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

Monday, October 7, 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 (9/9/2019) ***Information*** b. FY20 Quality Dashboard c. FY20 Pacing Plan d. Progress Against FY20 QC Goals e. Hospital Update f. Annual Performance Improvement Reports			
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**information 5:35 – 5:45**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**discussion 5:45 – 5:55**
6.	**FY19 ORGANIZATIONAL GOAL SCORE** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO	*public comment*	**possible motion 5:55 – 6:05**
7.	**FY20 ORGANIZATIONAL GOAL METRICS** **ATTACHMENT 7**	Cheryl Reinking, RN, CNO	*public comment*	**possible motion 6:05 – 6:20**
8.	**PATIENT EXPERIENCE STRATEGIC PLAN** **ATTACHMENT 8**	Cheryl Reinking, RN, CNO		**discussion 6:20 – 6:50**
9.	**REVISED QUALITY COMMITTEE CHARTER** **ATTACHMENT 9**	Cindy Murphy, Director of Governance Services	*public comment*	**possible motion 6:50 – 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: - Serious Safety Event/Red Alert Report	Cheryl Reinking, RN, CNO		**discussion 7:27 – 7:42**
15.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:42 – 7:43**
16.	**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.			
17.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:44 – 7:45pm**

Upcoming Meetings:

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

Educational Sessions: October 23, 2020 (with Hospital Board); 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, September 9, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present
Terrigal Burn, MD
Caroline Currie
Alyson Falwell
Peter C. Fung, MD
Julie Kliger, Chair
George O. Ting, MD, Vice Chair
Jack Po, MD
Krutica Sharma
Melora Simon

Members Absent
None

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. A silent roll call was taken. Committee member Melora Simon joined the meeting at 5:50 pm during Agenda Item 7: FY19 Organizational Score. 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. No items were pulled. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee (8/5/2019); and for information: FY19 Quality Dashboard; ED Patient Satisfaction; FY20 Pacing Plan, Progress Against FY20 QC Goals; Hospital Update; and Annual Performance Improvement Reports. **Movant:** Po **Second:** Ting **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma **Noes:** None **Abstentions:** None **Absent:** Simon **Recused:** None	***Consent Calendar approved***
4. INTRODUCTION OF NEW MEMBERS	Committee members and staff present participated in a round of introductions.	
5. REPORT ON BOARD ACTIONS	The Committee reviewed the Report on Board Action as provided in the meeting materials. Chair Kliger commented that the full Board is very interested in becoming more informed about quality.	
6. PATIENT STORY	Chair Kliger commented that the Patient Story will no longer be on the consent calendar, but rather a discussion item to ensure the Committee does not lose the patient voice in its discussions. Mark Adams, MD, CMO, reported that the patient story highlights that the	

	recent procedural changes in the Operating Room are going well from both the patient and physician perspective. He noted that there is still some resistance to change, but it is minimal. The Committee members discussed whether the patient should have a choice as to whether or not to be sedated during the checklist procedure.	
7. FY19 ORGANIZATIONAL GOAL SCORE	Cheryl Reinking, RN, CNO, reported that the organization achieved target for the HCAHPS domains of Nurse Communication and Responsiveness and maximum for Cleanliness. Ms. Reinking also explained how the metrics were originally set. Dr. Adams reported that the Mortality index is currently at 0.97, target was 0.95 and minimum was 1.0. He also reported that readmissions data is not in yet. In response to questions, Dr. Adams and Ms. Reinking reported that ECH patients return approximately 300 responses to the HCAHPS surveys each month. They also commented that moving these metrics is difficult even though the movement is small. Committee member Burn agreed. Chair Kliger asked that going forward the metrics be presented with more context (*i.e.*, previous year's results and results from other Bay Area hospitals). **Motion:** To recommend the Board approve the FY19 Organizational Score for the HCAHPs goals in the domains of Responsiveness, Nurse Communication, and Cleanliness. **Movant:** Ting **Second:** Simon **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None FY19 scores for Mortality and Readmissions will need to be brought to the October meeting.	***HCAHPS Goal Achievement for FY10 recommended for approval***
8. FY20 ORGANIZATIONAL GOAL METRICS	Ms. Reinking explained the FY20 HCAHPS goals in the domains of Responsiveness and Discharge Information. In response to questions, Ms. Reinking explained that the FY20 minimum goal for Responsiveness may appear to be lower than what was achieved in FY19, but the proposed measurement period and baseline for FY20 are different than FY19's. The FY20 baseline is a full 12 months, rather than Q4, and so is the measurement period. Chair Kliger requested that columns be added to the report to show results for California, the nation, and the Bay Area. Staff was also asked to annotate the run charts with tactics and interventions aimed at improving the metrics. **Motion:** To recommend the Board approve the FY20 HCAHPs goal metrics for the domains of Responsiveness and Discharge Information. **Movant:** Po **Second:** Ting **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***HCAHPS Goal Metrics for FY20 recommended for approval***

	FY20 metrics for Mortality and Readmissions will need to be brought to the October meeting.	
9. QUALITY AND SAFETY STRATEGIC PLAN	Dr. Adams reviewed the process that management used to develop a Quality and Safety Strategic Plan over the past 6 months as well as the national definition of Quality: Safe, Timely, Effective, efficient, equitable and patient centered ("STEEEP"). He explained that ECH currently has average quality and safety performance, but aspires to be a top tier organization and achieve zero preventable harm. Dr. Adams reviewed five strategic opportunities and described the plan to improve in these areas: 1. Leadership, Governance and Management 2. Quality Organization Integration 3. Performance Improvement Methods and Metrics 4. Journey to become a High Reliability Organization 5. Achieve a Culture of Quality and High Reliability Committee members asked questions about (1) the roadmap to achieve the plan, *i.e.*, what happens in year 1, year 2 and year 3? (2) outcome measures vs process, (3) what will be addressed first? Perhaps it should be physician-nurse culture, (4) what is senior leadership going to change make the plan real? The Committee requested that the plan be brought back to the next two Quality Committee meetings for further discussion.	
10. PUBLIC COMMUNICATION	There was no written or oral public communication.	
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:45pm. **Movant:** Po **Second:** Fung **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 7:45pm***
12. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 8:10pm. Agenda items 12-16 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (8/5/2019); and for information: Medical Staff Quality Council Minutes.	
13. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 8:11pm. **Movant:** Fung **Second:** Ting **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 8:11pm***

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 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/Chief Quality Officer
Date: October 7, 2019
Subject: FY20 Quality Dashboard

Purpose: To provide the Committee with a snapshot of the FY 2020 metrics monthly with trends over time and compared to the actual results from FY2019 and the FY 2020 goals.

Summary:

1. Situation: Annotation is provided to explain actions taken affecting each metric.

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

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

4. Assessment:

- Impact on inpatient hospice (GIP) evident on both the Mortality Index and Readmission Index.
- ED Throughput goal reduced to 266 minutes, and results are below new goal
- HCAHPS Discharge Information is at goal, Responsiveness and Likelihood to Recommend are below goal
- HAIs are less frequent than in FY19
- New metrics of Surgical Site Infections, Elective Delivery <39 weeks gestation, and Primary Cesarean Birth have been added for FY20

- 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.
- New SSI (Surgical Site Infections) metric added due to increase of SSI in FY2019

5. Other Reviews: N/A

6. Outcomes: N/A

Suggested Committee Discussion Questions: None

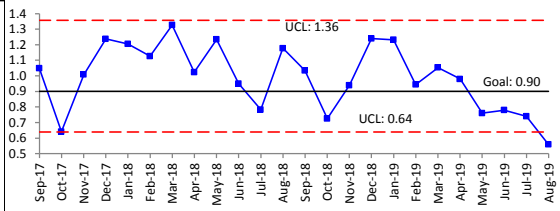
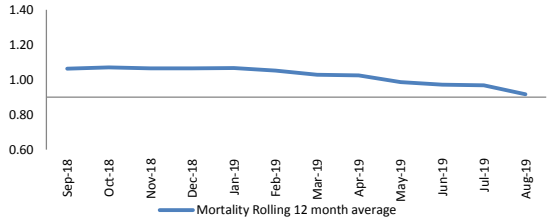
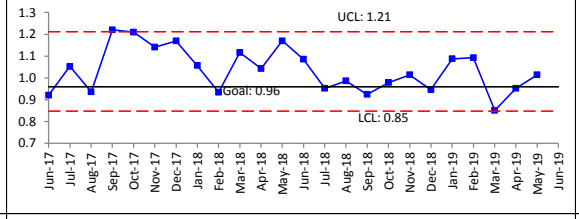
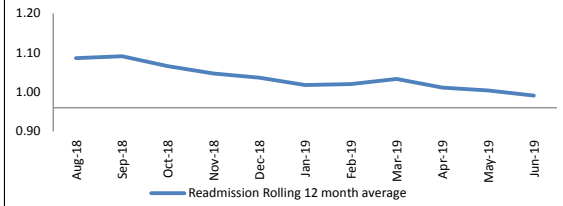
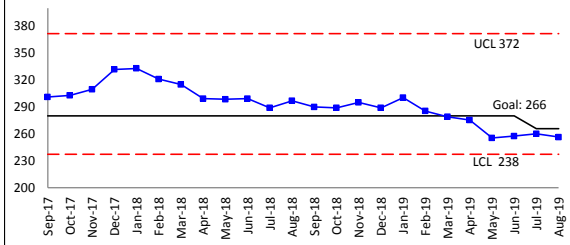
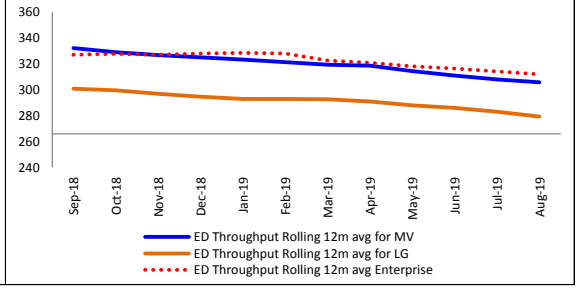
List of Attachments:
FY20 Quality Dashboard June data unless otherwise specified - final results

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

August 2019 (Unless otherwise specified)

Month to Board Quality Committee: October, 2019

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend (*showing at leasat the last 24 months of **available** data*)	Rolling 12 Months Average
Quality		Current month	FYTD				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: August 2019*	0.56 (1.00%/1.78%)	0.65 (1.53%/1.65%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: June 2019*	1.01 (7.97%/7.86%)	0.99 (7.58%/7.65%)	0.99	0.96		
3	**Patient Throughput- Median Time from Arrival to Head In Bed** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Date Period: August 2019*	MV: 275 min LG: 238 min Enterprise: 256.5 min	MV: 279 min LG: 238 min Enterprise: 258.5 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

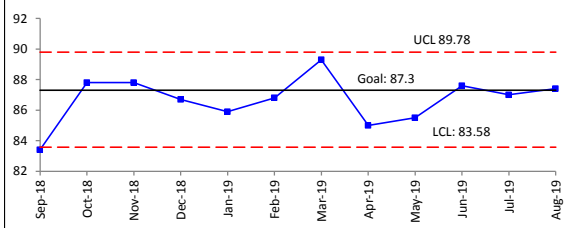
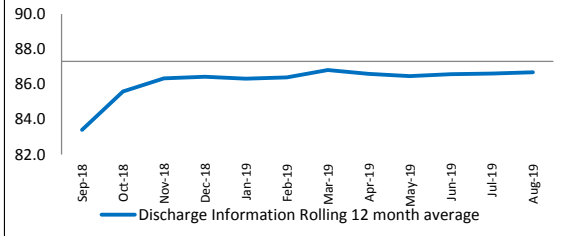
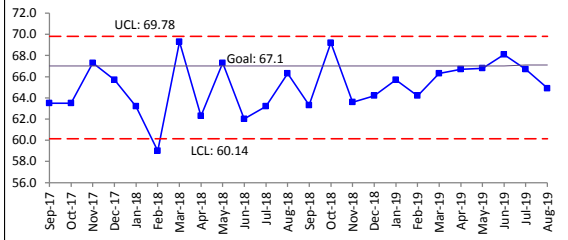
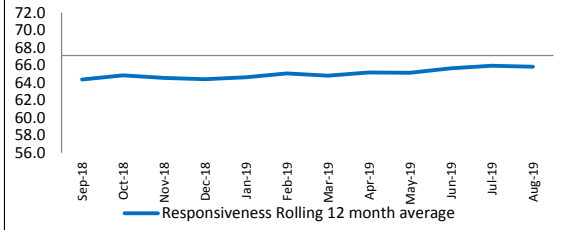
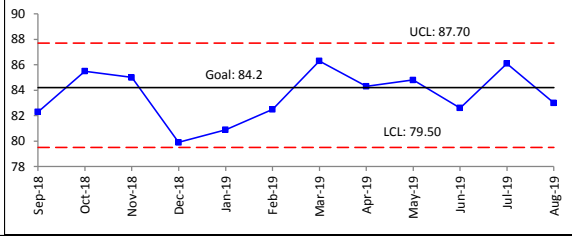
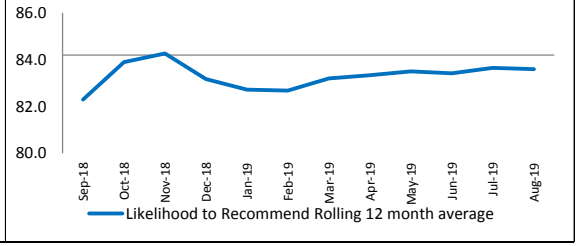
Measure Name	Comments	Definition Owner	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Mortality Index is just above the expected value and increased slightly over February.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient 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)	The ED value stream map was refreshed for flow on each campus to identify additional areas of opportunity for improvement work over new fiscal year. There has been ongoing work to manage flow with the PFC role, and we are monitoring daily performance at each campus. The Assistant Hospital Manager have started to report the daily throughput numbers at enterprise huddle.	Cheryl Reinking, Dolly Mangla	Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit	**iCare Report: ECH ED Arrival to Floor**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

August 2019 (Unless otherwise specified)

Month to Board Quality Committee: October, 2019

	Service	FY20 Performance Month	FY20 Performance FYTD	Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Discharge Information** **Top Box Rating of Always** *Date Period: August 2019*	87.4	87.2	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: August 2019*	64.9	65.8	65.7	67.1		
6	**HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: August 2019*	83	84.5	83.5	84.2		

Definitions and Additional Information

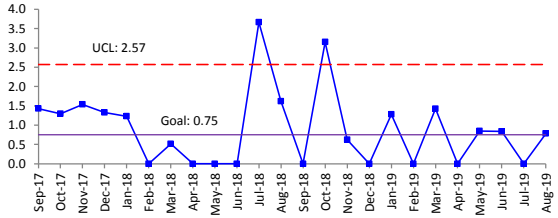
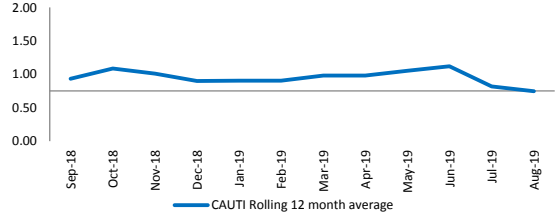
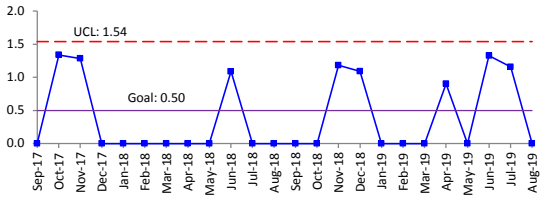
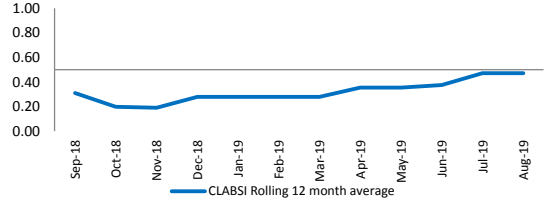
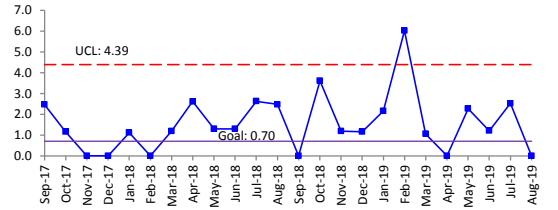
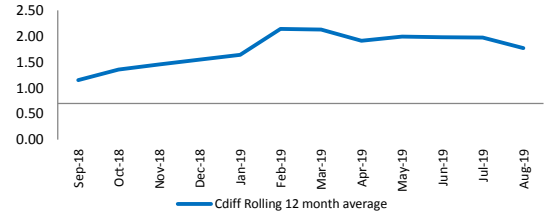
Measure Name	Comments	Definition Owner	- Arrival: Patient Arrived in ED - Head in Bed: Patient admitted in unit	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	Attended PFAC meeting for patient feedback to inform upcoming initiatives Modifying AVS to better serve patient needs Publishing discharge checklist in Patient Guide Books to help include patients in the process Modifying inpatient handbook to make it more patient-friendly Reviewing current post-discharge phone call process with a view to increasing coverage Rewards and recognition for affirming best practices	Yvette Million Cheryl Reinking	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	Added Patient and Family Advisory Council (PFAC) member in workgroup Audited call lights to anticipate reason patients may need help Leader rounding questions on call lights and staff responsiveness Reinforcing Enhanced Interactions Healthstream education Implemented No Pass Zone on all inpatient units Rewards and recognition for affirming best practices	Yvette Million Cheryl Reinking	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 Likelihood to Recommend Top Box	Team met to discuss plan Reinitiate and restructure Leader-Patient Rounding program for long-term sustainability Provide weekly/monthly/quarterly Leader-Patient Rounding data Discuss and address Emergency Department experience with patient/family during leader rounds.	Yvette Million Cheryl Reinking	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

FY 20 Organizational Goal and Quality Dashboard Update

August 2019 (Unless otherwise specified)

Month to Board Quality Committee: October, 2019

		FY20 Performance		Baseline FY18 Actual	FY19 Target	Trend	
Quality		Month	FYTD				
7	**Hospital Acquired Infections** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: August 2019*	0.78 (1/1275)	0.40 (1/2517)	1.09	SIR Goal: <= 0.75		
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: August 2019*	0.00 (0/788)	0.60 (1/1653)	0.36	SIR Goal: <= 0.50		
9	*Clostridium Difficile Infection (CDI)* *per 10000 patient days* *Date Period: August 2019*	0.00 (0/7879)	0.13 (2/15800)	1.96	SIR Goal: <= 0.70		

Definitions and Additional Information

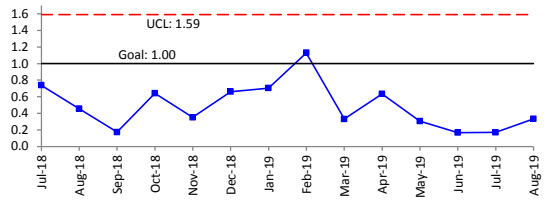
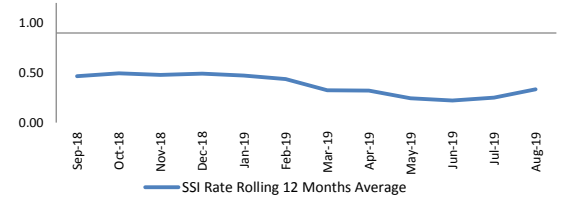
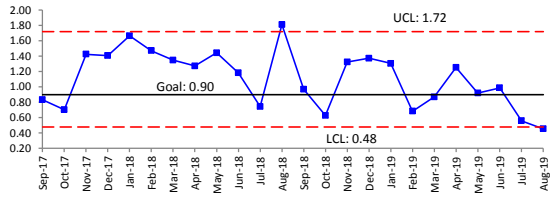
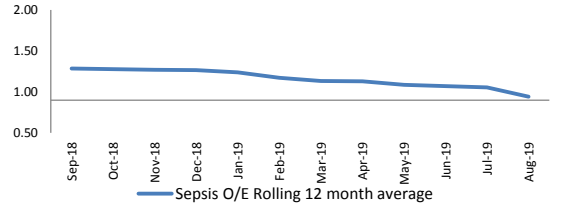
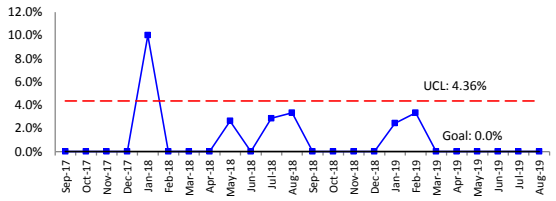
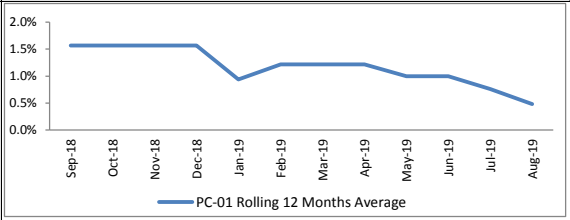
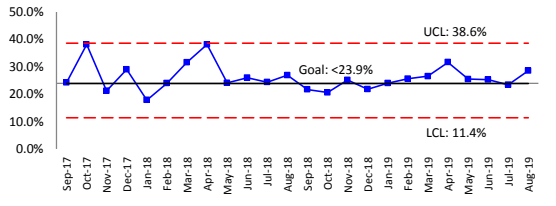
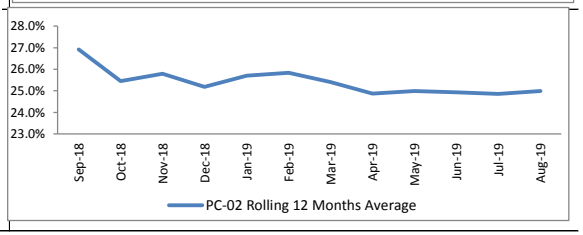
Measure Name	Comments	Definition Owner	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Zero CAUTI in July. 1 CAUTI in August in Los Gatos post extensive spine surgery, urine retention with re-insertion of foley catheter. Pt. was transferred to Acute Rehab with foley catheter, infection noted 5 days post insertion.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**CDC NHSN data base - Inf. Control**
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	1 CLABSI in July; Pt. underwent extensive abdominal surgery for cecal volvulus, developed peritonitis. CLABSI noted 1 month after surgery with staph epidermids, fever, tachycardia. Medicated bath and linen change not consistently documented and pt. refused bath for several days. Plan for pt. who refused bath to area surrounding CL site washed with CHG and to have pt. wash hands frequently and use CHG, to avoid site contamination. Zero CLABSI in August.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**CDC NHSN data base - Inf. Control**
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	2 C.Diff infections in July: 1 in LG admitted from an SNF with Anal cancer, on 2 ABX with 18 doses, developed C.Diff diarrhea after 5 days. 1 in MV: PT admitted and to surgery for bowel obstruction, difficult post op course and on 3 ABX for 18 doses, develop C. Diff diarrhea after 10 days. Zero C. Diff infections in August.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**CDC NHSN data base - Inf. Control**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

August 2019 (Unless otherwise specified)

Month to Board Quality Committee: October, 2019

		FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
		Month	FYTD				
10	**Organizational Goal** **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Date period: August 2019*	0.33 (2/601)	0.25 (3/1194)	0.52 (37/7167)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: August 2019*	0.45 (5.36%/12.03%)	0.50 (5.12%/10.31%)		0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) Enterprise Date period: August 2019	0% (0/39)	0% (0/73)	1.4%	0.0%		
13	**PC-02: Cesarean Birth** (lower = better) Enterprise Date period: August 2019	28.6% (48/168)	26.1% (85/326)	26.2%	<23.9%		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2019 Definition	Source
Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	Increases in SSIs noted by Quality Council in March 2019. New SSI Subcommittee of Quality Council began meeting in April to review data for trends, commonalities, causation, and to take actions to reduce SSIs. Committee found most SSIs caused by skin organisms. These SSIs are all Deep Incisional and Organ Space infections. Committee pushed to expand Nose-to-Toes Enterprise-wide on 5/8, preop ABX revised IC Med. Director w/Anesthesia, hand hygiene and surgical prep reviewed/assessed, surgical attire policy passed by OR Committee. LG: 1 SSI in July; right hip arthroplasty w/Staph aureas. MV: 2 SSIs in August: 1- Robotic gastrectomy/adhesions wl Strep & Staph anginousus. 2- Total Hysterectomy w/readmit for bowl peforation and abd. infection.		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated. *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is not visible if it is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Sepsis mortality index remains low due to lower volume in July/August and better physician documentation of risk of mortality.	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**
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	Elective Delivery challenges include those with prior cesarean section who desires repeat cesarean section and scheduled repeat cesarean section prior to 39 weeks. Outliers (average of 0.25 case/month) had conditions not included in the exclusion criteria e.g. borderline AFI as well as oligohydramnios and suspected macrosomia with history of shoulder dystocia with previous delivery and advanced maternal age.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	**IBM CareDiscovery Quality Measures**
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Our internal goal is aligned with the Let's Get Healthy California (LGHC) target goal of 23.9% or lower. We've had 2 insurance providers who indicated not sending patients to us if our rate is higher than the target goal. The MBU rate which is submitted to CMQCC is lower than IBM rate so we changed from 20% sampling to abstracting 100% of our cases to match their data. Currently LGHC rate is 24.5% and our FYTD is 24.9%.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	**IBM CareDiscovery Quality Measures**

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** ▪ **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 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 9. FY20 Org. Goal and Quality Dashboard Metrics 10. FY19 Organizational Goal Achievement (M, RA, ED) 11. Quality and Safety Strategic Plan	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Safety Report for the Environment of Care 11. Q1 FY20 Quarterly Quality and Safety Review 12. Performance Improvement with Physician Management 13. Q&S Strategic Plan	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

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

FY2020 Q3		
JANUARY 2020	**FEBRUARY 3, 2020**	**MARCH 2, 2020**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. 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
October 7, 2019
Mark Adams, MD, CMO

Quality and Safety

The General Inpatient Hospice (GIP) program has been very successful during the startup phase of the project at Mountain View. There have been 34 inpatients at the end of life that have qualified and chosen to be in this program. Our partner, Pathways Home Health and Hospice, is providing the hospice services in the hospital setting to our shared patients. The program allows patients who are not ready to be discharged to a different level of care outside the hospital to receive hospice services while in the acute care setting in an inpatient bed. This is a great transition program for our patient and their families who aren't ready to go home or a skilled nursing facility. Since the program has been a success, we plan to expand the GIP program to Los Gatos soon.

We installed a new robotic system for knee and hip replacement surgery at the Mountain View Campus and first utilized at ECH in late January 2019. Following staff trainings, initial knee procedures have been very successful. To date, we have performed over 100 knee procedures with the new system at ECH. In early July, the procedure was performed at Los Gatos with newly acquired equipment. The system uses personalized 3-D software maps based upon preoperative scans that allow the surgeon to perform robotic bone cuts with haptic guidance, which result in better-fitting artificial joints and improved ligament balancing. Evidence supports that this results in shorter length of stay, less pain, less opiates, and greater early functional outcome and stability.

Campus Development

We expect the Taube and Sobrato Pavilions to be ready to occupy in October and November 2019, respectively. Planning work for the Women's Hospital expansion project on the Mountain View Campus is ongoing. We have begun work on the assessment of campus redevelopment options to address seismic compliance issues at the Los Gatos Campus.

Information Services

El Camino Health provided the following presentations at the Epic User Group national forum this week highlighting our organization's leadership in the areas of innovation and delivery of best practices:

- Deb Muro and Robert Henehan presented Analytics and the Web based Enterprise Executive Dashboard using touch screen technology. ECH is the third highest user of this web based analytics tool out of all Epic organizations.
- Dr. Shin and Lian Chang presented a state of the art approach for potassium replacement

- Brian Fong, Johnna Mohun-Escobedo and Michelle Llamas presented a customized Epic Denials reporting solution.
- El Camino outcomes and achievements were included with other premier organizations during the Executive Address by Epic leadership to a large Epic Community audience (estimated at 10,000).

Corporate and Community Health Services

The Chinese Health Initiative ("CHI") provides fee-for-service Qigong classes to promote a healthy lifestyle in the Chinese community. The new sessions started in August with two classes for returning students and two beginning classes conducted in Mandarin or English. About 45 participants attended the free introductory classes and 34 signed up for the 8-week sessions in August.

CHI collaborated with two community service agencies that serve low-income families in Cupertino and Mountain View. CHI provided Mandarin interpretation for about 130 Chinese participants who are enrolled in Challenge Diabetes program and speak limited English. Interpretation was provided by 10 bilingual CHI volunteers at Challenging Diabetes in August.

Philanthropy

During period 1 of fiscal year 2020, which ended on July 31, El Camino Health Foundation secured $694,925. The 24th annual El Camino Heritage Golf Tournament will be held on Monday, October 28, 2019 at Sharon Heights Golf & Country Club and will benefit the Peter C. Fung, MD Stroke Center. The Taube Pavilion opening festivities for donors will be held on Thursday, October 24, 2019 and the Sobrato Pavilion Opening Celebration is planned for Sunday, November 17, 2019. These events are in the final planning stages. Board staff will provide additional information to Board members as it becomes available.

Auxiliary

The Auxiliary contributed 6,319 volunteer hours in August 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: October 7, 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. Health Information Management Department
2. Antimicrobial Stewardship
3. Orthopedic Service Line

Suggested Committee Discussion Questions: None.

Annual Performance Improvement Report

Department/Service Line: Health Information Management
Prepared by: Frank Kuziel
Date: August, 27, 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:

Data analysis and conclusions after review of the previous Data Dashboard for the reporting period

- *Chart Completion and Physician Suspension*
  - *Physician suspension rate down in 2019 by 12% from 2018 and down 20% from 2017*
  - *Turn Around time for coding of IP records improved by 0.6M based on discharged not billed (DNB) accounts within 14 day chart completion timeline*
- *Closed Record Review: Documentation Review and Improvement.*
  - *Focused review criteria unchanged: will continue to review charts*
  - *Physician education through peer review and from HIM staff at new physician on-boarding*
- *Duplicate Medical Record Rate:*
  - *Significant reduction of duplicate numbers by HIM staff after system processing at first pass*

Areas of Concern or Opportunities for Improvement:

Issues and opportunities identified for improvement:

- *Chart Completion and Physician Suspension:*
  - *Continued delinquency rate impacting patient continuum of care due to incomplete chart completion,*
  - *Incomplete/delinquent charts impacting IP/OP coding*
  - *Missing documentation for coding impacting revenue collection*

- *Closed Record Review: Documentation Review and Improvement*
  - *Incomplete or missing documentation directly impacting patient care*
  - *Incomplete or missing documentation impacting coding and revenue*

- *Duplicate Medical Record Rate:*
  Negative impact on patient care due to:
  - *Continued occurrences of duplicate medical records with clinic acquisition*
  - *Continued occurrences of duplicate IP/OP medical records at point of registration*

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

List actions taken:

- *Chart Completion and Physician Suspension:*
  - *HIM policy and procedure changes made to reflect new approaches to working with physicians*
  - *Updated providers of new HIM efforts through an all provider "fax-blast" and in presentation of new HIM workflows when on-boarding new physicians,*
  - *Implementation of new dictation system – M*Modal Fluency Direct, to facilitate chart completion for IP, OP and clinic visits.*

- *Closed Record Review: Documentation Review and Improvement*
  - *Modified procedure on chart review*
  - *Regulatory and Quality departments with HIM and Chief of staff to discuss and implement workflow changes*
  - *HIM assigned three staff to conduct chart reviews to maintain chart review consistency and provide back-up support*

- *Duplicate Medical Record Rate:*
  - *Contracted with external vendor for duplicate medical record rate exceeding 7,500 duplicate pairs*
  - *Cross-training of HIM Specialist II positions to include 4 FTEs to correct duplicate records*
  - *Re-training/education with registration staff as necessary*

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

Descriptive improvement:

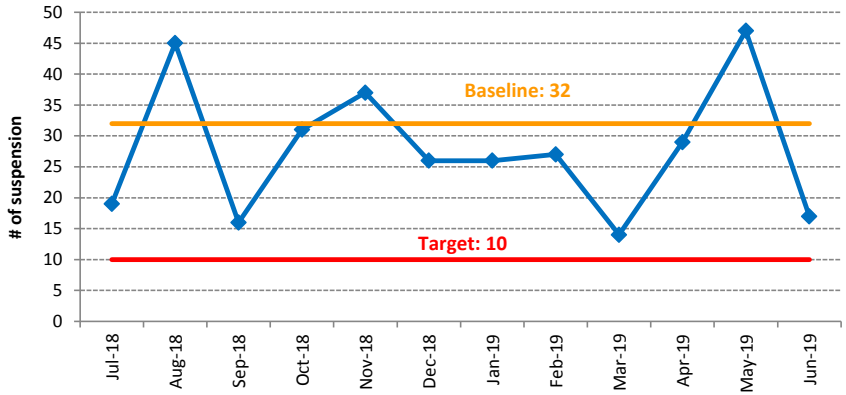
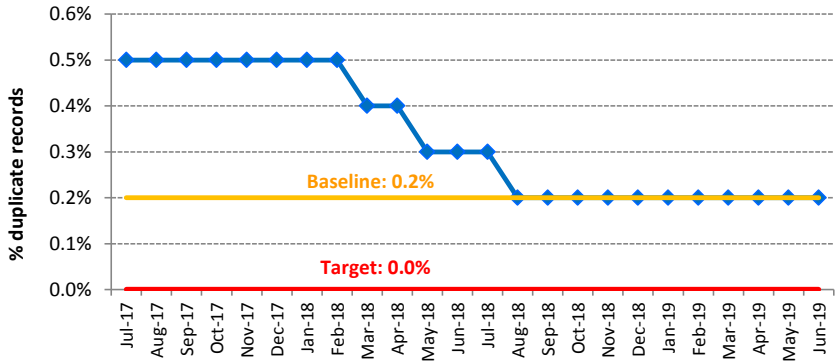
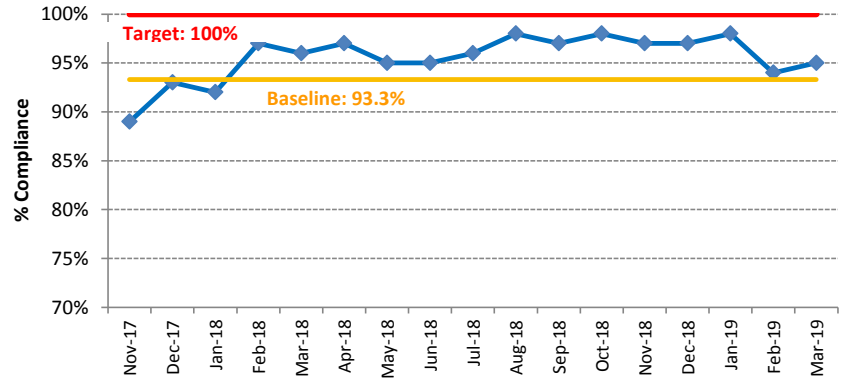
- *Chart Completion and Physician Suspension*
  - *Physician suspension count down from 2018 average of 30 physicians down to an average of 26 for 2019*
  - *Re-allocation of HIM staffing resource to work directly with physicians nearing chart completion deadlines*
  - *Implementation of new workflow to support chart completion efforts by HIM staff in assisting target physicians to prevent them going on the "suspension list"*

- *Closed Record Review: Physician Documentation Review and Improvement*
  - *Continued closed record review and reporting*
  - *Continued tracking of documentation deficiencies*

- *Duplicate Medical Record Rate:*
  - *Continued reduction of duplicate records through system (EPIC) auto analysis and HIM staff*

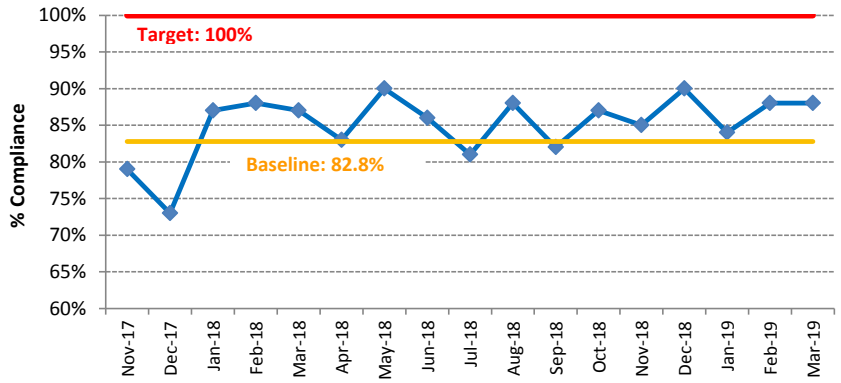
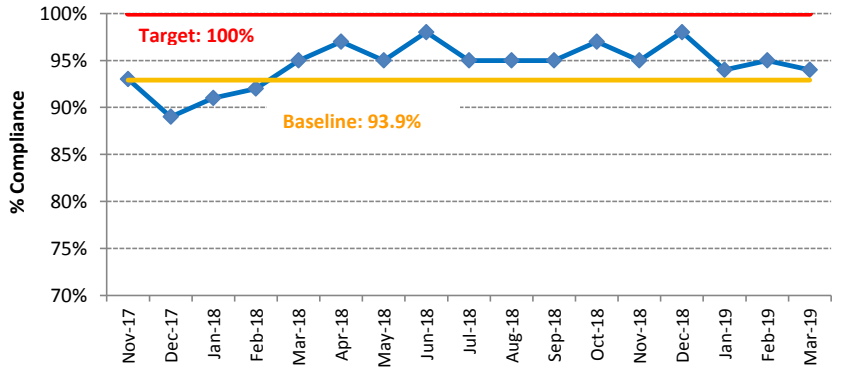
El Camino Health

Health Information Management Services Dashboard for FY 2019 - enterprise

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Trend Graph
	Latest Month	FY 19 Total			
Physician Suspension *Reporting Period: July 2018 - June 2019* *Lower is better*	17	28/ month 344 /year	32/ month 388/year	10/ month 120/ year	
Duplicate Medical Record Rate *Reporting Period: July 2017 - June 2019* *Lower is better*	0.013% (107)	5263 Duplicate pairs 0.65%	1744 Duplicate pairs 0.20%	0%	
HIM Chart Review **Informed Consent Compliance Rate** Reporting Period: November 2017 - March 2019 Higher is better	95%	96.70%	93.30%	100%	

El Camino Health

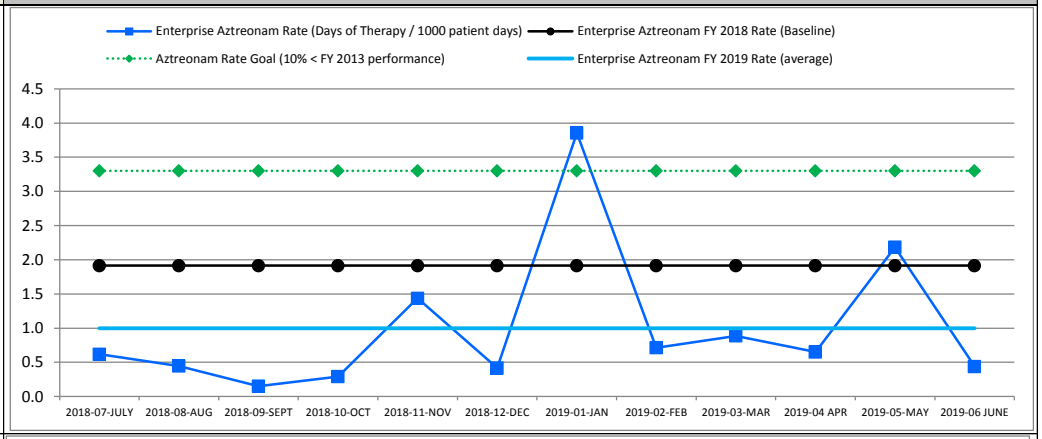
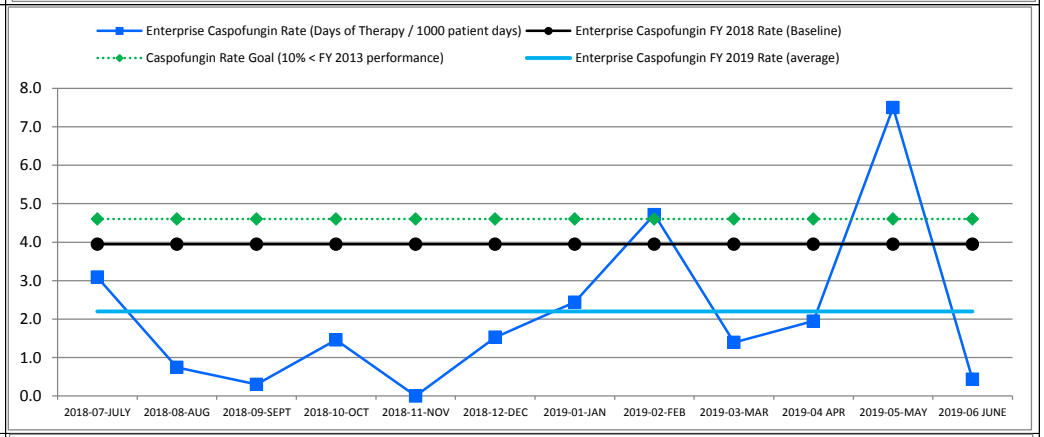
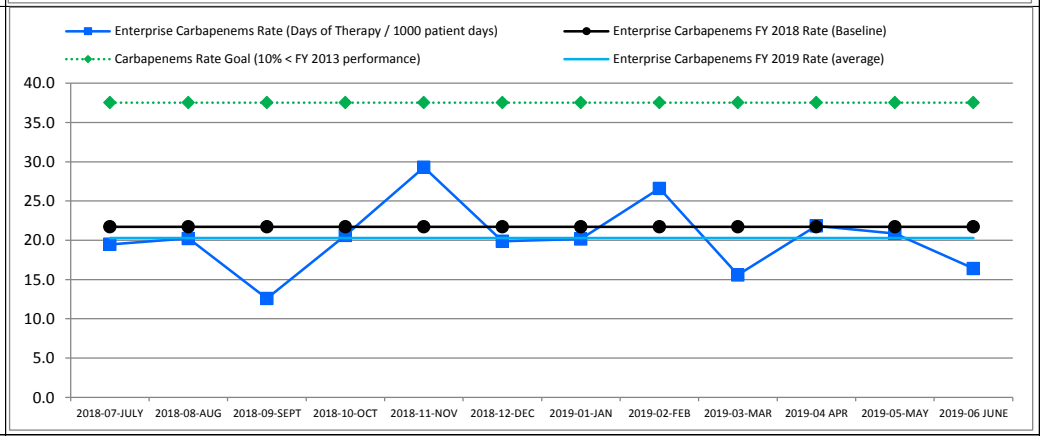
Health Information Management Services Dashboard for FY 2019 - enterprise

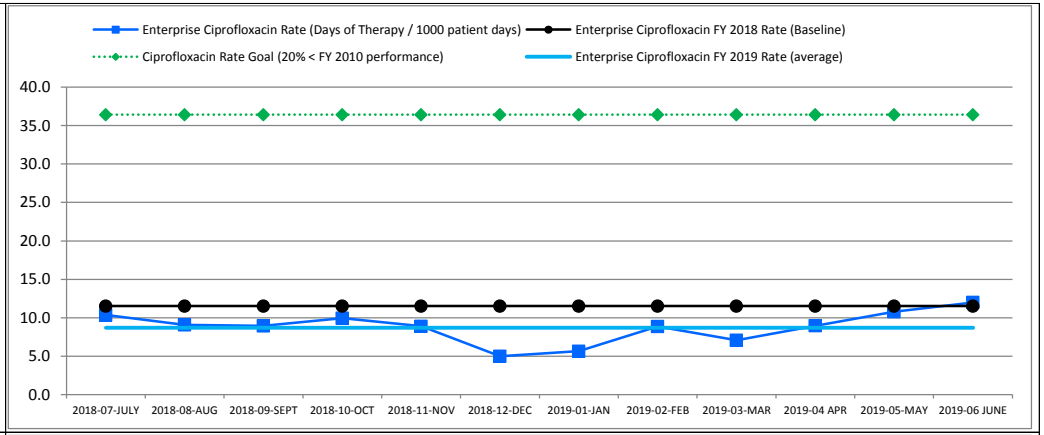
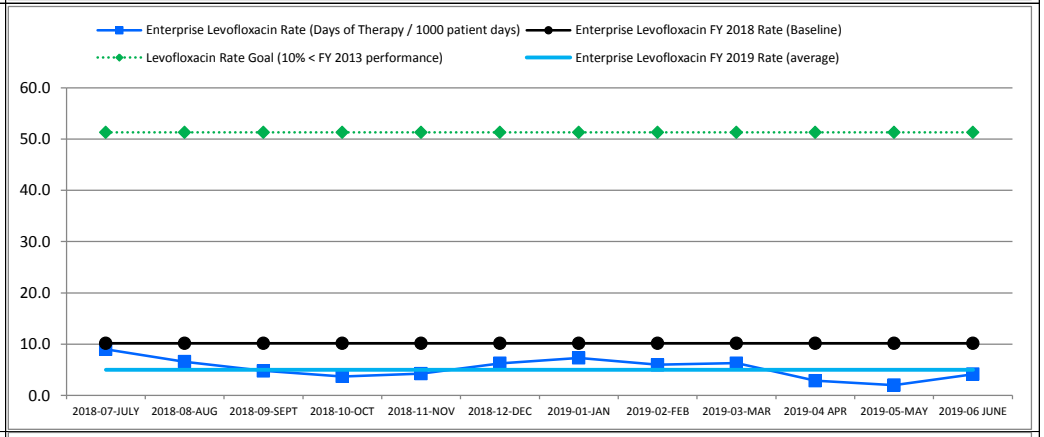
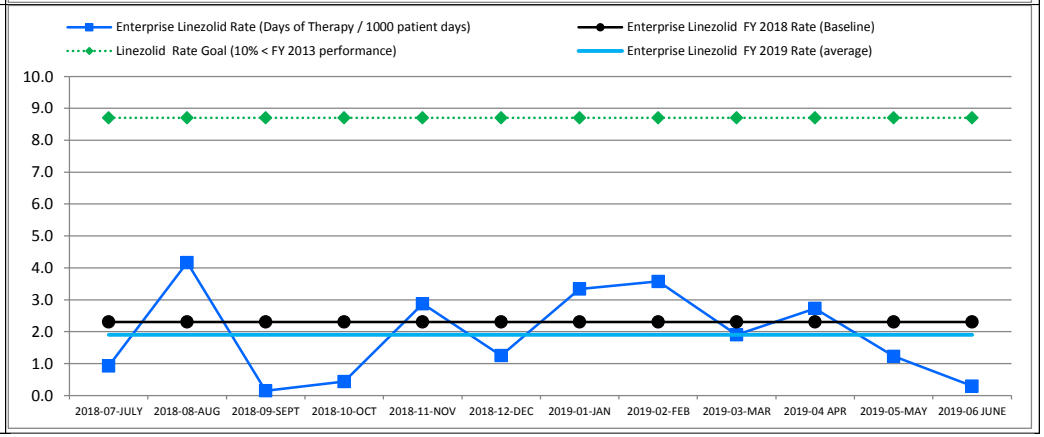
KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Trend Graph
	Latest Month	FY 19 Total			
HIM Chart Review **Immediate Post Procedure Note Compliance Rate** *Reporting Period: November 2017 - March 2019* *Higher is better*	88%	85.90%	82.80%	100%	
HIM Chart Review **Discharge Summary Compliance Rate** *Reporting Period: November 2017 - March 2019* *Higher is better*	95%	95.30%	92.90%	100%	

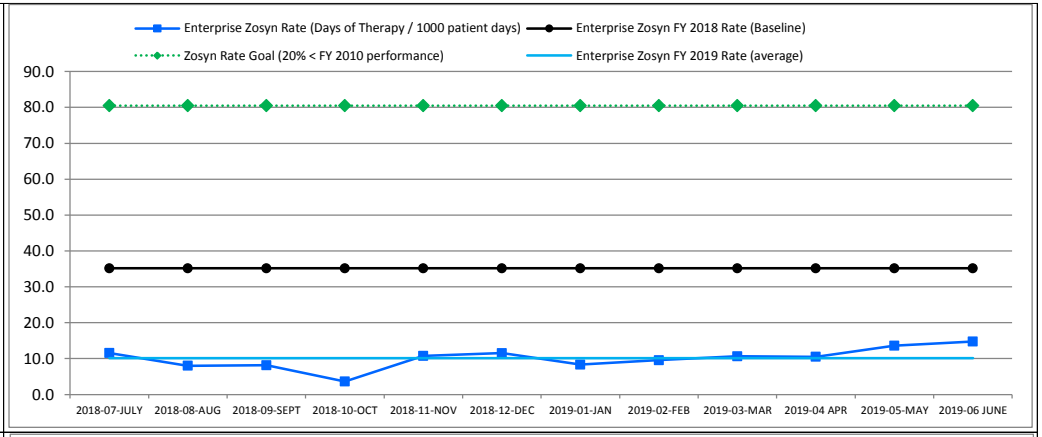
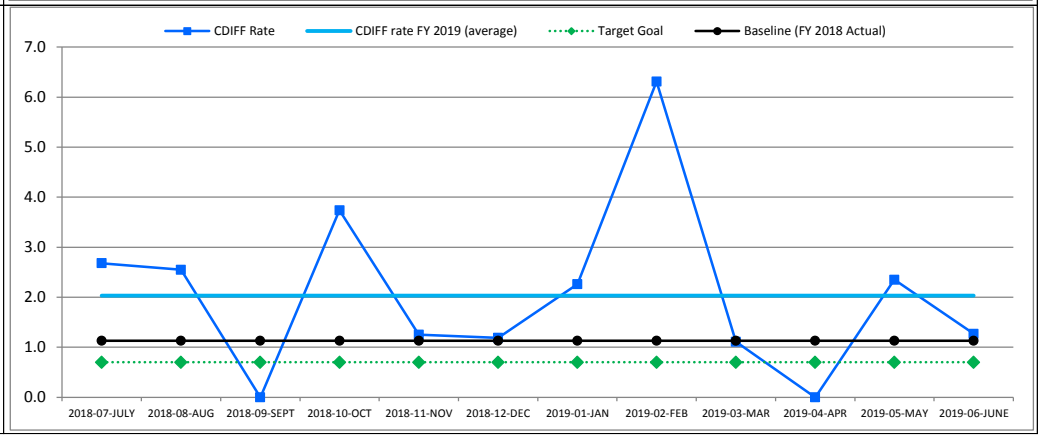
El Camino Health

Antimicrobial ABX Performance Dashboard-
FY19 Performance Tracking

Dashboard updated as of 2019-08-23

	Metrics	Actual Performance		FY 2018 (baseline)	Target Goal	Monthly Trend Graph (displaying only FY 2019 months)
		Latest Month	FY 2019			
1	**Enterprise Aztreonam Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	0.4	1.0	1.9	3.3 (10% < FY 2013 performance)	
2	**Enterprise Caspofungin Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	0.4	2.2	3.9	4.6 (10% < FY 2013 performance)	
3	**Enterprise Carbapenems (Ertapenem & Meropenem) Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	16.4	20.3	21.7	37.5 (10% < FY 2013 performance)	

4	**Enterprise Ciprofloxacin Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	12.0	8.7	11.5	36.4 (20% < FY 2010 performance)	
5	**Enterprise Levofloxacin Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	4.2	5.0	10.2	51.3 (10% < FY 2013 performance)	
6	**Enterprise Linezolid Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	0.3	1.9	2.3	8.7 (10% < FY 2013 performance)	

7	**Enterprise Zosyn (Piperacillin/Tazobactam) Rate** : Days of Therapy / per 1000 Patient Days Latest Month : June 2019	14.8	10.1	35.2	80.5 (20% < FY 2010 performance)	
8	**Clostridium Difficile Infection (CDI)** / 10,000 patient days Latest Month : June 2019	1.27 (1/7896)	2.03 (20/98371)	1.13	SIR Goal <= 0.70	

Annual Performance Improvement Report

Department/Service Line: Antimicrobial Stewardship
Prepared by: Jonathan Johansen, PharmD
Date: 8/26/19
Reporting Period: FY2019

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

Data Analysis & Conclusions:

Share your data analysis and conclusions after review of the previous Data Dashboard for the reporting period (data through CY2018 presented 3/6/19). Use bullet points:

- Primary process goals for the Antimicrobial Steward Program (ASP):
  - De-escalate broad spectrum antimicrobials
    - Targeted broad spectrum antimicrobial use continued to downtrend from ASP baselines (FY2010 and FY2013)
  - Limit unnecessary antimicrobial patient days of therapy
    - CY2017-2018 NHSN SAAR rates (observed-to-predicted use ratio) remained consistent and near predictive modeling
- Primary outcome goals: minimize selection of MDROs and hospital onset *C. diff*
  - Minimize fluoroquinolone (ciprofloxacin and levofloxacin) and piperacillin/tazobactam (PTZ) usage
    - Ciprofloxacin and PTZ usage continued to downtrend -75% and -66%, respectively, from FY2010 to FY2018
  - Ensure dose optimization and appropriate treatment duration of antimicrobials in adherence with best practice guidelines
    - Hospital onset *C. diff* rate continued to downtrend from 10.04 to 1.24 per 10,000 patient days (-87.6%) for FY2011 and FY2018, respectively
    - *C. diff* rate decreased from 1.99 to 1.24 (-37.7%) for FY2017 and FY2018, respectively
- Secondary process goals:
  - Antimicrobial monitoring and review
  - Guideline development and education

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- Physician collaboration with the ASP at LG
- Addressing continuing education needs
  - Medical staff
  - Pharmacists
  - Nursing
- Ongoing updates to Enterprise best practice guidelines
- Updating Epic order sets to be in-line with guideline recommendations
- Expanding Pharmacy driven protocols
- *C. diff* rate increased from 1.13 to 2.03 (79.6%) for FY2018 and FY2019, respectively; goal is ≤0.7

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

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

Use bullet points to list actions taken:

- ASP Pharmacist (0.5 FTE) established June '18 at LG
  - Medical staff, Pharmacist, and Nursing education provided at LG
- ID-trained ASP Pharmacist (1 FTE) hired into the vacant position July '19
- Updated Pharmacy renal dosing protocol to include hemodialysis patients
- Updated Pharmacy renal dosing protocol to be in-line with best practices
- Implemented blood culture PCR testing for rapid identification of bloodstream pathogens
  - Provided physician and pharmacist education
  - Blood culture reports created to alert ASP Pharmacists promptly of new results
  - Provide antimicrobial treatment recommendations based on PCR test results
- Continue to utilize antimicrobial usage and NHSN SAAR data to identify antimicrobial usage trends to help drive improvements
- Continue prospective audit with feedback of targeted antimicrobials
- Continue daily review of Pharmacy clinical documentation on targeted antimicrobials

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

Use bullet points to describe improvement:

- Primary process goals:
  - De-escalate broad spectrum antimicrobials
    - All targeted broad spectrum antimicrobial use continued to downtrend from FY2018 to FY2019
  - Limit unnecessary antimicrobial patient days of therapy
    - FY2018 and FY2019 NHSN SAAR rates decreased and remained below predictive modeling at 0.9914 and 0.9196, respectively
- Primary outcome goals: minimize selection of MDROs and hospital onset *C. diff*
  - Minimize fluoroquinolone and PTZ usage
    - Fluoroquinolone and PTZ usage rate/1,000 patient days continued to downtrend from 21.7 to 13.7 (-36.9%) and 35.2 to 10.1 (-71.3%) from FY2018 to FY2019, respectively
    - Overall increased Gram-negative isolate susceptibility for fluoroquinolones and PTZ from CY2017 to CY2018
      - *E. coli* susceptibility to fluoroquinolones increased 72% to 77%
      - *E. coli* susceptibility to PTZ increased 86% to 97%
  - Ensure dose optimization and appropriate treatment duration of antimicrobials
    - *C. diff* rate decreased from 10.04 to 2.03 (-79.8%) for FY2011 and FY2019, respectively
    - *C. diff* rate increased from 1.13 to 2.03 (79.6%) for FY2018 and FY2019, respectively
    - *C. diff* rate will continue to be monitored
- Secondary process goals:
  - Antimicrobial monitoring and review
    - Pharmacist interventions for the ASP remained consistent with 7,220 (23.9/1,000 patient days) and 7,760 (22.7/1,000 patient days) for CY2017 and CY2018, respectively
    - ASP comprised 29.1% and 31.7% of all documented interventions (not including PK dosing, renal dosing, IV to PO) for CY2017 and CY2018, respectively

Annual Performance Improvement Report

Department/Service Line: Orthopedic Service Line
Prepared by: Debbie Smyth BSN, RN, Pamela Coye, RN, Nate Sigler, Director, Viet Tran, Manager
Date: August 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:

Overview of Metrics

- Joint Commission Certified programs for the Total Hip Replacement, Total Knee, and Hip Fracture programs
- Metrics include re-admissions, complications, and processes of care. Metrics no longer visually reported include: LOS, DVT, Blood transfusions, and mortality; these are below significance.
- For the total joint replacement patients, data measurement for SSI, Caregiver class attendance, Early Mobilization and comorbid care plans at both campuses
- For the hip fracture patients, data measurement for Early mobilization, Nutrition Education, Vitamin D Screening and Readmissions at the Mountain View campus
- Performance measures were selected based on evidenced-based guidelines from national organizations including the Joint Commission, AORN, AHRQ, and historical opportunities.

Data Analysis & Conclusions:

- Improvement opportunity identified in the readmission of hip fracture patients. The causes of pneumonia and Urinary tract Infection have been identified as drivers.
- Increased rates of surgical site infection in the total joint population at both campuses.

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- As noted above, slight upward trend in Surgical Site Infections for Total Joint Replacement Patients in FY19; the additional surgical site infections were identified in hip fracture patients and knee replacement patients. Standardized Infection Rates (SIR), which are risk-adjusted, indicate increases of 3 infection occurrences above the expected rate, with a denominator of 1066 enterprise cases in FY19.
- Improvement needed in the rate of outpatient Pneumonia for the hip fracture patients discharged
- Low numbers of patients screened for Vitamin D deficiency within hip fracture population

[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:

Surgical Site Infection Prevention

1. Best practices such as Nose to Toes, pre-op home skin prep have been implemented and monitored. Distribution of skin prep products and education to patients at pre-op class.
2. Nose to Toes process has been adopted for all patients receiving a surgical incision including the hip fracture population
3. Orthopedic surgeons have championed clipping outside of the Operating Room for patients that require hair removal
4. Adoption of the R.E.C.K. premixed intraarticular injection (no more mixing in OR)
5. Orthopedic surgeons have attended Infection Task Force meetings and hosted Inf Control department personnel at co-management meetings, and contributed to a list of evidence-based process measures.

Caregiver Class Attendance & related patient-driven metrics – New patient-reported outcomes HOOS, JR and KOOS, JR collected at pre-op, 3 months, and 12 months since Fall 2018.Greater engagement.

Vitamin D Screening for Hip Fracture Patients

1. Annual goal added to the ortho co-management committee to screen for vitamin D levels for all elective total joint and hip fracture patients.

Re-admission: Pneumonia

1. Introduction of the new ICOUGH Bundle which includes Early mobilization for the Hip Fracture patient, Peridex Mouthwash twice a day, and Head of Bed elevation

Outpatient total joint

1. Teams assembled at both campuses, protocols developed and program launched same day discharge, which may help prevent infection and hold the performance for ambulation.

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

Use bullet points to describe improvement:

Surgical Site Infection - See attachment of graphs. Spine surgery infections have held at ZERO at LG.

Plans of Care for Co-Morbid Conditions - Improved noticeably to acceptable levels since recent efforts began.

Caregiver Class attendance – At or near goals for all populations.

Vitamin D – Hip Fracture Program

1. Work progressing to identify patients with low vitamin D levels and to order replacements as needed.

Re-admission - Pneumonia

1. Readmission rates have trended lower over the last 4 months.
2. Progress will be closely monitored and shared at the monthly Orthopedic Co-management Quality meeting

Outpatient total joint program

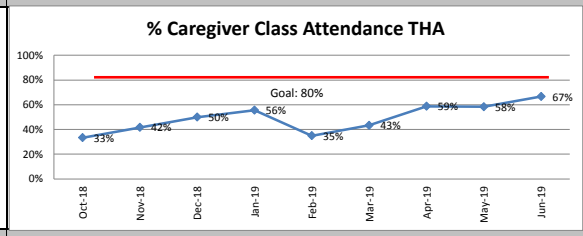
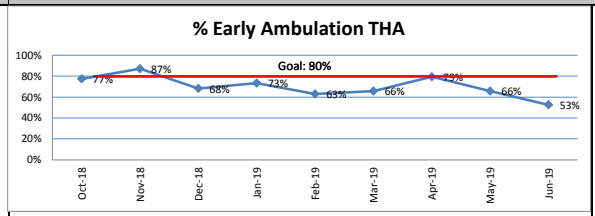
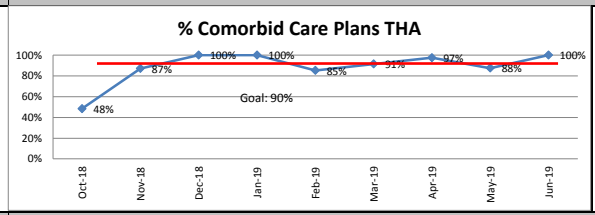
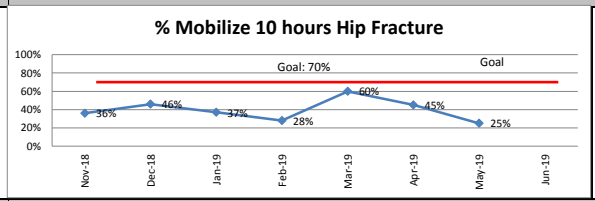
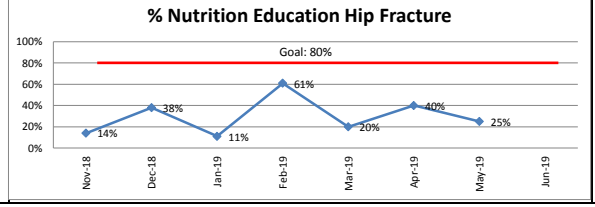
1. Successfully discharged 25 so far with 1 readmission.
2. Chart review is conducted on patients unable to discharge on the day of surgery and information shared to the team to further refine the program

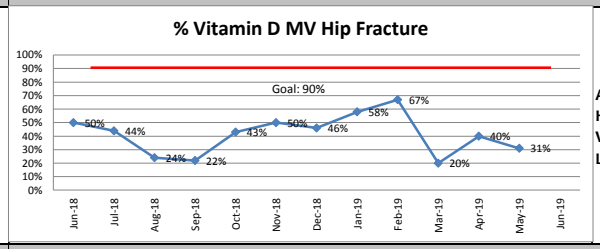
El Camino Health

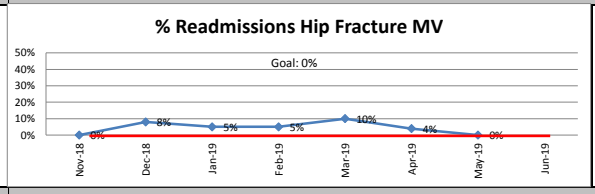
Ortho Service Line Dashboard

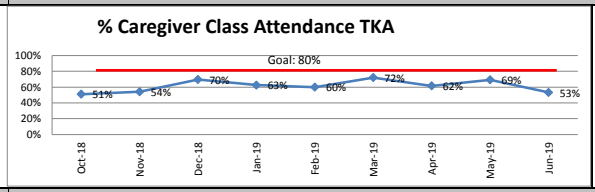
Dashboard Date: July 2019
(Each metric indicates the month for which data is complete.)
Last updated: 8/26/19

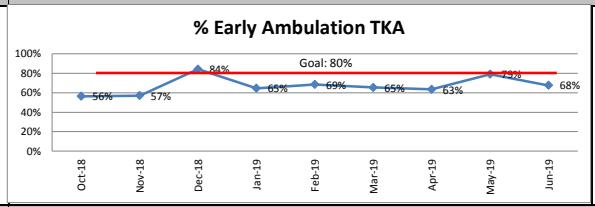
Ortho Service Line Dashboard

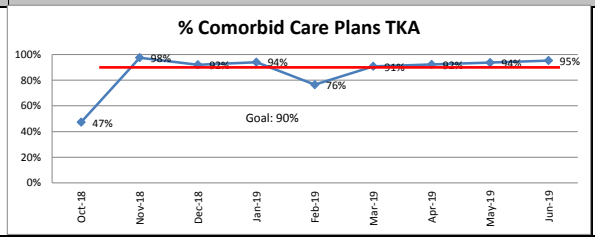
		Month	FY19	Baseline	FY19 Goal	Trend	Metric Name	Data Definition	Data Source
Quality		Current Month	FY19	FY18 (6/17-5/18)	FY19 Goal				
1	% Caregiver Class Attendance Total Hip Arthoplasty	67%	51%	59%	80%		**Caregiver Attendance to Pre-operative Joint Replacement Education Class**	Strategies to improve Caregiver Attendance: Collaborative approach with physicians offices to initiate scripting of expectation of class / caregiver attendance to begin in Physician office; scripting for scheduler of pre-op classes - often they are the first phone contact from the hospital regarding the classes - reinforcing the necessity to have a caregiver attend the class to ensure understanding of pre-op education and application in the post-discharge rehab period	**Hand Extraction**
Quality		Current Month	FY19	FY18	FY19 Goal				
2	% Early Ambulation Total Hip Arthoplasty	53%	73%	87%	80%		**Early Ambulation of Total Hip Patients, Day of Surgery, Within 4 Hours of Arrival to Post-op Unit**	Goal is to ambulate within 4 hours from arrival to the post-op unit. Nursing and Therapy have responsibility to ambulate patient. Some barriers: lack of documentation of mobilization by nursing in Activity Flowsheet; Patient status, such as nausea and vomiting, pain, orthostatic hypotension, decreased motor / sensation due to spinal. Working collaboratively with Rehab regarding time of arrival,. patient status, PT/OT availability; continual reinforcement of documentation education to nursing, reinforcement of collaborative responsibility of patient ambulation. Time of surgery plays a role in ambulation and is considered in PI work	**Hand Extraction**
Quality		Current Month	FY19	FY18	FY19 Goal				
3	% Comorbid Care Plans Total Hip Arthoplasty	100%	91%	N/A	90%		**Care Plans for Total Hip Patients to Include Co-morbid Conditions**	Care plans to include Patint's co-morbid conditions; medical conditions from "Summary" in EPIC. Gradual improvement since implementation 10 months ago. Collaborative education efforts with Educ. Department, peer to peer reinforcement, chart reviews, UPC, staff meetings Care plan task force created to evaluate care plan deficiencies enterprise wide for all programs and implement links in EPIC between Care Plans, Patient Education. Status: in process.	**Hand Extraction**
Quality		Current Month	FY19	FY18	FY19 Goal				
4	% Mobilize 10 hours Hip Fracture	25%	41%	N/A	70%		**Mobilization Within 10 Hrs Post Surgical Repair of Hip Fracture**	Goal is to ambulate withing 10 hours from arrival to the post-op unit. Nursing and therapy have responsibility to mobilize the patient. Barriers to reaching the goal include lack of documentation of mobilization by nursing in the activity flowsheet, patient status such as pain, hypotension. Working collaboratively with Rehab Services regarding time of arrival, PT/OT orders and ability to work with them and reinforcement of documentationeducation to nursing, reinforcment of collaborative responsibility of patient ambulation.	**Hand Extraction**
Quality		Current Month	FY19	FY18	FY19 Goal				
5	% Nutrition Education Hip Fracture	25%	40%	N/A	80%		**Nutrition Education Post Hip Fracture Repair Prior to Discharge**	Up to 80% of hip fracture patients could be malnurished according to literature. Nursing performs a nutrition assessment using the Malnutrition Screening Tool adopted by the hospital. False negatives can occur with patients who have Delirium or Demetia. Challenges exist with identifying these patients and providing nutritional supplements and patient education. Work has occurred to provide nursing staff with information on correct use of the tool and instruction patients in ingesting supplements when ordered.	**Hand Extraction**

Quality		Current Month	FY19	FY18	FY19 Goal				
6	% Vitamin D MV Hip Fracture Screening	31%	51%	N/A	90%		**Association between Hip Fracture and Vitamin D Serum Level**	Data shows hip fracture patients are at risk for low vitamin D levels when screening occurs. Low vitamin D levels can lead to poor bone healing and potention for re-fracture . Patients placed on Vitamin D prior to discharge have an increased chance of continuing vitamin D replacement in the outpatient setting. A new evidence base order set is being rolled out to include Vitamin D screening.	**Hand Extraction**

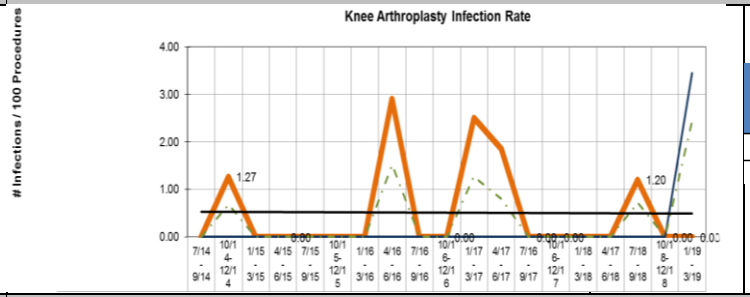
Quality		Current Month	FY19	FY18	FY19 Goal				
7	% Readmissions Hip Fracture MV	4%	6%	N/A	0%		**Readmissions from Hip Fracture**	TJC certification metric. See metric number 14 for risk adjusted readmissions. Readmissions for Hip Fracture patients include Pneumonia, Urinary Tract Infection and infection. Work to reduce readmissions has included adpotion of the ICOUGH Bundle, implementation of the Nose to Toes pre-operative prep for hip fracture patients having surgical repair and HOUDINI nursing protocol for removal of Foley catheter. Readmission EMR's are reviewed and trends monitored and shared with the Orthopedic quality and co-management teams.	**Hand Extraction**

Quality		Current Month	FY19	FY18	FY19 Goal				
9	% Caregiver Class Attendance TKA	53%	62%	52%	80%		**Caregiver Attendance to Pre-operative Joint Replacement Education Class**	Strategies to improve Caregiver Attendance: Collaborative approach with physicians offices to initiate scripting of expectation of class / caregiver attendance to begin in Physician office; scripting for scheduler of pre-op classes - often they are the first phone contact from the hospital regarding the classes - reinforcing the necessity to have a caregiver attend the class to ensure understanding of pre-op education and application in the post-discharge rehab period	**Hand Extraction**

Quality		Current Month	FY19	FY18	FY19 Goal				
10	% Early Ambulation TKA	68%	68%	82%	80%		**Early Ambulation of Total Knee Patients, Day of Surgery, Within 4 Hours of Arrival to Post-op Unit**	Goal is to ambulate within 4 hours from arrival to the post-op unit. Nursing and Therapy have responsibility to ambulate patient. Some barriers: lack of documentation of mobilization by nursing in Activity Flowsheet; Patient status, such as nausea and vomiting, pain, orthostatic hypotension, decreased motor / sensation due to spinal. Working collaboratively with Rehab regarding time of arrival,. patient status, PT/OT availability; continual reinforcement of documentation education to nursing, reinforcement of collaborative responsibility of patient ambulation for optimal patient outcomes in avoiding delay in discharge and readmissions	**Hand Extraction**

Quality		Current Month	FY19	FY18	FY19 Goal				
11	% Comorbid Care Plans TKA	95%	89%	N/A	90%		**Care Plans for Total Knee Patients to Include Co-morbid Conditions**	Care plans to include Patint's co-morbid conditions; medical conditions from "Summary" in EPIC. Gradual improvement since implementation 10 months ago. Collaborative education efforts with Educ. Department, peer to peer reinforcement, chart reviews, UPC, staff meetings Care plan task force created to evaluate care plan deficiencies enterprise wide for all programs and implement links in EPIC between Care Plans, Patient Education. Status: in process.	**Hand Extraction**

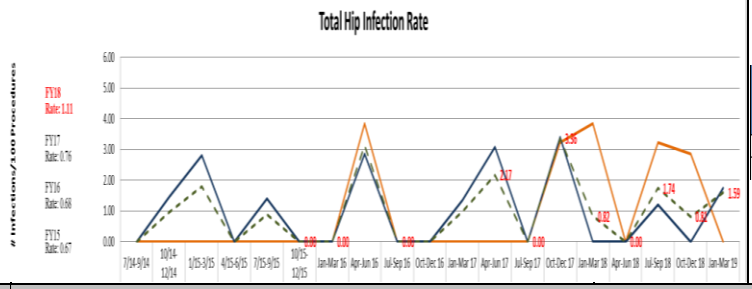
Quality		Current Month	FY19	FY18	FY19 Goal
12	Knee Arthroplasty Infection Occurence	1 (4/19-6/19)	4	0	SIR < 1



Procedure Code	FY2019: Procedure count (July 2018 – June 2019)	SSI Infection count	Number SSI "predicted"	SIR (SSI count/Number Predicted)
MV KNEE (KPRO)	313	3	2.022	1.48
LG KNEE (KPRO)	268	1	1.409	0.71

Infection Control Department

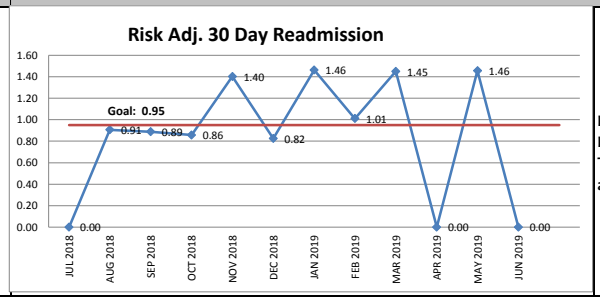
Quality		Current Month	FY19	FY18	FY19 Goal
13	Total Hip Infection Occurence	1 (4/19-6/19)	5	5	SIR < 1



Procedure Code	FY2019: Procedure count (July 2018 – June 2019)	SSI Infection count	Number SSI "predicted"	SIR (SSI count/Number Predicted)
MV HIP (HPRO)	359	2	3.46	0.58
LG HIP (HPRO)	126	3	1.037	2.9

Infection Control Department

Quality		Current Month	FY19	FY18	FY19 Goal
14	Risk Adj. 30 Day Readmission	0.00	0.85	N/A	0.95



Risk Adjusted 30 day Readmissions for Total Hip, Total Knee and Hip Fracture

Readmission causes include; infection, sepsis, pain, hyponatremia, abdominal pain, hip dislocation, muscle weakness. Nose to Toes has been implemented along with the home skin prep for all surgical patients now including inpatient surgical patients. Readmission EMR's are reviewed and trends monitored. Infections are reviewed by the Infection Prevention Team.

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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: October 7, 2019
Subject: Report on Board Actions

Purpose:

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

Summary:

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

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

3. Background: Since the last Quality Committee Meeting the Hospital Board has met once and the District Board has not. 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

September 11, 2019: No approvals of significance to the Committee

B. Finance Committee Actions:

- Vituity Medical Advisor Renewal Agreement
- Amendment to OB Hospitalist Program Agreement (LG and MV)
- NICU Quality Projects Amendment to Increase Hours

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

D. Executive Compensation Committee Actions:

September 19, 2019 approvals are conditional upon the Board's approval of the FY19 Organizational Goal Score on October 10, 2019 and approval of the FY19 financial audit and will be reported at a later date.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Please tell us about your experience at El Camino Hospital.

Thank you so much for taking care of me, for figuring out what was wrong with me and for treating me right away. I'll be forever grateful.

[redacted]

Is there anyone specific you would like to acknowledge?

The ER night staff and Dr. Tseng.

Date/Time: [redacted]

Room No./Department: ER night staff

Campus: ☐ Mountain View ☒ Los Gatos

Name/Telephone (Optional): [redacted]

Dear Susan, Rhonda, Ellen, Sharon and the entire El Camino ICU Staff,

Thank you so much for taking care of me when I was sick, I truly appreciate everything you did for me from dressing me, to feeding me, to making jokes and laughing with me :)

I know they say nurses run the world and I never understood why until now. I see how much you all do along with everybody else. I hope you are all cared for the way you care for others. ♡

Forever Grateful,

[redacted]

Organizational Goals FY19	Benchmark	Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY19 Result	
Organizational Goals									
Patient Throughput	Internal Benchmark *Based on CMS Core Measure Data*	319 Minutes	≤ 288	≤ 263	≤ 254	30%	Q4		262.5
Service - Nurse Communication	External Benchmark *PG-HCAHPS Adjusted/Received*	80	≥ 80.5	≥ 81	≥ 82	10%	Q4		81.1
Service - Responsiveness		65.1	≥ 65.6	≥ 67	≥ 68.5	10%	Q4		67.2
Service - Cleanliness		74.5	≥ 75	≥ 76	≥ 77	10%	Q4		78
Quality - Mortality Index	External Benchmark *Premier Quality Advisor*	1.02	≤ 1	≤ 0.95	≤ 0.9	10%	FY		0.97
Quality - Readmissions Index		1.08	≤ 1.07	≤ 1.05	≤ 1.03	10%	FY		0.99
People *(Management)* - Employee Engagement	External Benchmark *Press Ganey*	4.09	≥ 4.09	≥ 4.14	≥ 4.17	20%	FY		4.27
People *(Non-Management)* Participation in Survey		79%	≥ 79%	≥ 80%	≥ 82%	20%	FY		87%
Threshold Goals									
Budgeted Operating Margin	Internal	Achieved	95% of Budgeted Operating Margin			Threshold	FY		Met

Pillar	Weight	GOAL	OBJECTIVES/OUTCOMES	Baseline	Goal			Measurement Period
Finance	Threshold	Budgeted Operating Margin			95% of Budget			FY20
				FY19	**Minimum**	**Target**	**Stretch**	
Quality and Safety	30.0%	Zero Preventable Harm	Risk-Adjusted Inpatient Mortality Index	0.97	≤ 0.95	≤ 0.90	≤ 0.85	FY20
			Risk-Adjusted Readmission Index	0.99	≤ 0.99	≤ 0.96	≤ 0.94	FY20
Service	30.0%	Exceptional Personalized Experience, Always	HCAHPS : Staff Responsiveness	65.7	≥ 65.7	≥ 67.1	≥ 69.7	FY20
			HCAHPS: Discharge Information	86.7	≥ 86.7	≥ 87.3	≥ 88.4	FY20
People	20.0%	Teams Empowered with Trust and Purpose	Management: Employee Engagement	4.27	≥ 4.24	≥ 4.27	≥ 4.3	FY20
			Employees: Participation	87%	≥ 80	≥ 85	≥ 90	FY20
Growth	20.0%	Market Relevance and Access	Adjusted Discharges		98% of Budget	100% of Budget	102% of budget	FY20

El Camino Health

Patient Experience Strategic Plan

Cheryl Reinking

Real Patient Comments

- Superheroes! Both extremely competent and a delight to be with (nurses)
- Doctor came at 6:00 p.m. and spent one-half hour with me. He informed me what was taking place now & in the future. (doctors)
- Staff in Section 2C treated me and my family especially kindly and professionally. The discharge procedures were accomplished remarkably fast. I am grateful for skill and care from all the physicians and staff. (discharge)
- Room thermostat didn't seem to work very well. Heard lots of coming and going from our room at night - Think we were near a supply room. (environment)
- My IV was bothering me and the nurse who responded to call button (not my assigned nurse) assured me it was fine. After the shift change we discovered it was not okay and needed to be changed. That was the only time I didn't feel taken seriously. (responsiveness)

What are HCAHPS?

- Hospital Consumer Assessment of Healthcare Providers and Systems is a standardized national survey tool from the Centers for Medicare/Medicaid Services started in 2007

- The HCAHPS survey asks discharged patients 27 questions about their recent hospital stay via mailed-paper survey or telephone call survey
  - Text message and email surveys do not count towards HCAHPS score, currently

- The survey contains 18 core questions about critical aspects of patients' hospital experiences:
  - Communication with nurses and doctors,
  - Responsiveness of hospital staff,
  - Cleanliness and quietness of the hospital environment,
  - Communication about medicines,
  - Communication about pain
  - Discharge information,
  - Care transitions
  - Overall rating of hospital, and
  - Likelihood to recommend the hospital

Performance by Composite

ECH performs above the 50th percentile in 9 out of 10 composites locally, 8 of 10 in California, and nationally 7 out of 10. Discharge Information and Responsiveness emerge as areas requiring continuing improvement efforts.

Domain	Top Box FY19	Top Box FY20 YTD	3 year Target	%tile Rank All PG FY19	%tile Rank All PG FY20 YTD	Goal Difference	%tile Rank California FY19	%tile Rank California FY20 YTD	Goal Difference	%tile Rank Bay Area FY19	%tile Rank Bay Area FY20 YTD	Goal Difference
Rate Hospital 0-10	78.1	77.4 ▼	50th Percentile or Higher (National)	75	71	21	74	70	20	79	74	24
Recommend the Hospital	83.5	84.5 ▲		87	90	40	82	83	33	85	86	36
Comm w/ Nurses	80.6	82.1 ▲		52	62	12	73	82	32	69	89	39
Response of Hospital Staff	65.7	65.8 ▲		43	41	-9	53	55	5	72	57	7
Comm w/ Doctors	84.0	85.2 ▲		72	78	28	81	86	36	77	87	37
Hospital Environment	66.4	66.5 ▲		47	45	-5	69	68	18	90	78	28
Communication about Pain	68.7	68.0 ▼		67	61	11	70	68	18	87	74	24
Comm About Meds	63.7	64.9 ▲		46	53	3	36	44	-6	65	71	21
Discharge Information	86.7	87.2 ▲		40	45	-5	41	44	-6	40	49	-1
Care Transitions	57.0	59.1 ▲		71	78	28	73	81	31	75	82	32

Compared year over year.
i.e.: Green = improvement from previous month

Compared to 3-year target.
i.e.: Green = above 50th percentile target

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Performance by Survey

ECH performs above the percentile goal in 4 out of 5 composites locally and in California. However, nationally, the organization performs below the percentile goals.

OASCAHPS and Outpatient Services are scored based on the California percentile rank.
ED Satisfaction and Outpatient Oncology are scored compared to national rank.

Domain	Top Box FY19	Top Box FY20 YTD	3 year Target	%tile Rank All PG FY19	%tile Rank All PG FY20 YTD	Goal Difference	%tile Rank California FY19	%tile Rank California FY20 YTD	Goal Difference	%tile Rank Bay Area FY19	%tile Rank Bay Area FY20 YTD	Goal Difference
ED Satisfaction	66.7	69.8 ▲	Above 75th %tile (National)	43	53	-22	77	81	6	74	75	0
OASCAHPS	81.9	82.7 ▲	At or Above 50th %tile (California)	23	26	-24	43	51	1	55	60	10
Outpatient	79.5	80.8 ▲	Above 75th %tile (California)	44	52	-23	73	78	3	86	85	10
Outpatient Oncology	83.5	76.0 ▼	Above 75th %tile (National)	84	31	-44	84	32	-43	91	36	-39

Compared year over year.
i.e.: Green = improvement from previous month

Compared to 3-year target.
i.e.: Green = above 50th percentile target

El Camino Health

3 Year Plan for Patient Experience
Areas of Consideration/Incorporation

True North Statement:

Exceptional Personalized Experience, Always

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Key Activities in Year 1

- Hire, recognize and train employees as customer service ambassadors
- Establish opportunities for real-time feedback
    - Prioritize Executive Rounding
- Current technology
    - Understand availability and use
- Prioritize best practices for implementation
- Make data reports standardized
    - Unit-based and visible to all
- Establish internal brand for Patient Experience
- PFAC recruitment – more diversity and ages represented

Key activities of Year 2

- Implement information sharing with non-EPIC locations
- Realize Room of the future
- Focus on Engagement & Culture
  - Engagement events, excellence standards and culture, accountability, physician engagement survey
- Continue sustainment of implementation of best practices
  - Hourly Rounding, No Pass Zone and others
- Electronic VIS Boards
  - Streamline data updates and sharing
- Usable and friendly Intranet
- Patient reunion celebration at ECH
- PFACs for various service lines

Key activities of Year 3

- Technology
  - Effectively use and update solutions
  - Personalized care matching
  - Enhance data reports
  - Reducing redundancy
  - Anticipate patient needs
- Bring patient and staff stories to life
- Recognition
  - Service over just quality or quantity
- Hardwire culture of internal branding
- PFAC
  - Virtual platform for meetings
  - Consider employee PFAC members

Key Behaviors to Support PX & Safety Roadmaps

Core Values/Mission

Culture

Training

Daily Activities

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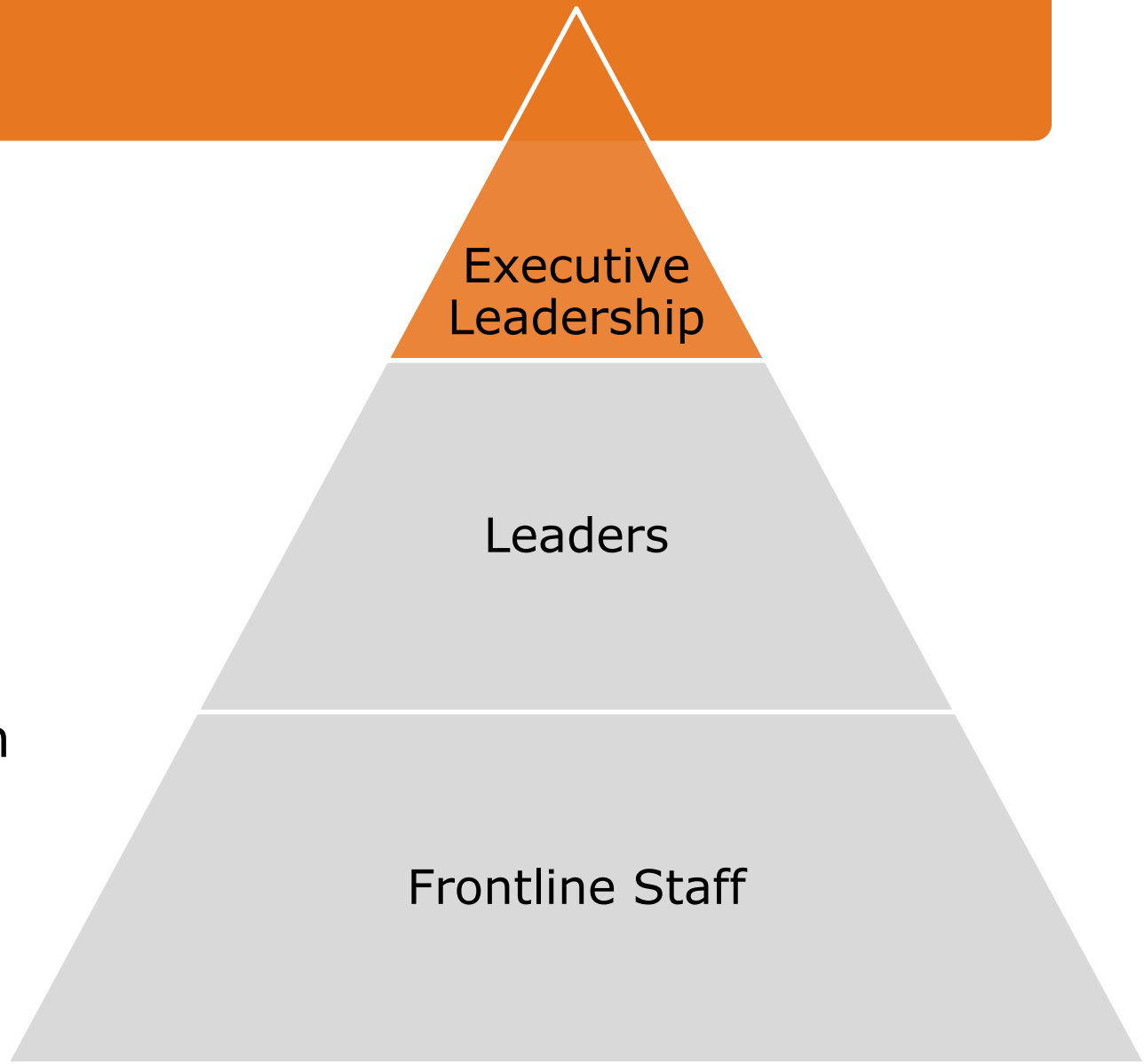
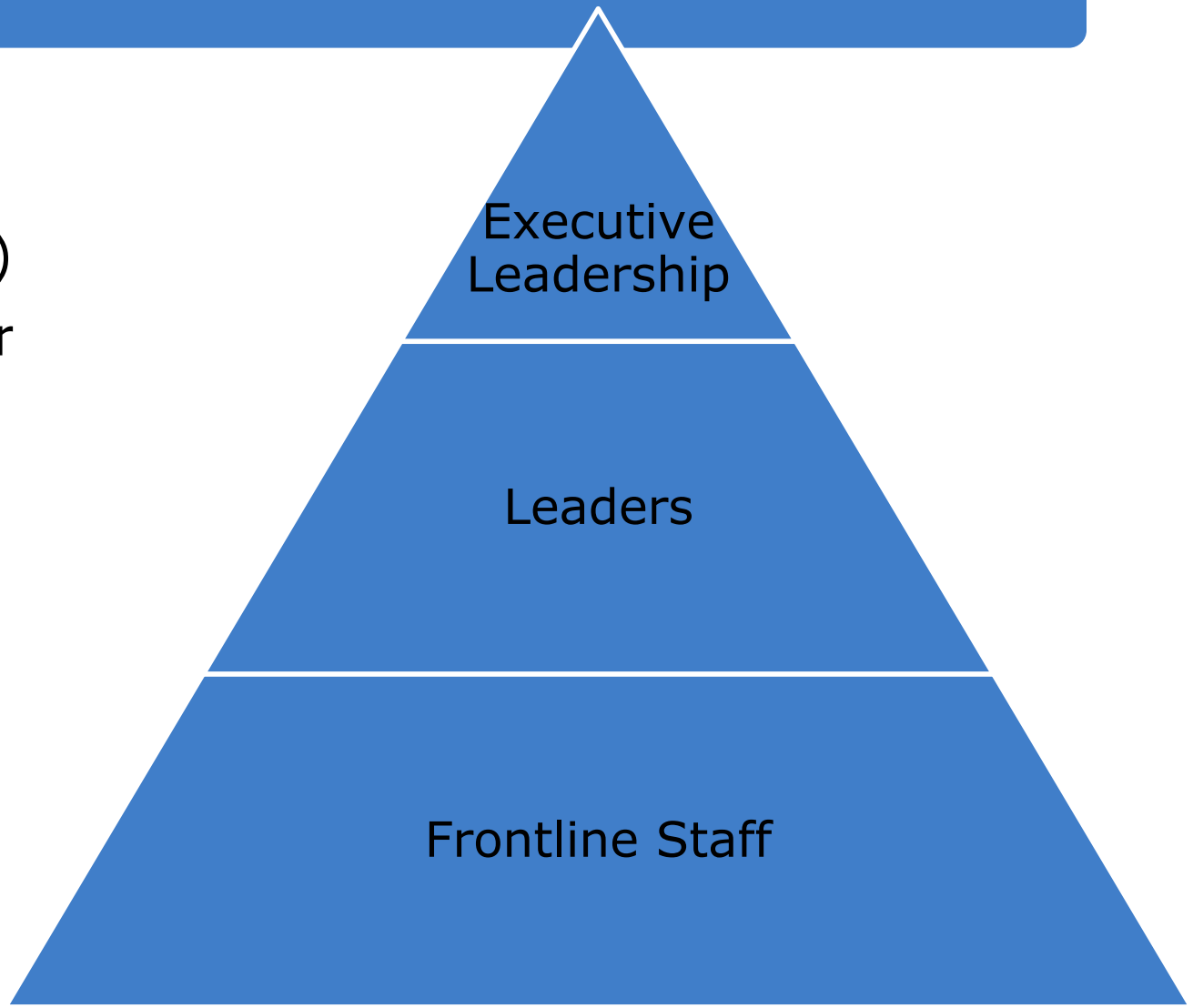
Core Values/Mission

- Promote and publicize "True North" statement for Patient Experience
- Establish a repeatable, easy and understandable statement with a memorable focus
- Revise the current Governance, Leadership, and Management structures for quality to meet the needs for alignment and coordination of quality efforts
- Include safety focus for all PFAC meetings



Culture: Quality, Safety and Patient Experience are in our DNA

- Re-Tool Recognition program (move from e-WOW and include physicians)
- Ensure all new hires will be customer service ambassadors
- Include safety focus for all PFAC meetings
- Proactive approach to addressing patient needs and safety
- Establish a means for real-time feedback utilizing just-culture practices

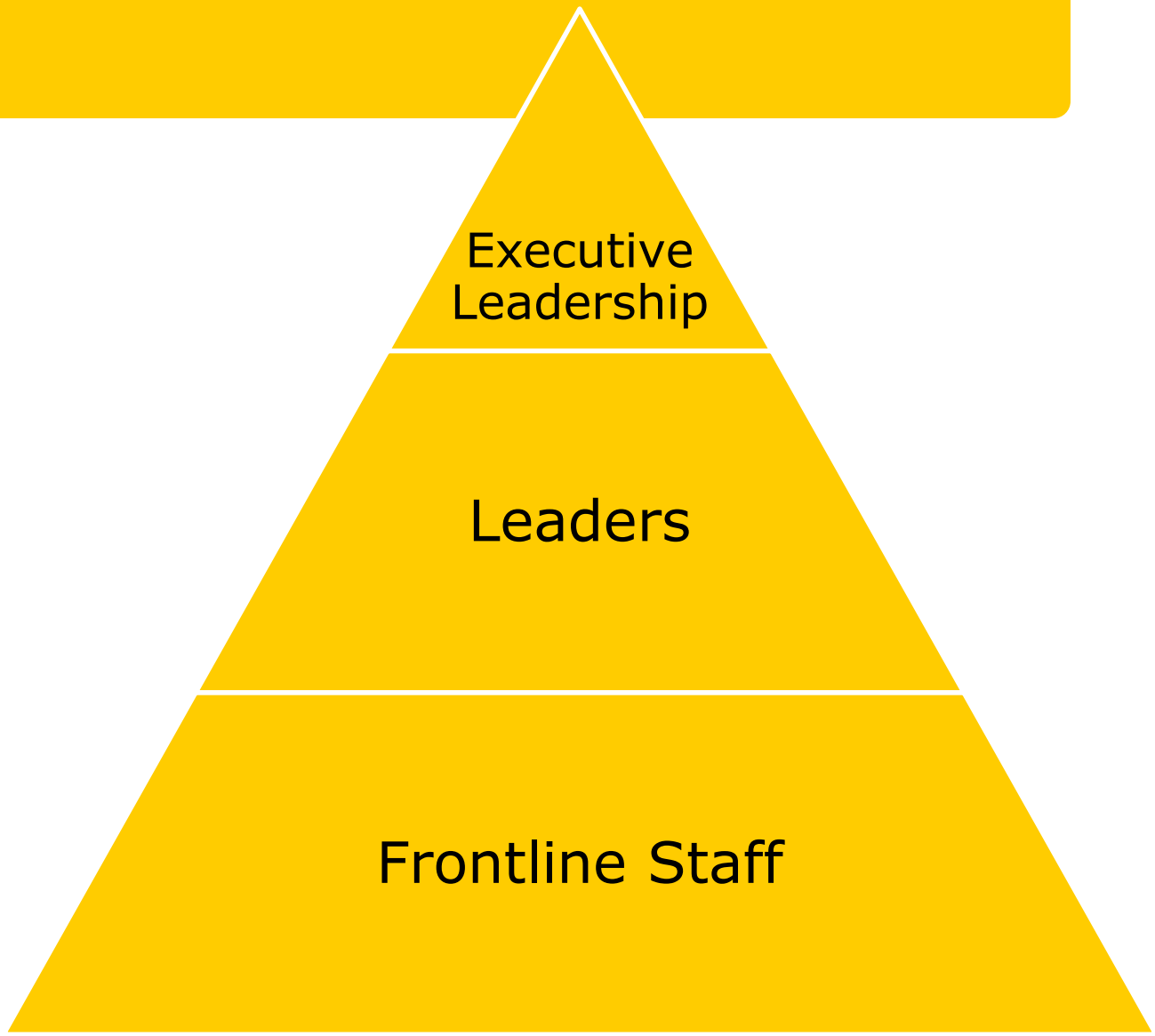


Training

- Service Culture Training
- Establish expectations and education for all current technology
- Create capacity, alleviate pain before adding more training
- Update new employee general orientation and physician onboarding

Daily Activities

- Leader Rounding for safety & patient experience
- Daily huddle focus on safety & patient experience
- Make data reports standardized, unit-based and visible to all for safety & patient experience



El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee ("Quality Committee")
From: Cindy Murphy, Director of Governance Services
Date: October 7, 2019
Subject: Proposed Revisions to the Quality, Patient Care and Patient Experience Committee Charter

Recommendation:

To consider proposed revisions to the Quality Committee Charter for submission to the Governance Committee for review and recommendation and to the Board for final approval.

Summary:

1. Situation: ECH's Quality Committee presently does not have a role in oversight of the Medical Staff credentialing and privileging process. Rather, Medical Staff credentialing and privileging recommendations currently go straight to the Board from the Medical Executive Committee ("MEC").

2. Authority: Revisions to Committee Charters are reviewed by the affected Committee, the Governance Committee, and ultimately approved by the Hospital Board.

3. Background: At its August 5, 2019 meeting, the Committee discussed Board-level Quality Committee Reporting. The Committee reviewed best practice guidelines and principles for health system Board Quality Committees, including oversight of the integrity and reliability of the credentialing process.

4. Assessment: If the Committee desires to take on this work, there will need to be a delegation from the Board through amendment(s) to the Committee's Charter. The proposed revisions will enable the Committee to make recommendations to the Board regarding approval of the MEC's monthly credentials and privileges report.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Proposed Revisions to the Quality, Patient Care and Patient Experience Committee Charter

Suggested Committee Discussion Questions:

1. Is this an area of oversight that Committee would like to take on?

Quality, Patient Care and Patient Experience Committee Charter
Draft Revised October 7, 2019

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH. The committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the El Camino strategic plan related to delivering high quality healthcare to the patients that we serve. High quality care is defined as care that is: safe, timely, effective, efficient, equitable, and person-centered.

The organization will provide to the Committee standardized quality metrics with appropriate benchmarks so that the Committee can adequately assess the level of quality care being provided.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

The Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Quality Committee may also include 1) no more than nine (9) external (non-Hospital Board member) members with expertise in in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine external members are recommended to serve on this committee.

- All Committee members shall be appointed by the Board Chair, subject to approval by the Board, for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.

Staff Support and Participation

The Chief Medical Officer (CMO) shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as members of the executive team may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. This may include the Chief/Vice Chief of the Medical Staff.

General Responsibilities

The Committee's primary role is to develop a deep understanding of the organizational strategic plan, the quality plan, and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for 1) ensuring that performance metrics meet the Board's expectations; 2) align those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring that communication to the Board and external constituents is well executed.

Specific Duties

The specific duties of the Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT).
- Review and approve an annual "Quality Dashboard" for tracking purposes.
- Oversee management's development of Hospital's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services.
- Review reports related to ECH-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    - ECH-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - ECH-wide patient safety goals and hospital performance relative to patient safety targets.

  - ECH-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
  - ECH-wide LEAN management activities and cultural transformation work.
  - ECH-wide patient satisfaction and patient experience surveys.
  - ECH-wide physician satisfaction surveys.

- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to including, but limited to, The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements.
- Review Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts as per the hospital and board policy.
- Oversee organizational quality and safety performance improvement for both hospital and medical staff activities.
- Ensure that ECH scope of service and community activities and resources are responsive to community need.
- Review the MEC's monthly credentialing and privileging reports and make recommendations to the Board.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.