El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Monday, February 4, 2019 - 5:30 p.m.
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Ina Bauman will be participating via teleconference from 11768 China Camp Road Truckee, CA 96161.

Jeffrey Davis, MD will be participating via teleconference from:
Diamante, Boulevard Diamante S/N, Lado Del Mar Colonia Los Cangr, Cabo San Lucas BCS, Mexico 23473.

Melora Simon will be participating via teleconference from 12850 Seal Beach Blvd. Seal Beach, CA 90740.

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**	Peter C. Fung, MD, Quality Committee Member		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Peter C. Fung, MD, Quality Committee Member		**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.*	Peter C. Fung, MD, Quality Committee Member	*public comment*	**Motion Required** **5:33 – 5:35**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (December 3, 2018) ***Information*** b. Patient Story c. FY19 Pacing Plan d. Progress Against FY19 Committee Goals			
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Peter C. Fung, MD, Quality Committee Member		**Discussion** **5:35 – 5:40**
5.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 5**	Mark Adams, MD, CMO		**Discussion** **5:40 – 5:50**
6.	**UPDATE ON PATIENT CARE EXPERIENCE** **ATTACHMENT 6**	Cheryl Reinking, RN, CNO		**Discussion** **5:50 – 6:05**
7.	**PHYSICIAN BURNOUT** **ATTACHMENT 7**	Mark Adams, MD, CMO		**Discussion** **6:05 – 6:35**
8.	**JOINT COMMISSION SURVEY RESULTS** **ATTACHMENT 8**	Mark Adams, MD, CMO		**Discussion** **6:35 – 6:50**
9.	**HOSPITAL UPDATE** **ATTACHMENT 9**	Mark Adams, MD, CMO		**Discussion** **6:50 – 6:55**
10.	**PUBLIC COMMUNICATION**	Peter C. Fung, MD, Quality Committee Member		**Information** **6:55 – 6:58**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**ADJOURN TO CLOSED SESSION**	Peter C. Fung, MD, Quality Committee Member		**Motion Required 6:58 – 6:59**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Peter C. Fung, MD, Quality Committee Member		**6:59 – 7:00**
13.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Peter C. Fung, MD, Quality Committee Member		**Motion Required 7:00 – 7:02**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (December 3, 2018)			
14.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Q2 FY19 Quality/Safety Review	Mark Adams, MD, CMO		**Discussion 7:02 – 7:12**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**Discussion 7:12 – 7:17**
16.	**ADJOURN TO OPEN SESSION**	Peter C. Fung, MD, Quality Committee Member		**Motion Required 7:17 – 7:18**
17.	**RECONVENE OPEN SESSION/REPORT OUT**	Peter C. Fung, MD, Quality Committee Member		**7:18 – 7:19**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**ADJOURNMENT**	Peter C. Fung, MD, Quality Committee Member	*public comment*	**Motion Required 7:19 – 7:20pm**

Upcoming FY19 Meetings: March 4, 2019 | April 1, 2019 | May 6, 2019 | June 3, 2019 || **Board/Committee Educational Gathering:** April 24, 2019

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, December 3, 2018
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present
Katie Anderson
Ina Bauman
Jeffrey Davis, MD
Peter C. Fung, MD
Julie Kliger, Chair
David Reeder
Wendy Ron
Melora Simon

Members Absent

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. Ms. Anderson arrived during Agenda Item 4: Report on Board Actions and Ms. Simon arrived during Agenda Item 5: FY19 Quality Dashboard. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (November 5, 2018); and for information: Patient Stories; FY19 Pacing Plan; Progress Against FY19 Committee Goals; and Article of Interest. **Movant:** Davis **Second:** Ron **Ayes:** Bauman, Davis, Fung, Kliger, Ron, Reeder **Noes:** None **Abstentions:** None **Absent:** Anderson, Simon **Recused:** None	***Consent Calendar approved***
4. REPORT ON BOARD ACTIONS	In response to questions, Cindy Murphy, Director of Governance Services, explained that the Board approved the revisions to the Quality Committee Charter that the Committee recommended at its August meeting.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the quality metrics on the Committee's FY19 dashboard and Cheryl Reinking, RN, CNO, reviewed the HCAHPS scores. Ms. Reinking noted that the scores improved significantly in October, but the preliminary data for November is not looking quite as good. Dr. Adams explained that some of the Hospital acquired infections can be explained by a failure to document the infections on admission. The Committee members and staff discussed the importance of instilling a culture of safety throughout the organization that includes careful monitoring of others. The Committee also asked staff to bring the data back plotted quarter by quarter as well as on a rolling -12 month basis.	

6. PSI-90 SCORES	Dr. Adams reported on the AHRQ Patient Safety Indicators for Q1 FY19. He noted that ECH performs better than the Premier Composite mean of 0.90 overall for FY18 and Q1 of FY19, but there is still room for improvement. Dr. Davis suggested that this data would be a good candidate for presentation on a rolling 12-month basis.	
7. THROUGHPUT CASE STUDY	Ms. Reinking reported that it is one of ECH's FY19 Organizational Goals to improve (decrease) the amount of time it takes from the time a patient arrives in the ED until they are admitted to an in-patient unit. She explained that the baseline median was 339 minutes and the goal is to get to 280. Ms. Reinking reported that the staff identified 65 barriers to throughput. One barrier was the time it takes to achieve RN to RN handoff once the physician writes the admission order. Staff is piloting making an appointment for the ED RN to give report to the Unit RN, which is already making some improvement.	
8. READMISSIONS	Dr. Adams reported that the organization is very focused on reducing preventable readmission and the effort is organized around teams composed of a mix of various clinicians and administrators. He explained that ECH is trying to focus efforts on those patients most at risk for readmission and that ECH has developed its own predictor tool and validated it. Teams include a Readmissions Review team, a Care Coordination team, a Palliative Care team, and a CV mortality and Readmissions team.	
9. CUTLURE OF SAFETY SURVEY REPORT	Dr. Adams reviewed themes from the culture of safety survey. Some of the Medical Staff members present commented that members of the Medical Staff report feeling as though hospital administration and the Board do not prioritize the needs of physicians, and need to focus on addressing physician burn-out issues. Dr. Davis asked Dr. Adams to take the lead in defining this problem and bring that back to the Committee and the Board. Chair Kliger requested that this be added to the Committee's Pacing Plan as a topic to revisit.	
10. HOW DOES ECH DEFINE QUALITY	Chair Kliger briefly reviewed the results of the Quality Strategy Maturity Model Survey, noting that 12 of 17 requested participants participated in the survey. She requested that the survey be re-administered to the 5 who did not participate and she also asked Dr. Adams to extend the survey to a broader group of participants. The Committee asked that additional information be provided in the responses that provide evidence that justifies or explains the response. Staff was directed to add this back to the Committee's Pacing Plan for the March 2019 meeting.	
11. HOSPITAL UPDATE	Mark Adams, MD, CMO, answered questions from the Committee members about the hospital update.	
12. PUBLIC COMMUNICATION	There were no comments from the public.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:28pm. **Movant:** Anderson **Second:** Reeder **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 7:28pm.***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/	Open session was reconvened at 7:38pm. Agenda Items 14-18 were covered in closed session.	

REPORT OUT	During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (November 5, 2018) a unanimous vote of all members present, (Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon).	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:40pm. **Movant:** Anderson **Second:** Reeder **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:40pm***

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

_____
Julie Kliger
Chair, Quality Committee

[redacted]

El Camino Hospital
The Patient Experience Team
[redacted]

Dear Team,

When our brother [redacted] came to El Camino Hospital in Mountain View for his final hours of life Friday, [redacted], the staff was entirely respectful of his desire to not be revived while they also worked to keep him comfortable, taking measures in case his health improved. With considerable effort, the Sunnyvale police where we live were called, and getting our cell phone number from our next door neighbor, notified us of [redacted] condition at the hospital while we were working on our boat in Richmond. We, [redacted] brother [redacted] and sister-in-law [redacted], were able to be present with his wife [redacted], for several hours at El Camino Hospital. [redacted] knew us and was comforted by his wife, [redacted] who brought him in as well as the 2 of us who arrived a few hours after [redacted] admittance.

At 10pm, the moment of [redacted] passing, Chaplain [redacted], was called from his home. His swift arrival, behavior and presence immediately comforted the 3 of us who were in the room with [redacted]. Chaplain [redacted] was neatly dressed and appeared comfortable with remaining in the room with us after he pronounced a benediction. We sincerely wish to express our appreciation for Chaplain [redacted] efforts and words of comfort. The Lord certainly provided the right person for this sad moment. Thank you all for every effort and action for [redacted] comfort as well as your kind acknowledgement of the importance of our presence.

Very truly yours,

[redacted]

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

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

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

FY2019 Q3		
JANUARY 2019	**FEBRUARY 4, 2019**	**MARCH 4, 2019**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 7. Q2 FY19 Quality and Safety Review (Q2 Reportable events if any) 8. ~~Physician Survey Results~~Physician Burnout 9. ~~Committee Recruitment~~ 10. Joint Commission Survey Results 11. Update on Patient Care Experience	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: ~~1. Update on Patient and Family Centered Care~~ ~~2. Mortality and Readmissions Metrics (FY19 Quality Goals)~~ ~~3.~~1. Proposed FY20 Committee Goals ~~4.~~2. Proposed FY20 Organizational Goals 3. Behavioral Health Services Quality Report 4. Committee Recruitment 5. What is Quality? (Maturity Model)

FY2019 Q4		
APRIL 1, 2019	**MAY 6, 2019**	**JUNE 3, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Leapfrog Survey 2. Value Base Purchasing Report 3. Pt. Experience (HCAHPS) 4. ED Pt. Satisfaction (Press Ganey) 5. Approve FY20 Committee Goals 6. Proposed FY20 Committee Meeting Dates 7. Proposed FY20 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Approve FY20 Committee Goals (if needed) 4. Proposed FY20 Organizational Goals 5. Proposed FY20 Pacing Plan 6. Q3 FY19 Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Approve FY20 Pacing Plan

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY18 Achievement and Metrics for FY19 (Q1 FY19) - FY20 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board – reviewed FY18 results on 9/5/18; FY20 goals review paced for 3/4/19
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) N/A - Review Medical Staff credentialing process (FY19) – COMPLETE - reviewed at 10/1/2018 meeting
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY19 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline – on track
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – paced quarterly
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals – on the FY19 dashboard

SUBMITTED BY:

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

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care, and patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: February 4, 2019
Subject: Report on Board Actions

Purpose:

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

Summary:

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

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

3. Background: Since the last Quality Committee Meeting the Hospital Board has met twice and the District Board has met three times.

A. ECH Board Actions

December 5, 2018

- Approved Period 3 Financial Report
- Approved Letters of Rebuttable Presumption of Reasonableness
- Approved the following Physician Contracts: Professional Services Agreements for the Perinatal Diagnostic Center, Radiology, and the Hospitalists for the Mountain View Campus; Medical Director Agreement for the Aspire Program; Orthopedic Co-Management Agreement; Gastroenterology and Orthopedic Surgery Call Panel Agreements

January 16, 2019

- Approved Period 4 Financial Report
- Appointed George Ting, MD to the Investment Committee and Quality, Patient Care, and Patient Experience Committee,
- Appointed Julia Miller as Co-Liaison to the El Camino Hospital Foundation Board
- Approved funding for the Los Gatos Cancer Center Construction not to exceed $6.4 million
- Revised Policies: Signature Authority; Corporate Compliance: Physician Financial Arrangements; Board of Director Approval of Hospital Policies
- Approved Acquisition of Interests in El Camino Ambulatory and capital improvements not to exceed $9.2 million in total

B. ECHD Board Actions

December 5, 2018

- Revised Community Benefits Grants Policy to comply with new statutory requirements
- Appointed John Zoglin as a member of the District's ECH Board Member Election Ad Hoc Committee
- Appointed Julia Miller as the District's Liaison to the CBAC

December 7, 2018

- Re-Elected Peter C. Fung, MD and elected George O. Ting, MD to four year terms on the ECH Board

January 22, 2019

- Recognized Community Benefit Partner Fresh Approach for its mobile farmers' markets and other programs that address nutrition education and food insecurity.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, Sr. Director, Quality Improvement and Patient Safety
Date: February 4, 2019
Subject: FY19 Quality Dashboard

Purpose:

To provide updated metrics for current Organization Goals, FY18 Organizational Goals, and additional quality metrics of interest.

Summary:

1. Situation: This report monitors progress toward FY19 Organizational Goals, and sustaining of FY18 Organizational Goals, and metrics monitoring sepsis.

2. Authority: The Quality Committee is responsible for oversight of quality and safety.

3. Background: These twelve metrics were selected for monthly review by this Committee as they reflect the Hospital's FY19 quality, efficiency, and service goals.

4. Assessment: For both Organizational Goals, Mortality and Readmission Index are at maximum level FYTD. For Hospital-Acquired Infections, there were zero Catheter Associated Urinary Tract Infections (CAUTIs) for December 2018. Average Length of Stay (ALOS)/Gemotric Mean Length of Stay (GMLOS) is up in the winter months as patients' psychosocial needs and issues with homelessness are not captured in the geometric LOS.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

FY19 Quality Dashboard (December data unless otherwise specified - final results)

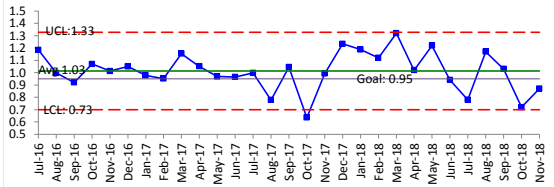
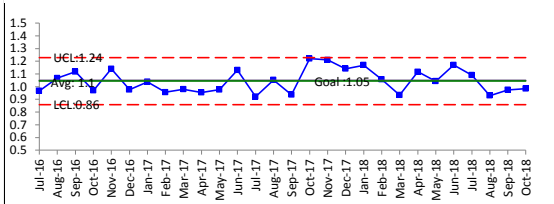
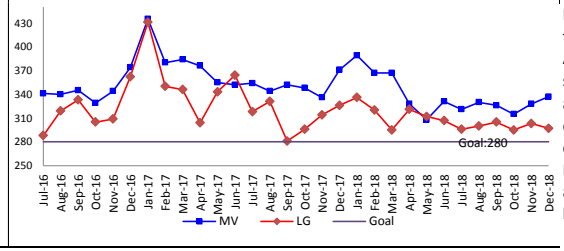
Suggested Committee Discussion Questions: None

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

December 2018 (Unless otherwise specified)

Month to Board Quality Committee: February, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Quality		**Month**	**FYTD**				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: November 2018*	0.87 (1.61%/1.85%)	0.90 (1.29%/1.43%)	1.05	0.95		Since March 2018, the Mortality Index has continued a downward trend. This index does move up with the Sepsis mortality rate, which increased in November. Improved physician documentation with CDI assistance continues to improve the Expected mortality rate - at 1.85% this month.
2	*Organizational Goal **Readmission Index (All Patient, All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: October 2018*	0.98 (6.72%/6.83%)	1.00 (6.89%/6.87%)	1.08	1.05		The improvements made since July by the 5 teams focused on Readmissions are affecting the Readmission Index. Zero readmissions for the COPD population in October also contribute.
3	* Organizational Goal **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: December 2018*	MV: 337 mins LG: 297 mins	MV: 325 mins LG: 299 mins	MV: 350 mins; LG: 314 mins	280 mins		In Mountain View: ongoing focus on order to floor time, and pilot nurse handoff has spread to all units. Adjustments made to Nursing Complex meetings each shift to support focus on the movement of patients and planning ahead. Meeting with providers to discuss options for improving time between ED consult for admission and admit orders. In LG, Pilot of ED nurses transporting pts to units and working with admitting providers to use bridge orders, though bridging orders have been refused by some physicians.

Definitions and Additional Information

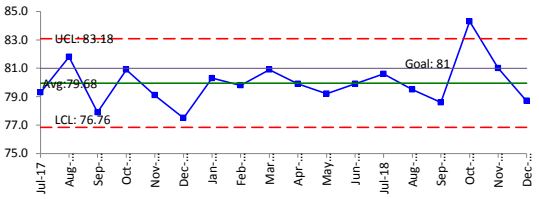
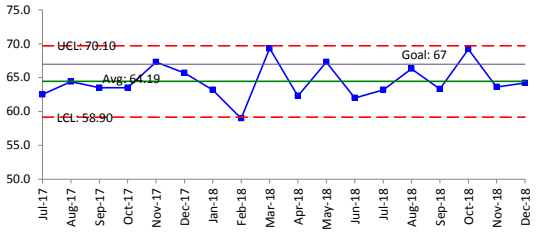
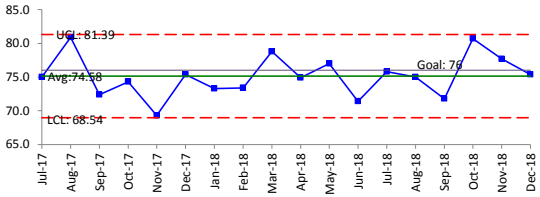
Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Catherine Carson			UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Readmission Index (All Patient, All Cause Readmit) Observed/Expected	Catherine Carson			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)	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**iCare Report: ECH ED Arrival to Floor**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

December 2018 (Unless otherwise specified)

Month to Board Quality Committee: February, 2019

	Service	FY19 Performance Month	FY19 Performance FYTD	HCAHPS Baseline Q4 2017-Q3 2018	FY19 Target	Trend	Comments
4	* Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: December 2018*	78.7 (212/270)	80.5 (1262/1568)	80.0	81.0		The Nursing Communications Team is using • Care Team Coaching appointment/reminder cards • Working on Enhanced Interactions/ Purposeful rounding • Created standard display of data on VIS boards
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: December 2018*	64.2 (163/254)	65.1 (967/1486)	65.1	67.0		The Responsiveness Team is: • Working with Admin Support (AS) staff to identify best practices with call lights • Standardizing Call Light Response and Escalation Structure
6	* Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: December 2018*	75.4 (202/268)	76.1 (1184/1555)	74.5	76.0		The Cleanliness Team is: • Working with Facilities on room and bathroom clutter strategies • EVS staff scripting, business cards and badge buddies • Monthly "Most Improved Unit- Taking Pride in Your Environment" Award started

Definitions and Additional Information

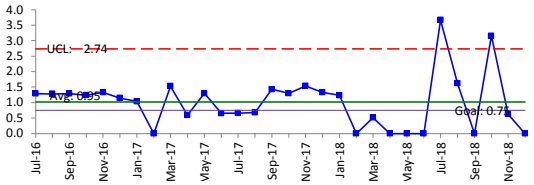
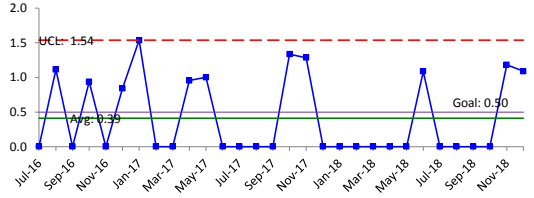
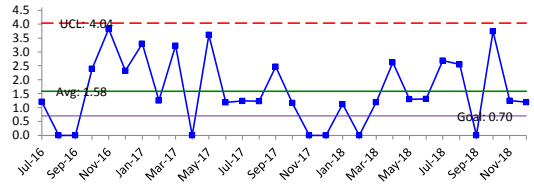
Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	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	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

December 2018 (Unless otherwise specified)

Month to Board Quality Committee: February, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Quality		**Month**	**FYTD**				
7	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: December 2018*	0.00 (0/1479)	1.42 (11/7739)	0.77	SIR Goal: <= 0.75		No new CAUTI HAIs in December.
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: December 2018*	1.09 (1/918)	0.38 (2/5266)	0.28	SIR Goal: <= 0.50		1 new CLABSI in December: Pt with many issues and complications with a PICC line for multiple incompatible infusions. CLABSI from contaminated PICC line draw. Nursing re-education on correct process for ensuring non-contaminated culture specimen.
9	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: December 2018*	1.19 (1/8383)	1.90 (9/47390)	1.13	SIR Goal: <= 0.70		1 new C. Diff HAI in December; required to be called "hospital-acquired" because though the correct C.Diff Surveillance test ordered after admission, the specimen was not collected until days later. Re-education on obtaining stool specimen when ordered.

Definitions and Additional Information

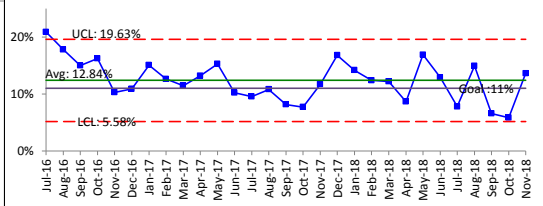
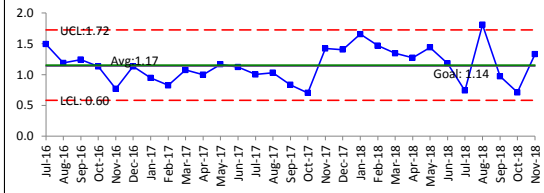
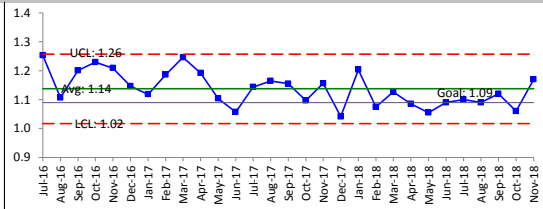
Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.	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.	
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Catherine Carson/Catherine Nalesnik			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.	
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Catherine Carson/Catherine Nalesnik			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.	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

December 2018 (Unless otherwise specified)

Month to Board Quality Committee: February, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
		Month	FYTD				
10	**Sepsis Mortality Rate Enterprise, based on ICD-10 codes** *Date Period: November 2018*	13.64%	9.90%	11.72%	11.00%		Of the Sepsis pts. who died in November: 13 were at the end of life: 8 w/terminal cancer, 9 presented on admission in Septic shock, 10 were 80 years and older. 2 died on the day of admission, and 16 had orders for comfort care/DNR. All Sepsis mortalities are reviewed for opportunities for improvement, and for these deaths, not a single case's outcome would have changed with better sepsis care, and many would have benefited from inpatient Hospice. This started at ECH in January 2019.
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: November 2018*	1.33 (13.64%/10.24%)	1.13	1.22	1.14		Sepsis mortality is affected by rapid and appropriate care that is part of the Sepsis Core Measure bundle; rapid fluid resuscitation and appropriate antibiotics. The November Core measure compliance rate was at 93%. The expected rate improved to over 10% due to better clinical documentation.
Efficiency							
12	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: November 2018*	1.17	1.11	1.12	1.09		ECH highest LOS is in Dec-Mar of every year per Care Coordination. In the winter, older patients come in and may start out as respiratory failure and eventually have multi-organ damage. Patients are more complex this time of year and this is the time when homeless patients are also more likely to get admitted and they have complex medical, psycho-social needs.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Rate Enterprise, based on ICD 10 codes	Catherine Carson			UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Catherine Carson			UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Arithmetic Observed LOS Average over Geometric LOS Expected (Medicare definition, MS-CC, Inpatient)	Cheryl Reinking Catherine Carson (Cornel Delogramatic)		The Observed LOS over the Expected LOS Ratio is determined by calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient's MD-DRG.	UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cheryl Reinking, RN, CNO
Date: February 4, 2019
Subject: Update on Patient Care Experience

Purpose:

To provide the Committee with an update on Patient Care Experience performance improvement with a focus on the Emergency Department.

Summary:

1. Situation: The Emergency Department has had variable patient experience results throughout the past two years. There was a particular event that occurred at the LG Emergency Department in June that lead the organization to do an in depth review of patient experiences in both Emergency Departments and to create a specific plan to address patient experience at each campus.

2. Authority: It is important for the Committee to stay abreast of the many efforts the hospital is working on to improve the patient experience in the entire organization as well as in the Emergency Department.

3. Background: The Emergency Department is ridden with complexity; multiple factors, including clinician communication wait times, affect the patient's measurement of experience. The hospital uses our patient experience survey vendor, Press Ganey, to measure our patient's point of view of their stay in the Emergency Department. You will see that after the event in June, our scores in the Emergency Department drastically dropped. A team including front line staff and executives immediately began to meet to address the issues. We have instituted multiple initiatives (that will be discussed further at the meeting) and have seen our scores improve in the 2nd quarter of FY19.

4. Assessment: We continue to evaluate our initiatives and in some cases have decided to switch to different alternatives when a change does not work well for our patients.

5. Other Reviews: The Executive Team and members of the Patient Experience Steering Committee are closely monitoring the changes and the concomitant surveys from our patients.

6. Outcomes: Improved Patient Experience scores in the entire organization, including in the Emergency Department

List of Attachments: None.

Suggested Committee Discussion Questions:

1. What has worked and what has not worked in addressing patient experience improvements in the Emergency Department?
2. What are the biggest challenges to addressing patient experience in the Emergency Department?

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: February 4, 2019
Subject: Physician Burnout

Purpose: To provide an introduction to the Committee on physician burnout.

Summary:

1. Situation: Physician burnout has become a widespread national problem with a prevalence of over 50% for some specialties.

2. Authority: This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients.

3. Background: There has been a steady increase in measurable physician burnout with concomitant increases in physician depression and even suicides. The Institute for Healthcare Improvement (IHI) in recognition of this disturbing trend has modified its original Triple Aim for healthcare improvement (Better Care, Better Health, Lower Cost) to now recognize burnout by designating a fourth (Quadruple Aim) area of focus: Care Team Well-Being or improving the work life of health care providers.

4. Assessment: There are specific reasons that physicians are vulnerable to burnout which include how they are educated and trained as well as the ever changing and challenging work environment. It is important for the Quality Committee to understand the nature of physician burnout and how this can be addressed.

5. Other Reviews: None.

6. Outcomes: Raise awareness and understanding of this phenomenon and how it relates to patient care. Discuss potential interventions to reduce burnout.

List of Attachments:

1. None

Suggested Committee Discussion Questions:

1. None

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, RN, CPHQ;
Sr. Director, Quality Improvement and Patient Safety
Date: February 4, 2019
Subject: Joint Commission Survey Results

Purpose:

To inform the Committee of the results of El Camino Hospital's Joint Commission Triennial Survey; December 17-21, 2018.

Summary:

1. Situation: The Joint Commission ("TJC") Survey is conducted every 3 years and with CMS deemed status, enables the hospital to receive Medicare/Medical payments.

2. Authority: CMS

3. Background: N/A

4. Assessment: New TJC survey approach, called the Safer Matrix includes "see one – cite one" and results in many findings. However, El Camino Hospital Acute Hospital results were very good with only 36 total findings and none in the high harm or immediate threat to life categories. Behavioral Health had only 2 findings. Further detail will be presented at the meeting.

5. Other Reviews: N/A

6. Outcomes: 3-year continued Accreditation for the Acute Hospital and Behavioral Health.

List of Attachments:

1. None

Suggested Committee Discussion Questions:

1. None

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Hospital Update
January 16, 2019
Mark Adams, MD, CMO

Quality and Safety

On December 21, 2018, the Joint Commission surveyors departed after their weeklong unannounced tri-annual survey which reviewed, among others, 268 standards, 1,622 elements of performance along with 16 National Patient Safety Goals. The Joint Commission works with hospitals to assess risk and improve processes that keep our patients safe. Subsequent to their visit, El Camino Hospital has received full accreditation from The Joint Commission.

Operations

We are launching the General Inpatient Hospice (GIP) program with Pathways as our partner this month. This program allows for patients who are hospice eligible, but too ill to go to their own home, to stay in the inpatient setting having high level care with the benefit of hospice care as well. Pathways will provide the hospice services while the patient is still an inpatient at ECH.

To further enhance orthopedic joint replacement surgery, an investment in a specialty designed robot for orthopedic joint replacement was approved. The addition of robotic assisted joint replacements will, as evidenced by clinical research, provide better quality outcomes for surgical knee and hip replacements, including more accurate placement of the artificial joint, reduced pain, faster recovery, and shorter hospital stays. Several orthopedic surgeons are currently being trained to utilize this new technology.

Facilities

In October, the Board authorized management to negotiate a purchase and sale agreement for the medical office property located at 700 W. Parr Ave. in Los Gatos at a cost not to exceed $14.5 million. The negotiations resulted in a Purchase and Sale Agreement with the cost of the property being $13,250,000. Additionally our brokers' fee of $245,000 was paid outside of Escrow which closed on December 21, 2018. We notified LAFCO before the close of Escrow and we took possession of the property on December 22, 2018.

Workforce

We launched the Enterprise Resource Planning (ERP) project on December 3, 2018. The cross-functional team from Human Resources, Finance, Payroll, and Supply Chain has been engaged in the planning of this project with the vendor since September and we are currently in the architect phase of the project plan before the work in configuring and building prototypes begins in late spring.

The 52nd Annual Employee Service Awards will be held at The Computer History Museum on Thursday, January 31st. Over 200 employees will be recognized for their service to El Camino Hospital ranging from 15 to 45 years of service. We will also be recognizing employees, leaders, and physicians who have been nominated by their peers for annual recognition in four different categories.

To promote employee career development, we will be hosting the first-ever Career Development Fair on January 29th from 7:30AM to 4 PM. More than 15 colleges and universities are expected to attend.

Marketing and Communications

We held this year's final Healthy Mind events at Monta Vista High School with FUHSD. In the last two years covering five schools, this program has reached up to 10,626 students and over 250 parents who have attended evening presentations.

Information Services

The Change Radiology PACS system implemented at ECH in December delivers a faster, more efficient reading experience with better diagnostic tools for our radiologists in both imaging and breast health services than our previous system. The radiologists' and physicians' feedback have been positive with several commenting that this was the "smoothest PACS implementation they have experienced," while noting that the new system is much easier to use. In addition, Vital Vitrea, a powerful advanced visualization solution that allows for 3D viewing and semi-automated measurements was implemented. We are the first organization to fully integrate Vitrea with our Change Radiology PACS, which gives our radiologists a new cohesive reading workflow.

During December, the new SMVD ENT Clinic on Grant Road went live on the Epic System. The total number of physicians implemented on Epic in ECH clinics is 15 with an additional 6 physicians using Epic in their offices as part of the Community Connect program.

iCare now has the ability to use a navigator for advanced care planning along with the ability to access Advance Care Planning videos. We integrated Epic with Open Placement, an external web application that integrates with Epic and the Allen TVs in patient rooms. Case Managers/ Care Coordinators launch the web application from Epic to select post-acute care facilities for patients. Patients can then review those options on the TVs in their room, or can request family members complete the review for them

Since go-live in November 2015, ECH has shared over 10 million records with other Epic organizations with sharing of information to 50 states, 1629 hospitals, 1445 Emergency Departments, and 37,006 Clinics.

MyChart Bedside was implemented in the Mother-Baby Unit and NICU with 45% enrollment of patients which is over the Epic benchmark of 40%. Patients surveyed have responded with high satisfaction with the use of MyChart Bedside.

Corporate and Community Health

This year, we introduced a new web version of our Community Benefit Annual Report, enabling broader promotion. Print and online distribution reached community members and stakeholders including elected officials, ECH Foundation Board, Community Benefit partners, ECH employees and physicians, and patients and consumers via social media. The new microsite experienced a 99% increase in page views and 66% increase in unique visits in its first month compared to

the first four months of last years' report. A first-ever email blast reached 220% more people than in FY17, showing high audience engagement:

The South Asian Heart center transitioned STOP-D (stop diabetes before it starts) program participants to the next 16-week semester with improvement in weight.

Each year, 80 dedicated, smart, and multi-talented volunteers participate in and help with the Chinese Health Initiative's community education efforts. Thirty volunteers attended our annual volunteer orientation/appreciation event on December 10th and shared their experiences and stories of why they volunteer. Several mentioned that they were immigrants and it means a lot to them to help other immigrants and serve the hospital community.

Government and Community Relations

ECH hosted two large civic leadership classes this month. Leadership Mountain View spent December 7 at ECH/MV learning about hospital services, community health needs, health technology, and mental health. On December 14th, Leadership Los Gatos met at our Los Gatos hospital, with similar programming provided by ECH staff.

Philanthropy

The El Camino Hospital Foundation has a fundraising goal of $6,175,000 for FY 2019 and as of November 30 has secured $2,363,943. The Foundation currently has more than $15.5 million in major and planned gift proposals in the pipeline supporting capital and programmatic priorities, scheduled to close in FY19. See the attached detailed report.

Auxiliary

The Auxiliary contributed 5,268 volunteer hours in December 2018.

Hospital Compare Overall Hospital Quality Star Rating

Below is the preview of the CMS Star Ratings Report which will be publicly released in February 2019. There are 7 categories of measures and each has a different data collection period. The report is summarized in the chart below.

Measure Group	Data inclusion period	# of measures	Measure weight in Star rating	ECH Measure Group Score	National Group Score (comparison)	Performance Category
Mortality	7/1/2014 – 6/30/2017	7	22.0%	0.37	0.0005	Same as national average
Readmission	7/1/2014-6/30/2017	9	22.0%	0.47	-0.6	Above the national average
Safety of Care	4/1/2017-3/31/2018	8	22.0%	0.15	-0.4	Above the national average
Patient Experience	4/1/2017-3/31/2018	10	22.0%	0.53	-0.001	Above the national average
Efficient Use of Medical Imaging	7/1/2016-6/30/2017	5	4.0%	0.44	0.005	Same as national average
Timeliness of Care *	4/1/2017-3/31/2018	7	4.0%	-0.49	-0.02	Below the national average
Effectiveness of Care	Varied by measure between 1/1/2017 – 3/31/2018	11	4.0%	-0.21	0.03	Same as national average

*The attached Table 3 shows what measures under *Timeliness of Care* contribute to the "below national average" result:

- Ed-1b: Median time from ED Arrival to ED Departure for Admitted ED Patients : at 325 minutes with mean national score of 273 minutes
- OP-18b: Median time from ED arrival to ED Departure for Discharged ED Patients: 172 minutes with a mean national score of 142 minutes

Table 1: Overall Hospital Quality Star Rating Results for Your Hospital and the Nation
EL CAMINO HOSPITAL
Results corresponding with data for January 2019 public reporting on Hospital Compare

Overall Hospital Rating Results	Your Hospital's Results	National Average
Star Rating [a]	**** (4 out of 5 stars)	*** (3 out of 5 stars)
Hospital Summary Score [b]	0.32	-0.02
Hospital Summary Score Confidence Interval - Lower Limit [c]	0.15	--
Hospital Summary Score Confidence Interval - Upper Limit [c]	0.50	--

[a] A star rating is categorized as one to five whole stars or "N/A". A greater number of stars indicates better performance. The National Average column shows the average star rating across the nation.
[b] A summary score is used to determine the star rating category and is calculated from each hospital's measure group scores shown in Table 2. A higher summary score indicates better performance.
[c] The 95% confidence interval for your hospital's summary score. The lower confidence limit and upper confidence limit are provided, with a 95% confidence that your performance falls within this range for summary scores.

The following Table 3 includes the individual Measure Score for El Camino Hospital for the Overall Hospital Quality Star Rating.

Table 3: Individual Measure Score Results for the Overall Hospital Quality Star Rating
EL CAMINO HOSPITAL
Results corresponding with data for January 2019 public reporting on Hospital Compare

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result on *Hospital Compare* [d]	Measure's National Mean of Scores [e]	Measure's Standard Deviation Across Hospitals [f]	Your Hospital's Standardized Measure Score [g]
Mortality	MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	11.1%	13.2%	0.01	1.73
Mortality	MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate	4.2%	3.2%	0.01	-1.02
Mortality	MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	8.2%	8.4%	0.01	0.18
Mortality	MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	11.4%	11.8%	0.02	0.26
Mortality	MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	15.3%	15.9%	0.02	0.29
Mortality	MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	13.8%	14.3%	0.02	0.32
Mortality	PSI-4-SURG-COMP	Death Rate Among Surgical Inpatients with Serious Treatable Complications	169.22	161.78	17.03	-0.44
Readmission	EDAC-30-AMI	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	29.4	7.1	22.68	-0.98
Readmission	READM-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate	12.3%	13.2%	0.01	0.69
Readmission	READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	20.8%	19.6%	0.01	-1.04
Readmission	EDAC-30-HF	Excess Days in Acute Care after Hospitalization for Heart Failure	11.4	4.5	25.14	-0.28
Readmission	READM-30-Hip-Knee	Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	3.5%	4.2%	0.005	1.40
Readmission	EDAC-30-PN	Excess Days in Acute Care after Hospitalization for Pneumonia (PN)	9.0	4.7	24.56	-0.18
Readmission	READM-30-STK	Stroke (STK) 30-Day Readmission Rate	11.0%	11.9%	0.01	1.05
Readmission	READM-30-HOSP-WIDE	HWR Hospital-Wide All-Cause Unplanned Readmission	14.9%	15.3%	0.01	0.51
Readmission	OP-32	Facility Seven-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	15.4	14.8	0.85	-0.75
Safety of Care	HAI-1	Central-Line Associated Bloodstream Infection (CLABSI)	0.486	0.783	0.66	0.45
Safety of Care	HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)	1.606	0.857	0.71	-1.06
Safety of Care	HAI-3	Surgical Site Infection from Colon Surgery (SSI-colon)	0.174	0.856	0.72	0.95
Safety of Care	HAI-4	Surgical Site Infection from Abdominal Hysterectomy (SSI-abdominal hysterectomy)	0.498	0.896	0.86	0.46
Safety of Care	HAI-5	MRSA Bacteremia	0.479	0.886	0.73	0.56
Safety of Care	HAI-6	Clostridium Difficile (C.difficile)	0.514	0.772	0.52	0.50
Safety of Care	COMP-HIP-KNEE	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	2.3%	2.6%	0.01	0.57
Safety of Care	PSI-90-Safety	Patient Safety and Adverse Events Composite	0.97	0.99	0.17	0.14
Patient Experience	H-CLEAN-HSP	Cleanliness of Hospital Environment	89	88	3.81	0.25
Patient Experience	H-COMP-1	Nurse Communication	92	91	2.61	0.25
Patient Experience	H-COMP-2	Doctor Communication	93	91	2.53	0.62
Patient Experience	H-COMP-3	Responsiveness of Hospital Staff	85	86	4.33	-0.17
Patient Experience	H-COMP-5	Communication About Medicines	79	79	4.27	-0.04
Patient Experience	H-COMP-6	Discharge Information	87	87	3.52	-0.06
Patient Experience	H-HSP-RATING	Overall Rating of Hospital	91	88	3.31	0.76
Patient Experience	H-QUIET-HSP	Quietness of Hospital Environment	81	82	5.17	-0.24
Patient Experience	H-COMP-7	HCAHPS 3 Item Care Transition Measure	83	82	2.74	0.39
Patient Experience	H-RECMND	Willingness to Recommend Hospital	93	88	4.34	1.13
Efficient Use of Medical Imaging	OP-8	MRI Lumbar Spine for Low Back Pain	N/A	40.4%	0.07	--
Efficient Use of Medical Imaging	OP-10	Abdomen CT Use of Contrast Material	5.0%	7.8%	0.08	0.37
Efficient Use of Medical Imaging	OP-11	Thorax CT Use of Contrast Material	1.0%	2.2%	0.04	0.29
Efficient Use of Medical Imaging	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	2.6%	4.4%	0.02	0.95
Efficient Use of Medical Imaging	OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	0.6%	0.9%	0.01	0.36

Measure Group [a]	Measure ID [b]	Measure Name [c]	Your Hospital's Measure Result on *Hospital Compare* [d]	Measure's National Mean of Scores [e]	Measure's Standard Deviation Across Hospitals [f]	Your Hospital's Standardized Measure Score [g]
Timeliness of Care	ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	325	273	109.63	-0.47
Timeliness of Care	ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	84	101	69.21	0.24
Timeliness of Care	OP-1	Median Time to Fibrinolysis	TFH	TFH	TFH	TFH
Timeliness of Care	OP-2	Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department Arrival	TFH	TFH	TFH	TFH
Timeliness of Care	OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	N/A	62	36.79	--
Timeliness of Care	OP-5	Median Time to ECG	4	8	6.01	0.71
Timeliness of Care	OP-18b/ED-3	Median Time from ED Arrival to ED Departure for Discharged ED Patients	172	142	42.05	-0.72
Timeliness of Care	OP-20	Door to Diagnostic Evaluation by a Qualified Medical Professional	14	22	13.50	0.59
Timeliness of Care	OP-21	ED-Median Time to Pain Management for Long Bone Fracture	51	50	17.37	-0.06
Effectiveness of Care	IMM-2	Influenza Immunization	94%	91%	0.14	0.22
Effectiveness of Care	OP-4	Aspirin at Arrival	93%	95%	0.07	-0.25
Effectiveness of Care	IMM-3/OP-27	Healthcare Personnel Influenza Vaccination	76%	87%	0.13	-0.84
Effectiveness of Care	OP-22	ED-Patient Left Without Being Seen	1%	2%	0.02	0.35
Effectiveness of Care	OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	65%	74%	0.19	-0.48
Effectiveness of Care	OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	55%	87%	0.19	-1.66
Effectiveness of Care	OP-30	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	85%	91%	0.14	-0.42
Effectiveness of Care	OP-33	External Beam Radiotherapy for Bone Metastases	N/A	86%	0.18	--
Effectiveness of Care	PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation	3%	2%	0.04	-0.32
Effectiveness of Care	SEP-1	Severe Sepsis and Septic Shock	62%	51%	0.19	0.59
Effectiveness of Care	VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism	0%	3%	0.06	0.47

[a] The measure group to which this measure is assigned.
[b] ID associated with each measure and corresponds with the measure ID on *Hospital Compare*.
[c] Measure name to describe each measure.
[d] Your hospital's measure result that will be publicly reported on Hospital Compare in January 2019.
[e] The national mean score for each measure based on the distribution of measure scores across all hospitals.
[f] The standard deviation for each measure based on the distribution of hospital results. The standard deviation is the same for all hospitals across the nation in this release of the Star Rating.
[g] Your hospital's standardized measure score. The standardized measure score may have been flipped so that a higher score means a better score. Winsorization may have been applied to the standardized measure score. Winsorization takes hospitals with standardized measure scores greater than +3 or less than -3 and sets them equal to +3 or -3, respectively. Your hospital's standardized measure score is calculated using the following formula: (Column D [Your Hospital's Measure Result on Hospital Compare] - Column E [Measure's National Mean of Scores] / Column F (Measure's Standard Deviation Across Hospitals]). Please note that the standardized measure score is multiplied by -1 for measures where a lower rate is better. See the Overall Hospital Rating Methodology Report posted on QualityNet for more information on how your hospital's standardized measure score is calculated.

Notes:
1. N/A = Measure will not be reported for your hospital on Hospital Compare in January 2019. Your hospital will not receive a standardized score for this measure.
2. -- = A standardized score for this measure was not calculated for your hospital because the measure will not be reported for your hospital on Hospital Compare in January 2019.
3. TFH = Measure results not available because there are too few hospitals reporting the measure for this reporting quarter. This measure is not used in the star rating calculation for this quarter.
4. SNL = Measures with statistically significant negative loading are not included in the star rating calculation.