

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

Monday, December 7, 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 <i>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</i>	Julie Kliger, Quality Committee Chair	<i>public comment</i>	motion required 5:33 – 5:34
Approval a. Minutes of the Open Session of the Quality Committee Meeting (11/02/2020) 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. 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. READMISSION DASHBOARD ATTACHMENT 6	Mark Adams, MD, CMO		discussion 5:44 – 6:04
7. PSI REPORT ATTACHMENT 7	Mark Adams, MD, CMO		discussion 6:04 – 6:19
8. PROGRESS ON QUALITY AND SAFETY PLAN ATTACHMENT 8	Mark Adams, MD, CMO		discussion 6:19 – 6:39
9. SYSTEMATIC APPROACH TO TRIGGERS FOR ADDING BACK IN METRICS FOR REVIEW	Mark Adams, MD, CMO		discussion 6:39 – 6:49
10. PUBLIC COMMUNICATION	Julie Kliger, Quality Committee Chair		information 6:49 – 6:52

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

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11. ADJOURN TO CLOSED SESSION	Julie Kliger, Quality Committee Chair	<i>public comment</i>	motion required 6:52 – 6:53
12. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Julie Kliger, Quality Committee Chair		information 6:53 – 6:54
13. CONSENT CALENDAR <i>Any Committee Member may pull an item for discussion before a motion is made.</i> Approval <i>Gov't Code Section 54957.2.</i> a. Minutes of the Closed Session of the Quality Committee Meeting (11/02/2020) Information b. Quality Council Minutes	Julie Kliger, Quality Committee Chair		motion required 6:54 – 6:55
14. Health and Safety Code Section 32155 MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT	Mark Adams, MD, CMO		motion required 6:55 – 7:05
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 7:05 – 7:10
16. ADJOURN TO OPEN SESSION	Julie Kliger, Quality Committee Chair		motion required 7:10 – 7:11
17. RECONVENE OPEN SESSION/ REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		information 7:11 – 7:12
18. CLOSING WRAP UP	Julie Kliger, Quality Committee Chair		discussion 7:12 – 7:17
19. ADJOURNMENT	Julie Kliger, Quality Committee Chair	<i>public comment</i>	motion required 7:17 – 7:18



**Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors**

Monday, November 2, 2020

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

Members Present

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

Members Absent

****via teleconference**

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	<p>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. Terrigal Burn, MD was absent during roll call. All other members were present and participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.</p>	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	<p>Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.</p>	
3. CONSENT CALENDAR	<p>Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. None were noted.</p> <p>Krutica Sharma, MD commented on the Serious Safety Events (SSE). In the future, she suggested that if management has enough data points, there should be information in the materials to present any correlations for indicators to identify trends. In order for that to happen, Dr. Adams stated there should be at least 12 months of data. On the Enterprise Dashboard, since there is not 12 months of data, what is presented is the number of SSE per month under Fiscal Year to Date.</p> <p>Dr. Sharma also inquired if the CDI Dashboard methodology has been previously discussed. Dr. Adams stated that there is a CDI Steering Committee that looks at this information. Dr. Sharma wanted more clarity around the targets in the goal setting and a presentation from the CDI Steering Committee would be helpful.</p> <p>Motion: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (10/05/2020); For 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 and (i) Article of Interest.</p> <p>Movant: Kan Second: Burn Ayes: Burn, Falwell, Kan, Kliger, Po, Sharma, Simon, Ting Noes: None</p>	<p><i>Consent Calendar approved</i></p>

	<p>Abstentions: None Absent: Marfatia Recused: None</p>	
<p>4. CHAIR'S REPORT</p>	<p>Chair Kliger gave the Chair's Report. She went over what occurred at the last board meeting. She noted that the hospital's COVID recovery plan continued to yield results that exceed the volume forecast.</p>	
<p>5. PATIENT STORY</p>	<p>Cheryl Reinking, RN, CNO, presented a Patient Story. She stated that it's a comment from the Press Ganey survey. This patient received care at Los Gatos and also had surgery there. The patient's comments overall were that the staff were all friendly but felt rushed due to patient rescheduling. She commented that Dr. Miller was the best. However, she had confusion for the preparation of her surgery and the nurse had problems placing the IV. Ms. Reinking stated that the hospital recently purchased technology to assist with location of veins for insertion of IVs. It arrived last week and will be distributed to the nursing units soon. The nurses will be able to view veins more readily and start the IV's with ease. Ms. Reinking stated she tested the technology on herself and was impressed how clearly visible her veins were. In regards to the issues on the change in the patient's scheduled time, it could be that the patient did perceive it to change her schedule perhaps. The nurses reiterate the time of surgery and requests a read back from the patients to ensure the patients comprehend. Nonetheless, with WeCare, the hospital ensures that they express empathy and apologize if something goes wrong and make changes based on process that have been identified to need improvement.</p>	
<p>6. QUARTERLY BOARD DASHBOARD REVIEW</p>	<p>Mark Adams, MD, CMO, presented the Quarterly Board Dashboard Review. Dr. Adams stated Q1 FY21 is the first time management has received real numbers to populate this Dashboard. In the Likelihood To Recommend (LTR), there are new targets for all of the measures presented in the packet. Even though the quarter shows red, they are all better than the baseline but not as good as where management would like to be. Nonetheless, Dr. Adams stated that the hospital is off to a good start looking at the entire year overall. The elective delivery has one case reported in the first three months and the C Section rate is up compared to the baseline. Dr. Adams noted that there are a number of providers that have come over from other hospitals and believe a spike in reports might be due to practice patterns.</p> <p>In response to committee members' questions, Ms. Reinking stated that visitor restrictions have had an effect on patient experience at ECH. The state came out with an All Facilities letter last week that only allowed one visitor per day. ECH has been allowing one visitor for inpatient and only for 2 hours. The only exception to that rule is for patients who have cognitive impairment or those who are delivering a baby. Ms. Reinking stated that last week the hospital did not allow visitors to the Emergency Room, but with the All Facilities letter, they are now allowing that. Management is hopeful that those changes will help. In addition, management has allowed exceptions for "end of life" to have their families be allowed to stay overnight.</p> <p>Ms. Kilger wanted to see what has impacted these data and also suggested to management that there are targets that are created so that the organization can develop a culture of self-management for how we're defining equitable to where we compare for standards.</p> <p>Melora Simon left the meeting.</p>	
<p>7. EL CAMINO</p>	<p>Mark Adams, MD, CMO presented the El Camino Health Medical Network</p>	

<p>HEALTH MEDICAL NETWORK REPORT</p>	<p>Report. He stated that the hospital entered into a PSA with San Jose Medical Group (SJMG) and wanted to emphasize that physicians that were not top performers have left the practice since that time. There are only 60% of physicians that were in the original group and 40% of them are new recruits into that group. With regards to the metrics, management picked those that cross from HEDIS to MIPS. MIPS is a payment system for CMS. There are basically four areas that MIPS focus on. What's important is that CMS is using those data to compare on their website to compare physicians. This will become more and more important whether it's for employers, physicians, or patients. Dr. Adams stated that management is paying a lot of attention to the MIPS program and wants to improve overtime.</p> <p>In response to committee members' questions, Dr. Adams stated that the data being extracted is in the right place and field. He also wanted to make sure that each physician is aware that they were being measured with each physician having received a report card in comparison to their groups and to the target. Bruce. Harrison, President, SVMD, also stated that one of the most important things was to get on a common system. The real push to getting everyone on EPIC is critical to reduce variations. He stated that the physician group does meet monthly, and the frontline groups meet regularly. In addition, Mr. Harrison stated that there are many different agencies that are looking for different things (measures, standards, etc.).</p> <p>Chair Kliger commented that she does recognize that they are new to ECH; however, they are not new physicians. She stated that these performance metrics were quite dissatisfying and quite low and is concerned with hospital's reputation not being good with it being associated with this medical group in performance. Mr. Harrison stated that with the next quarter, it will improve. Current numbers are with EPIC not being in place and only with the information that is in the computer systems. None of the historic information from SJMG was in their system. The work that ECHMN is doing is going to progressively improve upon these numbers.</p>	
<p>8. SAFETY REPORT FOR THE ENVIRONMENT OF CARE</p>	<p>Ken King, CASO, presented the Safety Report for the Environment of Care. He stated that the hospital had an excellent year. Highlights of the year had to do with great efforts by the team to see a significant decline of non-reportable injuries. Two new buildings in Mountain View were occupied and running. In terms of challenges, there was an increase of Code Gray (security incidents) calls, but sees that has a benefit to come up with processes in place. Workplace violence mainly was due to alcohol related issues with patients.</p> <p>In response to committee members' questions, Mr. King stated there is a bit of disparity between the Mountain View and Los Gatos campus in environment of care. Mr. King stated that Los Gatos is COVID free from an inpatient standpoint.</p>	
<p>9. PUBLIC COMMUNICATION</p>	<p>There was no public communication.</p>	
<p>10. ADJOURN TO CLOSED SESSION</p>	<p>Motion: To adjourn to closed session at 6:50pm. Movant: Burn Second: Ting Ayes: Burn, Falwell, Kan, Kliger, Po, Sharma, Ting Noes: None Abstentions: None Absent: Marfatia, Simon</p>	<p><i>Adjourned to closed session at 6:50pm</i></p>

	Recused: None	
11. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:11pm. Agenda items 11-16 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (10/05/2020), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
12. AGENDA ITEM 18: CLOSING WRAP UP	There were no closing comments.	
13. AGENDA ITEM 19: ADJOURNMENT	<p>Motion: To adjourn at 7:12pm.</p> <p>Movant: Kan</p> <p>Second: Burn</p> <p>Ayes: Burn, Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, Ting</p> <p>Noes: None</p> <p>Abstentions: None</p> <p>Absent: Marfatia, Simon</p> <p>Recused: None</p>	<i>Meeting adjourned at 7:12pm</i>

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 HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: December 7, 2020
Subject: FY21 Enterprise Quality, Safety, and Experience Dashboard

Summary:

1. **Situation:** The Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics are selected based on a careful review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization.
2. **Authority:** The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on key quality metrics.
3. **Background:** At the beginning of each fiscal year, an assessment is completed to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added. These twelve (12) metrics were selected for monthly review by this Committee as they reflect the Hospital’s FY 2021 Quality, Safety and Service Goals.
4. **Assessment:**
 - A. Readmission Index dropped in September, below target
 - B. SSEs have increase each month of FY21, to 7 in September
 - C. Mortality Index increased slightly to above target
 - D. HCAHPS Likelihood to Recommend below target for hospital & ED, improved and above target for ECHMN
 - E. Zero C.Diff HAI for the second month
 - F. Sepsis mortality Index spiked in October, all cases reviewed for SSEs
 - G. PC-01 at Zero for September
 - H. PC-02, Cesarean Birth dropped significantly from August
5. **Other Reviews:** N/A
6. **Outcomes:** N/A

Suggested Committee Discussion Questions: None

List of Attachments: FYTD 2021 Enterprise Quality, Safety, and Experience Dashboard, October data unless otherwise specified - final results

	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				
<p>*Organizational Goal Readmission Index (All Patient All Cause Readmit) Observed/Expected Premier Standard Risk Calculation Mode **Latest data month: September 2020</p>	0.83 (6.62%/8.01%)	0.87 (6.97%/8.00%)	0.96	0.93		
<p>*Organizational Goal Serious Safety Event Rate (SSER) # of events **Latest data month: September 2020</p>	7	3.98 (51/127985)	4.28	4.0		
<p>* Strategic Goal Mortality Index Observed/Expected Premier Standard Risk Calculation Mode Latest data month: October 2020</p>	0.89 (1.55%/1.74%)	0.78 (1.44%/1.85%)	0.74	0.76		
<p>*Organizational Goal IP Enterprise - HCAHPS Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted Latest data month: October 2020</p>	79	80.2	83.1	83.6		

	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				
<p>* Organizational Goal ED Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted</p> <p>Latest data month: October 2020</p>	76.8	74.6	75.7	78.2		
<p>* Organizational Goal ECHMN (El Camino Health Medical Network): Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted</p> <p>Latest data month: October 2020</p>	77.2	76.4	73.2	75.7		
<p>Hospital Acquired Infections Clostridium Difficile Infection (CDI) per 10,000 patient days</p> <p>Latest data month: October 2020</p>	0.00 (0/9989)	1.14 (4/34945)	1.46	<= 1.46 (MV: 10/LG: 3)		
<p>Organizational Goal Surgical Site Infections (SSI)- Enterprise SSI Rate = Number of SSI / Total surgical procedures x 100</p> <p>Latest data month: October 2020</p>	0.20 (1/506)	0.48 (11/2285)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

	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) <i>Latest data month: October 2020</i>	1.62 (14.53%/8.99%)	0.95 (9.98%/10.52%)	0.98	0.90		
10 PC-01: Elective Delivery Prior to 39 weeks gestation (lower is better) <i>**Latest data month: September 2020</i>	MV: 0.00% (0/10) LG: 0.0% (0/4) ENT: 0.00% (0/14)	MV: 0.00% (0/49) LG: 4.55% (1/22) ENT: 1.41% (1/71)	MV: 1.47% (5/341) LG: 0.00% (0/48) ENT: 1.29% (5/389)	1.3%		
11 PC-02: Cesarean Birth (lower is better) <i>**Latest data month: September 2020</i>	MV: 25.2% (35/139) LG: 18.2% (4/22) ENT: 24.2% (39/161)	MV: 29.13% (125/429) LG: 20.00% (17/85) ENT: 27.63% (142/514)	MV: 24.74% (412/1665) LG: 18.97% (48/253) ENT: 23.98% (460/1918)	23.5%		
12 *Strategic Goal Patient Throughput-Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns) <i>Latest data month: October 2020</i>	MV: 270 min LG: 240 min Ent: 255 min	MV: 276 min LG: 235 min Ent: 256 min	MV: 304 min LG: 263 min Ent: 284 min	MV: 263 min LG: 227 min Ent: 245 min		

** data available up to September
Report updated: 11/20/20

**Hospital Update
December 7, 2020
Mark Adams, MD, CMO**

Quality and Safety

I am pleased to report that Healthgrades named El Camino Hospital Mountain View as a recipient of three 2021 Specialty Clinical Quality Awards.

- America's 100 Best Hospitals for Cardiac Care Award: Recognizes superior clinical outcomes for heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment and heart valve surgery.
- America's 100 Best Hospitals for Gastrointestinal Care Award: Recognizes superior clinical outcomes in colorectal surgeries, gallbladder removal, esophageal/stomach surgeries, small intestine surgeries, and treating bowel obstruction, gastrointestinal bleeds, and pancreatitis.
- General Surgery Excellence Award: Recognizes superior clinical outcomes in bowel obstruction treatment, colorectal surgeries, gallbladder removal, esophageal/stomach surgeries, and small intestine surgeries.

Operations

ECH Los Gatos acquired a new image-guided, navigated, robotic bone cutting-guide on a computer-controlled arm for total knee arthroplasty surgery. The acquisition of this equipment, which integrates with x-ray-based software to model artificial joint fit in advance, allows more surgeons to utilize robotic technology for their patient's joint replacements.

In October, ECH has acquired two new computer vision software modules recently approved by the FDA for use with potential stroke patients. These new automated CT scan reads provide quick information as to the potential benefits and risks of thrombectomy (clot removal) based on the current damage to the brain, allowing for quicker decision-making to activate the catheterization lab teams. Evidence shows that millions of brain cells die each minute, and the ability to heal is correlated to more timely intervention.

A verbal update will be provided to the Board on the status of the virtual site visit for our 4th Magnet designation, which will take place November 10th – 12th.

Workforce

In October, we established a Diversity and Inclusion Committee, comprised of physicians, managers, and staff members. The work of the Committee is to acknowledge the perspectives, life experiences, and social/cultural identities that our



care providers and other staff members bring to the Hospital, as these bring great value to the healthcare environment and increase our ability to provide compassionate, innovative, and culturally competent care. Embracing diversity and equity in our workforce creates an inclusive work and care environment for employees and the community we serve.

The pandemic has potential impact on wellness throughout the organization. In response, we are regularly reminding our employees that counseling services are available through CONCERN: EAP. As well, we are offering those services to ECHMN and hospital-based physicians free of charge.

The El Camino Health Human Resources division is working with the City of Mountain View to develop an outdoor fitness court at Cuesta Park. The City's consultant designed a proposed fitness zone with 9 stations that could serve up to 37 people at a time. Discussions are focused on a potential partnership where the entities would split construction costs in order to provide this benefit to the entire community. City staff is tentatively planning to take the proposed outdoor fitness court to the City Council for project approval on December 8, 2020. If the City Council approves the project, ECH will target the approval of our financial support for the project in January 2021.

Facilities

Management engaged an architectural firm to provide a feasibility assessment for a Patient/Family Residence for consideration on the Healthcare District property located at 530 South Drive. We anticipate bringing a recommendation to you in the coming months regarding this concept that has already garnered significant interest from ECH Foundation donors since the initial concept was presented.

Information Services

MyChart adoption is currently at 51% and continues to climb. 76,700 of our patients have a MyChart account. We made significant progress over the past year (doubling the percentage) to move from 21% of patients seen 3+ times having a MyChart Account to the current status of 51% of patients having a MyChart account. We are in the middle 50%/median range of Epic customers with the goal of top 25% and ultimately the top 10%. We expect to make dramatic improvement in the next 3-6 months as the Epic data is the last 12 month average and due to the significant increases recently we will move into the higher ranges as the older less positive months drop off.

Community COVID-19 Testing

ECH continues to provide testing through the El Camino Healthcare District Community COVID-19 Testing Program. Over 9,000 tests have been administered at sites



throughout the District including our Mountain View campus, public school sites and downtown retail locations. Students, in addition to school employees, are now offered testing at public school sites where requested. 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 began administering a no-cost testing program at sites in the Los Gatos area on November 5th.

Corporate and Community Health Services

CONCERN: EAP will be providing EAP services to 25 new customers, covering 30,000 employees by January 2021.

Community Benefit staff requested an informational report from all grant partners requesting an update on the impact of the pandemic on their operations and use of grant funds, an added assessment step for the pandemic.

The South Asian Heart Center hosted three talks on "A Lifetime on Meds or a Lifestyle of MEDS" with 26 attendees, started a new monthly Diabetes Prevention Program and hosted an evening huddle regarding "Secrets of Self-Healing from Ayurveda" with 79 attendees. The Chinese Health Initiative translated Safe Care videos with Chinese voiceover and disseminated them through an enewsletter and social media channels, revised the bilingual "Health Resource Guide for Chinese Seniors in Santa Clara County" and continues its "Ask-a-Doctor" and "Emotional Well-Being" webinars. CHI also held an annual appreciation for Chinese-speaking physician's event with 22 physicians attending. Dr. Adams gave a presentation to the attendees on the "Journey to High Reliability."

Marketing and Communications

The recovery brand advertising campaign, Return to Health, continues to perform well. Since its launch in April, we have had over 73,000 page views with the Trade Desk ads as the main driver of website traffic, followed by Facebook, and then paid search. In collaboration with the COVID-19 workgroup, we launched online appointment scheduling for Los Gatos and an interactive map with our testing facilities on our website. We also added (1) new pharmacy content supporting the mobile app and medication use instruction and (2) online class support for Lifestyle Medicine by expanding online class offerings and to SAHC's AIM as well as New Beginnings mother-baby classes.

Media Coverage for October 2020 included the following:

- October 1, 2020 Patch (Campbell) Coronavirus Live Blog: Santa Clara County Says Private Hospitals Have To Do More Testing
- October 2, 2020 Los Altos Town Crier School districts, ECH offer on-campus COVID testing for teachers
- October 3, 2020 Patch (Campbell) Coronavirus Live Blog Binational Health Week Goes Online
- October 4, 2020 Patch (Campbell) Coronavirus Live Blog: County to Allow Indoor Dining if it Moves to Lower-Risk Reopening Tier
- October 13, 2020 Patch (Campbell) Coronavirus Live Blog: Gardner Health Center and County Increase Testing at Mexican Heritage Plaza
- October 27, 2020 The McMorrow Reports Facility Management & Design Insights: VirtualCast Healthcare releases seven episodes of 1 Hour (Ken King)

Government Relations

On October 26, the U.S. Department of Health and Human Services released its first report on hospital reporting compliance in regards to submitting COVID-19 data. In the first report, El Camino Health is shown as reporting at 100% for all seven days. This compared favorably to other regional hospitals which were shown at a lower level of compliance ranging from 63.4% - 99.3%.

To maintain stability in the EMS system, the Santa Clara County Board of Supervisors extended the contract with its current vendor to provide ambulance services through June 30, 2024. The County had previously been working toward a competitive bidding process for the ambulance contract, but given the COVID-19 pandemic and other challenges in 2020, this was put on hold. For Santa Clara County residents and hospitals, this will provide important stability for EMS services.

El Camino Health was a community sponsor of the Silicon Valley Council of Nonprofits "Be Our Guest" event. The organization helps nonprofits grow their capacity to build thriving and equitable communities. This event has heavy participation from important city, county, and state elected officials.

El Camino Health was the presenting sponsor of the Los Gatos Chamber of Commerce and the Saratoga Area Senior Coordinating Council's first-ever Drive-Thru Senior Resource Fair. Our Chief Nursing Officer and Director of Infection Prevention also provided COVID-19 safety guidance to the event organizers. As the presenting sponsor, El Camino Health was recognized in a radio ad as well as an advertisement, which ran in the Los Gatos Weekly. ECH staff handed out information on our services and programs to approximately 150 seniors during the event on October 28.

Philanthropy

Edward and Pamela Taft gifted \$300,000 to the nursing division for nursing research. We will use the funds for evidenced based projects and will disseminate the results of our work globally.

El Camino Health Foundation secured \$28,514 in Period 3 of fiscal year 2021, for a total of \$870,960 YTD, which is 11% percent of goal for the year. A detailed report is attached.

Auxiliary

The Auxiliary has contributed 4,892 volunteer hours in FY21, 1450 of those in the month of October.

**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: December 7, 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 Committee, the Hospital Board has met once and the District Board has not met. 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)
	November 11, 2020	<ul style="list-style-type: none"> - Resolution 2020-10 Recognizing Brian Richards' Service to the Organization - Medical Staff Report - Quality Council Minutes - Medical Staff Credentials and Privileges Report - Election of Carlo Bohorquez, CFO and Deb Muro, CIO to the Pathways Home Health and Hospice Board of Directors - Pathways FY21 Budget - FY21 Board Action Plan (Attached) - Revised Policy and Procedures for Nomination and Appointment of Community Members to the Board's Advisory Committees (Attached) - FY21 Board Retreat Agenda - Annual Safety Report for the Environment of Care - FY21 CEO Base Salary - FY20 CEO Incentive Compensation Payout (Partial)
	November 5, 2020	<ul style="list-style-type: none"> - FY21 CFO Individual Performance Goals - Renewal of Executive Compensation Consultant Contract
Compliance and Audit Committee	N/A	
Finance Committee	N/A	

FY21 El Camino Hospital Board Action Plan (Approved November 11, 2020)

	What	Who	By When	Current Status
Strategic Oversight				
1.	Define the role and establish process for Board oversight and engagement of the upcoming strategic planning process.	Board Chair, CEO	12/9/20 Board	
Clarify Governance Processes and Structures				
2.	Review pacing plan and past agendas to identify items that could be placed on the consent agenda or delegated to create more time for strategic discussion.	Chair, CEO, Dir. Gov. Services	12/30/20	
3.	Continue to provide executive summaries and framing questions for each agenda item to focus attention and stimulate discussion.	CEO, Executives, Dir. Gov. Services	12/30/20	
4.	Conduct a review of the current committee structure to determine if it is still in alignment with current governance responsibilities.	Governance Committee	2/2/21 GC 2/10/21 Board	
5.	Work with committee leadership and executive sponsors to develop a more effective mechanism for communication between the board and committees.	Chairs, Vice Chairs, Executives, Dir. Gov. Services	1/15/21	
Increase the Board's Diversity				
6.	Request the Governance Committee develop a set of recommendations to increase the representation of diversity on our governing bodies as reflected from the communities we serve.	Governance Committee	3/23/20 GC 4/7/21 Board	

**EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE COMMUNITY MEMBER
NOMINATION AND SELECTION PROCEDURES**

Adopted February 12, 2014

Revised (Approved) April 8, 2015; November 11, 2020

**01.07 HOSPITAL BOARD ADVISORY COMMITTEE COMMUNITY MEMBER
NOMINATION AND SELECTION PROCEDURES**

A. Coverage: El Camino Hospital Board Advisory Committees

B. Adopted: 2/12/2014

C. Procedure Summary:

The nomination and selection of each Hospital Board Advisory Committee (Advisory Committee) member (Member) shall follow the procedures below.

D. Procedure for Nominating and Appointing an Advisory Committee Community Member:

1. Eligibility and Qualifications

Each Advisory Committee shall determine minimum qualifications and competencies for its Members. In addition, the Governance Committee will periodically conduct a strategic assessment of the respective Advisory Committee's membership needs and ensure that it evolves with the Hospital's strategy.

2. Nomination and Declaration

- a. Nominations for Advisory Committee Community Membership may be received from any source.
- b. The Director, Governance Services will notify the Board, the Advisory Committee members, the Executive Leadership Team and the public of all vacancies for which new Advisory Committee Community Members are being recruited.
- c. A candidate shall submit an application to the Director, Governance Services that includes reason(s) the candidate wishes to serve, the candidate's relevant experience and qualifications, potential conflicts of interest including any personal or professional connections to ECH, a release to permit ECH Human Resources to conduct a background check, and specifies which Advisory Committees that the candidate wishes to be considered for.
- d. If the interested candidate is currently serving on another Advisory Committee at ECH, the candidate shall notify the Chair(s) of the Advisory Committee with a vacancy and the Advisory Committee on which they are serving. The interested candidate shall also notify the Director, Governance Services, provide all application materials, and be subject to all other requirements of this procedure.

- e. All candidates will be considered in the candidate due diligence process.
- f. In the event that no qualified candidates can be found through the routine recruitment procedures of the Hospital, the Committee may, in its discretion, obtain the services of a recruiting firm to identify qualified candidates.

3. Review of Candidates and Selection of New Members.

- a. Any committee recruiting new members shall appoint an Ad Hoc Committee comprised of two members to recruit new members. The Committee Chair shall be given first right of refusal to serve as a member of the Ad hoc Committee,
- b. The Director, Governance Services will forward the names and resumes of all applicants to the Executive Sponsor and the members of the Ad hoc Committee for review.
- c. The Ad hoc Committee, in consultation with the Executive Sponsor, shall (1) select and interview first round candidates and (2) select finalists for interview by the full Committee.
- d. The Committee will interview finalists and recommend appointments to the Board for approval
- e. The Board shall appoint the Advisory Committee Members in accordance with the Hospital Bylaws.

4. Obtaining Approval to Increase the number of Community Members of an Advisory Committee

- a. If an Advisory Committee Chair proposes to increase the number of Community Members of such Chair's Advisory Committee, then the Advisory Committee Chair must submit a brief description of the need (e.g., gap in skill-set) for an increase in membership to the Governance Committee.
- b. Upon review of the request, the Governance Committee shall make a recommendation to the Board whether the Community membership of such Advisory Committee should be increased.



EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND
SELECTION POLICY

**XX.XX HOSPITAL BOARD ADVISORY COMMITTEE COMMUNITY MEMBER
NOMINATION AND SELECTION POLICY**

A. Coverage:

El Camino Hospital Board Advisory Committees

B. Adopted:

June 12, 2013;

C. Policy:

It is the policy of ECH that appointment of Hospital Board Advisory Committee Community Members to vacant or newly created positions follow the procedure set forth in the attached Document entitled:

Hospital Board Advisory Committee Community Member Nomination and Selection Procedure

1. Length of Service and Term Limits for Committee Members

As provided in the Committee Charters, Committee Community Members will serve a term of one (1) year, renewable annually.

D. Reviewed:

Governance Committee March 31, 2015; October 13, 2020
ECH Board Approved April 8, 2015, November 11, 2020

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

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
5	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
6	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
7	Add Review of Lean Projects to Pacing Plan for FY21	3/2/2020	JG	Added to March 2021 Meeting	



Do Magnet[®]-Designated Hospitals Perform Better on Medicare's Value-Based Purchasing Program?

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OBJECTIVE: The aim of this study was to explore the relationship between a hospital's Magnet[®] recognition status, tenure, and its performance in the Hospital Value-Based Purchasing (HVBP) program.

BACKGROUND: Previous studies have sought to determine associations between quality of care provided in inpatient setting and the Magnet Recognition Program[®]; however, no study has done so using the most recent (FY2017) iteration of the HVBP program, nor determined the influence a hospital's Magnet designation tenure has on HVBP scores.

METHOD: This study used a cross-sectional study design of 2686 hospitals using propensity score matching to reduce bias and improve comparability.

RESULTS: Magnet-designated hospitals were associated with higher total performance, process of care and patient experience of care scores, and lower efficiency score. No association was identified between the length of time hospitals have been Magnet designated.

CONCLUSION: Findings suggest non-Magnet status hospitals need to consider implementing the principles of Magnet into their culture or participation in the Magnet Recognition Program to provide higher quality of care.

For more than a decade, hospitals have been reporting process, outcomes, and, more recently, structural data via the Centers for Medicare & Medicaid (CMS) Quality Reporting Program.¹ The intention is to provide public accountability for the provision of care and allow for informed consumer healthcare decisions.² The implications of reporting this information have extended beyond enhancing healthcare decision making impacting hospital reimbursement. One of the key programs that focus on both quality and reimbursement is the Hospital Value-Based Purchasing (HVBP) program introduced by CMS in 2012.³

The HVBP program incentivizes hospital performance on a variety of improvement initiatives to promote healthcare value. As a result, leaders have considered the effect of structural components of their quality program, such as the American Nurses Credentialing Center (ANCC) Magnet Recognition Program[®] (MRP).⁴ The ANCC MRP was developed in 1981 to designate hospitals that achieve nursing excellence.⁵ The MRP provides a framework to achieve nursing excellence through the development of a professional nursing practice environment. Hospitals must meet eligibility requirements addressing governance, structure, leadership, accountability, education of the nursing workforce, compliance with standards of practice, and data collection and submission.⁶ Magnet[®] designation has been associated with improved Hospital Consumer Assessment of Healthcare

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The authors declare no conflicts of interest.

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Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jonajournal.com).

DOI: 10.1097/NNA.0000000000000906

Providers and Systems scores, better use of evidence-based practice,^{4,5,7-9} and better patient outcomes when compared with non-Magnet hospitals.⁹

A previous study conducted by Lasater and colleagues⁹ found that Magnet-designated hospitals were associated with higher performance in 2 HVBP domains as well as overall performance. However, since the publication of the study, the measures included in the HVBP program along with associated weights have significantly changed. For example, the FY2017 CMS HVBP program included 4 domains presented in Supplemental Digital Content 1 (<http://links.lww.com/JONA/A764>), namely, clinical care, patient- and caregiver-centered experience of care/care coordination, safety, and efficiency and cost reduction.¹⁰ One major update was the introduction of the patient- and caregiver-centered experience of care/care coordination also known as patient and caregiver experience. Each domain is weighted at 25% and is used to calculate an organization's total performance score (TPS).¹⁰ It is important to provide updated information regarding the performance of Magnet hospitals in the HVBP program as the performance assessment has changed. In addition, no previous study has determined the influence a hospital's Magnet designation tenure has on the hospital's performance in the HVBP program.

Framework

Donabedian's¹¹ Structure-Process-Outcome model (Figure 1) provides a logical framework for understanding the potential associations between quality outcomes as defined by the HVBP program and the structural and process components relevant to Magnet designation. The structural component includes attributes such as human resources and organizational structure.¹¹ Magnet requirements include key structural requirements as discussed previously.⁶ The process attribute in the model represents the care that is being provided to

patients, whereas the achievement of Magnet designation has shown a reduction in barriers to nurses using evidence-based practice in their care of patients, leading to better outcomes, the 3rd component of the model.^{5,7}

Participation in Magnet designation is expected to benefit the whole organization in providing the highest standard of care to patients.⁶ This is achieved through fostering the ideal environment for nursing talent. Hallmarks of Magnet designation include a professional nursing practice that leads to quality of care that is sustained over time and nursing excellence and encourages innovation in the professional practice of nursing.⁷ In addition, it is logical to conclude that organizations that have maintained Magnet recognition for a longer duration have had an increased opportunity to adopt, implement, and hard-wire the structural and procedural aspects of the Magnet requirements, thus promoting better performance. We propose 2 central hypotheses:

Hypothesis 1 (H1): There is a positive association between a hospital's Magnet status and HVBP scores.

Hypothesis 1 (H2): There is a positive association between a hospital's Magnet status tenure (the last 2 years [2015-2017] and last 5 years [2012-2017]) and HVBP scores.

Methods

This study used the 2017 HVBP database,³ 2015 Area Health Resource Files (AHRF) database,¹² the 2014–2017 American Hospital Association (AHA) database,¹³ the 2014–2017 Medicare Final Rule Standardizing File,¹⁴ and the 2014–2017 Health Care Cost Report Information System (HCRIS).¹⁵ Through the ANCC, we identified Magnet hospitals, including hospital name, date of Magnet designation, and hospital location. Hospital

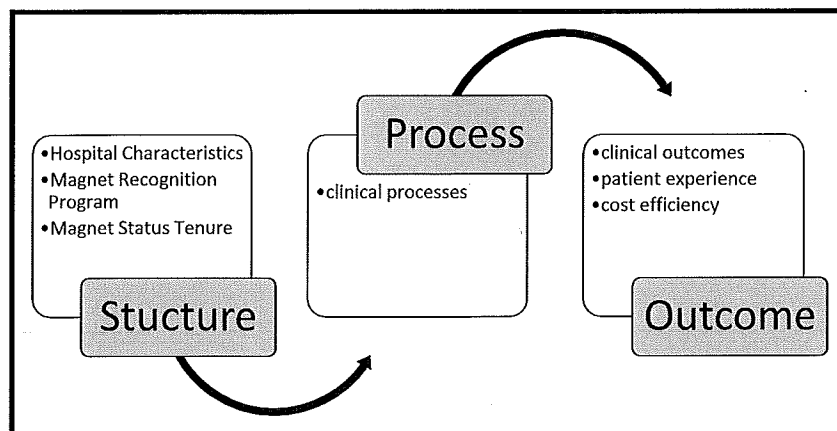


Figure 1. Donabedian's Structure-Process-Outcome model adapted to measure the impact of Magnet status and the HVBP program.

Medicare provider identification number was then established through Hospital Compare and AHA database searches. The HVBP database provides the value-based purchasing (VBP) scores and hospital provider identification numbers. The AHRF database provides the market variables such as market competition, aging population, and per capita income levels. The AHA database contains annual survey data collected from US hospitals and focuses on hospital characteristics, services, and functions.¹³ The Medicare Final Rule Standardizing File was used to obtain the Case Mix Index (CMI) variable for the analysis. Finally, the HCRIS data set includes annual reports submitted by healthcare institutions to CMS.

Data were merged via CMS provider identification numbers and Federal Information Processing Standards. Hospitals with incomplete records or did not participate in the HBVP program were excluded from the analysis. The final sample was composed of 2686 general, acute, short-stay US hospitals. As all data sources are publicly available and do not identify individual patients, institutional review board approval was not required for this study.

Measurement

The dependent variables for this study include the 4 HVBP domains and the HVBP TPS. The TPS score is calculated using the following domains and weights: clinical care (30%); patient- and caregiver-centered experience of care/care coordination (25%); safety (20%); and efficiency and cost reduction (25%).¹⁶

The main independent variable in this study is Magnet designation, which is defined as a binary variable where “no” is 0 and “yes” is 1. To evaluate time an organization has maintained Magnet designation, 2 additional variables were created. The 1st evaluated differences between hospitals that achieved Magnet designation in the last 2 years (2015-2017) compared with those who achieved Magnet designation before 2015. The 2nd extends the review period and compares hospitals that achieved Magnet designation during the last 5 years (2012-2017) compared with those who achieved Magnet designation before 2012.

To control for differing organizational characteristics, we used the following variables: organizational ownership (nonfederal government, for-profit, and not-for-profit),¹⁷ organizational size (small [<100], medium [<199], and large [$200+$ staffed beds]),¹⁸ teaching status (yes or no),¹⁹ average percentage of the population 65 years or older between 2010 and 2015, average Herfindahl-Hirschman Index (HHI) between 2014 and 2017, percentage of the hospital's Medicare and Medicaid population between 2014-2017, hospitals' average CMI between 2014 and 2017, hospitals' average operating margin between 2014 and 2017,²⁰ and

percentage of the population younger than 65 years without health insurance between 2010 and 2017.²¹ An HHI of 0 indicates a pure competition, and 1 indicates a pure monopoly.²² In addition, we used the hospital's Medicare and Medicaid population percentages to help identify payor mix and hospitals' average operating margin to help identify organization's financial standing.

Analysis

This analysis uses propensity score matching to compare 1) Magnet- versus non-Magnet-designated hospitals; 2) Magnet-designated hospitals that were awarded the designation in the past 2 years versus hospitals with Magnet designation greater than 2 years; and 3) Magnet-designated hospitals that were awarded the designation in the past 5 years versus hospitals with Magnet designation greater than 5 years. Propensity score matching is used in each analysis to reduce bias and improve comparability between organizations that have achieved Magnet designation and those that have not.²³ Propensity score matching compares characteristics between Magnet and non-Magnet hospitals through balancing and matching observed covariates (our control variables) across the groups. Balance is not always possible when considering the various organizational characteristics that may occur between the 2 groups. For instance, there may not be a large enough sample of medium-sized, rural hospitals located in nonmonopolistic markets to match Magnet- versus non-Magnet-designated hospitals. When balance criteria were not met, the covariates were evaluated to determine whether they should remain within the model. In some cases, covariates were dropped to help improve the balance between the groups of interest. A 2:1 matching ratio was used, whereby 2 non-Magnet hospitals were matched to each of the Magnet hospitals to reduce bias.²³ For each analysis, 5 models were run to define overall HVBP TPS as well as scores associated with each HVBP domain. STATA 15 (MP; College Station, Texas) was used to run all analyses, and models were estimated through maximum likelihood. All variables were checked for collinearity and outliers. Coefficients and 95% confidence intervals (CIs) are reported.

Results

We analyzed 2686 hospitals across all 50 states in the United States, and approximately 14% were Magnet-designated hospitals (Table 1). With regard to the variables of interest, there were no difference in the overall TPS score between Magnet- and non-Magnet-designated hospitals. However, all other variables considered demonstrated significant difference when comparing between the 2 groups. For instance, the mean process

Table 1. Continuous and Categorical Variables and Magnet Accreditation

Continuous Variables	Not Magnet Accredited			Magnet Accredited			Total			P
	Mean	SD	Population	Mean	SD	Population	Mean	SD	Population	
TPS	37.03	11.23	2310	36.49	8.95	376	36.95	10.93	2686	.807
Process of care	41.25	22.18	2310	54.92	22.24	376	43.17	22.68	2686	<.001
Patient experience of care	33.2	18.41	2303	34.78	15.18	376	33.42	18	2679	.002
Efficiency	20.1	24.97	2309	11.12	15.28	376	18.84	24.05	2685	.001
Safety	54.54	18.45	2147	45.13	13.65	375	53.14	18.13	2522	.001
HHI (average; 2014-2017)	0.39	0.39	2293	0.22	0.28	374	0.37	0.38	2667	<.001
Medicare percentage (average; 2014-2017)	0.44	0.08	2030	0.41	0.07	300	0.43	0.08	2330	.001
Medicaid percentage (average; 2014-2017)	0.21	0.12	2030	0.19	0.08	300	0.21	0.11	2330	.033
Average CMI (2014-2017)	1.51	0.25	2310	1.75	0.28	376	1.54	0.27	2686	.001
Operating margin (average; 2014-2017)	-0.01	0.19	2301	0.02	0.18	375	-0.01	0.19	2676	.001
Percentage of population older than 65 y (2010-2015)	0.85	0.04	2297	0.87	0.03	375	0.86	0.04	2672	.001
Percentage of population younger than 65 y without health insurance (average; 2010-2015)	15.66	5.3	2297	14.33	5	375	15.48	5.28	2672	.001
Categorical Variables			Not Magnet Accredited			Magnet Accredited			Total	P
Hospital size										
Small			679			16			711	<.001
Medium			1357			190			1,551	
Large			261			169			430	
Teaching										<.001
No			1173			64			1,253	
Yes			1137			312			1,455	
Ownership										<.001
Government (nonfederal)			334			33			367	
For-profit			512			16			528	
Not-for-profit			1451			326			1777	

Continuous variables assessed by Kruskal-Wallis test. Categorical variables assessed by Pearson χ^2 .

of care score was 54.92 versus 41.25 ($P < .001$) for Magnet- and non-Magnet-designated hospitals, respectively. Similarly, when comparing Magnet- versus non-Magnet-designated hospitals, the mean scores were: patient experience of care (34.78 vs 33.2, $P = .002$), efficiency and cost reduction (15.28 vs 20.1, $P = .001$), and safety (53.14 vs 54.54, $P = .001$). Furthermore, all control variables demonstrated a significant difference between Magnet- and non-Magnet-designated hospitals.

Table 2 highlights our findings from the propensity score matching of HVBP dimensions and Magnet-designated status. On the basis of this analysis, we found that Magnet-designated hospitals were associated with several statistically significant associations including: higher TPS (regression coefficient [RC], 2.21; 95% CI, 0.57-3.85), higher process of care scores (RC, 8.96; 95% CI, 4.78-13.15), higher patient experience of care scores (RC, 4.49; 95% CI, 1.91-7.06), but lower efficiency (RC, -2.47; 95% CI, -4.84 to -0.11). No statistically significant difference was found between HVBP safety domain score (95% CI, -3.21 to 0.74) and hospitals' Magnet-designated status. Furthermore, we found no statistically significant

association between the length of time a hospital had been Magnet designated.

Discussion

Health policy changes under the HBVP program highlight the importance of excellence in quality, efficiency, and performance. In support of H1, our findings align with previous research reporting that Magnet-designated hospitals are associated with higher CMS TPS when compared with non-Magnet-designated hospitals.^{4,8,9} This finding suggests Magnet-designated hospitals may be more likely to adhere to CMS regulations or are equipped with resources necessary to provide higher quality of care. A likely contributor is that nurses working in Magnet-designated hospitals have higher levels of education and specialty certifications on average than those in non-Magnet-designated hospitals,²⁴ which may affect care provided and thus help improve scores in associated areas. However, the individual domains of the HVBP program are not consistent in their support of H1.

The relationship between Magnet-designated hospitals' higher performance scores in processes of care

Table 2. Propensity Score Matching: HVBP Dimensions and Magnet Status

VBP Domains	Magnet Accreditation (0, no; 1, yes)		Magnet Accreditation in the Last 2 y (0, no; 1, yes)		Magnet Accreditation in the Last 5 y (0, no; 1, yes)	
	Coefficient (SE)	95% CI	Coefficient (SE)	95% CI	Coefficient (SE)	95% CI
TPS	2.21 (0.84)	0.57-3.85	0.91 (1.62)	-2.27 to 4.09	-0.74 (1.38)	-3.45 to 1.96
Process of care domain	8.96 (2.14)	4.78-13.15	-2.48 (4.05)	-10.41 to 5.45	-4.55 (3.40)	-11.22 to 2.12
Patient experience of care domain	4.49 (1.31)	1.91-7.06	4.75 (2.71)	-0.57 to 10.06	3.34 (2.07)	-0.72 to 7.40
Efficiency domain	-2.47 (1.20)	-4.84 to -0.11	1.11 (2.74)	-4.26 to 6.49	-2.58 (2.61)	-7.70 to 2.53
Safety domain	-1.23 (1.01)	-3.21 to 0.74	0.37 (3.06)	-5.62 to 6.36	1.88 (2.62)	-3.26 to 7.01

All models adjusted for ownership, size, teaching status, average Medicare percentage (2014-2017), average Medicaid percentage (2014-2017), average HHI (2014-2017), average CMI (2014-2017), operating margin (2014-2017), average percentage of population older than 65 years (2010-2015), and average population younger than 65 years without health insurance (2010-2015).

and patient experience of care scores is consistent with previous studies.^{4,9} Clinical processes and favorable outcomes are associated with the quality of the nursing work environment.⁸ Magnet-designated hospitals have significantly better work environments for direct health-care providers when compared with non-Magnet-designated hospitals.^{4,24} This is believed to be influenced by lower nurse-patient staffing ratios, open communication, nurse empowerment, adequate resources, and transformational leadership, which can be attributed to completion of clinical tasks, collaboration between team members, and other aspects of professional practice.²⁴ Similarly, previous studies indicated patient experiences were associated with nursing working conditions, staffing ratios, educational level, and lower turnover rates of the nursing staff.^{4,9}

Our finding that Magnet-designated hospitals were comparable with non-Magnet-designated hospitals in safety provides new information. Safety includes infections, surgical site complications, and other safety indicators.^{9,10} It is logical to conclude that Magnet-designated hospitals would have lower infection rates and surgical complications given the Magnet-designated work environment and leadership model. However, studies have demonstrated that healthcare-associated infections are slightly higher in Magnet-designated hospitals for certain multidrug-resistant organisms.²⁵ Previous inquiry has indicated fewer surgical complications are associated with Magnet-designated hospitals and hospitals with above-average nurse-patient staffing ratios.⁹ Greater training and associated attention to detail within Magnet-designated hospitals may either more accurately or consistently report certain safety indicators. This may ultimately result in similarities between the Magnet-designated and non-Magnet-designated hospitals. It is worth noting that the HVBP program relies upon administrative data that may not adequately capture clinical quality. Previous inquiry has identified disparity regarding medical records and the subsequent administrative medical coding process.²⁶ These

differences are important as changes in the medical coding process can influence outcomes that rely on administrative data.

Next, our study indicated Magnet-designated hospitals scored lower in efficiency than non-Magnet-designated hospitals. According to Karim et al,²⁷ quality does not affect reimbursement, and it may be a negative influencer due to the costs associated with improving quality across hospital units. In addition, Magnet designation was created not to improve hospital reimbursement but to indicate the strength and quality of nursing at an organization.⁵ Magnet designation is not without cost, and resources must be considered in evaluating this course.

Finally, our study is the first to include the length of time a hospital has maintained Magnet designation. Our analysis revealed no statistical association between the tenure of Magnet designation and improvements in HVBP domains. We believe this could be attributed to the Magnet-designated model that supports nursing, improves the work environment, and shifts the focus toward outcomes.⁶ The components of the Magnet-designated model align with work systems and human resource practices used in high-performance organizations to improve work environments through employee engagement and commitment.²⁸ Previous research indicated human resource practices that include innovative and supportive leaders, employee participation and decision making, information sharing, employee development, facilitation of communication, recruitment of qualified employees, and a focus on quality improvement have a positive influence on organizational performance and sustainability.²⁸ In addition, the consistently changing nature of the HVBP arrangement may create environments in which consistent improvement on quality measures is difficult to achieve. Magnet-designated hospitals may indeed realize additional quality and efficiency gains over time should these measures of quality be more consistently focused and measured.

Conclusions

This study is not without limitations. First, this is a retrospective review focused on determining associations between hospital characteristics and performance on the HVBP program. As such, there is an inability to determine causality. Second, it is likely there are variables that influence organizational performance that are not captured in this study. For instance, measures associated with healthy work environment, and organization's use of high-reliability structures, or staff perceptions of patient safety could influence outcomes. However, despite these limitations, the data used for this study were collected in a rigorous and standardized fashion, and the methods, analysis, and processes by which the data were collected, analyzed, and displayed are appropriate given the limitations associated with prospectively collecting this type of information.

Our study updated and extended the most recent study examining the relationship between hospitals' Magnet designation and performance on the VBP program. This study used the most recent information available for HVBP and quality measures used to assess and determine reimbursement. It extended the literature

through the inclusion of length of time a hospital attained Magnet designation to explore whether MRP hospitals can withstand the changing political climate. The study results were consistent with previous findings and highlight the importance of hospitals achieving Magnet designation rather than how long they have obtained Magnet redesignation. This information is important because it demonstrates that the structures and processes defined by Magnet designation are associated with improved outcomes as measured by the HVBP program. It also provides indication that a strong professional practice of nursing can promote improved patient care as measured by this federal policy. However, because there was no association with additional time as a Magnet-designated hospital and scores in the HVBP program, there is some additional inquiry and consideration needed. Future study needs to examine the underlining reason for hospitals pursuing Magnet designation and the hospital safety culture. In addition, economic analysis and return on investment assessments should be pursued to better articulate associations between Magnet designation and improvement in quality indicators.

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**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: December 7, 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 at the Los Gatos campus which included interactions with a physician and a radiology staff member. Complaint received through iSafe reporting system.
2. **Authority:** To provide insight into one patient’s experience at Los Gatos imaging and physician.
3. **Background:** While the patient found most the staff to be friendly and courteous, there was a lack of compassion expressed by the surgeon and the radiology technician.
4. **Assessment:** The patient’s experience was mixed due to the unfortunate communication from the technician and the physician related to her condition and the GI bowel series liquid requirements.
5. **Other Reviews:** None
6. **Outcomes:** We have communicated with the staff involved and provided service recovery from the manager of the med/surg department. The staff were provided corrective actions on “We Care” behavioral standards—particularly “Compassionate Communication”

List of Attachments: Patient Letter

Suggested Committee Discussion Questions:

1. How are you incorporating WeCare Standards into staff training and expectations?
2. What are the service recovery standards at ECH?

Staff and Physician Issues

Date of Event/Issue Is within Calendar 2020

(Date of Event/Issue Is within Calendar 2020) and (((File State Is equal to "New") or (File State Is equal to "In-Progress") or (File State Is equal to "Closed"))) and (((Focus Person Classification Is equal to "Employee") OR (Focus Person Classification Is equal to "Physician")))) and ((What Is this Issue about? Is equal to "Person")))) and (((Scope Is equal to "All")))

Grand Total (Focus Person Involved): 58

Focus Person Classification: Physician	Issue Date: 10-13-2020	Classification: Complaint	Issue Category Contents: Courtesy and Professionalism>Courtesy and respect;Courtesy and Professionalism>Helpfulness;Courtesy and Professionalism>Kindness/care exhibited by staff; Communication>Communication style/bedside manner;Communication>Explanation of plan of care;	Issue Status: Resolved
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Description

Nurse informed Patient Experience that Patient wants to talk while in-house at LG- Med/Surg

- pt wanted to share her experience
- she was happy with her attending doctor and nurses that are caring for her at Med/Surg. Everyone was very kind...except for two people.

- she went to the hospital Monday due to extreme nausea and violently vomiting during the weekend.
- Been feeling ill after her hip replacement on 10/7/2020.
- She was informed that she might be sick due to her gallbladder. Dr. order an ultrasound.
- The morning of 10/13/2020, she met with the surgeon who said "I don't think it's your gallbladder" and heard him say "wall thickening". He believes that she was constipated.
- Pt couldn't believe it since she had bowel movement during the weekend, surgeon decided to do a CT scan instead reluctantly.
- Before pt was sent to prepare for the CT scan, she heard the surgeon on the phone sounding very angry, very abrupt "she is constipated!" CT Scan show blockage, needed to do a GI bowel series.
- Not happy how the surgeon was in a cranky mood with her, almost rude with her.

Also upset with how a women technician came in while pt was attempting to drink the liquids before the XR GI bowel series.

- Was told in a stern voice "Now listen, you need to drink that to take your exam. If you don't drink it, we will not be able to do the exam. Can you drink it or not?" Pt immediately started to cry. It was not her fault that she couldn't drink it, pt was nausea.
- She was having trouble drinking it, but a nurse near by assisted her to drink the liquid little by little.

- She felt vulnerable, scared. She was having an emotional week and she wished that the surgeon and technician showed more compassion to the patient. It is already stressful with COVID and her situation. She became emotional.
- Her resolution that she ask is that someone in the unit knows about this and hope that the Bed-side manner will improve for future patients from both the surgeon and the technician.

**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director Quality
Mark Adams CMO
Date: December 7, 2020
Subject: YTD FY2021, 30 day All Cause, Unplanned Readmission Dashboard

Purpose:

To provide data on Readmissions based on the organization readmission dashboard. This includes the all payor/all cause readmissions through Q1 FY21 (July – September 2021). This dashboard is based on the CMS designated readmission categories that affect the readmission penalty program.

Summary:

1. **Situation:** Readmission index reduction is an enterprise performance goal. All Prospective Payment System (PPS) hospitals are subject to a penalty of up to 3% of DRG payments for Readmission rates that are above CMS calculated expected rates for 7 diagnoses and procedures. The most recent penalty for El Camino affecting FFY21 reimbursement is 0.3%. Readmission Teams are focusing on readmissions in each category. A penalty is assigned to the hospital if any of the 7 categories are above the Expected rate.
2. **Authority:** Quality Committee of the Board is responsible for oversight of quality & safety.
3. **Background:** Readmission rates are provided on the dashboard for the 7 diagnosis groups for FY2017, FY 2018, FY2019, FY2020 and Q1 FY2021.
4. **Assessment:** This report provides the detail behind the Readmission Index Organizational goal and shows improvement in the overall 7 diagnoses to 0.67 in Q1 FY21 from 1.0 in FY20. The O/E ratio is greater than 1.0 for Diagnosis/procedure for only 1 procedure: CABG to 1.80. The other 6 diagnosis are below 1, with the lowest value for COPD patients at 0.37 which is quite remarkable.
5. **Outcomes:** We will continue to track overall readmission index which currently is 0.87, below target of 0.93.

List of Attachments:

1. Q1 FY2021 30 day All Cause, Unplanned Readmission Dashboard
2. Historical summary of FFY readmission penalties

Suggested Committee Discussion Questions:

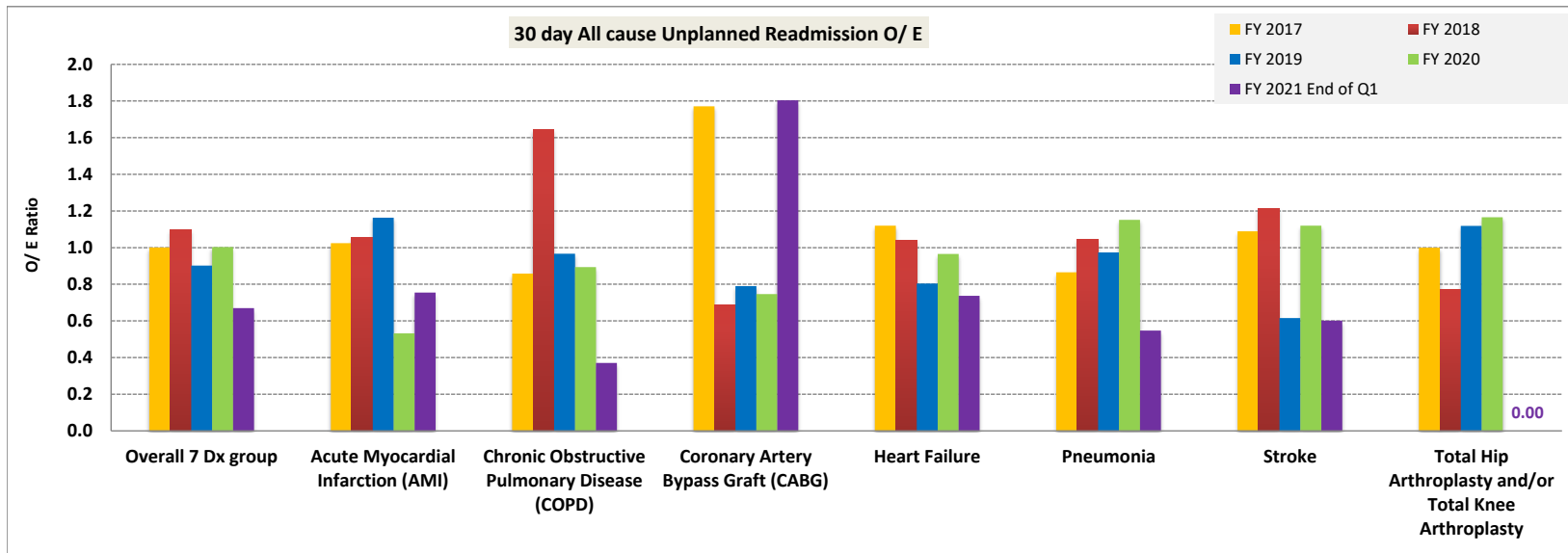
1. Are there particular areas of interest or suggestions for addressing the various diagnoses in the cohort impacting the readmission penalty program?

FY 2021 Q1 30 Day All-Cause Readmission Dashboard - ACA Dx.

Premier Risk Adjusted, All Payer, All Cause, Unplanned Readmits
Patient Type: Inpatient and Psych

	FY 2017			FY 2018			FY 2019			FY 2020			FY 2021 End of Q1		
	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio
Overall 7 Dx group	9.08%	9.08%	1.00	10.02%	9.11%	1.10	8.95%	9.92%	0.90	10.64%	10.60%	1.00	7.85%	11.72%	0.67
Acute Myocardial Infarction (AMI)	7.69%	7.51%	1.02	7.72%	7.30%	1.06	8.75%	7.53%	1.16	3.92%	7.36%	0.53	6.67%	8.84%	0.75
Chronic Obstructive Pulmonary Disease (COPD)	14.14%	16.48%	0.86	26.97%	16.41%	1.64	14.88%	15.40%	0.97	14.97%	16.75%	0.89	7.14%	19.24%	0.37
Coronary Artery Bypass Graft (CABG)	11.24%	6.34%	1.77	4.63%	6.76%	0.69	5.38%	6.81%	0.79	5.33%	7.15%	0.75	13.64%	7.56%	1.80
Heart Failure	17.79%	15.89%	1.12	16.17%	15.52%	1.04	13.39%	16.67%	0.80	16.44%	17.03%	0.97	13.51%	18.35%	0.74
Pneumonia	10.31%	11.92%	0.87	12.82%	12.30%	1.04	12.50%	12.84%	0.97	14.41%	12.51%	1.15	5.88%	10.74%	0.55
Stroke	7.17%	6.58%	1.09	8.20%	6.77%	1.21	4.56%	7.41%	0.62	8.15%	7.29%	1.12	4.69%	7.80%	0.60
Total Hip Arthroplasty and/or Total Knee Arthroplasty	2.06%	2.08%	1.00	1.63%	1.99%	0.77	2.54%	2.27%	1.12	2.83%	2.42%	1.17	0.00%	2.46%	0.00

* Source: Premier Quality Advisor-Standard CareScience Risk Calculation, All-Cause Hospital-Wide 30-Day Readmission Methodology with Planned Readmission Algorithm v4.0

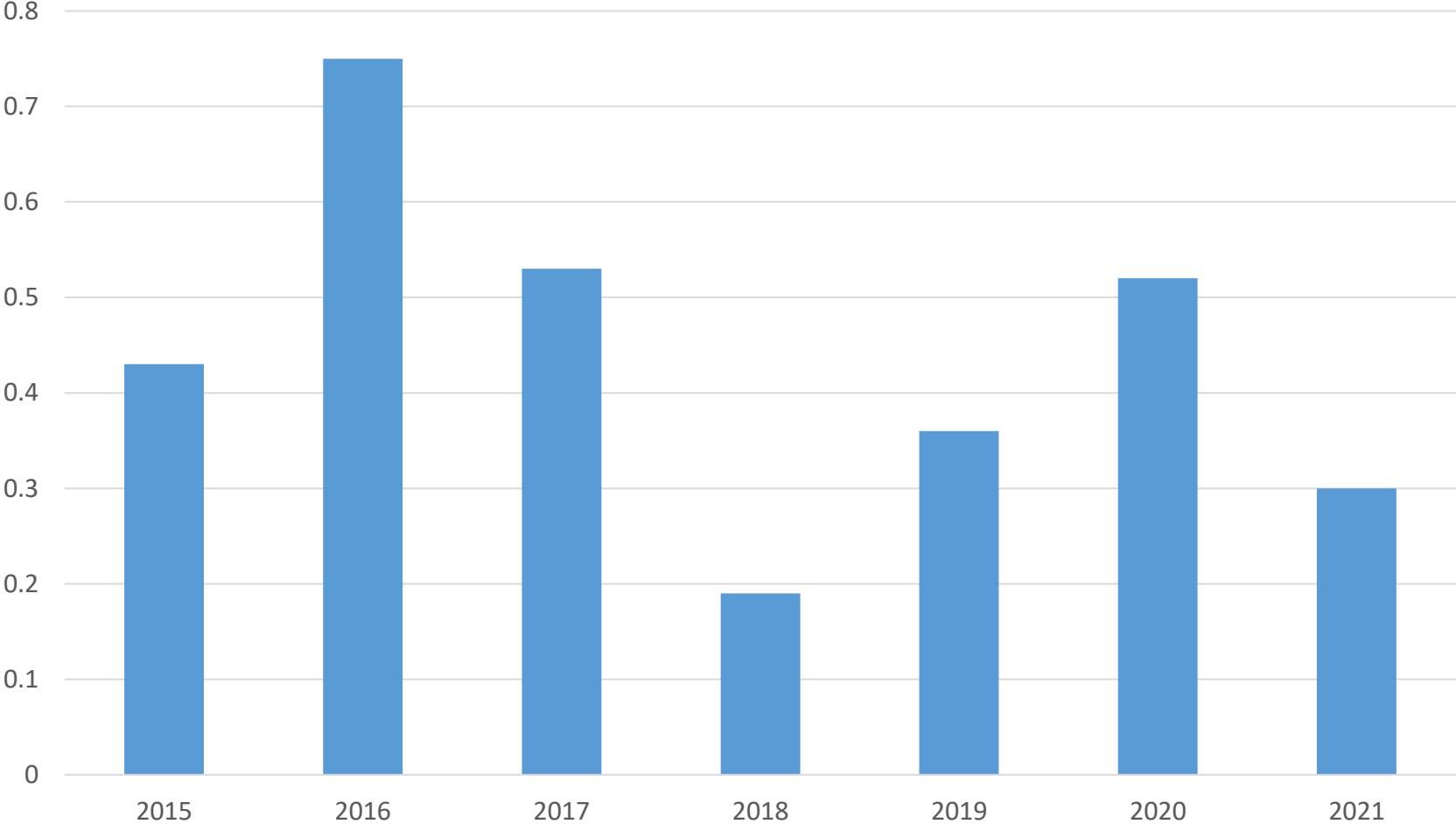


Report updated: 11/20/20

Data Source: Premier Quality Advisor

Readmission Penalty Program

Percentage reduction of PPS DRG payment



■ Readmission Penalty Program

CONFIDENTIAL
EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director Quality
Mark Adams CMO
Date: December 7, 2020
Subject: Patient Safety Indicator (PSI) Scores FY20 compared to Q1 FY21

Purpose:

To provide an update on the AHRQ Patient Safety Indicators for Q1 FY21.

Summary:

1. **Situation:** The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events for all patients following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.
2. **Authority:** Quality Committee of the Board is responsible for oversight of quality & safety.
3. **Background:** The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in-hospital complications using administrative data found in the typical discharge record. This includes indicators for complications occurring in hospital that may represent patient safety events. These indicators also have area level analogs designed to detect patient safety events on a regional level.
4. **Assessment:** Each of the PSI's are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. In this report PSI rates that are better than the Premier Mean are highlighted in green.
 - A. PSI-03 Pressure Ulcer – 1 in first quarter, each has a root cause analysis
 - B. PSI-04 Death in Surgical Pts – while above the Premier Mean, this rate is 4x less than FY20
 - C. PSI-96 Iatrogenic Pneumothorax – 2 occurrences
 - D. PSI-18 and PSI-19 OB Vaginal trauma with & without instrument – both being addressed by Maternal Child Health Medical Leadership with case review and education on documentation of injury and interventions to mitigate these injuries.
5. **Outcomes:** N/A

List of Attachments: Patient Safety Indicator (PSI) Scores FY20 compared to Q1 FY21.

Suggested Committee Discussion Questions:

1. How is this information used to improve quality of care?
2. Are there particular indicators that are of interest to the committee for further analysis?

Patient Safety Indicator Report (AHRQ) all patients FY20 compared to Qtr 1 FY21

Rate Measures

Patient Safety Indicator		Numerator (FY21 Q1)	Denominator (FY21 Q1)	Rate/1000 (FY21 Q1)	Premier Mean* (FY21 Q1)	Numerator (FY20, Q1-4)	Denominator (FY20, Q1-4)	Rate/1000 (FY20, Q1-4)	Premier Mean* (FY20, Q1-4)
PSI-02	Death in Low Mortality DRGs	0	161	0.00	0.54	0	674	0.00	0.54
PSI-03	Pressure Ulcer	1	1,703	0.59	0.46	5	6,924	0.72	0.46
PSI-04	Death in Surgical Pts w Treatable Complications	1	25	40.00	120.99	17	104	163.46	120.99
PSI-06	Iatrogenic Pneumothorax	2	2,691	0.74	0.14	2	11,594	0.17	0.14
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	2,416	0.00	0.10	0	10,136	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	0	2,263	0.00	0.10	2	9,781	0.20	0.10
PSI-09	Perioperative Hemorrhage or Hematoma	1	939	1.06	1.84	3	3,911	0.77	1.84
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	0	538	0.00	0.75	1	2,317	0.43	0.75
PSI-11	Postop Respiratory Failure	0	418	0.00	4.18	2	1,894	1.06	4.18
PSI-12	Perioperative PE or DVT	0	999	0.00	2.61	7	4,091	1.71	2.61
PSI-13	Postop Sepsis	0	538	0.00	3.46	4	2,289	1.75	3.46
PSI-14	Postop Wound Dehiscence	0	334	0.00	0.65	0	1,252	0.00	0.65
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	0	816	0.00	0.82	6	3,177	1.89	0.82
PSI-17	Birth Trauma Injury to Neonate	4	1,131	3.54	4.02	17	4,332	3.92	4.02
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	61	229.51	107.66	45	237	189.87	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	19	725	26.21	15.45	83	2,822	29.41	15.45

Count

Patient Safety Indicator		Cases (FY21 Q1)	Premier Mean Cases*	Cases (FY220, Q1-4)	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fragment	0	0.16	0	0.16

Green = better than Premier compartive mean

**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: December 7, 2020
Subject: Progress on Quality and Safety Plan

Purpose: The QC and Board previously approved a Quality/Performance Improvement and Patient Safety Plan (QAPI). This report will serve as an update on progress under that plan and provide the QC members an opportunity to provide feedback.

Summary:

1. **Situation:** Following a consulting engagement with Progressive Healthcare, a long term quality and safety plan was formulated and presented to the Board and Board QC in November of 2019. This was followed by a specific Quality/Performance Improvement and Patient Safety Plan (QAPI) which was presented to and approved by the QC in April of 2020. The QC has requested a periodic update on the progress of the plan.
2. **Authority:** This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients. Creation and adoption of a QAPI is a regulatory requirement for CMS Conditions of Participation and for accreditation by The Joint Commission.
3. **Background:** At the September QC meeting, we reviewed the background assessment used to create the current QAPI and the development of our common vision: “To consistently deliver the highest quality care with zero preventable harm.” We have identified five key areas of focus for our QAPI work representing strategic opportunities:
 - A. Governance, Leadership, and Management
 - B. Quality Organization Integration
 - C. Performance Improvement Metrics and Methods
 - D. Journey to High Reliability
 - E. Culture of Safety
4. **Assessment:** The measure of success of this QAPI plan lies in the quality and safety metrics that quantify the actual outcomes of the work. Selected high level metrics are reviewed regularly by the QC in the form of the enterprise quality and safety dashboard, the Board STEEEP quarterly dashboard, and several other focused dashboards such as the readmissions and PSI dashboards being reviewed at this meeting. The following are some select activities to illustrate some of the QAPI work underway:
 - A. **ICOUGH:** We recognized based on data review that hospital acquired pneumonia was a contributing factor in hospital mortality. This prompted this initiative to reduce this risk

factor. The components include a multi-pronged approach to reduce the underlying risk factors:

- i. I: Incentive spirometry to reduce atelectasis which predisposes to pneumonia
- ii. C: Cough—encourage patient coughing
- iii. O: Oral care—reduce oral bacteria which affects aspiration pneumonia
- iv. U: Understanding—educate patients
- v. G: Get up! Ambulate patients to reduce atelectasis
- vi. H: Head of bed—keeping the head of bed up 30 degrees reduces aspiration

ICOUGH teams are implementing this program which will be tracked by the Hospital Acquired Pneumonia (HAP) incidence.

- B.** ERAS: Early Recovery After Surgery is a program that addresses the potential risk factors contributing to Surgical Site Infections (SSI). The challenge in reducing SSI's is that there is no one common cause that can be identified. ERAS is a multi-faceted approach designed to address as many potential factors as possible. This includes pre-operative, peri-operative, and post-operative interventions. The measures vary in sophistication from metabolic regulation of temperature and serum glucose intraoperatively to chewing gum after surgery. Some of the measures are counter-intuitive or at least contrary to many years of traditional medical practice so there is a significant re-education of our clinicians required to be successful.
 - C.** Our High Reliability Organization (HRO) work continues by addressing those areas identified where human error reduction is necessary. We have linked the patient experience work branded as WeCare with a new brand to represent the HRO work signified by Safety First Mission Zero.
 - D.** Culture of Safety is the glue that holds all of the quality and safety work together. This is measured by safety culture surveys which will continue regularly and include physicians. The demands of COVID-19 has heightened awareness of safety which hopefully can be harnessed to enhance this work.
5. Outcomes: The Quality Committee will better understand the nature of the Quality/Performance Improvement and Patient Safety Plan (QAPI) and the multi-tiered approach being utilized to actualize it.

List of Attachments:

1. Explanation/description of the ICOUGH and ERAS programs
2. New HRO branding

Suggested Committee Discussion Questions:

How can we better link the QAPI work with the outcome metrics?

Are there areas missing that may need to be addressed?

So much of HRO depends on transforming habits—do any of the committee members have experience or suggestions in this regard?

Summary of ERAS and ICOUGH programs

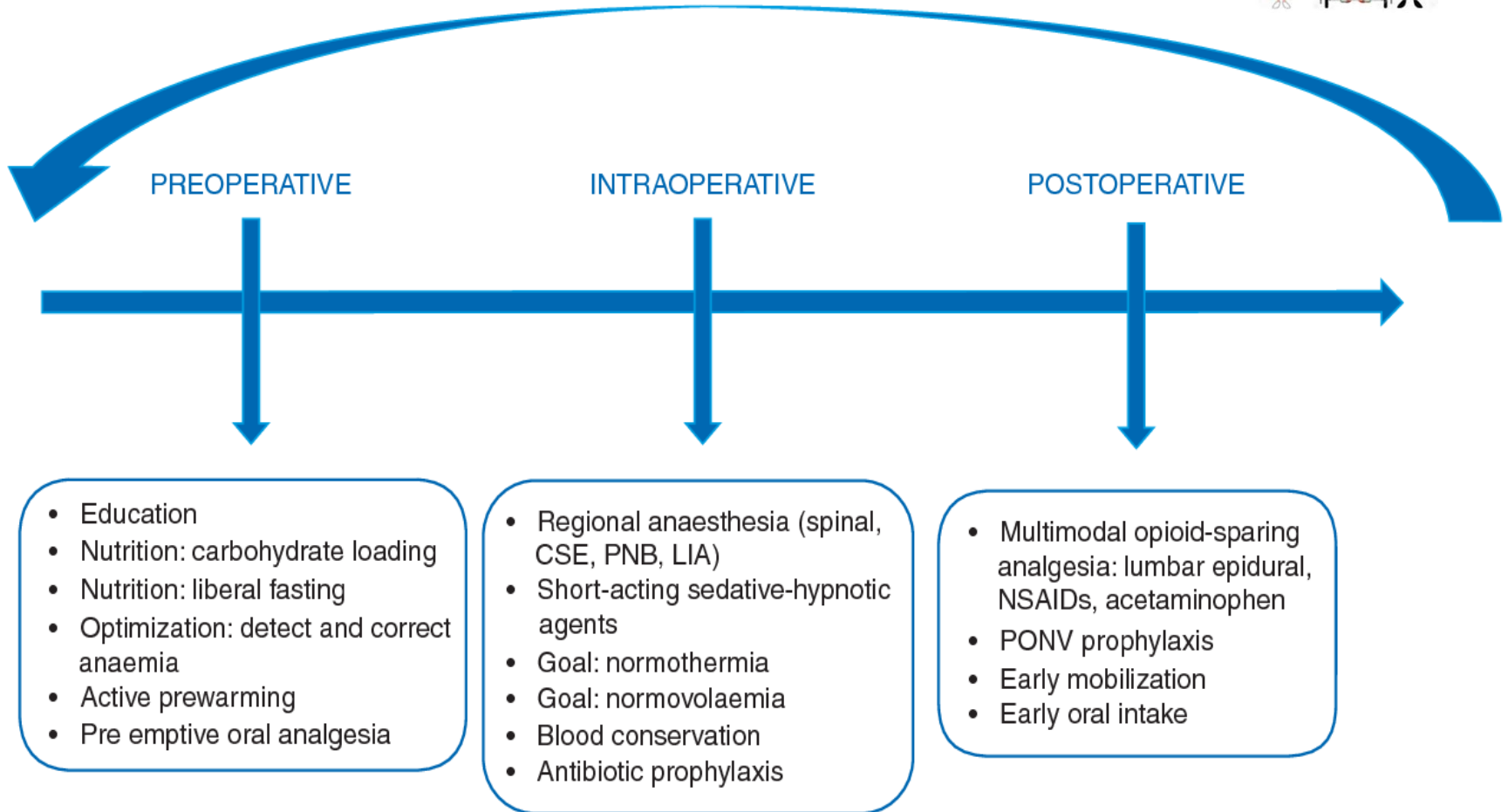
- Board Quality Committee
- December 7, 2020

Enhanced Recovery After Surgery



- Ann Aquino RN Co-Chair ERAS team
- Dr Lowe Co-Chair ERAS team
- Dr Xanthopoulos Co-Chair ERAS team
- Catherine Carson Executive Sponsor

What is ERAS?



Enhanced Recovery After Surgery (ERAS) Program

GOALS

Goal 1: Reduce postoperative complications

Goal 2: Accelerates patients recovery and supports early discharges

Goal 3: Reduction in length of stays (LOS)

Goal 4: Reduction in readmissions offsetting increased cost of care



Key Elements

Include patient/family education

Patient optimization prior to admission

Minimal fasting that optimally includes a carbohydrate beverage and at a minimum clear fluids up until 2 hours before anesthesia

Multimodal Analgesia(MMA) with appropriate use of opioids when indicated

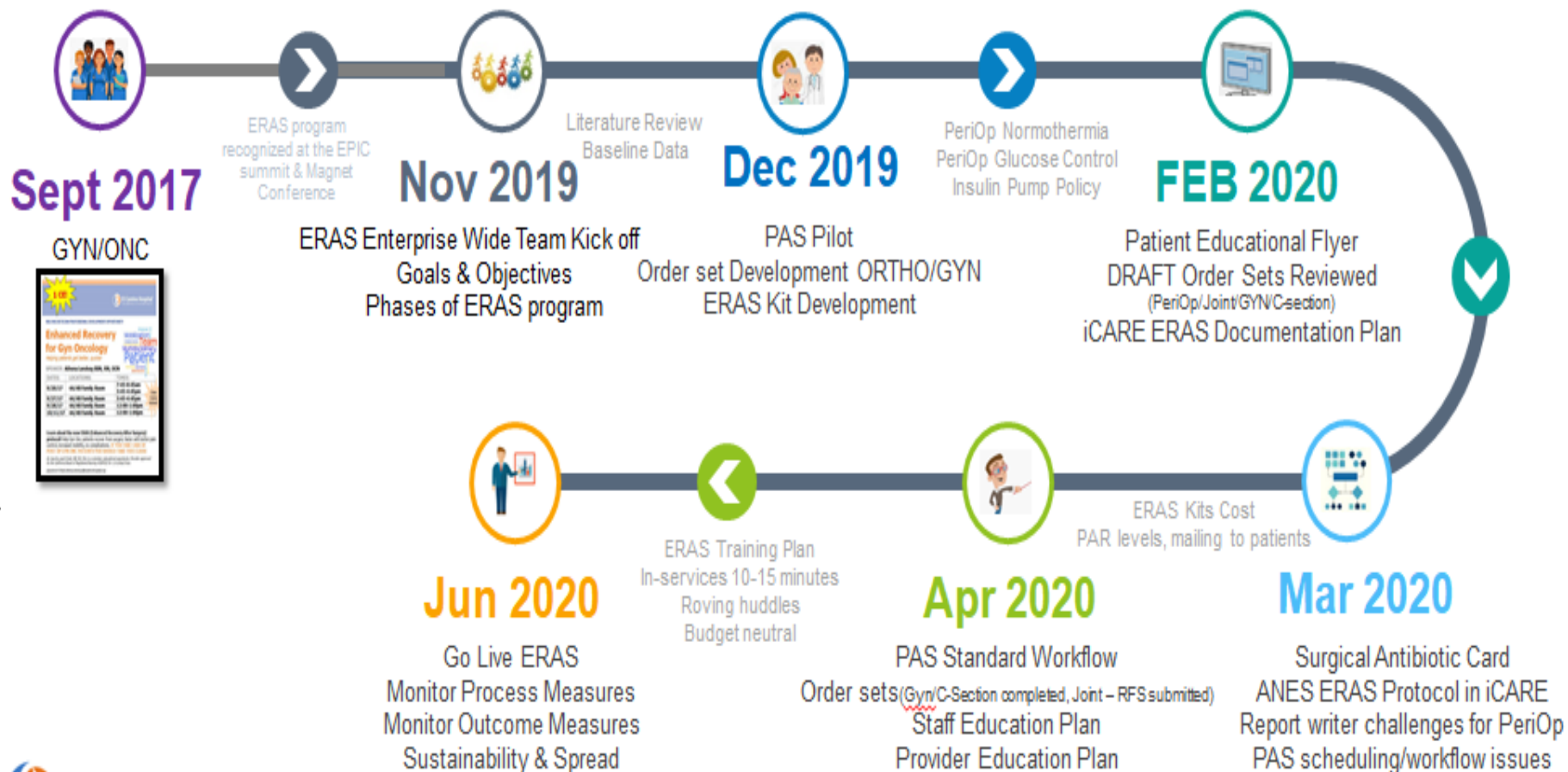
Return to normal diet and activities the day of surgery

ERAS Enterprise Wide

Executive Sponsor Catherine Carson

Project Co-chairs Ann Aquino RN Director for Medical-Surgical and Oncology Services

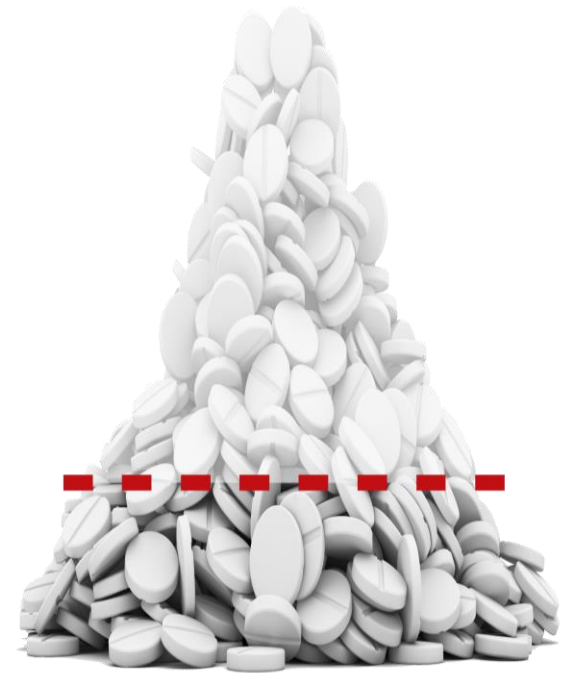
ANES Co-chairs Dr Lowe and Dr Xanthopoulos



ERAS success at El Camino

GYN Oncology ERAS Outcomes

- **58% decrease in opioid use**
- **62% decrease in anti-emetic use**
- **13% reduction in length of stay**



*Annual equivalent of 3,500
Oxycodone pills eliminated*

MD Champion Dr Dwight Chen

HAP – Hospital-acquired Pneumonia

The most prevalent and deadly Hospital-acquired Infection



Deidre Shin RT Respiratory Care Services Manager HAP
Team Leader

HAP – Hospital-acquired Pneumonia

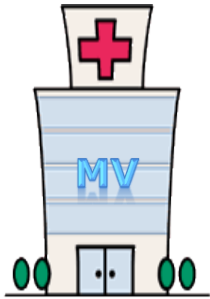
The most prevalent and deadly Hospital-acquired Infection

- HAP is the number one hospital acquired infection with NV-HAP representing 60% of cases
- LOS increase 13.1 days/per case*
- Mortality 15-30%
- 8.5 X more likely to die than equally ill patients who do not acquire PNA
- Average cost \$39,897

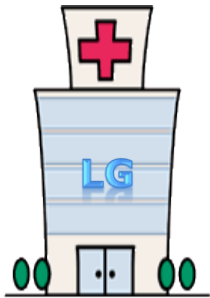


*Giuliano K, Baker D, Quinn B. The Epidemiology of Nonventilator Hospital-acquired Pneumonia in the United States. *American Journal of Infection Control*. 2017. doi:doi.org/10.1016/j.ajic.2017.09.005

HAP at El Camino Healthcare Jan-Dec 2019



= 147



= 25



37 DEATHS

Keys to Prevention of nvHAP

ORAL CARE

- Brush teeth 4X day while in the hospital, at meal time and bedtime
- Use antiseptic mouth rinse 2x/ day



MOBILITY

- Out of bed for meals
- Ambulate
- Head of bed up at 30 degrees or more

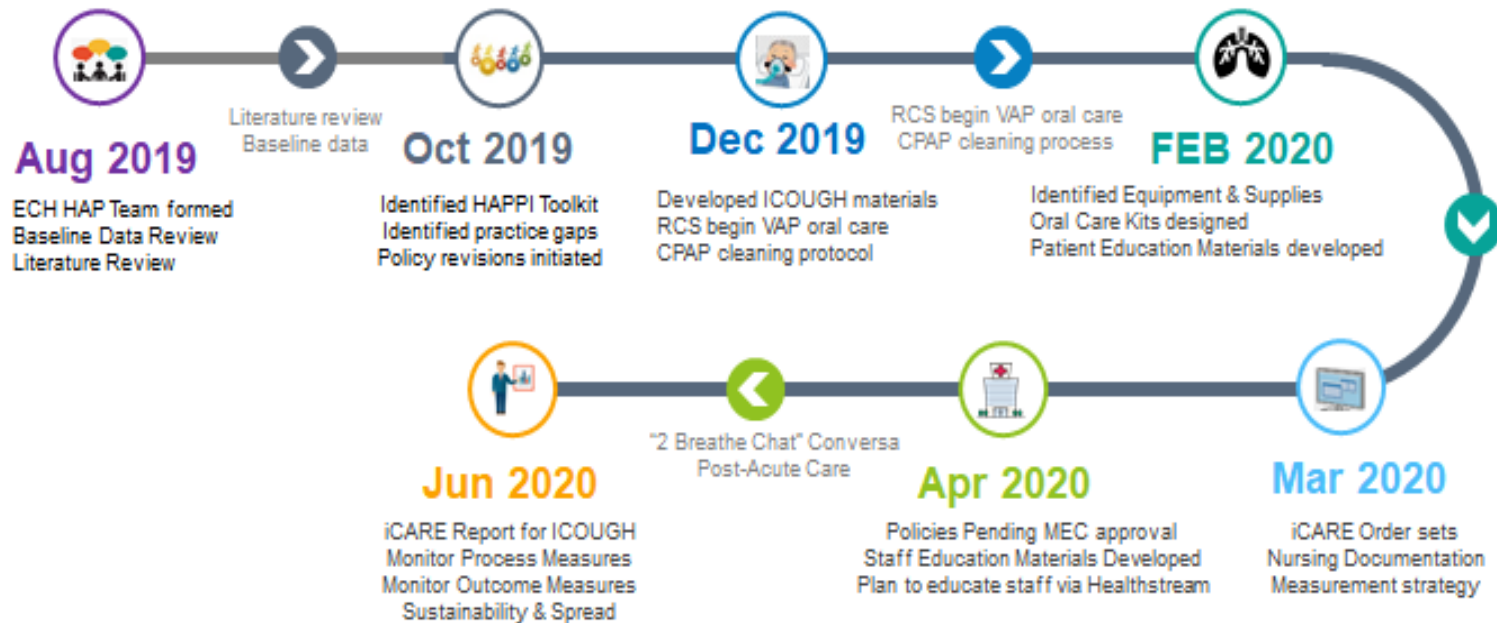


Go Live June 9, 2020

Hospital Acquired Pneumonia (HAP) Reduction Plan ICOUGH

Executive Sponsor Catherine Carson

Project Lead Deidre Shin RT





Board Quality Committee

Mark Adams, CMO

December 7, 2020

HRO Branding



safety
firstmission
zero