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

Monday, September 9, 2019 – 5:30pm
El Camino Hospital | Conference Room A&B
2500 Grant Road, Mountain View, CA 94040

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:35**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (8/5/2019) ***Information*** b. FY19 Quality Dashboard c. ED Patient Satisfaction d. FY20 Pacing Plan e. Progress Against FY20 QC Goals f. Hospital Update g. Annual Performance Improvement Reports			
4.	**INTRODUCTION OF NEW MEMBERS**	Julie Kliger, Quality Committee Chair		**information 5:35 – 5:50**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Julie Kliger, Quality Committee Chair		**information 5:50 – 6:00**
6.	**PATIENT STORY** **ATTACHMENT 6**	Mark Adams, MD, CMO		**discussion 6:00 – 6:10**
7.	**FY19 ORGANIZATIONAL GOAL SCORE** **ATTACHMENT 7**	Mark Adams, MD, CMO; Cheryl Reinking, RN, CNO	*public comment*	**possible motion 6:10 – 6:20**
8.	**FY20 ORGANIZATIONAL GOAL METRICS** **ATTACHMENT 8**	Mark Adams, MD, CMO	*public comment*	**possible motion 6:20 – 6:35**
9.	**QUALITY AND SAFETY STRATEGIC PLAN** **ATTACHMENT 9**	Mark Adams, MD, CMO		**discussion 6:35 – 7:05**
10.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 7:05 – 7:08**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:08 – 7:09**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 7:09 – 7:10**
13.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 7:10 – 7:12**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (8/5/2019) ***Information*** b. Medical Staff Quality Council Minutes			
14.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Annual Patient Safety Report	Sheetal Shah, Director, Risk Management and Patient Safety		**information 7:12 – 7:27**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**discussion 7:27 – 7:42**
16.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:42 – 7:43**
17.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:43 – 7:44**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:44 – 7:45pm**

Upcoming Meetings:

Regular Meetings: October 7, 2019; November 4, 2019; December 2, 2019; February 3, 2020; March 2, 2020; April 6, 2020; May 4, 2020; June 1, 2020

Educational Sessions: April 22, 2020

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, August 5, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present
Julie Kliger, Chair
George O. Ting, MD
Jack Po, MD
Melora Simon

Members Absent
Peter C. Fung, MD

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 5:36pm by Chair Kliger. A silent roll call was taken. Committee Member Fung was absent. Jack Po, MD arrived at 5:42 pm during Agenda Item 4. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. Chair Kliger noted that, going forward, the Patient Story will be an item for discussion on the agenda and the "Current" FY Quality Dashboard will be moved to the consent calendar. No items were pulled. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee (June 3, 2019); and for information: Patient Story, FY20 Pacing Plan, Progress Against FY19 Quality Committee Goals, and Hospital Update, and Annual Performance Improvement Report. **Movant:** Simon **Second:** Ting **Ayes:** Kliger, Ting, Simon **Noes:** None **Abstentions:** None **Absent:** Fung, Po **Recused:** None	*Consent Calendar Approved*
4. AD HOC COMMITTEE REPORT AND CANDIDATE INTERVIEWS	Chair Kliger reported on the Ad Hoc Committee work, noting that 8 applications for Committee membership were received, 5 candidates were interviewed and 4 are being brought forward to the Committee for further review. Candidates Caroline Currie, Alyson Falwell and Krutica Sharma, MD each joined the Committee (separately) for question and answer sessions. Following the sessions, the Committee members discussed the candidates, including candidate Terrigal Burn, MD, who was unavailable to meet with the Committee due to a previous commitment. **Motion:** To recommend that the Board appoint Terrigal Burn, MD, Caroline Currie, Alyson Falwell and Krutica Sharma, MD to the Quality, Patient Care and Patient Experience Committee for a term expiring on June 30, 2020. **Movant:** Simon	***Candidates recommended for approval***

	Second: Po **Ayes:** Kliger, Ting, Simon, Po **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	
5. REPORT ON BOARD ACTIONS	The Committee reviewed the Report on Board Action as provided in the meeting materials.	
6. APPOINTMENT OF VICE CHAIR	Chair Kliger reported that she appointed Committee member George O. Ting, MD as Vice Chair of the Committee.	
7. FY19 QUALITY DASHBOARD	The Committee reviewed the FY19 Organizational Goal and Quality Dashboard. Mark Adams, MD, CMO, reported that all metrics are stable or improving except for C.Diff. Preventive measures were discussed which include rigorous adherence to hand hygiene, C.Diff surveillance especially with nursing home admissions, and patient room disinfection. The Committee provided advice re enhancing hand hygiene compliance and asked for further information in an upcoming session.	
8. FY20 QUALITY DASHBOARD	Dr. Adams reviewed the proposed enterprise FY20 quality and safety dashboard metrics with the Committee. He explained that new measures include HCAHPS discharge instructions, Surgical Site Infections (SSI), Classification of Serious Safety Events (SSE), PC-01 Elective deliveries prior to 39 weeks, ED throughput (Door to Admit), and NTSV C-section rate. Mortality index, Readmission index, Staff responsiveness HCAHPS, CAUTI, CLABSI, C. Diff., and Sepsis index will be retained.	
9. PSI-4, 18-19 METRICS	As a follow up to the last meeting, Dr. Adams provided a more in depth review regarding PSI-4, PSI-18, and PSI-19. Dr. Adams explained that PSI-4 is defined as "Death Rate among surgical inpatients with serious treatable complications". Based on the review of 40 cases, 50% of the "serious treatable complications" were present on admission which indicates that not all of the cases were complications of surgery but rather "failure to rescue" which is a more accurate description of this indicator. 50% of the cases were complications of surgery and will be further investigated. The El Camino PSI-4 score of 202.13 is benchmarked against a Premier database mean of 130.28 and the national AHRQ benchmark of 170.00. A vigorous discussion ensued regarding the data and the Committee will look for more details on this measure in the future. PSI-18 is OB Trauma (defined as a 3rd or 4th degree vaginal laceration) Vaginal Delivery with Instrument and PSI-19 is OB Trauma Vaginal Delivery without Instrument. The PSI-18 score is 222.2 compared to the Premier mean of 107.1 and the PSI-19 score is 23.74 compared to a Premier mean of 15.67. The greatest contributing factor is the population race/ethnicity of our El Camino patients with roughly 60% being Asian/Pacific Islander. Multiple external studies have found significantly higher rates of OB trauma in that population. There are a number of interventions being implemented to address this challenge including reducing instrumentation, changing the method of episiotomy, and providing individual feedback to the obstetricians with education. The Committee requested follow up on this and the previous item in 3 months (PSI review quarterly).	
10. WHO MAKES UP ED CENSUS	ED demographic data was provided to the committee for review. Chair Kliger reminded the Committee that the questions to be answered were: (1) Is ECH seeing more elderly, with more complex care needs because there were	

	what seemed to be long lengths of stays in the ED; and (2) Have we seen much change over the last 5 years? Dr. Adams reported that the data shows that there has not been much change in these two areas over the last 5 years.	
11. DRAFT BOARD LEVEL QUALITY COMMITTEE REPORTING	Dr. Adams presented an overview of national best practice guidelines and principles for health system Board Quality Committees. Standard roles and responsibilities were provided for discussion. The principles include: 1) focus on governance, not operations; 2) accountability for quality/safety that mimics that of the Finance Committee; 3) oversight of theintegrity and reliability of the credentialing process; and 4) maintenance of a culture of openness and transparency. Dr. Adams and Committee members noted that the Quality Committee could get more involved in overseeing the Medical Staff credentialing process as well as SVMD physician practice quality. The Committee discussed an example of an ideal Quality Committee agenda and what information should be reported to the Board by the Quality Committee.	
12. PUBLIC COMMUNICATION	There was no written or oral public communication.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:59pm. **Movant:** Simon **Second:** Ting **Ayes:** Kliger, Ting, Po, Simon **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Adjourned to closed session at 7:59pm***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 8:45 pm. Agenda items 14-18 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (June 3, 2019); and for information: Quality Council Minutes.	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 8:46 pm. **Movant:** Simon **Second:** Po **Ayes:** Kliger, Ting, Po, Simon **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Meeting adjourned at 8:46pm***

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

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Julie Kliger, MPA, BSN
Chair, Quality Committee

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ;
Sr. Director, Quality Improvement and Patient Safety
Date: September 9, 2019
Subject: FY19 Quality Dashboard

Purpose: To 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. The Committee request regarding the addition of a rolling 12-month average for each metric has included. ED Throughput data has been combined for both MV and LG to comply with Committee's request for a control chart.

Summary:

1. Situation: The dashboard is made available at each Quality Committee meeting.

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

3. Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY19 Quality, Efficiency, and Service Goals.

4. Assessment: Review of June deaths revealed coding corrections needed; data resubmitted to Premier, with final Mortality Index data available on Monday, September 9, 2019.

The transfer of patient to GIP (inpt hospice) has positively affected both the Mortality Index and the Readmission Index.

The Mortality Index is just above the target value for FY19 Organizational goal.

The final FY19 Readmission Index value for June 2019 will not be available until mid-September, but as of May 2019, the Index is at the maximum value for FY19.

ED Throughput minutes declined steadily since March, with significant improvement at both campuses.

5. Other Reviews: N/A

6. Outcomes: N/A

Suggested Committee Discussion Questions: None, this is a consent item.

List of Attachments:

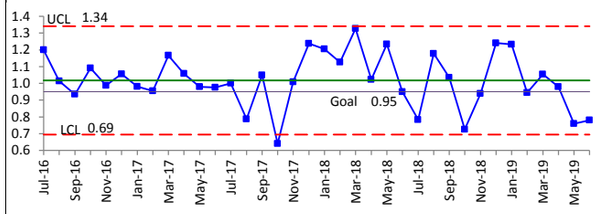
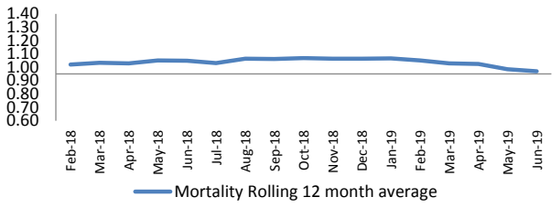
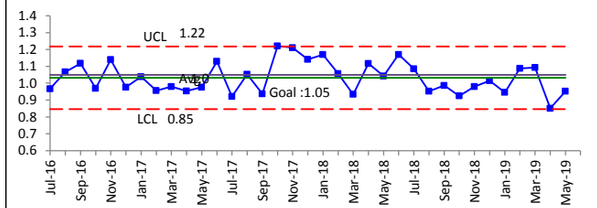
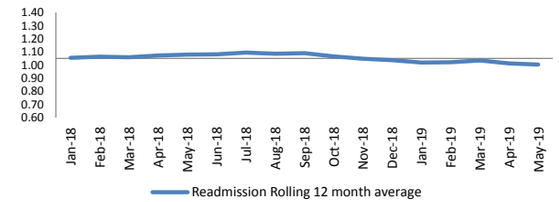
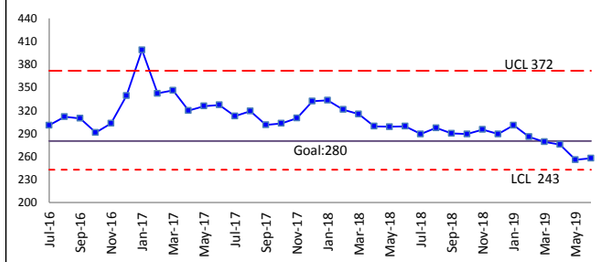
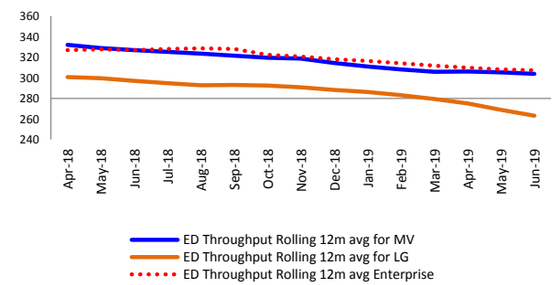
1. FY19 Quality Dashboard June data unless otherwise specified - final results

El Camino Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: September, 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: June 2019* ****see comments***	0.78 (1.44%/1.85%)	0.97 (1.59%/1.63%)	1.06	0.95		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: May 2019*	0.95 (7.19%/7.55%)	0.99 (7.54%/7.63%)	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

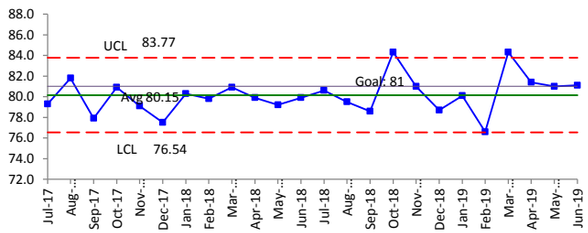
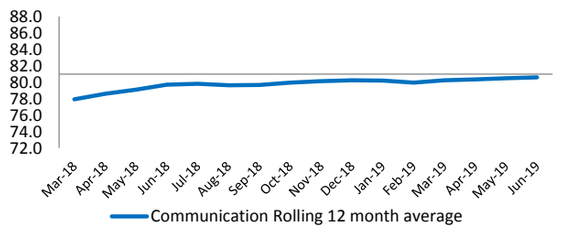
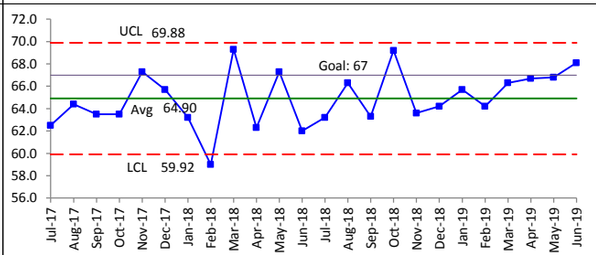
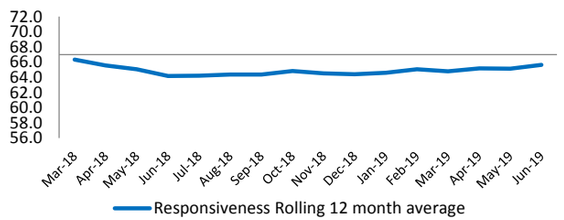
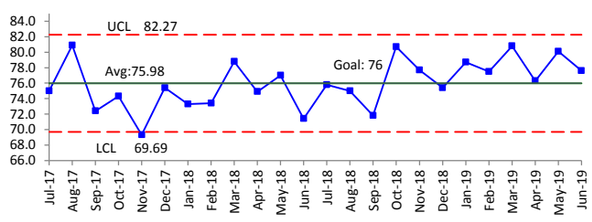
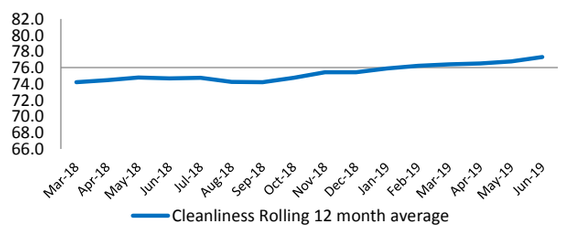
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Mortality Index dropping significantly with the use of GIP beginning in April. Review of deaths in June with many patients transferred into GIP, revealed 2 patients admitted through the ED on a Saturday who met and wanted GIP, but Pathways does not have wseekend coverage. 9 deaths were within 1 day of hospitalization. * **After review, issues found with coding of June deaths, data resubmitted to Premier and final report will be run on Monday, September 9, 2019.**	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	Readmission Index also increased in February. Weekly Readmission Review team found 67 Readmissions in February, with several due to UTI, medication side effects, and post-procedure infections. 10.5 % of these readmissions were sent for medical staff peer review due to complications.	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)	In Mountain View, the Capacity Management Center continues to help support throughput and identify barriers. 3CW (MCH overflow) has been opened as a med/surg unit during certain times as well when there has been a need for telemetry or med/surg overflow. The ED providers continue to have focus on the initial work up time. There has been improvement in discharge by noon which helps to create capacity for admits from the ED. In Los Gatos, the team continues to review barriers and partner with providers to understand when delays occur. The Relay Robot has been put into use to support transport of specimens to the lab to reduce variation in turn-around times. The ED RNs hand-off transfer of care in one call to the floor RNs. Floor RNs also proactively attempt to call the ED to get report.	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: September, 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

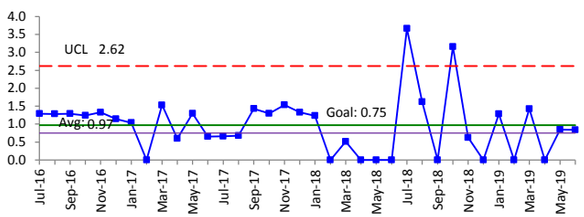
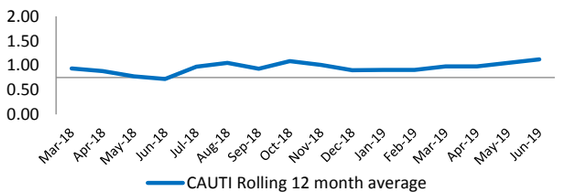
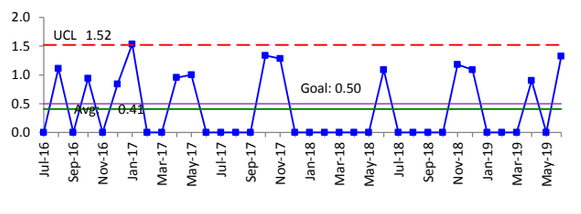
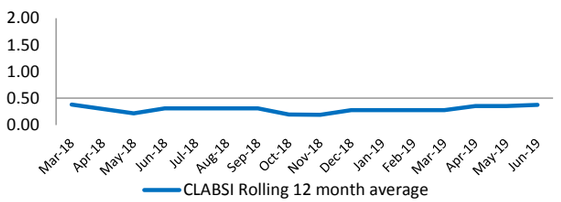
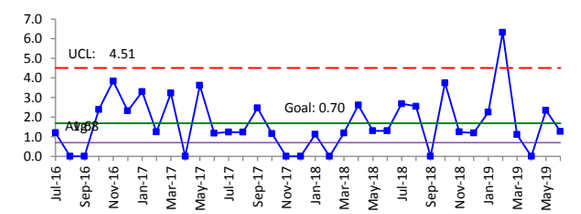
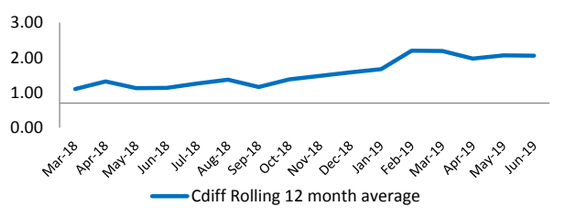
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	o Work to implement purposeful rounding done o Standardization and use of the "Brain" in EPIC was implemented to standardize bedside shift report.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	o Assessment of workflow for answering call lights completed and standard work created. o Administrative Support trained on standard work • Leader rounding implemented and positive outcomes reflected with an increase in HCAHPS scores.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	o Standard scripting created for all EVS staff when entering a patient room. o AIDET video created by and for EVS staff o Business cards created for EVS staff to leave with patients, indicating their name and the EVS phone number.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**

El Camino Health

FY19 Organizational Goal and Quality Dashboard Update

June 2019 (Unless otherwise specified)

Month to Board Quality Committee: September, 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

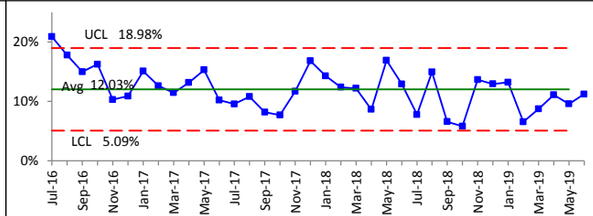
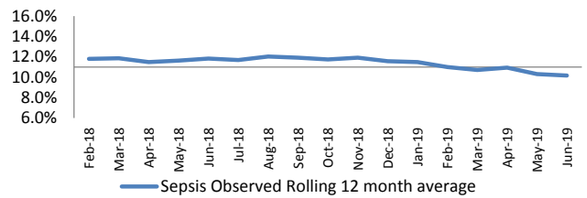
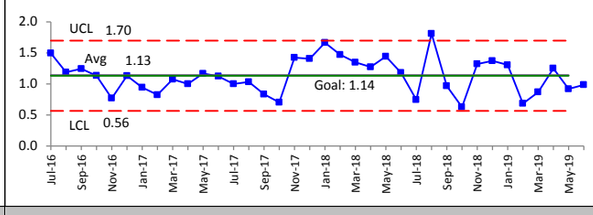
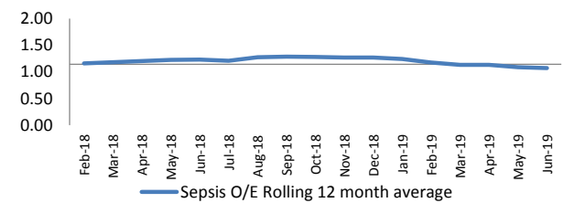
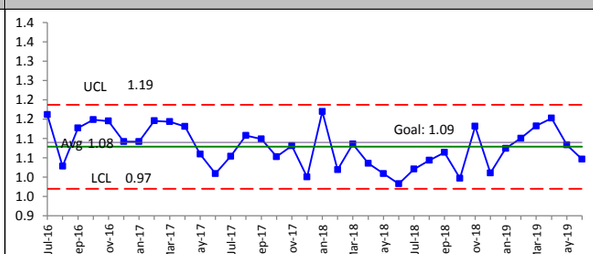
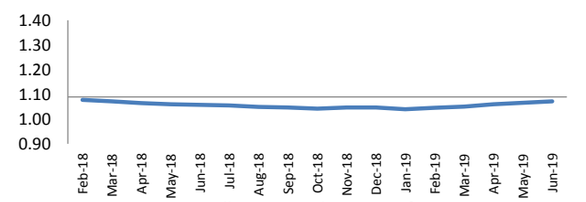
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	1- CAUTI for June: 86 y/o female admitted with loss of LOC, intercerebral hemorhhage, with foley for 14 days; due to high foley 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)	1- CLABSI in June: Pt admitted to 4B with Mediport in place; CLABSI due to skin organisms; staff re-educated regarding accessing the MediPort.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	1- C.Diff in 78 y/o male admitted with Resp. Failure, sepsis from home - not colonized w/C.Diff. Developed colitis after 10 days and treatment w/4 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: September, 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: June 2019*	11.22%	10.22%	11.72%	11.00%		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: June 2019*	0.99 (11.22%/11.38%)	1.06	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: June 2019*	1.05	1.07	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 septic cases that do expire have a very high risk of mortality from good physician documentation. In June 37% of the deaths were from Sepsis.	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. We have been without a Sepsis Manager since June, with the part time Sepsis Coordinator working hard to stay on top of the cases.	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)	Reduction in overall LOS continues; due to earlier Palliative Care referrals, transfering patients into GIP (inpt. Hospice) and Care Coordination beginning to get patients transferred into LTAC hospitals (long-term acute care that specialize in long term respiratory care with ventilator use.)	Grace Benlice, Cheryl Reinking		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 Health

ED SATISFACTION IMPROVEMENT TEAM

Accountability:
Sponsor: Cheryl Reinking
Operational Leaders: Alicia Potolsky, Jennifer Quihuis, Laura Cook, Karen Pike, Pamela Fiehmann, Meriam Signo
Performance Coach: Varsha Tickoo

Problem/ Issue:

El Camino Hospital recognizes the significance of the Emergency Department (ED) on the patient experience. The patient experience begins in the ED and is an important piece of many patients' hospital journey. Communication is a key component of every ED visit and sets the tone for the rest of the patient's stay. However, the overall score for the ED enterprise-wide is not meeting its goal.

Target: Top-box overall score for FY20

Min	Target	Max
67.2%	69%	69.7%

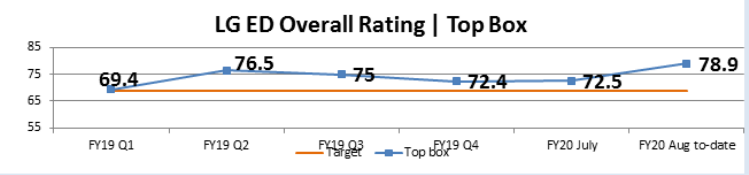
Leading metrics:

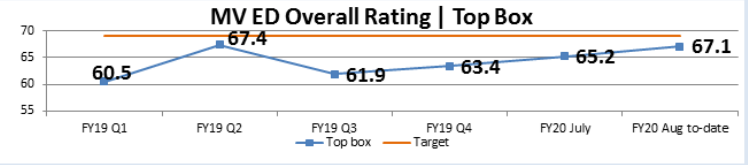
- % of ED staff that have completed Care Team Coaching
- % of eligible patients opting into ED Epic messaging

Baseline/ Current State:

ED Priority Index Apr 2019-Jun 2019

Order	Survey Item	Correlation	Order	Survey Item	Correlation
1	Informed about delays	0.75	6	Overall rating ER care	0.90
2	Adequacy of info to family/friends	0.79	7	Waiting time to treatment area	0.64
3	Nurses informative re treatments	0.78	7	Likelihood of recommending	0.87
4	Staff cared about you as person	0.82	9	Privacy during pers/insur info	0.66
5	Waiting time to see doctor	0.73	9	Nurses concern for privacy	0.73





Updated: Aug 30, 2019

Problem Analysis:

- There are inconsistencies in processes such as use of patient passport.
- Need to set reasonable expectations and manage wait time by keeping patient informed.
- More input from patients needed.
- Need to address patient concerns beyond the ED, e.g. caring for pets, children, etc.

Countermeasures:

- LG and MV ED physician and provider coaching done, staff coaching ongoing.
- ED Patient Experience Champion group up and running.
- Signage to increase ED Epic messaging adoption. Adding related question to PG survey question for pt feedback.
- ED leader rounding proposed.
- ED Press Ganey survey extract being modified to include information on mid-level providers.
- ED Press Ganey survey modified to reflect the appropriate care provider (MD/DO, PA or NP).

Milestones

Project	Due Date	Accountable Party	Status
Care Team Coaching for Scribes	8/31/2019	DTA	In Progress
Food Lockers for waiting room patients	9/1/2019	Quihuis	In Progress
Front desk sign to increase ED Epic alerts adoption	9/15/2019	Martinez	In Progress
RN/Tech Care Team Coaching	9/30/2019	ECH/DTA Coaches	In Progress
Diversity and Inclusion Training	9/30/2019	Tickoo/Stafford	In Progress
Leader Rounding Coaching	9/30/2019	DTA Coaches	In Progress
Scribe Pilot Phase II	9/30/2019	Cook/Liu	In Progress
Post Discharge Calls	12/31/2019	DTA/ ED/ PE Team	In Progress
Emmi Patient Education	12/31/2019	Million	In Progress
Post Admit Bedside Visit	12/31/2019	DTA/ PE Team	In Progress
Implement ED-Specific Listening Carefully Toolkit	12/31/2019	ED/ PE Team	In Progress
New ED Physician and PA Care Team Coaching	1/31/2020	DTA Coaches	In Progress

Sustain Results:

- Planned biweekly meetings for the work group.

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** ▪ **FY 20 Quality Dashboard (now on consent)** ▪ **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. Patient Story (Moved off Consent) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Introduction of New Members 8. Annual Performance Improvement Reports (rotating departments) Special Agenda items: 9. Update on Patient and Family Centered Care 10. Recommend FY20 Organizational Goal Metrics 11. Annual Patient Safety Report 12. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals) 13. Pt. Experience (HCAHPS) 14. ED Pt. Satisfaction (Press Ganey) 15. Quality and Safety Strategic Plan
FY2020 Q2		
OCTOBER 7, 2019	**NOVEMBER 4, 2019**	**DECEMBER 2, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Standing Agenda Items: 8. Report on Medical Staff Peer Review Process	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Safety Report for the Environment of Care 11. Q1 FY20 Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda items: 8. Update on Patient and Family Centered Care 9. Readmission Dashboard 10. PSI-90 Pt. Safety Indicators

Created April 25, 2019

	12. Performance Improvement with Physician Management	
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. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Q2 FY20 Quality and Safety Review 9. Update on Patient Care Experience	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Proposed FY21 Committee Goals 9. Proposed FY21 Organizational Goals
FY2020 Q4		
APRIL 6, 2020	**MAY 4, 2020**	**JUNE 1, 2020**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Value Based Purchasing Report 9. Pt. Experience (HCAHPS) 10. Approve FY21 Committee Goals 11. Proposed FY21 Committee Meeting Dates 12. Proposed FY21 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Approve FY21 Committee Goals (if needed) 11. Proposed FY21 Organizational Goals 12. Proposed FY21Pacing Plan 13. Q3 FY20 Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Update on Patient and Family Centered Care 9. Readmission Dashboard 10. PSI-90 Pt. Safety Indicators 11. Approve FY21 Pacing Plan 12. 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
September 9, 2019
Mark Adams, MD, CMO

Quality and Patient Safety

El Camino Hospital Mountain View received Get With the Guidelines Gold Plus with Honor Roll Elite Plus American Heart Association (AHA) National Stroke Award this year. This award recognizes 24 straight months of compliance with a set of treatment metrics involving time to treatment with IVrt-PA, administration of antithrombotic and anticoagulant therapy, prescribing of statins and anticoagulation therapy at discharge and smoking cessation education. The "Plus" Award is added for compliance with at least five quality metrics.

Information Services

Four of the five San Jose Medical Group clinics have converted to the Epic platform and ECH technology. We expect the fifth clinic to go live on August 19, 2019. This transition included network, PC's, printers, phones, Laboratory and PACS systems with large volumes of imaging studies migrated from the Verity PACS system. A Command Center is in place at the SVMD University Offices with a team including physicians and Epic vendor staff providing at the elbow support at each Clinic location. The go-lives are progressing well with daily status meetings monitoring activation metrics. There have been a low number of issues and tickets and minimal impact to patient throughput at the clinics

MyChart enrollment continues to focus upon the 50% patient enrollment goal. MyChart Bedside is live on 5 units (MCH, NICU, 3W, L/D) with 5th Unit (4A) implemented in June 2019. Adoption continues to meet or exceed benchmark of 40%.

Government and Community Relations

Staff met with Assemblymembers Evan Low and Kansen Chu, staff from other legislative offices, and hospital coalition partners to discuss bills on emergency department "surprise billing", rate regulation, nurse staffing ratios and penalties, 2030 seismic standards, and mental health. Brenda Taussig spoke to the Santa Clara Special Districts Association about ECH/ECHD structure, services, community benefit, and growth. El Camino Health and Stanford Healthcare were chosen by the Silicon Valley Leadership Group to host a group of state legislators for a November tour focusing on hospital innovation.

Staff, board, elected officials and school superintendents joined ECH's table at the June 7 "State of the Cities" luncheon for Los Altos and Los Altos Hills. Brenda Taussig was part of an invited community leader focus group for the day-long inaugural "Mountain View Police Department 101" program led by Chief Max Bosel and his department heads. On June 14, ECH held an LGBTQ Healthcare Symposium featuring Dr. Kristie

Overstreet, former County Supervisor Ken Yeager, and community nonprofits. We are recruiting ECH staff to participate in civic leadership programs in seven cities.

Corporate and Community Health Services

CONCERN released Concern's Luma 2.0 with features including quality of life survey, a personal dashboard, nudges to complete pre-post surveys and expanded counselor search capability. Luma's level of personalization and integration with digital therapeutics makes this engagement platform a real differentiator for CONCERN.

The South Asian Heart Center conducted workshops on Meditation, Exercise, Diet, and Sleep at Xoriant Corporation's Sunnyvale location with 40+ employees attending each workshop. We also presented Health 3.0 workshop at Apple Inc. in Cupertino attended by 80 employees and at the Indian Institute of Science Annual Nation Alumni conference to 100 attendees.

The Chinese Health Initiative served a total of 1781 individuals, with 3371 services provided at 70 events in FY19.

Philanthropy

As of June 30, 2019, El Camino Health Foundation secured $19,564,060 in donations, the highest annual yield in the Foundation's history.

Auxiliary

The Auxiliary contributed 5828 volunteer hours in June 2019 and 5972 in July 2019.

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: September 9, 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.

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 states that, "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: Each department of the Hospital completes these reports on an annual basis. They are presented on a rotating schedule of a few departments each month to the Medical Staff's Quality Council and this Quality Committee.

4. Assessment: See attached reports.

5. Other Reviews: The Quality Council of the Medical Staff reviews these reports as well.

6. Outcomes: 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.

List of Attachments: Annual Reports and Dashboards

1. Infection Control and Prevention Department
2. Los Gatos Emergency Department
3. Patient Experience
4. Palliative Care

Suggested Committee Discussion Questions: None.

Annual Performance Improvement Report

Department/Service Line: Infection Control and Prevention Department
Prepared by: Catherine Nalesnik, RN, BSN, CIC, Director Infection Prevention
Date: July 29, 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:

- ***Hospital-onset Multi-Drug Resistant Organisms (gram negative rods)***
  Enterprise rate decreased to "0"
  MV MDRO: decreased in FY19: 0 cases vs FY18: (2 cases)
  LG MDRO: "0" cases for FY18 and FY19
- ***Hospital-onset Central Line Associated Blood Stream Infections (CLABSI)***
  Enterprise rate decreased in FY19: 0.27 vs. FY18: 0.30
  MV CLABSI cases: Remained the same for both years: 4 CLABSIs
  LG CLABSI cases: "0" cases for FY18 and FY19
- ***Hospital-onset Catheter-Associated Urinary Tract Infections (CAUTI):***
  Enterprise rate increased in FY19: 1.09 vs. FY18: 0.90
  MV CAUTI cases: increased in FY19: (16 cases) vs FY18: (14 cases)
  LG CAUTI cases: Same outcome for both years (1 case)
- ***Hospital-onset Clostridium difficile (C.diff)***
  Enterprise rate increased in FY19: 1.96 vs. FY18: 1.24
  MV C.diff cases increased in FY19 (17 cases) vs FY18: (12 cases)
  LG C.diff cases increased in FY19 (3 cases); FY18 (0 cases)
- ***Hospital-onset Surgical Site Infections (SSI)***
  Enterprise rate increased in FY19: 0.52 vs. FY18: 0.20
  MV SS cases: increased in FY19: (26 cases) vs FY18: (9 cases)
  LG SSI cases: increased in FY19: (11 cases) vs FY18: (6 cases)

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:
Areas of Concern:

- **Surgical Site Infection: increase in Enterprise SSI cases**
  - *SSI case numbers: above state/ national benchmarks*
- **Containment of MDRO- CRE organisms in Santa Clara County**
  - *Multi-drug resistant pathogen (CRE) in Santa Clara County at local 6 SNFs*
  - *Require daily monitoring for patients at risk and prevention of transmission*
- **Global spread of emerging pathogens:**
  - *Ebola re-emergence in Democratic Republic of Congo*
  - *Continue to monitor global transmission with updates from CDPH and WHO*
- **Hospital-onset Catheter-Associated Urinary Tract Infections (CAUTI)**
  - *Continued partnership with Nursing to decrease CAUTIs*
- **Hospital-onset Central Line Associated Blood Stream Infections (CLABSI)**
  - *Continued partnership with Nursing to decrease CLABSIs*
- **Construction Projects – including new facility acquisitions**
  - *Continued partnership with Facilities to review all construction sites to conduct a Infection Control Risk assessment prior to set up appropriate barriers*
  - *IP Nurses continue to conduct daily walk-by assessments of construction sites*

482.21.

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

Use bullet points to list actions taken:

- ***Hospital-onset MDRO including Carbapenem-resistant enterobacteriacae (CRE)***
  1. IP Staff perform daily chart review of all new admissions to determine patient risk factors
    - *Start contact isolation to decrease cross-contamination risk*
    - *Order CRE surveillance screening on at-risk patients; monitor results*

  2. Report all cases CRE cases to Santa Clara County Public Health Department
  3. IP team Database: track results and monitor patient room locations for transmission
  4. Follow local, state, national and international trends on other emerging MDROs
- ***Hospital-onset Catheter-Associated Urinary Tract Infections (CAUTI):***
  1. Extensive HO case review with IP team; follow up with departmental staff, HAI A3 team
  2. Implemented Nurse driven protocol for Foley removal; support received from physicians
  3. New checklist: 2-Nurse insertion checklist to ensure sterile technique
- ***Hospital-onset Central Line Associated Blood Stream Infections (CLABSI)***
  1. Extensive HO case review with IP team; follow up with departmental staff, HAI A3 team
  2. Partner with HAI A3 team to advocate for best practice guidelines: use of Curos caps
  3. Supported development of central line dressing kit
  4. Central Line Insertion Practice: surveillance of insertion practice documentation
- ***Hospital-onset Clostridium difficile (C.diff)***
  1. IP team perform daily room tracking of all patients with C.diff to monitor for transmission
  2. Extensive HO case review with IP team; follow up with departmental staff, HAI A3 team
  3. IC Medical Director review of antibiotic appropriateness
  4. Attend Antibiotic Stewardship Committee to present HO case reviews

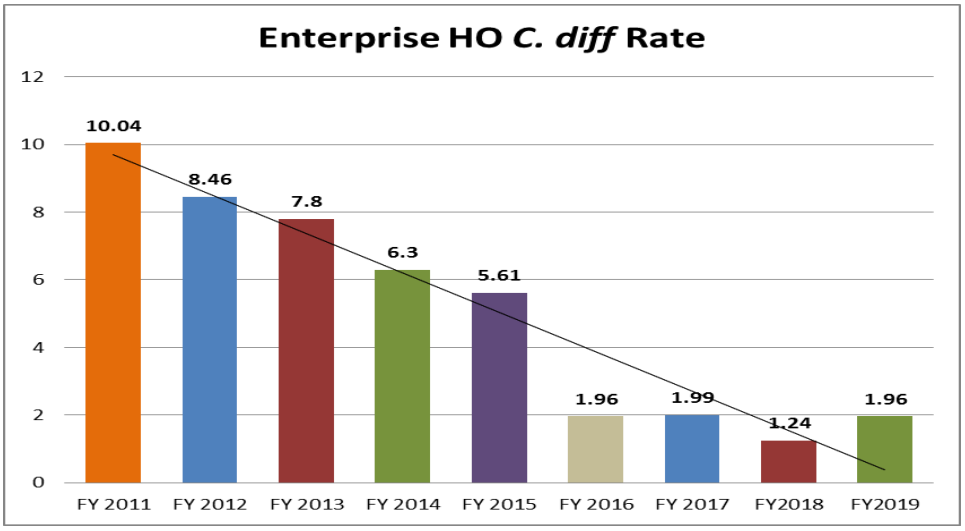
  Hospital-onset Surgical Site Infections (SSI)
  1. Extensive HO case review with IP team and IC Medical Director.
    - *IP team to trend factors: surgeons, pathogens, antibiotic appropriateness, surgical scrub, clipping practices, environmental risks, sterile processing instruments, etc.*
    - *SSI cases: IC Medical Director follow up with surgeons; IP team: Peri-op staff*

  2. SSI Subcommittee of Quality Council – multi-disciplinary committee to review SSI cases and support implementation of SSI reduction best practice guidelines:
    - *Hair clipping outside the OR*
    - *Nose-to-toes decolonization to all surgical patients*
    - *Hand hygiene compliance*
    - *Closing tray for colo-rectal procedures*

  3. In-services on SSI reduction measures and infection prevention guidelines:
    - *Ortho-symposium presentation*
    - *Pre-op staff; OR staff; SDP staff*

  4. SSI trending: Trend SSI outcomes for comparison with state and national benchmarks
    - *Informed Quality Manager and Medical Director of increase in SSIs*
    - *Advocated for executive leadership to support peri-operative staff*
      -- Surgical attire policy: compliance monitoring with physicians and staff
      --Adherence to dress code policy: no artificial nails/ gels
      --Peer review of all SSI cases

- ***FY19: Sustained improvement in Reduction of HO C.diff***
- ***Top performing hospital in California for decrease in HO C.diff!***

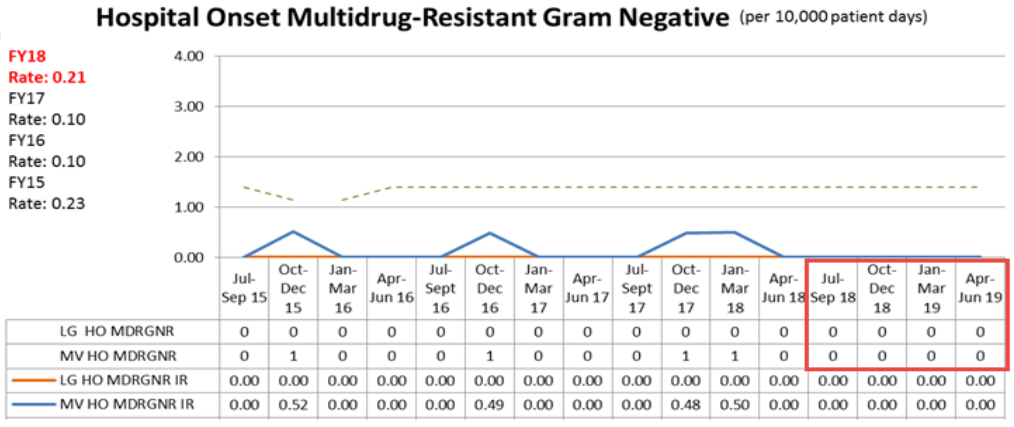


FY2019 Construction Summary: Mountain View and Los Gatos

FY 2019	Mountain View	Los Gatos	Total
New Infection Control Risk Assessment (ICRA) Construction Permits • *Construction Site evaluation by Infection Prevention (IP) Nurse and Project Coordinator prior to start of construction* • *Permit approved and issued by IP Nurse*	**28**	**25**	**53**
Construction Site Assessments • *Daily construction work site rounding by IP Nurse* • *Check compliance of ICRA permit guidelines and barrier set-up*	**506**	**173**	**679**

FY 19: "0" hospital-onset cases of Multi-drug resistant organisms

Hospital onset Multidrug-Resistant Gram Negative Rods



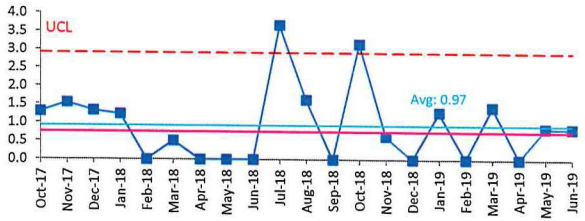
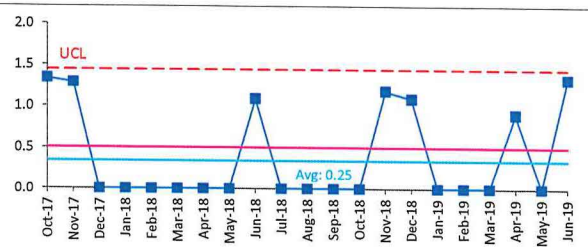
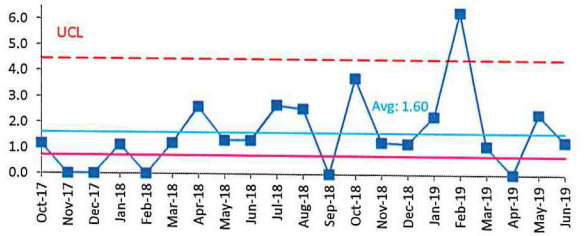
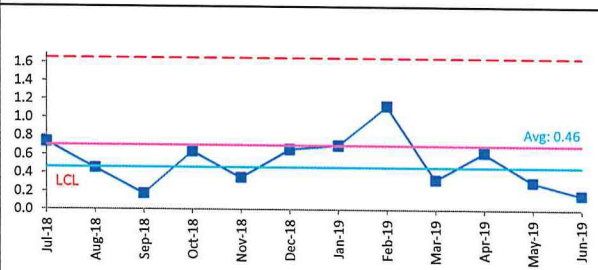
	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jun 16	Jul-Sept 16	Oct-Dec 16	Jan-Mar 17	Apr-Jun 17	Jul-Sept 17	Oct-Dec 17	Jan-Mar 18	Apr-Jun 18	Jul-Sep 18	Oct-Dec 18	Jan-Mar 19	Apr-Jun 19
LG HO MDRGNR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MV HO MDRGNR	0	1	0	0	0	1	0	0	0	1	1	0	0	0	0	0
LG HO MDRGNR IR	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MV HO MDRGNR IR	0.00	0.52	0.00	0.00	0.00	0.49	0.00	0.00	0.00	0.48	0.50	0.00	0.00	0.00	0.00	0.00

FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Total: 2 MV: 2 cases LG: 0	**Total: 1** MV: 1 case LG: 0	**Total: 1** MV: 1 case LG: 0	**Total: 2** MV: 2 cases LG: 0	**Total: 0** MV: 0 LG: 0

El Camino Health

Infection Prevention Dashboard- FY19

Report updated: 7/23/2019

	SAFETY EVENTS	FY19 Performance Current month	FY19 Performance FY 2019	Baseline FY 2018 Actual	Target FY 2019 Target/ Outcome	Trend	Comments
1	**Hospital Acquired Infection** (Infection rate) **Catheter Associated Urinary Tract Infection (CAUTI)** *per 1000 urinary catheter days* *Date period: July 2018 - June 2019*		1.09 (17/15625)	0.90	**SIR Goal: <= 0.75** (**MV:** 1.56/ **LG Main:** 0.0/ **Rehab:** 1.03) Risk Adjusted Ratio (not an infection rate)		**MV SIR: 1.56** / **LG Rehab SIR: 1.03** / **LG Main hospital SIR: 0.0** **Enterprise rate increased in FY19: 1.09 vs. FY18: 0.90** MV CAUTI cases: increased in FY19: (16 cases) vs FY18: (14 cases) LG CAUTI cases: Same outcome for both years (1 case)
2	**Central Line Associated Blood Stream Infection (CLABSI)** *per 1000 central line days* *Date period: July 2018 - 2019*		0.27 (4/14714)	0.30	**SIR Goal: <= 0.50** (**MV:** 0.36/ **LG:** 0.0) Risk Adjusted Ratio (not an infection rate)		**MV SIR: 0.36** / **LG SIR: 0.0** **Enterprise rate decreased in FY19: 0.27 vs. FY18: 0.30** MV CLABSI cases: Remained the same for both years: 4 CLABSIs LG CLABSI cases: "0" cases for FY18 and FY19
3	**Clostridium Difficile Infection (CDI)** *per 10,000 patient days* *Date period: July 2018 - June 2019*		1.96 (20/ 102026)	1.24	**SIR Goal: <= 0.70** (**MV:** 0.51/ **LG:** 0.52) CDC NHSN Risk Adjusted Ratio (not an infection rate)		**MV SIR: 0.51** / **LG SIR: 0.52** **Enterprise rate increased in FY19: 1.96 vs. FY18: 1.24** MV C.diff cases increased in FY19 (17 cases) vs FY18: (12 cases) LG C.diff cases increased in FY19 (3 cases); vs FY18 (0 cases)
4	**Surgical Site Infections (SSI)- Enterprise** SSI Rate = Number of SSI / Total surgical procedures x 100 *Date period: July 2018 - June 2019*		0.52 37/7167	0.2	**SIR Goal: <= 1.0** CDC NHSN Risk Adjusted Ratio (not an infection rate)		**Enterprise rate increased in FY19: 0.52 vs. FY18: 0.20** MV SS cases: increased in FY19: (26 cases) vs FY18: (9 cases) LG SSI cases: increased in FY19: (11 cases) vs FY18: (6 cases)

Annual Performance Improvement Report

Department/Service Line: LG ED
Prepared by: Pamela Fiehmann MSN, RN, NE-BC, CCRN, NVRN-BC
Date: 7/30/19
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:

- ***LIGATURE RISK Compliant Patient Rest Room and Patient Care Area***
  for TJC Compliance and BEST PRACTICE for Safe Patient Care.
  - *FMEA implemented*
  - *TJC Compliance and Certification with no LG ED findings*
- ***ED THROUGHPUT***
  - *Collaboration with all stakeholders actuated for timely placement for best patient care*
  - *LG ED surpasses FYF19 Org Goal for ED Throughput*
- ***FALL Risks for the ED Patient***
  - *ED Patient Falls increase*
  - *Goal for Zero Harm*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- ***LIGATURE RISK Compliant Patient Rest Room and Patient Care Area***
  - *Patient bathroom – upgrade to ligature free*
  - *Designate Behavioral Health patient care rooms*
  - *Need for Standard work for removal of ligature risks for patient placement*
  - *Telepsych for timely patient assessments*
- ***ED THROUGHPUT***
  - *Timely Patient placement in proper care unit for best in patient outcomes*
  - *Stakeholders collaboration*
  - *Improved Lab and Radiology results TAT*
  - *Utilization of "Bridge Orders" for Admit Orders*
  - *Inpatient bed/nurse availability and readiness to accept "PULL" admits*
- ***ED FALL Risk***
  - *Patient's high risk for falls from ED Gurneys*
  - *Decrease assessments for ED patient's Fall Risk*

[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:

- ***LIGATURE RISK Compliant Patient Rest Room and Patient Care Area***
  for TJC Compliance and BEST PRACTICE for Safe Patient Care.
  - *Extensive collaboration and work completion with Facilities and frontline ED Staff*
  - *Bathroom fixtures and accessories updated to ligature risk free*
  - *Standard Work for removal of ligature risk items to be removed at time of patient arrival and stored in Admin Office for safer environment*
  - *Standard Work with AHMs to provide PSA immediately for 5150 observations*
  - *FMEA complete*
  - *Telepsych activated with improvement of timeliness of patient assessment noted*

- ***ED THROUGHPUT***
  - *Collaboration with all stakeholders actuated for timely placement for best patient care*
  - *Bridging Orders – increased utilization (Collaboration with ED Providers and Admit Physicians*
  - *Lab and Radiology collaboration for improved TAT for results*
  - *New Centrifuge for LAB for improved TAT*
  - *Implementation of RELAY "WALL-E" Robot for Specimen Transport from ED to LAB*
  - *Attained GREATER than ORG Goal of 280 minutes for LG at 232 minutes for Q4 FY19*

- ***ED FALL Risks***
  - *Gurney Alarms implemented*
  - *ED focused Falls committee with ED staff participation*

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

Use bullet points to describe improvement:

- ***ED Ligature Risk Compliant Patient Rest Room and Patient Care Area***
  - *Streamlined process for patient safety and best outcomes*
  - *TJC Survey Compliant/Certified with no findings*
  - *Telepsych assessments for improved patient assessment timeframe*

- ***ED THROUGHPUT***
  - *Daily data collected by ED Charge RN and Inpatient Unit Charge RN*
  - *Data Driven "Just in Time" improvements and communication up the chain of command for assistance in improvement needs*
  - *Daily Review of reported category of ED Throughput barrier at Charge Nurse Huddle*
  - *Relay Robot "Wall-E" facilitates specimens to lab for improved TAT*
  - *LG ED Throughput Q4 FY19 surpasses stretch goal at 232 minutes*
  - *ED Throughput Org Goal Q4 FY19 = 262.5 minutes*

- ***ED FALL Risks***
  - *ED Gurney alarms use*
  - *FALL Risk Assessment for Levels 1,2,&3*
  - *Decreased LG ED Falls*

LG Emergency Department
Performance Improvement FY19

Pamela Fiehmann RN, MSN, NE-BC, CCRN, NVRN-BC
Clinical Manager Los Gatos Emergency Department & Intensive Care Unit
QIPSC Presentation
August 7, 2019

Los Gatos Emergency Department Safety FY19

PATIENT SAFETY

	Sparkline by Month	GOAL	CURRENT	FYTD
FALL		0	0 (0/0)	3 (1/2)
CLABSI		0	0	0
CAUTI		0	0	0
CDIFF		0	0	0
HAPI 3+		0	0	0

* For Fall: Current (Assist / No Assist)

Sources

HAI: Catherine Nalesnik

Fall: Jane Truscott

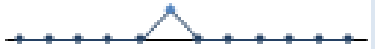
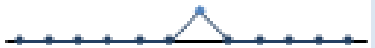
HAPI3+: Franz Encisz/ Chris Tarver

Employee Safety: Mari Numanlia-Wone

Link:

Nurse Sensitive Indicators Dashboard

EMPLOYEE SAFETY

	Sparkline by Month	GOAL	CURRENT	FYTD	Days ABS	Days MOD	OSHA
Bloodborne Pathogens Exp		0	0	0	0	0	0
Musculoskeletal Disorder		0	0	0	0	0	0
Safe Patient Handling		0	0	1	0	0	0
Slips/Trips/Falls		0	0	1	0	0	0
Work Place Violence		0	0	0	0	0	0
Other		0	0	3	0	0	0
TB Exposure		0	0	0	0	0	0
		0	0	0	0	0	0

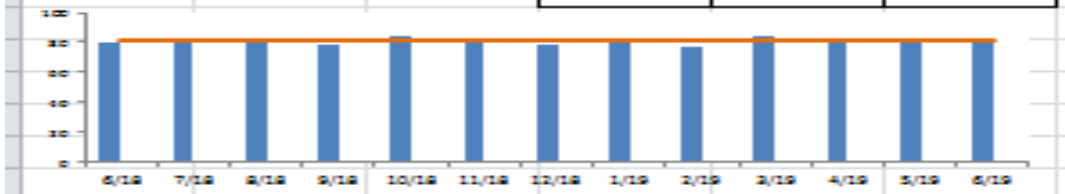
El Camino Health

Los Gatos Emergency Department Press Ganey FY19

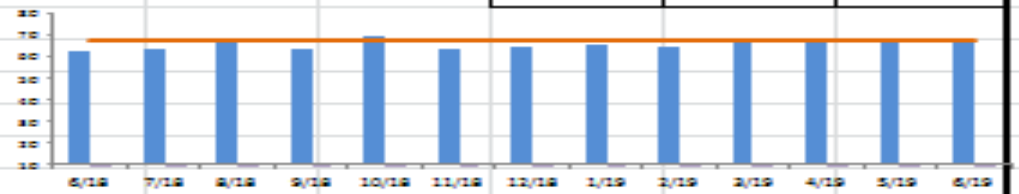
SERVICE Source: Press Ganey Improvement Portal

Run By Received Date & Adjusted — Jun-19

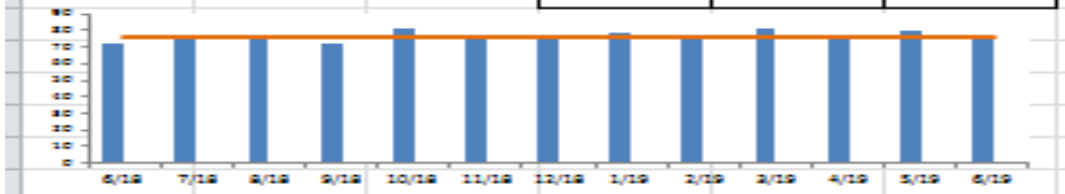
Enterprise Goal		Enterprise		
		Top Box	To Goal	N
HCAHPS Comm w/Nurse Composit	81	81	0.00	233



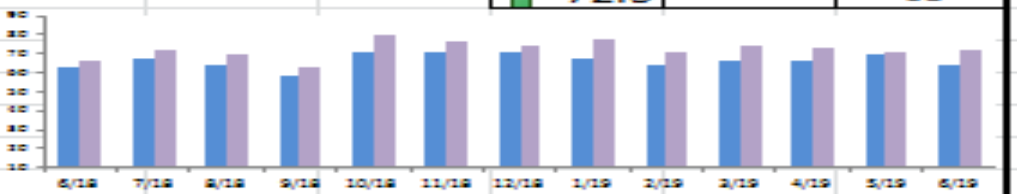
Enterprise Goal		Enterprise		
		Top Box	To Goal	N
HCAHPS Responsiveness	67	67.8	0.80	226



Enterprise Goal		Enterprise		
		Top Box	To Goal	N
HCAHPS Cleanliness	76	77.3	1.30	229



Enterprise Performance		Enterprise	
		Top Box	N
ED Overall		64.5	195
		Unit	
		Top Box	n
		72.5	65



El Camino Health

Los Gatos Emergency Department ED Throughput FY19

PATIENT THROUGHPUT

Admit Order To Floor

Target	Current	FYTD
60	49	57

ED Door To Floor

Target	Current	FYTD
280	227	264

Sources:
ED Throughput: EPIC "ED Admit Measurement Summary"
D/C Before Noon: EPIC "Patients DC by Noon Summary"

El Camino Health

Annual Performance Improvement Report

Department/Service Line: Patient Experience
Prepared by: Ashlee Fontenot
Date: July 3rd 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:

- *Nursing Communication*
  - *Data shows slight improvement from Q3 to Q4, meeting just above target of 81% top box*
  - *Since the implementation of leader rounding, there has been an upward trend in the data*

- *Responsiveness*
  - *Target is 67% top box and the current data trajectory looks to meet between minimum and target for Q4.*
  - *Standard work for answering of call lights as well as leader rounding appears to be positively impacting the scores.*
  - *Continue to monitor and assess key best practices as this goal remains for the next FY.*

- *Cleanliness*
  - *The data remains well above the max for goals set in FY19.*
  - *Sustainability of the initiatives put into place over the past FY must occur to maintain the scores.*

Areas of Concern or Opportunities for Improvement:

- *Nursing Communication*
  - *Although efforts were put into place for hourly/purposeful rounding, there is an opportunity to better educate all staff and reinforce the process.*

- *Responsiveness*
  - *Although improvements were implemented in FY19, an area of opportunity exists to implement the best practice of "No Pass Zone."*

- *Cleanliness*
  - *Strong improvement efforts were implemented for FY19, showing a drastic improvement in HCAHPS scores with this question on the survey. An area of opportunity exists to maintain these efforts.*

- *Implementation of best practices with proven positive outcomes should be implemented and sustained despite the specific metrics set forward for goals. Standardization of these best practices across all areas is essential and should not deviate from proven best practices.*

[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

- *Nursing Communication*
  - *Work to implement purposeful rounding done*
  - *Standardization and use of the "Brain" in EPIC was implemented to standardize bedside shift report.*

- *Responsiveness*
  - *Assessment of workflow for answering call lights completed and standard work created.*
  - *Administrative Support trained on standard work*

- *Cleanliness*
  - *Standard scripting created for all EVS staff when entering a patient room.*
  - *AIDET video created by and for EVS staff*
  - *Business cards created for EVS staff to leave with patients, indicating their name and the EVS phone number.*

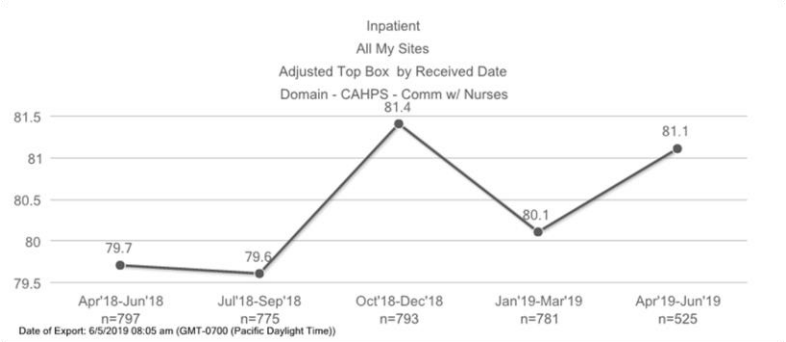
- *Leader rounding implemented and positive outcomes reflected with an increase in HCAHPS scores.*

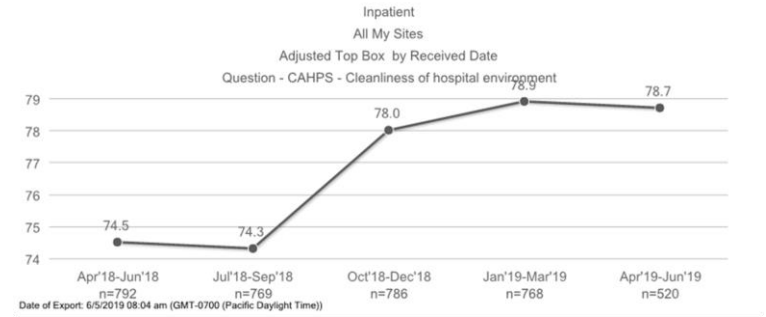
Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

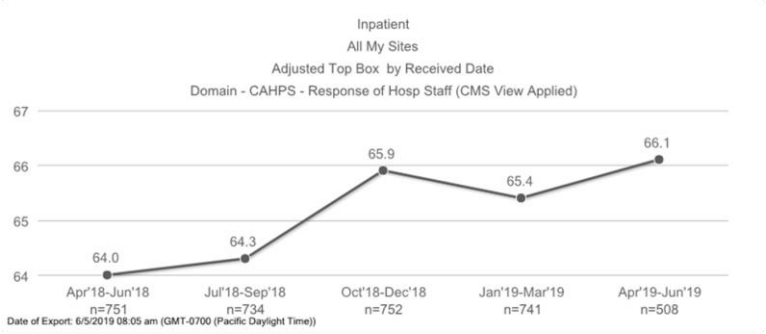
- *Nursing Communication*
  - *FY19 Q1: 79.6%*
  - *FY19 Q2: 81.4%*
  - *FY19 Q3: 80.1%*
  - *FY19 Q4TD: 81.5%*
- *Responsiveness*
  - *FY19 Q1: 64.3%*
  - *FY19 Q2: 65.9%*
  - *FY19 Q3: 65.4%*
  - *FY19 Q4TD: 66.9%*

- *Cleanliness*
  - *FY19 Q1: 74.3%*
  - *FY19 Q2: 78%*
  - *FY19 Q3: 78.9%*
  - *FY19 Q4TD: 78.7%*

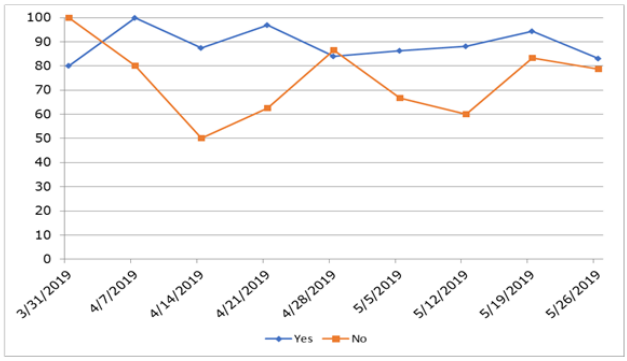
**all data is run received/adjusted*
Goals were set as (min/target/max):
80.5/81/82 Nursing Communication
65.6/67/68.5 Responsiveness
75/76/77 Cleanliness



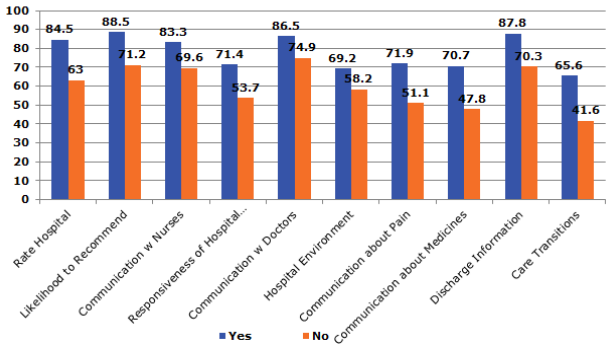




The top box % is greater for the "likelihood to recommend" domain when patients state they received a leader round



The top box % is greater in all domains when patients state they received a leader round



Annual Performance Improvement Report

Department/Service Line: Palliative Care
Prepared by: Grace Benlice
Date: July 31, 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:

- ***Organizational Goal- Mortality Index-*** *Identifying and providing for ECH patients with expected disease related deaths vs those with unexpected deaths. The impact of appropriately supporting end of life transitional care includes patient care and satisfaction and the financial impact of Medicare reimbursement penalties to the hospital.*
- ***Factors impacting mortality rates:***
  - *Utilization of available Palliative Care consultation services: 1188 FY 2019 Range of 80-140 month (99/month average)*
  - *Timeliness of Palliative Care Team Response / within 24 hours 82%*
  - *POLST status assessment/ Goals of Care 90.8%*
  - *Pain Management only consultation 20%- 42%*
  - *General Inpatient Hospice Care (GIP) (Partnering with Pathways Hospice) 0 consults in March, 28 as of July 25*
- ***Organizational Goal- Reduce Re-admissions*** *of Hospital inpatients through intensified discharge planning and placement. Palliative Care participation to review current and retrospective case management of chronic and terminally ill patients and interventions to support post-hospitalization use of community health resources for follow up vs readmission to inpatient status. FY 2019Target 1.05, Actual 0.99*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- *Expansion of Palliative Care and GIP programs in Los Gatos.*
- *Expansion of GIP program in Mountain View to other units, possibly CCU for post-extubations*
- *Expansion of Palliative Care Team to provide 7-day/week coverage for both campuses*
- *Structured GIP education program with/for clinical staff, possibly coordinate with Education Team to incorporate into clinical/new nurses' orientation program*
- *Recruit Physician champions*
- *Palliative Care Trigger Tool implemented- does not identify those patients already utilizing Palliative Care Services-revisions necessary*
- *Rapid increase of GIP services has stretched Pathways' staff and budget. Committee to review*
- *Lack of exposure/experience with GIP level of care by clinical and medical staff has highlighted areas in need of education and training within the hospital proper*
- *POLST Assessment- data collection tool requires clearer parameters for measuring impact of Palliative Care intervention*
- *Data collection of Referrals being seen within 24 hours of order. Bulk of those not seen within 24 hours were received on Mondays as referrals carried over from weekends- currently no Palliative Care presence evenings, weekends, and inconsistently in Los Gatos*

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

Use bullet points to list actions taken:

- *Goals for FY 2020 Reviewed with Team*
- *Workgroups to further investigate and recommend actions for areas not meeting goals/ expectations*
- *Additional Nurse Practitioner position filled*
- *Foundation grant proposals in process for additional RN and Spiritual Care positions*
- *Cross training program/ opportunities being developed for Med-Surg, CCU, ICU, PACU and float staff "Unit Champions" with the expectation that unit specific Palliative Care resource opportunities will improve referral and utilization rate of Palliative Care Services.*
- *Inclusion of Evette Khaen Manager of Nutritional Services, in Palliative Care Mortality and Readmission Committee to develop nutritional focused physical exam for enhanced assessment of patient needs.*
- *Cornel is pausing education on malnutrition documentation due to new rulings for CDI August 1st.*
- *Wound Care documentation update- RFS in final stages of development. Cornel training of wound care RN in process.*
- *Dr V Ram's palliative care note demonstrated learning from MD "Let's Talk" trainings held on April 28 & 29th.*
- *Dr. Chelamkuri to work on power point for proposed MD in-office education*
- *Linda Covert working to develop Healthstream power point presentation of basic Palliative Care principles and referral triggers*
- *Checklist of GIP referral and implementation developed as a comprehensive resource for GIP admission 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:

- *Mortality Index prior to implementation of GIP FY2019* ***1.00****. Following implementation in March of FY2019* ***0.76***

- *Length of Stay (LOS) multidisciplinary review of cases of actual, potential and/or retrospective extended stays are reviewed weekly providing opportunities for application of GIP, Comfort Care and Palliative Care assessments in addition to other efforts for appropriate intervention, discharge, and placement.*

- *Training of Palliative Care staff to be pro-active with education, support and increased presence at the bedside*

.

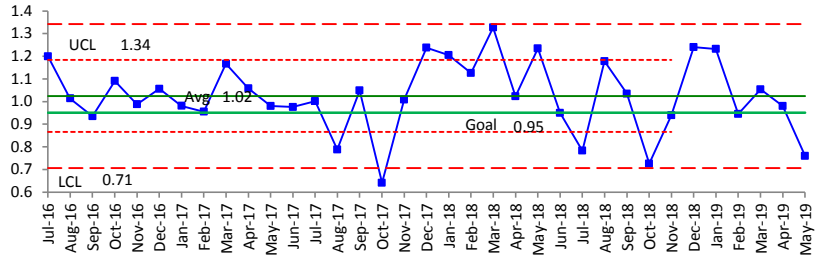
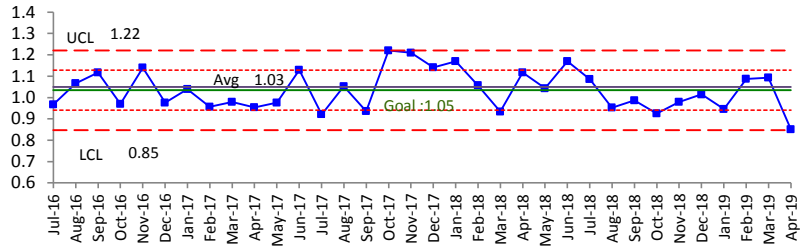
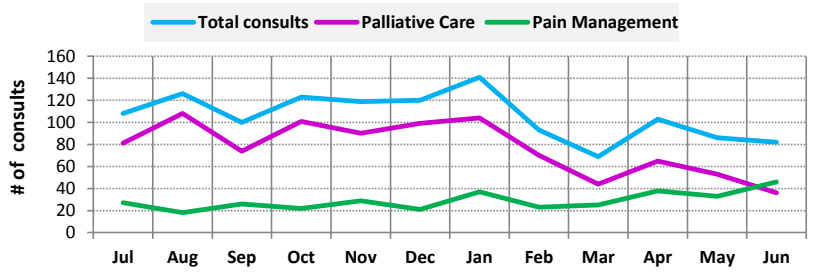
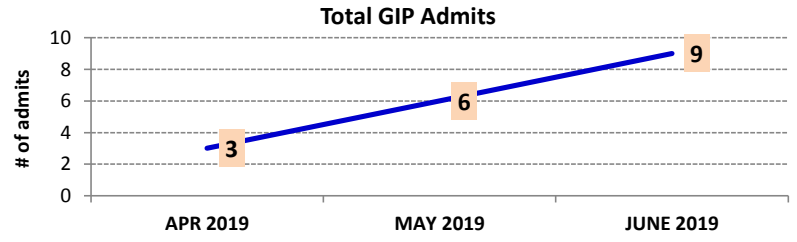
- *Full time, month long internship of Care Coordination RN to better understand the role and scope of Palliative Care and its relationship to appropriate discharge options.*

- *MD education seminar (full day, 2 sessions, 18 participants) focused on the importance of and skills necessary for end of life/ Advanced Care planning and decision-making.*

- *Readmission rate for FY2018 went from 1.08 to 0.99 with a target of 1.05.*
- *Improvements in process:*
  - *Expanding the bandwidth of Palliative Care services/ impact through hire of experienced staff to fill current vacancies and to procure additional staff.*
- *2-day Pain Management Seminar for clinical staff August 2019*

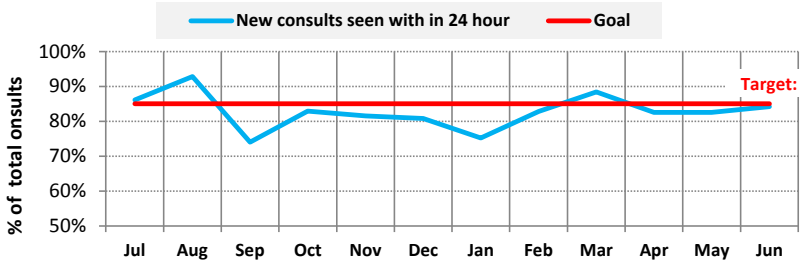
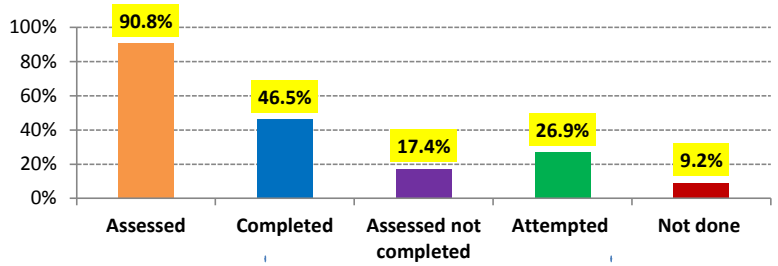
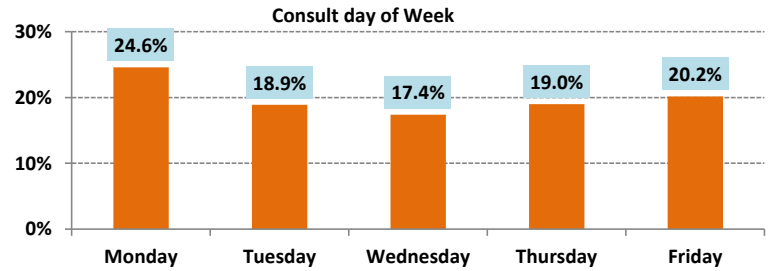
El Camino Health

Palliative Care Dashboard for FY 2019 - enterprise

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Trend Graph
	Latest Month/ FY	FYTD			
*** 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	
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	
Total # of Consults *Latest Data Month* : June 2019	86	1188 (99 per month)	924 (77 per month)	NA	
Total GIP admits *Latest Data Month: June 2019*	7	18	NA	NA	

El Camino Health

Palliative Care Dashboard for FY 2019 - enterprise

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Trend Graph
	Latest Month/ FY	FYTD			
New consults seen with in 24 hour of order (average) (Not including weekends and holidays) *Latest Data Month: June 2019*	84%	82%	77%	85%	
POLST status Reporting period: July 2018 - June 2019	90.8%	90.8%	NA	75%	
Consult Day of Week (excludes Saturday and Sunday) Reporting period: July 2018 - June 2019	NA	NA	NA	NA	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: September 9, 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 not has. 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

August 21, 2019

- Approved the FY20 El Camino Hospital Board Member Competency Matrix
- Approved the FY20 Board Education Plan
- Completed FY19 CEO Performance Evaluation
- Approved Cardiothoracic Surgery On-Call Panel Renewal
- Approved Colorectal Surgeon Physician Income Guarantee
- Approved FY19 Year-End Financial Report
- Approved FY20 and 21 Medical Staff Development Plan
- Approved Radiation Oncology Equipment Replacement
- Approved ED Remodel Project
- Approved Revised Medical Staff Bylaws
- Appointed Terrigal Burn, MD; Caroline Currie, Alyson Falwell and Krutica Sharma, MD to the Quality, Patient Care and Patient Experience Committee

B. Finance Committee Actions

July 29, 2019 – Approved Heart Failure Medical Director Agreement

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

D. **Executive Compensation Committee Actions**: None since last report.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

To everyone on the surgical team – admitting or recovery – who took care of me during my disc surgery yesterday:

Thank you all. I can't imagine anything any of you could have done better.

It's pretty humbling to be wheeled into that big operating room flat on your back with the little blue bonnet on your head.

Everyone was kind and thoughtful and professional and great on detail.

You should all be proud of who you are and what you do every day.

And in the end, for someone like me to be able to head home with my pain gone, it seemed like a miracle to me.

Thank you all

[REDACTED]

Organizational Goals – FY19

Organizational Goals FY19		Benchmark	Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	Q4 through June		FY19 through June	
Organizational Goals												
	Service - Nurse Communication	External Benchmark	80	≥ 80.5	≥ 81	≥ 82	10%	Q4		81.1		80.6
	Service - Responsiveness	*PG-HCAHPS Adjusted/Received*	65.1	≥ 65.6	≥ 67	≥ 68.5	10%	Q4		67.2		65.7
	Service - Cleanliness		74.5	≥ 75	≥ 76	≥ 77	10%	Q4		78		77.3

El Camino Health

Organizational Goals for FY20

Prepared: 8/29/2019

Organizational Goals FY20		Benchmark	Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY19 through June	
Organizational Goals										
	Service - Discharge Information	External Benchmark	86.7	≥ 86.7	≥ 87.3	≥ 88.4		FY		86.7
	Service - Responsiveness	PG-HCAHPS Adjusted/Received	65.7	≥ 65.7	≥ 67.1	≥ 69.7		FY		65.7

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: September 9, 2019
Subject: Strategic Quality Safety Plan

Purpose:

To review the proposed long term quality and safety strategic plan.

Summary:

1. Situation: While El Camino Health has a financial strategic plan and an operational strategic plan, there has not been a long term quality and safety strategic plan.

2. Authority: The ECH Board of Directors will approve any recommended plan.

3. Background: The Quality Committee is tasked with overseeing the quality and safety activities and outcomes of the organization on behalf of the Board. To achieve top tier quality and safety, a long term quality and strategic plan is necessary to achieve this goal.

4. Assessment: This plan has been developed over the past several months with extensive input from many parts of the organization.

5. Other Reviews: N/A

6. Outcomes: To obtain feedback from the Quality Committee regarding the plan and consider recommending the plan to the Board of Directors.

List of Attachments:

1. Draft Summary

Suggested Committee Discussion Questions:

1. Does the Proposed Plan make sense and is it meaningful?
2. Do the priorities in the Proposed Plan reflect the priorities of the organization?

Achieving Quality Excellence:

A Strategic Plan and Roadmap

prepared for

El Camino Health

by

Progressive Healthcare, Inc.

"Success is where preparation and opportunity meet"

-Racing great Bobby Unser

June 19, 2019

Table of Contents

Executive Summary

In January 2019, El Camino Health engaged Progressive Healthcare, Inc. to prepare an enterprise-wide, long-range Strategic Plan for Quality and Safety and to create a "next generation" quality management program and aspirational vision for quality and safety excellence. This section represents an executive summary of the final report of this work and is intended to serve as a quick reference for the work detailed in the accompanying document and Strategic Roadmap.

An initial deliverable for this work was to assess El Camino Health's Current State by viewing it through both external and internal lenses. El Camino's external metrics showed generally average performance on publicly reported measures for quality and safety. The most recent examples are the Spring 2019 Leapfrog scores that show no consistent trend in El Camino's system performance when compared to last year's scores, i.e., Mountain View's score declined from an overall B to a C, while the Los Gatos score improved from a C to a B. Similarly, the 2019 Watson Top 100 Report shows a negative performance trend in most measures other than financial performance. This reinforces that small declines in quality performance metrics, or no/little positive change in metrics when compared with peers (that are improving faster), has negative consequences to the external view. Internal benchmarks (not publicly reported) are similarly average in comparison to leading practices, e.g., El Camino's relatively high Serious Safety Event Rate of 3.76 per 10,000 patient-days.

El Camino Health has several cultural challenges that must be addressed to achieve its desired quality and safety transformation. These include but are not limited to 1) the evolution of the Board's role to support quality and safety across the rapidly expanding enterprise that includes a new employed medical group this year, expanded behavioral and maternal health facilities that are soon to open, and planning for a new hospital that will significantly expand the geographic service footprint; 2) engaging a medical staff that is very large for the size of the enterprise, shows polarity between the current two hospital campuses, and includes many physicians who are relatively unfamiliar with the organization's quality processes; and 3) leadership that must regularly manage through a culture of normalized deviant behaviors.

Fortunately, the El Camino team widely aspires to be a "top tier" organization, one that management and multidisciplinary Quality / Safety Workshop participants described as empowered to achieve an enterprise vision "to consistently deliver the highest quality care with zero preventable harm." El Camino has many excellent staff, medical staff, and leaders at all levels who are energized to provide an increasing scope of leading-edge healthcare offerings and service excellence to address the health care needs of the area's aging, multicultural community, while simultaneously engaging the market's many large, high-tech employers in exciting innovation work.

To accomplish this "top tier" organizational performance vision, five (5) essential strategic opportunities must be addressed:

1. Revise the current Governance, Leadership, and Management structures for quality to meet the needs for alignment and coordination of quality efforts across the growing El Camino Health enterprise that, by definition, involves a myriad of stakeholders. These will be addressed by:
    a. Establishing an Enterprise Quality Committee that reports to the Board Quality Committee and is responsible for:
        i. Establishing the annual quality plan, and

ii. Designing, prioritizing, and resourcing quality initiatives to fulfill the plan

b. Establishing an Office of the Quality Executive that is responsible to facilitate, coordinate, integrate, and communicate quality and safety throughout the enterprise

c. Creating a Board development plan for quality and safety that includes endorsing the vision statement and managing the various knowledge and skills gaps

d. Developing a longitudinal plan to achieve a top decile performance designation, thereby addressing all measures in addition to quality

e. Designing an annual quality plan with broad stakeholder input that can easily be translated into action and clearly identifies priorities and resources, then broadly and visibly communicating the plan (creating a palpable buzz)

f. Clarifying the roles (and value) of existing enterprise quality-related committees and structures, including the MEC and affiliated group activities, to minimize redundancy and non-value-added activities

g. Establishing a culture of both individual and team accountability for quality and safety through strategy deployment, leadership development, effective scorecards, as well as use of top project management and performance-related tools

h. Ensuring the overall organizational structure fully supports a "quality / safety first" culture and achievement of top tier performance. This includes a thorough review of organizational charts with specific attention to all leadership roles, including physicians, e.g., medical staff leaders, department chairs, and medical directors; as well as structural and functional organization of both hospital campus medical staffs.

2. Enhance the operational organization of the quality department and committees by ensuring adequate multidisciplinary participation by physicians, nurses, administration, staff, patients/families, etc. This will be addressed by:

   a. Aligning the hospital and medical staff quality and safety goals through the above-noted, jointly developed and communicated annual quality plan

   b. Optimizing resource distribution and reporting structures through the quality plan, project management, and deselection or realignment of misaligned work

   c. Establishing a project management office that balances resources among the various pillar strategies to ensure that quality and safety receive appropriate priority and achieve stated goals

   d. Aligning and enhancing process improvement support through inventory, management, and inclusion of related resources (e.g., business intelligence, information technology, risk management, patient safety, infection prevention, population health, care coordination, human resources) in developing the annual quality plan and budget

   e. Creating a required quality and safety training experience for all stakeholders that incorporates existing technologies (e.g., web-based learning) with newer approaches (e.g., simulation), that will eventually evolve into a certification program

f. Developing a longitudinal medical staff leadership development program that creates a pathway for advancement and succession of well-trained medical staff leaders.

3. Similar to leading organizations, establish a rigorous continuous performance improvement "business system" to focus efforts and accelerate quality improvement, creating greater efficiency and more consistent outcomes. This will be addressed by:

    a. Enhancing the identification of improvement opportunities to be less reactionary (e.g., to the QRRs) and more proactive vis-à-vis multi-stakeholder input and various needs assessment tools (e.g., the Community Health Needs Assessment, use of leading indicators, predictive analytics)

    b. Managing the prioritization of quality initiatives through service lines and a series of other multi-disciplinary teams that will reduce a sense of "flavor of the day" and "priority creep"

    c. Instituting and training on standardized and broadly accepted methodologies for quality improvement and high reliability, including apparent / root / common cause / failure modes analyses, Serious Safety Event Rate, Lean and Hoshin Kanri

    d. Developing a structured process to allocate analytic and reporting resources, and implementing templated enterprise-wide quality dashboards and scorecards

    e. Creating triad leadership teams (physician, nurse, administrator or PI leader) for all quality / safety committees and multi-disciplinary process improvement teams

    f. Encouraging and supporting (through monetary and non-monetary means) clinicians and front-line staff to participate in process improvement

    g. Creating and leveraging existing structures to promote innovation, adoption, and spread of best practices, and engagement with leading external quality organizations

4. Begin the journey to become a high reliability organization by adopting and managing the enterprise to the final "roadmap". This will be addressed by:

    a. Defining Safety as a Core Value and the burning platform for the quality and safety transformation

    b. Redefining the daily huddle to focus on safety and implement (via training, communication, support, and measurement) a series of safety leadership behaviors

    c. Develop and implement (via training, communication, support, and measurement) a series of error prevention behavioral tools and expectations for all stakeholders

    d. Establishing key safety leadership roles, including a medication safety officer and chief surgeon or "surgeon of the day"

    e. Developing and implementing safety communication tools, dashboards, and recognition programs, including an SSER dashboard and "faces of safety" slide, all of which are periodically updated according to a predefined schedule that ensures they are both current and "fresh"

    f. Launching industry-standard tools for causal analysis and implementing a "harm early warning system" using leading indicators for potential harm

g. Enhancing environment reliability and emergency preparedness through greater attention to patient and staff needs during crisis

5. Develop a self-propagating culture of quality and safety to ensure a successful and sustained transformation to top-tier designation for quality and safety. This will be addressed through:

    a. Demonstrating a meaningful leadership commitment to quality and safety to reinforce goals and expectations

    b. Refining the HR and medical staff recruiting / credentialing / peer review processes to emphasize quality values and cultural fit

    c. Implementing and promoting "Fair and Just Culture" practices

    d. Optimizing meaningful quality and safety reward and recognition programs for all stakeholders

    e. Increasing the transparency of quality and safety outcomes through internal and external dissemination of dashboards and scorecards

    f. Increasing stakeholder involvement in quality and safety activities, especially by including patients and their families/caregivers

El Camino has attempted to "reboot" a central quality and patient safety focus several times during the past 5 years. Therefore, it is important for El Camino's leadership to demonstrate a highly visible and sustained commitment to quality and patient safety via culture change from the top. A single, powerful change in structure, process or protocols can signal to all stakeholders the importance of the start of El Camino's quality and high reliability journey and set the stage for renewed organizational focus and enthusiasm for each individual to internalize the quality vision. El Camino leaders must select and implement at least one significant change that can be rapidly designed and implemented. Many examples of such "low-hanging fruit" surfaced during the current state assessment and are covered later in this document.

Leadership, through the Enterprise Quality Committee, must also immediately lay the groundwork for several intermediate (6-9 month) projects that demonstrate sustained and visible efforts and lead to FY20 goal achievements. Examples are detailed later in this document. While these projects will take additional time to plan and resource, they will demonstrate a meaningful commitment to sustainment while inspiring organizational excellence.

This strategy was developed using a highly inclusive and consensus-driven approach in an effort to create a viable and sustainable transformation plan. To ensure that planning and initial execution are successful, several critical factors must be actively and skillfully managed in support of the roadmap. These include but are not limited to appointing an owner, engaging MEC leadership, investing in Board and c-suite development, maintaining a sense of urgency, and ensuring resource availability. Suggestions to mitigate these factors are listed later in this document.

Through targeted reorganization, communication, and multidisciplinary integration of people, processes, and technology, El Camino will achieve its aspirational top tier quality and zero preventable harm (True North) goals.

Introduction

In January 2019, El Camino Health engaged Progressive Healthcare, Inc. to prepare an enterprise-wide long-range Strategic Plan for Quality and Safety and to create a "next generation" quality management program and aspirational vision for quality and safety excellence. The specifications required a comprehensive evaluation of current state quality and safety for the hospitals and related assets, assessment of relevant leading national practices, gap analysis between current state and leading practices, defining a compelling vision of the future, and preparing a roadmap to guide the organization to realize the future state. This document represents the final report of this work and provides a strategic roadmap to implement the conclusions.

The engagement was outlined in three distinct phases:

Phase I: Define El Camino's current state and vision of the future

Phase II: Generate solutions to address gaps between the current and future states

Phase III: Generate a long-range strategic plan and roadmap to guide implementation

This approach was created to actively engage all stakeholders across the care continuum and build enthusiasm towards launching a transformational journey. More than 60 people participated in interviews, workshops, and Steering Committee meetings with the intention to develop strong alignment of a core multidisciplinary stakeholder group of individuals who can help lead the organization in a common direction to achieve quality and safety excellence. Further, as the group expands to increasingly engage more stakeholders, the roadmap will serve as a template – a "living document" into which they will incorporate the then current theoretical frameworks for quality, reliability, and social determinants, along with new evidence-based and best practices.

Phase I began with a review of prior consultative reports, surveys, Board minutes, performance metrics and competitor characteristics, which guided a series of stakeholder interviews and targeted observations. This culminated in the clear articulation of El Camino's goals and aspirational future state. El Camino's leaders collectively defined their ambition to be a leading institution in the region and state, and to be recognized among the elite top decile performers in the United States (as defined by Premier and similar reports). Using this information, a quality vision and a set of quality principles were developed to guide the strategic planning process.

Phase II brought together representative stakeholders in both a Steering Committee and four workshop groups to outline a set of priorities for design and implementation that will guide El Camino towards a meaningful and sustained quality and safety transformation. The combined efforts of these groups, informed by leading practices, provided input for this document, and defined a tangible path forward to achieve True North for quality and safety

The journey to transform El Camino Health into a leading institution for quality and safety will be arduous and requires commitment that, using the organization's history as an indicator, will likely transcend the current leadership. The CEO – current and future – must serve as Captain of the Ship. People from all sectors of El Camino Health will wait to see the course set by the Captain. Responsibility and authority are widely delegated, but the Captain of the Ship is the decision-maker from which there is no appeal.

Only the Captain can overrule another leader's decision and make that stick. Anyone can say "go," but only the Captain – the CEO – can chart and inspire the True North course.

El Camino Health has several cultural challenges that must be addressed to achieve its desired quality and safety transformation. These include but are not limited to 1) the evolution of the Board's role to support quality and safety across the rapidly expanding enterprise that includes a new employed medical group this year, expanded behavioral and maternal health facilities that are soon to open, and planning for a new hospital that will significantly expand the geographic service footprint; 2) engaging a medical staff that is very large for the size of the enterprise, shows polarity between the current two hospital campuses, and includes many physicians who are relatively unfamiliar with the organization's quality processes; and 3) leadership that must regularly manage through a culture of normalized deviant behaviors.

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It is important to state that Change Management practices (e.g., Kotter) are necessary – El Camino must "go slow to eventually go fast." Further, El Camino must identify, cultivate, and reward champions of change. In Tipping Point (2000), Gladwell states that, "The success of any kind of social epidemic is heavily dependent on the involvement of people with a particular and rare set of social gifts." These include Connectors (those with an extraordinary knack for making friends and acquaintances), Mavens (information specialists who are almost pathologically helpful), and Salespeople (charismatic persuaders with powerful negotiation skills). It will be imperative to the success of this transformation for El Camino's executive and medical staff leaders to identify and empower these change agents.

Addressing El Camino's unique challenges will require significant attention to cultural embedding mechanisms, framed per Edgar Schein's 1985 Organizational Culture and Leadership book, as follows:

Primary Embedding Mechanisms	Secondary Reinforcement Mechanisms
1. What **leaders pay attention to**, measure and control	1. Organizational design and structure
2. How **leaders react to critical incidents** and crises	2. Organizational systems, and procedures
3. Criteria by which leaders **allocate scarce resources**	3. Organizational rites and rituals
4. Deliberate **role modeling**, teaching, and coaching	4. Design of physical space, facades, and buildings
5. Criteria by which leaders **allocate rewards and status**	5. Stories, legends, and myths about people and events
6. Criteria by which leaders **recruit, select, promote, retire, and excommunicate** organizational members	6. Formal statements of philosophy, values, and creed

Finally, Phase III brings all the above information together into a comprehensive, long-range Quality and Safety Strategic Plan. Accompanying the Plan is a strategic roadmap, which is a detailed action plan that specifies granular deliverables, milestones, responsible parties, and timelines for El Camino's journey to achieve its aspirational top tier quality and zero preventable harm (True North) goal.

Key Planning Components

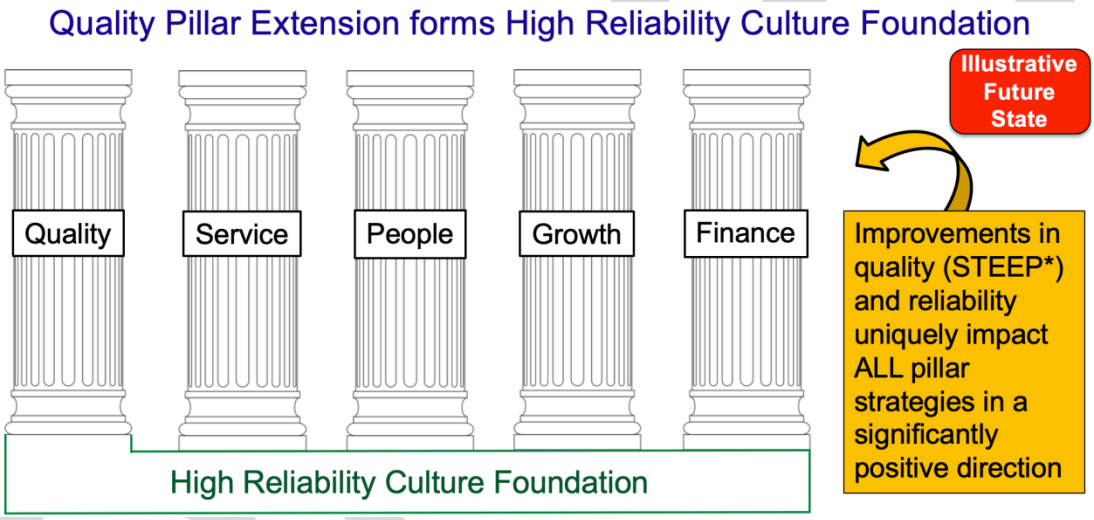
El Camino aspires to be a "top tier" organization, empowered to achieve the following vision through a sustainable Quality and Safety transformation that is achieved via use of the following guiding principles.

Vision Statement

To consistently deliver the highest quality care with zero preventable harm

Guiding Principles

- We are one enterprise that leads with quality, and delivers evidence-based, consistent, reliable, and high-value care across the continuum
- Of the enterprise's five strategic Pillars, our Quality Pillar extends to form our High Reliability Culture Foundation, where quality, safety, and patient experience are in our DNA

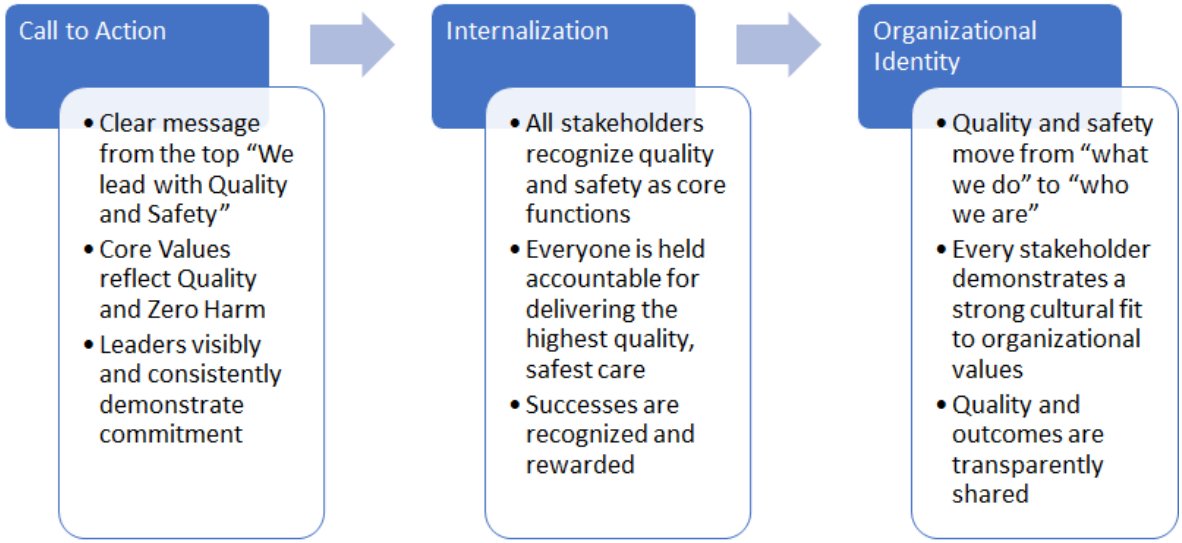


- Our leaders are committed to quality and safety, and communicate these as the top organizational priority
- We develop multi-disciplinary teams that include patients and families to identify, develop, and innovate best practices, and lead their adoption across the enterprise
- Everyone in our organization is engaged, held accountable, and recognized for improving quality, safety, and patient experience
- We consistently measure our performance using timely and actionable data, and are transparent by communicating it internally and externally

High Level Framework

We envision a future at El Camino Health where:

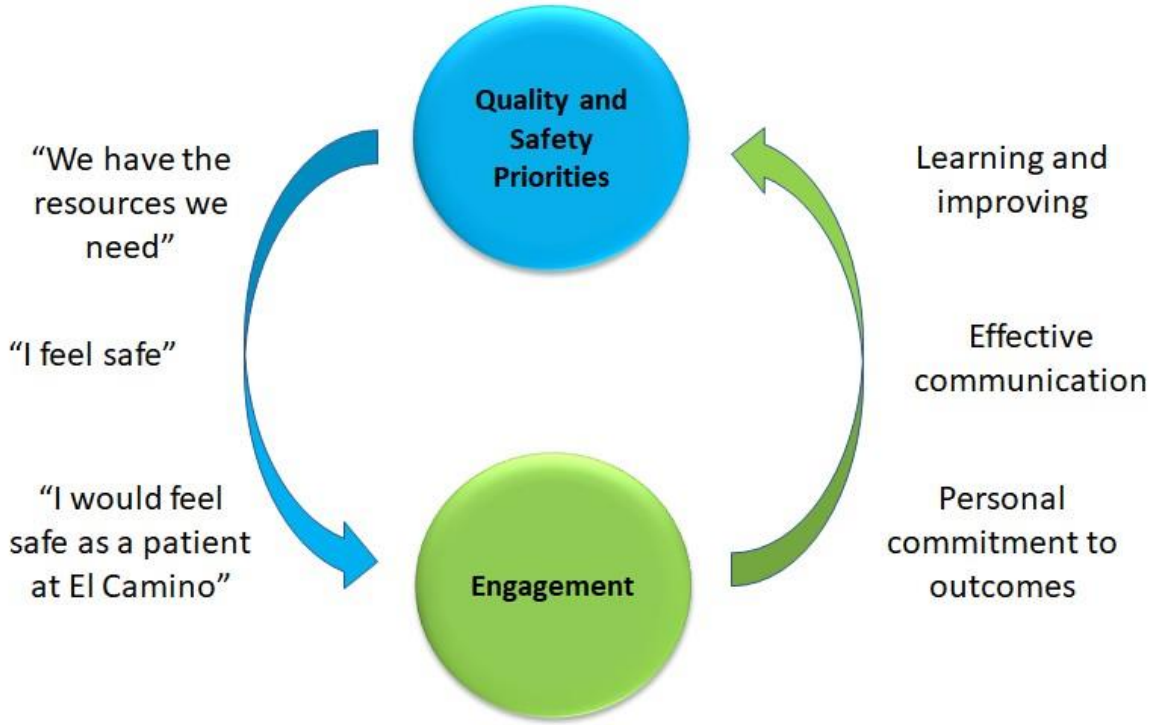
1. Quality, safety, and care experience are woven into its cultural fabric and define the organization's identity.



2. El Camino is more resilient and reliable, and it establishes an industry-standard Safety I culture that gradually transitions to a proactive Safety II:

Standard	Safety I – Reactive	Safety II – Proactive
Definition of "Safety"	"**~Nothing goes wrong**"	"**~Everything goes right**"
Safety Management Principle	**Reactive**, respond when wrong things happen	**Proactive**, anticipatory, standardize and reinforce managing to right
Explanation of Errors	**Errors are caused by failures and malfunctions**; the purpose of investigation is to identify causes and contributing factors	Purpose of an investigation is to **understand how things usually go right as a basis for explaining how things occasionally go wrong**
Attitude to Human Factor	**Humans are** predominately seen as **a liability or a hazard**	**Humans seen as a resource necessary for system flexibility and resilience**
Performance Variability	**Harmful – should be prevented** as much as possible	**Inevitable but also useful – opportunities to monitor and manage**

3. Quality and Safety activities across the enterprise are aligned and coordinated, and create a virtuous cycle of development that self-propagates and sustains excellence

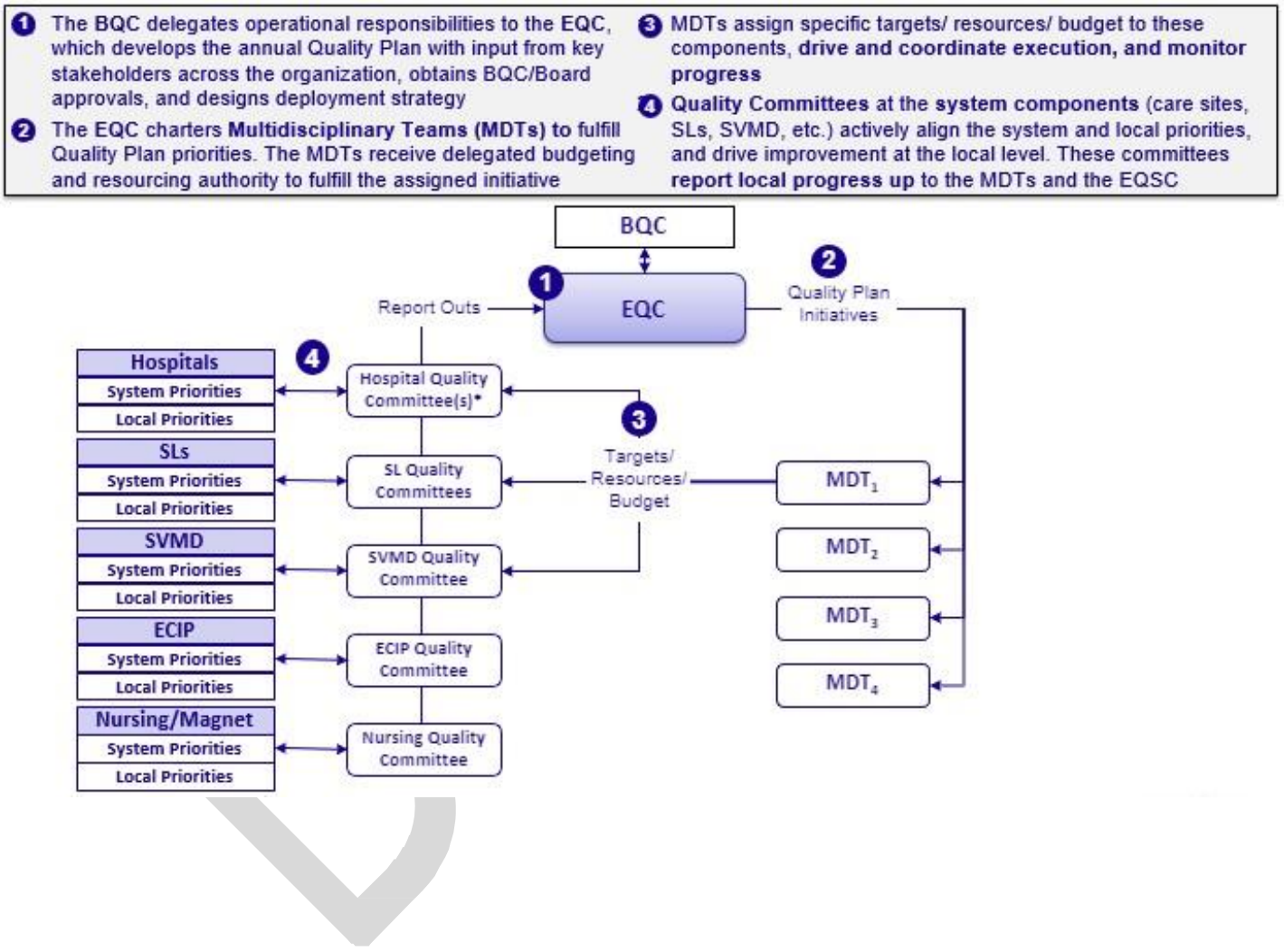


4. All quality and safety priorities receive adequate resources and leadership support to ensure successful progress and meaningful impact at the point of need.

To accomplish this transformation, the governance and management structure of quality will be revised by expanding it to both cover the entire, new El Camino Health enterprise and to ensure there are adequate accountabilities, effective communication, and time management (including meetings). The

Board's Quality Committee will continue to oversee Quality and Safety from a high-level perspective, but a newly formed Enterprise Quality Committee will be responsible to drive and manage the development and execution of an annual quality plan. Using project management tools (e.g., RACI) and by leveraging a newly formed Project Management Office, the Enterprise Quality Committee will assign and delegate responsibility for goal achievement, ensure that priorities and resources are aligned and optimized, and monitor progress towards goal attainment.

This following (proposed) enhanced matrix structure will enable alignment and coordination of resources across the enterprise and allow enough flexibility for growth and future system needs.



Essential Strategic Components

The comprehensive evaluation of El Camino's current state quality and safety, along with an assessment of relevant leading national practices and related gaps, are outlined in a separate "Current State Assessment" document. This Essential Strategic Components section categorizes the major identified gaps into five (5) Key Strategic Components:

1. Leadership, Governance, and Management Constructs
2. Quality Organization Integration
3. Performance Improvement Methods and Metrics
4. Journey to become a High Reliability Organization
5. Culture of Quality and High Reliability

Summary of Gaps Compared to Leading Practice Organizations

Component	ECH Gaps Compared to Leading Practice Organizations
Leadership, Governance, and Management Constructs	The enterprise commitment to top quality performance is not effectively supported by **governance functions, management structure, medical staff structure, functional committee structures, or dedicated and well-organized quality management constructs**. Medical staff, Service Lines, SVMD and programs (e.g., CME) are not well designed for quality/safety. Patients / families are not **directly involved** in the quality governance structure or functions.
Quality Integration	**Process improvement (PI) and project management are mostly siloed by executive function. Resources are not deployed and/or available** to effectively support quality integration across the enterprise. This contributes to hot-spotting, priority creep and loss of trust. **Quality improvement initiatives are usually not coordinated** and aligned across care sites or under the control of the Quality Organization.
Performance Improvement Methods and Metrics	El Camino focuses on **multiple priorities each year**, without aligned **prioritization, measurement, improvement and reporting structures** to maximize quality excellence. PI resources are siloed within operations. **The few metrics reports that are available lack leading indicators; leaders cannot access actionable data** from the EHR. There is **little structure to drive and disseminate** care standardization and EBM across the care continuum.
Stakeholder Engagement	All frontline stakeholders are **not always aligned with quality priorities**, and are rarely active participants in improvement efforts. A significant portion of the medical staff is not actively engaged in quality and safety work. **Balanced representation** from physicians, nursing, administrative, QI/PI experts, and patients is inconsistent across quality improvement efforts.
Culture of Quality and High Reliability	**Quality and Safety are not core values; expectations and accountability are not clear.** Incident reports are used for blame and defense; there exist **barriers to transparency** and the establishment of a "fair and just" culture. There is **little direct inclusion of patients and families** in quality improvement activities.

These gaps must be addressed through a series of well-defined and well-resourced tactics. In turn, El Camino's ability to successfully address these tactics will directly correlate with the enterprise's ability to realize its Quality and Safety Vision.

Component 1: Leadership, Governance, and Management

Desired Future State: Aligned leadership and disciplined management will facilitate El Camino Health's ability to achieve and sustain its desired top quality and safety performance results.

Revision of the current Leadership, Governance, and Management structures to meet the needs for alignment and coordination of quality efforts across the growing El Camino Health enterprise (and its myriad of stakeholders) will address the following strategic key concerns and opportunities.

Key Concerns and Opportunities:

- Lack of a unifying, enterprise vision for quality, overshadowed by a history of multiple false starts.
- El Caminos Board's transition from its operationally-focused approach to a quality and safety oversight role for the health system and medical staff is incomplete.
- Enterprise quality structures are currently hospital-centric and siloed, limiting the ability to share resources, align activities, and achieve effective communication.
- Medical Staff leaders do not meaningfully participate in enterprise quality functions, and the MEC's credentialing, peer review, OPPE/FPPE, and medical staff policy development work is nascent.
- Structural and functional organization of the two hospital facilities' medical staffs can be streamlined to more directly promote quality, patient safety, and high reliability.
- C-suite functions are siloed, process improvement (PI) is led through operations, and the lack of an organized project management approach leads to inequality of resources and risk for redundant work.
- Service Lines vary significantly in their development and range widely from nascent to robust.

Tactics to Clarify and Strengthen Governance and Management Structures

Input was obtained during the interviews, workshops, and steering committee meetings to recommend a set of tactics to close these gaps.

Tactic 1 Establish an Enterprise Quality Committee that reports to the Board Quality Committee

While El Camino's Board Quality Committee (BQC) governs enterprise-level quality and safety at El Camino, it ability to function at a strategic level will be greatly enhanced by chartering an Enterprise Quality Committee (EQC) that will serve as an operational forum to develop and drive execution of El Camino's enterprise quality agenda. This will also serve to coordinate and unify quality activities across the care continuum; align affiliated groups with El Camino's vision; and assess and facilitate both budgeting and resources. The EQC will prioritize quality initiatives to achieve strategic transformation, coordinate activities, and create a continuous feedback loop from the front line to the Board.

Recommendations:

El Camino has already initiated consolidation of high-level hospital and medical staff quality leadership committees. However, this new alliance with the medical staff is fragile and clear actions are needed to engage current and future medical staff leaders as equal partners in this effort. Other key quality committees are currently siloed outside the existing quality structure (primarily under the CMO and CNO). Deliberate efforts are needed to establish representative membership to engage these areas but limit size to maintain agility in the decision-making process. A relevant subcommittee structure will be developed, as needed, to enhance inclusiveness while managing various specific initiatives.

The EQC will be responsible for establishing the annual quality plan, and design, prioritize and resource quality initiatives to fulfill the plan. It will charter multi-disciplinary teams (MDTs – similar to those used by CHI, Mayo Clinic and elsewhere) consisting of leaders across the enterprise to manage the execution of each initiative. MDTs will, in turn, delegate responsibilities to specific enterprise sections (e.g., Service Lines, Units, Groups, Care Sites) to define and complete tasks and performance improvement work. The EQC will be mindful of Magnet (and other program) requirements as these teams are both engaged and empowered.

The EQC will also bear the primary responsibility for designing communication and change management tools related to quality and safety improvement efforts.

Tactic 2 Establish a Dedicated Quality Executive Role

While quality improvement is not the sole purview of an individual, a passionate and influential quality and safety thought leader(s) can inspire and support El Camino on its journey and ensure that it is successful. This leader would support and facilitate the EQC and related activities, but not be the sole owner or dictate the enterprise quality and safety agenda.

Recommendations

El Camino will appoint a dedicated Chief Quality Executive to lead the quality and safety transformation. To allow for the strategic transformation to begin immediately, El Camino will establish an "Office of the Chief Quality Officer," populated with up to 4 part time physicians and/or nurses who will jointly own the accountabilities of the CQE. The responsibilities of this role will be fashioned after the Institute for Healthcare Improvement job summary. Key leadership traits include the ability to facilitate, coordinate, integrate, and communicate without the need to control.

El Camino must evaluate the reporting structure for quality to send a clear message from the Board to the front line, and to the medical staff, that quality and safety hold equal priority to operations and finance.

Tactic 3 Create a Board Development Plan for quality and safety

Among their many responsibilities, the El Camino Board of Directors must ensure the quality of clinical care and work to improve the Board's own internal performance. While the Board has demonstrated a commitment to quality, they have not positioned it at a level equal to finance and operations. To create a culture of quality and high reliability, the Board must assess gaps in the Directors' knowledge (both as a

group and individually) and have an annually updated plan to educate themselves on STEEEP dimensions of quality, Quality Performance-based Payment Programs, safety science, just culture, best practice adoption, social determinants of health, and other relevant subjects. The Board must also focus on developing its role as an oversight body for quality and safety and its ability to balance the relationship between the needs of the hospital, medical staff, and community.

Recommendations

The Board must endorse a clear vision for quality and zero preventable harm, to include the positioning of Safety as a Core Value. The Board should spend at least equal time in full session focused on the quality and safety agenda, and the Board Quality Committee should take a more focused role in quality oversight – reviewing relevant data, approving credentialing/privileging data, organizational benchmarking, and review of the annual quality plan. The Board should open meetings with a moment for safety, sharing examples from harms or near-misses at El Camino and providing an opportunity to recognize "safety heros" and "great catches."

The Chief Quality Executive should assist the Board in assessing and managing gaps in knowledge. A good starting point is to administer the Institute for Healthcare Improvement's Governance of Quality Assessment to calibrate current state and develop an improvement plan.

Tactic 4 Develop a longitudinal (3-year) plan for Top Decile Performance

El Camino aspires to be recognized as an elite institution for quality and safety through designation as a Top Decile performer. This requires a multi-year effort with consistent leadership, a detailed planning and design process, and commitment from all stakeholders. El Camino leaders recognize that achieving awards and recognition as a Top Decile performer only serves as a tangible outcome from the more global need to transform quality and safety culture, and the transformation planning process will not exclusively focus on a specific award or related measures.

Recommendations

This process will be led by the Quality Executive(s). First, El Camino will assess and understand the financial, operational, and quality outcomes opportunities associated with each performance measure. It will develop and use business intelligence tools (e.g., Premier, Total Benchmark Solutions) to assess specific disease-related cost/quality variance opportunities for consideration. This analysis will form the basis of a detailed and prioritized work plan, as well as for targeting specific high-value opportunities. Next, a stakeholder education plan on each of the metrics (and drivers of the metric) will be developed and communicated. Finally, this material will be used to inform and update the annual quality plan, and to ensure the organization focuses activities and provides adequate resources.

Tactic 5 Redesign and communicate an Annual Quality Plan

To achieve the aspirational quality vision, El Camino will need to develop, coordinate, focus, align, and communicate a series of new and existing quality and safety imperatives across the enterprise and to all stakeholders. In contrast, El Camino currently has an Annual Quality Plan focused primarily on achieving CMS Value-Based metrics. During the Workshops, there was an emerging consensus that El Camino needs a clear quality and safety plan that engages all stakeholders, takes priority over other tasks, is clearly communicated from leadership to front line and medical staff, and integrates with the broader, enterprise-level financial, operational, and strategic goals. Participants expressed concern over prior false starts; the need to hardwire structure and inclusive processes within the Annual Quality Plan; the absence of an inclusive communication and education plan; and unclear lines of accountability.

Recommendations

El Camino will create an inclusive and recurring process for developing the Annual Quality Plan, ensuring that goals will: align with the long-range strategy, be focused on a set of agreed priorities, and be easily translated into tactical action items. The Plan will maximize impact on quality, safety, and patient experience, while providing clarity for the deselection of non-priority initiatives (which may serve as detractors to success if not appropriately addressed).

The Enterprise Quality Committee (representing the broad engagement of stakeholders) will host and facilitate an annual planning retreat to lay the groundwork for the Plan. High-impact items that do not make the final Plan will be maintained in a work wait-list (or Parking Lot) by the Quality Executive(s) for attention in future planning sessions. Senior enterprise leaders will communicate the Plan and associated organizational goals through multiple channels, including creating processes to monitor adherence (e.g., Hoshin X-matrix), and transparently manage course corrections.

Tactic 6 Clarify and refine the roles of other quality-related committees

Establishing a new quality management structure provides an opportunity to assess and delineate the roles of existing quality-related activities, with the goals of streamlining structure, reducing meetings and ensuring those that occur are run according to action-oriented agendas, and providing more unscheduled time for leaders and team members.

During interviews, workshops, and Steering Committee meetings, many leaders acknowledged the need to winnow and reduce redundant and unnecessary committees and meetings while preserving vital structures (e.g., MAGNET, Joint Commission specialty certifications). They identified that several key quality structures (e.g., PAMF Quality Committee, SVMD quality activities) were disengaged from the primary organizational quality structure, and that the perspectives of the medical staffs of the two hospitals were not fully aligned on vision, committee, and service lines. It was suggested that El Camino re-evaluate and clarify the role of the MEC, such that it represents all medical staff stakeholders, focuses on medical staff quality functions (e.g., credentialing, OPPE/FPPE, Peer Review) and has input into planning, design and execution of quality initiatives via an “up and over” model (similar to Memorial Hermann).

Recommendations

El Camino must perform an inventory of all quality management committees across the enterprise (e.g., MECs, MAGNET, Service Lines, IT, PAMF, Vituity, Envision, Team Health, etc.) and evaluate them for engagement, alignment, effectiveness, and accountability. The information generated from this work will be used to engage disparate committees, define authority and responsibilities, minimize overlap, reduce excess and non-value-added work, as well as redesign, align and streamline activities.

The current MEC role will evolve in a way that facilitates more unified input from all medical staff stakeholders, and enhances the MEC's ability to take a greater and more effective role in professional quality and safety accountability vis-a-vis the Credentials Committee, OPPE/FPPE, Peer Review Committees, and other direct accountabilities through updated Bylaws (e.g., required safety education). MEC leaders will represent the interests of the organized medical staff through the Enterprise Quality Council, and through "up and over" input to the Board Quality Committee. This will allow medical staff leaders to develop a more high-performing professional core without placing the entire burden for managing enterprise quality and safety on the MEC.

Tactic 7 Establish a culture of accountability

An enterprise-wide cultural transformation requires clarity around the roles of all leaders and committees to ensure that improvement efforts, and response to safety concerns, are appropriately owned, addressed, supported, and resourced. El Camino's current state has many examples of duplicated goals and metrics across multiple committees that are not working together, and often a lack of, or slowness of action on quality and safety events.

In interviews, leaders and staff expressed the desire to enhance a culture of accountability in a way that clearly delineates the roles of leaders, staff, and enterprise components (e.g., c-suite, Service Lines, MEC, nursing, private groups, PI staff).

There is active movement to democratize quality leadership by merging of several key hospital and medical staff committee structures. Interviewees expressed desire to not confine responsibilities for quality and process improvements to individual leaders, committees, and enterprise structures. Similarly, workshop participants indicated that roles and responsibilities for quality and safety be clearly defined and assigned to every stakeholder (e.g., physician, nurse, manager, patient), and that the impact of their efforts to improve quality and safety be measured, reported, and rewarded. Finally, there was a collective call for a process that holds leaders and team members accountable for assigned improvement responsibilities.

Recommendations

El Camino will implement a consistent and effective process for deployment of the Annual Quality Plan (e.g., Hoshin Kanri, ThedaCare Strategy Deployment) which uses specific tools and metrics (e.g., X-matrix,

Bowling Chart, Balanced Scorecard) to effectively create line-of-sight accountability from the front line to the Quality Plan.

El Camino will undertake an effort to clearly articulate every stakeholder's role and accountability for process improvement and safety activities, enhanced with and supported by project management tools (e.g., RACI, PICK charts, Kano charts) and a project management office (defined further below). Such structures will allow El Camino to streamline execution of quality and safety activities and to hold stakeholders accountable to assigned tasks.

El Camino must invest in leadership development of accountability and trust. This includes medical staff leaders who must have access to internal programs, supplemented by participation and access to external programs (several are currently available and tailored to their needs e.g., HCPro Greeley). Also, a robust Physician Leadership Development Academy model, in partnership with a local business school or national profession organization (e.g., Vizient) should be explored and required for department chairs and service line leaders. C-suite executives must have an individual and a group development plan, both of which are centered on teamwork and include specific team training (e.g., Human Synergistics Simulations) to optimize function and accountability. El Camino executives should determine an approach to management development that maximizes accountability and trust (e.g., Covey's Speed of Trust). An event/concern escalation model should be developed (described further below).

Tactic 8 Ensure Organizational Structure and Function Support "Quality / Safety First" Culture

Enterprise-wide establishment of standardized, quality and safety-first practices, along with the ability to ingrain them into organizational culture requires full participation of all stakeholders. In addition to current efforts to align affiliated practices, El Camino's medical staff leaders highlighted opportunities to achieve better structural and functional alignment of the two hospitals' medical staffs. Leaders also commented on how the various staffs emulate medical staff behaviors, both favorable and unfavorable to unified approaches.

Recommendations

As an adjunct to medical staff leadership development, engage medical staff leaders (e.g., medical staff leaders, department chairs, and medical directors) in planning and other activities to unify and align the hospital medical staffs and all enterprise stakeholders, including the multidisciplinary service line teams. This includes a thorough review of organizational charts with specific attention to tweaking of structural and functional organizations with the following two goals: 1) breaking down silos and promoting teamwork, and 2) facilitating achievement of zero preventable harm and high reliability performance status across the enterprise.

Component 2: Quality Organization Integration

Desired Future State: The quality organizational structure aligns resources across the system, while empowering all stakeholders with exceptional quality and safety education and improvement support.

An effective quality structure will positively impact the enterprise's quality and safety results. Interviewees, workshop, and Steering Committee attendees indicated that the current model for managing quality does not meet the enterprise's needs. Medical staff and executive leaders expressed a strong collective desire to both improve the availability and use of quality resources and strengthen support structures across the enterprise. Enhancements in Quality Organization Integration will address the following key concerns and opportunities:

Key concerns and Opportunities:

- Quality, Safety, and Process Improvement resources are in short supply within the hospital and associated ambulatory sites, and extremely limited or absent in most outpatient sites.
- The right quality and process improvement staffs with the right skill sets are not always available and system support is limited and siloed. Key safety roles are missing or folded into other responsibilities. Clinicians require more support than is available to prepare and interpret data.
- Educational opportunities for process improvement are available but access is limited to select individuals. Quality and safety education are not widely available, and onboarding education is inadequate. Frontline caregivers are many times unfamiliar with educational opportunities or quality and safety tools.
- As a resource for improvement, medical staff members are not engaged and often don't attend or participate in meetings that are relevant to their specialties. There are substantial opportunities for El Camino to formally develop Medical Staff leaders' knowledge and skills in quality, safety, patient experience, process improvement, and the impacts these have on their patients and the enterprise.

Tactics to improve Quality Organization Integration

The Current State Assessment indicated that El Camino relies on a few scarce resources to support the quality structure. One of the primary differentiators of leading quality and safety organizations is a commitment to providing skilled and motivated quality and safety staff across the enterprise and deploying them in a highly productive fashion. Staff and physicians are supported with educational offerings and tools, with tight connections to other resources (e.g., process improvement and clinical analytics), and with alignment of goals and purpose to ensure that the right processes are effectively and sustainably improved.

Tactic 1 Align hospital and medical staff goals

El Camino's current quality agenda is not well aligned between the following leadership teams: executive, medical staff, nursing, service line, and large stakeholder groups (e.g., (PAMF) which leads to confusion

(and at times friction), between the quality structures (e.g., quality, safety, risk management, process improvement), nursing councils, the medical staff office, elected medical staff leaders, and medical directors.

During interviews and Workshops, most of the leaders in these areas identified silo communication, fiefdoms to control resources, a practice of being disinvited to relevant meetings, lack of trust in paid medical staff leaders, along with lack of goal alignment. There is a reported historical lack of trust between medical staff and executive leaders, and between Mountain View and Los Gatos medical staff leaders. This leads to ineffective and unsustained quality improvement efforts, and providers "speak with their feet" by not attending committee meetings and town halls.

Recommendations

As previously described, the formation of an Enterprise Quality Council and ensuring its development of an Annual Quality Plan are the first steps to achieve alignment among stakeholders. Engaging stakeholders throughout the planning process, identifying them as leaders in quality and safety, providing support tools as further detailed below, and recognizing and rewarding involvement are key enabling factors. Given the complexity of El Camino's structure, much effort must be put into generic and specific communications. Each undertaking must have a well-crafted, stakeholder-specific communication plan to maximize coverage and "stickiness."

Since they are multidisciplinary, by design, El Camino's Service Lines can provide a key vehicle to support the quality structure, provide stakeholder input, identify relevant resource and educational needs, and drive sustainable change. However, most Service Lines are currently underdeveloped to perform these duties; a robust Service Line Development Plan (beyond the scope of this document) must be implemented to leverage and maximize their potential value in quality and safety improvement and adoption of best practices.

Tactic 2 Optimize resource distribution and reporting structures

Although El Camino quality and process improvement staffs are talented and highly motivated, our interviewees, Workshop participants, and the majority of El Camino's leaders cited significant opportunities for the enterprise to address the staff's insufficient numbers and deployment capabilities to effectively meet the current demand for their services.

PI resources report to operations and nursing, and the focus is primarily on strategies related to operations and throughput. Except for the emergency department, most ambulatory areas' needs are not addressed. A planned Lean deployment will further stretch limited resources (and management capacity) and, although there are many natural connecting points between Lean PI and Quality / Safety PI, these have not been formally developed and exploited.

Recommendations

El Camino will begin resource optimization by completing a thorough assessment of availability, skillsets, and allocation of resources against the Annual Quality Plan to identify gaps in allocation and training. Through a process of project deselection, resources will be redeployed to achieve the goals of the Plan. Ongoing resource assessments by the Enterprise Quality Committee against the short, intermediate, and long-term goals will facilitate the future alignment of budgeting and reallocation.

Tactic 3 Establish adequate project management resources

All quality initiatives require coordination, alignment, and support from related service areas (e.g., PI, IT, BI) to achieve goals. The Current State Assessment found that there was little or no formal process to charter a new quality initiative or to obtain access to limited resources. Since it appears to depend on "who you know," it also gives the appearance of being disorganized, unsupportive of critical concerns, and raises questions about possible favoritism for projects that optimize financial returns and operational efficiencies.

Recommendations

El Camino will establish sufficient project management resources to coordinate and align scare resources based on direction from executive leadership, balancing needs of the quality and safety strategy with operational and financial strategies. The project management resource will work with IT (including the CIO and CMIO) to establish an effective and efficient means to quickly access and report clinical data, and to implement high priority IT changes closer to real time.

Tactic 4 Align and enhance process improvement support

Availability, understanding and use of effective process improvement tools (e.g., cause-effect analysis, hazard analysis/control, population health analytics, benchmarking, reporting, dashboards, Epic query, and clinical variation management) will greatly accelerate El Camino's journey towards quality excellence. The Current State Assessment found that the availability and use of improvement tools is inadequate and varies significantly across the enterprise. Tool use is often limited to PI staff and select experts, and there are few or no opportunities for others to learn about tool availability and support for their use.

Recommendations

El Camino will inventory existing tools and educational offerings and reconcile them against the enterprise Quality and Safety strategy, short-, intermediate- and long-term goals to identify and fill gaps. The Quality Executive will be responsible for developing the following tools: a communication strategy to raise awareness of resources, an on-line compendium, training modules, and other educational offerings to train stakeholders about their optimal use. The help desk will be trained to provide support for these resources.

Leaders from functional areas related to these resources (e.g., PI, BI, IT, Risk, population health) will participate by developing the Annual Quality Plan to ensure availability and adequacy of resources through budgeting and pooling, and work with project management to create a structured process to request, approve, assign, and return resources.

Tactic 5 Create a mandate for enterprise-wide quality and safety training

During interviews, leaders indicated that education about quality and safety was not routinely and consistently provided to all executive stakeholders (including the Board). This was validated during a Board presentation and by hearing subsequent comments during Workshops. A Lean consulting firm (Moss Adams) will provide some education on PI but not specific to quality and safety tools, industry trends, and leading practices across all levels of the enterprise. Stakeholders desire information tailored

to their needs and roles, presented using adult learning principles. They also want the opportunity to attend external programs to identify new ideas and network with colleagues.

Recommendations

El Camino must perform an assessment of quality education and training needs across the enterprise, covering each Service Line, facility, and care site. A new education program will be developed for all stakeholders, and will address on-boarding, on-going education, and evolving needs. Educational programs will include simulation and other interactive modalities built on adult learning principles.

Over the long term, El Camino will develop a Quality Academy model that offers formal certification of added qualification, similar to the Mayo Clinic Quality Academy and Quality Fellows programs. This will ensure the development of the next generation of internal experts and champions. The curriculum should incorporate current and ongoing quality initiatives and PI projects, allowing students to serve as resources to complete these projects.

Tactic 6 Develop a Medical Staff Leadership Academy and Succession Plan

Leading organizations invest in the development and engagement of future medical staff leaders. Interviews of organized medical staff leaders indicated that there is little effort (and no formal combined effort with the hospitals) to identify and develop members of the medical staff interested in leadership roles. Many department chairs do not understand their roles, especially those that involve promoting a common standard of quality and safety vis-a-vis credentialing, privileging, OPPE/FPPE, peer review, and the setting of departmental and medical staff policies and standards. There is no formal succession of duties from the department chair, to key committee chair, to Chief of Staff and the emeritus role. As a result, medical staff initiatives are historically unsustained, and engagement poor.

Recommendations

El Camino must develop a means to engage, educate, and promote members of the medical staff. This can be accomplished by developing a Medical Staff Leadership Academy (on-site courses led by local experts but embellished by El Camino leaders), along with mentoring and participation in a meaningful project. Hybrid programs can incorporate off-the-shelf web modules (e.g., Vizient) with infrequent on-site workshops (e.g., HCPro Greeley), mentoring sessions, and a capstone project.

Further, the current Chiefs of Staff and Vice Chiefs should develop a “pathway” for medical staff leaders to become engaged and remain engaged over the course of many years, which can ensure the value of leadership development at El Camino is maximized. For example, Vice Chiefs could co-chair a safety committee, Chiefs could co-chair the Enterprise Quality Committee, and immediate past-Chiefs could chair the Credentials Committee.

Component 3: Performance Improvement Methods and Metrics

Desired Future State: El Camino is a learning and improving organization that uses sophisticated approaches to facilitate the identification, management, and monitoring of quality and safety, while simultaneously accelerating the adoption of best practices.

Leading organizations establish a rigorous performance improvement "business system" to focus efforts and accelerate quality improvement, thereby creating greater efficiencies and more consistent and positive outcomes. During interviews, executive and medical staff leaders highlighted the absence of system-wide performance improvement methods and metrics.

Revision of the current performance improvement approach will address the following strategic key concerns and opportunities.

Key concerns and Opportunities:

- Quality and safety priorities differ across enterprise components and are not aligned, leading to inadequate and/or duplicative efforts. Frontline caregivers are insufficiently involved in setting priorities.
- El Camino meetings routinely focus more on information-sharing than on creating and assigning responsibilities and timelines for action steps.
- El Camino has a significant opportunity to routinely use standard dashboards and scorecard templates (with a uniform look and feel but that also allow for customization) across the entire enterprise.
- Similarly, redefining and following the standard "El Camino way" to address quality, safety, and adoption of new and best practices can remediate today's culture of normalized deviance and the resultant clinical variation. This, in turn, will decrease risk of harm events (especially in procedural areas) and make widespread and sustained improvements possible.

Tactics to Improve Process Improvement Methods and Metrics

Tactic 1 Enhance identification of improvement opportunities

Timely identification of high value / high return quality and safety opportunities is vital to successful transformation into an elite organization. Top institutions establish systems to identify, capture, record and analyze opportunities from across their enterprises to guide the planning process. El Camino stakeholders related that quality and safety concerns from the frontline do not always receive attention from executive leaders. A recent shift to increased QRR reporting created frustration as the tool was occasionally used for blaming and creating a defensible position when issues arose. During interviews, El Camino leaders indicated that most process improvement is driven by publicly reported metrics (e.g., CMS VBP, SCIP) and regulatory requirements, and does not routinely include patients and families on a proactive basis to identify opportunities to improve the care experience.

Recommendations

El Camino will begin to actively leverage multiple stakeholders and data sources to identify appropriate opportunities for quality and safety improvements. A dedicated database will be created to capture and store input from all stakeholders and will generate regular reports for review and prioritization by executive leaders and the Enterprise Quality Committee. This could potentially evolve from the existing QRR system if the appropriate database software is identified. When available, integrated data will be used to more effectively guide improvement opportunities.

From an enterprise perspective, El Camino will leverage the Community Health Needs Assessment, outpatient practice knowledge, and regional support agencies/services to identify improvement opportunities across the care continuum (addressing both internal needs/resources and external determinates of health and care utilization).

Tactic 2 Manage prioritization of quality initiatives

El Camino initiates a range of quality projects every year. Prioritization is limited, stretching leaders and managers too thin to be effective. Leaders use phrases like, "priority/flavor of the day," "priority creep," and "too busy to get anything done" to describe the lack of prioritization and inability to deselect projects. During the Workshops, participants expressed support for a strategic plan and an enterprise led, locally implemented approach. For example, to reduce readmission for heart failure, the HVI Service Line may focus on optimizing medical management while the hospitalist service line focuses on diabetes and nutrition, and care coordination manages transportation to the follow-up appointment. Participants repeatedly expressed difficulties with frequently changing priorities.

Recommendations

The Enterprise Quality Committee will prioritize enterprise quality initiatives based on qualitative and quantitative input from local care sites, Service Lines, owned and aligned/affiliated practices. The Enterprise Quality Committee will charter Multidisciplinary Teams (MDTs) to develop detailed execution plans, and assign responsibilities, resources, budgets, and timelines. Service Lines, care cites, and other system components will develop specific quality improvement plans which are both aligned to their needs and supported by the MDTs. Standard forms and templates will be used to outline goals, priorities, and execution plans. A stringent approval process will be established to prevent priority creep or changes to priorities.

Tactic 3 Institute standard enterprise QI/PI/HRO methods (including ACA, RCA, FMEA and SSER)

A proven methodology that is adopted universally across the enterprise can serve as a powerful means to improve quality and accelerate the pace of change via a common approach and philosophy. El Camino has made significant investment in Lean education but during interviews and Workshops, participants indicated that many managers do not apply these tools independent of the PI Team. Stakeholders are not required to participate in PI projects, causing gradual loss of knowledge and skills.

The Current State Assessment also revealed that Apparent Cause Analysis (ACA) was rarely done on QRRs. Further, Root Cause Analyses (RCA) did not use an industry-accepted model (e.g., the 3-meeting process or "messenger model") and analyses were limited in number due to staff support and lack of willingness

to participate in the process (due to time commitments, pay, sense that "nothing changes," etc.). Serious Safety Event Rate methodology is not used and the current methods are both inconsistent and underreport safety concerns. Finally, an FMEA was most recently completed over a year ago (top organizations often do several FMEAs simultaneously).

Recommendations

El Camino will standardize QI/PI/HRO methods using Lean and Hoshin Kanri for improvement activities across the enterprise. The commitment to these methodologies will be highly visible and consistently communicated to all stakeholder groups. Education programs will be enhanced to provide adequate active learning opportunities for both internal and external stakeholders. Adult learning methodologies via computer-based and live simulations, learning while doing, and shared learning approaches. Knowledge and skill consolidation opportunities will be made available.

El Camino will provide required Apparent Cause Analysis (ACA) training for all managers as part of Safety Training and expect that it will be performed following all events of concern. Quality and Safety leaders will adopt an industry-standard RCA approach (TBD), and the importance of participation will be visibly communicated to stakeholders. Methods will be employed to enhance provider participation (e.g., messenger model, timing of meetings, video conferencing, etc.). Managers will release (and pay) hourly staff who need to participate in the RCA process. Leadership will adopt the SSE Classification System and SSER formula (further described below). Leadership will provide support to increase the number of FMEA to at least 3 per year, with a long-range goal of achieving 1 per month.

Tactic 4 Enhance measurement, analysis, and reporting processes / capacity

Leading institutions invest heavily in, and have an unwavering focus on structured, actionable reports and simplified and accessible reporting mechanisms. Through the interviews and workshops, stakeholders made it clear that reports are difficult to obtain, reflect "old news" rather than predictive trends, and are not action-oriented. There is a glut of Crystal and Epic Workbench reports that are not used or may not be used as intended. Efforts are under way to clean that up. Analytic resources are stretched thin due to a high number of report requests, delaying fulfillment by extended wait times (often several months). Further, reports are frequently for small projects or "curiosity" and many do not lead to local action, let alone enterprise action. Quality reports are often limited to annual incentive plan and strategic metrics, or (in the case of some departments e.g., lab), are overpopulated with stable (in control) watch metrics and details that detract from metrics of concern; interviewees desired a simplified dashboard or scorecard for efficient communication of metrics and reports relevant to their needs (e.g., a provider scorecard) and that emphasized leading metrics over lagging ones. Access to software that allows for data drilldown was also highly desired.

Recommendations

El Camino will develop a structured process (or improve upon the existing process) to allocate analytic and reporting resources. The process will account for accreditation, contractual requirements or management, public measures, and quality plan goals. It will also include an approval process to ensure that requests are properly prioritized and acted on in a timely manner. El Camino will create an enterprise-wide quality dashboard/scorecard template consistent with (or complimentary to) tools employed through Hoshin Kanri (e.g., Bowling Chart). The template will visually differentiate metrics of

active initiatives from tracking (watch) metrics and show trends and comparisons against goals and benchmarks. The template will auto-populate with pre-established metrics that will permit for the automatic generation of recurring reports. To meet the enterprise's reporting needs, El Camino will expand access to and training for Tableau, maximize Epic's reporting functions and provide training to all appropriate stakeholders.

Tactic 5 Create a consistent approach to using multidisciplinary teams and triad leadership

Multidisciplinary teams bring a diverse group of stakeholders together to design and implement solutions, leading to a more effective and sustained outcome. While El Camino uses multidisciplinary teams for many improvement projects, many stakeholders are not involved (e.g., pre- and post-hospital providers, patients and families). Workshop participants noted that projects needed greater participation from physicians and that those in outpatient settings were essentially uninvolved. Leaders proposed that engaging a physician, nurse and administrator triad would create a more efficient, meaningful, and sustained outcome from PI work. There was a widely held belief that El Camino is "burning out the high performers" by including them on too many committees and work groups. Ineffective meetings were frequently mentioned (and observed) that were populated by the same leaders and experts. This was especially frustrating for physician stakeholders and contributes to their lack of further participation. Several physicians passionately expressed concern for being actively excluded from PI projects that were impacting their work areas.

Recommendations

El Camino will create specific guidelines to achieve appropriate representation of stakeholders on quality-related structures (e.g., Enterprise Quality Committee, Multidisciplinary Teams, local improvement teams, regulatory work groups). The role of nursing in leading and managing PI activities, especially in relationship to Magnet structures, will be enhanced through a parallel dyad or triad leadership structure. Committees and other meetings will be streamlined via a Lean Meeting Initiative, and a set of meeting rules ("meeting etiquette") will be created to make meetings most effective. El Camino leaders will deliberately identify up-and-coming staff, providers, and others for inclusion on improvement teams and committees to reduce burden and burnout of high performers.

Tactic 6 Encourage and support clinicians and front-line staff in improvement efforts

Throughout interviews and workshops, it was clear that El Camino leaders, staff, and clinicians have a strong commitment to the success of the organization and want to contribute and do the "right thing" for patients and the community. During interviews and workshops, participants repeatedly expressed a desire to be "part of the solution" but needed more effective engagement/communication to be aware of activities and to make sense of data and improvement suggestions. Meeting scheduling must avoid interfering with patient care responsibilities. Staff desired support for dedicated quality time to participate in local and enterprise initiatives.

Recommendations

El Camino will revise staffing models to allow time each week for each staff member to participate in a Quality Plan-related activity (in addition to time dedicated to education). This can be achieved in part through the reallocation of time identified as "non-value add" through Lean projects. Over time, El

Camino will determine the right amount of non-clinical time for each team member that will be needed to optimize participation in quality initiatives while minimizing impact on other duties (perhaps modeled after ThedaCare or Virginia Mason). El Camino will incorporate meaningful participation monitoring into management responsibilities and use metrics to improve individual performance. In the future, integrated data and analytic capabilities will give individual staff the capability to monitor care metrics in near real-time and predict likely trends (e.g., Rothman Index peratrending, clinical surveillance systems, Advocate's sepsis program). This will enhance trust and increase individual accountability to support enterprise achievement of quality and safety goals.

Tactic 7 Promote innovation, adoption, and spread of best practice standards

Clinical variation is the enemy of quality. Leading organizations develop an approach to standardization and best practice management that prevents duplication and "lone wolf" care practices, while allowing for systematic refinement and innovation, culminating in a customized, proven, and effective care model.

During interviews and workshops, a recurring theme was that there was limited standardization and more of a "wild west" mentality (multiple pathways, customized orders, duplication of efforts, lack of teamwork and coordination). A frequent comment was that stakeholders (primarily physicians, but also nurses and other staff) who work at multiple institutions especially like El Camino because they can "be themselves" and are not held accountable to a prevailing standard(s). Participants noted that having a large and primarily independent medical staff was a particular challenge to creating care standards and protocols. Interviewees indicated that customization of care pathways (and case carts) by providers was excessive and burdensome on staff (and on IT for Epic requests). Several commented that it would be ideal to learn from other local institutions and national leading practices so as to not reinvent the wheel. Participants desired a well-managed, consistent approach to minimize clinical variation, but one that also was nimble enough to allow for research and innovation, and rapid change. It was suggested that a clinical leadership team could support and hold clinicians accountable to this effort.

Recommendations

El Camino will create a central repository of current and past quality initiatives to create a knowledge library to promote sharing and learning and reduce duplication and waste. To enhance coordination and build economies of experience, El Camino will develop enterprise "Expert Councils" (similar to those used at Mayo Clinic and Memorial Hermann). A best practice management system will be created to formalize and accelerate selection, validation, and adoption of best practices.

To reduce clinical variation, El Camino should establish a clinical leadership council with representation from across the enterprise, to act as a review and revision authority for care approaches, and to incorporate evidence-based approaches and standardization, while allowing for appropriate customization when needed. El Camino will develop multidisciplinary disease management teams to identify and support the adoption and utilization of best practices through order sets, care pathways, care coordination and other means. Adopting the CDC's 6-18 program (described below) across the enterprise is a practical, easy, and meaningful place to start this work.

El Camino will encourage innovation via development of an office of quality research and innovation. This office will identify and connect internal stakeholders with external (public and private) resources

interested in measurably accelerating clinical quality and safety, and promote multidisciplinary research efforts with industry, government (e.g., CDC) and academic partners.

El Camino will also encourage external engagement to share and learn for other organizations (e.g., IHI Open School, Premier Collaboratives). Over time, El Camino will lead the development of a regional collaborative for sharing of best practices (e.g., Indianapolis Patient Safety Coalition).

Component 4: Journey to become a High Reliability Organization

Desired Future State: Safety is El Camino's DNA, where anticipation, safe behaviors, process reliability, and resilience engineering lead to zero preventable harm.

Leading high reliability organizations have adapted to managing the unexpected by creating exceptionally prepared cultures. They have a pre-occupation with failure, noting that small inconsequential errors are a symptom that something is wrong. They pay attention to what is happening on the front-line and encourage diversity of experience, perspective, and opinions at the point of care/decisions. These organizations develop capabilities to detect, contain, and bounce back from error events when they do occur, and push decision-making down to team members and proximate others who have the most related knowledge and expertise. The most advanced organizations study how processes go right, and use human factors engineering to gain 100% reliability.

Finalizing and following the strategic plan ("taking the journey") to become a High Reliability Organization will address the following strategic key concerns and opportunities.

Key concerns and Opportunities:

- Safety is currently not a Core Value and leaders can jumpstart El Camino's high reliability journey by communicating Safety as a Core Value now. What this means is that all stakeholders must team together to ensure that El Camino never creates or endures a situation where preventable harm can occur to a patient, team member, or clinician.
- El Camino has not successfully established and followed a set of safety behaviors or safe communication protocols.
- Establishing a formal "Fair and Just Culture" for staff, one that meaningfully engages physicians in safety programs and peer review, and will serve to ensure and enforce practicing safe behaviors throughout the enterprise.
- Leader rounding for safety can be effectively stepped-up by addressing how to encourage and supportively recognize stakeholders for voicing safety concerns, while skillfully managing potential conflicts. Inclusion of Patient Safety leaders can help ensure success, which includes constructive, post-rounding follow-up and more widespread use of accepted tools for error prevention, safety communication and causal analysis.

Tactics to enhance the Journey to Become a High Reliability Organization

Tactic 1 Define Safety as a Core Value and vision of the journey

El Camino's aspirational vision for its quality and safety transformation includes having zero preventable harm. A large gap exists between the level of what reliability could be in patient care and the level patients and other stakeholders actually encounter across the enterprise, today. Safety is a well-defined science and multiple institutions have demonstrated that safety can be improved through the right mix of people,

process, and system design. In a discussion with the Board, we highlighted the analogy that high reliability is the chassis for improving all dimensions of quality of care, patient experience, growth and finance.

In interviews and workshops, participants repeatedly stated that the "burning platform" and call to action to consistently and reliability deliver safety were not clear. This is despite a strong desire to ensure safe care, reduce suffering, and improve El Camino's Leapfrog score to an "A." Participants also expressed concerns about a lack of transparency regarding safety (e.g., events, data, learnings), as well as a vacuum in the organizational culture that allows for unsafe individualist practices to exist.

Recommendations

El Camino will adopt the proposed vision statement that includes the aspiration of zero preventable harm. The Board will adjust the current statement of Values to add "Safety" with quality, calling out that high reliability is the foundation (the "DNA") of quality care (and all other pillars). El Camino will develop and adopt a "lead with safety" program (e.g., Ascension Health's Journey to Zero, WellStar's Safety First, Lee Memorial's SafeLee) to demonstrate a deep, lasting, and meaningful commitment to this value, and will incorporate a publicly stated goal of zero preventable harm. Transparency regarding safety will serve to motivate all stakeholders to more aggressively learn and participate in El Camino Health's High Reliability Culture transformation.

Quality and Safety will be on the agenda of every strategic meeting, and senior leaders will decisively prioritize these values in front of team members. Job roles and medical staff requirements will be modified to improve responsibility for and accountability to quality and safety improvement.

Tactic 2 Redefine the Safety Huddle and Implement Safety Leadership Methods

Leading organizations ensure that Leaders model the route to safety by setting expectations and both frequently and consistently demonstrating good examples for safe behaviors. Leaders model, inspire, train, encourage, and set the cultural tone. Leaders use accountability methods to reinforce sound practices, discipline those who make unsound choices, and support those who experience a true human error. Leaders also remove barriers to safe practices.

The morning leadership huddle was observed on several occasions as being primarily focused on operational issues and information sharing, rather than meaningful dialogue on risks, awareness, diligence, and focus on what may harm the next patient or staff member. There was no transparency for harm risks and safety events.

Recommendations

El Camino will redesign the morning leaders' huddle to focus primarily on patient and team member safety (and use visual means with other communication tools to share operational data). The huddle, leadership meetings, MEC and Board meetings will be used to share real safety stories (patient and staff – good, bad and ugly), and meaningfully recognize and reward team members for safety-related actions.

El Camino will develop a leadership tool kit for all executive and medical staff leaders, provide training, and monitor use. The tool kit will include techniques to lead the safety journey (e.g., how to encourage reporting, educating for safety, having a moment for safety in each meeting, sharing lessons learned), build accountability (e.g., rounding to influence, 5:1 feedback, red rules, fair and just culture), and finding

and fixing problems (e.g., stop the line, top 10 work list, action planning). Leader performance evaluations will incorporate measures of safety leadership.

Tactic 3 Implement error prevention behavioral tools and expectations for all stakeholders

A variety of behavioral tools have been developed and implemented by high reliability organizations to lower the risk of errors and preventable harm. Taken together, these safety tool kits are easy to use for coaching and adoption, facilitating stakeholders' moves from reactive to proactive approaches, and ensuring that as much goes right as possible at the point of care. Tools include: setting a minimum number of safety absolutes (e.g., Red Rules) – those rules that should never be broken without consequences (e.g., 2-patient identifiers), using evidence-based care bundles, using tools to improve situational awareness or cope with fatigue, improving communication, and promoting a questioning attitude.

During the Current State Assessment, participants could not articulate a specific set of tools used for error prevention (outside of SBAR, which is inconsistently used). Instead, they stated that they rely on prior training, intuition, and defer to experts or the physician in charge. Participants recognized that errors and preventable harm occur at El Camino, and at least two interviewees indicated during the course of routine conversation that they would not seek care for themselves or their families at El Camino due to known safety risks.

Recommendations

El Camino will develop evidence-based care bundles for specific high-risk clinical areas and implement widely accepted error reduction tools and checklists (e.g., The WHO Safe Surgery checklist). A Safety Behaviors toolkit will be developed, and customized for leaders, physicians, and staff. An education program will be developed as part of the roll-out and feature a multi-disciplinary cast so that all stakeholders can relate to the importance and new expectations. Safety coaches will be identified, developed, and time-protected so that they can do on-site education, peer-to-peer mentoring, and serve as resources for safety communication. El Camino will develop and field a teamwork program (e.g., TeamStepps, CUS) to decrease power gradients and improve interpersonal communication.

El Camino's malpractice insurer (Beta Healthcare) reportedly has a variety of safety program offerings (obstetrical safety, TeamStepps, Beta Heart, ED safety) that they either provide or support at no cost to the participants. This needs to be explored and further considered.

The enterprise will be more open about sharing performance, successes, and failures, with the common goal that every patient should receive the highest quality and safest care, and have the best care experience, at every encounter, regardless of time, location, setting, spoken language, etc.

Tactic 4 Establish key Safety Leadership Roles, including a medication safety officer

Although safety is everyone's responsibility, some areas are so high-risk that leading organizations have developed a select group of individuals to intensely focus on process, protocol, technology, and human factors. For example, the Institute for Safe Medication Practice (ISMP) recommends that hospitals have a dedicated Medication Safety Officer to identify and manage high-risk situations and provide continual coaching and resilience engineering across the organization.

During the Current State Assessment, participants identified that medication safety was a concern and that no one individual was the designated "go-to person". The ISMP newsletter is disseminated but processes are not necessarily identified and improved as a result. Further, there were no designated physician safety champions (beyond the CMO and associate CMO) and no physician leader(s) in the Operating Rooms (e.g., Chief Surgeon or Surgeon of the Day) that can adjudicate safety issues in real time. Several physicians expressed interest in serving as a local safety champion. The Patient Safety Officer is over-committed with duties and meetings, leaving no time for proactive work on safe design or reliability culture.

Recommendations

El Camino will promote or hire a medication safety officer (1 for every 300 beds); they will lead medication safety improvements based on best practices from the ISMP. El Camino will assess their position of Radiation Safety Officer to ensure that safety is managed proactively, especially ionizing radiation exposure monitoring for staff and providers in high risk areas (e.g., cath lab). Physician safety champions will be identified, trained, and engaged in the enterprise high reliability transformation. Working with hospital leaders, service line and medical staff leaders, a chief surgeon or surgeon of the day will be identified and trained to promote compliance with established and evidence-based safety practices in procedural areas. El Camino will add additional support resources for the Patient Safety Office, especially as safety reporting, educational programs, and RCAs increase.

Tactic 5 Develop safety communication tools, dashboards, and recognition programs

Leading organizations use a variety of tools to disseminate safety information, situational awareness, real-time surveillance, and systems to provide earlier warnings for potential harms. Many use a Safety Alert for immediate "cut through" communication that requires a signoff by either each individual team member or a member of the area management. Real time surveillance tools (e.g., automated sepsis monitoring, staffing alerts, weather alerts, Epic Epi-surveillance) are developed to further harden these organizations to prevent harm before it happens. When harms are averted, leading organizations have a culture of reward and recognition for "great catches" on the front line, for breakout safety champions, and for specific program initiatives.

During interviews and workshops, stakeholders indicated that dissemination of safety information is inadequate. Stakeholders are unable to get usable surveillance data beyond staffing and weather (pulled rather than pushed to them). There have been recognition programs for great catches, but they have not been sustained over time.

Recommendations

In addition to the Safety Huddle, El Camino will develop a series of communication tools to allow for immediate frontline communication and education to decrease the risk of preventable harm. This will include internal dashboards that show the SSER (including Faces of Safety) to better personalize otherwise impersonal data. The Quality Executive will oversee a review of available surveillance tools (e.g., Rothman Index, sepsis indicator tracking, staffing for surge, holidays, participation in DICON, etc.) and recommend approaches for discussion and action by the Enterprise Quality Committee. El Camino will develop a multi-level program for reward and recognition of safety catches and safety champions.

Tactic 6 Launch industry standard tools for causal analysis

Leading organizations use a combination of Apparent Cause Analysis, Root Cause Analysis, annual Common Cause Analysis, and Failure Mode and Effects Analysis to evaluate individual and grouped events and get a sense of their "safety health."

Current State Assessment revealed that only 12 RCAs were completed last year, despite many more concerning safety events being identified through the QRR system. Stakeholders indicated that they have not received adequate training on ACA, RCA or CCA, and time is not made available to participate in these activities. A FMEA is done in compliance with regulatory needs / policy, which is about every 18 months.

Recommendations

El Camino will adopt industry standard tools for causal analysis, train staff on their use, provide time for participation, and develop a series of internal experts to provide on-site consulting and to refine reporting. El Camino will increase both the use of Root Cause Analysis to better reflect a more accurate SSER, along with the number of FMEAs to better identify and manage potential fail points.

Tactic 7 Enhance Environmental Reliability and Emergency Preparedness

Emergencies impact the entire community and can disrupt utilities and other resources, services, and transportation access to and from care sites. Well-prepared organizations have developed a Continuity of Operations Plan (COOP) that goes beyond essential business and IT functions to include essential clinical care functions. For example, learnings from a disaster that impacted a hospital in Joplin, MO included always having easy access to key information attached to every patient, i.e., the patient's name, disease, medications and their administration (which may not be available if there is a loss of IT systems). Similarly, leading institutions use simulated exercises (sometimes including actors as patients) to prepare staff and providers for some of the most challenging events, e.g., vertical and horizontal evacuation, as well as care management during IT systems loss. They also have visitor management systems to reduce the probability of an uncontrolled public disturbance or active shooter scenario.

Interviews revealed that El Camino has a very good emergency management program that includes thorough Hazard Vulnerability Analysis done in partnership with other regional facilities, and regularly scheduled drills. This is reassuring given the urban location and seismic activity in the area. However, drills have poor participation by many stakeholders (especially physicians outside of the ED) and may not take full advantage of other community resources (e.g., police, fire, EMS, public health, urban search and rescue) that would be involved through a FEMA/NIMS Unified Command structure. A COOP is under development by a consultant but the process should be reviewed to ensure attention to these issues.

Tours of the emergency department and multiple entrances reinforce the need to optimize the environmental safety plan. There is no visitor management except for a reduction in available entries at night. Propped doors (that should have been secured) were observed. Several interviewees expressed concern for their safety in the emergency department and elsewhere, citing that other area hospitals use some form of management system (e.g., IDs, greater security presence, physical barriers).

Recommendations

El Camino will evaluate and modify the emergency management program to ensure greater coverage of patient safety issues and optimized engagement with community partners. This will include working with the COOP development team to ensure a focus on clinical issues. Planning will incorporate medical staff leaders to ensure better participation through the organized medical staff. El Camino will assess visitor management and implement a program to improve stakeholder safety.

Component 5: Culture of Quality and High Reliability

Desired Future State: Quality, safety, and High Reliability are woven into the cultural fabric that is El Camino Health, and every stakeholder is engaged, empowered, incentivized, and supported in their individual and team efforts to achieve quality, safety, and experience excellence.

El Camino aspires to have a successful and sustained transformation to be a national quality and safety leader. However, stakeholders indicate that the organization's culture appears to prioritize financial performance and efficiency over all other initiatives. In sum, El Camino has not yet established quality and safety as a defining identity.

Key concerns and Opportunities:

- Senior leaders (executives and medical staff) must leverage their newfound traction and continue to gain momentum by refining and following the Strategic Roadmap to achieve the culture change that is defined by leading with quality and safety.
- Counter today's variable leader commitment to quality by leadership development (at all levels) and ensuring prioritization of quality and safety related activities.
- Build on the few current formal reward and recognition programs for any stakeholders or teams whose performance meaningfully exceeds expectations to improve quality, safety, and patient experience.
- Overcome any remaining barriers to engaging patients and families in improvement efforts and ensure plans are in place to achieve their participation.

Tactics to Weave Quality, Safety, and High Reliability into El Camino's Cultural Fabric

Tactic 1 Demonstrate meaningful leadership commitment

To inspire the El Camino enterprise to achieve quality and safety excellence, all senior leaders must demonstrate a visible commitment to quality and safety and reinforce this commitment, daily. Organizations such as Memorial Hermann have Board members actively engaged as safety champions, and other non-hospital leaders have become nationally recognized for their commitment.

During the Current State Assessment, it was evident that El Camino's leadership is not uniform and consistent in their approach to and visible commitment to quality and safety. The CEO and CMO were called out by a number of participants as being available, communicating and supporting both enterprise and local goals, which is a change from the past. Stakeholders indicated that they would like for service line and facility leaders to visibly lead targeted quality and safety efforts in collaboration with frontline staff.

Recommendations

El Camino must clearly outline and hold senior leaders (executives and medical staff) accountable to a visible commitment to quality and safety (e.g., huddle participation, organized "quality moments," safety

articles in internal and external publications, rounding for purpose, town halls, rapid response to safety events and concerns). They are uniquely responsible for regularly reinforcing quality and safety goals and expectations. Leaders must meaningfully participate in quality committees and multidisciplinary teams, and over time, balance time commitments equally between quality, finance, and operations.

Tactic 2 Refine the HR and medical staff recruiting process

Leading organizations place great emphasis on cultural fit during the hiring process, selectively hiring or contracting with candidates who strengthen and improve the commitment to the culture of excellence.

During the Workshops, it was a collective desire to refine the hiring process to select individuals who shared El Camino's aspirational vision for quality and safety. Similarly, it was discussed that the medical staff needs to evaluate and deselect physicians who do not share a common vison for and commitment to quality and safety.

Recommendations

El Camino Human Resources will evaluate and, if needed, refine the hiring process to incorporate specific "quality values" that align with enterprise values. It will be helpful to define relevant attributes for a pre-hiring assessment. Quality and safety will be included as essential components of all job descriptions; over time, specific participation in quality and safety efforts will also be clearly stated. An increase in the performance incentive plan value for quality and safety will send another clear message of intent and focus across the enterprise.

The Medical Staff Credentials and Privileging process must be optimized to right-size the medical staff to community need, and to emphasize that it is a privilege to practice at an El Camino facility. Practitioners must be held accountable through this and the Peer Review process for quality and safety, moving away from an "open medical staff, do what you want, where you want, when you want, without accountability" approach. For high-risk procedures, effort should be made to prepare the provider and supporting staff through pre-procedure briefing and simulation, to reduce the probability of errors and increase efficiency. The MEC must require a minimum annual curriculum for quality and safety for all members and deselect those members who do not comply with training requirements or actively chose to thwart enterprise efforts to achieve quality and safety excellence.

Tactic 3 Implement and promote the use of Fair and Just Culture practices

Most everyone makes errors, and healthcare delivery is a high-risk environment that increases the chances that an error will occur. Leading institutions find that many common errors can be avoided by each individual practicing low risk behaviors, and by peer checking (200% accountability). A Fair and Just culture balances "no-blame, no-shame" at all levels where every individual is held accountable but true human error is not punished.

The Current State Assessment found that there was no formal Fair and Just Culture practice implemented at El Camino. The QRR system is at times used for blame or to create a defensible position. Interviewees reported deviant behavior among staff and physicians that went ignored and unmanaged, and they did not feel supported when reporting concerns or seeking assistance. The Culture of Safety Survey demonstrated a decline in scores from questions on reporting and the ability to raise safety concerns.

Recommendations

El Camino will evaluate, implement, and promote Fair and Just Culture practices. El Camino's malpractice carrier (Beta Healthcare) offers this at no charge to other institutions and may do the same for the enterprise. Of critical importance is that all stakeholders feel safe and supported when voicing their concerns. Further, they are encouraged to seek assistance when concerns for quality and safety of care delivery is being threatened. Supervisors, Managers, and key members of the medical staff will be trained to assess fatigue, workload burden and burnout, and to redistribute work (or seek help in redistributing work) when safety is threatened. El Camino must set a goal that everyone feels respected in every work-related interaction.

Tactic 4 Optimize Quality and Safety Reward and Recognition Programs for all Stakeholders

Leading organizations pay significant attention to cultural enablers, especially celebrating success of teams. El Camino has the opportunity to introduce rapid rewards and recognition (in addition to the annual performance plan and immediate recognition programs) designed to motivate stakeholders and enable enthusiastic support of the quality and safety vision.

Current State Assessment and Workshop input indicated a lack of quality and safety-related rewards and recognitions. Participants indicated that there were few incentives to go "above and beyond" or take extra time to improve quality. The consensus was that both monetary and non-monetary incentives would make a meaningful difference in support of quality and safety

Recommendations

El Camino will evaluate and optimize reward and recognition programs for all stakeholders, developing a range of monetary and non-monetary rewards (e.g., public recognition, leadership opportunities, PTO, financial bonuses, car wash certificates, Continuing Education credits, etc.) to incentivize stakeholders. Leaders will ensure that incentives are timely, related to performance, and monitor the impact of the program over time. Conversely, El Camino's quality culture will ensure that underperforming stakeholders are included in a "manage up or manage out" process.

Tactic 5 Increase transparency of quality and safety outcomes

Transparency is a powerful catalyst for change (no one wants to be less than an "A" student). Leading organizations use public metrics and agency ratings (e.g., Leapfrog) as an opportunity to motivate team members to quickly and measurably improve patient care, while making a clear commitment to the values of quality and safety, and needs of the community.

El Camino stakeholders indicated that there is little transparency for measures of quality and safety (outside of HVI and Cancer registry data being shared on the El Camino website). During the Workshops, participants indicated that sharing data could create healthy competition between teams and units and motivate better performance. Also, sharing of data was seen as signaling a new direction for the organization towards prioritizing quality and safety.

Recommendations

El Camino will begin disseminating quality and safety data internally to overcome barriers and prepare the enterprise for greater external sharing. After adequate time and with appropriate legal approval, El Camino will begin publicly sharing CMS Quality data and measures around select conditions. Over time, El Camino can leverage its leadership position in transparency to create a regional or statewide collaborative – such as the Indianapolis Patient Safety Coalition and the Wisconsin Collaborative for Healthcare Quality – that will significantly improve statewide transparency and create opportunities for shared learning.

Tactic 6 Increase Patient, Family and Caregiver involvement in quality and safety efforts

Patients and families are historically one of the most underutilized resources for quality and safety initiatives. Leading healthcare organizations consistently involve patients as active participants, advisors, and even leaders for improving quality, safety, and care experience. Some organizations require a patient or family member on all Process Improvement teams.

El Camino participants in the Current State Assessment agreed that the enterprise has substantial opportunity to engage patients and families. While there is a Patient Family Advocacy Council, it is not leveraged to identify participants for committees, PI teams, or to serve as advisors or observers.

Recommendations

El Camino will enhance the existing Patient Family Advisory Council, using the existing members to solicit input on how to engage them in quality and safety opportunities and initiatives. El Camino will identify other areas where Patient/Family input is valuable, including but not limited to identifying metrics that are meaningful to patients, community needs, advocacy issues, business strategy, etc. Patient representatives will be identified for the Enterprise Quality Committee and Multidisciplinary Teams. Over time, patients will be included in clinical care teams to serve as objective observers, as voices for consideration of care alternatives, and to lend thoughts into care model redesign.

Short Term Actions – Rapid Visible Results

It is critically important for El Camino's leadership to demonstrate a highly visible commitment to quality and patient safety. A single powerful change in structure, process or protocols can signal to all stakeholders the importance of the start of your quality and high reliability journey and set the stage for renewed organizational focus and enthusiasm for the quality vision.

El Camino has attempted to "reboot" a central focus on quality and patient safety several times over the past five (5) years. During interviews and Workshops, participants made references to the Greeley Report, the "Single Big Dot" and other activities that were enthusiastically kicked off and passionately promoted by individuals leading the organization at that time. However, most of these efforts quickly failed and few identifiable initiatives remain in place today. Participants indicated that they now require reassurance that this is not just another "flavor of the month" but rather a true enterprise transformation that will be sustained and transcend the current leaders.

El Camino leaders - executives and medical staff - either through existing forums or as the first action of the new Enterprise Quality Committee - must select and implement a significant change that can be rapidly designed and implemented. The Current State Assessment uncovered many examples of such "low-hanging fruit." For example:

- Redefine the morning Huddle to focus on patient and employee safety.
- Implement the WHO Safe Surgery Checklist to create a common standard of pre-operative care and reduce surgical site infections.
- Revamp the ACA and RCA process, and transform a sluggish and incomplete program to a rapid-response and value-added activity.
- Collect, assess, and visibly report on Serious Safety Events, including SSER and "faces of safety," and pave the way to create and leverage a true "burning platform" to implement high reliability training and tools.

Ideally, these changes will quickly have direct impact on leading indicators and metrics that will help to achieve FY20 performance goals. Subsequently, the successful change must be communicated widely and championed as being a leading indicator of El Camino's commitment to improving quality and patient safety.

Leadership, through the Enterprise Quality Committee, must also immediately lay the groundwork for several intermediate (6-9 month) projects that demonstrate sustained and visible efforts and lead to FY 20 (and beyond) goal achievements. These projects will take additional time to plan and resource but demonstrate a meaningful commitment to sustainment while inspiring organizational excellence. El Camino can also leverage the planned expansion of the Lean Process Improvement program to provide expertise and support for the design and implementation of these initiatives. Examples of high-impact, high visibility projects with enterprise-wide impact that can be completed during FY 20 include:

- Lean out meetings by creating El Camino's "meeting etiquette," supported by scheduling tools and action-oriented agendas, giving time back to all Stakeholders for attention to patient matters.

- Establish a Discharge Center model to improve safe patient transition to post-acute settings and decrease the rate of readmissions and medication errors.
- Address OR inefficiency through Lean PI and policy changes that improve on-time starts (from the current ~60% rate), room turn-around, and capacity management.
- Develop and begin training to a set of Safety Behaviors and Tools for Leaders, staff, and physicians, which will improve throughput and patient experience, while decreasing morbidity and mortality from preventable harms.
- Implement an interdisciplinary teamwork training program, beginning with the C-Suite, to address the greatest concerns from the Culture of Safety Survey and improve team communication.

The Enterprise Quality Committee must also begin to develop, design, and implement plans for long-term projects that will leverage the transitional and future quality and safety management structures. A highly important focus during FY20 is an enterprise-wide rollout of High Reliability training, using associated support tools and resources. Additionally, the Committee must begin to focus on and plan for changes that will impact the organization during a 3-year timeframe that will affect quality activities. These may include expansion of bundled payment programs, changing focus of publicly reported quality measures towards more predictive metrics, and changes to the structure of the organized medical staff (and the need for a Clinically Integrated Network to achieve more complex and meaningful enterprise quality goals). The CDC's 6-18 program (6 chronic diseases, 18 evidence-based interventions) provides an excellent long-range clinical project that aligns multidisciplinary teams, services lines, hospitals and outpatient (owned and aligned/affiliated) practices that can both refine the new model and build enthusiasm around the transformation. A similar evidence-based program that will impact patient mortality and resource utilization across the care continuum is the ABIMF "Choosing Wisely" program.

In parallel to the long-range activities, El Camino should consider the following initiatives:

- The El Camino Foundation could develop a strategy to identify ancillary financial support for specific quality / safety efforts and innovation work towards developing best practices.
- El Camino leadership could explore partnerships with academic institutions to identify opportunities for graduate student projects, internships and capstone projects that achieve the above tactics.
- El Camino executive and medical staff leaders could explore a more formal academic affiliation with regional medical schools to bring more trainees on site. While the presence of trainees creates new safety concerns, it also serves to drive attention to detail and adoption of evidence-based practices (and those benefits usually outweigh the risks).

Risk Mitigation Strategies

By implementing a Quality and Safety Strategy, El Camino is signaling a renewed effort to achieve enterprise-wide quality excellence in pursuit of its new Quality Vision. This strategy was developed using a highly inclusive and consensus-driven approach in an effort to create a viable and sustainable transformation plan. To ensure that planning and initial execution are successful, several critical factors must be actively managed in support of the Strategic Roadmap:

Action	Logic	Accountability
Appoint an owner	An appreciable obstacle is the lack of clear ownership that threatens this effort. This plan cannot suffer the fate of those that came before. To ensure progress, El Camino must assign ownership and accountability, and a formal executive leader with organizational stature and gravitas to drive this effort forward. The current Steering Committee should remain in place to assist this quality executive(s) in the next phase of implementation.	CEO CMO
MEC leader engagement	The fragile relationship between the MEC leaders and executive leaders needs immediate and continued attention and nurturing. Engagement across the three generations of Chiefs of Staff is needed to develop ideologic continuity and garner positive and supportive communication to the organized medical staff. Future leaders need to be identified and engaged, and investments made in their leadership skills.	CEO CMO Quality Executive Chiefs of Staff
Board and C-Suite development	Although much effort went into engaging and aligning key stakeholders to prepare this Roadmap, neither Board members (by request) or some C-suite members were fully engaged, and many members of the C-suite (by nature of their busy schedules) were only peripherally involved in discussions about quality and the priorities to pursue. El Camino should not underestimate the leadership team's upcoming effort and support that will be required to achieve true stakeholder alignment in pursuit of realizing El Camino's Quality Vision. In other words, now is the time to engage the Board and all C-suite members in active pursuit of High Reliability success.	CEO Quality Executive
Maintaining a sense of urgency	The Quality and Safety Strategy planning effort was communicated as a priority and a pivotal enterprise effort, aptly timed given the recent decline in Leapfrog scores, Culture of Safety Results, enterprise rebranding, engagement of Moss Adams re: Lean, and changes to the marketplace, including the purchase of physician groups by	CEO CMO CNO Quality Executive Chiefs of Staff Board Chair

	El Camino. The table has been set for a true cultural transformation. While several C-suite leaders expressed concern for organizational overload and whether staff could tolerate another major initiative at the onset of our engagement, this has largely dissipated when the Quality and Safety Strategy planning effort was communicated as a priority. Feedback during our interviews and workshops directly contradicted this concern, showing that all stakeholders are hungry for change. In essence, all stakeholders so far (we have not yet engaged patients and families) have shown significant enthusiasm and commitment during the planning process, and the table has been set for a true cultural transformation. If this effort is delayed due to perceived conflicting priorities, the loss of momentum will be devastating. Physician leaders will lose trust in enterprise executives, managers will feel a further sense of isolation and helplessness, team members will be discouraged, and patients (and the community) will not reap the benefits of improved quality and safety (harms will continue). Failure to promptly launch will compromise this and other future efforts. Parenthetically, effective branding and communication, featuring the voices of stakeholders, will enhance and accelerate urgency and implementation.	
Ensuring resource availability	Some of the tactics outlined in the Strategic Plan can be achieved with existing resources, while others will likely require investment – either one time or ongoing. The IT requirements alone for data mining and reporting requirements should not be underestimated. It is important to review and approve this plan with the understanding that the detailed operational plan will include proposals for funding associated with tactics.	CEO COO CIO Quality Executive

As El Camino succeeds with its Quality and High Reliability transformation, the enterprise will achieve significant progress towards its aspirational True North goal, and staff, patients and the community will benefit. As El Camino moves forward, the enterprise should anticipate the opportunity for national publications and presentations to share its accomplishments, elevate the brand, and be recognized as a leading practice which others aspire to emulate.