El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Monday, May 6, 2019 - 5:30 p.m.
El Camino Hospital | Conference Room A&B
2500 Grant Road, Mountain View, CA 94040

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		**5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 5:33 – 5:35**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (April 1, 2019) b. Proposed FY20 Committee Goals ***Information*** c. Patient Story d. FY19 Pacing Plan e. Progress Against FY19 Quality Committee Goals f. Hospital Update			
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**Information 5:35 – 5:40**
5.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 5**	Mark Adams, MD, CMO		**Discussion 5:40 – 6:00**
6.	**CDI DASHBOARD** **ATTACHMENT 6**	Mark Adams, MD, CMO		**Discussion 6:00 – 6:15**
7.	**CORE MEASURES** **ATTACHMENT 7**	Mark Adams, MD, CMO		**Discussion 6:15 – 6:30**
8.	**MEDICAL DIRECTOR GOAL PROCESS AND ACCOUNTABILITY** **ATTACHMENT 8**	Mark Adams, MD, CMO		**Discussion 6:30 – 6:50**
9.	**PROPOSED FY20 ORGANIZATIONAL GOALS** **ATTACHMENT 9**	Mark Adams, MD, CMO; Cheryl Reinking, RN, CNO; Jim Griffith, COO	*Public comment*	**Motion Required 6:50 – 7:05**
10.	**PROPOSED FY20 PACING PLAN** **ATTACHMENT 10**	Julie Kliger, Quality Committee Chair	*Public comment*	**Motion Required 7:05 – 7:10**

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.

11.	**AD HOC COMMITTEE: PROGRESS REPORT**	Julie Kliger, Quality Committee Chair		**Information 7:10 – 7:15**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**Information 7:15 – 7:16**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required 7:16 – 7:17**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**7:17 – 7:18**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (December 3, 2018) b. Minutes of the Closed Session of the Quality Committee Meeting (February 4, 2019) c. Minutes of the Closed Session of the Quality Committee Meeting (March 4, 2019) d. Minutes of the Closed Session of the Quality Committee Meeting (April 1, 2019)	Julie Kliger, Quality Committee Chair		**Motion Required 7:18 – 7:20**
16.	*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 - Follow Up: Imaging Patient Event	Mark Adams, MD, CMO		**Discussion 7:20 – 7:25**
17.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Q3 FY19 QUALITY AND SAFETY REVIEW	Mark Adams, MD, CMO		**Discussion 7:25 – 7:35**
18.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required 7:35 – 7:36**
19.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**7:36 – 7:37**
20.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 7:37 – 7:38 pm**

Upcoming FY19 Meetings: June 3, 2019 |

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, April 1, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Ina Bauman	**George O. Ting, MD**
Peter C. Fung, MD	**Melora Simon**
Julie Kliger, Chair	
Jeffrey Davis, MD	
Wendy Ron	
Katie Anderson	

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. *A silent Roll call was taken.* George O. Ting, MD and Melora Simon were absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	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 (December 3, 2018, February 4, 2019, March 4, 2019); and for information, Patient Story, FY19 Pacing Plan, Progress Against FY19 Quality Committee Goals, FY20 Committee Meeting Dates and Hospital Update. **Movant:** Ron **Second:** Davis **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Ron **Noes:** None **Abstentions:** None **Absent:** Ting, Simon **Recused:** None	*Motion Required*
4. REPORT ON BOARD ACTIONS	Dr. Fung provided an overview of board actions. Dr. Fung note that two main items were a) increasing El Camino Hospital Board to a maximum of 11 members and reserving a seat for the CEO; and b) ECH Sponsorship of SVMD as Risk Bearing Organization with Department of Managed Healthcare. There were no questions about the Report on Board Actions.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, participated by teleconference. Dr. Adams provided an overview of the Quality Dashboard. Dr. Adams reported that the monthly Mortality Index was higher than the March report and the FYTD index has increased over the target of .95. Dr. Adams attributed some of the increase to a higher number of patients admitted with terminal cancer dying in the hospital. Dr. Adams reported that ECH started an in-patient hospice program that allows patients to die in the hospital rather than their homes. Converting those patients to hospice removes them from the mortality index. Dr. Adams reported that the Readmission index is steady doing and is just below target. The Committee discussed the Patient Throughput and the different	

	challenges confronting Los Gatos versus Mountain View. Los Gatos reported better times than did Mountain View primarily due to the difference in size. LG is a smaller, more compact facility and because MV is vastly larger, its patients have farther to travel for diagnostics and from ED to a bed. Cheryl Reinking, Chief Nursing Officer commented that, to improve this metric, staff has broken down the whole process in several segments of time and are addressing 18 of 64 areas that need improvement. Ms. Reinking noted a couple of those being discharge rounds, bridge orders for patients that are being admitted, and changing the physician workflow. Dan Woods, Chief Executive Office responded to concerns of financial implications indicating that this is more of a service issue than a direct financial one. The Committee asked to see more granularity in this report that identifies the pain-points, correlates the impact of management's initiatives to those segments, and the expected date of completion. They want to know what is driving the variations, what is the intervention plan, and when is it going to be done. Dr. Adams reported an increase of C. Diff in patients transferred to ECH from nursing homes where C. Diff was present upon admission to ECH. Thus, precautions such as wearing personal protection attire, washing hands and quarantining infected patients are important and help prevent patient to patient transfer. Dr. Adams also reported sepsis mortality increased due to admission of patients with terminal cancer during the holiday season. Dr. Adams commented on future plans to incorporate Silicon Valley Medical Development into the organizational quality out-patient metrics. Chair Kliger suggested metrics of care transitions, tracking white space and adding to through-put.	
6. APPOINTMENT OF AD HOC COMMITTEE TO ADDRESS RECRUITMENT OF NEW COMMITTEE MEMBERS	Chair Kliger noted that the topic was before the Committee again because they did not have a quorum for the last meeting. She provided background of the Committee's desire to add members with certain competencies to have more experts on the committee. An Ad Hoc Committee will be tasked to work on the recruitment of new members. The Committee discussed how best to keep the patient voice on the Committee and means by which the Patient Family Advisory Committee (PFAC) could serve as the patient's voice. Linda Teagle, MD commented that taking out the patient voice reduces the Committee to only quality and not quality and patient care committee, that the hospital wants to give high tech high touch care and removing the patient voice leaves us with only high tech. Cheryl Reinking, RN, CNO noted that the Patient Family Advisory Committee (PFAC) is a monthly meeting and discussion group that does not discuss quality all of the time, but specific experiences. Chair Kliger, Chair proposed Jeff Davis, MD, Melora Simon, Mark	**Add PFAC updates to Pacing Plan Motion Required**

	Adams, MD, and herself as the Ad Hoc Committee members – pending acceptance by Ms. Simon. **Motion:** To approve the forming of an ad hoc committee to recruit new members. To bring in potential candidates, to screen and then bring to committee for approval. **Movant:** Ron **Second:** Anderson **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Ron **Noes:** None **Abstentions:** None **Absent:** Ting, Simon **Recused:** None	
7. WHAT IS QUALITY	Chair Kliger reported on the responses to the Quality Maturity Model Survey results. Ms. Kliger commented that the survey was intended to show how others view our collective capabilities here in these different domains (six survey topics) and where we have opportunities to continue to grow and mature. Ms. Kliger asked the questions: Were we surprised? Do we have questions? How does this inform the work that is going on? The Committee discussed the survey, its design, the wide range of responses and implications. Wendy Ron left the meeting at 6:46pm.	
8. VALUE BASED PURCHASING REPORT	Mark Adams, MD, CMO, provided an overview of the Value Based Purchasing Program. Dr. Adams reported the following: This is a zero sum budget based penalty program that allows us to "earn" back dollars based on our performance compared to all other participants. For FY19 we earned back all of the 2% withhold minus $234,000. For FY20 we are projecting to recover all but $313,000 of the $1.8 million withhold. The Committee reviewed the results in detail in each of the domains: clinical, safety, experience, and efficiency. The Committee discussed where ECH is under performing, and whether to incorporate additional key metrics and not just those linked to Medicare withholding. There is need to identify a list of important quality metrics to focus on being the best that we can be.	
9. PT. EXPERIENCE (HCAHPS)	Cheryl Reinking, RN, CNO, provided an overview of HCAHPS scores. Ms. Reinking, reported that ECH recently reinvigorated its leader rounding program where new patients and patients about to be discharged are rounded on by members of the leadership team. She noted that after two weeks 1100 rounds had been conducted, which is a significant improvement. We will know in the coming weeks if it improves our HCAHPS scores. The goals is to have 80% of our patients rounded on during their stay. • Ms. Reinking share some patient feedback such as: • "ECH is a phenomenal hospital" • "The entire team that cared for me was excellent…" • "Sometimes not clear on what CNA's do versus what nurses do…" • Ms. Reinking provided an overview of the Patient Family Advisory Council (PFAC). Ms. Reinking reported thatPFAC is currently comprised ofCurrently 10 past patients or family members from various backgrounds and experiences. She	

	explained that one of the purposes of the PFAC is to shape change throughout the hospitals. Recently, PFAC has provided feedback on the LifeLink project, Epic, patient billing, and organizational goal sub-committees;	
10. PROPOSED FY20 ORGANIZATIONAL GOALS	Katie Anderson left the meeting at 7:35 pm. Chair Kliger reported that even though the goals had not yet been submitted by the leadership team, the topic is open for discussion. Mark Adams, MD, CMO, asked the Committee to recommend organizational goals for 2020. Dr. Adams suggested that leadership is considering recommending mortality, readmissions, and physician engagement as quality metrics.	**Will be brought back to May 6th meeting**
11. PROPOSED FY20 COMMITTEE GOALS	Mark Adams, MD, CMO commented that there were no major changes to the proposed goals as further detailed in the materials. Julie Kliger, Chair, suggested including Committee engagement as an additional measure to include reliability, participation, and good dialogue. Dr. Adams commented that Committee members could do a self-assessment. The goals will be revised and brought back to the May meeting.	**Will be brought back to May 6th**
12. PUBLIC COMMUNICATION	There was no comment from the public.	
13. ADJOURN TO CLOSED SESSION	The meeting was adjourned to closed session at 7:49pm.	***Adjourned to closed session at 7:49pm***
14. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:50pm. Agenda Items 12-17 were covered in closed session.	
15. AGENDA ITEM 19: ADJOURNMENT	The meeting was adjourned at 7:53pm.	***Meeting adjourned at 7:21pm***

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

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Julie Kliger
Chair, Quality Committee

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Proposed 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**, 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) - FY21 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline –
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 –
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Review quarterly at the end of the meeting	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting
6. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals

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

From: [redacted]
Sent: [redacted]
To: Patient Experience
Subject: Reflections on a stay

Good Day -
Please forward the email below to Dr, Mark Adams:

Dr. Adams,
I recently had open heart surgery at El Camino Hospital. Over my 68 years I have visited most of the hospitals in the south bay and I have never experienced the compassionate and professional care that I received at your hospital. From Dr. Vial's and his surgical team's talent and care to the staffs in the Telemetry, Critical Care, Physical Therapy and Food Services. Whenever a opportunity arose to make my stay less stressful, or to prepare me for the next step in my recovery, your Team met the challenge.

The pride that your staff showed in being part of the El Camino Hospital was apparent.
My thanks to everyone I encountered as well as those behind the scene - You have a Staff and Facility that you should take great pride in. Please pass along my thanks.

One of the few things you have total control over - is the respect you show others.
[redacted]

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY19 Pacing Plan

FY2019 Q1		
JULY 2018	**AUGUST 6, 2018**	**SEPTEMBER 5, 2018**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Patient Story ▪ Progress Against FY 2019 Committee Goals (Nov 5, March 4, June 3) ▪ FY19 Pacing Plan ▪ Med Staff Quality Council Minutes	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY18 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 1. FY18 Quality Dashboard Results 2. Approve Committee Charter 3. Culture of Safety Discussion 4. LEAN Progress Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 7. Update on Patient and Family Centered Care 8. Mortality and Readmissions Metrics (FY19 Quality Goals) 9. Annual Patient Safety Report 10. FY18 Quality Dashboard Final Results 11. Pt. Experience (HCAHPS) 12. ED Pt. Satisfaction (Press Ganey)
FY2018 Q2		
OCTOBER 1, 2018	**NOVEMBER 5, 2018**	**DECEMBER 3, 2018**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: ~~1. Pt. Experience (HCAHPS)~~ 2. ED Pt. Satisfaction 3. Medical Staff Credentialing Process Update	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Safety Report for the Environment of Care 4. Quarterly Quality and Safety Review 5. Performance Improvement with Physician Management	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals – With FY19 QC Dashboard) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Culture of Safety Survey Report (Include OR) 6. Q1 FY19 Quality and Safety Review 7. What is Quality? (Maturity Model) 8. Throughput Case Study

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY19 Pacing Plan

FY2019 Q3		
JANUARY 2019	**FEBRUARY 4, 2019**	**MARCH 4, 2019**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 7. Q2 FY19 Quality and Safety Review (Q2 Reportable events if any) 8. Physician Burnout 9. Joint Commission Survey Results 10. Update on Patient Care Experience (ED Patient Satisfaction)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Proposed FY20 Committee Goals 2. Proposed FY20 Organizational Goals 3. Behavioral Health Services Quality Report 4. Committee Recruitment 5. What is Quality? (Maturity Model)
FY2019 Q4		
APRIL 1, 2019	**MAY 6, 2019**	**JUNE 3, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Committee Recruitment 2. What is Quality? (Maturity Model) 3. (Move to June) 4. Value Based Purchasing Report 5. Pt. Experience (HCAHPS) 6. (Done 2/4) 7. Approve FY20 Committee Goals 8. Proposed FY20 Committee Meeting Dates 9. Proposed FY20 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. PFAC Report 6. Hospital Update 7. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Approve FY20 Committee Goals (if needed) 4. Proposed FY20 Organizational Goals 5. Proposed FY20 Pacing Plan 6. Q3 FY19 Quality and Safety Review 7. Medical Director Goal Process and Accountability	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard ~~4.~~5. PFAC Report ~~5.~~6. Hospital Update ~~6.~~7. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Approve FY20 Pacing Plan 6. Leapfrog Survey

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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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	- FY18 Achievement and Metrics for FY19 (Q1 FY19) - FY20 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board – reviewed FY18 results on 9/5/18; FY20 goals review paced for 5/6/19
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) N/A - Review Medical Staff credentialing process (FY19) – COMPLETE - reviewed at 10/1/2018 meeting
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY19 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 – on track
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 – paced quarterly
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals – on the FY19 dashboard

SUBMITTED BY:

Chair: David Reeder
Executive Sponsor: Mark Adams, MD, CMO
Approved by the El Camino Hospital Board on June 13, 2018

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Hospital Update

May 6, 2019
Mark Adams, CMO

Operations

The patient experience team created a new "adopt a unit" approach to patient rounding. Every day, Monday-Friday, teams of leaders round on patients to receive feedback regarding their care. The themes from the feedback are collated and operational changes made based on patient real-time feedback. This is also a best practice across the country that is known to yield much more satisfied patients when leaders are able to address issues in the moment and/or recognize staff who have made a difference for patients during their stay.

Patient Messaging went live in the ED 3/25. We are using Epic to send emails and/or text messages to patients keeping them informed of their current ED visit. It provides them information on when they are next to be seen, when a provider has been assigned to them and when a test has been ordered. It also provides information guiding them through their visit.

Information Services

The imaging team configured and deployed the first pilot PACS workstation to a Radiologist's home. This remote workstation will assist with improving ED-Throughput. Once the pilot is complete, the team will coordinate to deploy the remaining three workstations to other radiologists' homes. Study Share, which is a tool to help organize and share images, teaching files, and reference case information for training and weekly conferences such as Tumor Board is now live in our Change PACS system. The tool is easy to use and the radiologists can quickly create teaching files on the fly while improving their efficiency. Our new "talk to text" has been live for just over a month and is receiving very positive reviews from physicians. This technology allows physicians to control the EHR via their voice and to quickly record documentation. Our Mountain View ED Medcial Director states this is the best product ECH has implemented as it now saves her 2 hours per day in medical decision making for patients in the Emergency Department. Training is currently underway for hospitalists at the MV campus.

We successfully upgraded to our EHR's current version on March 3rd with positive feedback regarding efficiencies of the new "Nurse Brain" feature to guide nursing regarding patient care actions. We also activated predictive analytics for unplanned re-admissions and fall risk. In addition, we implemented the wound care module for the wound clinic resulting in improved charge capture for physicians using automated charging based on more precise discrete documentation.

Workforce

Our new voluntary program for nurses which matches RN mentors with mentees kicked-off March25th and is designed to creates professional and personal development opportunities for employees by employees. Cohort 8 of our New Graduate RN Residency program begins on April 8th. We have developed a leadership development curriculum for the purpose of engaging

ECH's high-performing leaders in the area of leadership growth and learning. The first cohort begins April 22, 2019 and concludes June 24, 2019. We are excited about investing in the next wave of ECH leaders and look forward to their positive impact on the organization.

Philanthropy

As of February 28, 2019, El Camino Hospital Foundation has secured $17,826,215, the highest annual yield in the Foundation's history. In addition, many fundraising activities and events are scheduled for the remainder of the fiscal year.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care, and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: May 6, 2019
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. In addition, the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee. Going forward, those approvals will also be noted in this report.

A. ECH Board Actions

April 10, 2019

- Approved FY19 Period 7 and Period 8 Financial Reports.
- Approved the Annual Board Assessment Tool and Process to be Conducted by Via Healthcare Consulting

B. Finance and Audit Compliance and Audit Committee

- Approved Annual Summary of Physician Financial Transactions

C. Executive Compensation Committee Actions: None Since last Report

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: May 6, 2019
Subject: FY 19 Quality Dashboard

Recommendation(s):

Summary:

- Provide the Committee with a snapshot of the FY19 metrics monthly with trends over time and compared to the actual results from FY2018 and the FY 2019 goals.
- Annotation is provided to explain actions taken affecting each metric.
- Committee request to add a rolling 12-month average for each metric included.

1. Authority: Quality Comittee

2. Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2019 Quality, Efficiency and Service Goals.

3. Assessment:

4. Other Reviews:

5. Outcomes:

A. Mortality Index dropped in February; fewer deaths with documentation of active treatment and co-morbidities

B. Readmission Index dropped to below target level for FYTD with fewer COPD, Total Joint, and CHF readmissions, none for Pneumonia. Pts sent home with Telehealth per grant funding have a lower readmission rate, 3%.

C. Patient Throughput better at LG, with increased volume at MV, 10 beds in 3CW now can be used for med/surg/telemetry, to reduce holding in the ED.

D. Hospital-acquired Infections: Zero CLABSI for March 2019.

E. ALOS/GMLOS increased in February to above target level.

Suggested Committee Discussion Questions:

List of Attachments:

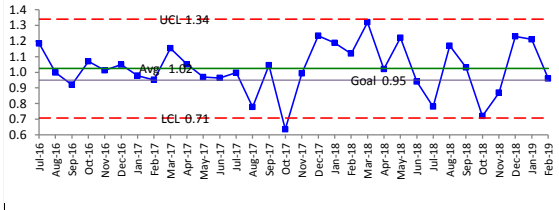
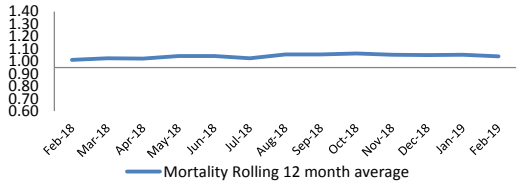
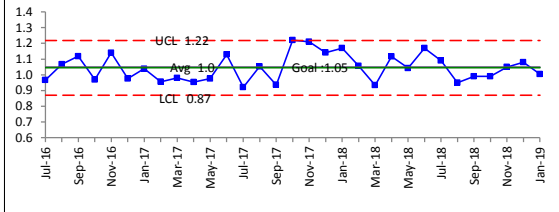
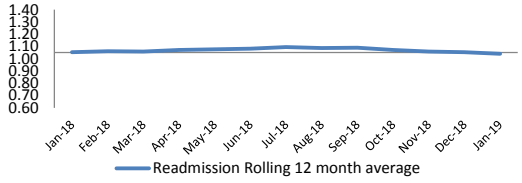
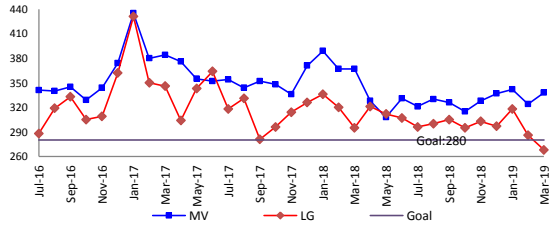
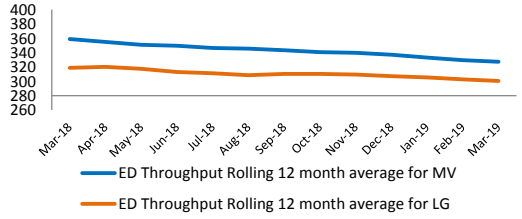
FY19 Quality Dashboard January 2019 data unless otherwise specified - final results

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

March 2019 (Unless otherwise specified)

Month to Board Quality Committee: May, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
Quality		**Month**	**FYTD**				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: February 2019*	0.96 (1.53%/1.60%)	1.00 (1.53%/1.52%)	1.05	0.95		
2	*Organizational Goal **Readmission Index (All Patient, All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: January 2018*	1.00 (7.47%/7.44%)	1.02 (7.21%/7.07%)	1.08	1.05		
3	* Organizational Goal **Patient Throughput- Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: March 2019*	MV: 338 mins LG: 268 mins	MV: 328 mins LG: 296 mins	MV: 350 mins LG: 314 mins	280 mins		

Definitions and Additional Information

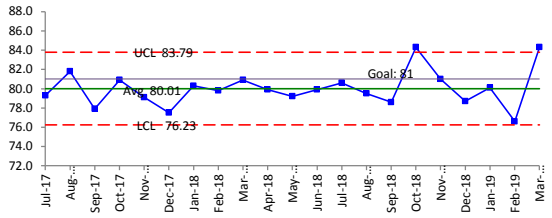
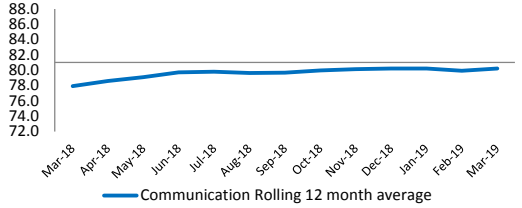
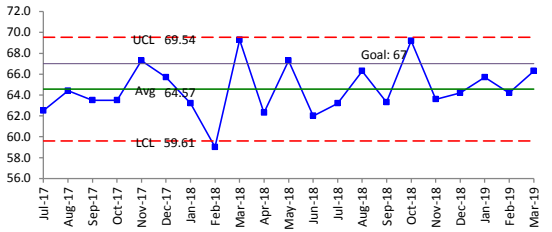
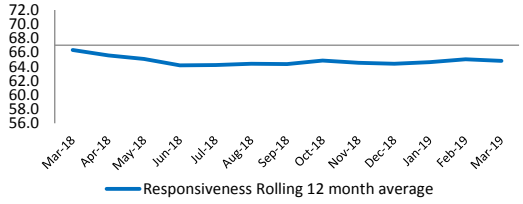
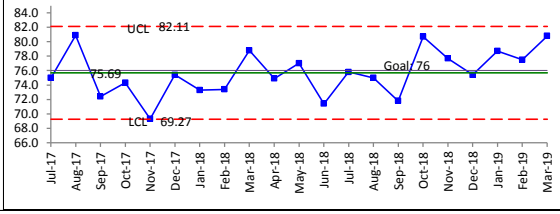
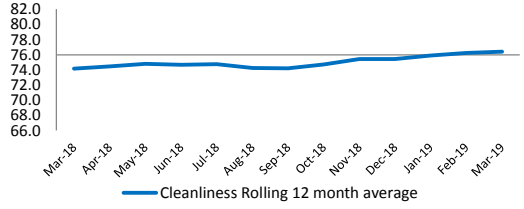
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Fewer in-hospital deaths than in January: 16 of 20 patients who died had DNR and Comfort Care orders at admission or with a week of admission. Expected ROM value higher than observed with better physician documentation of patient's co-morbidities and treatment.	Catherine Carson			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.	**Premier Quality Advisor**
Readmission Index (All Patient, All Cause Readmit) Observed/Expected	In Jan. fewer COPD readmits @ 8.33%, down from 16% in November. No readmits fro Pneumonia and low readmits for CHF (O/E 0.89%) and low for Total Joints @ 0.46 O/E. Weekly Readmit team reviewed 62 readmissions in January looking for preventable readmissions, issues with complications, or post-op infections, medication compliance, or social issues, with referrals as appropriate to medical staff peer review.l	Catherine Carson			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.	**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	In LG, the team has started to review daily delays for the various intervals to understand what barriers are slowing down flow. The nurses will step in and transport patients as needed. They are piloting a robot to help transport of lab specimens and are seeing an improvement in the frequency of times that the target for lab turn-arounds are met. They are also managing to the standard of nurse hand off to reduce phone tag. In MV, March volumes were higher, and there were many days were we didn't have enough of the right types of beds (i.e. PCU or tele). That led to a decision to create a flex unit on 3CW, which we could use for med/surg/tele or mother/baby as demand requires. The team was able to open up the unit the week of April 15 based on demand. A Capacity Management Center, pilot centralized bed mgmt, which started April 8th, to support managing flow across the hospital.	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**iCare Report: ECH ED Arrival to Floor**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

March 2019 (Unless otherwise specified)

Month to Board Quality Committee: May, 2019

	Service	FY19 Performance Month	FY19 Performance FYTD	HCAHPS Baseline Q4 2017 - Q3 2018	FY19 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: March 2019*	84.3 (212/252)	80.4 (1888/2349)	80.0	81.0		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: March 2019*	66.3 (160/242)	65.2 (1451/2227)	65.1	67.0		
6	* Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: March 2019*	80.8 (202/250)	77.1 (1790/2323)	74.5	76.0		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The following Nurse Communication Team projects continue: Leader Rounding, Enhanced interactions; whick include Bedside Handoff/Ppepp/Golden hour, and Care Team Coaching Appointment Process and Cards.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	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.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include: Leader Rounding, Standardized Call Light Answer Process and Escalation Process, and Enhanced Interactions.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	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.	**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include: Leader Rounding, Smile/Scan/Listen/Act which is Patient rounding for non-clinical staff, and Monthly Cleanliness Challenges.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	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.	**Press Ganey Tool**

El Camino Hospital
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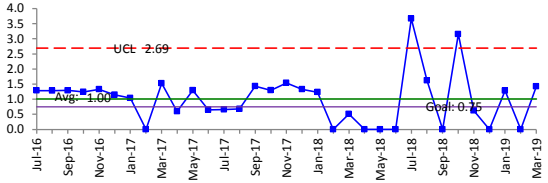
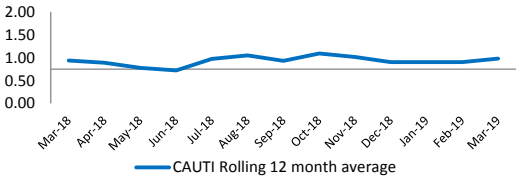
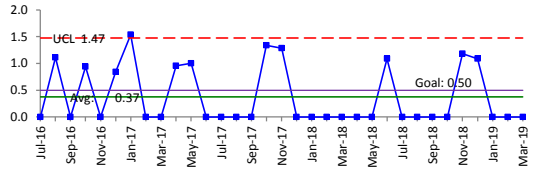
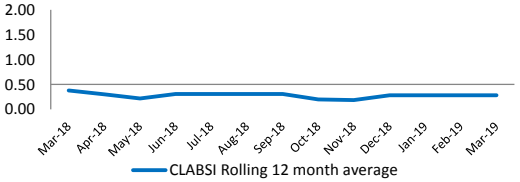
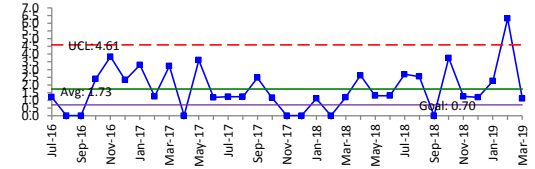
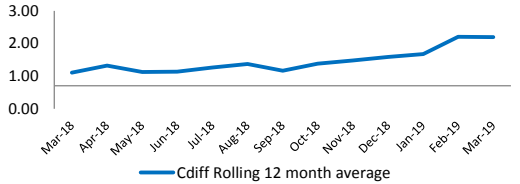
FY19 Organizational Goal and Quality Dashboard Update

March 2019 (Unless otherwise specified)

Month to Board Quality Committee: May, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	
Quality		**Month**	**FYTD**				
7	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: March 2019*	1.43 (2/1402)	1.26 (15/11936)	0.77	SIR Goal: <= 0.75		
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: March 2019*	0.00 (0/1082)	0.24 (2/8439)	0.28	SIR Goal: <= 0.50		
9	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: March 2019*	1.11 (1/9020)	2.32 (17/73196)	1.13	SIR Goal: <= 0.70		

Definitions and Additional Information

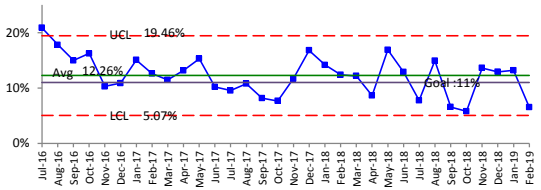
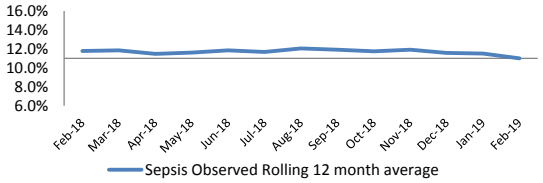
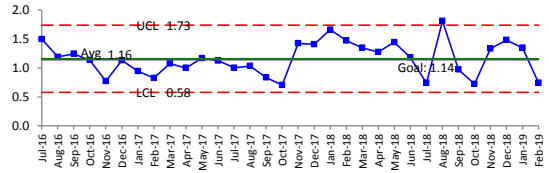
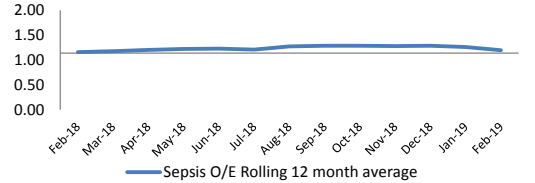
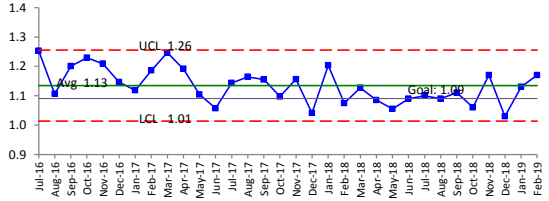
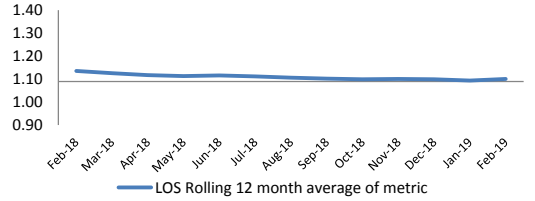
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	2 CAUTI in March: Both cases related to extended urinary catheter days (7,10 days) and both patients experienced increased bowel incontinence due to their treatments.	Catherine Carson/Catherine Nalesnik		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.	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.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Zero CLABSI for March 2019.	Catherine Carson/Catherine Nalesnik		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.	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.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	1 C.Diff hospital -acquired in March: 74 y/o admitted from home, post op spinal fusion with dehised wound and infection of neck, required mutiple antibiotics over 7 days, developed C. diff colitis after 6 hospital days.	Catherine Carson/Catherine Nalesnik		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.	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.	Clin Eff_IC_

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

March 2019 (Unless otherwise specified)

Month to Board Quality Committee: May, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
		Month	FYTD				
10	**Sepsis Mortality Observed Rate Enterprise, based on ICD-10 codes** *Date Period: February 2019*	6.54%	10.25%	11.72%	11.00%		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: Feburay 2019*	0.74 (6.54%/8.83%)	1.15	1.22	1.14		
Efficiency							
12	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: February 2019*	1.17	1.11	1.12	1.09		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Observed Rate Enterprise, based on ICD 10 codes	Review of Sepsis deaths shows active treatment with good documentation of co-morbidities.	Catherine Carson			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.	**Premier Quality Advisor**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Fewer patient died than expected. Regarding the Sep-1 bundle for the core measure, compliance at 80% in February. Also process metrics regarding Antibiotic administration at 74%, which translates to improved survival.	Catherine Carson			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.	**Premier Quality Advisor**
Arithmetic Observed LOS Average over Geometric LOS Expected (Medicare definition, MS-CC, Inpatient)	Index increased in Jan and February and Medicare LOS also increased to 5.25 in February. Issues with SNF facilities full with ECH patients waiting for beds. Utilization Management Committee seeking data on reasons for "avoidable days" through EPIC, requesting from Care Coordination. Area hospitals have contracted with SNF's to have beds available, ECH may need to consider this.	Cheryl Reinking Catherine Carson (Cornel Delogramatic)		The Observed LOS over the Expected LOS Ratio is determined by calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient's MD-DRG.	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.	**Premier Quality Advisor**

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: May 6, 2019
Subject: CDI Dashboard

Recommendation(s):

Summary: Provide the Committee with ECH current CDI metrics

1. Authority: Clinical Documentation Improvement is a department under Clinical Effectiveness which focuses on the quality of the documentation in the EHR and quality of the data sent for clinical informatics analysis.

2. Background: This dashboard provides metrics for assessing ECH's Clinical Documentation Improvement Program.

3. Assessment:

4. Other Reviews:

5. Outcomes:

A. The physician response rate to queries is at 100%, and the query agree rate has increased over last year.

B. Focus continues on physician education to document patient co-morbidities and to understand the effect of this documentation.

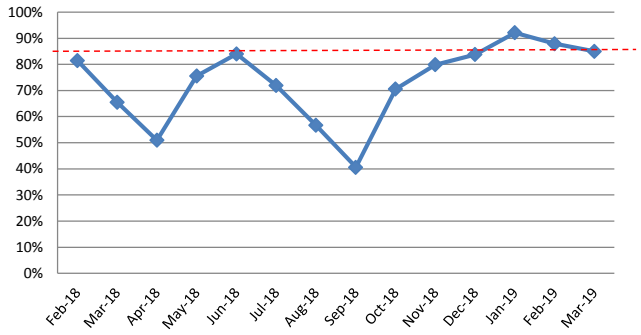
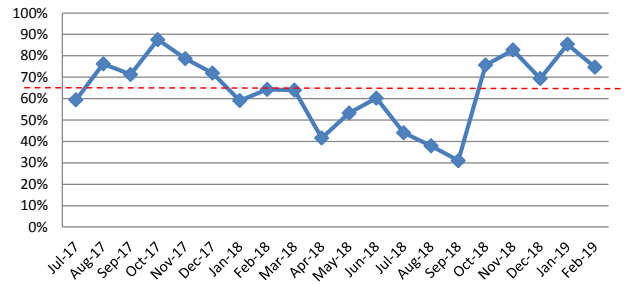
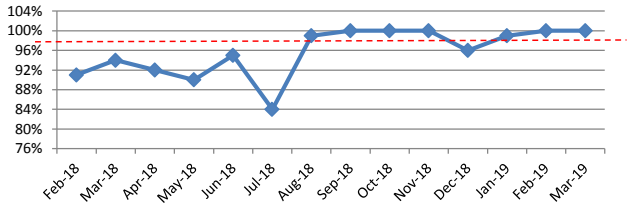
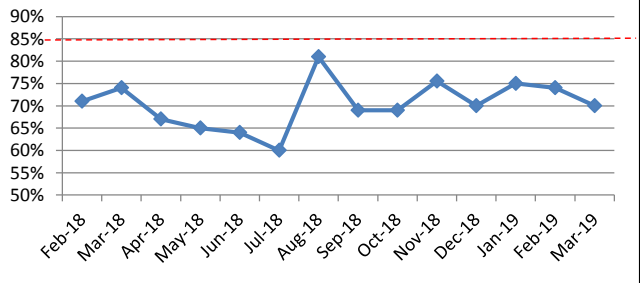
Suggested Committee Discussion Questions:

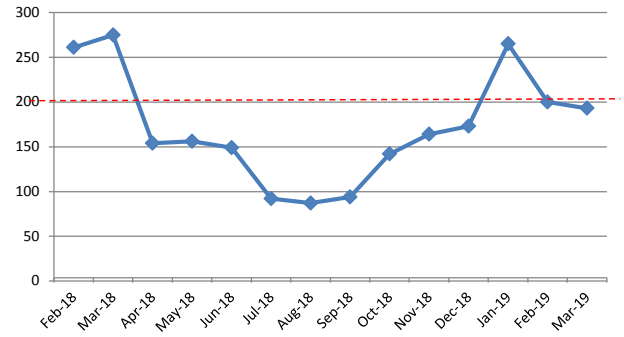
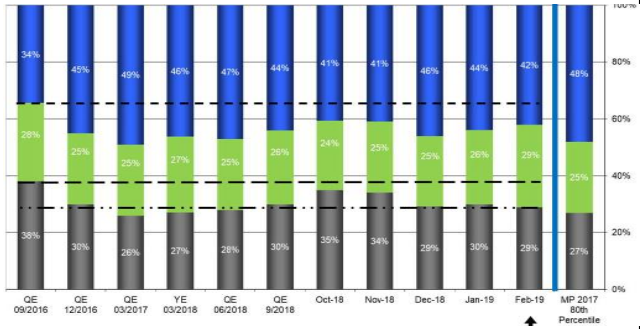
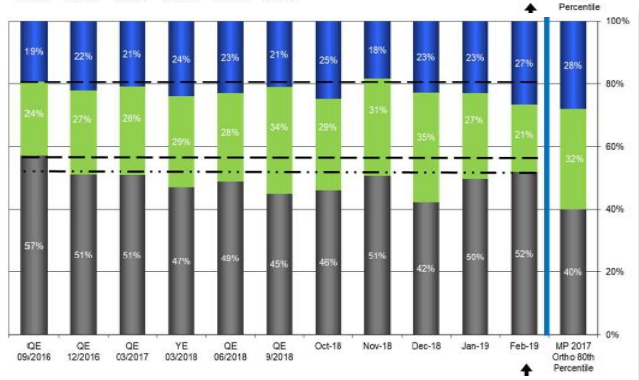
List of Attachments:

CDI Dashboard (to March 2019 data)

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Clinical Documentation Improvement Dashboard (Monthly)

As of April 10, 2019			Baseline	FY19 Goal	Trend	Comments
Coverage	Performance		FY2018	FY2019 goal		
1	**Medicare**	March 2019 605/514 85% / FYTD 76%	79%	85%		During month of Decmber through mid February department had all 5 FTE filled, reflected also in high coverage rate. One memebr left in mid February, actively looking for replacement.
2	**All Payor**	March 2019 885/705 80% / FYTD 64%	66%	65%		Focus of review on ALL PAYER - it is directed towards all ECH population expected mortality optimization. After long time we consistently started to cover above the set goals for FY 2019.
Physician Response	Performance		FY2018	FY 2019 goal		
4	**Query Response Rate**	March 2019 100% / FYTD 98%	92%	>90%		Consistently 100% for the last 3 months. At the highest level ever registered. Physicians very engaged in documentation clarification opportunities.
5	**Query Agree Rate**	March 2019 70% / FYTD 72%	66%	>85%		Agreement rate still in range of 70%. Opportunities has been indentified in queries with outcomes "clinicaly undetermined" and irrelevant commnets to the question adressed. Education around the rationale of the question. Expect numbers to increase with the new query templates developed in complinace with IPPS FY 2019 requirements.

#	Queries volume	Performance		FY2018	FY 2019 goal		
7	Query volume	**March 2019** 189 27%	**FYTD** 157	255	30% of all reviewed accounts		Query volumes have been trending up as the number of CDI staff increased. Direct correlation with the number of cases reviewed. Worh noting that despite increased number of queries placed the agreement rate al all time high.
8	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Feb 2019** MCC 42% CC 29% NCC 29%	**N/A**	**Nat 80th%** MCC 48% CC 27% No CC 29%	MCC 48% CC 25% No CC 27%		Higher MCC Capture Rate is better. This effects Reimbursement, Expected GMLOS, Expected Mortality %, and CMI. National 80th Percentile is computed by CMS and published annually on 10/1.
9	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Feb 2019** MCC 27% CC 21% NCC 52%	**N/A**	**Nat 80th% CMS 2018** MCC 31% CC 32% No CC 37%	**Nat 80th% CMS 2019** MCC 28% CC 32% No CC 40%		Surgical cases make up 30-40% of our Medicare patient volume. The biggest impact in reimbursement, CMI, GMLOS, and Expected mortality will come from increased Surgical CC/ MCC capture, coupled with sustained Medical CC/MCC capture. Working closely with HVI, orthopedic and stroke teams to document comorbid conditions.

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: May 6, 2019
Subject: 2019 Core Measure Summary Report

Recommendation(s):

Summary:

- Provide the Committee with ECH current performance of core measures
- Annotation includes what programs the different metrics are applied to

1. Authority: CMS reduces Hospital Medicare reimbursement if a hospital does not voluntarily collect core measure data and submit it quarterly on time.

2. Background: This report provides data through February 2019 of required CMS and TJC Core Measure metrics.

3. Assessment:

4. Other Reviews:

5. Outcomes:

A. Data is now presented in two dashboards, formated to allow for description and explanation of actions taken to address performance.

B. CMS and TJC retire measures that become "topped out" when most hospitals achieve 95% compliance or higher. New measures are also added each year in January.

C. Retired: ED-1b Median time from ED arrival to ED departure for admitted patient

D. Retired: TOB-1 Tobacco Treatment and SUB-1 Substance Use for Psychiatric patients
E. New measure for 2019 is PC-06 – Unexpected complications in term newborns.

Suggested Committee Discussion Questions:

List of Attachments:

CY 2019 Year to Date Core Measure Summary Report

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Core Measures Summary Report

Date Period: February 2019

Quality Committee of the Board
May, 2019

Chart Legend:

The blue line represents ECH observed value.
The green line shows the All Core Measures Hospitals benchmark value.
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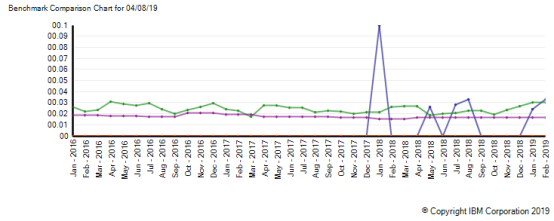
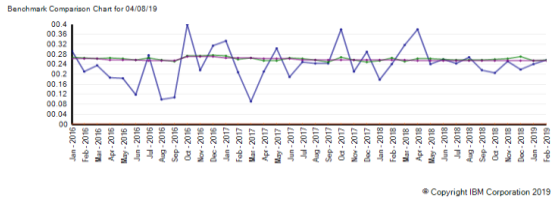
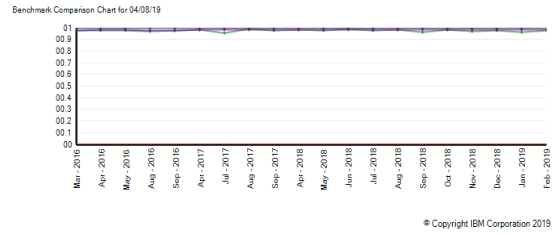
The purple line shows the Joint Commission benchmarks benchmark value

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Perinatal Care Mother		Month	FYTD				
1	**PC01- *Elective Delivery Prior to 39 weeks gestation (lower=better)*** *Date Period: February 2019*	3.33% (1/30)	1.42% (4/281)	1.40% (2/143)	0%		This measure is included in Leapfrog, Hospital Compare and Value-Based Purchasing public -reported data. This is also submitted to California Maternal Quality Care Collaborative (CMQCC). Results can be analyzed further to determine specific patterns or trends to help reduce elective deliveries based on specific ICD-10 codes or patient populations.
2	**PC02- Cesarean Birth (lower=better)** *Date Period: February 2019*	25.60% (32/125)	23.71% (289/1219)	26.27% (166/632)	<23.90%		Our internal goal is aligned with the Let's Get Healthy California (LGHC) target goal of 23.9% or lower. We've had 2 insurance providers who will stop sending patients to us if our rate is higher than the target goal. Let's Get Healthy California's Indicator Progress: In 2012 (baseline year), the NTSV Cesarean Birth Rate was 27.0%. The most recent rate available is 24.5% (2017). LGHC hopes to reach a target of 23.9% or lower by 2022.
3	**PC03- Antenatal Steroids** *Date Period: February 2019*	100%	100%	100%	100%		The National Institutes of Health 1994 recommendation is to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. A single course of corticosteroids should be given at 24 0/7 to 33 6/7 weeks gestation (NIH, 2000). A Cochrane meta-analysis reinforces the beneficial effect of this therapy regardless of membrane status and further concludes for all preterm deliveries the single course of corticosteroids should be routinely administered (Roberts & Dalziel, 2006).

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Data Source
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	**IBM CareDiscovery Quality Measures**
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	**IBM CareDiscovery Quality Measures**
PC-03: Antenatal Steroids Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed	Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed	**IBM CareDiscovery Quality Measures**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Core Measures Summary Report

Date Period: February 2019

Quality Committee of the Board
May, 2019

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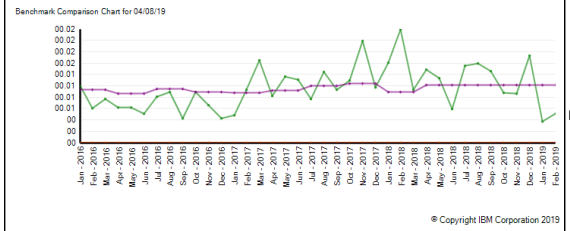
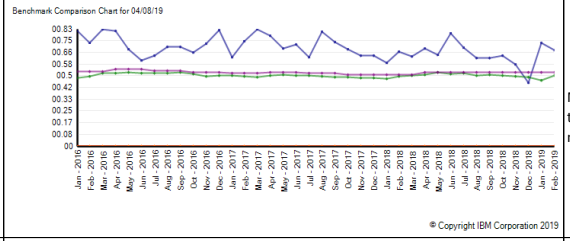
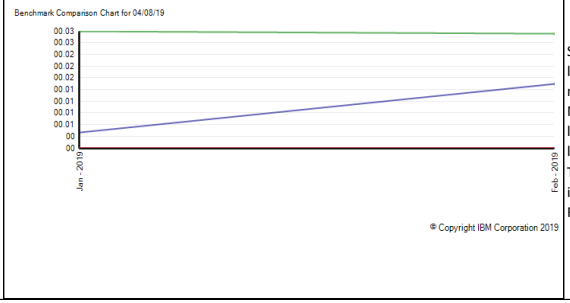
		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Perinatal Care Babies		Month	FYTD				
4	**PCB04- Health Care-Associated BSI in Newborns (lower=better)** *Date Period: February 2019*	0%	0%	0%	0%		Improvement Noted As: Decrease in the rate
5	**PC05- Exclusive Breast Milk Feeding** *Date Period: February 2019*	68%	63%	68%	70%		MBU has a committee for hand expressing breast milk and they're starting to review if this is impacting re-admission – how many of the readmissions are babies who were not exclusively breastfed?
6	**PC06- Unexpected Complications in Term Newborns (lower=better)** *Date Period: February 2019*	1.61%	0.99%	new in 2019	0%		Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe e.g. use of CPAP or bone fracture. Examples include less severe respiratory complications e.g. Transient Tachypnea of the Newborn, or infections with a longer length of stay not including sepsis, infants who have a prolonged length of stay of over 5 days. Fall outs are referred to Peer Review for screening.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
PCB-04: Health Care-Associated BSI in Newborns Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Newborns with septicemia or bacteremia Denominator Statement: Liveborn newborns	Numerator Statement: Newborns with septicemia or bacteremia Denominator Statement: Liveborn newborns	**IBM CareDiscovery Quality Measures**
PC-05: Exclusive Breast Milk Feeding during the newborn's entire hospitalization	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital		**IBM CareDiscovery Quality Measures**
PC-06: Unexpected Complications in Term Newborns - The percent of infants with unexpected newborn complications among full term newborns with no preexisting conditions.	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?		**IBM CareDiscovery Quality Measures**

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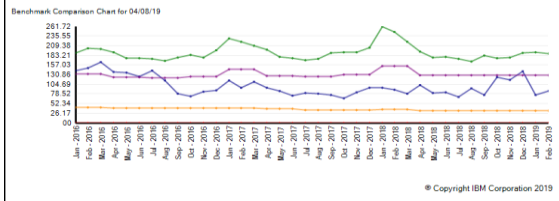
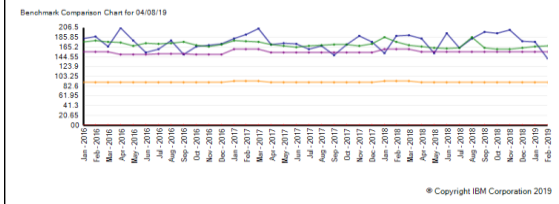
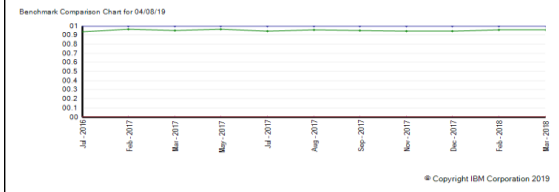
		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
ED Throughput		**Month**	**FYTD**				
7	**ED2b- Admit Decision Time to ED Departure Time for Admitted Patients (lower=better)** *Date Period: February 2019*	ENT 87 mins MV 90 mins LG 56mins	ENT 85 mins MV 87 mins LG 73 mins	ENT 95 mins MV 96 mins LG 79 mins	<120 mins		Description: Median time from admit decision time to time of departure from the emergency department for admitted patients.
8	***OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients(lower=better)*** *Date Period: February 2019*	ENT 141 mins MV170 mins LG 114mins	ENT 185 mins MV 202 mins LG 124 mins	ENT 183 mins MV 197 mins LG 137mins	<180 mins		Description: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
		Month	**FYTD**				
Outpatient Measures							
9	***PC-OP AMIPerfect Care Outpatient Acute Myocardial Infarction*** *Date Period: February 2019*	No cases	No cases	100%	100%		Description: Emergency Department acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients	TJC	Hospital has multiple mulit-disciplinary committees working on improving bridging orders, nursing hand-off interval, bed flow, etc.	Numerator Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients Denominator Statement:Any ED Patient from the facility's emergency department. Excludes Patients who are not an ED Patient.	Definition: The documented date the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status date is the date the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.	**IBM CareDiscovery Quality Measures**
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital OQR Specifications Manual		Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department		**IBM CareDiscovery Quality Measures**
Measure Name	**Definition Owner**	**Work Group**	**FY 2018 Definition**	**FY 2019 Definition**	**Source**
Perfect Care-OP-AMI: OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Hospital OQR Specifications Manual		OP2-Numerator Statement: Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less. Denominator Statement: Emergency Department AMI patients with ST-segment elevation on ECG who received fibrinolytic therapy.		**IBM CareDiscovery Quality Measures**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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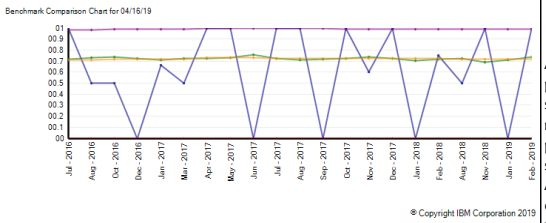
10	**OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke** *Date Period: February 2019*	100% 1/1	60% 3/5	69% 11/16	100%		AHA/ASA guidelines recommend that brain imaging be interpreted by a qualified provider within 45 minutes of ED arrival because results from these studies are critical to differentiate ischemic strokes, hemorrhagic strokes, and stroke mimics; imaging findings can be used to identify appropriate candidates for tissue plasminogen activator (tPA), which is the gold standard for treating acute ischemic stroke (Jauch et al. 2013). Because the Food and Drug Administration (FDA) has approved tPA for use within three hours of symptom onset, prompt imaging can accelerate administration of the time-sensitive therapy for eligible patients (Cheng et al. 2015).]

Definitions and Additional Information

OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and having a time from ED arrival to interpretation of the Head CT or MRI scan within 45 minutes of arrival.	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee	Numerator Statement: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator Statement: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well with an order for a head CT or MRI scan		**IBM CareDiscovery Quality Measures**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Hospital Based Inpatient Psychiatric Services (HBIPS)
Core Measures Summary Report

Date Period: February 2019

Quality Committee of the Board
May, 2019

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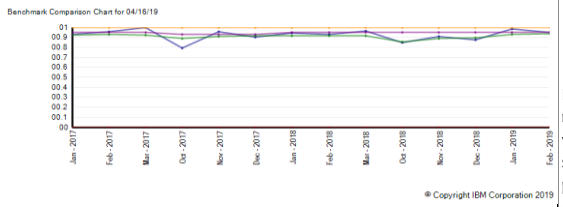
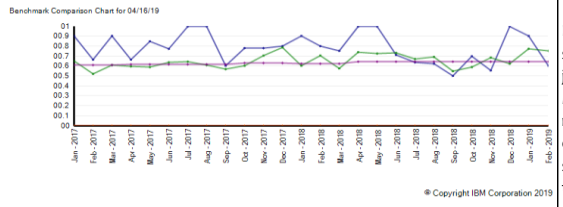
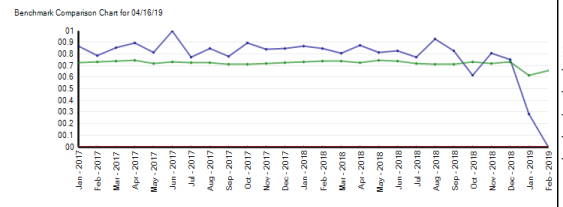
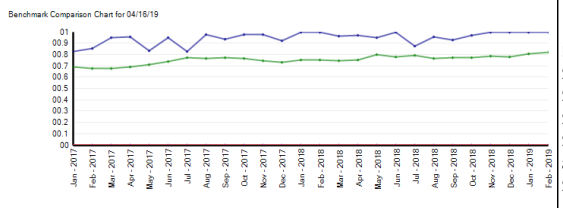
		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Hospital Based Inpatient Psychiatric Services (HI		Month	FYTD				
1	**IMM-2 Influenza Immunization** *Date Period: February 2019*	95%	91%	91%	100%		Each year, flu vaccines start to become available usually in September and most influenza vaccine is administered in October – December, but the vaccine is recommended to be administered throughout the influenza season which can last until May in some years. For the purposes of this project, the hospitals are only responsible for discharges October through March.
2	**HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification** *Date Period: February 2019*	60%	71%	84%	80%		Description: Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification Measure Analysis Suggestions: For quality improvement purposes, the measurement system may want to create reports to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. This would allow healthcare organizations to target education efforts.
3	**PC-TOB Perfect Care - Tobacco Use** *Date Period: February 2019*	0%	76%	84%	80%		Perfect Care-TOB comprises the following: TOB-1 Tobacco Use Screening TOB-2 Tobacco Use Treatment Provided or Offered TOB-2a Tobacco Use Treatment TOB-3 Tobacco Use Treatment Provided or Offered at Discharge TOB-3a Tobacco Use Treatment at Discharge
4	**PC-SUB Perfect Care - Substance Abuse** *Date Period: February 2019*	100%	96%	96%	80%		Perfect Care-SUB comprises the following: SUB-1 Alcohol Use Screening SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Data Source
IMM-2: Influenza Immunization	CMS/TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the	**IBM CareDiscovery Quality Measures**
HBIPS-5: Patients Discharged on multiple antipsychotic medications with appropriate justification	TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	**IBM CareDiscovery Quality Measures**
PC-TOB: Perfect Care - Tobacco Use	TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay within the first three days after admission Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.	Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay within the first three days after admission Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.	**IBM CareDiscovery Quality Measures**
PC-SUB: Perfect Care - Substance Abuse	TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Hospitalized patients who are screened within the first day of admission using a validated screening questionnaire for unhealthy alcohol use Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.	Hospitalized patients who are screened within the first day of admission using a validated screening questionnaire for unhealthy alcohol use Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.	**IBM CareDiscovery Quality Measures**

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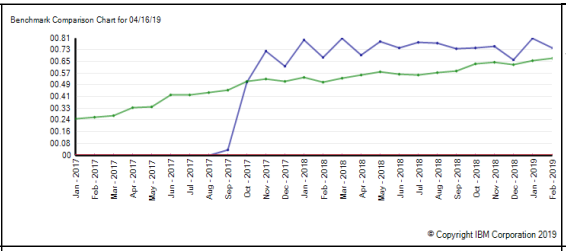
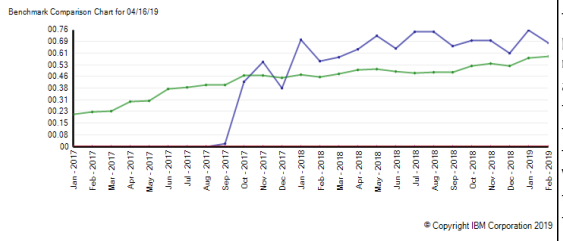
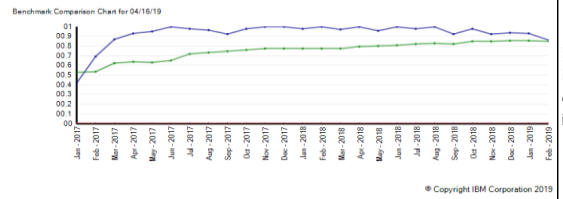
		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
		Month	FYTD				
Restraints and Seclusions							
5	**TR-1 Transition Record with Specified Elements Received by Discharged Patients** *Date Period: February 2019*	75%	75%	54%	75%		Transition record – A core, standardized set of data elements related to patient's demographics, diagnosis, treatment, and care plan that is discussed with and provided to the patient in a printed or electronic format at each transition of care and transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may only be provided in electronic format if acceptable to the patient and only after all components have been discussed with the patient.
6	**TR-2 Timely Transmission of Transition Record** *Date Period: February 2019*	68%	70%	44%	75%		Transmitted – A transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via mail, fax, and secure email. If the follow up healthcare professional has access to the electronic health record (EHR), this must be documented as the transmission method. It is also acceptable to provide a hard copy of the transition record to the personnel transporting the patient to the receiving facility. The time and method of transmission must be documented. Within 24 hours of discharge – Calculated as 24 consecutive hours from the time the facility ordinarily records the patient discharge. This may include transmission prior to discharge, but the timeframe must end 24 hours after discharge.
7	**MET Screening For Metabolic Disorders** *Date Period: February 2019*	86%	94%	98%	75%		Description: Percentage of patients discharged with antipsychotics from an IPF for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge either prior to or during the index IPF stay

Definitions and Additional Information

TR-1 Transition Record with Specified Elements Received by Discharged Patients	CMS/TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	**IBM CareDiscovery Quality Measures**
TR-2: Timely Transmission of Transition Record	CMS/TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	**IBM CareDiscovery Quality Measures**
MET: Screening For Metabolic Disorders	CMS/TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days.	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high	**IBM CareDiscovery Quality Measures**
Measure Name	**Definition Owner**	**Work Group**	**FY 2018 Definition**	**FY 2019 Definition**	**Source**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

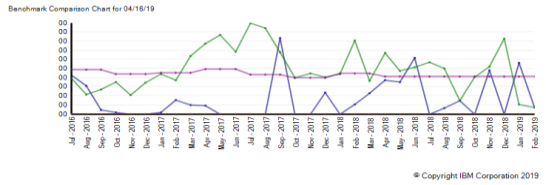
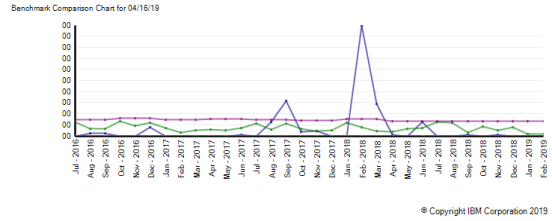
Hospital Based Inpatient Psychiatric Services (HBIPS)
Core Measures Summary Report

Date Period: February 2019

Quality Committee of the Board
May, 2019

Chart Legend:

The blue line represents your observed value.
The green line shows the All Core Measures Hospitals benchmark value.
The orange line shows the CMS Standard of Excellence - Top 10% of Hospitals benchmark value.
The purple line shows the Joint Commission benchmarks benchmark value

8	***Metrics #9 HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)*** *Date Period: February 2019*	0.0001 (0.8333/11232)	0.0002 (20.5833/112824)	0.0003 (42.2333/168648)	0.0004		Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.
9	**HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower=better)** *Date Period: February 2019* **Event measures (HBIPS-2 and HBIPS-3) are calculated by event occurrence date*	0 (0/11232)	0 (0.5833/112824)	0.0004 (60.2/168648)	0.0003		Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Definitions and Additional Information

HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)	TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Numerator : The total number of hours that all psychiatric inpatients were maintained in physical restraint Denominator : Number of psychiatric inpatient days	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**IBM CareDiscovery Quality Measures**
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower=better)	TJC	Quarterly meeting/monthly emails with BHS leadership and staff with iCare Support	Numerator:The total number of hours that all psychiatric inpatients were held in seclusion Denominator: Number of psychiatric inpatient days	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**IBM CareDiscovery Quality Measures**

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Medical Director Goal Process and Accountability

Mark Adams MD CMO
Quality Committee
May 6, 2019

Medical Director Goal Process

System Responsibilities:

- Adopt at least one organizational goal
- Attend the CMO Advisory Council
- Participate in the PULSE 360 program
- Participate in leadership development

Medical Director Goal Process

Individual Goals:

- Discuss potential goals with assigned director
- Select organizational goal
- Submit one outcomes goal and one process goal with specific metrics
- Review with CMO or designee for approval

Medical Director Goal Process

Goal monitoring and verification:

- Report on goal progress mid fiscal year
- Meet with CMO for annual performance review
- Submit final metrics at fiscal year end
- Verify final metrics with assigned director
- Final approval by CMO to authorize payment

El Camino Hospital Medical Director, **Interventional Services Electrophysiology** : MV Campus PAMF

Affiliation:
Palo Alto Medical Foundation

Years served as ECH Medical Director: 3

Compensation:
$195/hr
20 hours/mo; 240/yr
$46,800/yr
(annual comp below 75th %)

Total Hours Submitted in FY18:
181

Designated Manager:
Amy Maher

Medical Directorship Expires:
June 30, 2020

FY19 Quality Goals:

Quality Goal #1: Mortality Index - All Patients: External Benchmark: Premier Quality Advisor Top Quartile = 0.77 (2016 Premier Top Overall Performers)

ECH Baseline: 1.02
ECH Baseline Time Period: FY17
ECH Performance Metric Target: .95
ECH Performance Metric Time Period: July 1, 2018 through June 30, 2019

Quality Goal #2: Create a tool for implanting physicians to share with patients prior to implantation of the implantable cardioverter defibrillator (ICD) device to meet the new CMS requirement of documented 'Shared Decision Making' for patients receiving an ICD. Pamphlet/handout will include an explanation of risks and benefits of implanting the ICD.

Deliverable: Submit pamphlet/handout for approval at the Electrophysiology Operations Team meeting by October 31, 2018.

FY19 Quality Goal Progress/Notes: No issues

FY18 Quality Goals:

Quality Goal #1 ***(Goal Met)*****:** Improve NCDR Atrial Fibrillation Registry Quality of Life Survey collection rate.

ECH Baseline: 58.28%
ECH Baseline Time Period: June 1, 2016 through June 30, 2017
Performance Metric Target: 75%
Performance Metric Target Time Period: July 1, 2017 through June 30, 2018

Quality Goal #2 ***(Goal Met)*****:** Create a same-day discharge protocol for Atrial Fibrillation Ablation patients.

Deliverable: Submit protocol for approval by the HVI Business Team Meeting by June 30, 2018.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee ("Quality Committee")
From: Mark Adams, MD, Chief Medical Officer
Date: May 6, 2019
Subject: FY20 Organizational Incentive Goal Recommendations

Purpose: To obtain the Committee's recommendation that the Board approve the Proposed FY20 Quality and Patient Experience Goals, Methodologies for Determining Metrics and Weighting.

Summary:

1. Situation: Each fiscal year, the Board reviews and approves the final organizational incentive goals for management. These represent a small group of goals that are shared throughout the organization. The Quality Committee is tasked with recommending to the Board those organizational incentive goals that reflect patient quality, safety, and 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: For FY19, the Quality Committee recommended two quality and three experience goals that were subsequently adopted by the Board. For the quality goals, mortality index and readmission index were selected with the intent that these would be multi-year goals and would be carried forward to FY22 with the final year metrics achieving the top tier performance based on the Premier Care Science methodology. The experience goals were selected with the intent of emphasizing specific areas in need of improvement. The organizational incentive goals are a small subset of the many activities and metrics followed by the Quality Committee related to quality, safety, and experience. The incentive goals are selected based on the following principles: significantly impacts quality, safety, and experience; easy to understand, broad reach across the organization; impacts financial performance; impacts consumer choice; and aligns with strategic goals.

4. Assessment: The work of improving the mortality index and readmission index is underway with 10 interdisciplinary teams at work. These are multi-year goals and they meet all of the principles outlined above. Management is recommending that these be included in the organizational incentive goals for FY20. The HCAHPS experience measures—discharge information and staff responsiveness—were selected by management to be included in the organizational incentive goals as these goals also align with the principles above. Of course the Quality Committee will be tracking other metrics to be included on the Quality Committee Dashboard.

5. Other Reviews: The Executive Compensation Committee will review the overall structure of the goals and metrics at its May 30th meeting and the Finance Committee will review the financial goal at its May 28th meeting. When our FY 19 year end results are available in late summer, management will bring this topic back to the Committees and the Board to review and approve the actual metrics in accordance with the methodologies proposed here.

6. Outcomes: Management requests that the Quality Committee recommend these four goals to be included in the Board of Directors organizational incentive goals for FY20.

List of Attachments:

Proposed FY20 Organizational Goals
May 6, 2019

1. Proposed FY20 Organizational Goals

Suggested Committee Discussion Questions:

1. Do the goals align with the organization's strategic plan?
2. How were the methodologies for setting the metrics chosen?
3. Is the weighting appropriate for each goal?

FY20 PROPOSED ORGANIZATIONAL INCENTIVE GOALS

DRAFT 4/30/19

STRATEGY	Weight	GOAL	OBJECTIVES/OUTCOMES	Benchmark		Measurement Defined			Measurement Period	Owner
Finance	Threshold	Budgeted Operating Margin				95% of Budgeted			FY20	Iftikhar
	To Total 100%	What will be achieved to make strategy a success?	Define specific outcome and measurement	Internal Benchmarks	Provide source and benchmark data	Minimum	Target	Stretch	Whenever possible goal should be based on full fiscal year	
Quality and Safety	30.0%	Zero Preventable Harm	Risk-Adjusted Inpatient Mortality Index	1.05 in FY 18. 0.90 FY19 through 11/18. FY 19 target: 0.95	Premier Standard Risk Calculation	Lower of actual FY 19 or 0.95 (FY19 target)	1/3 gap to P85	1/2 gap to P85	FY20	Mark
			Risk-Adjusted Readmission Index	1.08 in FY 18. 1.00 through 11/18	Premier Standard Risk Calculation	Lower of actual FY 19 or 1.05 (FY19 target)	1/3 gap to P85	1/2 gap to P85		
Service	25.0%	Exceptional Personalized Experience, Always	HCAHPS : Staff Responsiveness	65.1 through 12/18. FY19 goal 67.0	HCAHPS baseline: 65.1 (Q417-Q318)	Improvement over FY 2019 = top 50% of improvers	Improvement over FY 2019 = top 30% of improvers	Improvement over FY 2019 = top 10% of improvers	FY20	Cheryl
			HCAHPS: Discharge Information		Improvement based on Press Ganey data for FY19 all hospitals	Improvement over FY 2019 = top 50% of improvers	Improvement over FY 2019 = top 30% of improvers	Improvement over FY 2019 = top 10% of improvers	FY20	
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. FY19 target 4.14	Press Ganey 4.32 is 90th percentile for FY19	4.24	4.27	4.30	FY20	Kathryn
			Employees: Participation in Employee Engagement survey	Last two surveys: 79% and 87%. FY19 target 80	Press Ganey average participation - 75%	80	85	90	FY20	Kathryn
Growth	20.0%	Market Relevance and Access	Adjusted Discharges	Adjusted discharges 0.7% below budget through P8FY19. Planned growth is 3% in FY20		98% of Budget	100% of Budget	102% of budget	FY20	Jim
Finance	5.0%	Sustainable Strength and Vitality	Net Operating Margin for El Camino Health	12.6% through P8FY18 which is 102% of budget		95% of Budget	100% of Budget	105% of Budget	FY20	Iftikhar

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

PROPOSED FY20 Pacing Plan

FY2020 Q1		
JULY 2019	**AUGUST 5, 2019**	**SEPTEMBER 9, 2019**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Patient Story ▪ Progress Against FY 2020 Committee Goals ▪ FY20 Pacing Plan ▪ Med Staff Quality Council Minutes	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY20 Quality Dashboard 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)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 7. Update on Patient and Family Centered Care 8. Recommend FY20 Organizational Goal Metrics 9. Annual Patient Safety Report 10. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals) 11. Pt. Experience (HCAHPS) 12. ED Pt. Satisfaction (Press Ganey)
FY2020 Q2		
OCTOBER 7, 2019	**NOVEMBER 4, 2019**	**DECEMBER 2, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Standing Agenda Items: 1. Report on Medical Staff Peer Review Process	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Safety Report for the Environment of Care 4. Q1 FY20 Quarterly Quality and Safety Review 5. Performance Improvement with Physician Management	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 1. Update on Patient and Family Centered Care 2. Readmission Dashboard 3. PSI-90 Pt. Safety Indicators

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

PROPOSED FY20 Pacing Plan

FY2020 Q3		
JANUARY 2020	**FEBRUARY 3, 2020**	**MARCH 2, 2020**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 7. Q2 FY20 Quality and Safety Review 8. Update on Patient Care Experience	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Proposed FY21 Committee Goals 2. Proposed FY21 Organizational Goals
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. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Value Based Purchasing Report 2. Pt. Experience (HCAHPS) 3. Approve FY21 Committee Goals 4. Proposed FY21 Committee Meeting Dates 5. Proposed FY21 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Approve FY21 Committee Goals (if needed) 4. Proposed FY21 Organizational Goals 5. Proposed FY21Pacing Plan 6. Q3 FY20 Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Readmission Dashboard 3. PSI-90 Pt. Safety Indicators 4. Approve FY21 Pacing Plan 5. Leapfrog Survey