interviews and analysis.

Taking a Holistic View of Physician Performance

WellSpan Medical Group in Pennsylvania provides an example of how high-performance organizations monitor an extensive range of physician performance indicators. WellSpan's physician report card not only includes basic financial and clinical quality metrics, but also measures how well the physician supports system growth initiatives and operates within a larger team. The report card depicts performance relative to peers and to group averages, allowing physicians and group leaders to identify opportunities for improvement.

Notably, many of the citizenship and professionalism metrics included in WellSpan's physician report card are similar to the responsibilities outlined in the physician compacts profiled on page 41 of this publication. Along with identifying areas for individual improvement, WellSpan's report card serves as an enforcement mechanism for the group's cultural values.

Medical Group Measurements Go Beyond the Basics

WellSpan Medical Group Physician Dashboard

$

Finance

- Work RVUs or other productivity measures
- Practice expenses in relation to budget

Growth

- PCP panel size
- Specialist responsiveness, discharge planning (as measured by PCP survey)

Citizenship

- Meeting attendance
- Community involvement (self-reported; only visible to administrative staff)

Quality

- Specialty-specific clinical quality indicators

Professionalism

- Timeliness, respect, communication (as measured by peer and staff surveys)

Case in Brief: WellSpan Medical Group

- 500-provider medical group within WellSpan Health, located in York, Pennsylvania
- Combined data from across health system to create comprehensive physician scorecard
- Leveraged scorecard for physician performance review

Source: Health Care Advisory Board interviews and analysis.

Unblinding Performance Data for Maximum Impact

Allowing individual physicians to see their performance relative to the rest of the group as a whole is, in and of itself, a powerful means to motivate behavior change. But many high-performance groups are taking transparency to the next level with fully unblinded data sharing, calling public attention to physicians' standing against their peers.

This page shows data from a study at ThedaCare, a Wisconsin health system that wanted to reduce the rate of elective inductions performed before 39 weeks gestation. The system first presented data to each obstetrician that compared individual performance to the department mean.

Although this initial information led to some improvement, the group's goals were not reached until the system began sharing each physician's induction rate by name. Following this change, the number of unnecessary elective inductions performed before 39 weeks dropped to 0 as physicians moved quickly to avoid being seen as an outlier.

Unleashing the Power of Peer Pressure

Adherence to Elective Induction Guidelines[1]

May 2007–April 2008

- May: 65%
- September: 84%
- April: 100%

Performance data presented, importance of initiative explained

Unblinded performance data posted in physicians' lounge
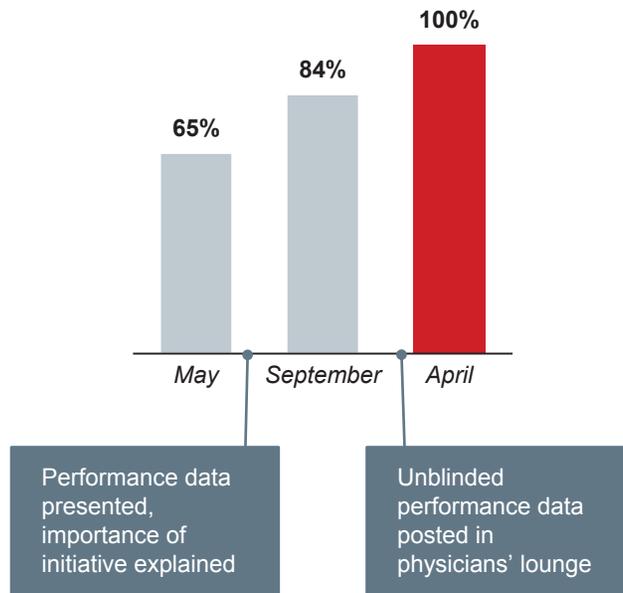
Naturally Competitive

"Data is…more powerful when it can be personalized, such as enabling physicians to see their own performance compared to that of their peers. Most powerful of all is unblinded data."

John Toussaint, MD
CEO Emeritus, ThedaCare

Case in Brief: ThedaCare

- Four-hospital health system located in Appleton, Wisconsin
- After finding that 35 percent of electively induced deliveries took place before 39 weeks, took steps to reduce early induction rate
- Blinded performance data encouraged initial but limited improvement
- Release of unblinded data motivated full physician compliance with standard

1) Apart from clinical necessity, prohibition on elective induction before 39 weeks of gestation.

Source: Toussaint, JS. "Writing the new playbook for US health care," *Health Affairs*, September/October 2009, 28:1343-1350; Health Care Advisory Board interviews and analysis.

Gradual Shift to Unblinded Data Sharing Designed to Ease Physician Concerns

Concerned about how physicians will react to unblinded data sharing, many high-performance medical groups have chosen to transition toward full performance transparency gradually, increasing the exposure levels in stages. However, as they go through this process groups report that physicians are often more receptive to the idea of unblinded data sharing than they had anticipated.

Consider the case of Covenant Health Partners (CHP), a clinically integrated physician network in Texas. CHP has signed payer contracts that reward the group under a shared-savings model, giving physicians a vested interest in quality and cost management. After several years spent reviewing blinded performance data, the physicians themselves approached network leaders to unblind the information, arguing that they needed greater visibility across the network to find new performance opportunities.

CHP surveyed the entire physician group and found that 70 percent supported greater data transparency. As a result, the network recently unblinded data within specialty divisions, with plans to unblind data across the entire network in the near future.

Loss of Anonymity Often an Anti-Climactic Event

Positioning Unblinded Data Sharing as a Longer-Term Goal

Collective performance by practice or specialty

Individual data by name within practice

Individual data by name across organization

Level of Individual Exposure

Individual data identified by code

Individual data by name within specialty
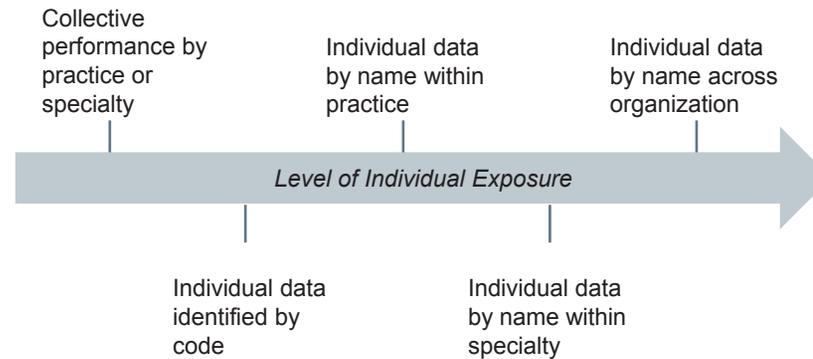
Guidance on Unblinding Data

- Begin with less competitive specialties

- Select less controversial metrics, such as operational indicators (on-time starts) or documentation metrics (incomplete records)

- Avoid sensitive peer review data (e.g., complications, infections)

Generating Surprising Physician Support for Full Transparency

Survey of Physicians in Covenant Health Partners' Clinical Integration Program

Opposed 30%

Supportive 70%
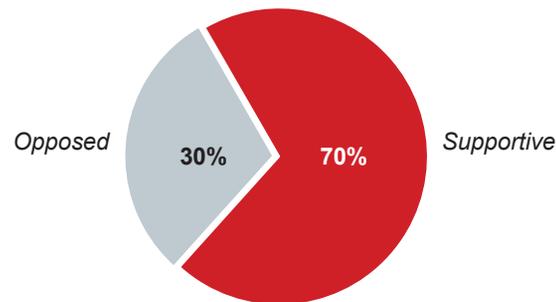
Case in Brief: Covenant Health Partners

- 300+ physician clinically integrated network affiliated with Covenant Health System located in Lubbock, Texas

- Physicians pushed for greater data transparency to spur competition, change referral patterns

- Backed by physician support, recently shifted from blinded to unblinded data among peers in same specialty

- Currently considering sharing data across specialties

Source: Health Care Advisory Board interviews and analysis.

Compensation the Last Resort for Motivating Change

Beyond communication and competition, financial incentives provide the medical group's final lever to motivate employed physicians. As noted earlier, however, high-performance groups turn to compensation change sparingly, in contrast to many hospital employers who view compensation as a primary means of motivating physician behavior.

Compensation is not something that medical groups ignore—indeed, most strive to ensure that their physicians maintain market-competitive rates of pay. But successful groups use compensation as a lever for behavioral change only in three select circumstances.

First, groups turn to compensation when other levers, such as communication, have failed. In that case, compensation incentives are seen as the last resort to win physician engagement for change. Second, groups occasionally deploy financial incentives to signal the importance attached to a particular initiative, shifting compensation as a way to "put their money where their mouth is." Finally, high-performance groups alter compensation if the existing model is itself a barrier to change and if reworking financial incentives to eliminate legitimate obstacles is critical for goal achievement.

High-Performance Groups Use Monetary Incentives Sparingly, Strategically

Reasons for Turning to Compensation as a Performance Lever

1

Replacing Other, Failed Mechanisms

"We tried to get physicians to use proper documentation by setting explicit expectations. It didn't work. We will now also use an incentive or a withhold."

CEO
Physician-owned health system

2

Communicating an Initiative's Importance

"Our culture enables us to drive change. But in some instances, we think it's important to show physicians that we're putting our money where our mouth is."

Vice President
Large employed medical group

3

Removing Legitimate Barriers to Change

"As primary care demand grows and reimbursement rates decline, our PCPs won't be able to make ends meet if we continue to pay them on productivity."

Medical Director
Large independent physician group

Source: Health Care Advisory Board interviews and analysis.

No Single Compensation Model Dominates in High-Performance Medical Groups

Unlike many of the other medical group attributes profiled in this publication, there is no "model" compensation plan used by high-performance medical groups. As shown by the examples on this page, compensation structures vary considerably between successful employed networks.

Instead, what groups have in common is not the specific method in which they pay physicians, but the fact that compensation models are carefully designed to reflect and further the group's larger strategic goals. Only if these objectives change do most groups consider altering their compensation model or deploying new financial incentives.

A Range of Incentive Structures in Use

At Risk for Population Health

Dean Clinic: More than 50 percent of primary care physician income at risk for quality, service, and panel size

A Blended Approach

Falstaff Clinic[1]: Physicians paid on RVU basis, but responsible for any overhead not deemed to improve quality; ancillary income is divided equally

At Risk for Productivity

Edith Smith Medical Group[1]: Compensation tied to productivity measured in RVUs with small quality bonus

Revenue Minus Expenses

St. John's Clinic: All physicians paid on net income model, with some incentive based on performance

Rejecting Uniformity

Beacon Medical Group[1]: Each of 26 specialty departments designs its own compensation model, which must include quality and patient satisfaction incentives

Salary with Bonus

Kelsey-Seybold Clinic: Tiered salary model with productivity bonus based on both RVUs and patient visits

1) Pseudonym.

Productivity-Based Models Increasingly Seen as Barrier to New Strategic Aims

For many high-performance groups, a fairly significant shift in strategic objectives is occurring today, as value-based purchasing and other payment reforms take root. In reaction to these changes, many medical groups are evolving their strategic objectives to incorporate broader aims around quality, cost, and coordination. Traditional compensation models designed solely to optimize individual practice financial performance are increasingly viewed as barriers to meeting these new objectives.

Even a relatively basic priority such as EMR adoption becomes difficult if the resulting slowdown in productivity negatively impacts physician income. Further, as groups prepare to assume increased payment risk, they find that existing compensation incentives are at direct odds with the type of transformed care that physicians will be asked to provide.

Mastering Yesterday's Goals, But Preventing Success on Emerging Objectives

Building on Private Practice Incentives

$ vs wRVUs
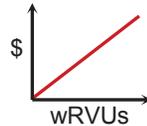
- Typical compensation plan designed to maximize visit-based productivity and/or minimize practice expenses

- Common models include revenue minus expenses, percentage of collections, pay based on wRVUs or other productivity measure

- Through focus on individual visits or financial outcomes, pay structure primarily promotes physician autonomy, productivity

Undermining Other Priorities

IT Adoption
New technologies temporarily slow physicians down, breeding resistance

Quality Improvement
Focus on productivity leaves little time for other improvement initiatives

Primary Care Redesign
New models call for longer visits, greater care team leverage

Utilization Reduction
Lower specialist visit volumes may challenge productivity expectations

Source: Health Care Advisory Board interviews and analysis.

Redesign Targets Conflicting Incentives While Mitigating Disruption to Physicians

As market imperatives evolve, many high-performance medical groups are focused on designing compensation models compatible with new objectives for the delivery of high-quality, low-cost, coordinated care. The focus here is on revising discrete aspects of the existing compensation model that serve as explicit barriers to meeting the organization's changing goals.

At the same time, groups also work to ensure that compensation redesign is not overly disruptive to physicians, many of whom may be wary about the impact of change on their personal income or practice style. To do so, groups couple compensation change with strategies designed to mitigate physician concerns.

These final two attributes of the high-performance medical group are explored further across the following pages.

Confronting the Twin Challenges of Compensation Change

Eliminate Pay-Based Barriers

Ensuring that existing compensation model does not discourage physicians from meeting quality, efficiency, or other system goals

Attribute #14: Compensation Narrowly Tailored to Advance Group Objectives

Prepare Physicians for Change

Retaining physician loyalty, trust, and satisfaction while transitioning to a new compensation model

Attribute #15: Staged Adoption of New Compensation Plans

Source: Health Care Advisory Board interviews and analysis.

For Both PCPs and Specialists, Moving Away from Pure Productivity

Compensation model change often occurs in reaction to past challenges or failures of incentive design. After salary-based compensation models led to heavy losses in the 1990s, many employers responded by implementing incentive plans focused on individual productivity or income performance. These models proved effective for several years to meet the imperatives of a purely fee-for-service market, but are increasingly seen as preventing the achievement of broader group goals.

As a result, many high-performance medical groups today are scaling back the proportion of physician compensation at risk for productivity alone. While productivity is and will remain an important component of compensation design, groups are supplementing it with incentives for quality improvement, care coordination, and clinical transformation. This shift away from pure production is most significant for primary care physicians, who play a large role in care management, although compensation redesign impacts specialists as well.

Failure of Existing Model Spurs Shift to Something New

Getting Burned by Flat Salary

Reproducing Private-Practice Economics

Striking a Balance Among Multiple Objectives

100%

Proportion of Salary Tied to Individual Productivity

Specialists

PCPs

0%

1990s   *2000s*   *Today*
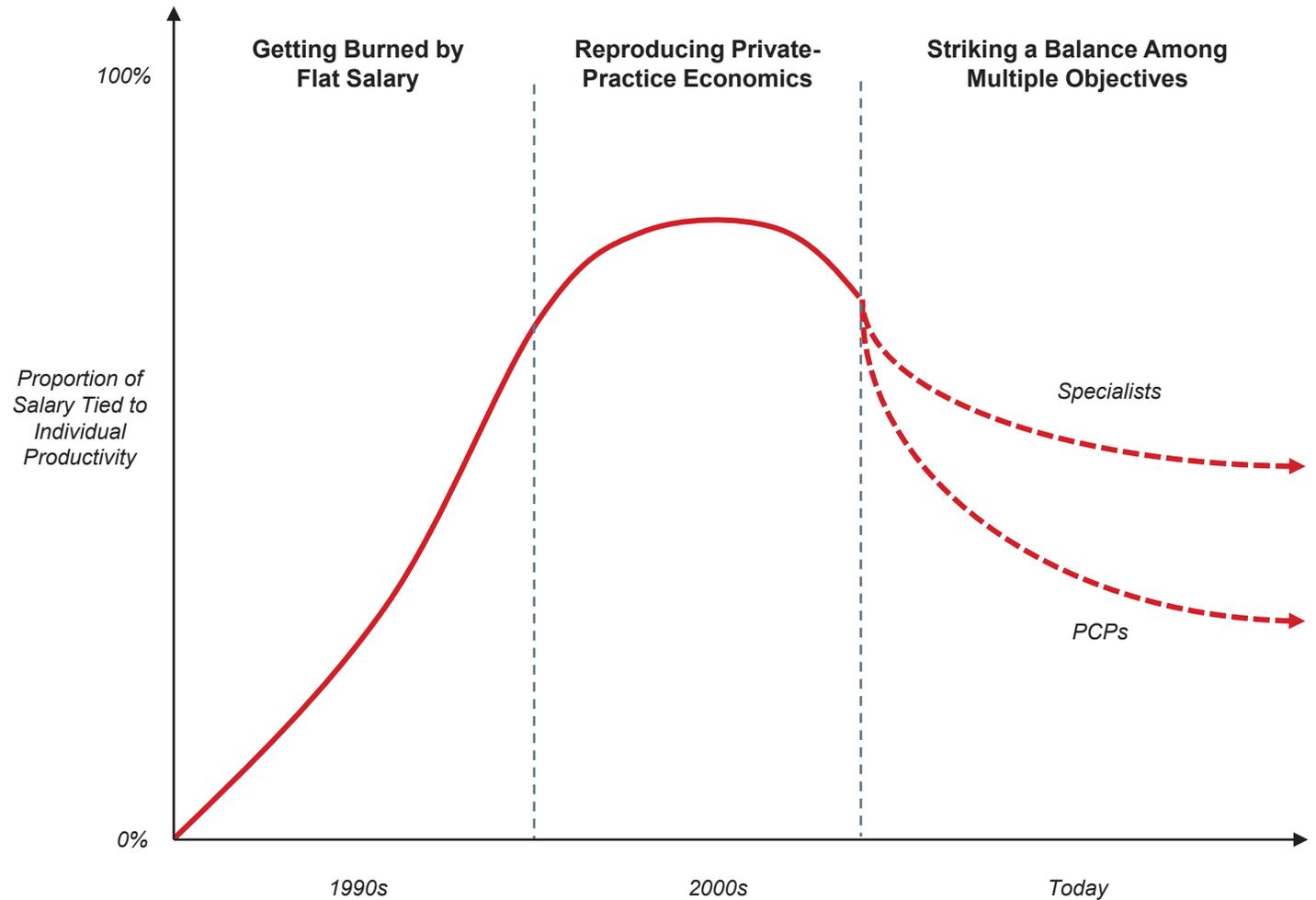
Source: Health Care Advisory Board interviews and analysis.

Legacy Compensation Models Inadvertently Preventing Care Redesign

For PCPs, compensation models based on pure productivity are often in direct conflict with emerging imperatives for enhanced coordination and team-based care.

Tracy Health System (a pseudonym) is an 11-hospital system in the South with 600 employed physicians, many of them PCPs. Tracy's original primary care compensation model was a fairly simple calculation of multiplying work Relative Value Units (wRVUs) by a conversion rate linked directly to practice cost control—dollars per wRVU. As a result, when system leaders suggested that PCP practices add new care team staff as part of a transition to the medical home model, physicians quickly realized the negative financial consequences for compensation and balked at the change.

When Tracy realized its legacy primary care compensation model was impeding the system's strategic objective to develop medical homes, it overhauled the model to incentivize PCPs against new goals. The details of the new model are outlined on the following page.

Incentive Structure Linked to Cost Control Discourages Investment in Practice

PCP Compensation Formula
2009

Work Relative Value Units: _____

X

Conversion Rate $: _____

=

Total Compensation: _____
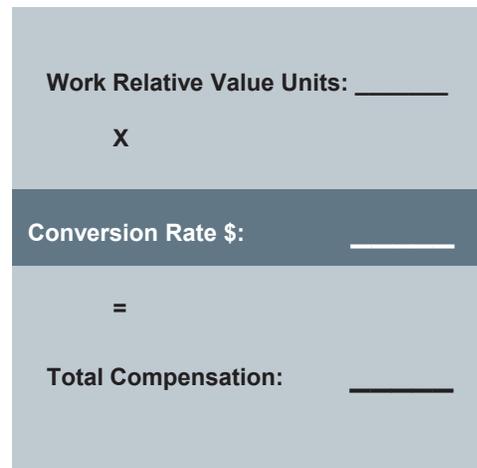
Conversion Rate Calculation
Zeroed in on Practice Cost Control

Conversion Rate

Practice Costs

Cost control-linked conversion rate hinders transformation to medical home
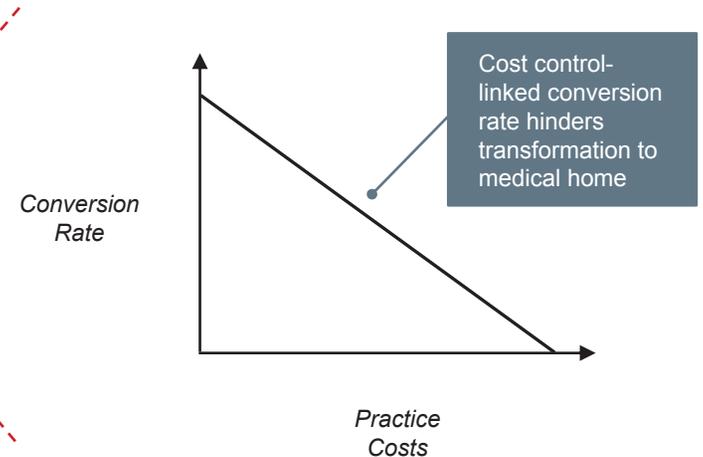
Case in Brief: Tracy Health System[1]

- 11-hospital system located in the South
- Initial compensation model focused on increasing wRVU productivity, controlling costs
- Increased costs of medical home implementation drove down physician compensation
- No commercial payer reimbursement for additional costs of medical home activity, certification
- New model focuses on panel size, mid-level staff efficiency, and PCP performance metrics

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

New Model Eliminates Conflicting Messages

In Tracy's new compensation model, productivity remains a core component, accounting for roughly 70 percent of total income. However, Tracy has redefined productivity to include both traditional measures of production and overall patient panel size per physician, recognizing the need to expand the base of managed lives within the medical home. Initially, active panel size accounted for 10 percent of base salary. As PCPs gained familiarity with medical home practice, Tracy increased the proportion of compensation at risk for panel size. PCPs are now incented on production and panel size equally.

The rest of the new compensation model also supports Tracy's medical home objectives. Approximately 15 percent of physician income is tied to the profitability of mid-level providers in order to encourage team-based care and enable panel expansion. The final 15 percent is tied to success against PCP scorecard metrics, which provides Tracy with flexibility to incentivize additional objectives in the future without needing to fundamentally rewrite the compensation model each time.

Aligning Compensation with Medical Home Practice Goals

Tracy Health System[1] Revised PCP Compensation Model

Base Salary Composition[2]

- 2010: 10% / 90%
- 2011+: 50% / 50%

Legend:
- ■ Active Panel Size[3]
- ■ Productivity

2010

Pie chart: 70%, 15%, 15%
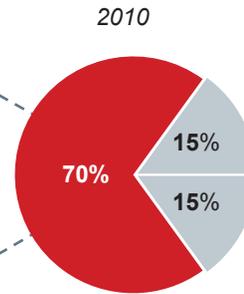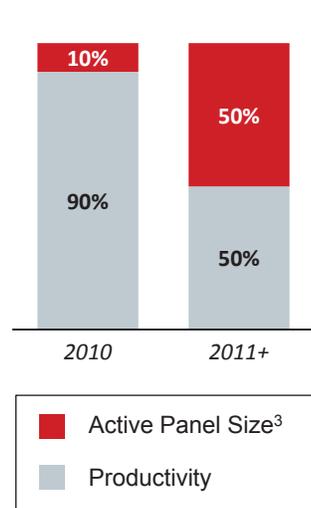
Mid-Level Performance

- Incents efficient use of mid-level staff
- Ultimately seek up to 1:1 ratio of mid-levels to PCPs

PCP Scorecard

- Nine performance metrics incent PCPs on clinical performance and efficiency
- $26,000 initial scorecard pool

PCP Scorecard Metrics

Access Target: 15%	New Patients: 10%	Diabetes Management: 15%
Patient Satisfaction: 5%	Expense per RVU: 10%	Hypertension: 15%
Budget Target : 10%	RVU Production: 10%	Medical Home: 10%

---

1) Pseudonym.
2) Fixed compensation rate per wRVU and per panel member.
3) Defined as patient contact in last 18 months.

Source: Health Care Advisory Board interviews and analysis.

Motivating Proceduralists to Coordinate Care

Productivity-based compensation creates less of a conflict for specialists, whose practices are not as affected by emerging care models. However, many high-performance medical groups recognize that specialists will play an important role in cross-continuum care management and are designing incentives to encourage them to meet those goals.

Pseudonymed Johnstown Physician Group is part of a four-hospital system that is actively seeking payer contracts with greater risk for population outcomes. In preparation, the medical group is working with physicians to design compensation incentives focused on clinical quality and care coordination.

Specialists are integrally involved in this process. For example, one new compensation metric will evaluate how well Johnstown's cardiac surgeons manage patients on anti-coagulation medication, who are at high risk for bleeding complications during surgery. Initially, proceduralists will be rewarded for participating in the design of an anti-coagulation medication management protocol. Ultimately, a portion of compensation will be at risk based on how effectively proceduralists comply with this protocol and communicate back to referring physicians, with an eye toward avoiding preventable readmissions or other complications.

Incentives Target Communication with PCPs, Avoidable Complications

Incenting Cardiac Surgeons on Anti-Coagulation Medication Management

Understanding the Clinical Challenge

Designing a Two-Part Incentive

- Patients on anti-coagulation therapy require management during surgery to avoid bleeding complications, readmissions
- Clear communication between referring physicians, proceduralists key to effective medication-bridging strategy

Year One

- Expected to meet with PCPs, cardiologists to develop surgical anti-coagulation management protocol
- Upside-only incentive; no penalty for non-compliance

Year Two

- Expected to provide clear discharge summaries to referring physician detailing anti-coagulation management plan
- Both upside and downside risk for compliance

Case in Brief: Johnstown Physician Group[1]

- 260-physician medical group associated with four-hospital system located in the East
- System aims to reduce utilization, improve care management in anticipation of risk contracts
- Physician compensation incentives designed to promote collaboration and standards development in the first year, standards-based practice and quality outcomes in subsequent years

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Designing Strategy-Aligned Compensation Plans

This page provides a high-level overview of how compensation incentives and targets will likely change for different physician types as payment models evolve.

As with the Tracy Health System case, PCP compensation will likely shift to reward objectives beyond individual productivity, such as care team productivity, panel expansion, and successful chronic disease management. For proceduralists, compensation will likely remain largely productivity-based, but employers will incorporate metrics that advance other organizational goals for quality, cost-control, and care coordination. Finally, hospital-based specialists, who often provide care in groups, may see a greater shift toward compensation that rewards for team-based outcomes, with incentives built in to encourage individual productivity and quality performance.

Identify Appropriate Incentives to Support New Physician Roles

Evolving Physician Incentives Under Payment Reform

	Primary Care Physicians	Proceduralists	Hospital-Based Specialists[1]
Evolution of Compensation Model Under Payment Risk	• Increasing focus on patient panel expansion • Incented on team productivity, office efficiency, use of extenders	• Increasingly paid with multi-tier models based on both productivity, strategic alignment with hospital goals • Zeroing in on profitability per case to improve hospital's overall margin	• Compensation becomes divided into flat salary and bonus • Bonus tied to quality, maintenance of productivity levels, non-clinical duties
Potential Performance Metrics	• Chronic disease management • Panel size • Medical home development • Performance of care team	• Quality outcomes • Team-based care • Referral communication • Consult availability • Time to appointment • Efficiency • Discharge planning	• Inpatient quality outcomes • Inpatient efficiency • Hospital-based quality improvement leadership • Administrative and academic activities • Readmissions decline

Additional Compensation Resources from the Health Care Advisory Board

Compensation Assessment Tool	*Next-Generation Physician Compensation*	*Strategy-Aligned Physician Compensation*
• Diagnostic questions to gauge effectiveness of existing compensation model, readiness for change • Available in the Appendix	• On-demand webconference examining emerging issues in physician compensation design • Available at www.advisory.com/HCAB	• Book-length study dedicated to physician compensation design • Published in 2009, available at www.advisory.com/HCAB

1) Includes radiologists, hospitalists, anesthesiologists, pathologists, and emergency medicine physicians.

Source: Health Care Advisory Board interviews and analysis.

Mitigating Physician Concerns About Compensation Change

Compensation change, while necessary to meet evolving imperatives, can nevertheless be frightening to physicians. Even if physicians understand the larger rationale for payment redesign, they still may feel understandably concerned about whether the new model protects physician interests and what the impact will be on their own income and practice habits.

High-performance medical groups design strategies to address these concerns proactively, as detailed across the following pages.

Payment Model Redesign Raises a Host of (Justifiable) Fears

Who is Making This Decision and Why?

Uncertain that pay redesign adequately reflects physician needs and practice habits

How Quickly Will I Have to Make this Change?

Concerned that rapid shift in practice expectations will strain capabilities and resources

What Will Happen to My Income?

Unclear how new incentives will translate into specific dollar figures, compare to current income

Source: Health Care Advisory Board interviews and analysis.

Empowering Physicians to Revamp Compensation Incentives

In order to ease concerns about whether the new compensation model will adequately reflect the realities of physician practice, successful medical groups ensure that all compensation decisions are physician-driven. Many groups create a physician-run committee to oversee compensation issues and to provide a forum for individual providers to air concerns.

Phoebe Putney Health System reformed employed physician compensation in 2009 as part of a larger overhaul of its 170-physician medical group. Recognizing that physician leadership of the process was essential for achieving buy-in, the system created a cross-specialty physician finance committee that developed a plan for shifting the compensation model from flat salary to RVU-based productivity. The committee worked to persuade rank-and-file physicians that the change was favorable to physician interests, ensuring a smooth transition to the new model. Today, the finance committee is working with the medical group's quality committee—which is also physician-run—to build new quality incentives into the compensation model.

Physician Leadership Eases Concerns About Intentions

Physician Finance Committee

- Composed of physicians across specialties
- Develops compensation model[1] and proposes to medical group board for approval
- Advocates for compensation model with rank-and-file physicians

Yesterday: Eliminating Salary

- In 2009, proposed shift from salary to productivity compensation model
- Addressed physician concerns about transition

Today: Introducing Quality Metrics

- With physician quality committee, discerning which quality metrics to incorporate into compensation

Letting Physicians Lead the Way

"You have to swallow hard and trust the physicians. It took work for us to trust the finance committee to develop the compensation model and answer directly to the board."

Bob LeGesse
VP, Physician Division
Phoebe Putney Health System

Case in Brief: Phoebe Putney Health System

- Five-hospital system employing a 170-physician medical group, located in Albany, Georgia
- In 2009, with help of physician champion, undertook reform of group structure and compensation; to win physician support, placed physicians on governing board and created physician committees
- Oversight of compensation model by physician finance committee, as well as physician champion, crucial for mitigating physician discomfort with shift to RVU-based compensation in 2009, addition of quality metrics in 2011

1) The physician finance committee proposes only the compensation model and has no power to suggest the actual amount physicians should receive in compensation.

Source: Health Care Advisory Board interviews and analysis.

Gradually Transitioning to New Payment Model

High-performance medical groups also roll out compensation change gradually, rather than implementing a major change in payment structure overnight. They take slow steps to increase both the amount of compensation at risk for new incentives and the complexity of metrics chosen, allowing physicians to adapt to the change over time.

Dean Clinic in Wisconsin is rapidly redesigning care delivery in anticipation of increased payment risk and evolving its compensation model in tandem with this change. Dean's ultimate goal is to implement a compensation model based almost entirely on salary, with additional incentives for indicators such as panel size and quality, with only a fraction at risk for productivity. However, Dean also recognizes that this new model will represent a major change from its traditional compensation structure, which was based almost entirely on productivity.

As a result, Dean is transitioning to the new model gradually. It began several years ago simply by measuring—not compensating on—basic quality indicators. A few years later, the clinic began attaching incentives to those metrics, but only placed a small amount of total compensation at risk. Across the next few years, it expects to slowly increase the number of metrics and amount of money at risk, moving gradually to allow physicians the time needed to successfully adjust practice patterns.

Starting with Quality Measurement, Then Slowly Linking to Pay

Incremental Transformation of Physician Compensation Model

Breakdown of Compensation by Component
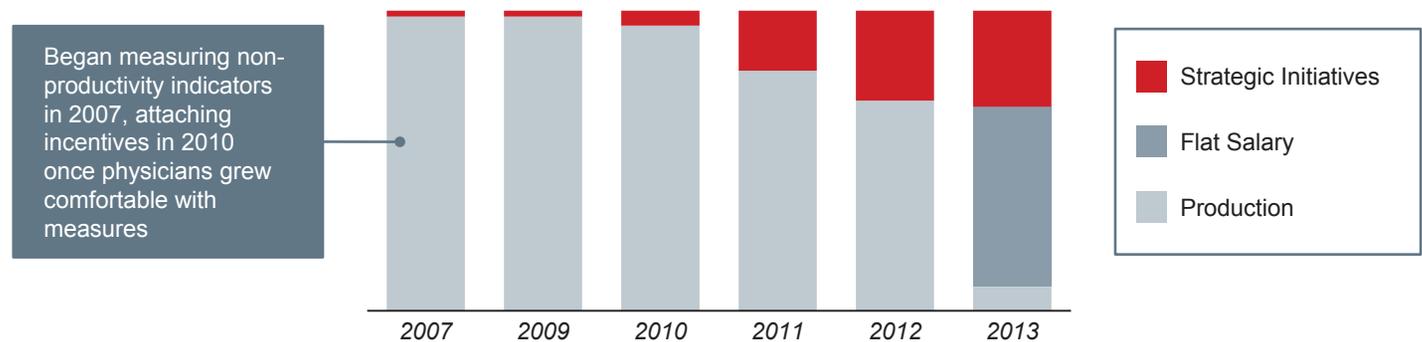
Began measuring non-productivity indicators in 2007, attaching incentives in 2010 once physicians grew comfortable with measures

Legend:
- Strategic Initiatives (red)
- Flat Salary (blue-gray)
- Production (light gray)

Years: 2007, 2009, 2010, 2011, 2012, 2013

Case in Brief: Dean Clinic

- Integrated system composed of 500 physicians and a 300,000-member health plan located in Madison, Wisconsin
- Redesigning care model to succeed against value-based contracts
- Gradually transitioning physicians from productivity-based compensation to payment tied to panel size, quality

Source: Samitt, C., "Physician Culture Change for Improving ACO Costs and Quality Outcomes," Center for Medicare and Medicaid Innovation Accountable Care Organizations Accelerated Development Learning Program, available at https://acoregister.rti.org, accessed on September 1, 2011; Health Care Advisory Board interviews and analysis.

Modeling the Impact of Compensation Redesign on Individual Income

A third tactic used to mitigate physician concerns about compensation change is shadow compensation, which provides physicians with visibility into how their current performance will reflect under a new payment model. In this strategy, medical group leaders meet with each individual physician before a new compensation model is implemented, comparing the physician's individual pay under the existing and new models. This conversation is based on the physician's existing performance, with the intention of communicating either that the physician will likely benefit from the compensation redesign or that the physician needs to improve performance against new goals in order to protect current earning levels.

Shadowing continues for three to six months, allowing physicians to compare their performance under current and proposed models side by side, evaluate the impact of practice changes, and provide feedback to leadership. Beyond reassuring physicians, shadow compensation also has the ancillary benefit of engaging physicians in performance change before a new compensation model even takes effect.

Shadow Compensation Gives Physicians Time to Prepare for Change

Dr. Jones

Actual   *Shadow*

Dr. Smith

Actual   *Shadow*

Physicians informed of compensation change

Physicians given monthly shadow compensation reports to compare existing, new models

New compensation model launched

January   *June*
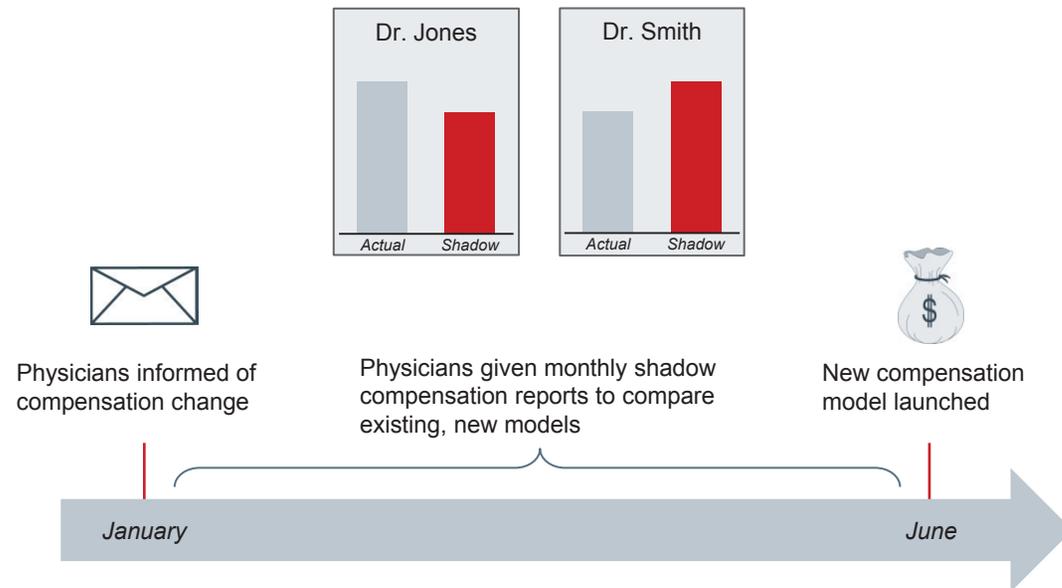
Tactic in Brief: Shadow Compensation

- Group leaders devise alternative physician compensation model
- Comparison of current earnings with projected earnings under new model shared with each physician for three to six months prior to new model launch
- Physicians reassured regarding future income or warned to improve performance in order to maintain current earnings under the new model
- Physicians given individual and system-level cost and quality data to facilitate performance improvement

Source: Health Care Advisory Board interviews and analysis.

Offering Ongoing Transparency into Payment Structure

Finally, high-performance medical groups provide resources to give physicians ongoing transparency into compensation, even long after a change has been implemented. This strategy—consistent with medical groups' broader embrace of transparency as a core cultural hallmark of effective team-based care—helps to ensure that compensation does not become a source of physician dissatisfaction and keeps physicians focused on the larger strategic goals that compensation is designed to advance.

Kelsey-Seybold Clinic in Texas, for example, employs a full-time, dedicated compensation consultant. The consultant works to keep the medical group's 370 physicians updated on progress toward productivity and quality goals and serves as a resource to answer physician questions about compensation structure. The consultant also plays a role during hiring and onboarding, meeting with both candidates and new physicians to explain how the clinic's compensation approach—a salary-based model that, while productivity-linked, is designed to encourage team-based care—supports Kelsey-Seybold's collegial culture.

Many organizations unable to support a full-time compensation consultant have integrated these duties into the roles of other administrative and support staff within the group.

Compensation Consultant Supports New and Tenured Physicians Alike

Physician Compensation Specialist

Educates Newly Hired Physicians

- Explains compensation model to new hires
- Stresses importance of quality in organizational culture during interview
- Clarifies that poor quality rather than low productivity can lead to termination

Ensures Ongoing Transparency and Trust

- Monitors productivity data
- Regularly reports data to physicians, enabling easy calculation of bonus
- Provides data on demand to resolve concerns or monitor improvement

Case in Brief: Kelsey-Seybold Clinic

- 370-provider physician group located in Houston, Texas
- Physicians paid one of four salary tiers tied to productivity percentile, with productivity-based bonus
- Staff member dedicated to managing compensation ensures transparency, clarifies how compensation supports the organization's culture of high productivity and high quality

For a full job description of the Physician Compensation Consultant, please see the High-Performance Medical Group Toolkit available at www.advisory.com/HCAB

Source: Health Care Advisory Board interviews and analysis.

Individual Behavior Aligned with Strategy

The box on this page provides a brief overview summary of the four attributes used by high-performance medical groups to design individual incentives that engage physicians against group goals. These elements involved in leveraging transparency and designing strategy-aligned compensation represent the third and final level of core tenets for the high-performance medical group.

Takeaway Summary for Health System Leaders

Attribute #12: Effective Bidirectional Communication Processes
Build multimodal communication systems to keep frontline physicians consistently updated on all group activities and strategic decisions; create regular opportunities for physicians to provide feedback up the chain of command

Attribute #13: Dissemination of Unblinded Physician Performance Data
Design physician scorecards that provide a comprehensive and holistic picture of individual performance; share unblinded data to maximize the performance-enhancing effect of peer pressure

Attribute #14: Compensation Narrowly Tailored to Advance Group Objectives
Deploy financial incentives sparingly and only as needed to advance group strategy; redesign productivity-only compensation models to eliminate barriers to delivery of high-quality, low-cost, coordinated care

Attribute #15: Staged Adoption of New Compensation Plans
Mitigate physician concerns about compensation change by engaging physician leaders in redesign, transitioning gradually to new incentive models and providing ongoing transparency into the impact of payment structure on individual physician income

Source: Health Care Advisory Board interviews and analysis.

Individual Behavior Aligned with Strategy

The box on this page contains key questions for health system leaders to discuss as they consider their own progress toward individually motivating employed practices against organizational objectives.

Key Questions for Health System Leaders

- Do our physicians feel well-informed around group strategy and the impact of group decisions on their practice? How do we build communication vehicles to engage the "silent majority" who do not readily seek information or provide feedback?

- Do we regularly share individual performance data with our physicians? Can our physicians benchmark their performance relative to peers? How do we build peer-driven processes to remediate underperformance?

- How do we foster a culture of complete transparency around individual performance? What are the barriers to unblinded performance data sharing across the group, and how can we migrate physicians toward acceptance?

- Have we reviewed physician compensation models to ensure they support our current strategic objectives? What barriers exist that could prevent physicians from fully partnering with us to advance care delivery? How do we evolve our compensation models to realign incentives with group and system strategy?

- How do we mitigate physician concerns about compensation change? How do we proactively provide transparency into the impact of model change on physician incomes and work with them to identify needed changes to ensure mutual success?

Appendix

- Compensation Diagnostic Questionnaire
- Compensation Discussion Guide

Compensation Diagnostic Questionnaire

Below are questions for senior executives and physician leaders to ask about physician compensation—a self-assessment of whether the model is appropriate in light of system goals. Each question targets a key consideration in designing compensation. A "no" response to any question suggests an area meriting further attention.

		YES	NO
1.	Does our compensation model effectively support our employment strategy, i.e., does its design advance our primary overall goals for employing physicians?	_____	_____
2.	Do physicians play a leadership role in spearheading compensation model design and selecting appropriate pay incentives?	_____	_____
3.	Do we use compensation incentives sparingly and only as needed to affect physician behavior, i.e. when other means of motivation have failed, to communicate an initiative's importance, or to remove barriers to goal achievement?	_____	_____
4.	Is our compensation model flexible enough to incorporate new or different incentives as our strategy or market dynamics change? Are we prepared to redesign compensation plans to eliminate barriers that arise as system goals evolve?	_____	_____
5.	Have we identified both the short- and long-term keys to program advancement in each specialty or department, and do our compensation model incentives for physician leaders reflect both those goal types?	_____	_____
6.	Do our goals for physicians differ across specialties to reflect specific strategic objectives?	_____	_____
7.	Do we regularly raise performance thresholds for physicians as they make progress against the goals we prioritize?	_____	_____
8.	Do our existing information systems enable us to easily collect adequate data to monitor all performance metrics linked to compensation?	_____	_____
9.	Is our compensation model reflective of and supported by external reimbursement structures (e.g., positions physicians to capture performance-based pay)? If we are shifting compensation to reward activities not supported by current payment models, are we prepared for the increased subsidies that practices may require as a result?	_____	_____
10.	Is physicians' take-home pay competitive with the income they could earn through other practice opportunities in our local market?	_____	_____
11.	In cases where we have compromised practice-level financials in pursuit of higher-priority organizational goals, have physicians been protected against any personal downside resulting from those choices?	_____	_____
12.	Do we have strategies in place to manage physician concerns about the impact of any compensation model change on their practice patterns or take-home pay?	_____	_____
13.	Are adequate compensation incentives in place for physicians engaged in leadership at the practice, medical group, and system levels?	_____	_____
14.	Have we audited the amount and type of time employed physicians spend on administrative and leadership duties to ensure adequate administrative compensation?	_____	_____

Compensation Discussion Guide

Complementing the Compensation Diagnostic Questionnaire, below is a list of open-ended questions intended to aid hospitals and health systems as they consider a redesign of their physician compensation model. Senior executives and physician leaders should use this guide to engage in a discussion about barriers to collaboration in the current incentive structure, short- and long-term goals, and opportunities to enhance the employment relationship.

1. What are our strategic goals for our employed physicians?

2. Specifically, how important are the following issues that might be influenced by the incentives in our compensation model?

   a) Maximizing employed physician productivity and revenue?
   b) Minimizing physician practice costs?
   c) Ensuring access to care for all patients, including the underserved?
   d) Capturing enhanced ambulatory and inpatient market share[1]?
   e) Increasing the percentage of patients receiving recommended and evidence-based care?
   f) Improving clinical quality and care efficiency outcomes?
   g) Standardizing clinical operations and business processes across sites?
   h) Improving proactive management of chronic illness?
   i) Implementing team-based care within the practice?
   j) Adoption of new clinical care models (e.g., medical home)
   k) Fostering cross-continuum coordination of patient care?
   l) Ensuring provision of care in most appropriate clinical setting[1]?
   m) Engaging physicians in leadership roles?
   n) Enhancing patient satisfaction, professionalism, or other citizenship measures?

3. What explicit or implicit incentives in our existing compensation model(s) for employed physicians prevent us from reaching the goals outlined in question 2?

4. How will we involve our physicians in selecting appropriate compensation design?

5. What proportion of total physician pay should we allocate to productivity vs. incentives for other strategic goals (e.g., quality improvement, patient satisfaction, leadership service)?

6. When compensating physicians for production, how will we balance rewards for individual vs. group or team productivity?

7. How will use of incentive structures vary between primary care physicians and specialists?

8. What specific metrics will we use to gauge performance against each incentive? Do our existing information systems enable us to easily collect data to monitor these metrics?

9. Are our physician incentives supported by our external reimbursement environment? For those that are not, are we prepared to fund the incentives ourselves through increased subsidies?

10. If we choose to redesign our existing compensation model, how will we manage physician concerns about the impact this change will have to their practice patterns or take-home pay?

11. How will we ensure that our compensation model remains flexible to incorporate new or different incentives as our strategy or market dynamics change?

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1) Hospitals should consult legal counsel to ensure relevant financial incentives do not violate fraud and abuse requirements.

Source: Health Care Advisory Board interviews and analysis.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP(c), RN, NEA-BC
Date: November 2, 2020
Subject: Patient Experience Comments

Purpose: To provide the Committee with written patient feedback that is received via the Press Ganey HCAHPS Survey tool.

Summary:

1. Situation: These comments are regarding a patient with experience in the OPS department at the Los Gatos campus.

2. Authority: To provide insight into one patient's experience who was having surgery in Los Gatos.

3. Background: While the patient found the staff to be friendly and courteous, there was a change in her surgery time that was not clearly communicated. The patient was then rushed to prepare for an earlier surgery time. There was a lack of clarity from one of the nurses in OPS. There was difficulty in starting the IV.

4. Assessment: The patient's experience was mixed due to the unfortunate communication lapses regarding the surgery time change, lack of clear communication, and IV start difficulties. The patient did find the staff to be friendly and identifies Dr. Miller as "the best".

5. Other Reviews: None

6. Outcomes: We have recently purchased new vein finder machines for the nurses to more easily access patient veins. The pre-admission program staff have built in a step in their process to assure that the routine night before surgery phone call to our patients re-iterates the time for surgery with repeat back. The OPS staff are being trained on the WeCare behaviors.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do you share opportunities for improvement with the staff?

2. What are the results so far of the changes you have made to the processes?

Press Ganey Survey, Sept 2020 Los Gatos

"All staff that I came in contact with were friendly and courteous. There was a little bit of a mix up, as my surgery was originally scheduled for 11:30am but changed without me received a message as to the time change to 8:30am. The day of surgery was rather stressful as I had limited time to prepare for the surgery (bacterial wash, etc.). Other than that, my experience was excellent. Dr. Miller is the best.

One of the nurses who helped me with the preparation was not being clear. The one who helped me with the IV before surgery had to poke a few times to get the IV in while I think my vein is pretty obvious. I believe nurses in this department should be more professional"

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

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

Purpose: To review the new Board Quality and Safety Dashboard.

Summary:

1. <u>Situation</u>: 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. <u>Authority</u>: 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. <u>Background</u>: 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 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.

4. <u>Assessment</u>: The Board's Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention and the Board will receive the new dashboard as a part of the Quality Committee report. The intent is to review those areas of potential concern (n red) and are noted below according to the Quality Domain**:**
   A. Safe Care:
      i. SSER rate is not yet based on a full 12 months of data and is variable @ 4.05 for July and August. Surgical Site Infections are SSEs, with an increase in Qtr.1.
      ii. CAUTI: one HAI from LG Rehab in 88 y/o woman with neurogenic bladder
      iii. C.Diff: 3 in July and1 in August: 3 of 4 cases with 3-4 antibiotics, 1 w/o antibiotics became symptomatic.
   B. Timely:
      i. Median Time Arrival to ED Departure: @ 255 minutes, monitored and investigated daily. New electronic ED SBAR Handoff tool implemented.
      ii. ED Arrival to Direct Discharge for ED pts. @ 151, and is reviewed daily.
   C. Effective Care:
      i. CMS SEP-1 Compliance rate: 74.6% for Q1, though achieved 100% in July, 80% in August. CMS median rate is 60% across all hospitals.
      ii. PC-01: 1 case w/clear medical indications for early elective delivery
      iii. PC-02 C/S rate: increased across both campuses and new providers in LG
   D. Efficient Care:
      i. ALOS/Expected LOS: Long term patients difficult to discharge and place including COVID-19 pts. impact this metric.
   E. Equitable Care: no issues
   F. Patient-Centered Care:
      i. Enterprise, ED, MCH and OAS LTR are all not meeting target but increasing this quarter. The lack of patient visitation due to COVID pandemic affects these scores

Board Quality and Safety Dashboard
November 2, 2020

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

6. <u>Outcomes</u>: The Quality Committee will become familiarized with this new dashboard construct.

List of Attachments:

1. PowerPoint illustrating the new dashboard

Suggested Committee Discussion Questions:

1. Are there any questions regarding the "red" metrics?
2. What recommendations does the committee have regarding how much information should be delivered to the Board to accompany the dashboard?
3. Would the Committee like to use findings on this dashboard to drive agenda items for more in depth reviews going forward?
4. What additional supporting information would be useful to the Committee to assist in evaluating the metrics?
5. What educational support might be useful to convey to the Board to help with interpretation of this information?

El Camino Health

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q1 (unless otherwise specified by *)

Quality Domain	Metric	Baseline FY 20	Target FY 21	Performance FYTD21, Q1	FYTD21, Q2	FYTD21, Q3	FYTD21, Q4	FYTD21 Total
Safe Care	Risk Adjusted Mortality Index	0.74	0.76	*0.75				**0.75**
	Sepsis Mortality Index	0.96	0.9	0.76				**0.76**
	Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun' 20)	3.78	4.28	*4.05				**4.05**
	Surgical Site Infections (SSI)	0.36	1.0 (SIR)	0.56				0.56
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.47	<= 0.48	0.51				**0.51**
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.15	<= 0.2	0.0				**0.0**
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6				**1.6**
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898				**0.898**
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min				**188 min**
	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255				**255**
	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	152 min				152 min
Effective	Risk Adjusted Readmissions Index	0.96	0.93	*0.89				**0.89**
	CMS SEP-1 Compliance Rate	70.9%	86%	74.6%				**74.6%**
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.29%	1.3%	*1.8% (1/57)				**1.8%**
	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	*29.2% (103/353)				**29.2%**
	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	63	59.0%				**67.0%**
	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<45	31.0%				**30.4%**
	HEDIS: Composite	NA	3.0	3.25				3.25
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.00	1.316				**1.316**
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None updated annually, January			**0.99**
Equitable	Hospital Charity Care Support	20.5 mil	NA	66.2k				**66.2k**
	Clinic Charity Care Support	44.3k	NA	8.5k				**8.5k**
	Language Line Unmet Requests (data collection started Q2)	0.34%	NA	0.39%				**0.39%**
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98				**3.98**
		White: 3.79		3.81				**3.81**
		Asian: 3.64		3.54				**3.54**
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7				**80.7**
	ED - HCAHPS Likelihood to Recommend	75.7	78.2	73.9				**73.9**
	ECHMN - HCAHPS Likelihood to Recommend	73.2	75.7	76.2				**76.2**
	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9				**82.9**
	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5				**83.5**
	NRC Net Promoter Score (NPS)	72.3	75	76.2				**76.2**

Report updated 10/28/20

* data available FYTD 21 up to August only

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: November 2, 2020
Subject: SVMD Quarterly Quality Report

Purpose: Provide the Board Quality Committee with a quarterly update on the status of SVMD quality.

Summary:

1. Situation: SVMD dba El Camino Health Medical Network (ECHMN) has grown exponentially over the past year with many new physicians and multiple sites of service. The system Board of Directors is very interested in understanding and tracking the quality and service performance of the various components of SVMD. It was agreed that the Board Quality Committee would review the status of quality and service performance within SVMD on a quarterly basis.

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

3. Background: SVMD is a wholly owned subsidiary of El Camino Hospital established as a separate corporation with its own tax ID number. It was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital based out patient care. The governance structure (as illustrated in the background attachment) is multilayered. SVMD is governed by a Board of Managers reporting to the parent organization—El Camino Hospital—which, in turn, is governed by the system Board of Directors. As this is relatively new and SVMD growth has been exponential over the past year, there is a great deal of interest on the part of the system governing Board regarding SVMD operations. However, much as the system Board is learning to trust its Quality Committee which has Board delegated oversight on quality, the Board and Board Quality Committee will need to learn to trust the SVMD Board of Managers to do their delegated oversight work.   The rapid growth of SVMD was generated by the acquisition of the San Jose Medical Group (SJMG). It is important to know that of the original group, only 60% remain while 40% were more recently recruited and added to the group. In the course of the acquisition, less desirable physicians were released and a deliberate strategy of identifying top physician talent to add to the group has taken place. While the name is the same, this is essentially a new group of high quality physicians.

4. Assessment: There are three key areas of focus for SVMD with respect to quality and service:

    A.   HEDIS (Healthcare Effectiveness Data and Information set)
    B.   MIPS (Medicare Incentive Payment System)
    C.   NPS (net promoter score)

    ECHMN has established true north pillars, one of which is quality and service. For quality, the goals are: achieve top decile HEDIS composite score by 2023 and achieve MIPS composite exceptional rating annually. While there are many more HEDIS measures, 8 key metrics have been selected based on importance to patient care, impact on financial reimbursement, and concordance with MIPS measures. These 8 metrics are then compiled into a composite score as illustrated in the attachment material. The most recent is on page 7 of the PP. For interest, there

is a comparison between ECMA and SJMG results which helps to explain the impact of data collection since ECMA has had several years to fine tune their workflows to record and retrieve their HEDIS data while SJMG is still catching up after going live with Epic a little over a year ago. A multi-pronged action plan has been underway to address these gaps.

MIPS is a CMS program that is designed to improve quality of care by linking physician payment to quality outcomes. The MIPS program assesses four areas for performance: quality, cost, promoting interoperability (formerly meaningful use), and quality improvement activities. While it is limited to Medicare patients only, it has an impact beyond Medicare because establishing the means to score well affects all patients. This data will be used by CMS to establish "doctor compare" analogous to the current "hospital compare" to be used by consumers of health care. It also promotes standardization of care and enhances the discipline needed to emphasize overall health on a consistent basis.

Included on slide 17 of the PP you will find some comparison data based on Integrated Healthcare Association (IHA) scoring of medical groups based on commercial or Medicare Advantage product lines. (They have not scored SJMG so far.) Medicare Advantage—we are not currently involved in that product—groups tend to score higher as there is much more incentive to do so. The commercial PPO quality ratings—more analogous to SVMD business— is similar to SVMD with Kaiser not surprisingly leading the pack given their long standing infrastructure built to maximize these scores.

Finally, the NPS score for ECHMN is included which has shown a steady improvement. Net Promoter Score is calculated by asking patients to rate on a 1 to 10 scale their likelihood to recommend. The percent of 9's and 10's is reduced by the number of 1's through 5's. (6, 7, and 8's do not count).

5.   Outcomes: The Quality Committee will have a better understanding of how SVMD fits into the corporate structure, how it is governed, and how quality and service is being addressed in the organization. While quality and service are just as important in a physician practice, ambulatory physician practice business is much different than hospital business so requires a different mindset and approach.

List of Attachments:

1.   Power Point background material to pre-read to facilitate the discussion and use as a reference for discussion.

Suggested Committee Discussion Questions:

What do committee members look for when choosing a physician practice?
What areas should SVMD be focusing on to improve service?
How do we promote our ambulatory practices?
How do committee members assess the quality of care they are receiving from their physician?
What additional information would be helpful for the committee to have to satisfy any concerns about quality and service in SVMD?

SVMD Quarterly Quality Report

Board Quality Committee
November 2, 2020

Mark Adams, M.D., Chief Medical Officer

Ute Burness, RN, Managed Care Operations Consultant

Governance Structure

El Camino Hospital Board of Directors

El Camino Hospital

SVMD Board of Managers

SVMD
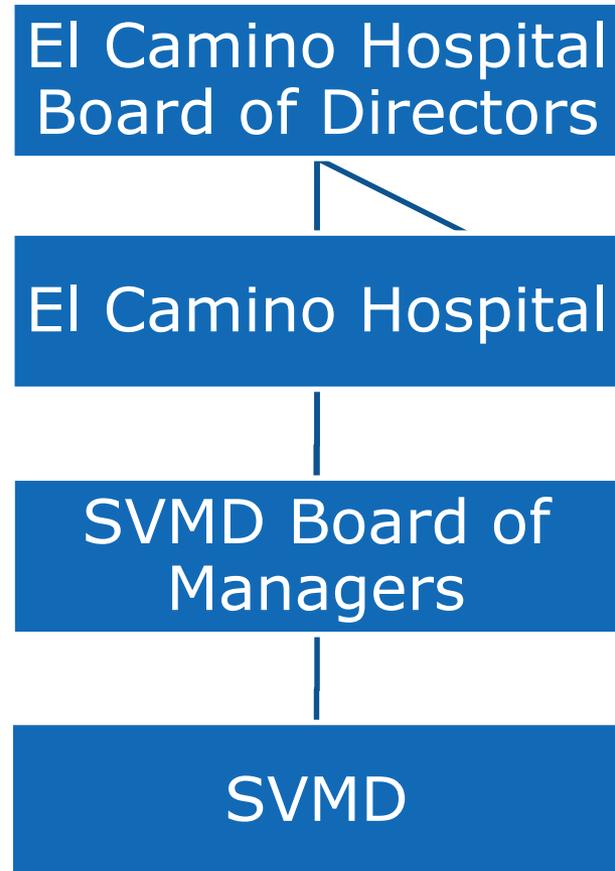
Relationship Structure

El Camino Health Medical Network is a single Tax ID entity with a Board and Management structure that supports Ambulatory and Managed Care operations for the Health System

Silicon Valley Medical Development dba El Camino Health Medical Network

- Branded as El Camino Health & ECHMN
- Single Tax ID, Board and management
- Payer contracting with Health Plan as El Camino Health Medical Network
- Combined physician leadership and quality oversight
- Standard operations across the enterprise

ECHMN Contracts with Providers to Work at El Camino Health Through PSA's

El Camino Health Medical Network
- Clinics
- Urgent Care Centers
- Hospitalists
- Hospital Professional Services

El Camino Health Medical Network — Risk Bearing Organization
- Manages risk
- Oversees quality
- Utilization management
- Pays claims
- Credentialing
- Provider contracts

Professional Services Agreements (PSA's)

- **El Camino Medical Associates** (friendly PC)
- **San Jose Medical Group** (Medical Group Corporation)
- **Direct Urgent Care**

(Formation) Independent Physician Association (IPA)

Contracts with Providers to serve patient population

- Hospitals
- 100 + Independent Physicians

Silicon Valley Medical Development

El Camino Health Medical Network
True North Pillars and Metrics

GROWTH

SERVICE

QUALITY & SERVICE

PEOPLE

OPERATIONAL EFFICIENCY

FINANCE

Patient Access and Market Relevance	Exceptional Personalized Experience, Always	Top Tier Performance with Zero Preventable Harm	Teams Aligned & Empowered with Trust and Purpose	Optimize Care Delivery	Sustainable Strength and Vitality
• Increase growth of active patients to 100K by 2023 • The medical network will represent 20% of ECH medical net revenue by 2023 thus serving as a prime source of patient access and continuity of care within the system	• Achieve top quartile for Patient Experience as measured by Net Promoter Score by 2023	• Achieve top decile HEDIS Composite score by 2023 • Achieve MIPs Composite Exceptional rating annually	• Achieve top quartile physician engagement by 2023 • Achieve top quartile staff engagement by 2023	• Overall productivity above the 50%tile • 85% in-network referral retention	• Achieve budget • System revenue to be greater than investment into network • Achieve investment per provider at median by 2023

ECHMN is focusing on achievement of the above pillars in order to advance as a successful medical group enterprise for El Camino Health.

Silicon Valley Medical Development

2020/21 Quality Metrics

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

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

- *Epic* and MIPS scoring data and ranking system were used as the benchmark for provider and system level reporting.

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

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

Quality Metrics

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

SVMD Leading HealthCare Metrics
Target Versus Actual as of September 2020

Metric	Target	July-Sept 20 Performance	Trend vs Prior Quarter
COMPOSITE SCORE	3.0	3.25	⬆
Documentation of Current Meds	89%	83%	⬆
BMI Screening and Intervention	47%	45%	⬇
Hemoglobin A1C	less than 45%	31%	⬇
Breast Cancer Screening	48%	42%	⬇
Colorectal Cancer Screening	45%	31%	⬆
Tobacco Screening and Intervention	90%	92%	⬆
Fall Screening	56%	46%	⬆
Controlling Blood Pressure	63%	59%	⬆

Silicon Valley Medical Development

El Camino Medical Associates Versus San Jose Medical Group Metrics

Metric	ECMA – Q1 Performance	SJMG – Q1 Performance
Controlling Blood Pressure to less than 140/90	53%	44%
Diabetes: Hemoglobin A1c Poor Control (>9%)	36%	50%
Documentation of Current Medications	97%	75%
Falls: Screening for Future Fall Risk	0%	0%
Body Mass Index (BMI) and Follow Up Plan	87%	36%
Breast Cancer Screening	61%	27%
Colorectal Cancer Screening	52%	22%
Tobacco Use and Cessation Intervention	96%	52%

Action Plan to Address the Care/Process Gaps

- We have put together a team to include Mandeep Khabra, M.D., Ute Burness, R.N and Matt Niedzwiecki, COO to develop a short and long-term quality plan

- Gaps in care identified

- Training materials revised

- Launched practice retraining and gap closure targets on September 20th.

- Data extraction for gap closure

- Outreach to patients for gap closure

- Weekly team meetings

- Practice reports for gap closure

MIPS Program Overview

- Merit Based Incentive Payment System (MIPS) was designed by CMS to tie payments to quality and cost efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.

- The MIPS Performance Year begins on January 1 and ends on December 31 each year.

- There are four performance categories that make up our final score –

    Quality, Cost, Promoting Interoperability and Improvement Activities

- **Payment adjustments** are applied based on performance two years prior.

- Performance thresholds and payments adjustments continue to increase each year.

    ➢ For CY 2020 Exceptional performance bonus will require more improvement efforts – the exceptional bonus threshold increases to 85 points (from 75 in 2019).

    ➢ Clinicians also have to do more to avoid a penalty; you now need 45 MIPS points (up from 30 in 2019) to avoid a penalty.

MIPS Program Overview

Calendar Year	Maximum Possible +/- Payment Adjustment
2020	1.68% (based on 2018 performance)
2021	4.5% to 5.5% (based on 2019 performance)
2022	6.25% to 6.75% (based on 2020 performance)
2023	6.9% to 7.4% (based on 2021 performance)

MIPS Program Overview

Performance categories carry different weights that shift as the program progresses.

Performance Category	Performance Year 2020	Performance Year 2021	Performance Year 2022
Quality (12 Months)	45%	40%*	30%*
Cost (12 Months)	15%	20%*	30%*
Promoting Interoperability (90 Days)	25%	25%	25%
Improvement Activities (90 Days)	15%	15%	15%

2020 SVMD MIPS Performance Estimate

- Both SJMG and ECMA earned an initial bonus + partial exceptional bonus in 2019

- SVMD Quality Committee and Management are actively focusing on improving to 85% in order to achieve exceptional level for CY20.

SVMD (SJMG) Performance as of August 7th, 2020: **Estimated Score: 82.2/100**

Category	Score	Weight	MIPS Points
Quality (1/1/2020 – 12/31/2020)	88.50%	45.00%	39.8
Promoting Interoperability (5/10/2020 – 8/7/2020)	64.00%	25.00%	16
Improvement Activities (5/10/2020 – 8/7/2020)	100.00%	15.00%	15
Cost (CY2019 Final Performance)*	75.71%*	15.00%	11.4

ECMA 2020 Performance as of August 7th, 2020: **Estimated Score: 78.4/100**

Category	Score	Weight	MIPS Points
Quality (1/1/2020 – 12/31/2020)	88.50%	45.00%	39.8
Promoting Interoperability (5/10/2020 – 8/7/2020)	65.00%	25.00%	16.3
Improvement Activities (5/10/2020 – 8/7/2020)	100.00%	15.00%	15
Cost (CY2019 Final Performance)*	48.6%*	15.00%	7.3

Silicon Valley Medical Development

MIPS Improvement: Other Quality Targets

Below are the proposed improvement shifts for the other quality measures to help mitigate risks if the primary target measures are not met.

Other MIPS Quality Targets					
Measure	Practice	Current Performance *(As of 9/29)*	Target Performance	Target Patients or Records count (rounded)	Action Required
CMS-22 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	SVMD	33.9% 4538 out of 13385	61.53% 8238 out of 13385	3,700	Larger opportunity here to shift performance 2-3 deciles
	ECMA	37.2% 2024 out of 5442	61.53% 3349 out of 5442	1,325	
CMS-165 Controlling High Blood Pressure	SVMD	53.3% 3666 out of 6625	80.0% 5306 out of 6625	1,040	Larger opportunity here to shift performance 2-3 deciles
	ECMA	60.1% 1194 out of 1986	80.0% 1589 out of 1986	395	
CMS-122 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	SVMD	36.9% 975 out of 2639	< 31.4% 830 out of 2639	Reduce by 145 *Note: This is an inverse measure*	We are doing well here, the lower performance the better. There is only incremental improvement shifts that will impact the MIPS score.
	ECMA	42.2% 325 out of 771	< 31.4% 240 out of 771	Reduce by 85 *Note: This is an inverse measure*	

MIPS Improvement: Other Quality Targets

| Other MIPS Quality Targets					
Measure	Practice	Current Performance *(As of 9/29)*	Target Performance	Target Patients or Records count (rounded)	Action Required
CMS-127 Pneumococcal Vaccination Status for Older Adults	SVMD	76.1% 6715 out of 8827	88.82% 7840 out of 8827	1,125	There is only incremental improvement shifts that will impact the MIPS score.
	ECMA	73.1% 2464 out of 3373	88.82% 2999 out of 3373	535	
CMS-347 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	SVMD	73.4% 4431 out of 6034	83.51% 5041 out of 6034	610 in total across all three sub-components	There is only incremental improvement shifts that will impact the MIPS score. This is based on the total of three sub-components: • Patients w/ Clinical ASCVD • Patients w/ Hypercholesterolemia • Patients Aged 40-75 w/ Diabetes
	ECMA	71.5% 1611 out of 2252	83.51% 1881 out of 2252	270 in total across all three sub-components	
CMS-68 Documentation of current Medications in the medical record	SVMD	76.1% 52728 out of 69326	99.69% 69113 out of 69326	16,385	We are doing well here. To shift in decile, it would require us to be doing this 100% of the time.
	ECMA	89.9% 16353 out of 18196	99.69% 18143 out of 18196	1,790	
CMS-2 Preventive Care and Screening: Screening for Depression and Follow-Up Plan	SVMD	15.7% 3441 out of 21857	65.21% 14261 out of 21857	10,820	There is only incremental improvement shifts that will impact the MIPS score.
	ECMA	44.6% 3792 out of 8494	65.21% 5542 out of 8494	1750	

Silicon Valley Medical Development

MIPS Improvement: Other Quality Targets (continued)

Other MIPS Quality Targets					
Measure	Practice	Current Performance *(As of 9/29)*	Target Performance	Target Patients or Records count (rounded)	Action Required
CMS-125 Breast Cancer Screening	SVMD	38.9% 2168 out of 5568	69.36% 2168 out of 5568	1,695	While there is large opportunity gain here, this is not currently a top 6 MIPS measure. Therefore, it would require significant effort to meet and exceed a performance rate of a current metric that is already performing well.
	ECMA	40.2% 811 out of 2019	69.36% 1401 out of 2019	590	
CMS – 130 Colorectal Cancer Screening	SVMD	26.8% 2864 out of 10695	70.01% 7489 out of 10695	4,625	While there is large opportunity gain here, this is not currently a top 6 MIPS measure. Therefore, it would require significant effort to meet and exceed a performance rate of a current metric that is already performing well.
	ECMA	28.0% 1058 out of 3775	70.01% 2643 out of 3775	1,585	
CMS-138 Cessation Intervention for Tobacco Users	SVMD	14.2% 130 out of 915	73.98% 680 out of 915	550 of the Cessation Intervention for Tobacco Users	This measure takes a significant performance shift to increase the decile.
	ECMA	26.3% 47 out of 179	73.98% 132 out of 179	85 of the Cessation Intervention for Tobacco Users	
CMS-139 Falls: Screening for Future Fall Risk	SVMD	27.1% 2404 out of 8875	65.27% 5794 out of 8875	3,390	This measure takes a significant performance shift to increase the decile.
	ECMA	36.9% 1248 out of 3380	65.27% 2208 out of 3380	960	

IHA Medical Group Reporting – 2019-2020 Edition

Name of Entity	Commercial Quality Rating	Commercial Pt Experience Rating	Medicare Advantage Quality Rating
Affinity	3.2	5	4.5
Kaiser	4.5	4.5	4
PMG	2.6	2	3
SCIPPA	2.5	3	4
Sutter	3.8	5	5
SJMG	Not Reported	Not reported	Not Reported

Net Promoter Score Trend by Quarter

Net Promoter Score Trend by Quarter
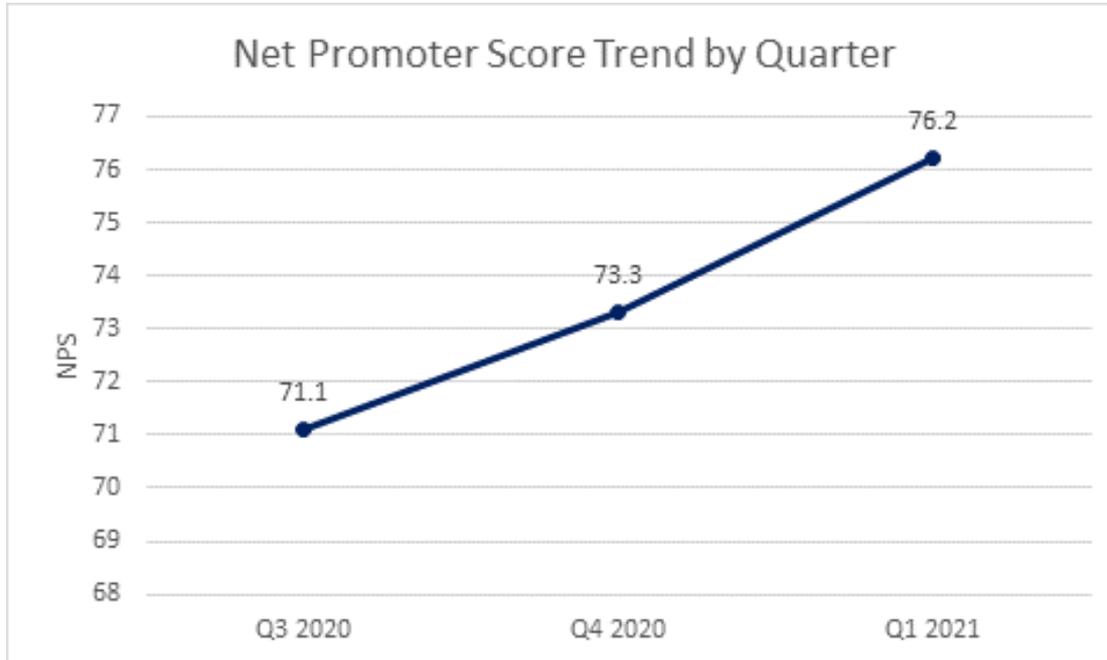
EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CAO
Date: November 2, 2020
Subject: Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): The Safety Committee and the Emergency Management Committee of the Hospital recommends that the Board Quality Committee approve the Annual Report, Evaluation of the Environment of Care & Emergency Management.

Summary:

1.   Situation: Despite the challenges presented by a global pandemic the management of the environment of care, the safety program with all its elements and the emergency management plan produced solid results. Highlights include:

     a)   The rate of OSHA recordable incidents per 100 FTE continue to **decline in FY-20 to 4.7 as compared to 5.9 in FY-19.** The total *number* of recordable incidents decreased to 120 compared to 145 in FY-19. **Another record low!**

     b)   No reportable Hazardous Material incidents or Waste Water Discharge violations occurred during FY-20.

     c)   There were five loss of power incidents (4 in Los Gatos, 1 in Mountain View) with no negative impact to operations. Emergency systems performed as designed.

     d)   The education and training associated with the activation the Taube Pavilion, the Sobrato Pavilion and the Willow Outpatient Surgery Department was completed in accordance with standards and solid planning.

     e)   The response to the COVID-19 pandemic and shelter in place orders presented many challenges that were faced head on and while significant effort was required the measures taken ensured a safe environment of care.

     There were also elements of the safety program that warrant continued effort and attention.

     a)   We continue to see an increase in Code Gray incidents and the number of reportable workplace violence incidents increased 23% from last year.

     b)   Due to multiple factors the preventive maintenance of high risk medical equipment was only 88% compliant with the goal of 100%.

2.   Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.

3.   Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

4.   Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement. The resources and prior planning and drilling helped to ensure a positive response to an unprecedented situation with a global pandemic and concurrently identifying areas in which we can improve our preparations for future events.

5.   <u>Other Reviews</u>: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.

6.   <u>Outcomes</u>: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-21.

List of Attachments:

1.   Full Report – Evaluation of the Environment of Care & Emergency Management

Suggested Quality Committee Discussion Questions:

1.   What steps are being taken to reduce the increase in workplace violence.
2.   What steps are being taken to ensure that all high risk medical equipment receives preventive maintenance at 100%.
3.   Are there improvements that need to be made in preparation for a future pandemic?

FY-2020 Evaluation of the Environment of Care
and
Emergency Management

Prepared by:

Steve Weirauch
   Manager, Environmental, Health & Safety

Matt Scannell
   Director, Safety and Security

Created: 08/26/2020

Table of Contents

Program Overview

The Joint Commission (TJC) standards provide the framework for the Safety Program for Managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends (See Attachment 2a). The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2020. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management
*Work Group Chair: **Mari Numanlia-Wone***

Scope

Safety Management is the responsibility of hospital leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

- Employee Wellness & Health Services
- Education Services
- Quality and Patient Safety
- Infection Prevention
- Security Management

- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-20. This includes data from both the Mountain View and Los Gatos campuses.

[See Attachment 1 for a definition of terms and formulas used to calculate in this report.]

### A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE continue to **decline in FY-20 to 4.7 as compared to 5.9 in FY-19.** The total *number* of recordable incidents decreased to 120 compared to 145 in FY-19. **Another record low!**

The rate of lost work days for all open claims (per 100 FTEs) **sustained at 0.9 in FY-20 compared to 0.9 in FY-19. This is the lowest rate in the last ten years!**

ECH - OSHA Recordable Injury/Illness (Rate per 100 FTE)

Analysis

- In FY-20 we had a **17% reduction** in OSHA recordable injuries compared to FY-19.

- The decreased in injuries are in part due to another great year with our Safe Patient Handling Program and partnership with Environmental Services. This will be explained in detail in the section below.

- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were **Musculoskeletal Disease (MSD)-not related to patient handling at 33%**, exposures at 30% followed by slips/trips/falls at 12%.
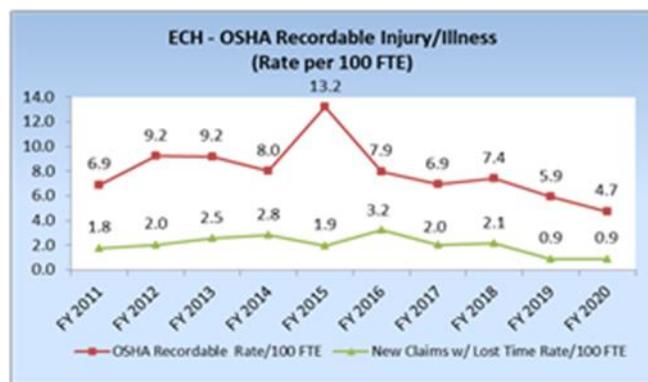
EC 1.0 - Safety Management

Improvement Strategies:

In FY-19 we had 235 musculoskeletal disorder (MSD) injuries not related to patient handling under total injuries. Among the improvement strategies for FY-20 we targeted MSD injuries not related to patient handling within the Environmental Services Department. The graph below depicts the departments with the highest numbers of MSD injuries not related to patient handling in FY-19. It was not a surprise that our Environmental Services (EVS), due to the nature of the work they do, had the highest incident of these types of injuries.
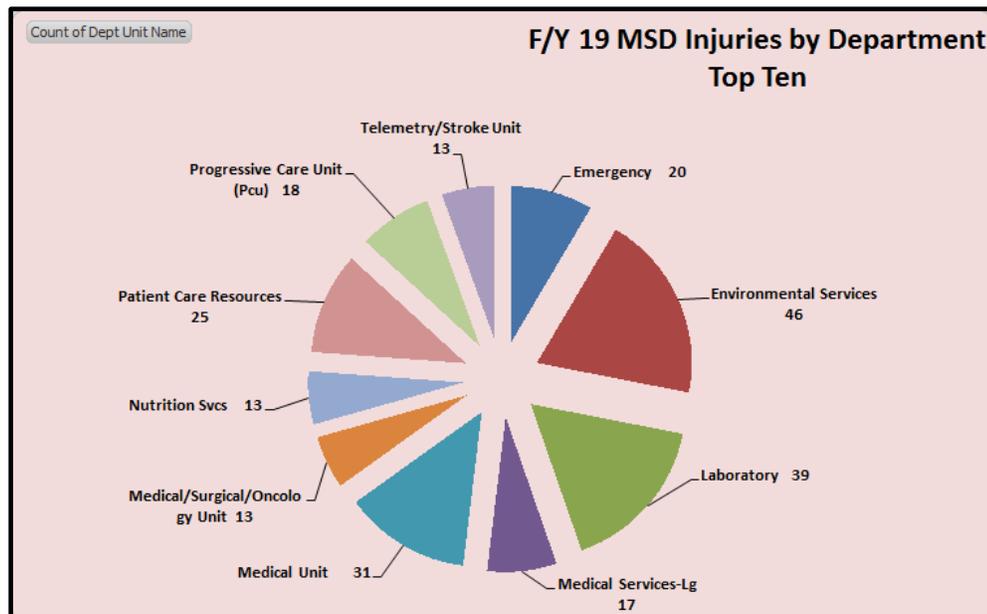
In FY-20 we partnered with the EVS Department in efforts to reduce MSD injuries. We conducted an initiative in collaboration with an outside vendor that included the following deliverables:

1. Completed a musculoskeletal injury risk analysis for primary tasks within the Environmental Services department.

2. Reviewed pertinent injury data related to sprain/strain or other musculoskeletal injuries sustained in the environmental services department over the past 3 years.

3. PowerPoint based training deck that details job/task specific musculoskeletal risk potential, risk reducing controls and employee expectations. This training was delivered in person to all EVS staff.

In FY-20 EVS had 7 MSD injuries not related to patient handling for <u>an 85% reduction and OVERALL total of 2 days of loss time!</u>

EC 1.0 - Safety Management

B. OSHA Recordable Injury/Illness Rates as Compared to U.S. & CA Hospitals

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[1].

The ECH injury/illness rate in *calendar year 2019* was 5.1 which is below the state and national averages in 2018 (the most recent year available from the BLS). The ECH lost work cases rate was 0.5 which is below national average and below state average. Our lower rate in loss time cases is due to our Safe Patient Handling Program and our success in reducing injuries among our Environmental Services staff.

El Camino Health's robust Transitional Work Assignment Program shows a commitment to getting people back to work as quickly as possible after an injury or illness explaining our slight above average transitional work cases (2.4) compared to the national and state averages.

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **decreased further in FY-20, from 0.7 in FY-19 to 0.4 in FY-20!** This is a significant accomplishment, since the previous fiscal year was the first time the rate was under 1.0. This is the first year that the rate of all SPHM injuries reported (both OSHA and first aid types) is under 1.0.

- **Total Injuries**: A persistent downward trend in the total number of patient handling injuries reported over the last 4 years has continued, including another record low number of all SPHM injuries reported and the percentage of those that are OSHA recordable.

SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 14-20)

SPHM Injuries	2014	2015	2016	2017	2018	2019	2020
Total Reported	53	38	48	44	41	29	23
OSHA-recordable	35	29	34	29	23	16	10
% OSHA	66%	76%	71%	66%	56%	55%	43%

- **Lost Days due to SPHM Injuries:** The record low number of lost days (5 during the fiscal year) was achieved again this year; 98% fewer than in FY-18.

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[1]The BLS data is calculated by calendar year. Data for the last full year is typically not available until fall.
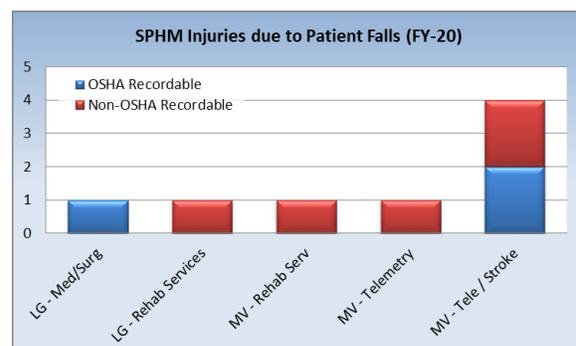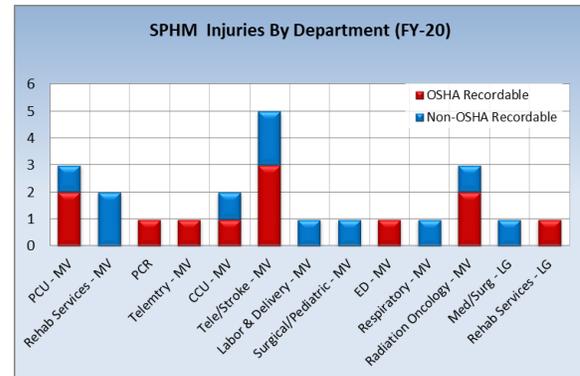
EC 1.0 - Safety Management

SPHM Injuries by Type Fiscal Years 15 – 20

Activity	2015	2016	2017	2018	2019	2020
Combined Transfer	6	8	6	5	5	2
Cumulative Pt Handling	5	1	5	4	0	1
Lateral Transfer	8	6	8	1	5	3
Patient fall/prevention	5	6	5	9	8	8
Car extraction	0	0	0	0	0	1
Pt Holding	2	3	2	3	2	1
Turning/Pulling	12	12	12	16	5	6
Vertical Transfer	5	12	5	3	4	1
Grand Total	**43**	**48**	**43**	**41**	**29**	**23**

- Injuries by Department

    o Inpatient Rehabilitation continues to shine. Once the department with the most SPHM injuries, there were none in FY-20 due to manager and on-site therapy collaboration, support and training of SPHM equipment.

    o CCU had also historically been in the top 3 departments with SPHM injuries. They have continued to show improvement, with reduction to 1 OSHA recordable in FY-20. Active involvement with their educator, additional sit/stand/walk aids, and adoption of repositioning sheets has proven successful.

    o Following an upward trend in SPHM injuries in the Women's Hospital that spurred active intervention and training, new equipment, and HoverMatt use policy, there were no patient handling injuries reported in FY-20.

    o The Imaging department reported the highest rate of SPHM injuries in FY-19: 4, all OSHA recordable. Since targeted education and practice using SPHM equipment, and collaboration with patient transfers from the ED, none were reported in FY-20.

    o Patient fall prevention/assistance continues to be the most common, and rising, cause of injury, accounting for 35% of those reported in FY 20.

![El Camino Health]
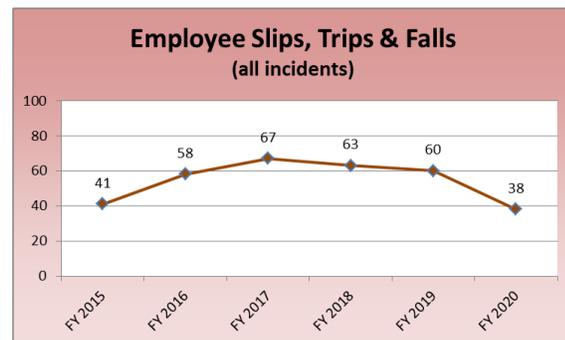
EC 1.0 - Safety Management

Improvement strategies:

- The Patient- and Employee- Fall Prevention Committees continue to partner to identify opportunities for prevention. An after fall huddle/report is under consideration; training and provision of gait belts is being evaluated; sit/stand/walk aids encouraged; and 3 low frame beds are now available for fall risk patients.

- Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication is being strategized to promote equipment use and fall prevention.

- A bariatric task force accomplished goals set to standardize, publicize, and normalize safe care with equipment for patients of size.

- Partnership with management and education on the Tele/Stroke unit, where the most injuries occurred, is planned.

- The organization is confronted with identifying means to train and empower Safe Patient Handling Unit champions to continue progress in injury reduction during a pandemic demanding social distancing.

D. Slips, Trips, Falls Injuries

Analysis

- **Injury Incidence**: Interventions initiated in FY 17 due to a steady annual increase of employee slips, trips and falls (STFs) have been successful. There was a 36% reduction of STFs in FY 20, as compared to FY 19.


- **Injury Types:**

EC 1.0 - Safety Management

Improvement Strategies:

- Task force continues to meet remotely monthly, to investigate all accidents. Manager of each department with a STF injury reviews the cause and strategizes prevention efforts.

- Partnership with Facilities for prompt identification and correction of hazards; annual outside stair maintenance.

- Signage on stairs and landscaping to promote safety measures and safe routes, with 50% reduction in falls on stairs and 20% reduction in STFs outside.

- Awareness campaign promoting culture of safety, "good catches" and reminder to "Keep a Lid on It."

- "Cover Your Cup" campaign promoted on patient care units, now stocking lids for hot cups.

- Cord clamps trialed and encouraged, with 60% reduction in STFs due to cords/tubes.

- Contaminants/slippery floor continue to be the most common hazard. Promote "No Pass Zone" to encourage responsibility to all to pick up debris/clean spills.

E. Blood-borne Pathogen (BBP) Exposures

The rate of blood-borne pathogen exposures per 100 FTE **decreased to 1.6 in FY-20 compared to 2.0 in FY-19.** The total number of exposures for both campuses decreased to 41 exposures in FY-20 compared to 48 in FY-19. Of these, 36 were percutaneous exposures and 5 were body fluid exposures due to splashes.

Exposure Rate (per 100 FTE)
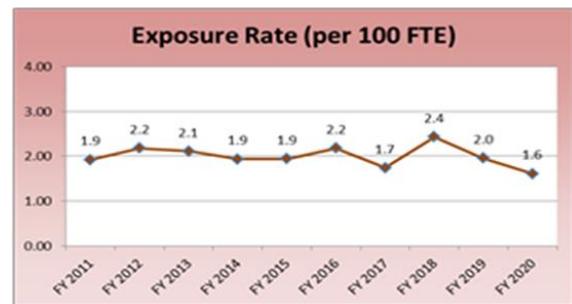
Analysis:

- In October, 2019 a full needle conversion was implemented at both campuses, based on findings by our Sharp Taskforce and to reduce variation among floors and among campuses.

- In FY-19, 33% of exposures due to needle sticks were the result of handling subcutaneous needles; mostly insulin syringes. In FY-20 we saw a 4% reduction in overall needle sticks compared to FY-19 and a 22% reduction in needle stick by insulin syringes.

- The implementation of our universal masking and eye protection programs due to COVID-19 the blood-borne pa BBP exposures due to splashes were reduced by 72%.

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO

- Continue to meet with 1:1 with injured employees to identify preventable root causes

- We found that nursing new grads account for some of the injuries. EWHS will partner with Clinical Education to explore ways to increase awareness and possible education among our nursing new grads.

F. TB Conversions

There were no known occupational exposure conversions at either campus during FY-20.

EC 1.0 - Safety Management

G. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-based training is required for all employees. The Life Safety courses required for all employees and provided as on-line modules on topics including fire, evacuation, hazardous materials, and other safety topics. These are:

- New employee orientation: 100% (Target: 100%)
- Life Safety - Non-Clinical: 95% (Target: 95%)
- Life Safety - Clinical: 93% (Target: 95%)

H. Safety Inspections

Safety inspections (Environmental Tours) are conducted monthly. Clinical departments are inspected twice per year, once by the Safety Inspection team, and once by the unit. Nonclinical areas are inspected annually by the Safety Inspection team. Problems noted are documented and delegated to the department manager and remain open until corrected.

The most noted problems in calendar year 2019 involved:

Problem Type	Category
• Are all ceiling tiles in place and in good condition (unbroken, free of dirt, mold, dust, water stains)?	*General Safety*
• Are items stored at least 18 inches below sprinkler heads?	*Fire Safety*
• Are clean linen carts covered (no linen on top of cart) or is linen stored in a separate linen closet?	*Hazardous Material Mgmt.*
• Are all electrical panels accessible – not blocked by carts, boxes, trash cans, or other items?	*Utility Management*
• Are all walls in good condition (undamaged, free of holes or water damage)?	*General Safety*
• Are all outlets / electrical box cover plates in good shape, not damaged or missing?	*Utility Management*
• Is paper signage laminated or in plastic sleeves?	Infection Prevention

Effectiveness

Key indicators were identified to establish goals for FY-19 with opportunities to improve Safety Management within the Environment of Care.

FY 20 Goals

1) Reduce Bloodborne Pathogen (BBP) exposures related to needle sticks

   Measurement of success: Reduce BBP exposures related to needle sticks by 5%

   This goal was accomplished. In FY-20 we reduced BBP exposure related to needle sticks by 10% compared to FY-19.

2) Reduce Musculoskeletal Disease injuries among our EVS population

   Measurement of success: Seek assistance from an outside consultant to assess and implement an EVS Ergonomic & Injury Prevention Program with the goal of reducing MSD injuries among our EVS population by 5%.

   This goal was accomplished. In FY-20 EVS had 7 MSD injuries not related to patient handling for an 85% reduction and OVERALL total of 2 days of loss time!

EC 2.0 - Security Management
*Work Group Chair: **Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple

- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery

- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

Workplace violence (WPV) prevention has been a focus of the health care community for many years. In 1993 the California Health and Safety Code adopted Sections 1257.7 and 1257.8, requiring hospitals to conduct annual security and safety assessments and implement a security plan to protect employees, patients and visitors from aggressive and violent behavior at work. The laws require hospitals to report injuries sustained by personnel to law enforcement, and to provide training to hospital employees regularly assigned to the emergency department and other high-risk areas, as identified by the hospital.

In October, 2016, an additional health care workplace violence prevention regulation, Section 3342 of Title 8 of the California Code of Regulations, was adopted with full compliance required by April 1, 2018. A task force was created to oversee the implementation of the hospital's Workplace Violence Prevention Plan. All required elements of the program have been implemented. The task force has disbanded and oversight and update has been given to the Workplace Violence Committee.

Plan Element: Written Plan	Status: COMPLETED
- The written plan has been completed and approved. - The plan requires annual review / update by the Workplace Violence Committee. The plan was reviewed, revised and approved by the Workplace Violence Committee in July of FY 2020.	

Plan Element: Response: Investigate violent incidents	Status: Completed
This is being completed through the Workplace Violence Committee. The plan includes a comprehensive violent incident investigation process.	

Plan Element: Training (annual)	Status: ONGOING
- The hospital has developed two levels of training. - AVADE – Computer based training module assigned to most staff. - Nonviolent Crisis Intervention (NCI) training – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to: - Behavioral Health - Assistant Hospital Managers (Hospital Supervisors)	

EC 2.0 - Security Management

o Emergency Department	o Security
o Facilities Engineering	o Course is also available as an option to all staff.
o Charge Nurses/Clinical Managers	

Plan Element: **Reporting:** All physical assaults against staff to OSHA	Status: **ONGOING**

- An ongoing WPV Reporting team is ensures reporting is completed as required.
- In FY-20, 63 incidents were reported to OSHA.
  - o OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
- 51% (32) of incidents resulted in no injury. The remaining events were minor injuries with 71% being bruises or abrasions. No major injuries were reported.

EC 2.0 - Security Management

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY-20. The data includes activity from both campuses.

There were a total of 528 reported security incidents for FY-20 requiring immediate response. This is an increase from the FY-19 total of 462.

Security Incidents FY-20

Code Gray, 303
Accident, 44
Code Red, 51
Distrubance, 27
Code Green, 23
Theft, 20
Assault, 21
Suspicious Activity, 10
Other, 29
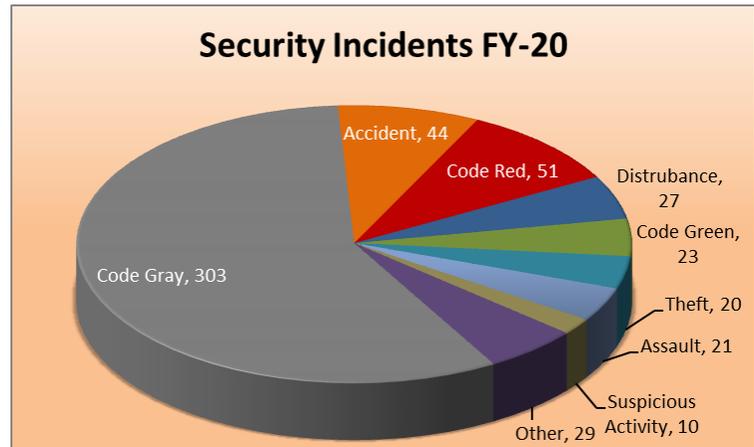
Review of the major FY-20 incidents showed:

- There were 63 Workplace Violence (WPV) incidents reported to CA-OSHA. This is a 23% increase from FY-19. Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
  - Patients that are medicated sometimes become combative.
  - Increased incidents of elderly dementia patients acting out and incidents of younger chemical dependent patients becoming combative.
  - Restricted visitation due to COVID-19 precautions raised patients level of anxiety.

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY-20 was 303 compared to 220 in FY-19.

Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- MV Emergency Department (ED) – 21%
- MV Progressive Care unit (PCU) – 17%
- MV Medical Unit (2C) – 15%
- MV Telemetry/Stroke (3C) 15%

ECH - Code Gray Events

FY 2011: 101
FY 2012: 108
FY 2013: 110
FY 2014: 135
FY 2015: 117
FY 2016: 129
FY 2017: 167
FY 2018: 197
FY 2019: 220
FY 2020: 303

Responses are tracked through the Code Gray critique form and monitored to help identify possible improvements to the process.

The Hospital utilizes the **Non-violent Crisis Intervention® (NCI)** training program for all staff who deals with angry or agitated persons. This is part of the Workplace Violence Prevention program and is required for staff in designated high-risk areas. Staff in other departments is encouraged to take this training as an optional course.

B. Bulletins, Alerts & Presentations
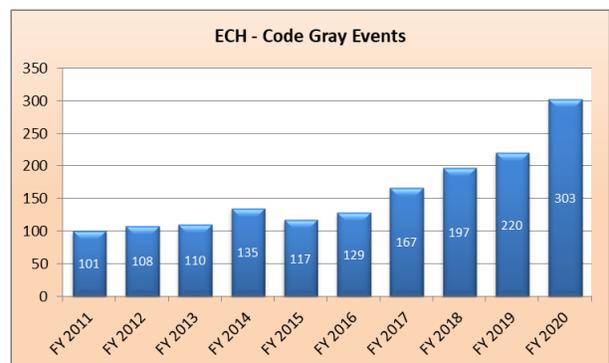
EC 2.0 - Security Management

Security Services issued 1 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 4,866 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 1,968 patient watches, standbys and restraints. This was a significant increase over FY-19 which was 1,667 & FY-18 which was 956. Hospital Supervisors notify Security of these events which can last several hours. They primarily occur in the Emergency Department, Behavioral Health and on the Medical Units. Patient watches are also handled by the ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 100 fire drills and are 100% up-to-date. A total of 2 fire watches were performed in FY-20.

F. General Assistance

Security Officers performed 74,943 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Services issued 1,895 Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 2,032 temp badges were issued.

H. Investigations & Audits

Security Services performed 91 investigations and audits including but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost And Found

Security Officers performed 479 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 15,297 (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 191 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

EC 2.0 - Security Management

In addition to daily parking control and 'space availability' counts, Security Officers performed 134 vehicle-related services including jump-starts, door unlocks and tows. 750 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 49 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

N. Statistics –Police Department Crime Data

	Mountain View (Source: 2019 MVPD Annual Report)	Los Gatos (Source: 2018 LGPD Annual Report)
Square Miles:	12	11.25
Population:	83,377 (County of Santa Clara 1,945,940)	30,516
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics *UCR data includes attempts and actual crimes*		
Part I UCR:	2,274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2,164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2,497	Not Collected
Previous Year	2,800	Not Collected
Arrests-Misdemeanor:	1,235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1,553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1,827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2,199	Not Collected
Indexes *Per 1,000 current year population*		
Violent:[2]	2.11	0.35
Previous Year	2.33	0.48
Property:[3]	26.29	15.53
Previous Year	24.46	18.98

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[2] Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery
[3] Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson

EC 2.0 - Security Management

Effectiveness

Key performance indicators were identified in the FY-20 to improve Security Management within the Environment of Care.

FY-20 Goals

1) 90% non-medical emergency security response time less than 3 minutes.

   This goal was accomplished.

2) 10% reduction in number of reportable workplace violence incidents. In FY-20 there was a 23% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

   This goal was not met.

EC 3.0 - Hazardous Materials & Waste Management
*Work Group Chair: **Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Hospital. The work group chair serves as the central contact point for the reporting and documentation for the Hazardous Materials & Waste Management work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

A. Hazardous Material Incidents

Facilities Services maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

- **Recordable Hazardous Material Incidents[4]:**

1) Chemo spill – Mountain View Infusion Center: IV tubing malfunction, disconnected during infusion. **Cleanup was handled safely.**

2) Chemo spill - 4B: IV tubing malfunction, disconnected during infusion. Cleanup was handled safely.

3) Gram Stain waste spill: Microbiology staff failure to monitor and manage waste containers used to catch stain waste under sink. The secondary container was full and overflowed. RCA performed, gap identified, staff re-trained and leak detector/sensor was purchased and installed.

4) Formalin spill in Los Gatos OR #2: spilled quantity of Formalin due to container lid failure (leaking).   Spill was cleaned up. Reviewed procedures for Formalin handling and reviewed secondary containment for process improvement.

5) Formalin spill in Mountain View Imaging, CT #2: Specimen container knocked over during biopsy procedure. Reviewed procedures for Formalin handling for improvement process.

6) Medication spill – In-Patient Pharmacy: The storage bag of the medication had a hole in the bottom. Reviewed procedures to inspect the condition of the storage container bag prior to use.

- **Reportable Hazardous Material Incidents[3]** – No reportable spills.

B. Waste Water Discharge Violations:

- **No Waste Water Discharge Violations**

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[4] Reportable and recordable hazardous material incidents are defined by state and federal regulations and are determined based on the quantity and hazard of the spill.

EC 3.0 - Hazardous Materials & Waste Management

C. Monitoring and Inspections

- **Hazardous Waste Inspections**-No Inspections for FY-19

- **Santa Clara County Annual Medical Waste Inspections**-No Inspections for FY-20

  o Continued monitoring and education to ensure waste segregation compliance :
    - Annual Waste Management education for staff
    - Daily rounds by EVS supervisors
    - Monthly Safety Rounds that include observation of waste segregation practices
    - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly.

E. Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[5] training course.

Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve hazardous materials & waste management.

FY-20 Goals:

1) Controlled Substance Diversion Program – CsRx Program partnership with Stericycle established February with a plan, education material, and containers ready offsite to address diversion and mitigation of pharmaceutical contamination of the environment.

   - **Measurement of success**: Complete partnerships, draft a plan, and educate nursing/pharmacy staff to implement the utilization of controlled substance waste containers and service.

   - ***This goal was accomplished.***

     o Due to extenuating circumstances with the COVID-19 Pandemic, delivery of the containers was delayed, resulting in pushing the installation date to August, 2020. However, the plan was complete and ready to implement by the end of FY-20.

2) Review and update Health Stream Education/Test module for EVS and Clinical Staff

   - ***Measurement of Success:*** Update the annual education materials to reflect current and best practices for safe handling of waste and to update assignments to appropriate staff

   - ***This goal was accomplished.***

     o 2 modules/tests and an updated assignment list are live in Health Stream.

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[5] HAZWOPER: Hazardous Waste Operations and Emergency Response
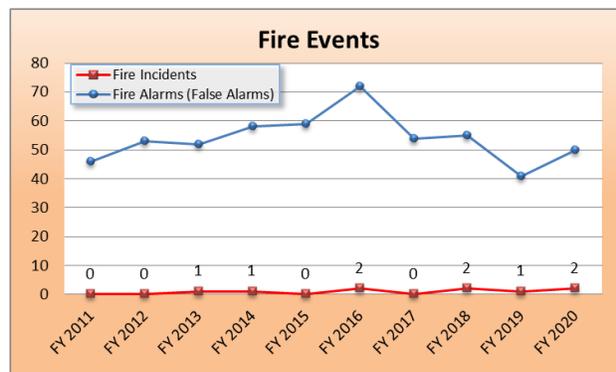
EC 4.0 - Fire Safety Management
*Work Group Chair: **John Folk***

Scope

The Fire Safety Management Plan is designed to assure appropriate, effective response to a fire emergency situation that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management during FY-20.

Fire Events chart showing Fire Incidents and Fire Alarms (False Alarms) from FY 2011 to FY 2020. Fire Incidents: 0, 0, 1, 1, 0, 2, 0, 2, 1, 2.

A. Fire Incidents

There were 2 reported fire incidents in FY-20.

1. **Smoke Detector – MV Hospital Penthouse (September)**: At approximately 1:30 in the afternoon, a smoke detector activated in the New Main Penthouse for Elevator #8. Upon responding the alarm, it was found that the room was filled with smoke caused by the elevator motor brake overheating. The Fire Department responded, and the elevator was secured by Engineering until Otis Elevator made the required repairs.
2. **Fire in Conference Room C food cart** (November 21): At approximately 12:30 PM staff notified security and facilities of smoke in the Physician's Dining Room. The source was determined to be from lit, gel-fuel containers used for heating chafing dishes being put into the food transport cart. The cart was quickly removed from the building. There was no damage or injury.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All cases are evaluated for potential opportunities for improvement.

The total number of events in FY-20 (51) was an increase compared to FY-19 (41). There were 51 events in Mountain View and 0 in Los Gatos. This increase can be attributed to the heavy construction activity requiring the connection, and integration of the Sobrato Pavilion, Taube Pavilion, and the New Main Connector new fire alarm systems to the existing hospital fire alarm system during FY-20.

C. Fire Drills Completed / Scheduled

All required fire drills (total of 100) were completed in FY-20. For all drills, there were 4 required actions by staff. All issues were fully corrected either on the spot or with further education by the dept. Manager.

Effectiveness

Key indicators were targeted to establish goals for FY-20. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 20 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new Sobrato and Taube pavilions.

   This goal was accomplished. Initial training for all Engineering staff was completed and additional training will continue as the buildings continue to be occupied.

2) Identify staff to attend NFPA code classes to further their knowledge and applications of fire safety codes.

   Ongoing: We will continue to Schedule Engineers to receive the recommended **NFPA** training.

3) Develop an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.

   This goal was accomplished. Ongoing monitoring is in place with the new Sobrato and Taube pavilions to ensure compliance with the Life Safety and NFPA codes.

4) Increase oversight and improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities.

   This goal was accomplished. Continued ongoing monitoring and education of contractors is still in place.

EC 5.0 - Medical Equipment Management
*Work Group Chair: **Jeff Hayes***

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-20.

A. Reports to the FDA –

There were 8 reports through the Medwatch[6] system in FY-20. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% in all areas. Additionally, high risk equipment was maintained at 88% a completion. The goal for high risk equipment is 100%.

Preventative Maintenance (PM) Completions

o   The completion rate for Clinical Engineering achieved 74% for FY-20.

o   All high risk, life safety equipment was maintained at 88% completion rates
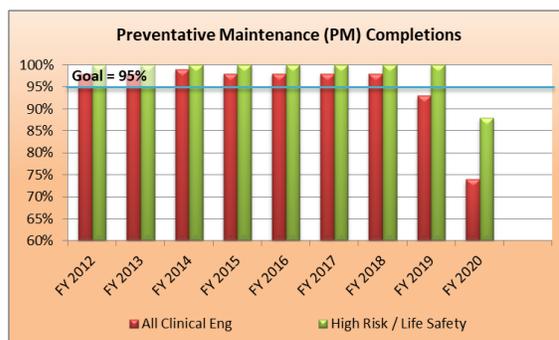
C. Product Recalls Percentage Closed / Received

For FY-20, there were 64 recorded medical equipment related recalls.

Effectiveness

Key indicators are targeted to established goals for the fiscal year. A deep dive into the Clinical Engineering database found inconsistencies with the inventory and data present. Through this evaluation year equipment generating PM schedules were found to be removed from service thus generating a higher than normal number of unable to locate devices. Through a process of data management, department assistance of locating or correcting inventory and a strong effort to clean up the inventory, standardize equipment and schedules in the database which assisted to identify

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[6] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

EC 6.0 – Medical Equipment Management

all device appropriately was develop to address these inconsistencies. Continued monitoring of this process will improve the effectiveness of the program.

EC 6.0 - Utilities Management
*Work Group Chair: **Nick Stoliar***

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-20.

A. Utility Reportable Incidents

There were 5 reportable incidents in FY-20. All were electrical outages or voltage fluctuations.

- In August, April, May, and June, Los Gatos had a momentary loss of electrical utility (PG&E) campus wide.
  - The August, April and May events activated the emergency generators on.

ECH - Reportable Utility Incidents

- In March, Mountain View had a loss of electrical to the campus due to a PG&E mechanical malfunction.
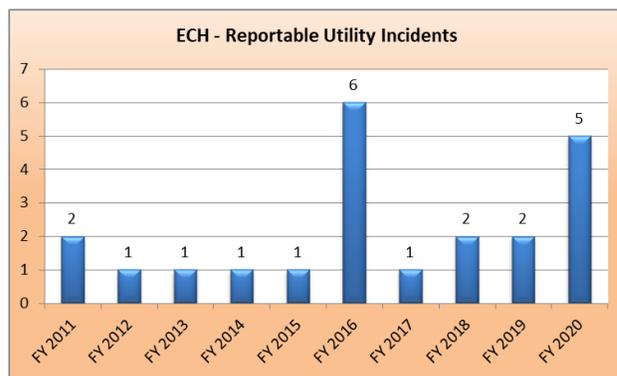
B. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was **95%,** meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

C. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

EC 6.0 - Utilities Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented opportunities to improve Utility Management within the Environment of Care.

Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 20 Goals

1) Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.

    In progress **-** Ongoing education and familiarization for all engineering staff will occur over the course of the next few months as the new buildings come on line **and are occupied**.

2) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

    This goal was accomplished. Process in place for access control, ongoing monitoring for effectiveness is in place.

3) Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.

    In progress - **There will continue to be** some equipment that needs to be added to the renovation and or replacement plan for both sites.

FY 21 Goals

1) **Continue to work** with PG&E to improve communication related to Planned/Unplanned utility disruption events

2)   **Continue to educate** all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.

3)   Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

4) **Increase review of procedures and protocols for utility outage response.**

EM – Emergency Management
Committee Chair: ***Steve Weirauch***

Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee ensures an effective response to these events. The hospital actively participates with state and local emergency management entities to coordinate community planning efforts and response. Emergency Management is a separate chapter under The Joint Commission; however the annual reporting is being combined with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported through the monthly committee meetings. Significant events are presented quarterly to the Central Safety Committee. The following Emergency Management indicators were reported in FY-19.

A. Activation of Hospital Incident Command System (HICS)

There were two recorded events and/or emergencies during FY-20 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. **Power Outage – Los Gatos Campus (08/23/2019, 09:45)** – A PG&E power failure occurred on the morning of August 23rd. Command team met in the HCC to ensure all systems were operational. One piece of equipment in the lab was affected, but no other operations were impacted. The incident was closed at 10:45 AM.

2. **COVID-19 Pandemic** – The outbreak of COVID-19 critically impacted El Camino Health as the pandemic quickly spread across the world. Upon the first indications that the Novel Coronavirus was beginning to spread across the globe, a limited activation of HICS was done beginning on February 4th. The HICS team met each morning to discuss hospital status including staffing and supplies. At the time it was decided that enterprise operations of HICS would be run from Mountain View with remote connections to the Los Gatos campus.

   The first patient was admitted to the Mountain View campus on February 27th. It was decided to fully activate HICS at that time and the Hospital Command Center (HCC) was opened in Mountain View on Friday, February 28th. The HCC remained open until Sunday May 10th, an unprecedented 72 days.

   See the attached **Mid-Response Action Report** at the end of this section for more information on the COVID-19 response.

B. Events / Emergencies

The hospital responded to additional emergency incidents that did not activate the Hospital Command Center. These included:

1. **Public Safety Power Shutoff (10/09/19 and 10/25/19) –** PG&E implemented a *Public Safety Power Shutoff* (PSPS) program in 2019 to proactively shut off electrical power in key areas where weather conditions could cause powerline failure and ignite wildfires. Two PSPS events were initiated in the local area during October of 2019. Neither campus was directly in the area of the power shut off; however transmission lines to the hospitals did cross some

EM – Emergency Management

of the impacted areas. Key staff drafted plans for continued operations should power be interrupted. Communications were sent to all staff informing them of the situations and providing critical information. Fortunately, neither incident caused an impact to hospital operations.

2. **Hazardous Chemical Spill in Microbiology (12/15/2019) –** approximately 1 – 2.5 gallons of gram stain waste was spilled in the microbiology area of the Clinical Lab. The waste collection container under a sink overflowed. The sink is used only for the disposal of stain materials. Due to hazardous waste requirements, this sink cannot be connected to the drain so a container is used to collect the waste. Staff failed to monitor the waste container, leading to the overflow. The spill was contained and cleaned up. Several action items were implemented to prevent a recurrence. This includes additional training for staff to understand the system and the installation of high liquid level alarms.

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY-20, this was met through separate planned exercises at both campuses (see below) and the COVID-19 pandemic response. The exercises are summarized below. Action items were created to improve future responses.

Note, during most years, the hospitals participate in a statewide medical and health exercise in November. Due to the PSPS events, this was postponed until March, 2020. However, with the COVID-19 pandemic in progress, neither facility participated in the reschedule exercise.

a. **Mountain View Functional Exercise in Taube Pavilion (10/30/2019)** – in preparation for the opening of the new behavioral health facility, a series of functional exercises was conducted to test procedures and familiarize staff with the new building.

b. **Los Gatos Functional Exercises (11/21/2019)** – A functional exercise was conducted involving response to a wildfire. HICS was activated and the HCC was opened. The hospital had a surge of patients with injuries related to the wildfires, the possibility of a shortage of medical supplies due to supply routes being closed, and the potential for a hospital evacuation.

Additional Exercises were conducted to assess and test our preparedness to other emergency events

c. **Code Pink Drills – Mountain View & Los Gatos (12/2019)** - Exercises were conducted at both campuses to test staff's ability to respond to an infant security band alert.

D. Emergency Management Training

- **New hire orientation** (100% for all employees)

- **Safety coordinator meetings** (40% attendance overall for the quarterly meetings). Safety Coordinators unable to attend the meetings are provided with detailed notes and information and are expected to complete all assignments.

- **CHA Disaster Preparedness Conference –** the CHA hosts an in-depth conference related to disaster response and preparedness each year in September. The hospital has always sent a contingent to this conference. This year, the conference was streamed live so additional staff were able to attend remotely.

EM – Emergency Management

E. Community Involvement

The hospital continues to be an active participant in the Santa Clara County Hospital Emergency Preparedness Partnership (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives of all Santa Clara County hospitals and the county EMS. The emphasis is creating a collaborative county-wide emergency response and disaster plan. The group also organizes and facilitates county-wide disaster exercises in which the hospital actively participates.

The EPHC expands many of the same elements of the SCCHEPP to all healthcare facilities in the county including clinics, skilled-nursing facilities and dialysis clinics. This group meets quarterly and shares information and provides training to help all healthcare facilities prepare for emergencies. Steve Weirauch is currently the Education Committee chairperson of Santa Clara County EPHC and has participated in several conferences sharing the experiences and benefits of developing regional coalitions.

F. Hazard Vulnerability Assessment (HVA)

The HVA is an assessment of each facilities risk for various emergency situations. The HVA is reviewed and revised annually. Separate HVA's are completed for the Los Gatos and Mountain View campuses to account for physical differences in the locations and facilities. Efforts are then focused on attempting to minimize the highest risks during the fiscal year.

- There were several changes to the HVAs at both campuses in FY-20. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Mass Casualty - Medical/Infectious	(2) Information System Failure
(3) Person with a Weapon	(3) Communication System Failure
(4) Cyberattack	(4) Electrical Power Failure
(5) Information Management System Failure	(5) Seasonal Influenza

- Note: the 2020 HVA was completed prior to the COVID-19 pandemic.

EM – Emergency Management

G. Effectiveness

Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve emergency management.

FY-20 Goals

1. Expand the use of mass notification system (Everbridge) to all employees

    a. Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.

    b. Evaluate and set up logical groups and rules for notifications.

    c. Train key staff to be able to use/send alerts

    This goal was partially accomplished. Expanded funding for this was finally secured and work is underway with IT and HR to incorporate automatic upload of staff information.

2. Revise and distribute the Emergency Management Guides for both campuses.

    a. Revision of content to include latest information.

    b. Roll out of app for the guide on Android and iOS devices in addition to wall-mounted guides.

    This goal was accomplished. The revised guides were distributed in all areas by the end of 2019. The MyEOP app was launched in early 2020. The app contains all of the elements of the wall-guides for easy reference on smart devices (Apple and Android).

3. Train staff on emergency procedures in new Taube and Sobrato Pavilions.

    This goal was accomplished. A multi-department effort was undertaken to provide training for all staff. This consisted of numerous live tour/training sessions, online modules and practice scenarios. Both building opened during the fourth quarter.

FY-21 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY-20)

    a. Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.

    b. Evaluate and set up logical groups and rules for notifications.

    c. Train key staff to be able to use/send alerts

2. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.

3. Revise Hospital Surge Plan.

Novel Coronavirus (COVID-19)

Mid-Response Action Report

February 28 – May 10, 2020

2500 Grant Road | Mountain View, CA 94040 | 650-940-7000
815 Pollard Road | Los Gatos, CA 95032 | 408-378-6131

elcaminohealth.org

EM – Emergency Management: COVID-19 Mid-Response Action Report

Overview

Event Name	Novel Coronavirus (COVID-19)
Dates	February 28, 2020 – May 12, 2020
Key Issues	1. Provide adequate supplies of Personal Protective Equipment for staff as needed to ensure safety. 2. Rapid dissemination of updated and changing recommendations to protect staff 3. Long-term Operation of Labor Pool 4. Just-in-Time PPE Training 5. Just-in-Time N-95 Fit testing 6. Sharing of resources between hospitals/agencies 7. Communications with community 8. Tracking and acceptance of donations from the community 9. Facility access 10. Staff Well-Being 11. Negative Air Flow Rooms
Threat or Hazard	Pandemic

El Camino Health

FY-20 Evaluation of the Environment of Care

EM – Emergency Management: COVID-19 Mid-Response Action Report
Event Summary

The Novel Coronavirus (COVID-19) was first identified in early 2020. The first known case presenting to El Camino Health presented to the Mountain View Emergency Department on February 2nd, 2020. The patient was not admitted to the hospital. At this time the hospital began conducting daily briefings to prepare for additional cases which may arise. Key leaders were involved in discussing appropriate care and safety for patients, visitors and staff, and to monitor equipment and supplies.

The first confirmed patient was admitted to the Mountain View hospital on February 27th, 2020. In response to this, it was decided to open a Hospital Command Center in Mountain View to coordinate the response for both campuses. The HCC activated on February 28th and was operational until May 12th, a total of 72 days.

During this time, as more was learned about the virus and how to care for patients and protect everyone there were continual updates to procedures. This sometimes led to confusion and increased stress for staff, patients and visitors.

A simple timeline is included below for the event as it unfolded at El Camino Health.
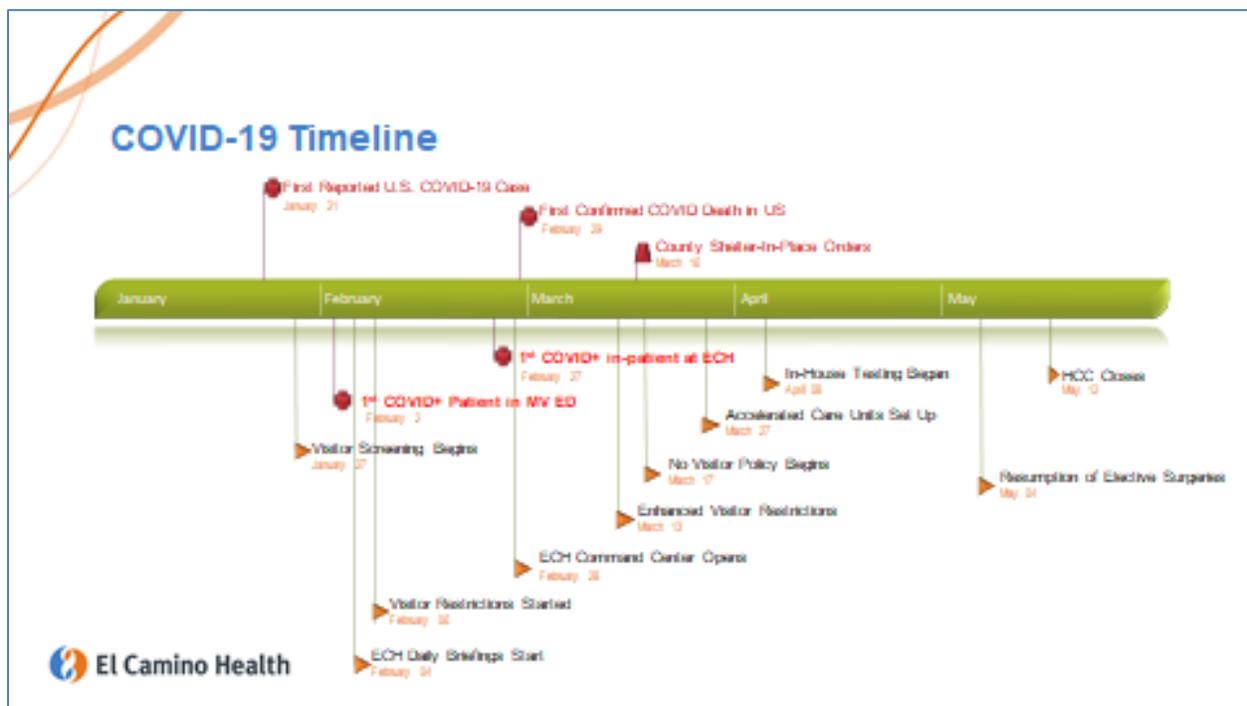
During this period, El Camino Health had the following number of patients:

	Los Gatos	Mt. View	Enterprise
COVID+ Patients Admitted	5	50	55
COVID Deaths	1	7	8

El Camino Health

EM – Emergency Management: COVID-19 Mid-Response Action Report

Analysis of Issues

Table 1 includes the issues, aligned core capabilities, and performance ratings for each core capability as observed during the COVID-19 period through the closure of the Hospital Command Center on May 12th.

Issue	Core Capability	Performed without Challenges (P)[7]	Performed with Some Challenges (S)[8]	Performed with Major Challenges (M)[9]	Unable to be Performed (U)[10]
Provide adequate supplies of Personal Protective Equipment for staff as needed to ensure safety.	Equipment			x	
Rapid dissemination of updated and changing recommendations to protect staff.	Organization		x		
Long-term Operation of Labor Pool	Planning		x		
Just-in-Time PPE Training	Training		x		
Just-in-Time N-95 Fit testing	Training			x	
Sharing of resources between hospitals/agencies	Planning		x		
Communications with community	Organization		x		
Tracking and acceptance of donations from the community	Planning	x			
Facility access	Organization		x		
Staff Well being	Planning		x		
Negative Pressure areas	Equipment		x		

Table 1. Summary of Core Capability Performance

The following sections provide an overview of the performance related to each issue and associated core capability, highlighting strengths and areas for improvement.

---

[7] **Performed without Challenges (P):** The critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

[8] **Performed with Some Challenges (S):** The critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.

[9] **Performed with Major Challenges (M):** The critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.

[10] **Unable to be Performed (U):** The critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).

El Camino Health

EM – Emergency Management: COVID-19 Mid-Response Action Report

Issue 1: Provide adequate supplies of Personal Protective Equipment for staff as needed to ensure safety.

Strengths:
- Rapidly realized need for additional equipment and PPE. Supply chain began efforts to secure equipment from alternative sources.
- Daily (or more) meetings to report equipment supplies and develop plan to ensure adequate usage.

Areas for improvement
- Not all staff aware of the critical equipment shortages.
- Some PPE was stolen from unattended carts and departments
- Tracking of par levels for key equipment was not initially part of the HCC operations
- Inconsistent information on the use and types of equipment caused confusion among the staff.

Analysis

The HCC and command team tracked supplies and daily usage. As it became apparent that orders of some equipment was not able to be fulfilled by suppliers, the supply chain began searchong for other sources. In addition, additonal measures were taken to conserve supplies. The HCC became directly involved with the deployment of critical equipment. This did help in getting the hospital through the most difficult times. Procedures and information changed frequently and this was shared with manager in the daily briefings. However, some staff were unaware of the severe shortages and became frustrated with the inability to get the quantities of suppleis requested.

Issue 2: Rapid dissemination of updated and changing recommendations to protect staff

Strengths
- Creation of SharePoint site for centralized location of all COVID-19 infomration to staff
- Frequent updates by Executive staff to employees
- Implementation of Elemeno.
- Use of Zoom meetings to quickly and safely inform staff of hospital status and changes

Areas for Improvement
- Outdated information was not always removed completely causing confusion, especially with the rapidly changing situation
- Multiple formats and undated documents caused confusion
- Critical information was not disseminated to ALL staff on ALL shifts.

Analysis

As new information became available about the virus, there were continual, frequent changes to procedures for keeping staff and patients safe. This resulted in multiple updates tp guidelines and procedures. Revised documents were created and distributed. However, initially it was difficult to ensure outdated information was removed. To address this, a SharePoint site (COVID-19) was created as a repository for the latest information. Updates were also shared at the daily briefings. While this helped, there were still some gaps in ensuring old documents were removed promptly.

EM – Emergency Management: COVID-19 Mid-Response Action Report

Issue 3: Long-term Operation of Labor Pool

Strengths
- Once operational, labor pool was able to coordinate staff deployment
- Utilization of staff that would otherwise be off work.

Areas for Improvement
- Took several days to implement the Labor Pool operations.

Analysis

During course of the response, there were needs identified for key staff to assist in the response. This included runners to transport supplies, lab specimens and food, screeners to conduct health monitoring of persons entering the hospital. As the needs arose, the labor pool was able to meet these needs utilizing staff who would otherwise have not been working due to departments being closed or having limited patient needs. This did take some time to put into place.

Issue 4: Just-in-Time PPE Training

Strengths
- Nursing Education team coordinated training and information sharing through InTouch nursing newsletters.
- Training procedures posted on COVID-19 SharePoint and Elemeno sites.

Areas for Improvement
- Non-nursing staff did not have access to all the critical training information. InTouch only emailed to nurses.

Analysis

Due to the rapidly changing procedures updates and training infroamtion was shared with clinical staff utilizing the InTouch Nursing Newsletter. However, it was noted that this email does not reach non-nursing, clinical staff. A plan needs to be adopted to ensure all the staff are notified.

Issue 5: Just-in-Time N-95 Fit testing

Strengths
- EWHS able to coordinate N-95 fit testing for all required staff. Fit testing was done on multiple shifts and at multiple locations.

Areas for Improvement
- Had to bring in outside contract help to conduct fit testing.

Analysis

We had moved away from N-95 masks for most airborne isolation patients, opting instead for using MaxAir PAPRs. This removed the need for annual fit testing to the N-9r respirators. However, a shortage of the disposable lens cuffs for the PAPRs occurred requiring a change to using N-95 masks. This required a massive effort to fit test all employees who would need to care for positive and suspect patients. A plan for dealing with this sort of situation if it should arise again is needed.

El Camino Health

FY-20 Evaluation of the Environment of Care

EM – Emergency Management: COVID-19 Mid-Response Action Report

Issue 6: Sharing of resources between hospitals/agencies

Strengths
- Frequent teleconferences with public health and other facilities to share and obtain current information.
- Executive contacts with government officials to assist in locating potential resources.
- Shared equipment between hospitals – HEPA filters, PPE swaps, etc.

Areas for Improvement
- Initial confusion over using WebEOC for resource requests vs. direct communications with the Resource Request form.

Analysis

Initially, the county instructed hospitals to utilized the resource request options on WebEOC. However there were delays and issues using the program and facilities were then instructed to use the 213 RR (Resource Request) form instead. A determination needs to be made county-wide over the use of one or the other systems.

Issue 7: Communications with community

Strengths
- Updates to social media of hospital status

Areas for Improvement
- More frequent updates were requested by community
- Consistent messaging to screeners and staff about visitation policy changes.

Analysis

During the rapidly changing situations, we sometime lagged behind in updating and providing current infromation to the community.

Issue 8: Tracking and acceptance of donations from the community

Strengths
- Generous community donated large quantities of supplies and food for staff

Areas for Improvement
- Develop plan handling donations of equipment and food early

Analysis

During the early weeks of the pandemic, the shortage of PPE was pusblicized through the media. The community responded in unexpected ways with an outpouring of donated supplies, equipment and food. Initially we did not have a way to track this to ensure the donors were appropriately thanked and to ensure the supplies were properly inventoried for future use. The Foundation stepped up to oversee this program. A plan should be drafted to handle this from the start in the future.

El Camino Health

FY-20 Evaluation of the Environment of Care

EM – Emergency Management: COVID-19 Mid-Response Action Report

Issue 9: Facility access

Strengths
- Ability to limit access to facility.
- Addition of badge readers in Los Gatos to secure facility.
- Deployed screeners to entry points to hospitals.

Areas for Improvement
- Ensure consistent procedures and training for screeners.

Analysis

As the pandemic worsened and we had to limit access to the facilities, there was confusion and some issues surrounding the screening and access of visitors, contractors and others that did not have badges. This process has been developed and should be formalized for use in the event of future events.

Issue 10: Staff Well-Being

Strengths
- Providing child care for staff at local YMCA facilities.
- Nutrition Services offering essential grocery items for staff out of cafeteria.
- Access to Concern EAP.

Areas for Improvement
- Formalize the process for setting up childcare and sleeping spaces for staff

Analysis

Providing resources for staff and their families in the form of contacts for childcare and the use of the local YMCA facilities was greatly appreciated by staff. We have plans for this in our Emergency Operations Procedures, but should review/revise the plans now that they have been put into actual use.

Issue 11: Negative Air Flow Rooms

Strengths
- Ability to convert air flow to negative in rooms to allow flexibility for COVID-19 patient care. Cohorting patients in one area better use of resources than utilizing negative pressure rooms scattered throughout the hospital.
- Deployment of HEPA filters to provide additional negative airflow in rooms.

Areas for Improvement
- Provide better method for tracking equipment (HEPA) filters.
- Formalize process for air flow changes to allow more rapid set up in the future.

Analysis

The abilitiy to convert patient rooms and areas to negative air flow was a major benefit for ensuring a safe environment for patients and staff. The procedures should be formalized in procedures for rapid deployment in the future.

El Camino Health

EM – Emergency Management: COVID-19 Mid-Response Action Report

Appendix A: Improvement Plan

Core Capability	Issue/Area for Improvement	Corrective Action	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Organization	1. Communication with all Staff	Expand hospital-wide communications to all staff using all available platforms to ensure staff are aware of critical issues	Talent Development	Tamara Stafford	08/01/2020	
Organization	2. Update of information on media platforms	Develop plan to ensure Toolbox, Elemeno and other documented information is continually reviewed and updated.	Talent Development	Tamara Stafford	08/01/2020	
Training	3. Plan for rapid N-95 fit testing	Develop a plan to conduct wide-spread fit testing as needed.	Employee Wellness and Health Services	Mari Numanlia-Wone	08/01/2020	
Planning	4. Consistent process for requesting resources from the community	Work with SCC to decide upon one process for the reporting and requesting of resources.	Safety	Steve Weirauch	08/01/2020	
Training	5. Define the role and oversight of screeners	Standardize the process for screening of public at entries	Patient Experience	a) Christine Cunningham b) Stefanie Shelby c) Jody Charles	08/01/2020	
Organization	6. Formalize the process for setting up employee and family support	Document the processes used for childcare system at YMCA and other staff support sites for future reference.	Human Resources	Beth Shafran-Mukai	08/01/2020	
Equipment	7. Document process for creating negative air flow rooms	Document the procedures for converting, maintaining negative airflow rooms.	Facilities Engineering	John Folk	08/01/2020	
Equipment	8. Develop process to better track equipment. HEPA filters and PAPRs were difficult to track in facilities	a) Develop a procedure to inventory and track PAPRs on a daily basis. b) Develop an inventory and tracking system for HEPA filters	a) Supply Chain b) Facilities Engineering	a) Manny Hernandez b) John Folk	08/01/2020	

This IP has been developed specifically for El Camino Health as a result of the response to the COVID-19 Pandemic from March – May, 2020.

El Camino Health

Executive Summary

Safety Management

Effectiveness

- Key indicators were identified to establish goals for FY-20 with opportunities to improve Safety Management within the Environment of Care.

FY 20 Goals

1) Reduce Bloodborne Pathogen (BBP) exposures related to needle sticks

   - **Measurement of success:** Reduce BBP exposures related to needle sticks by 5%

   - **This goal was accomplished.** In FY-20 we reduced BBP exposure related to needle sticks by 10% compared to FY-19.

2) Reduce Musculoskeletal Disease injuries among our EVS population

   - **Measurement of success:** Seek assistance from an outside consultant to assess and implement an EVS Ergonomic & Injury Prevention Program with the goal of reducing MSD injuries among our EVS population by 5%.

   - **This goal was accomplished.** In FY-20 EVS had 7 MSD injuries not related to patient handling for an 85% reduction and OVERALL total of 2 days of loss time!

Security Management

Effectiveness

- Key performance indicators were identified in the FY-20 to improve Security Management within the Environment of Care.

FY-20 Goals

1) 90% non-medical emergency security response time less than 3 minutes.

   - **This goal was accomplished.**

2) 10% reduction in number of reportable workplace violence incidents. In FY-20 there was a 23% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

   - **This goal was not accomplished.**

Executive Summary

Hazardous Material Management

Effectiveness:

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve hazardous materials & waste management.

FY-20 Goals

1. Controlled Substance Diversion Program – CsRx Program partnership with Stericycle established February with a plan, education material, and containers ready offsite to address diversion and mitigation of pharmaceutical contamination of the environment.
   - **Measurement of success**: Complete partnerships, draft a plan, and educate nursing/pharmacy staff to implement the utilization of controlled substance waste containers and service.
   - **This goal was accomplished.** Due to extenuating circumstances with the COVID-19 Pandemic, delivery of the containers was delayed, resulting in pushing the installation date to August, 2020. However, the plan was complete and ready to implement by the end of FY-20.

2. Review and update Health Stream Education/Test module for EVS and Clinical Staff.
   - **Measurement of Success:** Update the annual education materials to reflect current and best practices for safe handling of waste and to update assignments to appropriate staff.
   - **This goal was accomplished.** 2 modules/tests and an updated assignment list are live in Health Stream.

Fire Safety Management

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 20 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new Sobrato and Taube pavilions.
   - **This goal was accomplished**. Initial training for all Engineering staff was completed and additional training will continue as the buildings continue to be occupied.

2) Identify staff to attend NFPA code classes to further their knowledge and applications of fire safety codes.
   - **Ongoing.** We will continue to Schedule Engineers to receive the recommended NFPA training.

3) Develop an internal auditing process to ensure contract fire system companies are meeting all contractual obligations.
   - **This goal was accomplished.** Ongoing monitoring is in place with the new Sobrato and Taube pavilions to ensure compliance with the Life Safety and NFPA codes.

4) Increase oversight and improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities.
   - **This goal was accomplished.** Continued ongoing monitoring and education of contractors is still in place.

Executive Summary

Medical Equipment

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve medical equipment management within the Environment of Care.

FY 20 Goals

1. PM completion rate of 95% in all areas with 100% completion for all high risk equipment.

   - **This goal was not accomplished.**
     - o The completion rate for Clinical Engineering achieved 74% for FY-20.
     - o All high risk, life safety equipment was maintained at 88% completion rates.

   - **Action Item-** Key indicators are targeted to established goals for the fiscal year. A deep dive into the Clinical Engineering database found inconsistencies with the inventory and data present. Through this evaluation year equipment generating PM schedules were found to be removed from service thus generating a higher than normal number of unable to locate devices. Through a process of data management, department assistance of locating or correcting inventory and a strong effort to clean up the inventory, standardize equipment and schedules in the database which assisted to identify all device appropriately was develop to address these inconsistencies. Continued monitoring of this process will improve the effectiveness of the program.

Utility Systems

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 20 Goals

1) Educate all engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.

   - **In progress:** Ongoing education and familiarization for all engineering staff will occur over the course of the next few months as the new buildings come on line and are occupied.

2) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

   - **This goal was accomplished.** Process in place for access control, ongoing monitoring for effectiveness is in place.

3) Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.

   - **In progress:** There will continue to be some equipment that needs to be added to the renovation and or replacement plan for both sites.

Executive Summary

Emergency Management

Effectiveness

- Key indicators were targeted to establish goals for FY-20. The following goals presented opportunities to improve emergency management.

FY-20 Goals

1. Expand the use of mass notification system (Everbridge) to all employees

   - **This goal was partially accomplished.** Expanded funding for this was finally secured and work is underway with IT and HR to incorporate automatic upload of staff information.

2. Revise and distribute the Emergency Management Guides for both campuses.
   a. Revision of content to include latest information.
   b. Roll out of app for the guide on Android and iOS devices in addition to wall-mounted guides.

   - **This goal was accomplished.** Revised guides were distributed in all areas. The **MyEOP** app was launched in early 2020. The app contains all of elements of the wall-guides for easy reference on smart devices.

3. Train staff on emergency procedures in new Taube and Sobrato Pavilions.

   - **This goal was accomplished.** A multi-department effort was undertaken to provide training for all staff, consisting of live tour/training sessions, online modules and practice scenarios. Both building opened during the fourth quarter.

Attachment 1 - Employee Health Services Definitions

1.	**OSHA Recordable Injuries / Illnesses per 100 FTEs**	Number of injuries/illnesses multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# of OSHA recordable injuries ∗ 200,000 / Productive Hrs.]
2.	**Lost Work Day NEW cases per 100 FTEs**	Total number of new injuries occurring in this fiscal year quarter multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# new cases in qtr. w/ lost work days ∗ 200,000 / Productive Hrs.]
3.	**Patient Lift / Transfer Injuries per 100 FTEs**	Number of OSHA recordable injuries resulting from a specific event involving the lifting and transferring of patients and/or pulling up in bed multiplied by 200K and divided by Productive Hours*. Does not include pushing patients in beds, gurneys, wheelchairs, or other transport devices. [# patient lift injuries ∗ 200,000 / Productive Hrs.]
4.	**Exposures to Blood and Body Fluids per 100 FTEs**	Number of exposures to blood/body fluids during a quarter or year x 200K divided by Productive Hours*. [# BBPs ∗ 200,000 / Productive Hrs.]
5.	**Productive Hours**	Total number of hours worked for the quarter or year by all organizational employees. Includes overtime but does not include education, vacation, PTO, ESL, or other non-productive time. This does not include outside labor.

Attachment 2a - Safety Trends

Indicators	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
E.C. 1.0 - SAFETY MANAGEMENT							
Employee Safety							
1. Total Injury/Illness Incident Reports	458	618	428	470	411	439	305
2. OSHA Recordable Injury/Illness (Total)	171	306	193	164	176	145	120
a. Lost Time	61	38	78	45	51	22	22
b. No Lost Time	110	268	113	119	125	133	98
3. Patient Lift/Transfer Injuries (OSHA Recordable)	36	27	37	28	23	16	23
4. Patient Lift/Transfer Injuries	54	37	48	43	41	29	10
5. Trip/Slip/Fall	50	41	58	67	63	60	38
Infection Control							
8. TB Conversions (mo.)/qtr. %	0	0	0	0	0	0	0
9. Blood & Body Fluid Exp.	44	45	53	42	58	48	41
a. Percutaneous	28	38	39	30	36	30	36
b. Skin/Mucus Membrane Contact	16	7	14	12	22	18	5
E.C. 2.0 - SECURITY MANAGEMENT							
1. Code Grey Incidents	135	117	129	167	197	222	303
2. Security Response Time < 3minutes (Goal: >90%)	N/A	N/A	N/A	N/A	N/A	82%	98%
3. Reportable Workplace Violence Incidents	N/A	N/A	N/A	N/A	61	51	63
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT							
1. Reportable Hazardous Material Incidents	0	0	0	0	0	0	0
2. Recordable Hazardous Material Incidents	0	4	0	0	1	5	6
3. Waste Water Discharge Violations	0	0	0	0	0	1	0
4. Staff ability to locate SDS online	N/A	N/A	N/A	N/A	N/A	95%	100%
5. Staff know eyewash rinse time if exposure is 15 minutes	N/A	N/A	N/A	N/A	N/A	79%	100%
E.C. 4.0 LIFE SAFETY							
Fire Safety							
1. Fire Incidents -Actual	1	0	2	0	2	1	2
2. Fire Alarm Events	58	59	72	54	55	41	50
3. Fire Drills comp/scheduled	97%	100%	100%	103%	103%	118%	113%
4. Staff ability to define RACE and PASS	94%	100%	100%	100%	100%	91%	100%
5. Staff ability to locate fire extinguishers and pull stations						96%	100%
6. Staff can define horizontal and vertical evacuations						91%	99%
Life safety & Regulatory Compliance Goals: Performance data - TMS							
1. Utility Reportable Incidents	1	1	6	1	2	2	4
2. % of Life Safety Work Order Completions	100%	100%	100	100	100%	90%	100%
3. PM Completion Rate % completed/scheduled	92.7%	90.9%	97%	90%	89%	95%	95%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT							
1. Reports to FDA	2	6	3	6	15	16	8
2. PM Completion Rate %							
a. ECH High Risk/Life Support PMs*	N/A	N/A	N/A	N/A	N/A	N/A	88%
b. ECH Non High Risk/Life Support PMs*		N/A	N/A	N/A	N/A	N/A	74%
c. ECH Overall PM completion*	N/A	N/A	N/A	N/A	N/A	N/A	75%
3. Equipment Unable to Locate	98%	88%	78%	95%	82%	10%	23%

*New trend in FY-20. No previous year's data.

Attachment 2b - Safety Trends Definitions

E.C. 1.0 SAFETY MANAGEMENT	
Employee Safety	
1. Injury/Illness Reports	Total number of injuries/illnesses reported on *Report of Accident, Injury, Incident or Exposure*, (Form 309) and followed up by Employee Health Services. Includes first aid cases that do not meet the criteria as OSHA Recordable.
2. OSHA Recordable Injury and Illness	Total number of employee injuries and illnesses meeting the OSHA recordable definition and as recorded on the OSHA 300 log.
a. OSHA Recordable: Lost Time	Number of injuries/illnesses with days away from work.
b. OSHA Recordable: No Lost Time	Number of injuries/illnesses with no lost work time, includes cases with transitional work (modified work) when there is no lost work time.
3. Patient Lift/Transfer Injury (OSHA Recordable)	Number of OSHA recordable injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital. Does not include reported injuries with no specific lift/transfer incident.
4. Patient Lift/Transfer Injury (All)	Total number of injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital.
5. Trip/Slip/Fall (all incidents reported)	Number of Trip/Slip/Fall incidents resulting from the unintended or unexpected change in contact between the feet or footwear and the walking or working surface.(All incidents)

6. TB Conversion Rate (Monthly number/quarterly rate)
    a. Percutaneous
    b. Skin, Mucous Membrane Contact
	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.

Infection Control	
1. TB Conversion Rate (Monthly number / quarterly rate)	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.

2. Blood & Body Fluid Exposures
    a. Percutaneous
    b. Skin, Mucous Membrane Contact
	A percutaneous injury (e.g., a needle stick or cut with a sharp object), contact of mucous membranes or non-intact skin (e.g., when the exposed skin is chapped, abraded, or non-intact due to dermatitis), or contact with intact skin when the duration of contact is prolonged, (i.e., several minutes or more) or involves an extensive area, with blood, tissue or other body fluids. Body fluids include:
	a) Semen, vaginal secretions or other body fluids contaminated with visible blood that have been implicated in the transmission of blood borne pathogens
	b) Cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids which have an undetermined risk for transmitting HIV.

E.C. 2.0 SECURITY MANAGEMENT	
1. Code Gray Incidents	Code Grey is called when immediate assistance is required to respond to potential or actual violent situations involving visitors, patients, or family members.
2. Security Response Time < 3minutes (Goal: >90%)	The percentage of security responses within 3 minutes of receiving the request for assistance. The goal is >90%.
3. Reportable Workplace Violence Incidents	The number of workplace violence incidents - patient assault of staff that was reported to CA-OSHS during the year.

El Camino Health

Safety Trends Definitions

E.C. 3.0 HAZARDOUS MATERIALS MANAGEMENT	
1. Reportable Hazardous Materials Incidents	Any unauthorized discharge which is determined not to be recordable and must be reported to the City of Mountain View (subsection 24.5.0.a.1 (a) of Mountain View Health and Safety Code) or the Town of Los Gatos.
2. Recordable Hazardous Materials Incidents	An unauthorized discharge of hazardous or other regulated material defined as a discharge from a primary to a secondary container, cleanup of a discharge to a secondary container requiring greater than 8 hours, no increase of fire or explosion nor production of poisonous gas or flame, or no degradation of secondary container, the discharge does not exceed one (1) ounce by weight or can be cleaned up in 15 minutes following deterioration of the primary container.
3. Waste Water Discharge Violations	Monthly sampling analysis > than the Maximum Limit (mg/L): Zinc 2.0; Total Toxic Organic 1.0; Single Toxic Organic 0.75; Formaldehyde 5.0; Copper 0.25.
4. Staff ability to locate SDS online	Staff able to demonstrate ability to look up a Safety Data Sheet through the Toolbox and MSDS Online program.
5. Staff know eyewash rinse time if exposure is 15 minutes	Staff able to state the minimum required time required to flush a person's eyes after exposure to a hazardous chemical. The requirement is a minimum of 15 minutes.
E.C. 4.0 FIRE PREVENTION MANAGEMENT	
Fire Safety	
1. Fire Incidents	Number of actual fire incidents/month.
2. Fire Alarm Events	Number of fire/smoke alarms activated by an event not classified as an actual fire or false alarm (example: burnt toast, dust, steam, etc.)
3. Fire Drills Completed/Scheduled	Number of fire drills completed/number scheduled.
4. Staff ability to define RACE and PASS	Staff should be able to define RACE (Remove, Alarm, Confine, Extinguish) for responding safely to a fire and PASS (Pull, Aim, Squeeze, Sweep) when using a fire extinguisher.
5. Staff ability to locate fire extinguishers and pull stations	During regularly scheduled fire drills, staff can locate the nearest fire extinguisher and pull station to their normal work area.
6. Staff can define horizontal and vertical evacuations	Staff are able to define the two types of evacuations • Horizontal - evacuate staff to another smoke compartment on the same floor • Vertical - evacuate the building, floor by floor, starting with the upper levels and proceeding until everyone is out of the building.
Life Safety & Regulatory Compliance Goals: Performance data - TMS	
1. Utility Reportable Incidents	Utility System incidents with actual or potential significant impact on safe patient care, staff health and safety or resource/property loss.
2. % of Life Safety Work Order Completions	The percentage of life safety work orders submitted to Facilities that have been completed.
3. PM Completion rate % Completed	Scheduled preventive maintenance completed with 28 days of the prescribed interval/items scheduled for maintenance. Reported quarterly.
E. C. 5.0 MEDICAL EQUIPMENT MANAGEMENT	
1. Reports to FDA	Number of reports to FDA as defined by Safety Medical Device Act requirements. Reported quarterly.
2. PM % Completion	Scheduled preventive maintenance completed. Reported quarterly.
a. ECH High Risk/Life Support PMs*	All critical, life safety equipment PMs completed by ECH Clinical Engineering
b. ECH Non High Risk/Life Support PMs*	Other equipment PMs completed by ECH Clinical Engineering Department
c. ECH Overall PM completion*	Overall completion rate for all equipment PMs
3. Equipment unable to locate	The % of equipment on Clinical Engineering's inventory that is not able to be found.

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