El Camino Health

AGENDA

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

Monday, June 1, 2020 – 5:30pm

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

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 Dated March 18, 2020, El CAMINO HEALTH WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT 1-866-365-4406 MEETING CODE 9407053#.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (05/04/2020) ***Information*** b. FY20 Quality Dashboard c. FY20 Pacing Plan d. Progress Against FY20 Committee Goals e. Hospital Update	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:34**
4.	**QUALITY COMMITTEE FOLLOW-UP TRACKING** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**information 5:34 – 5:36**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Julie Kliger, Quality Committee Chair		**information 5:36 – 5:41**
6.	**PATIENT STORY** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**discussion 5:41 – 5:46**
7.	**APPROVE FY21 QUALITY SAFETY EXPERIENCE INCENTIVE GOALS** **ATTACHMENT 7**	Mark Adams, MD, CMO	*public comment*	**motion required 5:46 – 6:01**
8.	**READMISSION DASHBOARD** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:01 – 6:11**
9.	**PSI REPORT** **ATTACHMENT 9**	Mark Adams, MD, CMO		**discussion 6:11 – 6:21**
10.	**MEDICAL STAFF CREDENTIALING PROCESS** **ATTACHMENT 10**	Mark Adams, MD, CMO		**discussion 6:21 – 6:36**
11.	**ECHMN QUALITY IMPROVEMENT**	Shabnam Husain, MD		**discussion**

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
	PROGRAM UPDATE **ATTACHMENT 11**			**6:36 – 7:01**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information** **7:01 – 7:04**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required** **7:04 – 7:05**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information** **7:05 – 7:06**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required** **7:06 – 7:07**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (05/04/2020) ***Information*** b. Medical Staff Quality Council Minutes (including API Reports)			
16.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required** **7:07 – 7:12**
17.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**discussion** **7:12 – 7:22**
18.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required** **7:22 – 7:23**
19.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information** **7:23 – 7:24**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
20.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion** **7:24 – 7:29**
21.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required** **7:29 – 7:30**

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, May 4, 2020
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

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

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. A verbal roll call was taken. Caroline Currie was absent. Imtiaz Qureshi, MD was not present during roll call, but participated part of the meeting. Linda Teagle attended the meeting in person and all other members were present and participated telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (04/06/2020); For information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 Committee Goals, and Hospital Update **Movant:** Ting **Second:** Po **Ayes:** Falwell, Fung, Kliger, Po, Qureshi, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Burn, Currie **Recused:** None	***Consent Calendar approved***
4. QUALITY COMMITTEE FOLLOW-UP TRACKING	Chair Kliger asked if any members of the Committee had any questions about the Quality Committee Follow-Up Tracking. None were reported.	
5. REPORT ON BOARD ACTIONS	Chair Kliger asked if any Committee members had any questions about the Report on Board Actions. No questions were reported.	

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6. PATIENT STORY	Cheryl Reinking, RN, CNO, presented a patient letter received by the hospital complimenting the staff regarding the care of an emergency department patient who arrived at the hospital with abdominal pain. While most of her experience was positive, she reported an encounter with a phlebotomist who she felt did not treat her with kindness. Ms. Reinking confirmed that the hospital provided the employee with feedback and service training. In response to a committee member's questions, Ms. Reinking explained that it was an early morning experience and this is an anomaly and not a trend.	
7. BOARD QUALITY AND SAFETY DASHBOARD	Mark Adams, MD, CMO, stated the Board Quality and Safety Dashboard is to be able to provide the board for quick reference on the quality and safety progress of the organization. The dashboard is very resource intensive and will be provided on a quarterly basis to the board as part of the quality report. Chair Kliger stated that she would like to see an explanation of what the impact was, the money we're losing, and all of the "what" questions. She would also want the plan of corrections to the "what" questions. Ms. Simon recommends that the 'Equitable' on the dashboard should come from Length of Stay, Outpatient measurements, etc. In response to a Committee member's questions, Dr. Adams explained that ethnicity is reported in Epic and is our own real data. He also explained that the state of California does have a breakdown of all ethnicities, and there has not been a much difference on impact from COVID-19 on specific ethnicities. **Motion:** To approve the Board Quality and Safety Dashboard **Movant:** Teagle **Second:** Sharma **Ayes:** Burn, Falwell, Fung, Kliger, Po, Qureshi, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie **Recused:** None	***Board Quality Dashboard Report approved***
8. CDI DASHBOARD	Dr. Adams presented the CDI Dashboard which shows how we are assessing the patients and documenting all the relevant aspects of their care. It's very important that the medical records contain all essential information. This dashboard impacts our revenue, statistics, and indices. The hospital is very excited that the query rate from physicians has been high. This could be due to the quality of questions. In response to committee members' questions, for #6 and 7, Dr. Adams explained that hospital is trying to compare them to the national benchmark percentage and use that as a guideline and not a target. This is separate from coding. This CDI Dashboard is a working dashboard that the team uses and is very physician driven.	
9. CORE MEASURES	Dr. Adams presented the Core Measures. He explained that the Core Measures cannot be changed as CMS sets them. He noted that in each case and as referenced in the packet, the blue is the observed rate and the green is the benchmark. The hospital is generally doing well including number of C-	

	sections being below the benchmark, the steroid use is excellent, and blood stream infections in babies are zero. In response to committee members' questions, Dr. Adams explained that CMS sets these benchmarks, and they are currently valid.	
10. PROPOSED FY21 PACING PLAN	Chair Kliger asked if any member of the Committee had any other comments or questions. No comments were noted. **Motion:** To approve the FY21 Pacing Plan **Movant:** Ting **Second:** Simon **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie, Qureshi **Recused:** None	***FY21 Pacing Plan approved***
11. DISCUSS FY21 ORGANIZATIONAL GOALS	Dr. Adams stated this was brought back to discuss how the committee is going to determine the targets. As referenced in the packet, this is what management has recommended. Dr. Adams stated that the Serious Safety Event (SSE) needs to have at least six (6) months to get the baseline. SSE usually goes up before it comes down. Because it got pushed back due to COVID-19, management has projected a 5 point rating which is a 20% decrease. Readmissions will be recalculated by Premier and does change from year to year. The baseline for the fiscal year will not be received until October. The hospital wants to commit to a 10% improvement. In response to committee members' questions, Dr. Adams stated that the hospital is not pushing back on measuring the SSE. It's the high reliability work and the hospital is putting in place the measures. Those are quite resource intensive as there will need to be training to be done for all employees which costs money to do and don't have at the moment due to fiscal constraints. Dr. Adams confirmed that hospital is continuing to commit to quality goals. The Organizational Goals will be brought back to the next meeting for a vote on a recommendation to the Board. There will be no discussion needed unless something changes.	
12. PUBLIC COMMUNICATION	There was no public communication.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:58pm. **Movant:** Ting **Second:** Teagle **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** None **Absent:** Currie, Qureshi **Recused:** None	***Adjourned to closed session at 6:58pm***
14. AGENDA ITEM 20: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:33pm. Agenda items 14-19 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (04/06/2020) and Medical Staff Credentialing and Privileges Report; and for	

	information: Medical Staff Quality Council Minutes including API reports.	
15. AGENDA ITEM 21: CLOSING WRAP UP	There were no closing comments.	
16. AGENDA ITEM 22: ADJOURNMENT	**Motion:** To adjourn at 7:37pm. **Movant:** Simon **Second:** Teagle **Ayes:** Burn, Falwell, Fung, Kliger, Po, Sharma, Simon, Teagle, Ting **Noes:** None **Abstentions:** Currie & Qureshi **Absent:** None **Recused:** None	***Meeting adjourned at 7:37pm***

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

_____
Julie Kliger, MPA, BSN
Chair, Quality Committee

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: June 1, 2020
Subject: FY20 Quality Dashboard for June meeting

Recommendation(s): Review and accept the Organizational Goal and Quality Dashboard

Summary:

- Provide the Committee with a snapshot of the FY 2020 metrics monthly with trends over time and compared to the actual results from FY 2019 and the FY 2020 goals.
- Annotation is provided to explain actions taken affecting each metric.

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

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

3. Assessment:

- Mortality Index is at target for April's data, and is under target for FYTD, and remains well below 1.0
- Readmission Index increased for March data and above target for FYTD, and is still below 1.0
- Continued reduction in ED Throughput metric with April data reflecting December results
- All HCAHPS metrics are below target for FYTD
- Only 1 – HAI: 1 CAUTI from LG Acute Rehab. No HAIs across both campuses for April data.
- SSI back to zero for April and well below target since February 2019
- PC-02 Primary C/S rate increased for both campuses

4. Other Reviews: None

5. Outcomes: None

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

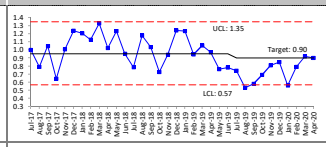
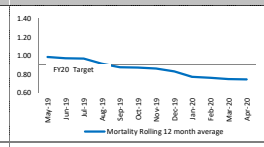
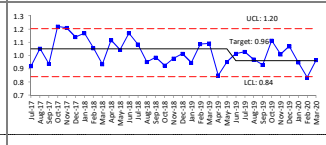
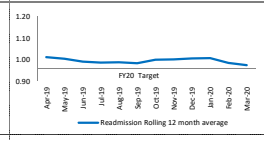
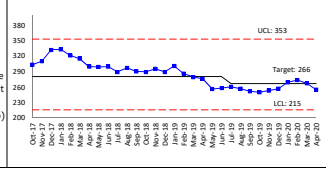
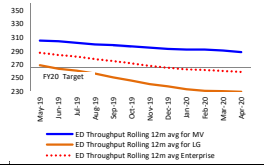
Suggested Committee Discussion Questions: None

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

April 2020 (Unless otherwise specified)

Month to Board Quality Committee: June, 2020

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend (showing at least the last 24 months of **available** data)	Rolling 12 Months Average	Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Quality		Latest month	FYTD									
1	* Organizational Goal **Mortality Index** *Observed/Expected* ***Premier Standard Risk Calculation Mode*** *Date Period: April 2020*	0.90 (1.75%/1.94%)	0.74 (1.47%/2.00%)	0.97	0.90			**Mortality Index (Observed/Expected)**	Good physician documentation continues with high expected mortality. Observed mortality less than in March and still under the expected value. For 11 months, the index has been below 1.0.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: March 2020*	0.97 (7.68%/7.94%)	0.99 (7.89%/7.99%)	0.99	0.96			**Readmission Index - All Patient All Cause Readmit (Observed/Expected)**	Pneumonia, Stroke and Post total hip/knee arthroplasty continue as the top 3 reasons for readmission. Respiratory Therapy has now 5 pneumonia patients being followed post discharge with the Conversa (chat box) in April.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
3	**Patient Throughput-Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Date Period: April 2020*	MV: 285 min LG: 224 min Enterprise: 255 min	MV: 289 min LG: 230 min Enterprise: 260 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)			**Patient Throughput-Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients and Newborns)**	In April, both the EDs experienced a significant drop in their census given shelter in place orders due to COVID-19 pandemic. In addition, both locations continued with dedicated areas for separately caring for COVID-19 PUIs within the hospital premises as well as setting up ED tents in the ECH parking lots/drive-ways. COVID testing sites also went live (for procedural patients), often using ED staff to perform the swabs. Given these changes, some of the front-end processes are taking slightly longer time than usual. However, overall the throughput goal is very close to target performance despite these unique challenges. New triage process went live at the end of April in MVED, and construction was completed. The next phases of construction (for behavioral health area) is already underway. We started chart audits for patients who were individually longer than the expected. Improvement work is planned during May/June for the units.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *LCL is set to '0' if value is less than or equal to zero.*	**iCare Report: ECH ED Arrival to Floor**

Definitions and Additional Information

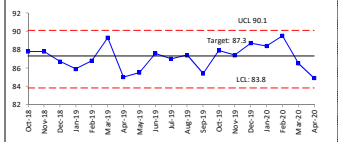
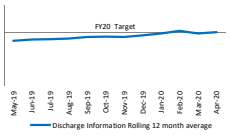
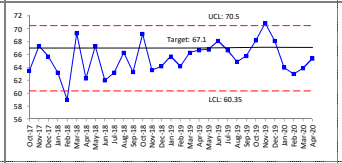
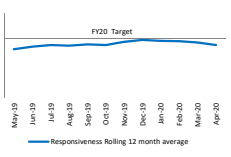
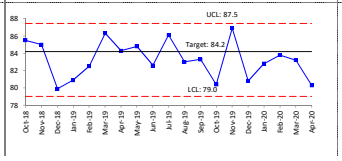
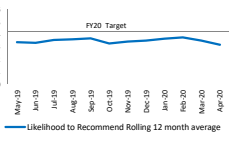
El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

April 2020 (Unless otherwise specified)

Month to Board Quality Committee: June, 2020

Definitions and Additional Information

	Service	FY20 Performance: Latest month	FY20 Performance: FYTD	Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average	Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
4	* Organizational Goal **HCAHPS Discharge Information** **Top Box Rating of Always** *Date Period: April 2020*	84.9	87.3	86.3	87.3			**HCAHPS Discharge Information Domain Top Box Rating of Always**	This metric is on target for the quarter and fiscal year to date . Strong improvements have been made in our Inpatient Units at both hospitals and in the / Mother/Baby unit in Los Gatos. This metric has seen a slight decline during the COVID-19 pandemic due to our zero visitor policy with patients receiving discharge instructions alone. We are looking to implement a process that includes technology in the discharge planning process to overcome this obstacle.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero..*	**Press Ganey Tool**
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: April 2020*	65.4	65.9	65.7	67.1			**HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples**	This metric is below target fiscal year to date as an enterprise, however Mother / Baby units in both hospitals are exceeding the goal. The Inpatients units in both hospitals are below target however, this metric has steadily improved from February to April. Hourly rounding / purposeful rounding program is being reviewed in order to improve its efficacy, however, this has been difficult during the COVID-19 pandemic due to staffing issues and many patients in isolation.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**
6	*Organizational Goal **HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: April 2020*	80.3	82.9	83.5	84.2			**HCAHPS Likelihood to Recommend Top Box**	Likelihood to Recommend is our loyalty score and the industry standard of measuring experience. Mountain View Inpatient Units are exceeding the target and is in the top decile through April. However, the COVID-19 pandemic has affected this metric due to the limited ability of our staff to round and connect personally with our patients. This is largely due to anxiety of staff and patients, patients feeling isolated due to the zero visitor policy and the uncertainty of testing despite virtual rounding. We are working on a plan to safely return to nurse and leader rounding.	Yvette Million Cheryl Reinking	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**Press Ganey Tool**

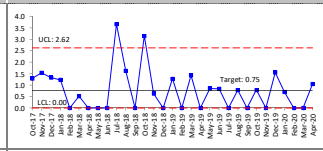
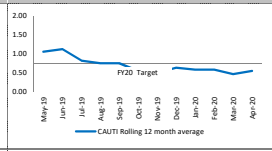
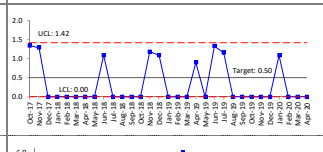
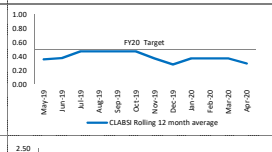
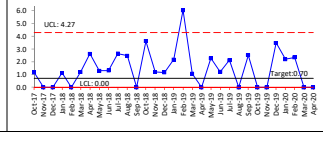
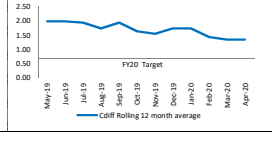
El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

April 2020 (Unless otherwise specified)

Month to Board Quality Committee: June, 2020

Definitions and Additional Information

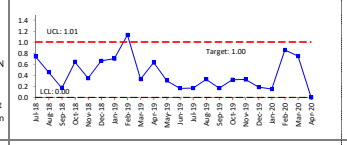
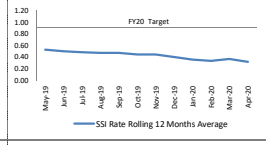
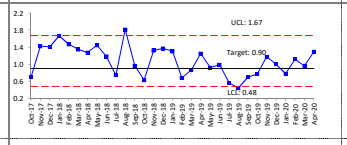
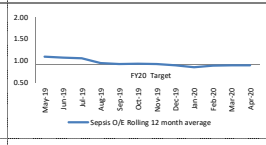
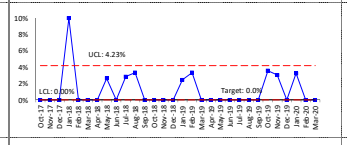
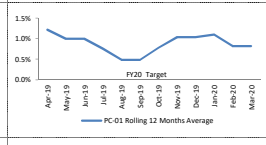
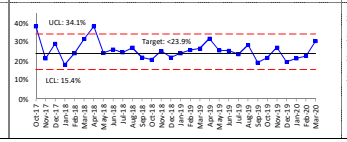
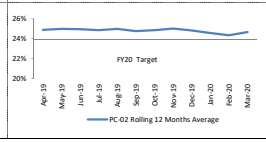
		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend		Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Quality		Latest month	FYTD									
7	***Hospital Acquired Infections*** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: April 2020*	1.05 (1/948)	0.48 (6/12412)	1.09	SIR Goal: <= 0.75			**Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)**	1 CAUTI - LG Reb: 76 y/o female admitted from Stanford for reahab after spine surgery, with Foley catheter in place for retention. New temp and positive urine culture after 4 days.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is not visible if value is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
8	***Hospital Acquired Infections*** *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: April 2020*	0.00 (0/562)	0.22 (2/9116)	0.36	SIR Goal: <= 0.50			**Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)**	Zero CLABIs in February, March and April. The CLABSI infections have been only in MV. LG has not had a CLABSI Infection since July 2017.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: April 2020*	0.00 (0/5869)	1.35 (11/81776)	1.96	SIR Goal: <= 0.70			**Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)**	Zero C.Diff infections in March and April.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

April 2020 (Unless otherwise specified)

Month to Board Quality Committee: June, 2020

		FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average	Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
		Latest month	FYTD									
10	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Date period: April 2020*	0.00 (0/563)	0.30 (17/5631)	0.22 (37/7167)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)			**Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100**	Zero SSIs in April, Two SSIs in March; Noting that elective surgery was stopped on March 18th. FY to date for 2020 ECH has 17 SSIs, while for FY19, ECH had 37. Quality Council receives a quarterly report on SSIs to sustain improvements made in FY 19. ERAS (enhanced recovery after surgery) will be rolling out enterprise-wide for all surgeries June 30th.		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated. *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is not visible if it is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
11	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Date Period: April 2020*	1.30 (15.05%/11.61%)	0.94 (10.38%/11.00%)	1.06	0.90			**Sepsis Mortality Index Observed over Expected, based on ICD 10 codes**	Sepsis Quality Committee focusing on individual measures in the bundle through manager chart review to find which pieces of the bundle that need most improvement; timing of antibiotic administration (1 hr. vs 3 hrs.), meeting MAP goal of > 65 mmHg w/I 6hrs of TOP, and have the most impact on mortality. Sepsis deaths reviewed/scored as serious safety events if GAP exits (deviation from generally accepted practice/guidelines).	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) *Date period: March 2020*	MV: 0.0% (0/40) LG: 0.0% (0/4) **ENT: 0.0%** (0/44)	MV: 1.15% (3/262) LG: 0.00% (0/38) **ENT: 1.0%** (3/300)	MV: 1.11% (4/360) LG: 0.00% (0/44) **ENT: 0.99%** (4/404)	0.0%			**PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed**	Zero occurrence of an early elective delivery prior to 39 weeks gestation.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
13	**PC-02: Cesarean Birth** (lower = better) *Date period: March 2020*	MV: 30.08% (37/123) LG: 29.17% (7/24) ENT: 29.93% (44/147)	MV: 24.52% (307/1252) LG: 16.96% (29/171) ENT: 23.61% (336/1423)	MV: 26.28% (425/1617) LG: 14.29% (30/210) **ENT: 24.90%** (455/1827)	<23.9%			**PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth**	C/S rate increased to above 30% for both LG & MV in March. Increase in LG could be related to new provider volume coming from Good Samaritan. Physician Leadership will re-focus on documentation in May, after the focus on COVID processes in Feb-April.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**

Definitions and Additional Information

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

FY2020 Q1

JULY 2019

No Board or Committee Meetings

Routine Consent Calendar Items:

- **Approval of Minutes**
- **FY 20 Quality Dashboard**
- **Progress Against FY 2020 Committee Goals**
- **FY20 Pacing Plan**
- **Med Staff Quality Council Minutes (Closed Session)**
- **Hospital Update**
- **QC Follow-up Items**

AUGUST 5, 2019

Standing Agenda Items:

1. Board Actions
2. Consent Calendar
3. Progress Against FY19 Committee Goals
4. FY20 Quality Dashboard (Discuss - should this be on consent? Only discuss if something outside normal variation? Deeper Dive Quarterly?)
5. Hospital Update
6. Serious Safety/Red Alert Event as needed

Special Agenda Items

1. FY19 Quality Dashboard Results (Includes FY19 Org. Incentive Goals)
2. LEAN Progress Report
3. Q4 FY19 Quarterly Quality and Safety Review
4. Physician Engagement
5. Committee Recruitment (If needed)
6. Who makes up census in the ED?
7. draft Board-level QC reporting
8. PSI-90 metrics

SEPTEMBER 9, 2019

Standing Agenda Items:

1. Board Actions
2. Consent Calendar
3. Progress Against FY20 Committee Goals
4. Patient Story
5. Hospital Update
6. Serious Safety/Red Alert Event as needed
7. Introduction of New Members
8. Annual Performance Improvement Reports (rotating departments)

Special Agenda items:

9. Update on Patient and Family Centered Care
10. Recommend FY20 Organizational Goal Metrics
11. Annual Patient Safety Report
12. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals)
13. Pt. Experience (HCAHPS)
14. ED Pt. Satisfaction (Press Ganey)
15. Quality and Safety Strategic Plan

FY2020 Q2

OCTOBER 7, 2019

Standing Agenda Items:

1. Board Actions
2. Consent Calendar
3. Progress Against FY20 Committee Goals
4. Patient Story
5. Hospital Update
6. Serious Safety/Red Alert Event as needed
7. Annual Performance Improvement Reports (rotating departments)

Standing Agenda Items:

8. Report on Medical Staff Peer Review Process
9. FY20 Org. Goal and Quality Dashboard Metrics
10. FY19 Organizational Goal Achievement (M, RA)

NOVEMBER 4, 2019

Standing Agenda Items:

1. Board Actions
2. Consent Calendar
3. Progress Against FY20 Committee Goals
4. Patient Story
5. Hospital Update
6. Serious Safety/Red Alert Event as needed
7. Annual Performance Improvement Reports (rotating departments)

Special Agenda Items:

8. CDI Dashboard
9. Core Measures
10. Safety Report for the Environment of Care
11. Q1 FY20 Quarterly Quality and Safety Review
12. Debrief 10/23 Session 13. Q&S Plan

DECEMBER 2, 2019

Standing Agenda Items:

1. Board Actions
2. Consent Calendar
3. Progress Against FY20 Committee Goals
4. Patient Story (Not Positive)
5. Hospital Update
6. Serious Safety/Red Alert Event as needed
7. Annual Performance Improvement Reports (rotate)

Special Agenda items:

8. Readmission Dashboard
9. PSI- Indicators
10. Peer Review Process
11. Drill Down on Q1 Q&S Review

FY2020 Q3

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

JANUARY 2020	FEBRUARY 3, 2020	MARCH 2, 2020
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Q2 FY20 Quality and Safety Review 9. Update on Patient Care Experience 10. Draft Revised Charter (C&P, Chiefs) 11. SVMD Reporting to Quality Committee 12. Follow up on PSI 4, 18, 19	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Proposed FY21 Committee Goals 9. Proposed FY21 Organizational Goals 10. Update on Patient and Family Centered Care 11. Update on LEAN Transformation 12. Goal Attainment 13. Board Quality Dashboard Report
FY2020 Q4		
APRIL 6, 2020	**MAY 4, 2020**	**JUNE 1, 2020**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments – PLUS Bring Back HIMS, Ortho. Antimicrobial from October) 8. Credentials and Privileges Report Special Agenda Items: 9. Value Based Purchasing Report 10. Pt. Experience (HCAHPS) 11. Approve FY21 Committee Goals 12. Proposed FY21 Committee Meeting Dates 13. Proposed FY21 Organizational Goals 14. QAPI	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items: 6. CDI Dashboard 7. Core Measures 8. Proposed FY21 Organizational Goals (Methodology) 9. Proposed FY21Pacing Plan 10. Q3 FY20 Quality and Safety Review 11. Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report Special Agenda Items: 6. Readmission Dashboard 7. PSI Report 8. Med Staff Credentialing Process 9. El Camino Medical Health Network Report 10. Approve FY21 Organizational Goals

El Camino Health

FY20 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY19 Achievement and Metrics for FY20 (Q1 FY20) (Complete) - FY21 Goals (Q3 – Q4) (Complete)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) (Complete) - Review Medical Staff credentialing process (FY21) On June 1, 2020 Agenda
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline – (Complete)
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – (Complete)
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Review quarterly at the end of the meeting (Use Closing Wrap-Up Time)	Attend 2/3 of all meetings in person (Achieved) Actively participate in discussions at each meeting (Achieved)
6. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals (Ongoing)

SUBMITTED BY: **Chair**: Julie Kliger, MPA, BSN
Executive Sponsor: Mark Adams, MD, CMO Approved by the ECH Board of Directors 6/12/2019

El Camino Health

Hospital Update
June 1, 2020
Mark Adams, MD, CMO

Operations

ECH is one of the first hospitals in the US participating in the TRILUMINATE clinical research study, sponsored by Abbott. The primary purpose of this study is to evaluate safety and effectiveness of the Tricuspid Valve Repair System (TVRS) for treating symptomatic moderate or greater tricuspid regurgitation (TR) in patients currently on medical management and who are deemed appropriate for percutaneous transcatheter intervention.

We began our extracorporeal membrane oxygenation (ECMO) program as a bridge to receiving a transplant, in the last 45 days. ECMO is a life support machine for patients with a severe and life-threatening illness that stops their heart or lungs from working properly. Patients needing an organ transplant or other care can be placed on ECMO here at ECH and then transferred to another facility that provides those services.

The Los Gatos Infusion Center opened on April 27th.

Our COVID-19 Incident Command Center is now closed and all duties have been distributed within our operations. We will continue to monitor COVID-19 cases in our community and reopen should the need arise.

Facilities

New move-in dates have been established for moving clinical departments into our new Mountain View campus buildings. Clinical departments will move into the Taube Pavilion on June 10th and into the Sobrato Pavilion on June 24th.

Workforce

ECH will continue to fund "kid's camps" at the Mountain View and Saratoga YMCAs for children ages 3-12 to support our essential staff members through what would have been the end of the normal school year. We also launched an assistance program (funded by $150,000 in donations to the ECH Foundation) to assist our employees who may be struggling financially due to the COVID-19 pandemic.

Since May 12, 2020 would have marked Florence Nightingale's 200th birthday, 2020 is the year of the nurse! We are very proud of Chief Nursing Officer Cheryl Reinking, RN, MSN, NEA-BC who is currently working on her Doctor of Nursing Practice (DNP) at the University of San Francisco. Cheryl's article, one aspect of her work towards her DNP, "*Nurses Transforming Systems of Care: The Bicentennial of Florence Nightingale's Legacy,*" was published in the May 2020 issue of Nursing Management.

Wednesday May 6th marked the beginning of the annual Nurse Week. Due to shelter in place orders, we were unable to celebrate with our original plans for the week; however, we were still able to recognize our staff.

The police and fire departments from jurisdictions throughout the El Camino Healthcare District arrived at the Mountain View campus at 3:30pm on May 6th with lights blazing and created a recognition "parade route" at the main entrance for all of our staff. Nurse week culminated on Tuesday, May 12th with roving cupcake carts delivered to all departments.

Corporate and Community Health Services

CONCERN EAP provided 15 webinars attended by 2,000 participants on topics including (1) Managing Anxiety and Stress and (2) Strategies for Remote Workers. Our Community Benefit staff administered a survey questionnaire to FY21 grant applicants to gather supplemental information as it relates to COVID-19 response efforts and engaged in discussions with current grant partners about new and changing community health needs related to the COVID-19 pandemic. We learned that our partners are rapidly pivoting the way they provide grant funded services to their clients and the community.

The South Asian Heart Center is providing virtual programs including TECH (Tuesday Evening Community Huddles) weekly on lifestyle topics, a nutrition workshop for the Aga Khan community (Ismaili branch of Shiite Islam) and a diabetes prevention program.

The Chinese Health Initiative ("CHI") staff coordinated with the ECH Foundation and Chinese community organizations for donations to the COVID-19 Emergency Response Fund. CHI initiated 2 weekly webinar series: (1) Healthy Lifestyle (diet, exercise, lifestyle medicine and emotional health), conducted by registered dieticians, a Lifestyle Medicine physician and a clinical psychologist and (2) a bilingual Qigong demo promoting physical activity.

RoadRunners is still drastically reducing their normal everyday rides to only medical appointments and grocery store runs due to the COVID-19 pandemic. We are still using Lyft for Behavioral Health clients who live out of service area. In March, RoadRunners/Lyft completed 544 rides, but only 157 rides in April.

The Health Library and Resource Center is closed to the public. We are however, taking consultation appointments by telephone for Eldercare, Medicare, Advance Healthcare Directive Assistance, Dietitian, and Pharmacist appointments.

El Camino Health

Marketing and Communications

We launched an external interim COVID-19 campaign to patients and the community. This weekly e-newsletter featured articles and resources designed to help patients and the larger community during this challenging time. In April, we deployed three, each reaching: 57,000 El Camino Hospital patients, 12,000 SVMD patients, and 40,000 inactive patients (patients who have not had an encounter with us for at least 3 years). Staff continues email communications to SVMD and hospital patients informing them of the availability of virtual doctor visits, drive-thru testing, our enhanced safety precautions, and our respiratory clinic.

The El Camino Health Website has an updated COVID-19 page design with updated FAQs system, quick links, and clearer informational alerts. We also published 21 blog articles supporting HealthPerks and COVID-19 efforts, covering topics such as mental health, at-home activities, primary care services and general health tips.

Our team proactively facilitated several media stories including:

- NBC-11: Live interview with Dr. Lisa Packard on childbirth and COVID-19
- NBC-11: Interview with Brandi Fitzsimmons about grocery offerings in Café for employees (not yet aired)
- MV Voice: Interview with Mark Adams about the resumption of elective surgery (not yet published)
- Los Altos Town Crier: Interview with Kathryn Fisk about the YMCA Child Care Program and support for ECH workers (not yet published)

Philanthropy

During period 9 of fiscal year 2020, El Camino Health Foundation secured $2,494,585, bringing the total raised by end of March to $8,778,274, which is 114% of the annual goal. The majority of the period 9 gifts were to the rapidly launched El Camino Health COVID-19 Emergency Response Fund.

Auxiliary

Sadly, our Auxillians are still sheltering in place. However, we appreciate them helping us flatten the curve and we look forward to their return!

Quality Committee Follow up Item Tracking Sheet (05/21/20)

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Add a discussion around goal attainment to the pacing plan	11/4/2019	CM	Added to 2/3/20 Meeting then moved to 3//2/20 due to full agenda on 2/3/20	3/2/2020
4	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
5	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
6	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
7	Follow-Up on PSI 4, 18 and 19: 1. % breakdown by ethnicity, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for ethnic population) 2. % breakdown by low protein/vegan diets, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for diet-based population)	12/2/2019	CC/MA	On 2/3/20 Agenda; Bring back in August	
8	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
9	Bring back Revised Board Level Quality Dashboard	3/2/2020	MA	on 4/26/20 Agenda	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

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: June 1, 2020
Subject: Report on Board Actions

Purpose:

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

Summary:

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

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

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

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	May 20, 2020	FY20 Period 9 Financials Medical Staff Report Imaging Equipment Service Agreements Revised Investment Policy
ECHD Board	May 19, 2020	FY20 YTD Financials Proposed Budget Expense Allocations to ECHD for FY21 (Community Benefit Staff SW&B and Association Memberships) Resolution 2020-04 Requesting for and Consenting to Consolidation of Election Funding for District to Provide COVID-19 Community Testing

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Finance Committee		- None since last report (Meeting 6/3/20)
Compliance and Audit Committee		- None since last report (Meeting 5/21/20)
Exec. Comp Committee		- None since last report (Meeting 5/28/20)

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Dear Patient Experience Staff,

My name is .
I was admitted to El Camino Health - Mtn. View's ICU-unit on 3/21/20 and discharged on 3/27/20. I was told that I was among the first COVID-19 patients in the ICU. I know I was the first positive COVID-19 patient for a few of the nurses who helped save my life.

Enclosed are thank you cards for the nurses and doctors who saved me. Some were in the ICU, some in the CCU - "3C" wing where I was later transfeared before I was well enough to be discharged.

Being a COVID-19 patient, in complete isolation, scared, lonely, desperate for human contact and compassion, these nurses provided me with comfort, strength, and motivation to continue to fight this awful disease. I heard the smiles in their voices, saw the gentleness in their eyes, despite all the PPE, I felt their care and for some, that extra love and sympathy.

→
PS 2

I understand that some who cared for me were travel nurses. Please, please make every effort to send them my thank you card. I want them all to know that my family and I are eternally grateful for saving me.

Enclosed are postage stamps to help cover costs, please just label the card and send it for me.

During these scary times, I know our nurses and doctors need this love too, to know that there are millions ofpeople who appreciate what they do each day. They are our heroes.

Please help me share my gratitude with them. Please make sure they all receive my cards.

Thank you so much,

ICU + CCU - "3C"
- Dr. Kemper
Dr. Roed
COVID-19 Patient + Survivor!! ☺

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: June 1, 2020
Subject: FY21 Incentive Goals

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

Summary:

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

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

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

4. Assessment: Management is proposing the following quality, safety, and patient experience incentive goals for FY21: Reduction of SSER, Reduction of Readmissions, and Likelihood to Recommend. The Quality Committee has reviewed these goals and they are ready for a motion to recommend to the Board.

5. Other Reviews: None

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

List of Attachments: Power Point listing the goals

Suggested Committee Discussion Questions: None

El Camino Health

FY21 Quality/Safety and Experience Goals

Mark Adams MD CMO
Cheryl Reinking RN CNO
June 1, 2020

FY21 Organizational Goals

The Quality Committee reviewed a potential recommendation to the Board to adopt the following FY21 incentive goals:

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

FY21 Quality Goals

Top Tier Performance with Zero Preventable Harm

Measure	FY21 Target	Why did we select this metric?	Target setting logic / methodology
Serious Safety Events	Decrease SSER from x to y (expected 4-5/10,000 adjusted patient days)	Key indicator for our HRO journey	Improve by 1/10,000 ad pt days; baseline TBD with at least 6 months of SSE classification
Hospital Readmissions	Readmission Index	Key indicator for readmission penalty program, BPCI-A	Interim target to step up to top performer level (premier) in two years
Healthcare Effectiveness Data and Information Set (HEDIS)	HEDIS aggregate score of the 8-10 measures selected (from x to y)	Key indicator of quality and safety in the ambulatory area	10% improvement over new hospital baseline assuming April re-measure comparable to 2019 baseline of 3.76

FY21 Service Goals

Exceptional Personalized Experience Always

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

Proposed Fiscal Year 2021 Incentive Goals

STRATEGY	Weight	GOAL	OBJECTIVES/OUTCOMES	Benchmark		Measurement Defined			Measurement Period
				Internal Benchmarks	External Benchmark	Minimum	Target	Stretch	
Quality and Safety	30.0%	Zero Preventable Harm	Serious Safety Event (SSEs) Rate	FY20 Internal calculation - June 2020 Baseline TBD with >6 mon of SSE classification	External Baseline - best practice is to reduce to zero	Maintain Baseline	Improve by 1/10K adj pt days	Additional 10% improvement over target	FY21
			Risk-Adjusted Readmission Index	FY20 Internal calculation - June 2021	Premier Standard Risk Calculation	FY20 Target or Baseline	Interim target to step up to top performer level in two years		FY21
			Healthcare Effectiveness Data and Information Set (HEDIS) Composite Score	FY20 Internal calculation - April 2020 Aggregate score of the 8-10 selected measures	Internal Calculation; limited external benchmarks	Establish Baseline	10% improvement over baseline	15% improvement over baseline	FY21
Service	30.0%	Exceptional Personalized Experience, Always	Likelihood to Recommend (LTR) – Inpatient	FY 19: 83.4. FY20 YTD Thru April: 82.9	Press Ganey Top 30% of performers: FYTD 85.5	2 of metrics reach 30% of improvers (target)	3 of 4 metrics reach 30% of improvers (target)	4 of 4 metrics reach 30% of improvers (target)	FY21
			LTR – Emergency Department	FY 19: 71.3. FY20 YTD Thru April: 76.8	Press Ganey Top 30% of performers: FYTD 80.8				FY21
			LTR – Outpatient Surgery	FY19: 83.2 OAS CAHPS FY20 YTD Thru April: 84.6	Press Ganey Top 30% of performers: FYTD 86.4				FY21
			LTR – El Camino Health Medical Network	Baseline: 71.9 FY20 Q3: 71.1	NRC Net Promoter 50%ile: 78.8				FY21
People	20.0%	Teams Empowered with Trust and Purpose	Management: Overall employee satisfaction on Employee Engagement Survey for El Camino Hospital	ECH results last two surveys: 4.09 and 4.27.	Press Ganey 4.33 is 90th percentile for FY20	4.24	4.27	4.30	FY21
Finance	10.0%	Sustainable Strength and Vitality	Operating EBIDA	FY19: $160.8M or 16.9%. FY20 YTD P10: $91.7M or 11.7%		100% of rolling forecast model (post Oct '20 update)	110% of rolling forecast model (post Oct '20 update)	120% of rolling forecast model (post Oct '20 update)	Nov 20 – Jun 21
Growth	10.0%	Market Relevance and Access	Net Revenue	FY19 - 35,500 FY20 - TBD	Financial Data	90% of rolling forecast model (post Oct '20 update)	105% of rolling forecast model (post Oct '20 update)	110% of rolling forecast model (post Oct '20 update)	Nov 20 – Jun 21

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director/Chief Quality Officer
Date: June 1, 2020
Subject: YTD FY2020, to end of Q3, 30 Day All Cause, Unplanned Readmission Dashboard

Purpose: To provide data on Readmissions, all payor/all cause through Q3 FY20 (July – March 2020)

Summary:

1. Situation: ECH Organizational goal: Readmission Index, and hospitals incur as penalty under ACA of up to 3% of DRG payments for Readmission rates that are above CMS calculated expected for 7 diagnosis and procedures. Penalty for FFY19 based on actual performance July 2014-June 2017 = 0.36% ($354,500) 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 provided the 7 diagnosis groups for FY2017, FY 2018, FY2019 and FYTD 2020 (end of Q3)

4. Assessment: This report provides the detail behind the Readmission Index Organizational goal. The O/E ratio is greater than 1.0 for Diagnosis/procedure for 3 ACA readmission penalty diagnosis: Pneumonia, Stroke, and Total Hip/Knee Arthroplasty.

5. Other Reviews: None

6. Outcomes: None.

List of Attachments: FYTD 2020, to Q3, 30 day All Cause, Unplanned Readmission Dashboard

Suggested Committee Discussion Questions: None

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FY 2020, to End of Q3, 30 Day All-Cause Readmission Dashboard - ACA Dx.

Premier Risk Adjusted, All Payer, All Cause, Unplanned Readmits

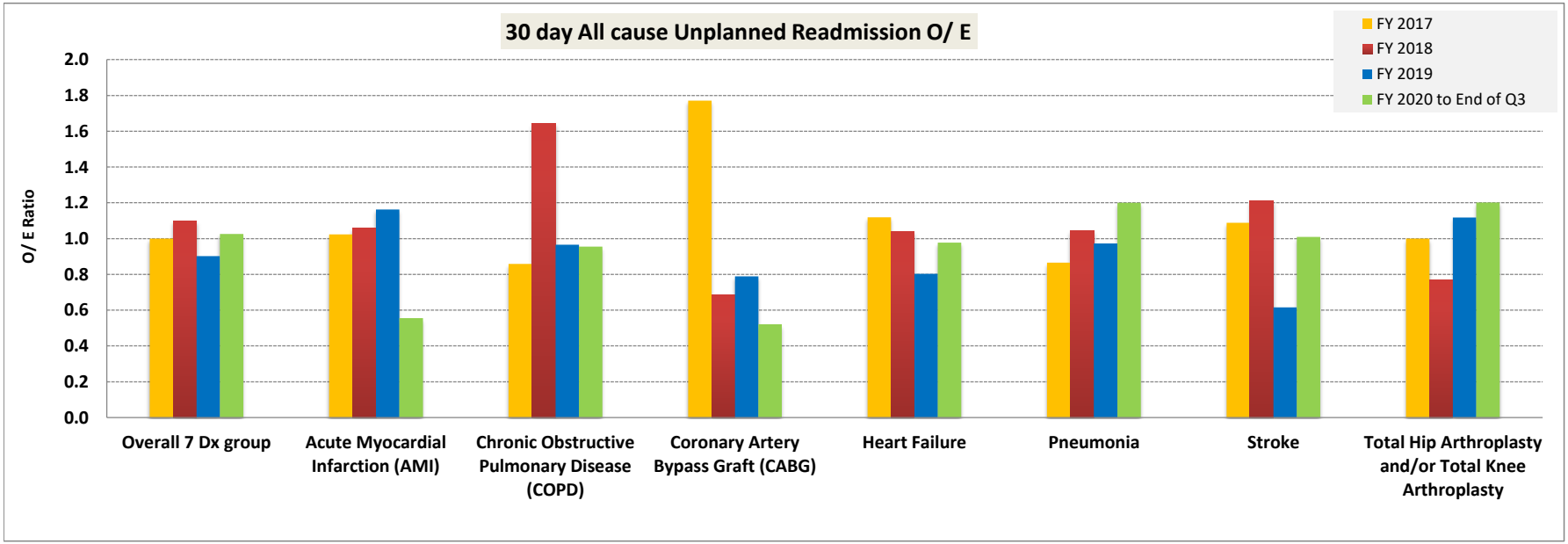
Patient Type: Inpatient and Psych

	FY 2017			FY 2018			FY 2019			FY 2020 to End of Q3		
	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	10.54%	9.96%	1.03
Acute Myocardial Infarction (AMI)	7.69%	7.51%	1.02	7.72%	7.30%	1.06	8.75%	7.53%	1.16	2.65%	7.42%	0.56
Chronic Obstructive Pulmonary Disease (COPD)	14.14%	16.48%	0.86	26.97%	16.41%	1.64	14.88%	15.40%	0.97	14.94%	14.86%	0.95
Coronary Artery Bypass Graft (CABG)	11.24%	6.34%	1.77	4.63%	6.76%	0.69	5.38%	6.81%	0.79	0.00%	6.82%	0.52
Heart Failure	17.79%	15.89%	1.12	16.17%	15.52%	1.04	13.39%	16.67%	0.80	17.10%	17.10%	0.98
Pneumonia	10.31%	11.92%	0.87	12.82%	12.30%	1.04	12.50%	12.84%	0.97	17.56%	12.90%	1.20
Stroke	7.17%	6.58%	1.09	8.20%	6.77%	1.21	4.56%	7.41%	0.62	7.38%	7.51%	1.01
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	3.06%	2.42%	1.20

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

Population used: CMS Readmissions and Mortality Populations (Historical), FY20

Data run date: 5/ 15 /2020



Report updated: 5/18/20

Data Source: Premier Quality Advisor

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams MD CMO
Lisa Packard MD, Maternal Child Health Service Line Medical Director
Date: June 1, 2020
Subject: Patient Safety Indicator (PSI) Scores Q3 FY20 compared to FYTD Q1-Q3

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

Summary:

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

2. Authority: 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; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. 7 of the 17 PSIs are over the Premier Mean for Q3 2020; with 5 PSIs with only 1,2 or 3 patients. These PSIs are: Death in Surgical Pts. with Treatable Complications, Postoperative Acute Kidney Injury Requiring Dialysis, In-hospital fall with Fracture, Postop Respiratory Failure, Unrecognized Abdominopelvic Accidental Puncture or Laceration, OB Trauma Vaginal Delivery with Instrument and OB Trauma Vaginal Delivery without Instrument. The committee has focused on the vaginal trauma PSI's in the past and requested additional information which will be provided at this meeting.

5. Other Reviews: None.

6. Outcomes: None.

List of Attachments:

1. Patient Safety Indicator (PSI) Scores Q3 FY20 compared to FYTD Q1-Q3 2020.
2. PSI 18 & 19: OB Perineal Laceration Report

Suggested Committee Discussion Questions: None

Patient Safety Indicator Report (AHRQ)

FY20 Q3 compared to FYTD Q1-Q3

Rate

Patient Safety Indicator		Numerator (FY20, Q3)	Denominator (FY20, Q3)	Rate/1000 (FY20 Q3)	Premier Mean*	Numerator (FY20, Q1-3)	Denominator (FY20, Q1-3)	Rate/1000 (FY20 Q1-3)	Premier Mean*
PSI-02	Death in Low Mortality DRGs	0	158	0.00	0.54	0	554	0.00	0.54
PSI-03	Pressure Ulcer	0	1,979	0.00	0.46	3	5,607	0.54	0.46
PSI-04	Death in Surgical Pts w Treatable Complications	3	19	157.89	120.99	10	76	131.58	120.99
PSI-06	Iatrogenic Pneumothorax	0	3,102	0.00	0.14	2	9,405	0.21	0.14
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	2,626	0.00	0.10	0	8,105	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	1	2,659	0.38	0.10	2	7,991	0.25	0.10
PSI-09	Perioperative Hemorrhage or Hematoma	1	940	1.06	1.84	2	3,170	0.63	1.84
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	1	548	1.82	0.75	1	1,914	0.52	0.75
PSI-11	Postop Respiratory Failure	2	423	4.73	4.18	2	1,569	1.27	4.18
PSI-12	Perioperative PE or DVT	0	977	0.00	2.61	5	3,310	1.51	2.61
PSI-13	Postop Sepsis	1	534	1.87	3.46	4	1,899	2.11	3.46
PSI-14	Postop Wound Dehiscence	0	308	0.00	0.65	0	985	0.00	0.65
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	3	797	3.76	0.82	5	2,506	2.00	0.82
PSI-17	Birth Trauma Injury to Neonate	3	1,013	2.96	4.02	14	3,277	4.27	4.02
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	66	212.12	107.66	33	180	183.33	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	15	662	22.66	15.45	67	2,135	31.38	15.45

Count Measures

Patient Safety Indicator		Cases (FY20 Q3)	Premier Mean Cases*	Cases (FY20 Q1-3)	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fra	0	0.16	0.00	0.16

Source: Quality Advisor 5/20/20

El Camino Health

PSI 18 &19: OB Perineal Laceration Report

Quality Committee of the Board
June 2020
Maternal Child Health Service Line

OB Perineal Injury Taskforce Team Members

- Dr. Lisa Packard, Medical Director, OB
- Dr. Linda Teagle, Los Gatos Chief of Staff
- Dr. Alissa Erogbogbo, Vice Chief OB/GYN LG
- Dr. Lynn Gretkowski, Medical Director, OB Hospitalists
- Dr. Dr. Kavitha Raj, Chief OB/GYN MV
- Dr. Marty Halum, OB Anesthesia
- Maria Greulich, Certified Nurse Midwife
- Lin Lee, Certified Nurse Midwife
- Brittney Wood, Certified Nurse Midwife
- Christine Borden, Certified Nurse Midwife
- Ellen Keohane, Nurse Educator OB
- Indira McKay, MV L&D Clinical Manager
- Meriam Signo, Director Patient Care Services LG
- Leslie Vazquez, MCH SL Coordinator, OB Concierge
- Tony Liu, MCH Service Line Operations Specialist
- Heather Freeman, Sr. Director Service Lines

Action Steps Since January 2020 Report: A3 Problem Solving with OB Perineal Injury Task Force

Current State and Problem Analysis

- Analyzed FY19 lacerations, trends
- Developed Epic lacerations report
- Analyzed FY20 performance through April, by volume, by provider, by problem
- Additional chart reviews, literature review, cause analysis

- Countermeasures:
  - Developed process for warm compress, developing documentation
  - Engaged Stanford for education/ discussion: May 29
  - Developing nutritional guide for vegetarian/vegan pregnant women
    - South Asian Heart Center partnership
  - Distributing unblinded data and information in May again
  - Vaginal dilator study: summer
  - Exploring episiotomy improvements
  - Individual provider support and follow up

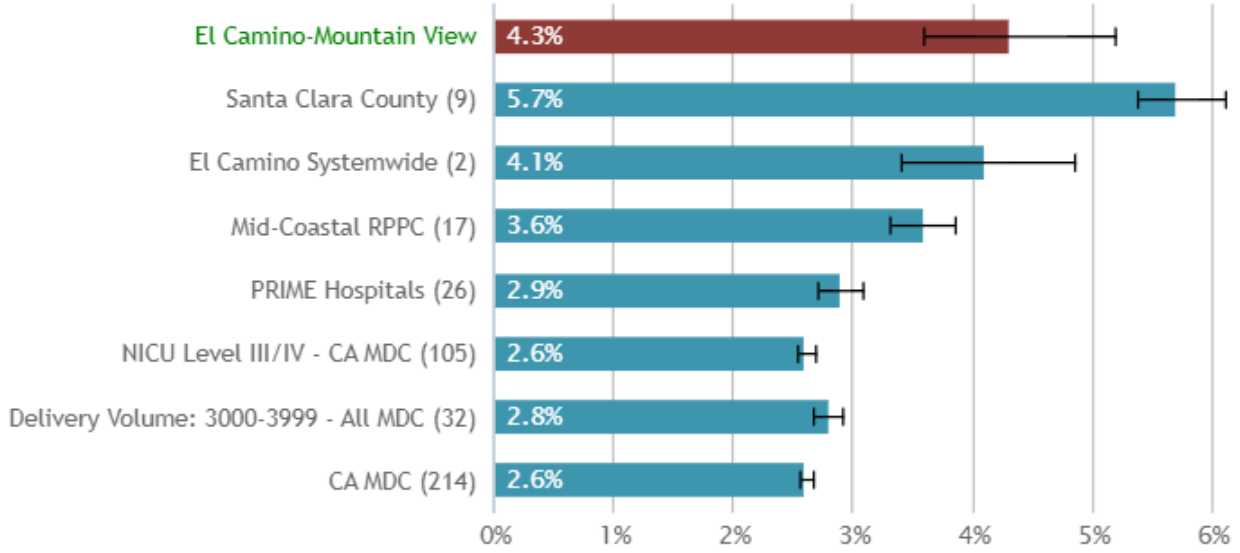
PSI 18 and 19 Performance:
Above National Average, Below Santa Clara County Average

National Performance: Patient Safety Indicator Report, Quality Advisor

Patient Safety Indicator		Numerator (FY20, Q3)	Denominator (FY20, Q3)	Rate/1000 (FY20 Q3)	Premier Mean*	Numerator (FY20, Q1-3)	Denominator (FY20, Q1-3)	Rate/1000 (FY20 Q1-3)	Premier Mean*
PSI-18	OB Trauma Vaginal Delivery with Instrument	14	66	212.12	107.66	33	180	183.33	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	15	662	22.66	15.45	67	2,135	31.38	15.45

California Performance: CMQCC

- 3rd and 4th degree laceration, all vaginal deliveries, Apr 2019-Mar 2020, peer comparison



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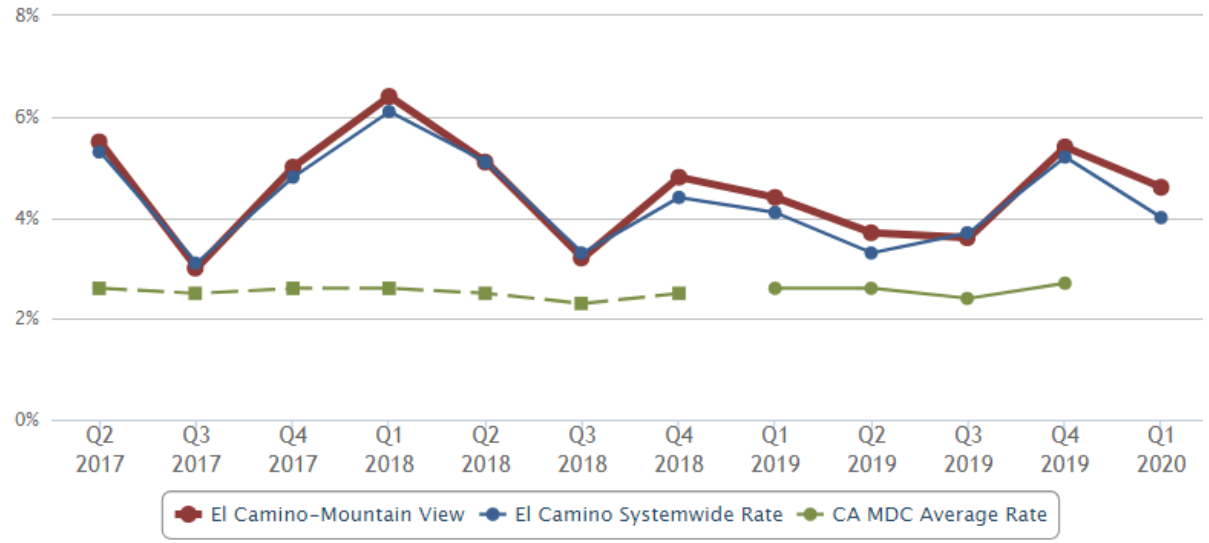
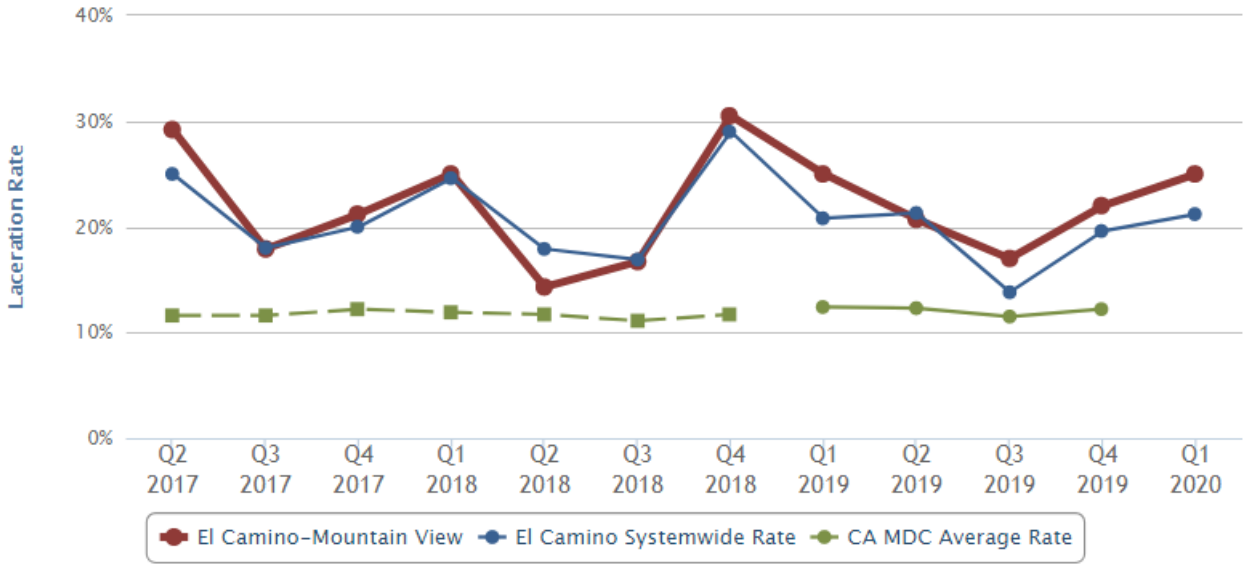
Performance Over Time: 2017 Q2 - 2020 Q1

3rd and 4th Degree Laceration, All



- 3rd and 4th Degree Laceration with Instrument



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3rd and 4th Degree Lacerations Analysis FY20 thru April

- Total 3rd and 4th degree lacerations: 110
  - **3rd degree: 90%** (99)
  - 4th degree 10% (11)
- Delivery types
  - Inductions: 34.5% (38)
  - **Spontaneous delivery: 72%** (79)
    - Vaginal breech: 1
- Instruments
  - **Vac-assist delivery: 33%** (36)
  - Forceps delivery: 1.8% (2)
- Episiotomy: 15% (17)
  - **Medial: 11** (10 = 3rd degree)
  - Medial-lateral: 6 (all 3rd degree)
  - No documentation: 9
  - Documented indications for episiotomy:
    - Instrumented Delivery: 9
    - Fetal intolerance of labor:7
    - Shoulder dystocia: 4
    - Macrosomia: 1

ACOG Practice Bulletin 2016: Prevention and Management of Obstetric Lacerations

- **Strongest risk factors:** based on a 22 study meta-analysis
  - Forceps delivery, **vacuum assisted delivery** (increased if has episiotomy)
  - Increased fetal birth weight
- Other risk factors:
  - Primiparity (first baby)
  - **Asian ethnicity**
  - Labor induction or augmentation
  - Epidural
  - Occiput posterior fetal position

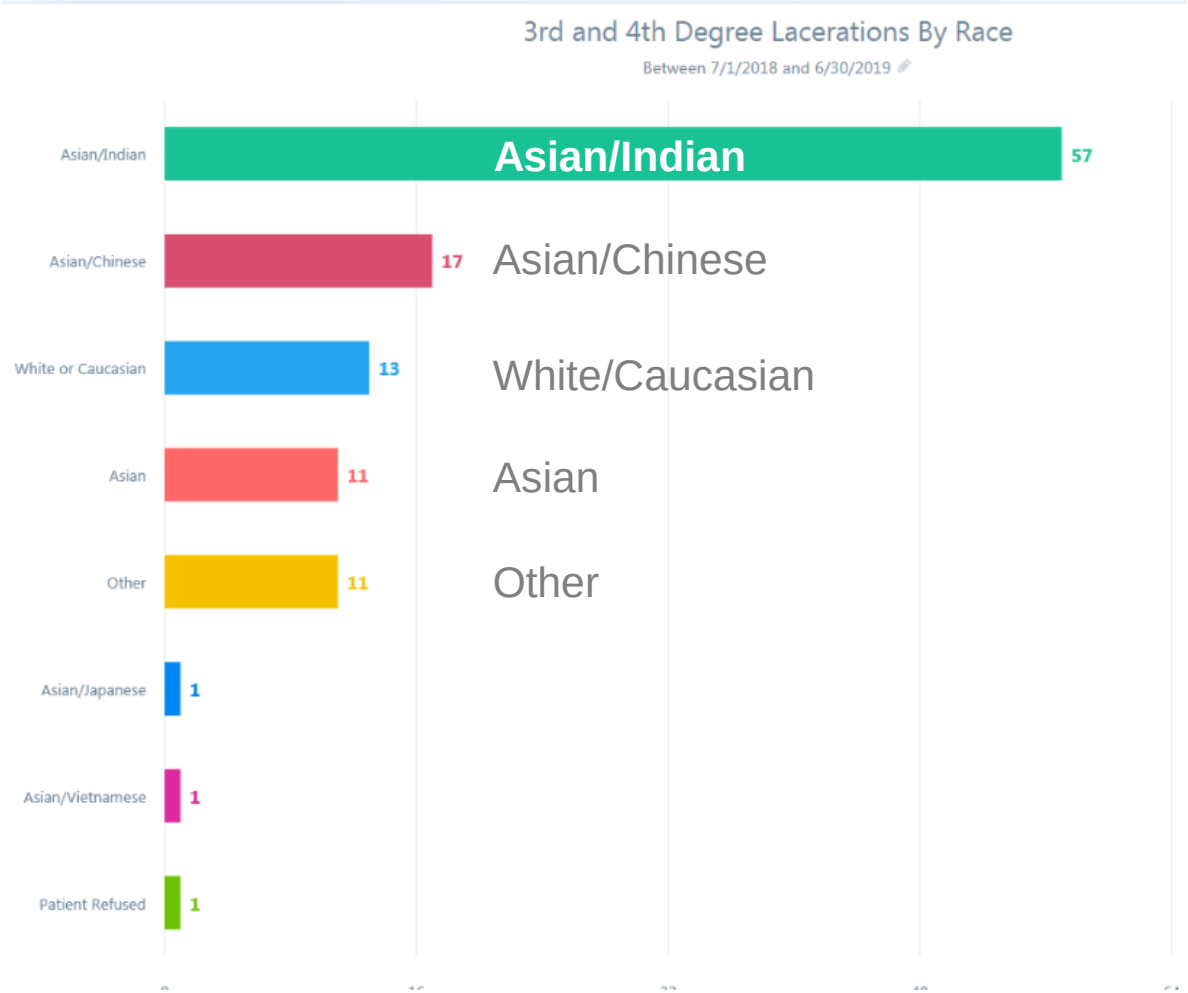
- **Recommendations**:
  - Level A Evidence:
    - Use **warm perineal compresses** intrapartum
    - **Decrease use of episiotomy, instrumentation**
  - Level B Evidence:
    - Perineal massage intrapartum
    - **Consider medial-lateral episiotomy**

2016 ACOG Committee Opinion #647:
Limitations of Perineal Lacerations as an Obstetric Quality Measure
Not recommended as quality measure due to variable definitions, mostly non-modifiable risk factors, and reducing rate likely to result in increased C-sections

El Camino Health

Risk Factor: Asian Ethnicity

- 64% Asian OB population at ECH MV
- 76% of 3rd and 4th degree lacerations at ECH are in the Asian population
- Perineal Body Length:
  - Asian population has shortest perineal body length, therefore the greatest risk for 3rd/4th degree laceration
    - Yeaton-Massey et al., 2015; Deering et al., 2004



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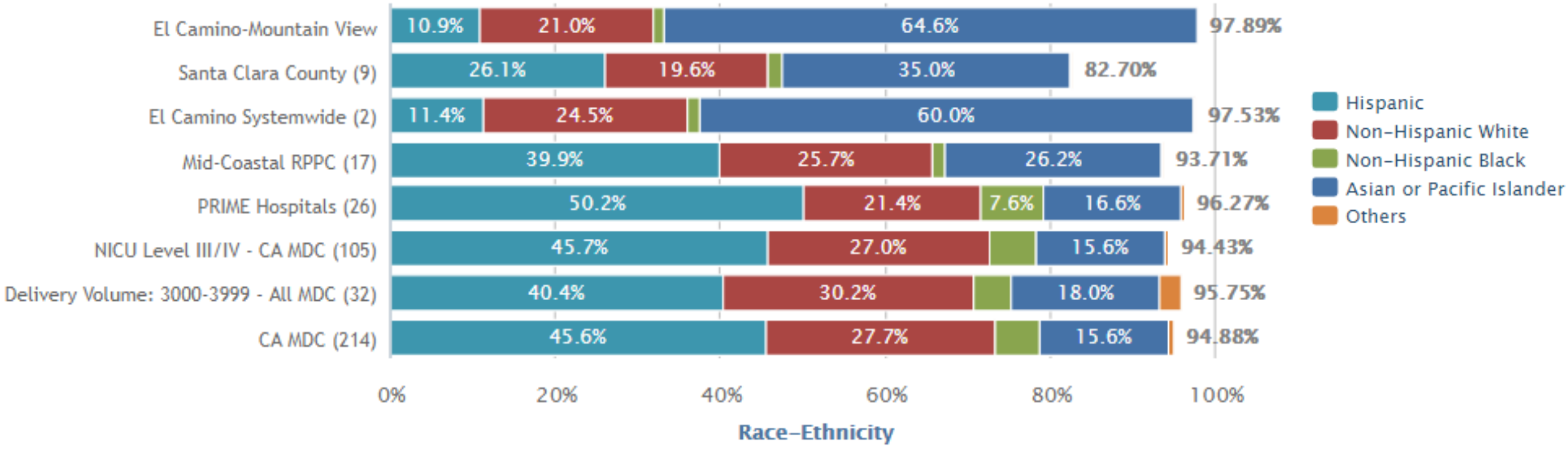
ECH MV Asian Population is 4x the California Average



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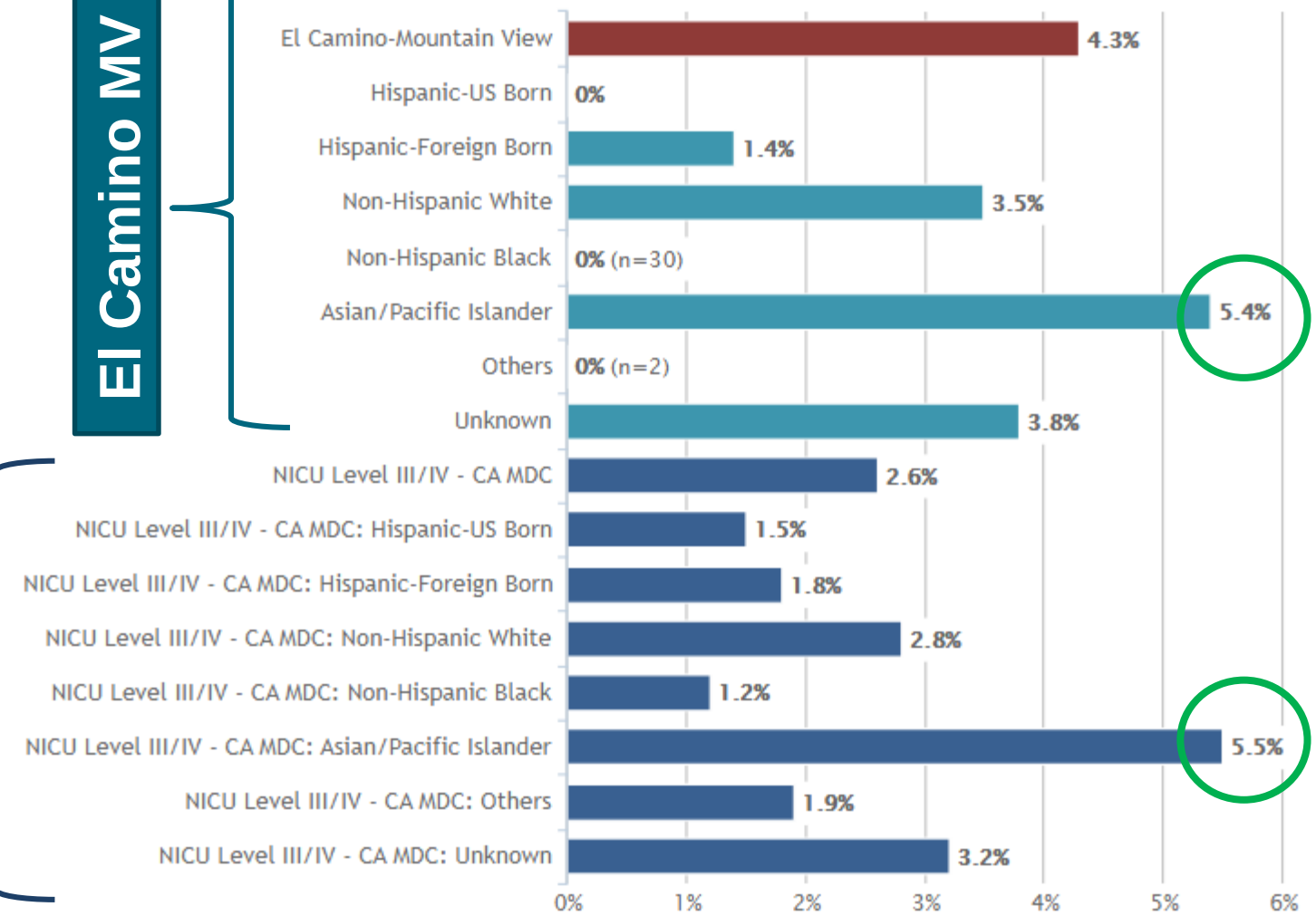
El Camino MV

California MDC



3rd & 4th Degree Lacerations/OB Trauma – All Vaginal Deliveries: Apr 2019 – Mar 2020

El Camino Health

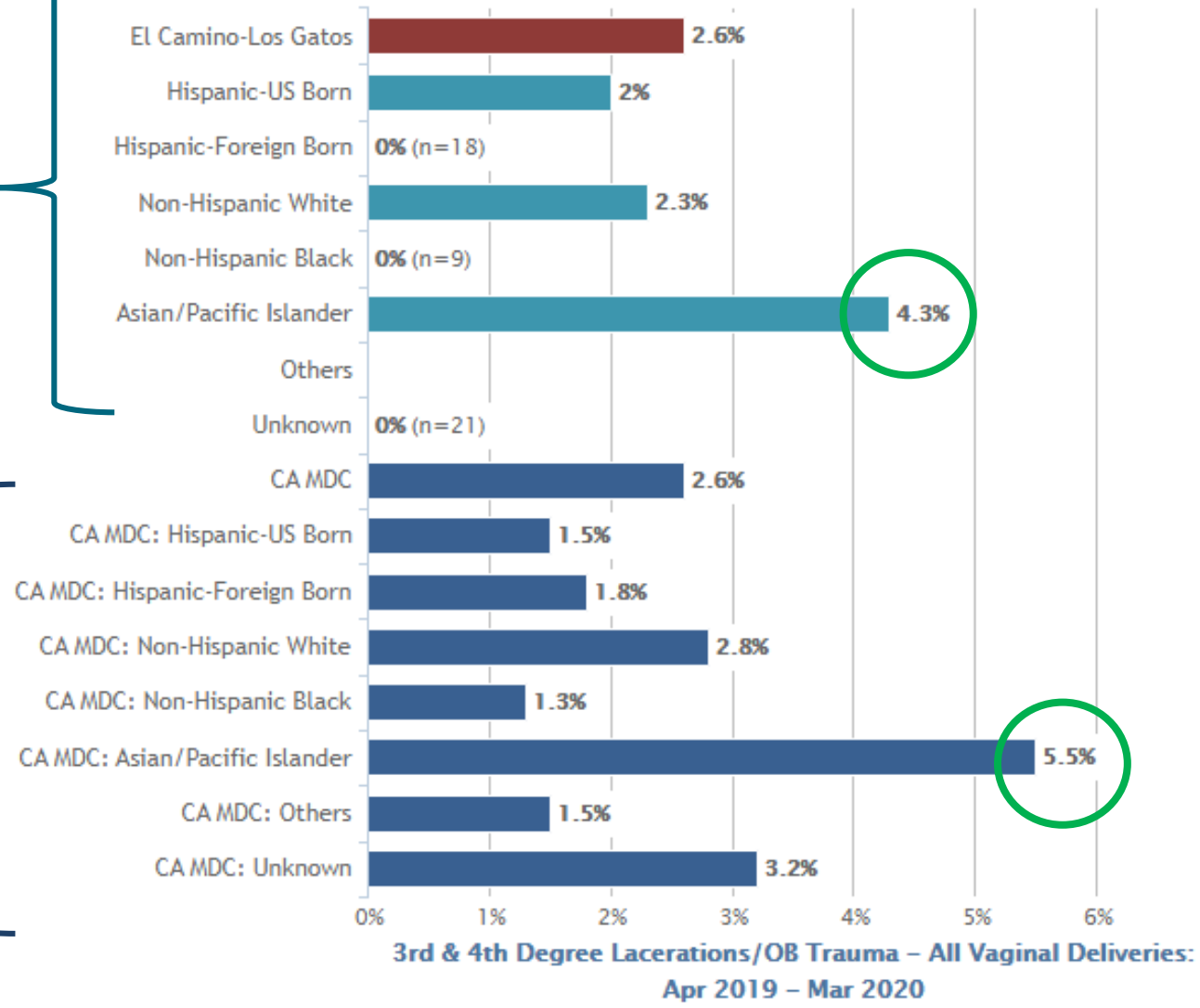
CA Asian/Pacific Islander **risk of laceration is 2X higher than the average**

- CA overall rate: 2.6%
- CA Asian/Pacific Islander rate: 5.5%
- ECH MV Asian/Pacific Islander rate: 5.4% (89/1659)

ECH performs at average for Asian/Pacific Islander Population

El Camino LG

California MDC



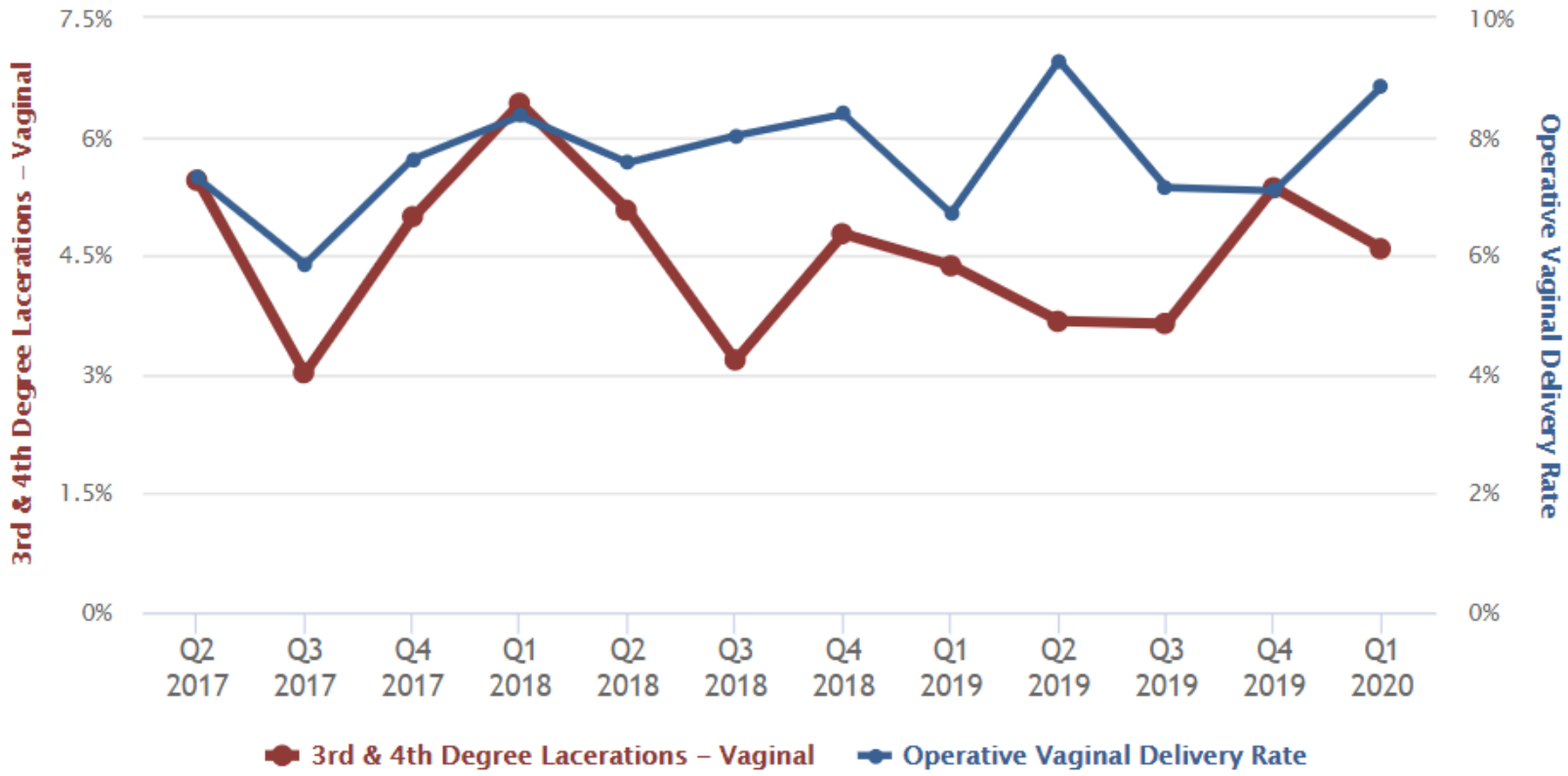
3rd & 4th Degree Lacerations/OB Trauma – All Vaginal Deliveries: Apr 2019 – Mar 2020

Los Gatos Campus 3rd and 4th degree laceration rate is average, with Asian/Pacific Islander population performing worse, similar to CA

- CA overall rate: 2.6%
- CA Asian/Pacific Islander rate: 5.5%
- ECH LG Asian/Pacific Islander rate: 4.3% (6/139)

El Camino Health

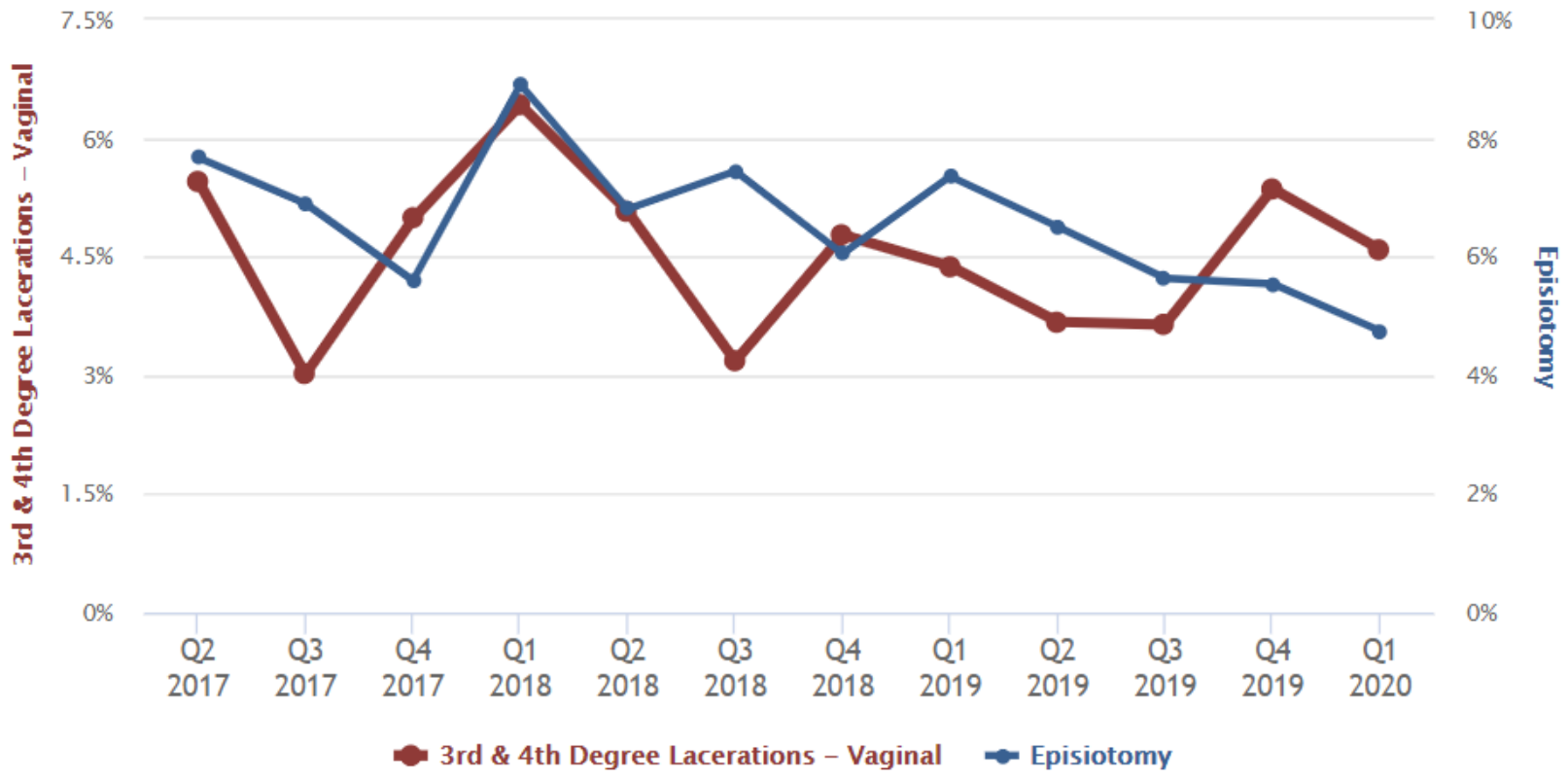
Risk Factor: Operative Vaginal Delivery



- Although operative vaginal delivery is a risk factor for laceration, it has not correlated tightly with laceration rate.
- Operative vaginal delivery is used to avoid C/S delivery

El Camino Health

Risk Factors: Episiotomy



- Episiotomy tends to trend more closely with laceration rates.
- ECH episiotomy rate is 1% higher than CA average
- Per our analysis, most are medial (higher risk)
- Opportunity to improve

Initiatives to Decrease OB Trauma

- Review low and high rate providers, learn best practices, support improvement
- Improve use of episiotomy and type; provider support
- Document and track warm compresses use
- Develop recommendations for management of perineum/perineal massage
- Develop nutrition recommendations/support for vegetarian/vegan women
- Trial slow vaginal dilation device intrapartum (NIH trial, Materna, Dr. Azad PI): Summer
- Education and discussion forum with midwives and Stanford OB: May 2020
- Distribute unblinded data and information

- **Target: Improve MV 3rd and 4th degree laceration with instrument by 15% from 22.2% to 18.9% on MV campus by July 1, 2020; FYTD = 21.6%**

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: June 1, 2020
Subject: Medical Staff Credentialing and Privileging Process

Purpose: Review the process for medical staff membership and privileging

Summary:

1. Situation: The Board Quality Committee desires to assure that only qualified physicians are accepted onto the El Camino Health medical staff

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 Health patients.

3. Background: The Quality Committee periodically reviews medical staff activities such as credentialing, privileging, peer review, and other TJC and CMS regulatory requirements.

4. Assessment: El Camino Health has a rigorous process to assess the eligibility and qualifications of prospective physicians who apply for medical staff membership and privileges.

5. Other Reviews: None

6. Outcomes: The Quality Committee members understand the basic process used by El Camino Health to credential and privilege physicians.

List of Attachments: Power Point summarizing the process

Suggested Committee Discussion Questions:

1. How can we be assured of the quality of physicians joining the medical staff?
2. What are the rights of physicians if denied medical staff membership?

El Camino Health

Medical Staff Credentialing Process

Mark Adams MD

Board Quality Committee

June 1, 2020

Medical Staff Credentialing Process

Application to include:

- Contact information
- Education
- Work history
- Current CV
- State Licensure
- Board certification
- Malpractice Liability Insurance
- DEA certification

Medical Staff Credentialing Process

Primary Source Verification:

- Verifying training and education through the American Medical Association or the Educational Commission for Foreign Medical Graduates if the applicant was educated outside the United States
- Verifying current medical licensure in the state
- Verifying employment history
- Verifying Medicare sanction information through the OIG sanctions exclusion database
- Querying the National Practitioner Data Bank on closed and settled claims history

Medical Staff Credentialing Process

Primary Source Verification:

- Reviewing any time gaps in education or career (if the applicant has more than a six month period of time when they are not enrolled in a program at a medical teaching institution or employed as a physician, the applicant is asked to provide a detailed explanation on the application)
- Verifying the status of the applicant's privileges at hospitals and other health care facilities as listed on the application

Medical Staff Credentialing Process

- Criminal Background Check
- Peer References
- Malpractice Claims Review (NPDB)

Medical Staff Credentialing Process

- Does the applicant meet the qualifications for medical staff membership specified in the medical staff bylaws
- Graduate of accredited medical school (AAMC – LCME)
- Completion of approved residency (ACGME)
- Board certified or eligible (ABMS)
- If so, next step is consideration of Privileges

Medical Staff Privileges

- Applicant completes privilege request form
- Based on the specialty, this is reviewed by the pertinent department chair
- Core privileges vs specialized privileges considered
- Request then reviewed by the enterprise credentials committee
- Enterprise credentials committee reports to MEC
- MEC reports to Board QC which then recommends approval to the Board of Directors

Medical Staff Privileging

- Provisional Status
- Focused Professional Practice Evaluation
- Proctoring as needed

Medical Staff Privileging

- Provisional Status changed to Active
- Ongoing Professional Practice Evaluation q 8 months to include core competencies

Core Competencies

- Patient care
- Medical Knowledge
- Professionalism
- Systems-based Practice
- Practice-based Learning
- Interpersonal and Communication Skills

Privileging and Credentialing

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Shabnam Husain, MD, Member, Silicon Valley Medical Development (SVMD) Board of Managers and Co-Chair Silicon Valley Medical Development Quality Improvement Committee
Date: June 1, 2020
Subject: SVMD Quality Improvement Committee Report

Purpose: To provide the first quarterly report on the SVMD Quality Improvement Program to the El Camino Hospital Board's Quality, Patient Care and Patient Experience Committee.

Summary:

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

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

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

Assessment: The QIC has selected 8 leading metrics for 2021 and are provided in Attachment 1. The metrics were chosen based on a review of common top priority metrics across HEDIS and MIPS in addition to the Committee's perspective priorities for improvement. Data for these measures will come from the Epic electronic medical record.

For Patient Experience, In FY20 SVMD began participating in Real-Time surveys through NRC. Data is received daily and we receive monthly reports on our Net Promoter Score. A target was not established in CY 2020. Our NPS has increased from 70.4 in January to 76.0 in May with an average

of 72.1. In addition, we participated in the voluntary Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS which measures 10 key domains of patients' experiences of care that are referred to as summary survey measures. The ECHMN score for 2019 was 82.1% which placed us just above the 50th%ile. A score of 93.4 would have been required to achieve the 75th percentile.

4. Other Reviews: The SVMD Board of Managers received a Quality Improvement Committee report at its May 22, 2020 meeting.

5. Outcomes: The Board Quality Committee will have a better understanding of the structure and processes in place within SVMD to manage and improve quality, safety, and patient experience. In the future, the Quality Committee will receive updated metrics pertaining to those areas on a quarterly basis.

List of Attachments

1. SVMD Quality Improvement Committee

Suggested Committee Discussion Questions:

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

Silicon Valley Medical Development

2020 Quality Improvement Program Update

June 1, 2020

Presented by Shabnam Husain, M.D.
Quality Committee Co-Chair

QUALITY IMPROVEMENT COMMITTEE

Daniel Morgan, MD – Chair and
Shabnam Hussain, MD, Co-Chair

Members: Richard Ornelas, MD, Addy Squarer, MD, LaCrista Mazeke-Kelley, MD, Sheetal Ankolekar, MD, Mauro Ruffy, MD, Osama Lam, MD, Robert Filuk, MD
Mark Adams MD ECH CMO, ex officio member

Credentialing Committee

Shabnam Husain, MD - Chair

Members:
Richard Ornelas, MD
Addy Squarer, MD
LaCrista Mazeke-Kelley, MD
Mauro Ruffy, MD
Robert Filuk, MD

Peer Review Committee

Shabnam Husain, MD - Chair

Members:
Richard Ornelas, MD
Addy Squarer, MD
LaCrista Mazeke-Kelley, MD
Mauro Ruffy, MD
Robert Filuk, MD
Daniel Morgan, MD

Quality Improvement Program Purpose

- To ensure the necessary infrastructure and the formal process needed to coordinate care, promote quality, performance, and efficiency on an ongoing basis.
- The requirements for the QI program are based on the National Committee for Quality Assurance (NCQA), and in compliance with State and Federal regulations.
- The QI Program promotes the accountability of all employees, providers, contracted providers, and any downstream and related entities for the care and service provided to members.
- QI activities are coordinated with other performance monitoring activities and management functions including, but not limited to, compliance, utilization management, case management, population health management, grievances, risk management, patient safety, credentialing, claims, customer services, and network management.

Quality Committee Charter

- Measuring and reporting performance using measurement tools.
- Continuous monitoring and evaluation of clinical and service quality indicators that reflect important aspects of care and service using benchmarks and performance goals.
- Correcting all problems that come to its attention through internal surveillance, complaints or other mechanisms.
- Development of an annual QI Work Plan.
- Implement a program review process for formal evaluation of the impact and effectiveness of the QI Program and Work Plan at least annually.
- Assessing each member's cultural, linguistic, and health literacy needs and delivering of care and services in a culturally and linguistically appropriate manner to meet each member's needs.
- Providing timely access and availability of care via a comprehensive provider network that is credentialed and re-credentialed in a timely manner that complies with regulatory requirements.

Quality Committee Charter - cont.

- Ensuring the provider network complies with SVMD medical record standards and evidence-based clinical practice guidelines.
- Implementing corrective actions when care and/or services delivered are identified to be of questionable quality, and monitoring of the effectiveness of the corrective actions.
- Ensuring the participation of contracted providers in the planning, design, implementation and review of QI Program initiatives.
- Complying with contracted Health Plans for audits, overseeing all functions delegated by the contracted Health Plans and performing internal audits.
- Ensuring the QI program addresses contracted Health Plan issued Corrective Action Plans (CAP) when performance does not meet Program expectations.

Quality Committee Achievements – 4/19 to Present

- Developed and established committee charters
- Established committee membership, including physicians both medical groups, ECMA and SJMG
- Developed a Quality Improvement Program
- Developed Quality Indicators Program (QIP)
- Developed the annual Quality Improvement work plan and submitted to payors
- Developed quality management policies and procedures
- Established 8 leading key metrics for 2021 for our patients
- Began real-time patient satisfaction survey through NRC
- Conducted CAHPS for MIPS survey through NRC
- Implemented EPIC for San Jose Medical Group
- Developed reporting capabilities in EPIC to collect and report data
- Submitted MIPS for ECMA
- Granted exception for SJMG MIPS reporting due to system conversion

Peer Review Committee Charter and Achievements

Charter

- Reviews all potential quality issues (PQI) that are referred due to the assigned severity level and assesses the appropriateness of practitioner judgment or decision-making functions
- The peer review process includes direction to conduct additional review steps to determine if the concern is an individual issue or a practice pattern.
- The Peer Review Committee conducts secondary review and may refer cases to a non-affiliated specialty provider for review and recommendation.

Achievements

- Investigated 6 Peer Review Issues

Credentialing Committee Charter and Achievements

Charter

- The Credentialing Committee reviews and recommend the credentialing and recredentialing of all practitioners and organizational providers within SVMD.

Achievements

- Developed credentialing policies and procedures
- Enhanced the credentialing verification software system
- Received delegation status from Aetna and UHC
- Audited all provider credentialing files
- Changed the recredentialing cycle for all providers to every 24 months
- Established process for credentialing approval by the Board
- Credentialed 55 physicians and recredentialed 101 physicians

Hospital Metrics versus Ambulatory Quality Metrics

Hospital Metrics

- *Case Mix Index*
- *Length of Stay*
- *Readmission Rates*

VS

Ambulatory Metrics

- *HCC (Hierarchical Condition Category)*
- *Coordination of Care*
- *Post Discharge- Office Visit*
- *Post Discharge – Medication Reconciliation*
- *Readmission Prevention*

Relevant Ambulatory Metrics to SVMD

- Healthcare Effectiveness Data and Information Set (HEDIS)
  - Standardized performance measures that compare health plan performance
  - HEDIS Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes
  - Health Plans hold medical groups accountable for performance to these metrics

- Hierarchical Condition Category (HCC) is a method of risk stratification used by CMS to determine level of payment for Medicare Advantage Plans
  - Reimbursement is tied to documentation abiding by CMS guidelines
  - Documentation must be correlated to support the submitted diagnosis and indicate the provider's assessment plan for the management of the condition

- Centers for Medicare and Medicaid (CMS) services Merit-based Incentive Payment System (MIPS) measures
  - The Quality Payment Program ties reimbursement to value and outcomes.
  - Performance is measured through four areas – Quality Improvement Activities, Promoting Interoperability and Cost.

8 Leading Metrics Approved by QIC for 2021

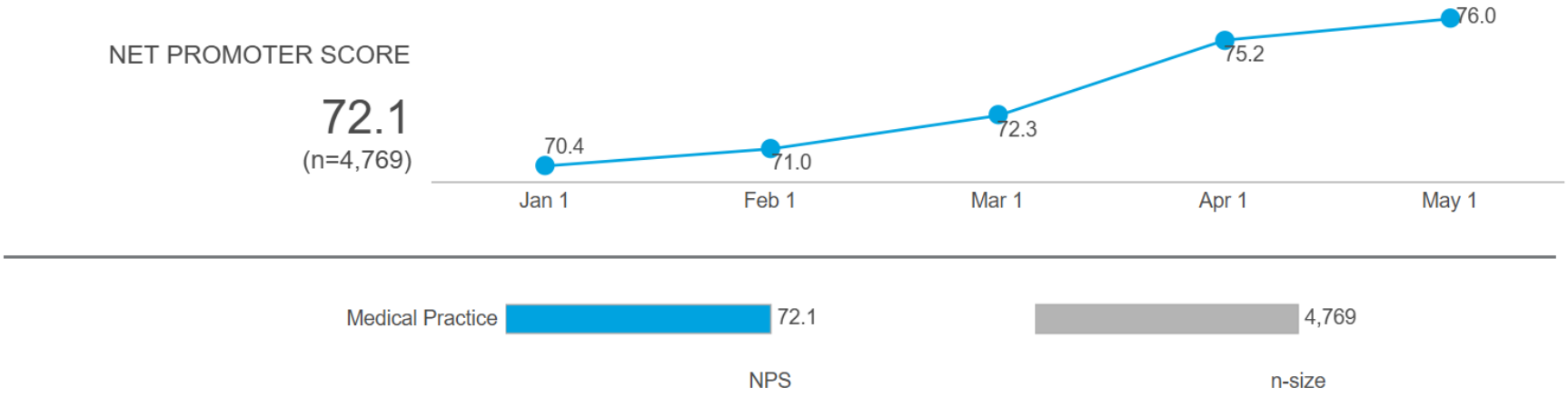
Metric	Target	1st Qtr Performance *
Controlling Blood Pressure to less than 140/90	70%	44%
Diabetes: Hemoglobin A1c Poor Control (>9%)	47%	53%
Documentation of Current Medications	99%	71%
Falls: Screening for Future Fall Risk	98%	0%
Body Mass Index (BMI) and Follow Up Plan	94%	32%
Breast Cancer Screening	81%	26%
Colorectal Cancer Screening	85%	20%
Tobacco Use and Cessation Intervention	97%	88%

* Lower scores can be attributed to immaturity of EPIC data

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%

Patient Experience – Net Promoter Score



Patient Experience – CAHPS for MIPS

	CAHPS Dimensions	Benchmarks		El Camino Health MIPS Overall
Overall		**MIPS/ACO 50th Percentile***	**MIPS/ACO 75th Percentile**	**MIPS/ACO 90th Percentile**	**2019**
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?		81.8 n-size: 20,510	93.4 n-size: 20,510	94.0 n-size: 20,510	82.1% (n=274)

Key Drivers		**MIPS/ACO 50th Percentile***	**MIPS/ACO 75th Percentile**	**MIPS/ACO 90th Percentile**	**2019**
In the last 6 months, how often did this provider show respect for what you had to say?	How Well Your Providers Communicate	89.5 n-size: 20,441	96.5 n-size: 20,441	97.2 n-size: 20,441	91.8% (n=279)
In the last 6 months, how often did this provider listen carefully to you?	How Well Your Providers Communicate	86.5 n-size: 20,446	95.2 n-size: 20,446	95.8 n-size: 20,446	88.3% (n=273)
In the last 6 months, how often did this provider spend enough time with you?	How Well Your Providers Communicate	82.7 n-size: 20,411	93.8 n-size: 20,411	94.7 n-size: 20,411	84.9% (n=279)

QI Projects for the Remainder of 2020

- Monthly quality committee meetings
- Focus on improvement on leading metrics
- Improve patient experience
- Provider and staff education and training
- Improve system for receiving, monitoring and tracking complaints and grievances
- Participate with our contracted payers with quality projects
- Create a provider manual

Board Questions

- Develop a shared understanding of committee(s) charter(s)
- Discuss the frequency, communication and reporting structure
- Discuss quality metrics