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

Monday, August 5, 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 – 5:32 pm**
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.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (June 3, 2019) ***Information*** b. Patient Story c. FY20 Pacing Plan d. Progress Against FY 2020 Quality Committee Goals e. Hospital Update f. Annual Performance Improvement Report	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 5:33 – 5:36**
4.	**AD HOC COMMITTEE REPORT AND CANDIDATE INTERVIEWS** **ATTACHMENT 4** a. Caroline Currie b. Alyson Falwell c. Krutica Sharma, MD	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 5:36 – 6:36**
5.	**REPORT ON BOARD ACTIONS**	Julie Kliger, Quality Committee Chair		**Information 6:36 – 6:41**
6.	**APPOINTMENT OF VICE CHAIR**	Julie Kliger, Quality Committee Chair		**Information 6:41 – 6:43**
7.	**FY19 QUALITY DASHBOARD RESULTS (Includes FY19 Org. Incentive Goals)** **ATTACHMENT 7**	Mark Adams, MD, CMO		**Discussion 6:43 – 7:03**
8.	**FY20 QUALITY DASHBOARD** **ATTACHMENT 8**	Mark Adams, MD, CMO		**Discussion 7:03 – 7:08**
9.	**PSI-4,18-19 METRICS** **ATTACHMENT 9**	Mark Adams, MD, CMO		**Discussion 7:08 – 7:18**

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	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10.	**WHO MAKES UP ED CENSUS** **ATTACHMENT 10**	Mark Adams, MD, CMO		**Discussion** **7:18 – 7:28**
11.	**DRAFT BOARD-LEVEL QC REPORTING** **ATTACHMENT 11**	Mark Adams, MD, CMO		**Discussion** **7:28 – 7:48**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**Information** **7:48 – 7:49**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required** **7:49 – 7:50**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**7:50 – 7:51**
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 Close Session of the Quality Committee Meeting (June 3, 2019) ***For Information*** b. Med Staff Quality Council Minutes	Julie Kliger, Quality Committee Chair		**Motion Required** **7:51 – 7:53**
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	Mark Adams, MD, CMO		**Discussion** **7:53 – 7:58**
17.	**Q4 FY19 QUARTERLY QUALITY AND SAFETY REVIEW**	Mark Adams, MD, CMO		**Discussion** **7:58 – 8:08**
18.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required** **8:08 – 8:09**
19.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**8:09 – 8:10**
20.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required** **8:10 – 8:11 pm**

Upcoming FY 20 Meetings:

Monday, September 9, 2019	Monday, February 3, 2020	Monday, June 1, 2020
Monday, October 7, 2019	Monday, March 2, 2020	
Monday, November 4, 2019	Monday, April 6, 2020	
Monday, December 2, 2019	Monday, May 4, 2020	

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, June 3, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Julie Kliger, RN, Chair	**Ina Bauman**
Jeffrey Davis, MD	**Wendy Ron**
George O. Ting, MD	**Peter C. Fung, MD**
Melora Simon	
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 5:32pm by Chair Kliger. *A silent roll call was taken.* Ina Bauman, Wendy Ron, and Peter C. Fung, MD 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. The Committee pulled Item 3(c) for discussion. It was confirmed that "in the ED" would be added to "Who makes up census" for the August 2019 meeting. **Motion:** To approve the consent calendar: a. Minutes of the Open Session of the Quality Committee (May 6, 2019); and for information: b. Patient Story, c. FY20 Pacing Plan, d. Progress Against FY19 Quality Committee Goals, and e. Hospital Update, and f. List of Medical Directorships. **Movant:** Simon **Second:** Anderson **Ayes:** Kliger, Davis, Ting, Anderson, Simon **Noes:** None **Abstentions:** None **Absent:** Bauman, Ron, Fung **Recused:** None	*Consent Calendar Approved*
4. REPORT ON BOARD ACTIONS	Chair Kliger provided brief highlights of Board actions including the election of ECH Board Officers and two new Board members as further detailed in the report.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the Quality Dashboard. Dr. Adams highlighted Mortality and Readmission Indexes, and that Throughput made progress. He noted that the data in the dashboard was from February and March. In response to questions from the Committee, Dr. Adams discussed measures at LG, such as employing Wall-E the robot to transport labs, as attributing to better Throughput numbers. Cheryl Reinking, RN, CNO, reviewed the HCAHPS: ▪ Nurse Communication at 81.4 was above the 81.0 target; ▪ Responsiveness at 66.7 was .03 below the target of 67; and ▪ Cleanliness of hospital environment at 76.3 was above the target of 76. Ms. Reinking explained that purposeful rounding continues to affect and improve their scores. One of the questions asked of patients during	

	rounding is whether anyone has regularly checked on them. The goal is to have the patients not need to use the call light. Dr. Adams commented that Hospital Acquired Infections and C. Diff were both down, as expected and Sepsis looks good.	
6. FY20 QC DASHBOARD CONTENT	Dr. Adams provided an overview of the Proposed FY20 QC Dashboard Content. He noted that the first six of the twelve FY19 metrics are organizational goals linked to the incentive plan. For the first few months of FY20 these metrics will continue to be reported since this report is historical data. Dr. Adams explained the rationale for selecting the metrics proposed for FY20 as contained in the QC Dashboard content report. He explained The Mortality Index, Readmission Index, and two in the HCAHPS domain are FY20 organizational goals for quality and safety. He also introduced as new metrics to track for FY20: ▪ SSI (Surgical Site Infections) – particular focus due to an upsurge in infections. An area where the organization wants the Committee's help; ▪ Classification of Serious Safety Events – measures serious safety events and focuses on having a culture of safety; ▪ PC-01 Elective Delivery (prior to 39 weeks) – measuring due to increased occurrences, currently above 2% when it should be zero; Melora Simon recommended adding Nulliparous, Term, Singleton, and Vertex (NTSV) Cesarean Birth Rate to the dashboard. The Committee discussed the proposed list of dashboard metrics and shifting its focus from a granular level monitoring to innovation or areas where they could offer advice. The Committee requests the following: ▪ Add discussion of 2021 QC Dashboard to Pacing Plan; ▪ Add FY20 QC Dashboard to consent calendar and discuss report by exception, for significant events (as defined on executive-level). ▪ Add two additional metric to the Quality Dashboard: (a) delivery before 39 weeks and C-section rates, and (b) ED Throughput. ▪ A report that provides background, contexts and links the various dashboard domains to the ECH strategic plan and the five pillars – at a high level; and ▪ Add FY20 QC DASHBOARD CONTENT DISCUSSION to August meeting to discuss "review and reallocation of time." Chair Kliger commented on the desire to have the dashboard reflective of the ECH delivery of care standards and best practices in a holistic view without being over-burdensome. Dr. Adam concurred and suggested that the Committee focus on discussing a single parameter from the dashboard.	*Add QC Dashboard to consent calendar.* *Add discussion of 2021 Dashboard metrics to Pacing Plan.*
7. INFECTION PREVENTION PLAN AND HAND HYGIENE COMPLIANCE REPORT	Dr. Adams provided an overview of the Annual Infection Prevention Plan and Hand Hygiene Compliance Report based upon an observational study of hand washing among staff upon entry and exit of hospital spaces. The results showed more hand washing upon entry. Dr. Adams noted that proposed strategies included utilizing technology to signal non-compliance. However, the greatest efficacy to increase compliance is awareness and patient engagement. In response to Committee questions Daniel Shin, highlighted the rate of	

	active TB in Santa Clara County which is three times higher than the national average. Most of those infected are immigrants. Enterprise wide the hospital and staff are well trained and good about isolating. **Motion:** To approve the Annual Infection Prevention Plan And Hand Hygiene Compliance Report. **Movant:** Simon **Second:** Anderson **Ayes:** Kliger, Davis, Ting, Anderson, Simon **Noes:** None **Abstentions:** None **Absent:** Bauman, Ron, Fung **Recused:** None	
8. PFAC REPORT	Ms. Reinking provided highlights from the Patient, Family Advisory Council meeting from May. The Council offered the following suggestions: (a) display "free" and "pull forward" on valet parking signs; and (b) inform registering patients of free parking and complimentary valet. They expressed concerns about: (a) Having the front lobby staffed at all hours. As a result, there are now paid positions to cover certain hours at both campuses. (b) The security guard sits too far back from the MV ED entrance. As a result, security will have an entrance post after remodeling of the MV ED is finished. Other areas of interest expressed by the council were for more electric car charging and the potential for a healthy-choices discount in the cafeteria.	
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Ms. Reinking provided an overview of the Patient And Family Centered Care report. Highlights included: a) She noted an increase for Leader Rounding Data. b) More than half of patients receive leader rounding. c) Food and communication topped the list of all patient comments as further detailed in the report. Ms. Reinking shared anecdotal patient stories.	
10. COMPARISON DATA	Dr. Adams provided an overview of the Quality and Safety Comparisons to Other Regional Hospitals. He reported the following: ▪ The CMS (Medicare) Star Rating represents a summary of seven groups of measures. ECH, Stanford and two Kaiser Hospitals earned four Stars and Sequoia, alone, earned five Stars. ▪ Emergency Department "Door to Floor" Time is the only area in the CMS rating where ECH is lower than average. ▪ There is a financial impact of these various score related to VBP. Sequoia, as one of three, earned money in the CMS "Pay for Performance" Program. ECH, however, lost money due to its readmission score. ▪ Leapfrog, based on data from last year, rates LG as a 'B' and MV as a 'C'. Our scores were impacted by not having all of the statistics they requested.	
11. PSI-90 PT. SAFETY INDICATORS	Dr. Adams provided an overview of the PSI-90 (Pt. Safety Indicators). He reported on areas of high scores were PSI-90, PSI-04, PSI-18 and PSI-19.	*Bring back as an information*

	The Committee requests to revisit this topic as an information item to provide definitions of these categories at the August FY 20 meeting.	*item to learn August FY20*
12. AD HOC COMMITTEE: PROGRESS REPORT	Chair Kliger reported on the Ad hoc Committee's efforts to recruit new members to fill three vacancies. She noted that the Committee would meet to determine which of eight potential candidates to invite to the August QC Meeting to interview. Members not returning in FY20 are Ms. Anderson, Dr. Davis, Ms. Ron and Ms. Bauman.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:42pm. **Movant:** Simon **Second:** Anderson **Ayes:** Kliger, Davis, Ting, Anderson, Simon **Noes:** None **Abstentions:** None **Absent:** Bauman, Ron, Fung **Recused:** None	***Adjourned to closed session at 7:40pm***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:42 pm. Agenda Items 16-17 were covered in closed session. During the Closed Session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (May 6, 2019).	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:43 pm. **Movant:** Simon **Second:** Anderson **Ayes:** Kliger, Davis, Ting, Anderson, Simon **Noes:** None **Abstentions:** None **Absent:** Bauman, Ron, Fung **Recused:** None	***Meeting adjourned at 7:43 pm.***

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

_____
Julie Kliger, RN
Chair, Quality Committee

2019

Dear Cheryl -

I'd like to share our personal experience at El Camino Hospital, Los Gatos as my husband, was treated for a GI bleed and presented through the ER on 2019. The treatment we received by your nursing staff - all along the continuum of care was nothing short of remarkable and made our stay a lot easier. My husband had another hospitalization earlier this year and post admittance to your hospital to compare it to.

We felt compelled to share our experience with you in the spirit of recognizing your team members that went above and beyond and to reinforce the great work you are doing.

was admitted through the ER on Saturday, with a GI bleed from an ERCP procedure performed at UCSF on for gall stones which were cleared with this procedure. He has Hepatocellular Carcinoma, DM2 and HTN so his case is complex, and he has lots going on.

Your nursing team including Pam, your nursing leader was on top of everything, including me, and my family at all times.

The following notes are from :

Nursing team in the ER - Christy and Lillian - their compassion, level heads, responsiveness and knowledge are why I am alive

ICU nurses - Sharyn – personal note from – "your above and beyond care was appreciated. Get yourself to Maui. You above all embody the Aloha spirit. More important though is the intuitive way you treated my family during this time – staying on top of communication, vitals, with a sense of humor made it so much easier – and less scary. I can't tell you how much I appreciate you".

Ronda - climb on - you are so cool and Neil, and Dharnya and Melissa – you were all so caring and on top of things.

Inge - you were the boss of me. And why I am here. Enjoy your retirement. You are special and your family is lucky to have you watch over them.

You usually meet special people here and there, but it's rare to have met and spend time with all of you that not only saved my life, but expressed interest in me as a person, and my family, I felt like an extension of your own families and for that I am grateful.

Unfortunately, was readmitted to Good Samaritan within 48 hours after discharge for another GI bleed – Good Sam is closer to our home and he was in cardiac trouble. Otherwise we would have gone back to El Camino. He is out of the woods now and resting at home,

thankfully. However, you may consider reviewing your discharge protocol as we suspect he was discharged too soon from ICU to home by Dr. Yeh.

The joy and compassion your nurses put in their work made a huge difference in our ER and ICU stay. We have had the unfortunate opportunity to experience a number of hospitals since was diagnosed in including Stanford, Sutter CPMC, UCSF, Ochsner in New Orleans, Good Samaritan and El Camino Hospitals in Los Gatos. What set this hospital experience apart from the rest was the nursing team that seemed to be genuinely enjoying their work, working as a close team, with the support of their leadership. In addition, as wife and primary care giver, I didn't feel the need to "control" the care he was being given as it became obvious that the staff was on top of everything and kept close communication with us on the next steps in his care and what was going on. I could relax, even get sleep with the confidence and comfort that your team was on it – what a gift.

We would like to recognize these extraordinary nurses and ask for your guidance in how to do this in the most impactful way.

Warm regards,

Los Gatos, CA

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

FY2020 Q1		
JULY 2019	**AUGUST 5, 2019**	**SEPTEMBER 9, 2019**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ 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 (Discuss - should this be on consent? Only discuss if something outside normal variation? Deeper Dive Quarterly?) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 1. FY19 Quality Dashboard Results (Includes FY19 Org. Incentive Goals) 2. LEAN Progress Report 3. Q4 FY19 Quarterly Quality and Safety Review 4. Physician Engagement 5. Committee Recruitment (If needed) 6. Who makes up census in the ED? 7. draft Board-level QC reporting 8. PSI-90 metrics	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. 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) 13. Quality and Safety Strategic Plan
FY2020 Q2		
OCTOBER 7, 2019	**NOVEMBER 4, 2019**	**DECEMBER 2, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. 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

Created April 25, 2019

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

FY2020 Q3		
JANUARY 2020	**FEBRUARY 3, 2020**	**MARCH 2, 2020**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. 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

El Camino Health

FY20 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY19 Achievement and Metrics for FY20 (Q1 FY20) (On the Agenda) - FY21 Goals (Q3 – Q4) (Paced)	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) (Paced) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline – (Paced)
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – (PACED)
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, MPA, BSN
Executive Sponsor: Mark Adams, MD, CMO

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

El Camino Health

HOSPITAL UPDATE
August 5, 2019
Dr. Mark Adams, CMO

Information Services

The next phase of M*Modal voice recognition (talk to text) includes implementation of the transcription module. Moving to the M*Modal platform for transcription increases accuracy, timeliness and productivity by providing upfront tools to physicians while reducing cost per line. Use of the M*Modal voice recognition tool has demonstrated reductions in transcription volumes and therefore transcription costs.

We completed an upgrade to the most current version of Epic on June 2nd, which provides the required changes for collecting and reporting Meaningful Use, MIPS, and Quality Measures for CY 2019.

Patients are now able to receive automatic notifications for their ED visit which provides real time messages regarding when they will see their provider and progression towards other important care points during their stay. A report highlighting ECH patients who have active MyChart accounts from ECH or referring Epic organizations which have received care at ECH with patient data contributed to the patients MyChart account demonstrates an increased enrollment number **over 46%.**

Workforce

The El Camino Hospital Nursing Division submitted our 4th designation documents to the Magnet program appraisers, which is administered by the American Nurses Credentialing Center on June 3rd. Magnet designation is a rare and distinct honor. Less than 10% of hospitals are designated Magnet.

Government and Community Relations

In support of community health concerns about greater availability and use of cannabis products, ECH hosted a seminar for Leadership Mountain View participants and alumni. The audience included community leaders, elected officials, and school resource police officers. Mountain View Police Chief Max Bosel provided an update on federal, state and local law regarding cannabis use and sale, what is available in local cannabis dispensaries, and how police departments are handling juvenile and adult use of cannabis products. ECH Behavioral Health & Addictions Services Medical Director Dr. Dan Becker discussed what medical research and clinical practice has shown about the negative effects of cannabis on the developing adolescent brain. Later in the month, during our mental health awareness public education series, ECH hosted a very well-attended program on the same topic by Dr. Becker.

Corporate and Community Health Services

CONCERN initiated its new "counselor connect" referral service for their largest customers. This service allows the call center to call the counselor and transfer a new client into voicemail or to the counselor directly instead of the client having to make a separate call. CONCERN also launched a statewide specialty counselor network for first responders. Barbara Avery, Community Benefit Director, participated in a focus group conducted by the Santa Clara County Office of Women's Policy. The focus is to develop a community health planning process to assess barriers to health for women in Santa Clara County. The South Asian Heart Center (SAHC) attended TiEcon 2019 Health Fair ("The Indus Entrepreneurs") and the Sunnyvale Temple Kiosk where we conducted biometric screenings and made attendees aware of our programs offered through the SAHC.

The Chinese Health Initiative ("CHI") completed the first Diabetes Prevention Learning Series on lifestyle changes for 80 community members who are pre-diabetic or diabetic. The 4-month program offers in-depth information on diet, exercise, sleep and stress management for diabetes prevention. CHI also recruited 15 bilingual volunteers to help clients with language barriers participating in the Challenge Diabetes programs at Community Service Agencies in Mountain View, Sunnyvale and Cupertino. The Health Library & Resource Center provided outreach at the Elder Summit, Aging Services Caregivers Count Conference at the Campbell Community Center, Mountain View Senior Resource Fair and the Advance Health Care Directive presentation at Santa Clara University.

Philanthropy

As of April 30, 2019, El Camino Hospital Foundation has a secured $18,875,491 since the start of FY19, the highest annual yield in the Foundation's history.

Marketing and Communications

We launched the El Camino Health website on May 1st as the first forward-facing initiative of the unified brand. The brand rollout continued with a new *Intercom* look and feel, e-signatures, and email addresses.

Auxiliary

The Auxiliary contributed 5,757 volunteer hours in April 2019 and 5,996 in May 2019.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, CMO

Date: August 5, 2019
Subject: Annual Performance Improvement Reports

Purpose:

To provide information and evidence on the hospitals' annual performance improvement reports for all services to the Board through the Quality Committee of the Board.

Summary:

1. Situation: CMS Conditions of Participation 482.21 on Quality Assurance and Performance Improvement states that "The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. "

2. Authority: CMS Conditions of Participation 482.21 "The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services, and focuses on indicators related to improved health outcomes and the prevention and reduction of errors."

3. Background:

4. Assessment:

5. Other Reviews:

6. Outcomes: Provide information and evidence on the hospitals' annual performance improvement reports for all services to the Board through the Quality Committee of the Board.

List of Attachments:

1. Information Services: Data & Analytics
2. Peri-Operative Services
3. Clinical Laboratory and Pathology Services
4. NeuroScience Service line (Stroke)

Suggested Committee Discussion Questions:

None.

Annual Performance Improvement Report

Department/Service Line: Information Services: Data & Analytics
Prepared by: Dave Zucker
Date: May 24, 2019
Reporting Period: FYTD 2019

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

Share your data analysis and conclusions after review of the previous Data Dashboard for the reporting period. Use bullet points:

- ***Data Requests***
  - *Accurate, timely, and coherent data is invaluable to organization decision making.*
  - *New self-service reporting tools have been released that can help with data analysis and visualization.*

- ***MyChart***
  - *Patients can have access to their personal information using Epic MyChart.*
  - *Patients have the opportunity to view notes, send messages, submit questionnaires, check in, view documents, and access medications.*
  - *El Camino can continue to grow and maintain patient relationships electronically.*

- ***Communications Among Staff and Providers***
  - *Clinicians use various devices: Desk phone, Mobile Phone, Vocera, Email, Text.*
  - *Confidential conversations and updates regarding specific patients often occur.*
  - *Urgent information communicated efficiently can significantly improve service.*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- ***Data Requests***
  - *There are multiple reporting tools and thousands of reports which are hard for users to take advantage of, so as a result many data needs come through as new requests.*
  - *New self-service data tools that breakdown and visualize data had not been customized and implemented to help with data analysis.*

- ***MyChart***
  - *Many patients have MyChart accounts with other organizations but not El Camino.*
  - *MyChart activations need to be tracked at the organization and department levels to evaluate department performance and initiatives.*
  - *Signing up for MyChart can be difficult and activations are more difficult after patients leave the clinic.*
  - *Patients want to do more with their MyChart accounts.*

- ***Communications Among Staff and Providers***
  - *Voice communications over phones or Vocera can be disruptive.*
  - *Voice or plain text messages are insufficiently secure for communicating PHI.*
  - *Locating a specific staff member, provider or Administrator can be challenging.*

[1] Comprehensive Accreditation Manual for Hospitals, LD.01.03.01 EP6, and CMS Condition of Participation 482.21.

Describe quality improvement actions taken to address the data and outcomes:

Use bullet points to list actions taken:

- ***Data Requests***
  - *iCare reporting and application teams collaborated to retire reports that had not been used in 400 days and implemented a comprehensive Report Catalog to give access to all reports and dashboards available to individual users in Epic.*
  - *iCare reporting and business intelligence teams implemented new tools and reports to address data needs.*

- ***MyChart***
  - *iCare MyChart team, Reporting, Managers, and Marketing worked together to communicate the value of MyChart and help patients sign up.*
  - *iCare MyChart team implemented new functionality including: self-signup, instant activation, questionnaires, direct scheduling, eCheck-in, document viewing, and MyChart Bedside for inpatients.*

- ***Communications Among Staff and Providers***
  - *Implemented Tiger Text where messages reside on secure server, not the phone.*
  - *Signed up over 1000 clinical and administrative staff for Tiger Text.*
    - *Added over 150 members of the Medical Staff to Tiger Text.*

Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):7

Use bullet points to describe improvement:

- ***Data Requests***
  - *78 New Reports, 40 New Radar Dashboards, 67 Custom Dashboard Metrics Created in FY2019.*
    - *Moving away from individual reports to flexible metrics, tools, and dashboards.*
  - *Over 3500 reports and 703 templates were retired that had not been used in a year.*
  - *Key reports and data provided to help with organization initiatives and quality improvement opportunities – ranging from Radiology Turnaround, Capacity Management, Clinic Management, Finance, ED Throughput, Press Ganey Patient Experience, to Executive dashboards for leadership.*

- ***MyChart***
  - *MyChart Monthly Active Accounts for Patients with Encounters increased significantly from April 2018 – April 2019.*
    - *Enterprise – 12.6 - 21.7%*
    - *El Camino Medical Associates– 10.8 – 30.3%*

- ***Communications Among Staff and Providers***
  - *Messages are encrypted for security of confidential information.*
  - *Confidential messages are not stored on the phone, and are deleted periodically.*
  - *Silent text message interface minimizes distractions to patients and other staff.*
    - *Participating Tiger Text users can be found in the user directory.*
    - *Both Staff and Providers can easily communicate without sharing phone numbers or email addresses.*

El Camino Health

Annual Performance Improvement Report

Department/Service Line: Clinical Laboratory and Pathology Services
Prepared by: Laura Gutierrez, Director
Date: June 5, 2019
Reporting Period: FY2019

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

Share your data analysis and conclusions after review of the previous Data Dashboard for the reporting period. Use bullet points:

- *All chemistry TAT(Troponin, Chem Comp, Lactic Acid), Urinalysis TAT, met the target completion rate of 90% under 30 and 35 minutes for the respective tests every month in the fiscal year 2019. The most recent month ending April also highlights the average completion time under 30 and 35 minutes while reaching above the 90% completion threshold within those time frames.*
- *For 2018, the Protime for Stroke received a newly defined TAT goal of <35 minutes from order to verification. This newly defined time of <35 minutes is a reduction of 22.2% from the previous metric of <45 minutes TAT order to verification. The overall order to verification process maintained a completion rate above the threshold of 80% completion rate at <35 minutes.*
- *The intended goal outlined for AFB TAT has not been met for the months of Jul 2018 to Feb 2019. Upon changes to workflow outlined in quality improvement action, the lab has been able to make the adjustments necessary to ensure the proper completion of AFB samples within 24 hours for 90% of samples. Further details outlined in section 3.*
- *The overall blood culture contamination percentages have been below the limit of 2% for lab draws and 3% for all draws combined. The month of December saw a breach above the threshold of 2% in contamination rate for blood culture draws by lab. At this juncture, there was a reassessment and education of lab staff that repeatedly committed blood culture contamination. There was oversight during the process of collection to ensure an acceptable collection method had been utilized*
- *Pathology Preliminary Autopsy Diagnosis reports have been completed within 48 hours 100% of the time and that trend is the same for the Final Autopsy Diagnosis.*
- *Leading trend in the % wastage of blood products have been due to expiration of thawed and unused FFP/CRYO.*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- Upon investigating outpatient registration and order errors, there was a quality metric that was found to be caused by a system issue. By including the system error, it captured errors that were unavoidable. In order to get a better representation of overall performance with regards to outpatient registration, the Registration Error will be separated by System error and Human error. With this differentiation, there will be an assessment of the current goal in place of <1.25% errors and adjust the goal to best meet the change that will take place.
- Wastage of blood products has dramatically decreased, but there are areas in which we can continue to improve upon. Mainly, improving upon blood product handling once taken for transfusion and limiting the thawing of products to patients that have a transfuse order with confirmation of being transfused should have products thawed. Better allocation and utilization of shorter expiry should take precedence.
- CBC TAT for infusion patients have an average TAT of approximately 9.7 minutes, but due to the higher volume of manual differentials performed for these specimens, the 90% completion rate is at an average of 32.7 minutes. Moving forward, there will be a strong focus on reducing the time frame of the manual differentials placed on pending for analysis.

Bullet point issues and opportunities identified for improvement:

- Various months indicate a need for monitoring the absolute necessity for thawed products. Many FFPs and Cryo go unused upon request for transfusion. However, MTP occurrences are unavoidable and require the immediate issuance and continued thawing of products to meet the demand of the situation.

Describe quality improvement actions taken to address the data and outcomes:

Use bullet points to list actions taken:

- *Due to the inability to meet the appropriate TAT for AFB specimens, the workflow was assessed and the time in which the AFB slides being processed was addressed. By hiring an individual who could attend to the AFB and microbiology needs starting at 4am rather than the previous 6 to 7am initial time frame, the work was put into place for processing in advance so that the CLS to read the slide had enough time to complete all specimens before the 24hour mark.*
- *To best capture real errors occurring in the process of collecting clerical error data, there will be a differentiation of system errors from human errors under registration errors. Those registration errors that are not true errors caused by staff will not be included in the statistics for the overall error %.*
- *To best address and collect accurate data regarding outpatient registration error, the Phlebotomy Manager and Quality Assurance Specialist will work in conjunction to determine the new parameter and how to sort the data between human vs non-human error in the registration process.*

Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

Use bullet points to describe improvement:

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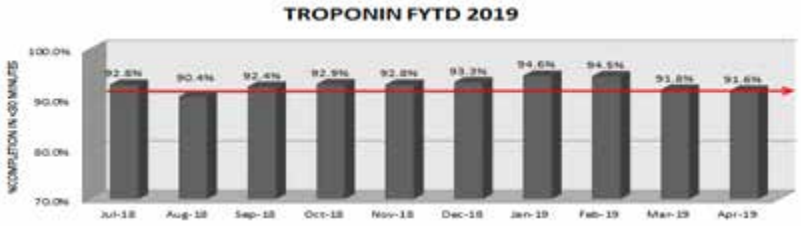
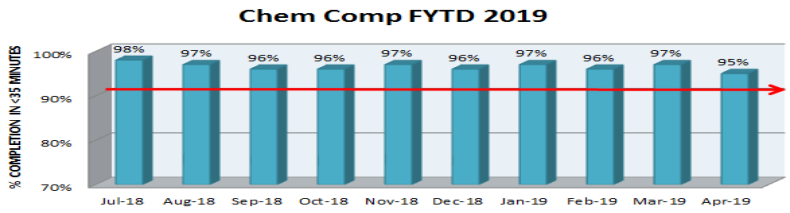
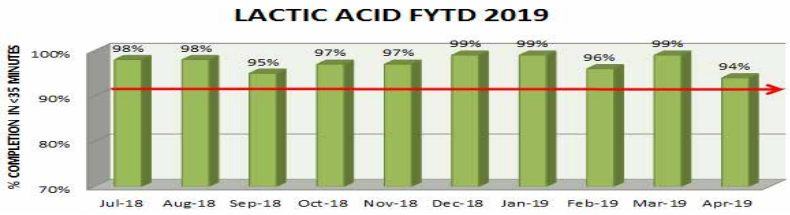
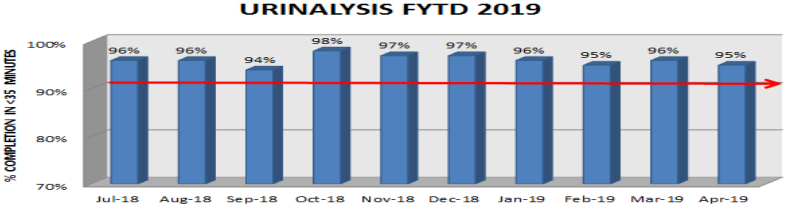
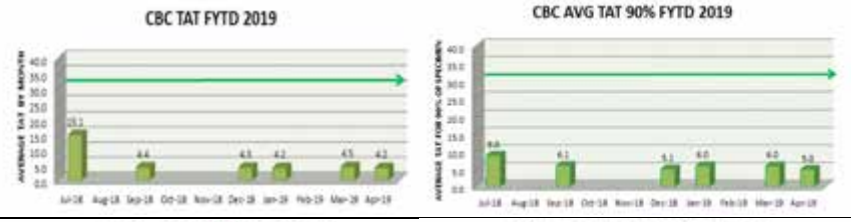
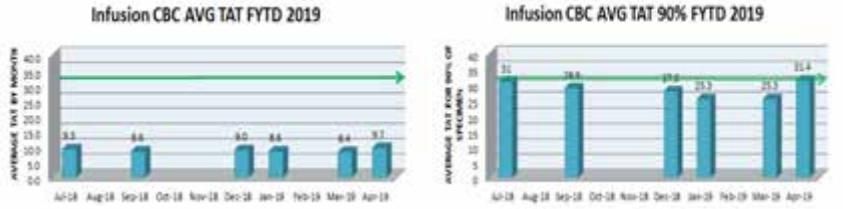
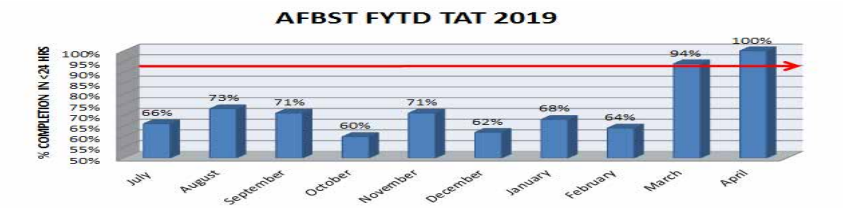
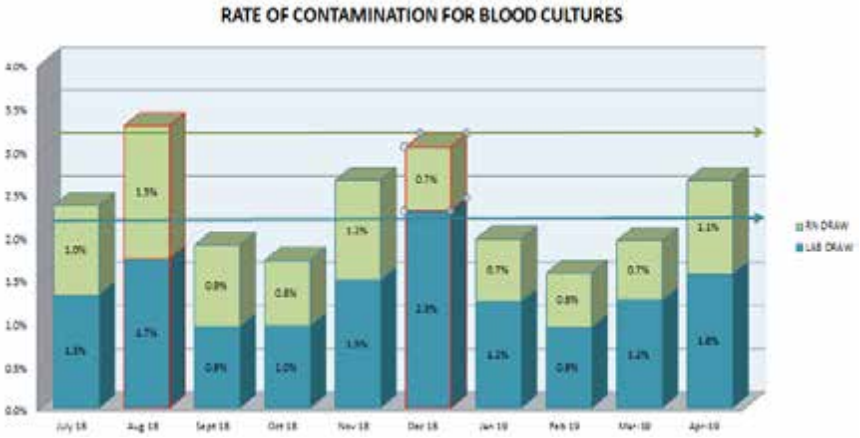
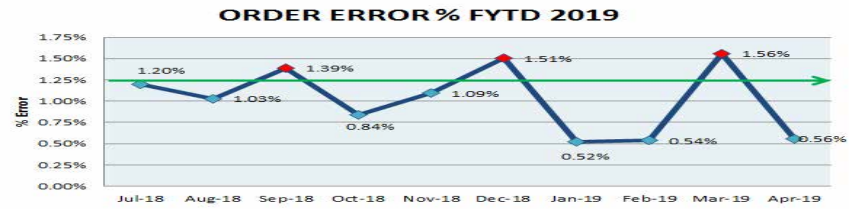
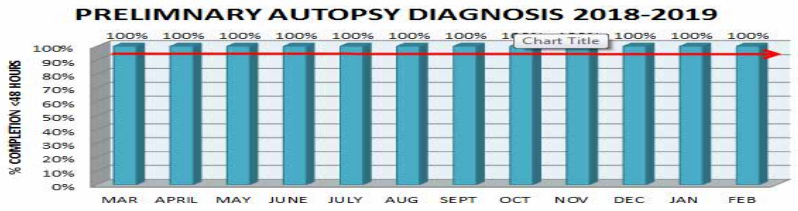
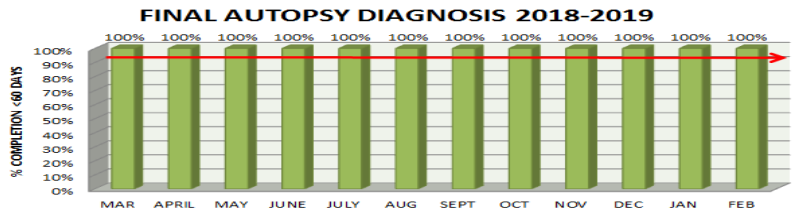
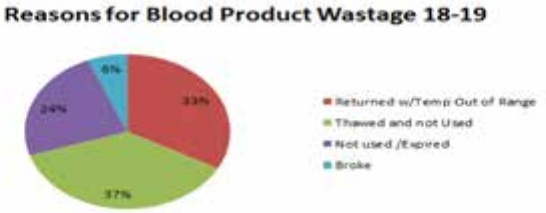
El Camino Health

LABORATORY PERFORMANCE DASHBOARD - FYTD 2019

DEPARTMENT	KPI	LATEST MONTH		FYTD	TARGET	TRENDING	COMMENTS
CHEMISTRY	STAT TROPONIN TAT - RECEIVED TO VERIFICATION	26.2 MIN (AVG)	29.0 MIN (90% COMP)	93%	90% COMPELTION IN < 30 MINUTES		
	STAT CHEM COMP TAT - RECEIVED TO VERIFICATION	21.4 MIN (AVG)	27.0 MIN (90% COMP)	97%	90% COMPLETION in <35 MINUTES		
	STAT LACTIC ACID TAT - RECEIVED TO VERIFICATION	24.3 MIN (AVG)	28.3 MIN (90% COMP)	97%	90% COMPLETION in <35 MINUTES		
URINALYSIS	STAT URINE TAT - RECEIVED TO VERIFICATION	15.0 MIN (AVG)	27.0 MIN (90% COMP)	96%	90% COMPLETION in <35 MINUTES		
COAGULATION	STROKE ALERT PT SPECIMEN TAT - ORDER TO VERIFICATION	22 MIN (AVG)		94%	80% COMPLETION IN <35 MINUTES		

HEMATOLOGY	**STAT CBC TAT - RECEIVED TO VERIFICATION**	**4.2 MIN (AVG)**	**5.0 MIN (90% COMP)**	**6.2 MIN AVG FOR 90% OF COMPLETIONS FYTD**	**90% COMPLETION IN <30 MINUTES**		Historical data files corrupted and unretrievable. Files fixed moving forward.
	INFUSION CBC TAT - RECEIVED TO VERIFICATION	**9.7 MIN (AVG)**	**32.7 MIN (90% COMP)**	**28.0 MIN AVG FOR 90% OF COMPLETIONS FYTD**	**90% COMPLETION IN <30 MINUTES**		Historical data files corrupted and unretrievable. Files fixed moving forward. More Manual Diffs ordered
MICROBIOLOGY	**AFB TAT W/IN 24 HRS**	**18.9 HOURS (AVG)**	**22.5 HOURS (90% COMP)**	**73%**	**90% COMPLETION IN <24 HOURS**		ASSESSED WORK FLOW AND RESTRUCTURED THE PROCESSING TIME TO ENSURE SLIDE READING AND REPORTING OF AFB WITHIN 24 HRS STARTED IN MARCH
PHLEBOTOMY	**BLOOD CULTURE CONTAMINATION RATE FOR LABORATORY**	**1.6 % (APRIL)**		**1.4%**	**< 2%**		HIGHER RATE OF CONTAMINATION DURING THE MONTH OF DECEMBER 2018 WITHIIN THE LAB AT 2.3%. EDUCATION AND RETRAINING OF LAB PERSONNEL FOR PROPER COLLECTION LED TO THE DIRECT DECREASE IN SUBSEQUENT MONTHS
	BLOOD CULTURE CONTAMINATION RATE W/ RN DRAWS	**2.6% (APRIL)**		**2.3%**	**< 3%**		
CLERICAL	**OUTPATIENT REGISTRATION /ORDER ERROR**	**0.6% (18 OF 3235 REGISTRATIONS)**		**1.05%**	**<1.25% OF TOTAL ERROR**		

PATHOLOGY	PRELIMINARY AUTOPSY DIAGNOSIS	100%	100%	90% COMPLETION <48 HOURS		
	FINAL AUTOPSY DIAGNOSIS	100%	100%	90% COMPLETION <60 DAYS		
BLOOD BANK	BLOOD PRODUCT WASTAGE	0 products	0%	1.00%	<1.00% WASTED		LEADING TREND IN WASTAGE FOR ALL MONTHS WITH INCREASED WASTAGE ABOVE 1% HAS BEEN DUE TO UNUSED PRODUCT WITH A REQUEST FOR TRANSFUSION OF FFPs AND CRYO
	REASON FOR WASTAGE	0		ON AVERAGE 2 PRODUCT PER MONTH	Returned w/ temp out of range		
		0		ON AVERAGE 2 PRODUCT PER MONTH	Thawed and unused		
		0		ON AVERAGE 1 PRODUCT PER MONTH	Expired		
		0		ON AVERAGE 0 PRODUCT PER MONTH	Broke		

Annual Performance Improvement Report

Department/Service Line: Peri-operative Services
Prepared by: Shelly Reynolds, RN, MSN, CNOR
Date: 5/28/19
Reporting Period: FY19 YTD

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

- *Many efforts towards improving Patient Experience, measured by OASCAHPS performance. Rate the Hospital and Communication Domains are both on the rise and meeting or exceeding targets.*
- *On Time Starts- small efforts being made, in this regard. Trending favorably.*
- *Turnover Times- Looking very good, enterprise wide. Expected variability across various specialties. Working with Ortho at MV and GYN/GI at LG, for further improvement.*
- *Robotics- growth is amazing, at both campuses. Program contributes favorably to the margin, reduced length of stay (as compared to open procedures), fewer complications and readmissions.*

Areas of Concern or Opportunities for Improvement:

- SSI- LG has no reportable SSIs for the third quarter, but both have higher incidence rates than last year. MANY efforts are happening, with a great deal of organization attention to correcting this problem. Will continue to collaborate with all departments, as SSIs occur as a result of pre-, post-, and intra-procedural challenges. Hand hygiene, appropriate attire, NTT, home care and many other factors influence outcomes.
- Room Utilization- across all procedural areas, we still have capacity. Ongoing efforts to monitor appropriate staffing levels to demand, enhance communication with surgeons/proceduralists to release blocks/fill open times, and make efficiency improvements.
- Reportable events- changes to reporting requirements have led to an increase in possible retained foreign objects (suture needles) reports.

[1] Comprehensive Accreditation Manual for Hospitals, LD.01.03.01 EP6, and CMS Condition of Participation 482.21.

Describe quality improvement actions taken to address the data and outcomes:

- *Enhanced NTT- all patients who have an incision, collaborated with inpatient units and ED to enhance pre-operative bathing.*
- *Working with MSO and OR teams to improve compliance with appropriate attire policies and hand hygiene compliance.*
- *OR Committee monitors block utilization- for the first time in five years, we have had to reduce blocks for those who utilize poorly, which allows for better access for some of our new surgeons/proceduralists.*
- *Working with PI team to match staffing to demand.*
- *Working with Jim G. and others to re-establish a Robotics Steering Committee for policy oversight, physician engagement, Specialty certification, etc…*

Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

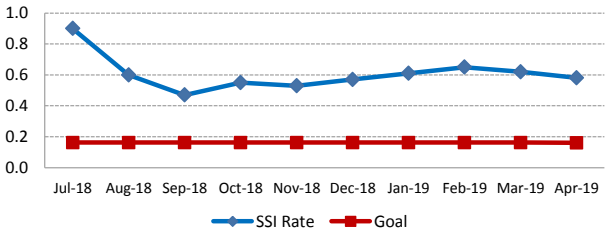
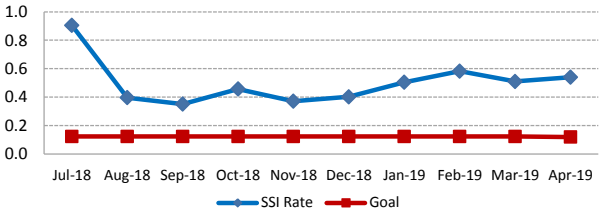
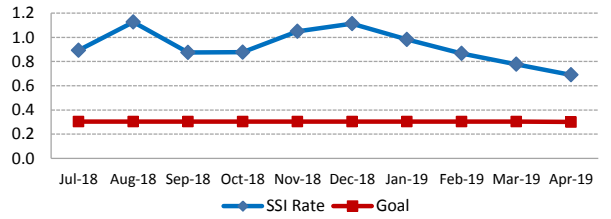
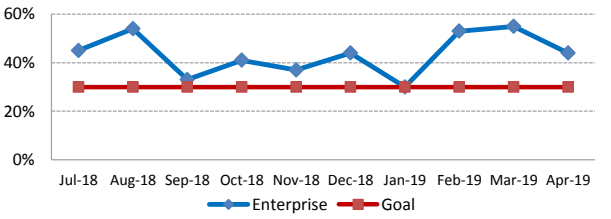
- *OASCAHPS Rate the Hospital up from 22%ile to 44%ile.*
- *OASCAHPS Communication Domain up from 88.3 to 89.0, MV only. Significant efforts on one question, in particular, " Anesthesia Side Effects Easy to Understand".*
- *Robotics volumes are growing at both campuses.*
- *Overall turnover times below target- great news, but still have some work to do for some surgical specialties (Ortho and GYN/GI).*
- *Rolled out full, three part NTT for all patients. Also working to move all hair clipping outside of the procedural areas.*

El Camino Health

Periop Dashboard- FY19

Reporting period: July - April 2019

Report updated: 05/28/2019

	Measures	Performance Current month	Performance FYTD	Baseline FY 2018 Actual	Target FY 2019 Target	Trend FY19 Rolling	Comments
1	**SSI Enterprise** *Incident rate per surgery* *Date period: April 2019*	0.19 (1/531)	0.57 (28/4876)	0.20	0.1822 (10% reduction)		High level of concern, organization wide, related to the increase in SSI rates, as compared to previous years. We still have several weeks left in the fiscal year, with associated surveillance periods that extend beyond June 30th. The good news- MANY efforts to improve processes and compliance, including, but not limited to, NTT for all patients who will receive an incision (three components), surgical attire policy approval and adherence, hand hygiene observations and improvements, ERAS, SSI reduction bundles and others.
	SSI MV OR *Incident rate per surgery* *Date period: April 2019*	0.25 (1/404)	0.54 (20/3710)	0.15	0.139 (10% reduction)		
	SSI LG OR *Incident rate per surgery* *Date period: April 2019*	0.00 (0/127)	0.69 (8/1157)	0.38	0.3409 (10% reduction)		
2	**OASCAHPS ENTERPRISE** *Rate the Hospital 0- 10* *Date period: April 2019*	44%tile (n=239)	45%tile (n=2313)	22%ile	30%ile		We are exceeding the FY19 goal and making efforts to continue to focus on our patients' experiences in the ambulatory surgery setting. Many of our patients are admitted prior to or following their surgical procedure and they are not surveyed in this group. They receive HCAHPS instead.

El Camino Health

Definitions and Additional Information

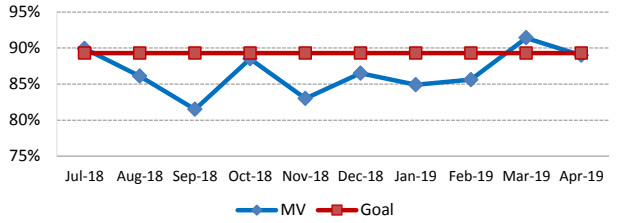
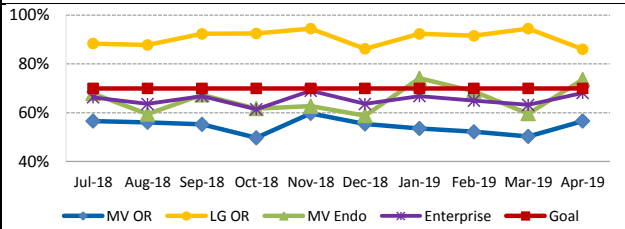
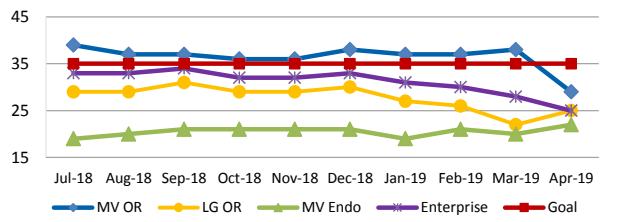
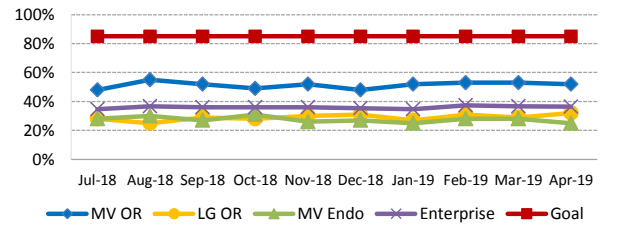
		Data Owner	Work Group	Definition	Data Source
Measures					
1	**SSI Enterprise** *Incident rate per surgery* *Date period: April 2019*	Hsiao-Lan (Dee) Shih	Quality Council	29 Operative procedures considered reportable to NHSN database. Some have a 30 day surveillance period (including C-section, colons surgery abdominal hysterectomy) and some have a 90 day period (including total joint replacements, pacemakers, spinal fusions and cardiac surgery).	Catherine Nalesnik
	SSI MV OR *Incident rate per surgery* *Date period: April 2019*	Hsiao-Lan (Dee) Shih	Quality Council		Catherine Nalesnik
	SSI LG OR *Incident rate per surgery* *Date period: April 2019*	Hsiao-Lan (Dee) Shih	Quality Council		Catherine Nalesnik
2	**OASCAHPS ENTERPRISE** *Rate the Hospital 0- 10* *Date period: April 2019*	Hsiao-Lan (Dee) Shih	Quality Council	Organization Strategic Goal. In the first year, the goal is to improve to the 30th %ile and a five year plan to be > = 50th %ile.	Press Ganey Improvement Portal

El Camino Health

Periop Dashboard- FY19

Reporting period: July - April 2019

Report updated: 05/28/2019

	Measures	Performance Current month	Performance FYTD	Baseline FY 2018 Actual	Target FY 2019 Target	Trend FY19 Rolling	Comments
	Periop OASCAHPS MV OR *Communication 0-10* *Date Period: April 2019*	89.0% (n=145)	86.8% (n=1473)	88.3%	89.3 % (measurement period is Q4)		This domain, with OASCAHPS, is comprised of five questions and is strongly correlated with the rate the hospital goal above. The MV peri-operative teams are focused on this domain, with particular attention on the lowest scoring question, "Anesthesia Side Effects are easy to understand".
3	**On Time Starts (ALL)** *Date period: April 2019*	68.1	65.3	64%	>=70%		This is an efficiency metric that we monitor. Literature shows that when cases start on time, particularly first cases, the day is more efficient and the gains are in terms of OR capacity.
4	**Room Turnover (ALL)** *Date period: April 2019*	35	31	26	<=35		This is another efficiency metric, which actually has more focus, at this time. We partner with our PI department, specifically Ameya, to evaluate current processes and make improvements with input from our staff and surgeons. Our overall target is 35 minutes or less, with recognition that all case types are not equal and variability in expectations exist (ie- cardiac surgery cases have longer turnover times than ophthalmology).
5	**Room Utilization (ALL)** *Date period: April 2019*	36.0%	35.9%	35.7%	>=85%		The gold standard for room utilization is 85%. These charts demonstrate that we still have capacity in all peri-op locations. We continue to evaluate staffing to demand, robotic accessability, and after hours/weekend needs.

El Camino Health

Definitions and Additional Information

		Data Owner	Work Group	Definition	Data Source
Measures					
	Periop OASCAHPS MV OR *Communication 0-10* *Date Period: April 2019*	Hsiao-Lan (Dee) Shih			
3	**On Time Starts (ALL)** *Date period: April 2019*	George B.	Quality Council	A case is considered late if the difference between the scheduled setup complete time for first cases or the scheduled in room time for subsequent cases and the actual in room time is greater than 6 minutes. If the first case in the room is an add-on, it will be considered a first case for that room. First cases are only included if they are scheduled between 0600 and 0759. On Fridays, first cases are only included if they are scheduled between 0600 and 0900. Only locations listed within the user's record will be included in the report. Cases on holidays and weekends are excluded. Cases in MV PACU Proc 1, MV PACU Proc 2, or MV IS Bedside are excluded.	EPIC Slicer Dicer
4	**Room Turnover (ALL)** *Date period: April 2019*	George B.	Quality Council	This report tracks average room turnover (in minutes) between consecutive cases in the same room. Turnover is defined as the duration between the previous case out of room time and the following case in room time. Turnovers greater than 60 minutes are excluded from the average calculation. Turnovers with a scheduled gap greater than 0 minutes are excluded from the average. The scheduled gap is the duration between the scheduled cleanup complete of the previous case to the scheduled setup start of the following case. Only locations listed within the user's record will be included in the report.	EPIC Slicer Dicer
5	**Room Utilization (ALL)** *Date period: April 2019*	George B.	Quality Council	This report measures how efficiently a specific operating room's available time is being used. Available time is shown as open time on the room template.	EPIC Crystal Reports

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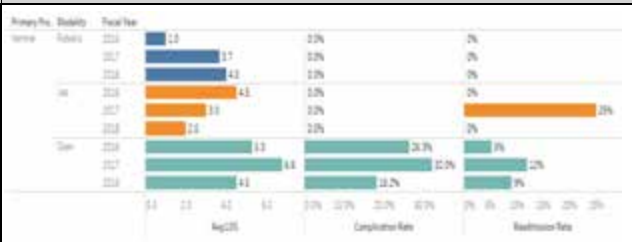
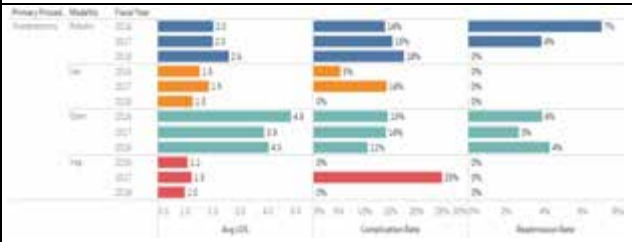
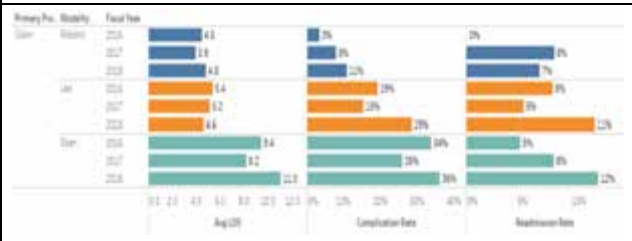
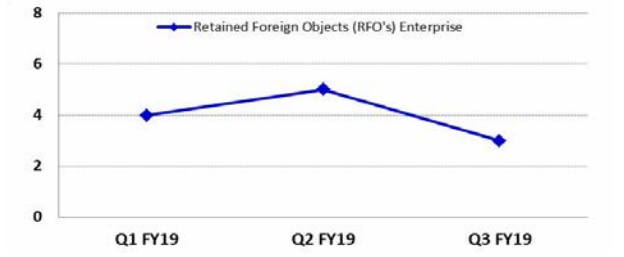
Periop Dashboard- FY19

Reporting period: July - April 2019

Report updated: 05/28/2019

Measures		Performance Current month	Performance FYTD	Baseline FY 2018 Actual	Target FY 2019 Target	Trend FY19 Rolling	Comments
6	**Compare: Ventral Hernia Inpatient – ALOS, Complications and Readmissions**						Robotic displays lower ALOS, compared to Open, but in recent years, higher compared to Laparoscopic. Robotic and Laparoscopic complication rates are comparable to Laparoscopic, and much lower than Open. Robotic readmission rate are better than that of Lap and Open.
7	**Compare: Hysterectomy Inpatient – ALOS, Complications and Readmissions**						Robotic displays lower ALOS, compared to Open, but higher compared to Laparoscopic and Vaginal. Vaginal displays lowest ALOS amongst all modalities.
8	**Compare: Colon Inpatient – ALOS, Complications and Readmissions**						Robotic displays lower ALOS, compared to Open, but higher compared to Laparoscopic and Vaginal. Vaginal displays lowest ALOS amongst all modalities. Vaginal displays lowest ALOS amongst all modalities. Robotic complication rates are comparable to other modalities. Robotic readmission rate exceeds that of Lap and Vaginal, and sometimes Open.
9	**Reportable Events/CDPH Self-Reports** *Retained Foreign Objects(RFO)*	1	12	18	0		Q1 - Retained Foreign Object: MV: 3 (needle) LG: 1 (distal portion of mediport catheter) Q2 - Retained Foreign Object: MV: 2 (needle), 1 (missing needle tip), 1 (broken ortho tracker pin) LG: 1 (needle) Q3 - Retained Foreign Object: MV: 1 (sponge in L&D), 1 (device malfunction, balloon burst in Cath Lab), 1 (iodine swab stick from ED foley insertion)

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Definitions and Additional Information

		Data Owner	Work Group	Definition	Data Source
Measures					
6	**Compare: Ventral Hernia Inpatient – ALOS, Complications and Readmissions**	Mary Wong	Quality Council		EPSI - EPIC - Watson (Truven)
7	**Compare: Hysterectomy Inpatient – ALOS, Complications and Readmissions**	Mary Wong	Quality Council		EPSI - EPIC - Watson (Truven)
8	**Compare: Colon Inpatient – ALOS, Complications and Readmissions**	Mary Wong	Quality Council		EPSI - EPIC - Watson (Truven)
9	**Reportable Events/CDPH Self-Reports** *Retained Foreign Objects(RFO)*	Franz Encisa	Quality Council		

Annual Performance Improvement Report

Department/Service Line: NeuroScience (Stroke)
Prepared by: Sherril Hopper
Date: 5/23/2019
Reporting Period: (FY 2019)

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

Share your data analysis and conclusions after review of the previous Data Dashboard for the reporting period. Use bullet points:

- ***Door-to-Drug Times (#8 on Dashboard)***
  - *The DTD times demonstrate continued improvement. Currently for FY2019 we are at 71% < 45 minutes and 33% <30 minutes. In the coming fiscal year we will be looking to meet the newest national goal of Door-to-drug times of < 45 minutes 75% of the time and < 30 minutes 50% of the time.*
- ***Door-to-Groin Puncture Times (#9 on dashboard)***
  - *This time goal is 120 minutes from patient arrival to groin puncture. The success rate is variable; we do not consistently meet this goal. The PI team is still working on learning where we can save time and how personnel who provide contracted services can be held accountable.*
- ***Required Documentation of Vital Signs and Neuro Checks post tPA or NIR intervention (#6 on dashboard)***
  - *The Joint Commission gave us a finding for having incomplete documentation after tPA in 2016. A PDSA PI plan has been in place for 2 years to improve this documentation. Our goal is 90%. Last year we were at 33%. Current ED 79% and CCU 84% with overall 68%.*
- ***Risk-adjusted Re-admission Rate is at an appropriate level.*** PAMF follow-up clinic recently begun.

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- **Door-to-Drug Times (#8 on Dashboard)**
  - There is difficulty tracking all times we need for analysis, especially times for calling and return calls as well as times of physician arrival.
  - Opportunity for improvement lies is using telemedicine for neurologist stroke response.
- **Door-to-Groin Puncture Times (#9 on dashboard)**
  - There is difficulty tracking all times we need for analysis, especially times for calling and return calls as well as times of physician arrival.
  - Ensuring the correct team is called in to the cath lab 100% of the time.
  - Assisting the cath lab team to set up cases within 15 min of arrival when they are called in.
  - Work with the Neurointerventionalists to ensure 100% buy-in to arrive in the hospital within 30 minutes of being called.
  - Get Neurointerventionalist on-call involved as early as possible for potential Thrombectomy candidate.
- **Required Documentation of Vital Signs and Neuro Checks post tPA or NIR (#6 on dashboard)**
  - New managers for ED and CCU need to follow-up within 24-48 hours 1:1 with RNs who have any outliers, after the outliers are sent by stroke core team.
  - Large numbers of new RNs in ED: to ensure they know how to document a complete neuro assessment and where it should be documented.
- **Risk-adjusted Mortality has increased in the most recent data and is now being investigated with accountability to the Stroke Medical Director. Tactics to be rolled-out once understood.**

[1] Comprehensive Accreditation Manual for Hospitals, LD.01.03.01 EP6, and CMS Condition of Participation 482.21.

Use bullet points to list actions taken:

- **Door-to-Drug Times**
  - We have created time sheet and educated ED staff to track times of each step within the process more accurately.
  - We have also created a form to assist ED physician for quicker decision making whether pt is a tPA candidate or not.
  - We request feedback/reasons from neurologist/ED physicians/nursing for delay in treatment
  - We continue to monitor these times but have met our goals for Door-to-Drug times and will continue to drive them down further.
- **Door-to-Groin Puncture Times**
  - A new cath lab on-call team Matrix is created. ED staff, hospital assistant managers, operators, and Flex nurses are educated about this Matrix to ensure correct team would be called.
  - Role and responsibilities are clearly defined and staff are educated for stroke alert process to avoid confusion.
  - A new ED-Cath Lab work group including ED MD and neurointerventionalists has been started to review each case's times and identify gaps and areas for improvement
  - ED Time sheet is being modified to continue the use in cath lab for reminding cath lab team on time elapsed since ED arrival, which will also capture arrival times for cath lab team, neurointerventionalist and anesthesiologist.
  - Stroke core team is committed to sending each case's times within next business day to ED and cath lab leadership.
- **Required Documentation of Vital Signs and Neuro Checks post tPA or NIR**
  - Concurrent auditing by Spring and/or Christine for all tPA and NIR cases
  - Email/call/Tigertext sent to RN(s), educator(s), manager(s), and cc'd to service line director for outliers
  - Kudos sent for 100% compliant chart
  - Data shared with unit manager(s) monthly
  - Documentation performance shared with ED, CCU/ICU RNs weekly

- ***Door-to-Groin Puncture Times***

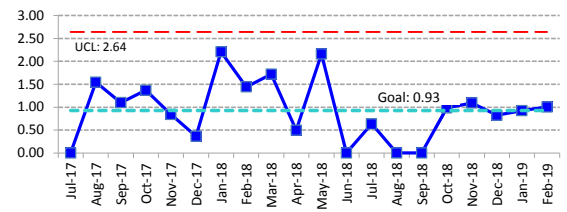
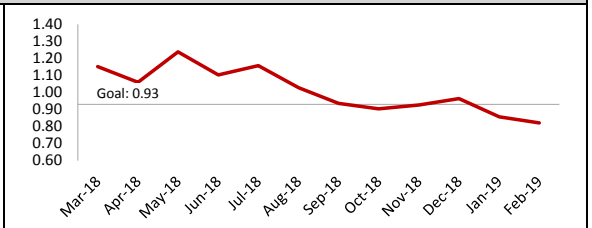
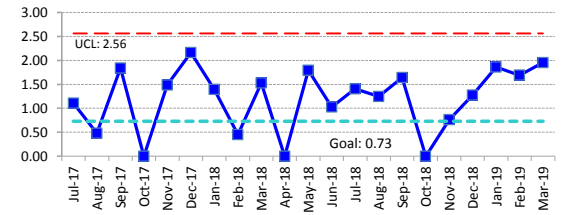
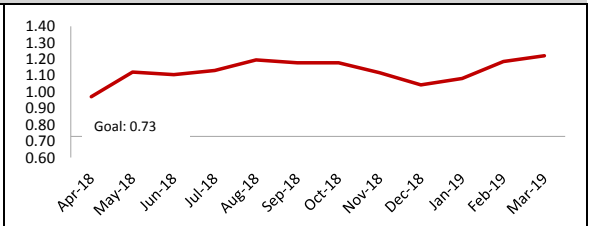
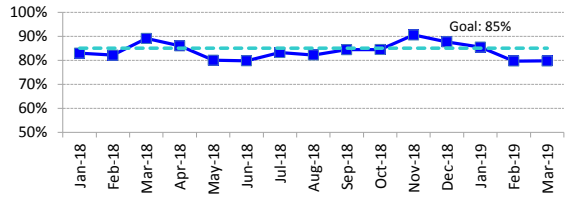
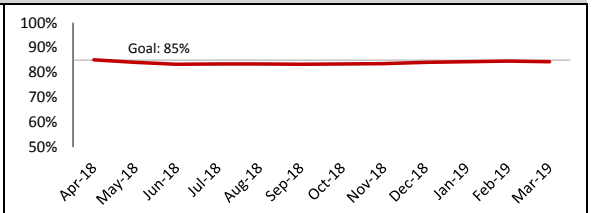
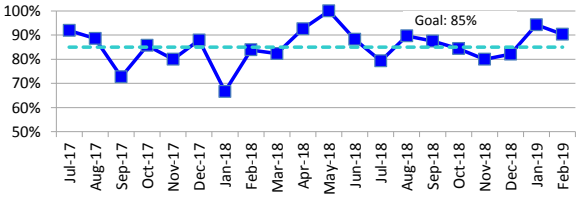
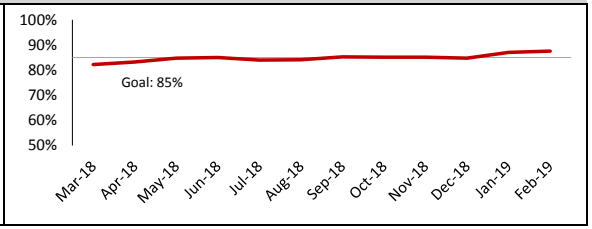
	FY 2019 (YTD):	*FY 2018*
Avg:	*2:05*	*2:41*
≤120 min	*52%*	*22%*
≤90 mi	*19%*	*0%*

- ***Required Documentation of Vital Signs and Neuro Checks post tPA or NIR***
  - *Compliance with required documentation is up to **67%** from **33%** last year. This documentation needs to be complete above the 90% level to achieve success, after which maintenance may be as much work as achieving the goal.*

El Camino Health

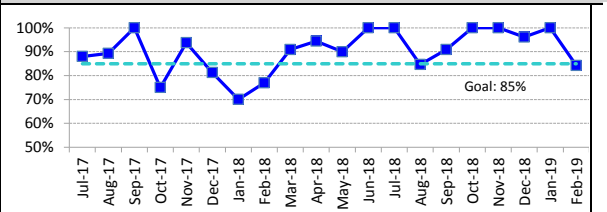
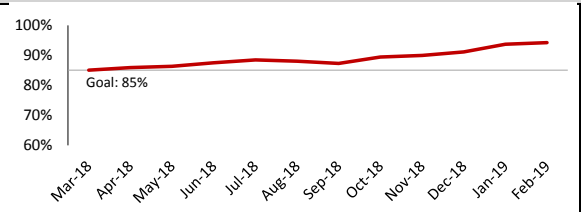
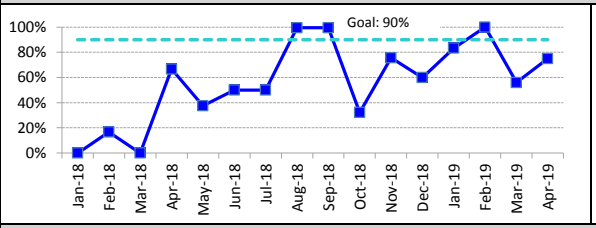
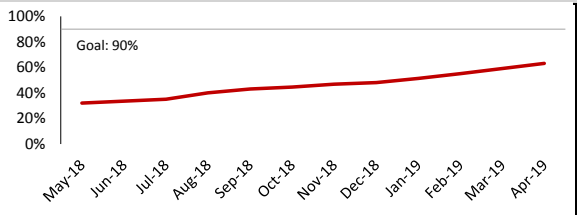
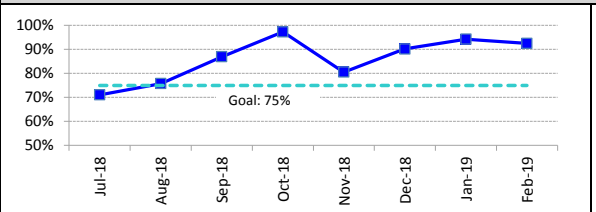
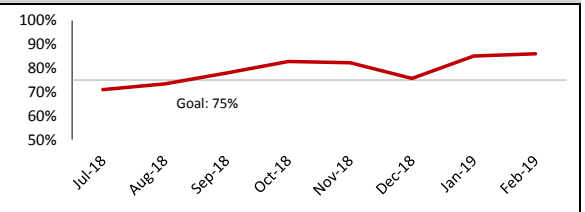
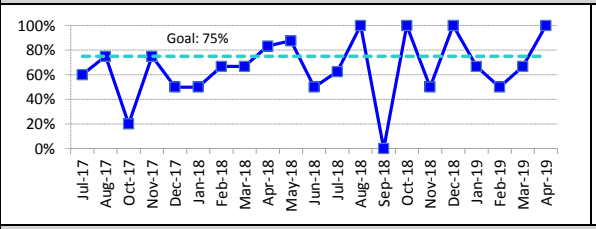
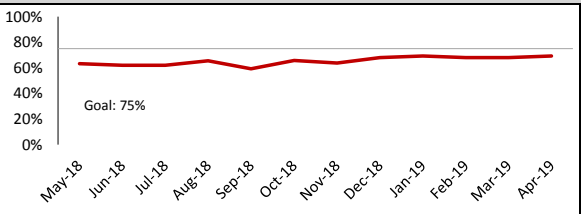
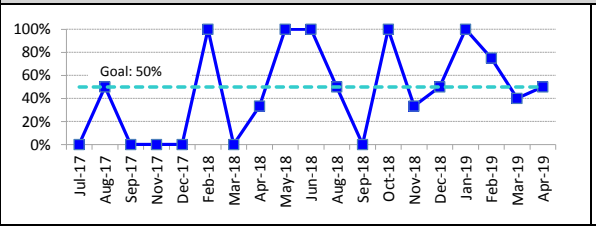
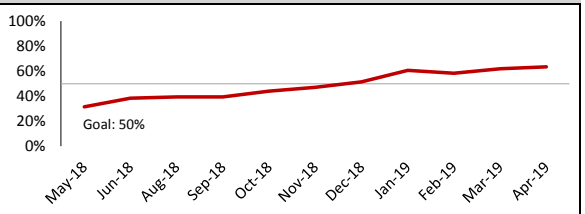
Stroke Program Dashboard

Dashboard Date: February 2019
(Each metric indicates the month for which data is complete.)
Last updated: 5/23/2019

		Month	FYTD	Baseline	FY19 Goal	Trend	12-mo Rolling Average
Quality		Current Month	FYTD	FY18 Actual	FY19 Goal		
1	**Stroke Readmission Index (All Patient, All Cause Readmit)** *Observed/Expected* ***Premier Standard Risk Calculation Mode*** *Date Period: February 2019* *Lower than goal is better*	**1.01**	**0.67**	1.08	0.93		
Quality							
2	**Stroke Mortality Index Enterprise** *Observed/Expected* *Date Period: March 2019* *Lower than goal is better*	**1.95**	**1.20**	1.25	0.73		
Service							
3	**Patient Satisfaction** *Date Period: March 2019* *Higher than goal is better*	**79.69%**	**84.04%**	82.20%	85%		
Quality							
4	**Dysphagia Screen** *Date Period: February 2019* *Higher than goal is better*	**90.32%**	**85.94%**	84.43%	85%		

Stroke Program Dashboard

Metric Name	Comments	Data Definition	Data Source
Stroke Readmission Index (All Patient, All Cause Readmit) *Observed/Expected* ***Premier Standard Risk Calculation Mode***	Process Improvement Updates: May 2019: Implemented Comprehensive Family Assessment for Stroke Patients discharged home (by Care Coordination); will help with transition to home and potentially minimize readmissions. Future plans: Stroke Program NP will round on Stroke/TIA patients during their stay and continue to see some of the patients at the post-Stroke and TIA clinic providing opportunities for more education and follow up, thus potentially minimizing readmissions.	Risk adjusted data is run on cases codes with hemorrhagic stroke or ischemic stroke. FY19 goal is based on Premier FY18 Stroke Population overall top performers. 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**
Stroke Mortality Index Enterprise *Observed/Expected* ***Premier Standard Risk Calculation Mode***	Process Improvement Updates: May 2019 Plan: * Reach out to Quality to get detailed information per MD and per patient to further analyze mortalities. Work with Corneliu Delogramatic (Doc Improvement Manager) and Viet Tran (Service Line Ops Manager) to provide education for better documentation of severity level and care. * Review encounter coding criteria with HIMs. * Better identify patients with severe prognosis and possibly involve hospice earlier during the stay.	Risk adjusted data is run on cases codes with hemorrhagic stroke or ischemic stroke FY19 goal is based on Premier FY18 Stroke Population overall top performers. 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 Satisfaction	Process Improvement Updates Feb 2019: Revised questionnaire to remove "Would you say you received prompt care in the ED?" which has been almost 100% Yes, and replaced with 2 questions: "Have you been taking your prescribed discharge mediations?" and "Do you have or have you had follow up appointments with your PCP and neurologist?"	Patient Satisfaction calls are made to Ischemic and hemorrhagic stroke & TIA patients discharged Home, Home with home healthcare, and to Rehab. Only includes patients who answered questions are included. Patients called, but who did not answer/respond are not included. Average percentage of # of yes answers / Total number of questions asked per patient.	**Stroke Program Patient Satisfaction spreadsheet**
Dysphagia Screen	Process Improvement Updates: Feb 2019: Limited RN education to do a dysphagia screen for all patients who have CT/MRI head ordered including "dizzy" patients. 2/22 Stroke Committee - Official PDSA PI project for Dysphagia Screen to begin Apr 2019: Stroke Champions work group discussed 2 implementation plans. ED RNs will be educated to do a dysphagia screen for all patients who get a Head CT/MRI. CCU/Floor RNs issue is related to documentation of the correct route of meds given (ie, oral vs by g-tube.) May 2019: Request made to iCare by ED Medical Director to implement a "BPA" for RNs to perform a dysphagia screens for all patients getting the initial Head CT/MRI	Percentage of Ischemic and Hemorrhagic stroke who have a dysphagia screen documented before receiving anything by mouth.	**GWTG Quality Measure Report**

		Month	FYTD	Baseline	FY19 Goal	Trend	Rolling Average
Quality		Current Month	FYTD	FY18 Actual	FY19 Goal		
5	**Stroke Education** *Date Period: February 2019* *Higher than goal is better*	**84.21%**	**95.14%**	85.02%	85%		
Quality							
6	**Post-tPA documentation Compliance** *Date Period: April 2019* *Higher than goal is better*	**75.00%**	**67.39%**	33.33%	90%		
Quality							
7	**Admit Order Set Use** *Date Period: February 2019* *Higher than goal is better*	**92.50%**	**86.35%**	ND	75%		
Quality							
8	**tPA ≤ 45 minutes** *Date Period: April 2019* *Higher than goal is better*	**100.00%**	**69.05%**	65.08%	75%		
Quality							
9	**Doort-to-Groin ≤ 120 minutes** *Date Period: April 2019* *Higher than goal is better*	**50.00%**	**52.38%**	31.58%	50%		

Metric Name	Comments	Data Definition	Data Source
Stroke Education	Process Improvement Updates Jun 2018: Began rolling out new emmi video & My Road to Home Checklist. Stroke Champions assigned to help with educating RNs on correct charting & with auditing charts. Feb 2019: Now focusing on teaching documentation of personalized risk factors & next med dose documentation on AVS	Percent of patients with Ischemic, Hemorrhagic Stroke or TIA who were given education during the hospital stay addressing ALL of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency medical system, need for follow-up after discharge, and medications prescribed; excluding patients with comfort care measures only and patients discharged to hospice, acute care facility, healthcare facility (SNF, IRF), leaving AMA and expired.	**GWTG Quality Measure Report**
Post-tPA documentation Compliance	Process Improvement Updates Concurrent auditing and reminders (by Christine and Spring.) Weekly status and monthly data statistics provided. Use of golden rod sheet to remind RNs of required charting. Feb 2019: Real-Time audits - CCU assigns stroke RN buddy to verify accurate post-tPA/NIR charting each shift. Apr19: ED=50% (1/2) & CCU = 100% (4/4, includes 2 additional NIR cases.)	Percentage of charts post tPA and NIR with all vital signs and neuro checks charted according to protocol for 24 hours. Chart shows separate results for ED, CCU and All.	**Stroke Program tPA and NeuroIR spreadsheets**
Admit Order Set Use	Process Improvement Updates July 2018: Began sharing data with Hospitalist groups TeamHealth and PAMF Ongoing: Provide education regarding stroke order sets for new physicians March 2019: Neurologist began entering basic admit and stroke orders for stroke alert patients	Percentage of admitted and observation Ischemic and Hemorrhagic Stroke and TIA patients admitted with the correct Stroke Admit order set, excluding patients who become comfort care and in-patient strokes. Numerator includes when proper Stroke Admit Order set was used. (ie, if admitted for ICH, stroke - hemorrhagic focused order set.)	**GWTG Data Download Report**
tPA ≤ 45 minutes	Process Improvement Updates Will need to revisit Program goal to align with new Target Stroke Phase III award levels which was just announced in Feb 2019: 50% of cases ≤ 30 mins & 75% ≤ 45 mins	Percentage of patients who receive tPA within 45 minutes of arrival. (Raw Data)	**Stroke Program tPA spreadsheet**
Doort-to-Groin ≤ 120 minutes	Process Improvement Updates: Will need to revisit Program goal to align with new Target Stroke Phase III award levels NeuroIR Task Force met monthly to discuss & implement plans to reduce times: 3/18/2019 meeting included creation of a Roles and Responsibilities form and discussion of earlier (possible) single activation based on GFAST score and initial head CT May 2019: Focused ED/Cath Lab work group began meeting FY 2018 = no patients under 90 minutes. 24% (5/21) under 90 mins in FY 2019	Percentage of actual and aborted thrombectomy cases for which arrival to groin puncture is within 120 minutes. (Raw Data)	**Stroke Program Neurointervention spreadsheet**

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Julie Kliger, Committee Chair
Date: August 5, 2019
Subject: Ad Hoc Committee Report

Recommendation(s):

To recommend that the Board appoint the following candidates _____ to the Quality, Patient Care, and Patient Experience Committee.

Summary:

1. Situation: Due to the departure of a number of our Committee members and a need for representation of additional technical competencies as well as the patient voice, the Quality Committee appointed an Ad Hoc Committee, comprised of myself and Jeff Davis, MD, tasked with recruiting new members.

2. Authority: The Committee Charter as well as the Board's Advisory Committee Member Nomination and Selection Policy and Procedures allow the Committee to appoint an Ad Hoc Committee for this purpose.

3. Background: Dr. Davis and I, along with Dr. Adams, sought applicants through public advertising, as well as through the Board, Committee and leadership team networks. Our search was focused on the following areas of expertise: (1) Innovation [within or outside of healthcare], (2) Customer or Patient Experience, (3) Data and Technology Expertise or (4) Recent Patient (or Family of Patient) Experience at El Camino Hospital. We received nine applications and interviewed 5 candidates. We decided to bring four candidates forward for the full Committee's consideration. One of those candidates, Dr. Terrigal Burn, was not available for our August meeting but we have asked him to be available for our September meeting. Ms. Falwell, Dr. Sharma and Ms. Currie will be present at our August 5th meeting for a brief interview with the Committee after which we will have some time to discuss the candidates. Two of the other candidates, one whom we interviewed, have significant patient experience at ECH and I would like to consider inviting them to attend a future meeting to share their experiences with us.

4. Assessment: Dr. Davis, Dr. Adams and I believe all four candidates would make excellent additions to the Committee and hope the Committee will recommend the Board appoint all four candidates.

5. Other Reviews: None other than the Ad Hoc Committee.

6. Outcomes: Enhanced technical competencies and a new patient voice on the Committee.

List of Attachments:

1. Candidate Profile – Terrigal Burn, MD
2. Candidate Profile – Caroline Currie

3. Candidate Profile - Alyson Falwell
4. Candidate Profile – Krutica Sharma, MD

Suggested Committee Discussion Questions:

1. Which of the candidates will bring additional valuable expertise or experience to the Committee?
2. Is it too disruptive to alter the composition of the committee by adding four new members all at once, especially given that we also have a new Board member joining us?

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tburn@pamf.org

CAREER SUMMARY

Primary care internist with extensive experience in medical practice leadership and administration as well as managed care provision in community practice and academic settings. Led a 330 physician medical group through the process of evaluating and deciding in favor of merging with 2 sister groups to form 8th largest medical group in the US. Introduced managed care at two academic medical centers, and led its oversight in community practice. Twenty-five years of primary care medical practice and teaching experience. Highly effective change agent, leader, and team builder, with a strong commitment to improving quality of health care while lowering its cost.

PROFESSIONAL EXPERIENCE

PALO ALTO FOUNDATION MEDICAL GROUP

Current — Primary care internal medicine practice (50% time)

2014 to 2016 — Medical Director, Lean Promotion Office. Clinical practice, internal medicine (50% time)

2011 to 2014 — Member, Board of Directors, Palo Alto Foundation Medical Group. Board Liaison to Leadership Development Committee. Physician Champion, Lean Promotion Office. Clinical practice, internal medicine. (Currently 50% time)

2008 to 2011 — Chairman, Board of Directors, and CEO, Palo Alto Foundation Medical Group
Member, Board of Trustees, Sutter Health Peninsula Coastal Region
Internal Medicine Practice

PALO ALTO MEDICAL FOUNDATION (PAMF)

2005 to 2008 — Medical Director and Executive Board Chairman, Palo Alto Medical Clinic
Co-Chair, Pharmacy and Therapeutics Committee
Member, Board of Trustees, Palo Alto Medical Foundation
Internal Medicine Practice
Adjunct Clinical Professor of Medicine, Stanford University School of Medicine

MANAGEMENT RESPONSIBILITIES:
Provide leadership and oversight to our 330 physician medical group. Duties include:

- Oversight of physician staffing, recruitment, compensation, and quality of care
- Working with Foundation staff in planning and implementation of growth in existing and new markets
- Coordination of care delivery with sister medical groups within the Foundation
- Representing our organization at local and national levels

CLINICAL CARE RESPONSIBILITIES:
Care for a panel of 300 patients.

1998 to 2004 Medical Director, Health Plans and Utilization Management
Secretary, Executive Board, Palo Alto Medical Clinic
Chair, Quality Improvement Steering Committee
Chair, Utilization Management Committee

MANAGEMENT RESPONSIBILITIES:
Managed the provision of capitated care to 70,000 managed care enrollees for medical group. This represented 40% of the group's practice; 10% of the enrollees are Medicare HMO members. Significant accomplishments include:

- Led the organization's first chronic disease management initiative, developing bi-annual physician profiles in diabetes management, improving diabetes teaching programs.
- Improved case management, discharge planning, and utilization management functions at PAMF and Stanford to achieve and maintain low inpatient utilization in commercial and Medicare enrollments.
- Developed an early transfer program from Stanford Hospital to contracting SNFs to control inpatient costs.
- In charge of developing a resource team to evaluate and oversee quality improvement and evidence based medicine within PAMF.

1995 to 1997 Associate Medical Director, Health Plans

UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO

1993 to 1995 Associate Clinical Professor of Medicine
Medical Director for Managed Care Programs, UCSF Clinical Practice Organization

MANAGEMENT RESPONSIBILITIES IN THE UCSF CLINICAL PRACTICE ORGANIZATION:
Managed the UCSF HMO Programs office, supervised an office staff of 25. Responsibilities included distribution of over $18 million in annual capitation revenues for our 17,000 HMO members. Significant accomplishments include:

- Managed the development of capitated care at UCSF. Directed the growth of the HMO Programs office from a staff of 1 to present size, and from an enrollment of 500 to 17,000 members.
- Participated in the selection and implementation of a managed care hardware and software system to perform claims processing, utilization review, and management reporting, enabling automation of office functions in a complex academic environment.
- Supervised the incorporation of 160 community physicians based at UCSF's Mt. Zion Hospital Campus into UCSF's managed care network.
- Developed specifications, hired staff, and purchased hardware and software to create reports profiling clinical patterns of care and resource utilization by primary care physicians at UCSF for their panels of managed care patients.

CLINICAL CARE AND TEACHING RESPONSIBILITIES:
Cared for a panel of 400 patients and taught medical students and medicine residents in in- and outpatient settings.

1987 to 1992 Assistant /Associate Clinical Professor of Medicine
Director of Clinical Programs, Division of General Internal Medicine (DGIM)
Director of HMO Programs, UCSF Clinical Practice Organization

MANAGEMENT RESPONSIBILITIES IN DGIM: Managed finances, personnel, quality, utilization review, and care delivery at 4 internal medicine practices, the UCSF urgent care clinic, and the DGIM Satellite in Daly City. These 6 practice sites in combination delivered 65,000 patient visits per year, and billed over $4 million in annual revenues. Significant accomplishments included:

- Expanded DGIM's outpatient delivery sites from 3 to 5 clinics, increasing annual patient volume by 25%.
- Developed the role of clinician-educator in DGIM and recruited 10 physicians to staff these positions, doubling the size of the Division's faculty.
- Developed the physician management structure in the General Medical Practices to improve efficiency, and develop more creative and rapid problem solving.

STANFORD UNIVERSITY MEDICAL CENTER

1983 to 1987 Assistant Clinical Professor of Medicine
Associate Director, Stanford Medical Group
Medical Director of HMO Programs

EDUCATION

Fellowship	California Health Care Foundation in Healthcare Leadership, 2007
M.S.	University of Wisconsin-Madison, in Administrative Medicine, 1992
M.D.	SUNY at Buffalo, 1978
B.S.	Vassar College, 1974. Phi Beta Kappa, Thesis and Departmental Honors
Internship	University of California at San Francisco, 1978-79
Residency	University of California at San Francisco, 1979-81

HONORS AND MEMBERSHIPS

Elected, Alpha Omega Alpha, SUNY at Buffalo School of Medicine, 1978. Nominated for Kaiser Teaching Award, Stanford University School of Medicine, 1985. Diplomat, American Board of Internal Medicine.

PERSONAL INTERESTS

Fluent in Spanish and French. Accomplished jazz pianist, dogged runner, occasional ocean kayaker, and enthusiastic hiker/backpacker.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Candidate Questionnaire (T. BURN)
Quality, Patient Care and Patient Experience Committee

1. Quality, Patient Care and/or Patient Related Experience – Please describe how your professional background demonstrates your knowledge and experience with any of the following:
    a. An environment where patient or customer experience, safety and quality and process improvement were key market differentiators. As a physician practicing at PAMF and previously, UCSF and Stanford I have been responsible for providing high quality care and service. As the Medical Director of PAMF's Lean Promotion Office, and previously of PAMF's Quality Improvement Steering Committee I was responsible for overseeing and in some cases designing quality improvement programs.
    b. Establishing new patient or customer care, quality and/or safety programs and procedures.
    c. Innovation (within or outside of healthcare)
    d. Customer or Patient Experience
    e. Data and Technology Background
    f. Examples of situations where you made recommendations for change with any of the above areas. Helped bring UpToDate to PAMF. Started PAMF's Quality Improvement Steering Committee. Developed the guideline that flags all Sutter Epic Charts for patients over 65 to ask about Advance Directives.

2. In addition to candidates with the technical competencies described above, we are also hoping to recruit members with experiences at El Camino Hospital. To the extent you are comfortable disclosing, please describe any recent experience you or a close member of your family had at El Camino Hospital. I have had many patients cared for by my PAMF colleagues at ECH.

3. Why are you interested in being considered as a member of El Camino Hospital's Quality, Patient Care and Patient Experience Committee? Excellent hospital doing good work; my patients benefit from improved quality. The chair of the committee is a forward thinking leader.

4. Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check? No

5. Are you able to make the necessary time commitment? Yes

6. Would this position create a conflict of interest with any of your other commitments? No

CAROLINE R. M. CURRIE
linkedin.com/in/carolinecurrie

SUMMARY

Highly energetic professional with a hard-wired athlete's mentality and a passion for healthcare innovation. 10 years of success in program management, vendor strategy, clinical operations, and team leadership in both clinical and fast-paced tech environments.

EXPERIENCE

Apple Inc., Cupertino, CA **2015 - Present**

Engineering Manager, Health Studies Data Acquisition *(2018-present)*

Engineering Project Manager, Health Studies *(2015-2018)*

UCSF Orthopedic Institute, San Francisco, CA **2013 - 2015**

Clinical Project Manager
Managed 30+ clinical studies on Sports Medicine team, reporting to Chief of Surgery. Implemented multi-center clinical trials (both NIH and industry-sponsored), as well as investigator-initiated clinical trials. Managed a Research Assistant and oversaw intern team.

- Oversaw execution of clinical research activities, including patient screening, scheduling, physical testing, specimen collection and processing, data collection, analysis, and presentation.
- Created study protocols, standard operating procedures, databases, IRB and FDA submissions, informed consent forms, and case reports.
- Managed departmental study funds, including federal, non-federal, and foundational grants. Communicated regularly with sponsors, created and negotiated budget contracts, and drafted invoices.

EARLY EXPERIENCE

Project Wellness, *Founder and General Manager*, Palo Alto, CA **2012 - 2015**
Culminated years of formal and experiential education in medicine, nutrition, fitness, and health research, to build a consumer-facing consulting and educational program with a focus on achieving life-long, overall wellness. Transitioned to not-for-profit program in 2014; taught weekly classes at low income housing community center in Palo Alto.

Basis Science (acquired by Intel in Mar 2014), *Content Strategy Copywriter*, San Francisco, CA **2013 - 2014**
Independent Contractor on Content Strategy team with the goal of providing a voice for the brand. Published scientifically-backed content for consumer audiences on topics in health, fitness, sleep, and nutrition, as well as an eBook comparing Basis to other fitness trackers.

Children's Hospital Boston*, Research Assistant,* Boston, MA **2010 - 2011**
Designed and executed bench studies on Pediatric Oncology/Hematology team, at the direction of 4 physician scientists.

Maine Medical Center Research Institute*, Clinical Research Assistant*, Scarborough, ME **2008 - 2009**
Managed study strategy, kickoff, data collection, and all ongoing study operations for a clinical study that examined the impact of exercise and nutrition on childhood obesity.

Maine Medical Center, *Case Study Writer,* Portland, ME **2008 - 2009**
Conducted extensive literature searches, examined and analyzed patient charts, and wrote full case reports for the Division of Maternal-Fetal Medicine, one of which was selected for publication in October 2009.

EDUCATION

University of New England College of Osteopathic Medicine, *D.O. Candidate,* Biddeford, ME **2011 - 2012**

Bowdoin College, *B.A. in Biology and Pre-Medicine, 3.90 GPA,* Brunswick, ME **2004 - 2008**

- Phi Beta Kappa (Sep 2007), Magna Cum Laude (May 2008), Bowdoin Scholar award (2005-2008).
- Varsity Women's Ice Hockey, 2004-2008. Starter and impact player.

KEYNOTE PRESENTATIONS & PUBLISHED RESEARCH

Currie, Caroline. “Designing Technology for Health.” Silicon Valley Women in Engineering Conference: Emerging Technologies for Improving Health, 16 March 2019, San Jose State University, http://siliconvalleywie.org/

Currie, C., JR Wax, MG Pinette, and J Blackstone (2009) Cogan’s Syndrome complicating pregnancy. Journal of Maternal-Fetal and Neonatal Medicine. 22(10): 928-30

Jonathan W. Snow, Jonghwan Kim, Caroline R. Currie, Jcian Xu, and Stuart H. Orkin. (2010) Sumoylation regulates interaction of FOG1 with CTBP. Journal of Biological Chemistry. 285: 28064-28075

Shao, L., W Feng, Y Sun, H Bai, J Liu, C Currie, J Kim, R Gama, Z Wang, Z Qian, L Liaw, and W Wu (2009) Generation of iPS cells using defined factors linked via the self-cleaving 2A sequences in a single open reading frame. Cell Research. 19: 296–306

Candidate Questionnaire
Quality, Patient Care, and Patient Experience Committee

Applicant: Caroline Currie

Question 1 Response

As the daughter of a GYN-oncologist surgeon and an infectious disease nurse, understanding patient care is deeply-rooted in my upbringing. I remember doing rounds with my Dad on the weekends in the pre-HIPAA days and listening to his lessons before entering each room, and then watching his approach and demeanor with very sick women and their families. It was a profound experience as a child to understand empathy.

While I did not pursue medicine, my entire career has been dedicated to patient care and participant experience in health/clinical research. I have designed over 50 health-related research studies and managed research teams who have executed them. In the early years of my career, I was the one executing the studies – recruiting eligible patients, explaining the research, consenting them – I was the first face they would see before the physician came in.

a. Every experience I have had, from my first job in clinical research to my current role managing health study development at Apple, has focused on patient safety, participant experience, and process improvement.
b. I helped develop the processes and procedures for Apple's health programs, trained health teams to human ethics, safety, and risk, and currently oversee participant experience flow for health study protocol design.
c. Innovation is at the heart of the work I do at Apple. I had to think creatively to evolve my traditional clinical research approach to fit the needs of a fast-moving innovation-focused tech company, while still adhering to the principles of GCP, human rights, patient safety, and ethics.
d. In my early career, I was particularly involved with direct customer, patient, and participant experience. I have worked in restaurants in customer-focused settings, I have interned and volunteered in hospitals, and of course, I have executed clinical research studies (recruiting, consenting, and facilitating the study procedures). These experiences have helped shape the wisdom and philosophies about "people care" to which I train teams today. Aside from my professional development, I have also been a patient in a countless number of hospitals and clinics. I have been on the receiving-end of terrible patient care, as well as phenomenal, and over-time I have developed a good understanding of the nuances that tip the scale in one direction vs. another.
e. My overarching deliverable at Apple is to deliver health data to our organization for the development of technology features/products. I also appreciate that intuition, creativity, and a high EQ are essential to my work, particularly as it relates to designing technically complicated studies to have high-quality participant experience.
f. When I first came to Apple, I was tasked to build up health study knowledge and infrastructure. I created a Research Protocol and Informed Consent Form template, and

trained research teams on the key elements of protocol/study design, risk assessment, informed consent, and adverse events. This was in 2015, and these tools are still being used company-wide today.

Question 2 Response

My wife and I delivered our daughter at El Camino. I carried, and therefore experienced first-hand the anxiety and unknowns of a first-time pregnancy, as well as experienced the compassion, patience, and professionalism of the staff at El Camino. Between weeks 36 and 40, we came to El Camino A LOT, super convinced that something was either wrong, or that I was in early labor. The staff were friendly and patient as they saw my familiar face marching (back) in for a fetal stress test exam, and then would politely assure me everything was fine and to go home. Once I was finally admitted in actual labor, everyone was simply wonderful. The delivery of my daughter was one of my favorite days. She was born surrounded by strong women: my wife, my sister, my OB, 2 nurses, and me. The following 2 days in the hospital we were met with outstanding support.

As a same-sex couple, however, my wife and I acknowledged that – for a hospital in the ultra-inclusive Bay Area – El Camino (and PAMF) under-represented same sex parenting. From brochures to classroom materials, we saw appropriate representation of different races and ethnicities, but there were no same sex couples (at least in any of the OB/maternity materials). We joked about this lightly, but during the delivery it became a stronger concern, as my wife, the second parent, had to walk around with a “father” wristband and was forced to sign along the “father” line on various forms. My wife voiced her concern about this, and El Camino took it seriously and put steps in motion to change things. This was most impressive and made us feel part of the El Camino community.

Question 3 Response

I have two motivations. First, as stated in the second paragraph above, I feel like my wife and I are part of the El Camino community. We love El Camino’s commitment to improvement – and to actually following through. My wife is part of a monthly group at El Camino Hospital, and I would like to give back to El Camino as well. I believe I would bring value and perspective to the group based on my professional and personal experiences. I am also a dynamic problem solver, a thoughtful listener, and am comfortable sharing my views in a room full of people.

My second motivation is for my own growth. I love to be continuously learning, and I see this as a valuable opportunity to not only share my knowledge and experience to better El Camino patient care/experience, but also to expand the breadth of my knowledge and then apply this in my profession as I continue to improve the best practices and standard of care in that arena.

Question 4 Response: No.
Question 5 Response: Yes.
Question 6 Response: No.

Alyson Falwell, MPH
1571 De Anza Way
San Jose, CA 95125
(408) 438-3061 • alysonfalwell@gmail.com

Over 15 years of experience in clinical research at top tier academic medical centers with 10 years in managerial and leadership roles. Deep expertise in Phase I-IV clinical trial startup and management in adult and pediatric populations in both the inpatient and outpatient settings. Experience with both drug and device trial feasibility assessment and implementation. Extensive experience with regulatory submissions, developing and scaling research programs, federal audits, training clinical and non-clinical stakeholders, managing large cross-functional teams, developing guidelines and SOPs, and management of up to 15 independent, concurrent clinical trials. Experienced public speaker and writer with co-authorship on 8 published articles in peer-reviewed journals.

Experience

Clinical Research Operations Manager **April 2019 -- Present**
Stanford Children's Health

- Manages and directs all clinical and programmatic aspects of clinical research operations
- Responsible for the implementation and monitoring of an effective and ongoing Clinical Research Support Office adhering to quality, compliance, and patient safety standards
- Collaborates in research planning activities, working closely with principal investigators and research teams to help develop and review potential protocols prior to study initiation, including assisting with assessing feasibility, operational needs, and budget development
- Educates clinical and research staff on established policies, processes, and procedures
- Serves as a clinical research expert resource and provides guidance and education for all aspects pertaining to implementation of research projects
- Plans protocol, develops policies, and establishes standards for the research unit
- Provides leadership in determining, recommending, and implementing improvements to policies/processes; define best practices

Clinical Research Program Lead **December 2017 – March 2019**
El Camino Hospital

- Responsible for developing and deploying an internal and external quality monitoring and assurance program
- Developed and implemented strategy and roadmap for clinical trial quality oversight and management within the Clinical Research Department
- Developed metrics and tools to track, measure, and address quality in research across the enterprise
- Generate and oversee new Standard Operating Procedures related to subject enrollment, informed consent, regulatory management and adverse event detection and management
- Train staff on tools and processes focused on consistent program compliance and proper clinical trial conduct
- Actively manage 5-10 interventional pulmonology clinical trials
- Advise leadership on standards and best practices related to clinical trial compliance and Federal regulations

Senior Associate/Director **February 2016 - December 2017**
Alvarez & Marsal, Healthcare Industry Group

- Worked with Performance Improvement and Healthcare Industry business units on health equity, hospital philanthropy and clinical service line development
- Partnered with Clinical Senior Director to lead best practices research for 4 chronic diseases and develop framework for disease management across conditions. Also led development of health equity maturity model and assessment tools
- Developed tools and processes for grants management program including: evaluation protocol for funding requests, active award reporting and tracking dashboard, and impact assessment of funded activities
- Served in interim management role for a large regional healthcare foundation where responsibilities included optimizing workflows, creating tools to improve staff efficiency, and supporting staff fundraising efforts

Manager, Multi-Specialty Cooperative Group Research **December 2013 - January 2016**
Stanford University School of Medicine, Cancer Clinical Trials Office

- Responsible for overseeing operations of the Stanford University Cooperative Group Research Program, including staff and clinical trials associated with Stanford membership in NIH NCI Cooperative Groups: SWOG, ECOG, NRG and COG
-Managed a staff of 25-35 research coordinators and data managers
-Responsible for overseeing progress towards targets required as part of NIH U10 grant award
-Responsible for all aspects of hiring, mentorship, performance management, strategic planning and resource allocation for Stanford Cooperative Group program
- Worked with Stanford IRB and Regulatory Department to improve processes for regulatory management of NCI CIRB trials
- Implemented Lean processes in work several groups including daily huddles and visible tracking boards to improve staff efficiency and reduce delays in patient enrollment
- Coordinated preparation for and management of multiple on-site NCI audits
- Participated in development of clinical trials infrastructure for Adolescent and Young Adult Cancer Program with Stanford Hospital and Lucile Packard Children's Hospital
- Partnered with local, state and Federal regulatory agencies and complying with regulatory requirements

Clinical Trials Supervisor **January 2011 - December 2013**
Stanford University School of Medicine, Department of Pediatrics, Division of Hematology/Oncology
- Responsible for operations and conduct of more than 150 clinical trials in pediatric hematology and oncology
- Managed budgets, hiring, and performance of 7 research coordinators to ensure compliance with protocols, GCP, and University practices
- Using PDSA, implemented systems to improve operational efficiency including developing standard operating procedures for managing clinical trials and implementation of a single Universal consent form for patient sample collection
- Worked with physicians, nurse practitioners and pharmacists to implement a double-check system to ensure that clinical trial patients receive the correct chemotherapy treatment plan
- Worked with physicians and nurse practitioners to expand the role of research coordinators and improve integration into clinical care team
- Managed Phase I-III clinical trials for Neuroblastoma, Ewings sarcoma and Osteosarcoma
- Deepened cross-functional relationships through organized, monthly, faculty led educational sessions for coordinators
- Ensured charts were always "audit ready" through oversight of regular, internal reviews of chart data quality
- Managed successful team completion of quarterly data deadlines for Cooperative Group studies
- Coordinated preparation for and management of NCI audit for Children's Oncology Group

Director of Operations **January 2009 - January 2011**
The Altos Group
- Responsible for managing all operations for organizational improvement and management advisory firm that works exclusively with healthcare organizations
- Managed implementation of multi-million dollar change management grant funded by the Gordon and Betty Moore Foundation at three Bay Area community hospitals
- Oversaw compliance with protocol, developed and modified project tools, participated in curriculum development and organized clinician trainings
- Worked with hospital leadership to develop and train high functioning teams of nurses, physicians and allied health professionals

Research Project Manager **May 2005 - September 2008**
Stanford University, Center for Health Policy/Primary Care and Outcomes Research
- Oversaw several federally and privately funded grants studying medical errors and patient safety in US Hospitals
- Responsible for ensuring timely and accurate achievement of all project goals
- Participated in development of new project ideas, wrote and submitted grant applications, developed project budgets, hired and trained staff, and supervised a team of research assistants and data analysts
- Prepared reports for submission to funder, managed all human subjects requirements, conducted data analyses, participated in preparation of manuscripts, and presented findings at national scientific meetings
-Responsible for managing consortium of 150 US hospitals and medical centers. Maintained communication with and prepared individual reports for all hospitals on their safety culture
- Coordinated partnerships with federal government, Joint Commission, Institute for Safe Medication Practices and other partner organizations and entities

- Planned and organized large annual meeting for all hospitals and affiliate organizations
- Worked with team of diverse investigators to ensure compliance with project protocols

Research Coordinator **June 2003 - May 2005**
University of Washington, Harborview Medical Center, End of Life Care Research Program
- Coordinated multi-faceted intervention to improve palliative care in seven distinct intensive care units at Harborview Medical Center
- Managed both pre-intervention and post-intervention data collection, coordinated intervention activities, managed IRB activities, and ensured compliance with human subjects and HIPAA regulations
- Supervised research assistant activities and coordinated meetings and communication with diverse project team

Research Coordinator **September 2002 - September 2003**
University of Washington, Department of Psychiatry and Behavioral Sciences
- Assisted with research activities in the area of stress & coping
- Extracted relevant physiological data from medical records
- Coordinated human subjects applications for University of Washington IRB and NIH
- Performed literature searches and assisted with preparation for grant submission

Research Coordinator **May 2000 - August, 2002**
University of Pennsylvania, Department of Psychiatry, Bipolar Disorders Program
- Coordinated industry sponsored clinical trials for the treatment of Bipolar Disorders
- Acted as liaison between sponsoring agencies, laboratories, patients and Bipolar Disorders Program
- Set up and ran patient clinics and ensured drug accountability
- Responsible for clinical trial regulatory compliance, CRF management, patient recruitment, patient screening, and IRB coordination
- Performed assessments using structured interviews and rating scales

Education

University of Washington - *Master of Public Health, 2004*
Skidmore College - *Bachelor of Arts, 1998*

Consulting Work

2008-2009	**Stanford University School of Medicine**
	Consulting on management and closeout of federally funded simulation grant
2009	**iAccessCare**
	Survey design and market research for healthcare startup
2009-2011	**Convergence Health Consulting**
	Authored report on Operational Efficiency for California HealthCare Foundation and Safety Net Institute
	Conduct Meta analysis of research on hospital characteristics and performance

Invited Lectures

MD Anderson Children's Cancer Hospital, Pediatric Grand Rounds, November 4, 2013. "Safety Culture and Efficiency in Clinical Research: A View From The Trenches"

Teaching

2019: Incoming Instructor for UCSD Clinical Trials Design and Management Program. Developing course on Critical Competencies for Clinical Research Professionals

Awards

Retirement Research Foundation Masters Student Research Award, American Public Health Association, 2004.
Academy of Management, Health Care Management Division, Best Paper, 2009.

Membership in Professional Organizations

American Public Health Association; since 2003; AcademyHealth; since 2005

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Candidate Questionnaire (A. Falwell)
Quality, Patient Care and Patient Experience Committee

1. Quality, Patient Care and/or Patient Related Experience – Please describe how your professional background demonstrates your knowledge and experience with any of the following:
    a. An environment where patient or customer experience, safety and quality and process improvement were key market differentiators.
    b. Establishing new patient or customer care, quality and/or safety programs and procedures.
    c. Innovation (within or outside of healthcare)
    d. Customer or Patient Experience
    e. Data and Technology Background
    f. Examples of situations where you made recommendations for change with any of the above areas

I have extensive experience establishing and managing programs in the clinical research space within both academic medical centers and community hospitals. My experience managing large clinical research programs and developing quality and regulatory infrastructure and processes would be a good fit for the Quality, Patient Care and Patient Experience Committee. Additional relevant experience includes:

10+ years of experience as a working manager leading small and large high-functioning research teams with a focus on regulatory compliance and quality improvement;
• Experience as the Director of Operations for a healthcare consulting firm;
• Project management experience including developing complex project plans, performance dashboards, identifying potential project risks, adhering to project timelines and meeting project milestones;
• Experience working with organizational leadership to develop strategic plans and roadmaps to achieve those plans;
• Experience developing and scaling research programs including providing financial and administrative oversight;
• Experience developing SOPs, policies and workflows to improve quality and regulatory compliance
• Experience using a data-driven approach to guide programmatic decision-making;
• Experience working on cross-functional teams and collaborating with physicians, administrators, nurses, sponsors, and other key stakeholders;

2. In addition to candidates with the technical competencies described above, we are also hoping to recruit members with experiences at El Camino Hospital. To the extent you are comfortable disclosing, please describe any recent experience you or a close member of your family had at El Camino Hospital.

- As a former employee of El Camino Hospital, I am familiar with both the employee and patient culture at the hospital. I worked at El Camino Hospital for 15 months helping develop a quality program within the Clinical Research Department, and have a good understanding of some of the strengths and challenges of the organization. Personally, I have had several friends deliver babies at El Camino Hospital and have other friends that have received both emergency and ongoing care at the facility.

3. Why are you interested in being considered as a member of El Camino Hospital's Quality, Patient Care and Patient Experience Committee?

In the Bay Area, large healthcare players dominate the medical landscape. The role of a community hospital is an important one and El Camino Hospital plays a critical role for those who seek outstanding heart and vascular or pulmonary care, among others, in the context of a community hospital setting. Ensuring that patients have a good care experience while ensuring that the providers are able to provide cutting edge medical care in a culture that supports innovation and rapid cycle improvement will be critical for ECH's survival in the Bay Area healthcare marketplace. As a member of the community and a resident of the South Bay, I'm interested in helping ensure that all current and future patients continue to receive the highest quality care and an optimal care experience at the hospital.

4. Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check?

No

5. Are you able to make the necessary time commitment?

Yes

6. Would this position create a conflict of interest with any of your other commitments?

No

KRUTICA SHARMA

krutica.sharma@gmail.com

Krutica Sharma is a Healthcare Management Consultant with a combination of clinical background and experience with strong technical and analytical skills. Ms. Sharma's areas of focus include quality, compliance, performance improvement, and physician productivity and compensation.

PROFESSIONAL EXPERIENCE

Alvarez and Marsal LLC

Senior Associate, Healthcare Industry Group **2018 - Present**

Associate, Healthcare Industry Group **2014 - 2018**

Analyst, Healthcare Industry Group **2013 - 2014**

Intern, Healthcare Industry Group **2012**

- Assisted several locations of a multi-facility international faith based not for profit health system with financial turnaround and cost saving effort
- Provided operational advisory and project management support to a county health system with acquisition and integration of a private non-profit health system
- Involved with assisting a large academic medical center and public hospital with system-wide clinical and operational performance improvement and compliance with Centers for Medicare and Medicaid Services Conditions of Participation under a Systems Improvement Agreement
- Served as the Quality Review Organization and reviewed the compliance and quality programs at a large academic hospital and public hospital system in Dallas, Texas
    - Project Management
    - Perform audits on floors and clinics to ensure adherence to organizational policies and procedures and industry best practice standards
    - Work directly with client for regular meetings reviewing and analyzing adverse safety events
    - Review quality of care dashboards and analyze for trends
    - Investigate adverse safety events
    - Draft regular reports submitted to the hospital leadership and DHHS
    - Monitor progress on organization workplan
- Involved with Strategic Planning for the world's largest Organ Recovery Organization
- Performed commercial due diligence for a Private Equity client looking to invest in a specialty clinic chain
- Program review and recommendations for performance improvement around a community program of a non-profit organization
- Review and crosswalk of sanctions and deficiencies identified as part of a CMS audit of Medicare Advantage & Prescription Drug Program involving a major insurance provider
    - Research and review historical OIG reports on compliance and billing audits and identify trends with the audit score and sanctions
    - Obtain and analyze data to assist the Health Plan, and their attorneys, in responding to a decision by CMS to impose intermediate sanctions on their Medicare Advantage plans.
    - Research similar sanctions against other MA plans
    - Prepare analytical and presentation materials for the Health Plan's attorneys to use in response to CMS action
- Provided analytical support and process mapping for a Revenue Cycle Assessment and Process Improvement project at a medical device manufacturing company

- Assessed clinical quality and performance at a multi-facility Retirement system
- Provided analytical support on a project involving performance-based payments for a large non-profit health system in the mid-West
    - Create a Value Based Purchasing dashboard
    - Assist in cost center mapping
- Conducted healthcare industry research to aid in authoring of intellectual property as well as assist in formulating strategies for existing clients
- Assisted senior management in producing client-facing marketing materials, resulting in new business
- Devised internal group exercises and analyses

Tulane University, New Orleans, LA

Tutor and Teaching Assistant **2009-2011**

- Tutored graduate and undergraduate students in Biology, Genetics, Cell & Molecular Biology, Biochemistry, and General Chemistry
- Supported the professor for the course Principles of Health Systems Management

EDUCATION

Tulane School of Public Health and Tropical Medicine, New Orleans, LA **2011**

Master of Public Health Systems Management

- Received the Gaylord Cummins Outstanding Master of Public Health Student Award May 2011
- Awarded honorary membership to Delta Omega National Honorary Society in Public Health, Eta Chapter
- Research Projects:
    - "Effectiveness of Counseling Session on Knowledge of First-Aid among Primary (Elementary) School teachers of a metropolitan city in India"
    - "Study of Reimbursement Procedures for Medical Devices and In-Vitro Diagnostics" in India, Under the International Society for Pharmacoeconomics and Outcomes Research (ISPOR)

Smt. N.H.L. Municipal Medical College, Gujarat University, India **2009**

M.B.B.S (Bachelor of Medicine and Bachelor of Surgery) (M.D.)

- Graduated with distinction (Equivalent GPA 4.0 as calculated by the World Education Services International Credential Evaluation)

SKILLS

- Clinical Data Review
- Literature Review
- Truven Database
- Definitive Healthcare Product Suite
- Microsoft Office Suite
- SQL
- SAS
- SPSS

3 – 5 YEAR GOALS

- Venture into Health-tech
- Advance in Healthcare Quality and compliance

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Candidate Questionnaire (K. Sharma)
Quality, Patient Care and Patient Experience Committee

1. Quality, Patient Care and/or Patient Related Experience – Please describe how your professional background demonstrates your knowledge and experience with any of the following:
    a. An environment where patient or customer experience, safety and quality and process improvement were key market differentiators.
    b. Establishing new patient or customer care, quality and/or safety programs and procedures.
    c. Innovation (within or outside of healthcare)
    d. Customer or Patient Experience
    e. Data and Technology Background
    f. Examples of situations where you made recommendations for change with any of the above areas

ANSWER: Being trained as a physician, I have had extensive experience interacting with patients in various care settings. Additionally, working as a healthcare management consultant, I have been deeply involved with client engagements focused on patient safety and quality and advising on quality program review / redesign.

I have been part of CMS approved monitoring team at one of the largest public hospitals in the country under their Corporate Integrity Agreement (CIA). Prior to this role, I was involved with system-wide clinical and operational performance improvement, and compliance with CMS Conditions of Participation (CoP) under a Systems Improvement Agreement (SIA) for the same organization.

I also performed clinical quality review and provided recommendations for performance improvement at a multi-facility Retirement System in Texas.

In addition to experience with Patient Safety and Quality of Care, other areas that I have championed include:

- Strategic planning for the world's largest Organ Recovery Organization,
- Commercial due diligence for private equity firms looking to invest in the healthcare space,
- Program review and go-to-market plans for Silicon Valley and Boston based technology startups entering healthcare, and non-profit organizations,
- Financial turnaround and health system integration.

Data analytics is core to all of client related decision making and recommendations and I have extensive expertise using various data analysis techniques.

For additional experience, please refer to the attached bio at the end of this document.

2. In addition to candidates with the technical competencies described above, we are also hoping to recruit members with experiences at El Camino Hospital. To the extent you are comfortable disclosing, please describe any recent experience you or a close member of your family had at El Camino Hospital.

ANSWER: Prefer not to answer

3. Why are you interested in being considered as a member of El Camino Hospital's Quality, Patient Care and Patient Experience Committee?

ANSWER: Access to affordable, safe, and quality healthcare is one of the key fundamental human rights. With quality being one of El Camino Hospital's core values, I would like to get involved the hospital's leadership and board's efforts for continuous enhancement of quality of care and patient safety, thereby being able to provide my assistance and expertise toward the effort that would greatly impact my community in the South Bay.

4. Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check?

ANSWER: None

5. Are you able to make the necessary time commitment?

ANSWER: Yes

6. Would this position create a conflict of interest with any of your other commitments?

ANSWER: No

Krutica Sharma, MD

- Krutica Sharma is a Healthcare Management Consultant, with a combination of clinical background and experience with strong technical and analytical skills. Ms. Sharma's areas of focus include quality, compliance, performance improvement, and physician productivity and compensation.

- In her current role, Ms. Sharma has been involved with assisting a large academic medical center and public hospital with system-wide clinical and operational performance improvement, and compliance with Centers for Medicare and Medicaid Services Conditions of Participation under a Systems Improvement Agreement. She was later involved as the Quality Review Organization, reviewing the compliance and quality programs at the same organization.

- Most recently Ms. Sharma has been involved with turnaround and cost saving efforts at several locations of a multi-facility international faith based not for profit health system. She is currently helping a county health system with acquisition and integration of a private non-profit health system.

- Her other engagements include:
  - Strategic planning for worlds' largest Organ Recovery Organization
  - Assessment and re-engineering of the revenue cycle of a multi-state skilled nursing and assisted living facility with more than 70 centers nationwide
  - Revenue cycle assessment and process improvement at a medical device manufacturing company
  - Clinical quality and performance assessment at a multi-facility Retirement System in Texas
  - Performance based payments for a large non-profit health system in the mid-West
  - Review of sanctions and deficiencies identified as part of a CMS audit of Medicare Advantage & Prescription Drug Program of a major Health Plan and provide analytical and presentation material to the attorneys of the plan to use in response to the CMS sanctions
  - Healthcare Industry and clinical research aiding in formulating strategies for existing clients

- Ms. Sharma is a physician, trained at one of the most esteemed Medical Centers in India and has earned her Master's in Public Health Systems Management from the Tulane School of Public Health and Tropical Medicine. She is a member of the Delta Omega Honorary Society in Public Health, Eta chapter.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: August 5, 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 and the District Board has met once. In addition, since the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee those approvals are also noted in this report.

A. ECH Board Actions

June 12, 2019

- Approved FY19 Period 10 Financials
- Approved FY20 Organizational Goals
- Approved FY20 El Camino Hospital Capital and Operating Budget
- Approved FY20 Community Benefit Plan
- Approved FY20 CEO Salary Range
- Approved FY20 Master Calendar, Committee Appointments and Committee Goals
- Approved Infection Control Medical Director Agreement

B. ECHD Board Actions

June 18, 2019

- Approved Resolution 2019-05 Recognizing ECH Community Benefit Grantee Cristo Rey San Jose Jesuit High School
- Approved Resolution 2019-06 Establishing Tax Appropriation Limit
- Approved FY20 Community Benefit Plan

- Approved FY20 ECH Capital and Operating Budget, FY20 ECHD Consolidated and Stand-Alone Budget and FY19 Period 10 Financials
- Allocated $6,958,521 of tax revenues to the Mountain View Campus Women's Hospital Expansion/Renovation/Reconstruction Project
- Appointed Director Julia Miller as the District's Liaison to the Community Benefit Advisory Council
- Elected New Board Officers
  - Gary Kalbach, Chair
  - George O. Ting, MD, Vice Chair
  - Julia Miller, Secretary/Treasurer
- Appointed Julia Miller as Chair of the ECH Board Member Election and Re-Election Ad Hoc Committee, George O. Ting, MD as a member of the Committee and Lanhee Chen and Christina Lai as advisors.

C. Finance Committee Actions

- Approved Lithotripsy Professional Services Agreement and Behavioral Health Unit On-Call Panel Agreements
- Approved Funding for MV Campus Signage not to exceed $2.5 million

D. Compliance and Audit Committee: None since last report.

E. Executive Compensation Committee Actions

- Approved FY20 Executive Bases Salary Ranges and Base Salaries
- Approved FY20 Individual Executive Goals

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
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: August 5, 2019
Subject: FY 19 Quality Dashboard for August meeting

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.
- ED Throughput data combined for both MV and LG to comply with Committee's request for a control chart.

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

2. Background: These 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:

Suggested Committee Discussion Questions:

1. The effect of transferring dying patients into the GIP is clear with the significant reduction in the Mortality Index for May.
2. The Readmission Index is below target with significant reduction in April.
3. Hospital-acquired Infections: 1 HAI for CAUTI, CLABSI and C.Diff across the Enterprise.
4. Sepsis Mortality metrics continue to be very low and is attributed to 88% compliance with the Sep-1 Early (3-hr) Management Bundle.

List of Attachments:

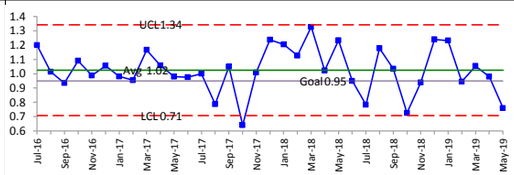
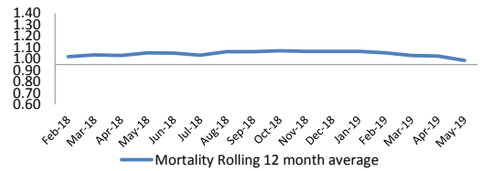
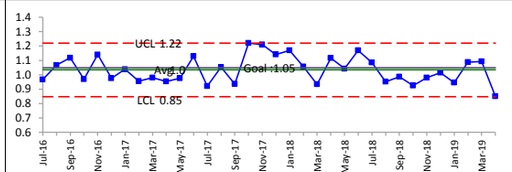
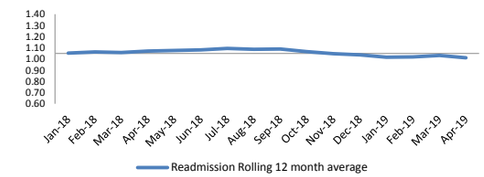
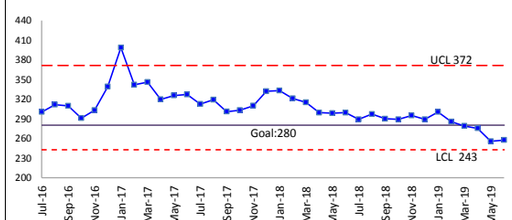
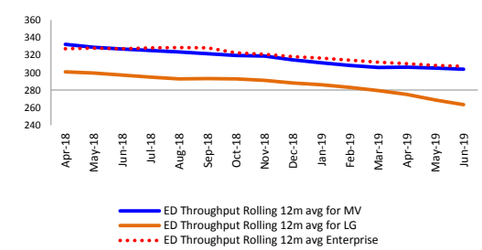
FY19 Quality Dashboard June data unless otherwise specified - final results

El Camino Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: August, 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: May 2019*	0.76 (1.21%/1.58%)	1.00 (1.60%/1.61%)	1.06	0.95		
2	***Organizational Goal** **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: April 2019*	0.85 (6.76%/7.95%)	0.99 (7.58%/7.64%)	1.08	1.05		
3	*** Organizational Goal** **Patient Throughput- Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients and Newborns)* *Date Period: June 2019*	MV: 288 mins LG: 227 mins	MV: 304 mins LG: 249 mins	(Q4 2017 to Q3 2018) MV: 336 mins LG: 302 mins	280 mins		

Definitions and Additional Information

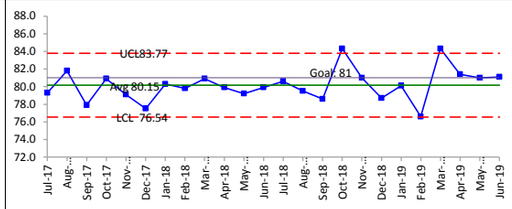
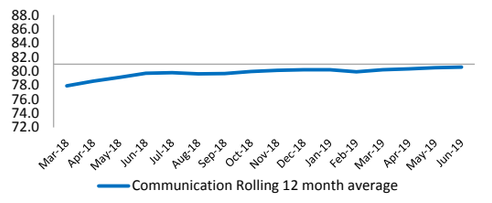
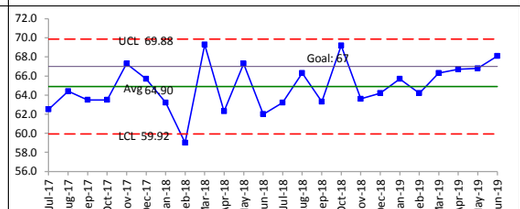
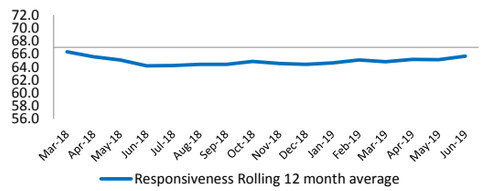
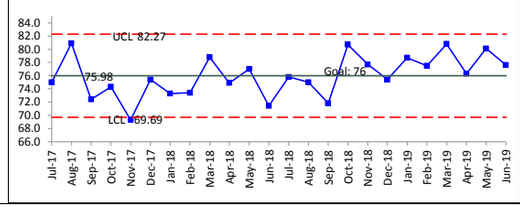
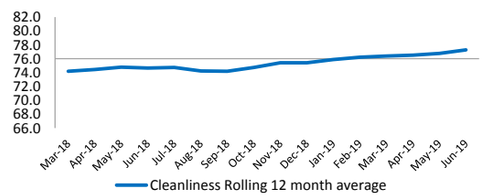
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	The GIP (in hospital hospitce) started in Jan. 19 but the first pt. was not tranferred until April 2019 with 3 pts. May had 7 pts. transferred into GIP (who did not die in the hospital). This had a significant impact on the Morality Index. We have had 9 more pts. tranferred into GIP in the momth of June.	Catherine Carson			Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Readmission Index (All Patient All Cause Readmit) Observed/Expected	This lagging metric showed much improvement with April's data, even though we had 83 readmits reviewed by the Weekly Readmit Review team. We had an unusally high cenus in April. The number of readmits dropped to 67 in May and 54 in June.	Catherine Carson			Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is 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 and Newborns)	For MV, the team has worked on identifying patients needing admission sooner to support a shorter ED length of stay, and the work of the Capacity Management Center continues to help support timely patient movement. MV continues to open up 3CW as needed to help meet demands for telemetry beds. For LG, the team has continued to follow the standard for supporting efficient movement of a patient once the order is placed. The ED providers have also worked in partnership with the hospitalists to enter bridge orders to support patient movement. To Provide a control chart, the data for both MV and LG is combined reflecting the FY 19 Target metric.	Cheryl Reinking, Michelle Gabriel; Heather Freeman			Arrival to Head in Bed. This metric is the median arrival to patient admitted time in the unit. It excludes psychiatric patients and newborns. This metric includes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery patients who arrive via the ED.	**iCare Report: ECH ED Arrival to Floor**

El Camino Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: August, 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: June 2019*	81.1 (191/236)	80.6 (2490/3091)	80.0	81.0		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: June 2019*	68.1 (156/229)	65.7 (1933/2945)	65.1	67.0		
6	* Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: June 2019*	77.6 (180/232)	77.3 (2362/3056)	74.5	76.0		

Definitions and Additional Information

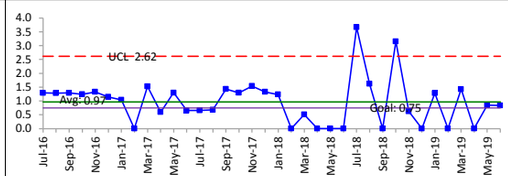
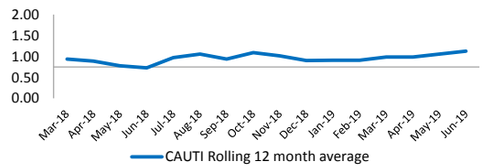
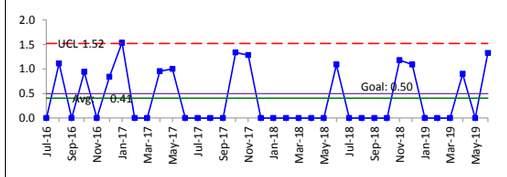
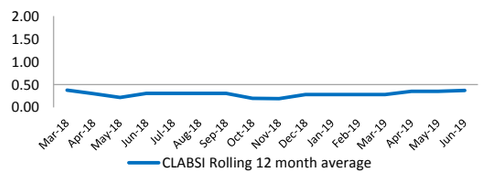
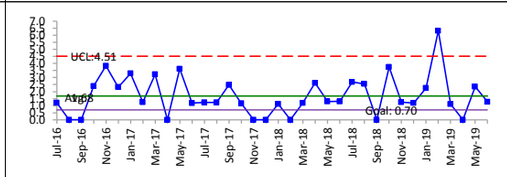
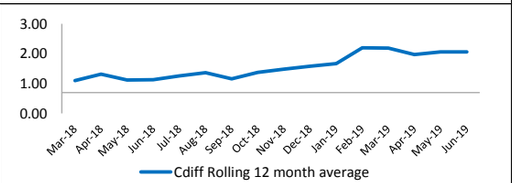
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The measurement period for the Organization goal for this metric was only the 4th qtr. FY19; for which the target level was achieved at 81.1. This domain is not part of the FY20 Service Goals.	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 measurement period for the Organization goal for this metric was only the 4th qtr. FY19; for which the target level was achieved at 67.2. This domain is part of the FY20 Service metric goals.	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 measurement period for the Organization goal for this metric was only the 4th qtr. FY19; for which the maximum level was achieved and exceeded with a score of 78.7 (max=77). This HCAHPS question is not part of the FY 20 Service goals.	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 Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: August, 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: June 2019*	0.84 (1/1193)	1.09 (17/15625)	0.77	SIR Goal: <= 0.75		
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: June 2019*	1.33 (1/754)	0.36 (4/11262)	0.28	SIR Goal: <= 0.50		
9	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: June 2019*	1.27 (1/7896)	2.03 (20/98371)	1.13	SIR Goal: <= 0.70		

Definitions and Additional Information

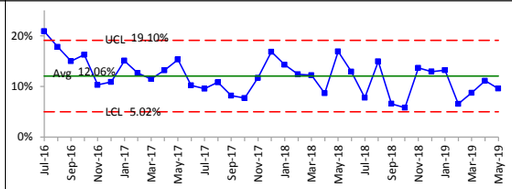
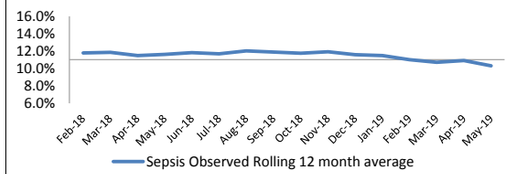
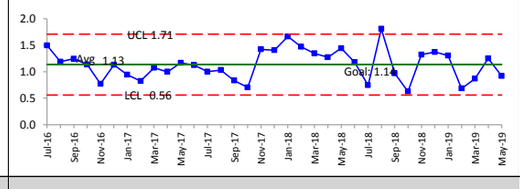
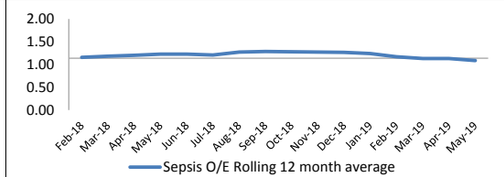
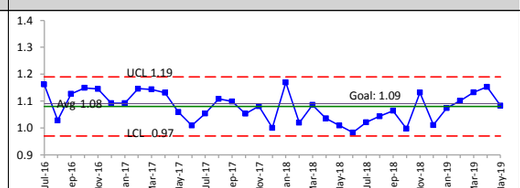
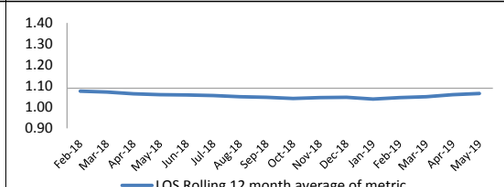
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	This one CAUTI occurred 14 days in MV after Foley insertion. Event review: CAUTI attributed to increased duration of Foley catheter 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_
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	This one CLABSI occurred in MV 7 days after admission; patient admitted with mediport in place. Event review: Opportunity for retraining of staff on accessing ports for maintenance and blood draws (ED and nursing units). For FY19, ECH is below the goal of an SIR of 0.50 which is the CDC goal for 2020.	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)	MV case: C. Diff HAI occurred 10 days after admission; 78 yo admitted with sepsis requiring multiple days of antibiotics.	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 Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: August, 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: May 2019*	9.57%	10.12%	11.72%	11.00%		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: May 2019*	0.92 (9.57%/10.42%)	1.07	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: May 2019*	1.08	1.08	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	Sepsis mortality rate continues to be low, and the 12 month rolling average demonstrates a continued trend. The ED physician's goal and focus on ordering and giving antibiotics within the first hour our time of presentation may be contributing to improved survival. The core measure Sep-1 data results for May are at 79% compliance and just the Early Management (3 hr) Bundle measures are at 88.24% compliance and is the focus of the ED's. These are the key metrics to early identificaiton and effective intervention for sepsis cases and affect the mortality rate.	Catherine Carson			Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is 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	Sepsis mortality index is below the expected value of 1.00 and well below the target goal. This index contributes positively to the Mortality Index Organizational goal.	Catherine Carson			Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is 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)	This LOS index dropped below target goal for the first month since the winter, fewer long stay patients were discharged in May. The impact of 7 pts. transferred into GIP also affects this LOS metric.	Cheryl Reinking Grace Benlice, 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.	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient, exclude cases with Patient Type=Psychiatirc, Rehab & Hospice. 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
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, CMO

Date: August 5, 2019
Subject: FY20 Quality and Safety Dashboard Metrics

Purpose:

To review and inform the Committee of the planned FY20 Quality and Safety Dashboard Metrics

Summary:

1. Situation: This is the El Camino enterprise quality and safety dashboard metrics for FY20

2. Authority: ECH Board of Directors

3. Background: The dashboard itself is under construction. This is a summary of the metrics that will be tracked on the dashboard

4. Assessment: Key metrics will include mortality index, readmission index, HCAHPS Responsiveness of Staff Domain, HCAHPS Discharge Information, CAUTI, CLABSI, CDI, Sepsis Mortality Index, SSI, Classification of Serious Safety Events, PC-01 Elective Delivery Prior to 39 weeks, PC-02 NTSV C-section

5. Other Reviews:

6. Outcomes: QC will review and track these measures.

List of Attachments:

1. Summary of FY20 Metrics

Suggested Committee Discussion Questions:

1. None

El Camino Health

Quality Committee

Mark Adams CMO

August 5, 2019

Quality and Safety Dashboard Metrics

Proposed Metrics for FY20:

- Mortality Index (Org goal)
- Readmission Index (Org goal)
- HCAHPS Responsiveness of Staff Domain (Org goal)
- HCAHPS Discharge Information (Org goal)
- CAUTI
- CLABSI
- CDI (C. Diff.)
- Sepsis Mortality Index
- SSI (Surgical Site Infections)
- Classification of Serious Safety Events
- PC-01 Elective Delivery Prior to 39 weeks
- PC-02 NTSV C-section

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, CMO

Date: August 5, 2019
Subject: PSI-4, 18, 19 Metrics

Purpose:

To review and inform the Committee about three PSI indicators that are higher than benchmarks

Summary:

1. Situation: There are several specific PSI metrics that are higher than national and/or CA benchmarks that the QC noted and requested more information/explanation to better understand why this is occurring

2. Authority: ECH Board of Directors

3. Background: The PSI-90 index is no longer being reported as such as we have moved to reporting each PSI indicator instead. Three of the indicators showed abnormally high values by comparison and an analysis was done to better understand why

4. Assessment: The increased vaginal injury with and without instrumentation is significantly influenced by patient demographics. The elevated deaths from preventable surgical complications are a result of several different factors

5. Other Reviews:

6. Outcomes: Information only

List of Attachments:

1. OB Trauma
2. Surgical Complications

Suggested Committee Discussion Questions:

1. None

El Camino Health

PSI-04 Analysis

Mark Adams CMO

August 5, 2019

PSI – 04 Analysis

Definition:

Death Rate among Surgical Inpatients with Serious Treatable Complications calculated by in-hospital deaths per 1000 surgical discharges among patients aged 18 to 89 including obstetric patients

PSI – 04 Analysis

Serious Treatable Complications:

Deep Vein Thrombosis/pulmonary embolism, pneumonia, sepsis, shock/cardiac arrest, or gastrointestinal hemorrhage/acute ulcer in elective type of admissions OR any admission in which the earliest operating room procedure occurs within two days of admission

PSI – 04 Analysis

Failure to Rescue more accurately describes this indicator as serious treatable conditions rather than complications since patients may present to the hospital and surgery with the condition already present.

PSI - 04

Findings:

40 cases that qualify for this PSI – 04 were reviewed.

30% of those cases could have qualified for GIP Hospice and would have been excluded.

50% of the cases were complications acquired in the hospital

PSI - 04

Findings (cont):

- 5 cases could be considered futile and not performed at all
- 2 cases could have been delayed to allow more time to treat the underlying serious condition

PSI – 04 Analysis

Benchmark Note:

The report to the QC in June showed a PSI-04 score of 202.13 compared to a Premier database median of 130.28. For reference, the AHRQ median is ~170.00.

PSI – 04 Analysis

El Camino Health

El Camino Health

OB Trauma Report

July 2019

PSI 18 and 19 OB Trauma Performance FY19

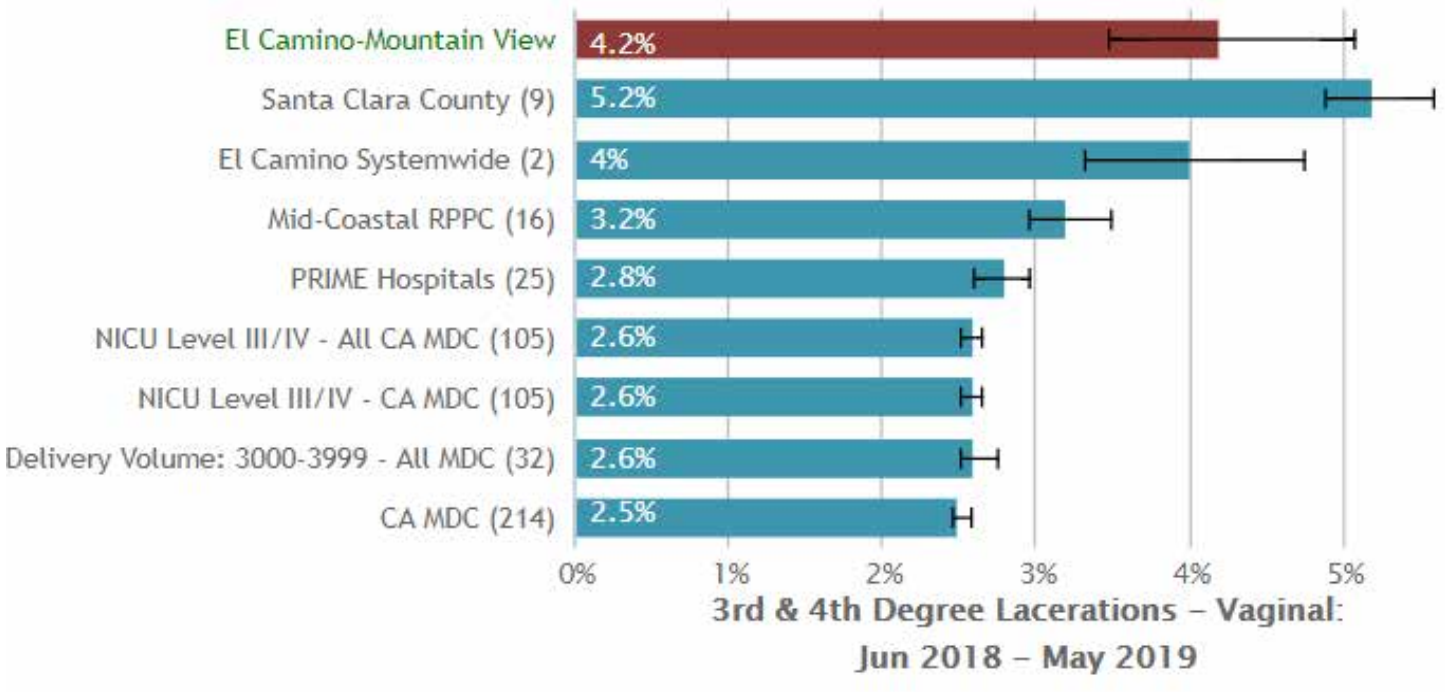
- National Performance: Premier

Patient Safety Indicator		Numerator	Denominator	Rate/1000	Premier Mean*	Premier Median*	Premier 25th Pctl*	Premier 10th Pctl*
PSI-18	OB Trauma Vaginal Delivery with Instrument	42	189	**222.22**	107.10	**90.91**	44.12	0.00
PSI-19	OB Trauma Vaginal Delivery without Instrument	55	2,317	**23.74**	15.67	**14.42**	8.64	3.88

Facility: El Camino Hospital Los Gatos (661972) (CA) (Facility:07-01-2014 to 06-19-2019) (Peer:07-01-2014 to 04-30-2019), El Camino Hospital Mountain View (635796) (CA) (Facility:07-01-2014 to 06-19-2019) (Peer:07-01-2014 to 04-30-2019)
Month: JULY 2018, AUGUST 2018, SEPTEMBER 2018, OCTOBER 2018, NOVEMBER 2018, DECEMBER 2018, JANUARY 2019, FEBRUARY 2019, MARCH 2019, APRIL 2019
Inpatient/Outpatient: Inpatient:
AHRQ QI Version:2018

- California Performance:

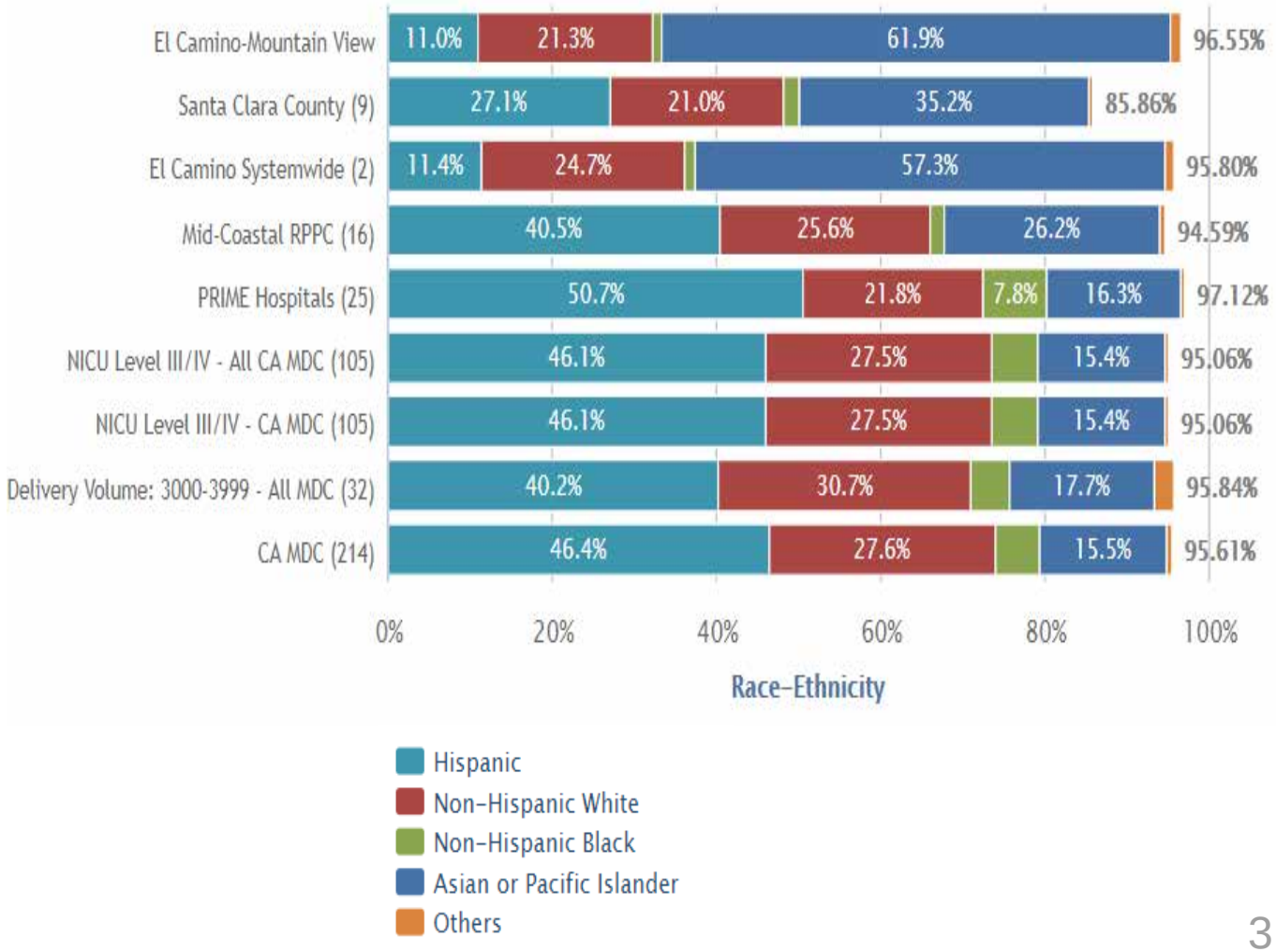
  CMQCC



El Camino Health

Contributing Factors: Population Race/Ethnicity

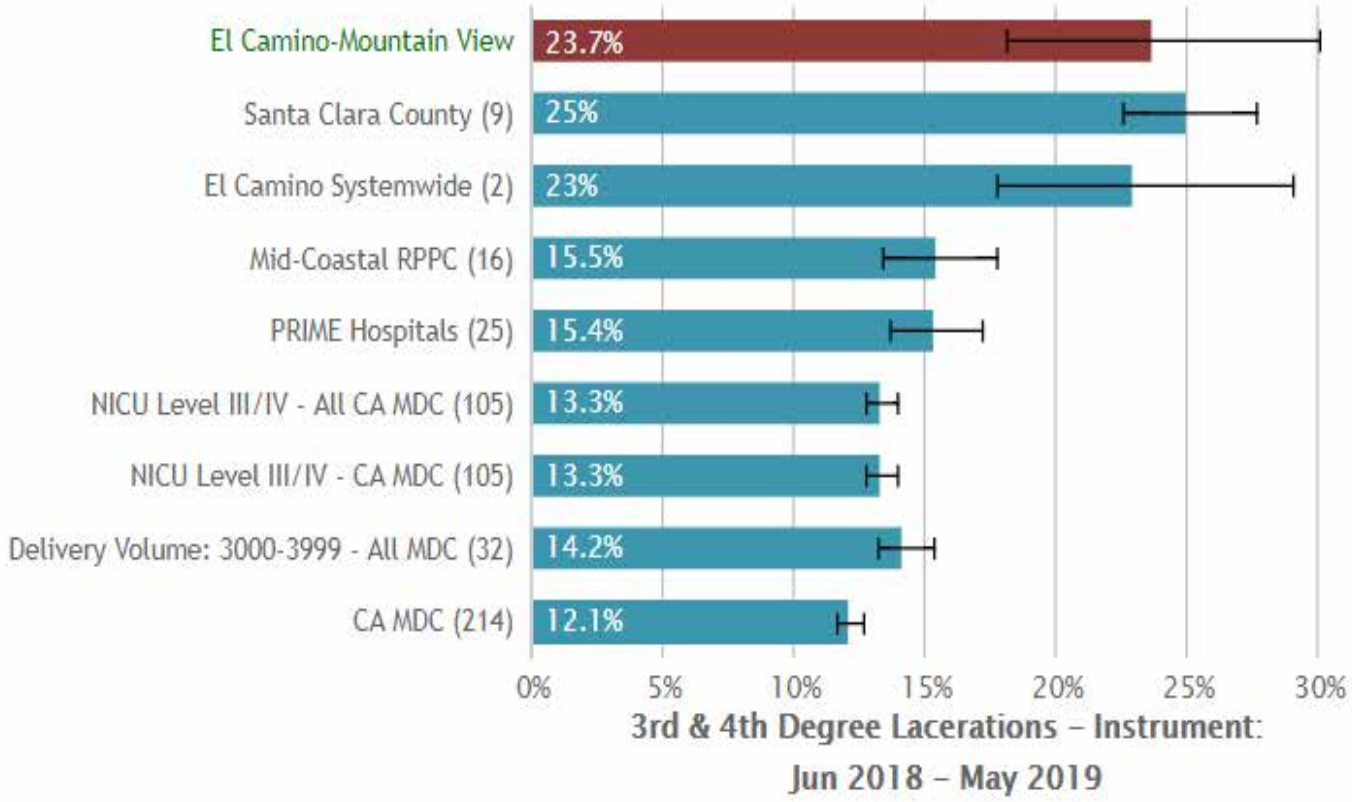
- MV campus has 62% Asian/Pac Islander population, about 4x CA average.
- Multiple studies have found a significantly higher rate of OB trauma in Asian/Pac Islander population
  - A recent multicenter study of 115,502 women (Grobman et. al, 2015) reports rates 2-3x other races/ethnicities.
  - When statistically control for race/ethnicity, ECH performs about the same as CA average in the last 12 months overall, <u>but worse in the instrumented population</u>



El Camino Health

Contributing Factors: Instrumentation

- 8% operative vaginal delivery rate (MV), compared to 6.3% (214 CA hospital mean)
- Episiotomy often needed to use instruments. Episiotomies have well established higher rates of laceration/OB trauma.
  - Episiotomy type: Midline more likely to result in 3-4th degree laceration than medial-lateral



Improvement Opportunities

- Delivery type: Operative delivery rate higher than average and are the greatest area for improvement and largest gap (after statistical control for ethnicity).
- Procedure: Episiotomy use and type have large impact
- Population: Largest gap in performance is in Asian/Pacific Islander and Non-Hispanic Black populations.

- **Target: Improve OB trauma for MV campus with instrument by 15% by July 1, 2020**

Next Steps:

- Performance and information packets for provider, to include:
  - Cover letter: current performance and risk factors, improvement target
  - Individual provider performance rates: episiotomy, 3rd/4th degree lacerations, operative deliveries
  - Unblinded provider comparison of provider rates for the above
  - Updated ACOG recommendations: Prevention and Management of Obstetric Lacerations (Sept 2018)
  - UpToDate review topics: Approach to Episiotomy, Repair of Perineal and other Lacerations Associated w Childbirth, Postpartum Perineal Care and Management of Complications
- Provide unblinded performance reports to provider groups
- Request education from Stanford for OB department
- Continue to provide quarterly performance reports
- Monitor performance and follow up as needed
- Research ways to mitigate risk for Asian/Pacific Islander population

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, CMO

Date: August 5, 2019
Subject: ED demographics

Purpose:

To review and inform the Committee regarding ED demographics

Summary:

1. Situation: The QC requested information re El Camino ED demographics

2. Authority: ECH Board of Directors

3. Background: The QC, in reviewing the ED thru-put metrics, wanted to better understand who our ED customers are.

4. Assessment: This is a breakdown of our ED visitors as represented in the attachment

5. Other Reviews:

6. Outcomes: Information only

List of Attachments:

1. ED demographics

Suggested Committee Discussion Questions:

1. None

El Camino Health

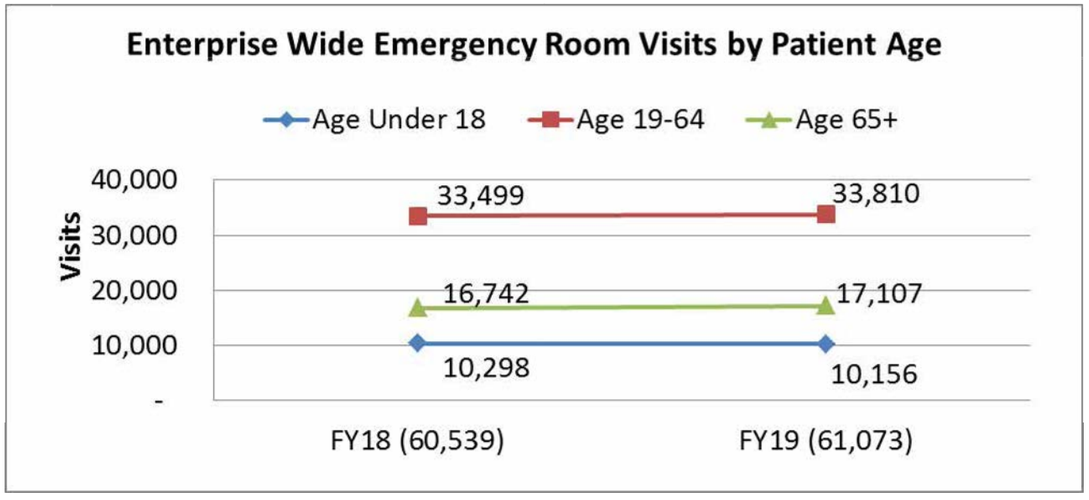
Quality Committee Report on ED Demographics

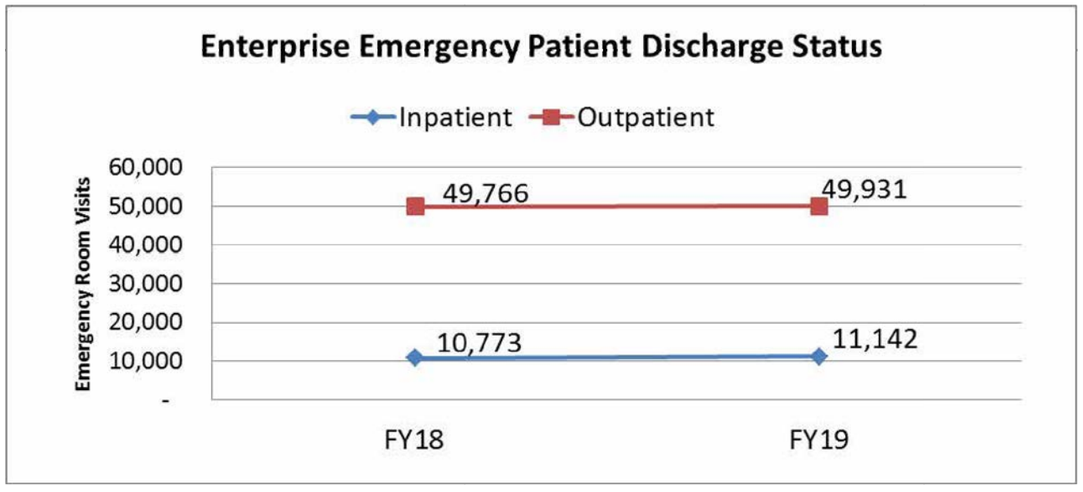
Mark Adams CMO

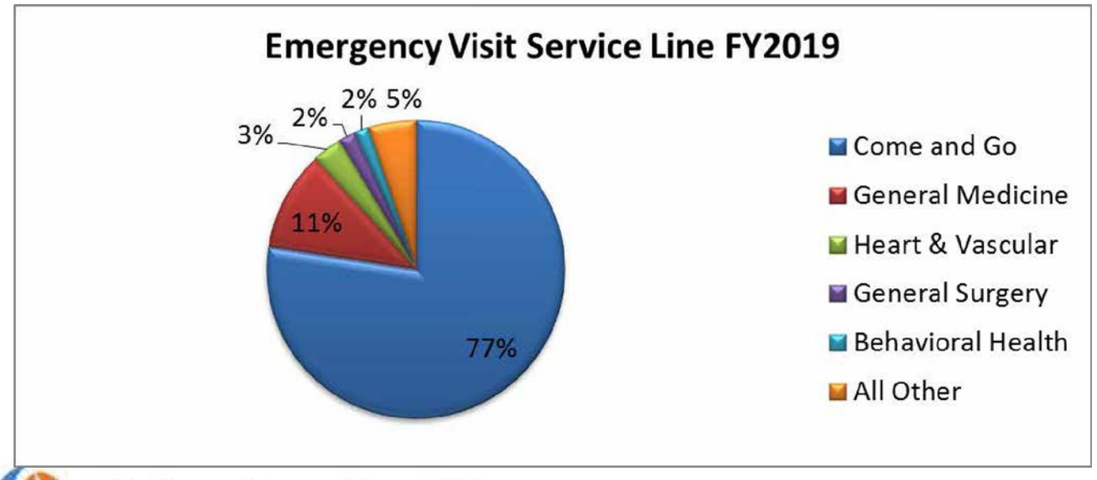
August 5, 2019

Emergency room visits increased by 1% (534 visits) from 60,539 in FY18 to 61,073 in FY19 enterprise wide

- Visits increased for adult age categories but declined for minors
- 18% of the FY19 emergency visits resulted in inpatient admission, a slightly higher percentage than seen in FY18
- 77% of the visits were “come and go” services not requiring surgery, cardiac catheterization or endoscopy
- 80.5% of the visits were provided to residents of ECH’s primary service area





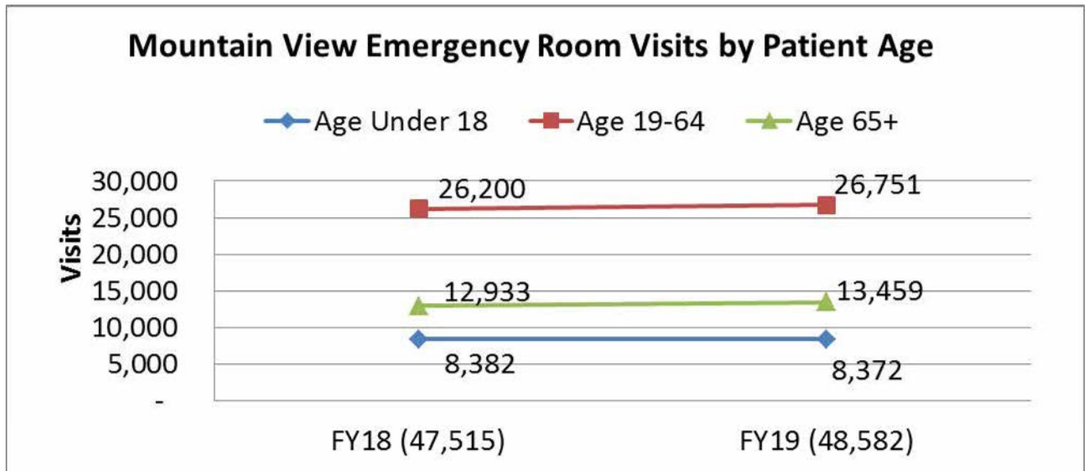


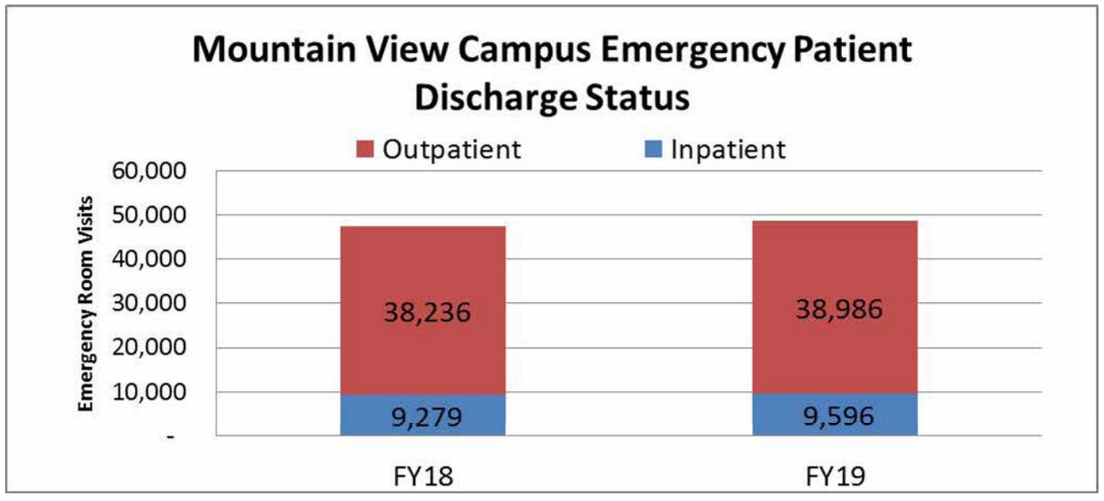
Enterprise Wide Emergency Visits by Patient Residence			
	In Primary Service Area	**Rest of Santa Clara County**	**Out of County**
FY18	80.4%	8.5%	11.1%
FY19	80.5%	8.2%	11.3%

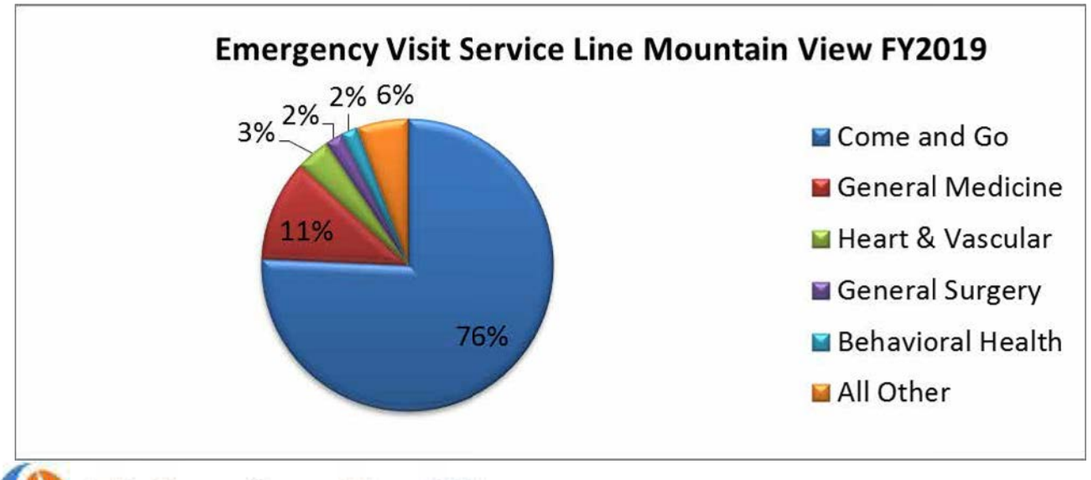
El Camino Health

Emergency room visits to the Mountain View campus increased by 2% (1,067 visits) from 47,515 in FY18 to 48,582 in FY19

- Visits increased for adult age categories but declined for minors
- 19.8% of the FY19 emergency visits resulted in inpatient admission, a slightly higher percentage than seen in FY18
- 76% of the visits were “come and go” services not requiring surgery, cardiac catheterization or endoscopy
- 80.1% of the visits were provided to residents of ECH’s primary service area (48% from the Mountain View service area/23% from the Eastern service area/9% from the Los Gatos service area)





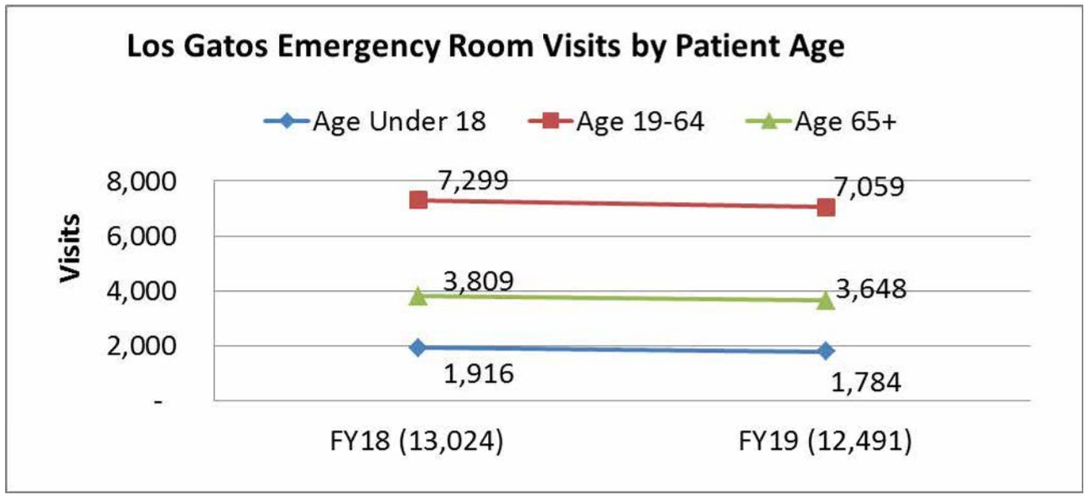


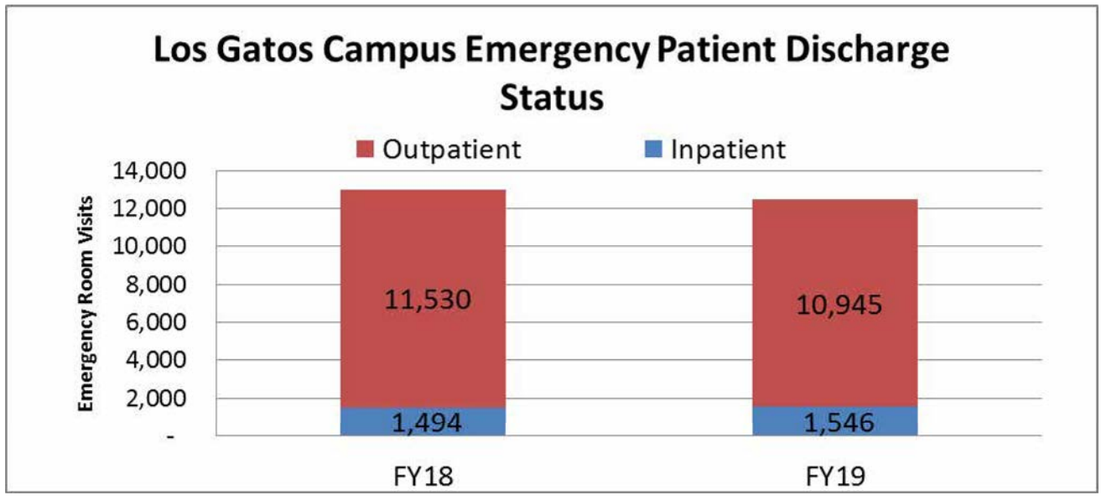
Mountain View Emergency Visits by Patient Residence			
	In Primary Service Area	**Rest of Santa Clara County**	**Out of County**
FY18	80.1%	8.1%	11.8%
FY19	80.1%	7.9%	11.9%

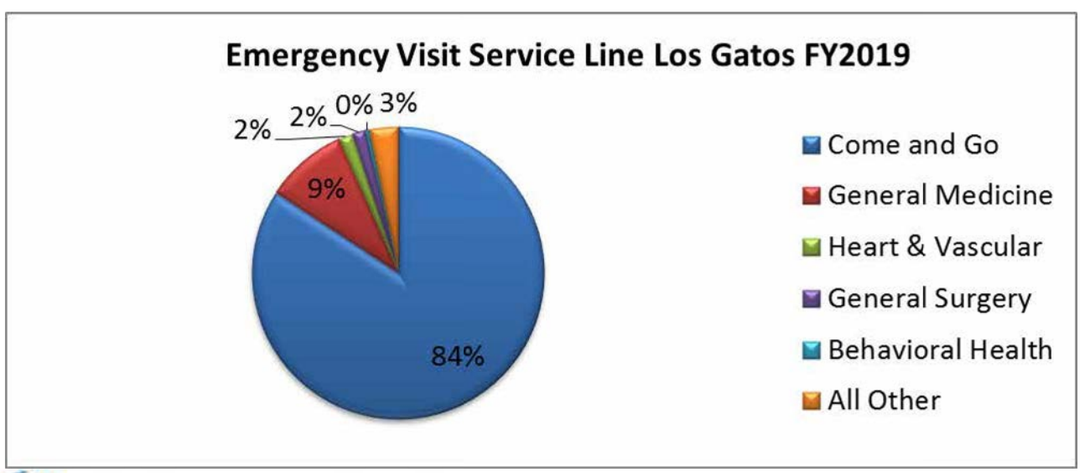
El Camino Health

Emergency room visits to the Los Gatos campus decreased by 4% (-533 visits) from 13,024 in FY18 to 12,491 in FY19

- Visits decreased for all age categories but notably the overall decline only occurred in the first 6 months of the fiscal year (-10%) while the second 6 months recovered (+1.6%) year over year
- 12% of the FY19 emergency visits resulted in inpatient admission, a slightly higher percentage than seen in FY18
- 84% of the visits were “come and go” services not requiring surgery, cardiac catheterization or endoscopy
- 82.1% of the visits were provided to residents of ECH’s primary service area (69% from the Los Gatos service area/10% from the Eastern service area/3% from the Mountain View service area)

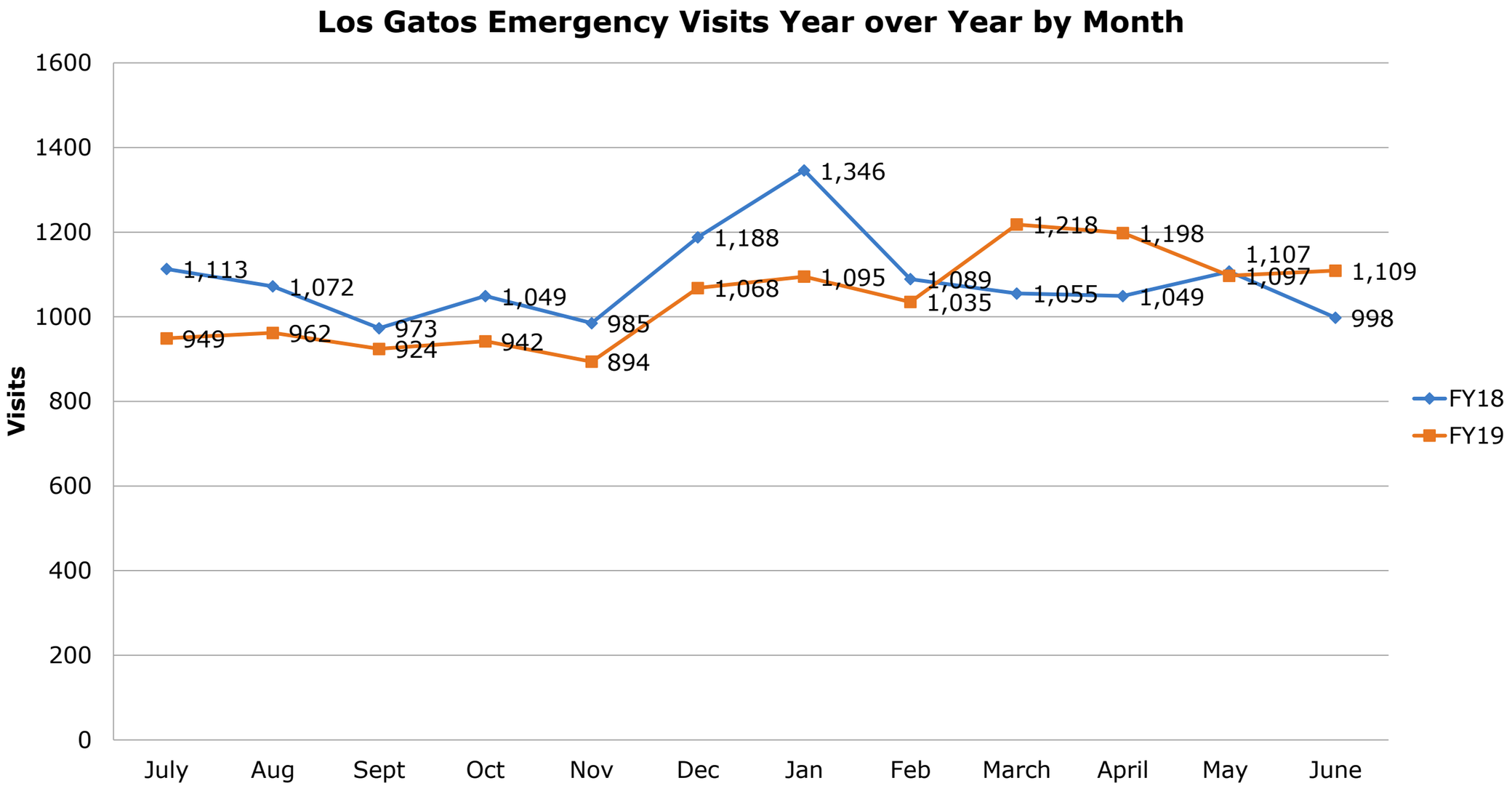






Los Gatos Emergency Visits by Patient Residence			
	In Primary Service Area	Rest of Santa Clara County	Out of County
FY18	81.3%	10.0%	8.7%
FY19	82.1%	9.2%	8.7%

Los Gatos By Month (incident in June 2018)



El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, CMO

Date: August 5, 2019
Subject: Draft Board-Level QC Reporting

Purpose:

To review and inform the Committee regarding national standards for health system board of director quality reporting

Summary:

1. Situation: The QC requested information to aid in improving the QC oversight of and reporting to the Board on quality and safety activity

2. Authority: ECH Board of Directors

3. Background: The QC is tasked with overseeing the quality and safety activities and outcomes of the organization on behalf of the Board. The Board is interested in assuring that the QC is reporting in a way that satisfies the fiduciary responsibility or the Board to assure the highest standards of quality and safety are being maintained

4. Assessment: This provides an overview and draft of an approach advocated by national organizations to organize and enhance the QC work and communicate that work to the Board as a whole

5. Other Reviews:

6. Outcomes: Information only

List of Attachments:

1. Draft Summary

Suggested Committee Discussion Questions:

1. None

El Camino Health

Quality Committee

Mark Adams CMO

August 5, 2019

Quality Committee Role

Principles:

- Focus on Governance, not Operations
- Accountability for Quality/Safety should mimic that of the Finance Committee
- Oversee Integrity and Reliability of Credentialing Process
- Maintain a Culture of Openness and Transparency

Focus on Governance

- The committee's function should not be confused with efforts led by physicians, staff, or senior executives to improve quality.

- However, the outcomes of these initiatives are accountable to the committee.

Accountability for Quality/Safety

- Develop broad and easily understood organizational goals to be approved by the Board
- Work with management to identify specific quality and safety priorities
- Identify measures and set targets
- Use nationally standardized metrics and benchmarks
- Monitor underperformance until issues are resolved
- Monitor regulatory compliance
- Monitor employee, provider, and customer satisfaction

Oversee Integrity of Credentialing

- While credentialing and privileging are the responsibility of the medical staff, the quality committee should oversee the process on behalf of the Board.

- Assure that credentialing criteria reflects physician use of best practices and protocols for safety and quality

Openness and Transparency

- Adopt a “patients-as-only-customer” mantra
- Develop and publicize a strong “disclosure-and-apology” plan
- Recommend that the Board adopt a “just-culture” philosophy to support a high reliability organization approach

QC Best Practice Agenda

1. Approval of minutes (5 minutes)
2. Patient story (5 minutes)
3. Review of progress toward strategic quality aims (40 minutes)
4. Exception report for any regulatory compliance issues that have arisen (20 minutes)
5. Review of new policies or recommendations to the full board (30 minutes)
6. Other agenda items (15 minutes)
7. Meeting evaluation (5 minutes)

QC report to the Board

- Provide high level nationally recognized and benchmarked metrics
- Focus on problem areas, not successes
- Avoid clinical or technical details
- Supplement with background education
- Provide progress report on strategic quality plan
- Report and review Serious Safety Events
- Report compliance with regulatory and quality standards