El Camino Health

AGENDA

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

Monday, December 2, 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.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (11/4/2019) ***Information*** b. FY20 Quality Dashboard c. FY20 Pacing Plan d. Progress Against FY20 QC Goals e. Hospital Update	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:35**
4.	**FOLLOW UP ITEMS FROM LAST MEETING** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**discussion 5:35 – 5:40**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Julie Kliger, Quality Committee Chair		**information 5:40 – 5:50**
6.	**PATIENT STORY** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**discussion 5:50 – 6:00**
7.	**READMISSION DASHBOARD** **ATTACHMENT 7**	Cheryl Reinking, RN, CNO		**discussion 6:00 – 6:10**
8.	**PATIENT SAFETY INDICATORS** **ATTACHMENT 8**	Cheryl Reinking, RN, CNO		**discussion 6:10 – 6:20**
9.	**PEER REVIEW PROCESS** **ATTACHMENT 9**	Shreyas Mallur, MD, Associate CMO; Daniel Shin, MD, Medical Director, Quality & Patient Safety		**discussion 6:20 – 6:50**
10.	**ANNUAL PERFORMANCE IMPROVEMENT REPORTS** **ATTACHMENT 10**	Cheryl Reinking, RN, CNO		**discussion 6:50 – 7:00**
11.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 7:00 – 7:03**

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
12.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:03 – 7:04**
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 7:04 – 7:05**
14.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**motion required 7:05 – 7:07**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (12/2/2019) ***Information*** b. Medical Staff Quality Council Minutes			
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Q1 Quality and Safety Review	Cheryl Reinking, RN, CNO		**discussion 7:07 – 7:27**
16.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Cheryl Reinking, RN, CNO		**discussion 7:27 – 7:37**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:37 – 7:38**
18.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 7:38 – 7:39**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
19.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:39 – 7:40pm**
20.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:40 – 7:45pm**

Upcoming Meetings:

Regular Meetings: February 3, 2020; March 2, 2020; April 6, 2020; May 4, 2020; June 1, 2020
Educational Sessions: April 22, 2020

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, November 4, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

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

Members Absent
Peter C. Fung, MD

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. A silent roll call was taken. Committee member Peter C. Fung, MD was absent and members Caroline Currie and Alyson Falwell joined the meeting at 5:35 after the vote to approve the consent calendar. 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 removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee (10/7/2019); Minutes of the Open Session of the Special Joint Meeting to Conduct a Study Session of the Hospital Board and the Quality Committee (10/23/2019); and for information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 QC Goals; and Hospital Update. **Movant:** Burn **Second:** Simon **Ayes:** Burn, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** Currie, Falwell, Fung **Recused:** None	***Consent Calendar approved***
4. REPORT ON BOARD ACTIONS	It was noted that the District Board elected Directors Rebitzer and Kliger to second terms on the Board. There were no questions about the report.	
5. PATIENT STORY	Chery Reinking, RN, CNO, commented that the patient letter in the packet related to key aspects of HCAHPS domains that the organization is focusing on this year. The Committee requested that staff bring patient stories to the Committee about experiences where things have not gone well, either by reaching back to a patient with a negative experience or simply gathering the information, even when there is not patient letter about the experience.	

6. DEBRIEF: JOINT MEETING OF THE QUALITY COMMITTEE AND THE BOARD	Chair Kliger conducted a de-brief about the recent Joint Board and Committee Education Session. Mark Adams, MD, CMO, noted that the purpose of the session was to level set understanding of quality and safety in the organization, how ECH compares with other similar organizations, how ECH measures quality and safety, and, specifically, explain and understand what the role of the Quality Committee and the Board is in overseeing this area. Dan Woods, CEO, commented that the session was the first in a multi-year journey and that the next phase of the discussion is to have conversations about how to fulfill the roles. Mr. Woods and Chair Kliger agreed that the Medical Staff leaders should be invited to future educational sessions about quality and staff was asked to look for available dates. Chair Kliger asked that those who were not at the meeting be provided with copies of the materials. There was also discussion about a group visit to other healthcare organizations that are high performing.	
7. ANNUAL PERFORMANCE IMPROVEMENT REPORTS	Dr. Adams reviewed the annual performance improvement reports delivered to the Quality Council. This included reports from the Heart and Vascular Institute, Care Coordination, Pharmacy, and Dietary Services. Going forward, these reports will flow from the Quality Council to the Board Quality Committee. These will routinely be included in the consent agenda but if there are particular areas of concern, those items will be pulled from the consent agenda for committee discussion. Dr. Adams agreed to add control limits to the data where possible. The Committee members commented that it is important to them to have some understanding of the discussion at the Quality Council about areas of concern regarding underperforming areas. Dr. Adams agreed to look at how the Quality Council minutes might be revised to give more insight into the discussion there and invited the Committee members to contact him if they would like to sit and observe a Quality Council meeting.	
8. QUALITY AND SAFETY STRATEGIC PLAN	Dr. Adams provided an update on our Quality and Safety Plan. An executive summary was provided along with a high level work plan. The five areas of focus were reviewed: 1. Governance, Leadership, and Management; 2. Quality Organization Integration; 3. Performance Improvement Metrics and Methods; 4. Journey to High Reliability; 5. Culture of Quality and Safety. Dr. Adams explained that the work plan is divided into three categories to include short term, intermediate, and long range performance improvement. Many elements of the plan have already been implemented or are in progress. The quality structure of the organization was reviewed and attention was focused on how SVMD fits into that structure. The committee discussed the difference between short term (annual) organizational incentive goals and aspirational goals. The former are linked to the STEEEP framework for quality and safety. The specific metrics are the same as those used in many other organizations. Aspirational goals are linked to our vision: "To consistently deliver the highest quality care with zero preventable harm." Chair Kliger requested that a discussion around goal attainment be added to	

	the Pacing Plan for a future meeting	
9. ANNUAL SAFETY REPORT FOR THE ENVIRONMENT OF CARE	The Annual Safety Report for the Environment of Care was presented by Matthew Scannell, director of safety and security, and Steve Weirauch, environmental, health, and safety manager. Areas of concern include planning and staging for the opening of two new buildings. A comprehensive FMEA (failure mode effects analysis) will be performed in preparation for the operation of the new mental health and addictive services building. Staff and patient security was discussed with the committee noting the significant decrease in employee injuries. **Motion**: To recommend Board approval of the Report **Movant:** Po **Second:** Simon **Ayes:** Burn, Currie, Falwell, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Recommend-ed approval of the Annual Safety Report for the Environ-ment of care***
10. CDI DASHBOARD	Dr. Adams provided an overview of our Clinical Documentation Integrity program. This work drives our ability to accurately measure our true quality metrics as well as impacts our revenue cycle. The team has achieved a 100% physician inquiry response rate with an even more impressive 80% agreement rate.	
11. CORE MEASURES	The most recent core measure report was reviewed by the committee. Of note, the previously increasing PC-01 (pre-term elective deliveries) has diminished to zero. The remaining measures are on target or improving.	
12. PUBLIC COMMUNICATION	There was no written or oral public communication.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:45pm. **Movant:** Sharma **Second:** Simon **Ayes:** Burn, Currie, Falwell, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Adjourned to closed session at 7:45pm***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 8:35pm. Agenda items 14-18 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (10/7/2019); and for information: Medical Staff Quality Council Minutes.	
15. AGENDA ITEM 20: CLOSING WRAP UP	This item was not addressed	
16. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 8:35pm. **Movant:** Sharma **Second:** Po **Ayes:** Burn, Currie, Falwell, Kliger, Ting, Po, Sharma, Simon **Noes:** None	***Meeting adjourned at 8:35pm***

	Abstentions: None **Absent:** Fung **Recused:** None	

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

_____
Julie Kliger, MPA, BSN
Chair, Quality Committee

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Date: December 2, 2019
Subject: FY20 Quality Dashboard for December meeting

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.

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 thirteen (13) 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) continues and is evident on the Mortality Index
- Readmission Index reduced significantly after increasing over the summer months.
- ED Throughput goal reduced to 250 minutes, and Enterprise results are below new goal.
- The HCAPS metrics for Responsiveness and Discharge Information are both above target. The Likelihood to Recommend metric went down.
- Only 1 HAI in October, a CAUTI due to ED insertion.
- New metrics of Surgical Site Infections, Elective Delivery <39 weeks gestation, and Primary Cesarean Birth have been added for FY20. The Perinatal Care Core Measures, PC-0 1 and PC-02, are reported by hospital campus and for the Enterprise.
- PC-02 C/Section rate went down in October.

5. Other Reviews: N/A

6. Outcomes: N/A

Suggested Committee Discussion Questions: None

List of Attachments:

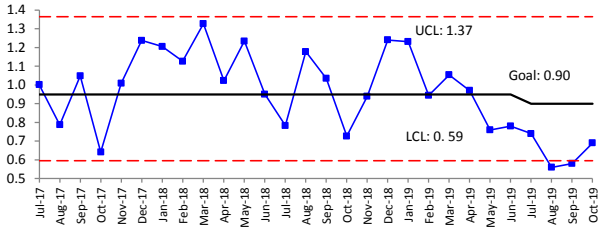
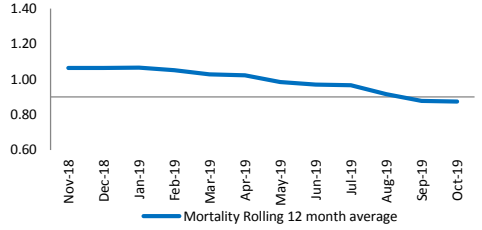
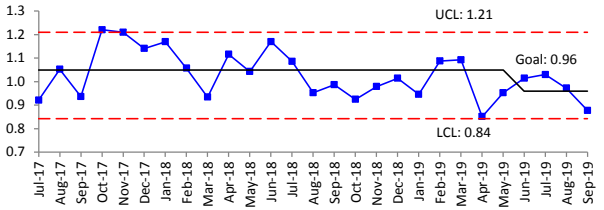
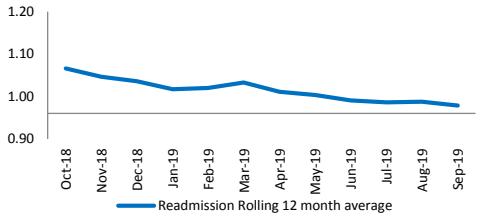
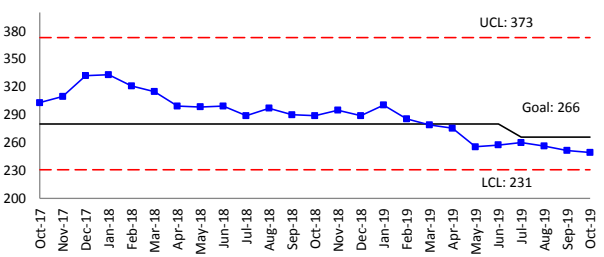
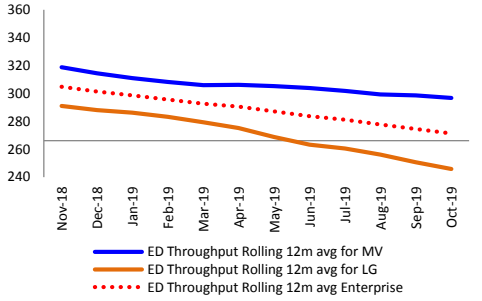
1. FY20 Quality Dashboard, October data unless otherwise specified - final results

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

October 2019 (Unless otherwise specified)

Month to Board Quality Committee: December, 2019

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend (showing at least 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: October 2019*	0.69 (1.18%/1.69%)	0.63 (1.12%/1.77%)	0.97	0.90		
2	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: September 2019*	0.88 (6.81%/7.76%)	0.96 (7.51%/7.82%)	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: October 2019*	MV: 277 min LG: 222 min Enterprise: 250 min	MV: 282 min LG: 228 min Enterprise: 255 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

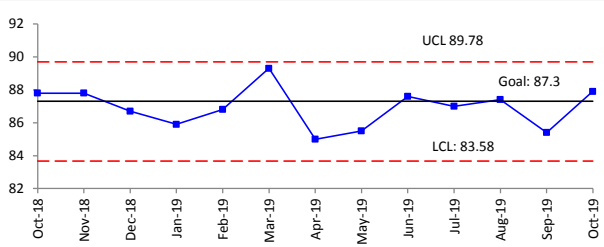
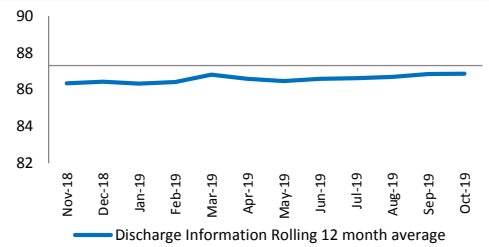
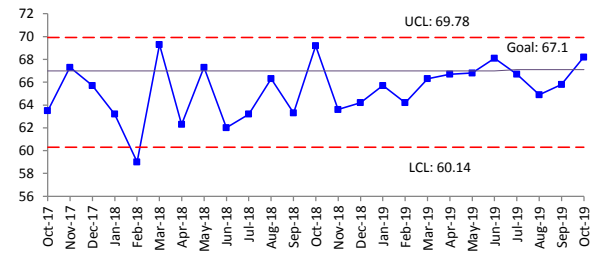
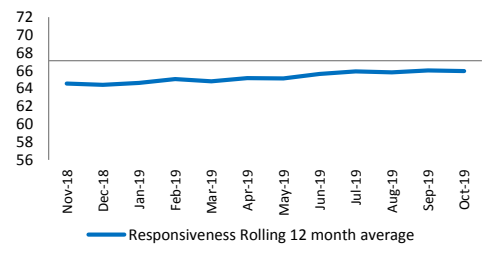
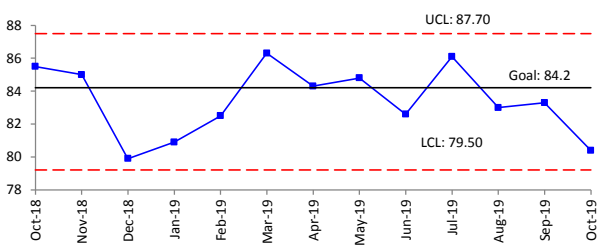
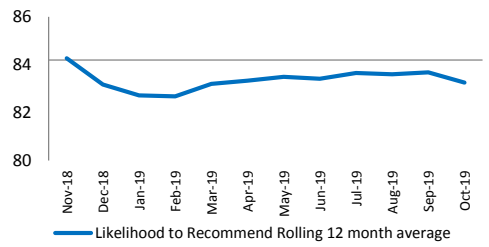
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	The effect of transferring patients who qualify and accept GIP (inpt hospice) is clear since May 2019. The increase in the Index in October is directly related to a slow down in transfer of patients into GIP, only 2 trasnsferred during October. Palliative Care Team is conducting analysis to determine any causes of this change.	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	The increase in Readmissions Index over the summer months has resolved with a significant reduction in September.	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)	Both campuses continue to work on problem solving and implementing improvements that were identified from the ED value stream refresh earlier this July. Los Gatos is stabilizing on improvements that were identified during their first 2 Rapid Process Improvement Workshops to help improve the initiation of care and ancillary testing. MV is also in the process of implementing recommendations from a working session with ED MD and Hospitalist leaders to help improve "Consult to Admit" order timeframes. Work continues to be in process on both campuses to help implement elements of Daily Management System related to ED throughput. Please note that MV ED is also undergoing construction and does not have access to a few of their exam rooms. Despite that they are trying to maintain their performance on Time from Arrival to Head in Bed.	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

October 2019 (Unless otherwise specified)

Month to Board Quality Committee: December, 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: October 2019*	87.9	87	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: October 2019*	68.2	66.4	65.7	67.1		
6	**HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: October 2019*	80.4	83.2	83.5	84.2		

Definitions and Additional Information

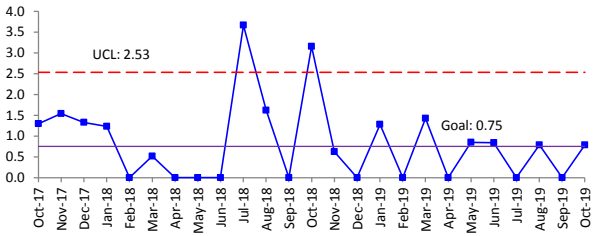
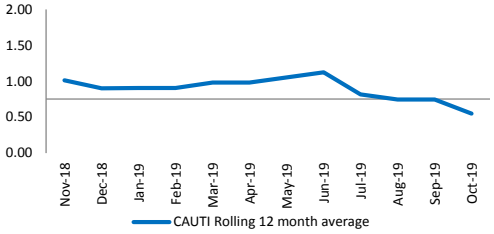
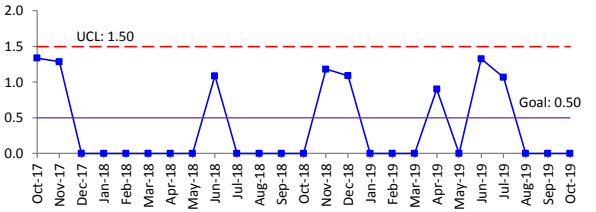
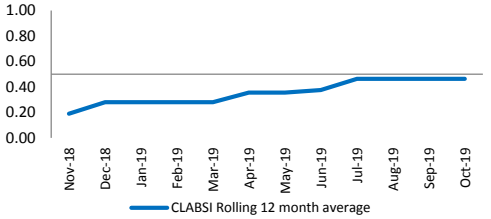
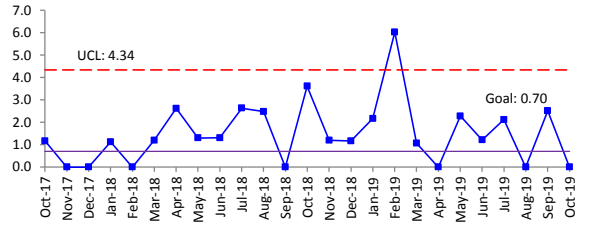
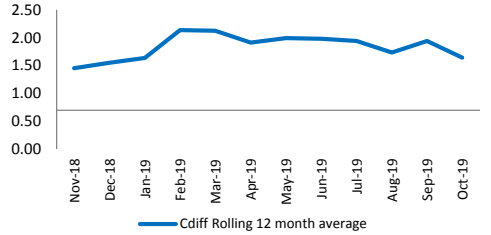
Measure Name	Comments	Definition Owner	- Arrival: Patient Arrived in ED	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	a. New AVS signs and symptoms section is live b. "Do you have the help you need at home" whiteboard initiative underway c. Publishing discharge checklist in Patient Guide Books to help include patients in the process d. Continued exploration on post discharge phone calls process e. 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	a. Taking a deep dive into metrics by division to determine best practices b. Confirmed via call light audit the reasons patients ask for help (bathroom, pain, etc.) c. Emphasize leader rounding questions on call light and help needed d. Working with our team to determine the impact of No Pass Zone project	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	a. Six month review of Leader Rounding Best Practice to determine areas of improvement for long term sustainability and impact b. Provide monthly Leader Rounding Updates / review data and comments with actionable data for improvements and recognition c. Add Leader Rounding to Emergency Department d. Review and finalize key drivers for Likelihood to Recommend	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

October 2019 (Unless otherwise specified)

Month to Board Quality Committee: December, 2019

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend	
Quality		Month	FYTD				
7	**Hospital Acquired Infections** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: October 2019*	0.79 (1/1273)	0.40 (2/4976)	1.09	SIR Goal: <= 0.75		
8	***Hospital Acquired Infections*** *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: October 2019*	0.00 (0/900)	0.28 (1/3569)	0.36	SIR Goal: <= 0.50		
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: October 2019*	0.00 (0/8366)	1.19 (4/33648)	1.96	SIR Goal: <= 0.70		

Definitions and Additional Information

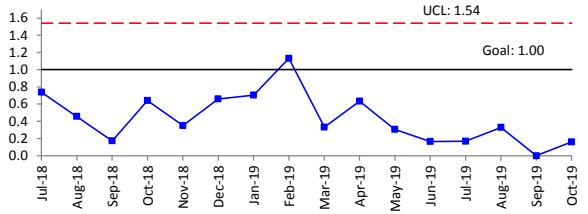
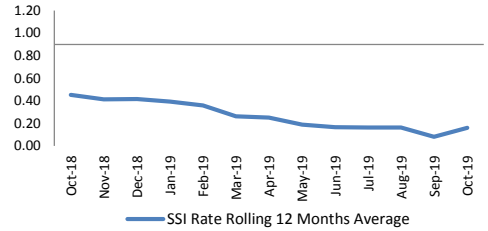
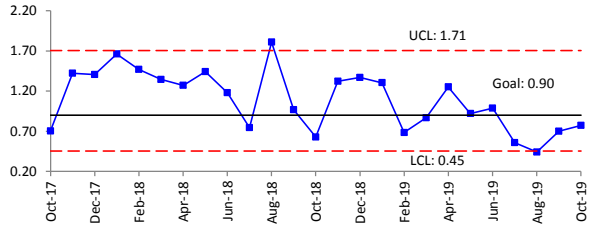
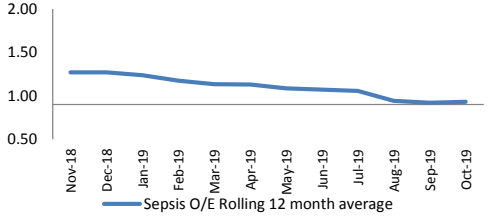
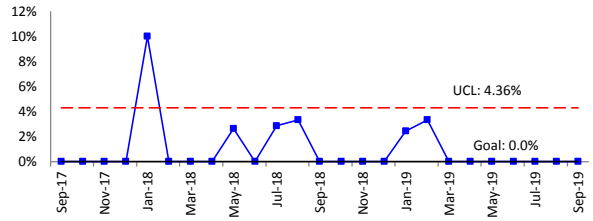
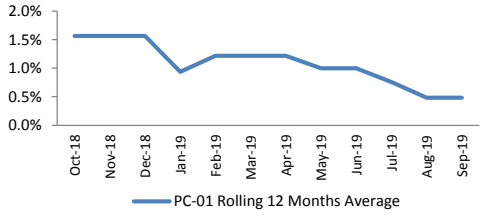
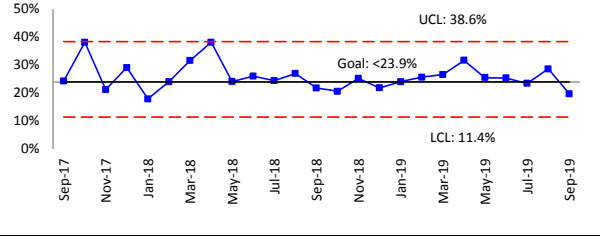
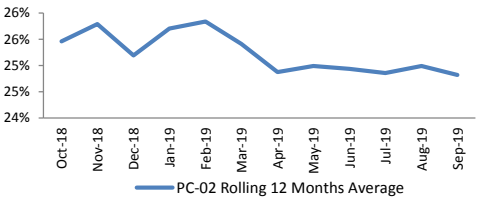
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	1 CAUTI occurred in October; in unit 4B: 63 y/o male admitted w/Hx of prostrate cancer and urinary retention with acute kidney injury. New infection after normal urinalysis and insertion of catheter in the ED.	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)	Zero CLABSI in October 2019 and continued zero CLABSI over 3 months.	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)	Zero C.Difficile HAI in October.	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

October 2019 (Unless otherwise specified)

Month to Board Quality Committee: December, 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: October 2019*	0.16 (1/625)	0.17 (4/2411)	0.22 (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: October 2019*	0.77 (8.25%/10.66%)	0.60 (6.02%/9.97%)	1.06	0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) Enterprise Date period: September 2019	MV: 0.00% (0/27) LG: 0.00% (0/3) ENT: 0.00% (0/30)	MV: 0.00% (0/90) LG: 0.00% (0/13) ENT: 0.00% (0/103)	MV: 1.11% (4/360) LG: 0.00% (0/44) ENT: 0.99% (4/404)	0.0%		
13	**PC-02: Cesarean Birth** (lower = better) Enterprise Date period: September 2019	MV: 19.70% (24/112) LG: 10.00% (2/20) ENT: 19.70% (26/132)	MV: 26.90% (78/290) LG: 18.92% (7/37) ENT: 25.99% (85/327)	MV: 26.28% (425/1617) LG: 14.29% (30/210) ENT: 24.90% (455/1827)	<23.9%		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1 SSI in October in Mountain View: 54 y/o female admitted for Ex.Lap, TAHBSO, tumor debulking, developed pelvic absess 16 days post-op.		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.*	**CDC NHSN data base - Inf. Control**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Sepsis mortality index remains low due to l better physician documentation risk of mortality amd improvements in Sep-1 Core Measure/Bundle compliance. ED data shows Antibiotics given within 1 hour of Time of Presentation at 79% and Antibiotic Adminstration within 1 hour of Order at 90%. Earlier appropriate treatment with fluids and antibiotics improves 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. Both campus have sustained zero since March.	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		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)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Safety Report for the Environment of Care 11. Q1 FY20 Quarterly Quality and Safety Review 12. Debrief 10/23 Session 13. Q&S Plan	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotate) Special Agenda items: 8. ~~Update on Patient and Family Centered Care~~ 9. Readmission Dashboard 10. PSI-~~90 Pt. Safety~~ Indicators 11. Peer Review Process 12. ~~Draft Revised QC Charter~~ ~~12.~~13. Drill Down on Q1 Q&S Review

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 (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Q2 FY20 Quality and Safety Review 9. Update on Patient Care Experience 10. Goal Attainment ~~9.~~11. Draft Revised Charter	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Proposed FY21 Committee Goals 9. Proposed FY21 Organizational Goals 10. Update on Patient and Family Centered Care ~~9.~~11. Update on LEAN Transformation
FY2020 Q4		
APRIL 6, 2020	**MAY 4, 2020**	**JUNE 1, 2020**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments – PLUS Bring Back HIMS, Ortho. Antimicrobial from October) 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 (Not Positive) 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) (Complete) - 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) (On December Agenda) - 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 (Use Closing Wrap-Up Time)	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 (nbgoing)

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

El Camino Hospital Update
December 2, 2019
Mark Adams, MD, CMO

Workforce

In the first month following "go live" on Workday, we have had great employee and manager acceptance and support for our new Enterprise Resource Planner. In addition to the metrics listed below, the paycheck of October 25th included annual employee salary adjustments including base salary increases for PRN nurses. These transactions were undertaken seamlessly and without incident. We will continue to stabilize and begin to optimize the Human Resource and Finance tenets as we prepare to add/implement Supply Chain in 2020. Key metrics include:

- 3,071 unique users logged in
- 16,764 General Ledger transactions posted
- 823 candidates accessed our Job Board
- 6,274 invoices submitted
  - 6,020 approved
- 332 expense reports submitted
  - 293 approved; monitoring remaining approvals

Operations

El Camino Hospital acquired a new computer-guided robotic arm that assists in the location and trajectory of pedicle screws for spine fusion. Evidence shows that robotic-assisted placement is more accurate and has fewer complications than manual screw placement. The new equipment will link to existing stealth navigation computers and will be utilized by multiple surgeons who are already certified in the technology. The acquisition builds on the spine service line strategy of offering meaningful cutting-edge technology and nimble innovation to improve quality.

Dr. Krishna has completed 14 robotic bronchoscopy cases at ECH. We were able to do a FIRST EVER biopsy of 6MM lung nodule on the periphery of the lung and obtain a diagnosis. It was a tremendous result to catch this cancer in a very early stage of development.

A delegation from staff attended the Magnet Conference on October 9-12, 2019. The conference attracts over 10,000 nurses from around the world and typically receives submissions of over 1600 abstracts for poster and podium presentations. ECH was selected to present two podium presentations at the conference. Athena Lendvay, RN presented information on Early Recovery After Surgery (ERAS) protocols we implemented with great success at ECH. Jackie Keane, RN and Patty DeMellopine, RN presented the activities the hospital has been engaged with for the LBGTQ community and the patients served at ECH to become a leader in health care equity. Both presentations were greatly attended with much interest!

El Camino Health

Corporate and Community Health Services

Cecile Currier, VP, Corporate and Community Health Services and President, CONCERN EAP, received Momentum for Mental Health's Shining Star Award at its annual Gala. This award recognizes individuals who have made a significant contribution to improving access and quality of services in the behavioral health field.

The FY19 Community Benefit Annual Report was published, went live online, and was presented to both the ECH and ECHD Boards. We will disseminate the FY19 Community Benefit Annual Report, which was published and presented to the Board in October, to the community in November. The microsite is at www.elcaminohealth.org/microsites/communitybenefit2019/

West Valley Community Services Agency honored El Camino Health as a Champion of Compassion at their 2019 annual Chef of Compassion event. Jim Griffith accepted the award for the Hospital. Recent El Camino Hospital Sponsorships include:

- Child Advocates Silicon Valley – Wine, Women and Shoes
- Alzheimer's Association – Walk
- Next Door Solutions for Domestic Violence – Light up the Night
- Hispanic Foundation – Annual Ball
- American Cancer Society – Breast Cancer Walk
- YWCA Silicon Valley – Inspire Luncheon

The South Asian Heart Center (SAHC) held a physician continuing medical education event with 64 physicians in attendance and 33 physicians joining the SAHC physician network. The SAHC participated in corporate benefits health fairs resulting in SAHC program signups and cookbook requests at KLA Tencor, and at Oracle locations in Santa Clara and Pleasanton. We also launched new outreach locations at the Foster City and Sunnyvale Farmer's markets.

The Chinese Health Initiative (CHI) held its annual physician appreciation dinner with 30 physicians attending. Dan Woods, CEO, presented El Camino Health's branding strategy & new clinical services and Dr. Ed Yu, family medicine, presented CHI's upcoming launch of diabetes prevention program. The Chinese-speaking physician network was launched in 2010 to help Chinese community members connect with physicians from all specialties who speak their language.

CHI also participated at CASPA (largest Chinese engineering professional association in the region) reaching out to high tech professionals to promote diabetes prevention program. We distributed diabetes information to 500+ conference attendees.

The Health Library & Resource Center gave a presentation about its services at the Cancer Center, had information tables at the ECH Benefits Fair in MV and LG and the Saratoga Senior Center and continues weekly information tables at the Mountain View Senior Center and the Indian Community Center.

El Camino Health

Marketing and Communications

Marketing, Government Relations and the El Camino Health Foundation collaborated for the Taube Pavilion, Scrivner Center for Mental Health and Addiction Services grand opening events. In addition to an evening VIP program and ribbon cutting on October 24, 2019, we held an open house for physicians and staff on Friday, October 25, followed by a community open house on Saturday, October 26. Saturday's event kicked off with a second VIP program attended by many elected officials, including U.S. House Representative Anna Eshoo State Assemblymembers Berman and Kalra, Santa Clara County Supervisor Joe Simitian and mayors and city councilmembers from several cities. Over the course of the afternoon, several hundred community members attended and received guided tours of Taube Pavilion.

Recent media coverage included articles about the Taube Pavilion in The Los Altos Town Crier and Mountain View Voice with future coverage pending. We distributed a media release for the first GammaTile procedure on the West Coast and a patient story highlighting the impact of bronchial lung volume reduction earned placements in the 10 largest Designated Market Areas in the U.S.: NYC, LA, Chicago, Houston, Philadelphia, Phoenix, San Antonio, San Diego, Dallas, and San Jose. That is a total audience of 82,551,806.

We completed principal production of the new El Camino Health announcement campaign and launched an advertising campaign to support brand awareness for primary care services for El Camino Health. The campaign includes paid media, a dedicated landing page, direct mail and email marketing efforts reaching thousands in the Bay Area.

The marketing team initiated advertising and brand tracking studies to measure corporate brand advertising effectiveness and brand health. We are pursuing drivers and comparative segment analysis for NRC dataset to obtain market insights.

Marketing and HR collaborated to hold seven employee town hall meetings across campuses. 645 individuals attended.

Philanthropy

During Period 3 of fiscal year 2020, El Camino Health Foundation secured $77,343 in donations. Since September investment income is not available yet, the Period 3 fundraising report shows a fundraising total of $1,240,957, which reflects donations through September 30, 2019 but investment income only through August 31, 2019.

Auxiliary

The Auxiliary volunteer hours for October 2019 were not available at the time of publication of this report and will be reported next month.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: December 2, 2019
Subject: Follow-Up Items from the November 4, 2019 Meeting

Purpose:

To ensure that these items are tracked and that the full Committee has transparency into the follow-up of the items.

Summary:

1. Situation: The initials of the team member who owns the follow up appears in parentheses.

A. Item: Bring "negative" patient story either through reaching back to a patient or just bringing a story about a patient where things did not go as well as they could have even though the patient did not write a letter.

Follow Up: Provided for December 2, 2019 Meeting. This is also noted on the Pacing Plan. (CR)

B. Item: Copy slide "Committee Responsibilities" from the Joint Meeting packet for those who were not there.

Follow Up: Hard copies of the materials from the October 23rd joint meeting will be available at the December 2nd Meeting. (CM)

C. Item: Add control limits where possible to the data in the Annual PI Reports

Follow-Up: The Annual PI Reports that are included in this month's packet had already been prepared when the Committee requested this at its November 4th meeting. Control limits will be added to future reports. (CC/MA)

D. Item: Add a discussion around goal attainment to the Pacing Plan

Follow-Up: Paced for February 2020 meeting. (CM)

E. Item: Next Meeting – Drill down on all Q1 Quarterly Quality and Safety Review.

Follow-Up: On the December 2, 2019 meeting agenda. (CC/MA)

2. Authority: The Committee Chair requested that this be added as a regular agenda item.

List of Attachments: None.

Suggested Committee Discussion Questions: None.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: December 2, 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, Patient Care and Patient Experience Committee meeting, the Hospital Board met once and the District Board has not met. 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: November 6, 2019

- Approved Revised Committee Charters
- Approved FY20 Board Action Plan (attached)
- Recommended the ECHD Board Approve a Revised Process for Election and Re-Election of Non-District Board Members to the El Camino Hospital Board of Directors
- Approved Resolution 2019-12 Authorizing Forward Starting Interest Rate Hedge
- Approved Revised FY20 Pathways Home Health and Hospice Budget
- Approved the Annual Safety Report for the Environment of Care

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

C. Executive Compensation Committee Actions: November 7, 2019

- Approved FY20 Individual Incentive Goals for the President of the Foundation
- Approved Revised FY20 Individual Incentive Goals for the General Counsel

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: Board Action Plan

Suggested Committee Discussion Questions: None.

Approved by the Hospital Board
11/6/2019

Board Action Plan

	What	Who	By When	Current Status
Quality Oversight				
	Adopt a customized, actionable approach to effective quality. • Review and discuss available approaches to quality oversight. Frameworks to consider might include IHI Framework for Governance of Health System Quality, AHRQ High Reliability Organizations, and LEAN Six Sigma among others. • Identify and incorporate aspects from the different frameworks to create a customized approach to quality oversight at ECH.	Quality Committee Chair, CMO	End Q1 2020	
	Hold an educational meeting or series of meetings focused on quality oversight. These sessions will provide: • Additional education on the board's role in quality oversight including information on quality goals, indicators and how to interpret data. • An opportunity to discuss how ECH defines quality and what the organization's approach should be.	Quality Committee Chair, CMO	Scheduled for October 23, 2019	
Meeting Effectiveness				
	Restructure board meeting presentations to improve focus and promote dialogue.	CEO, Dir Gov Services	December 2019	
	Implement a board meeting evaluation to assess quality of materials, mechanics and results of the meeting.	Board Chair, CEO	September 2019	
Ongoing Governance Education/Training				
	Develop an intentional, multi-year strategy for ongoing board education. The intent would be to identify topics and modalities that would enhance the governance competencies and engagement of the ECH Hospital Board.	Governance Committee	December 2019	
Enhancing Board Culture				
	Convene board members outside the typical board meeting structure to facilitate greater cohesiveness and teamwork on a quarterly or bi-annual basis.	Board Chair, CEO, Dir Gov Services	Ongoing	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cheryl Reinking, RN, CNO
Date: December 2, 2019
Subject: Patient Story

Purpose:

To update the Committee on a "negative" patient story.

Summary:

1. Situation: Staff was asked to provide a "negative" patient story, either through reaching back to a patient or bringing a story about a patient where things did not go as well as they could have even though the patient did not write a letter. These comments are from the HCHAPS Survey.

2. Authority: N/A

3. Background: Here are the comments:

Responsiveness:

- I noticed a big difference between the day and pm nurses compared with night nurses' the day shifts really had that extra caring ...as though they really liked nursing...cheerful, seemed to like each other and worked as a team....perhaps the night nurses were just tired or it was a busy evening.....they were kind but that extra something seemed missing.
- The nurses tried but to help but I had to ask 2 or 3 times to help w/the temp in the room. Too hot. Had to keep door closed because of the noise. I was right next to nurses station.
- There was lack of attention to those using call buttons & even more delays to actual person responding to your room. Nursing checks were done about every 4-6 hrs. vs. regular 1 hour!

Discharge Information:

- There were a lot of discharges so we could understand the delay in processing my discharge. ..but it was really a hassle for my husband.....he waited at the entrance for me to come down....and then big lines for courier to park car so he parked himself....way far away from hospital and he is not young but it was partly my fault as I called him as soon as I knew I would be coming home. I did not realize what was involved in discharge process.
- I was supposed to be seen by PT daily starting my second day, but never did until the final day as I was being discharged, and then my discharge was delayed several hours waiting for the prosthetist to come and fit me for the brace I needed to be mobile safely at home.

4. Assessment: Several issues emerge in these comments. First, the communication is not consistent from shift to shift and the responsiveness to call lights at night was a concern. Communication regarding discharge process was also not clear. And, the timeliness of ordered care from PT was not made a priority.

5. Other Reviews: The organization reviews these letters at the unit and department level and provides feedback to staff to assist them with connecting their caring behaviors to the desired

HCHAPS results. With the overall goal of meeting our true north for service which is providing an exceptional personalized experience, always. Inconsistency in care emerges in these comments.

6. Outcomes: We will continue to monitor patient communication as sources for opportunities for improvement and will make adjustments and improvement plans based on the feedback.

List of Attachments: None

Suggested Committee Discussion Questions:

1. Are there any changes you have made specifically addressing these comments?

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Date: December 2, 2019
Subject: Q1 FY20, 30 day All Cause, Unplanned Readmission Dashboard

Purpose:

To provide data on Readmissions, all payor/all cause through Q1 FY20 (July – September 2019)

Summary:

1. Situation: ECH Organizational goal: Readmission Index, and hospitals incur as penalty under ACA of up to 3% of DRG payments for Readmission rates that are above CMS calculated expected for 7 diagnosis and procedures. Penalty for FFY19 based on actual performance July 2014-June 2017 = 0.36% ($354,500) Readmission Teams are focusing on readmissions in each category. A penalty is assigned to the hospital is any of the 7 categories are above the Expected rate.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: Readmission rates provided for FY2017, FY 2018, FY19 and Q1 FY2020

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

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Q1 FY20, 30 day All Cause, Unplanned Readmission Dashboard

Suggested Committee Discussion Questions: None

FY 2020, Q1 30 Day All-Cause, Unplanned Readmission Dashboard

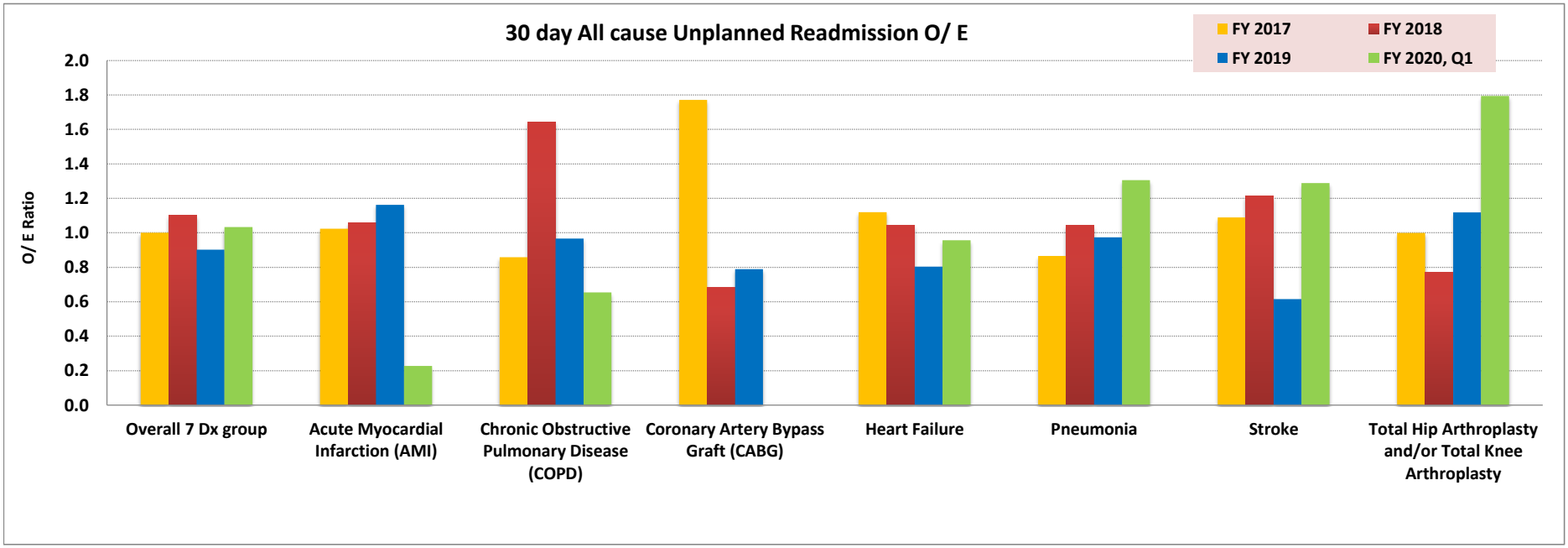
Premier Risk Adjusted, All Payer, All Cause, Unplanned Readmits
Patient Type: Inpatient and Psych

	FY 2017			FY 2018			FY 2019			FY 2020, Q1		
	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio
Overall 7 Dx group	9.08%	9.08%	1.00	10.02%	9.11%	1.10	8.95%	9.92%	0.90	10.42%	10.08%	1.03
Acute Myocardial Infarction (AMI)	7.69%	7.51%	1.02	7.72%	7.30%	1.06	8.75%	7.53%	1.16	2.00%	8.77%	0.23
Chronic Obstructive Pulmonary Disease (COPD)	14.14%	16.48%	0.86	26.97%	16.41%	1.64	14.88%	15.40%	0.97	10.00%	15.27%	0.65
Coronary Artery Bypass Graft (CABG)	11.24%	6.34%	1.77	4.63%	6.76%	0.69	5.38%	6.81%	0.79	0.00%	6.31%	0.00
Heart Failure	17.79%	15.89%	1.12	16.17%	15.52%	1.04	13.39%	16.67%	0.80	15.57%	16.28%	0.96
Pneumonia	10.31%	11.92%	0.87	12.82%	12.30%	1.04	12.50%	12.84%	0.97	16.81%	12.87%	1.31
Stroke	7.17%	6.58%	1.09	8.20%	6.77%	1.21	4.56%	7.41%	0.62	9.68%	7.51%	1.29
Total Hip Arthroplasty and/or Total Knee Arthroplasty	2.06%	2.08%	1.00	1.63%	1.99%	0.77	2.54%	2.27%	1.12	4.69%	2.61%	1.79

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

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

Q1 data run as of 11/ 15 /19



El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Date: December 2, 2019
Subject: Patient Safety Indicator (PSI) Scores Q1 FY20

Purpose:

To provide an update on the AHRQ Patient Safety Indicators for Q1 FY20.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. 5of the 18 PSIs are over the Premier Mean: Pressure Ulcer, Death in Surgical Pts. with Treatable Complications, Unrecognized Abdominopelvic Accidental Puncture or Laceration, OB Trauma Vaginal Delivery with Instrument and OB Trauma Vaginal Delivery without Instrument.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Patient Safety Indicator (PSI) Scores Q1 FY20

Suggested Committee Discussion Questions:

1. None

Patient Safety Indicators

Report Filter:

***AHRQ QI Version* 2018**

Facility:El Camino Hospital Los Gatos (661972) (CA) (Facility:07-01-2014 to 11-05-2019) (Peer:07-01-2014 to 09-30-2019), El Camino Hospital Mountain View (635796) (CA) (Facility:07-01-2014 to 11-05-2019) (Peer:07-01-2014 to 09-30-2019)
Month:
JULY 2019, AUGUST 2019, SEPTEMBER 2019
Inpatient/Outpatient:Inpatient:
AHRQ QI Version:2018
Patient Type = "INPATIENT"

Population Size: 5,655 Drill to Numerator Patients Drill to Denominator Patients Switch to Analytical View PSI Stratified View

Rate Measures

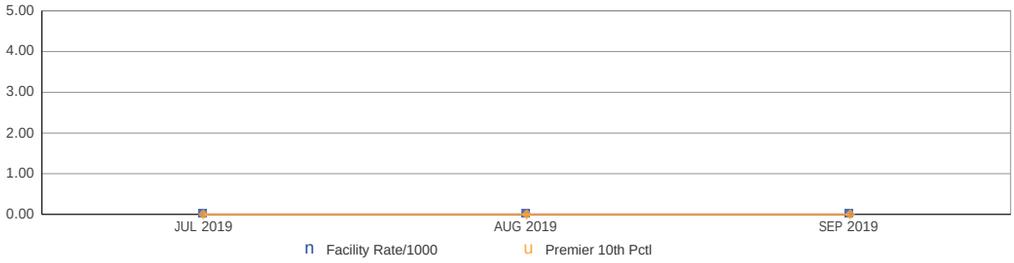
Patient Safety Indicator		Numerator	Denominator	Rate/1000	Premier Mean*	Premier Median*	Premier 25th Pctl*	Premier 10th Pctl*
PSI-02	Death in Low Mortality DRGs	0	177	0.00	0.46	0.00	0.00	0.00
PSI-03	Pressure Ulcer	2	1,738	1.15	0.52	0.16	0.00	0.00
PSI-04	Death in Surgical Pts w Treatable Complications	4	23	173.91	126.39	130.28	50.00	0.00
PSI-06	Iatrogenic Pneumothorax	1	3,077	0.32	0.15	0.00	0.00	0.00
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	1,613	0.00	0.06	0.00	0.00	0.00
PSI-08	In Hospital Fall with Hip Fracture	0	2,594	0.00	0.11	0.00	0.00	0.00
PSI-09	Perioperative Hemorrhage or Hematoma	0	1,086	0.00	1.64	1.23	0.00	0.00
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	0	652	0.00	0.81	0.00	0.00	0.00
PSI-11	Postop Respiratory Failure	0	553	0.00	4.87	2.95	0.00	0.00
PSI-12	Perioperative PE or DVT	1	1,135	0.88	2.81	2.31	0.00	0.00
PSI-13	Postop Sepsis	3	646	4.64	4.76	1.99	0.00	0.00
PSI-14	Postop Wound Dehiscence	0	325	0.00	0.69	0.00	0.00	0.00
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	1	821	1.22	0.94	0.00	0.00	0.00
PSI-17	Birth Trauma Injury to Neonate	3	1,118	2.68	3.96	2.74	0.61	0.00
PSI-18	OB Trauma Vaginal Delivery with Instrument	8	58	137.93	107.10	90.91	44.12	0.00
PSI-19	OB Trauma Vaginal Delivery without Instrument	21	720	29.17	15.67	14.42	8.64	3.88

Count Measures

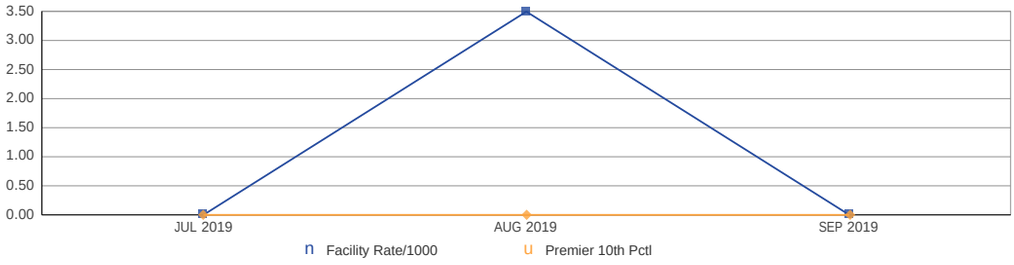
Patient Safety Indicator		Cases	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fragment	0	0.14
PSI-16	Transfusion Reaction	0	0.02

*** Premier Population Statistics (Rate/1000)**
(10-01-2017 to 09-30-2018)

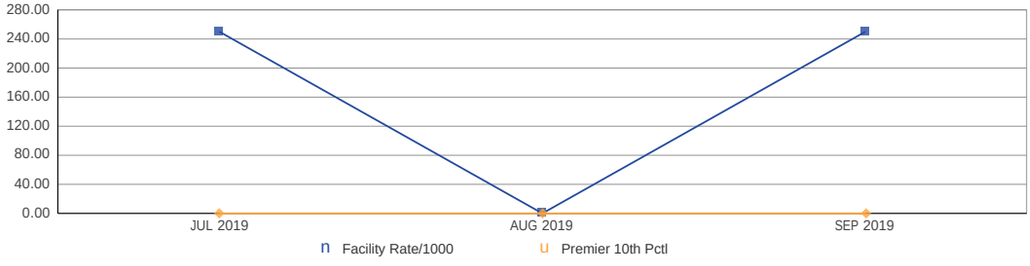
PSI-02:Death in Low Mortality DRGs



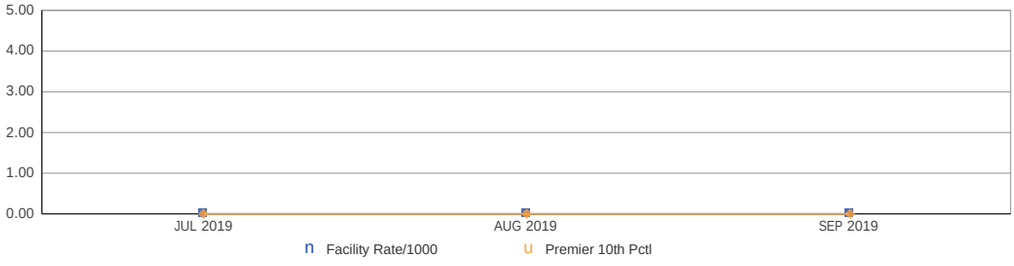
PSI-03:Pressure Ulcer



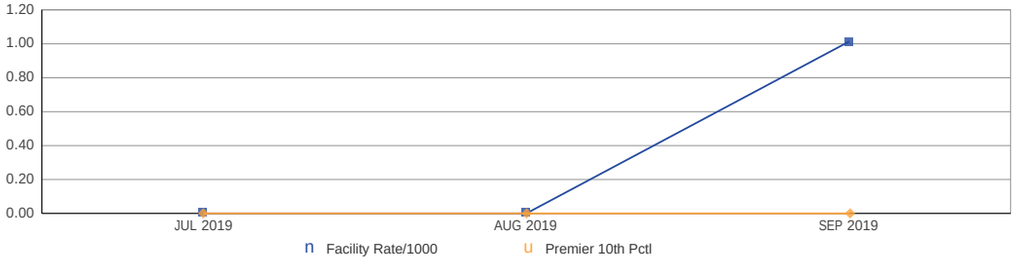
PSI-04:Death in Surgical Pts w Treatable Complications



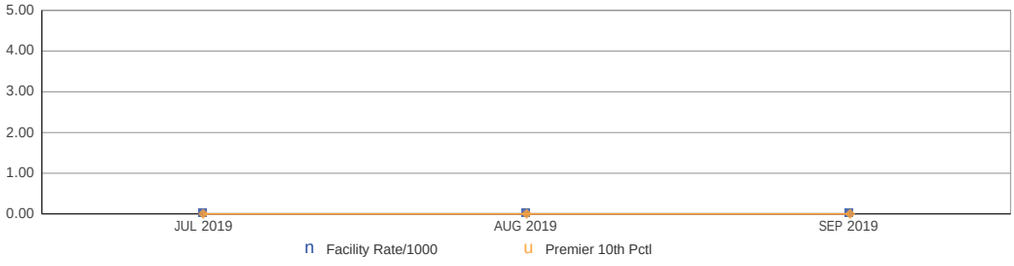
PSI-05:Retained Surgical Item or Unretrieved Device Fragment



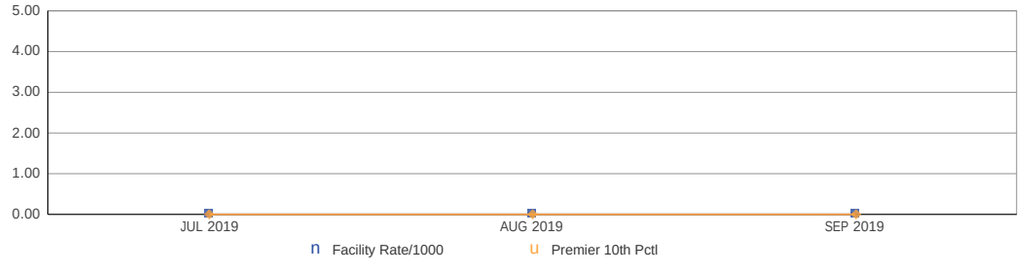
PSI-06:Iatrogenic Pneumothorax



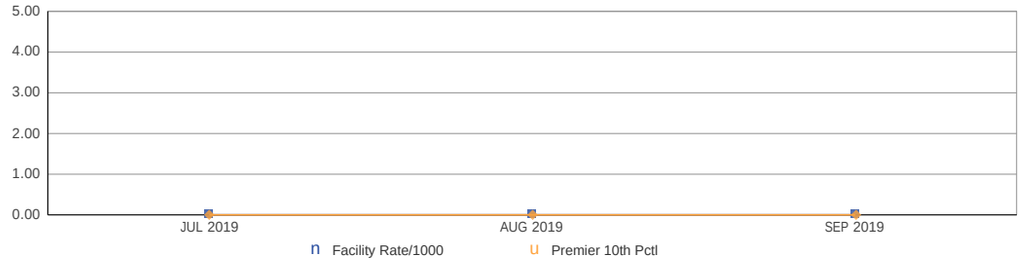
PSI-07:Central Venous Catheter-Related Blood Stream Infection



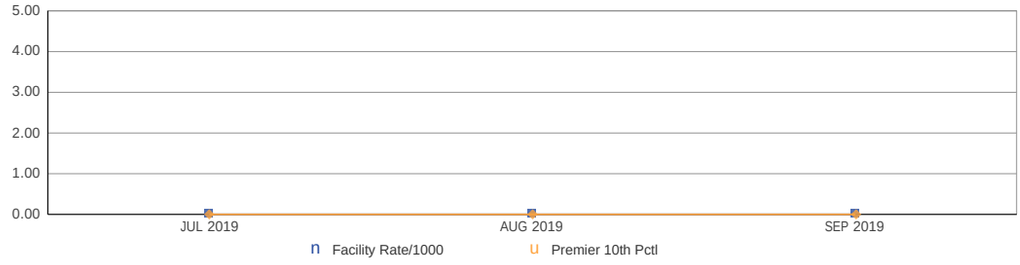
PSI-08:In Hospital Fall with Hip Fracture



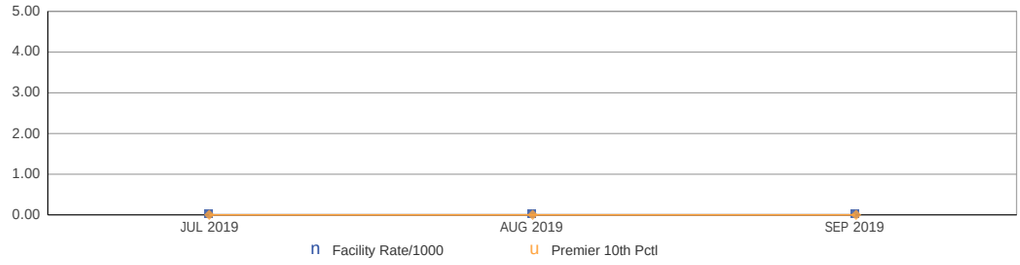
PSI-09:Perioperative Hemorrhage or Hematoma



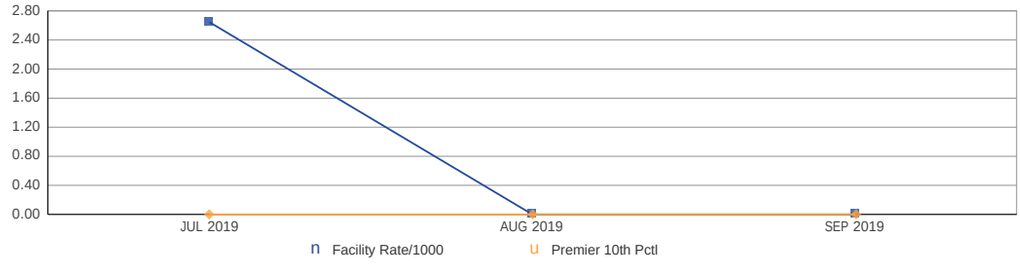
PSI-10:Postoperative Acute Kidney Injury Requiring Dialysis



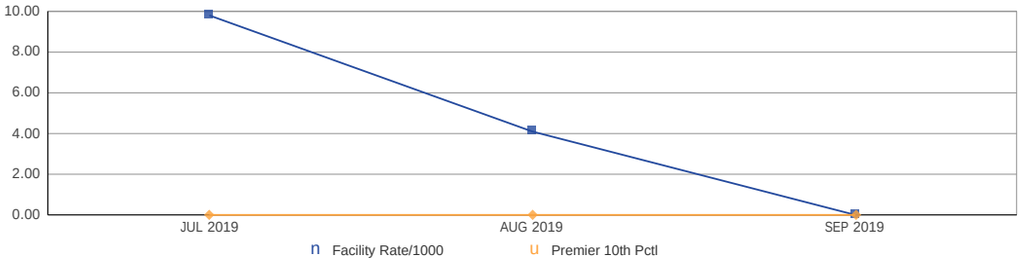
PSI-11:Postop Respiratory Failure



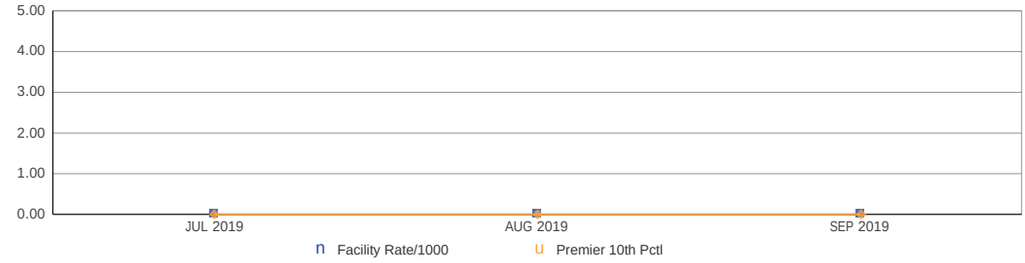
PSI-12:Perioperative PE or DVT



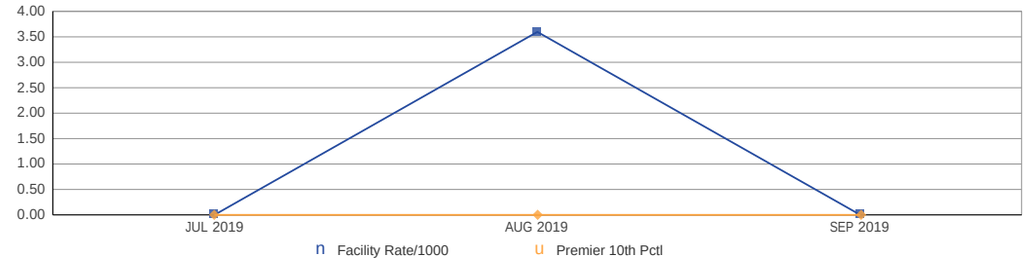
PSI-13:Postop Sepsis



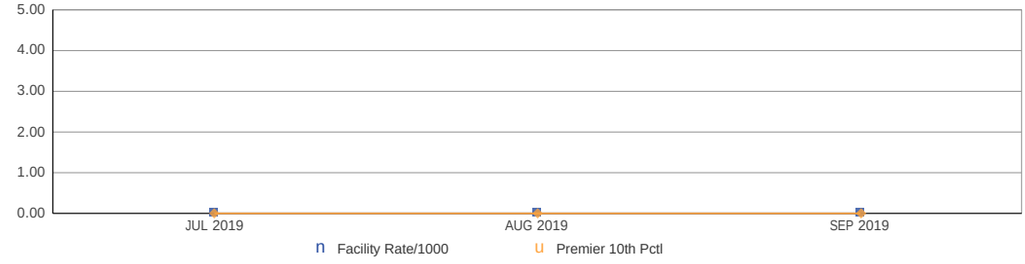
PSI-14:Postop Wound Dehiscence



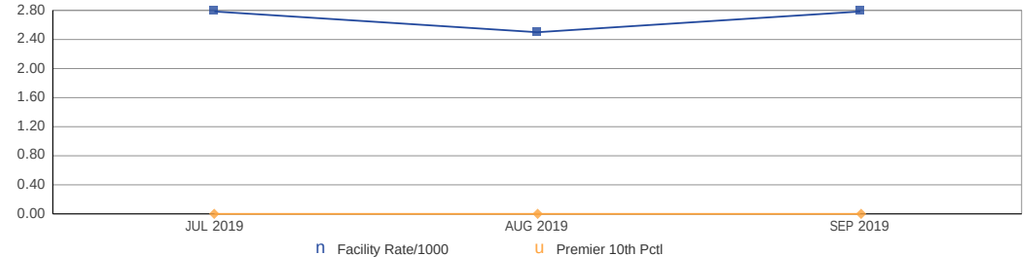
PSI-15:Unrecognized Abdominopelvic Accidental Puncture or Laceration



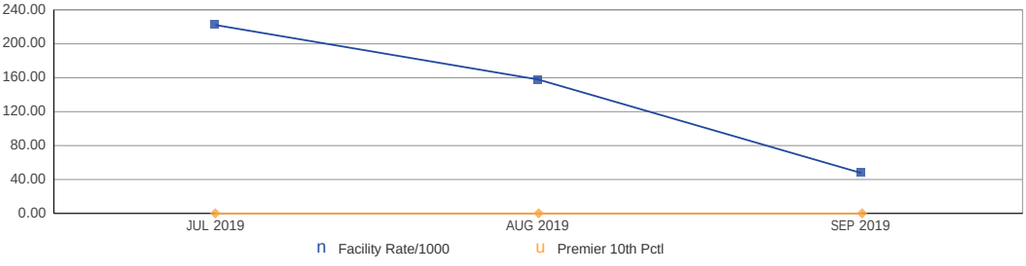
PSI-16:Transfusion Reaction



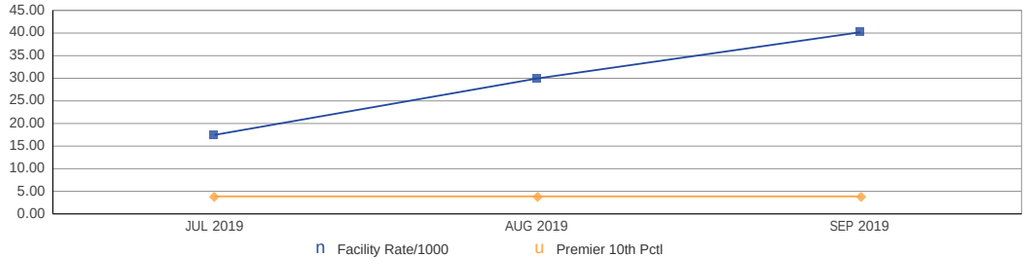
PSI-17:Birth Trauma Injury to Neonate



PSI-18:OB Trauma Vaginal Delivery with Instrument



PSI-19:OB Trauma Vaginal Delivery without Instrument



El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: December 2, 2019
Subject: Peer Review

Purpose:

To update the Quality Committee on Peer Review.

Summary:

1. Situation: Practitioner peer review is an important component of overall quality performance.

2. Authority: The Quality Committee requested a review of the medical staff peer review process

3. Background: Many organizations have moved from a traditional department based peer review process to a more modern system multispecialty peer review approach

4. Assessment: The Medical Staff has committed to revamp their peer review process along the lines of a multispecialty peer review system.

5. Other Reviews: None

6. Outcomes: Informational only

List of Attachments:

1. Peer review presentation

Suggested Committee Discussion Questions:

1. What are the advantages of a system multispecialty peer review approach?

El Camino Health

PEER REVIEW

Board Quality Committee

December 2, 2019

Dan Shin, MD & Shreyas Mallur, MD

Peer Review Agenda

- What is Peer Review?
- Why is the Peer Review process changing?
- What are the underlying principles?
- What factors must be considered?
- How is the El Camino medical staff transforming this process?

What is Peer Review?

"'**Peer Review**" refers to the good faith activities utilized by the organized **medical staff** to conduct patient care **review** for the purpose of analyzing and evaluation the quality and appropriateness of care provided to patients.

One of the most essential functions of the organized medical staff.

What is Peer Review?
It may depend on the perspective!

- Physician - a method of delivering me my performance information evaluated by my peers so that I may improve my clinical care - Excellence standard

- Medical Staff leadership - a method of delivering performance information so that I may evaluate individual performance for acceptability - Competence standard

Where is the World headed?

- Historically, physician peer review systems were:
  - Dependent on case review
  - Conducted by specialty
  - Inconsistent and inherently biased

- Contemporary peer review models are:
  - Moving from a dependence on case review to utilization of aggregate data
  - Conducted in forums with multi-specialty participation

Basic Underlying Principles

- Fairness
- Credibility
- Consistency
- Efficiency

Fairness

- Limit bias (individual or group) to the extent possible
- Conflict of interest - Absolute vs. Relative
- Decide measurement factors proactively
- Maintain process transparency

Credibility

- Its all about the data
  - Attribution
  - My patients are sicker
  - The p isn’t less than 0.05

- The enemy of good should not be perfect
- Data sources should be as good as possible

Consistency

- Inter-rater reliability
  - Case review
  - Aggregate data

- Collect equivalent data for equivalent practitioners

Efficiency

- Make best use of physician time as possible
  - Focused reviews
  - Committee time has bias towards action
  - Separate rating/evaluation function from action responsibility

- Support staff has marked limitations as well- make good use of limited resources
- Automate to the extent possible

Peer Review System Design Factors

- Must apply the Basic Underlying Principles
  - Define who is a peer
  - Define what performance data is to be collected- Indicators
  - Define how that data is transformed into useful information
  - Define the process of performance reporting and management
  - Define a viable peer review structure
  - Define a viable case review process

What makes up a good Case Review Process?

1. Case Gathering
2. Case Screening
3. Initial Review
4. Initial Committee Discussion
5. Involved Practitioner Input
6. Final Committee Decision
7. Communication of Decision
8. Improvement plan

Multispecialty Peer Review

- The medical staff has approved moving from the current old school system to this new approach

- While some departments may continue to perform baseline peer review, all final adjudication of peer review findings will be the responsibility of this enterprise Practitioner Excellence Committee

Multispecialty Peer Review

- Indicators that trigger peer review have been identified
- Committee membership will be based on expertise and commitment
- Trending and tracking will be emphasized over incident reporting to reduce bias
- Training of the new committee will begin in December
- Care Review Committee will be phased out

Multispecialty Peer Review

- Possible determinations by the committee:
  - Care meets standards
  - Opportunity for Improvement Minor
  - Opportunity for Improvement Major
  - Exceptional Care
  - System Issue identified

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cheryl Reinking, RN, CNO
Date: December 2, 2019
Subject: Annual Performance Improvement Reports

Purpose:

To provide information and evidence on the Hospital's 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. Heart & Vascular Institute (HVI)
2. Care Coordination
3. Pharmacy
4. Nutrition Services

Suggested Committee Discussion Questions: None.

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Annual Performance Improvement Report

Department/Service Line: Core Measures
Prepared by: Amie Selda
Date: 10/28/2019
Reporting Period: CY 2019 (January –August 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:

Non-HBIPS

- *PC01- Elective Delivery Prior to 39 weeks gestation- Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Target goal is 0%; CYTD 2019 Performance: 0.75%*
- *PC02- Cesarean Birth- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CYTD 2019 Performance is 26.36%*
- *PC03- Antenatal Steroids- The measure recommends to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Target goal is 100%; CYTD 2019 Performance: 100%. No outliers since 2014.*
- *PC04- Health Care-Associated BSI in Newborns- Staphylococcal and gram negative septicemias or bacteremias in high-risk newborn. Target goal is 0%; CYTD 2019 Performance: 0%*
- *PC05- Exclusive Breast Milk Feeding- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; CYTD 2019 Performance: 68%.*
- *PC06- Unexpected Complications in Term Newborns- TJC's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; CYTD 2019 Performance: 1.48%*
- *ED2b- Admit Decision Time to ED Departure Time for Admitted Patients- Median time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room. Target goal is 120 minutes or less. CYTD 2019 ENT 81 mins, MV 81mins, LG 82mins*
- *OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients- Median time patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; CYTD 2019 rate is 172 minutes*
- *OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. Target goal is 100%; CYTD 2019 80%*

Data Analysis & Conclusions:

HBIPS

- *IMM-2 Influenza Immunization Patients assessed and given influenza vaccination. Target goal is 100%; CYTD 2019 rate is 96%.*
- *HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80% CYTD 2019 rate is 84%*
- *PC-TOB Perfect Care - Tobacco Use-Target goal is 80% CYTD 2019 rate is 25.42%*
- *PC-SUB Perfect Care - Substance Abuse- Target goal is 80% CYTD 2019 rate is 95%*
- *TR-1 Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% CYTD 2019 rate is 81%*
- *TR-2 Timely Transmission of Transition Record- Target goal is 75%; CYTD 2019 rate is 71%*
- *MET-1 Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; CYTD 2019 rate is 90%*
- *HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours) Target goal is 0.0004; CYTD 2019 rate is 0.0002*
- *HBIPS-3 Hours of Seclusion Use (per 1000 patient hours) Target goal is 0.0004; CYTD 2019 rate is 0.0001*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- *PC01- Elective Delivery Prior to 39 weeks gestation- challenges include potentially modifiable factor such as patient preferences, those with prior cesarean section who desires repeat cesarean section and scheduled repeat cesarean section prior to 39 weeks. Outliers had conditions not included in the exclusion criteria e.g. borderline amniotic fluid index (AFI) as well as oligohydramnios and suspected macrosomia with history of shoulder dystocia with previous delivery and advanced maternal age.*

- *PC02- Cesarean Birth- NTSV - Covered California: in their 2017 contracts with Health Plans— For hospitals be included their Network, they need to have an NTSV rate ≤23.9% by 2019 Allowed Exception: if actively working on the topic and showing improvement*
  This has engaged many managed care groups in the State who are now reaching out to hospitals. Other large Health Plans are working on their strategies for alignment on this topic California Association of Health Plans, which represents 46 insurance exchanges, will work with Covered California to implement appropriate quality measures.
  Oakland, Calif.-based Kaiser Permanente has some of the lowest C-section rates in the state and the provider uses midwives. In 2014, the C-section rate at its Redwood City hospital was 16%.

- *PC05- Exclusive Breast Milk Feeding- Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration.*

- *ED2b- Admit Decision Time to ED Departure Time for Admitted Patients- This measure is focused on admitted patients and depends on bed availability throughout the hospital.*

- *OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- early identification of stroke s/s and use of stroke order sheet.*

HBIPS

- *IMM-2 Influenza Immunization- follow through of Influenza immunization nursing process i.e. documentation between October 1 and March 31 whether patient received or refused an influenza immunization.*

- *HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification. Abilify is used to treat depression but still should be counted as an anti- psychotic medication.*

- *PC-TOB Perfect Care - Tobacco Use*
  Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention. There is a current project focused on this measure since there is a significant drop in our performance rate.

- *TR-2 Timely Transmission of Transition Record- patient with no PCP on record remains a challenge.*

- *MET-1 Screening for Metabolic Disorders – Blood glucose documentation that the patient fasted prior to the test is required. If there is no documentation that the patient fasted, that test cannot be used for this data element.*

- *HBIPS-2- Hours of Physical Restraint Use (per 1000 patient hours) and HBIPS-3- Hours of Seclusion Use (per 1000 patient hours) ECH is at below ECH-defined goals and TJC rate for both hours of physical restraint and seclusion use.*

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

Use bullet points to list actions taken:

- *PC01- Elective Delivery Prior to 39 weeks gestation- fallouts are referred to peer review coordinator*
- *PC02- Cesarean Birth- Fallouts are referred to peer review coordinator; the most common indications for primary cesarean delivery included, abnormal fetal heart rate tracing, CPD, preeclampsia and suspected fetal macrosomia. Arrest of labor and abnormal or indeterminate fetal heart rate tracing. LG has certified nurse-midwife on staff.*
- *PC05- Exclusive Breast Milk Feeding- communicated drops in performance rate and ensured best practices are implemented and reinforced. MBU has a taskforce committee for hand expressing breast milk, Lactation specialists provide information and support to breastfeeding. We offer outpatient consulting and a free, drop-in support group. Los Gatos campus is a designated Baby-Friendly Hospital, recognizing that we offer an optimal level of care for breastfeeding mothers and babies*
- *PC06- Unexpected Complications in Term Newborns- cases are forwarded to peer review RN for review and follow up*
- *ED2b- Admit Decision Time to ED Departure Time for Admitted Patients- collaborated with PI Data Analyst to ensure data definition and collection is meeting CMS standards.*
- *OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- This measure has a very low volume. Outliers are shared with Stroke clinical coordinator for further review and action plan. Analysis includes CT TAT (ordering, initiating, completing, and interpretation). Challenges include communicating the stroke alert e.g. if radiology is unaware of case being a stroke, the exam would fall into the normal reading queue. Reasons for delay are multi-disciplinary most of the time.*

HBIPS

- *IMM-2 Influenza Immunization- Included BPA in ordering flu vaccine and scheduled it for administration during hospitalization prior to discharge.*
- *HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification. Fallouts sent to BHS team for further review and education to providers.*
- *PC-TOB Perfect Care - Tobacco Use*
  Fallouts sent to BHS team for further review and education to providers. iCare modified tobacco order set to increase compliance.
- *TR-1 Transition Record with Specified Elements Received by Discharged Patients*
  The value of integrated care is the main focus of this measure. BHS team invited charge nurses, admin assistant and front life staff to the quarterly meetings.

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

- *PC01- Elective Delivery Prior to 39 weeks gestation- Hospital Compare PC-01 from 10/1/2017 to 9/30/2018 national and state is 2%. Because of strong medical evidence for reduction of neonatal and maternal harm, strong support from professional organizations, including the American College of Obstetricians and Gynecologists (ACOG), transparency through public reporting i.e. CMS Hospital Compare and part of pay-for –performance VBP this has been an established ongoing measure.*

- *PC02- Cesarean Birth- The average rate of NTSV cesarean births has remained virtually stagnant since being at 26.4% in 2015, most recently hovering at 26.3% in 2017 and 26.1% in 2018. This is above Leapfrog's target for hospitals of 23.9%.*

- *PC05- Exclusive Breast Milk Feeding- Our current rate of 68% is better than TJC benchmark which is 51%*

- *ED2b- Admit Decision Time to ED Departure Time for Admitted Patients- Median times have reduced in 2019 CYTD and continue to be shorter than ECH goal and TJC Median (149minutes).*

- *OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients- ECH is 172 minutes compared to National: 144 Minutes; California: 206 Minute*

- *OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- California and national average is 72% vs. ECH of 80%*

HBIPS

- *IMM-2 Influenza Immunization- California rate is 79% while national is 82%, ECH is 92%*

- *HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification California 70%; national 66% compared to ECH 74%*

- *TR-1 Transition Record with Specified Elements Received by Discharged Patients. California 55%; national 50% compared to ECH 76%*

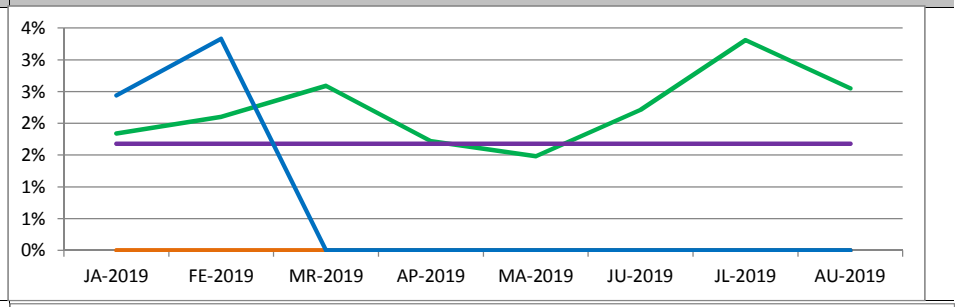
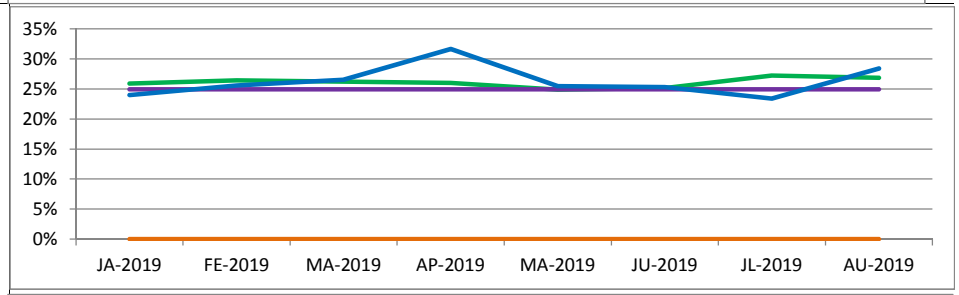
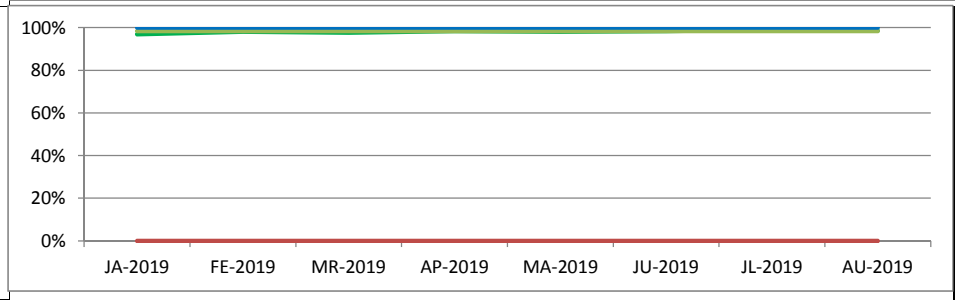
- *TR-2 Timely Transmission of Transition Record California 49%; national 45% compared to ECH 70%*

- *MET Screening For Metabolic Disorders California 68%; national 65% compared to ECH 92%*

El Camino Health

Core Measures Summary Report

Date Period: August 2019

		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
Perinatal Care Mother		**Month**	**2019 CYTD**			
1	PC01- Elective Delivery Prior to 39 weeks gestation (lower=better) Date Period: August 2019	Ent 0% (0/39) MV 0% (0/32) LG 0% (0/7)	Ent 0.75% (2/267) MV 0.85% (2/235) LG 0% (0/32)	Ent 1.32% (4/302) MV 1.61% (4/265) LG 0% (0/37)	0%	
2	PC02- Cesarean Birth (lower=better) Date Period: August 2019	Ent 28.4% (48/169) MV 29.68% (46/155) LG 14.29% (2/14)	Ent 26.36% (319/1210) MV 27.73% (295/1064) LG 16.44% (24/146)	Ent 24.13% (331/1372) MV 25.20% (309/1226) LG 15.07% (22/146)	<23.90%	
3	PC03- Antenatal Steroids Date Period: August 2019	100%	100%	100%	100%	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	CY 2018 Definition	CY 2019 Definition	Data Source
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Target goal is 0%; CYTD 2019 Performance: 0.75% Hospital Compare PC-01 from 10/1/2017 to 9/30/2018 national and state is 2%. Elective Delivery challenges include potentially modifiable factor such as patient preferences, those with prior cesarean section who desires repeat cesarean section and scheduled repeat cesarean section prior to 39 weeks. Outliers had conditions not included in the exclusion criteria e.g. borderline amniotic fluid index (AFI) as well as oligohydramnios and suspected macrosomia with history of shoulder dystocia with previous delivery and advanced maternal age.	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to peer review coordinator	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	IBM CareDiscovery Quality Measures
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CYTD 2019 Performance is 26.36%. We've had 2 insurance providers who indicated not sending patients to us if our rate is higher than the target goal. Fallouts are referred to peer review coordinator; the most common indications for primary cesarean delivery included abnormal fetal heart rate tracing, CPD, preeclampsia and suspected fetal macrosomia, arrest of labor and abnormal or indeterminate fetal heart rate tracing. LG has certified nurse-midwife on staff.	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	IBM CareDiscovery Quality Measures
PC-03: Antenatal Steroids Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns	The measure recommends to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Target goal is 100%; CYTD 2019 Performance: 100%. No outliers since 2014.	TJC	No issues	Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed	Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed	IBM CareDiscovery Quality Measures

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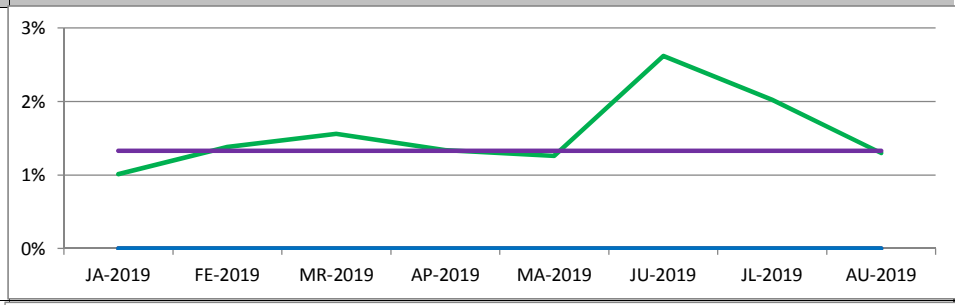
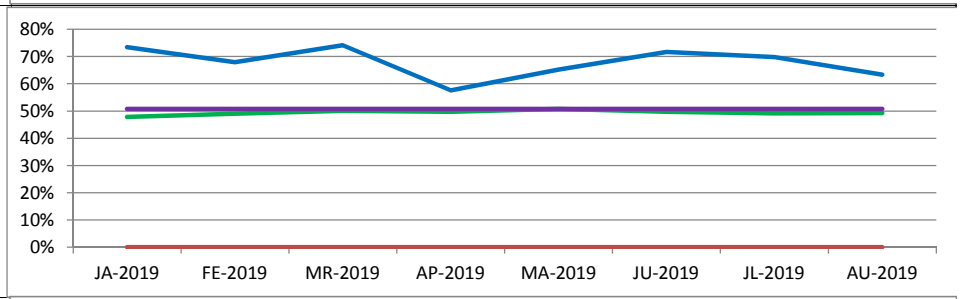
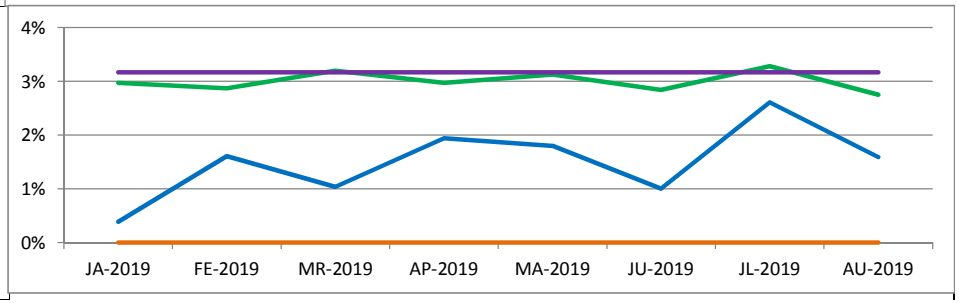
		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
Perinatal Care Babies		**Month**	**CYTD**			
4	PCB04- Health Care-Associated BSI in Newborns (lower=better) Date Period: August 2019	0%	0%	0%	0%	
5	PC05- Exclusive Breast Milk Feeding Date Period: August 2019	Ent 63.38% (45/71) MV 56.90% (33/58) LG 92.31% (12/13)	Ent 67.86% (340/501) MV 64.10% (275/429) LG 90.28% (65/72)	Ent 63.58% (473/744) MV 59.97% (385/642) LG 86.27% (88/102)	70%	
6	PC06- Unexpected Complications in Term Newborns (lower=better) *Date Period: August 2019*	1.59%	1.48%	new in 2019	0%	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	CY 2018 Definition	CY 2019 Definition	Data Source
PCB-04: Health Care-Associated BSI in Newborns Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns	This is aligned with NHSN definition of Health Care-Associated BSI. Staphylococcal and gram negative septicemias or bacteremias in high-risk newborn. Target goal is 0%; CYTD 2019 Performance: 0%	TJC	No issues	Numerator Statement: Newborns with septicemia or bacteremia Denominator Statement: Liveborn newborns	Numerator Statement: Newborns with septicemia or bacteremia Denominator Statement: Liveborn newborns	IBM CareDiscovery Quality Measures
PC-05: Exclusive Breast Milk Feeding during the newborn's entire hospitalization	Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; CYTD 2019 Performance: 68%. TJC is 51% Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	IBM CareDiscovery Quality Measures
PC-06: Unexpected Complications in Term Newborns - The percent of infants with unexpected newborn complications among full term newborns with no preexisting conditions.	The Joint Commission's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; CYTD 2019 Performance: 1.48% This is a new measure and we started to refer and send the fall outs to Peer Review for screening and trending. Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe e.g. use of CPAP or bone fracture. Examples include less severe respiratory complications e.g.	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	New in 2019	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	IBM CareDiscovery Quality Measures

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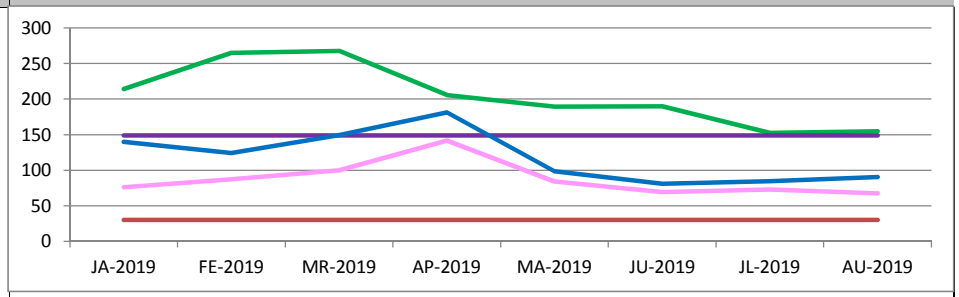
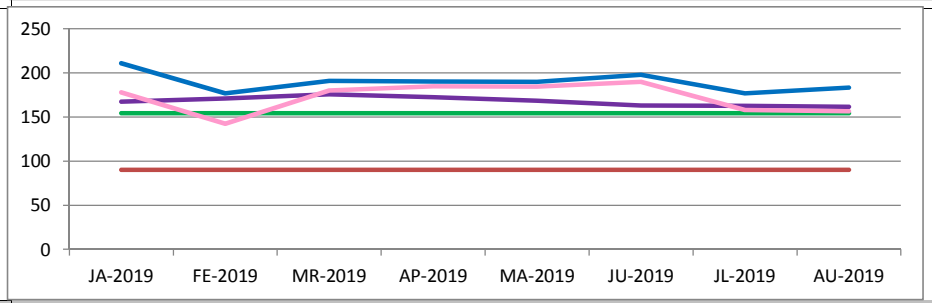
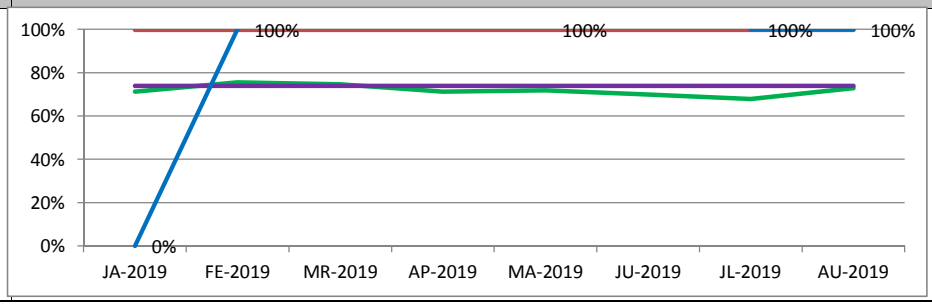
		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
ED Throughput		**Month**	**CYTD**			
7	ED2b- Admit Decision Time to ED Departure Time for Admitted Patients (lower=better) Date Period: August 2019	ENT 67.5 mins MV 67.5mins LG 68 mins	ENT 81 mins MV 81 mins LG 82 mins	ENT 95 mins MV 95 mins LG 94 mins	<120 mins	
8	*OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients(lower=better)* *Date Period: August 2019*	ENT 156.5 mins MV 156 mins LG 151 mins	ENT 172 mins MV 172 mins LG 167mins	ENT 183 mins MV 183 mins LG 184 mins	<180 mins	
Outpatient Measures		**Month**	**CYTD**			
10	OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Date Period: August 2019	100% 1/1	80% 4/5	62.50% 5/8	100%	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	CY 2018 Definition	CY 2019 Definition	Data Source
ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients	Median time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room. Target goal is 120 minutes or less. CYTD 2019 ENT 81 mins, MV 81mins, LG 82mins This measure is focused on admitted patients and depends on bed availability throughout the hospital. Quality collaborated with PI Data Analyst to ensure data definition and collection is meeting CMS standards. TJC median is 149 minutes	TJC	Hospital has multiple mulit-disciplinary committees working on improving bridging orders, nursing hand-off interval, bed flow, etc.	Numerator Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients Denominator Statement:Any ED Patient from the facility's emergency department. Excludes Patients who are not an ED Patient.	Definition: The documented date the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status date is the date the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.	IBM CareDiscovery Quality Measures
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients	Median Time from ED Arrival to ED Departure for Discharged ED Patients- Median time patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; CYTD 2019 rate is 172 minutes compared to National: 144 Minutes; California: 206 Minute	Hospital OQR Specifications Manual		Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department	same as 2018	IBM CareDiscovery Quality Measures
OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. Analysis includes CT TAT (ordering, initiating, completing, and interpretation). Target goal is 100%; CYTD 2019 80%. California and national average is 72% Improvement noted after Clinicians' reminder focused on early identification of stroke s/s and use of stroke order sheet. This measure has a very low volume. Outliers are shared with Stroke clinical coordinator for further review and action plan. Challenges include communicating the stroke alert e.g. if radiology is unaware of case being a stroke, the exam would fall into the normal reading queue. Reasons for delay are multi-disciplinary most of the time.	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)	Numerator Statement: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator Statement: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well with an order for a head CT or MRI scan	Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	IBM CareDiscovery Quality Measures

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Core Measures Summary Report

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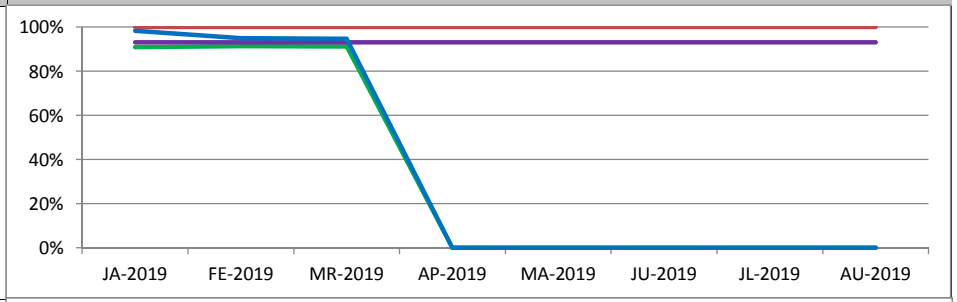
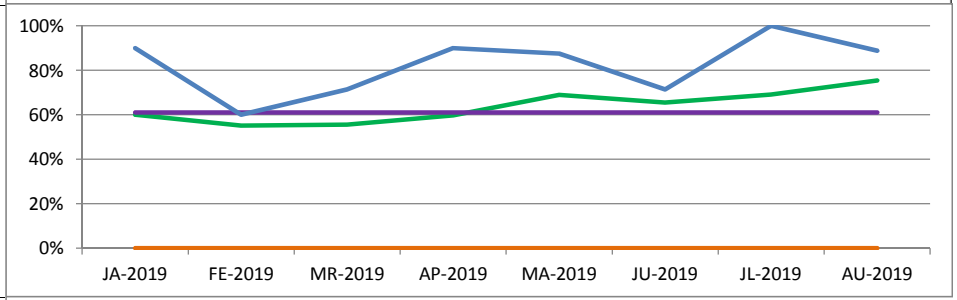
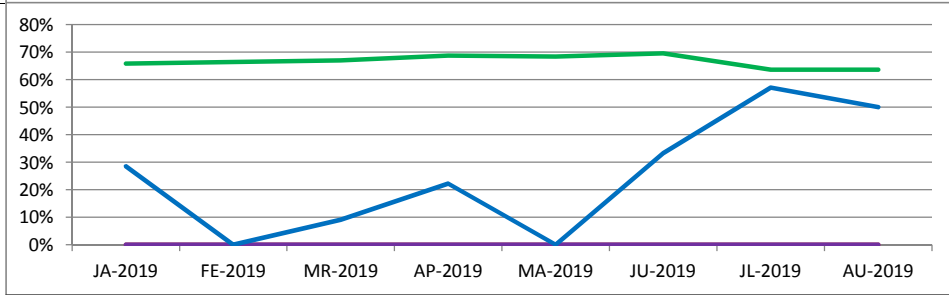
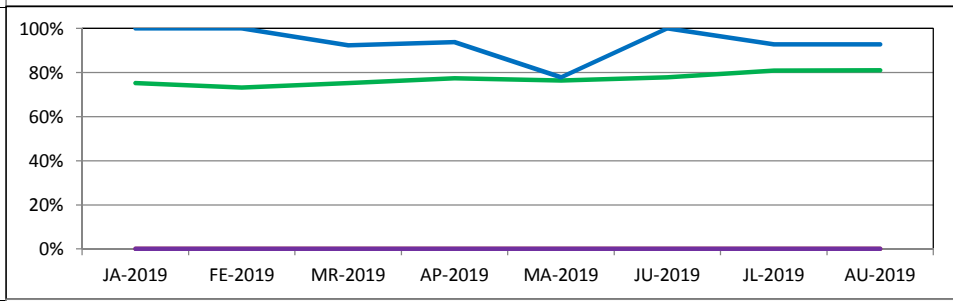
Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value
Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark

	Hospital Based Inpatient Psychiatric Services (HBIPS)	CY19 Performance Month	CY19 Performance CYTD	Baseline CY18	CY19 Target	
11	IMM-2 Influenza Immunization Date Period: August 2019	Not Flu Season	96%	91%	100%	
12	HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification Date Period: August 2019	89%	84%	76%	80%	
13	PC-TOB Perfect Care - Tobacco Use Date Period: August 2019	50%	25%	82%	80%	
4	PC-SUB Perfect Care - Substance Abuse Date Period: August 2019	93%	95%	97%	80%	

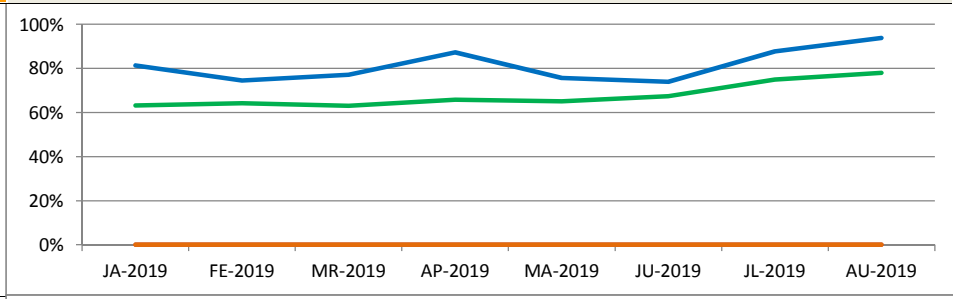
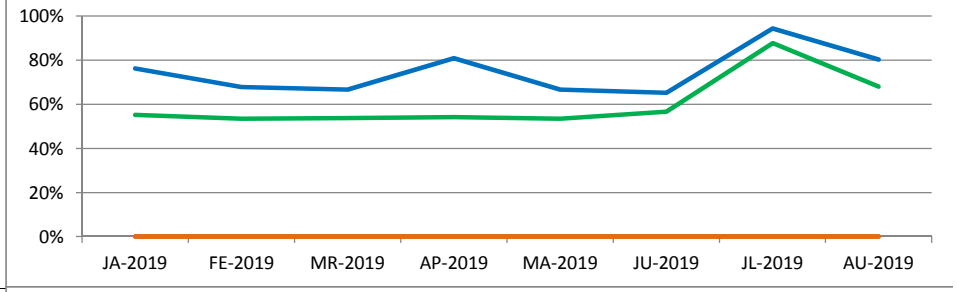
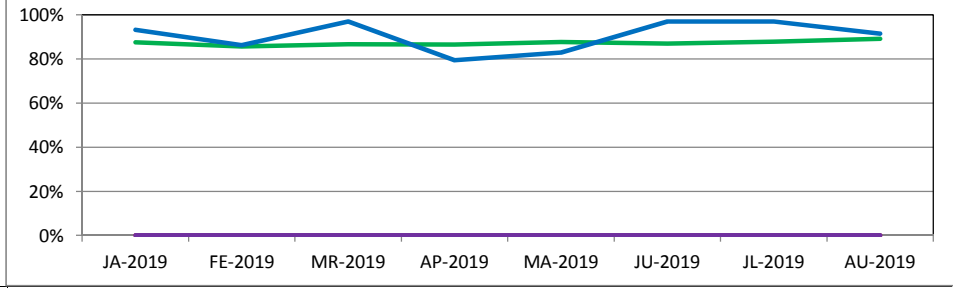
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	CY 2018 Definition	CY 2019 Definition	Data Source
IMM-2: Influenza Immunization	Patients assessed and given influenza vaccination. Target goal is 100%; CYTD 2019 rate is 96%. CMS retired IMM2 beginning January 2019 discharges and is only collected by TJC for BHS HBIPS. Follow through of Influenza immunization nursing process i.e. documentation between October 1 and March 31 whether patient received or refused an influenza immunization. Included BPA in ordering flu vaccine and scheduled it for administration during hospitalization prior to discharge.	CMS/TJC	quarterly meeting/email to BHS team	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA	IBM CareDiscovery Quality Measures
HBIPS-5: Patients Discharged on multiple antipsychotic medications with appropriate justification	Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%; CYTD 2019 rate is 84% Reports were created and shared monthly to BHS leadership to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. Education efforts targeted to remind providers that even if they prescribed antipsychotic (e.g. Abilify) to treat depression, it's stil counted as antipsychotic. Also not to bypass or work-around the hardwired discharge documentation of reason for 2 or more antipsychotics by answering NO.	TJC	quarterly meeting/email to BHS team		Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	IBM CareDiscovery Quality Measures
PC-TOB: Perfect Care - Tobacco Use	Target goal is 80% CYTD 2019 rate is 25.42%. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention. There is a current project focused on this measure since there is a significant drop in our performance rate.Fallouts sent to BHS team for further review and education to providers. iCare modified tobacco order set to increase compliance. Perfect Care-TOB comprises the following: TOB-1 Tobacco Use Screening TOB-2 Tobacco Use Treatment Provided or Offered TOB-2a Tobacco Use Treatment TOB-3 Tobacco Use Treatment Provided or Offered at Discharge TOB-3a Tobacco Use Treatment at Discharge Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of	TJC	quarterly meeting/email to BHS team	N- Tob 1 The number of patients who were screened for tobacco use status within the first day of admission (by end of Day 1). D- Tob 1 Denominator Statement: The number of hospitalized inpatients 18 years of age and older. Numerator Statement for Tob 2, 2a, 3 and 3a TOB-02: The number of patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the hospital stay. TOB-2a: The number of patients who received practical counseling to quit AND received FDA-approved cessation medications during the hospital stay.	No tob 1 , same Tob 2 and 3	IBM CareDiscovery Quality Measures
PC-SUB: Perfect Care - Substance Abuse	Target goal is 80% CYTD 2019 rate is 95% Perfect Care-SUB comprises the following: SUB-1 Alcohol Use Screening SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge Brief intervention on Unhealthy Alcohol use was added to education documentation. Patients are referred to facilities that are able to address issues with alcohol and drug use disorder.	TJC	quarterly meeting/email to BHS team	Numerator Statement: The number of patients who were screened for alcohol use using a validated screening questionnaire for unhealthy drinking within the first day of admission (by end of Day 1). Denominator Statement: The number of hospitalized inpatients 18 years of age and older. Numerator Statement: SUB-2: The number of patients who received or refused a brief intervention. SUB-2a: The number of patients who received a brief intervention. Denominator Statement: The number of hospitalized	No Sub 1, same SUB 2 and 3	IBM CareDiscovery Quality Measures

El Camino Health

Core Measures Summary Report

Date Period: August 2019

		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
5	TR-1 Transition Record with Specified Elements Received by Discharged Patients *Date Period: August 2019*	94%	81%	75%	75%	
14	TR-2 Timely Transmission of Transition Record Date Period:August 2019	80%	72%	67%	75%	
15	MET -1 Screening For Metabolic Disorders Date Period: August 2019	91%	90%	97%	75%	

Restraints and Seclusions	Month	CYTD			

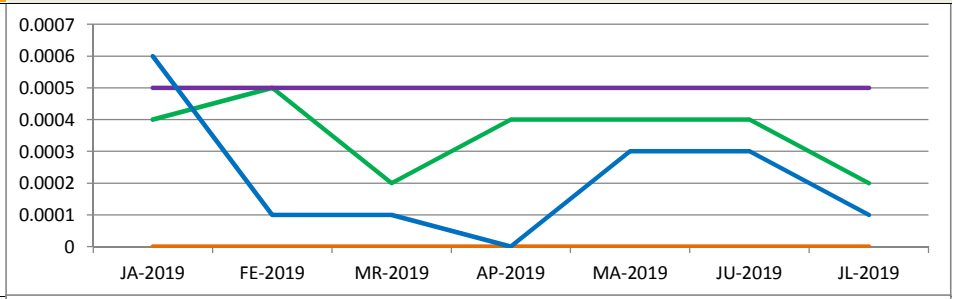
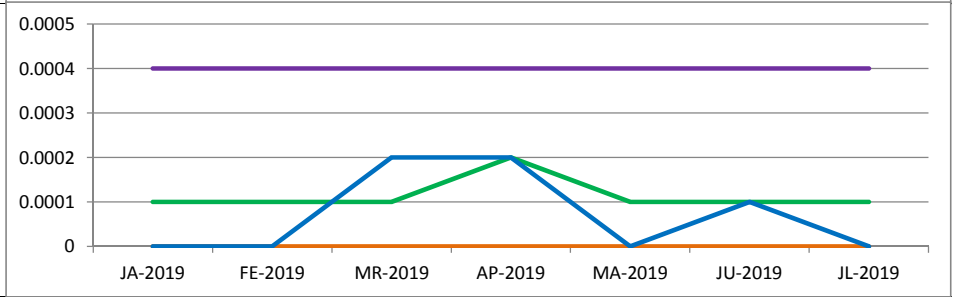
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	CY 2018 Definition	CY 2019 Definition	Data Source
TR-1 Transition Record with Specified Elements Received by Discharged Patients	Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% CYTD 2019 rate is 81% The value of integrated care is the main focus of this measure Transition Record improved significantly August 2019 is 94% r/t recent focus on Advanced Directive and also BHS team invited charge nurses, admin assistant and front life staff to the quarterly meetings.	CMS/TJC	quarterly meeting/email to BHS team	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	IBM CareDiscovery Quality Measures
TR-2: Timely Transmission of Transition Record	Timely Transmission of Transition Record- Target goal is 75%; CYTD 2019 rate is 71% When TR is not complete the case not only fails TR1 but also an automatic fail of TR2 measure. Most fallouts are related to patients not having their own PCP. The education is focused on transmitting the TR to the next provider whether it's the patient's pcp or not.	CMS/TJC	quarterly meeting/email to BHS team	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	IBM CareDiscovery Quality Measures
MET: Screening For Metabolic Disorders	Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; CYTD 2019 rate is 90% Fallouts r/t mising Blood glucose- documentation that the patient fasted prior to the test is required. If there is no documentation that the patient fasted, that test cannot be used for this data element.	CMS/TJC	quarterly meeting/email to BHS team	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with	IBM CareDiscovery Quality Measures

El Camino Health

Core Measures Summary Report

Date Period: August 2019

		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
16	*HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)* *Date Period: July 2019*	0 (0.9167/12984)	0.0002 (22.333/101976)	0.0002 (34.933/169896)	0.0004	
17	HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower=better) Date Period: July 2019 *Event measures (HBIPS-2 and HBIPS-3) are calculated by event occurrence date	0 (0/12984)	0.0001 (7.7/101976)	0.0002 (41.7667/169896)	0.0003	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	CY 2018 Definition	CY 2019 Definition	Data Source
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)	ECH is at below ECH-defined goals and TJC rate for both hours of physical restraint and seclusion use. Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	TJC	quarterly meeting/email to BHS team	Numerator : The total number of hours that all psychiatric inpatients were maintained in physical restraint Denominator : Number of psychiatric inpatient days	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	IBM CareDiscovery Quality Measures
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower=better)	ECH is at below ECH-defined goals and TJC rate for both hours of physical restraint and seclusion use. Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.	TJC	quarterly meeting/email to BHS team	"Numerator:The total number of hours that all psychiatric inpatients were held in seclusion Denominator: Number of psychiatric inpatient days"	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	IBM CareDiscovery Quality Measures

El Camino Health

Core Measure Summary Report

VBP Included in CMS Value-Based Purchasing Program: ☆ Included in CMS Star Ratings:
PRIME Included in PRIME: Included in Leapfrog:
95%-100%= G 90% - 94% = Y <90% = R

Inpatient Measure name		ECH Goal	CY 2018	CY 2019								2019 YTD	External Benchmark (TJC)
				Jan	Feb	Mar	Apr	May	June	Jul	Aug		
PC-01	Elective Delivery Prior to 39 weeks gestation (lower =better) VBP ☆	0%	1.32% (4/302)	2.4%	3.3%	0%	0%	0%	0%	0%	0%	0.75%	1.68%
PC-02	Cesarean Section Rate (lower=better) PRIME	<23.9 %	24%	24%	25%	27%	32%	26%	25%	23%	28%	26%	25%
PC-03	Antenatal Steroids	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
PC-04	Health Care-Associated Bloodstream Infections in Newborns (lower=better)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1.33%
PC-05	Exclusive Breast Milk Feeding During Hospital Stay PRIME	70%	64%	73%	68%	74%	58%	65%	72%	70%	63%	68%	51%
PC-06	Unexpected Complications in Term Newborns(lower=better)	0%	New in 2019	0.39%	1.61%	1.04%	1.9%	1.5%	1%	2.61%	1.59%	1.48%	3.17%
ED-2b	Median time from admit Decision Time to ED Departure Time for Admitted Patients ☆	<120 mins	95	76	87	100	142	84	69	73	68	81	30

El Camino Health

Core Measure Summary Report

VBP Included in CMS Value-Based Purchasing Program: ⭐ Included in CMS Star Ratings:

PRIME Included in PRIME: 🐸 Included in Leapfrog:

95%-100%= G | 90% - 94% = Y | <90% = R

Outpatient Measure name		ECH Goal	CY 2018	CY 2019								2019 YTD	External Benchmark (CMS Standard of Excellence- Top 10% of Hospitals)
				Jan	Feb	Mar	Apr	May	June	Jul	Aug		
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower=better) ⭐	<180 mins	183	178	143	180	169	184	190	158	157	172	90%
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival ⭐	100%	63% 5/8	0% 0/1	100% 1/1	No cases	No cases	100% 1/1	No cases	100% 1/1	100% 1/1	80% 4/5	99.8%

Core Measures	*External Benchmark source- IBM Care Discovery Quality Measures January 2019- August 2019
Perinatal (PC)	TJC
Non PC	CMS Standard of Excellence-Top 10% of Hospitals

Annual Performance Improvement Report

Department/Service Line: **Oncology Service Line**
Prepared by: **Markettea Beneke & Dr. Shyamali Singhal**
Date: **November 7, 2019**
Reporting Period: **CY18 and FY19**

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:

- CMS Quality Measurement for Oncology in QOPI – Pain Intensity and Intervention. Benchmark of 85% with a baseline of 95.8%, our goal was to maintain or improve over FY18. Our actual average was 96.2%.
- American College of Surgeons Commission on Cancer (ASOC COC) set the standard for Survivorship Care Plans @ 50% for Calendar Year 2018. This standard was met by end of CY18. By end of FY19, our average was 56%.
- Participating in the Enterprise quality goals of Readmissions and Mortality, Oncology pursued goals of decreasing the FY18 baseline by 5% each. The 2018 Baseline for each was 1.11. Readmissions O/E average was 0.86. Mortality average was 1.53. There is opportunity for improvement.

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- Concern is maintaining the ASOC COC standard as it stands for CY19. Nurse Coordinators are feeling overwhelmed and have very little time to prepare the Care Plans.
- Standardize among providers when patients should be perceived as curative. New oncologist needs more orientation into the culture of ECH Oncology. Must get Mortality O/E to less than 1.05.

[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:

- Short term to have administrative personnel to help nurses with mailout, Long term asking physicians to click the "Survivorship Button" to help identify patients real time, rather than waiting for a report to be run. Obtaining monthly report of number of Plans done.
- Monthly meetings with Teams/Providers and Management to open communications. Ongoing "training" for newest Oncologist through 1:1 with Medical Directors and Tumor Board Conferences, helping to decrease mortality rate.

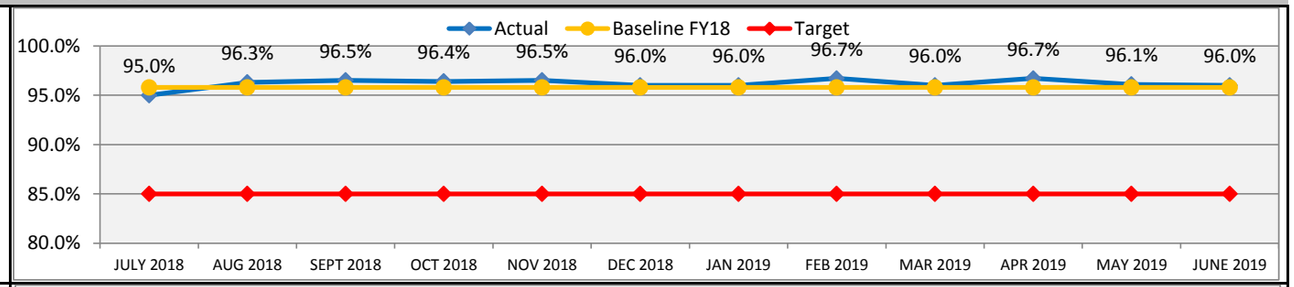
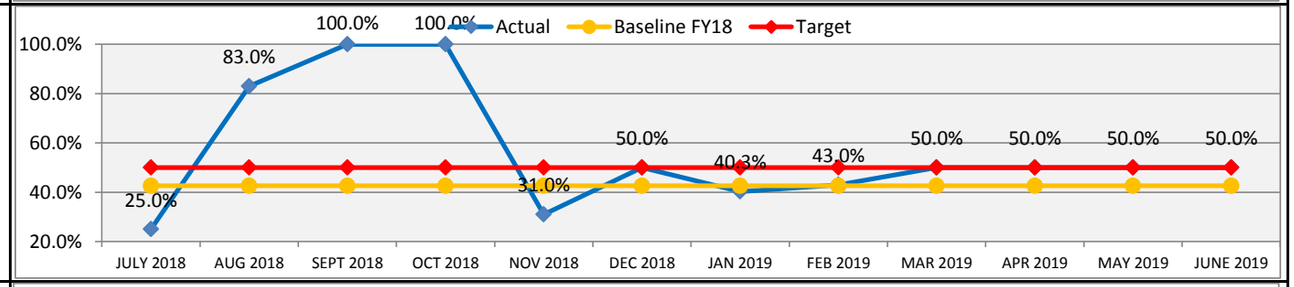
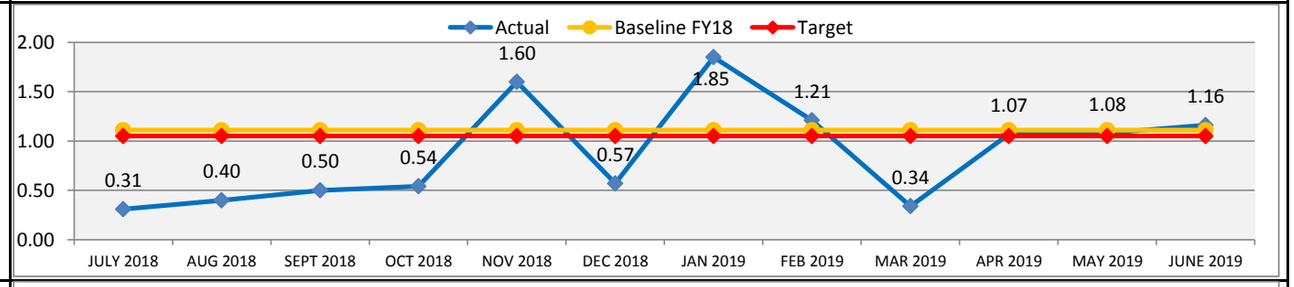
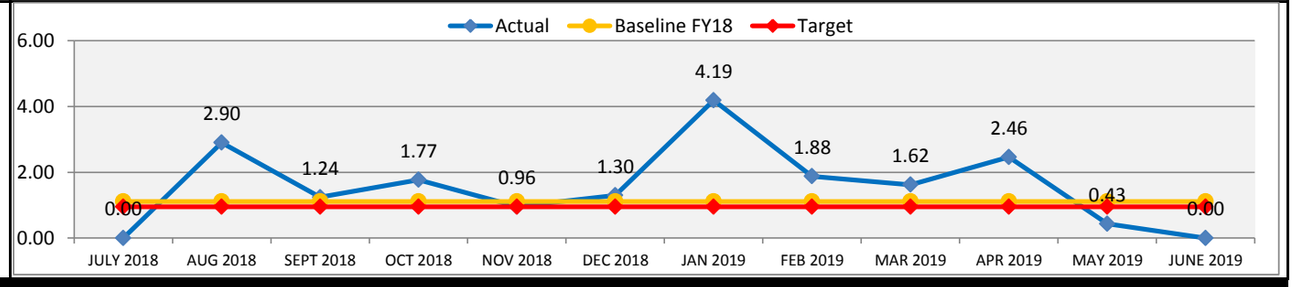
Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

Use bullet points to describe improvement:

- With additional staff help, on schedule to have the necessary plans complete by end of November to meet ACOS COC standard.
- Last month of FY19, no observed mortality. Providers are on same page as to when medical treatment is futile. Will continue to monitor quarterly.
- Largest 3-year improvement is achieving Gold Status for zero deficiencies from ACOS COC. Survey covered CY2016-2018.

El Camino Health

Cancer Center Dashboard - FY 2019 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Jun-19	FY19 Avg			
METRICS					
QOPI - Pain Intensity and Intervention Source : EPSi *Latest Data Month* : June 2019	96.0%	96.2%	95.8%	85.0%	
% Survivorship Care Plans Completed Source : EPSi *Latest Data Month* : June 2019	50.0%	56.0%	42.6%	50.0%	
Readmission Index (O/E) *(Observed Rate / Expected Rate)* *Hematology/Oncology & Medical Oncology* Source : Premier Quality Advisor *Latest Data Month* : June 2019	1.16 (21.05% / 18.16%)	0.86 (12.09% / 14.13%)	1.11 (17.03% / 15.38%)	1.05 (5% reduction improvement from FY 2018 baseline)	
Mortality Index (O/E) *(Observed Rate / Expected Rate)* Source : Premier Quality Advisor *Latest Data Month* : June 2019	0.00 (0.00% / 3.76%)	1.53 (5.93% / 3.88%)	1.11 (5.19% / 4.66%)	1.05 (5% reduction improvement from FY 2018 baseline)	

Annual Performance Improvement Report

Department/Service Line: Human Resources
Prepared by: Tamara Stafford, Director, Talent Development/Employee Wellness & Health Svc
Date: November 6, 2019
Reporting Period: FY2019

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

Data Analysis & Conclusions:

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

- ***Reduce Patient Lift/Transfer Injuries:*** There is a consistent, positive downward trend in the total number of patient handling injuries reported.
- ***Maintain RN Turnover below CHA benchmark:*** RN turnover continues to trend lower than the CHA benchmark by a significant amount.
- ***Maintain Compliance with Mandatory Education:*** Mandatory education compliance has improved since last fiscal year and is currently above the benchmark of 90%

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- ***Reduce Patient Lift/Transfer Injuries:*** Historically, repositioning patients had been the most common cause of Patient Lift/Transfer injury, and those from patient falls were among the least, however, in 2019 this trend seemed to be reversed.
- ***Maintain RN Turnover below CHA benchmark:*** Although, ECH's RN turnover remains lower than the CHA benchmark, the market for RN hiring is competitive and there is a high number of staff at or approaching retirement age.
- ***Maintain Compliance with Mandatory Education:*** The regulatory environment continues to increase mandatory education requirements making it challenging for employees to keep up. In addition, compliance performance has been variable from year to year as focus has shifted between priorities.

[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:

- ***Reduce Patient Lift/Transfer Injuries:*** Focus was placed on departments with the highest incidence of Patient Lift/Transfer injuries, especially those with injuries related to patient falls. Specific interventions included: refreshed training in using Patient Mobility Assessment Tool, providing lifts/slings together near the point of care, having accessible, appropriate bariatric equipment on-site, and dedicated time for training with equipment on off-shifts.

- ***Maintain RN Turnover below CHA benchmark:*** Focus continues to be on annual internal RN Transition to Specialty and RN New Graduate programs to ensure opportunities for professional growth as well as a consistent hiring pipeline. An ESL buyout option for individuals planning to retire is also continuing to promote pre-planning so key positions can be filled and knowledge transferred.

- ***Maintain Compliance with Mandatory Education:*** Enhancements to the learning management system were implemented to provide more real-time data to managers and employees regarding upcoming required training. In addition, HRBPs have supported managers to use the appropriate progressive discipline for non-compliance.

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

Use bullet points to describe improvement:

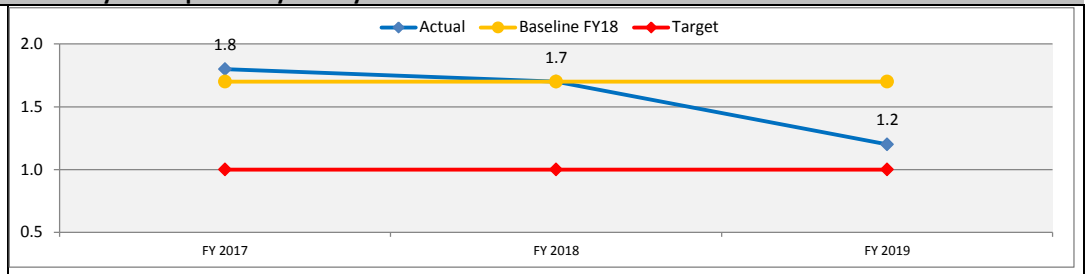
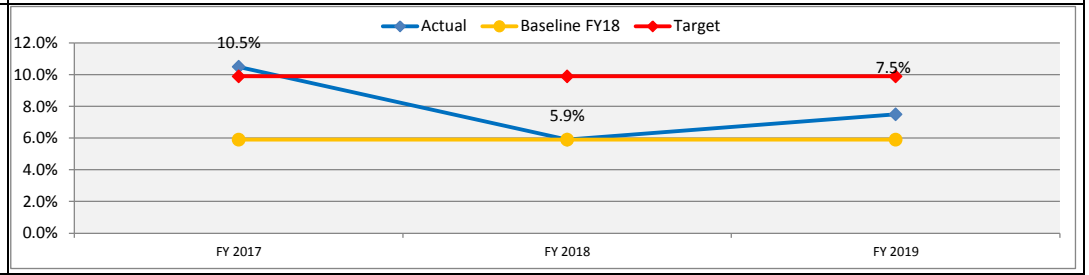
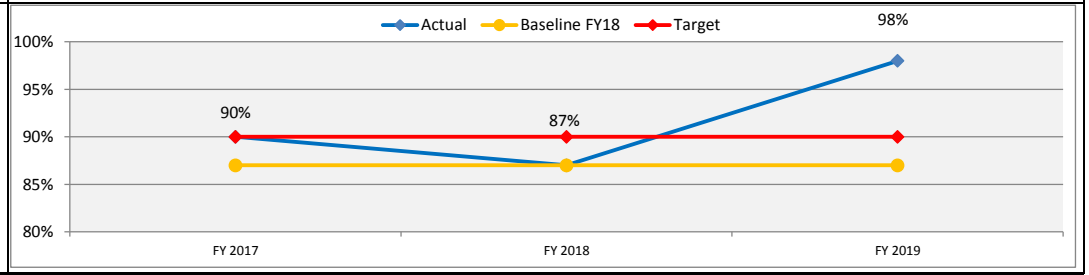
- ***Reduce Patient Lift/Transfer Injuries:*** There were a record low number of lost days incurred during FY-19 (5 lost days); 98% fewer than in FY-18

- ***Maintain RN Turnover below CHA benchmark:*** RN turnover continues to trend lower than the CHA benchmark by a significant amount.

- ***Maintain Compliance with Mandatory Education:*** Mandatory education compliance has improved since last fiscal year and is currently above the benchmark of 90%.

El Camino Health

Human Resource Dashboard - FY 2019 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance	Baseline FY 2018	Target or Benchmark	Trend Graph
These metrics are presented annually and reported by fiscal years				
Reduction Patient Lift Transfer Injury Rate per 100 FTE **ENTERPRISE** *Latest Data Month* : June 2019	1.2	1.7	1.0	
Maintain RN Turnover below CHA Benchmark **ENTERPRISE** *Latest Data Month* : June 2019	7.5%	5.9%	9.9%	
Maintain Compliance with Mandatory Education Completion **ENTERPRISE** *Latest Data Month* : June 2019	98%	87%	90%	

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Annual Performance Improvement Report

Department/Service Line: Maternal Child Health
Prepared by: Heather Freeman
Date: October 28, 2019
Reporting Period: FY19

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:

- **Early Elective Delivery PC-01:**
  - FY19 Performance: 2.9% CMQCC all cases. Variable with upward trend
  - FY20 Target: CMQCC 1.2% (CA top 25%)
- **NTSV C-Section Rate PC-02**:
  - FY19 Performance: 24.3% CMQCC Increasing in MV. May be associated w ARRIVE study
  - FY20 Target: CMQCC 23.8% (UC average)
- **OB Trauma PSI 19:** 3rd and 4th degree laceration with instrument:
  - FY19 Performance: CMQCC 22.2% Higher than peers. Some lacerations resulted from neonatal emergency situations (e.g., shoulder dystocia)
  - FY20 Target: CMQCC 18% (15% reduction)
- **NICU Chronic Lung Disease**:
  - FY19 Performance: 32.14%. Trending up, higher than CPQCC average
  - FY20 Target: 20.2% (CPQCC average)
- **NICU Growth and Nutrition**:
  - FY19 Performance: 66% No Extra Uterine Growth Restriction (EUGR). Performance improved steadily over FY19 and into FY20
  - FY20 Target: No EUGR $\geq$ 75%
- **Prolacta Monitoring**
  - Quality testing results and Certifcate of Compliance of Nutritional Analysis & Bioburder by lot #

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- **Early Elective Delivery**:
  - Cannot currently see EDD when C/S or induction is scheduled.
  - Because we can't see early elective deliveries before they happen, only doing retrospective reviews.
- **NTSV C-Section Rate**:
  - Not clear if providers are following NTSV reduction protocol or what the major issues are.
- **OB Trauma**:
  - MV has higher risk population with 62% Asian/Pac Islander. Asian/Pac Islander population has 2x published risk of laceration. Instrumented deliveries are more frequently r/t lacerations than non-instrumented
- **NICU Chronic Lung Disease**:
  - Not currently using the best respiratory technology to decrease CLD
- **NICU Growth and Nutrition**:
  - Expand Grow Baby Grow program to meet the needs of specific populations

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

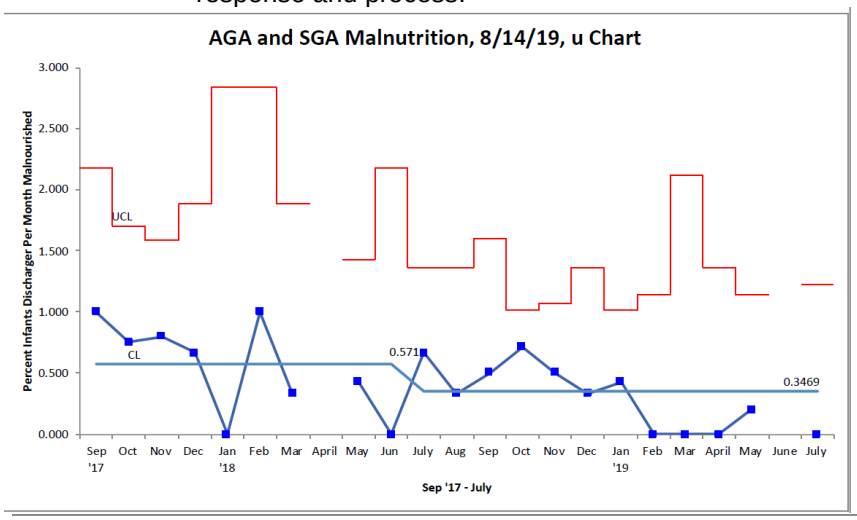
Use bullet points to list actions taken:

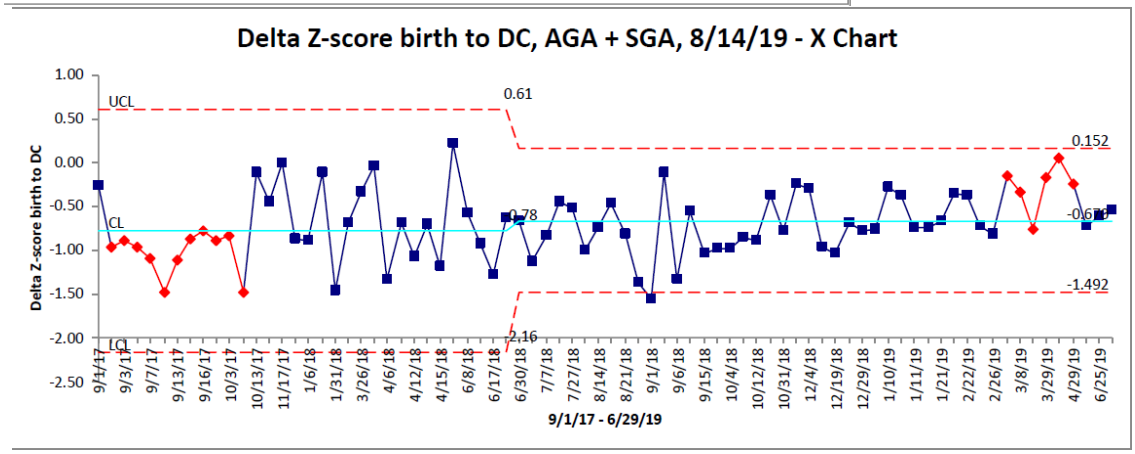
- **Early Elective Delivery**:
  - Requested report so we can see when deliveries are scheduled prior to 39 weeks. Will audit weekly
- **NTSV C-Section Rate**:
  - Developing concurrent audit tool to capture processes for C/S
  - Participating in NTSV reduction collaborative via CMQCC
- **OB Trauma**:
  - Distributing unblinded data and prevention info to providers
  - Requesting education from Stanford
  - Dr. Azad's group may trial Materna device to prevent trauma.
  - Understand current state of episiotomy process, improve processes as needed
  - Understand current state of instrumented deliveries, reduce where possible.
- **NICU Chronic Lung Disease**:
  - Went to Columbia to learn bubble CPAP and best practices.
  - Will implement bubble CPAP in January
  - Considering NAVA (neutrally adjusted ventilator assist) ventilation.
- **NICU Growth and Nutrition**:
  - Grow Baby Grow Initiative refinement and program expansion (see also below)

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

Use bullet points to describe improvement:

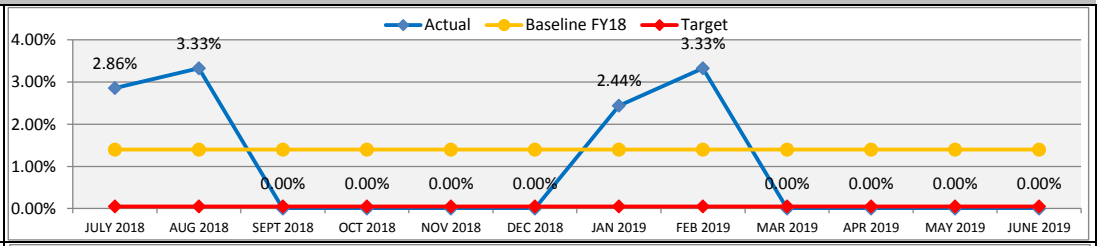
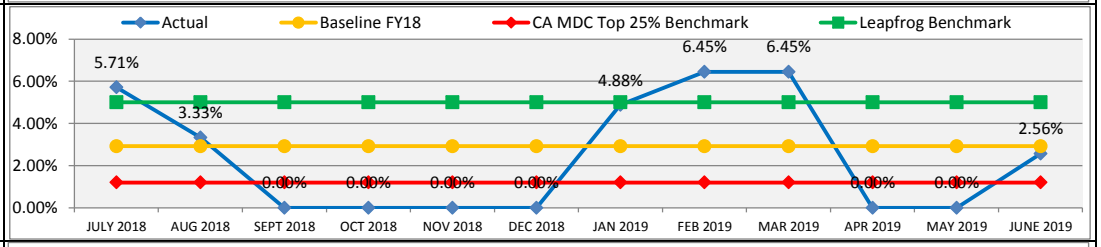
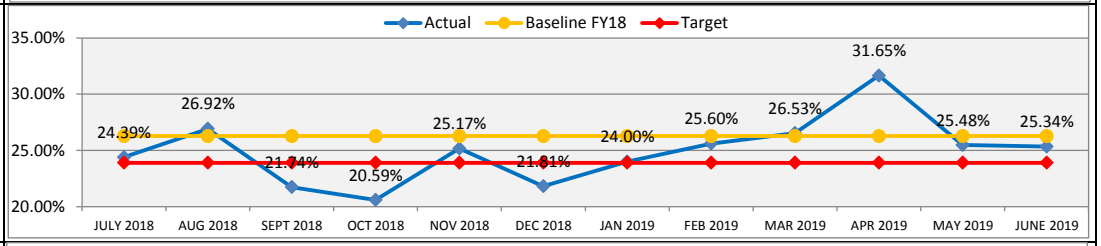
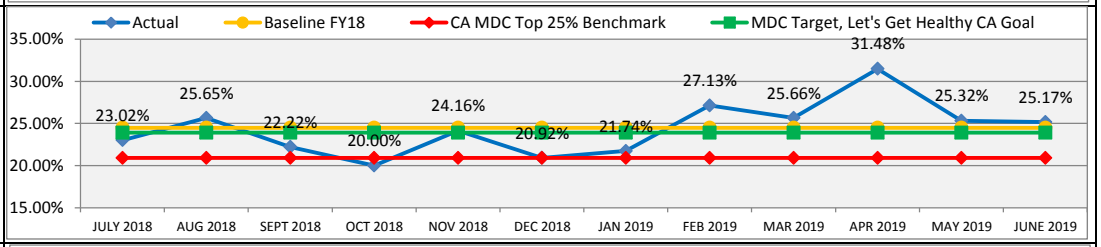
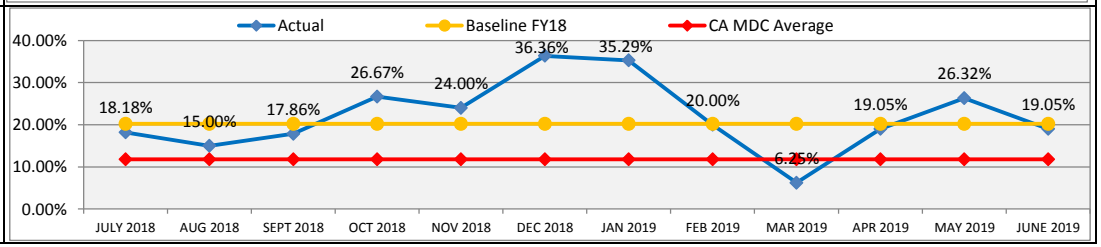
- **Improvements Made to Reduce NTSV C-Section Rate**:
  - Participated in CMQCC collaborative to reduce C/S
  - Developed new policies/modified policies to reflect best-practice recommendations for laboring women
- **Improvements Made to Improve NICU Nutrition, Growth:** Grow Baby Grow (see charts below)
  - Implemented changes to the feeding protocol and TPN pathway,
  - Created unit specific nutrition nursing flow sheet
  - Started nutrition time out (NTO) during weekly multi-disciplinary rounds.
  - Parents invited to participate in weekly rounds, emphasizing nutrition
- **Other NICU improvements made FY19**:
  - **Family Centered Care**: immediate postpartum communication improved 394%, hand expression improved 280), patient satisfaction with communication 36%.
    - Interventions included developing an antepartum education eBook, process for early kangaroo care, D/C teaching eBook, weekly parent letter, monthly handmade art work, and trained 14 parents to be NICU parent buddies
  - **Neonatal Codes**: implemented consistent neonatal mock codes to improve code response and process.





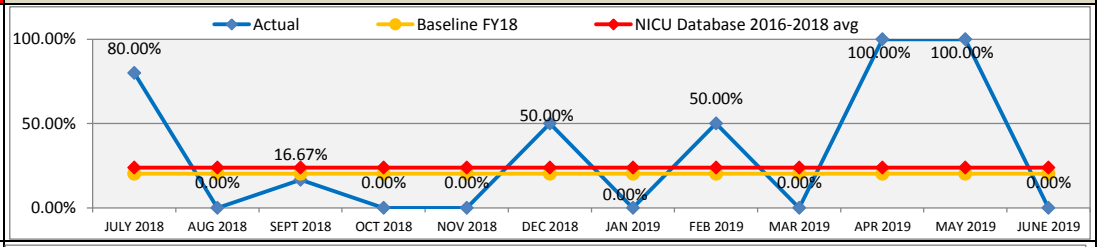
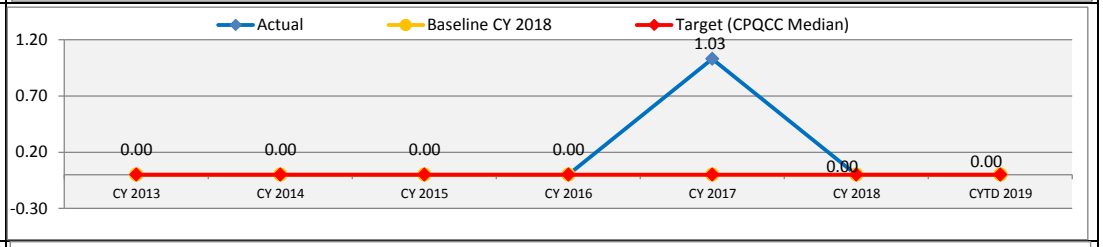
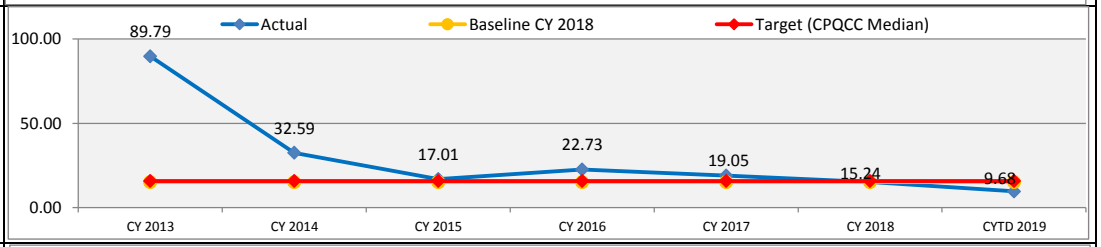
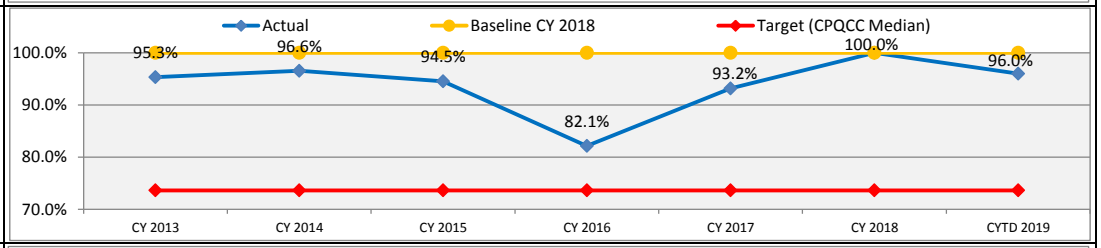
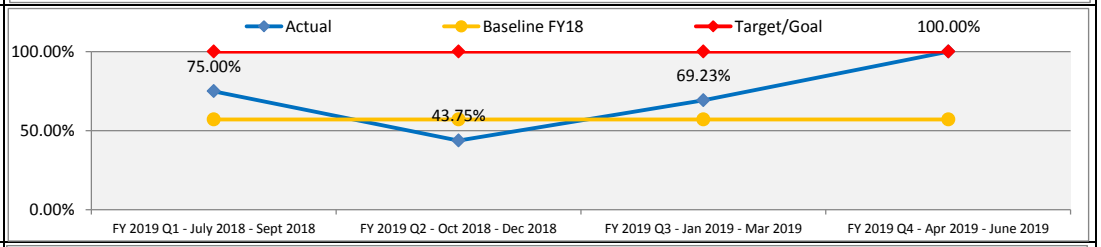
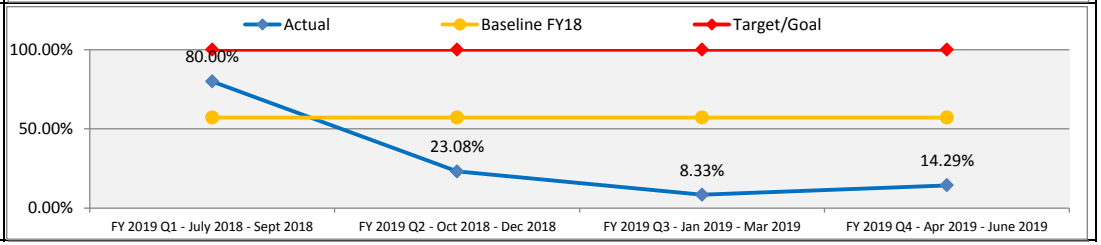
El Camino Health

Maternal Child Health Service Line Dashboard - FY 2019 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Jun-19	FY19 Avg			
METRICS					
PC-01 - Elective Delivery Prior to 39 weeks gestation *(lower = better)* **ENTERPRISE** Source : IBM CareDiscovery Quality Measures *Latest Data Month* : June 2019	0.00% (0/38)	0.99% (4/404)	1.40% (2/143)	0.00%	
PC-01 - Elective Delivery Prior to 39 weeks gestation *(lower = better)* **ENTERPRISE** Source : CMQCC CA State Database *Latest Data Month* : June 2019	2.56% (1/39)	2.43% (10/412)	2.92% (12/411)	<5% (Leapfrog Benchmark) <1.2% (CA MDC Top 25% Benchmark)	
PC-02 - NTSV C-Section Rate *(lower = better)* **ENTERPRISE** Source : IBM CareDiscovery Quality Measures *Latest Data Month* : June 2019	25.34% (37/146)	24.90% (455/1827)	26.27% (166/632)	< 23.90%	
PC-02 - NTSV C-Section Rate *(lower = better)* **ENTERPRISE** Source : CMQCC CA State Database *Latest Data Month* : June 2019	25.17% (38/151)	24.29% (460/1894)	23.93% (492/2056)	<23.9% (MDC Target, Let's Get Healthy CA Goal) <20.9% (CA MDC Top 25% Benchmark)	
PSI-19: OB Trauma: 3rd and 4rth Lacerations with Instrument **ENTERPRISE** Source : CMQCC CA State Database *Latest Data Month* : June 2019	19.05% (4/21)	22.17% (51/230)	20.2% (45/225)	11.80% (CA MDC Average)	

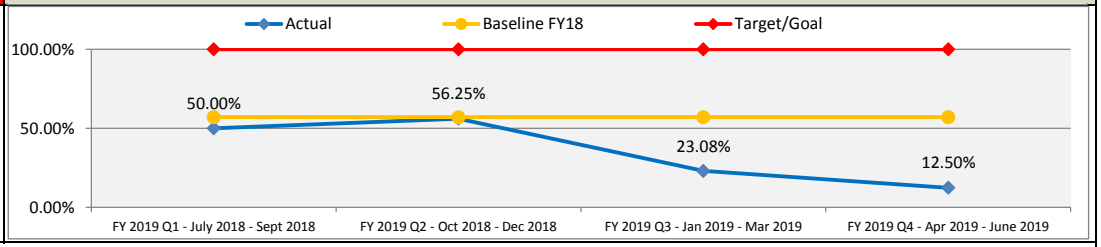
El Camino Health

Maternal Child Health Service Line Dashboard - FY 2019 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Jun-19	FY19 Avg			
Chronic Lung Disease 401-1500 g or 21-29 GA - NICU KPI **ECH MV Campus** Source : CPQCC CA State Database *Latest Data Month* : June 2019	0.00% (0/2)	32.14% (9/28)	26.09% (6/23)	23.90% (NICU Database 2016-2018 avg)	
NICU Central Line Associated Blood Stream Infection (CLABSI) per 1000 line days *Reported by Calendar Years* Source : CPQCC CA State Database	0 so far in **CYTD 2019**		0.00 (0/1119) **(baseline = CY 2018)**	0.00 (CPQCC Median)	
Antibiotic Use per 100 patient days *Reported by Calendar Years* Source : CPQCC CA State Database	9.68 (259/2675) so far in **CYTD 2019**		15.24 (608/3989) **(baseline = CY 2018)**	15.8 (CPQCC Median)	
Human Milk @ Discharge (All CPQCC Babies) Source : CPQCC CA State Database	96.0% (24/25) so far in **CYTD 2019**		100% (37/37) **(baseline = CY 2018)**	73.6% (CPQCC Median)	
Return to BW by DOL 10 for GBG qualifying babies Source : Epic Charts *Latest Data Month* : June 2019	100.0% (8/8)	66.67% (30/45)	57.1% (16/28)	100.0%	
EUGR incidence for AGA GBG qualifying babies Source : Epic Charts *Latest Data Month* : June 2019	14.3% (1/7)	24.3% (9/37)	42.3% (11/26)	0.0%	

El Camino Health

Maternal Child Health Service Line Dashboard - FY 2019 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Jun-19	FY19 Avg			
Malnutrition incidence for GBG qualifying babies Source : Epic Charts *Latest Data Month* : June 2019	12.5% (1/8)	37.8% (17/45)	57.1% (16/28)	0.0%	
Breast Milk Supplier **Service : Prolacta Bioscience**	*see attached PDF of Contract Services Performance Evaluation & Certficate of Compliance by Lot # and copies of its Nutritional Analysis & Bioburden results*				

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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Mountain View, CA 94040-4378
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CLINICAL CONTRACT SERVICES PERFORMANCE EVALUATION

Name of Service: Prolacta Bioscience

Nature of Service: Breast Milk Supplier

Review Period: January 1, 2019 – December 31, 2019

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	

Performance Metrics

METRIC – suggest a minimum of one clinical outcome metric and one process metric	1st QTR 2019	2nd QTR 2019	3rd QTR 2019	4th QTR or Annual for 2019
Provides copy of current tissue Bank License from the State of California Department of Public health for Prolacta Bioscience Inc.	X	X		
Provides quarterly copy of quality testing results: Finished Goods Certificate by lot number for Nutritional Analysis	X	X		
Provides quarterly copy of quality testing results: Finished Goods Certificate by lot number for Bioburden.	X	X		

Comments (Required if contract does not meet expectation in any area.)

Conclusion (check one)

X Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply:)
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: _____

Vendor Contact (Print Name)	Title
Signature	Date
Responsible ECH Director (Print Name)	Title
Signature	Date

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF061824USA Prolact+6 H²MF

Lot Release Date: 06DEC18
Expiration Date: 24OCT20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	138 Cal/100g
Protein Content	5.76% w/w
Fat Content	8.99% w/w
Total Carbohydrate	8.39%
Calcium	347.09 mg/100g
Chloride	0.10%
Copper	0.26 mg/100g
Iron	0.1145 mg/100g
Magnesium	22.67 mg/100g
Manganese	0.018 mg/100g
Phosphorus	187.86 mg/100g
Potassium	189.85 mg/100g
Sodium	127.57 mg/100g
Zinc	2.40 mg/100g
Ratio Ca:P	1.8:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

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Certificate of Compliance

Lot#: CF061823USA Prolact+6 H²MF

Lot Release Date: 13DEC18
Expiration Date: 11OCT20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	140 Cal/100g
Protein Content	5.74% w/w
Fat Content	9.15% w/w
Total Carbohydrate	8.55%
Calcium	353.79 mg/100g
Chloride	0.10%
Copper	0.24 mg/100g
Iron	0.1014 mg/100g
Magnesium	22.70 mg/100g
Manganese	0.018 mg/100g
Phosphorus	188.04 mg/100g
Potassium	188.19 mg/100g
Sodium	128.65 mg/100g
Zinc	2.30 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	2 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF061827USA Prolact+6 H²MF

Lot Release Date: 20DEC18
Expiration Date: 06NOV20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	138 Cal/100g
Protein Content	5.71% w/w
Fat Content	9.04% w/w
Total Carbohydrate	8.37%
Calcium	361.32 mg/100g
Chloride	0.10%
Copper	0.25 mg/100g
Iron	0.1037 mg/100g
Magnesium	22.47 mg/100g
Manganese	0.018 mg/100g
Phosphorus	182.03 mg/100g
Potassium	183.44 mg/100g
Sodium	125.39 mg/100g
Zinc	2.28 mg/100g
Ratio Ca:P	2.0:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF081811USA Prolact+8 H²MF

Lot Release Date: 27SEP18
Expiration Date: 05SEP20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	137 Cal/100g
Protein Content	5.67% w/w
Fat Content	9.15% w/w
Total Carbohydrate	8.09%
Calcium	268.76 mg/100g
Chloride	0.09%
Copper	0.20 mg/100g
Iron	0.1037 mg/100g
Magnesium	17.24 mg/100g
Manganese	0.010 mg/100g
Phosphorus	139.36 mg/100g
Potassium	154.75 mg/100g
Sodium	106.54 mg/100g
Zinc	1.95 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF081813USA Prolact+8 H²MF

Lot Release Date: 19NOV18
Expiration Date: 18OCT20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	142 Cal/100g
Protein Content	5.77% w/w
Fat Content	9.17% w/w
Total Carbohydrate	9.03%
Calcium	276.71 mg/100g
Chloride	0.09%
Copper	0.19 mg/100g
Iron	0.1097 mg/100g
Magnesium	17.63 mg/100g
Manganese	0.013 mg/100g
Phosphorus	143.43 mg/100g
Potassium	155.45 mg/100g
Sodium	106.40 mg/100g
Zinc	1.88 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
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Certificate of Compliance

Lot#: CF081814USA Prolact+8 H²MF

Lot Release Date: 17JAN19
Expiration Date: 15NOV20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	136 Cal/100g
Protein Content	5.76% w/w
Fat Content	9.03% w/w
Total Carbohydrate	7.95%
Calcium	268.16 mg/100g
Chloride	0.09%
Copper	0.18 mg/100g
Iron	0.1092 mg/100g
Magnesium	17.93 mg/100g
Manganese	0.014 mg/100g
Phosphorus	138.12 mg/100g
Potassium	149.98 mg/100g
Sodium	104.63 mg/100g
Zinc	1.83 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

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Certificate of Compliance

Lot#: **CF081815USA Prolact+8 H²MF**

Lot Release Date: 30JAN19
Expiration Date: 11DEC20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	137 Cal/100g
Protein Content	5.74% w/w
Fat Content	9.10% w/w
Total Carbohydrate	8.15%
Calcium	273.52 mg/100g
Chloride	0.09%
Copper	0.19 mg/100g
Iron	0.09522 mg/100g
Magnesium	17.97 mg/100g
Manganese	0.013 mg/100g
Phosphorus	141.66 mg/100g
Potassium	155.33 mg/100g
Sodium	106.05 mg/100g
Zinc	1.87 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
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Certificate of Compliance

Lot#: **CF081903USA Prolact+8 H²MF**

Lot Release Date:	03APR19
Expiration Date:	05MAR21

Appearance Test	**Result**
Color/Visual Inspection	Pass

Nutritional Analysis	**Result**
Caloric Content	138 Cal/100g
Protein Content	5.90% w/w
Fat Content	9.18% w/w
Total Carbohydrate	8.00%
Calcium	265.69 mg/100g
Chloride	0.09%
Copper	0.20 mg/100g
Iron	0.1092 mg/100g
Magnesium	17.19 mg/100g
Manganese	0.015 mg/100g
Phosphorus	140.84 mg/100g
Potassium	148.28 mg/100g
Sodium	104.50 mg/100g
Zinc	1.96 mg/100g
Ratio Ca:P	1.9:1

Bioburden	**Result**
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF081904USA Prolact+8 H²MF

Lot Release Date: 11APR19
Expiration Date: 20MAR21

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	137 Cal/100g
Protein Content	5.75% w/w
Fat Content	9.19% w/w
Total Carbohydrate	7.80%
Calcium	267.71 mg/100g
Chloride	0.09%
Copper	0.18 mg/100g
Iron	0.1036 mg/100g
Magnesium	17.36 mg/100g
Manganese	0.015 mg/100g
Phosphorus	137.05 mg/100g
Potassium	151.52 mg/100g
Sodium	105.19 mg/100g
Zinc	1.85 mg/100g
Ratio Ca:P	2.0:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF081905USA Prolact+8H^{2}MF

Lot Release Date: 22APR19
Expiration Date: 02APR21

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	135 Cal/100g
Protein Content	5.70% w/w
Fat Content	9.01% w/w
Total Carbohydrate	7.76%
Calcium	276.48 mg/100g
Chloride	0.09%
Copper	0.17 mg/100g
Iron	0.1094 mg/100g
Magnesium	18.65 mg/100g
Manganese	0.016 mg/100g
Phosphorus	136.63 mg/100g
Potassium	151.04 mg/100g
Sodium	107.99 mg/100g
Zinc	1.84 mg/100g
Ratio Ca:P	2.0:1

Bioburden	Result
Total Aerobic Count	1 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF081910USA Prolact+8 H²MF

Lot Release Date: 26JUL19
Expiration Date: 02JUL21

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	137 Cal/100g
Protein Content	5.72 % w/w
Fat Content	9.00 % w/w
Total Carbohydrate	8.16 %
Calcium	272.53 mg/100g
Chloride	0.09%
Copper	0.18 mg/100g
Iron	0.1025 mg/100g
Magnesium	16.95 mg/100g
Manganese	0.016 mg/100g
Phosphorus	140.10 mg/100g
Potassium	149.68 mg/100g
Sodium	104.78 mg/100g
Zinc	1.89 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
Advancing the Science of Human Milk

Certificate of Compliance

Lot#: CF101803USA Prolact+10 H²MF

Lot Release Date: 04OCT18
Expiration Date: 13SEP20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	134 Cal/100g
Protein Content	5.67% w/w
Fat Content	8.86% w/w
Total Carbohydrate	7.84%
Calcium	222.17 mg/100g
Chloride	0.08%
Copper	0.17 mg/100g
Iron	0.09590 mg/100g
Magnesium	14.87 mg/100g
Manganese	0.008 mg/100g
Phosphorus	119.57 mg/100g
Potassium	133.86 mg/100g
Sodium	90.38 mg/100g
Zinc	1.62 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	1 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

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Lot#: CF101901USA Prolact+10 H²MF

Lot Release Date: 22APR19
Expiration Date: 28MAR21

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	136 Cal/100g
Protein Content	5.69 % w/w
Fat Content	9.02 % w/w
Total Carbohydrate	8.01 %
Calcium	220.83 mg/100g
Chloride	0.08%
Copper	0.17 mg/100g
Iron	0.09934 mg/100g
Magnesium	14.98 mg/100g
Manganese	0.013 mg/100g
Phosphorus	117.77 mg/100g
Potassium	135.95 mg/100g
Sodium	89.35 mg/100g
Zinc	1.65 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

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Certificate of Compliance

Lot#: **CR261901USA Prolact RTF 26**

Lot Release Date:	30MAY19
Expiration Date:	15APR21

Appearance Test	**Result**
Color/Visual Inspection	Pass

Nutritional Analysis	**Result**
Caloric Content	90 Cal/100g
Protein Content	2.57 % w/w
Fat Content	5.25 % w/w
Total Carbohydrate	8.02 %
Calcium	129.50 mg/100g
Chloride	0.066%
Copper	0.08431 mg/100g
Iron	0.04627 mg/100g
Magnesium	7.60 mg/100g
Phosphorus	69.63 mg/100g
Potassium	86.13 mg/100g
Sodium	57.86 mg/100g
Zinc	0.82 mg/100g
Ratio Ca:P	1.9:1

Bioburden	**Result**
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

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Lot#: CR281803USB Prolact RTF 28

Lot Release Date: 07DEC18
Expiration Date: 01NOV20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	95 Cal/100g
Protein Content	2.82% w/w
Fat Content	5.92% w/w
Total Carbohydrate	7.69%
Calcium	140.27 mg/100g
Chloride	0.073%
Copper	0.08922 mg/100g
Iron	0.04732 mg/100g
Magnesium	8.59 mg/100g
Phosphorus	76.76 mg/100g
Potassium	94.56 mg/100g
Sodium	63.69 mg/100g
Zinc	0.89 mg/100g
Ratio Ca:P	1.8:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL

Prolacta BIOSCIENCE
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Certificate of Compliance

Lot#: CR281802USA Prolact RTF 28

Lot Release Date: 19NOV18
Expiration Date: 20SEP20

Appearance Test	Result
Color/Visual Inspection	Pass

Nutritional Analysis	Result
Caloric Content	95 Cal/100g
Protein Content	2.77% w/w
Fat Content	5.86% w/w
Total Carbohydrate	7.75%
Calcium	140.80 mg/100g
Chloride	0.073%
Copper	0.09088 mg/100g
Iron	0.04690 mg/100g
Magnesium	8.69 mg/100g
Phosphorus	75.79 mg/100g
Potassium	96.98 mg/100g
Sodium	63.46 mg/100g
Zinc	0.90 mg/100g
Ratio Ca:P	1.9:1

Bioburden	Result
Total Aerobic Count	0 CFU/mL
Bacillus cereus	0 CFU/mL
E.coli /Coliform	0 CFU/mL
Salmonella	Negative/25mL by ELFA
Pseudomonas aeruginosa	0 CFU/mL
Staphylococcus aureus	0 CFU/mL
Mold	0 CFU/mL
Yeast	0 CFU/mL